

Department of Health Care Services

**County Support Webinars Q&A:
Continuous Coverage Unwinding Process
Updated: April 23, 2024**

During weekly county support webinars, county representatives have raised questions regarding the continuous coverage unwinding process. These questions and related answers are provided in this Questions & Answers (Q&A) page which will be updated every Tuesday by close of business.

For tracking purposes, the Update Log in Appendix B will indicate new items added or changes made. The most recent questions will include the date added, and be bolded, underlined, and noted as ***“New.”*** Questions that have been updated will be noted as ***“Updated,”*** with updated text as **bolded/underline** and removed text ~~crossed-out~~.

The organization of this Q&A is by major topic, with smaller subcategories as needed to group similar topics together. New questions will generally be displayed at the topic, however some sections may have older question(s) display first if they are flagged as containing foundational or important pieces for that subsection.

For more information, please reference [MEDIL I 23-06](#).

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A. Renewals

1. **Renewals - General Clarifications**

The purpose of this section is to provide policy clarification on Medi-Cal renewals during the continuous coverage unwinding period.

a. **Can counties grant good cause to a member that reports they did not receive their renewal packet timely? (Added 10/17/2023)**

If a Medi-Cal member reports a delay in timely receipt of their packet, such as a delay caused by the postal service or the county is made aware of a printing delay, good cause can be granted.

b. **If the county receives a Covered California application for an individual during their renewal, can the application be used to complete the renewal? (Added 10/09/2023)**

As part of ex parte review during renewal, counties can use all available information on file, including information completed on an application. Since Covered California utilizes the Single Streamlined Application, which is an acceptable application for Medi-Cal, counties may leverage the application to complete the renewal. If additional information is needed based on information provided on the application, counties are to follow existing business processes to determine if any waivers apply and request any additional required information.

c. **Can DHCS clarify policy in ACWDL 22-18 and ACWDL 22-33 – which letters are counties to follow for processing renewals during the unwinding period? (Added 07/18/2023)**

ACWDL 22-33 is the guidance intended for normal business operations outside of the continuous coverage unwinding period and has several changes to renewal processing that differs from current SAWS functionality. During the unwinding period, counties must process cases using guidance in [ACWDL 22-18](#), and existing renewal guidance as outlined in [ACWDLs 14-18](#), [14-22](#), [14-32](#), [14-35](#), [14-38](#), [14-41](#), [16-16](#), [16-18](#), [17-26e](#), [18-16](#), [20-17](#), [20-21](#), and [22-20](#).

Please note that additional responses in this Q&A have been reflected to remove reference to 22-33 to reduce confusion.

- d. Once the Continuous Coverage Unwinding renewal is completed for an individual, are they still protected during the unwinding period? *(Added 07/18/2023)***

Once the continuous coverage redetermination has been completed, the individual is no longer under continuous coverage requirement protections and the county should follow normal case processing guidance and business processes when addressing reported changes in circumstances and annual redeterminations. Please note, there are some flexibilities such as reasonable explanation that are now permanent policy and counties should continue to apply the policy guidance beyond the continuous coverage unwinding.

- e. When any of the federal waivers are leveraged, what can counties indicate in the case narrative? *(Updated 10/31/2023)***

Counties may leverage the following language below in the case narrative when applying various Section 1902 waivers during the unwinding period:

“The *[Name of Flexibility]* waiver was applied while processing the continuous coverage unwinding renewal based on CMS waiver approval under Section 1902(e)(14)(A).”

For flexibilities that are not through Section 1902(e)(14)(A) waivers, counties may use the template below:

“The *[Name of Flexibility]* flexibility was applied while processing the continuous coverage unwinding renewal based on DHCS allowed policies during the continuous coverage unwinding.”

- f. For a MAGI case, in CalHEERS the verification statuses Income, Death and Incarceration needs to be e-verified to push forward without a packet. Are these the same statuses that need to be verified by Non-MAGI cases? *(Added 06/13/2023)***

For Non-MAGI, the county may complete the annual redetermination using the ex parte review during the unwind period, when:

- all available sources of information reflect that the individual remains Medi-Cal eligible; and
- income verification is located electronically or through case files that are open or closed within the last 90-days that reflects the most current

income information known to the county or that verifies a change in income (i.e., verified Social Security increase); and

- there is no information/verification located in the case or available data that shows the beneficiary has had a change that may negatively affect their eligibility such as a change in income/household size.

Please refer to [ACWDL 22-18](#) and [MEDIL 22-28](#) for processing annual renewals for the Continuous Coverage Unwinding Period using ex parte processes.

Counties must initiate an ex parte renewal prior to sending a packet for Non-MAGI cases. This means to utilize the most current reliable available case information and electronic sources of information, such as IEVS/MEDS.

Additionally, per [ACWDL 20-17E](#) the following are verifications that, when e-verified, must be used in Non-MAGI Medi-Cal eligibility determinations:

- Citizenship and Identity Verification
- Immigration Status
- SSN Verification
- Medicare Verification
- Incarceration Verification
- Deceased Verification
- Disability Verification
- Income information obtained through Verify Current Income (VCI) service for the Aged, Blind, and Disabled (ABD) Federal Poverty Level program, to confirm self-attested information.

This e-verification is most common in situations where one or more Non-MAGI members of the household are in a mixed household with MAGI members whose individual eligibility is run through the CalHEERS Business Rules Engine (BRE) or, when a MAGI individual has transitioned to Non-MAGI eligibility but still has relevant e-verified information on file.

g. Can previous renewal documents submitted during the continuous coverage requirement be utilized by counties during the ex parte review process? (Added 06/13/2023)

As part of ex parte review, as described in [ACWDL 22-18](#), counties shall utilize any available information to process the redetermination. This includes review of renewal documents or verifications submitted during the continuous coverage unwinding period to verify for updated contact information or any

other information that may be helpful for the county in completing the redetermination.

h. Can a determination change referral received from CalHEERS through eHit be considered a renewal? (*Updated 09/12/2023*)

Yes, someone completing the annual renewal or reporting a change in circumstance during the renewal period in the Covered California portal constitutes completion of the annual renewal. During the renewal period, there is no functional difference between an individual submitting a reported change in circumstance versus a renewal in CalHEERS as all information must be reviewed and completed. Just like with an annual renewal that is mailed to the county, if information did not e-verify, the county must follow the verification process to complete the annual renewal.

i. Can counties consider good cause if the Medi-Cal member states they did not receive their packet timely? (*Added 06/13/2023*)

Mailing delays, including from the post office or mailing vendor are acceptable reasons for good cause consideration ([22 CCR Section § 50175](#)). If the member was discontinued, the county must rescind the discontinuance if good cause is determined and if needed, provide a reasonable amount of time for the Medi-Cal member to provide any additional information needed to complete the determination.

j. Does retroactive coverage for applications after April 1st fall under protection for continuous coverage if requesting for the months of January, February, or March? (*Added 06/06/2023*)

Yes, for applications made after April 1st requesting retroactive coverage for months under the continuous coverage requirement, they would be protected under the requirement. Per [MEDIL I 22-10](#), these individuals are considered beneficiaries as the month of application is not the deciding factor, but the benefit month. For instance, if the application date was April 20th, but the individual requested retroactive coverage and benefits began March 1, then they would be protected under the continuous coverage requirement.

k. For Non-MAGI cases, what level of narrative is needed when ex parte is successful and a pre-populated renewal packet is not sent? (Added 05/02/2023)

Case narratives for successful Non-MAGI ex parte eligibility determination can mirror MAGI auto-ex parte case narratives in a streamlined journal template. Counties should include additional case narration when the ex parte source used to complete the redetermination is unclear.

l. Do counties have the flexibility to start the manual ex parte process earlier for Non-MAGI Medi-Cal than the existing timeframes to ensure the review can be completed before renewal packets are generated? (Added 05/02/2023)

During the continuous coverage unwinding period, counties may start the manual ex parte process for Non-MAGI Medi-Cal members earlier than the established timeframes of renewal processing to support the county's ability to complete the required procedure.

m. What data elements (income, incarceration, and death) need to be verified for an ex parte Non-MAGI? (Added 05/23/2023)

Please refer to [ACWDL 22-18](#) and [MEDIL 22-28](#) for processing annual renewals for the Continuous Coverage Unwinding Period using ex parte processes.

Counties must initiate an ex parte renewal prior to sending a packet for Non-MAGI cases. This means to utilize the most current reliable available case information and electronic sources of information, such as IEVS/MEDS.

For Non-MAGI, the county may complete the annual redetermination using the ex parte review during the unwind period, when:

- all available sources of information reflect that the individual remains Medi-Cal eligible (this includes deceased and incarceration check); and
- income verification is located electronically or through case files that are open or closed within the last 90-days that reflects the most current income information known to the county or that verifies a change in income (i.e., verified Social Security increase); and
- there is no information/verification located in the case or available data that shows the beneficiary has had a change that may negatively affect their eligibility such as a change in income/household size.

Additionally, per [ACWDL 20-17E](#) the following are verifications that, when e-verified, must be used in Non-MAGI Medi-Cal eligibility determinations:

- Citizenship and Identity Verification
- Immigration Status
- SSN Verification
- Medicare Verification
- Incarceration Verification
- Deceased Verification
- Disability Verification
- Income information obtained through Verify Current Income (VCI) service for the Aged, Blind, and Disabled (ABD) Federal Poverty Level program, to confirm self-attested information.

This e-verification is most common in situations where one or more Non-MAGI members of the household are in a mixed household with MAGI members whose individual eligibility is run through the CalHEERS Business Rules Engine (BRE) or, when a MAGI individual has transitioned to Non-MAGI eligibility but still has relevant e-verified information on file.

n. How should counties complete annual renewals where the renewal date is unknown? *(Added 04/04/2023)*

Please follow guidance as detailed in [ACWDL 22-18](#): For Craig vs Bonta cases received while the continuous coverage requirement was effective that were unprocessed, cases shall be redetermined at the next annual renewal post-continuous coverage requirement using existing processing guidelines outlined in [ACWDL 07-24](#). The first annual renewal month after the continuous coverage requirement shall be based on the month the Medi-Cal member was placed on the exceptions eligible list. For MEDS restoration cases, counties will process these cases based upon the last known redetermination month.

For instances where the above is not applicable and the renewal date is unknown, counties may select an appropriate renewal month based on county discretion in instances when the renewal date is unknown. This information will also be clarified in a forthcoming MEDIL that provides guidance on the restoration cases.

o. Are there any circumstances where counties may complete the annual renewal if there is no change in eligibility for existing household members? *(Added 03/21/2023)*

When counties need to run EDBC with all needed information to complete the annual renewal, counties may complete the annual renewal with no change. For example, when adding a person to a case and there is no change for existing Medi-Cal members, all information is collected to complete the eligibility determination for the applicant. Because the county has collected and verified all information for all household members, the county may complete the annual renewal even in the circumstances where there is no change for existing household members. This may also apply to other situations where all information is collected and EDBC will be ran.

Another example is regarding determining eligibility for a Medicare Savings Program. If an individual ages out of their MAGI based aid code, but the change would result in an equivalent aid code, counties would normally delay processing the change until the annual renewal. However, these individuals would also need to be evaluated for an MSP. As the MSP determination requires all needed information, counties may complete the annual renewal at that time.

p. Can counties effectuate a discontinuance prior to July 1, 2023? (Added 03/21/2023)

Counties may only process a discontinuance prior to July 1, 2023, if the discontinuance is based upon the following circumstances:

- Change in circumstance – if a change in circumstance was reported prior to July 1, 2023, that would result in a positive eligibility result for at least one member of the household, but a negative result for another member of the household, the county may conduct the renewal at that time and not delay finalizing the eligibility even if it results in a discontinuance prior to July 1, 2023.
- Craig v Bonta – due to the processing guidelines for Craig v Bonta referrals, counties may complete the eligibility determination prior to a July 1, 2023, effective date. Counties may effectuate the discontinuance earlier than July 1, 2023, if applicable.

q. SAWS does not currently allow a text or Interactive Voice Response (IVR) signature on the renewal forms. Can counties obtain an e-signature on a recently populated SAWS2Plus with current information, in lieu of the wet signature on renewal packet? (Added 02/28/2023)

Per [ACWDL 19-17E](#), counties may use electronic or telephonic signatures in lieu of wet signatures. In this instance, the SAWS2Plus may be leveraged in lieu of the renewal form signature to capture the signature. The county should clearly document in the case narrative the action taken.

