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

JENNIFER KENT
Director

EDMUND G. BROWN JR.
Governor

October 9, 2015

To: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY PUBLIC HEALTH DIRECTORS
ALL COUNTY MENTAL HEALTH DIRECTORS

Letter No: 15-33

SUBJECT: Discontinuance Notice of Action – Over Income and Not Otherwise Medi-Cal Eligible

Purpose

The purpose of this All County Welfare Directors Letter (ACWDL) is to provide clarification to counties and Statewide Automated Welfare Systems consortia on the requirements for issuing a Notice of Action (NOA) to individuals who lose Medi-Cal eligibility as a result of the following:

- Being over income for the appropriate Modified Adjusted Gross Income (MAGI) program;
- Not eligible for Consumer Protection Programs (CPP); and
- Having no potential eligibility for Non-MAGI Medi-Cal programs after ex parte review or declining a non-MAGI assessment.

Currently, the approval notice generated by the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) for individuals who are discontinued from MAGI Medi-Cal and transitioned to coverage with Advanced Premium Tax Credit (APTC) through Covered California indicates ineligibility for Medi-Cal. However, this notice may not be received prior to discontinuance and does not clearly state what day Medi-Cal eligibility will end. Therefore, the Department of Health Care Services (DHCS) is taking measures to clearly indicate the Medi-Cal discontinuance status to impacted beneficiaries prior to the discontinuance and transition, should it occur. There may be other MAGI beneficiaries who are found Medi-Cal ineligible for reasons other than the reason provided in this ACWDL. Future guidance will be issued to address any gaps that are brought to DHCS' attention that may result in individuals not receiving an appropriate Medi-Cal discontinuance NOA.

Discontinuance NOAs for Loss of Medi-Cal due to Over Income for MAGI Limit

An over income eligibility determination for Medi-Cal may result from a change in circumstances, such as an increase in income, change in household size, or an individual's age where program eligibility is based on age and income limits. Effective immediately, counties must ensure that a timely and adequate manual discontinuance notice is issued to all individuals who lose eligibility for Medi-Cal due to an increase in income for the appropriate MAGI eligibility group, where the individual has no potential eligibility for CPP or non-MAGI Medi-Cal after ex parte review or who declines an assessment for non-MAGI Medi-Cal after receiving the non-MAGI screening packet. Please see ACWDL 14-18 for guidance on the ex parte and non-MAGI review process. Sending the discontinuance notice to individuals losing Medi-Cal for the reasons outlined in this ACWDL is required whether or not an individual has new eligibility for APTCs, Cost Sharing Reductions or unsubsidized coverage per Welfare and Institutions (W & I) Code, Section 14005.37(o).

Note: Please refer to ACWDL 14-18 for information about individuals who are no longer eligible for MAGI Medi-Cal and are approved for Non-MAGI Medi-Cal.

Over Income NOA Included with this ACWDL

Included with this letter is the manual discontinuance NOA (Attachment 1) that counties must use to notify individuals of their discontinuance from Medi-Cal, where the individual has no potential eligibility for CPP or non-MAGI Medi-Cal after ex parte review or who declines an assessment for non-MAGI Medi-Cal and the individual is over income for the appropriate Medi-Cal program. Counties must ensure that the appropriate boxes within the NOA are marked to identify the specific reason(s) the individual was determined to be over income for the Medi-Cal program. Counties must check one or more of the boxes depending on the individual's circumstances.

The chart below lists the rules and regulations that must be listed on the discontinuance NOA when income is found above the MAGI Federal Poverty Level (FPL) limit, depending on the individual's circumstances.

