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TO: ALL COUNTY WELFARE DIRECTORS Letter No.: 22-33
ALL COUNTY WELFARE ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS
ALL COUNTY MEDS LIAISONS

SUBJECT: MEDI-CAL REDETERMINATION PROCESS
(Reference: All County Welfare Directors Letters [14-05](#), [14-18](#), [14-22](#),
[14-32](#), [14-35](#), [14-38](#), [14-41](#), [15-27](#), [15-32](#), [16-16](#), [16-18](#), [17-26](#), [17-32](#), [17-35](#),
[18-12](#), [18-16](#), [18-24](#), [19-03](#), [19-17E](#), [20-17](#), [20-21](#), [21-12](#), [21-22](#),
[21-24](#), [21-27](#), [22-01](#), [22-09](#), [22-13](#), and [22-20](#); Medi-Cal Eligibility Division
Information Letters [I 14-60](#), [I 19-08](#), and [I 20-39](#))

PURPOSE

The purpose of this letter is to provide counties with updated requirements for Medi-Cal redeterminations, including change in circumstance redeterminations and annual renewal redeterminations.

BACKGROUND

Previous guidance on the Medi-Cal redetermination process has been issued through various All County Welfare Directors Letters (ACWDLs) and Medi-Cal Eligibility Division Letters (MEDILs). The intent of this letter is to provide comprehensive Medi-Cal redetermination policy for change in circumstance and annual renewal redeterminations for Modified Adjusted Gross Income (MAGI) and Non-MAGI beneficiaries. The following ACWDLs and MEDILs will be obsolete when the policy in this letter is implemented by the State Automated Welfare System (SAWS): ACWDLs [14-18](#), [14-32](#), [14-35](#), [14-38](#), and MEDIL [I 14-60](#).

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Per MEDILs [I 20-07](#) [I 20-08](#) and [I 20-18](#), counties shall delay processing of Medi-Cal annual renewals, and defer discontinuances and other negative actions due to the COVID-19 public health emergency (PHE), except for the exceptional scenarios provided in those MEDILs. Additionally, counties should process annual renewals and reported changes in circumstances during the COVID-19 PHE unwinding period as outlined in ACWDL [22-18](#). This ACWDL details policy and guidance for changes in circumstance and annual renewal redeterminations outside of the PHE.

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SECTION 1 - CHANGE IN CIRCUMSTANCE REDETERMINATIONS

Welfare and Institutions (W&I) Code §[14005.37](#) outlines the requirements for Medi-Cal change in circumstance redeterminations. Per W&I Code §[14005.37](#), a beneficiary's eligibility "shall be promptly redetermined whenever the county receives information about changes in a beneficiary's circumstances that may affect eligibility for Medi-Cal benefits." This letter describes the procedures for Medi-Cal eligibility redeterminations for changes in circumstance and shall apply to all Medi-Cal beneficiaries.

Medi-Cal eligibility shall continue during the redetermination process. A beneficiary's Medi-Cal eligibility shall not be terminated until the county makes a specific determination based on facts clearly demonstrating that the beneficiary is no longer eligible for Medi-Cal benefits under any basis and when all due process rights have been met. The determination of whether a beneficiary is eligible for Medi-Cal benefits under any basis includes, but is not limited to:

- a determination of eligibility for both MAGI and Non-MAGI Medi-Cal following the hierarchy of Medi-Cal programs outlined in ACWDL [17-03](#),
- an assessment for Consumer Protection Programs (CPPs), Transitional Medi-Cal (TMC), and 4-Month Continuing Eligibility as outlined in ACWDL [21-27](#), and
- an assessment for spousal impoverishment per ACWDLs [17-25](#) and [18-19](#) and MEDIL [121-07](#), where necessary.

Note: When the county has facts clearly demonstrating that a Medi-Cal beneficiary cannot be eligible for Medi-Cal due to death or change of state residency, or the beneficiary requests discontinuance, Medi-Cal benefits shall be discontinued without following the redetermination process outlined below for that individual. However, the county shall document the reason the beneficiary is not eligible under any basis and that a full redetermination could not result in Medi-Cal eligibility, or their request for discontinuance, in the case file. The county shall also send an adequate notice of action (NOA) to the beneficiary specifying the basis for their discontinuance from Medi-Cal. The exception to this is when the Department of Health Care Services (DHCS) discontinues the beneficiary's Medi-Cal benefits and sends the NOA, such as for the residency verification program in connection with the Public Assistance Reporting Information System (PARIS).

Change in Circumstance Redetermination Definition

A change in circumstance redetermination is an eligibility redetermination completed by the county when the county receives information about a change to the beneficiary's circumstances that may affect a beneficiary's eligibility for Medi-Cal benefits. This includes

information reported by the beneficiary or information available to the county from another source, including but not limited to Covered California, the California Work Opportunity and Responsibility to Kids (CalWORKs) program, CalFresh, the Social Security Administration (SSA), Asset Verification Reports (AVP), or the Income Eligibility Verification System (IEVS).

For purposes of this letter, a “change in circumstance redetermination” means determining a beneficiary’s eligibility, as a result of new or changed information, in either:

- the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) Business Rules Engine (BRE) for MAGI Medi-Cal; and/or
- the SAWS Eligibility Determination and Benefits Calculation (EDBC) for Non-MAGI Medi-Cal.

The above definition applies when the county is responsible for case management of the Medi-Cal case.

The following are examples of a beneficiary’s changes in circumstance **that require** an eligibility redetermination, as they may affect eligibility:

- reported or discovered changes in income or property;
- reported or discovered changes in household size or tax filing status;
- reported or discovered change in citizenship or immigration status;
- a loss of contact as a result of mail that is returned as undeliverable (See ACWDL [22-09](#));
- no longer eligible under a particular Medi-Cal program, such as an individual no longer eligible for MAGI Medi-Cal, Non-MAGI Medi-Cal, Supplemental Security Income (SSI), or CalWORKs.

When the county receives new or updated information that does not affect eligibility, the county shall act on that information as needed. However, that action is not considered a change in circumstance that requires an eligibility redetermination. The following are examples of new or updated information that **do not require** an eligibility redetermination, as they do not affect eligibility:

- a change in address or telephone number;
- a change in name;
- a change in address to another county within California for their family, where the county need only conduct an intercounty transfer (ICT) to move the beneficiary’s case management to the new county.

Additionally, based on previous discussions with counties and SAWS, a child moving from one MAGI aid code to another, such as a result of turning 1 or 6 years old, where there is no change in level of benefits, is not considered a change in circumstance for purposes of resetting the annual renewal date, per ACWDL [14-22](#).

Change in Circumstance Redetermination

Step 1:

Ex Parte Review of Available Information

The Medi-Cal redetermination process for changes in circumstance begins with an ex parte review of all available information before contacting the beneficiary. When the county receives information about changes in a beneficiary's circumstances that may affect their Medi-Cal eligibility, the county shall first review all of the most recent or last known information about the beneficiary or the beneficiary's household members. Sources for this ex parte review shall include all information contained in the beneficiary's Medi-Cal file or more recent information or verification available to the county including, but not limited to:

- Information or verification in the beneficiary's Medi-Cal, CalWORKs, and CalFresh case files or any such files of their immediate family members that are open or that were closed within the last 90 days, and that is more recent or is not currently available in the beneficiary's Medi-Cal case file;
- Information or verification accessed through any available electronic databases or electronic verification services including, but not limited to, the Federal Data Services Hub (FDSH) and AVP; and
- All other sources of relevant information or verification reasonably available to the county that are in accordance with the law and DHCS policy.

If the county locates the information or verification necessary to complete the Medi-Cal eligibility redetermination through the ex parte process, the county shall not reach out to the beneficiary to request additional information. Instead, the county shall promptly redetermine the beneficiary's eligibility, reset the annual renewal date per ACWDL [14-22](#), and send the appropriate NOA. As a reminder, if there is no change in eligibility or level of benefits, the county shall send the beneficiary the NOA provided in ACWDL [19-03](#).

Note: In order to reset the annual renewal date for a new 12-month period for Non-MAGI beneficiaries, the county shall have up-to-date information and verification for both income and property. For example, if the Non-MAGI beneficiary only reports a change in property, and the county is able to locate property verification in the AVP reports, the county shall update the Non-MAGI beneficiary's eligibility based on the new property. However, the county shall not reset the annual renewal date. Please see ACWDLs [21-24](#) and [22-13](#) for information on using AVP reports for property verification.

