



State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

April 8, 2014

TO: ALL COUNTY WELFARE DIRECTORS Letter No.: 14-18
ALL COUNTY WELFARE ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS
ALL COUNTY MEDS LIAISONS

SUBJECT: Policies and Procedures for Annual Renewal and Change in Circumstance Redeterminations and Discontinuance from Medi-Cal

The Department of Health Care Services (DHCS) is providing guidance as a result of Assembly Bill (AB) x1 1, Chapter 3, Statutes of 2013, as well as recent guidance provided by the federal Centers for Medicare & Medicaid Services (CMS) on the Affordable Care Act of 2010 (ACA). This letter is to provide the Statewide Automated Welfare Systems (SAWS) and counties with policy guidance.

This guidance is focused on policies and procedures for discontinuing a Medi-Cal beneficiary at annual or change in circumstance redeterminations. This guidance will address discontinuances for both MAGI and Non-MAGI Medi-Cal beneficiaries.

Background

As stated in Welfare and Institutions Code (WIC) Section 14005.37, Medi-Cal beneficiaries must be evaluated for all Medi-Cal programs before they are discontinued from benefits and forwarded to Covered California to be evaluated for Advanced Premium Tax Credits (APTC) or Cost Sharing Reductions (CSR). This means that when a beneficiary is no longer eligible for MAGI Medi-Cal, he/she must be evaluated for Non-MAGI Medi-Cal if potentially eligible on a Non-MAGI basis before being discontinued from benefits. Similarly, when a beneficiary is no longer eligible for Non-MAGI Medi-Cal, he/she must be evaluated for MAGI Medi-Cal before being discontinued from benefits. The beneficiary must remain on the appropriate Medi-Cal program which they were on prior to the renewal or change in circumstances until all applicable bases for eligibility are evaluated. Counties are instructed to conduct an ex parte review of available information, as prescribed in WIC 14005.37 so that a beneficiary is requested to provide information **only** after an ex parte review is

conducted, and **only** if the ex parte evaluation is unsuccessful in establishing ongoing eligibility.

The exception to this rule is when a Medi-Cal beneficiary fails to cooperate. Since MAGI and Non-MAGI Medi-Cal programs have different eligibility rules, beneficiaries may be required to submit different types of documentation depending on what they are being evaluated for. If, after all ex parte reviews have been completed and more information is needed and requested of the beneficiary, the beneficiary fails to provide the requested information or documentation within the timeframes, after being given a reasonable opportunity period to provide the information or documents, the beneficiary shall be discontinued from benefits for lack of cooperation after the proper NOA has been provided. Beneficiaries who turn in documents late after discontinuance will still be evaluated under the 90 day period to cure.

The purposes of this letter is to provide guidance to counties when beneficiaries are being discontinued from Medi-Cal after the ex parte review has been unsuccessful, and after they have provided all the requested documentation needed to make an eligibility determination, because they are determined based on the information provided to be ineligible for either MAGI or Non-MAGI Medi-Cal.

Medi-Cal Beneficiary Discontinued From MAGI Medi-Cal

As a result of an annual redetermination or change in circumstance redetermination, a MAGI Medi-Cal beneficiary may be determined no longer eligible for MAGI Medi-Cal. Prior to evaluating the beneficiary for APTC/CSR benefits, the beneficiary must be evaluated for Non-MAGI Medi-Cal programs if potentially linked on a Non-MAGI basis. Upon adjudicating the redetermination and finding the beneficiary no longer MAGI eligible, the county shall take the steps below to assist in determining if the beneficiary has eligibility for Medi-Cal on the basis of Non-MAGI Medi-Cal.

Potential Linkage to Non-MAGI Medi-Cal

If the beneficiary has a potential linkage to a Non-MAGI Medi-Cal program, the beneficiary shall be evaluated using the Non-MAGI Medi-Cal rules. Counties shall conduct an ex parte review of all available information in an attempt to establish Non-MAGI Medi-Cal eligibility. If the county cannot establish Non-MAGI eligibility by completing the ex parte review, the county shall promptly send the beneficiary the Non-MAGI Screening Packet. In doing so, the county may only ask for information or documents not already available or identified for the county through the ex parte review.