2. Renewals – General Waiver Clarifications

The purpose of this section is to provide general waiver clarifications on Medical renewals during the continuous coverage unwinding period.

a. For the self-attestation waiver in [MEDIL I 23-49E](#), can the self attestation be over the phone, or must it be in writing? *(Added 12/19/2023)*

The self-attestation can be obtained via any acceptable modality such as phone, in-person, electronic means (including fax or e-mail if counties have the ability) and does not need to be in writing.

b. When applying the renewal packet flexibility, do counties need to send the member a Statement of Facts (SOF)/SAWS2Plus after the unwinding renewal is completed? *(Added 12/19/2023)*

When counties utilize the renewal packet flexibility and are able to complete the renewal process without sending or obtaining the completed renewal packet, the county does not need to send the member a Statement of Facts (SOF) unless requested by the member. The NOA to the member will contain the information used to complete the renewal.

c. Can any of the waivers apply to renewals months that are prior to the effective date? *(Added 11/14/2023)*

The waiver effective dates are applicable when the renewal is processed, not based on the renewal month. When processing renewals for months prior to the effective date, counties can leverage any applicable waivers.

d. Do the unwinding waivers apply to those without a Social Security Number (SSN)? *(Added 10/09/2023)*

SSN is not a requirement to be met for any of the unwinding waivers to be applied. If the respective waiver criteria is met, then the unwinding waiver can be applied regardless of whether the individual has an SSN or not.

- e. **Can the renewal packet waiver described in MEDIL I 23-49 be utilized with other waivers, such as the 100% FPL waiver? (Added 10/09/2023)**

The renewal packet waiver can be utilized with other unwinding waivers.

- f. **Can utilization of any of the waivers lead to a negative action (such as discontinuance, moving to a Share-of-Cost)? (Added 09/26/2023)**

These waivers can be utilized when the outcome is either positive or neutral for a Medi-Cal member. Per [ACWDL 22-18](#) and existing policy, an ex parte review cannot lead to a discontinuance and must be verified. If the outcome is negative, then the renewal form and/or verification must be requested in order to determine the action is appropriate and the member has been screened for all appropriate Medi-Cal programs.

- g. **Do the unwinding waivers apply to Craig vs Bonta cases? (Added 09/26/2023)**

Yes, all waivers also apply to Craig vs Bonta cases, when the waiver is applicable and meets the criteria detailed in the respective policy guidance.

3. Renewals – Use of CalFresh/CalWORKs Information

The purpose of this section is to provide clarification on the use of CalFresh and/or CalWORKs information while conducting Medi-Cal renewals during the continuous coverage unwinding period.

- a. **If a verification provided for CalWORKs/CalFresh recertification leads to discontinuance in that program, can that verification be used for Medi-Cal? (Added 01/09/2024)**

If the county is processing Medi-Cal with a CalWORKs/CalFresh recertification with verifications provided, the recertification can be leveraged to process the continuous coverage unwinding Medi-Cal renewal. The recertification can be utilized regardless of the outcome of the CalFresh/CalWORKs eligibility determination. If the CalFresh/CalWORKs recertification would lead to a Medi-Cal discontinuance, the county must assess for consumer protection programs and other Non-MAGI Medi-Cal programs prior to discontinuance.

- b. **CalFresh does not ask about tax filing information, so should counties assume this information hasn't changed when using CalFresh paperwork to complete a Medi-Cal redetermination during the unwinding period? (Added 10/31/2023)**

Correct, if counties are not alerted to any changes in tax filing information, counties may assume the original self-attested information is still accurate to complete any Medi-Cal redeterminations needed.

- c. **Can the newly released CDSS application [CalFresh Elderly Simplified Application](#) (CF 485) be considered a sufficient Statement of Facts for Medi-Cal? (Added 10/31/2023)**

The CF 485 is not considered a sufficient Statement of Facts for Medi-Cal and would not be used to preserve an application date, as it does not have a question that requests Medi-Cal, unlike the CF 285 form. However, information provided on the CF 485 can be used to update case records or as part of the ex parte processing for Medi-Cal applications, annual renewals, or change in circumstance redeterminations for Medi-Cal members following current policies for the unwinding period.

- d. **For situations when the county processing Medi-Cal with CalFresh, the CalFresh program does not ask about tax filing information. Do counties assume it hasn't changed when using paperwork or information reported to perform a Medi-Cal renewal? (Added 10/24/2023)**

Correct, if there is no information or paperwork provided to CalFresh that indicates a change in tax filing status, the county can assume the information has remained the same.

- e. **If the CalFresh application or recertification paperwork is complete and signed, can the worker attempt to e-verify income and complete the Medi-Cal renewal, even though income may still be required to fully complete the CalFresh? (Added 02/21/2023)**

The county should attempt to e-verify the income information in order to complete the Medi-Cal renewal.

- f. **What is the guidance for when a Medi-Cal renewal packet is sent, but then the CalFresh recertification occurs? (Added 02/21/2023)**

Counties may have instances where the Medi-Cal renewal packet was sent but not returned, but the CalFresh recertification occurs. For these instances, counties do not need to receive the renewal packet for Medi-Cal if complete information is obtained during the CalFresh recertification. However, the county

must ensure the proper steps are completed in SAWS to indicate the Medi-Cal renewal packet has been received.

- g. If an individual completes a CalFresh application with a SAWS 1, but their income is e-verified, would that be considered a full redetermination even though no Statement of Facts has been completed for Medi-Cal? (Added 02/21/2023)**

A SAWS 1 is not considered a complete application or recertification for Medi-Cal and would not be considered a full redetermination for Medi-Cal.

- h. What are the paperwork and interview requirements when a county determines Medi-Cal with the CalFresh application or renewal as described above? (Added 02/21/2023)**

Counties can use the CalFresh application or recertification form in lieu of the Statement of Facts in order to complete the Medi-Cal redetermination. The CalFresh interview is not required, as Medi-Cal does not require an interview.

- i. For a CalFresh intake or recertification where a Medi-Cal renewal is processed simultaneously, if the Medi-Cal member fails to provide their verification are counties allowed to discontinue? (Added 02/21/2023)**

If the county processes a Medi-Cal renewal with a CalFresh application or recertification and verification is requested via the MC 355 but not provided, the county may proceed with a discontinuance. Counties must still evaluate for consumer protection programs.

- j. In a dual eligibility CalFresh/Medi-Cal case, if counties are processing the CalFresh renewal or application that occurs before the continuous coverage unwinding renewal, can the Medi-Cal unwinding renewal be processed as well? (Updated 07/06/2023)**

Counties can process the unwinding Medi-Cal Renewal with CalFresh application or recertification when the CalFresh application or recertification is complete, including all verifications. Counties may need to request Medi-Cal specific verifications using the MC 355 in order to complete the renewal. In instances when processing the Medi-Cal renewal with CalFresh would lead to a negative action such as over income and not eligible for any other Medi-Cal program or not providing the Medi-Cal specific verification, the county must assess for consumer protection programs, including 12-month post-partum.

Effective with the release of [MEDIL I 23-40](#), counties may process the Medi-Cal renewal using information on a SARS 7 or an incomplete CalFresh application following the policy guidance in the MEDIL.

4. Renewals - Non-MAGI Screening

The purpose of this section is to provide clarifications on the Non-MAGI screening process during the continuous coverage unwinding period.

- a. If a county determines that a Non-MAGI applicant is eligible under the Aged/Blind/Disabled (ABD) program aid code 1H (either through ex-parte or with the information provided at application), can counties proceed with finalizing the Non-MAGI eligibility without the MC 604 IPS? Or, do counties need to issue the MC 604 IPS and wait for the form to be returned to finalize the Non-MAGI eligibility? *(Added 02/13/24)***

In determining Non-MAGI eligibility for an applicant, if the county's ex parte process using information from the application or reliable data from the case file or available data bases provides all necessary information to determine program eligibility the county should complete the determination without sending the MC 604 IPS.

- b. [ACWDL 17-26](#) includes a Non-MAGI informing letter (cover letter) that is to be used when issuing the required supplemental forms. With the elimination of assets, is there a target date to provide counties with an updated Non-MAGI informing letter (cover letter) that can be used as part of the supplemental forms required for applicants requesting a Non-MAGI eligibility determination? *(Added 01/16/24)***

DHCS will issue future updated policy regarding forms to use for Non-MAGI applications that will replace ACWDL 17-26 and 17-26E. In the interim, counties should use the updated MC 604IPS form and PUB 10 that were provided to CalSAWS that do not have asset information. The current Non-MAGI applicant cover letter in ACWDL 17-26 should not be sent to the applicant as the information is out-of-date. DHCS recommends sending the CW 2200 request for information with the MC 604IPS and the PUB 10.

- c. Once the MC 604 IPS screening packet has been mailed out to client do counties need it completed either telephonically or physically? *(Updated 01/09/2024)***

If the county is **unable** to obtain any missing information via ex parte, **including using a MAGI renewal, CalWORKs/CalFresh renewal, or**

application with current income and deductions information, and then the packet is sent, the screening packet must be signed under penalty of perjury and returned (or completed via any common modality such as telephonically, in person, etc.) to evaluate for Non-MAGI eligibility.

If the Medi-Cal member provides the information requested in the MC 604 IPS over the phone **or through any of the ex parte means listed above**, counties may use telephonic signatures to complete the MC 604 IPS per ACWDL 19-17E. Counties should leverage existing business processes in order to do so.

Asset information and questions are not required to be completed for Medi-Cal members for both the annual renewals and the MC 604 IPS used as part of the Non-MAGI screening packet. [ACWDL 17-26E](#) details the requirement for the screening packet and provides details for possible outcomes.

- d. **If a Medi-Cal member is losing eligibility to MAGI, can the Non-MAGI determination be completed telephonically without sending the MC 604 IPS? (Updated 01/09/2024)**

If all information is located through ex parte, **including using a MAGI renewal, CalWORKs/CalFresh renewal, or application with current income and deductions information** and/or speaking with the individual on the phone, the MC 604 IPS does not need to be sent out and the signature under penalty of perjury is not required, ~~as the form has not been initiated.~~

- e. **What if a Medi-Cal member marks "No" to the review of the full Medi-Cal hierarchy in CalHEERS? Should counties reach out to the customer to confirm before screening for Non-MAGI Medi-Cal when a Medi-Cal member is longer eligible to MAGI Medi-Cal? (Added 05/23/2023)**

Per [ACWDL 17-03](#), counties are required to review for all basis of Medi-Cal eligibility through the Medi-Cal hierarchy. The full hierarchy question in CalHEERS is for review at application, and should not be taken into consideration when a Medi-Cal member is losing MAGI-based eligibility.

- f. **Can counties accept a SAWS2Plus or other form in lieu of the MC 604 IPS? (Added 05/23/2023)**

If a SAWS2Plus or other application form is received, signed under penalty of perjury, and contains all necessary information, that is acceptable in lieu of the MC 604 IPS. However, the SAWS2Plus must not be sent out in lieu of the

screening packet as that requests more information than is required. Please note that counties must also obtain required verifications must also obtained.

g. Will the MC 604 IPS be revised to delete the asset information? (Added 05/09/2023)

All relevant renewal forms have gone through revisions due to the asset waiver and will be available in systems by January 1, 2024.

h. Are there any forms other than the SAWS2Plus or sworn statement that can be used to attest to assets at application? The MC 604 IPS asks property questions but does not include information about balances or account numbers. (Added 05/09/2023)

DHCS agrees that the SAWS2Plus or sworn statement can be used at application to attest to assets. The MC 604 IPS asks property questions but does not ask for balances or account numbers, however if an applicant notes that information on the MC 604 IPS the county must accept it.

r. If counties are able to determine eligibility to Non-MAGI through ex parte, is confirmation needed from the Medi-Cal member that they would like to be Non-MAGI? (Added 05/09/2023)

Per [ACWDL 17-03](#), counties are required to review for all basis of Medi-Cal eligibility through the Medi-Cal hierarchy. [ACWDL 17-35](#) further clarifies unless the Medi-Cal member has clearly indicated they do not want to be evaluated, counties must complete the Non-MAGI screening process to determine if there is linkage to Non-MAGI Medi-Cal. If all information can be found via ex parte, no further confirmation is needed from the Medi-Cal member.

i. Does the Non-MAGI screening packet still need to be sent even if the Medi-Cal member has no linkage to Non-MAGI? (Added 05/09/2023)

[ACWDL 17-26](#) details the scenarios in which a Non-MAGI screening packet must be sent. If there is **no linkage** to Non-MAGI and the Medi-Cal member does not request Non-MAGI or a full eligibility determination (and all other conditions met in ACWDL 17-26), then the Non-MAGI screening packet does not need to be sent.

j. With the asset waiver, are counties still required to send the Non-MAGI Screening packet when a Medi-Cal member is in Soft Pause? (Updated 01/09/23)

County eligibility workers can complete the Non-MAGI screening (604-IPS) using ex parte, **including using a MAGI renewal, CalWORKs/CalFresh renewal, or application with current income and deductions information,** when all information is known to the county in order to complete the Non-MAGI determination. This includes self-attestation and verification (electronic or administrative) of Non-MAGI income sources and deductions. ~~As a reminder, an ex parte review cannot be performed if it would result in a negative action to eligibility such as moving to a share of cost or having an increase in share of cost.~~

B. Changes in Circumstances

The purpose of this section is to provide clarifications on when changes in circumstances are reported during the unwinding period, either prior to, during, or after the renewal process.