Reasonable Explanation of Income

Pursuant to [42 CFR 435.952\(c\)\(2\)](#), counties shall seek additional information, including a statement which reasonably explains the discrepancy, from an applicant or beneficiary if the information provided is not reasonably compatible with data obtained through electronic data source(s). In order for counties to obtain a reasonable explanation, when self-attested income information is found not reasonably compatible with information obtained through an electronic data source at initial application, or annual renewal, CEWs, as a best practice, should first try to obtain a reasonable explanation by phone or in person. Please refer to ACWDL [22-22](#) for more information about reasonable explanation of income.

Change in Circumstance Redetermination

Step 2:

Send the MC 355 (Medi-Cal Request for Information)

If the county is unable to locate the information needed to complete the Medi-Cal eligibility redetermination through the ex parte process, the county shall send the beneficiary the MC 355 and provide the beneficiary 30 days to return the necessary information to the county via the Internet, by telephone, by mail, in person, or through other commonly available electronic means. The MC 355 shall request only the information that is necessary to redetermine eligibility. Refer to MEDIL [120-13](#) for information on the potential use of the CW 2200 in combined cases.

If the beneficiary does not respond to the MC 355 request within the 30-day period or has provided an incomplete response, the county shall attempt to contact the beneficiary in the beneficiary's preferred method to request the necessary information. As a best practice, counties should attempt to make this follow up contact no later than 15 days after the MC 355 is sent. Additionally, counties may choose to send this reminder in writing to ensure the communication is made and properly documented. Counties shall document the method, date, and details of the attempted contact in the case file.

Example 1: The county sends an MC 355 to a beneficiary requesting verification of income and additional information about the tax household on July 2, with a due date of August 1. On July 10, the beneficiary returns the MC 355 with a handwritten note regarding their current tax household information. The county shall contact the beneficiary in the beneficiary's preferred method to remind the beneficiary that income verification is needed and of the August 1 due date to provide the income verification. As a best practice, the county should attempt to make this contact no later than July 17.

Example 2: The county sends an MC 355 to a beneficiary requesting verification of income on July 2, with a due date of August 1. The county has not received any information or response within the first 15 days after the MC 355 is sent.

The county shall contact the beneficiary in the beneficiary's preferred method to remind the beneficiary that income verification is needed and of the August 1 due date to provide the income verification. As a best practice, the county should attempt to make this contact no later than July 17.

If incomplete information is received after the MC 355 has been sent and the additional attempted contact has been made, but before the discontinuance date, counties shall evaluate whether there was good cause (22 CCR §[50175](#)) for providing incomplete information. If good cause is found, counties shall continue to work with the beneficiary to attempt to obtain the remaining missing information.

Note: Guidance provided on the change in circumstance redetermination process before 2014 required counties to follow the "SB 87 Process," including that counties attempt to contact the beneficiary by phone after ex parte review but before mailing the MC 355. Effective January 1, 2014, W&I Code §[14005.37](#) was revised to require an attempted contact(s) after the MC 355 has been sent, per the guidance above.

Change in Circumstance Redetermination Step 3: Process the Redetermination

(a) Necessary Information Not Received

If, after the 30-day period following the mailing of the MC 355 and the additional attempted contact, the beneficiary does not provide the information and/or verification requested, the county shall send a timely 10-day NOA explaining the reason for discontinuance from Medi-Cal. Per ACWDL [15-27](#), the NOA shall list the specific information or verification(s) missing and needed to redetermine eligibility. Additionally, the NOA shall include the 90-Day Cure Period NOA language.

Note: If the beneficiary provides all requested information before the discontinuance date, the county shall rescind the discontinuance and complete the eligibility redetermination following the guidance provided below to avoid a break in aid.

(b) Necessary Information Received

If the county receives the information necessary to determine eligibility, the county shall update the case file and promptly complete the eligibility redetermination. Please see the sections below for more information.

(i) Beneficiary Remains Medi-Cal Eligible

If the beneficiary remains eligible for Medi-Cal, the county shall reset the annual renewal date per ACWDL [14-22](#) and send the appropriate NOA. As a reminder, if there is no change in eligibility or level of benefits, the NOA provided in ACWDL [19-03](#) shall be sent.

Note: In order to reset the annual renewal date for a new 12-month period for Non-MAGI beneficiaries, the county must have up to date information and verification for both income and property. However, the county may typically only ask for updated information and verification for the information that has been reported or identified as changed. For example, if the Non-MAGI beneficiary only reports a change in property, the county shall only request information or verification needed for the change in property on the MC 355. Please see ACWDLs [21-24](#) and [22-13](#) for information on using AVP reports for property verification. If the required property verification is located in AVP reports or otherwise provided by the beneficiary, the county shall update the Non-MAGI beneficiary's eligibility based on the new property. However, the county shall not reset the annual renewal date.

In accordance with ACWDL [21-24](#), if a Non-MAGI beneficiary reports a change in circumstance, counties are required to request an updated AVP report. Should a Non-MAGI beneficiary report a change in income, provide any necessary verification of the income, and the updated AVP report reflects property under the property limit, counties may reset the annual renewal date as both income and property are considered up to date.

(ii) MAGI Beneficiary is No Longer MAGI Medi-Cal Eligible

Beneficiaries with No Potential Linkage to Non-MAGI Medi-Cal

Based on information currently known to the county following the ex parte review and/or MC 355 process described above, non-disabled, non-blind, non-parent/caretaker, non-pregnant individuals between the ages of 21-64 who are not in long term care and who do not have any other form of linkage to Non-MAGI Medi-Cal shall be referred to CalHEERS to be evaluated for other insurance affordability programs (IAPs) through Covered California when determined ineligible for MAGI Medi-Cal.

For beneficiaries without potential linkage to Non-MAGI Medi-Cal, the county shall send a timely 10-day NOA explaining the reason for discontinuance from MAGI Medi-Cal. As a reminder, if the reason for discontinuance from MAGI Medi-Cal is a

result of income over the MAGI limit, the NOA outlined in ACWDL [22-01](#) shall be sent.

As a result of Senate Bill (SB) 260, individuals discontinued from MAGI Medi-Cal who become eligible for Advanced Premium Tax Credits (APTC) will be automatically enrolled into the Covered California lowest-cost silver health plan available or the individual's same managed care plan (if this information is available to Covered California) before their current coverage ends. The transitioning beneficiary can keep, change, or cancel the automatically selected plan and must then take timely action to effectuate their health plan coverage. SB 260 prohibits the premium due date from being sooner than the last day of the first month of the health plan coverage.

Individuals discontinued from MAGI Medi-Cal who are not eligible for APTC will not be automatically enrolled into a Covered California health plan. Per ACWDL [16-18](#), the discontinuance of MAGI Medi-Cal is considered a loss of minimum essential coverage (MEC), which is treated as a Qualifying Life Event (QLE) and opens up a Special Enrollment Period (SEP) for Covered California. Accordingly, coverage can begin the month following the final Medi-Cal eligibility determination if the beneficiary picks a Qualified Health Plan (QHP) and pays their premium by the due date outside of open enrollment. Counties shall include all applicable QLEs when the referral is made to Covered California. Please see ACWDL [22-20](#) for more information about the process of transitioning discontinued beneficiaries to Covered California and the counties role in providing assistance with enrollment.

Beneficiaries with Potential Linkage to Non-MAGI Eligibility

If a MAGI beneficiary is found to no longer be eligible for MAGI Medi-Cal, the beneficiary shall be evaluated for CPPs and Non-MAGI Medi-Cal programs, if there is potential linkage, before referring the beneficiary to CalHEERS to be evaluated for other IAPs through Covered California.

The county shall keep the beneficiary in their original MAGI aid code until the Non-MAGI eligibility determination is complete. Counties shall first conduct an ex parte review of all available information in an attempt to establish Non-MAGI Medi-Cal eligibility. If the county cannot establish Non-MAGI eligibility by completing the ex parte review, the county shall promptly send the beneficiary the Non-MAGI Screening Packet to ask for additional information not found in the ex parte review. The Non-MAGI Screening Packet consists of:

1. The Non-MAGI Informing Letter, which can be located on the DHCS website [here](#).
2. MC 604 IPS, which can be located on the DHCS website [here](#).

3. The Non-MAGI Medi-Cal Brochure (Pub 10) which can be located on the DHCS website [here](#).
4. The *Now that you're enrolled* Brochure, which can be located on the Covered California website in English [here](#), and in Spanish [here](#).

