DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657-2941

June 19, 2001

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons
All County Health Executives
All County Mental Health Directors
All CalWORKs Program Managers

Letter Number 01-36

MEDI-CAL ELIGIBILITY DETERMINATION PROCESS

Ref: All County Welfare Directors Letter No. 01-17

The purpose of this All County Welfare Directors Letter (ACWDL) is to instruct counties on changes in the Medi-Cal eligibility determination process. Changes described in this ACWDL include requirements set forth by Senate Bill (SB) 87, including use of the *ex parte* redetermination process. This letter also instructs the counties that, to a limited extent, they shall attempt to use the *ex parte* process in other situations, such as Medi-Cal-Only eligibility determinations and annual redeterminations.

SB 87 mandates that counties continue Section 1931(b) Medi-Cal eligibility for discontinued California Work Opportunity and Responsibility to Kids (CalWORKs) beneficiaries except in those circumstances that clearly demonstrate that the beneficiary is not eligible. Additional ACWDLs are forthcoming regarding separate issues to be addressed, such as, disability determinations, forms and instructions for complete implementation of SB 87 requirements.

The goal of the Department of Health Services (DHS) is to continue to remove barriers, improve access to health care, and simplify the application and retention process of health benefits for eligible persons. The Medi-Cal program is designed to provide comprehensive health, dental and vision benefits to eligible Californians. To accomplish this goal, it is imperative that counties encourage and assist families to enroll in the Medi-Cal program and retain eligibility.

The instructions that are provided in this ACWDL shall be fully implemented effective July 1, 2001.

CALWORKS DISCONTINUANCES

Implementation of welfare reform, January 1, 1998, delinked CalWORKs and Medi-Cal and created the Section 1931(b) Medi-Cal program. When CalWORKs is approved, Medi-Cal eligibility under Section 1931(b) is also approved; however, a discontinuance of CalWORKs benefits does not constitute discontinuance from the Section 1931(b) Medi-Cal program. Unless there is clear evidence (e.g. death or incarceration) that eligibility for ongoing Medi-Cal benefits is lost, discontinued CalWORKs recipients must continue to receive ongoing Medi-Cal benefits under the Section 1931(b) Medi-Cal program. (See attached table for further circumstances regarding discontinuance of CalWORKs cases.)

CalWORKs cases discontinued for reasons such as, but not limited to, failure to provide the monthly income report, non-cooperation with Welfare to Work requirements or reaching the 60 (sixty) month time limit for receipt of CalWORKs benefits are **not** considered changes in circumstances that affect Medi-Cal eligibility. Therefore, Section 1931(b) Medi-Cal program eligibility is **not** affected, discontinuance is **not** appropriate and a Medi-Cal-Only eligibility determination *(ex parte)* is **not** required.

CalWORKs cases discontinued for reasons that do not affect Section 1931(b) Medi-Cal program eligibility (see above) must be converted into Aid Code 3N. The next scheduled Medi-Cal annual redetermination date will remain unchanged from the CalWORKs case, and shall be no earlier than twelve (12) months from the date of the most recent CalWORKs annual redetermination. If no such annual redetermination has been conducted, then the next annual redetermination date will be twelve (12) months from the date cash aid was granted. This does not preclude a review of eligibility when a change in circumstances occurs that may affect Medi-Cal eligibility. In such cases, the Medi-Cal eligibility worker shall follow the procedures for the *ex parte* process as described below.

Example:

CalWORKs case is approved for cash aid in August 2000. The case is discontinued November 30, 2000, due to failure to provide the monthly income report. Benefits shall continue under the Section 1931 (b) Medi-Cal program and the annual redetermination date for the Medi-Cal case is August 2001.

SB 87 mandates a notification for all cases being discontinued from CalWORKs to include specific information about the continuance of Medi-Cal benefits. DHS and the California Department of Social Services (CDSS) are working together on the development of this notification.

EX PARTE PROCESS

Changes In Circumstances:

Pursuant to SB 87 requirements, the county shall make a Medi-Cal-Only eligibility determination without the involvement of the beneficiary by use of the *ex parte* process when a change in circumstances affecting Medi-Cal eligibility occurs.

