



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



EDMUND G. BROWN JR.  
Governor

Date: January 31, 2014

Medi-Cal Eligibility Division Information Letter NO.: I 14-11

TO: ALL COUNTY WELFARE DIRECTORS  
ALL COUNTY ADMINISTRATIVE OFFICERS  
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS

SUBJECT: System Workarounds and Overrides

The purpose of this Medi-Cal Eligibility Division Informational Letter (MEDIL) is to provide updated guidance on workarounds and system overrides within Statewide Automated Welfare Systems (SAWS) and the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) that are approved by the Department of Health Care Services (DHCS) for use by county eligibility workers for Medi-Cal eligibility determinations. The purpose of a workaround or override is to ensure implementation and recording of the appropriate eligibility determination when one or more automation system may not accurately implement, record, or display that information. Further, workarounds or overrides are also needed to ensure that both CalHEERS and SAWS record and/or display the same eligibility status or information in both systems, until needed system corrections can be implemented.

In addition to known defects, other situations as described in this letter and any future guidance released by DHCS, for all cases where workarounds or overrides are needed, CalHEERS and the counties should track impacted cases for purposes of reporting back to DHCS, and ensuring correct eligibility is entered into both SAWS and CalHEERS as needed. In addition, SAWS shall develop the specific instructions needed to implement the policy and processes, described below, and provide this information to DHCS. To the extent SAWS have current functionality that can support the workarounds specified in this letter; they shall leverage such functionality to support the eligibility determination process. SAWS shall provide DHCS descriptions of this functionality.

Designated county eligibility supervisors are being provisioned with CalHEERS override functionality, and will be provided further technical instructions from CalHEERS regarding the use of this functionality. Policy direction regarding the use of this functionality is provided below in the various sections. In general, counties should use this function to

January 31, 2014

ensure the same eligibility status is recorded in both systems, to minimize coverage gaps and avoid double-coverage.

As used in this guidance, Pre-Affordable Care Act (ACA) refers to an existing Medi-Cal case that has yet to transition to the new income methodology using Modified Adjusted Gross Income (MAGI) criteria and information.

DHCS will continue to work with the counties, SAWS and the CalHEERS team on matters pertaining to the interface between SAWS and CalHEERS, including the development of solutions for identified system defects and the timing of deployment of applicable system fixes within SAWS and CalHEERS. As warranted, DHCS will issue further workaround guidance based on input from the counties.

### **New or Unknown Defects**

If a county identifies an issue or potential defect that is impacting eligibility, which does not meet one of the identified situations, the county will submit the defect/issue to SAWS, CalHEERS, and/or DHCS in the following manner, based on the remedy sought. When submitting these requests, to ensure expedited handling of the issue/defect, the county should note "workaround process" in the actual request:

- DHCS policy issues - online to the [CountyOpsCall@dhcs.ca.gov](mailto:CountyOpsCall@dhcs.ca.gov)
- SAWS related issues - SAWS ticket process
- CalHEERS related issues - CalHEERS ticket process
- Medi-Cal Eligibility Data System (MEDS) - MEDS Remedy ticket

DHCS will work with the counties, SAWS and CalHEERS to provide direction, within two business days, on whether a workaround or override should be implemented. However, if the consumer develops an immediate medical need, as specified below, then the provisions regarding immediate medical need should be implemented for that individual and counties shall create a case for SAWS using the current county ID on MEDS (9 + Client Index Number) for each person who meets the requirements for immediate medical need.

If DHCS does not provide a response on whether a workaround or override should be used, counties should, in consultation with their SAWS consortia if needed, proceed to implement a workaround or override as needed to provide appropriate eligibility in accordance with DHCS Medi-Cal eligibility policies. In this situation, counties should track the use of this process and provide information to DHCS, SAWS, and CalHEERS regarding the process being used.

### **Immediate Medical Needs**

The applicable SAWS and CalHEERS workarounds and overrides, as well as applicable MEDS transactions, including requesting a new Beneficiary Identification Card for the person, should be used to address immediate medical needs as outlined in the following reference sources:

- Medi-Cal Eligibility Procedures Manual 4J
- All County Welfare Directors Letters: C81-04, C82-60, C88-01, and C89-12

If an individual has an immediate medical need such as being an uninsured pregnant woman, a sick child or a terminally ill adult, or other medical need, and the county believes that the system is incorrectly determining eligibility, then the county can override the SAWS and CalHEERS systems and submit an online MEDS transaction to provide immediate coverage. In these instances of override, the county must document the circumstance and override to DHCS within 24 hours so that DHCS, County Welfare Directors Association, CalHEERS, and SAWS can assess the system defects and provide appropriate guidance to all counties on next steps.

### **Citizenship/Immigration Status and Medi-Cal Scope of Benefits**

For purposes of individuals applying for coverage, existing Medi-Cal policy should be followed to ensure appropriate Medi-Cal coverage is granted to individuals, based on their citizenship/immigration status, including completion of the MC 13 for all non-U.S. citizens. To the extent eligibility determinations are resulting in incorrect Medi-Cal coverage, meaning the granting restricted-scope versus full-scope Medi-Cal, the county shall implement the use of the override policy in the appropriate system to ensure the correct assignment of Medi-Cal benefits.

