Revision Date:
May 1, 2022

Background:
Medi-Cal beneficiaries must have their eligibility redetermined every 12 months.

Purpose:
This section is revised for the sunset review, and to provide information on using electronically verified (e-verified) information for Medi-Cal Non-Modified Adjusted Gross Income (MAGI) cases.

Policy:
04.15.01A Frequency
All Medi-Cal beneficiaries must have their eligibility for Medi-Cal redetermined every 12 months. Complete the annual redetermination (RV) within 12 months of the approval of eligibility on any application, reapplication, or restoration, which required a Statement of Facts (SOF) or within 12 months of the last annual redetermination. For Former Foster Youth (FFY) redetermination processes refer to MPG 05.15.10.

04.15.01B Process
All annual redeterminations are completed by mail, except when the:
- Beneficiary is Administratively Redetermined (auto-renewed)
- Beneficiary requests for a face-to-face interview
- Human Services Specialist (HSS) determines good cause exists to require a face-to-face interview upon receipt and review of the annual redetermination form

Examples of good cause include, but are not limited to:
- Questionable information on the redetermination form or verification(s) provided
- Individual/family has no visible means of support such as in-kind income or means of support is not reported for the individual
- Obvious discrepancies between information reported on the redetermination form and assets or income on the Income Eligibility and Verification System (IEVS)
- A self-employed individual whose income and expenses do not match reported income and that questionable information could not be resolved with follow-up telephone contact and/or mail

04.15.01C MAGI Administrative Redetermination
Two months prior to the RV due month, (for example, 01/2015 for 03/2015 RV) an administrative redetermination process is initiated with an automatic *ex parte* review of all available information in the California Work Opportunity and Responsibility to Kids Information Network (CalWIN), the California Healthcare Eligibility Enrollment, and Retention System (CalHEERS), and other state/federal data systems to determine ongoing eligibility.

For MAGI cases, when CalHEERS confirms eligibility, CalWIN will:
- Receive eligibility results from CalHEERS
- Authorize the case during the overnight batch process
- Reset the RV date to 12 months from the original RV month
- Send a Notice of Action (NOA)

If CalHEERS does not confirm MAGI eligibility, CalWIN will generate and send the MC 216 Medi-Cal Redetermination Form to the beneficiary. Non-MAGI cases do not auto-renew. For a list of acceptable e-verified data elements to use in determining Non-MAGI eligibility, see MPG 04.07.01.

04.15.01D Statement of Facts (SOF)
If not administratively renewed, the beneficiary or person acting on behalf of an incompetent beneficiary is required to complete a new SOF as part of the redetermination process. Acceptable SOFs for the annual redetermination process are listed in 04.15.3A.

04.15.01E Information that must be Verified at Annual Redetermination
The following information must be verified at annual redetermination:

- Incapacity
- Legal responsibility for a child applying alone
- Refusal of the parent to apply for an 18 to 21-year-old child
- Countable Income based on programs evaluated
- Status and value of non-exempt property (Non-MAGI only)
- Immigration status (only when a change is reported or discovered), except for beneficiaries receiving restricted benefits
- Student status (if applicable)

Do not request information that is not relevant to ongoing eligibility or that has already been provided with respect to eligibility criteria not subject to change, such as date of birth, social security number or United States (U.S.) citizenship.

Photocopies of all verifications are acceptable. Do not request to view originals of documents.

Social Security Number (SSN)
It is not necessary to re-verify the SSN at annual redetermination. However, if during the annual redetermination process, the HSS discovers that the SSN of a beneficiary has not been verified via electronic verification, they will inform the beneficiary that they have 30 days to provide acceptable verification of the SSN or evidence of application for the SSN. Refer to 04.11 for SSN referral/verification.

Citizenship and Identity
When a beneficiary reports a change in their citizenship status at annual redetermination, certify the redetermination as complete with no reduction in benefits if the only outstanding verifications are for citizenship and/or identity and the beneficiary is otherwise eligible and is making a good faith effort to provide the required citizenship and/or identity documents.

Refer to MPG 04.07.13 for instructions on requesting citizenship and/or identity documents.

04.15.01F Income Eligibility Verification System (IEVS)
An IEVS Recipient System report provides sufficient income information to satisfy state and federal requirements pertaining to the use of IEVS during the annual redetermination.

An IEVS Applicant System report will not be generated unless the situation suggests that it would be wise to obtain a report from the IEVS Applicant System (for example, the information from the IEVS Recipient System is, out of date, unreliable, or unavailable due to technical issues).

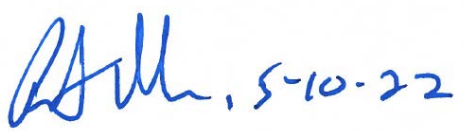
Procedure:
Medi-Cal Redetermination procedures can be found in Processing Guide 01 – Medi-Cal Annual and Change of Circumstances Redeterminations.

Program Impacts:
None

References:
ACWDLs 06-16, 06-17, 07-12, 08-03, 11-30, 11-23, 20-17
Senate Bill 1341
W&I Code 14005.37

Sunset Date:
This policy will be reviewed for continuance by April 30, 2025.

Approval for Release:



Rick Wanne, Director
Self-Sufficiency Services

Revision Date:
May 1, 2022

Background:
The annual redetermination is a full eligibility review that is conducted once every 12 months. The annual redetermination (RV) month is generally set 12 months from the first day of the application month. However, if the applicant is not Medi-Cal eligible in the month of application, then the RV month is set 12 months from the approval month. The approval month is the first month in which the applicant meets all eligibility criteria.

