DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: September 30, 2024

TO: ALL COUNTY WELFARE DIRECTORS Letter No.:24-11
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: UPDATED POLICY REGARDING NON-MODIFIED ADJUSTED GROSS INCOME ELIGIBILITY DETERMINATION PROCEDURES
(Ref: All County Welfare Director Letters 14-18, 17-08 17-26, 17-26E, 22-22, 22-33 and Medi-Cal Eligibility Division Information Letter I -23-06)

Purpose

The purpose of this All-County Welfare Directors Letter (ACWDL) is to provide updated guidance to counties regarding changes to the Non-Modified Adjusted Gross Income (Non-MAGI) Medi-Cal eligibility screening process and inform the counties of the elimination of the Non-MAGI Medi-Cal Screening Packet. Effective upon release of this letter, counties shall no longer mail or wait for the return of a Non-MAGI Medi-Cal Screening Packet when determining an applicant's or member's eligibility for Non-MAGI Medi-Cal programs. Please note, the Statewide Automated Welfare System (SAWS) shall make programming changes during the next available SAWS release to discontinue mailing the Non-MAGI Medi-Cal Screening Packets. The Department of Health Care Services (DHCS) understands Non-MAGI Medi-Cal Screening Packets may continue to be mailed to the applicant or member until the programming changes occur.

Furthermore, this letter obsoletes the portions of the guidance outlined in ACWDLs 14-18, 17-08,17-26 17-26E, and 22-33 and Medi-Cal Eligibility Division Information Letter I -23-06 regarding the use of the Non-MAGI Screening Packet materials.

Background

DHCS released several ACWDLs to provide guidance to counties regarding the Non-MAGI screening process and required forms which include:

- ACWDLs 14-18 and 22-33: Provide counties with processes and forms for obtaining additional information for Non-MAGI Medi-Cal eligibility for members no longer eligible for MAGI Med-Cal.

- ACWDL 17-08: Instructed counties to use processes and forms outlined in ACWDL 14-18 for individuals in the MAGI New Adult Group who are eligible for or enrolled in Medicare.
- ACWDL 17-26 and 17-26E: Informed counties to use process and forms to evaluate applicants for Non-MAGI Medi-Cal eligibility when they were found ineligible for MAGI Medi-Cal.

DHCS instructed counties to mail the Non-MAGI Screening Packet supplemental forms to applicants or members potentially eligible for Non-MAGI Medi-Cal programs if the necessary information to complete the Non-MAGI Medi-Cal determination was not available through ex-parte review. The Non-MAGI Screening Packet included a cover letter, the Income and Property Supplement form (MC 604IPS) to collect asset, income, expenses, and household information required to complete the Non-MAGI Medi-Cal eligibility determination, a Non-MAGI Medi-Cal brochure (Pub 10), and a Covered California Advanced Premium Tax Credits (APTC) or Cost Sharing Reductions (CSR) brochure.

Elimination of the Asset Test

Assembly Bill (AB) 133 (Chapter 143, Statutes of 2021) eliminated the asset test effective January 1, 2024, for purposes of determining eligibility for Non-MAGI Medi-Cal programs, including Long-Term Care and Medicare Savings Programs. In preparation for the implementation of asset elimination, DHCS and counties reviewed current processes and procedures related to the Non-MAGI Medi-Cal eligibility screening process. Counties reported that the Non-MAGI Screening Packet is no longer needed, as county eligibility workers (CEWs) obtain the majority of required information from application and renewal forms or through the ex-parte review of case files to complete the Non-MAGI Medi-Cal eligibility determination.

Requirements for Non-MAGI Medi-Cal Determinations

Counties shall continue to complete Non-MAGI Medi-Cal determinations:

- For applicants who are not eligible for MAGI Medi-Cal, if they are potentially eligible for Non-MAGI Medi-Cal or if they specifically request a Non-MAGI Medi-Cal eligibility determination.
- For Medi-Cal members at redetermination if they are no longer eligible for MAGI Medi-Cal and if they are potentially eligible for Non-MAGI Medi-Cal.
- For MAGI Medi-Cal members in the New Adult Group who are eligible for Medicare, (e.g., turning age 65 years) or enrolled in Medicare and not eligible for

MAGI Medi-Cal. As a reminder, even those who are eligible for MAGI Medi-Cal and have Medicare should be assessed for Medicare Savings Programs.