The county may only ask for information or verification not already available or identified through the ex parte review. The beneficiary shall be given 30 days from the date the Non-MAGI Screening Packet is mailed to complete and return the information requested in the Non-MAGI Screening Packet to the county. Counties shall accept this information via Internet, by telephone, by mail, in person, or through other commonly available electronic means. During the 30 days, the county shall attempt to contact the beneficiary in the beneficiary's preferred method to provide a reminder that the Non-MAGI Screening Packet is due and restate the packet's due date. See the [No Response or Incomplete Response to Non-MAGI Screening Packet](#) section below for more information on the additional contact(s).

Non-MAGI Eligibility Determination for Beneficiaries with Potential Linkage

If the county has enough information via the ex parte review, or the beneficiary responds to the Non-MAGI Screening Packet and provides the necessary information, the county shall determine Non-MAGI Medi-Cal eligibility.

- Found Eligible for Non-MAGI Medi-Cal with no Share-of-Cost (SOC)

Beneficiaries who are found eligible for a Non-MAGI Medi-Cal program with no SOC shall be promptly moved to the corresponding aid code. The county shall lift the soft pause indicator (if applicable), send the appropriate NOA and reset the annual renewal date in accordance with ACWDL [14-22](#).

- Found Eligible for Non-MAGI Medi-Cal with a Share-of-Cost (SOC)

If a beneficiary responds to the Non-MAGI Screening Packet requesting a Non-MAGI evaluation and is determined eligible for SOC Medi-Cal, the county shall move the beneficiary into SOC Medi-Cal and refer the beneficiary to CalHEERS to determine eligibility for other IAPs through Covered California. Beneficiaries determined eligible for a Non-MAGI program with a SOC have their choice of SOC Medi-Cal only, SOC Medi-Cal and a Covered California plan (with or without financial assistance), or only a Covered California health plan (with or without financial assistance). If the individual is found eligible for a Covered California plan (with or without financial assistance), the individual can choose to effectuate coverage or not.

In this scenario, the county will lift the soft pause indicator (if applicable) and send a timely 10-day NOA explaining the reason for discontinuance from MAGI Medi-Cal. As a reminder, if the reason for discontinuance from MAGI Medi-Cal is a result of

income over the MAGI limit, the NOA outlined in ACWDL [22-01](#) shall be sent. Additionally, the county shall send the appropriate approval NOA showing the start date for Non-MAGI Medi-Cal and the correct SOC amount, and shall reset the annual renewal date in accordance with ACWDL [14-22](#). The approval NOA shall be sent at least 10 days before the SOC taking effect. Counties should make every attempt to send the MAGI discontinuance NOA and the SOC approval NOA at the same time to provide the beneficiary with accurate eligibility determination information.

Please refer to the "[Beneficiaries with No Potential Linkage to Non-MAGI Medi-Cal](#)" section above and ACWDL [22-20](#) for more information about the process of transitioning discontinued beneficiaries to Covered California and the counties role in providing assistance with enrollment.

- *Determined Ineligible for Non-MAGI Medi-Cal*

If the individual is determined ineligible for a Non-MAGI Medi-Cal program, the county shall lift the soft pause indicator (if applicable) and send a timely 10-day NOA explaining the reason for discontinuance from MAGI Medi-Cal. As a reminder, if the reason for discontinuance from MAGI Medi-Cal is a result of income over the MAGI limit, the NOA outlined in ACWDL [22-01](#) shall be sent. Additionally, the county shall send the Non-MAGI denial NOA outlined in [ACWDL 18-12](#). Counties should make every attempt to send the MAGI discontinuance NOA and the Non-MAGI denial NOA at the same time to provide the beneficiary with accurate eligibility determination information.

The county shall refer the beneficiary to CalHEERS to be evaluated for other IAPs through Covered California. Please refer to the "[Beneficiaries with No Potential Linkage to Non-MAGI Medi-Cal](#)" section above and ACWDL [22-20](#) for more information about the process of transitioning discontinued beneficiaries to Covered California and the counties role in providing assistance with enrollment.

No Response or Incomplete Response to Non-MAGI Screening Packet

If the beneficiary does not respond to the Non-MAGI Screening Packet within the 30-day period or has provided an incomplete response, the county shall attempt to contact the beneficiary in the beneficiary's preferred method to request the necessary information and verification. As a best practice, counties should attempt to make this follow up contact no later than 15 days after the Non-MAGI Screening Packet is sent. Additionally, counties may choose to send this reminder in writing to ensure the communication is made and properly documented. Counties shall document the method, date, and details of the attempted contact in the case file.

Example 1: The county sends the Non-MAGI Screening Packet to a beneficiary on July 2, with a due date of August 1. On July 10, the beneficiary returns the information requested in the MC 604 IPS, but does not provide necessary verification of property. The county shall contact the beneficiary in the beneficiary's preferred method to remind the beneficiary that property verification is needed and of the August 1 due date to provide the property verification. As a best practice, the county should attempt to make this contact no later than July 17.

Example 2: The county sends the Non-MAGI Screening Packet to a beneficiary on July 2, with a due date of August 1. The county has not received any information or response within the 15 days after the Non-MAGI Screening Packet is sent. The county shall contact the beneficiary in the beneficiary's preferred method to remind the beneficiary that the information and verification requested in the Non-MAGI Screening Packet is needed and of the August 1 due date. As a best practice, the county should attempt to make this contact no later than July 17.

If the beneficiary fails to return the Non-MAGI Screening Packet or other requested information/verification within the 30-day period and after at least one attempt to contact the beneficiary, the county shall lift the soft pause indicator (if applicable) and send a timely 10-day NOA explaining the reason for discontinuance from MAGI Medi-Cal. As a reminder, if the reason for discontinuance from MAGI Medi-Cal is a result of income over the MAGI limit, the NOA outlined in ACWDL [22-01](#) shall be sent.

Additionally, if the beneficiary declines the Non-MAGI evaluation or does not complete the Non-MAGI evaluation, the MAGI discontinuance NOA shall include:

- the Non-MAGI NOA language provided in ACWDL [18-24](#) and MEDIL [I 19-08](#); and
- the 90-Day Cure Period NOA language.

The county shall refer the beneficiary to CalHEERS to be evaluated for other IAPs through Covered California. Please refer to the "[Beneficiaries with No Potential Linkage to Non-MAGI Medi-Cal](#)" section above and ACWDL [22-20](#) for more information about the process of transitioning discontinued beneficiaries to Covered California and the counties role in providing assistance with enrollment.

(iii) Non-MAGI Beneficiary is No Longer Non-MAGI Eligible

Determine Whether Potential MAGI Medi-Cal Eligibility Exists

If a Non-MAGI beneficiary is found to no longer be eligible for Non-MAGI Medi-Cal during the change in circumstance redetermination, the county shall screen the beneficiary for potential eligibility for MAGI Medi-Cal programs before discontinuing the beneficiary. The county should review available information to determine if the Non-MAGI beneficiary may be or has become potentially MAGI Medi-Cal eligible as a child, parent/caretaker relative, pregnant individual or a non-Medicare recipient who is age 19 up to age 65. Note that a parent/caretaker relative of any age may be eligible for MAGI Medi-Cal if their income is under the parent/caretaker federal poverty limit, regardless of whether they have Medicare.

Counties shall not send eligibility determination requests to CalHEERS for Non-MAGI cases where no potential MAGI eligibility exists. See ACWDL [18-16](#) and ACWDL [20-17](#) for information about Non-MAGI individuals who are sent to CalHEERS as a part of a mixed Medi-Cal household and the potential availability of verifications through the FDSH. If the beneficiary has no potential eligibility for MAGI Medi-Cal, the county shall send a timely 10-day NOA explaining the reason for discontinuance from Non-MAGI Medi-Cal.

MAGI Eligibility Determination for Beneficiaries with Potential Eligibility

If potential MAGI eligibility exists, the county shall conduct an ex parte review to locate any available tax household information. If additional tax household information is needed, the county shall request any required tax household information not currently in the case file by sending the beneficiary a Request For Tax Household Information (RFTHI) with a 30-day due date for the beneficiary to provide the information, before sending the beneficiary's information to CalHEERS. If, after the 30 days and after at least one attempt to contact the beneficiary, the beneficiary fails to return the tax household information needed to determine MAGI Medi-Cal, the county shall send a timely 10-day NOA explaining the reason for discontinuance from Non-MAGI Medi-Cal. See the [No Response or Incomplete Response to Non-MAGI Screening Packet](#) section above for more information on how to make an additional contact(s), as this guidance also applies to the RFTHI request.

