State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

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TO: ALL COUNTY WELFARE DIRECTORS Letter No.: 06-16
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALIST/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS

SUBJECT: ANNUAL REDETERMINATION

The purpose of this letter is to provide counties with policy clarification and instructions for the completion of the Medi-Cal Annual Redetermination.

I. Federal and State Requirement

Title 42, Code of Federal Regulations, Section 435.916 (a) states that the agency must redetermine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least once every 12 months. Welfare and Institutions Code (W&I), Section 14012 states that reaffirmation shall be filed annually and may be required at other times in accordance with general standards established by the California Department of Health Services (CDHS). Title 22, California Code of Regulations (CCR), Section 50189 (c)(1) states the county shall complete the redetermination within 12 months of the most recent approval of eligibility on any application, reapplication or restoration which requires a Statement of Facts.

The Medi-Cal Annual Redetermination requires the beneficiary to cooperate with a full eligibility review by completing an Annual Redetermination form to provide information on household circumstances and verification of income and/or property. The beneficiary must cooperate with the Annual Redetermination requirements to ensure continuing Medi-Cal coverage. The county, when completing the Annual Redetermination, shall not request the beneficiary to provide information that is not

relevant to their ongoing eligibility or that has already been provided with respect to an eligibility factor that is not subject to change, such as date of birth, social security number or United States citizenship. The county shall not require the beneficiary to complete the Annual Redetermination sooner than the eleventh month following the beneficiary's initial application, reapplication or the most recent Annual Redetermination.

II. The Annual Redetermination Date

The Annual Redetermination is different from the change-of-circumstances redetermination process described in W&I Code, Section 14005.37. The change-of-circumstance redetermination is conducted whenever the beneficiary reports a change of circumstances or when the county learns of a change in circumstances that may affect ongoing eligibility. The Annual Redetermination is conducted once every 12 months with a full eligibility review. Any change-of-circumstances redetermination during the 12-month period does not change the Annual Redetermination due month.

The Annual Redetermination due date is set from the first day of the application month in most cases. (See the exceptions described below.) Generally, Medi-Cal applicants are determined eligible for Medi-Cal benefits from the first date of the month in which the application was filed. For Annual Redetermination purposes, the initial application is defined as the month in which a request for Medi-Cal was made. The first Annual Redetermination shall be completed by the last day of the twelfth month counting from the application month as the first month of eligibility. Thereafter, each Annual Redetermination is set at a 12-month interval. Example 1 in Section III of this letter explains these timelines. Counties shall note that the Annual Redetermination due month is set from the month of application, even if the person is granted retroactive benefits for the three months preceding the month of application. Example 2 in Section III of this letter explains these timelines.

There are case exceptions when the Annual Redetermination month is not established from the application month. The exceptions are:

A. <u>The applicant is not eligible in the month of application</u>.

If the applicant does not meet all of the eligibility criteria during the month of application, the Annual Redetermination month is set from the first month in which the applicant meets all eligibility criteria. For example, an applicant who has excess property in the month of application will have to spend down before eligibility criteria are met. The first month in which the applicant meets eligibility criteria (spend down completed), is the

initial month of eligibility. The first Annual Redetermination month is then set from the month in which eligibility criteria are met. Example 3 in Section III of this letter explains these timelines.

B. Family members have different initial eligibility months.

There will be situations where one application covers one or more Medi-Cal Family Budget Unit (MFBU) members who are eligible in the month of application, and others who do not meet eligibility criteria until a later month or are added to the case during the 12-month period. In these situations, the MFBU members who were determined eligible first shall set the Annual Redetermination due month for all MFBU members even when new MFBU members are added to the case during the 12-month period. Examples 4 and 5 in Section III of this letter explain these timelines.

When the Annual Redetermination is due for this type of case situation, all members of the family are part of the MFBU and will have their eligibility redetermined at the same time. However, if there are children added to the case during the 12-month period, and the children being added to the existing case already have Continuous Eligibility for Children (CEC) program eligibility from another case, these CEC children shall retain their original 12-month eligibility period under CEC even when the MFBU is determined to have a share-of-cost (SOC) after the Annual Redetermination. The CEC children added to the case later shall continue to get no SOC Medi-Cal under their original 12-month CEC period.

If applicable, when the MFBU is determined eligible for no-cost Medi-Cal at the Annual Redetermination, the county shall establish a new concurrent CEC period for all the children in the MFBU, including those children who were added to the existing MFBU with their own CEC period from another Medi-Cal case. Example 5 in Section III of this letter explains the CEC situation.

C. Deemed Eligibility for Infant.

Infants receiving benefits during the Continuous Eligibility period (now also known as deemed eligibility (DE)) are still part of the family and will have their eligibility redetermined along with the other MFBU members when the MFBU has its Annual Redetermination. The infant remains eligible until he/she turns one year old if he/she meets the requirements of DE, even if other family members in the MFBU became ineligible due to reported changes or failure to cooperate with the Annual Redetermination.