1. Changes in Circumstances – General Clarifications

- a. For individuals that are turning 65 and aging out, and now have Medicare entitlement, should counties conduct a reevaluation and evaluate for Medicare Savings Programs (MSP)? (Added 03/21/2023)**

To clarify, [ACWDL 22-18](#) instructs counties to follow guidance in the letter under the "Reported Change in Circumstances" section of the letter for individuals aging out. Depending on the action taken, whether to process the change in circumstance or wait until the regularly scheduled annual renewal, counties must complete a full evaluation of the Medi-Cal hierarchy per [ACWDL 17-03](#), which includes Medicare Savings Programs.

- b. For a MAGI individual who reports a change in circumstances for income, if all information returns as e-verified, does this count as a full redetermination since the case e-verified, or do the counties still need to get the renewal packet or conduct an annual renewal? (Added 02/21/2023)**

Counties should follow change in circumstance guidance detailed in [ACWDL 22-18](#) for instances when an individual reports a change with updated information. The action that the county takes will depend on whether the change is positive, no change/neutral, or negative as detailed in the letter. If the change is positive and all information e-verifies, then this would be considered a complete renewal.

- c. What is the recommended timeline for the two reminder contacts when sending the renewal packet for a positive change in circumstance? (Added 02/14/2023)**

Counties are still required to complete the two-contact requirement when the change in circumstance renewal packet is sent. DHCS recommends that this additional contact should occur ten calendar days from the date of the initial reminder contact and no later than ten calendar days prior to the annual renewal form due date.

- d. If counties process renewal based on a positive change in circumstance, the renewal date is reset to the following year. Would that reset be to the preset renewal due date, or based on the month the county is processing the renewal? For example, renewal is processed due to a positive change in May 2023, but the original renewal due date is August 2023. Would counties be resetting to May 2024 or August 2024? (Added 02/14/2023)**

Counties would reset the next renewal 12 months following the completed renewal as outlined in [ACWDL 14-22](#). In the example provided, the next renewal would be in May 2024.

- e. For the additional contact for change in circumstance that requires a full redetermination, could a county use the reminder notice as one contact 15 days after renewal form was sent and a phone call for the additional contact at 10-day notice cut off? Or must the reminder notice be sent out twice? (Added 02/14/2023)**

The county can utilize multiple modalities to complete the two-contact reminder as long as the county completes and documents in the case file the two contacts.

- f. When an individual is reported out of state or deceased are counties to continue to follow the current guidance and discontinue the individual, even if it results in a negative household change? (Added 02/14/2023)**

Counties may still process allowable discontinuances under [ACWDL 22-18](#) and [21-16](#) during the continuous coverage unwinding. However, counties must follow ACWDL 22-18, "Change in Circumstances reported During the PHE Unwinding Period" guidance depending on if the outcome for the other individuals in the household will be positive, negative, or no change.

- g. If a renewal packet is mailed at change of circumstance, does the renewal month need to be adjusted to align with the due date to support automated discontinuance and reminder notice functionality? (Added 02/14/2023)**

Counties should not adjust the renewal date in SAWS when processing the change in circumstance until after the renewal is completed. Once the change in circumstance renewal is complete, counties shall follow the guidance in ACWDL [14-22](#) for setting the renewal date.

- h. If counties are completing the annual renewal early due to the reported change, do they also need to send the annual informing notices? Some counties' informing notices are sent in a packet with the pre-populated renewal form. (Added 02/14/2023)**

Yes, the annual informing notices should also be sent if the annual renewal is completed early.

- i. For a change in circumstance that leads to a positive result, please clarify if the "completed" annual renewal has to occur during the unwinding period, or if it can happen within the last 12 months prior to the unwinding period and still be considered "completed annual renewal?" (Added 02/14/2023)**

As per ACWDL 22-18, if an annual renewal was completed (through auto ex parte or manual processing) in the last 12 months, counties should follow the normal change in circumstances processing which would not require the full redetermination process prior to applying the change. If an annual renewal was not completed (this would include instances when the renewal date was systematically changed), counties will need to complete a full redetermination as outlined in the "Annual Redeterminations" section of ACWDL [22-18](#) when the positive change is reported and not delay processing until the Medi-Cal member's scheduled annual renewal.

- j. How should counties handle cases where a change in circumstance is reported for individuals who have aged out of their aid code (e.g., a 66-year-old client who is on M1 due to continuous coverage requirement, or Adoption Assistance program child aging out)? (Added 02/14/2023)**

Per [ACWDL 22-18](#), during the continuous coverage unwinding period, counties shall follow the "Reported Change in Circumstances" policy when a Medi-Cal

member has a change in age which normally requires a redetermination such as a child turning 19 or an adult turning 65. This includes individuals aging out of foster care and the Adoption Assistance Program.

- k. For the Aged, Blind or Disabled (ABD) Federal Poverty Level (FPL) Medi-Cal members who are pending the application of the 2023 Cost of Living Adjustment (COLA) until the 2023 Federal Poverty Levels are updated in SAWS: If SAWS runs the batch on or after April 1 and an individual is found to be no longer be eligible to Medi-Cal, or is switching to a Medically Needy program with share-of-cost (SOC), are the negative actions allowed? Or should they the negative action be paused until the ABD individual's renewal month? (Added 02/07/2023)**

Medi-Cal cases that have not yet had a renewal during the Unwinding period should only be processed if the COLA would lead to a positive change for at least one member of the household. Otherwise, the updated information should not be processed until the individual's scheduled annual renewal. If the individual has already had their renewal during the Unwinding, then the county may process the change due to the updated COLA per normal business operations.

- l. If a renewal packet is sent out in 04/2023 and in 05/2023 the county has not yet received that paperwork, but the county does receive newly reported income- can the county consider this a change in circumstance and process it without the renewal paperwork that was sent in 04/23? (Added 02/07/2023)**

Once the renewal packet is mailed to the Medi-Cal member, it must be completed in person, by phone, through the mail, or online.

- m. If someone is reported as incarcerated and counties are suspending the record, is that a change in circumstance that the county can push the redetermination date for? (Added 02/07/2023)**

Suspending a Medi-Cal member in MEDS would not constitute a full annual renewal or a change in circumstance and therefore the renewal date should remain. Although incarceration is considered a change in circumstance for the individual because they are residing in a public institution and their benefits are going to be suspended, it is not a change that requires a redetermination because neither of those changes would affect ongoing eligibility for Medi-Cal. Thus, incarceration change in circumstance alone does not require a change in

circumstance redetermination. The county should continue to suspend eligibility for the incarcerated member following the same guidance provided in ACWDL [22-21](#), [22-26](#), and [MEDIL I 20-11](#) and [22-40](#).

n. Should the county complete the full redetermination early if the individual is placed in a Burman hold? (Added 02/07/2023)

The existence of a Burman hold does not modify the counties case processing actions during the unwinding period. The Burman hold will be removed once the county completes the full annual renewal during the unwinding period. If counties encounter issues in MEDS that are causing access to care barriers, please notice DHCS immediately for technical support.

o. When is renewal paperwork required for a change in circumstance redetermination? (Added 02/07/2023)

If the reported change is positive for at least one member of the case, then the county would conduct the annual renewal for the entire household at that time as detailed in [ACWDL 22-18](#). The county must follow the entire annual renewal processing steps to complete the redetermination. Medi-Cal members will have 30-days to return the renewal packet and counties must send the required reminders, if necessary.

p. If a change in circumstance is completed prior to the cases' unwinding period (for example, a beneficial change found for one household member), does it count as the "unwinding" renewal and any changes thereafter will be treated under normal processing standards? (Added 02/07/2023)

Per [ACWDL 22-18](#), if a continuous coverage annual renewal was not completed, counties will need to complete a full redetermination as outlined in the "Annual Redeterminations" section of the letter when the positive change is reported and not delay processing until the Medi-Cal member's scheduled annual renewal. This will be considered the required unwinding renewal and any changes reported thereafter should follow normal processing standards.

q. For CalWORKs and Medi-Cal households who have their annual redetermination due in April, if the household is being terminated due to income and they do not qualify to Transitional Medi-Cal (only or last child aged out), is the termination of Medi-Cal acceptable? (Added 02/07/2023)

Households with an annual redetermination due in April will not have their renewal completed until April 2024. At that time period, counties must follow all annual renewal activities to determine ongoing eligibility.

2. Changes in Circumstances –Hard-to-Reach Population Waiver

The purpose of this section is to provide policy clarification on the changes in circumstances redeterminations for hard-to-reach population waiver described in MEDIL I 23-40 during the continuous coverage unwinding period.

- a. For the Hard-to-Reach population, are counties required to talk to the member and ask if all their information remain the same such as still the same income, same address, etc.? Or can the counties just apply the waiver if there was any contact without asking any questions related to Medi-Cal? (Added 10/17/2023)**

The waiver can be applied if there was any contact with the county and the criteria of the waiver is met, i.e. if the county receives information about a change in a beneficiary's circumstances and it has enough information available to renew eligibility with respect to all eligibility criteria or the beneficiary voluntarily provides needed information (e.g., an attestation of income).

- b. A lot of our homeless population utilize general delivery as a mailing address and we have found that much of the mail we send to them comes back as returned. We have no indication that they are no longer in the county. Are there any flexibilities that we can utilize so that we can avoid discontinuing this hard-to-reach population due to returned mail? (Added 10/17/2023)**

First, during the continuous coverage unwinding process, the county should follow processes detailed in [ACWDL 22-09](#), [MEDIL I 23-11e](#), and [MEDIL I 23-45](#). In addition to these processes, prior to discontinuing an individual for returned mail, the county should review for any possible waivers that could be applied. For example:

- Has the individual reached out recently and made contact with the county to leverage the hard-to-reach population waiver?
- Does the individual's income meet any of the applicable income waivers?

Additionally, as a best practices counties are encouraged to engage with local community partners that serve populations experiencing homelessness to better access the population, and health enrollment navigators in county communities.

- c. For processing reported changes as a result of the Hard-to-Reach Population waiver for Medi-Cal, does that include SAR7's that may not have had the renewal dates aligned between CalFresh and Medi-Cal? (Added 10/17/2023)**

Correct, a SAR 7 example is included in [MEDIL I 23-40](#). The renewal dates do not need to be aligned between the two programs to leverage a SAR 7 for the waiver.

- d. When contact is made with a hard-to-reach individual and the county is processing the change in circumstance eligibility redetermination, if the beneficiary has not completed an annual renewal in the last 12 months, are counties required to complete an annual renewal packet, or can counties continue processing the change in circumstance eligibility redetermination as long as the required information was verified and the change is positive or neutral? (Added 09/26/2023)**

For the hard-to-reach waiver, a subsequent renewal is not needed to be completed to utilize this waiver when the change is neutral or positive. The county can complete the change in circumstance redetermination and move the renewal date ahead 12 months.

- e. For the waiver regarding conducting changes in circumstances for hard-to-reach populations, [MEDIL I 23-40](#) provides examples for CalFresh. Can this waiver be used if information is collected for the CalWORKS program, or General Assistance/General Relief (GA/GR)? (Added 08/01/2023)**

The waiver allows for counties to use CalWORKS as well as GA/GR information to conduct a change in circumstance as long as the criteria is met as outlined in [MEDIL I 23-40](#).

C. Verification

The purpose of this section is to provide policy clarification on various verification processes during the continuous coverage unwinding period.

1. Income Verification

a. General Income Verification

The purpose of this section is to provide policy clarification on income verification policy during the continuous coverage unwinding period.

- i. For the following scenario, can DHCS please clarify if proof of income must be requested? A Medi-Cal renewal is received, and the Medi-Cal member reports income over MAGI limit. The county calls to confirm income with the Medi-Cal member and the member has no linkage to Non-MAGI. Can counties move forward with discontinuing the MAGI and transition the individual to Covered CA without proof of income? (Added 05/09/2023)**

In this instance, the county has confirmed the self-attestation with the Medi-Cal member and they are no longer within the Medi-Cal limits and have no eligibility for any other Medi-Cal programs, including Consumer Protection Programs. The county may update the case record with the increased income and evaluate the individual for other coverage with Covered California per [ACWDL 14-18](#).

b. Reasonable Explanation

The purpose of this section is to provide policy clarification on the reasonable explanation policy during the continuous coverage unwinding period.

- i. With reasonable explanation is there a limit to what is considered reasonable? (Added 02/28/2023)**

The explanations listed in [ACWDL 22-22](#) that are considered reasonable causes for discrepancies between self-attested income and the federal data service hub are not intended to be exhaustive. CEWs may receive explanations that are not already included in ACWDL 22-22 or form DHCS 7103. While reasonable explanations when provided may vary, CEWs must evaluate each explanation provided to determine whether it resolves or explains the income discrepancy. CEWs must ensure that case narratives describe the reasonable explanation that was provided, whether the reasonable explanation resolved the discrepancy, and if not, steps taken to clear up the discrepancy.

