THE HEALTH CONSUMER ALLIANCE

The Health Consumer Alliance

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November 21, 2014

Toby Douglas, Director
Department of Health Care Services
1501 Capitol Ave., 6th Floor, MS 0000
Sacramento, CA 95814

RE: Improper Terminations and Application of MAGI income rules to non-MAGI populations

Dear Toby,

We are writing on behalf of the Health Consumer Alliance to ask DHCS to halt the improper application of the MAGI income rules to the non-MAGI beneficiaries at annual renewal of their ongoing eligibility for Medi-Cal, and to direct the counties not to terminate coverage for any of these individuals until the counties review all of these cases for non-MAGI eligibility. Specifically, the state's policy that counties should terminate the coverage of non-MAGI eligible beneficiaries (referred to by the state as "pre-ACA beneficiaries") for failure to return the Request for Household Tax Information ("RFHTI") Redetermination Packet, or otherwise provide the requested RFTHI MAGI income information, violates state law and multiple federal regulations.[1] These beneficiaries have non-MAGI linkage based on their age, disability, or blindness and MAGI related income information is not required in order to determine non-MAGI eligibility. Further, through the ex parte review that is required by state and federal law to be completed, most, if not all, of the information necessary to maintain these individuals on coverage is available to the counties and should be relied on before asking the beneficiary for anything more at renewal.

"Pre-ACA beneficiaries" are individuals who were enrolled in Medi-Cal prior to the ACA coverage expansion and changes to income rules beginning in 2014. While MAGI is the methodology now used to determine most individual's Medi-Cal income eligibility, it is not the methodology for all applicants and beneficiaries. Under federal Medicaid regulations, there are certain individuals for whom MAGI-based income determination

[1] 42 C.F.R. § 435 et seq.; Welf. & Instit. Code § 15926(h)(2)

methods do not apply, including those persons who are age 65 or older and individuals who are evaluated for eligibility on the basis of their blindness or another qualifying disability.[2] For those non-MAGI linked individuals, the state still must redetermine eligibility once every 12 months, but is required to make a redetermination first based on the information in the beneficiary's account or information derived from accessible data bases before requesting information from the beneficiary.[3]

Accordingly, California is treating 2014 as a "conversion year" for all pre-ACA beneficiaries.[4] The conversion process in California is comprised of two steps: (1) the county sends a RFTHI Redetermination Packet to all beneficiaries other than those receiving SSI, in foster care, or in long term care, and (2) the beneficiary must return the RFTHI to the county or otherwise provide the requested tax based income information.[5] Counties are required to give beneficiaries a minimum of 60 days to receive and complete the RFTHI (or provide the information) and must provide a reminder notice 20 days before the end of the renewal period.[6] If the beneficiary does not respond in 60 days, and after 2 attempts to contact the beneficiary, the State instructs the county to discontinue benefits for lack of cooperation after sending a timely 10-day notice.[7] The state also developed an updated "Alternate Renewal" Policy Letter that supplements the guidance in earlier policy letters (14-03, 14-03E, 14-11, and 14-18) and further instructs counties to: (a) complete additional outreach to beneficiaries, and (b) to conduct an ex parte review in SAWS or other data sources before taking negative action and sending a timely NOA to discontinue Medi-Cal benefits.[8]

Nevertheless, according to ACWDLs 14-11 and 14-18, for the 2014 renewals the counties must send all pre-ACA beneficiaries, including those eligible based on age, blindness and disability, RFTHI forms for a MAGI evaluation despite their non-MAGI linkage.[9] And if such pre-ACA beneficiaries don't respond to the RFTHI forms within 60 days with the requisite information, the state's policy and instruction is for counties to discontinue their Medi-Cal due to lack of cooperation (after taking additional steps outlines in ACL 14-31).[10]

Required Renewal Rules for Non-MAGI Eligibility Groups

The federal regulations are clear in terms of the state's obligation to review non-MAGI cases: The agency must make a redetermination of eligibility through an ex parte review if sufficient information is available to do so, including but not limited to information accessed through any data bases accessed by the agency under §435.948.[11] If the state cannot redetermine eligibility under the ex parte process, the state must require

[2] 42 C.F.R. § 435.603(j).
[3] 42 C.F.R. § 435.916(b).
[4] Cal. Dep't of Health Care Serv., All County Welfare Directors' Letter No. 14-11 (March 4, 2014), *available at* http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-03E.pdf. See also All County Welfare Directors' Letter No. 14-18 (April 8, 2014).
[5] Id. (Note that the counties are not reviewing the information on the form at this time).
[6] All County Welfare Directors' Letter No. 14-11, *supra* note 4; Cal. Welfare & Inst. Code Ann. § 14005.37(f).
[7] All County Welfare Directors' Letter No. 14-11, *supra* note 4; Cal. Welfare & Inst. Code Ann. § 14005.37(f).
[8] Id. All County Welfare Directors' Letter No. 14-31 (Sept. 11, 2014), page 4.
[9] All County Welfare Directors' Letter No. 14-11, *supra* note 4.
[10] All County Welfare Directors' Letter No. 14-11, *supra* note 4; Cal. Welfare & Inst. Code Ann. § 14005.37 (f)(3).
[11] 42 CFR § 435.916(a)(2).

