CONNECT
TO CARE BY CMSP

AND

PATH TO HEALTH™

ELIGIBILITY MANUAL

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ARTICLE 1 **DEFINITIONS, ABBREVIATIONS AND PROGRAM TERMS**

1-010. General

The purpose of this manual is to set forth standardized definitions and eligibility criteria to be used by designated community health centers in the determination of an individual's or family unit's eligibility for Connect to Care and/or Path to Health covered services.

While many provisions in this manual may duplicate various CMSP and Medi-Cal criteria and requirements, this manual is a separate and distinct document that is to be applied to the Connect to Care and Path to Health Programs only. Connect to Care and Path to Health eligibility is not bound in any way to CMSP or Medi-Cal criteria and requirements. Further, county eligibility offices play no administrative role in the eligibility process for Connect to Care and Path to Health. County eligibility offices do administer eligibility for the CMSP benefit program and are required to follow the CMSP Eligibility Manual when determining eligibility for CMSP.

1-011. Definitions – General

The definitions in this article shall apply to Connect to Care and Path to Health unless the context requires otherwise.

1-012. Abbreviations

The following abbreviations shall apply to Connect to Care and Path to Health:

CalWORKs	California Work Opportunity and Responsibility to Kids Program
CIN	Client Identification Number
CMSP	County Medical Services Program
CTC	Connect to Care
EP	Enrollment Provider
FBU	Family Budget Unit
FPL	Federal Poverty Level
GA/GR	General Assistance/General Relief
IHSS	In-Home Supportive Services
mCase	Enrollment System Created by RedMane
NOA	Notice of Action
OASDI	Old Age Survivors and Disability Insurance
Other PA	Other Public Assistance
PA	Public Assistance
PI	Personal Information
PTH	Path to Health
SSA	Social Security Administration
SSI/SSP	Supplemental Security Income/State Supplemental Payment

SSN Social Security Number
UIB Unemployment Insurance Benefits

1-013. Adult

For Connect to Care, Adult refers to a person who is 21 years of age or older. Applicants must be between the ages of 21 and 64 to qualify for Connect to Care coverage. Persons are considered 21 years of age on the first day of the month following the month in which they reach age 21. Persons are considered 65 years of age on the first day of the month in which they reach age 65.

For Path to Health, Adult refers to a person who is 21 year of age or older. Applicants must be aged 26 to 49 to qualify for Path to Health coverage. Persons are considered 26 years of age on the first day of the month following the month in which they reach age 26. Persons are considered to be 50 years of age on the first day of the month which they turn age 50.

1-014. Adverse Action

Adverse Action is any action which the CMSP Governing Board takes that results in the discontinuance of Connect to Care or Path to Health eligibility. Discontinuance due to any of the following reasons shall not be considered Adverse Action:

A) Death of the Beneficiary, for a one person FBU
B) The whereabouts of the Beneficiary are unknown and the post office has returned mail addressed to the Beneficiary indicating that they have moved and left no forwarding address
C) Admission of the Beneficiary to an Institution that renders the Beneficiary ineligible
D) Beneficiary resides in another County or state
E) Receipt of the Beneficiary’s clear written or verbal statement that does either of the following:
    1. States the Beneficiary no longer wishes to receive Connect to Care or Path to Health benefits; or,
    2. Gives information that requires discontinuance and includes the Beneficiary’s acknowledgement that the information supplied would result in discontinuance

1-015. Aid

Aid means any form of cash assistance, CalFresh, Medi-Cal, CMSP, Connect to Care, or Path to Health.

1-016. Aid Category

Aid Category means the specific category under which a person is eligible to receive services.

1-017. Aid Code

Aid Code refers to the numbers, letters, or combinations thereof that indicate the Aid Category under which a person is eligible for CMSP and various Medi-Cal programs. There is no Aid Code for Connect to Care or Path to Health because eligibility is determined by a separate eligibility system, mCase, that is outside of the California Statewide Automated Welfare Systems. See Section 1-086 for information about Restricted Scope Aid Codes.

1-018. Appeal

An appeal is defined as a request to review an action taken by the CMSP Governing Board that resulted in the denial or discontinuance in Connect to Care or Path to Health eligibility or benefits.

1-019. Applicant

Applicant refers to the individual or family making, or on whose behalf is made, an Application, Reapplication, or request for Restoration of aid.

1-020. Application

Application refers to a request for Connect to Care or Path to Health aid filed on behalf of an Applicant by an Application Assister through the mCase enrollment system.

1-021. Application Assister

Application Assister refers to the staff member in a participating community health center whose role is to collect necessary information and verification documents to submit, on the Applicant’s behalf, an application for Connect to Care and/or Path to Health.

1-022. Approval of Eligibility

Approval of Eligibility refers to the determination made by a CMSP Governing Board Eligibility Worker that a person(s) is/are eligible for Connect to Care or Path to Health.

1-023. Authorized Representative

Individual(s) or organization(s) chosen by a competent Applicant/Beneficiary to assist, accompany, and/or represent him/her in the making of an application.

1-024. Beneficiary

An individual approved for and receiving Connect to Care or Path to Health benefits, also known as a Member.

1-025. Certification Effective Date

Certification Effective Date means the date the Member is certified eligible to receive Connect to Care or Path to Health benefits.

1-026. Certification for Connect to Care

Certification for Connect to Care means the determination by the CMSP Governing Board Eligibility Worker that a person is eligible for Connect to Care.

1-027. Certification for Path to Health

Certification for Path to Health means the determination by the CMSP Governing Board Eligibility Worker that a person is eligible for Path to Health.

1-028. Child or Children

Child or Children means a person or persons under the age of 21 years.

1-029. Client

Client means a person who has been determined eligible for Connect to Care or Path to Health, also referred to as a Beneficiary or Member.

1-030. Client Identification Number (CIN)

CIN means a nine-character identification number assigned to Medi-Cal and CMSP members, consisting of eight digits followed by a letter. A valid CIN is required for any application to the Path to Health expedited enrollment process.

1-031. Competent

Competent means being able to act on one's own behalf in business and personal matters.

1-032. Connect to Care

Connect to Care means the program authorized by the CMSP Governing Board to provide primary health care services for Adults in CMSP Counties.

1-033. Conversion of Property

Conversion of Property means changing property from one form to another without changing ownership.

1-034. County Agency

County Agency means either an administrative division of a County government or a non-County organization that has a contract with the County to act on the County's behalf.

1-035. County Department

County Department means the department authorized by the County Board of Supervisors to conduct eligibility administration for the CMSP benefit program.

1-036. County Medical Services Program (CMSP)

County Medical Services Program (CMSP) means the program authorized by Sections 16709, 16709(a), 16709(d), and 16809 et seq of the Welfare and Institutions Code to provide for the health care of medically indigent Adults residing in rural and semi-rural counties of California which contract with the Governing Board to participate in CMSP.

1-037. County Medical Services Program (CMSP) County

CMSP County means those rural and semi-rural California counties which contract with the Governing Board to participate in CMSP. The following 35 counties participate in CMSP: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba.