The change of circumstances redetermination is an eligibility review that is completed when information is received about a change to the beneficiary's circumstances (for example, change to income, household composition, or countable property).

Purpose:
This section is revised to add additional clarification about the change of circumstances redeterminations.

Policy:

04.15.02A Setting the RV due month
Regardless of whether the applicant is granted retroactive Medi-Cal, the table below illustrates when annual RVs are due:

If the applicant is eligible in the ...	Then the RV month is set …
application month,	12 months from application month. Example: Application month: 5/10 RV month: 4/11
month following the application month,	12 months from the month in which the applicant is eligible. Example: Application month: 3/10 Eligible month: 4/10 RV month: 03/11

When Medi-Cal Family Budget Unit (MFBU) members have different initial eligibility months, the MFBU members who were determined eligible first shall set the RV month for all MFBU members.

04.15.02B Disability Determination Services Division (DDSD) Applicants
During the application process, if the applicant claims a disability, but no other Medi-Cal linkage exists, forward the disability packet to DDSD for a disability evaluation. Upon receipt of the disability determination confirming the applicant's disability, complete the annual RV as follows:

If a disability-approved decision is received from DDSD …	Then complete the annual RV 12 months from the …
within 90 days of the application date,	month in which the applicant is eligible for Medi-Cal.

after 90 days but prior to the last day of the 11th month,	month in which the applicant is eligible for Medi-Cal.
after 11th month,	date that the County determined the applicant is eligible for Medi-Cal.

04.15.02C Categorically Eligible (CE)

Parents receiving Medi-Cal only benefits in their children's California Work Opportunity and Responsibility to Kids (CalWORKs) case are not required to complete a separate Medi-Cal only annual RV if they cooperate with all CalWORKs requirements for reporting changes and completing the CalWORKs annual redetermination.

04.15.02D CalWORKs Approved

When a family has Medi-Cal only and later applies and is approved for CalWORKs, the annual redetermination is set 12 months from the CalWORKs application month. If there are family members that remain Medi-Cal only, the next annual redetermination will also be set 12 months from the CalWORKs application month.

04.15.02E CalWORKs Discontinued for no Redetermination

When a family is discontinued from CalWORKs for failure to complete the CalWORKs annual redetermination, the family is placed on Aid Code 38 pending a change in circumstance Medi-Cal redetermination.

- Complete an *ex parte* review prior to requesting information from beneficiaries
- Obtain the Request for Tax Household Information (RFTHI) form by phone or mail and run the beneficiaries through the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) Business Rule Engine (BRE), completing the redetermination as a regular redetermination
- If unable to obtain by phone, mail the RFTHI during the month after the CalWORKs case discontinued. Allow 60 days for return of the RFTHI

The RV month for the Medi-Cal only case is set 12 months after the month in which the Human Services Specialist (HSS) completed the Medi-Cal Only RV.

Example:
CalWORKs discontinued for no redetermination: 10/11
HSS completed the Medi-Cal only RV: 12/11
Next Annual Redetermination is due: 11/12

04.15.02F Deemed Eligible Infants

The RV month for infants who are receiving benefits during the continuous eligibility period (also known as Deemed Eligibility [DE]) is set as follows:

If other MFBU members are ...	Then the RV month of the DE infant is ...
receiving Medi-Cal,	the same as that of the other MFBU members.
discontinued from Medi-Cal for failure to complete the annual RV,	reset to the month of the infant's first birthday.

Complete a RV of eligibility for Medi-Cal when the infant turns one year old. The RV process for the DE infant will depend on the situations outlined in MPG 05.15, Appendix H – Deemed Infant Approaching One Year of Age.

04.15.02G Transitional Medi-Cal (TMC)

Beneficiaries receiving Medi-Cal under TMC are not required to complete an annual RV while they are receiving TMC benefits. Complete a redetermination of eligibility under other Medi-Cal programs by the last month of the TMC period. (Refer to MPG 05.07 – Transitional Medi-Cal). The RV month is set as follows:

If ...	**Then ...**
all MFBU members are receiving TMC, and their annual RV is due **before** their TMC period expires,	set the RV month to the last month of the TMC period. Example: Original RV month: 07/11 TMC expires: 10/11 New RV month: 10/11
all MFBU members are receiving TMC, and their annual RV is due **after** their TMC period expires,	maintain the original RV month.
all MFBU members are receiving TMC with different TMC expiration dates,	set the RV month to the last month of the TMC period that will end first. • This RV month will apply to all other MFBU members • At the end of the other MFBU member's TMC period, the Human Services Specialist (HSS) must redetermine that individual's Medi-Cal benefits using information available in the existing case
some MFBU members are receiving TMC, and others are not,	maintain the RV month of the other non-TMC MFBU members. This RV month will apply to all other MFBU members.

