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

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TO: ALL COUNTY WELFARE DIRECTORS Letter No.: 21-16
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: Case Processing Actions Allowed during the Coronavirus (COVID-19) Public Health Emergency (PHE)
(Reference: Medi-Cal Eligibility Division Information Letters I 20-25 and 21-04)

The purpose of this All County Welfare Directors Letter (ACWDL) is to instruct counties on allowable case processing actions during the Novel Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE) based on guidance issued by the Centers for Medicare and Medicaid Services (CMS) in order to help alleviate any outstanding work due to the federal COVID-19 PHE.

**Background**
During the federal COVID-19 PHE, the Department of Health Care Services (DHCS) used various program flexibilities to respond to the crisis and provide continuous access to care for millions of Californians. As a result of Governor Gavin Newsom's March 4, 2020, State of Emergency declaration and the President's subsequent Federal declaration on March 13, 2020, DHCS released policy guidance through multiple Medi-Cal Eligibility Division Informational Letters (MEDILs) on modifying case processing during the federal COVID-19 PHE. MEDIL 20-25 instructed counties to delay the processing of Medi-Cal annual redeterminations, discontinuances, and negative actions for Medi-Cal, Medi-Cal Access Program (MCAP), Medi-Cal Access Infant Program (MCAIP), and County Children's Health Initiative Program (CCHIP) throughout the federal COVID-19 PHE.

In order to prepare for the end of the federal COVID-19 PHE, DHCS is collaborating with various stakeholders to develop a comprehensive plan for reinstating regular Medi-Cal eligibility determinations by addressing the outstanding work that has accumulated during the federal COVID-19 PHE. DHCS will release two ACWDLs

outlining the plan and timeline for resumption of regular county operations and processing the backlog. This ACWDL is the first letter that will outline allowable activities, based on CMS recommendations, that counties can complete during the federal COVID-19 PHE to reduce the volume of outstanding work. The second ACWDL will contain timelines and instructions on reinstating regular county operations and processing any outstanding work once the federal COVID-19 PHE is lifted.

**CMS Guidance**

CMS released the Interim Final Rule (IFR) – "Additional Policy and Regulatory Revisions in response to the federal COVID-19 Public Health Emergency" on November 6, 2020. The IFR implements section 6008 of the Families First Coronavirus Response Act which includes provisions requiring the maintenance of Medi-Cal beneficiary eligibility and enrollment as a condition of receiving the temporary increase in federal funding authorized in that section. Additionally, the IFR outlines allowable case actions during the COVID-19 PHE and defines which beneficiaries must be protected as a result of these provisions.

CMS also released State Health Official (SHO) letter 20-004 – "Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the federal COVID-19 Public Health Emergency" on December 22, 2020, and SHO 21-002 – "Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency" on August 13, 2021. SHO 20-004 and 21-002 provide guidance to states on planning for the eventual return to regular operations, including establishing a timeframe in which outstanding work must be completed, ending temporary processing procedures when the federal COVID-19 PHE concludes, making some temporary changes permanent, and addressing pending eligibility and enrollment actions that developed during the federal COVID-19 PHE.

<u>IFR Provisions</u>

*Validly Enrolled*

The IFR requires that states maintain Medi-Cal enrollment of "validly enrolled beneficiaries" in one of three tiers of coverage during the remainder of the federal COVID-19 PHE so that beneficiaries do not experience a reduction in covered benefits, with limited exceptions. A validly enrolled beneficiary is a beneficiary who is eligible for a Medi-Cal program, including during the retroactive eligibility period, on or after March 18, 2020. A beneficiary is considered **not** validly enrolled only if the Medi-Cal eligibility

determination was erroneously granted at application or at last redetermination (if such redetermination was completed before March 18, 2020) based on:

- Agency error; or
- Beneficiary fraud (only after a fraud conviction) or abuse that is material to the determination of eligibility (only after completion of a full administrative investigation into suspected abuse as described in Title 42 Code of Federal Regulations (CFR) 455.15 and 455.16).

