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Medi-Cal Eligibility Division Information Letter No.: I 22-10

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY WELFARE ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS

SUBJECT: ADDITIONAL AND UPDATED FREQUENTLY ASKED QUESTIONS DUE
TO THE COVID-19 PUBLIC HEALTH EMERGENCY (SUPERSEDES
MEDIL I 21-04)

The purpose of this Medi-Cal Eligibility Division Information Letter (MEDIL) is to provide additional and updated frequently asked questions (FAQs) to address county questions related to guidance issued by the Department of Health Care Services (DHCS) relative to the COVID-19 public health emergency (PHE). Several MEDILs were provided to counties with guidance regarding the delay of processing Medi-Cal annual redeterminations and the delay of discontinuances and negative actions for Medi-Cal programs as a result of the COVID-19 PHE. Additional and updated questions and answers will be released periodically in future MEDILs and counties should follow the guidance outlined in the most current version of the FAQs. This MEDIL supersedes [MEDIL I 21-04](#).

The following questions and answers have been added to the FAQs:

- Section B, question 14, 15
- Section F, question 9, 10
- Section K, question 2
- Section Q, question 2
- Section R, question 3
- Section S, question 1, 2, 3, 4

The following question and answer has been edited in the FAQs:

- Section B, question 1, 5, 11
- Section D, question 1, 2
- Section E, question 1, 3, 4
- Section F, question 2
- Section P, question 3

Please continue to reference the following All County Welfare Directors Letters (ACWDLs) and MEDILs regarding PHEs or disasters:

- [MEDIL I 21-04](#) – Additional and Updated Frequently Asked Questions Due to The COVID-19 Public Health Emergency
- [MEDIL I 20-26](#) – Additional Frequently Asked Questions Due to the COVID-19 Public Health Emergency
- [MEDIL I 20-20](#) – Extend Eligibility for Refugee Medical Assistance Applicants -- and Beneficiaries Due to the COVID-19 Public Health Emergency
- [MEDIL I 20-19](#) – Outreach Letters to Two Populations Regarding the Spousal Impoverishment Provisions
- [MEDIL I 20-16](#) – Companion to MEDIL I 20-12 - Applications Received Through SAWS Portal
- [MEDIL I 20-15](#) – Prioritizing Case Processing Activities Through the Duration of the Covid-19 Public Health Emergency
- [MEDIL I 20-14](#) – Extension of Delaying Annual Redeterminations, Discontinuances, and Negative Actions Due to Covid-19 Public Health Emergency
- [MEDIL I 20-12](#) – Applications Received Without Applicant Signature
- [MEDIL I 20-11](#) – Follow-up Guidance to MEDIL I20-07 and I20-08 on Medi-Cal Inmate Eligibility Programs & Medi-Cal Beneficiaries Who Become Incarcerated
- [MEDIL I 20-06](#) – Public Health Crisis or Disaster Reminders for Medi-Cal,
- [ACWDL 19-01](#) – Exceptions due to Public Health Crisis or Disaster,
- [MEDIL I 17-16](#) – Processing Applications from Individuals Affected by Disasters, and
- [ACWDL 15-36](#) – Guidance to Counties on Treatment of Applications/Redeterminations in Disaster Areas and Treatment of Disaster

If you have any questions, or if we can provide further information, please contact us by email at MCED.COVID@dhcs.ca.gov.

Original Signed by

Sandra Williams, Chief
Medi-Cal Eligibility Division

Enclosure

**Frequently Asked Questions (FAQs) Due to the COVID-19 Public Health
Emergency (PHE)
Updated xx/xx/2022**

A. 90-Day Suspension

1. Which months does the 90-day suspension referenced in MEDIL I 20-07 refer to?

The time period for the delay in processing renewals and the delay of negative actions outlined in MEDIL I 20-07 are for the months of March, April, and May 2020. [MEDIL I 20-14](#) extends the timeframe beyond the original 90-days, through the end of the COVID-19 PHE.