The determination shall be based on information/verification contained in open public assistance (PA) case records of the individual and their immediate family members and/or case records that have been closed within the last forty-five (45) days. In addition, information/verification available through county accessible systems such as Income Eligibility Verification System, Systematic Alien Verification for Entitlements System, Employment Development Department/State Disability Insurance, State Data Exchange, and Beneficiary Data Exchange shall be accepted and used in determining eligibility.

Since PA programs require regular redeterminations/recertifications of eligibility and prompt reporting of changes in circumstances by the beneficiary, information/verifications available from these programs shall be used in determining Medi-Cal-Only eligibility, as long as it was obtained within the last twelve (12) months, not subject to change and relevant to the eligibility determination.

Furthermore, SB 87 stipulates that when the *ex parte* process has resulted in insufficient information/verification for an accurate determination of eligibility, county staff must document in the case record the exact reason for contacting the individual and follow the procedures in the section titled "Requesting Additional Information".

When it is established that changes in circumstances have occurred that require a referral or updating of information to other agencies (i.e., District Attorney's Family Support, DHS' Recovery/Third Party Liability Unit), the county may require the appropriate forms.

Annual Redeterminations:

In addition to the SB 87 requirements, DHS further directs counties to use the resources described above in verifying information provided by the beneficiary during the annual redetermination process to the extent possible.

There is no change to the required annual redetermination forms (i.e., MC 210RV) or the necessary contact with the beneficiary for an accurate eligibility redetermination (refer to section titled "Requesting Additional Information").

Counties shall not take any adverse action until efforts to retrieve information/verification from a current or prior PA case record available to the county has been exhausted.

Other PA Program Initiated Medi-Cal Applications:

In addition to the SB 87 requirements, counties shall also pursue the gathering of information/verifications with the use of the resources described above, to the extent possible, when Medi-Cal benefits are initiated by the request of an individual or family transitioning or currently receiving assistance from another public benefits program (i.e., Food Stamps, General Assistance, etc).

There is no change to the required forms or the necessary contact with the applicant for an accurate eligibility determination (refer to section titled "Requesting Additional Information").

An initial Medi-Cal-Only eligibility determination must not be delayed beyond forty-five (45) days, pending information/verification from a current or prior PA case record. Counties are reminded that property limits must be met sometime during the month of application and will be valid for twelve (12) months or until there is a reported or discovered change in resources that require an eligibility review.

No *Ex Parte* Process*

There will be no *ex parte* review for ongoing Medi-Cal benefits for persons discontinued from CalWORKs due to changes in circumstances that terminate or transition Medi-Cal benefits for the following reasons:

- loss of California residency,
- the beneficiary's written request to discontinue Medi-Cal benefits,
- incarceration,*
- death,* or
- the individual is transitioning into another PA program that provides Medi-Cal benefits (i.e., Foster Care, SSI, IHSS, AAP, etc.)*

**The status of other family members in the case record must be reviewed for ongoing Medi-Cal-Only eligibility.*

When an individual's eligibility is not being reviewed for ongoing Medi-Cal-Only benefits via the *ex parte* process, counties shall document in the case record those facts substantiating why no *ex parte* review is required.

AID CODE 38

Placement in Aid Code 38 no longer requires completion of the Edwards packet for the continuation of Medi-Cal coverage. The use of the Edwards redetermination form (MC 210E) shall be eliminated effective July 1, 2001.

Aid Code 38 continues to be a transitional aid code for persons discontinued from CalWORKs requiring an immediate review for continued eligibility of Medi-Cal benefits.

Counties shall transfer discontinued CalWORKs beneficiaries into Aid Code 38 for the following reasons:

1. Failure to complete the CalWORKs annual redetermination. CalWORKs discontinuances due to failure to complete the annual redetermination will require a Medi-Cal annual redetermination to be completed. In lieu of the Edwards MC 210E, counties shall use the Medi-Cal annual redetermination form (currently the MC 210RV). Failure to complete the MC 210RV shall result in timely discontinuance of Medi-Cal benefits. If the individual completes the MC 210RV and is found eligible to continued Medi-Cal benefits, the next annual redetermination date shall be twelve (12) months from completion of the Medi-Cal-Only redetermination.