Please Note: Based on information submitted on required redetermination forms established by the department, non-disabled, non-blind, non-parent/caretaker, non-pregnant individuals between the ages of 22-64 who are not in long term care and who do not have any other form of linkage to non-MAGI Medi-Cal, shall be immediately evaluated for APTC/CSR benefits upon being determined ineligible for MAGI Medi-Cal.

All other persons should be considered potentially eligible for Non-MAGI Medi-Cal.

Non-MAGI Screening Packet

The Non-MAGI Screening Packet consists of the following forms:

1. **The Non-MAGI Informing Letter:** The Non-MAGI Informing letter has multiple objectives:
 - a. Informs the beneficiary that he/she does not or no longer qualifies for MAGI Medi-Cal
 - b. Informs the beneficiary that he/she may still qualify for Non-MAGI Medi-Cal
 - c. Provides an overview of Non-MAGI Medi-Cal and APTC/CSR
 - d. Informs the beneficiary that he or she will be enrolled in no Share of Cost (SOC) Non-MAGI Medi-Cal if found eligible when the requested information is returned to the county.
2. **MC 604 IPS:** The MC 604 IPS acquires the necessary Non-MAGI asset, income, and deduction information to evaluate an individual for Non-MAGI eligibility when such information has not been obtained through the ex parte review process summarized above.
3. **The Non-MAGI Medi-Cal Brochure:** Entitled "Other Medi-Cal Programs," the brochure provides the beneficiary with detailed information about the Non-MAGI program, including how Non-MAGI eligibility is determined and what information the beneficiary will need to provide in order to qualify.
4. **The APTC/CSR Brochure:** The brochure provides the beneficiary with information about APTC and CSR.

The beneficiary shall be given 30 days from the date the letter is mailed to complete and return the Non-MAGI Screening Packet.

Evaluation for Non-MAGI Medi-Cal

If the county has enough information via the ex parte review, or the beneficiary returns the MC 604 IPS or otherwise provides the necessary information, to conduct a Non-MAGI eligibility determination, the county shall attempt to determine Non-MAGI Medi-Cal eligibility.

If the individual is found eligible for a Non-MAGI Medi-Cal program, the county shall immediately move the individual to the corresponding aid code and notice the beneficiary appropriately. The county shall also update the case in the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) so that CalHEERS knows the beneficiary is now enrolled in Non-MAGI Medi-Cal.

Please Note: If the individual is found eligible for Medi-Cal with a SOC, the county shall call the CalHEERS Business Rules Engine (BRE) to determine eligibility for APTC/CSR.

Individuals have the option of having SOC Medi-Cal, SOC Medi-Cal and APTC/CSR, or APTC/CSR. If the individual is found eligible for APTC/CSR, the individual can choose to enroll in the program or not.

If the individual is found not eligible for a Non-MAGI Medi-Cal program, the county shall immediately rerun the beneficiary through the CalHEERS BRE to determine APTC/CSR eligibility. If the beneficiary is found eligible for APTC/CSR benefits, the county shall assist the individual in completing the enrollment process into APTC/CSR including assisting with health plan selection if so requested. Once the beneficiary's eligibility determination for APTC/CSRs is complete, the county shall send the beneficiary a timely discontinuance notice and discontinue the beneficiary's Medi-Cal benefits.

Please Note: During the Non-MAGI evaluation process, the beneficiary shall remain in his/her existing MAGI Medi-Cal aid code to the extent possible. If, because of lack of system functionality with the applicable SAWS, the beneficiary cannot be left in his/her existing aid code, the beneficiary shall be moved into aid code 38 if the beneficiary is receiving full-scope benefits or aid code 58 if the beneficiary is receiving restricted scope benefits.

Evaluation for APTC/CSR

If the beneficiary elects to disenroll from the Medi-Cal program and to be evaluated instead for APTC/CSR benefits, the county shall promptly rerun the beneficiary through the CalHEERS BRE to determine APTC/CSR eligibility. If the beneficiary is found eligible for APTC/CSR benefits, the county shall assist the individual in completing the enrollment process into APTC/CSR including assisting with health plan selection if so requested. Once the beneficiary's eligibility determination for APTC/CSRs is complete, the county shall send the beneficiary a timely discontinuance notice and discontinue the beneficiary's Medi-Cal benefits

Beneficiary Fails to Respond

If, after 30 days, and after at least one attempt to contact the beneficiary by phone or other means preferred by the beneficiary, the beneficiary fails to return the Non-MAGI Screening Packet, or otherwise provide the requested information, the beneficiary shall be discontinued from Medi-Cal only after the beneficiary is sent a timely discontinuance Notice of Action and after the required notice period, if the person does not make a timely appeal and request aid pending the appeal. The beneficiary shall be immediately evaluated for APTCs and forwarded to Covered California.