If the county has enough information from the ex parte review, or the beneficiary responds to the RFTHI and provides the necessary information by Internet, by telephone, by mail, in person, or through other commonly available electronic means, the county shall send the beneficiary's information to CalHEERS to determine if MAGI eligibility exists. Non-MAGI beneficiaries shall remain in their existing aid code during the redetermination process. If the beneficiary is found to be

MAGI eligible and required information is verified through the FDSH, the county shall send the appropriate MAGI approval NOA and reset the annual renewal date in accordance with ACWDL [14-22](#).

If the individual is found eligible for a Covered California plan (with or without financial assistance), the county shall send a timely 10-day NOA explaining the reason for discontinuance from Non-MAGI Medi-Cal. Please refer to ACWDL [22-20](#) for more information about the process of transitioning discontinued beneficiaries to Covered California and the counties role in providing assistance with enrollment.

No Response or Incomplete Response to MAGI Verification Request

If, after sending the beneficiary's information to CalHEERS, the beneficiary's MAGI Medi-Cal eligibility is pending due to verification that cannot be obtained electronically, the county shall send the beneficiary the MC 355 with a 30-day due date to provide the required verification. See the [Change in Circumstance Redetermination; Step 2; Send the MC 355](#) section above for more information on additional contacts during the 30 days. If, after the 30 days and after at least one attempt to contact the beneficiary in the beneficiary's preferred method, the beneficiary fails to return the required information or verification requested in the MC 355, the county shall send a timely 10-day NOA explaining the reason for discontinuance from Non-MAGI Medi-Cal. If the beneficiary does not provide the information requested in the MC 355 to determine MAGI eligibility, the Non-MAGI discontinuance NOA shall also:

- list the specific items of information or verification needed to determine MAGI eligibility per ACWDL [15-27](#); and
- include the 90-Day Cure Period NOA language.

Note: If the beneficiary provides all requested information before the discontinuance date, the county shall rescind the discontinuance and complete the eligibility redetermination to avoid a break in coverage.

Change in Circumstance Redetermination

Step 4:

90-Day Cure Period

A beneficiary is entitled to a 90-Day Cure Period if they are discontinued for failing to provide needed information or verifications. This includes all scenarios where the beneficiary must provide information or verification, including those outlined in this ACWDL and all other scenarios where the beneficiary must cooperate with a program requirement, such as the requirements for compliance outlined in ACWDL [19-13](#). The Centers for

Medicare and Medicaid Services (CMS) provided states with updated guidance on the 90-Day Cure Period that has led to ongoing discussions for clarity. As a result, DHCS will release a future ACWDL with specific guidance on the 90-Day Cure Period. **In the meantime, counties shall follow current business practices for the 90-Day Cure Period.**

Change in Circumstance Redetermination Exceptions

As a reminder, counties should refer to ACWDL [14-05](#) for guidance on when to send an MC 355 related to a child's eligibility for Continuous Eligibility for Children (CEC). Additionally, ACWDL [14-41](#) provides guidance related to the circumstances for which a Former Foster Youth (FFY) may be sent the MC 355. Notably, a beneficiary's failure to respond to requests for information during a change in circumstance redetermination is **not** a basis for discontinuing benefits for the following programs (except as noted under the FFY Program bullet below):

- FFY Program; however, counties may discontinue benefits when the individual is aging out of the FFY Program and the county has been unable to obtain required information or verification to redetermine eligibility after following the process outlined above. See ACWDL [14-41](#) for more information.
- Medi-Cal categories where the county does not control the record, such as individuals eligible through Supplemental Security Income/State Supplementary Payment, Kinship Guardianship Assistance (Kin-GAP), or Adoption Assistance.
- Children eligible for CEC. See ACWDL [14-05](#) for more information.

SECTION 2 - ANNUAL RENEWAL REDETERMINATIONS

W&I Code § [14005.37](#) outlines the requirements for Medi-Cal annual renewal redeterminations. Per W&I Code § [14005.37](#), a county shall perform eligibility redeterminations for Medi-Cal beneficiaries every 12 months. The procedures for redetermining Medi-Cal eligibility during annual renewal redeterminations described in this letter shall apply to MAGI and Non-MAGI Medi-Cal beneficiaries.

Medi-Cal eligibility shall continue during the redetermination process and a beneficiary's Medi-Cal eligibility shall not be terminated until the county makes a specific determination based on facts clearly demonstrating that the beneficiary is no longer eligible for Medi-Cal benefits under any basis and all due process rights have been met. A beneficiary's eligibility determination for Medi-Cal benefits under any basis shall include, but is not limited to:

- a determination of eligibility for both MAGI and Non-MAGI based Medi-Cal following the hierarchy of Medi-Cal programs outlined in ACWDL [17-03](#).

- an assessment for Consumer Protection Programs (CPPs), Transitional Medi-Cal (TMC), and 4-Month Continuing Eligibility as outlined in ACWDL [21-27](#), and
- an assessment for spousal impoverishment per ACWDLs [17-25](#) and [18-19](#) and MEDIL [121-07](#), where necessary.

Annual Renewal Definitions

Annual Renewal Due Month: The month in which the annual renewal is due. Typically, the annual renewal due month is the 11th month after the application month (i.e. the 12th month when including the application month). For example, if an individual applies in August, their annual renewal due month is set to the following July, and if an individual applies in January, their annual renewal due month is set to the following December.

However, per ACWDL [14-22](#), the annual renewal due month shall be reset after a change in circumstance results in an eligibility redetermination. If a beneficiary's eligibility is redetermined during a change in circumstance redetermination, their annual renewal due month is reset to the 11th month after the month the change in circumstance redetermination is complete (i.e. 12th month when including the redetermination month). For example, if a beneficiary has an annual renewal due month of July 2024 and a change in circumstance redetermination is completed in March 2024, the annual renewal due month is reset to February 2025.

Annual Renewal End Date: The last day of the annual renewal due month. For example, if the annual renewal due month is July, the annual renewal end date is July 31.

Annual Renewal Form Due Date: The date the annual renewal form is due, which is 60 days from the date that the annual renewal form is sent to the beneficiary. The annual renewal form due date occurs before the annual renewal end date and shall allow adequate time for the timely 10-day discontinuance NOA before the annual renewal end date, if necessary. For example, if the annual renewal due month is July, the annual renewal form due date shall allow adequate time for the 10-day discontinuance NOA to be sent before the annual renewal end date of July 31.

Annual Renewal Redetermination

Step 1:

Ex Parte Review of Available Information

The Medi-Cal annual renewal redetermination process begins with an ex parte review of all available information before contacting the beneficiary. In order to allow sufficient time to send a renewal form and discontinuance NOA if necessary, the ex parte review should be completed no less than 85 days before the annual renewal end date for both MAGI and

Non-MAGI Medi-Cal. For example, if the annual renewal end date is July 31, the ex parte review should be completed no later than May 7. As part of the ex parte review process, the county shall first review all of the most recent or last known information about the beneficiary or the beneficiary's household members. Sources for these efforts shall include all information contained in the beneficiary's Medi-Cal file or more recent information or verification available to the county including, but not limited to:

- Information or verification in the beneficiary's Medi-Cal, CalWORKs, and CalFresh case files or any such files of their immediate family members that are open or that were closed within the last 90 days, and that is more recent or is not currently available in the beneficiary's Medi-Cal case file;
- Information or verification accessed through any available electronic databases or electronic verification services including, but not limited to, the Federal Data Services Hub (FDSH) and Asset Verification Reports (AVP); and
- All other sources of relevant information or verification reasonably available to the county that are in accordance with the law and DHCS policy.

For MAGI based Medi-Cal beneficiaries, the automatic ex parte review consists of sending the beneficiary's current case information, including available information updated in the Medi-Cal case file as a result of other public social service programs, to CalHEERS to determine if MAGI eligibility can be established and verified electronically through the FDSH. For Non-MAGI based Medi-Cal beneficiaries, the process consists of reviewing all available information, as stated above, to determine if the county has enough information to determine if Non-MAGI eligibility can be established and verified.

If the county locates the information needed to redetermine eligibility through the ex parte process, the county shall not reach out to the beneficiary to request any additional information, and instead shall promptly redetermine ongoing eligibility and complete the annual renewal. This includes the county receiving a determination of MAGI eligible or conditionally eligible from CalHEERS. Once the redetermination is complete, the county shall send the appropriate NOA. As a reminder, if there is no change in eligibility or level of benefits, the NOA provided in ACWDL [19-03](#) shall be sent.

Note: Guidance provided on the annual renewal redetermination process before 2014 required counties to follow the "SB 87 Process," including ex parte review, an attempt at telephone contact, and mailing the MC 355 after an incomplete annual renewal form was received. Effective January 1, 2014, W&I Code [§14005.37](#) was revised to require ex parte review before mailing the annual renewal form and an additional contact(s), as described below.