2. Income increase. The loss of CalWORKs cash aid due to an income increase will require placement in Aid Code 38 for the review of this change as it relates to income eligibility under the Section 1931(b) Medi-Cal program, Transitional Medi-Cal (TMC), Four-month Continuing, Percentage programs, Medically Needy-No SOC (share-of-cost), Medically Needy-SOC, Medically Indigent Programs, etc.

3. Loss of contact/whereabouts unknown. When loss of contact/whereabouts unknown (as determined by returned mail with no forwarding address) is the basis for placement in Aid Code 38, the Medi-Cal eligibility worker shall attempt to contact the beneficiary by telephone (when feasible). Additionally, the Medi-Cal eligibility worker shall send the **Request for Information** form (see "Request for Additional Information" section), to the last known address advising the beneficiary to contact the Medi-Cal office to update their current living situation. SB 87 requires specific timelines for this process that will be addressed in a separate ACWDL. When the *ex parte* process and all attempts to contact the beneficiary have been unsuccessful, the case shall be discontinued with a timely notice mailed to the last known address.

   To ensure that these discontinued CalWORKs cases continue Medi-Cal-Only benefits under Aid Code 38, MEDS termination reason code 098 will automatically roll individuals into Aid Code 38. The use of the MEDS termination reason code 098 shall **only** be used by CalWORKs' staff when cash aid is terminated due to loss of

contact/whereabouts unknown. Medi-Cal eligibility staff shall use MEDS termination reason code **089** when discontinuing Medi-Cal benefits for loss of contact/whereabouts unknown. Use of MEDS termination reason code **089** will terminate Medi-Cal benefits.

4. Only eligible child leaves the home. Persons placed in Aid Code 38, who have lost CalWORKs cash linkage due to the only eligible child leaving the home, shall be reviewed for ongoing linkage under all other Medi-Cal aid categories. If the Medi-Cal eligibility worker determines that no other linkage exists for the family member(s), they shall be discontinued with a timely notice (see "Exhausting All Avenues of Eligibility" section).

5. Change in household composition that has resulted in non-cooperation with the evidence gathering requirements for the Assistance Unit (AU). Persons placed in Aid Code 38 due to a change in household composition resulting in non-cooperation of CalWORKs evidence gathering requirements shall be reviewed for Medi-Cal-Only eligibility. For example, when the absent parent has returned to the home and refuses to provide information/verification to the CalWORKs program in order to calculate the AU's correct grant, Medi-Cal eligibility staff shall determine ongoing eligibility through the *ex parte* process. Medi-Cal eligibility staff shall attempt to obtain information/verifications necessary for an accurate eligibility determination and the exact reason for contacting the individual must be documented in the case record.

Beneficiaries in these Aid Code 38 situations shall be treated as all other Medi-Cal-Only beneficiaries in that when the *ex parte* process, requests for information/verification, attempts to contact and all avenues of continued eligibility have not been successful, the beneficiaries shall be discontinued with a timely notice of action.

EXHAUSTING ALL AVENUES OF ELIGIBILITY

When conducting a review of eligibility caused by a change in circumstances, counties shall consider eligibility under all possible categories beginning with "no SOC" categories.

After completion of the *ex parte* process, if eligibility under all categories fails, counties shall provide the individual with the **Request for Information** form (see "Request for Additional Information" section), if not previously used in the gathering of information/verification. This form will explain the potential basis for eligibility, which may provide the county with new information/verification, such as pregnancy, incapacity, or disability, not apparent from the *ex parte* review. Timeframes allowed for the

applicant/beneficiary to respond to the **Request for Information** form, indicating whether any of the eligibility categories apply to them or any household member of the case record, will be explained in a subsequent ACWDL. Counties will also receive instructions on how to proceed after the form is returned or when the timeline has elapsed with no response before issuing a termination notice.

Counties shall follow existing procedures outlined in ACWDL(s) 91-66, 99-16, 01-01 and Procedure Manual Section 5H for continued eligibility for pregnant women and children. Counties shall also continue to make appropriate referrals to other available resources such as County Medical Services Program (CMSP), Access for Infants and Mothers (AIM), Healthy Families for Children, etc.