Note: MEDIL 21-04, question 13 under "Section B – Delayed Negative Actions" regarding discontinuance based on fraud and question 2 under "Section F- Other Case Processing Actions" regarding retroactive Medi-Cal are now obsolete. County Eligibility Workers (CEWs) shall follow the policy guidance in this letter regarding administrative errors and retroactive Medi-Cal during the federal COVID-19 PHE. DHCS will release updated federal COVID-19 PHE frequently asked questions in the future.

Agency error is limited to the following scenarios:

- CEW or Covered California Service Center Representative data entry error
- CEW acceptance of incorrect Eligibility Determination and Benefit Calculation (EDBC) results in the Statewide Automated Welfare Systems (SAWS)

Errors made as a result of CEWs not processing change in circumstances or annual renewals timely or data entry errors made by beneficiaries that result in them being granted Medi-Cal eligibility are **not** considered agency errors. A beneficiary's mistake or failure to timely report a change in circumstance is not automatically abuse or fraud. In these instances, CEWs shall follow the existing fraud and overpayment process as specified in Title 22 California Code of Regulations (CCR) Sections § 50781 through § 50793 and found in the Medi-Cal Eligibility Procedures Manual (MEPM) "Article 16 – Overpayments and Fraud" and continue Medi-Cal coverage until the end of the federal COVID-19 PHE or a fraud determination can be made.

Effective with the release of this ACWDL, CEWs shall complete a redetermination of Medi-Cal eligibility (consistent with Welfare and Institutions Code 14005.37 and 42 CFR 435.916) when the county identifies a beneficiary is enrolled in a Medi-Cal program based on agency error, fraud, or abuse. To redetermine eligibility, the county shall start with an ex-parte review of the case. When the county is unable to complete the redetermination through ex-parte review, the CEW will need to obtain additional verification from the beneficiary in order to redetermine Medi-Cal eligibility using the current circumstances of the case. The CEW shall use existing processes outlined in ACWDL 14-18, including contacting the beneficiary by phone and/or issuing an MC 355

as applicable, for requesting additional information. After completing all required steps in ACWDL 14-18, including assessing for other Insurance Affordability Programs, the CEW shall discontinue or reduce the Medi-Cal eligibility only after sending a notice of action that includes fair hearings rights to the beneficiary at least 10 days prior to the first month in which the adverse action becomes effective, excluding the date of mailing. Upon discontinuance, the 90-day cure period is available to all beneficiaries. As a reminder, under federal COVID-19 PHE rules, beneficiaries currently have 210 days to file a State Fair Hearing as outlined in MEDIL 20-25.

Note: The current state fair hearing extension will continue to be applied through the duration of the federal COVID-19 PHE.

*Three Tiers of Coverage*
Counties must maintain the Medi-Cal eligibility of validly enrolled beneficiaries within one of three tiers described below.

- Tier 1: Beneficiaries who have Minimum Essential Coverage (MEC) as of or after March 18, 2020, must remain in their same tier of eligibility through the end of the month in which the federal COVID-19 PHE ends.
    - Tier 1 programs include, but are not limited to, full scope Modified Adjusted Gross Income (MAGI) Programs, the 250 Percent Working Disabled Program, Supplemental Security Income (SSI) Linked Medi-Cal, and the Aged, Blind, and Disabled Federal Poverty Level Program, Medicare Savings Programs (MSPs), Optional Targeted Low Income Children's Program with or without premiums, Craig v. Bonta, transitional Medi-Cal, and Pregnancy and Post-Partum program.
    - CEW's may transition a beneficiary from a Tier 1 program with no premium to another Tier 1 program (with or without a premium) as the change does not provide a reduction of benefits.
    - In California, Pregnancy-related care for those who have satisfactory immigration status is considered MEC.
    - Note: Program administrative vendor for MCAP, MCAIP, and CCHIP will follow the guidance in this ACWDL for all beneficiaries provided protected coverage during the PHE.

