

Medi-Cal for CalWORKs Advocates

Pitfalls, Policy Changes, and Advocacy Strategies to Help Your CalWORKs Clients Get and Keep Medi-Cal

Medi-Cal is a more protective, generous program than CalWORKs. Medi-Cal eligibility is automatic for CalWORKs recipients. Yet CalWORKs recipients often lose Medi-Cal unnecessarily, especially after welfare reform. Below is a list of ten common problem areas in the CalWORKs/Medi-Cal crossover area, with a brief description of the Medi-Cal protection, the implementation problem, and advocacy tips so you can help your CalWORKs clients keep the Medi-Cal they are eligible for.

Themes / Pitfalls

1. CalWORKs and Medi-Cal policy are moving in opposite directions. SB87 v. welfare reform -- (Protection v. punishment)
2. Because of rule of least common denominator, Medi-Cal policy is compromised.
3. Workers are slow to change; don't assume they are right.
4. Even though both CW and MC workers are in DPSS, they are working under different state departments – there is often a complete disconnect – different training, different ACL's, different understanding of obligations/responsibilities.
Arm yourself with basic Medi-Cal knowledge – you will likely know more than the worker does.

Issues – Problems areas in Medi-Cal/CalWORKs crossover

1. Section 1931(b) Medi-Cal for Families

The protection: Section 1931(b) Medi-Cal has more generous income requirements, more generous rules about participant responsibility, more lenient reporting requirements, and more protections to ensure retention than CalWORKs. Section 1931(b) is the most generous Medi-Cal program for families. Today, applicants can get 1931(b) with incomes up to 100% FPL and recipients (that includes people who were eligible in one of the last 4 months) can get Medi-Cal at higher income levels because of very generous earned income disregards. It is not necessary to receive CalWORKs to get 1931(b), however, 1931(b) should be automatic for CalWORKs recipients.

The problem: CalWORKs workers misapply more punitive CalWORKs rules to 1931(b) Medi-Cal. Eligible families are not properly screened for 1931(b) Medi-Cal or they lose it unnecessarily when they lose CalWORKs. Or, they are told they are not eligible because they do not get CalWORKs.

Advocacy Strategy: If your client loses CalWORKs, assume that she is still eligible for 1931(b) Medi-Cal and treat every termination as potentially improper. If your client loses 1931(b) or gets a Share of Cost (SOC) when she loses CalWORKs, check to see if that was improper under SB87, CEC, DE, and/or TMC. The 1931(b) Medi-Cal rules are tricky – it is common for an EW to misapply them. Do your own calculations by using this advocacy fact sheet: <http://www.healthconsumer.org/cs0151931b.pdf>.

2. Sneed / Gamma

The protection: Medi-Cal deeming rules are more protective than those in CalWORKs. First, under a lawsuit called *Sneed*, the only income that can be deemed available to an applicant/recipient is income of a parent or of a spouse. Second, under *Gamma*, before deeming a parent or spouse's income available to an applicant/recipient, you must subtract an allowance for that person's needs due to a formula, so that not all of the income counts. This means income from grandma or mom's boyfriend doesn't count, and not all of the income from mom or dad or husband or wife.

The problem: Medi-Cal workers don't always properly screen for Sneed / Gamma, and workers in CalWORKs units do so even less often. That means applicants or recipients who are eligible are either improperly denied Medi-Cal or are given a share of cost.

Advocacy Strategy: If you have a client who has any household members other than a parent or spouse who has income, assume that income has been improperly used against your client in determining eligibility. Do the math yourself to see whether your client is eligible for free Medi-Cal, and if not, what the SOC should be. Use the advocacy checklist and chart at <http://www.healthconsumer.org/cs030SneedGamma.pdf> and <http://www.healthconsumer.org/cs031Sneedproratedchart.pdf>.

3. Deprivation

The protection: Part of the deprivation test called the 100-hour rule says that two-parent working families cannot get Medi-Cal if the Primary Wage Earner (PWE) works more than 100 hours a month. However, this rule does not apply to recipients in the 1931(b) program and children in the Federal Poverty Level Percentage programs. That means they can live in two-parent working families and still get Medi-Cal.

The problem: Applicants are often denied Medi-Cal in two-parent families based on misapplication of the deprivation test. When a family loses Medi-Cal when a second non-disabled parent moves to the home, the family should not lose Medi-Cal under 1931(b) or an FPL program on that basis.

Advocacy Strategy: In every family with more than one parent, or when a second parent moves into the home, make sure the family does not unnecessarily lose Medi-Cal. If the family is already on 1931(b) or was eligible for either 1931(b) or CalWORKs in any one of the last four months, then the deprivation test does not apply. If the children are not eligible for 1931(b) but are eligible for an FPL program, deprivation doesn't apply. See income levels for 1931(b) and FPL programs at <http://www.healthconsumer.org/cs012FPLchart.PDF>.

