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

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

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TO: ALL COUNTY WELFARE DIRECTORS Letter No. 14-38
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS

SUBJECT: ANNUAL REDETERMINATION PROCESS FOR MEDI-CAL AND COVERED CALIFORNIA MIXED HOUSEHOLDS (REFFERENCE ACWDL 14-32 and 14-18)

The Department of Health Care Services (DHCS) is providing guidance as a result of Assembly Bill (AB) x1 1, Chapter 3, Statutes of 2013, as well as guidance provided by the federal Centers for Medicare and Medicaid Services (CMS) on the Affordable Care Act of 2010 (ACA). This letter is to provide the Statewide Automated Welfare Systems (SAWS) and counties with policy guidance.

This guidance is focused on implementing annual redeterminations for Modified Adjusted Gross Income (MAGI) Medi-Cal and Covered California (Covered CA) mixed coverage households. A mixed coverage household is defined as a household with at least one member receiving MAGI Medi-Cal benefits and at least one member receiving Covered CA benefits. All County Welfare Directors Letter (ACWDL) 14-32 outlines the process for implementing annual redeterminations for 2015 and beyond for Medi-Cal beneficiaries who are eligible under MAGI categories.

This ACWDL provides instructions supplemental to ACWDL 14-32 and 14-18.

Annual Redetermination Dates for Mixed Coverage Households

Due to the different annual redetermination periods and processes for Medi-Cal and Covered CA, as described below, there will be two different annual redetermination dates for members of a mixed coverage household - one annual redetermination period for Medi-Cal (any time during the year) and another annual redetermination period (before January 1) for Covered CA.

Medi-Cal Annual Redetermination

As prescribed in Welfare and Institutions Code (W&I Code) Section 14005.37(a), Medi-Cal beneficiaries shall have their annual redetermination date set for 12 months from their initial application date or most recent redetermination of eligibility. This means that if a beneficiary applies for and is determined eligible for benefits in June, the beneficiary's Medi-Cal annual redetermination date would be the following May.

Covered CA Annual Redetermination

Covered CA shall re-determine the eligibility of a qualified individual, who is enrolled in a Covered CA Program (CCP) during the annual redetermination period. The annual redetermination period for Covered CA is not predetermined. However, for the 2014 benefit year, Covered CA will start processing their redeterminations in early October. Consumers will have 34 days from the date of their annual redetermination notice (NOD12) to actively complete their annual redetermination via the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) online portal. If the consumer does not actively complete their annual redetermination by the 34 days after their redetermination notice date, Covered CA will re-enroll the consumer into the current plan the consumer is enrolled in for the 2015 benefit year. If a consumer is unhappy with the plan they selected, or the plan they were automatically enrolled in, they can change their plan during Open Enrollment. Open Enrollment starts November 15, 2014 and ends February 15, 2015.

The CCP annual redetermination and Medi-Cal annual redetermination are two separate processes that may or may not occur concurrently depending on the Medi-Cal redetermination month. As such, the CCP 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 at the Medi-Cal beneficiary's annual redetermination date. If the CCP annual redetermination date and the Medi-Cal annual redetermination date are not aligned, any changes reported to the case via the CCP redetermination will be reported to the Medi-Cal program as a change in circumstance for the Medi-Cal beneficiaries. Covered CA will always send out the necessary redetermination notices for the CCP population once the annual redetermination period is opened up. The notice will notify the beneficiary that a separate process is required for Medi-Cal in order to eliminate any confusion.

Example: A family loses Minimal Essential Coverage (MEC) through dad's employer in April 2014 and applies for health coverage. Since the loss of MEC triggers a Special Enrollment Period (SEP), the application is approved for Advanced Premium Tax Credit (APTC) for both parents, and the children are approved for Medi-Cal. The Medi-Cal annual redetermination date will be March 2015 for the children, but the redetermination period for APTC will be prior to January 1, 2015.