2. Does the 90-day suspension referenced in MEDIL I 20-07 apply to applications that result in a denial, such as denied for over income?

No, the delay of negative actions does not apply to applications. If an application is received and the applicant is determined to be over income, counties should continue to follow current processes. This includes screening the applicant for all available programs, including Covered California programs. Please refer to [ACWDL 14-18](#) for additional guidance. Counties may also deny applications for failure to provide requested verifications.

B. Delayed Negative Actions

1. Are increases in Medi-Cal premiums and increases in share of cost considered a negative action? (Updated)

Previously, increases in Medi-Cal premiums were considered negative actions and were not be processed per [MEDIL I 20-25](#). Effective with the release of [ACWDL 21-16](#), counties may transition a beneficiary from a Tier 1 program with no premium to another Tier 1 program (with or without a premium) as the change does not provide a reduction in benefits. Counties must continue to delay transitions from no share of cost to share of cost aid codes, as well as increases in share of cost, throughout the COVID-19 PHE.

2. How should the county process eligibility for individuals who have aged out of an eligibility group?

Per [MEDIL I 20-25](#), continuous coverage applies to individuals who might otherwise have their coverage terminated or benefits negatively affected after a change in circumstance, including individuals who age out of a Medi-Cal eligibility group, for the duration of the public health emergency. Counties shall not

process negative actions for individuals who aged out of an eligibility group. This may include individuals who are aging out of former foster youth, individuals turning 65, or young adults aging out of full scope Medi-Cal (counties may utilize aid code 38 for managed care beneficiaries to ensure access to care).

Foster Care

Foster care individuals who age out during the PHE, the following county action must be taken:

- Leave the Foster Care individuals in their current aid codes for the remainder of the PHE. If that action is not technically possible follow instructions below:
- Cash payment FC aid code is terminated, place the individual into aid code 38. They will remain eligible until new policy guidance has been issued.
- If the individual cannot remain in the same aid code, aid code 38 can be assigned.

When the PHE ends, normal procedures shall be followed in evaluating aging-out foster care children for other coverage programs (e.g. FFY, MAGI).

Former Foster Youth

When Former Foster Youth (FFY) age out during the PHE, counties must take the following action:

- Leave the FFY in the 4M aid code for the remainder of the PHE.

When the PHE ends, normal procedures shall be followed in reassessing aged-out FFY for all Medi-Cal programs.

AAP/Kin-GAP

When AAP/Kin-GAP children age out during the PHE, counties must take the following action:

- Leave AAP/Kin-Gap individuals in their same aid codes for the remainder of the PHE.

When the PHE ends, AAP/Kin-GAP individuals must be evaluated for other coverage programs (e.g. MAGI).

- 3. When counties are informed that a beneficiary no longer qualifies for a waiver, such as a child no longer qualifying for the IHO/DDS (Medicaid Waiver benefits) under institutional deeming rules, should a negative action be taken?**

No, counties should not take a negative action on cases for individuals who no longer qualify for a waiver for the duration of the COVID-19 PHE.

4. How should the county process a case when a household is adding a person that would result in a negative action, such as not providing verification or causing the household to be over income?

The counties shall continue to send out the MC 355 when seeking additional verification/information for the newly added person. The county shall not take a negative action on the existing household member(s)' case per [MEDIL I 20-25](#), if the requested information is not provided or if existing household members are no longer eligible to the same level of Medi-Cal benefits due to the additional household member. If the additional household member is eligible for Medi-Cal but there is a negative impact on the existing household member(s), counties will give the additional household member eligibility but shall make changes and/or take the processing steps necessary to maintain the current Medi-Cal eligibility for the existing household member(s).