Reasonable Explanation of Income

Pursuant to [42 CFR 435.952\(c\)\(2\)](#), counties shall seek additional information, including a statement which reasonably explains the discrepancy, from an applicant or beneficiary if the information provided is not reasonably compatible with data obtained through electronic data source(s). In order for counties to obtain a reasonable explanation, when self-attested income information is found not reasonably compatible with information obtained through an electronic data source at initial application, or annual renewal, CEWs, as a best practice, should first try to obtain a reasonable explanation by phone or in person. Please refer to ACWDL [22-22](#) for more information about reasonable explanation of income.

Annual Renewal Redetermination

Step 2:

Send the Annual Renewal Form

If the county is unable to redetermine continued eligibility through the ex parte process, the county shall send the pre-populated annual renewal form and provide the beneficiary a 60-day annual renewal form due date. The annual renewal form due date shall allow adequate time to send a timely 10-day discontinuance NOA before the end of the annual renewal due month, if necessary.

Example: The annual renewal due month is June and the annual renewal end date is June 30. The county sends the annual renewal form by April 16 and provides an annual renewal form due date of June 15, providing 60 days to return the form and sufficient time to send a timely 10-day discontinuance NOA before the annual renewal end date, if necessary.

The annual renewal form shall be pre-populated with information in the beneficiary's county case file and shall request only the additional information needed by the county to determine eligibility. See the "[Medi-Cal Annual Renewal Forms](#)" section below for more information.

Beneficiaries may provide the information requested in the annual renewal form through any of the available means, including online, by phone, in person, by mail, or through commonly available electronic means. Beneficiaries do not need to return the paper annual renewal form; however, they must provide the necessary information requested in the form and sign the form through any of the available means. See MEDIL [18-13](#) and ACWDLs [19-17E](#) and [21-12](#) for more information on telephonic or electronic signatures and signature requirements for affidavits.

Annual Renewal Redetermination
Step 3:
Additional Contact(s) if Needed

During the 60 days after the annual renewal form is sent, counties shall attempt at least one additional contact with the beneficiary if no information or incomplete information is received, in accordance with W&I Code §[14005.37](#). The following guidance includes requirements for additional contact(s) during the 60 days, and best practices for the timing of the contact(s). Counties shall document the method, date, and details of the attempted contact(s) in the case file.

- If no information is received by the 30th day after the annual renewal form is sent, counties shall contact the beneficiary in the beneficiary's preferred method to provide a reminder that the information and verification requested in the annual renewal form is due and to provide the due date. For example, if the annual renewal form was sent on April 16 and the due date is June 15, and no information has been received by May 16, the county shall contact the beneficiary. As a best practice, the county should attempt to make this contact around May 16. This contact may be made in writing or over the phone through "verbal contact."

"Verbal contact" is defined as live communication between the county and beneficiary (voice mail or answering machine messages left by the county for the beneficiary are not defined as verbal contact). As a best practice, counties may choose to send this reminder in writing to ensure the communication is made and properly documented.

- If incomplete information is received after the first contact has been made but before the annual renewal form due date, counties shall attempt one additional contact using the MC 355 to request the information or verification that is still missing and required. The MC 355 shall indicate that the missing information or verification is due by the annual renewal form due date.
- If incomplete information is received after the first contact has been made and after the annual renewal form due date, but before the annual renewal end date, counties shall still attempt one additional contact with the beneficiary using the MC 355 to request the information or verification that is still missing and required. The MC 355 shall indicate that the missing information or verification was due by the annual renewal form due date.
- If incomplete information has been received before the 30th day after the annual renewal has been sent, counties shall contact the beneficiary using the MC 355 to request the information or verification that is still missing and required at the time the

partial information is received. The MC 355 shall indicate that the missing information or verification is due by the annual renewal form due date.

- If additional incomplete information is received after the first MC 355 has been sent but before the annual renewal form due date, counties shall attempt one additional contact with the beneficiary using the MC 355 to request the required information or verification that is still missing. The second MC 355 shall indicate that the missing information or verification is due by the annual renewal form due date.
- If additional incomplete information is received after the first MC 355 has been sent and after the annual renewal form due date, but before the annual renewal end date, counties shall still attempt one additional contact with the beneficiary using the MC 355 to request the information or verification that is still missing and required. The second MC 355 shall indicate that the missing information or verification was due by the annual renewal form due date.

Note: When the MC 355 is used after the annual renewal form is sent, a 30-day due date shall not be provided. The MC 355 due date shall be the annual renewal form due date as described above. Refer to MEDIL [1 20-13](#) for information on the potential use of the CW 2200 in combined cases.

As a reminder, in order for the annual renewal form to be considered complete, the beneficiary must provide all information and verification necessary to determine eligibility, and must sign the form through any available means, including online, by phone, through available electronic means, or by providing the signed form in person or through the mail.

Annual Renewal Redetermination

Step 4:

Process the Redetermination

(a) Necessary Information Not Received

If, after following the process outlined above, the necessary information and verification is not received by the annual renewal form due date, the county shall send a timely 10-day NOA explaining the reason for discontinuance from Medi-Cal. As a reminder, if the reason for discontinuance is a failure to return the annual renewal form, the NOA language outlined in ACWDL [17-32](#) shall be sent. If the annual renewal form was received but the information and or verification was incomplete after the additional contacts, the NOA shall list the specific information or verification(s) missing and needed to redetermine eligibility per ACWDL [15-27](#). Additionally, the NOA shall include the 90-Day Cure Period NOA language.

Note: If the beneficiary provides all requested information before the discontinuance date (before the annual renewal end date), the county shall rescind the discontinuance and complete the eligibility redetermination to avoid a break in coverage. Additionally, if the county receives information from the beneficiary in the final days of the month and is unable to determine if the information is complete before the discontinuance date, the county shall rescind the discontinuance to allow time to review the information for completeness. If the information continues to be incomplete, the county shall send a new timely 10-day NOA explaining the reason for discontinuance from Medi-Cal for the end of the month following the renewal due month, which lists the specific information or verification(s) missing and needed to redetermine eligibility per ACWDL [15-27](#) and includes the 90-Day Cure Period NOA language.

(b) Necessary Information Received

If the county receives the information necessary to determine eligibility, the county shall update the case file and promptly complete the eligibility redetermination before the annual renewal end date to prevent a break in aid.

(i) Beneficiary Remains Medi-Cal Eligible

If the beneficiary remains eligible for Medi-Cal, the county shall send the appropriate NOA. As a reminder, if there is no change in eligibility or level of benefits, the NOA provided in ACWDL [19-03](#) shall be sent.

(ii) MAGI Beneficiary is No Longer MAGI Medi-Cal Eligible

Beneficiaries with No Potential Linkage to Non-MAGI Medi-Cal

Based on information currently known to the county following the ex parte review and/or annual renewal form processes described above, non-disabled, non-blind, non-parent/caretaker, non-pregnant individuals between the ages of 21-64 who are not in long term care and who do not have any other form of linkage to Non-MAGI Medi-Cal, shall be referred to CalHEERS to be evaluated for other IAPs through Covered California upon being determined ineligible for MAGI Medi-Cal. As a reminder, if the reason for discontinuance from MAGI Medi-Cal is a result of income over the MAGI limit, the NOA outlined in ACWDL [22-01](#) shall be sent. The individuals should not be moved into other IAPs through Covered California sooner than the month after the annual renewal due month. However, counties may send the NOA earlier than the NOA cutoff date where possible, to allow the beneficiary more time to effectuate plan enrollment.

As a result of SB 260, individuals discontinued from MAGI Medi-Cal who become eligible for APTC will be automatically enrolled into the Covered California lowest-cost silver health plan available or the individual's same managed care plan (if this information is available to Covered California) before their current coverage ends. The transitioning beneficiary can keep, change, or cancel the automatically selected plan and must then take timely action to effectuate their health plan coverage. SB 260 prohibits the premium due date from being sooner than the last day of the first month of the health plan coverage

Individuals discontinued from MAGI Medi-Cal who are not eligible for APTC will not be automatically enrolled into a Covered California health plan. Per ACWDL [16-18](#), the discontinuance of MAGI Medi-Cal is considered a loss of MEC, which is treated as a QLE and opens up a SEP for Covered California. Accordingly, coverage can begin the month following the final Medi-Cal eligibility determination if the beneficiary picks a QHP and pays their premium by the due date outside of open enrollment. Counties shall include all applicable QLEs when the referral is made to Covered California. Please see ACWDL [22-20](#) for more information about the process of transitioning discontinued beneficiaries to Covered California and the counties role in providing assistance with enrollment.