If, as a result of the Annual Redetermination, all other MFBU members are terminated from Medi-Cal, the Annual Redetermination date for the DE case shall be reset to the month of the infant's first birthday because Counties cannot terminate the infant as long as the infant continues to meet DE requirements (or where applicable, CEC requirements). Deemed eligibility gives an infant continuous Medi-Cal until the infant turns one year old regardless of the MFBU eligibility. When the infant turns one year old, a redetermination of eligibility for all other Medi-Cal programs must be completed for the infant before benefits can be terminated at that time.

If the other MFBU members are terminated from Medi-Cal for failure to cooperate with the Annual Redetermination and the parent contacts the county after 30 days of the termination without good cause, the parent must complete a new application because the Annual Redetermination requires the beneficiaries to complete a full eligibility review. (See processing the Annual Redetermination in Section VII of this All County Welfare Directors Letter (ACWDL)).

ACWDL No. 03-49, dated October 6, 2003, contains additional details about DE and redeterminations. Please note that if the Annual Redetermination review determined the infant eligible for a no SOC program, the infant would also be concurrently eligible under CEC until the MFBU's next Annual Redetermination.

In addition, if the Annual Redetermination shows a decrease in income, the county must determine its impact on the infant. That is, if the infant has been in a SOC program under deemed, the infant must be moved to a no SOC program or has a reduced SOC.

D. Transitional Medi-Cal (TMC).

Beneficiaries receiving Medi-Cal under TMC are not required to complete an Annual Redetermination while they are receiving TMC benefits. The Annual Redetermination for the TMC beneficiaries will be delayed to the end of their TMC period. When the Annual Redetermination is due for TMC beneficiaries will depend on who in the MFBU is receiving TMC.

Non-TMC MFBU members are required to complete the Annual Redetermination when it is due. If non-TMC members fail to cooperate with the Annual Redetermination, only non-TMC MFBU members shall be terminated from Medi-Cal. The TMC eligible MFBU members shall remain on TMC for the entire TMC period if they meet all requirements of TMC. At the end of their TMC period, the county shall review the TMC beneficiary's eligibility under other Medi-Cal programs.

1. All MFBU members are receiving TMC.

   When all MFBU members are receiving TMC benefits and their Annual Redetermination is due before their TMC period expires, the county shall reset their Annual Redetermination month to the end of their TMC period. The Annual Redetermination for all MFBU members shall be completed on the last month of their TMC period so that counties may redetermine the MFBU's eligibility for other Medi-Cal programs.

2. MFBU members with different TMC expiration dates.

   If the MFBU has members receiving TMC with different TMC expiration dates, the Annual Redetermination completed for the first MFBU member at the end of his/her TMC period shall establish the next Annual Redetermination for the entire MFBU. At the end of the other MFBU member's TMC period, the county shall redetermine that individual's Medi-Cal benefits using information available in the existing case.

3. Some MFBU members are receiving TMC.

   If some MFBU members are receiving TMC and others members are not when the Annual Redetermination is due for the MFBU, the non-TMC MFBU members are required to complete the Annual Redetermination. Once the Annual Redetermination is completed for the MFBU, the Annual Redetermination date is established for the entire MFBU. At the end of the TMC period for other MFBU members, counties shall complete a redetermination of eligibility under other Medi-Cal programs for them using information already available in the case file.

III. Examples of Setting the Annual Redetermination Date

The five examples below illustrate how the Annual Redetermination date is set and are not inclusive of all case scenarios.

Example #1: Medi-Cal approved from the month of application

Application date: January 21, 2004
Application approved: February 15, 2004
Eligibility effective date: January 1, 2004
Twelfth month ends: December 31, 2004
Annual Redetermination due: December 2004

Initial 12-month Period

01/04	02/04	03/04	04/04	05/04	06/04	07/04	08/04	09/04	10/04	11/04	12/04
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Application Month Eligible	Approval Month Eligible										Annual Due

New twelve-month period begins: January 2005
Next Annual Redetermination due: December 2005

New 12-month Period

01/05	02/05	03/05	04/05	05/05	06/05	07/05	08/05	09/05	10/05	11/05	12/05
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
New 12-month begins											Next Annual

Example #2: Medi-Cal approved for the month of application and retroactive months.