5. If a case was approved due to system or administrative error, should the county take a negative action? (Updated)

If eligibility was granted after the federal COVID-19 PHE began, the beneficiary must remain enrolled. Previously counties were instructed to allow beneficiaries to remain in coverage regardless of whether the beneficiary was erroneously granted coverage in full scope Medi-Cal. Effective with the release of ACWDL 21-16, per CMS guidance, a person is considered invalidly enrolled if the Medi-Cal eligibility determination was erroneously granted due to an administrative error or fraud at application or at last redetermination (if such redetermination was completed before March 18, 2020).

When counties identify a beneficiary who is not validly enrolled, the county must redetermine eligibility based on the process outlined in ACWDL 21-16.

6. Should the county take a negative action for Transitional Medi-Cal (TMC) households who did not provide their TMC report or have ended their 12-month TMC period?

No, the county shall not take a negative action on these redetermination cases per [MEDIL I 20-25](#) and shall retain the eligibility in a transitional aid code for the duration of the COVID-19 PHE.

7. Does continued eligibility during the executive order period count towards months of TMC?

Yes, however, if the TMC period ends prior to the end of the public health emergency, TMC will continue and discontinuance of the program shall be delayed for the duration of the COVID-19 PHE.

8. If a Modified Adjusted Gross Income (MAGI) Medi-Cal beneficiary reports an increase in earned income that causes them to exceed the income limit, should the county transition the individual into Transitional Medi-Cal?

No, counties shall not transition individuals into TMC. Counties shall continue Medi-Cal for these individuals in their MAGI aid code through the end of the COVID-19 PHE or leave them on aid code 38 if being discontinued from CalWORKS and ineligible to MAGI Medi-Cal.

9. When a county inmate needs the MCIEP aid code, are counties to suspend the Medi-Cal aid code or allow both aid codes to run at the same time?

The federal Centers for Medicare and Medicaid Services (CMS) clarified that suspension of Medi-Cal benefits for incarcerated individuals is not considered a negative action during this public health crisis. Please see newly released [MEDIL I 20-05](#) for Medi-Cal Eligibility Data System (MEDS) changes, and continue to follow existing inmate suspension guidance via [MEDIL I 20-11](#), [ACWDL 14-26](#) and [14-26E](#), and MCIEP guidance via [ACWDL 13-18](#).

10. Are the counties suspending the negative action of an individual who has failed to pay their premium payment?

Yes, counties shall not take negative actions on individuals who fail to pay their premium payment.

11. How should the county process a negative action currently on hold once the public health emergency is terminated?

Per CMS guidance, counties shall complete the beneficiary's redetermination in accordance with Title 42 Code of Federal Regulations (C.F.R.) section 435.916 prior to taking an adverse action after the end of the federal COVID-19 PHE, even if a redetermination was conducted during the federal COVID-19 PHE that deemed them ineligible. DHCS will provide further instruction on this in a future ACWDL.

12. How should the county process a Craig vs. Bonta Case?

Counties shall leave *Craig vs. Bonta* individuals in the corresponding aid code for the duration of the public health emergency.

13. If counties receive a request from a DHCS Fraud investigator to discontinue a Medi-Cal case, can counties proceed to take negative action during the PHE?

No. Per [MEDIL I 20-25](#) and [20-14](#), counties shall delay negative actions for Medi-Cal, Medi-Cal Access Program (MCAP), Medi-Cal Access Infant Program (MCAIP), and County Children's Health Initiative Program (CCHIP) through duration of the COVID-19 PHE.

14. When evaluating a Craig v. Bonta beneficiary for Long Term Care (LTC), what should the county do if the individual has excess property?

When a beneficiary is not eligible for LTC due to excess property, counties should maintain eligibility in Craig vs. Bonta for the duration of the COVID-19 PHE.

15. What should the county do when Craig v. Bonta eligibility is terminated in MEDS since the eligibility is posted by the Social Security Administration?