Beneficiaries with Potential Linkage to Non-MAGI Eligibility

If a MAGI beneficiary is determined to no longer be eligible for MAGI Medi-Cal, the beneficiary shall first be evaluated for CPPs and Non-MAGI Medi-Cal programs, if there is potential linkage, before referring the beneficiary to CalHEERS to be evaluated for other IAPs through Covered California. The county shall keep the beneficiary in their existing MAGI aid code until the Non-MAGI eligibility determination is complete.

Counties shall first conduct an ex parte review of all available information in an attempt to establish Non-MAGI Medi-Cal eligibility. If the county cannot establish Non-MAGI eligibility by completing the ex parte review, the county shall promptly send the beneficiary the Non-MAGI Screening Packet to ask for additional information not found in the ex parte review. The Non-MAGI Screening Packet consists of:

1. The Non-MAGI Informing Letter, which can be located on the DHCS website [here](#).
2. MC 604 IPS, which can be located on the DHCS website [here](#).
3. The Non-MAGI Medi-Cal Brochure (Pub 10) which can be located on the DHCS website [here](#).
4. The *Now that you're enrolled* Brochure, which can be located on the Covered California website in English [here](#), and in Spanish [here](#).

The county may only ask for information or verification not already available or identified through the ex parte review. The beneficiary shall be given 30 days from the date the Non-MAGI Screening Packet is mailed to complete and return the information requested in the Non-MAGI Screening Packet. Counties shall accept this information via Internet, by telephone, by mail, in person, or through other commonly available electronic means. During the 30 days, the county shall attempt to contact the beneficiary in the beneficiary's preferred method to provide a reminder that the Non-MAGI Screening Packet is due and restate the packet's due date. See the [No Response or Incomplete Response to Non-MAGI Screening Packet](#) section below for more information on the additional contact(s).

Non-MAGI Eligibility Determination for Beneficiaries with Potential Linkage

If the county has enough information via the ex parte review, or the beneficiary responds to the Non-MAGI Screening Packet and provides the necessary information, the county shall determine Non-MAGI Medi-Cal eligibility.

- *Found Eligible for Non-MAGI Medi-Cal with no SOC*
Beneficiaries who are found eligible for a Non-MAGI Medi-Cal program with no SOC shall be moved to the corresponding aid code. The county shall lift the soft pause indicator (if applicable) and send the appropriate NOA. The beneficiary should not be moved into the new aid code sooner than the month after the annual renewal due month.

- *Found Eligible for Non-MAGI Medi-Cal with a SOC*
If a beneficiary responds to the Non-MAGI Screening Packet requesting a Non-MAGI evaluation and is determined eligible for SOC Medi-Cal, the county shall move the beneficiary into SOC Medi-Cal and refer the beneficiary to CalHEERS to determine eligibility for IAPs through Covered California. Beneficiaries determined eligible for a Non-MAGI program with a SOC have their choice of SOC Medi-Cal only, SOC Medi-Cal and a Covered California plan (with or without financial assistance), or only a Covered California health plan (with or without financial assistance). If the individual is found eligible for a Covered California plan (with or without financial assistance), the individual can choose to effectuate coverage or not.

In this scenario, the county will lift the soft pause indicator (if applicable) and send a timely 10-day NOA explaining the reason for discontinuance from MAGI Medi-Cal. As a reminder, if the reason for discontinuance from MAGI Medi-Cal is a result of income over the MAGI limit, the NOA outlined in ACWDL [22-01](#) shall be sent. The beneficiary should not be moved into the new aid code sooner than the month after the annual renewal due month. However, counties may send the

NOA earlier than the NOA cutoff date where possible, to allow the beneficiary more time to effectuate plan enrollment.

Additionally, the county shall send the appropriate approval NOA showing the start date for Non-MAGI Medi-Cal and the correct SOC amount. The approval NOA shall be sent at least 10 days before the SOC takes effect. Counties should make every attempt to send the MAGI discontinuance NOA and the SOC approval NOA at the same time to provide the beneficiary with accurate eligibility determination information.

Please refer to the "[Beneficiaries with No Potential Linkage to Non-MAGI Medi-Cal](#)" section above and ACWDL [22-20](#) for more information about the process of transitioning discontinued beneficiaries to Covered California and the counties role in providing assistance with enrollment.

- *Determined Ineligible for Non-MAGI Medi-Cal*

If the individual is determined ineligible for a Non-MAGI Medi-Cal program, the county shall lift the soft pause indicator (if applicable) and send a timely 10-day NOA explaining the reason for discontinuance from MAGI Medi-Cal. As a reminder, if the reason for discontinuance from MAGI Medi-Cal is a result of income over the MAGI limit, the NOA outlined in ACWDL [22-01](#) shall be sent. Additionally, the county shall send the Non-MAGI denial NOA outlined in ACWDL [18-12](#). Counties should make every attempt to send the MAGI discontinuance NOA and the Non-MAGI denial NOA at the same time to provide the beneficiary with accurate eligibility determination information.

The county shall refer the beneficiary to CalHEERS to be evaluated for other IAPs through Covered California. Please refer to the "[Beneficiaries with No Potential Linkage to Non-MAGI Medi-Cal](#)" section above and ACWDL [22-20](#) for more information about the process of transitioning discontinued beneficiaries to Covered California and the counties role in providing assistance with enrollment.

No Response or Incomplete Response to Non-MAGI Screening Packet

If the beneficiary does not respond to the Non-MAGI Screening Packet within the 30-day period or has provided an incomplete response, the county shall attempt to contact the beneficiary in the beneficiary's preferred method to request the necessary information and verification. As a best practice, counties should attempt to make this follow up contact no later than 15 days after the Non-MAGI Screening Packet is sent. Additionally, counties may choose to send this reminder in writing to ensure the communication is made and properly documented. Counties shall document the method, date, and details of the attempted contact in the case file.

Example 1: The county sends the Non-MAGI Screening Packet to a beneficiary on July 2, with a due date of August 1. On July 10, the beneficiary returns the information requested in the MC 604 IPS but does not provide necessary verification of property. The county shall contact the beneficiary in the beneficiary's preferred method to remind the beneficiary that property verification is needed and of the August 1 due date to provide the property verification. As a best practice, the county should attempt to make this contact no later than July 17.

Example 2: The county sends the Non-MAGI Screening Packet to a beneficiary on July 2, with a due date of August 1. The county has not received any information or response within the first 15 days after the Non-MAGI Screening Packet is sent. The county shall contact the beneficiary in the beneficiary's preferred method to remind the beneficiary that the information and verification requested in the Non-MAGI Screening Packet is needed and of the August 1 due date. As a best practice, the county should attempt to make this contact no later than July 17.

If, after the 30 days and after at least one attempt to contact the beneficiary, the beneficiary fails to return the Non-MAGI Screening Packet or otherwise provide the requested information, the county shall lift the soft pause indicator (if applicable) and send a timely 10-day NOA explaining the reason for discontinuance from MAGI Medi-Cal. As a reminder, if the reason for discontinuance from MAGI Medi-Cal is a result of income over the MAGI limit, the NOA outlined in ACWDL [22-01](#) shall be sent.

Additionally, if the beneficiary declines the Non-MAGI evaluation or does not complete the Non-MAGI evaluation, the MAGI discontinuance NOA shall also include:

- the Non-MAGI NOA language provided in ACWDL [18-24](#) and MEDIL [1-19-08](#);
and
- the 90-Day Cure Period NOA language.

The county shall refer the beneficiary to CalHEERS to be evaluated for other IAPs through Covered California. Please refer to the "[Beneficiaries with No Potential Linkage to Non-MAGI Medi-Cal](#)" section above and ACWDL [22-20](#) for more information about the process of transitioning discontinued beneficiaries to Covered California and the counties role in providing assistance with enrollment.

Note: If the beneficiary provides all requested information before the discontinuance date, the county shall rescind the discontinuance and complete the eligibility redetermination to avoid a break in coverage.

iii. Non-MAGI Beneficiary is No Longer Non-MAGI Eligible

Determine Whether Potential MAGI Medi-Cal Eligibility Exists

If a Non-MAGI beneficiary is determined to no longer be eligible for Non-MAGI Medi-Cal during the annual renewal redetermination, the beneficiary shall be screened for potential eligibility for MAGI Medi-Cal programs before discontinuing the beneficiary. The county should review available information to determine if the Non-MAGI beneficiary may be or has become potentially MAGI eligible as a child, parent/caretaker relative, pregnant individual, or a non-Medicare recipient who is age 19 up to age 65. Note that a parent/caretaker relative of any age may be eligible for MAGI Medi-Cal if their income is under the parent/caretaker federal poverty limit, regardless of whether they have Medicare.