Application date: January 21, 2004
Retroactive Medi-Cal requested: November and December 2003
Application approved on: February 15, 2004
Eligible for retroactive months and from application month
Twelfth month of eligibility ends on: December 31, 2004
Annual Redetermination due: December 2004

Application with Retroactive Months

										11/03	12/03
										Retro Eligible	Retro Eligible
01/04	02/04	03/04	04/04	05/04	06/04	07/04	08/04	09/04	10/04	11/04	12/04
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Application Month Eligible	Approval Month Eligible										First Annual Due

In example #2, the retroactive months of November and December 2003 are not counted in the 12-month period because the application was received in January 2004.
New twelve month begins: January 2005 – December 2005

Next Annual Redetermination completed by: December 2005

New 12-month Period

01/05	02/05	03/05	04/05	05/05	06/05	07/05	08/05	09/05	10/05	11/05	12/05
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
New 12-month begins											Next Annual Due

Example #3: Eligibility criteria not met in the month of application (Section II, A)

Application date: January 21, 2004
No eligibility for January and February 2004 due to excess property
Application approved on: March 2, 2004, for March 1, 2004, and forward
First month of eligibility: March 2004
Twelfth month of eligibility ends: February 2005
Annual Redetermination due: February 2005

Initial 12-month Period

										01/04	02/04
										Application Over Property	Over Property
03/04	04/04	05/04	06/04	07/04	08/04	09/04	10/04	11/04	12/04	01/05	02/05
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
First Eligible Month											First Annual due

In example #3, the application was received in January 2004. Eligibility was not established for January and February 2004 due to excess property. The applicants met all eligibility criteria when they spent down their property in March 2004, which is the initial month of eligibility. The first Annual Redetermination date is set, in this example, from the month in which eligibility criteria are met.

New twelve month begins: March 2005 – February 2006
Next Annual Redetermination due: February 2006

New 12-month Period

03/05	04/05	05/05	06/05	07/05	08/05	09/05	10/05	11/05	12/05	01/06	02/06
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
New 12-Month begins											Next Annual Due

Example #4: Family members have different initial eligibility dates (Section II, B)

Application date: January 21, 2004
Application approved for two children in Federal Poverty Level (FPL) program from January 2004 and forward
Parents not eligible in January 2004 due to excess property
Parents became eligible in February 2004 due to spend down
Twelfth month of eligibility ends for MFBU: December 31, 2004
Annual Redetermination for MFBU due: December 2004

Initial 12-month Period

01/04	02/04	03/04	04/04	05/04	06/04	07/04	08/04	09/04	10/04	11/04	12/04
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Application Month Children Eligible Parents Over Property	Parents Eligible Due to Spend-Down										First Annual Due for MFBU Parents/ children

In Example 4, the family applied on January 21, 2004. The children were approved for benefits under the FPL program effective January 1, 2004, due to family income and waiver of assets. The parents had linkage to Medi-Cal but they had excess property. In February, the parents had spent down their assets and were approved for Medi-Cal effective February 1, 2004. Since the children were first approved for Medi-Cal in January 2004, the MFBU's Annual Redetermination is twelve months from the month of the children's eligible month, January 2004.

New twelve month begins for the MFBU: January 2005 – December 2005
Next Annual Redetermination for the MFBU due: December 2005

New 12-month Period

01/05	02/05	03/05	04/05	05/05	06/05	07/05	08/05	09/05	10/05	11/05	12/05
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
New 12-Month Begins											Next Annual Due

Example #5: MFBU with three children eligible for the CEC program and two different CEC periods (Section II, B)

Application date for parents and two children (#1 and #2): January 21, 2004
Application approved on: February 2, 2004, effective January 2004
Child #3 was on Medi-Cal in another MFBU with CEC period from 04/2004 – 03/2005 returns home and reunites with the family in May 2004. Child #3 keeps his CEC period
The MFBU is determined to have SOC in August 2004 from mid-year status report
Child #1 and #2 CEC period is: January 2004 – December 2004
Annual Redetermination for MFBU due: December 2004

Initial 12-month Period

01/04	02/04	03/04	04/04	05/04	06/04	07/04	08/04	09/04	10/04	11/04	12/04
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Appl. Month Parents and child #1 and #2. MFBU eligible with no SOC	Approval month			Child #3 returns home with own CEC Period			SOC Month for MFBU CEC For child #1 and #2				Annual Due for MFBU, CEC ends for child #1 and #2
01/05	02/05	03/05									
CEC cont. for child #3	CEC cont. for child #3	CEC ends for child #3									

Example #5 above shows child #3's CEC period continues until March 2005 even though the other MFBU members remain SOC Medi-Cal after the Annual Redetermination. At the end of child #3's CEC period, the county shall complete an *ex parte* eligibility review for child #3.

If the MFBU continues to have a SOC after the Annual Redetermination, the county shall review the Medi-Cal to Healthy Families Bridging Program (Bridging) for child #1 and #2 whose CEC period has expired on the Annual Redetermination month. If the family did not check the box indicating that they do not want their children's information shared with the Healthy Families (HF) Program, the county will share the children's information with HF. The counties shall follow the instructions outlined in ACWDL No. 03-01 because they are no longer eligible for no-SOC Medi-Cal.