1-038. County Medical Services Program (CMSP) Governing Board

The CMSP Governing Board (Governing Board) is comprised of County supervisors, County administrators, County welfare directors, County health directors, and a representative of the Secretary of the California Health and Human Services Agency in accordance with the California Welfare and Institutions Code, Section 16809.4. The CMSP Governing Board shall govern the CMSP Program and any pilot projects.

1-039. Covered California

Covered California is the health insurance exchange in the State of California established under the Affordable Care Act that provides eligible individuals and small businesses the opportunity to purchase private health insurance coverage at federally subsidized rates.

1-040. Connect to Care Person or Family Member

Connect to Care Person or Family Member means a person or Family Member eligible for benefits under Connect to Care.

1-041. Dependent Relative

Dependent Relative means a Relative who is either of the following:

- Claimed as a tax dependent by the Applicant or Beneficiary, regardless if the individual is residing with the Applicant or Beneficiary; or

- Receiving more than one-half of his/her basic needs for food, shelter, clothing, and transportation from the Applicant or Beneficiary.

Dependent Relatives residing with the Applicant or Beneficiary will be included in the FBU.

1-042. Eligibility Services

Eligibility Services means those services provided by the CMSP Governing Board's Eligibility Worker relating to the initial and continuing determination of Connect to Care and Path to Health eligibility.

1-043. Encumbrances of Record

Encumbrances of Record means obligations for which property is security as evidenced by a written document.

1-044. Enrollment Provider

Enrollment Provider means a community health center that serves as both a provider of health care services and assists applicants for Connect to Care and Path to Health in applying for benefit coverage.

1-045. Fair Market Value

Fair Market Value means the amount (price) an item would sell for, if made available for sale on the open market in the geographic region where the item is located.

1-046. Family Budget Unit (FBU)

Family Budget Unit (FBU) means the person or persons who will be included in the determination of eligibility for Connect to Care and Path to Health.

1-047. Family Member

Family Member means any of the following persons living in the home or declared as a tax dependent:

A. A Child or sibling Child;

B. The Married or unmarried Parents of the Child or sibling Children;

C. The stepparents of the sibling Children;

D. The separate Children of either unmarried Parent or of the Parent or stepparent; or

E. If there are no Children, Family Member means a single person or Married couple.

Family Members residing with the Applicant/Beneficiary will be included in the FBU.

1-048. Fleeing Felon

Fleeing Felon means an individual who is fleeing to avoid prosecution, or custody or confinement under the laws of the place from which the individual flees, for a crime, or an attempt to commit a crime, which is a felony under the laws of the place which the individual flees, or which, in the case of New Jersey, is a high misdemeanor under the laws of such State, or violating a condition of probation or parole imposed for committing a felony under Federal or State law. Fleeing Felons are ineligible for benefits under Connect to Care and Path to Health and are treated as ineligible members of the FBU.

1-049. Full Time Employed

Full time employed means working 40 hours or more per week.

1-050. Heirloom

Heirloom means any item of Personal Property other than cash, securities, or other liquid resources, which has substantial sentimental value, has been owned by the same family for at least two generations, and is intended to be retained by the same family in succeeding generations.

1-051. Inmate

Inmate means a person either living or being cared for in an Institution, or a person under the direct control of a penal authority. Excluded from this definition are persons residing at a facility for vocational training or educational purposes, and persons temporarily in an Institution pending more suitable arrangements, such as Children in a local agency facility pending foster care placement.

1-052. Institution

Institution means an establishment, which provides food, and shelter to four or more persons unrelated to the proprietor and, in addition, provides some treatment or services, which meet needs beyond basic provision of food and shelter.

1-053. Institution – Medical

Medical Institution means any public or private acute care hospital, acute psychiatric hospital, intermediate care facility, skilled nursing facility, or other medical facility licensed by an officially designated state standard setting authority.

1-054. Institution – Mental Diseases

An Institution for Mental Diseases means an Institution primarily engaged in providing diagnosis, treatment, or care for persons with mental illness.

1-055. Institution – Nonmedical

Nonmedical Institution means any Institution providing nonmedical residential care, custodial care, custody, or restraint. This term includes penal institutions.

1-056. Institution – Private

Private Institution means a proprietary or nonprofit Institution managed and controlled by an individual, private association, or corporation.

1-057. Institution – Public

Public Institution means an Institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. Excluded from this definition are medical facilities and publicly operated community residences designed to serve and serving no more than 16 persons.

1-058. Institution – Tuberculosis

Tuberculosis Institution means an Institution, which is primarily engaged in providing diagnosis, treatment, or care of persons with tuberculosis, including medical attention, nursing care, and related services.

1-059. Life Estate

Life Estate means a legal arrangement whereby the Member (i.e., the life tenant) is entitled to the use and/or income from the property for his or her life. Upon the death of the life tenant, the property will revert to the holder of the remaining interest or to the grantor.

1-060. Life Insurance

Life Insurance means a contract from which premiums are paid during the lifetime of the insured and on which the insuring company pays the face amount of the policy to the Beneficiary of the policy upon the death of the insured. Life insurance may also be purchased by a single premium or by letting dividends accumulate.

1-061. Marriage

Marriage is defined as a legal union of two consenting adults of either sex as evidenced by the issuance of a valid marriage license and solemnization. Solemnization is authorized by California Family Codes Section 400 et. seq.

1-062. Medi-Cal

Medi-Cal means California's Medicaid (medical assistance) Program and the benefits available under that program.

1-063. Medicare

Medicare is a national health insurance program in the United States administered by the federal Centers for Medicare and Medicaid Services (CMS) that provides health coverage for Americans aged 65 and older and for certain other persons with a disability status.

1-064. Member Identification (ID) Card

The Member Identification (ID) Card is a paper card each enrolled Beneficiary is issued following approval for Connect to Care or Path to Health. The program-specific card provides information regarding benefit coverage administered by the CMSP Governing Board's Third-Party Benefits Administrator and Pharmacy Benefits Administrator. The card specifies the effective dates of coverage.

1-065. Overpayment

Overpayment means the receipt of Connect to Care or Path to Health benefits when there is no entitlement to all or a portion of the benefits received.

1-066. Parent

Parent means the natural or adoptive Parent of a Child.

1-067. Path to Health

Path to Health means the program authorized by CMSP Governing Board to provide for the primary health care services for undocumented immigrant Adults; residing in rural and semi-rural counties of California which contract with the Governing Board to participate in CMSP; and who are not claiming PRUCOL or otherwise entitled to full-scope Medi-Cal or Covered California.

1-068. Path to Health Expedited Eligibility Process

Path to Health Expedited Eligibility Process means at the time of application, an Applicant is residing in a CMSP County, is not pregnant, and is actively enrolled in an allowable Restricted Scope Aid Code for Medi-Cal issued by a CMSP County. The Applicant can forgo supplying income and residency verification as part of the Application process in the instances where the Applicant is the only Applicant from the FBU or if all other Applicants in the FBU qualify for the Path to Health Expedited Eligibility Process. All Applicants are required to supply a signed Rights and Responsibilities Form and provide sufficient identification.

1-069. Patient

Patient means a person receiving individual professional services directed by a licensed practitioner of the healing arts towards maintenance, improvement, or protection of health or the alleviation of disability or pain.