04.15.02H Actions that do not Change the Redetermination Month

Once the RV month is established, the following events will not change the RV month:

- Beneficiary submits the RV packet within 90 days after Medi-Cal has been terminated AND is found eligible
- Beneficiary submits the RV packet more than 90 days after discontinuance date, but good cause exists AND benefits are restored without a break in aid
- The HSS completes and processes the RV packet early (in the month(s) prior to the RV month). For example, HSS mailed the RV packet in the 10th month, and it was completed and returned promptly

04.15.02I Change of Circumstances Redeterminations

The annual RV date will be reset for a new 12-month period whenever a Medi-Cal beneficiary reports a change of circumstance that requires a re-evaluation of Medi-Cal eligibility. For this purpose, re-evaluation of eligibility is defined as a change that requires either:

- The CalHEERS BRE to be run for Modified Adjusted Gross Income (MAGI) Medi-Cal
- Eligibility Determination and Benefits Calculation (EDBC) run in CalWIN for Non-MAGI Medi-Cal

The following are examples of changes of circumstance that require an eligibility redetermination:

- Reported or discovered changes in income or property
- Reported or discovered change in household size or tax filing status
- A reported or discovered move outside of California
- A reported or discovered change in citizenship or immigration status
- Being determined no longer eligible under a particular Medi-Cal category, such as an individual determined no longer eligible for MAGI Medi-Cal, Non-MAGI Medi-Cal, Supplemental Security Income (SSI), or CalWORKs

A change of circumstance can be accepted by phone, in person, or electronically, including telephonically recorded signatures as well as handwritten signatures transmitted via fax or email. See telephonic/electronic signatures processing guide located in the Eligibility Essentials, Eligibility Operations SharePoint site for methods of accepting telephonic/electronic signatures. When the change is processed, determine Medi-Cal eligibility for the future month.

Example: A MAGI beneficiary reports a change of circumstance on 02/10/2019. The BRE is run to determine eligibility for March 2019. If the beneficiary is determined Medi-Cal eligible after running the BRE, the new annual RV due date is reset to February 2020.

The annual RV date will **not** be reset when the beneficiaries are already in, or are placed into the following consumer protection programs because of the changes of circumstance:

- Continuous Eligibility for Children (CEC)
- Deemed Infants
- Transitional Medi-Cal (TMC)
- Continuous Eligibility (CE) for Pregnant Women

This policy does not apply to beneficiaries of Mega-Mandatory eligible aid types including Cash Aid Recipients, Pickle, Disabled Adult Children (DAC), Disabled Widows(ers) (DW), Foster Care (FC), Former Foster Youth (FFY), Kinship-Guardian Assistance Program (Kin-GAP) and Adoption Assistance.

To reset the annual RV date for Non-MAGI beneficiaries, we must have up to date information and verification for both income and property. If, for example, the Non-MAGI beneficiary only reports a change in income and we are able to *ex parte* from the CalFresh case, update the Non-MAGI beneficiary's eligibility based on the new income. However, do not reset the annual RV date. Do not advance the annual RV on cases that include a Non-MAGI beneficiary unless property is verified via *ex parte* at the time the change of circumstances is reported. Do not request property verifications at change of circumstances.

Procedure:
Refer to the procedures outlined in Processing Guide 01 – Medi-Cal Annual and Change of Circumstances Redetermination Section Z for additional information about resetting the annual redetermination date.

Follow the procedures outlined in Processing Guide 01 – Medi-Cal Annual and Change of Circumstances Redetermination Section W when additional information is needed.

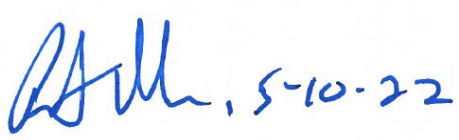
Medi-Cal Redetermination procedures can be found in Processing Guide 01 – Medi-Cal Annual and Change of Circumstances Redeterminations.

Program Impacts:
None

References:
ACWDLs 06-16, 06-17, 11-23, 11-33, 14-15, 14-18, 14-22, 19-17
WIC 14005.07

Sunset Date:
This policy will be reviewed for continuance by April 30, 2025.

Approval for Release:



Rick Wanne, Director
Self-Sufficiency Services

Revision Date:
May 1, 2022

Background:
Redetermination information is requested using specific forms. Beneficiaries may report the information over the phone.

Purpose:
This section is revised to update the location of the process for accepting telephonic/electronic signatures, the name of Processing Guide 01, and information about pre-populated redetermination forms.

Policy:
04.15.03A Acceptable Annual Redetermination (RV) Forms
Federal law requires annual redetermination forms to be pre-populated with case information that beneficiaries are asked to confirm or update if inaccurate. Accept any of the following RV forms, as the Statement of Facts (SOF) for the annual RV process.

Form Number	When to Use
MC 216	When a Modified Adjusted Gross Income (MAGI) based RV is not auto-renewed, CalWIN will send the MC 216 pre-populated with Business Rule Engine (BRE) information
MC 210 RV	Pre-populated form containing property and resource questions used for Non-MAGI redeterminations including Long Term Care (LTC) beneficiaries and those not listed below
MC 217	Pre-populated form for cases that include both MAGI and Non-MAGI aid types and includes resource and property questions
MC 250 A	Used for beneficiaries receiving Medi-Cal under the Former Foster Youth (FFY) program, but the form is not required to complete the FFY redetermination process. Refer to MPG 05.15.10
SAWS 2 Plus	Accepted as a substitute for any of the above annual redetermination forms

04.15.03B Annual Redetermination Packet
The table below identifies forms that must be included in the Medi-Cal annual redetermination packet:

Form #	Title
MC 019	MC Information Notice – Medi-Cal Information for Beneficiaries
RV Statement of Facts	Medi-Cal Annual Redetermination Form, based on the specifics of the case
MC 219	Important Information for Persons Requesting Medi-Cal
16-64 HHSA	Voter Preference Form, previously known as the Voter Registration Interest/Declination
Voter Registration	CA Voter Registration Form (also referred to as a Voter Registration Card or VRC)
Pub 183(English) or Pub 184 (Spanish)	Child Health Disability Prevention (CHDP) Brochure