- ii. In looking at the reasonable explanation request form DHCS 7103, the form states: "We could not verify the income that was reported to Medi-Cal for..." Will there be a space for the worker to describe the discrepancy? The form also lists potential non-financial**

discrepancies. Additionally, the options for getting this information to the county lists Covered CA and BenefitsCal, will CalWIN also be an option? (Added 02/28/2023)

The DHCS 7103 form is not intended to be utilized as an independent form for requesting information and must be sent with the appropriate request for information form. County eligibility workers can utilize the request for information form to enter a complete description of what the county is requesting from the applicant or Medi-Cal member.

All reasonable explanation examples listed in DHCS 7103 are directly related to why income may not be found reasonably compatible. For example, an applicant who has been displaced by a natural disaster or claims homelessness, may experience hardships which can in turn inhibit the applicant's ability to file a tax return in a timely manner, which can potentially affect whether the self-attested income information can be found reasonably compatible.

Lastly, when an individual goes to BenefitsCal site, it will redirect the individual to the appropriate online portal, where they can submit the necessary information being requested.

iii. If a Medi-Cal member is reporting a change in circumstance that could lead to a negative change in benefits, the reasonable explanation cannot be processed and renewal cannot be pushed forward? (Added 02/28/2023)

Correct. Any change in circumstance reported during the continuous coverage requirement period and the subsequent continuous coverage unwinding period that could lead to a negative action shall be paused, until the Medi-Cal member's annual redetermination is initiated, as determined by their redetermination date on their Medi-Cal case record. This is true even when a reasonable explanation has been obtained when the change is not reasonably compatible with data obtained through electronic data source(s). CEWs can refer to [ACWDL 22-18](#) when:

- The change in circumstance results in a positive change, or
- When there is a change that is positive for some household members and cause a negative action for other household members.

Additionally, CEWs must return to normal change in circumstances processing procedures outlined in [ACWDL 14-18](#) once a post-continuous coverage unwinding redetermination is completed.

- iv. **Is new employment not an allowable reasonable explanation when there is no reported previous employment? Would manual verification or documentation always be required for new employment? (Added 02/28/2023)**

Individuals who report new income with no previous employment information on file at application, change in circumstance or at renewal, would not be considered as an acceptable reasonable explanation. In these instances, CEWs must request manual verification.

- v. **Can you confirm reasonable explanation is not allowed for a reported increase in income, correct? How does reasonable explanation work for fluctuating income? (Added 02/28/2023)**

Income is considered to be “fluctuating” when the continuing income amount is different from month to month (which may include an increase), or starts and stops ([ACWDL 21-04](#)). Alternatively, Medi-Cal members that provide an explanation that they recently received a raise or an increase in income, is not considered to be “fluctuating income,” if the Medi-Cal member does not expect the increase to be different month to month or anticipates the increase to end. Medi-Cal members that report an “increase of income” would be an acceptable reasonable explanation if the employment is consistent with current information on file.

- vi. **Can reasonable explanation be used if income cannot go through the federal hub because there is no Social Security Number on file? (Added 02/28/2023)**

Individuals who are unable to be electronically verified through the federal data services hub or through other electronic sources such as individuals without a social security number on file are unable to have a reasonable compatibility check and therefore a reasonable explanation may not be used.

- vii. **[ACWDL 22-22](#) appeared to read for only applications and renewals for reasonable explanation. Can reasonable explanation also be leveraged for changes in circumstances? (Added 02/28/2023)**

The intent of reasonable explanation is to help the county eligibility worker (CEW) in the verification process by assisting to reconcile a discrepancy in an efficient and streamlined manner. While reasonable explanation can be used for a change in circumstance, DHCS understands that it will be limited in instances.

Counties are not expected to obtain a signature under penalty of perjury for either the change in circumstance or the reasonable explanation, and can renew eligibility without requiring any additional information. County eligibility workers must ensure that case narratives describe the reasonable explanation that was provided, whether the reasonable explanation resolved the discrepancy, and if not, steps taken to clear up the discrepancy. This is to ensure there is clear documentation of how the discrepancy was verified, including for auditing purposes. The case narrative template has been provided in [ACWDL 22-22](#).

viii. What if the Medi-Cal member does not provide their renewal packet? If the renewal packet is never returned but the Medi-Cal member provides the statement of reasonable explanation, can the renewal be processed if income was the only verification needed? (Added 02/21/2023)

A reasonable explanation alone without the Medi-Cal member completing the annual renewal paperwork, does not suffice in completing the annual renewal process. However, the county should attempt to complete the annual renewal telephonically or in person when appropriate to assist the Medi-Cal member in completing the annual renewal.

ix. What is the difference between a written statement for a reasonable explanation versus an affidavit signed under penalty of perjury? (Added 02/21/2023)

An affidavit is the method of last resort by which the applicant or Medi-Cal member agrees under penalty of perjury that their self-attested information given is in fact true, after all means of attempting to collect verification, including a reasonable explanation, has been done by the county, applicant, or Medi-Cal member. This could be used to verify a specific dollar amount such as someone who is paid cash.

A reasonable explanation explains why the self-attested income amount does not match what was found in electronic sources. It is used only to verify the self-attested amount.

- x. **Is a written statement required when an explanation is needed, or can the reasonable explanation be obtained verbally? (Added 02/21/2023)**

Per [ACWDL 22-22](#), counties must accept the reasonable explanation provided by the applicant or Medi-Cal member through any allowable pathway including in person, telephonically, through accessible electronic methods, mail, and fax. Reasonable explanations are not required to be signed under penalty of perjury and can be a verbal statement.

c. **Verify Current Income (VCI)**

The purpose of this section is to provide policy clarification during the continuous coverage unwinding period for the policy surrounding the Verify Current Income (VCI) service used during electronic verification.

- i. **If counties send a verification request because income is not reasonably compatible and there is VCI data on file, should the county include the specific employer in the income verification request? (Added 05/16/2023)**

When income is not reasonably countable, the county should request for all income that effect the individual(s) who are not reasonably compatible. As a recommended business process, the CEW could include the VCI employer information on the request to assist the Medi-Cal member in providing the necessary information.

- ii. **In [MEDIL I 23-21](#), the following statement reads: "Electronic verification is not successful via CalHEERS during the Continuous Coverage unwinding period ex parte renewal process and the county has not received any conflicting income information from other sources in accordance with the MAGI-based eligibility verification plan" does "conflicting income information from other sources" include Verify Current Income (VCI) response? (Added 05/09/2023)**

Correct, VCI would be included as a source in instances where income was not electronically verified and the county has conflicting information from other sources.

- iii. **If income is considered reasonably compatible during the renewal and VCI data is received, do counties leave the self-attested income in the system and do not replace it with VCI information if it differs? (Added 05/09/2023)**

Correct, in this instance reasonable compatibility success is supporting self-attestation as per [ACWDL 21-04](#) and [ACWDL 22-08](#). The income is considered e-verified regardless of the VCI amount and no further verification is required.

d. Income Verification Waivers

The purpose of this section is to provide policy clarification during the continuous coverage unwinding period for the policy surrounding various income verification waivers available during the continuous coverage unwinding.

i. *NEW* Does the stable income waiver apply to Foster Care, KinGap and AAP programs? (Added 04/18/2024)

The Stable Income Waiver does not apply to Foster Care, KinGAP, and AAP programs due to Medi-Cal being categorically eligible. The waiver would only apply once the youth was out of placement. If the individual is found ineligible for these programs at renewal, the Medi-Cal program will be reevaluated using ex parte and the stable income waiver (if there is any income reported on file), or any other available waiver to ensure individual is continued eligible for Medi-Cal coverage.

ii. Can the income waivers be used on a reported change in circumstance after the continuous coverage unwinding renewal is completed? (Added 11/14/2023)

At this time, the federal approvals for the zero income, 100% FPL, and stable income waivers are for renewals completed during the continuous coverage unwinding. Once the unwinding renewal is complete, counties are to follow guidance in [ACWDL 22-18](#) and return to normal business operations.

DHCS will provide updated guidance if any waivers are approved on a permanent basis, or outside of the unwinding renewal.

iii. Can the stable income waiver be applied for Spousal Impoverishment cases? (Added 11/07/2023)

No, the Stable Income Waiver should not be applied to cases involving Spousal Impoverishment provisions, as the cases require a careful review of the spousal income allocation and the impact on the eligibility of both spouses. The LTC/HCBS Spouse and the Community Spouse may request an adjustment in

the spousal income allocation in order to allow for the most beneficial eligibility outcomes.

iv. Is In-Kind Income considered a stable income source? (Added 10/24/2023)

In-Kind Income is considered a stable income source and was included in the SAWS stable income automation.

v. If counties identify a case that has increased income or an income change after an ex parte renewal is completed, how should the county process? (Added 10/17/2023)

For instances where the county identifies changes in income after the ex parte renewal was completed, the county would treat this as a change in circumstance redetermination and take action accordingly when the discovery is made.

vi. For the stable income waiver, if the renewal packet has been provided and the only income reported is stable income, can the waiver be used if the client currently has a share of cost? (Added 10/17/2023)

The stable income waiver cannot be used if the member has a Share-of-Cost with the exception of LTC cases. Additionally, the waiver cannot be used to increase a Share-of-Cost and verification must be obtained prior to doing so.

vii. For stable income waiver, if the income on file is not verified and the renewal packet is sent but the stable income reported is over income limits- can the waiver be applied and a negative action be taken for being over income? (Added 10/17/2023)

The waiver cannot be applied if it will lead to a negative action. In those instances, the county must request verification to confirm the change.

viii. Does the stable income waiver only apply when it continues existing eligibility? For example, if the client goes from no SOC to SOC, would documentary verification be required? (Added 10/03/2023)

Correct, the waivers should only be applied to neutral or positive changes. Per [ACWDL 22-18](#) and existing policy, an ex parte review cannot lead to a discontinuance and must be verified. If the outcome is negative, then the renewal form and/or verification must be requested in order to determine the

action is appropriate and the member has been screened for all appropriate Medi-Cal programs.

- ix. **Regarding the stable income waiver in [MEDIL I 23-42](#) – these types of income often receive Cost of Living Adjustments (COLAs). Are counties okay to authorize without having that COLA information? (Added 10/03/2023)**

Correct - counties are permitted to authorize the stable income waiver without COLA information. This information is expected to be updated during the next renewal following the end of the continuous coverage unwinding period.

- x. **Regarding the 100% FPL Waiver described in [MEDIL I 23-40](#): Is this at the individual level or household-level? (Added 08/15/2023)**

As a reminder, per [ACWDL 16-16](#), Medi-Cal eligibility is conducted at the individual-level basis. However, an individual's countable income may include others in the household, depending on the household composition. Counties should follow existing guidance on determining household composition and income counting (depending on program eligibility) for applying the 100% FPL waiver.

Example 1: A married couple living in the home together have MAGI eligibility and are due for their 2023 continuous coverage unwinding renewal. One spouse has income at \$1400/month and the other does not, and there is no contradictory information on file. Using the [MAGI Medi-Cal Household Composition Chart](#) and [Whose Income Counts Chart](#), the household is 2 individuals and their income counts for one another. The 2023 FPL limit is 1644 for two individuals. Since the total countable income for both individuals is 1400, the county can apply the 100% FPL waiver.

- xi. **[MEDIL I 23-21E](#) (Zero Income Waiver) allows for counties to waive the return of a renewal packet for unsheltered individuals, if the criteria detailed in the guidance is met. Does this also apply to the 100% FPL Waiver detailed in [MEDIL I 23-40](#)? (Added 07/18/2023)**

Yes, this is also allowable for the 100% FPL Waiver, as the intent is to closely mirror the Zero Income Waiver guidance.

2. [Property/Assets/Resources Verification](#)

The purpose of this section is to provide policy clarification during the continuous coverage unwinding period for the verification of property, assets, and/or resources

a. Property/Asset/Resource Verification General Guidance

The purpose of this section is to provide general policy clarification during the continuous coverage unwinding period for the verification of property, assets, and/or resources.

- i. If a Medi-Cal member's prior information in the case file had property over the limit, but the case was protected from a negative action due to the continuous coverage requirement, what action should counties take with the property amounts at renewal? (Added 04/18/2023)**

In instances when making changes to the property record would not impact CalWORKS or CalFresh, the record can be end dated. The county eligibility worker must use the standard waiver language provided by DHCS in the case file. If end-dating the property record would affect another social service program, the county eligibility worker cannot let the property negatively impact Medi-Cal eligibility and would need to ensure correct eligibility was finalized which may require a system override.

b. Asset Verification Program (AVP)

The purpose of this section is to provide policy clarification during the continuous coverage unwinding period for the Asset Verification Program (AVP).

- i. The Asset Verification Program (AVP) policy indicates when a complete attestation of property or assets is required. What is considered a "partial" attestation? (Added 03/14/2023)**

A partial attestation is when a client does not provide the minimum necessary information for or an attestation of not owning one or more of the asset types listed in [MEDIL I 22-49](#).