Please Note: If the beneficiary provides the requested information prior to this discontinuance action taking affect, the county shall rescind the discontinuance action and properly work the case.

The county shall ensure that the beneficiary is properly noticed of the discontinuance action. Upon discontinuance, the beneficiary is given a 90-day cure period. During the

cure period, if the beneficiary provides the needed information, the county shall treat the information as if it were received timely, and immediately determine eligibility. If eligibility is found, eligibility shall be granted back to the date of discontinuance.

Medi-Cal Beneficiary Discontinued from Non-MAGI Medi-Cal

As a result of an annual redetermination or change in circumstance redetermination, a Non-MAGI Medi-Cal beneficiary may be determined no longer eligible for Non-MAGI Medi-Cal. Prior to discontinuing the beneficiary, the county must evaluate the individual for MAGI Medi-Cal.

Request For Tax Household Information (RFTHI) Redetermination Packet

In order to determine the Non-MAGI Medi-Cal beneficiary for MAGI Medi-Cal, the county must send the beneficiary the RFTHI Redetermination Packet. As prescribed in WIC Section 14005.37, the beneficiary shall be given 30 days from the date the form is mailed to return the packet.

Please Note: Prior to sending the beneficiary the RFTHI Redetermination Packet, the county shall conduct an ex parte review to see if the tax household information is already known. For example, if the Non-MAGI beneficiary is in a household with MAGI individuals, it is likely that the tax household information is already known about the Non-MAGI individual. As such, the RFTHI Redetermination Packet shall not be sent to the beneficiary and the known tax household information shall be used to conduct a MAGI eligibility determination.

MAGI Medi-Cal Evaluation

The beneficiary can return the RFTHI Redetermination Packet by mail, or convey its contents over the phone, by fax, or in person and must be documented in the case. If the RFTHI Redetermination Packet is not returned and its information is not provided by the beneficiary, follow the related guidance in the "Process Exceptions" on page 6..

Please Note: The beneficiary is not required to submit any supporting documentation with the beneficiary's responses to the questions asked in the RFTHI Redetermination Packet. The packet is only to acquire information to be verified through the federal verification hub and available state data sources. Documentation shall only be required to the extent that the electronic verification through the CalHEERS BRE finds the information not reasonably compatible or cannot verify information that must be verified and the information is not available via ex-parte review. In such cases, follow the reasonable opportunity process for the beneficiary to respond to address the incompatibility, as set forth below.

County Responsibility After Sending the RFTHI Redetermination Packet

As prescribed in WIC Section 14005.37, if during the 30-day period the beneficiary has not returned the RFTHI Redetermination Packet, or has not otherwise provided all of the

requested information, the county shall first complete an ex-parte review to attempt to verify information. If the information is unavailable or cannot be verified, the county must attempt to contact the beneficiary requesting the information and provide a 10-day deadline following the contact. Contact can be attempted via the Internet, by telephone, or by other means available to the county and should be conducted according to the beneficiary's preferred method of contact if a method has been identified as required by WIC section 14005.37 and the county has the capabilities to do so. This information must be documented in the case file.

Eligibility is Determined

Once the RFTHI Redetermination Packet is returned, or information is otherwise provided, the SAWS shall use the CalHEERS BRE to determine continued Medi-Cal eligibility. If the beneficiary is found MAGI Medi-Cal eligible, the county shall ensure the beneficiary is placed in the appropriate aid code and send a corresponding Notice of Action. If the beneficiary is found APTC/CSR eligible, the county shall immediately discontinue the beneficiary from Medi-Cal and send the appropriate Notice of Action.