New Aid Code **6J** (Pending Disability Determination – SB 87)

During the *ex parte/*redetermination process, if the beneficiary alleges that he or she is disabled and if no other basis for eligibility exists, Medi-Cal eligibility shall continue and the county shall transfer the beneficiary into new Aid Code 6J. The allegation of disability shall be documented in the case file, either by means of the **Request for Information** form or other written documentation signed by the beneficiary, stating his or her belief that he or she is disabled. Counties shall immediately begin the process of referring the case to the State Programs-Disability and Adult Program Division (SP-DAPD) for a disability determination. If the disability is confirmed by SP-DAPD, counties shall transfer the individual from Aid Code 6J into the appropriate disability aid code and send relevant approval notice. If the disability is denied by SP-DAPD, or if the beneficiary fails to supply requested information/verification to the county or the SP-DAPD within the applicable timeframes, counties shall discontinue the individual with timely notice, provided all other eligibility linkage factors are exhausted.

Counties shall also pursue disability-based linkage through SP-DAPD, as described above, whenever a beneficiary who is currently receiving Medi-Cal benefits under another linkage factor declares (either orally or in writing) that he or she may be disabled.

Counties shall ensure that their data systems can accommodate new Aid Code 6J by July 1, 2001. DHS realizes this deadline may not be possible, therefore, counties shall flag these cases and continue the beneficiary in Aid Code 38 until Aid Code 6J is available in their data systems.

REQUESTING ADDITIONAL INFORMATION

When counties are unable to make an eligibility determination through the *ex parte* process, the Medi-Cal worker shall attempt to reach the individual by telephone to request the necessary information/verification. The exact reasons for contacting the individual and all attempts made shall be documented in the case record.

When the *ex parte* process and telephone contact have been unsuccessful, SB 87 mandates that by July 1, 2001, the Medi-Cal worker shall use a **Request for Information** form together with an explanatory cover letter that will highlight only the information/verification needed to complete a Medi-Cal eligibility review. DHS is currently developing the **Request for Information** form, which will be released with instructions under a separate ACWDL. Counties may use existing county forms until the **Request for Information** form is released under a separate ACL.

Counties shall not request information or verification that:

- has been previously provided within the last twelve (12) months,
- is not subject to change (i.e. Identification, Social Security Card, etc.),
- is available for verification by eligibility staff, or
- is not necessary for completing an eligibility determination.

When conducting the *ex parte* process, counties must not combine a written request for information/verification with the termination notice.

When the individual fails to respond to the **Request for Information** form or does not provide the necessary information/verification within the required time frames (to be explained in the subsequent ACWDL), counties shall evaluate the individual for other Medi-Cal program eligibility without the additional information/verification. For example, if counties are requesting property verification that does not affect eligibility under a Federal Poverty Level (FPL) program, the eligible individual shall be placed into this eligibility category since property is not considered until property verification is provided.

LOSS OF SECTION 1931(b) ELIGIBILITY

Counties are reminded that any beneficiary who is discontinued from CalWORKs and is no longer eligible for cash-based Section 1931(b) or who is discontinued from Section 1931(b)-Only due to increased earnings from employment or increased child/spousal support, must be evaluated for the Transitional Medi-Cal (TMC) and Four-month Continuing programs. It is irrelevant whether Section 1931(b) eligibility was established through the CalWORKs or Medi-Cal-Only programs.

CALWORKS DENIALS

CDSS issued All County Information Notice (ACIN) I-32-01 on May 10, 2001 as a reminder to counties of the importance of referral to the Medi-Cal program for all denied or discontinued CalWORKs cases, including Diversion cases, for a determination of Medi-Cal eligibility. CDSS regulations (MPP 40-103.44) provide that appropriate action on a cash aid application includes authorization of a cash grant and certification for Medi-Cal assistance. CalWORKs denials shall be reviewed for Medi-Cal-Only eligibility through the *ex parte* process when the applicant had completed the SAWS 2 Statement of Facts form.

Once the *ex parte* review is completed and eligibility for Medi-Cal-Only benefits is established, the annual redetermination date will be twelve (12) months from the date of the CalWORKs application.