Example 1: A client attests to owning a Wells Fargo checking account valued at \$2,000, but there is no attestation on record for non-exempt jewelry.

Example 2: A client attests to owning a Bank of America checking account valued at \$5,000, but indicates they do not know if they own any other assets.

As a reminder, attestation must include a specified value (along with the other minimum necessary information for the asset type) or a stated absence of ownership, but the information must be on record. Statements indicating uncertainty (e.g., "I don't know/unknown") do not count as attestation.

- ii. **Counties may struggle with the wording of "complete attestation," because when a client provides an attestation the worker would not be able to determine whether it is complete or not without the context of an AVP report. Can DHCS please clarify? (Added 03/14/2023)**

Determining whether an attestation is complete is entirely separate from the AVP reports. This is because DHCS realizes that not all countable asset types will be returned by the AVP report. When determining the completeness of an attestation, please refer to [MEDIL I 22-49](#) and not the AVP reports.

- iii. **SAWS adds the AVP reports for annual renewal more than 30 days ahead of the renewal month. If there is no AVP report available at the time the renewal is processed, can the renewal be processed under the timeliness waiver? (Added 03/14/2023)**

Per page 3 of [MEDIL I 22-20E](#), the 30-day count for annual renewals begins on the 5th of each month, not when counties begin processing the case. The timeliness waiver would only apply if over 30 days have passed between the 5th of the month and the AVP data being loaded into CalSAWS. As a reminder, DHCS notifies counties when the timeliness standard has passed and which files/batches are affected.

- iv. **For the following scenario, is the attestation considered partial: An individual reports assets in a checking and savings account, and the AVP report returns those same accounts with higher amounts (but reasonable compatible). The individual did not indicate whether they own any other assets. Is this attestation is considered partial? In a situation like this, would it be appropriate to contact the individual and get a verbal attestation of the missing information to make it a complete attestation? (Added 03/14/2023)**

In this scenario, the attestation is considered partial since the individual did not affirmatively state that they did not own any other assets. In this situation, it is appropriate for CEWs to contact the individual and get a verbal attestation of the missing information to make the attestation complete.

v. If counties request administrative/manual verification at the same time as an attestation, could that be considered over-requesting? (Added 03/14/2023)

In order to save time during the eligibility determination process, administrative verification should not be requested at the same time as attestation unless the case involves trusts, annuities, or Spousal Impoverishment. See [ACWDL 22-13E](#), page 4, Reminders on Attestation: "Attested information cannot be accepted for trusts (including special needs trusts), annuities, and Spousal Impoverishment (SI) cases. For these scenarios, CEWs must continue to obtain administrative verification and follow standard eligibility approval procedures."

vi. Can DHCS please clarify the 20-day timeliness standard at application? Per MEDIL 22-20E, no further verification required. Does this apply to applications when AVP is being leveraged? (Added 03/14/2023)

Unfortunately, the Section 1902(e)(14)(A) waiver flexibilities do not extend to applications, so administrative verification must still be requested if the AVP reports are not received within the 20-day timeliness standard. The waiver flexibilities, at this time, only apply to changes in circumstances and renewals. As for applications, DHCS discussed this matter internally and agreed that while the 20-day count applies for timeliness, CMS did not issue a formal approval to exempt administrative verification at this stage. (For reference, the CMS-approved waiver strategy is called "Facilitating Renewal for Individuals with no Asset Verification Program Data Returned within a Reasonable Timeframe," and specifically refers to changes in circumstances and renewal.)

c. Asset Waiver

The purpose of this section is to provide general policy clarification during the continuous coverage unwinding period for the verification of property, assets, and/or resources.

i. Do counties still count property for the Community Spousal Resource Allowance (CSRA)? (Added 05/16/2023)

The temporary waiver in regards to the verification of property only applies at renewal and/or whenever there is a change in circumstance. If either an institutionalized spouse or an HCBS spouse are applicants, then the CSRA is verified during the application process. The CSRA is evaluated for the month of admission to a LTC facility or the month in which Medi-Cal is requested for inpatient care. If a case has a couple that consists of a community spouse and Home and Community Based Services (HCBS) spouse, then CEWs would obtain property verification for the CSRA for the month in which HCBS or In-Home Support Services (IHSS) is requested and there is a needs assessment or a signed and dated MC 604 MDV indicating that the HCBS spouse was at nursing facility level of care for the month of request.

ii. Are the resource/asset questions required to be completed on the pre-populated renewal forms in order for the renewal to be completed? (Added 05/02/2023)

Due to the asset waiver, Medi-Cal members are not required to complete the asset/property section of the annual renewal and the renewal cannot be returned to the Medi-Cal member for the asset/property section being incomplete.

iii. When a Medi-Cal member is admitted to LTC mid-year (not associated to the renewal), does the Non-MAGI asset waiver apply? (Added 05/02/2023)

Per [MEDIL I 23-29](#), counties can complete a redetermination of Medi-Cal eligibility without requesting verification for Non-MAGI at annual renewal or reported change in circumstance, including LTC admission mid-year.

iv. Does the asset waiver apply to Home and Community-Based Services (HCBS) Spousal Impoverishment Upon Request Program? (Added 05/02/2023)

Per [MEDIL I 23-29](#), the asset waiver applies to all Non-MAGI Medi-Cal members, including the HCBS Spousal Impoverishment Upon Request Program.

- v. Can DHCS provide a language for counties to leverage regarding assets and the asset waiver when the continuous coverage unwinding renewal is completed? (Added 04/18/2023)**

When documenting in the case narrative relating to assets, counties should use the following statement:

“Assets waived when processing the continuous coverage unwinding renewal based on CMS asset waiver approval under Section 1902(e)(14)(A).”

- vi. For the asset waiver flexibilities, are counties able to use the data for 2022 to complete the renewal process if that is the only data available? (Added 04/18/2023)**

Per [MEDIL I 23-19](#), "CEWs must redetermine eligibility using available property information already in the case file or from their last eligibility determination." If no new AVP report is available, the existing AVP report from 2022 can be leveraged as part of the waiver. Additionally, CEWs must document the use of the asset waiver in SAWS narratives.

- vii. Does the asset waiver apply to all Non-MAGI programs, or only those subject to AVP? Also, are there any scenarios where asset verification is still required at renewal? (Added 04/18/2023)**

The asset waiver applies to all Non-MAGI Medi-Cal programs with an asset test (even those that are not subject to AVP). There is no time asset information is required as part of the unwinding annual renewal.

- viii. Does the new asset waiver apply to Craig vs. Bonta cases? (Added 04/11/2023)**

Per [MEDIL I 23-29](#), the asset waiver applies to all Non-MAGI Medi-Cal members, including Craig vs. Bonta.

- ix. How does the asset waiver apply to add person requests, where an application is requesting aid on a Medi-Cal members' case? (Added 04/11/2023)**

The newly added person would be considered an applicant and existing asset rules would apply. However, the county must not take any negative

action on existing Medi-Cal members based on failure to provide asset verifications or being over the asset limit.

- x. **Does the asset waiver apply in situations where in the household, all members are MAGI eligible but one spouse goes into LTC? (Added 04/11/2023)**

Per [MEDIL I 23-29](#), the property waiver flexibility applies to all Non-MAGI programs, including when a spouse goes into LTC. It is important to note that the county will still need to assess for Spousal Impoverishment in regards to income when a spouse transitions into LTC.

- xi. **In regards to the asset waiver for Medi-Cal members during the continuous coverage unwinding period, how should counties handle MAGI Medi-Cal members going into Non-MAGI? (Added 04/11/2023)**

The property waiver flexibility applies to Medi-Cal members that are moving from MAGI Medi-Cal to Non-MAGI Medi-Cal. The county would not be required to request property information. Additionally, counties must still request an AVP data report and must document this step, including the use of the asset waiver in SAWS narratives.

3. Citizenship/Immigration Verification

The purpose of this section is to provide policy clarification during the continuous coverage unwinding period for the verification of citizenship and immigration statuses.

- a. **Is the MC 13 form (*Statement of Citizenship, Alienage, and Immigration Status*) a required form during the Continuous Coverage Unwinding? (Added 07/18/2023)**

No. All County Welfare Directors Letter [17-01](#) provides guidance on proper use of the MC 13. Based on that guidance, the MC 13 is no longer a required form for United States citizens or nationals, or those claiming satisfactory immigration status for Medi-Cal eligibility purposes, (with the exception of those who claim the last Permanently Residing Under Color of Law (PRUCOL) category on the MC 13).

Counties must not require that the MC 13 be completed as a condition of eligibility during the unwinding or at any other time. Counties also must not re-verify immigration status at redetermination unless there is a change in

status which requires verification. Counties may utilize the MC 13 when the county is unable to determine, from the individual's application or verbal statement, if the individual is claiming citizenship/satisfactory immigration status.

4. Other Unwinding Waivers

a. Unconditionally Available Income Waiver

The purpose of this section is to provide policy clarification during the continuous coverage unwinding period for the Unconditionally Available Income process waiver described in [MEDIL I 23-43](#).

i. Regarding MEDIL I 23-43, will members still be required to agree to cooperate with unconditionally available income at application? (Added 10/17/2023)

Under the unconditionally available income waiver, members do not have to cooperate with applying for unconditionally available income. As a best practice, counties should still alert individuals if they may have income available.

b. Medi-Cal Support Enforcement Process Waiver

The purpose of this section is to provide policy clarification during the continuous coverage unwinding period for the Medical Support Enforcement process waiver described in [MEDIL I 23-44](#).

ii. Regarding MEDIL I 23-44, are counties expected to send out the CW 2.1 form for medical support enforcement at application but not required to follow-up on them? (Added 09/26/2023)

To clarify, the entire process of medical support enforcement is waived. Counties are not required to screen for medical support enforcement, send the CW 2.1 at application, or follow-up on compliance with the form after benefit approval.

D. Other Case Processing

The purpose of this section is to provide policy clarification on various case processing actions that may occur for a Medi-Cal case during the continuous coverage unwinding period.

1. Adding and Removing an Individual

The purpose of this section is to provide policy clarification on adding or removing an individual for the renewal or change in circumstance process during the continuous coverage unwinding period.

- a. If counties are removing a person from a case because they are no longer in the home and screening them on their own case, what would the application and renewal date be for the individual? (Added 06/20/2023)**

Counties shall move the Medi-Cal member who is reported out of the household into their own case, utilizing most current case information and electronic sources of information available. The application month is the same month as the case the member was associated with if the individual was a member of the case when it opened. If the individual became a member of the case at a later date the application date would be that date. The first month of the new 12-month period starts the month after the completion of the Medi-Cal only redetermination that was completed as a result of the change in circumstances when moving the member to their own case. The next Annual Renewal shall be completed by the last day of the 12th month.

See [MEDIL 22-28](#) for flow charts that align with the case processing instructions counties must take during the COVID-19 continuous coverage unwinding period.

- b. To request missing information in a situation for adding a person that results in a positive change for at least one household member and renewal has not been done, are counties expected to issue a CW 2200 for the applicant, and for the beneficiaries a pre-populated renewal form (and if needed MC 355 with mid-point contact)? What are the timeframe due dates for the individual being added and existing beneficiaries? (Added 06/20/2023)**

[MEDIL 22-42](#) provides guidance for adding a person to an existing case during normal Medi-Cal operations. See [MEDIL 22-43](#) for guidance on adding a person to the case during the COVID-19 continuous coverage unwinding period.

Counties shall follow the application processing timeframes for new persons and current non-applying case member applying for coverage:

- 90 days to complete the eligibility determination for applicants who apply based on disability.
- 45 days for all other applicants.

Even though other case members have current Medi-Cal eligibility, counties must follow normal application processes including ex parte review to obtain sufficient data regarding a new person who requests coverage. Counties may use the SAWS CW 2200 Request for Verification or other county generated verification forms to request verifications and information from applicants to determine Medi-Cal eligibility. Counties shall follow the Second Contact process and timeframe requirements in [ACWDL 08-07](#) when requesting information or verifications from applicants using the CW 2200 or other county generated forms.

Per [MEDIL 22-43](#), if adding the new person will provide a positive change for at least one household member and if the case has not yet had its annual renewal, the county shall conduct the annual renewal for the entire household at that time. The county will begin with an ex parte review and collect the necessary information to add the individual to the case. If the ex parte redetermination fails to support continued eligibility, the county will send a prepopulated annual renewal form and follow all renewal procedures, timeline and midpoint contact. If the annual renewal had already been completed during the continuous coverage unwinding period, the county shall follow the guidance outlined in MEDIL I 22-42 to add a new household member.

c. If an application is not needed in the case for a person moved from one case into another, how should counties document this in case of an audit? (Added 03/21/2023)

A new statement of facts is not required for the removed person (Medi-Cal member moving out of the home). Counties must provide clear and full documentation for audit purposes. The new case file should contain information from the last application/annual redetermination signed under penalty of perjury to begin the Medi-Cal member's new case. The county would include in the new case file the image of the signed SAWS2Plus or Single Streamlined Application along with a case narrative of the circumstances of transferring the Medi-Cal member into their own case using the last reported case file documentation, along with the notices of action showing ex parte redeterminations for the Medi-Cal member, if any.

d. What is the process for counties to follow when a household member is being added and renewal forms have already been sent to the household? (Added 03/21/2023)

This process is situational and would be dependent on the case and county business processes as there is no correct process as long as both the application determination and the renewal process are completed within specified timeframes.