Counties shall not send eligibility determination requests to CalHEERS for Non-MAGI cases where no potential MAGI eligibility exists. See ACWDLs [18-16](#) and [20-17](#) for information about Non-MAGI individuals who are sent to CalHEERS as a part of a mixed Medi-Cal household and the potential availability of verifications through the FDSH. If the beneficiary has no potential eligibility for MAGI Medi-Cal, the county shall send a timely 10-day NOA explaining the reason for discontinuance from Non-MAGI Medi-Cal.

MAGI Eligibility Determination for Beneficiaries with Potential Eligibility

If potential MAGI eligibility exists, the county shall conduct an ex parte review to locate any available tax household information. If additional tax household information is needed, the county shall request any required tax household information that is not currently in the case file by sending the beneficiary a RFTHI with a 30-day due date for the beneficiary to provide the information before sending the beneficiary's information to CalHEERS.

If, after the 30 days and after at least one attempt to contact the beneficiary in the beneficiary's preferred method, the beneficiary fails to return the tax household information needed to determine MAGI Medi-Cal, the county shall send a timely 10-day NOA explaining the reason for discontinuance from Non-MAGI Medi-Cal. See the [No Response or Incomplete Response to Non-MAGI Screening Packet](#) section above for more information on how to make an additional contact(s), as this guidance also applies to the RFTHI request.

If the county has enough information via the ex parte review, or the beneficiary responds to the RFTHI request with the necessary information via Internet, by telephone, by mail, in person, or through commonly available electronic means, the county shall send the beneficiary's information to CalHEERS to determine if MAGI eligibility exists. Non-MAGI beneficiaries shall remain in their existing aid code during the redetermination process.

If the beneficiary is determined to be MAGI eligible and the required information is verified through the FDSH, the county shall promptly send the appropriate MAGI approval NOA. If the individual is found eligible for a Covered California plan (with or without financial assistance), the county shall send a timely 10-day NOA explaining the reason for discontinuance from Non-MAGI Medi-Cal. Please refer to ACWDL [22-20](#) for more information about the process of transitioning discontinued beneficiaries to Covered California and the counties role in providing assistance with enrollment.

No Response or Incomplete Response to MAGI Verification Request

If, after sending the beneficiary's information to CalHEERS, the beneficiary's MAGI Medi-Cal eligibility is pending due to verification that cannot be obtained electronically, the county shall send the beneficiary the MC 355 with a 30-day due date to provide the required verification. See the [Change in Circumstance; Step 2; Send the MC 355](#) section above for more information on additional contacts during the 30 days. If, after the 30 days and after at least one attempt to contact the beneficiary, the beneficiary fails to provide the required information or verification requested in the MC 355, the county shall send a timely 10-day NOA explaining the reason for discontinuance from Non-MAGI Medi-Cal. If the beneficiary does not provide the information requested in the MC 355 to determine MAGI eligibility, the Non-MAGI discontinuance NOA shall also:

- list the specific items of information or verification needed to determine MAGI eligibility per ACWDL [15-27](#); and
- include the 90-Day Cure Period NOA language.

Note: If the beneficiary provides all requested information before the discontinuance date, the county shall rescind the discontinuance and complete the eligibility redetermination to avoid a break in coverage.

Annual Renewal Redetermination Step 5: 90-Day Cure Period

A beneficiary is entitled to a 90-Day Cure Period if they are discontinued for failing to provide needed information or verifications. This includes all scenarios where the beneficiary must provide information or verification, including those outlined in this ACWDL and all other scenarios where the beneficiary must cooperate with a program requirement, such as the requirements for compliance outlined in ACWDL [19-13](#). CMS provided states with updated guidance on the 90-Day Cure Period that has led to ongoing discussions for clarity. As a result, DHCS will release a future ACWDL with specific guidance on the 90-Day Cure Period. **In the meantime, counties shall follow current business practices for the 90-Day Cure Period.**

Medi-Cal Annual Renewal Forms

ACWDL [20-21](#) and MEDIL [I 20-39](#) provide three updated pre-populated annual renewal forms to be used for MAGI Medi-Cal beneficiaries, Non-MAGI Medi-Cal beneficiaries, and Mixed Households. Per MEDIL [I 21-16](#), the English and Spanish versions of the updated pre-populated forms, as described below, are currently programmed by SAWS and in use. For MAGI Medi-Cal beneficiaries, the annual renewal form is the pre-populated MC 216 form. For Non-MAGI beneficiaries, the annual renewal form is the newly developed pre-populated MC 210 RV form. Additionally, the newly developed pre-populated MC 217 form is to be used when individuals in a mixed Medi-Cal household have an annual renewal due at the same time. As stated in ACWDL [20-21](#), the MC 262 will no longer be used at annual redetermination for individuals in long-term care (LTC), as the LTC beneficiaries will be included in one of the updated annual renewal forms. Please see ACWDL [20-21](#) and MEDILs [I 20-39](#), [I 21-16](#), and [I 22-07E](#) for more information about the updated pre-populated annual renewal forms and the SAWS programming timeline.

Covered California and Medi-Cal Mixed Household Annual Renewals

The Covered California annual renewal and Medi-Cal annual renewal are two separate processes that may or may not occur concurrently depending on the Medi-Cal annual renewal due month. The Covered California portion of the mixed household population will have their benefits renewed every January while the Medi-Cal portion of the mixed household population will have their benefits renewed based on the Medi-Cal beneficiary's annual renewal due month. If the Covered California annual renewal date and the Medi-Cal annual renewal date are not aligned, any changes reported to the case via the Covered California renewal will be reported to the Medi-Cal program and should be reviewed for any potential change in circumstances for Medi-Cal. Covered California has the responsibility to send out the necessary annual renewal notices for the Covered California population. The

notice informs the beneficiary that a separate process is required for Medi-Cal in order to eliminate any confusion.

Covered California beneficiaries belonging to mixed households may complete their annual renewal using several methods, including:

- passive renewal for those who have provided consent,
- self-initiated online annual renewals through CalHEERS,
- contacting the Covered California service center, or
- contacting the county directly.

If counties receive beneficiary information as a result of the Covered California annual renewal that does not change a Medi-Cal beneficiary's eligibility, the county should not process a change in circumstance. The county shall retain the Medi-Cal annual renewal due month and make no changes to the case. The Medi-Cal annual renewal shall be processed for the appropriate month in which it is due.

Per W&I Code §[14015.7\(b\)](#), counties are responsible for Medi-Cal eligibility determinations and ongoing case management of Medi-Cal cases, including mixed households with individuals eligible for Covered California programs. As counties are required to complete all Medi-Cal eligibility determinations and redeterminations, counties are required to assist with renewals for mixed households when changes are reported for Covered California household members that may impact Medi-Cal or Covered California eligibility. As a reminder, Covered California will send requests for Covered California specific verifications to individuals conditionally eligible for IAPs through Covered California, including those in mixed households. Counties do not need to send requests for Covered California specific verifications; however, they shall process any verifications that are received for mixed households.

Counties are reminded to assist with completing mixed household annual renewals if individuals contact the county directly or are referred to the county by a Covered California service center representative (SCR). SCRs are able to complete only Covered California related information on the annual renewal; however, any changes or elements reported that impact Medi-Cal eligibility will be referred to the county for processing. As noted above, any information impacting Medi-Cal eligibility shall be reviewed and processed by the county; therefore, these cases will be referred to counties by Covered California for assistance with completing the mixed household annual renewal.

Annual Renewals for Former Foster Youth up to Age 26

As required by W&I Code §[14005.28](#)(a)(3), the annual redetermination process for FFY has been simplified. FFY should not receive an annual renewal form unless they are part of a household where other household members must complete an annual renewal to retain their Medi-Cal benefits or if they are aging out of FFY. See ACWDLs [14-41](#) and [15-32](#) for more information about FFY eligibility processing, including changes in circumstance, annual renewals, and the scenarios in which an FFY may be discontinued.

SECTION 3 – ADDITIONAL INFORMATION

Individual Eligibility

Per ACWDL [16-16](#), Medi-Cal eligibility is determined on an individual basis. As a result, the change in circumstance and annual renewal redetermination guidance outlined in this ACWDL shall be followed for each individual household member. This means that some household members may have eligibility redetermined during ex parte review, while other household members must be sent an MC 355 or annual renewal form. When multiple members of a household must be sent an MC 355 or the same renewal form, counties shall send only one consolidated form.