- Tier 2: Beneficiaries who have limited scope coverage (not MEC) as of or after March 18, 2020, that includes access to both testing services and treatment for COVID-19 must remain in their same tier of eligibility or higher.

    - Tier 2 programs include, but are not limited to COVID-19 Uninsured Group, Breast and Cervical Cancer Treatment Program, and Medically Needy with a share of cost.

- Tier 3: Beneficiaries who do not have MEC and coverage that does not cover testing services and treatment for COVID-19 related services as of or after March 18, 2020, must remain in the same tier of eligibility or higher.
    - Tier 3 programs include but are not limited to, coverage available through the eligibility groups limited to family planning (such as Family planning, Access, Care and Treatment) or tuberculosis-related services.

For more examples of MEC and non MEC groups, counties may refer to ACWDL 17-30.

Note: CEWs should remind beneficiaries with a premium about the option to request a premium waiver when interacting with the beneficiary over the phone or in person.

An individual who is validly enrolled in Tier 1 coverage as of or after March 18, 2020, must remain in the same tier of eligibility through the end of the month in which the federal COVID-19 PHE ends and cannot be moved to a coverage group within Tier 2 or 3 because it is not the same level of eligibility. However, beneficiaries that are no longer eligible for their current Tier 1 Medi-Cal program but qualify for another coverage group or program within Tier 1 can be laterally transitioned to the other Tier 1 coverage group during the federal COVID-19 PHE. This includes a beneficiary moving from a Tier 1 Medi-Cal program without a premium to a Medi-Cal program with a premium. Conversely, if a beneficiary is validly enrolled in Tier 1 coverage is no longer eligible for their current Medi-Cal program during the federal COVID-19 PHE and is not eligible to any other Tier 1 Medi-Cal program, the CEW shall not move that beneficiary to any other Tier or discontinue Medi-Cal eligibility unless they meet one of the allowable terminations outlined in MEDIL 20-25 or are not validly enrolled. Additionally, Counties shall not discontinue Tier 1 MEC when beneficiaries gain additional or new MEC such as Medicare.

Example 1
A beneficiary turns 19 years old and they no longer qualify for the MAGI Mandatory Children's group but are eligible for the MAGI New Adult group, the CEW would transition that beneficiary to the new coverage group because it is the same scope of Medi-Cal eligibility and coverage.

Example 2
If a beneficiary is approved for Medicare and they no longer qualify for the MAGI New Adult group, the CEW must attempt to determine eligibility under the Non-MAGI Medi-Cal program. The CEW may be required to request additional information to transition that beneficiary to the new coverage group. Note that the beneficiary can only be transitioned when the new coverage group is in the same or higher tier (i.e. could transition to Non-MAGI program if eligible for Aged, Blind, and Disabled Federal Poverty Level but not Medically Needy with a share of cost).

Beneficiaries with coverage in Tier 2 can transition between coverage groups in the same tier but they cannot move to a lower tier. Validly enrolled beneficiaries in Tier 2 or 3 can be moved to a higher tier but cannot be discontinued during the federal COVID-19 PHE unless they meet one of the four allowable terminations outlined in MEDIL 20-25. However for Tier 3, eligibility in a program is for a specific set of coverage and moving a beneficiary within Tier 3 would lead to a loss of coverage. If a beneficiary becomes eligible for another coverage group that is also within tier 3, the CEW shall not move the beneficiary to the other coverage group unless the beneficiary requests a voluntary transition to another Tier 3 coverage group.

Beneficiaries in restricted scope coverage shall remain in the same tier of coverage or better until the conclusion of the federal COVID-19 PHE. Pregnant and postpartum individuals, regardless of immigration status, shall continue to receive non-emergency, medically necessary services beyond their 60-day postpartum period during the federal COVID-19 PHE. DHCS will be issuing additional guidance in the near future to counties pertaining to this policy area.