Counties must maintain the same level of coverage for a beneficiary during the PHE. In some instances, this may require the county to post eligibility directly in MEDS or complete an override in SAWS (as a last resort). Counties should discuss any functional barriers with SAWS to determine the approved process in those scenarios. Please note, when there are barriers to using the original aid code such as 6E (Craig v. Bonta Disabled - pending SB 87 redetermination) , counties may utilize aid code 38 (Edwards v. Kizer).

C. Allowable Negative Actions

1. How can counties move beneficiaries into LTC aid codes while complying with the delayed negative action requirements?

Transitioning a beneficiary into an LTC aid code is considered a positive action as it prevents any access to care issues. Counties shall process cases for individuals going into LTC and put them into the appropriate LTC aid code, if applicable. If there are cases where an individual does not qualify for LTC due to excess property, contact DHCS for technical assistance.

2. Is it allowable to increase LTC beneficiaries SOC?

Yes. Beneficiaries placed in a LTC aid code retain \$35 as a personal need allowance and the remaining countable income becomes the individual's SOC amount. Individuals in LTC have their SOC auto-obligated, making them systematically eligible to services on the first of each month. Increases to the SOC amount for a LTC beneficiary would not be considered a negative action as

the individual continues Medi-Cal coverage at the same benefit level month to month, and maintains their \$35 per month personal need allowance, which meets the federal “continuous coverage” requirement. Therefore, beneficiaries in an LTC aid code can have their SOC amount increased during the PHE with timely notice.

3. Can the county discontinue an individual who is over income for Medi-Cal but has accepted coverage for a Qualified Health Plan (QHP) case through Covered California?

Individuals who have enrolled in a QHP through Covered California and effectuated their plan are considered to have voluntarily requested disenrollment from Medi-Cal and can be discontinued accordingly.

4. If an individual becomes eligible for Medi-Cal under a cash-based program (e.g. CalWORKs, SSI/SSP), can the county discontinue providing Medi-Cal to the individual during the public health emergency period?

Yes, the county may discontinue a Medi-Cal Only individual in order to approve benefits under a cash-based program such as CalWORKs, as long as the level of Medi-Cal benefits and services remains the same. Per CMS, “...states may increase the level of assistance provided to a beneficiary who experiences a change in circumstances, such as moving the individual to another eligibility group which provides additional benefits, (however) states may not reduce benefits.”

D. Benefit Reinstatement Guidelines

1. Should the counties reinstate benefits to beneficiaries who have been discontinued (effective April 2020) and are requesting a reinstatement?

In accordance with [MEDIL I 20-25](#), counties must prioritize requests for Medi-Cal reinstatement from individuals who were discontinued effective April 1, 2020. The county shall reinstate the case without requiring additional documents, verifications and/or information from the individual. These cases should be identified for future processing once the COVID-19 PHE is terminated. In instances when the county is unable to reinstate the Medi-Cal beneficiary, the beneficiary will be included as part of the DHCS monthly reinstatement process.

2. Should counties reinstate benefits to beneficiaries who have been discontinued effective March 2020 or before and are requesting a reinstatement?

In accordance with [MEDIL I 20-25](#), individuals discontinued effective March 1, 2020 are within their 90-day cure period and must work with the county, providing information and/or documentation required to resolve any outstanding eligibility issues, prior to the county restoring Medi-Cal eligibility.

3. How do the Medi-Cal reinstatements affect beneficiaries who previously had In-Home Supportive Services (IHSS)?

Beneficiaries who had their Medi-Cal reinstated as part of the restoration efforts by DHCS and previously had IHSS eligibility, should be automatically re-enrolled in IHSS.