Process Exceptions

RFTHI Redetermination Packet Not Returned and Information Not Provided

If after 30 days, during which time the county has attempted to reach the beneficiary as discussed above following the ex parte review, the Medi-Cal beneficiary does not return the RFTHI Redetermination Packet, or does not provide all the requested information and the information is not available from an ex parte review in SAWS or other data sources, the beneficiary shall be sent a notice of termination and discontinued from Medi-Cal benefits at the end of the annual redetermination due month in accordance with due process requirements. The beneficiary shall be sent a Notice of Action explaining the basis for termination and the ability to cure within 90 days.

Please Note: If the beneficiary provides the requested information prior to this discontinuance action taking affect, the county shall rescind the discontinuance action and properly work the case.

The beneficiary who is discontinued shall also be notified in writing that he/she has a 90-day cure period to provide any missing information. During the cure period, if the beneficiary returns the RFTHI Redetermination Packet, or otherwise provides the requested information, the county shall treat the information as if it were received timely, immediately enter the information into the SAWS system and submit to the CalHEERS BRE as prescribed above.

If the beneficiary is subsequently found Medi-Cal eligible, the county shall grant benefits back to the date of discontinuance and notify the beneficiary that their Medi-Cal benefits have been restored back to date of discontinuance. The original application and renewal dates shall be retained in the case once benefits are restored. Please note, as

prescribed in WIC Section 14005.37(i), the submittal of the RFTHI Redetermination Packet, or the otherwise providing of the requested information, does not constitute a finding of Medi-Cal eligibility. The discontinuance action shall not be overturned until the information is run through the CalHEERS BRE and eligibility is found.

Information that is Not Reasonably Compatible

When submitting the RFTHI Redetermination Packet information through the CalHEERS BRE to determine continued Medi-Cal eligibility, if the result of the eligibility determination is not reasonably compatible, the county shall check available data sources ex parte to resolve the incompatibility, including data in SAWS and MEDS. If, after checking all available data sources, the incompatibility still cannot be resolved, the county shall immediately send the beneficiary the MC 355 form to request paper verification of the data element(s) that is (are) not reasonably compatible. For example, if income is not reasonably compatible, the MC 355 form should be sent asking only for the beneficiary to provide paper verification of income.

The MC 355 shall not ask for verification of information that was already verified through the CalHEERS BRE or other available data sources. Furthermore, the form shall not ask for information that is not relevant to the eligibility determination.

The beneficiary shall be given 30 days to respond to the MC 355. If during the 30-day period the beneficiary has not responded to the form, nor otherwise provided the requested information, the county shall attempt to contact the beneficiary requesting the information. Contact can be attempted through any of the means available to the county and should be conducted according to the beneficiary's preferred method of contact if known and must be documented in the case.

If the MC 355 is returned timely, or needed information otherwise provided, the county shall verify that the information returned is correct. For example, if the beneficiary was required to submit income verification, the county shall verify that the document submitted is a valid income document.

Once the county approves the verification document, the county shall enter the data element into the SAWS and re-submit the redetermination to the CalHEERS BRE to continue with the eligibility determination.

If the information requested through the MC 355 is not returned timely, and needed information is either not otherwise provided or is incomplete, the county shall attempt to contact the beneficiary to obtain the information. If still unsuccessful, the beneficiary shall be discontinued from Medi-Cal benefits for lack of cooperation at the end of the month at which the 30-day period ends. If the 30-day period ends prior to the annual redetermination month, the beneficiary shall not be discontinued until the end of the redetermination month.

The county shall ensure that the beneficiary is properly noticed of the discontinuance action. Upon discontinuance, the beneficiary is given a 90-day cure period. During the cure period, if the beneficiary returns the MC 355, or otherwise provides the needed information, the county shall treat the information as if it were received timely, immediately enter the information into the SAWS system and submit to the CalHEERS BRE as prescribed above.

If the beneficiary is subsequently found Medi-Cal eligible, the county shall grant benefits back to the date of discontinuance.

Please note: the submittal of the MC 355, or otherwise providing the information, does not constitute Medi-Cal eligibility. The discontinuance action shall not be overturned until the information is run through the CalHEERS BRE and eligibility is found. Once eligibility is found, the county shall provide notice to the beneficiary that his/her benefits have been restored back to the date of termination.