If the MFBU becomes no-SOC Medi-Cal after the Annual Redetermination, child #3 may have a concurrent CEC period based on the MFBU's Annual Redetermination completed in December 2004. If applicable, all the children in this MFBU will have the same CEC period from January 2005 - December 2005.

New 12-month begins for the MFBU: January 2005 – December 2005
Next Annual Redetermination for the MFBU due: December 2005

New 12-month Period

01/05	02/05	03/05	04/05	05/05	06/05	07/05	08/05	09/05	10/05	11/05	12/05
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
No SOC for MFBU, new CEC period for all three children											Next Annual

IV. Setting the mid-year status report (MSR) timeline within the 12-month period

The following illustrates the timeline for the MSR and Annual Redetermination.

Medi-Cal application date: January 21, 2004
Eligibility approved on: February 2, 2004, for January 2004 and ongoing
MSR mail to non-exempt beneficiary: June 2004
MSR due: July 2004
Annual Redetermination due: December 2004

Initial 12-month Period

01/04	02/04	03/04	04/04	05/04	06/04	07/04	08/04	09/04	10/04	11/04	12/04
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Application Month Eligible					MSR mailed	MSR Due				Mail Annual packet by end of month	Annual Due

New 12-month period begins: January 2005
MSR mail to non-exempt beneficiary: June 2004
Next Annual Redetermination due: December 2005

New 12-month Period

01/05	02/05	03/05	04/05	05/05	06/05	07/05	08/05	09/05	10/05	11/05	12/05
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
New 12-month begins					MSR mailed	MSR Due					Next Annual Due

V. California Work Opportunity and Responsibility to Kids (CalWORKs) Cases

A. Parents receiving Medi-Cal only benefits in their children's CalWORKs case

Some counties, for simplicity of case administration, are aiding non-cash eligible, Medi-Cal only parents on their children's CalWORKs case. Since these parents do not have a separate Medi-Cal case set up, they will not be required to complete a separate Medi-Cal-only Annual Redetermination as long as they cooperate with all the CalWORKs requirements for reporting changes and completing the Annual Redetermination.

B. CalWORKs discontinued for non-cooperation with the Annual Redetermination

Counties are reminded that individuals on CalWORKs must not be terminated from Medi-Cal for failure to meet CalWORKs ONLY requirements. When CalWORKs assistance is being terminated, the CalWORKs recipient's eligibility for Medi-Cal benefits must be reevaluated because the Medi-Cal program has less restrictive rules. For example, Medi-Cal Only beneficiaries are not required to attend a face-to-face interview at their Annual Redetermination. If the parents in these CalWORKs cases

failed to appear for their face-to-face interview, the family still can get Medi-Cal if the parents cooperated with other requirements such as returning a signed CalWORKs Statement of Facts form (SAWS 2) and providing information necessary to complete the Medi-Cal Only review. Therefore, when a CalWORKs case is being discontinued for non-cooperation with the CalWORKs Annual Redetermination, counties must ensure the family is determined for on-going Medi-Cal only benefits. Counties shall note that the CalWORKs discontinuance action on these cases will place the family in the transition Medi-Cal aid code "38" pending a determination for Medi-Cal only benefits.

If the CalWORKs case file contains current (within the last 30 days) information, such as a signed but incomplete SAWS 2 form, the county shall continue to process the Medi-Cal Annual Redetermination using the information from the case file. If additional information is needed, counties must follow instructions outlined in ACWDL No. 01-36 and 02-59 to complete the Annual Redetermination for Medi-Cal.

If the CalWORKs case does not contain a current SAWS 2 form, the county shall send a Medi-Cal Annual Redetermination Packet to the beneficiary with instruction that his/her Medi-Cal benefits may also be terminated if the MC 210 RV form is not returned to the County. The county shall process the Medi-Cal-only Annual Redetermination as outlined in this letter.

C. Resetting the Annual Redetermination date from a CalWORKs case.

When the beneficiary is terminated from CalWORKs cash assistance for failure to complete the Annual Redetermination, the case is placed into a Medi-Cal transition Aid Code "38" pending a Medi-Cal only evaluation. During the transition, the case is opened with an overdue Annual Redetermination and the beneficiary continues to receive Medi-Cal benefits. Counties, upon completion of the Medi-Cal redetermination, may set a new Medi-Cal Annual Redetermination date by starting a new 12-month period. See timeline example below:

Resetting the Annual Redetermination Date from CalWORKs to Medi-Cal

									10/03	11/03	12/03
									CW RV overdue Disc.	MC RV Pending	MC RV completed
01/04	02/04	03/04	04/04	05/04	06/04	07/04	08/04	09/04	10/04	11/04	12/04
New 12-month Begins											MC Annual Due

The above example shows the CalWORKs case was discontinued in October 2003 for failure to complete the Annual Redetermination. The case file was transferred from the CalWORKs program to Medi-Cal in November 2003 pending a Medi-Cal only redetermination. The Medi-Cal only redetermination was completed in December 2003. The new 12-month period began in January 2004 and the next Medi-Cal Annual Redetermination is due in December 2004. If there are children in this MFBU, the CEC period for the children is from January 2004 – December 2004. Counties shall not reset the Annual Redetermination date for other discontinued CalWORKs cases that are being transition from cash assistance to Medi-Cal only.

