Article 4 Section 13 –Denial/Discontinuance/Restoration Requirements

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04.13.01 Request for Withdrawal/Discontinuance

A. General

The following procedures will apply whenever an applicant/beneficiary or person authorized to act on behalf of the applicant/beneficiary requests withdrawal of an application for Medi-Cal or requests discontinuance of Medi-Cal benefits.

An applicant/beneficiary may withdraw his/her application for Medi-Cal or request discontinuance of Medi-Cal benefits by:

- Indicating the request on Form MC 215;
- Submitting a signed statement indicating the request for withdrawal/discontinuance; or
- Making an oral request for withdrawal/discontinuance.

MPG LTR 631 (5/08)

B. Processing Request for Withdrawal or Discontinuance

When the request is ...	Then the worker will ...
Written	• deny/discontinuance the case; • send the appropriate NOA to the client; • retain a copy of the written request, along with the NOA, in the case file.
Oral	• ask that the request be made in writing; • document in case comment of the oral request and that written confirmation has been requested; • deny/discontinue the case; AND • send appropriate NOA. It is not necessary to wait for the written request before the case is

	denied/discontinued. When the written request is received, it is to be filed with a copy of the NOA.

MPG LTR 631 (5/08)

C. Timely Notice Requirement

Timely notice is not required when the beneficiary provides a clear and signed written request for discontinuance of Medi-Cal benefits. Adequate notice is required.

Timely notice is required when only an oral request is made and the worker is unable to obtain a written request from the beneficiary.

MPG LTR 631 (5/08)

D. Disputed Requests for Withdrawal or Discontinuance

If the applicant/beneficiary fails to return a written request for withdrawal/discontinuance and later disputes the oral request, and there is not other basis for denial/discontinuance, the worker will immediately rescind the action. Otherwise, the action will be considered valid.

MPG LTR 631 (5/08)

04.13.02 Denial/Discontinuance Due to Lack of Information

A. General

Applications are NOT to be denied solely because the worker has not received all required verifications within given deadlines unless the applicant/beneficiary is not cooperating within his/her ability or limitations.

The following procedures must be followed when Medi-Cal benefits are to be denied or discontinued due to lack of information.

MPG LTR 631 (5/08)

B. Worker Assistance

In addition to following the 10/10 timeframe when requesting for information/verifications necessary to complete eligibility determination, the worker is required to review the applicant/beneficiary's ability to obtain the required verifications and offer assistance as necessary in obtaining verifications.

The type of worker assistance required varies depending on the limitation of the applicant/beneficiary. In some situations, assistance in identifying the address of the verification source may be all that is needed. In others, the worker may need to obtain the applicant/beneficiary's written authorization and

request the verification on behalf of the applicant.

MPG LTR 631 (5/08)

C. Denials Due to Lack of Information

Prior to denying an applicant for failure to provide essential information, the worker must:

Step	Action
1	Provide the applicant with a list of outstanding verifications and allow the applicant at least 10 calendar days to provide. The worker must extend the 10-day deadline if the applicant indicates that he/she may have difficulty in providing the verifications by the given deadline. If an extended deadline is agreed to, the worker will document that fact in CalWIN.
2	When the deadline has passed and verifications are still missing, provide the applicant with a 2nd request for information/verifications. Allow the applicant another 10 calendar days to provide.

If, at the end of the second deadline, there is no contact from the applicant and no apparent reason of a need for a longer period in which to obtain the verifications, the worker will deny the application failure to provide essential information. When denying the application for failure to provide essential information, the worker must:

- Determine which member of the MFBU lacks the required information AND whether the denial action applies 1) solely to that person or 2) to that person AND those for whom he/she is responsible, or 3) to the entire MFBU; AND
- Determine whether the remaining MFBU members are still linked to the program. If not, then they will be denied as Medi-Cal linkage does not exist.

MPG Letter 684 (08/09)

D. Applicant Provides After Denial

The following procedures shall apply when applicant contacts the County after denial within a specified timeframe.