MC 003	Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) Brochure
Pub 13	Your Rights Under California Public Benefits Program Pamphlet
MC 372	Breast and Cervical Cancer Treatment Program (BCCTP) Brochure
GEN 1365	Notice of Language Services
Envelope	Postage Paid Envelope
09-98 HHSA*	CalFresh Flyer for Medi-Cal (for non-LTC cases)
CF 285*	Application for CalFresh Benefits (for non-LTC cases)
14-116 HHSA	Medi-Cal Redetermination Packet Coversheet
20-44 HHSA*	Civil Rights Information
16-157-A HHSA	Text Message Service Agreement
*	San Diego Gas and Electric CARE Program Application

* Indicates county required forms

Note: The RV forms can be accepted by phone, in person, or electronically, including telephonically recorded signatures as well as handwritten signatures transmitted via fax or email. See telephonic/electronic signatures processing guide located in the Eligibility Essentials, Eligibility Operations SharePoint site for methods of accepting telephonic/electronic signatures.

04.15.03C Mailing Date

The first step in the annual redetermination process is to complete an *ex parte* review. MAGI based Medi-Cal will run against the federal data hub as part of *ex parte* for MAGI cases. When verifications are required after the *ex parte* review, the Medi-Cal Annual Redetermination Notice and annual redetermination packet are automatically mailed to the beneficiary. The notice and packet must be mailed to the beneficiary:

- No earlier than the 1st day of the 10th month
- 60 days prior to the redetermination due date

Example:
Annual Redetermination is Due: May 31, 2016
Earliest Mailing Date: March 1, 2016
Latest Mailing Date: April 1, 2016

See Processing Guide 01 – Medi-Cal Annual and Change of Circumstances Redeterminations for automated mailing dates.

04.15.03D Due Date

The annual redetermination form is considered "timely" if the County receives the form from the beneficiary by the last day of the RV month.

04.15.03E Forms Provided to Non-MAGI and Low-Income Subsidy (LIS) Extra Help Households at Redetermination

The Non-MAGI Screening Packet for Beneficiaries is to be provided to Non-MAGI and LIS Extra Help Medi-Cal beneficiaries and to those who are subject to a property evaluation for Medi-Cal eligibility at redetermination:

Form #	Title
CSC 99	Non-MAGI Informing Letter for Beneficiaries
Pub 10	Non-MAGI Medi-Cal Programs Brochure
MC 604 IPS	Additional Income and Property Information Needed for Medi-Cal
MC 007	Medi-Cal General Property Limitations
DHCS 7077	Notice Regarding Standards for Medi-Cal Eligibility
DHCS 7077-A	Notice Regarding Transfer of a Home for Both a Married and Unmarried Applicant/Beneficiary
	APTC/CSR Brochure – "Covered CA Can Help You Get Affordable Health Coverage"
	Postage paid pre-addressed return envelope

Note: The forms can be accepted by phone, in person, or electronically, including telephonically recorded signatures as well as handwritten signatures transmitted via fax or email. See telephonic/electronic signatures processing guide located in the Eligibility Essentials, Eligibility Operations SharePoint site for methods of accepting telephonic/electronic signatures.

Procedure:
Medi-Cal redetermination procedures can be found in Processing Guide 01 – Medi-Cal Annual and Change of Circumstances Redeterminations.

Program Impacts:
None

References:
ACWDLs 06-16, 11-23, 19-17, 20-21, 20-22

Sunset Date:
This policy will be reviewed for continuance by April 30, 2025.

Approval for Release:

5-10-22

Rick Wanne, Director
Self-Sufficiency Services

Revision Date:
May 1, 2022

Background:
Redetermination information must be returned by the beneficiaries.

Purpose:
This section is revised to provide additional clarification when the redetermination form is returned as undeliverable by the Post Office.

Policy:
04.15.04A Redetermination Returned Timely:
When the beneficiary returns the annual redetermination (RV) form or provides the RV information timely (by the last day of the RV month), review the returned RV form for completeness and determine if:

- The RV form was signed by the beneficiary
- Additional information and/or verifications are needed to complete an accurate Medi-Cal eligibility determination

Beneficiaries continue to receive their Medi-Cal benefits while the Human Services Specialist (HSS) completes the review and requests additional information/verifications or forms that are needed.

If the beneficiary returns an incomplete RV form after the Notice of Action (NOA) cutoff date but prior to the RV due date, rescind the failure to complete the annual redetermination discontinuance. Notify the beneficiary that benefits are restored and continue to process the RV form following the guidelines specified below in C.

04.15.04B Unsigned Forms
When an unsigned form is returned, mark the form received. Attempt to contact beneficiary over the phone to obtain telephonic/electronic signature (See Telephonic/Electronic Signature Eligibility Operations Processing Guide [EOPG]). If unable to contact, mail the unsigned RV form back to the beneficiary and instruct them to sign and return the form within 30 calendar days. Process if received, discontinue with timely notice if not received within 30 days.

Refer to 04.15.04D when the RV form is unsigned AND additional information/verifications are also needed.