4. Transitional Medi-Cal

The protection: Families leaving 1931(b) or CalWORKs can get up to two years (up to one year for kids) of additional Medi-Cal under Transitional Medi-Cal (TMC) if they are leaving CW or 1931(b) due to 1) an increase in income; 2) loss of earned income disregards; or 3) return to work of a PWE in a CalWORKs household. They can get the first six months regardless of income. After that, they can get more TMC if they meet reporting requirements and have income under 185% FPL.

The problem: TMC is severely underutilized. Both Medi-Cal workers and EW's in CalWORKs units fail to screen for TMC and send termination notices instead of putting eligible people on TMC.

Advocacy Strategy: Every time your client loses Medi-Cal or 1931(b) due to one of the three reasons above, assume she is eligible for TMC. Check to see if she should have received it. Also, note that she only needs TMC if she is already found ineligible for all of the other Medi-Cal programs – if she can get Medi-Cal another way she doesn't need TMC. Also, if your client gets on TMC but her income goes down again, she should be put back on 1931(b) immediately, and she can always get TMC again if she needs it – there is no lifetime limit on TMC and you can get it as many times as you are eligible. For more information, see the advocacy fact sheet: <http://www.healthconsumer.org/cs014TMC.pdf>.

5. SB87 (redetermination and *ex parte* review)

The protection: As of July 1, 2001, people on Medi-Cal are guaranteed ongoing Medi-Cal until the county proves them ineligible for all Medi-Cal categories through an exhaustive redetermination process with minimal burden on the recipient. The burden of proof of eligibility has shifted away from the recipient and onto the county. Also, there are special rules for CalWORKs recipients – if you lose CalWORKs for a reason that does not affect Medi-Cal eligibility (such as hitting time limits, failure to meet reporting requirements in CalWORKs, non-cooperation with WTW requirements), your Medi-Cal should automatically continue in aid code 3N without a redetermination.

The problem: This bill changed Medi-Cal policy overall, yet implementation has been spotty and slow, especially by CalWORKs workers. EW's send termination notices when people lose 1931(b) or CalWORKs without following SB87 – this means eligible people unnecessarily lose Medi-Cal.

Advocacy Strategy: The bottom line is that you should treat every Medi-Cal termination – whether or not the recipient is losing CalWORKs – as an SB87 case to make sure your client was not terminated without a proper redetermination (without the county proving

your client ineligible for all Medi-Cal categories). For more information see the following guides: <http://www.healthconsumer.org/SB87.pdf> and the attached SB87 fact sheet “How to Keep Medi-Cal and Prevent Wrongful Terminations.” A few important tips:

- **Assume no redetermination necessary:** If your client is losing CalWORKs, assume no redetermination is necessary, especially if your client is losing CalWORKs due to sanctions or time limits.
- **Ex parte review:** SB87 begins with an ex parte review, which means “without client contact.” This means if the county learns of a change in your client’s life that does affect Medi-Cal, the first step of the redetermination is for the county to do an exhaustive search of all available records, including the Medi-Cal, Food Stamps, and CalWORKs files of the client and family members to see if the EW can find the information needed to establish ongoing eligibility.
- **Contact with client is minimal, specific:** Only if the county can’t assess eligibility through the ex parte review, the EW then contacts the recipient by phone to see if she can establish eligibility, and then by mail by sending the MC 355 Medi-Cal Request for Information Form. These oral and written requests violate SB87 (and are illegal) if they request information that 1) has been provided before, including to the CalWORKs or Food Stamps cases, such as in a CW or FS report; 2) is not subject to change, such as a DOB or SSN; or 3) is not absolutely necessary to determine eligibility (such as a driver’s license or SSN’s of people not seeking Medi-Cal).
- **SB87 replaces Edwards:** If your EW says she’s following Edwards, she’s wrong. Edwards is superseded by SB87, which is more protective.
- **Don’t believe a recipient’s “request to close case”** -- there is way too much misinformation about losing Medi-Cal, especially by CalWORKs workers. If your client tells you she wants to request that her case be closed, or if the EW encourages it, that may be because they do not understand all of the ways they could be eligible, and have not done the exhaustive review. Educate your client and/or the worker that Medi-Cal laws have changed and there are more ways to keep Medi-Cal now.

6. Inter-County Transfer (ICT)

The protection: Federal law (and a new DHS ACL that is on the way) require that when a recipient moves to a new county, Medi-Cal should continue with no gap in coverage. The recipient should never have to re-apply for Medi-Cal or for a redetermination, and neither the first county nor the second county should condition the ICT on a redetermination of eligibility. In fact, the recipient should get continued Medi-Cal and the first county should never do a redetermination. The second county may only do a redetermination after already establishing eligibility, but not based on the move itself – there must be another reason that affects Medi-Cal eligibility that requires a redetermination, and the redetermination must follow SB87.

The problem: Neither the Medi-Cal or CalWORKs workers follow this rule. They tell the recipient to reapply or they won't do the transfer until a redetermination in the first county. To make things worse, the CalWORKs rules are more punitive and require reapplication and redetermination.