During the unwind period a full redetermination must be completed, counties may process the new applicant information first using ex parte and may reach out telephonically to the primary contact to obtain missing applicant information and complete the full renewal including telephonic signature. Or, if all information is returned on the annual renewal form, the counties may process per normal business practices. Counties would use Medi-Cal member processes for both the applicant and Medi-Cal members when requesting missing information (MC 355) and would add a person through those actions. (See [MEDIL 22-42](#) for Adding a Person Reminders and [22-43](#) for Adding a Person during the Unwinding Period.)

- e. **If the primary applicant reports someone is out of the home and does not request to discontinue, the counties will remove the household member and put them in their own case. If the new address is not known and information is required to determine ongoing eligibility, what address do counties use for the new case? (Added 02/28/2023)**

In this instance, the county would use the last known address to the county. If mail is returned, counties must follow the process outlined in [ACWDL 22-09](#), [MEDIL 22-45](#), and any subsequent undeliverable mail guidance issued by DHCS.

- f. **For individuals that are reported as no longer in the home, and are no longer a tax dependent and moved to a new case, do counties need a Statement of Facts on the newly opened case? (Added 02/28/2023)**

A Statement of Facts would not be required for a Medi-Cal member that is no longer being claimed as a tax dependent, since the Medi-Cal member was already part of a case with a Statement of Facts already on file.

Consistent with the requirements found in 42 Code of Federal Regulations (CFR) § 435.916(d)(1) counties must promptly redetermine eligibility between regular renewals of eligibility described in paragraphs (b) and (c) of this section whenever it receives information about a change in a Medi-Cal member's circumstances that may affect eligibility. Furthermore, counties must limit any requests for additional information from the individual to information relating to

such change in circumstance, if the county has enough information available to it to renew eligibility with respect to all eligibility criteria.

- g. Can only the primary applicant or case name (referred to as primary household member in ACWDL 22-18) report someone moving out of the home? (Added 02/28/2023)**

Medi-Cal members shall be required to report any change in circumstances that may affect their eligibility within 10 calendar days following the date the change occurred. [ACWDL 22-18](#) does state “Primary household member” must report the changes, however DHCS recognizes others who can report changes that are consistent with California Code of Regulations (CCR) Title 22 § 50163 that specifies who is authorized to complete and sign the Statement of Facts. The applicant, adult child, spouse, or an Authorized Representative can report changes to the case.

- h. The renewal forms provide space to update household members who are no longer in the home, but does not indicate whether the primary applicant is requesting/not requesting to discontinue benefits for the individual leaving the home. How do counties address this? (Added 02/28/2023)**

The county could use documentation in the case file that occurred during the continuous coverage requirement to identify if there was a request to discontinue. Without a specific declaration requesting eligibility to be discontinued, the county should assume the Medi-Cal member is still requesting coverage and needs to be transferred into a new case for the household member moving out.

- i. At what point do counties stop asking/accepting information from the primary applicant/case name once the primary applicant/case name has reported that an individual is no longer part of their household or tax household? (Added 02/21/2023)**

During the continuous coverage unwinding renewal, counties will use the reported information from the primary applicant/case name to determine whether someone has moved out of the home and whether a separate case for the Medi-Cal member that moved out of the home is needed. The county must communicate directly with the Medi-Cal member who has moved out of the home to obtain any additional information necessary to establish ongoing eligibility.

Guidance regarding removing a household member can be found in [ACWDL 22-18](#) and a process flow is found in [MEDIL I 22-28](#).

- j. If a person is added but counties hold processing the renewal as it would negatively impact the other household members, do counties reset the renewal date in SAWS? (Added 02/21/2023)**

During the continuous coverage unwinding, the county would keep the existing system renewal date and complete the redetermination at that time. Once the continuous coverage unwinding for the existing household members, the renewal would be reset.

- k. If the add person applicant is determined ineligible but their ineligibility does not negatively impact the original household, are counties able to deny the applicant and send them a NOA? (Added 02/14/2023)**

Yes, counties may deny the application and must send the appropriate NOA to the applicant.

- l. How do counties process and confirm eligibility for the newly added person without affecting other members of the household? (Added 02/14/2023)**

Counties must attempt to add the person to the case to ensure that eligibility is provided to those that need it and that qualify for coverage. To the extent that this negatively impacts other individuals on the case, counties must follow approved system work arounds to continue coverage for the existing Medi-Cal members. Counties should seek technical assistance from the SAWS as needed for workarounds, manual Notices of Action (NOA), system overrides, or potentially opening new cases.

- m. If the head of household or case owner passes away, should a new Medi-Cal application be sent to the other household members to submit a new application and open a new case for them? (Added 02/14/2023)**

If the Head of Household passes away, a new application is not necessary for the remaining Medi-Cal members in the case. The county should contact the spouse or other adult in the household to determine if they will become the primary contact/head of household. Then, the county should provide the MC 219 Rights and Responsibilities to the new head of household.

The county should treat this a change in circumstances to obtain updated information from the new primary contact for the case file such as current household size and tax filing and dependency, etc.

2. Inter-County Transfers

The purpose of this section is to provide policy clarification on the Inter-County Transfer (ICT) process during the continuous coverage unwinding period.

- a. For the ICT process for an inmate released to rehabilitation, can DHCS please clarify if this for State Parole or County Probationers? If counties ICT probationers, they may lose AB 109 funding due to loss of county residence. (Added 05/23/2023)**

In these instances, an ICT is only required if the individual intends to permanently reside in a county other than where they receive their Medi-Cal upon release. An ICT is not required for an individual being released to another county to access services temporarily, including substance use treatment that may be required by the courts. Please refer to DHCS' Behavioral Health Informational Notice [21-032](#) and [21-072](#) for guidance on how this can be accomplished. Additionally, DHCS is not aware of any linkage between the county of responsibility used by Medi-Cal to provide health care benefits and AB 109 funding since it appears the AB 109 funding is administered through corrections agencies, not DHCS or Medi-Cal.

- b. Instead of conducting a partial/manual inter-county transfer (ICT), can counties just move the Medi-Cal member to their own case, and transfer that case instead? (Added 05/02/2023)**

DHCS originally provided guidance to counties that partial ICT would be a manual process due to systems capabilities, however, we now understand that some counties are able to do this through the SAWS e-ICT process. As long as the Medi-Cal member does not have a break in coverage during the ICT, the county may separate the Medi-Cal member to their own case and send the eICT.

- c. Can DHCS confirm the MC 360 is not required to complete an ICT? (Added 05/02/2023)**

Per ACWDL [18-02E](#), the MC 360 form is no longer required when using the electronic Intercounty Transfer (eICT) interface as it contains all of the information contained on the MC 360. However, the Sending County should

verify that all of the information that is captured on the MC 360 form is provided in the e-ICT information. Where applicable, the county should allow their SAWS to create the e-ICT. However, if the county is not able to initiate an e-ICT due to systems outage, the county must use the MC 360 form to send a manual ICT. Also, if an individual has permanently moved out of the household to a new county, and the Sending County is sending a manual ICT to the Receiving County, a MC 360 form will need to be included.

d. Is there an escalation process that counties can use when experiencing difficulties during the ICT process? (Added 05/02/2023)

The escalation process can be found within the [ICT Communication Protocol Baseline Document](#). Per this document for the General Escalation Process, the county staff will contact their county's ICT Coordinator/Liaison to work with the other county ICT Coordinator/Liaison in these situations. Also, there are Executive Management - County Administrative Officers designated in each county to assist in the resolution of ICT issues per the escalation process.

e. Do counties ICT FFY (4M) cases if the individual moves? (Added 05/02/2023)

When an individual leaves foster care, counties are to follow Medi-Cal guidance, since the 4M FFY aid code is a Medi-Cal aid code.

According to the ICT guidelines set out in ACWDLs [16-10](#), [16-10E](#), [18-02](#), and [18-02E](#), counties should initiate an ICT for 4M FFY cases if the Medi-Cal member moves from one county to another.

f. Is the ICT coordinator escalation process via coordinator to coordinator? Or should line staff directly contact coordinators? (Added 05/02/2023)

Per the [ICT Communication Protocol Baseline Document](#), communication should be ICT Coordinator/Liaison to ICT Coordinator/Liaison - For unresolved issues or no response, the worker will refer the communication request to their county's ICT Coordinator/Liaison who will contact the other county's ICT Coordinator/Liaison for resolution. Note: Counties agree that direct contact information for the ICT Coordinator/Liaison or Executive Management is not to be shared with county workers or clients.

- g. If the SAWS system is not correctly picking the right ICT documents, should counties manually try to resend them in the SAWS system? Or, should counties just e-mail the documents to the other county? (Added 05/02/2023)**

The county can either send the correct documents through CalSAWS manually or via e-mail to the worker listed. When sending this information manually, it must include a MC 360 with the identifying case number and/or ICT reference number to link the additional documentation to the initial ICT. Also make a note on the case. See the [ICT Communication Protocol Baseline Document](#) for more information.

3. Returned Mail/Undeliverable Mail

The purpose of this section is to provide policy clarification on returned or undeliverable mail during the continuous coverage unwinding period.

- a. When the Medi-Cal member fails to respond to the MC 355 requesting new address on the Medi-Cal only case, is the appropriate discontinuance reason “whereabouts unknown” or “failure to provide address info”? (Added 07/11/2023)**

In the case where there is no other information needed from the Medi-Cal member, and there is no in-state forwarding address provided, DHCS accepted county feedback that "whereabouts unknown" would be the most in alignment or most used Notice of Action. Please reference [ACWDL 22-09](#) for additional clarification.

- b. Should the MC 355 must be sent to both the last known address and the forwarding address? (Added 07/11/2023)**

Per [ACWDL 22-09](#), the county is required to attempt an additional contact with the beneficiary by telephone, in writing, or by other commonly available electronic means, during the 30 days after the MC 355 is sent, to obtain the necessary information if the beneficiary has not responded to the MC 355 or has provided an incomplete response. If that reminder is provided in writing, the county shall send the additional reminder contact to both the last known address and the forwarding address.

- c. Does the automatic MC 355 reminder letter count as an additional contact? (Added 07/11/2023)**

Yes, the automated MC 355 reminder counts as an additional contact.

- d. Are counties supposed to scan hard copies or contents of the returned mail that is indicated in the list from DHCS per [ACWDL 22-09](#)? (Added 02/21/2023)**

For the list of returned mail provided by DHCS for state-generated communications, counties will only be receiving the lists with information on the returned mail and not copies of the returned mail, so scanning or capturing the images is not required. However, counties must document the source of the returned mail in the case notes. For returned mail received by the counties where a physical copy is provided, counties must still follow guidance in ACWDL 22-09.

- e. Regarding [MEDIL 22-45](#): If mail was addressed to the primary applicant and returned with an in-state forwarding address, can counties update the case record for the entire household, or just for the primary household member? (Added 02/14/2023)**

Effective October 18, 2022, counties can treat updated in-state Medi-Cal member contact information received from the National Change of Address (NCOA) or United States Postal Service (USPS) returned in-state mail as reliable and valid. During the continuous coverage unwinding period, the county can accept the in-state forwarding address from NCOA or USPS and update the Medi-Cal member's case record, regardless of whether it is multi-person household.

However, the updated address would not be applied to any household members that are known to the county to have a different address than the one being updated. For example, if a parent and adult child are both in the same household and are known to the county to have different addresses, and the county is updating the primary applicant adult's address based on a new forwarding address, the county would not update the adult child's separate address unless the county has been informed that the household members are now at the same address.

- f. *When the county receives returned mail, what is the county required to review on the case file as part of ex parte?* (Added 05/23/2023)**

The county must review imaged documents received during the public health emergency and the continuous coverage unwinding that may contain updated

or USPS returned address information. This includes annual renewal forms, scanned undeliverable mail envelopes, and any other correspondence. Additionally, the county must review prior case notes to determine if an address was reported and not updated. The county must also follow all processes outlined in [ACWDL 22-09](#) to obtain updated contact information when mail is returned as undeliverable.

4. Spousal Impoverishment

The purpose of this section is to provide policy clarification on policy surrounding Spousal Impoverishment (SI).

a. How should counties handle situations where the Medi-Cal members were approved based on Skilled Nursing Facility (SNF) need level, but who were not placed into a waiver program? (Added 07/05/2023)

At renewal determine if the individual is:

- 1) On a waiver or program waitlist,
- 2) Has applied for Home and Community Based Services (HCBS), or
- 3) Has an HCBS application in progress.