1-070. Persons Living in the Home

Persons Living in the Home means any of the following:

A) Persons physically present in the home.

B) Persons temporarily absent from the home because of hospitalization, visiting, vacation, trips in connection with work or because of similar reasons.

    1. A temporary absence is normally one in which the person leaves and returns to the home in the same or following month;

    2. A Child temporarily absent from the home as defined in Item B.1. above shall be considered to be living in the home as long as the Parent continues to have responsibility for the care and control of the child.

1-071. Pharmacy Benefit Manager

The Pharmacy Benefit Manager is the company hired by the CMSP Governing Board to administer the retail pharmacy benefits included in Connect to Care and Path to Health benefit coverage.

1-072. Principal Residence

Principal Residence means the property in which the Applicant or Beneficiary has an ownership interest and which the Applicant or Beneficiary uses as his/her home.

1-073. Program

Program means Connect to Care and/or Path to Health which were established by the CMSP Governing Board to provide benefit coverage for primary care services to eligible Applicants.

1-074. Property

"Property" for purposes of this manual means any real, liquid or personal possessions also commonly referred to as "assets" and/or "resources."

1-075. Property – Personal

Personal property means possessions or interest, exclusive of Real Property, that may be easily transported or stored; including but not limited to cash on hand, bank accounts, notes, mortgages, deeds of trust, cash surrender value of Life Insurance, motor vehicles, uncollected judgments, an interest in a firm in receivership, a lawsuit, patents, copyrights, household goods, and musical instruments.

1-076. Property – Real

Real property means land and improvements, which generally include any stationary property attached to the land and any oil, mineral, timber or other rights related to the land.

1-077. Path to Health Person or Family Member

Path to Health Person or Family Member means a person or Family Member eligible for benefit coverage under Path to Health.

1-078. Public Agency

Public Agency means an administrative division of local, state, or federal government, or an organization that has a contract to act in behalf of the local, state, or federal government.

1-079. Quality Control

Quality Control means the review of Connect to Care and Path to Health cases to ensure proper submission of applications and determination of eligibility.

1-080. Reapplication

Reapplication means another Application for Connect to Care or Path to Health eligibility made at any participating community health center that serves as an Enrollment Provider after the previous Application was denied or withdrawn or when the certification period for enrollment ended in the previous month or will come to an end the following month and a renewal of eligibility is being sought.

1-081. Relative

Relative means a mother, father, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, niece, half-brother, half-sister, or any such person of a preceding or succeeding generation denoted by a prefix of grand, great or great great.

1-082. Repayment

Repayment means the liquidation of an Overpayment in response to issuance of demands and recovery thereof by the CMSP Governing Board.

1-083. Residence

Residence means the place in which a person or family lives or is physically present and the person or family has no present intention of leaving.

1-084. Responsible Relative

Responsible Relative means a Family Member who is responsible to contribute to the cost of health care services received by a Beneficiary.

1-085. Restoration

Restoration means restoring Connect to Care or Path to Health eligibility for a person or family, due to an erroneous discontinuance, fair hearing decision, or administrative error. Eligibility is restored to the end of the original certification period.

1-086. Restricted Scope Aid Code

Restricted Scope means a Medi-Cal aid code which only covers emergency and pregnancy related services. For the purposes of the Path to Health Expedited Eligibility Process, Applicants must have one of the following Medi-Cal Restricted Scope Aid Code issued through a CMSP County: 1U, 3T, 55, 58, 5F, 5T, C1, C2,

C3, C4, C5, C6, C7, C8, D2, D3, D4, D5, D6, D7, J3, J4, J6, J8, K3, K5, K7, K9, M2, or M4 and are not pregnant.

1-087. Satisfactory Immigration Status

Satisfactory Immigration Status means lawful admission for permanent Residence in the United States, or status as an alien permanently residing in the United States under color of law.

1-088. Third-Party Benefits Administrator

The Third-Party Benefits Administrator is the firm hired by the Governing Board to administer Connect to Care and Path to Health benefits, including payment of medical care claims and issuance of Member ID cards. The Third-Party Benefits Administrator does not administer Connect to Care and Path to Health retail pharmacy benefits.

1-089. Transfer of Property

Transfer of Property means a change in ownership whereby a person no longer holds title to, or beneficial interest in, property.

1-090. U.S. Citizenship

U.S. Citizenship is legal residency in the United States as a result of birth or naturalization, a process in which an immigrant applies for United States citizenship and is accepted.

1-091. Undocumented Immigrant

Undocumented Immigrant means an individual who does not have satisfactory immigration status. Applicants for Path to Health must be undocumented immigrants who are not claiming PRUCOL or otherwise entitled to full-scope Medi-Cal or Covered California.

1-092. Verification

Verification means the process of obtaining acceptable evidence, which substantiates statements made by an Applicant or Beneficiary.

1-093. 138% Federal Poverty Level (FPL) Income Test

138% Federal Poverty Level Income Test means the total gross income of the Applicant's FBU must be less than, or equal to, the 138% FPL limit for an applicant(s) to be eligible for Path to Health benefit coverage.

1-094. 300% Federal Poverty Level (FPL) Income Test

300% Federal Poverty Level Income Test means the total gross income of the Applicant's FBU must greater than 138% FPL and no more than the 300% FPL limit for an applicant(s) to be eligible for Connect to Care benefit coverage.

ARTICLE 2 **COMMUNITY HEALTH CENTER RESPONSIBILITY**

2-010. Community Health Center Serving as Enrollment Provider – Responsibility

A community health center that serves as an Enrollment Provider shall be responsible for assisting applicants in making applications for Connect to Care and Path to Health and shall submit completed applications to the CMSP Governing Board using the mCase Enrollment System.

2-011. Use of mCase Enrollment System

Only authorized users are permitted to use the mCase Enrollment System in accordance with the terms specified in the CMSP Governing Board's "Use of Connect to Care Enrollment System Policies and Procedures" document contained in Exhibit A. In summary, authorized users agree to abide by all applicable federal and state laws and CMSP Governing Board policies and shall:

1) Follow all CMSP Governing Board eligibility policies and procedures for Connect to Care and Path to Health, use the eligibility system only for required eligibility processing, and share records only as needed to fulfill their job duties.
2) Protect all data, in any format (e.g. electronic, paper, etc.), while in their possession or use, to the best of their abilities.
3) Ensure that if it is necessary and allowed, that data will be destroyed by complying with all applicable laws, statutes, polices, and directives.
4) Safeguard the privacy of protected health information belonging to persons served by the health center and applying for or receiving benefits from the Connect to Care or Path to Health Program.
5) Notify their immediate supervisor and the health center official responsible for eligibility system access upon the discovery of an actual or suspected security breach of the system.
6) If their employment or contracting relationship ends, they shall not subsequently access, use or disclose any Connect to Care or Path to Health eligibility information to any third party.

