Annual Redetermination

AB 1296 Workgroup

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Authority: Annual Redeterminations

- Federal Law: Agency must redetermine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least once every 12 months.
  42 CFR 435.916 (a)

- State Law: Reaffirmation shall be filed annually and may be required at other times in accordance with general standards established by the California Department of Health Care Services.
  Welfare and Institutions Code Section 14012

- State Regulations: 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.
  Title 22, California Code of Regulations (CCR), Section 50189 (c)(1)

- County Performance Standards: Counties are subject to the Annual Redetermination Performance Standards per Senate Bill X1 26.
  Welfare and Institutions Code Section 14154 (c)

- Policies and Procedures:
  ACWDL 06-16, 06-17,11-23 and MEDIL I-11-05

Medi-Cal Annual Redetermination Policies

- The beneficiary must complete the Annual Redetermination form (MC 210 RV) or other acceptable Medi-Cal Statement of Facts form and provide information on changes in household circumstances and verification of income and/or property.
- The county must accept other Statement of Facts forms (i.e. SAWS 2, MC 210, MC 321 HF) and not require the beneficiary to complete a MC 210 RV.
- The beneficiary must cooperate with the Annual Redetermination requirements to ensure continuing Medi-Cal coverage

Who is exempt from Medi-Cal Annual Redeterminations?

Beneficiaries who receive Medi-Cal benefits through public cash assistance programs are exempt because those agencies or departments have an annual eligibility redetermination process:

- Supplemental Security Income/State Supplementary Payment program (SSI/SSP)
- California Work Opportunity and Responsibility to Kids (CalWORKs);
- Foster Care Assistance program; or
- Aid for Adoption of Children program.
- In addition, the Former Foster Care Children (FFCC) receiving Medi-Cal benefits have a simplified annual review process

When is the Annual Redetermination completed?

- The Beneficiary must submit the Annual Redetermination form to the county by the last day of the 12th month to be considered “timely”. Each subsequent Annual Redetermination is scheduled for the same calendar month. Submitting an Annual Redetermination form early or late does not change the Annual Redetermination month.