If the beneficiary paid out of pocket to the IHSS provider before their Medi-Cal benefits were reinstated, they may be entitled to get reimbursed, in accordance with their applicable Share-of-Cost (SOC), through the *Conlan* beneficiary reimbursement process for those expenses by filing a claim by calling or writing to Medi-Cal at:

- For Medical, Mental Health, Drug and Alcohol, and In-Home Supportive Services Claims:
California Department of Health Services Beneficiary Services
P.O. Box 138008
Sacramento, CA 95813-8008
(916) 403-2007 TDD: (916) 635-6491
- For Dental Claims:
Denti-Cal Beneficiary Services
P.O. Box 526026
Sacramento, CA 95852-6026
(916) 403-2007 TDD: (916) 635-6491

If the beneficiary received IHSS services before their Medi-Cal benefits were reinstated but was unable to pay the provider, the beneficiary may contact the county IHSS department to have the provider payment reviewed. Once the county IHSS department confirms the eligibility and/or the change of SOC in MEDS, the provider may be reimbursed for the services in excess of the SOC amount.

E. Annual Redeterminations

1. Are counties permitted to delay processing all annual renewals? (Updated)

Yes. However, counties are permitted to work annual renewals as long as it does not lead to an adverse action on the case as outlined in [ACWDL 21-16](#).

2. Will Medi-Cal redetermination dates be pushed out for 12 months?

No. At this time, CMS timeliness flexibilities for annual renewals do not include pushing out Medi-Cal redetermination dates for 12 months. Instead, renewals will start over at the expiration of the PHE.

3. Are counties expected to continue to send out redetermination packets during this time?

Only packets sent out through an automated process will continue. Counties should not send out any manual renewal packets at this time.

4. If counties have the ability to process redeterminations, can counties continue to process cases where no negative actions would occur?

Yes, Previously counties were instructed to halt processing redeterminations per [MEDIL I 20-25](#). Effective with the release of [ACWDL 21-16](#), counties may process redeterminations as long as it does not lead to an adverse action on the case.

5. Should individuals that are included as part of the CalWORKS household or those individuals who are not aided in CalWORKS cases but have a Medi-Cal-only record on the case have their renewal date moved forward six months to align with CalWORKS?

For cases in which an individual is receiving Medi-Cal-only on a CalWORKs case, the individual's Medi-Cal redetermination date should align with the CalWORKs renewal date. DHCS is working with SAWS to align these dates.

6. If a beneficiary does not comply with their CalWORKs redetermination, does the Medi-Cal eligibility continue?

Yes, the county shall keep the individual on transitional aid code 38 for the duration of the PHE. The redetermination will be completed after the PHE has been lifted.

7. If a beneficiary reports a change separately from their annual renewal, and the counties process the reported change, can the counties also process the renewal?

If an individual reports a change separate and apart from their renewal and that change results in a positive outcome, counties can continue with processing the change and set the renewal date out one year. Since the county has acted on the most current information due to the reported change in circumstance, processing the actual renewal package is no longer needed.

F. Other Case Processing Guidance

1. **Should counties process carry forward referrals that come as “pending eligible”?**

Counties shall not delay the processing of carry forward referrals. Per [ACWDL 17-07](#), a Covered California enrollee in carry forward status is not an existing Medi-Cal beneficiary and the Covered California referral is treated as a new application for Medi-Cal purposes. Per [MEDIL I 20-25](#) and [MEDIL I 20-15](#), counties shall prioritize eligibility determinations for transitioning cases in Carry Forward Status to prevent gaps in coverage.

2. **What action should counties take if an individual applies for Medi-Cal and is eligible for the first month but is ineligible the following month due to an increase in income?**

The individual must remain enrolled in Medi-Cal and the negative action should not be applied for the duration of the public health emergency. Once the individual is found eligible for the application month, they are considered a beneficiary and the rules outlined in [MEDIL I 20-25](#) apply. The case should be tracked for future processing once the suspension of negative action activities is lifted.

- **Please note:** A beneficiary is considered enrolled in Medi-Cal based on a determination of eligibility in the retroactive eligibility period. Counties should keep the individual enrolled in the group in which they were determined eligible during the retroactive period for purposes of the continuous enrollment requirement. If county workers have terminated any cases because only the retroactive months made the individual enrolled as of March 18, 2020, county workers are instructed to restore these cases immediately.