Additionally, authorized users of the mCase eligibility system agree not to:

A) Reveal client data to any person or persons outside or within the Community Health Center who have not been authorized to receive such data
B) Attempt or achieve access to data not related to their job duties
C) Enter, alter, or erase client data for direct OR indirect personal gain or advantage
D) Enter, alter, or erase client data maliciously or in retribution for real or imagined abuse, for personal amusement or any other unauthorized or improper use
E) Use another person's personal login IDs, User IDs, or passwords
F) Reveal their personal login IDs, User IDs, or passwords to another person

G) Ask another user to reveal his/her personal login IDs, User IDs, or passwords
H) Leave their workstation unattended while logged into the eligibility system
I) Subvert or bypass any security measures for the eligibility system
J) Attempt to use the eligibility system to gain unauthorized access to any other computer systems or networks

2-012. User Access Forms for Health Centers

Prior to receiving mCase system access, all health center employees or contractors that are requesting authorization to use the eligibility system must read, sign, and submit a mCase System User Agreement to the health center administrative official responsible for mCase Enrollment System access. Additionally, this health center administrative official shall document that the user completed system training conducted by the CMSP Governing Board, its benefits administrator for Connect to Care and Path to Health, or the health center administrative official prior to being granted user access to the eligibility system.

2-013. mCase User Guide

The mCase User Guide was developed to assist health centers in properly creating and completing Applications for Connect to Care and Path to Health. The User Guide is a tool and does not supersede any of the Eligibility Policies contained within this Eligibility Manual.

2-014. Community Health Center – Receiving Transfer of Enrollment

If a Member wants to renew Connect to Care or Path to Health eligibility at a community health center other than where their initial enrollment occurred, the community health center where the Member wants to take this action (receiving health center) may request access to the Member’s detailed application information from the CMSP Governing Board. After meeting specified validation requirements, the Governing Board may allow for a transfer of the Member’s information to the receiving community health center in the mCase eligibility system.

ARTICLE 3 **ADMINISTRATION**

3-010. Explanation of Roles

The mCase enrollment system contains several roles necessary to process an application: Read-Only, Application Assister, Application Supervisor, Eligibility Worker, Eligibility Supervisor, and Organization Administrator.

3-010.1. Read-Only

Read-Only is a role for front desk staff, billing, and finance staff at community health center provider locations. Read-Only users can validate a Member's Connect to Care or Path to Health coverage.

3-010.2. Application Assister

Application Assister is a role for community health center staff who will help Applicants apply for and enroll in Connect to Care and Path to Health. Application Assisters can create and submit applications, access any applications in the application pool for their health center, collect and upload verification documents, send verification requests to Applicants, and add and read notes on application screens.

3-010.3. Assister Supervisor

Assister Supervisor is a role for community health center staff who lead a team of Application Assisters. They can view their team's workload and assign applications to Application Assisters.

3-010.4. Eligibility Worker

Eligibility Worker is a role for CMSP Governing Board staff. The Eligibility Worker reviews submitted Connect to Care and Path to Health applications, determines whether submitted verifications are valid or invalid, and either approves or denies eligibility.

3-010.5. Eligibility Supervisor

Eligibility Supervisor is a role for CMSP Governing Board staff who leads a team of Eligibility Workers. They can view their team's workload, assign applications to Eligibility Workers, and transfer Member records from one community health center system to another upon request.

3-010.6. Organization Administrator

Organization Administrator is a role for CMSP Governing Board staff. The Organization Administrator has full access to the mCase system across all organizations, can add or remove organizations, organization locations, and manage users in the system.

3-011.1. Application Workflow – Data Collection by Application Assister

The Application Assister works with the Applicant to complete the application and upload necessary document verifications for identification, residency (if applicable), Rights and Responsibilities form, enrollment in a Restricted Scope Aid Code for Medi-Cal (if applicable) and income (if applicable) provided by the Applicant. The Application Assister must complete and submit the application within thirty days of the original date of the application or the application will expire. If an Applicant's application expires, the Applicant must begin the application process again to restart the application process.

3-011.2. Application Workflow – Connect to Care Application Review by Eligibility Worker

The Eligibility Worker reviews the application thoroughly and views all uploaded verification documents. If documents are illegible, out of date, or unrelated to the item they are intended to verify, the document will be marked invalid. The application will be approved for Connect to Care by the Eligibility Worker when the Applicant is within the ages of 21 to 64; has no other healthcare coverage; is not pregnant; has income greater than 138% and no more than 300% FPL; resides within a CMSP County: self-attests to having assets below the asset limit; and legible, accurate, up-to-date documents from the Applicant are uploaded to the mCase system and those documents verify identity, residency, and income of the Applicant. All applications must also include a signed Rights and Responsibilities form, with Telephonic Signature Form if applicable. Otherwise, the application will be denied. The Eligibility Worker must review and complete disposition of the application within thirty days of receipt of the application in the mCase system.

3-011.3. Application Workflow – Path to Health Expedited Eligibility Process by Eligibility Worker

The Eligibility Worker reviews the application thoroughly and views all uploaded verification documents. If documents are illegible, out of date, or unrelated to the item they are intended to verify, the document will be marked invalid. The application will be approved for Path to Health by the Eligibility Worker when the Applicant is at least 26 years old and not more than 49 years old; resides within a CMSP County; is not pregnant; has an allowable Restricted Scope Aid Code from Medi-Cal issued from one of CMSP's 35 contracted counties; and legible, accurate, up-to-date documents from the Applicant are uploaded to the mCase

system and those documents verify the Applicant's identity and Restricted Scope Medi-Cal coverage of the Applicant. All applications must also include a signed Rights and Responsibilities form, with Telephonic Signature Form if applicable. Otherwise, the application will be denied. The Eligibility Worker must review and complete disposition of the application within thirty days of receipt of the application in the mCase system.

3-011.4 Application Workflow – Path to Health Standard Review by Eligibility Worker

The Eligibility Worker reviews the application thoroughly and views all uploaded verification documents. If documents are illegible, out of date, or unrelated to the item they are intended to verify, the document will be marked invalid. The application will be approved for Path to Health by the Eligibility Worker when the Applicant is at least 26 years old and not more than 49 years old; is an undocumented immigrant who is not claiming PRUCOL or possessing any other immigration status that would qualify them for full-scope Medi-Cal; has no other healthcare coverage; has income at or below 138% FPL; resides within a CMSP County; is not pregnant; and legible, accurate, up-to-date documents from the Applicant are uploaded to the mCase system and those documents verify identity, residency, and income of the Applicant. All applications must also include a signed Rights and Responsibilities form, with Telephonic Signature Form if applicable. Otherwise, the application will be denied. The Eligibility Worker must review and complete disposition of the application within thirty days of receipt of the application in the mCase system.

3-011.5. Workflow – Approval of Application

An Applicant whose application has been approved will receive a Notice of Action (NOA) informing them of their approval, the program to which they were approved, and the start and end date of their coverage. They will also receive a member guide from the Third-Party Administrator providing information on medical and pharmacy benefits that are covered and the services that are not covered, and a Member ID card to verify their coverage with their health care providers. Before their Member ID card is received, a Member may use their Approval NOA to verify Connect to Care or Path to Health coverage.

3-011.6. Application Workflow – Denial of Application

An Applicant whose application has been denied will receive a Notice of Action informing them of their denial, the reason for denial, and an explanation of how to appeal the Eligibility Worker's decision. The Appeals process is explained in Article 12.