### **Deemed Infants**

**Pre-ACA Medi-Cal Case:** Counties shall utilize existing processes that are currently programmed in SAWS for adding deemed infants to Pre-ACA cases. Counties should look to their SAWS consortia for guidance on how to add a deemed infant to an existing Pre-ACA Medi-Cal case.

**MAGI Medi-Cal Case:** The CalHEERS business rules engine (BRE) is programmed to grant deemed infant eligibility for MAGI Medi-Cal cases. As such, for infants subsequently born to a woman on MAGI Medi-Cal, the infant shall be added to the case by adding them to the CalHEERS case.

January 31, 2014

### **Add a Person to a Pre-ACA Case**

Pre-ACA Medi-Cal Case: To the extent a person needs to be added to a Pre-ACA case that has not yet been transitioned to the use of MAGI, the county shall determine whether adding the person will impact the Pre-ACA case members. There are three different scenarios that may occur when adding a person to an existing SAWS case:

1. The individual is already known to the case but is not aided, for example mom or dad is now requesting to be aided with the children.
2. The individual is not known to the case but either has no income or not enough income factors that would negatively impact the Pre-ACA case members.
3. The individual is not known to the case but has income that may result in a negative change for the Pre-ACA case members.

Under scenarios 1 and 2 listed above, counties shall aid the individual on the Pre-ACA case in SAWS using Pre-ACA rules. Generally, Pre-ACA rules are not used for new applicants, but as a temporary workaround, individuals may be added to existing Pre-ACA cases with Pre-ACA aid codes. To the extent this workaround is used for scenarios 1 and 2 listed above, the counties shall not ask for property or tax household information.

Under scenario 3 listed above, counties shall request the appropriate information from the individual requesting to be added to the case in order to complete a Pre-ACA or MAGI determination. The individual is not required to complete a new application, but will be required to provide the information required to run them through the CalHEERS business rules engine (BRE). The individual may complete the MC 371 and the Request for Tax Household Information form or they can provide the needed information over the phone. Once the appropriate information is on file, a new case can be opened for that individual. SAWS will provide counties with instructions on how to set up the new case.

At renewal, the county will merge the 2 cases. In the event that the Pre-ACA case is Medi-Cal only, the Pre-ACA case shall be discontinued and the Pre-ACA case members will be moved to the new case that was established to aid the additional person. The annual renewal date from the Pre-ACA case will be retained and the county shall ensure that all adequate case data is transferred to the new case.

In the event that the Pre-ACA case is associated with CalFresh and/or CalWORKs in addition to Medi-Cal, SAWS will provide instructions to counties on how to merge the 2 cases at renewal.

When closing and merging the cases, the county will need to provide appropriate notice to the affected beneficiary. Because of the needed workaround to merge the two cases into one case, the affected beneficiary who has their case closed will receive two notices – one for discontinuance (closing the case) and one for the outcome of their annual redetermination. Counties should take necessary steps to inform the beneficiary on why they received the two notices to the extent inquiries are received.

**MAGI Medi-Cal Case:** To the extent a person needs to be added to a MAGI Medi-Cal case, the county shall add the person to the case to effectuate the appropriate eligibility determination. To the extent the case has not yet been transferred to the SAWS from CalHEERS, the needed actions to add the new person to the MAGI case will be done in CalHEERS. DHCS will issue future guidance on the steps that should be taken when the MAGI Medi-Cal case has been transferred to SAWS and individuals need to be added to the case.

### **Discontinuances**

Previously DHCS issued guidance via MEDIL 14-03 to not act on changes in circumstances or to take negative actions on cases in CalHEERS. Since the release of that instruction, DHCS is modifying its guidance to encompass the following actions that shall be taken by the counties:

- Deceased individuals – to the extent the county learns of the death of an individual, the case shall be discontinued in accordance with current Medi-Cal policy, leveraging business rules that are in the SAWS. To the extent this change results in a positive action for individuals remaining on the Pre-ACA case, but an incorrect determination of eligibility is returned from CalHEERS for such individuals, counties shall use Pre-ACA rules for the affected individual(s), place them in the appropriate Pre-ACA aid code and send applicable transactions to MEDS to effectuate the change. To the extent this change results in a negative action for individuals remaining on the Pre-ACA case, counties shall ensure that the individuals remaining on the case are not adversely affected and eligibility for these individuals will be reviewed at annual renewal. This workaround shall only apply to Pre-ACA Medi-Cal beneficiaries.
- Individuals living out of state – to the extent information is presented to the county that a Medi-Cal beneficiary is now living out-of-state, including information from the Public Assistance Reporting Information System (PARIS) data matching, the case shall be discontinued in accordance with current Medi-Cal policy, leveraging business rules that are in the SAWS. To the extent this change results in a positive action for individuals remaining on the Pre-ACA case, but an incorrect determination of eligibility is returned from CalHEERS for such individuals, counties use Pre-ACA rules for the affected individuals and place them in the appropriate Pre-ACA aid code and send applicable transactions to MEDS to effectuate the change. To the extent this change results in a negative action for individuals remaining on the Pre-ACA case, counties shall ensure that the individuals remaining on the case are not adversely affected. This also applies if California residency is lost for the primary applicant. Eligibility for the additional case members shall be reviewed at renewal and California residency shall be re-established in order to approve on-

January 31, 2014

going eligibility. This workaround shall only apply to Pre-ACA Medi-Cal beneficiaries.