The Advocacy strategy: When your client moves to a new county, assume the EW is using outdated, illegal instructions. The DHS ACL is expected out later in March, but until then, use the attached federal instruction in a Dear State Medicaid Directors Letter, dated December 4, 2000, as an authority to show your EW that continued Medi-Cal is automatic, and the burden is on the county, not the recipient.

7. Continuous Eligibility for Children (CEC)

The protection: Children on Medi-Cal are guaranteed Medi-Cal until their next scheduled annual redetermination – even if their families' income goes up and would otherwise make them ineligible, even if their parents lose Medi-Cal. If income goes up and they would have a Share of Cost (SOC), they instead continue to get free Medi-Cal with no SOC.

The problem: This is a far-reaching policy change, because all children's Medi-Cal policies have to be changed to incorporate this new protection. Medi-Cal and CalWORKs EW's alike make mistakes and either discontinue a child or give her a SOC when she should have gotten ongoing free Medi-Cal under CEC.

Advocacy Strategy: Every time your clients who are children receive a new SOC or are terminated, assume the EW made a mistake and failed to apply CEC. Demand the EW continue the client's Medi-Cal with no SOC until the next scheduled Medi-Cal annual redetermination. This is important for clients losing CalWORKs – make sure they don't also wrongfully lose Medi-Cal. We are working on a new advocacy flyer, but until then, use the state statute, WIC §14005.25.

8. Newborn enrollment (Deemed Eligibility (DE))

The protection: Under federal law, newborns born to mothers on Medi-Cal are “deemed eligible” for one full year of Medi-Cal.

The problem: Newborns have trouble getting care even though mom's BIC card is good for the baby, and EW's wrongfully terminate baby's Medi-Cal if mom loses Medi-Cal during the year (due to increased income, failure to return the annual redetermination form, etc). Also, workers occasionally misapply the MFG rule in CalWORKs, which prohibits family from getting additional cash aid for MFG babies. MFG does not apply to Medi-Cal. Babies not only *can* get Medi-Cal if mom was on CalWORKs, but Medi-Cal is *automatic* for newborns when mom is on Medi-Cal.

Advocacy Strategy: If you have pregnant clients or clients with newborn babies, make sure the babies have Medi-Cal. The MFG rule does not apply in Medi-Cal, and baby should never lose Medi-Cal before age 1. You will likely have to educate the worker on this policy. DHS is working on a new ACL that clarifies this policy, but until it is out, you can refer to the federal statute, 42 USC §1396e (a)(4).

9. Annual Redetermination

The protection: In Medi-Cal, there is no Quarterly reporting requirement today, and recipients are only required to meet annual redetermination requirements and also report to the county a change in circumstances that affects Medi-Cal eligibility within 10 days of the change. Combining this rule with CEC and SB87, your clients should get Medi-Cal for a full year in most cases once they are found eligible at application or at annual redetermination. All annual redeterminations must follow SB87 (see above). Also, LA County has a protective redetermination pilot that prohibits counties from requiring documentation or verification at annual redetermination

The problem: First, between the annual redeterminations, EW's often burden the recipient with requests for documentation or information unnecessarily. Second, at annual redetermination, EW's often fail to apply SB87 (in other words, they terminate without evaluating whether the recipient is still eligible for any Medi-Cal categories). Third, despite LA's protective pilot, workers in the CalWORKs unit often violate this protection and overburden the recipient, and as a result the recipient loses Medi-Cal unnecessarily.

Advocacy Strategy: Be wary of any termination that happens at annual redetermination. Tell your clients when you see them that in most cases, they should not lose their Medi-Cal at annual redetermination, and if they do, or if they have trouble with the forms, they should contact you. In LA County, more people are terminated for failure to comply with the redetermination or based on processing of the redetermination than any other reason – we think most of these terminations are wrong and unnecessary. Build troubleshooting at annual redetermination into your regular case management and educate all of your clients of their rights.

10. Foster Care and Continued Eligibility

The protection: Foster children are guaranteed Medi-Cal. Also, due to the new Former Foster Care Children (FFCC) program, children are guaranteed Medi-Cal through age 21 when they leave foster care – regardless of changes in income.

The problem: Neither Medi-Cal workers in DPSS or DCFS workers apply this rule properly. Kids lose Medi-Cal despite ongoing eligibility because their cases are wrongfully terminated.

Advocacy Strategy: Make sure all of your kids in foster care get Medi-Cal. Educate them

that even if their incomes go up when they leave foster care, they get Medi-Cal through age 21. This includes when a child leaves foster care to return home – at any age. It is likely the DCFS worker will misapply this rule and won't properly transfer the case to DPSS.

Remember, the burden is on the county here. We're working on advocacy with the county agencies and the state on this, but if you get a case ask the worker to reinstate Medi-Cal with no gap, cite SB87, and see the attached advocacy flyer at <http://www.healthconsumer.org/cs043FosterCareRights.pdf> .

Tools

1. DHS All County Letters (assume CalWORKS worker doesn't know about it)
2. DHS Regulations (22 CCR) – there are very few and they have been slow to change; many are out of date
3. DHS Eligibility Procedures Manual (also slow to change; often out of date)