information through use of a pre-populated form.[12]

Instead of renewing such beneficiaries directly using the required non-MAGI renewal process – using available resources such as the beneficiary's account information, SAWS, other databases to perform an ex parte review before requesting any information from the beneficiary - the State is putting the burden on the beneficiaries who are elderly or have disabilities to produce information that is not even required for non-MAGI eligible individuals.[13] And per State instructions, when the pre-ACA beneficiaries fail to meet their burden of producing this information, their benefits are discontinued for lack of cooperation and they are not given a non-MAGI evaluation.[14]

Requiring pre-ACA beneficiaries who are in an aged, blind and disabled aid code to complete the MAGI evaluation process in order to remain on coverage is both a direct violation of the state law and federal regulations as well as unduly burdensome on these beneficiaries and administratively burdensome for the counties. As it now stands, counties are waiting on detailed RFTHI responses from persons who should not be required to produce it and will have difficulty gathering the requisite information. Furthermore, the federal regulations require that when a beneficiary is evaluated for non-MAGI, the State may consider blindness and disability as a continuing condition until the review team (under § 435.531 and § 435.541) respectively determines that the beneficiary no longer meets the definition.[15] The State and counties know all pre-ACA beneficiaries' eligibility when the beneficiary has an established linkage based on age, blindness or disability. Instead of requesting RFTHI redetermination packets from such persons, the state should consider their conditions on-going until a review determines otherwise. Current State policy fails to adhere to the state and federal requirements.

Best Interest of Beneficiaries and Simplicity of Administration

The State has an obligation to ensure simplistic administration of the redetermination process that is in the best interest of the beneficiary.[16] In addition, the State has a responsibility to collect any and all additional information as may be necessary to determine Medicaid eligibility on any basis other than the MAGI standard and provide benefits on such a basis.[17] This includes beneficiaries who have turned in an application or renewal forms, as well as beneficiaries whom the State identifies "on the basis of other information available to the State, as potentially eligible on a basis other than the applicable MAGI standard."[18] In the case of pre-ACA beneficiaries who are elderly, blind or have qualifying disabilities, it is irrefutable that the State has available information identifying such beneficiaries as potentially eligible for redetermination on a basis other than the applicable MAGI standard because of their pre-existing aid codes. Therefore, the State must use available information to make a renewal determination on

[12] Id. at § 435.916(a)(3); 42 CFR §435.916(b)
[13] 42 C.F.R. § 435.916(b); Cal. Dep't of Health Care Serv., All County Welfare Directors' Letter No. 14-18 (April 8, 2014), *available at* http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf.
[14] All County Welfare Directors' Letter No. 14-18, *supra* note 13.
[15] 42 C.F.R. § 435.916(b)(1), (b)(2).
[16] 42 C.F.R. § 435.902.
[17] 42 C.F.R. § 435.911(c)(2).
[18] 42 C.F.R. § 435.911(d)(1).

a non-MAGI basis. They cannot legally terminate their coverage for not providing MAGI income information when no such review for non-MAGI has occurred.

Eligibility Determination on Any and All Bases

It is a longstanding tenet of federal and state law that no beneficiary may be terminated unless and until they are determined to be ineligible on any other basis.[19] The State's policy and instruction to the counties to terminate eligibility if beneficiaries fail to return the RFTHI form or otherwise provide the MAGI income and other information fails to comport with that requirement. Counties must be instructed to do a full redetermination on the basis of non-MAGI eligibility, using ex parte review, and seek only the non-MAGI information they need to renew eligibility.

Beneficiaries Right to Choose Coverage Category

Finally, beneficiaries who are eligible under more than one category shall be determined for eligibility under the category they choose.[20] Therefore, a beneficiary should be allowed to request to be found eligible for a non-MAGI eligibility group/program based on continuing age, blindness or disability, even if the beneficiary might be MAGI eligible in the end as well (if they chose to provide all of the MAGI income information or RFTHI forms). However, they cannot be simply terminated due to the state insistence on a MAGI determination or its refusal to conduct such a non-MAGI review.