04.15.04C Additional Information Not Needed

If …	**Then …**
there is no change reported by the beneficiary and on-going eligibility exists,	• certify the beneficiary for a new 12-month period based on the **original** RV month. • check the Medi-Cal Eligibility Data System (MEDS) after the redetermination is complete to be sure that the most recent annual redetermination information was transmitted to MEDS.

the beneficiary is found ineligible to Non-Modified Adjusted Gross Income (MAGI), **or** the beneficiary is found ineligible to any MAGI group	See 04.15.05 for additional guidance on cases transitioning between MAGI and Non-MAGI.
reported changes result in beneficiaries moving from zero share of cost (SOC) to SOC Medi-Cal or increase in SOC	• apply the new or increased share of cost (SOC) to the 1st of the month in which timely notice can be given. • provide the beneficiary with a NOA about restoration and the change to SOC. • check MEDS after the redetermination is complete to be sure that the most recent annual redetermination information was transmitted to MEDS.

Example – Beneficiary whose eligibility changed from zero SOC to SOC
The County discontinued the beneficiary's Medi-Cal on February 28th because the beneficiary did not return the RV form. On March 26th, the beneficiary returns the RV form along with verification. On March 27th, the HSS rescinds the discontinuance and determines on-going eligibility with a SOC. As the HSS does not have sufficient time to provide 10-day notice before April 1st, the HSS will send out a timely NOA prior to April 20th indicating the beneficiary has:

- Zero SOC Medi-Cal for March and April
- SOC Medi-Cal beginning May

04.15.04D Complete Forms but Additional Information Needed
When the beneficiary returns the RV form timely and additional information/verifications are needed, complete an *ex parte* review, and request missing information/verifications following the procedure in Processing Guide 01– Medi-Cal Annual and Change of Circumstances Redetermination – Complete Forms but Additional Information Needed. Allow 30 days for return of additional information/verifications.

04.15.04E Returned within 90 days of Redetermination Discontinuance Date
When the RV packet is returned within 90 days after the discontinuance date (for example, RV due July 2015, RV packet was submitted to the County on August 10, 2015), do not immediately rescind the discontinuance. Determine if the beneficiary is still eligible to Medi-Cal before rescinding.

Follow the procedures outlined in the Medi-Cal Annual and Change of Circumstances Redetermination Processing Guide 01 Section Y when the RV form is returned within 90 days of the discontinuance date.

04.15.04F Returned more than 90 days from Redetermination
When the redetermination form is returned more than 90 days after the discontinuance date, do not restore Medi-Cal benefits because the RV form was received. The beneficiary's Medi-Cal benefits will remain discontinued until the HSS determines that the beneficiary remains eligible for Medi-Cal and had good cause for not submitting information timely.

04.15.04G Examples of Good Cause

Good cause shall include but is not limited to:

- Beneficiary is unable to read or complete the RV form without assistance because the RV form is not available in the written language that they understand
- The postal service fails to deliver the redetermination packet in a timely manner
- Physical or mental illness or incapacity prevented the beneficiary from submitting the forms in a timely manner

Refer to MPG 04.21 for general information on good cause.

04.15.04H RV Not Returned

When a beneficiary fails to return the RV form or provide the information to the County by the last day of the RV month and the annual redetermination packet was not returned by the post office as undeliverable, discontinue with timely 10-day NOA for failure to cooperate with the annual redetermination requirements. The discontinuance action is effective the last day of the RV month.

Note: Two contact attempts are required prior to discontinuing for failure to cooperate with annual RV.

04.15.04I RV Returned as Undeliverable

When the RV packet is returned as undeliverable by the Post Office, make reasonable attempts to contact the beneficiary. Prior to discontinuing the case, staff will:

- Perform an *ex parte* review of the information available in the various systems for the beneficiary and immediate family members* to determine the most current contact information
- Mail the MC 355 – Medi-Cal Request for Information, if contact is unsuccessful and allow the beneficiary 30 days to provide
- Attempt to contact the beneficiary by phone, or their preferred method of contact during the 30 days
- Note all case actions in Case Comments including that the:
  - Mail was returned as undeliverable
  - Date the mail was sent and returned undeliverable
  - The document that was returned, and the address that was used
  - Ensure that the Returned Mail Notification or the return envelope and its contents are imaged into the CalWIN Electronic Records Management System (CERMS)

*Immediate family members are defined as any of the individuals who make up the Medi-Cal household of the beneficiary for purposes of the eligibility determination. To use an address provided by immediate family members, the address must be a more recent than the one already on file.

Note: Do not use a forwarding address provided by the Post Office or handwritten on the envelope unless the address has been confirmed by the beneficiary.

If the MC 355 is undeliverable or not returned by the beneficiary:

- Discontinue the case, timely 10-day NOA is not required, however the NOA must include the 90-day cure period language
- The NOA must list the missing information that is needed to determine eligibility, including that the address is not current

If whereabouts become known resend the RV packet to the new address and allow 30 days for return. Discontinue with timely 10-day notice if not returned.

04.15.04J Adding a Person
The MC 210 RV allows the beneficiary to add a person to their Medi-Cal case at annual redetermination, but no forms are required, and the information can be taken over the phone. Enter the information into the automated system and run against the Hub (if applicable) and complete an *ex parte* review prior to requesting paper verifications. If information is not e-verified and paper verifications are required, request additional information/verification of the new person to establish eligibility.

04.15.04K Telephone Information
Redetermination information can be obtained over the phone provided that all the information is clearly narrated in the case file. A telephonic signature is required. Inform the beneficiary that they are making this statement under the penalty of perjury and their statement on the phone carries the same weight and effect of a written signature and narrate thoroughly in the case file. See telephonic/electronic signatures processing guide located in the Eligibility Essentials, Eligibility Operations SharePoint site for methods of accepting telephonic/electronic signatures.