Missing Information

If the RFTHI Redetermination Packet is returned, or information is otherwise provided, but there is not enough information to determine eligibility for MAGI Medi-Cal, counties should immediately send the beneficiary the MC 355 form. The form should request only the information that is required to complete the MAGI eligibility determination. The beneficiary can return the form, or otherwise provide the requested information, by mail, or convey its contents over the phone, by fax, or in person and must be documented in the case file.

The beneficiary shall be given 30 days to respond to the MC 355. If during the 30-day period the beneficiary has not responded to the form, nor otherwise provided the requested information or provided incomplete or insufficient information, the county shall attempt to contact the beneficiary requesting the information. Contact must be documented in the case and can be attempted through any of the means available to the county and should be conducted according to the beneficiaries preferred method of contact if known.

If the MC 355 is returned timely, or needed information otherwise provided, the county shall enter the data element into the SAWS and submit the redetermination to the CalHEERS BRE for an eligibility determination.

If the MC 355 is not returned timely, or needed information is either not otherwise provided or is insufficient/incomplete, the beneficiary shall be discontinued from Medi-Cal benefits for lack of cooperation at the end of the month at which the 30-day period ends. If the 30-day period ends prior to the annual redetermination month, the beneficiary shall not be discontinued until the end of the redetermination month.

Please Note: If the beneficiary provides the requested information prior to this discontinuance action taking affect, the county shall rescind the discontinuance action and properly work the case.

The county shall ensure that the beneficiary is properly noticed of the discontinuance action. Upon discontinuance, the beneficiary is given a 90-day cure period. During the cure period, if the beneficiary returns the MC 355, or otherwise provides the needed information, the county shall treat the information as if it were received timely, immediately enter the information into the SAWS system and submit to the CalHEERS BRE as prescribed above.

If the beneficiary is subsequently found Medi-Cal eligible, the county shall grant benefits back to the date of discontinuance and the original application and renewal dates shall be retained on the case.

Please note: the submittal of the MC 355, or otherwise providing the information, does not constitute Medi-Cal eligibility. The discontinuance action shall not be overturned until the information is run through the CalHEERS BRE and eligibility is found. Once eligibility is found, the county shall provide notice to the beneficiary that his/her benefits have been restored back to the date of termination.

Beneficiary Determined Eligible for APTC/CSR

If a beneficiary is determined to be ineligible for MAGI Medi-Cal, the beneficiary shall immediately be evaluated for APTC/CSR. In this situation, the beneficiary has been found ineligible for Medi-Cal as both Non-MAGI and MAGI Medi-Cal determinations have been made. A Medi-Cal discontinuance NOA shall be sent timely to the beneficiary and the beneficiary can be terminated after the required notice period, if the person does not make a timely appeal and request aid pending the appeal.

Loss of Contact

If the RFTHI Redetermination Packet is sent back, such as "return to sender," or "no forwarding address" the county shall attempt to contact the beneficiary as required in WIC section 14005.37(c). This shall include first, an ex parte review of information available to the county in SAWS about the beneficiary or his or her family members, such as from a CalFresh file with more current contact information for the beneficiary, and, then, if necessary, by attempting to contact the beneficiary via the Internet, by telephone, or by other means available to the county according to the beneficiary's preferred method of contact if a method has been identified. Attempts to contact the beneficiary shall be documented in the case. For beneficiaries other than former foster youth, if all required attempts at contact fail, the county shall send a notice of discontinuance. If contact cannot be made with former foster youth, eligibility shall not be discontinued but the individual shall be placed in fee-for-service Medi-Cal.

April 8, 2014

As required by WIC Section 14005.28 (a)(3), former foster youth are to receive a simplified annual renewal packet and should not receive the RFTHI Packet. If a county receives an RFTHI packet as return to sender or otherwise undeliverable, before proceeding with the steps to discontinuance, the county shall check all available sources to see if the beneficiary is a former foster youth. Former foster youth up to age 26 shall not be discontinued due to a loss of contact. Rather, they shall be placed into fee-for-service Medi-Cal.

If you have any questions, please contact Braden Oparowski by phone at (916) 552-9570 or by email at Braden.Oparowski@dhcs.ca.gov.

Original Signed By:

Tara Naisbitt, Chief
Medi-Cal Eligibility Division

Attachments