Annual Redeterminations for Mixed Household with the Same Date

As prescribed on page 2, the CCP portion of the mixed household population will have a December annual redetermination date with a January 1, 2015 effective date. Since Medi-Cal rules stipulate that the Medi-Cal annual redetermination process must start at least 60 days in advance of the annual redetermination date, the Medi-Cal annual redetermination process should always initiate the annual redetermination process for mixed household cases where the Medi-Cal and CCP annual redetermination dates are the same.

Step 1: Ex Parte Review of Available Information

The MAGI Medi-Cal annual redetermination process begins with an ex parte review of available information pursuant to W&I Code Section 14005.37(e). As noted above, the ex parte process must be completed at least 60 days before the annual redetermination due date. For beneficiaries who are up for the annual redetermination, counties must first review the most recent or last known information contained in the beneficiary's active Medi-Cal case file or other information available to the county about the beneficiary and/or the beneficiary's immediate family or tax household members. This includes, but is not limited to, information from CalWORKs, CalFresh, or Covered CA, as well as other state and federal data records. An ex parte review should include the review of information from cases that are either open or were closed within the last 90-days.

After the county has collected the beneficiary's most recent information that is relevant to the Medi-Cal annual redetermination, the county shall enter the information in SAWS. The information will then be sent via electronic Health Information Transfer (e-HIT) to CalHEERS for a MAGI Medi-Cal eligibility determination and to complete the electronic ex-parte review of the case.

Please Note: The use of annual redetermination forms is not being eliminated. Instead, the annual redetermination process will start with an ex-parte review to determine ongoing eligibility. If the ex-parte review cannot sufficiently affirm eligibility, counties shall then send the appropriate annual redetermination form to beneficiaries as the second step in the process. If the ex-parte review is sufficient to affirm eligibility, a redetermination form is not required.

Example 1: No changes have been reported on the case and there are no other cases such as CalFresh or CalWORKs for the county to review; therefore, the most recent information is what is already contained in the Medi-Cal and CCP cases. The county ensures all information in CalHEERS and SAWS is current. No further review is required and the information is sent to CalHEERS for a MAGI determination.

Example 2: The most recent information on the case is an income verification that was provided for a CalFresh case that was closed 2 months ago. The county must ensure that the Medi-Cal income is updated to reflect the information reported on the CalFresh case before sending the information to CalHEERS for a MAGI eligibility determination.

Consistent with ACWDL 14-32, if a beneficiary is not found to be eligible via the ex parte review, the county will need to send the beneficiary the pre-populated redetermination form that will be generated by the SAWS. By law, the Medi-Cal beneficiary must be given at least 60-days to provide the information requested on the form. Therefore, the ex parte review must be completed by the county and/or SAWS at least 60 days prior to the Medi-Cal annual redetermination date. As a reminder, the annual redetermination date is the last day of the redetermination month. This accounts for the time needed to mail the beneficiary the redetermination form should the ex parte process not establish continued eligibility.

For example, if the Medi-Cal annual redetermination month is July 2015, the last day for the beneficiary to provide necessary information to the county will be July 31, 2015. This means that the redetermination form must be mailed to the beneficiary no later than June 1, 2015, which also means that the ex parte review must be completed prior to June 1, 2015.

<u>If the Ex Parte Review Confirms Continued MAGI Medi-Cal Eligibility</u>

If CalHEERS confirms continued MAGI Medi-Cal eligibility based on information from the ex parte review, SAWS will receive an eligibility result back from CalHEERS. Once the on-going eligibility is confirmed in SAWS, CalHEERS will generate a Notice of Action (NOA) confirming eligibility that will be sent to SAWS. The eligibility result will consist of the beneficiary's new Medi-Cal aid code for the upcoming benefit year. The county shall review and finalize the eligibility result and ensure that the beneficiary receives the NOA.

The NOA informs the beneficiary that their eligibility has been continued for another year, and that no additional information is needed. The NOA also includes the MAGI household size and income amount that was used to determine eligibility for each beneficiary in the household. If a beneficiary believes the income and household size reported on the NOA is incorrect, the beneficiary must contact the county via phone, email, in-person, or other commonly available electronic means within 90 days to provide the most current information. The NOA also informs the beneficiary that if the information is correct, no further action is necessary.