- Non-Payment of Premiums – When counties receive the Non-Payment Premium list from MAXIMUS, counties shall review alternate Medi-Cal eligibility for the affected individual. First, the county shall review Pre-ACA eligibility for the affected individual. If the individual is eligible for a non-premium Medi-Cal program, the county shall place the individual in the appropriate Pre-ACA aid code and send the applicable transactions to MEDS to effectuate the change. If the beneficiary does not qualify for another zero share-of-cost (SOC) Medi-Cal program, the county shall then provide the beneficiary with the opportunity to provide information to be screened for SOC Medi-Cal. If the beneficiary does not wish to be screened for SOC Medi-Cal, fails to provide the requested information, or does not qualify, the county shall send adequate and timely notice and discontinue the beneficiary.

### **Former Foster Care**

Effective January 1 2014, individuals who were formerly in foster care are now afforded Medi-Cal up to the age of 26. DHCS issued MEDIL 14-05 regarding the former foster care eligibility category. As some of the SAWS have not yet programmed the aid code with the age set at 26, counties should use override or workaround processes in accordance with specific instructions from their consortia to provide eligibility to former foster youth in accordance with MEDIL 14-05.

### **Processing Requests for Skilled Nursing Facility Services**

Individuals eligible under MAGI Medi-Cal, including the newly eligible adult, are afforded all of the same full-scope benefits as a Pre-ACA full-scope eligible individual. For purposes of requests for long-term care services and supports such as skilled nursing facility care or In-Home Supportive Services (IHSS), to the extent the person is in a MAGI full-scope aid code and are under the age of 65, there are no additional steps that must be taken when being placed in skilled nursing facilities or seeking IHSS from an eligibility perspective. This means there is no need to change their eligibility aid code.

For new applications from individuals who are parents, children and pregnant women, or who are under 65 years of age who are in need of skilled nursing facility services, counties can assist them by entering the information into SAWS for a MAGI determination. If the eligibility result returned via e-HIT is incorrect and an override is not allowed, then log into or call CalHEERS to submit the beneficiary's information as a new application. This method is working for current SOC individuals who are submitting new applications through CalHEERS. They are being determined eligible under the appropriate MAGI coverage groups, where appropriate, and the information is being transmitted to MEDS and successfully updating their aid codes with new MAGI aid codes. If the case causes the BRE to fail for a MAGI determination, the case can then run via the SAWS as a

January 31, 2014

non-MAGI case. Once this is done, the final Medi-Cal disposition should be sent to MEDS.

For new applications from individuals who are not described in the paragraph above, and in need of skilled nursing facility services, the county should process the case as they did under Pre-ACA rules by collecting all of the same Pre-ACA information on property and income, apply long-term care (LTC) SOC and spousal impoverishment rules and evaluate transfers of property. However, because SAWS are programmed to run MAGI first, the case in this instance should be first run through CalHEERS and because the information will cause the BRE to fail for a MAGI determination, the case can then run via the SAWS as a non-MAGI case. Once this is done, the final Medi-Cal eligibility disposition should be sent to MEDS. For applicants who are ineligible for MAGI, there is no change in how the application is processed and SAWS systems and MEDS should do business as usual.

For continuing non-MAGI individuals converting to LTC, coverage counties are not to process changes in circumstances through March 31, 2014, other than revising the aid code for the LTC individual to reflect LTC. This means that the SOC, if any, should not be changed, unless spousal impoverishment rules would reduce the SOC for the individual in LTC, then the county shall proceed with re-calculating the SOC for the LTC individual. A non-MAGI zero SOC LTC aid code shall be used for these non-MAGI LTC individuals and the \$35 maintenance need allowance will not apply. Therefore, for no SOC individuals, counties will need to override any SOC in SAWS to reflect zero SOC in order to ensure there is no SOC in MEDS. For non-MAGI individuals who do not have a spouse or family and have SOC Medi-Cal before entering LTC, a LTC aid-code shall be granted and the SOC shall be overridden in SAWS to reflect the same SOC the individual had prior to entering LTC. Counties should confirm this transaction correctly posted in MEDS reflecting the SOC remains the same.

Any of the aforementioned workarounds for placement into an LTC aid code, if applicable, shall be properly documented in the case record for the affected individual and the case should be flagged for correction when counties are again processing changes in circumstances after March 31, 2014. Those individuals who need to have SOC adjustments shall have their cases reviewed for appropriate eligibility.

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

Sincerely,

Original Signed By:

Tara Naisbitt, Chief  
Medi-Cal Eligibility Division