If so, then the spousal impoverishment provisions continue to apply. If none of these have occurred, then the continuous period of institutionalization (HCBS participation) ends when the HCBS spouse does not receive HCBS waiver or program services for a full calendar month. The county must assess for other eligibility. The requirements for completing the request for HCBS is set forth in [ACWDL 18-19](#).

If the individual was not previously accepted into the HCBS program they applied for, they may start the process again by requesting HCBS and establishing they meet nursing facility level of care because their circumstances may have changed.

b. Can counties take a Medi-Cal member's statement on property for the Non-MAGI institutional deeming? For context, parents often do not want to go through the hassle of providing since they are usually not Non-Magi eligible. (Added 07/05/2023)

At application, if the required property verifications are not available, counties may utilize sworn statements. At renewal verification of the

member's property is not required pursuant to the asset waiver authority ([MEDIL I 23-19](#)).

- c. If the spouse that needs coverage is currently in long-term care or hospice, would Spousal Impoverishment apply or would they have to be home and applying for In-Home Supportive Services (IHSS)? (Added 07/05/2023)**

The Spousal Impoverishment rules apply for married couples when one spouse is a community spouse and the other spouse is in long-term care or requesting/receiving home and community-based services. There is a list of the HCBS waivers and programs the SI provisions apply to linked in the SI screening tool and listed in [ACWDL 18-19](#).

E. Other Programs

The purpose of this section is to provide policy clarification on special Medi-Cal programs that may have special guidance or processes during the continuous coverage unwinding period.

1. Foster Care/Former Foster Youth/Adoption Assistance Program/KinGap

The purpose of this section is to provide policy clarification on the Former Foster Youth (FFY), Foster Care (FC), Adoption Assistance Program (AAP), and KinGap programs during the continuous coverage unwinding period.

- b. Is guidance in ACWDL 02-59 still accurate for a Foster Care child that loses eligibility (follow SB 87 process, place them in CEC, and new application is not required)? Are any forms needed to open the case? (Added 06/13/2023)**

For these instances, please review [ACWDL 14-05](#) which supersedes [ACWDL 02-59](#) in the sections referencing CEC.

- c. For youth that aged out of AAP, do counties reassess for FFY, if they meet the criteria? What about individuals who were Kin-Gap at age 18 – are they eligible to the FFY program? (Added 04/25/2023)**

Youth who exit the AAP program or Kin-Gap program are not eligible for the FFY program.

d. How do counties review Foster Care case for court jurisdiction? (Added 04/25/2023)

Counties should reach out to the county in which the youth was in foster care (if in another county). The Foster Care eligibility worker should have access to the status on court jurisdiction.

e. What is the process for counties conducting a redetermination if the Foster Care youth's whereabouts are unknown? What about an aged-out youth with unknown whereabouts? (Added 04/25/2023)

Please refer to ACWDLs [14-41](#), [16-20](#), [22-09](#), and [22-18](#). If county is unable to verify the youth's address, do not terminate the Medi-Cal coverage – instead, move the youth into fee-for-service and leave the youth in aid code 4M.

f. What process do counties follow for non-FFY cases (Foster Care, KinGap, AAP) that were granted Medi-Cal during the continuous coverage requirement, but since being granted they have been reunified with parent? (Added 04/25/2023)

Follow the guidance set out in ACWDL [22-18](#) for during the continuous coverage unwinding.

g. For Foster Care, FFY, AAP, KinGap cases- is there generally a specific NOA to use or do counties issue a manual NOA? (Added 04/25/2023)

Follow the guidance set out in ACWDL [22-18](#). If a FFY ages out during the unwinding, follow the guidance set out in ACWDL [15-32](#).

h. Can you clarify the process for individuals aging out of FFY prior to the continuous coverage unwinding period? What about during the unwinding period? (Added 03/14/2023)

For any FFY who were moved into another aid code because they aged out of the FFY Program during the continuous coverage requirement, follow the guidance set out in ACWDLs [22-18](#).

For any FFY who will be aging out during the Continuous Coverage Unwinding period and thereafter, follow the guidance in ACWDLs [14-41](#) and [15-32](#) and [MEDIL I 21-33](#).

- i. **When a youth has aged out of FFY and a full assessment must be completed, does this include an ex parte and full review of the Medi-Cal hierarchy? (Added 03/14/2023)**

During the Continuous Coverage Unwinding period please follow the guidance set out in ACWDLs [22-18](#). This includes a full Medi-Cal hierarchy assessment of the individual for any other Medi-Cal program eligibility.

- j. **Is the renewal packet required for Adoption Assistance Program (AAP) renewals? These individuals do not go through the auto-renewal process and packets are not sent. (Added 03/14/2023)**

Yes, these individuals still must have a full redetermination conducted. Please follow the guidance set out in ACWDLs [22-18](#).

- k. **What is the process if a county is unable to reassess for FFY eligibility if the county receives returned mail for the individual with whereabouts unknown? (Added 03/14/2023)**

Please follow the guidance in [ACWDL 22-18](#) if the FFY aged out of the FFY program during the Public Health Emergency. If the youth will be aging out of the FFY Program during the Continuous Coverage Unwinding period, follow the guidance in [ACWDLs 14-41 and 15-32 and MEDIL I 21-33](#). For the youth who is not aging out, if contact is not established follow the guidance in ACWDL 14-41 and continue the Medi-Cal member in aid code 4M and place in fee-for-service.

- l. **What forms should be sent to discontinued AAP, Foster Care and KinGap to renew, if those programs no longer apply? Are there any special rules or considerations? Such as: should Foster Care children be sent a separate application to the family? (Added 03/14/2023)**

For these programs, please follow the guidance in ACWDLs [22-18](#) and complete a full redetermination for the individual. If a child is still in foster care, do not send an application to the child's parents.

- m. **Are Former Foster Youth (FFY) NOAs programmed into SAWS? (Added 03/14/2023)**

[ACWDL 15-32](#) requested counties program the FFY NOAs into SAWS. DHCS recommends checking with your county MEDS coordinator.

n. Who is the contact for any further questions regarding Former Foster Youth? (Added 03/14/2023)

For any further questions specific to FFY, please send your emails to FFY@dhcs.ca.gov.

2. Transitional Medi-Cal

The purpose of this section is to provide policy clarification on the Transitional Medi-Cal program during the continuous coverage unwinding period.

a. Should counties evaluate for Transitional Medi-Cal (TMC) during the continuous coverage unwinding period? If so, when should this occur? (Added 04/11/2023)

CMS provided clarification to DHCS that individuals who were never evaluated for TMC during the continuous coverage requirement must be evaluated during the unwinding period, regardless of when the increase income occurred.

Counties shall begin to evaluate cases for TMC at the time of their next normally scheduled annual renewal date. Counties shall continue to follow guidance issued in All County Welfare Director's Letter 21-27 ([ACWDL 21-27](#)). Individuals must meet all the requirements to be eligible for the extended eligibility period of TMC.

b. If a Medi-Cal member does not meet all the requirements to be eligible for extended eligibility period of TMC, are counties allowed to take negative action? (Added 04/18/2023)

Counties cannot take a negative action on a Medi-Cal member until the unwinding annual renewal is complete. If during the annual renewal, the county eligibility worker determines the Medi-Cal member is not eligible to the second six months of TMC, the county can redetermine eligibility to the appropriate coverage. As a reminder, the county must screen for all other Medi-Cal eligibility including consumer protection programs and Non-MAGI prior to determining coverage to Covered California.

c. What are the TMC reports? (Added 04/18/2023)

Families enrolled in TMC must report their income through three quarterly status reports. Information about the quarterly reports can be found in [ACWDL 21-27](#).

- d. **Once counties establish the TMC period, for example starting in June 2023, does the individual automatically get 12 months of TMC, or do counties still follow the process for evaluating the initial 6 months followed by an additional review for the remainder? (Added 04/18/2023)**

CEWs must follow the process in [ACWDL 21-27](#) and must evaluate for the Initial Extended Eligibility Period of TMC (6 months), and follow the process for the Second Extended Eligibility Period of TMC (second 6 months)

- e. **If an individual has been in aid code 38 or Soft Pause for less than 12 months, are counties expected to transition to the respective 39/59 aid code? Or, do counties just leave them in Soft Pause/aid code 38 until the TMC period is done? (Added 04/18/2023)**

DHCS is not requiring counties to transition individuals into aid codes 39/59. DHCS will defer to the county if system functionality allows for placement into aid code 39/59. As a reminder, counties must assess and apply TMC eligibility when appropriate using Soft Pause or aid code 38 when 39/59 are not functionally possible.

- f. **What is the expectation for TMC individuals who placed into aid code 38 or the Soft Pause functionality during the unwinding period? (Added 04/11/2023)**

Individuals placed into soft pause or aid code 38 during the continuous coverage requirement in lieu of a TMC aid code for at least 12 months are considered as enrolled for their extended eligibility period of TMC. These individuals should not be evaluated for TMC again when processing the unwinding annual renewal.

In circumstances where the individual still has remaining months of TMC, the county must ensure the individual is assessed for the remaining months prior to lifting soft pause or discontinuing aid code 38.

- g. **When does the TMC clock begin? (Updated 07/10/2023)**

The TMC time clock begins the first month of the new certification period. -For example, the county began renewal activities on April 1, 2023 for Medi-Cal members with a June 2023 renewal date. During this time, if the individual with a June renewal month is determined TMC eligible, the TMC clock starts July 2023.

3. Covered California

The purpose of this section is to provide guidance during the continuous coverage unwinding period on Covered California-related policy or business processes.

a. Does Covered California have guidance on enrollment eligibility to APTC when the individual's case is still in the 90-day cure period? *(Added 06/13/2023)*

If an individual was discontinued from Medi-Cal due to a Negative Action that meets the 90-day cure period, they are still evaluated for Covered CA programs. However, generally they would be unsubsidized because their FPL is under the Medi-Cal thresholds, so no Automatic Plan Selection will occur.

If the individual then provides updated information to the county during the 90-day cure period that results in eligibility to financial assistance with Covered CA, then the counties have the authority to utilize the SEP overrides to give the consumer the eligibility to enroll in a Covered CA plan as of the first of the month after the last day of their Medi-Cal coverage, even if that date is in the past. Covered CA has previously provided guidance on this in Covered California Memo "M-20-1: Special Enrollment Period During the 90-Day Cure Period."

b. Would an individual who is evaluated for Non-MAGI Medi-Cal with a Share-of-Cost also transition to Covered California with Senate Bill (SB) 260? *(Added 04/18/2023)*

Yes. Since the Non-MAGI with a Share-of-Cost is not considered Minimum Essential Coverage, the individual would be included in the transition.

c. Should counties backdate income to the beginning of the year if they are reporting a new job that started prior to 01/2023? *(Added 04/18/2023)*

Financial assistance from Covered California is based on annual income. Prior to the continuous coverage requirement, when an individual started a new job, they would report the information timely to the county which allowed the individual to transition to Covered California with the correct annual income amount. During the continuous coverage requirement, income updates were not applied "real time" leaving the record potentially out of alignment with the annual income. The county must complete data entry in SAWS to ensure the correct annual income is captured when processing the annual renewal.

- d. For Medi-Cal members that end up being eligible to both Covered California and Medi-Cal due to them curing their case during the 90-day cure period, is there a customer action needed? Additionally, if the individual has bills during that time, is Medi-Cal or Covered California the primary coverage? *(Added 04/18/2023)***

IRS acknowledges that there are certain allowable times when an individual will have eligibility to both Medi-Cal and Covered California during the transition period. However, it is critical to ensure once the Medi-Cal has been reinstated or Covered California newly approved, that the individual is terminated from the respective program for ongoing eligibility.

In instances when the individual has both a health plan from Covered California and Medi-Cal, the health plan from Covered California would be primary.

- e. Where can the policy guidance from Covered California on the extended SEP for the 90-day cure period be located? *(Added 05/23/2023)***

The policy guidance for this can be located in “Covered California Policy Memo M-20-1: Special Enrollment Period During the 90-Day Cure Period.”

4. Other Programs

The purpose of this section is to provide guidance during the continuous coverage unwinding period on other special programs not covered in other subsections.

- a. Are Breast and Cervical Cancer Treatment Program (BCCTP) recipients considered beneficiaries when evaluating for Medi-Cal? *(Added 11/107/2023)***

BCCTP is a Non-MAGI Medi-Cal program. BCCTP recipients shall be considered Medi-Cal members when evaluating for other Medi-Cal programs.

- b. Are members in receipt of the American Rescue Plan Act (ARPA) coverage required to have their aid extended through the end of the continuous coverage unwinding? For example, a member who was pregnant in 2021 and who is running in a Burman hold currently and generated MEDS alerts. Does the member stay in the ARPA aid code and if so, when should they be transitioned out? *(Added 10/17/2023)***

For members that meet this criteria, the member should remain in their ARPA aid code until their scheduled continuous coverage unwinding renewal eligibility redetermination.

F. Business Processes/Other

The purpose of this section is to provide guidance and clarification on business process-related items not directly related to eligibility determinations.