Please Note: This concludes the MAGI Medi-Cal annual redetermination since the appropriate information was electronically verified and continued eligibility confirmed. If the beneficiary reports a correction to the information reported on the NOA, the county shall process the corrected information for future months as a change in circumstance,

not as part of the annual redetermination because the annual redetermination for the beneficiary has already been completed. If such a change in circumstance is reported by the beneficiary following the completion of the annual redetermination, refer to ACWDL 14-22 for information on resetting redetermination dates when a change in circumstance is processed.

Step 2: Pre-Populated Annual Redetermination Form (MC 216)

If CalHEERS cannot confirm a beneficiary's continued MAGI Medi-Cal eligibility via the ex parte review process, the next step in the annual redetermination process requires the counties to send the beneficiary the MC 216, the new Pre-Populated MAGI Medi-Cal Annual Redetermination form.

The MC 216

After the ex parte review process, as prescribed on page 4, is completed, CalHEERS will transmit to the SAWS which data elements could not be verified. The MC 216 shall be populated to only ask for the information that could not otherwise be verified.

For example, if the only data element that could not be verified was income, the form would only ask for income information. Likewise, if the only information that could not be verified was incarceration status, the form would only ask for incarceration status.

SAWS shall pre-populate the information it has for the beneficiary pertaining to the unverified data element on the form. This should be the same information that the county sent to CalHEERS via the ex parte review; meaning, if income is being pre-populated, the county would pre-populate the same income data elements that it sent to CalHEERS via the ex parte review process.

Per W&I Code Section 14005.37(f), a beneficiary has 60-days to provide the requested information identified in the MC 216 form by phone, e-mail, the web, in person, or through other commonly available electronic means if available in the county. If the information is provided over the phone and paper verifications are required, the beneficiary must provide a copy of the necessary paper verifications in order for the verification requirement to be met. The beneficiary may return the MC 216 by mail or in person. The form must be signed by the beneficiary or their authorized representative for it to be considered complete. The county should ensure that a beneficiary's attempt to contact them with information is recorded as an attempted contact and the case is not counted as a "failure to cooperate" and that the SAWS barcode is appropriately marked as received.

Counties must ensure that the MC 216 is mailed to the beneficiary at least 60 days before the beneficiary's redetermination date, with a return date to allow sufficient time to collect the beneficiary's information and run the information through the CalHEERS Business

Rules Engine (BRE) for a MAGI Medi-Cal eligibility determination by the last day of eligibility.
For purposes of this section, sufficient time means at least 60 days. This does not preclude the county or SAWS from sending the MC 216 out more than 60 days before the beneficiary's redetermination date.

If the beneficiary fails to provide the needed information requested on the MC 216 in the prescribed timeframes and communication methods, the county shall follow the related guidance in the "Process Exceptions" section on Page 7.

County Responsibility after Sending the MC 216

As prescribed in W&I Code Section 14005.37(f)(2), if during the 60-day period, the beneficiary has not returned the MC 216, or has not otherwise provided all of the requested information, the county must attempt to contact the beneficiary to request the needed information at least one time after the MC 216 is sent to request the information.

Per W&I Code Section 14005.37(t), counties must contact the beneficiary using the beneficiary's preferred method of contact, if a method has been identified, to the extent possible. If no preferred method of contact was identified, counties shall use all reasonable efforts to determine the most effective method to reach the beneficiary, considering past successful efforts. All attempted contacts and the method of contact used should be documented in the Medi-Cal case file.

As a best practice, it is recommended that the county contact the beneficiary at least 30 days after sending the MC 216. This allows the beneficiary enough time to respond and provide ample processing time in the event that additional information needs to be verified or requested from the beneficiary. If the beneficiary responds to the request for additional information within the 60 day time period, but the information provided is incomplete or insufficient, the county shall not discontinue benefits and must work with the beneficiary to complete the information.

Eligibility is Determined

Once the beneficiary provides the information needed and it is entered into SAWS, CalHEERS will attempt to determine continued MAGI Medi-Cal eligibility.

- *If MAGI Eligible* – If the beneficiary is determined eligible for MAGI Medi-Cal, the beneficiary shall be sent a NOA and shall have his/her eligibility extended for a new 12-month period.