VI. Informing the Beneficiary of the Annual Redetermination Requirements

The county must ensure that the beneficiary understands the Annual Redetermination process and requirements, as well as his or her rights and responsibilities under the Medi-Cal program. The county must inform the beneficiary that completing the Annual Redetermination in a timely manner will ensure continuing benefits coverage if he/she remains eligible and that non-cooperation may cause interruption or termination of Medi-Cal benefits at the end of the twelfth month.

The first step in processing the Annual Redetermination is to mail the Annual Redetermination Notice and form to the beneficiary by the last date of the eleventh month. The county shall inform the beneficiary of the date that the Annual Redetermination form must be returned in order to continue benefits. A new Medi-Cal Annual Redetermination Notice has been developed and contains the following information:

- Purpose of the Annual Redetermination,
- Requirements of the Annual Redetermination,
- Date the required forms must be completed and returned to the county for benefits to continue.

A Medi-Cal Annual Redetermination Notice has been developed based on input from counties and consumer advocates. The sample notices, in English and Spanish, are attached with this letter as reference. The Annual Redetermination notice will be translated into other threshold languages. Counties are permitted to modify the notice with county specific information. Counties shall submit a copy of the modified notice to CDHS for review and approval. All county modified Annual Redetermination Notices

must contain the language text provided in the sample notice to ensure consistency in the statewide administration of the Medi-Cal program.

VI. The Annual Redetermination Packet

To simplify the processing of the Annual Redetermination, the county shall mail only the MC 210 RV form that the beneficiary must complete along with mandated program information that must be provided at the Annual Redetermination. Counties are not required to complete an *ex parte* review prior to mailing the Annual Redetermination packet to the beneficiary.

A. Annual Redetermination forms, MC 210 RV and MC 262 for Long Term Care (LTC).

There are two Annual Redetermination forms for the Medi-Cal Annual Redetermination. The MC 210 RV is for the general Medi-Cal population and the MC 262 is for those beneficiaries residing in an LTC. The beneficiary or his/her representative must complete a MC 210 RV or MC 262 and return it by the due date for benefits to continue.

B. Important Information for Persons Requesting Medi-Cal (MC 219).

The MC 219 is a required form that explains the beneficiary's rights and responsibilities under the Medi-Cal program. The counties must provide the MC 219 to the beneficiary at Annual Redetermination, but the beneficiary is not required to sign and return the MC 219 to the county. The county use section of the MC 219 allows the county to indicate how the form was provided to the beneficiary, in person or by mail.

The following forms and notices should also be included if the case situation applies:

- Child Health and Disability Prevention Program Brochure if there are persons under 21 years of age in the family.

- Early, Periodic, Screening, Diagnosis and Treatment Mental Health Services General Information Notice (MC 003) if there are persons under 21 years of age in the family. The MC 003 informs the beneficiary of benefits provided through the CHDP Program for Medi-Cal children not enrolled in a Medi-Cal managed care plans.

- Notice and Agreement for Child, Spousal and Medi-Cal Support (CA 2.1 Q and A) if absent parent deprivation exists and the forms have not been completed previously.

In addition, counties shall continue to comply with the National Voter Registration Act of 1993 (42 U.S.C. 1973gg) at Annual Redetermination. Joint CDSS/CDHS ACWDL No. 94-85 and Medi-Cal Eligibility Information Letter I-96-05 shall continue to apply. However, the first full paragraph on page three of ACWDL 94-85 no longer applies.

VII. Processing the Annual Redetermination

The county shall limit the scope of the eligibility review to information that is necessary to determine ongoing eligibility and information that relates to circumstances that are subject to change, such as income and non-exempt resources and/or property. The county must allow the beneficiary at least 20 days to complete and return the required forms to the county. If a beneficiary requests information and explanation for any program or referral to any services, the county must ensure the beneficiary's request is met and the action taken is annotated in the case record.

The county must not require the beneficiary to attend a face-to-face interview unless the information and/or discrepancy cannot be resolved with one or more steps of the *ex parte* process, a follow-up telephone contact and/or by mail (MC 355) or one more of the following circumstances apply:

- The beneficiary requests a face-to-face interview and assistance with the forms;
- The county, after reviewing the information/verifications provided by the beneficiary and there is a suspicion of fraud;
- The individual/family has no visible means of support, such as in-kind income, or the individual's specified means of support is not reported for the individual and/or family; or
- There are obvious discrepancies between information reported to the county and Income Eligibility Verification System on assets or income.