3-011.7. Application Workflow – Connect to Care (CTC) Reapplication

An approved CTC Member is eligible for up to six months of coverage. The Member may reapply for CTC at any point in the last month of coverage prior to discontinuance in order to continue their CTC coverage with no break in aid for another enrollment term of up to six months.

3-012. Statistical Reporting

During the Application process, the Application Assister will ask supplemental survey questions of the Applicant about their health status, recent health center visits, and recent hospitalizations. Applicants will also be asked how they heard about the Programs. Responding to these questions will be optional for the Applicant and the answers will not have an effect on the Applicant's eligibility for Connect to Care or Path to Health.

3-013. Confidentiality of Application Records

CMSP and community health centers shall retain case records through the mCase system and ensure confidentiality. RedMane, which owns and operates the mCase system, the CMSP Governing Board, and Community Health Centers will maintain confidentiality in accordance with all federal and state regulations governing confidentiality of health care information, federal tax information, and case records of income-based aid, such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Welfare and Institutions Code Section 10850 and 45 CFR Section 205.50(a). Refer to Article 2 for the mCase System User Agreement and Use of the mCase Enrollment System Policy and Procedures.

3-013.1. Confidentiality of Application Records – Destruction of Records

The CMSP Governing Board may authorize the destruction of Application records over three years old providing that no record of unresolved issues or pending civil or criminal actions exist.

3-014. Rights and Responsibilities

Applicants must sign, or verbally consent over the telephone, the Rights and Responsibilities form as a part of the application process. The Application Assister will, if needed, provide an explanation of this form and its contents. By signing this form, Applicants declare under penalty of perjury that they understand the eligibility requirements of Connect to Care and Path to Health, as well as their rights to fair treatment, non-discrimination, and confidentiality.

ARTICLE 4 **INSTITUTIONAL STATUS**

4-010. Institutional Status – General

The status of persons in public or private institutions shall be a factor in the determination of their eligibility as specified in Section 4-011. The eligibility of persons whose institutional status does not cause ineligibility under Section 4-011 shall be contingent upon all other eligibility requirements being met.

4-010.1. Ineligible Due to Institutional Status

In accordance with the provisions set forth below, persons who are classified as Inmates of a public or private institution are ineligible for Connect to Care and Path to Health. Such ineligibility begins on the day institutional status commences and ends on the day institutional status ends.

A) Inmates in public or private Institutions shall be ineligible for Connect to Care and Path to Health if they are any of the following:
    1. Detained under the penal system (including house arrest).
    2. Detained under Section 602 (wards of the juvenile court), California Welfare and Institutions Code.
    3. Inmates in an institution for the treatment of tuberculosis.
    4. Inmates in an Institution for mental health treatment.
    5. Inmates of a public Institution which is not a medical facility.
B) Institutional status of persons detained under the penal system including Section 602 of the California Welfare and Institutions Code shall be considered to be terminated only when the Inmates are released from the public Institution on permanent release, bail, probation or parole (but not including house arrest). Institutional status of such persons shall not be affected by an outpatient visit to a physician or other medical practitioner outside the public Institution or transfer to a public or private medical facility.
C) Institutional status for persons in non-penal facilities shall be considered to be terminated when either of the following situations exists:
    1. Persons are released from an Institution for mental health treatment or tuberculosis or transferred from such an Institute to a public or private medical facility. Institutional status of such persons shall not be affected by an outpatient visit to a physician or other medical practitioner outside the Institution.
    2. Persons are on conditional release or convalescent leave from an Institution for mental health treatment.

4-010.2. Fleeing Felon

Any person who is running or hiding from the law for a felony or attempted felony, or who is in violation of probation or parole, shall be ineligible for Connect to Care and Path to Health.

ARTICLE 5 **CITIZENSHIP, IDENTITY AND RESIDENCY**

5-010. Citizenship or Immigration Status – Connect to Care

CTC will be granted to all otherwise eligible Applicants regardless of their citizenship or immigration status. Applicants will not be asked to provide verification of citizenship or immigration status but may choose to provide such documentation to verify their identity.

5-011. Citizenship or Immigration Status – Path to Health

Path to Health will be granted to all otherwise eligible Applicants only if they are undocumented immigrants who are not claiming PRUCOL or otherwise entitled to full-scope Medi-Cal or Covered California. Applicants will not be asked to provide verification of citizenship or immigration status but may choose to provide such documentation to verify their identity.

5-012. Identity

Applicants must submit verification of their identity. Identity may be verified with documents such as:

A) Birth certificate
B) Passport, issued by any country
C) Immigration documents
D) Driver's license or state ID
E) Matricula Consular
F) School ID
G) Marriage certificate
H) Social Security card
I) Divorce decree
J) Adoption record
K) Court order for name change

5-013. Residence – General

An individual applying for or receiving Connect to Care or Path to Health benefits must be a resident of a CMSP County. County residence shall be established by either physical presence, if there is no intention of leaving the County, unless the Applicant maintains a home outside the County of physical presence, or living in the County at the time of Application, and having entered the County with a job commitment or to seek employment, whether or not currently employed. Once County residence is established, it shall continue until residence is established in another County.

Residency may be verified with documents such as:

A) California driver's license or state ID
B) Lease or rental agreement
C) A rent or mortgage receipt
D) A utility bill
E) Bank or other financial documents listing the Applicant's home address, including personal checks with address printed on them
F) California vehicle registration form
G) Paystub or other income documents listing the Applicant's home address
H) Envelopes addressed to the Applicant that were sent by a mail delivery service such as the United States Postal Service (USPS), United Parcel Service (UPS), or FedEx; this verification document will be marked "Mail Received".
I) Other official documents listing home address.
J) If the Applicant does not have a home address, the Applicant may submit a written notice from a County Social Services Department, homeless shelter, or local nonprofit organization verifying receipt of services.

5-013.1. Residence – Family Members

Family Members may establish separate residences without a break in marital or family ties. Only those Family Members who meet the requirements of this article, and all other eligibility factors, may be eligible for Connect to Care or Path to Health.

ARTICLE 6 **FAMILY BUDGET UNIT DETERMINATION**

6-010. Responsible Relatives

In determining Connect to Care or Path to Health eligibility, Relative responsibility shall be determined in accordance with the following:

A) Relative responsibility shall be spouse for spouse or registered domestic partner for registered domestic partner when the spouses or registered domestic partners are living together in the same home.
B) Parent for ineligible Child living in the Parent's home.
C) Unmarried Parents shall have their eligibility determined as a family unit when both unmarried Parents and their common Child or Children live together in the same home.

6-011. Family Budget Unit (FBU)

The Family Budget Unit (FBU) shall be the basic unit of persons considered in determining an Applicant's or Member's eligibility. The FBU shall be established in accordance with Section 6-012.

6-012. FBU Determination

The FBU shall be determined in accordance with the following:

A) All Family Members living in the home, other than individual Adults, shall be included in the FBU in accordance with Section 6-010, whether or not they are eligible for, or wish to receive, Connect to Care or Path to Health.
B) Once the potential members of the FBU have been identified, the FBU shall be determined in accordance with Section 6-010 Responsible Relatives. Spouses and legal dependents must be included in the FBU. Ineligible individuals may still count in the FBU, such as individuals enrolled in other health coverage or Fleeing Felons.

