

**Department of Health Care Services
Proposed Trailer Bill Legislation**

Align Medi-Cal Redeterminations with Federal Guidelines

FACT SHEET

Issue Title: Update Medi-Cal Redetermination Statute to Align with Federal Guidelines.

The Department of Health Care Services (DHCS) is proposing to align state law with federal guidelines related to the 90-Day Cure Period and processing Medi-Cal Change in Circumstance redeterminations.

Background: County eligibility workers perform an annual renewal, which is a full eligibility redetermination that is conducted at least once every 12 months to redetermine eligibility for Medi-Cal beneficiaries. The annual renewal due month is generally set 12 months from the application month. However, if the applicant is not Medi-Cal eligible in the month of application, then the annual renewal is set 12 months from the first month in which the applicant meets all eligibility criteria. Counties must also conduct a change in circumstance redetermination between regular annual renewal redeterminations anytime there is a change in a beneficiary's circumstances that may affect eligibility, such as a new job or if someone gets married.

State law and federal guidelines for Medi-Cal redetermination processing are misaligned in two areas: the 90-day Cure Period and Change in Circumstance. This conflict may lead to the potential loss of federal financial participation (FFP) and more burdensome processes for beneficiaries and county eligibility workers.

90-Day Cure Period

Beneficiaries who are discontinued from Medi-Cal as a result of not providing required information are given 90 days to submit their required information without needing to reapply for Medi-Cal. This is referred to as the 90-day Cure Period.

State law requires that if a discontinued beneficiary provides the necessary information during the 90-Day Cure Period and continues to be eligible for Medi-Cal, the beneficiary's eligibility can be reinstated back to the date of discontinuance and the annual renewal date remains the same (Welfare and Institutions (W&I) Code section 14005.37(i)). For example, a beneficiary discontinued at the end of their October 2021 annual renewal month (October 31, 2021), who provided the required information in January 2022 and was still eligible for Medi-Cal, would have eligibility reinstated with no break back to October 31, 2021, and the annual renewal due month would remain October, with the next annual renewal due October 2022.

However, on December 4, 2020, the Centers for Medicare and Medicaid Services (CMS) released a [Center for Medicaid and Medicaid and Children's Health Insurance Program Services Informational Bulletin](#) that clarifies that discontinued beneficiaries who return required information during the 90-Day Cure Period must be treated as new applicants, with eligibility only reinstated for any of the previous months if the individual requested retroactive eligibility and is found eligible for the requested months. Additionally, in a follow-up Webinar provided by CMS on January 13, 2020, CMS clarified that the annual renewal date would

also be reset based on the new application date. For example, a beneficiary discontinued at the end of their October 2021 renewal month (October 31, 2021) would be sent a notice of action (NOA) with information about the 90-Day Cure Period, and an explanation regarding the ability to apply for retroactive coverage if needed. If the discontinued beneficiary provides the required information in January 2022, they would be treated as a new applicant with eligibility beginning in January 2022 and would have their annual renewal date set to 12 months later, in December 2022. The beneficiary would need to request retroactive coverage for November and December in order to have no break in coverage. However, beneficiaries have up to one year from the month they received services to request retroactive coverage for the retroactive month. Requesting retroactive coverage would not reset the renewal date.

Federal regulations require that an annual renewal redetermination occur “no more frequently” than once every 12 months. As CMS considers information received during the 90-Day Cure Period to be a new application with no automatic retroactive eligibility restoration and a new annual renewal date set for 12 months later, it is possible CMS’ future audit of Medi-Cal cases could determine that FFP is unallowable and DHCS must return FFP due to improper retroactive eligibility determinations and annual renewals that occur too frequently. To date, DHCS has not received any audits with these findings. However, now that CMS has clarified their guidance on the 90-Day Cure Period, DHCS would not be able to argue an assumption that automatic reinstatement and keeping the original renewal date was the correct process. Prior to receiving this guidance from CMS, DHCS worked under the assumption that the DHCS policy and the CMS guidance were in alignment.

Change in Circumstance Redetermination Processing

The change in circumstance redetermination is an eligibility review that is conducted when a county receives information about a change in a beneficiary’s circumstances that may affect eligibility, such as a new job or when someone gets married. This can occur when the beneficiary reports changes to their county eligibility worker, as is required within 10 days of the change, or when the county receives information about a change from other sources such as electronic databases or other public social services programs. Existing law requires the county to send a form to the beneficiary that is prepopulated with existing information obtained after the ex parte review process and that the beneficiary must sign under penalty of perjury (W&I Code section 14005.37(g) and (r)). Federal regulation does not require a prepopulated form or the beneficiary to sign under penalty of perjury (Title 42 Code of Federal Regulations (CFR) section 435.916). As a result, the processes for Change in Circumstance in state law are far more restrictive and burdensome for beneficiaries and county eligibility workers and are not required by federal regulation.

Due to other priority assignments related to the Affordable Care Act (ACA) and higher priority forms and systems that needed to be implemented, DHCS never updated the change in circumstance form to be pre-populated or require a signature. Counties currently use the “Medi-Cal Request for Information” form (also known as MC 355) to request necessary information, which is not pre-populated and does not include a signature requirement. The current process, which is in alignment with the federal regulation, has been in place for years and is a proven and effective method for collecting such information.

During a change in circumstance redetermination, counties may only request information related to the specific change in circumstances that is reported. For example, if a beneficiary

reports a change in income and the county is unable to verify the new income information electronically, the county may only ask the beneficiary for the income verification and may not ask for any additional information or verification. Sending a form to the beneficiary clearly requesting only the income verification is a simple and clear way to request the required information. Sending a form with pre-populated information for a change in circumstance redetermination would add a layer of complexity. Requiring the beneficiary to review the pre-populated information, agree to or update it before signing the form under penalty of perjury, and return the form to the county creates an extra burden for the beneficiary without adding any value as the county only needs the beneficiary's income verification.

In addition to repealing the provisions in law that do not comply with federal regulations, conforming changes in state statute will remove a duplicative statement regarding when to discontinue a beneficiary when there is no response to the change in circumstance form (W&I Code Section 14005.37(g)(1)).

Justification for the Change: Aligning the state statute with federal guidelines eliminates potential loss of FFP, lessens administrative burdens and requirements for county eligibility workers, and ensures the integrity and accountability of DHCS' policy requirements. Updating the state statute will also align the current application and 90-Day Cure Period processes to ensure consistent policy and equal treatment of individuals requesting Medi-Cal coverage. Additionally, updating the state statute will allow the continuation of current Change in Circumstances business processes and eliminate the complexity and workload burden that the statutorily required process, including a prepopulated and signed form, would create for beneficiaries and county eligibility workers.

Summary of Arguments in support:

- Aligns state law with federal guidelines
- Prevents loss of FFP
- Streamlines and simplifies process for Medi-Cal beneficiaries and county eligibility workers