When a face-to-face interview is conducted for the Annual Redetermination, the county shall document the reason in the case record for program review and audit purposes.

A. <u>The complete form is returned timely to the County</u>.

The Annual Redetermination form is considered complete if the beneficiary answered each question and signs the form. Counties shall note that any optional questions not

completed by the beneficiary shall not render the form incomplete. If the complete form and/or information provided indicate no change in eligibility from the initial application or most recent Annual Redetermination or reported change-of-circumstances such as the MSR determination, where applicable, the Annual Redetermination has been completed. The county shall establish a new 12-month period from the first day of the month following the month that the Annual Redetermination is due.

If the county determines there is a change in eligibility, such as increased income that will change any member of the MFBU from zero SOC Medi-Cal to SOC Medi-Cal, a timely Notice of Action (NOA) showing the new budget computation must be provided to the beneficiary. If there are any children in the MFBU changing from zero SOC to SOC, the county shall follow the process under the Bridging program for Children as outlined in ACWDL 03-01.

There will be circumstances that the beneficiary or his/her representative completes and returns a signed Medi-Cal application such as the MC 321 HFP, MC 210 or SAWS 2 to the county instead of the MC 210 RV or the MC 262. The county shall accept any of these completed and signed forms for the Annual Redetermination and continue to process the Annual Redetermination using the information provided on these completed forms. The county shall not request the beneficiary or his/her representative to complete another Annual Redetermination form.

B. Form is returned timely either incomplete or complete but additional information is required to finish the eligibility review.

CDHS has made a policy decision to utilize the *ex parte* process described in W&I Code, Section 14005.37 and 14005.39 as part of the Annual Redetermination process when a signed, but incomplete, Annual Redetermination form is received or when a completed form indicates a change of circumstances and that additional information or verification is required to completed the annual eligibility review process. Counties should consult ACWDLs 01-36, 01-39, and 02-59 for guidance on this process.

1. Incomplete signed form

   If the beneficiary returns a signed but incomplete form timely, the beneficiary is cooperating with the Annual Redetermination requirements. Since the form received by the county is incomplete and additional information is necessary to determine ongoing benefits, the county shall continue with the Annual Redetermination process using instructions outlined in ACWDLs 01-36, 01-39

and 02-59, beginning with an *ex parte* review of the case files to obtain information and complete the eligibility review. The county must annotate in the case record each action related to obtaining missing or additional information/verification from the beneficiary. The county shall not terminate Medi-Cal benefits as long as the beneficiary cooperates with the county, using the process and timeline described in ACWDLs 01-36, 01-39 and 02-59 as guidelines.

2. Complete form without signature

   If the beneficiary returns a completed Annual Redetermination form without a signature, it is not necessary to conduct an *ex parte* review or telephone call prior to mailing the unsigned Annual Redetermination form back to the beneficiary with instructions to sign and return the form to the county. The county must annotate in the case record of each action related to the unsigned Annual Redetermination form and the beneficiary shall remain eligible during this process.

3. Complete form indicates change and verification not provided

   If the beneficiary returns the Annual Redetermination form complete with information indicating that there are changes that could affect ongoing eligibility and that no verification of these changes is provided to the county with the returned form, under this situation, the beneficiary is cooperating with the Annual Redetermination requirements. Since the required verification was not provided with the returned form for the county to complete the eligibility review, the county shall continue to process the Annual Redetermination using instructions outlined in ACWDLs 01-36, 01-39 and 02-59 to obtain information and complete the eligibility review. The county must annotate in the case record each action related to obtaining additional information/verification from the beneficiary.

Counties, before initiating any discontinuance action based on an inability to make an eligibility determination using information supplied by the beneficiary on the Annual Redetermination form during the Annual Redetermination process must: 1) conduct an *ex parte* review, 2) attempt telephone contact with the beneficiary, and 3) mail the Request for Information form (MC 355) to the beneficiary. If this process fails to establish continued eligibility for the beneficiary, the county must send a timely NOA on to the beneficiary on the termination of benefits.

C. Form is not returned to the county

If the beneficiary fails to return the Annual Redetermination form to the county by the requested due date and the Annual Redetermination packet is not returned as undeliverable, the county shall send a timely 10-day NOA to terminate Medi-Cal benefits for failure to cooperate with the Annual Redetermination requirements. The discontinuance action shall be effective on the last day of the month the Annual Redetermination is due provided the county can issue a timely NOA to inform the beneficiary of the termination for failure to cooperate with the Annual Redetermination. The SB 87 process does not apply to this situation because failure by the beneficiary to complete and return the MC 210 RV constitutes a failure to cooperate and not a change in circumstances.