Rules and Regulations – Income Is Above MAGI FPL

Parent/Caretaker Relative	CA W & I Code §§ 14005.30, 14005.64
Undocumented Parent/Caretaker Relative	CA W & I Code §§ 14005.30, 14005.64, CA Code Regs. tit. 22, § 50302
Adults 19-64 Years Old	CA W & I Code §§ 14005.60, 14005.64
Undocumented Adults 19-64 Years Old	CA W & I Code §§ 14005.60, 14005.64, CA Code Regs. tit. 22, § 50302
Full Scope Pregnant Women	Current full-scope up to 60%, use: CA W & I. Code §§ 14005.1, 14050.1, 14005.64
	Once full scope is 109%, use: CA W & I Code §§ 14005.22, 14005.64
	Once full scope is 138%, use: CA W & I Code §§ 14005.22, 14005.225, 14005.64
Undocumented Pregnant Women up to 60 percent	CA W & I Code §§ 14005.1, 14050.1, 14005.64, CA Code Regs. tit. 22, § 50302
Limited Scope Pregnant Women	CA W & I Code § 14005.64
Undocumented Pregnant Women up to 213 percent	CA W & I Code § 14005.64, CA. Code Regs. tit. 22, § 50302
Children - 6-18 years old, 0-138 percent FPL	CA W & I. Code § 14005.64
Undocumented Children – 6-18 years old, 0-138 percent FPL	CA W & I Code § 14005.64, CA Code Regs. tit. 22, § 50302
Children - 6-18 years old, 139 percent-266 percent	CA W & I Code §§ 14005.26, 14005.64
Undocumented Children - 6-18 years old, 139 percent-266 percent	CA W & I. Code §§ 14005.26, 14005.64, CA Code Regs. tit. 22, § 50302
Children - 1-5 years old, 0 -147 percent FPL	CA W & I Code § 14005.64
Undocumented Children - 1-5 years old, 0 - 147 percent FPL	CA W & I Code § 14005.64, CA Code Regs. tit. 22, § 50302
Children - 1-5 years old, 148 -266 percent FPL	CA W & I Code §§ 14005.26, 14005.64
Undocumented Children - 1-5 years old, 148 - 266 percent FPL	CA W & I Code §§ 14005.26, 14005.64, CA Code Regs. tit. 22, § 50302
Infant - under 1 year old, 0-213 percent FPL	CA W & I Code § 14005.64
Undocumented Infant - under 1 year old, 0-213 percent FPL	CA W & I Code § 14005.64, CA Code Regs. tit. 22, § 50302
Infant - under 1 year old, 214-266 percent FPL	CA W & I Code §§ 14005.26, 14005.64
Undocumented Infant - under 1 year old, 214-266 percent FPL	CA W & I Code §§ 14005.26, 14005.64, CA Code Regs. tit. 22, § 50302

Senate Bill 1341

Senate Bill (SB) 1341 was signed into law September 2014 and requires the Statewide Automated Welfare System (SAWS) to create and send NOAs for the Medi-Cal program, including the MAGI NOAs currently generated by CalHEERS. As a result of transitioning MAGI NOAs to SAWS, it is expected that the Over Income NOA will be programmed to generate automatically for the appropriate scenarios with the implementation of SB 1341. The manual process described in this letter is intended to be used only until such time as SAWS programs the Over Income NOA to be generated automatically.

NOA Policy Requirements

Counties are reminded that all requirements outlined in ACWDL 13-13: *Medi-Cal General Notice of Action (NOA) Policy*, including the requirement to include the NA Back 9 hearing rights information and the multilingual notification, and the requirement to adhere to timely 10-day notice must be followed.

Additionally, for MAGI eligibility evaluations, counties must include the Affordable Care Act Bureau designation on the NA Back 9, as required by the California Department of Social Services, in order to ensure the hearing requests, based on MAGI eligibility evaluations, are routed to the correct hearing location. The English and Spanish versions of the correct NA Back 9 to be used for MAGI eligibility evaluations are included with this letter as attachments 2 and 3. Counties may include the local legal aid agency within the designated area of the NA Back 9.

If you have any questions or require additional information, please contact Ms. Alison Brown at (916) 319-9565 or by email at Alison.Brown@dhcs.ca.gov.

Original Signed By

Alice Mak
Acting Chief
Medi-Cal Eligibility Division

Attachments

NOTICE OF ACTION
DISCONTINUANCE OF BENEFITS

Notice Date: _____
Case Number: _____
Worker Name: _____
Worker ID Number: _____
Worker Telephone Number: _____
Office Hours: _____
Office Address: _____

DISCONTINUANCE NOTICE FOR:
Insert Name(s) Here

We have looked at all information available to us about your circumstances and based on this information, your Medi-Cal will be discontinued on _____.

The reason your benefits are stopping is:

You no longer qualify for Medi-Cal because your household income is above the applicable Medi-Cal limit. We counted your household size and income to make our decision. This is the result of:

- ☐ A change in income
- ☐ A change in household size
- ☐ Your age is above the age range allowed, where program eligibility is based on age and income.

As a result of this determination your case has been referred for an evaluation for health coverage through Covered California. If eligible, you will receive notification from Covered California.

Please Note: Other family members with different eligibility status may receive a separate notice.

We used the information you gave us and our records to make our decision. If you have questions or think we made a mistake, or if you have more information to give us, call or write to your worker right away.