Per ACWDL 17-03, applicants or members who are eligible for MAGI Medi-Cal and also potentially eligible for Non-MAGI Medi-Cal may choose to have eligibility determined under those programs if they are willing to provide all information necessary to complete a Non-MAGI Medi-Cal determination and can establish linkage through the following criteria:

- Disability.
- Age.
- Blindness.
- Parent / caretaker status of children under the age of 21.
- Child under 21
- Pregnant individual
- Seeking Long Term Care Services
- Seeking services under a Home and Community Based Services Waiver Program

Application

According to WIC §15926 and 42 CFR §435.911 (c)(3),.if an applicant qualifies for both MAGI and Non-MAGI Medi-Cal programs, the county shall enroll them in the most advantageous program according to the Medi-Cal Hierarchy. However, if an applicant qualifies for MAGI Medi-Cal, they can choose to be placed in Non-MAGI Medi-Cal instead.

Redetermination

In accordance with WIC §14005.37 and 42 CFR §435.911(c)(3), counties shall complete a Non-MAGI Medi-Cal eligibility determination when a current Medi-Cal member is determined no longer eligible for a MAGI Medi-Cal program and has potential linkage for Non-MAGI Medi-Cal. Medi-Cal eligibility shall continue during the redetermination process. A member's Medi-Cal eligibility shall not be terminated until the county makes a specific determination based on facts clearly demonstrating that the member is no longer eligible for Medi-Cal benefits under any basis and when all due process rights have been met. The member may be placed in soft pause and must remain in the MAGI Medi-Cal aid code during the Non-MAGI Medi-Cal eligibility determination.

Counties shall obtain additional information as required to determine Medi-Cal eligibility on another basis prior to discontinuance. The CEW shall review if the member qualifies for Consumer Protection Programs and if there is linkage for a Non-MAGI Medi-Cal program eligibility prior to referring the member for a determination of other Insurance

Affordability Programs (IAPs) through Covered California. Please refer to ACWDL 22-33 for guidance regarding completing change in circumstance and annual renewal determinations, including referring members for determination of other IAPs with or without financial assistance.

Counties shall follow the steps below to determine Non-MAGI Medi-Cal eligibility for members with potential linkage and may complete the Non-MAGI Medi-Cal eligibility determination at any step that all information is available for the determination. Additionally, at any step members that do not have linkage for Non-MAGI Medi-Cal programs or are determined eligible for Share of Cost (SOC) Non-MAGI Medi-Cal must have a determination of other IAPs through Covered California per ACWDL 22-33.

Non-MAGI Medi-Cal Determination —First Step—Ex-Parte Review

Counties shall begin the Non-MAGI Medi-Cal eligibility determination with an ex-parte review of relevant information available prior to contacting the applicant or member. Sources of information available to the county include:

- Information in the applicant/member's case file or information available to the county, including but not limited to:
    - Information from the Medi-Cal, CalWORKs, or CalFresh case files of the applicant/member or immediate family members. Information shall be from an open case, or a case that was closed within the last 90 days.
    - Information available from Covered California, and
    - State and federal data records including but not limited to the Medi-Cal Eligibility Data System (MEDS), the Income and Eligibility Verification System (IEVS), and/or the Federal Data Services Hub (FDSH).

Reminder: During this step, CEWs shall review the case file for potential Non-MAGI Medi-Cal linkage due to age, disability, and pregnancy.

If counties obtain all necessary information required to complete the Non-MAGI Medi-Cal eligibility determination during the first step of the ex-parte review, the county shall approve Non-MAGI Medi-Cal program eligibility including Non-MAGI Medi-Cal SOC without requesting additional information from the member.

Non-MAGI Medi-Cal Determination —Second Step—Request for Reasonable Explanation of Income or Other Information or Verifications

Per ACWDL 22-22, at application and annual renewal, if appropriate, CEWs may obtain a reasonable explanation for both MAGI Medi-Cal and Non-MAGI Medi-Cal

determinations when income is found not reasonably compatible with the FDSH, or any electronic source and the determination cannot be made through the ex-parte process. The CEW must attempt to obtain a reasonable explanation or verification to complete the financial eligibility determination for Non-MAGI Medi-Cal. As a best practice CEWs should first try to call the applicant or member to obtain a reasonable explanation. When CEWs are unable to obtain a reasonable explanation in person or through phone, the CEW may include the option for the applicant or member to provide a reasonable explanation and/or verification of their income when sending the written request.