- *If Not MAGI Eligible* – The process and procedures for individuals found ineligible

for MAGI Medi-Cal at redetermination (both annual redetermination and change in circumstance redetermination) are prescribed in ACWDL 14-18.

- *Not Enough Information to Determine Eligibility* – If the beneficiary provided additional information in response to the MC 216, but it is not enough information to determine ongoing eligibility, the county shall continue to work with the beneficiary to collect the necessary information as per current policy. The county shall attempt to work with the beneficiary in their preferred method of contact, to the extent possible. If the county feels the beneficiary is not making a good faith effort to provide the requested information, and the 60-days to provide the information has passed, the county shall discontinue the case for failure to provide information.

Process Exceptions

No Response to MC 216

If after 60-days, during which time the county has attempted to reach the beneficiary as discussed on page 6, the beneficiary fails to provide all the requested information through any of the available means, the beneficiary shall be discontinued from Medi-Cal benefits for lack of cooperation at the end of the annual redetermination due month. In accordance with due process requirements, counties shall send the beneficiary a timely and adequate discontinuance NOA explaining the basis for termination.

Please Note: If the beneficiary provides the requested information prior to the effective date of discontinuance, the county shall rescind the discontinuance action and continue the redetermination process.

90-Day Cure Period

The beneficiary has an additional 90 days after the date of termination to provide the additional information needed for redetermination. If the beneficiary provides the requested information on the MC 216 within the 90-day cure period, the county shall treat the information as if it were received timely. The county shall immediately enter the information into the SAWS system, and run the information through the CalHEERS BRE as prescribed on page 6 to determine continued eligibility.

If the beneficiary is redetermined for continued eligibility during the 90-day cure period, the county shall grant benefits back to the date of discontinuance, retain the application and annual redetermination dates, and notify the beneficiary that their Medi-Cal benefits will be restored back to the date of discontinuance. County workers must promptly act to process the information provided by the beneficiary during the 90-day cure period. As a reminder, counties should ensure that the good cause regulations are followed if a

beneficiary presents outside of the 90-day cure period with good cause for not providing timely information.
Please Note: As prescribed in W & I Code Section 14005.37(i), the submission of the MC 216, or otherwise providing requested information, does not constitute a finding of Medi-Cal eligibility. The discontinuance action shall not be overturned until the information is processed (i.e., run through the CalHEERS BRE and verified against the federal hub) and Medi-Cal eligibility is found. If the beneficiary is no longer eligible under a MAGI category, but is found eligible for a Covered CA product, the beneficiary will be determined eligible for the Covered CA product. The county can contact the beneficiary by any means available to the county, including by sending out the Non-MAGI screening packet as prescribed in ACWDL 14-18, to see if the beneficiary wants to be evaluated for Non-MAGI Medi-Cal eligibility.

Annual Redeterminations for Mixed Household with Different Dates

If a Medi-Cal redetermination occurs prior to the Covered CA redetermination, the transaction will be treated as a change of circumstance for the CCP. The change of circumstance will be sent from SAWS to CalHEERS via the e-HIT process. CalHEERS will update the beneficiary's Covered CA account. Beneficiaries who are still eligible for, and enrolled in a Covered CA plan, will still go through the Covered CA annual redetermination period once it occurs.

If the Covered CA redetermination occurs prior to the Medi-Cal redetermination, the Covered CA redetermination will be treated like a change in circumstance for those beneficiaries in the case who have Medi-Cal eligibility. Any new information received by Covered CA as part of the Covered CA redetermination will be sent down to SAWS via the e-HIT. The county shall ensure that it works the change in circumstance as prescribed in ACWDLs 14-22.

If counties receive beneficiary information that does not change the information currently on file, the county should not process a change in circumstance. The county shall retain the Medi-Cal annual redetermination date and make no changes to the case as there is no new information to act upon and the Medi-Cal annual redetermination shall be processed for the appropriate month in which it is due.