1. Outreach/Communication

The purpose of this section is to provide guidance and clarification on outreach and communication efforts either by DHCS or the counties relating to the continuous coverage unwinding period.

- a. How should counties determine if a county created message is considered “closely related to the application purpose” as defined in [MEDIL 23-12](#)? (Added 03/14/2023)**

DHCS defers to the local county office to determine whether a county created message (those not approved by DHCS or automated through SAWS) meets the definition of “closely related to the application purpose.”

2. Program Integrity

The purpose of this section is to provide guidance and clarification on processes for ensuring program integrity for the Medi-Cal program, such as case review or fraud information.

- a. DHCS previously mentioned the potential state-level review of county cases during the unwinding period. Can DHCS provide additional information on this process? What criteria will the state use when reviewing county cases? (Added 05/09/2023)**

Due to federal requirements, DHCS will leverage data to monitor application and renewal processing times. If the data shows that specific counties are unable to meet the processing times, DHCS will perform an informal review to identify causes for the delays, and provide technical assistance to ensure that all applications and renewal are proceed timely. Counties will not be subject to any adverse actions, and a corrective action plan is not required. The sole intent of these reviews is to ensure the integrity of determinations, the timeliness of case work actions, and to work collaboratively with counties to overcome any obstacles that cause delays of actions.

The assessment process will include comprehensive case reviews that will focus on:

- Timeliness of processing applications and renewals
- Accuracy of the determination
- Trends/actions that contributed to delays in the application or renewal process

Case elements that will be reviewed for accurate data entry, policy application, and adherence to proper document acquisition and retention protocol include but are not limited to:

- Appropriate assignment to eligibility group/category (MAGI)
- Household composition
- Income
- Property (Non-MAGI - *Application only*)
- Citizenship
- Issuances of mandatory Notices of Action
- Minimum Essential Coverage (MEC)
- Medicare entitlement (Non-MAGI)
- Social Security Number
- Identity
- Pregnancy Status
- Age
- Deductions
- Disability Status
- Program Specific Deductions (Non-MAGI)
- Notices of Action
- Request for manual verifications
- Electronic sources used to confirm required data elements (IEVS, MEDS, FDSH, PVS, LTC AVP Reports)

b. When a scam or fraud is reported, what information should county staff obtain for reporting these encounters? (Added 05/02/2023)

Counties should gather as much information as they can to assist with the fraud investigation. Most importantly, including the following information about the potential scammer:

- Name
- Organization

- Contact information (phone number, email address, physical address).

Additionally, any details about the specific message the Medi-Cal member received, as well as the Medi-Cal member's name and contact information in case DHCS' Audits and Investigations Division needs to follow-up. These should be submitted directly to audits and investigations using the fraud inbox at fraud@dhcs.ca.gov.

3. Other

The purpose of this section is to provide guidance and clarification on non-policy items.

a. Is there a contact person that counties can reach out to if they have issues accessing the SFTP? (*Added 02/07/2023*)

For SFTP access or questions please reach out to Bonnie Tran:
bonnie.tran@dhcs.ca.gov.

Appendix A: Guidance and Resources

DHCS has released multiple guidance letters throughout the duration of the continuous coverage unwinding to assist counties with frequently asked questions, policy changes, policy clarifications and other useful information. The guidance can be found at the following links:

General Unwinding Policy Guidance		
Letter	Date	Title
MEDIL I 23-41	August 14, 2023	Guidance for Carr V Bercerra Restoration List Effort
MEDIL I 23-36	May 16, 2023	Annual Renewal Date Sharing Between Counties and Managed Care Plans During the Continuous Coverage Unwinding Period
MEDIL I 23-31	April 27, 2023	Guidance for Monthly List Efforts During the Continuous Coverage Unwinding Period
ACWDL 23-09	April 17, 2023	Discontinuance of the COVID-19 Uninsured Group
ACWDL 21-03E	April 14, 2023	Errata to Provisions from the Coronavirus Response and Relief Supplemental Appropriations Act, 2021
MEDIL I 23-18	March 15, 2023	Updated Guidance on the January 31 Injunction for Individuals Enrolled in Medicare Savings Programs during the COVID-19 Public Health Emergency Period
MEDIL I 23-07	February 10, 2023	Updated Guidance on Continuous Coverage for Individuals Enrolled in Medicare Savings Programs during the COVID-19 Public Health Emergency Period
MEDIL I 23-06	February 7, 2023	County Support Webinars Q&A: Continuous Coverage Unwinding Process
MEDIL I 23-02	January 10, 2023	Updated Guidance for Counties on Resuming Medi-Cal Redeterminations

General Unwinding Policy Guidance		
MEDIL I 23-03	January 10, 2023	Updates to the County Readiness Toolkit for the Preparation of Novel Coronavirus (COVID-19) Public Health Emergency (PHE) End of Continuous Coverage Requirement
MEDIL I 22-43	November 01, 2022	COVID-19 Public Health Emergency Unwinding Period: Adding a Person to an Existing Case
MEDIL I 22-34	August 22, 2022	COVID-19 Public Health Emergency (PHE) Unwinding for Individuals who Aged out of the Young Adult Expansion during the PHE
MEDIL I 22-28	July 11, 2022	COVID-19 Public Health Emergency (PHE) Unwinding Flow Charts
ACWDL 22-18	June 24, 2022	Case Processing Actions after the Conclusion of the Coronavirus (COVID-19) Public Health Emergency (PHE)
ACWDL 22-13	May 12, 2022	Changes to Asset Verification Review Requirements Due to July 2022 Asset Limit Increase
MEDIL I 21-09	June 24, 2021	Continuing Telephonic Flexibilities for the Minor Consent Program beyond the COVID-19 Public Health Emergency
Waiver Flexibilities		
MEDIL I 24-03	February 5, 2024	Extension of Unwinding Waivers and Flexibilities
MEDIL I 23-49E	November 2, 2023	Errata to MEDIL I 23-49
MEDIL I 23-49	October 4, 2023	Approval of Additional Unwinding Flexibilities During the Unwinding: Annual Redetermination Packets and Reasonable Explanation
MEDIL I 23-44	September 15, 2023	Approval of Additional Section 1902(e)(14)(A) Waiver Flexibility: Medical Support Enforcement

Waiver Flexibilities		
MEDIL I 23-42	August 31, 2023	Approval of Additional Section 1902(e)(14)(A) Waiver Flexibilities: Unconditionally Available Income and Stable Income Renewal Waiver
MEDIL I 23-40	July 3, 2023	Approval of Additional Section 1902(e)(14)(A) Temporary Flexibility Waivers During the Continuous Coverage Unwinding Period
MEDIL I 23-26	June 23, 2023	Section 1902(e)(14)(A) State Fair Hearings Waiver Flexibilities
MEDIL I 23-19	March 29, 2023	Additional Section 1902(e)(14)(A) Waiver Flexibilities
MEDIL I 23-21E	March 22, 2023	COVID-19 Public Health Emergency Waiver Flexibility for Individuals With No Income
MEDIL I 23-09	February 21, 2023	The Continuous Coverage Requirement Unwinding Period Temporary Waiver Timeframes
MEDIL I 22-20E	June 24, 2022	Errata to the Medi-Cal Eligibility Division Information Letter NO. I 22-20 for Updates Regarding the Approval of Temporary Waiver Requests as a result of the COVID-19 Public Health Emergency
Medi-Cal Transitions		
MEDIL I 23-23	March 30, 2023	Updates on Senate Bill (SB) 260
ACWDL 22-20	July 11, 2022	Senate Bill 260 Streamlining Transitioning to Covered California
Undeliverable Mail		
MEDIL I 23-11	February 24, 2023	Conducting Multiple Modality Outreach Based on Returned Mail Prior to Termination
MEDIL I 23-05	January 25, 2023	End of Continuous Coverage Requirement Outreach Returned Mail Process
MEDIL I 22-45	November 09, 2022	Updates Regarding the Processing Of Returned Mail With In-State Forwarding Address
ACWDL 22-09	March 17, 2022	Updated Guidance on the County Process When Mail is Returned Undeliverable

Outreach		
MEDIL I 23-12	February 28, 2023	The Telephone Consumer Protection Act Requirements During the Continuous Coverage Unwinding Period
MEDIL I 22-01	January 14, 2022	Federal Covid-19 Public Health Emergency Additional Contact Requirement
Craig v. Bonta		
MEDIL I 23-10	February 22, 2023	Clarification for Craig v. Bonta Case Processing During the Continuous Coverage Unwinding Period
Reasonable Explanation and Reasonable Compatibility		
MEDIL I 22-48	November 22, 2022	Instructions for the Request for Additional Income Information for Medi-Cal Form to Obtain a Reasonable Explanation
ACWDL 22-22	August 8, 2022	Introduction of Reasonable Explanation for Medi-Cal Determinations
ACWDL 22-17	June 17, 2022	Increase to the Reasonable Compatibility Threshold in the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS)
Consumer Protection Programs		
ACWDL 22-23	October 17, 2022	American Rescue Plan Act Postpartum Care Extension
Former Foster Youth and Special Programs		
MEDIL I 23-37	May 17, 2023	Clarification for Redeterminations of Incarcerated Individuals During the Continuous Coverage Unwinding Period
MEDIL I 23-33	May 8, 2023	Transitional Medi-Cal During the Continuous Coverage Unwinding Period

Former Foster Youth and Special Programs		
MEDIL I 23-32	May 2, 2023	Processing Minor Consent During the Continuous Coverage Unwinding Period
MEDIL I 23-28	April 12, 2023	Processing Former Foster Youth during the Unwinding of Continuous Coverage

Appendix B: Continuous Coverage Unwinding Waiver and Flexibility Reference Chart

The table below is for county reference regarding various 1902(e)(14) waivers and other unwinding-related flexibilities.

Waiver or Flexibility	Authority	Letter
MAGI Medi-Cal Reasonable Compatibility Threshold Increase	MAGI Verification Plan	ACWDL 22-17
Reasonable Explanation	MAGI Verification Plan	ACWDL 22-22
Partnering with Managed Care Plans to Update Beneficiary Contact Information	1902(e)(14)(A)	MEDIL 22-20E
Partnering with Program of All-Inclusive Care for the Elderly (PACE) Organizations to Update Beneficiary Contact Information	1902(e)(14)(A)	MEDIL 22-45
Partnering with the National Change of Address Database and United States Postal Service In-State Forwarding Address to Update Contact Information	1902(e)(14)(A)	MEDIL 22-45
Asset Test Waiver	1902(e)(14)(A)	MEDIL 23-19
Ex Parte Renewal for Individuals With Zero Income Waiver	1902(e)(14)(A)	MEDIL 23-21E
State Fair Hearings Waiver Flexibilities	1902(e)(14)(A)	MEDIL 23-26
Ex Parte Renewal for Individuals With Income at or Below 100 Percent of the Federal Poverty Limit Waiver	1902(e)(14)(A)	MEDIL 23-40
Hard-to-Reach Population Redetermination Flexibility	1902(e)(14)(A)	MEDIL 23-40
Unconditionally Available Income Requirement Waiver	1902(e)(14)(A)	MEDIL 23-42
Stable Income Waiver	1902(e)(14)(A)	MEDIL 23-42
Medical Support Enforcement Waiver	1902(e)(14)(A)	MEDIL 23-44
Ex Parte Without Returned Renewal Packet Flexibility	MAGI Verification Plan	MEDIL 23-49E

Appendix C: Update Log

02/13/2024	Q&A added
01/23/2024	Q&A added
01/09/2024	Q&A added, Q&As updated
12/19/2023	Q&As added
11/21/2023	Q&As added
11/14/2023	Q&As added
11/07/2023	Q&As added
10/31/2023	Q&As added
10/24/2023	Q&A added, Appendix B added
10/17/2023	Q&As added
10/03/2023	Q&As added
09/26/2023	Q&As added
09/19/2023	Q&A modified
08/08/2023	No updates to Q&A
08/01/2023	Q&A added
07/25/2023	No updates to Q&A
07/18/2023	Q&As added
07/11/2023	Q&As updated (TMC)
07/05/2023	Q&As added
06/27/2023	No updates to Q&A
06/20/2023	Q&As added
06/13/2023	Q&As added
06/06/2023	Q&As added
05/30/2023	Q&As added
05/23/2023	Document reorganized and Q&As added
05/16/2023	Q&As added
05/09/2023	Q&As added
05/02/2023	Q&As added
04/23/2023	Q&As added

04/18/2023	Q&As added
04/11/2023	Q&As added, Renamed section I to be more general
04/04/2023	Q&A added, Appendix A added, page numbers added
03/28/2023	No updates to Q&A
03/21/2023	Q&As added
03/14/2023	Q&As added, Table of Contents added
03/07/2023	No updates to Q&A
02/28/2023	Q&As added
02/23/2023	Q&As added and categories reorganized
02/14/2023	Q&As added, one modification made to Renewals Q.1
02/07/2023	Q&A Document Created