When…	Then…
Applicant contacts within 30 days of denial notice date AND request for more time	Evaluate the applicant's reason fore requiring additional time. The worker will allow additional time if it appears that the applicant is making a good faith effort to obtain the verifications, and/or the delay is beyond the applicant's control. The contact with the applicant and the worker decision must be

	documented in the case file. If an extended period is allowed and verifications are not provided by the deadline, a second denial NOA is to be sent. If the verifications are provided and eligibility exists, the original denial is to be rescinded.
Verifications are received within 30 days of denial notice date	Consider the verifications as timely and rescind the denial, if otherwise eligible. If some verifications are still missing, the worker must document the case file and send a note to the applicant stating that the original denial stands. A copy of the note is to be filed in the case. If all verifications are provided but ineligibility exists for a different reason, a second denial NOA must be sent.
Contacts are made or verifications received more than 30 days after the denial notice date	The denial will stand and the applicant shall be advised to reapply. However, the supervisor may approve rescission of the denial under extenuating circumstances. Extenuating circumstances could include an applicant who has been hospitalized, or had a similar family emergency, and contacts the worker within a day or two after the emergency is over. The applicant must be advised of the decision either orally or in writing. The worker must document the oral contact in case comment or retain a copy of any written contact in case file.

E. Discontinuance Due to Lack of Information

A second phone contact attempt is required before Medi-Cal benefits may be discontinued for failure to provide reason. The phone contact attempts are to be made as follows:

- Make the first phone contact attempt on the day that a written request for the missing item(s) is mailed.
- Make the second phone contact on the fifth business day after the written request for the missing item(s) was mailed or when partial items are received from the first request.
- If only partial items are provided after two attempted phone contacts have been made, a courtesy phone contact is

suggested to clarify what is needed.

The worker must document all phone contacts, and/or attempted phone contacts, in the case. In addition to the phone contact, workers are encouraged to mail out the Reminder Flyer 14-76 HHSA (DISC) to promote the importance of health coverage and to encourage beneficiaries to return the forms.

Reminder: Workers are precluded from requesting certain information from a Medi-Cal beneficiary to complete an eligibility review. Workers are not to request information which:

- has been previously provided within 12 months from the date the eligibility determination was made; and
- is not subject to change;
- is available for verification by the worker (for example, in an other PA case file); or
- is not absolutely necessary.

The worker will follow the same general procedures as used at application in evaluating the beneficiary's need for assistance in obtaining verifications needed for redetermination or upon change of eligibility or share of cost factors. Certification for Medi-Cal shall not be delayed or discontinued pending verifications from a person who is currently eligible unless the beneficiary refuses to cooperate.

Loss of Contact

Revision Date:
08/01/2022

Background:
An application for Medi-Cal may be denied or an active Medi-Cal case discontinued for loss of contact only after reasonable attempts are taken to contact the customer. The Human Services Specialist (HSS) must confirm contact information any time they speak with a customer by phone or in-person.

Purpose:
This section has been updated to provide guidance on the process when a Medi-Cal customer's mail is returned as Undeliverable. In addition, the section has been reformatted and updated for sunset review.

Policy:
Upon receipt of returned mail or another indication that a customer has moved without reporting a change of address, the HSS will make reasonable attempts to contact the customer.

Phone Contact Requirements
Prior to proceeding with the undeliverable mail process below, the HSS must first attempt to contact the customer phone. Additionally, a second contact is required once the MC 355 has been mailed to the customer.

1. First attempt
   If contact is made…
   - Confirm the customer's address
   - Update the case address if necessary
   - Document the contact in Case Comments

   If unable to reach the customer…
   - Proceed with the undeliverable mail process below
2. Second attempt
   Make a second attempt to contact the customer by phone after the MC 355 is sent, according to the undeliverable mail process below. If contact is made…
   - Confirm the customer's address
   - Update the case address if necessary
   - Document the contact in Case Comments

Note: If there is no phone number on file, add a case comment and continue with the undeliverable mail process below.