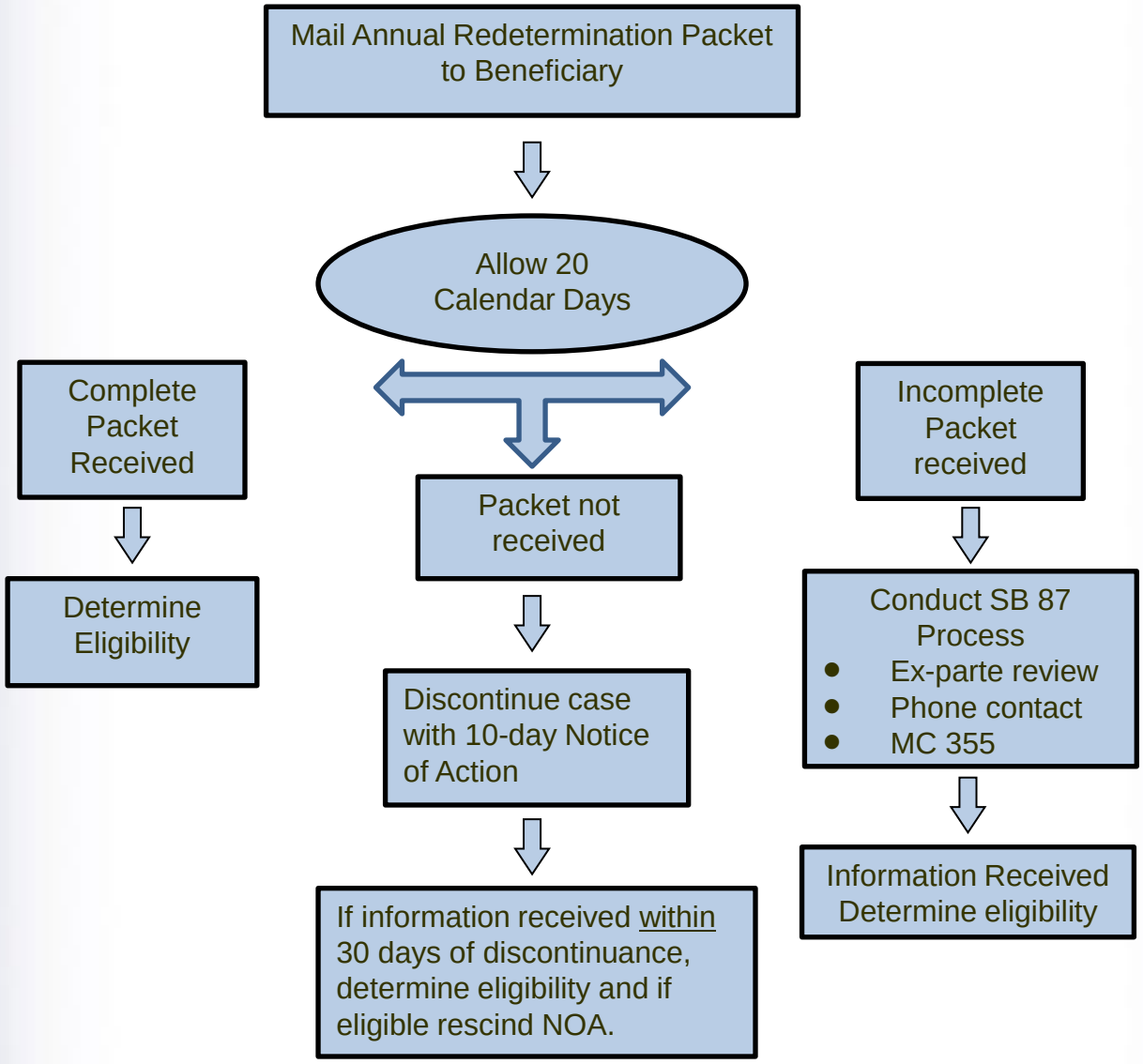
- Counties must:

  - Mail the Annual Redetermination packet to the beneficiary no earlier than the first day of the 10th month and no later than the last day of the 11th month. The packet contains the Annual Redetermination notice and MC 210 RV form and other mandated program information.