Example 1: Household consists of a parent and a child under the age of 19 on MAGI Medi-Cal. Parent reports an increase in household monthly income to \$1,839. As part of the change in circumstance redetermination, the county submits the updated case information to CalHEERS. Household income e-verifies at \$2,500. CalHEERS returns a result that the newly reported income is e-verified for the child because reported and e-verified household income are under the threshold for the Optional Targeted Low-Income Program for two individuals (\$4,060 in 2022) and the income is reasonably compatible for the child. CalHEERS returns a result that the newly reported income is not e-verified for the parent because reported household income is under the MAGI Medi-Cal limit for the new adult group for two individuals (\$2,106 in 2022) but the verified household income is over the threshold for the new adult group and is not reasonably compatible for the parents.

The change in circumstance redetermination for the child is complete as a result of the ex parte process. The approval NOA outlined in ACWDL [19-03](#) is sent to the child. As income verification is still needed for the parent, one MC 355 is sent to the parent to request the income verification needed to redetermine eligibility.

Example 2: Household consists of parent 1 and parent 2 and two children under the age of 19. Current known information in the case file shows that household monthly income from parent 1 and parent 2 is \$2,900. During the ex parte review process for an annual renewal redetermination, the county submits known information to CalHEERS. Household income e-verifies at \$3,500. CalHEERS returns a result of MAGI Medi-Cal eligible for the children because reported and e-verified household income are under the threshold for the Optional Targeted Low-Income Program for four individuals (\$6,153 in 2022) and the income is reasonably compatible for the children. CalHEERS returns a result of pending MAGI Medi-Cal for parent 1 and parent 2 because reported household income is under the MAGI Medi-Cal limit for the new adult group for four individuals (\$3,192 in 2022) but the verified household income is over the threshold for the new adult group and is not reasonably compatible for the parents. Note the parents remain MAGI eligible for the duration of the annual renewal redetermination process; the pending status is used to alert counties that additional information or verification is needed from the parents.

The annual renewal process for the children is complete as a result of the ex parte process. The approval NOA outlined in ACWDL [19-03](#) is sent to the children. As the ex parte process was not able to confirm eligibility for parent 1 and parent 2, one prepopulated MC 216 is sent to the parents to request the information and verification needed to redetermine eligibility.

Example 3: Household consists of a 66 year old Non-MAGI beneficiary and their 62 year old MAGI Medi-Cal spouse. As part of the ex parte process, the county sends information to CalHEERS for the MAGI Medi-Cal beneficiary and reviews all available ex parte sources to see if all information necessary to determine eligibility for the Non-MAGI Medi-Cal beneficiary is already available. CalHEERS returns a result of pending MAGI eligible for the MAGI beneficiary as income verification is needed. Additionally, after reviewing case files, the county determines that updated income and property information and verification is needed from the Non-MAGI beneficiary. The county sends one mixed household annual renewal MC 217 form to the beneficiaries (Note: please see MEDIL [120-39](#) for information on automation of the mixed household annual renewal form).

Continuous Eligibility for Children at Annual Renewal

In accordance with ACWDL [14-05](#), children under age 19 who are approved for MAGI Medi-Cal are eligible to receive CEC when there is a change that would disadvantage the child or when there is a loss of contact with the family. As stated in the Individual Eligibility section above, when certain individuals in a household are found eligible or conditionally

eligible during the annual renewal ex parte process, their annual renewal eligibility determination is considered complete regardless of whether other household members have pending eligibility. The county shall send the annual renewal form to only those household members that have pending eligibility status.

If the household provides updated information or verification as part of the annual renewal process that would disadvantage a child that was already found eligible or conditionally eligible during the ex parte process, the county will place the child in the appropriate CEC aid code or follow the soft pause procedures outlined in ACWDL [17-35](#) until their next annual redetermination date, or until the child(ren) turn 19, whichever comes first, at which time the child shall be reassessed for ongoing eligibility. If the annual renewal form or verifications are not provided after following the annual renewal process outlined in this ACWDL, only the household members with pending eligibility will be discontinued for failing to complete the annual renewal process and the county shall place the child in the appropriate CEC aid code or follow the soft pause procedures outlined in ACWDL [17-35](#) until their next annual renewal due date or until the child(ren) turn 19, whichever comes first.

Example: Household consists of parent 1 and parent 2 and two children under the age of 19. During the ex parte review process for the family's January 2024 annual renewal redetermination, the county submits known information to CalHEERS. CalHEERS returns a result of MAGI Medi-Cal eligible for the children because reported and e-verified household income are under the threshold for the Optional Targeted Low-Income Program for four individuals and the income is reasonably compatible for the children. CalHEERS returns a result of pending MAGI Medi-Cal for parent 1 and parent 2 because reported household income is under the MAGI Medi-Cal limit for the new adult group for four individuals but the verified household income is over the threshold for the new adult group and is not reasonably compatible for the parents. Note the parents remain MAGI eligible for the duration of the annual renewal redetermination process; the pending status is used to alert counties that additional information or verification is needed from the parents.

The annual renewal process for the children is complete as a result of the ex parte process. The approval NOA outlined in ACWDL [19-03](#) is sent to the children. As the ex parte process was not able to confirm eligibility for parent 1 and parent 2, one prepopulated MC 216 is sent to the parents to request the information and verification needed to redetermine eligibility. The parents return all required information and verifications, and the county updates the case information and submits the new information to CalHEERS. Based on the information or verification provided, all four household members are found to be over income for MAGI Medi-Cal.

As the children's annual renewal was complete and they were already found eligible for MAGI Medi-Cal, this is considered to be new information that would disadvantage the children. The county will place the children in the appropriate CEC aid code or follow the soft pause procedures outlined in ACWDL [17-35](#) until their next annual renewal due date of January 2025 or until the child(ren) turn 19, whichever comes first. The county would follow the process to evaluate the parents for Non-MAGI Medi-Cal and Covered California as outlined above.

Medi-Cal Postpartum Care

In accordance with ACWDL [21-15](#) and MEDIL [121-13](#), effective April 1, 2022, the Medi-Cal postpartum coverage period is extended from 60 days to 12 months. The 12-month postpartum coverage period for Medi-Cal eligible pregnant individuals will begin on the last day of the pregnancy and will end on the last day of the month in which the 365th day occurs.

Due to Continued Eligibility for Pregnancy (CEP) rules, pregnant individuals who are eligible under a Medi-Cal program will maintain coverage through their pregnancy and an extended postpartum coverage period regardless of income changes, citizenship or immigration status. These individuals shall maintain continuous eligibility in their full scope pregnancy and postpartum coverage through the 12-month postpartum period.

Incarcerated Individuals

In general, incarcerated individuals are ineligible for Medi-Cal. Notwithstanding the Medi-Cal Inmate Eligibility Program (MCIEP), if an individual is a Medi-Cal beneficiary on the date they become an inmate of a public institution, their benefits shall be suspended. Counties shall refer to ACWDLs [21-22](#), [22-26](#), and [22-27](#) for guidance on Medi-Cal redeterminations of Medi-Cal beneficiaries with suspended benefits.

The MCIEP is only available to eligible county or state incarcerated individuals who receive inpatient hospital services provided in a medical facility off the grounds of the correctional facility. Incarcerated individuals enrolled in the MCIEP, follow the standard Medi-Cal rules for redeterminations. Counties shall refer to ACWDL [11-27](#) and [13-18](#) for additional information related to the MCIEP.

Loss of Contact Reminder

If the county receives returned mail marked in such a way as to indicate that it could not be delivered to the intended recipient during the change in circumstance or annual renewal redetermination process, counties shall follow the process outlined in ACWDL [22-09](#). For loss of contact with an FFY, counties shall follow the guidance in ACWDL [14-41](#) and [16-23](#).

Implementation Timeline

To the extent that counties are not able to effectuate portions of the policy described in this ACWDL because required system programming is not yet available, counties shall continue to follow current business practices until system changes are complete. DHCS will provide confirmation of the automation timelines in a future MEDIL.

DHCS will issue the following additional guidance in the future:

- An ACWDL to provide updated 90-Day Cure Period guidance.
- A MEDIL with the implementation date of necessary system programming.

If you have any questions or if we can provide further information, please contact Alison Brown by phone at (916) 345-8078 or by email at Alison.Brown@dhcs.ca.gov.

Original Signed By

Sandra Williams, Chief
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