Counties must accept the reasonable explanation provided by the member through any allowable pathway, including in person, telephonically, through accessible electronic methods, mail, or fax, and document how the reasonable explanation was obtained in the case file as directed in ACWDL 22-22.

Reminders:

- Counties must use reasonable explanations for Non-MAGI Medi-Cal applicants or members when there are income discrepancies with data found in electronic sources, including (but not limited to):
    - MEDS,
    - IEVS, or
    - Verify Current Income Service (VCI) responses, when applicable.
- CEWs must continue to follow guidance found in ACWDL 20-17E for acceptable e-verifications for Non-MAGI Medi-Cal, as well as ACWDL 22-08 regarding the use of VCI Service response for the Aged, Blind, and Disabled Federal Poverty Level (ABD-FPL) Non-MAGI Medi-Cal cases when VCI responses are generated and available to the CEW.
- Per ACWDL 22-22, if a discrepancy is found and the CEW obtains a reasonable explanation that verifies the discrepancy but would result in a Non-MAGI Medi-Cal SOC or higher Non-MAGI Medi-Cal SOC, the CEW must obtain additional verification. The CEW must request manual verification of income to verify the discrepancy and ensure the Non-MAGI Medi-Cal SOC would be accurate with manual verification.

When the county still cannot complete the Non-MAGI Medi-Cal eligibility determination due to missing information or verifications, the county shall follow existing guidance for mailing the appropriate request for information form in MEDIL I 20-13. Missing information may include household composition, income such as rental income, or expenses such as childcare costs. Counties shall no longer mail the Non-MAGI Screening Packet to obtain information for the Non-MAGI Medi-Cal eligibility determination

Counties may still accept telephonic attestations and affidavits, reasonable explanations or determine Non-MAGI Medi-Cal eligibility with any ex-parte information that becomes available during this period.

For Medi-Cal members no longer eligible for MAGI Medi-Cal and who have potential linkage to Non-MAGI Medi-Cal, if after the 30-day period following the mailing of the request for information form (e.g., MC 355 form) and the additional attempted contact the member does not provide the information and/or verification requested, the county shall send a timely 10-day Notice of Action (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.

Additional Reminders

Counties shall do the following when completing the Non-MAGI Medi-Cal eligibility determination:

- Request information from Medi-Cal applicants following the Second Contact requirements in ACWDL 08-07 and ACWDL 22-12.
- Request information from Medi-Cal members using the Request for Information (MC 355) form and provide 30 days for response. During the 30-day period, the county shall attempt to contact the member using their preferred method to remind the member of the information requested and the due date to provide the information to the county. Refer to ACWDL 18-25 for additional guidance.
- Accept the applicant's or member's information, by telephone, by mail, in person, via the Internet or through other commonly available electronic means.
- Mail the appropriate Non-MAGI Medi-Cal approval or Non-MAGI Medi-Cal denial NOA to applicants who have the Non-MAGI Medi-Cal eligibility determination.
- Mail the MAGI Medi-Cal discontinuance NOA and appropriate Non-MAGI Medi-Cal approval NOA or Non-MAGI Medi-Cal denial NOA to the member once the Non-MAGI Medi-Cal determination is complete.
    - In accordance with ACWDL 24-06, in circumstances where both MAGI Medi-Cal and Non-MAGI Medi-Cal information should be included in a single NOA, counties may continue to send separate notices to members in instances when one combined notice is not automatically generated.
- In accordance with MEDIL I 23-61, counties shall follow best practices for using the temporary version of the "Ways to Reduce Your Share of Cost" (SOC) insert until it is finalized and automated, including sending it along with the appropriate

Non-MAGI Medi-Cal approval NOA to applicants or members who are approved for Non-MAGI Medi-Cal with a SOC.

- After counties complete the Non-MAGI Medi-Cal determination and provide the Non-MAGI Medi-Cal SOC NOA to the applicant or member, the individual may choose to disenroll from or accept Non-MAGI Medi-Cal with a SOC. Depending on their circumstances, they may also qualify to enroll in an IAP with or without financial assistance and elect to have both Non-MAGI Medi-Cal with a SOC and IAP coverage. Please refer to ACWDL 22-20 for information on transitioning members to Covered California.

If you have any questions, or if we can provide further information, please contact Priscilla Peco, by phone at (916) 345-7802 or by email at Priscilla.Peco@dhcs.ca.gov.

Sincerely,

Sarah Crow, Chief
Medi-Cal Eligibility Division