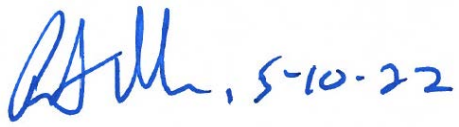
Procedure:
Medi-Cal Redetermination procedures can be found in Processing Guide 01 – Medi-Cal Annual and Change of Circumstances Redeterminations.

Program Impacts:
None

References:
ACWDLs 06-16, 07-24, 14-15, 14-18, 14-22, 16-23, 19-17

Sunset Date:
This policy will be reviewed for continuance by April 30, 2025.

Approval for Release:



Rick Wanne, Director
Self-Sufficiency Services

Revision Date:
May 1, 2022

Background:
Beneficiaries who are no longer eligible to Modified Adjusted Gross Income (MAGI) Medi-Cal because of an annual redetermination (RV) or change of circumstance redetermination must be evaluated for Non-MAGI prior to being evaluated for Advanced Premium Tax Credit/Cost Share Reduction (APTC/CSR), if potentially linked to Non-MAGI Medi-Cal. Beneficiaries who are no longer eligible to Non-MAGI because of an annual redetermination or change of circumstance redetermination, must be evaluated for MAGI Medi-Cal prior to discontinuance if applicable.

Non-MAGI linkage applies to individuals who are:
- Children (under 21 years of age)
- Aged (65 years of age or older)
- Blind/disabled
- Parent/caretakers
- Pregnant
- In Long-Term Care (LTC)

Individuals between the ages of 21-64, who have no linkage to Non-MAGI Medi-Cal, will be immediately evaluated for APTC/CSR.

Purpose:
This section is revised to incorporate information about the MAGI and Non-MAGI Medi-Cal evaluations that was previously issued in Special Notice 13-09 Addendum M.

Policy:
04.15.05A Soft Pause
Per the Welfare and Institutions Code (WIC) Section 14005.37, Medi-Cal beneficiaries must be evaluated for **all** Medi-Cal programs before they are discontinued from benefits and forwarded to Covered California to be evaluated for APTC/CSR.

During the evaluation, the beneficiary will remain in their existing MAGI aid code to the extent possible. This is referred to as a “Soft Pause”. The purpose of the Soft Pause is to protect the beneficiary from an adverse action while they are being evaluated for Non-MAGI, APTC/CSR, or other Consumer Protection Programs (CPP), including:
- Continuous Eligibility for Children (CEC)
- Deemed Eligible Infants (DE)
- Transitional Medi-Cal (TMC)
- Continuous Eligibility for Pregnant Women
- Former Foster Youth (FFY)
- 4-Month Continuing Medi-Cal

If, because lack of system functionality, the beneficiary cannot be left in his/her existing aid code, move them into aid code 38 if receiving full-scope benefits or 58 if receiving restricted benefits until the redetermination is complete.

The following adverse actions will cause the Soft Pause functionality:

- Moving from MAGI to APTC/CSR
- Moving from non-premium MAGI to premium MAGI
- Moving from full scope MAGI to limited or restricted scope MAGI
- Moving from full scope MAGI to Pregnancy Related Medi-Cal
- Losing eligibility for MAGI, including, but not limited to, turning 65 years old, becoming eligible for Medicare before age 65, or experiencing an increase in income that renders the beneficiary ineligible due to being over the income limits

The Soft Pause will be lifted **after** the Non-MAGI or CCP eligibility evaluation is completed.

If the beneficiary indicates they only want to be evaluated for APTC/CSR, rerun the beneficiary through the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) Business Rules Engine (BRE) to determine APTC/CSR eligibility. If the beneficiary is found eligible, lift the Soft Pause, and assist the customer with completing the enrollment process including plan selection if requested. They may also contact the Covered California Service Center at (800) 300-1506 for assistance.

Refer to the Electronic Health Information Transfer (eHIT) Bulletin #20 for information on lifting the Soft Pause.

<u>04.15.05B Non-MAGI Medi-Cal Evaluation – Screening Packet</u>

Conduct an *ex parte* review of all available information to establish Non-MAGI eligibility. If unable to establish eligibility via *ex parte*, mail the applicant/beneficiary the Non-MAGI Screening Packet for Beneficiaries and allow 30 days to provide:

Form #	Title
CSC 99	Non-MAGI Informing Letter for Beneficiaries
Pub 10	Non-MAGI Medi-Cal Programs Brochure
MC 604 IPS	Additional Income and Property Information Needed for Medi-Cal
MC 007	Medi-Cal General Property Limitations
DHCS 7077	Notice Regarding Standards for Medi-Cal Eligibility
DHCS 7077-A	Notice Regarding Transfer of a Home for Both a Married and Unmarried Applicant/Beneficiary
	APTC/CSR Brochure – "Covered CA Can Help You Get Affordable Health Coverage"
	Postage paid pre-addressed return envelope

Contact the beneficiary at least once after mailing the packet, by their preferred method of communication (phone or mail) to remind them to return the MC 604 IPS. Document the attempted contact in the case record.

If the form is not received after the 30 days:

- Discontinue MAGI Medi-Cal with a timely Notice of Action (NOA)
- Release the Soft Pause to evaluate for APTC/CSR

If the information is provided prior to the discontinuance action taking effect, rescind the discontinuance and evaluate for Non-MAGI.

Beneficiaries have a 90-day cure period to provide. If the information is provided within 90 days, and the case is found to be eligible, benefits will be reinstated to the date of discontinuance.

Non-MAGI Medi-Cal Evaluation

Conduct a Non-MAGI evaluation if enough information is available via *ex parte* or the beneficiary returns the MC 604 IPS.