Requirements for Processing Undeliverable Mail
When mail is returned to the county as undeliverable, the HSS will take the following steps:

1. Enter a case comment that includes the…
   - Type of mail (Notice of Action [NOA], form, letter)
   - Address the mail was sent to
   - Date the mail was sent
   - Date the mail was returned
   - Safe at Home (SAH) status if applicable

2. Conduct an Ex Parte Review
   - Review all available information in California Healthcare Eligibility, Enrollment and Retention System (CalHEERS), Medi-Cal Eligibility Data System (MEDS) or through an immediate family member's* California Work Opportunity and Responsibility to Kids (CalWORKs)/CalFresh case to confirm the undelivered mail was sent to the appropriate address
   - For SAH participant, attempt to verify the new address via the SAH Program Administrator
   - If an updated address is located, indicate in the case comments where the address was found, and attempt to send the previously undelivered mail to the customer at the new address

   **An "immediate family member" is an individual within the customer's Medi-Cal household with whom they were living according to last known information.*
3. Send the MC 355
   - If unable to locate a more recent address using ex parte, the HSS will send an MC 355 to the customer's last known address, with a 30-day deadline to return the requested information
   - The MC 355 will request only the customer's current address and any other information necessary to determine eligibility
   - If the United States Postal Service (USPS) provides a forwarding address, the HSS will also send the MC 355 requesting the missing information to the forwarding address, even if it is out of state
4. When information is not returned by the customer

   When the MC 355 is returned as undeliverable, the customer does not return the information requested on the MC 355 or does not confirm their updated address by the MC 355 due date and after the required additional county contact, the HSS will follow the guidelines below for redetermination based on the customer's individual circumstances. This guidance applies to all members of a household where the address is unknown, and not just the primary applicant/case name.

   <u>USPS has not provided a forwarding address or has provided an out-of-state forwarding address</u>

   The HSS will discontinue with a timely 10-day NOA when all the following apply:
   - The USPS provides no forwarding address or an Out-of-State forwarding address
   - The HSS has made the required additional attempt to contact after sending the MC 355
   - An updated address is not confirmed by the customer within the 30-day deadline

   The timely 10-day NOA must be sent to the last known address (not the forwarding address) and must list the missing information that is needed to determine eligibility and include the 90-day cure period language.

   <u>USPS has provided an in-state forwarding address</u>

   If a <u>Medi-Cal only</u> customer (excluding SAH participant) does not confirm the new address after the MC 355 has been sent and additional required contact has been attempted, the HSS will:
   - Update the case record of the <u>Medi-Cal only</u> customer with the in-state forwarding address provided by the USPS
   - If the address is in another county, the HSS will initiate an intercounty transfer (ICT) for the <u>Medi-Cal only</u> customer when no other information is needed beyond the updated address

- The Medi-Cal only customer will not be discontinued if the only thing required is an updated address

If the customer is eligible for both Medi-Cal and other public social services programs, such as CalWORKs and CalFresh, or the customer is a SAH participant, and does not confirm the new address, the HSS **will not** update the case record with the in-state forwarding address provided by the USPS or perform an ICT. The address on the case record remains the last known address confirmed by the customer.

If more information than the updated address is needed to determine ongoing eligibility, the HSS will discontinue the customer with a timely 10-day NOA when all of the following apply:

- The USPS provides an in-state forwarding address
- The HSS requires more information than the updated address to determine ongoing eligibility
- The HSS has made the required additional attempt to contact after the MC 355 is sent
- The customer has not responded to the MC 355 by the 30-day deadline

Reminders for processing undeliverable mail

- Undeliverable mail resulting from a returned annual renewal form may be received early enough to conduct the undeliverable mail activities prior to the annual renewal due date. Depending on when the HSS receives the undeliverable annual renewal form, it is possible for customers to receive an additional month(s) of eligibility beyond their annual renewal month to allow the 30-day due date for the MC 355 and the10-day NOA
- If an undeliverable annual renewal form is received after the customer has been discontinued for no renewal, the HSS must reinstate eligibility without a break in coverage, then follow the steps outlined above
- If the original mail that was returned as undeliverable is a discontinuance NOA unrelated to whereabouts unknown, a NOA informing a customer about an increase in their share-of-cost or a NOA informing them of an adverse change to their eligibility, the HSS must reinstate eligibility to the previous level without a break in coverage, then follow the steps outlined above
- Evaluate for good cause if the customer contacts the HSS after discontinuance