ARTICLE 7 **PROPERTY**

7-010. Property – General

No documentation of property is necessary for Connect to Care. However, all Applicants for Connect to Care must self-attest their asset amount. Assets shall include all of the following: cash; un-cashed checks; checking account or savings account balances; shares of stock or mutual funds; Individual Retirement Accounts (IRAs, Keoghs, or work-related pension funds); annuities; trusts or similar agreements; court-ordered settlements; judgments; promissory notes; mortgages or deeds of trust (excluding principal residence); any other real estate or property that is not a principal residence; motor vehicles (excluding primary vehicle), which shall include cars, motorcycles, trailers, and boats. A FBU of one may have property valuing $20,000 maximum. The limit for an FBU of two is $30,000, and this limit increases by $1500 for each additional FBU member after two.

Property limits do not apply to Path to Health, as the FBU has household income of 138% FPL or less. Property limit only applies when a household’s income is above 138% FPL.

ARTICLE 8 **INCOME**

8-010. Income – General

Income includes payment for labor services provided, business activities, returns from real or Personal Property, contributions, retirement/pension payments, or other similar sources. Such income shall be considered as income only if it is currently available. Income from these sources shall be divided into gross earned income, gross unearned income, and self-employment income. Connect to Care and Path to Health only consider gross income and do not allow for deductions, with the exception of certain self-employment income as detailed in 8-013. An Applicant's income must be greater than 138% FPL, but not greater than 300% FPL, for an Applicant to qualify for Connect to Care. An Applicant's income must be exactly 138% FPL or less for an Applicant to qualify for Path to Health.

Applicants with an allowable Restricted Scope Aid Code for Medi-Cal issued from a CMSP County can forgo supplying income verification as part of the Application process in the instances where the Applicant is the only Applicant from the FBU or if all other Applicants in the FBU qualify for the Path to Health Expedited Eligibility Process.

8-011. Gross Earned Income

Earned income for the FBU includes:

A) Wages, including amounts designated for meals provided by an employer or business enterprise, salaries, bonuses, and commissions from an employer or business enterprise, and including payments issued from employer to employee in cash or via app such as Venmo, Cash App, or PayPal.
B) Payments under the Job Training Partnership Act (JTPA). Payments identified by the local JTPA office as incentive payments or training allowances shall be considered as gross unearned income.
C) Payments under the Economic Opportunity Act.
D) Training incentive payments and work allowances under ongoing manpower programs, not including Welfare-To-Work or JTPA.
E) Income received for providing IHSS services as an IHSS provider.
F) Earnings from public service employment.
G) Tips actually received for the performance of work activities, notwithstanding the amount calculated by the employer for tax withholding purposes.

8-012. Gross Unearned Income

Unearned income for the FBU includes:

A) Old Age, Survivors, and Disability Insurance (OASDI) payments from the SSA, also known as Retirement, Survivors, and Disability Insurance (RSDI) payments.
B) Annuities, which are sums paid yearly or at other specific intervals in return for payments of a fixed sum by the annuitant.
C) Pensions.
D) Retirement payments other than SSA Retirement benefits, Railroad Retirement payments, or pensions.
E) Disability payments from an employer or insurance.
F) Veteran's payments which include pensions based on need, compensation payments, or educational assistance. The Aid and Attendance portion of Veteran's payment is considered a third-party payment and is exempt.
G) Worker's Compensation.
H) Railroad Retirement or any other payments made by the Railroad Retirement Board.
I) Unemployment Insurance Benefits, exempting Lost Wages Assistance (LWA) payments issued in response to the Public Health Emergency of 2020.
J) Proceeds from a Life Insurance policy which are in excess of the lesser of $1500 OR the amount expended on the insured person's last illness and burial expenses.
K) Other insurance payments.
L) Loans which do not require repayment.
M) Gifts.
N) Non-exempt child support, whether provided voluntarily or by court order.
O) Spousal support payments.
P) Inheritances.
Q) Prizes and awards.
R) Dividends.
S) Interest payments from any source, including trusts, trust deeds, and contracts of sale.
T) Royalties including, but not limited to, payments to a holder of a patent or copyright for the use of invention, or to the owner of a mine, oil well, or similar holdings for the extraction of the product or other use.
U) Income from a Public Assistance Program including, but not limited to, CalWORKs, SSI/SSP, GA/GR, Refugee Cash Assistance, and Adoption Assistance.
V) Incentive payments or training allowances under the Workforce Investment Act (WIA).
W) Proceeds from Indian Gaming
X) Any other income, which is available to meet current needs.

8-012.1. Available Unearned Income

Only income which is actually available to meet the needs of a person or family shall be considered in determining that person's or family's eligibility. Income shall

be considered available in the month it is received, unless it is unavailable in accordance with Section 8-012.2, or to be apportioned over time.

8-012.2. Unavailable Income

Income which is not available to meet current needs of a person or family shall not be considered in determining the person's or family's eligibility. Unavailable income includes, but is not limited to:

A) That portion of workers' compensation and other public or private insurance settlements designated for medical, legal, or related expenses, or not controlled by the Applicant or Member.
B) That portion of a contribution that is both from a person living in the household for which the household has no legal responsibility to support, such as an unrelated Adult or Adult Child, or used to meet the actual costs of the contributor's share of housing, utility, food, and other household costs.

8-013. Self-Employment Income

For Self-Employed individuals, the gross amount of income shall be used if the income is between 0% and exactly 138% FPL for Path to Health, or at least one penny above 138%, up to 300% FPL for Connect to Care. However, if a Self-Employed individual has income in excess of 300% FPL, a 10% deduction on all Self-Employment income will be applied. If this deduction results in countable income of 300% FPL or below, the Applicant will be eligible for Connect to Care if all other eligibility requirements are met.

8-014. Pay Periods

Income received more frequently than monthly or semi-monthly (twice a month) shall be converted to monthly income through the use of multipliers. Weekly income shall have a multiplier of 4.33, and biweekly income shall have a multiplier of 2.167.

8-015. Fluctuating Income

Fluctuating income shall be determined by estimating the amount to be received in the month. This estimate shall include the income pattern over the last year, the actual income received in the last month, and the Applicant's statement of anticipated income.