DO NOT THROW AWAY YOUR BENEFITS IDENTIFICATION CARD (BIC)
If you already have a plastic Benefits Identification Card (BIC), do not throw it away. You can use it again if you become eligible for Medi-Cal.

<_____> is the regulation or law we used to make this decision. If you think we made a mistake, you can appeal. See the reverse side of this notice to learn how to appeal. You have only 90 days to ask for a hearing. The 90 days started the day after the county sent you this notice.

YOUR HEARING RIGHTS

You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice. If you have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, a hearing may still be scheduled.

If you ask for a hearing before an action on Cash Aid, Medi-Cal, CalFresh, or Child Care takes place:

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your CalFresh benefits will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, CalFresh or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ CalFresh ☐ Child Care

While You Wait for a Hearing Decision for:

Welfare to Work:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

Cal-Learn:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

OTHER INFORMATION

Medi-Cal Managed Care Plan Members: The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

Child and/or Medical Support: The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask for it.

Hearing File: If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

TO ASK FOR A HEARING:

- **Fill out this page.**
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**
  California Department of Social Services
  State Hearings Division, ACAB
  744 P Street, MS 9-17-97
  Sacramento, CA 95814
  OR fax to 1-916-651-2789
- **Call toll free:** **or** for hearing or speech impaired who use TDD, **1-800-952-8349**.

To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST

I want a hearing due to an action by the Welfare Department of _____ County about my:

☐ Cash Aid ☐ CalFresh ☐ Medi-Cal

☐ Other (list) _____

Here's Why: _____

_____

_____

_____

_____

_____

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: _____

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED		
BIRTH DATE	PHONE NUMBER	
STREET ADDRESS		
CITY	STATE	ZIP CODE
SIGNATURE	DATE	
NAME OF PERSON COMPLETING THIS FORM	PHONE NUMBER	

☐ **I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person can be a friend or relative but cannot interpret for you.)**

NAME	PHONE NUMBER	
STREET ADDRESS		
CITY	STATE	ZIP CODE

SU DERECHO A UNA AUDIENCIA

Usted tiene derecho a solicitar una audiencia si no está de acuerdo con cualquier acción que el Condado tome. Solamente tiene 90 días para solicitar una audiencia. Los 90 días comenzaron el día después de la fecha en que el Condado le dio o envió esta notificación. Si tiene un motivo justificado para no haber solicitado una audiencia antes de los 90 días, usted todavía puede solicitar una audiencia. Si proporciona un motivo justificado, es posible que todavía se programe una audiencia.

Si solicita una audiencia antes de que entre en vigor una acción en relación a la asistencia monetaria, Medi-Cal (Programa de Asistencia Médica de California), CalFresh, o cuidado de niños:

- Su asistencia monetaria/Medi-Cal no cambiará mientras espera a que se lleve a cabo la audiencia.
- Es posible que sus servicios de cuidado de niños no cambien mientras espera a que se lleve a cabo la audiencia.
- Sus beneficios de CalFresh no cambiarán mientras espera a que se lleve a cabo la audiencia o hasta el final de su período de certificación, lo que ocurra antes.

Si la decisión de la audiencia indica que estamos en lo correcto, usted nos deberá cualquier asistencia monetaria, beneficios de CalFresh o servicios de cuidado de niños que haya recibido de más. Para que reduzcamos o descontinuemos sus beneficios antes de la audiencia, marque a continuación:

Sí, reduzcan o descontinúen: ☐ Asistencia monetaria ☐ CalFresh ☐ Cuidado de niños

Mientras que espera la decisión de una audiencia relacionada a:

Programa para la Transición de la Asistencia Pública al Trabajo *(Welfare to Work)*:

No tiene que participar en las actividades.

Es posible que reciba pagos en relación al cuidado de niños para trabajar y participar en actividades aprobadas por el Condado antes de esta notificación.

Si le dijimos que los pagos para sus otros servicios de apoyo se iban a descontinuar, no recibirá más pagos, aunque participe en la actividad.

Si le dijimos que pagaríamos sus otros servicios de apoyo, se le pagarán de acuerdo a la cantidad y de la manera que le indicamos en esta notificación.

- Para recibir esos servicios de apoyo, tiene que participar en la actividad en que el Condado le pidió que participara.
- Si la cantidad que el Condado le paga para servicios de apoyo mientras que espera la decisión de la audiencia no es suficiente para que usted pueda participar, puede dejar de participar en la actividad.