County Responsibility with Mixed Household Renewal Processing

As outlined in W&I Code section 14015.7(b), counties are responsible for Medi-Cal eligibility determinations and on-going case management of Medi-Cal cases with regards to cases that may have contact with the Exchange (Covered CA), including mixed households. As reinforced in W&I Code section 14005.37, counties are responsible for completing Medi-Cal redeterminations and processing changes in circumstances.

Due to the fact that counties are required to complete all Medi-Cal eligibility determinations and redeterminations, counties are required to assist with renewals for mixed households where changes are reported for the CCP that may impact Medi-Cal eligibility.

Covered CA beneficiaries belonging to mixed households may complete their annual redetermination using several methods, including: self-initiated online annual redeterminations via CalHEERS, by contacting the Covered CA service center, or contacting the county directly. Counties are reminded to assist with completing mixed household annual redeterminations should such individuals contact the county directly or be referred to the county by a Covered CA service center representative (CSR). CSRs are able to complete Covered CA only related information on the annual redetermination; 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 must be reviewed and processed by the county; therefore, such cases will be referred to counties by Covered CA for assistance with completing the annual redetermination.

Example 1: A mixed household beneficiary contacts the Covered CA service center to complete his or her annual redetermination. The family has no changes to report, such as income, that will impact eligibility. The CSR will process the annual redetermination and the county will be notified via SAWS, per current practice, that an action has been completed in CalHEERS. As in any other situation where a referral or case update is received from CalHEERS to SAWS, the county will review the information appropriately and process the Medi-Cal portion of the case as indicated in this letter.

Example 2: A mixed household beneficiary contacts the Covered CA service center to complete his or her annual redetermination. The family has several household changes to report that will impact eligibility, including a pregnancy and change in income. Due to the fact that the change in household size and income will likely impact Medi-Cal eligibility, the CSR refers the individual to the county for further review. The county will be responsible for processing the household and income change in SAWS as part of the annual redetermination or change in circumstance, whichever is applicable.
Counties are also reminded that they are also responsible for assisting with plan selection for the CCP mixed household individuals who require or request assistance with plan selection. With the exception of plan selection which occurs in CalHEERS, counties are not required to take any extra steps besides processing the case in SAWS in order to complete the Medi-Cal annual redetermination or change of circumstance that is being processed. This will also conclude the annual redetermination process for the CCP, with no additional steps that must be taken in CalHEERS.

Loss of Contact

If the MC 216 is returned to the county with a "return to sender" or "no forwarding address," before proceeding with the steps to discontinue the beneficiary, the county shall first check all available sources to see if the beneficiary is a deemed infant or former foster youth and follow the appropriate process for either population. The county shall then attempt to contact the beneficiary as required in W&I Code Section 14005.37(c). This shall include first, an ex parte review of information available to the county about the beneficiary or his or her family members, such as from the Covered CA case or CalFresh file with more current contact information for the beneficiary. Then, if necessary, make an attempt to contact the beneficiary by e-mail, by telephone, or by other means available to the county according to the beneficiary's preferred method of contact if a method has been identified. For beneficiaries other than deemed infants or former foster youth, if all required attempts at contact fail, the county shall send a notice of discontinuance and document the inability to make appropriate contact in the case file.

Former Foster Youth up to Age 26

As required by W&I Code Section 14005.28(a)(3), the annual redetermination process for former foster youth is simplified and former foster youth should not receive the MC 216 unless they are part of a household where other household members must complete a MAGI Medi-Cal evaluation to continue to receive Medi-Cal benefits.

Former foster youth up to age 26 shall not be discontinued due to a loss of contact. As discussed under Loss of Contact above, if the county receives an MC 216 as "return to sender" or otherwise undeliverable, before proceeding with the steps to discontinue, the county shall check all available sources to see if the beneficiary is a former foster youth. If a beneficiary is found to be a former foster youth for which the county has lost contact, the beneficiary should be placed into fee-for-service Medi-Cal until such time as contact is re-established or information is received that would require a discontinuance (such as death, loss of California residency, or aging out of the program).

If you have any questions, please contract Braden Oparowski by phone at (916) 552-9570 or email at Braden.Oparowski@dhcs.ca.gov.

Original Signed By:

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