Improper Terminations Are Happening Throughout the State

Terminations due to the State's illegal policy are already occurring in San Mateo, San Bernardino, Orange County, and will begin in other counties, including Los Angeles, at the end of November. Preliminary data from San Mateo County indicates that almost 44% of those who did not return the RFTHI forms were in either an aged or disabled aid code. In just this small county that totals 1,491 individuals. These are some of the most vulnerable Medi-Cal recipients, many of whom have serious chronic medical conditions and are dependent on IHSS for their day to day safety. These illegal terminations from Medi-Cal not only have caused the beneficiaries to lose their Medi-Cal coverage, they also lost coverage in the state's duals demonstration waiver program – CalMediConnect (CMC) Program. Below are a few examples of such individuals assisted by the Health Consumer Alliance and who were terminated in San Mateo.

Case Example #1: A 66-year-old, dually eligible consumer contacted San Mateo's Health Consumer Center (HCC) for assistance in early August when he discovered that he had been terminated without notice from Medi-Cal and CareAdvantage CMC, the San Mateo County CMC Program. The consumer is homeless, and receives his notices from Medi-Cal at the county welfare office. Upon investigation, the HCC discovered that Medi-Cal had mailed the 2014 renewal form (the RFTHI) to a local county welfare office for pick up, but when the consumer did not retrieve the notice within a few weeks, the forms were returned as undeliverable to the central Medi-Cal office and the consumer's Medi-Cal benefits were scheduled for termination August 1 due to non-cooperation for

[19] 42 C.F.R. §§ 435.911; 435.916(f)(1).
[20] 42 C.F.R. § 435.404.

failure to return the forms. On July 28, the consumer's coverage under CMC was also terminated based on the anticipated Medi-Cal termination, even though the time for appealing the Medi-Cal termination and obtaining "Aid Pending" had not yet run.

Although it was several days past the August 1 effective date of the termination, the HCC immediately filed a request for a fair hearing and requested "Aid Pending" since the client had never received notice of the termination. At the same time, HCC contacted the supervisor of the specialized Medi-Cal unit that serves seniors and people with disabilities and requested expedited reinstatement. The supervisor was able to obtain the information necessary to immediately reinstate the consumer to Medi-Cal. However, it initially appeared that the consumer would need to wait and voluntarily re-enroll in CMC in a subsequent month. So HCC enlisted the assistance of Health Plan of San Mateo, which worked directly with CMS to reinstate the consumer's coverage under CMC without a break in coverage.

Case Example #2: A 66-year-old woman was a CMC plan member with the Health Plan of San Mateo. In late August, the consumer received a call from the health plan explaining that she needed to immediately submit her Medi-Cal renewal forms or she would lose her Medi-Cal effective September 1, 2014. Upon hearing this, the consumer rushed down to the local Human Services Agency and submitted her RFTHI forms. Because San Mateo County is only terminating beneficiaries for failure to submit the required RFTHI forms, the consumer believed she had fulfilled her renewal obligations and that her Medi-Cal would continue. However, she was disenrolled from her CMC plan effective September 1, 2014, without any notice. Next the CalWIN system incorrectly terminated her from Medi-Cal because of a systems glitch. Although a correction was made and the consumer's Medi-Cal was restored on September 6, she was still unable to fill a prescription because she was no longer a CMC plan member. The pharmacy did not offer to sign her up for LINET, but instead made her pay $219 out of pocket. The consumer then had to re-enroll in the CMC plan effective October 1.

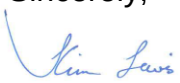
Conclusion

The State should immediately instruct the counties to: (1) halt any terminations of non-MAGI eligible individuals, and (2) not require the RFTHI information from a non-MAGI eligible person and instead only seek the information still needed to determine eligibility utilizing the non-MAGI rules. The State's current policy to discontinue benefits for pre-ACA beneficiaries who are elderly, blind or have qualifying disabilities for failure to return RFTHI forms (or information) is inconsistent with the state and federal law and is resulting in terminations from Medi-Cal of potentially hundreds of thousands of eligible beneficiaries. We are already seeing such terminations throughout the state (as the cases above exemplify) and tens of thousands more are set to be terminated at the end of November. Terminating eligible beneficiaries also adds to the already administratively burdensome county redetermination process. By conducting an ex parte review using available information on the pre-ACA beneficiaries before asking for any additional (non-MAGI) information, using the existing MC 210 RV or other relevant non-MAGI renewal forms, the State can ensure the legally required continuing coverage for beneficiaries who are part of a non-MAGI eligibility group. Given that the State recently also admitted that it does not intend to comply with the federal regulation requiring that only pre-populated forms be used for non-MAGI beneficiaries in either 2014 or 2015,

this problem will only be exacerbated as beneficiaries receive multiple forms asking for extensive amounts of information.

We would like to meet with you to discuss our concerns. Please contact Kim Lewis by email at lewis@healthlaw.org or by phone at (310) 736-1653.

Sincerely,



Kim Lewis
National Health Law Program and Health Consumer Alliance

cc: Cindy Mann, CMCS