D. Form is returned within 30 days after Medi-Cal has been terminated

1. County has all information necessary to complete the eligibility review.

   If the beneficiary returns a signed and complete Annual Redetermination form with requested verification to the county within 30 days of the Medi-Cal termination, the county must determine eligibility as though the form was submitted in a timely manner. If there is no change reported by the beneficiary and ongoing eligibility exists, the county shall rescind the discontinuance with no break in benefits. The county shall establish a new 12-month period from the first day of the month following the discontinuance action. The beneficiary shall be certified for a new 12-month period.

Current 12-month period

01/04	02/04	03/04	04/04	05/04	06/04	07/04	08/04	09/04	10/04	11/04	12/04
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
											Annual due, RV form not returned, NOA to disc end of month

New 12-month period

01/05	02/05	03/05	04/05	05/05	06/05	07/05	08/05	09/05	10/05	11/05	12/05
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Complete Form Rec'd. Rescind Disc. If eligible											Next Annual Due

If the beneficiary returns a complete and signed Annual Redetermination form to the county within 30 days of the Medi-Cal termination and ongoing eligibility is established for the current and future months but the MFBU becomes SOC Medi-Cal, the county shall restore the beneficiary's Medi-Cal benefits and apply the appropriate SOC amount to the correct budget month(s).

When the county takes action to restore Medi-Cal benefits, the county must provide the beneficiary with a Notice of the restoration and the applicable SOC amount for the appropriate budget month(s). If any child in the MFBU is now only eligible for SOC Medi-Cal and the family did not check the box indicating that they did not want their child's information shared with the HF program, the counties will share the child's information with HF. The county shall review the Bridging program for the child as outlined in ACWDL No. 03-01. See charts below.

Current 12-month period

01/04	02/04	03/04	04/04	05/04	06/04	07/04	08/04	09/04	10/04	11/04	12/04
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
											Annual due, form not returned, NOA disc.

New 12-month period

01/05	02/05	03/05	04/05	05/05	06/05	07/05	08/05	09/05	10/05	11/05	12/05
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Form rec'd. Restore if eligible. If SOC, apply correct SOC or MC to HF Bridge for SOC children											Next Annual Due for MFBU

2. County does not have all necessary information to complete the eligibility review.

   If the beneficiary returns a complete and signed Annual Redetermination form to the county within 30 days of the Medi-Cal termination and information provided indicates there are changes to the beneficiary's circumstances, but the information provided is incomplete or not adequate for the county to determine ongoing eligibility, the county is not required to restored benefits until the beneficiary provides adequate information/verification to complete the annual eligibility review. Although restoration is not required, the county must contact the beneficiary and inform him/her via telephone or written correspondence that the information/verification provided is not sufficient to rescind their discontinued Medi-Cal case and additional information is needed to determine ongoing eligibility within this 30 day period.

   In this situation, since benefits have already been terminated with proper notice, another NOA is not required to inform the former beneficiary. The county, however, must annotate in the case record each action related to obtaining additional information/verification from the beneficiary. If during this 30-day period, the beneficiary provides all necessary information/verification to the county and if a beneficiary is found eligible, benefits must be restored with no break in aid.

E. Form is returned more than 30 days after Medi-Cal has been terminated.

1. Beneficiary has good cause.

If the beneficiary contacts the county or returns the form to the county after Medi-Cal has been terminated for more than 30 days, the county shall determine if good cause existed under Title 22, CCR, Section 50175 (c). Three examples of good cause are listed below:

- The beneficiary is unable to read or complete the MC 210 RV form without assistance because the MC 210 RV form is not available in the written language that he/she understands,

- Postal system fails to deliver the Annual Redetermination notice and forms in a timely manner, or

- Physical or mental illness or incapacity prevented the beneficiary from submitting the forms in a timely manner.

Counties shall evaluate good cause for each case separately. There will be situations that are unique to the individual beneficiary. If good cause exists, the county shall allow the beneficiary to complete the Annual Redetermination and restore Medi-Cal without any break in benefits.

2. Beneficiary does not have good cause.

If the beneficiary contacts the county after Medi-Cal has been terminated for more than 30 days and he/she does not have good cause, the county shall advise the beneficiary that he/she must reapply for Medi-Cal and complete the application and eligibility determination process.

F. Annual Redetermination packet is returned as “undeliverable-no forwarding address”

If the Annual Redetermination packet is returned as undeliverable, the county shall follow the three-step SB 87 process to locate the beneficiary. If, through the *ex parte* process, the beneficiary’s whereabouts remain unknown, the county must try to contact the beneficiary by phone if a number is available. If not, the county shall send a written Request for Information (MC 355). If the MC 355 is also returned “marked as undeliverable”, the entire case shall be terminated with a timely NOA to the address

on file. If the NOA is also returned to the county, it must be filed in the case record. The county must not terminate benefits before the three step SB 87 process is completed.