8-016. Income Exemptions

Certain items of earned and unearned income shall be exempt from consideration in determining an Applicant's eligibility for Connect to Care and Path to Health, including the following:

A) Property Tax Refunds.
B) The cash value of CalFresh benefits.
C) Payments issued under the Welfare-To-Work program component of CalWORKs.
D) In-Kind benefits such as In-Home Supportive Services (IHSS), childcare, and training and rehabilitation services.
E) Federal housing assistance in the form of rent subsidies, loans, or partial house payments under the U.S. Housing Act of 1937, the National Housing Act, Title V of the Housing Act of 1949, or the Housing and Urban Development Act of 1965.
F) Training expenses paid by the Department of Rehabilitation to persons participating in that Department's training programs.
G) The portion of Foster Care payments designated by the County Department for care and supervision, if such a designation is made.
H) Loans made under Title III of the Federal Economic Opportunity Act, Special Program to Combat Poverty in Rural Areas.
I) Loans or grants to an undergraduate student for educational purposes made or insured by the Federal Commissioner of Education, including but not limited to Supplemental Education Opportunity grants, National Direct Student loans, College Work Study, Basic Educational Opportunity grants, and federal insured student loans.
J) Payments made under the California Victim of Crimes program.
K) Relocation Assistance Benefits paid to a person who has been relocated as a result of a program of area redevelopment, urban renewal, freeway construction, or any other public development involving demolition or condemnation of existing housing.
L) Certain federal payments to Indians and Alaskan Natives per CMSP Eligibility Manual 8-036.
M) AmeriCorps Payments.
N) Workforce Investment Act (WIA) Payments.
O) Executive Volunteer Programs such as the Service Corps of Retired Executives (SCORE) and the Active Corps of Executives (ACE).
P) The actual Earned Income Tax Credit (EITC) Payment, whether received as a tax refund or advance payment.
Q) Recovery Rebates (also known as economic impact payments or stimulus payments) provided under Section 2201 of the CARES Act.

8-017. Cash or Self-Employment Form

If the Applicant is employed by an employer who pays cash for services rendered, or if the Applicant is self-employed, and no other form of verification can be provided by the Applicant to verify their income, the Application Assister shall

provide the Applicant with the Cash or Self-Employment Form. Applicants who complete this form shall attest under penalty of perjury that the income reported is accurate for the purposes of determining eligibility for Connect to Care and Path to Health.

8-018. Other Compensation in Lieu of Cash Payments

Other compensation provided by an employer, including stipends or other payments for housing or meals, shall be considered income for the purposes of determining gross income of an Applicant. Public Assistance benefits provided by a federal, state or county government for housing and meals shall not be considered income for the purpose of determining gross income of an Applicant.

ARTICLE 9 **PERIOD OF ELIGIBILITY**

9-010. Period of Eligibility – Connect to Care

Following the successful review and approval of an application, the Period of Eligibility for Connect to Care shall be up to six months, beginning the first of the month the application is started and ending the last day of the sixth month of eligibility. If a Member wishes to reapply to extend their eligibility without a break in aid, they may file a reapplication at any time in the last month prior to discontinuance.

9-011. Period of Eligibility – Path to Health

Following the successful review and approval of an application, the Period of Eligibility for Path to Health will begin the first of the month the application is started and end on December 31, 2023 unless the Member turns 50 years old before the coverage end date. Path to Health Members turning 50 years old prior to December 2023 will have coverage end dates for the last day of the month prior to their 50th birthday.

9-012. Change of Circumstance

Any Applicant or Member must notify the community health center or CMSP immediately if a change of circumstance may affect their status with Connect to Care or Path to Health. This includes but is not limited to pregnancy, change in residence, a significant change in income and/or assets, changes in marital status, change in immigration status, change in health coverage, and an addition of a person in the household or death or departure of anyone residing in the household.

In situations where an adult is added to an existing case, a new certification period will be established for both adults the first of the month following the change.

In situations when a Member no longer resides in a CMSP county, dies, becomes pregnant, obtains other health care coverage, and/or wishes to withdraw from Connect to Care or Path to Health, the Member will be disenrolled from coverage.

Other changes in circumstances may require the Member's eligibility to be redetermined.

10-010.1. Other Health Coverage – General

Potential applicants for Connect to Care and Path to Health will be asked during the application process if they have any other health coverage. If the answer is yes, the potential applicant will not be eligible for Connect to Care. For undocumented immigrants applying for Path to Health, if the other health coverage is something different than an allowable Restricted Scope Aid Code for Medi-Cal issued by a CMSP County, the potential applicant will not be eligible for Path to Health. If the potential applicant chooses to continue with the application process, the Application shall be denied for failure to meet the other health coverage requirement.

10-010.2. Other Health Coverage – Path to Health

Potential applicants will be asked during eligibility screening if they have any other health coverage. If the answer is yes, the Assister will need to determine what type of Other Health Coverage the Applicant has. If the Applicant has Restricted Scope Medi-Cal issued by a CMSP County, the Assister must input the Medi-Cal aid code and Medi-Cal county code, along with the Applicant's CIN. So long as every potentially eligible adult within the FBU also has an allowable Restricted Scope Aid Code from Medi-Cal issued by a CMSP County, this will route the Applicant into the Path to Health Expedited Eligibility Process, and the Applicant will not need to verify income or residency.

Alternatively, if any potentially eligible adult in the household does not have an allowable Restricted Scope Aid Code from a CMSP County or any other health coverage, the application will default to the traditional workflow for Applicants in the family budget unit.

Pregnant individuals, or individuals who may be otherwise eligible for coverage such as full scope Medi-Cal or the Medi-Cal Access Program, will not be eligible for Path to Health benefits and will be appropriately referred to their prospective qualifying program. Path to Health Applicants may be enrolled in Restricted Scope Medi-Cal and be eligible for Path to Health. While Applicants and Members of Path to Health who are not enrolled in Restricted Scope Medi-Cal are not required to apply for Medi-Cal to obtain Path to Health coverage, referrals to Medi-Cal are encouraged.

10-010.3. Other Health Coverage – Connect to Care

Pregnant individuals, or individuals who may be otherwise eligible for coverage such as Medi-Cal or the Medi-Cal Access Program, whether full scope or restricted scope, will not be eligible for Connect to Care benefits and will be appropriately referred to their prospective qualifying program.

ARTICLE 11 OVERPAYMENTS, FRAUD, AND IMPROPER UTILIZATION

11-010. Potential Overpayments

A Potential Overpayment occurs when a Member willfully fails to report facts, or reports incorrect facts which, when considered in conjunction with the other information available on the Member's circumstances, would result in ineligibility, including enrollment in any other health care or health insurance coverage, other than allowable Restricted Scope Medi-Cal from one of CMSP's 35 contracting counties. No Potential Overpayment exists if an unforeseen change occurred in a person's circumstances after eligibility has been determined.

11-011. Fraud

Fraud occurs if the Member or the person acting on the Member's behalf willfully fails to report facts which, when considered in conjunction with the other information available on the Member's circumstances, would result in ineligibility, with the intention of deceiving the Program or the health center for the purposes of receiving Connect to Care or Path to Health benefits to which the Member was not entitled. An Overpayment will have occurred due to these actions.

11-012. Action on Potential Overpayments

The CMSP Governing Board shall take the following action when it appears that there may be a potential Overpayment:

A) Determine the correct eligibility status based on the correct income, property, household size, and other circumstances.
B) Determine whether a potential Overpayment exists in accordance with Section 11-010.
C) Determine the amount of Connect to Care or Path to Health benefits received during the period when the potential Overpayment occurred.
D) In those instances where a potential Overpayment is due to the Application Assister's willful failure to report facts, refer the Application Assister to the Application Supervisor or other health center staff management for disciplinary procedures.