As a reminder, counties shall follow the Medi-Cal hierarchy outlined in ACWDL 17-03 when processing cases with a positive or lateral change in program.

Note: MEDIL 21-04, question number 2 under “Section B- Delayed Negative Actions” regarding how to process individuals who have aged out of an eligibility group will be expanded in the future to reference the guidance outlined in this ACWDL.

SHO 20-004 and 21-002
CMS SHO 20-004 and 21-002 provide guidance and strategies to prepare for the eventual end of the federal COVID-19 PHE. Included in the guidance are recommendations for resuming some normal operations before the end of the federal COVID-19 PHE. These case processing activities include:

- Making timely determinations of eligibility for new applicants

- Completing redeterminations for individuals whose eligibility can be redetermined based on available information via ex-parte,
- Requesting additional information from beneficiaries for changes in circumstance when necessary to redetermine eligibility, and
- Ensuring eligible individuals (especially those with ongoing health care needs) remain enrolled.

DHCS will release a second ACWDL in the near future that will provide prioritization and policy guidance for all cases with or without a deferred eligibility determination after the conclusion of the federal COVID-19 PHE.

**Allowable activities during the federal COVID-19 PHE**
Based on the guidance provided by CMS, DHCS is authorizing counties to begin processing cases that have a change in circumstance that results in either no change or a positive change to the beneficiaries' Medi-Cal eligibility and coverage. For those validly enrolled, counties shall continue to delay discontinuances and negative actions and maintain Medi-Cal eligibility in accordance with MEDIL 20-25. Counties will be required to track beneficiaries that are pending a deferred eligibility determination for future processing based on guidance in a subsequent ACWDL.

Effectively immediately, counties may begin working cases with change in circumstances that include, but are not limited to, the following as long as they result in the same tier of coverage or a better tier of coverage:

- Craig v. Bonta
- Updates to immigration status
- Sending Non-MAGI Screening Packets
- Processing Non-MAGI Screening Packets
- Moving an individual to the appropriate coverage group
- Income changes
- Property changes
- Tax household changes
- Returned Mail
- California Department of Corrections and Rehabilitation Pre-release cases
- Waiver cases (Home and Community-Based Services Waiver)
- Qualified Medicare Beneficiary Renewals
- Annual renewals (both ex-parte and manual)

As a reminder, CEWs shall only process change in circumstances that result in no change or positive change in eligibility and coverage for Medi-Cal beneficiaries who are validly enrolled. If the redetermination of Medi-Cal eligibility results in a negative action in eligibility, CEWs must not finalize the eligibility result(s) in SAWS.
Counties should also continue with the following case processing activities as instructed in MEDIL 20-25:

- Processing Intercounty Transfers
- Moving someone into and out of Long Term Care
- Transition Children's Health Insurance Program and Medi-Cal Access Program beneficiaries to Medi-Cal
- Adding a person to the case or household

Note: CEWs shall continue to promptly work the monthly list they receive from Medi-Cal managed care plans (MCPs) so as to update any outdated, or duplicative, information per Welfare and Institutions Code 14005.36(c).

**Requesting Verifications**
DHCS understands that many of these activities will require CEWs to request additional information from the beneficiary in order to process the change in circumstance. Per Welfare and Institutions Code 14005.37, CEWs must complete an ex-parte review when a change in circumstance occurs to attempt to verify information prior to contacting beneficiaries. If the CEW is unable to redetermine Medi-Cal eligibility through ex parte, CEWs may request additional information from beneficiaries using the process outlined in ACWDL 14-18. CEWs may call the beneficiary to obtain required information and/or send out an MC 355 form for all verification requests. However, if the beneficiary fails to provide any requested information during the federal COVID-19 PHE or if the information provided would ordinarily lead to a negative action on the case, CEWs shall not take a negative action and the beneficiary shall remain in the same level of coverage until the end of the federal COVID-19 PHE. CEWs shall not send out any negative Notice of Actions (NOAs) to individuals who fail to provide information during the federal COVID-19 PHE. DHCS will release a second ACWDL in the near future that will provide prioritization and policy guidance for all cases with or without a deferred eligibility determination at the conclusion of the federal COVID-19 PHE.