- Approve Non-MAGI if the beneficiary is determined eligible
- Evaluate for APTC/CSR if the beneficiary is ineligible to Non-MAGI or is eligible with a Share of Cost (SOC)

Individuals have the option of having only SOC Medi-Cal, SOC Medi-Cal **and** APTC/CSR, or only APTC/CSR. Beneficiaries who choose to discontinue their SOC Medi-Cal will be mailed a timely discontinuance notice.

Note: SOC Medi-Cal does not meet Minimum Essential Coverage.

04.15.05C Beneficiaries Discontinued from Non-MAGI Medi-Cal

Beneficiaries who are no longer eligible to Non-MAGI as a result of an annual redetermination or change of circumstance redetermination, must be evaluated for MAGI Medi-Cal prior to discontinuance if applicable. When there is no eligibility to MAGI the CalHEERS BRE will not be run. For more information on applications that **must** and **must not** be run through CalHEERS BRE see MPG 04.02.22I & 04.02.22J.

Conduct an *ex parte* review to determine if the tax household information is contained in the case record. If this information is not available, mail the MC 01-2014 RFTHI packet and allow the beneficiary 30 days to provide.

The RFTHI can be provided by phone, in person, or electronically, including telephone recorded signatures as well as handwritten signatures transmitted via fax, or email. The beneficiary is not required to submit any supporting documentation with the completed RFTHI form. The form is only to acquire information to be verified through the federal data hub and available state data sources. Documentation will only be required if:

- CalHEERS BRE response does not verify the information
- Electronic verification through the BRE finds the information not reasonably compatible
- Information cannot be verified via an *ex parte* review

If during the 30-day period the beneficiary has not returned the MC 01-2014 RFTHI, or provided the RFTHI information:

- Complete an *ex parte* review to attempt to verify the information

- Contact the beneficiary by their preferred method of communication (phone or mail) and provide a 10-day deadline following the contact
- Document the attempted contact in the Case Comments

When the RFTHI information is returned or the information is otherwise provided, run the case through the CalHEERS BRE. Refer to eHIT Bulletin #3 for required entries to run the BRE for the MAGI evaluation. Then:

- Approve MAGI if the beneficiary is determined eligible or,
- Evaluate for APTC/CSR if the beneficiary is not eligible to MAGI, and discontinue the Non-MAGI Medi-Cal with timely notice

Missing RFTHI Information

If the RFTHI packet is returned, or information is otherwise provided, but there is not enough information to determining eligibility to MAGI:

- Send the MC 355 requesting the information and allow the beneficiary 30 days to provide
- If during the 30-day period the beneficiary has not returned the RFTHI, or provided the RFTHI information, contact the beneficiary by their preferred method of communication (phone or mail) and request the information
- Document the attempted contact in the Case Comments

Failure to Provide the RFTHI:

If the RFTHI is not returned or the RFTHI information is not provided during the 30-day period, and the information is not available via *ex parte* review:

- Discontinue the beneficiary with timely notice. Beneficiaries have a 90-day cure period to provide the information
- If the information is provided prior to the discontinuance, rescind the discontinuance, and process the case

Upon receipt of returned mail as undeliverable (for example, the Non-MAGI Screening Packet, RFTHI), or other indication that the beneficiary has moved, and there has been no change of address reported, make reasonable attempts to contact the beneficiary. Prior to discontinuing the case:

- Perform an *ex parte* review of the information available is the various systems for the beneficiary and immediate family members* to determine the most current contact information
- Mail the MC 355 if contact is unsuccessful and allow the beneficiary 30 days to provide
- Attempt to contact the beneficiary by phone, or their preferred method of contact during the 30 days
- Note all case actions in Case Comments

*Immediate family members are defined as any of the individuals who make up the Medi-Cal household of the beneficiary for purposes of the eligibility determination. To use an address provided by immediate family members, the address must be a more recent than the one already on file.

Note: Do not use a forwarding address provided by the Post Office or handwritten on the envelope unless the address has been confirmed by the beneficiary.

If the MC 355 is undeliverable or not returned by the beneficiary:

- Discontinue the case, timely 10-day NOA is not required, however the NOA must include the 90-day cure period language
- The NOA must list the missing information that is needed to determine eligibility, including that the address is not current

Refer to MPG 04.13.03 for additional policy and procedures for returned mail.

Information that is Not Reasonably Compatible:
Mail the MC 355 Medi-Cal Request for Information form to request paper verification if the CalHEERS BRE returns results that are not reasonably compatible (for example, income), and the information is not verified via *ex parte* review. Allow the beneficiary 30 days to provide.

During the 30-day period, contact the beneficiary at least once by their preferred method of communication (phone or mail) to remind then to return the information. Document the attempted contact in the Case Comments.

If the information is provided prior to the discontinuance action taking affect:
- Review the verification documents and verify that the information provided is correct. For example, if income verification is pending, verify that the document submitted is a valid income document
- Rescind the discontinuance and evaluate for MAGI

If the information is not received after the 30 days:
- Attempt to contact the beneficiary to obtain the information
- If still unsuccessful, discontinue the beneficiary with a timely Notice of Action. Beneficiaries have a 90-day cure period to provide the information

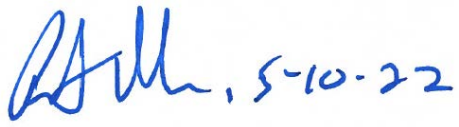
Procedure:
Medi-Cal Redetermination procedures can be found in Processing Guide 01 – Medi-Cal Annual and Change of Circumstances Redeterminations.