VIII. Annual Redetermination Information on Medi-Cal Eligibility Data System (MEDS)

The counties, with completion of the Annual Redetermination, shall ensure that the most recent Annual Redetermination due month and year information is transmitted to MEDS. W&I Code, Section 14005.35 directs CDHS to explore means by which Medi-Cal managed care plans can receive information on the beneficiary's upcoming Annual Redetermination date and W&I, Section 14018.1 requires CDHS to notify a Medi-Cal managed care plan of the date of the Annual Redetermination of a Medi-Cal beneficiary who is in a disabled aid category.

Medi-Cal health plans and providers can use the Annual Redetermination information to remind their members/patients of the Annual Redetermination requirements when providing services directly to the beneficiaries. In addition, counties are encouraged to work with health plans on outreach and education efforts such as the importance of providing current contact information and timely submission of the MC 210 RV at Annual Redetermination. For those beneficiaries who are in the disabled aid categories, maintaining eligibility for Medi-Cal and the coordination of care by the providers is critical to their health when the continuity of care is dependent on being Medi-Cal eligible. Any interruption of their Medi-Cal benefits can cause delay or denial of necessary services.

Some counties currently do not have system capability of automatically transmitting the Annual Redetermination information from the county's system to MEDS. Therefore, counties must instruct their staff to manually enter the Annual Redetermination month and year information on MEDS when completing the Annual Redetermination for those beneficiaries who are receiving Medi-Cal benefits in the disabled aid codes. Counties may enter the Annual Redetermination data on MEDS by using the EW05, EW20, EW25 and EW30 screens. For example, if the beneficiary's Annual Redetermination is due in September 2004 and the county completes processing the Annual Redetermination in October 2004, the correct data the county shall enter into MEDS is 09/2004, the most recent Annual Redetermination due month and year, not 10/2004, the month and year the county completed processing the Annual Redetermination.

If you have questions regarding this letter, please contact Ms. Debora Wong-Kochi at (916) 552-9490 or by email: dwongkoc@dhs.ca.gov

Original signed by

Tameron Mitchell, R.D., M.P.H., Chief
Medi-Cal Eligibility Branch

Enclosures

MEDI-CAL ANNUAL REDETERMINATION NOTICE

Notice date:_____

Case number: _____

Worker name: _____

Worker number: _____

Worker telephone number: _____

Office hours: _____

DON'T LOSE YOUR MEDI-CAL OR HEALTH PLAN BENEFITS!
Fill out and turn in the enclosed Annual Redetermination form.

Medi-Cal law says in order to keep your Medi-Cal, you have to give us information at least once a year. We use the information you give us to see if you can still get Medi-Cal. This is called an Annual Redetermination.

Fill out the Annual Redetermination form and send it back to us by _____.

Your Medi-Cal is still active for now. If you do not fill out and return the Annual Redetermination form, we will take steps to stop your Medi-Cal.

Fill out and return the form even if you think you may not be eligible. We need the form and information to find out if you or your family are still eligible and which Medi-Cal program is best for you or your family. If you have questions or need help with the form, call your worker at the telephone number listed on this notice.

Remember, if we do not get your completed form, your Medi-Cal or health plan benefits may be stopped. If you missed the due date and still want Medi-Cal, call your worker NOW!

NOTIFICACIÓN DE NUEVA DETERMINACIÓN ANUAL DE MEDI-CAL

Fecha de la notificación:_____

Número del caso: _____

Nombre del/de la trabajador(a): _____

Número del/de la trabajador(a): _____

Número de teléfono del/de la trabajador(a):
_____

Horas hábiles:_____

¡NO PIERDA SUS BENEFICIOS DE MEDI-CAL O DE UN PLAN MÉDICO!
Llene y devuelva el formulario adjunto de una Nueva Determinación Anual.

Las leyes de Medi-Cal estipulan que, a fin de mantener su Medi-Cal, usted tiene que darnos información, por lo menos una vez al año. Nosotros utilizamos la información que usted nos da, para ver si usted puede seguir recibiendo Medi-Cal. A esto se le llama una Nueva Determinación Anual.

Llene el formulario de Nueva Determinación Anual, y envíenoslo, a más tardar el _____.

Por ahora, su Medi-Cal sigue activa. Si usted no llena ni devuelve el formulario de Nueva Determinación Anual, tomaremos medidas, para interrumpir su Medi-Cal.

Llene, y devuelva el formulario, aunque usted piense que posiblemente no tenga derecho a beneficios. Necesitamos el formulario y la información, para averiguar si usted o su familia siguen teniendo derecho a beneficios, y qué programa de Medi-Cal es mejor para usted o su familia. Si usted tiene preguntas, o necesita ayuda con el formulario, llame a su trabajador(a), al número de teléfono que se indica en esta notificación.

Recuerde, si no recibimos su formulario completado, es posible que sus beneficios de Medi-Cal o de un plan médico se interrumpan. Si a usted se le pasa la fecha en que se vence, y aún desea recibir Medi-Cal, ¡llame a su trabajador(a), AHORA!