Additionally, per SHO 20-004 and SHO-21-002, CEWs shall use current case information to redetermine eligibility (through the ex-parte process) during the federal COVID-19 PHE. The CEW would first redetermine eligibility through the ex-parte process based on information already on file. If the result is unsuccessful and not e-

verified, then the county must obtain updated verifications using the process outlined in ACWDL 14-18

As a reminder, the CEWs shall accept written affidavits, including those that are telephonically signed by applicants or beneficiaries, that are unable to obtain a verification due to the federal COVID-19 PHE. Telephonic signatures for affidavits are permissible in situations where affidavits are allowed and when no other verification documentation is available.

**Address Change**
Before mailing a request for additional information to a beneficiary, the CEW shall review the case file to determine if a change to contact information has been reported by the beneficiary, an authorized representative, the health plan, or from any other allowable source, including CalHEERS, and ensure the address is updated with the new information. If there are no address changes on file but the CEW determines that mail has been previously returned as undeliverable, CEWs shall attempt to contact the beneficiary by their preferred method of contact in attempt to update the case file and counties shall follow the guidance outlined in ACWDL 16-23. However, counties shall disregard the steps in ACWDL 16-23 that advise counties to discontinue a beneficiary due to whereabouts unknown and to send a negative action NOA. Beneficiaries shall not be discontinued due to whereabouts unknown during the federal COVID-19 PHE.

**Tracking**
In accordance with MEDIL 20-25, counties are required to track cases that have a deferred eligibility determination based on the eligibility determinations CEWs are conducting during the federal COVID-19 PHE. When available, counties may use special indicators or tasks in SAWS to track the reason for the deferred eligibility determination. With the release of this ACWDL, counties may utilize the tracking categories outlined below as a guideline to track cases with a deferred eligibility determination. Counties will be required to complete a redetermination using updated case information for all cases being tracked to ensure the beneficiary's current situation is used to determine Medi-Cal eligibility. DHCS will release a second ACWDL in the near future that will provide policy guidance for all cases with or without a deferred eligibility determination after the conclusion of the federal COVID-19 PHE.

**Tracking Categories**
DHCS understands that many counties have already created their own tracking mechanism for cases that ordinarily would have led to a negative action during the federal COVID-19 PHE. Counties are not required to transition previously tracked items

into the new tracking categories. The following list is meant to guide counties to organize their tracking indicators to keep cases organized:

- Category 1: Failure to Provide
  - Examples: Non-MAGI screening packet is not returned, failure to provide income or property verifications, or failure to comply with assigning support rights
  - Please note that failure to provide does not apply when beneficiaries provide the requested information via telephonic attestation, or other means beyond the packets or paper verifications.

- Category 2: Ineligible due to eligibility rules
  - Examples: Over income or over property

- Category 3: Change in Benefits
  - Examples: Moving from MAGI Medi-Cal to Non-MAGI Medi-Cal with a share of cost, aging out of a non-premium program into a premium, reduction in scope of benefits or end of the postpartum period

- Category 4: Returned Mail
  - Examples: Undeliverable mail, no current address on file

DHCS will continue to collaborate with consumer stakeholders, counties, SAWS, and the County Welfare Directors Association of California to develop a comprehensive plan for counties to complete Medi-Cal case processing at the conclusion of the federal COVID-19 PHE.

If you have any questions, or if we can provide further information, please contact Luba Villarreal, by phone at (916) 345-8158, or by email at Luba.Villarreal@dhcs.ca.gov.

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