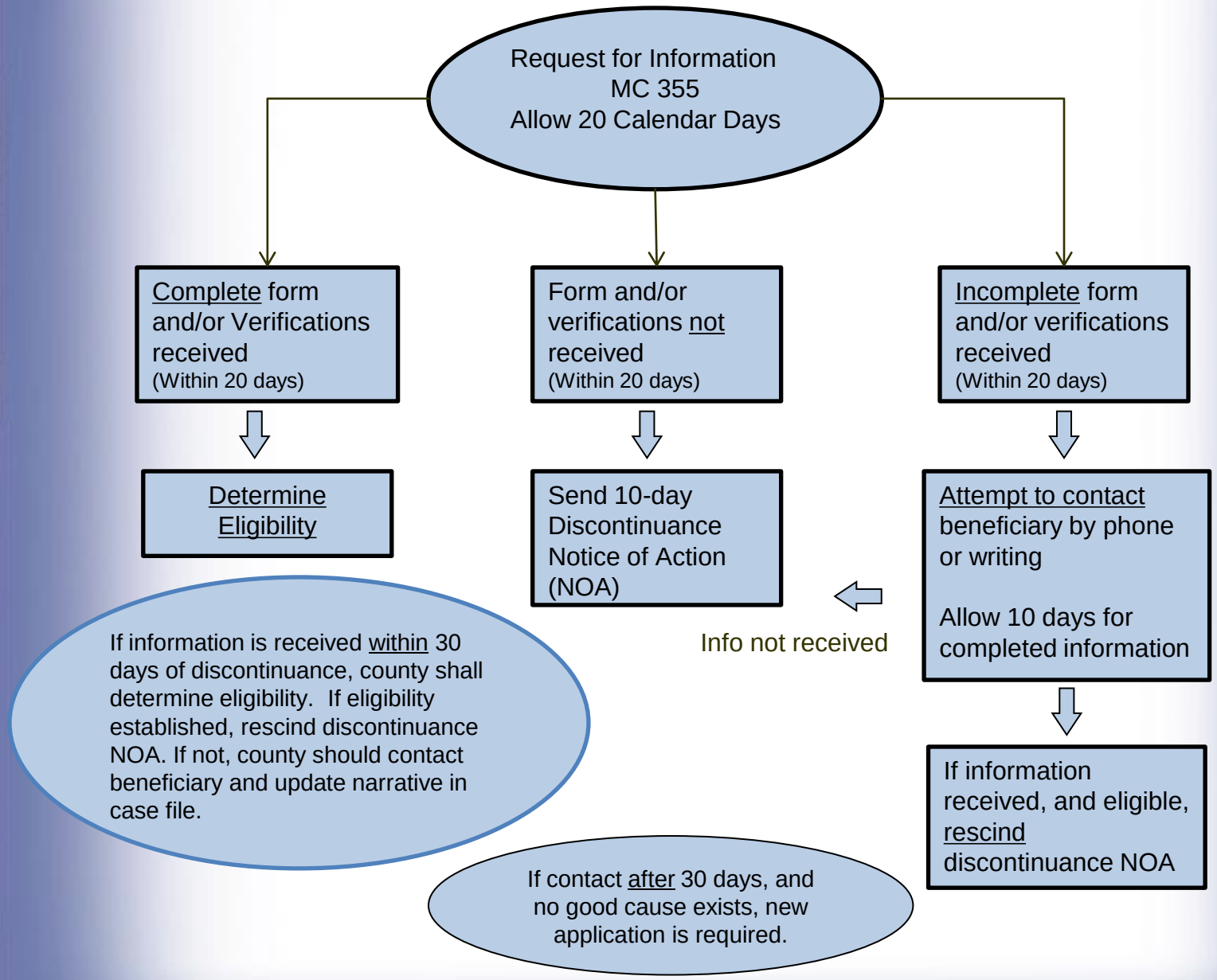
  - Give the beneficiary at least 20 days to complete, sign and return the forms along with the verifications.

  - Not request information that has already been provided, that is not subject to change (i.e. date of birth, social security number or United States citizenship)

Medi-Cal Annual Redetermination Process



SB 87 Process



MEDI-CAL ANNUAL REDETERMINATION FORM

You must fill out this form and return it to the county to keep your Medi-Cal!

Case Number *(optional)*	**Social Security Number** *(optional)*	
Print Your Full Name *(If you have not moved, put address label here if one is provided)*	**Birth Date** *(optional)* **(mm/dd/yyyy)**	
Current Street Address, Apartment Number ☐ *(check here if address is new)*	**City/State**	**Zip Code**
Mailing Address *(If different from above)*	**City/State**	**Zip Code**

Use ink and **PRINT** your answers. Make sure you sign and date the form. Use the postage paid envelope to return it. If you need more space, attach a separate sheet to this form. If you have any questions or need help filling out this form, call your worker at the telephone number listed on the Annual Redetermination Notice.

Section 1. Income

(a) Do you or any family member in the home get money from a job, child support or alimony, social security, veteran benefits, unemployment or disability benefits, retirement, gifts, or interest or dividends? ☐ Yes ☐ No

If yes, complete below and list each source of income on a separate line.

Attach most recent pay stubs showing income before taxes or deductions, benefit or award letters, checks received or signed statement from employer, or last year's federal income tax return. If income is from self-employment, send a copy of your most recent tax return or profit and loss statement.

Name of Person with Income *(Include first and last name)*	**Source of Income**	**Income Amount** *(before any deductions)*	**How Often Paid** *(weekly, monthly, twice a month)*	**Hours Worked** *(per week or month)*

(b) Do you or any family member in the home get rent, utilities, food, or clothing entirely free? ☐ Yes ☐ No

If yes, who?_____

What was free?_____

(c) Was the free rent, utilities, food, or clothing received in exchange for work done? ☐ Yes ☐ No