11-013. Action on Overpayments

The CMSP Governing Board shall take the following action on Overpayments:

A) Determine the amount of benefits received by the Member for the period in which there was a potential Overpayment.
B) Compute the actual Overpayment in accordance with the following:

1. When the potential Overpayment was due to excess property, the actual Overpayment shall be the lesser of the actual cost of services paid by the Program during the period of consecutive months in which there was excess property throughout each month, or the amount of property in excess of the property limit during that period when excess property existed for the entire calendar month(s).
2. When the potential Overpayment was due to other factors, which result in ineligibility, the Overpayment shall be the actual cost of services paid by Connect to Care or Path to Health.
3. Potential Overpayments, due to Member possession of other health coverage other than Restricted Scope Medi-Cal through one of CMSP's 35 contracting counties, shall be the actual cost of services paid by Connect to Care or Path to Health which would have been covered by private health insurance or other health coverage had the coverage been known to CMSP. The actual Overpayment shall not include any costs which can be recovered directly by Connect to Care or Path to Health from the health insurance carrier or other sources. Such potential Overpayment should be processed according to (1) above.

11-014. Demand for Repayment

CMSP shall demand Repayment of an Overpayment only if it is made as a result of the Member's willful failure to meet the reporting responsibilities as specified in Section 11-010.

A) Repayment shall be demanded of a Member who has property or income which meets all of the following conditions:
   - The property can be reasonably converted to cash within one year of the time the Overpayment is reported. The value assigned to property other than cash shall be the net market value of the property, less reasonable selling costs.
   - The property is not essential to safe and healthful household operation.
B) The County may enter into a Repayment agreement with a Member who does not currently have property or income that can be used for Repayment in accordance with (A) if it appears that such property or income will become available within one year of the date of the discovery of the Overpayment.
C) CMSP may take other collection actions as permitted under state law.

11-015. Failure to Repay

If the Member refuses to repay the total amount of the Overpayment, which is subject to a demand for Repayment, the CMSP Governing Board shall proceed to reduce the court judgment to a lien by having an abstract of judgment recorded in

any County in which the Member owns Real Property, pursuant to Section 697.530, Code of Civil Procedures. Thereafter, the CMSP Governing Board shall take all appropriate action to execute the judgment. As one way of satisfying an otherwise uncollectible Overpayment, the CMSP Governing Board may arrive at a reasonable settlement for its demand for Repayment with the Member.

12-010. Appeals

An Applicant or Member is entitled to file an appeal if they are dissatisfied with any negative action or inaction of CMSP relating to eligibility or benefits provided by Connect to Care or Path to Health. Appeals must be submitted in writing or through mCase and submitted within sixty calendar days of the date of the Notice of Action.

12-011. Review of Appeals

Upon receipt of a Connect to Care or Path to Health appeal, the Eligibility Supervisor and the CMSP Governing Board's Executive Director shall review the information provided in the appeal along with all information and documents provided during the Application process.

A) If it is determined that the Application was incorrectly dispositioned, the Eligibility Supervisor shall retroactively approve benefits to the first of the month of the Application in dispute.
B) If it is determined that the Application was correctly dispositioned, the Applicant will receive written notice of the decision and no benefits shall be granted for the Application/Appeals timeframe.

12-012. Board Review of Appeals

If an Eligibility Supervisor and CMSP Governing Board's Executive Director determine an appealed Application was correctly dispositioned, and the Applicant disagrees with this determination, they may make a secondary appeal to the CMSP Governing Board. The Board shall review the information provided in both primary and secondary appeals, along with all information and documents provided during the Application process.

A) If it is determined the Application was incorrectly dispositioned, the Eligibility Supervisor shall retroactively approve benefits to the date of the initial Application.
B) If it is determined the Application was correctly dispositioned, the Applicant will receive written notice of the decision and no benefits shall be granted for the Application/Appeals timeframe. The Board's decision shall be final, with no further appeals possible.

12-013. Right to Representation

An Applicant filing an Appeal may seek legal assistance with their Appeal. All Denial Notices of Action will provide name and contact information for a legal aid agency located within the Applicant's county of residence.

EXHIBIT A USE OF THE MCASE ENROLLMENT SYSTEM POLICIES AND PROCEDURES

County Medical Services Program Governing Board

("Governing Board")

Use of the mCase Enrollment System Policy and Procedures

EXHIBIT A **USE OF THE MCASE ENROLLMENT SYSTEM POLICIES AND PROCEDURES**

1. PRIVACY AND CONFIDENTIALITY

A. The County Medical Services Program ("CMSP") Enrollment Provider and its workers covered by this Policy ("EP Workers") may use or disclose Personal Information ("PI") only as permitted in this Policy and only to assist in the administration of Connect to Care and Path to Health, or as required by law. Disclosures that are required by law (such as a court order) or made with the explicit written authorization of the Connect to Care or Path to Health client, are permissible. No EP Worker shall duplicate, disseminate, or disclose PI except as allowed in this Policy.

B. Pursuant to this Policy, EP Workers may use PI only to perform administrative functions related to determining eligibility for individuals applying for Connect to Care and Path to Health.

C. Access to PI shall be restricted to only EP Workers who need the PI to perform their official duties to assist in the administration of Connect to Care and Path to Health.

2. PERSONNEL CONTROLS

A. The CMSP Enrollment Provider shall train EP Workers, who have access to PI of the confidentiality of the information, on the safeguards required to protect the information, and the sanctions for non-compliance as an employee and those under federal and/or State law, including but not limited to California Civil Code § 1798.21.

B. The CMSP Enrollment Provider shall ensure that all EP Workers who assist in the administration of Connect to Care and Path to Health and use or disclose PI sign a mCase Enrollment System User Agreement.

C. The CMSP Enrollment Provider shall immediately notify the Governing Board regarding any unauthorized access, disclosure or use of PI.

D. The CMSP Enrollment Provider shall apply appropriate sanctions to EP Workers who access, disclose, or use PI in a manner or for a purpose not authorized by this Policy, which may include immediate termination of EP Worker's access to the mCase Enrollment System and reporting of this action to the Governing Board.

E. The CMSP Enrollment Provider shall immediately terminate any EP Worker's access to the mCase Enrollment System upon request by the Governing Board.

3. MANAGEMENT OVERSIGHT AND MONITORING

A. The CMSP Enrollment Provider shall establish and maintain ongoing oversight of EP Workers' compliance with the privacy and security safeguards in this Policy when using or disclosing PI.

B. The CMSP Enrollment Provider shall ensure that management oversight and monitoring activities are performed by workforce members whose job functions are separate from those who use or disclose PI as part of their routine duties.

4. ASSESSMENTS AND REVIEWS

In order to enforce this Policy and ensure compliance with its provisions, the CMSP Enrollment Provider agrees to allow CMSP Governing Board to inspect the facilities, systems, books, and records of the CMSP Enrollment Provider, with reasonable notice from Governing Board in order to perform assessments and reviews. Such inspections shall be scheduled at times that take into account the operational and staffing demands. The CMSP Enrollment Provider agrees to promptly remedy any violation of any provision of this Policy and certify the same to the Governing Board Executive Director in writing, or to enter into a written corrective action plan with the Governing Board containing deadlines for achieving compliance with specific provisions of this Policy.