Program Impacts:
None

References:
ACWDLs 14-15, 14-18, 14-22, 16-18, 16-23, 17-35, 19-17, 20-22

Sunset Date:
This policy will be reviewed for continuance by April 30, 2025.

Approval for Release:



Rick Wanne, Director
Self-Sufficiency Services

Revision Date:
May 1, 2022

Background:
A mixed household is defined as a household with at least one member who is receiving Modified Adjusted Gross Income (MAGI) Medi-Cal benefits and at least one member who is receiving Covered California (CA) benefits. Medi-Cal beneficiaries have their annual redetermination (RV) set for 12 months from their initial application date or most recent redetermination of eligibility. For individuals enrolled in a Covered CA Plan (CCP), Covered CA re-determines eligibility for the next benefit year during the annual open enrollment period.

Purpose:
To inform staff of the redetermination process for mixed households. This section is revised to update the title of the section and Processing Guide 01, no policy or procedures have been changed.

Policy:
04.15.06A Annual RV Due Date MAGI vs Covered CA
The CCP and MAGI Medi-Cal annual RV are separate processes that may not occur concurrently depending on the Medi-Cal RV month. The CCP portion of the mixed household population will have their benefits renewed every January while the Medi-Cal portion will be renewed at the annual RV due date. If the CCP and Medi-Cal RV are not aligned, any changes reported to the case via the CCP RV will be reported to the Medi-Cal program as a "change of circumstance" for the MAGI Medi-Cal beneficiaries.

Due to different annual redetermination periods and processes for MAGI Medi-Cal and Covered CA programs, there may be two different annual RV dates for members of a mixed household.

04.15.06B Annual RV for Mixed Households with the Same Date
For mixed households with the same RV due date, the Medi-Cal annual RV process will initiate the RV for both the MAGI and CCP programs.

04.15.06C Annual Redeterminations for Mixed Household with Different Dates
If a Medi-Cal redetermination occurs prior to the Covered CA redetermination, the transaction will be treated as a change of circumstance for the CCP. The change of circumstance will be sent from the California Work Opportunity and Responsibility to Kids Information Network (CalWIN) to the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) via the Electronic Health Information Transfer (eHIT) transaction. CalHEERS will update the beneficiary's Covered CA account. Beneficiaries who are still eligible for, and enrolled, in a Covered CA plan will still go through the Covered CA annual redetermination period once it occurs.

If the Covered CA redetermination occurs prior to the Medi-Cal redetermination, the Covered CA redetermination will be treated like a change of circumstance for those beneficiaries in the case who have Medi-Cal eligibility. Any new information received by Covered CA as part of the Covered CA redetermination will be sent down to CalWIN via the eHIT.

04.15.06D County Responsibility with Mixed Household Redetermination Processing

Counties are responsible for Medi-Cal eligibility determinations and ongoing Medi-Cal case management for mixed cases, including redeterminations and processing changes in circumstance. CCP beneficiaries who belong to a mixed household may complete their annual redetermination using several methods, including:

- Completing the redetermination online in CalHEERS
- Contacting the Covered CA service center. Covered CA service center representatives are only able to complete the Covered CA related information on the annual redetermination. However, they will refer beneficiaries to the county if there are any changes or elements reported that impact Medi-Cal eligibility.
- Contacting the County. Human Services Specialists (HSSs) must assist with completing mixed household redeterminations when beneficiaries contact the county directly by processing the changes in CalWIN.

Procedure:

Medi-Cal Redetermination procedures can be found in Processing Guide 01 – Medi-Cal Annual and Change of Circumstances Redeterminations.

Program Impacts:

None

References:

ACWDL 14-38

Sunset Date:

This policy will be reviewed for continuance by April 30, 2025.

Approval for Release:

5-10-22

Rick Wanne, Director
Self-Sufficiency Services

Annual Redetermination - Split Cases	Number	Page
	04.15.07	1 of 1

Revision Date:
May 1, 2022

Background:
Adults who are no longer tax-dependents of the Medi-Cal primary tax filer are required to apply for Medi-Cal for themselves and will be in their own case. Eligibility for these Individuals must be maintained until their redetermination is complete.

Purpose:
This section is revised for the sunset review, no policy or procedures have been changed.

Policy:
04.15.07A Split Case
To split a case, means to remove the adult from the existing case and place them in a new case of their own, although an application for Medi-Cal benefits has not been completed. The individual must be split between the two cases to ensure that Medi-Cal eligibility continues, without a break in aid until an eligibility determination is made. The individual must complete and return the Medi-Cal application within 30 days or benefits may be discontinued.

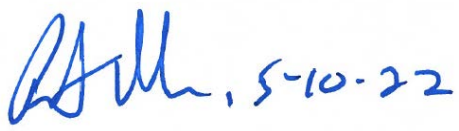
Procedure:
Section AA - Splitting Cases has been added to Medi-Cal Processing Guide 01 - Medi-Cal Annual and Change of Circumstances Redeterminations.

Program Impacts:
Automation: California Work Opportunity and Responsibility to Kids Information Network (CalWIN) is not designed to split cases and continue eligibility for individuals removed from a case. Use steps in Processing Guide 01 to process.

References:
ACWDLs 06-16, 06-17, 11-23, 11-33, 14-15, 14-18, 14-22

Sunset Date:
This policy will be reviewed for continuance by April 30, 2025.

Approval for Release:



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