When the CalWORKs denial is due to failure to complete the SAWS 2 (failure to provide the application), no *ex parte* review of Medi-Cal-Only eligibility shall be conducted.

When failure to provide information/verification is the cause for the CalWORKs denial, the Medi-Cal eligibility worker shall determine if the missing information/verification is relevant to an accurate Medi-Cal-Only eligibility determination. Counties shall make every effort to determine eligibility for Medi-Cal-Only benefits.

EXTENDED OUTREACH

DHS recognizes that maintaining current beneficiary contact information (name, address, and telephone number) is the most effective means of preventing loss of Medi-Cal benefits.

DHS is working with Medi-Cal Managed Care Plans (MCPs) to facilitate the sharing of updated beneficiary contact information with counties. Counties shall incorporate contact information received from a MCP into the beneficiary's Medi-Cal case file. The Department is developing a consent form counties may use to obtain the beneficiary consent and it will be distributed with the **Request for Information** form under a separate ACWDL. Additionally, SB 87 stipulates that counties undertake outreach efforts to beneficiaries in maintaining current contact information and to encourage, assist and facilitate timely submission of the annual redetermination forms and when applicable, the TMC program reporting forms. A county may collaborate with community-based organizations, provided that beneficiary confidentiality is protected.

CLOSING COMMENTS

In implementing these instructions, DHS realizes that sharing information between programs may be difficult; however, in order to comply with SB 87 requirements, counties must develop internal procedures to handle issues of logistics and remove barriers to ensure that persons/families in different programs continue to receive health coverage. For example, counties are encouraged to use copiers, fax machines or computer software to transmit information between distant office locations.

Counties shall pursue initial and/or ongoing eligibility under the most beneficial Medi-Cal program beginning with the review of eligibility under Pickle and the Section 1931(b) programs.

DHS has developed a table for counties to reference discontinued CalWORKs reasons that may or may not need the *ex parte* process, Aid Code 38 placement or uninterrupted Section 1931 (b) benefits. Realizing that not all CalWORKs discontinuance reasons can be identified on this table, counties are encouraged to contact the DHS for further guidance when uncertain as to what action is necessary.

Should you have any questions regarding these instructions, please contact:

- Tanya Homman (916) 657-1469 (DHS Analyst)
- Mack Guynn (916) 657-1064 (DHS Analyst)
- Linda Lattimore (916) 653-5830 (CalWORKs Eligibility Bureau)

Sincerely,

ORIGINAL SIGNED BY

Shar Schroepfer, Chief
Medi-Cal Eligibility Branch
Department of Health Services

ORIGINAL SIGNED BY

Charr Lee Metsker, Chief
Employment and Eligibility Branch
Department of Social Services

Attachment

Discontinued CalWORKs Reasons
Ex Parte/Aid Code 3N/Aid Code 38
TABLE

REASON FOR CALWORKS DISCONTINUANCE*	EX PARTE REQUIRED	ELIGIBLE AID CODE 3N PLACEMENT	REQUIRED AID CODE 38 PLACEMENT
Loss of California residency	No	No	No
Written request to discontinue CalWORKs and Medi-Cal	No	No	No
Incarceration	No	No	No
Death of beneficiary	No	No	No
Transition into another PA program that provides Medi- Cal benefits	No	No	No
Failure to provide monthly income report	No	Yes	No
Non-cooperation with Welfare-to-Work requirements	No	Yes	No
Expiration of CalWORKs time limits	No	Yes	No
Failure to complete the CalWORKs annual Redetermination	Yes	No	Yes
Loss of contact/whereabouts unknown	Yes	No	Yes
Only eligible child leaves home	Yes	No	Yes
Change in household composition that has resulted in non-cooperation with the evidence gathering requirements for the AU	Yes	No	Yes
Change in household circumstances that affect Medi-Cal eligibility	Yes	No	Yes
Resources exceeds limits	Yes	No	Yes
Income exceeds standards	Yes	No	Yes
Failure to cooperate with child support requirements	Yes	No	Yes

*Counties are encouraged to contact DHS for further guidance on other discontinued CalWORKs reasons when uncertain as to what action is necessary.