5. 90-Day Cure Period

If the customer provides all information necessary to determine eligibility within 90 days of the discontinuance date, the HSS will make a redetermination using the existing the 90-Day Cure Period process.

Exempt From Discontinuance

Loss of contact is not a basis for discontinuing Medi-Cal benefits for the following programs:

- Former Foster Youth (FFY)
- Children eligible for Continuous Eligibility for Children (CEC)
- Deemed Eligible Infants (under 1 year)
- Medi-Cal Access Program (MCAP)
- Pregnant beneficiaries
- Beneficiaries in their 12-month postpartum period
- Aid types where the county does not control the Medi-Cal record such as Supplemental Security Income/State Supplementary Payment (SSI/SSP), KinGAP, or Adoption Assistance

Program Impacts:
CalFresh cases should not be discontinued for Whereabouts Unknown. When discontinuing Medi-Cal for one of the undeliverable mail situations above, ensure the action taken in CalWIN does not affect the CalFresh benefits.

References:
ACWDL 22-09

Sunset Date:
This policy will be reviewed for continuance by 08/31/2025

Approval for Release:

8-17-22

Rick Wanne, Director
Self-Sufficiency Services

04.13.04 Rescission of Medi-Cal Denial/Discontinuance

A. Requirement

The worker must rescind the denial/discontinuance of the Medi-Cal case when any of the following conditions apply:

- A state hearing decision orders rescission of the denial/discontinuance;
- The worker receives an Out of Hearing Resolution from Appeals instructing the worker to rescind the denial/discontinuance; or
- The worker/ES determines that the denial/discontinuance was in error.

MPG LTR 11 (04/88)

04.13.05 Restoration of Full-Scope Medi-Cal

A. General

The following procedures apply whenever an applicant or beneficiary provides acceptable evidence of citizenship/identity after "limited scope benefits are granted.

MPG LTR 631 (05/08)

B. Restoring Full-Scope

Applicants or beneficiaries who receive "limited scope" Medi-Cal for failure to provide evidence of citizenship/identity will have their full scope eligibility restored back as follows:

If documents are provided	And if…	Then full-scope shall be restored to…
Within one year of application/re-determination date	Good cause exist	the month that limited scope eligibility began
	Good cause does not exist	1st of the month in which the document is received
More than one year of application/re-determination date		1st of the month in which the document is received.

MPG LTR 631 (05/08)

C. Establishing Good Cause

Good cause exists when the applicant or beneficiary is unable to provide acceptable evidence of citizenship and/or identity for reasons beyond his/her control or knowledge.
Examples of good case in these cases include but are not

limited to:

- A prior belief that the documents did not exist or were unattainable.
- Mental or physical impairment that was an impediment to obtaining the documents;
- Securing the documents could result in physical danger or familiar discord.

Refer to MPG 04.21.01 for general information on good cause.

MPG LTR 803

D. Recoupment of Previously Paid Expenses

Applicants or current beneficiaries who paid for medical or dental care while obtaining their citizenship and identity documents may be reimbursed by Medi-Cal for these expense. In these cases, the applicant or current beneficiary shall be referred to the California Department of Health Services Beneficiary Services at 916-403-2007 for more information.

MPG LTR 631 (05/08)

E. Outstanding Expenses

For medical and dental bills that have not yet been paid and if warranted under the good cause provision as specified above in MPG 4-13-5B, an eligibility letter of authorization (MC 180) will issued upon request to facilitate the payment of services render by providers more than one year after the month of services. Refer to MPG 14-3-1 for procedures on completion of MC 180.

MPG LTR 631 (05/08)