Cal-Learn (un programa de California para la educación de los padres adolescentes que reciben asistencia monetaria):

- No puede participar en el Programa de Cal-Learn si le dijimos que no le podemos asistir.
- Solamente pagaremos los servicios de apoyo de Cal-Learn si se trata de una actividad aprobada.

OTRA INFORMACIÓN

Miembros de planes de cuidado médico administrado de Medi-Cal: Es posible que la acción de esta notificación no le permita recibir servicios de su plan de salud de cuidado médico administrado. Puede comunicarse con la oficina de servicios de membresía de su plan de salud si tiene preguntas.

Mantenimiento de niños y/o en relación al cuidado de la salud: La oficina local de mantenimiento de hijos le ayudará gratuitamente a cobrar mantenimiento de hijos, aunque usted no esté recibiendo asistencia monetaria. Si ahora cobran mantenimiento de hijos para usted, continuarán haciéndolo a no ser que usted les pida por escrito que lo dejen de hacer. Le mandarán la cantidad actual de mantenimiento que se cobre pero se quedarán con los atrasos que se cobren que se le deban al Condado.

Planificación familiar: La oficina de bienestar público le dará información cuando usted la pida.

Expediente de audiencia: Si solicita una audiencia, la División de Audiencias con el Estado abrirá un expediente. Usted tiene derecho a ver este expediente antes de la audiencia y a recibir una copia de la declaración escrita de posición del Condado relacionada a su caso por lo menos dos días antes de la audiencia. Es posible que el Estado le dé el expediente de audiencia de usted al Departamento de Bienestar, y a los Departamentos de Salud y Servicios Humanos y de Agricultura de los Estados Unidos. **(Secciones 10850 y 10950 del Código de Bienestar Público e Instituciones - W&IC.)**

PARA SOLICITAR UNA AUDIENCIA:

- **Complete esta página.**
- Haga una copia de esta página y de la primera página para sus expedientes.
  Si la pide, su trabajador le dará una copia de esta página.
- **Envíe o lleve esta página a:**

  California Department of Social Services
  State Hearings Division, ACAB
  744 P Street, MS 9-17-97
  Sacramento, CA 95814

  O fax a 1-916-651-2789
- **Llame gratuitamente al: 1-855-795-0634.** Las personas sordas/con problemas del habla que usan TDD* pueden llamar al **1-800-952-8349**.

Para obtener ayuda: Puede pedir información acerca de su derecho a una audiencia o sobre oficinas de asesoramiento legal llamando a los teléfonos estatales gratuitos mencionados arriba. Es posible que pueda recibir asesoramiento legal gratuito en la oficina local de asesoramiento legal o en la oficina de defensa de los derechos relacionados a la asistencia pública.

Si no quiere ir a la audiencia solo, puede llevar a un amigo o a otra persona con usted.

PETICIÓN PARA UNA AUDIENCIA

Deseo solicitar una audiencia a causa de una acción tomada por el Departamento de Bienestar Público del Condado de _____ acerca de mi(s):

☐ Asistencia monetaria ☐ CalFresh ☐ Medi-Cal

☐ Otro (anote)_____

La razón es la siguiente:_____

_____

_____

_____

_____

☐ **Si necesita más espacio, marque aquí y adjunte otra página.**

☐ Necesito que el Estado me proporcione un intérprete gratuitamente. (Un familiar o un amigo no puede actuar como intérprete de usted en la audiencia.)

Mi idioma o dialecto es el: _____

NOMBRE DE LA PERSONA A QUIEN LE NEGARON, CAMBIARON O DESCONTINUARON LOS BENEFICIOS		
FECHA DE NACIMIENTO	NÚMERO DE TELÉFONO	
DIRECCIÓN: CALLE		
CIUDAD	ESTADO	CÓDIGO POSTAL
FIRMA	FECHA	
NOMBRE DE LA PERSONA QUE COMPLETA ESTE FORMULARIO	NÚMERO DE TELÉFONO	

☐ **Quiero que la persona nombrada a continuación me represente en esta audiencia. Doy permiso para que esta persona vea mis expedientes o vaya a la audiencia por mí. (Esta persona puede ser un amigo o familiar, pero no puede actuar como su intérprete.)**

NOMBRE	NÚMERO DE TELÉFONO	
DIRECCIÓN: CALLE		
CIUDAD	ESTADO	CÓDIGO POSTAL

*TDD: aparato de telecomunicaciones para las personas sordas