3. **What should the county do if the applicant/beneficiary cannot provide a social security number (SSN)?**

The county shall be flexible regarding the requirement to apply for or provide the SSN due to the current public health crisis and as a result of Social Security Administration (SSA) offices being closed. [ACWDL 19-13](#), which describes the requirement to apply for and provide an SSN, includes the following guidance:

“Note that if a beneficiary informs the county that an application has been made to comply with the requirement, and the delay is a result of the entity making the decision, the beneficiary shall not be discontinued pending the outcome of the decision. Counties may determine their own best practices for following up with the individual after a reasonable amount of time to determine if the individual has received the approval or denial or is not responding to the county.”

This policy guidance can also be applied where the beneficiary is unable to apply for or obtain a SSN due to office closures or delays due to current SSA office closures. Counties must notate the reason for the delay in the case record and, per the guidance above, determine their own best practices for following up with the beneficiary, depending on the length of the crisis or delays at SSA.

4. Can the county accept written affidavits telephonically signed by the applicant or beneficiary?

Yes, during the federally declared emergency, counties may accept written affidavits that are telephonically signed for verification of items such as income ending and proof of property spenddown. [MEDIL I 20-25](#) provides guidance regarding the acceptance of affidavits over the telephone. Furthermore, if an applicant or beneficiary has recently lost employment or does not have access to a verification due to the COVID-19 PHE, the county shall offer the individual the opportunity to complete a telephonically signed, written affidavit attesting to the change in income or other item in need of verification.

Counties may provide the option of completing the written affidavit with a telephonic signature by asking the applicant or beneficiary, “If you do not have any verification available, you may complete a sworn statement and telephonically sign it over the phone. Would you like to complete one at this time?”

5. During this public health crisis, can counties utilize the CW2200 form for Medi-Cal-only application verification requests?

Yes, the CW2200 form can be used by counties for Medi-Cal-only cases during intake or counties can use other county generated verification forms to request verifications and information from applicants to determine Medi-Cal eligibility. Counties shall follow the two applicant contacts and timeframe requirements in [ACWDL 08-07](#) when requesting verifications using the CW2200 or other county generated forms.

6. In calculating the minimum monthly maintenance allowance of the community spouse of an institutionalized or home and community based services spouse, should Pandemic Unemployment Compensation (PUC) payments the community spouse is receiving be excluded as income when determining income available to the community spouse?

Yes, according to [ACWDL 20-09](#), Section 2104 of the CARES Act states that the additional payments shall be disregarded and not counted in the eligibility determination. This includes determining the income available to a community spouse in calculating the community spouse’s monthly income allowance.

- 7. Would an individual who is subject to Medi-Cal’s transfer-of-property rules and who transfers their recovery rebate without receiving something of equal value in return be subject to a transfer of property penalty?**

The answer depends on when the transfer occurs relative to the receipt of the recovery rebate. According to [ACWDL 20-09](#), Section 2201 of the CARES Act states that recovery rebates are excluded as income and exempt as property for 12 months from receipt of the benefit. This means that for any portion of a recovery rebate transferred for less than fair market value that occurs in the month in which the recovery rebate is received or within the 12 months following receipt of the rebate, no penalty would apply because there is no penalty for transfers of income or exempt property. However, transfers of any portion of a recovery rebate for less than fair market value that occur more than 12 months following receipt of the rebate would be subject to the transfer of property rules.

- 8. Are supplemental payments for workers such as “hazard pay,” “hero pay,” supplemental payments to long-term services and supports (LTSS) direct care workers through Appendix K of an HCBS waiver, or other additional wages paid by employers counted as income?**

The supplemental payments are counted as income for both MAGI and Non-MAGI.

- 9. Should counties continue to screen individuals for eligibility for Medicare Savings Programs (MSPs) during the PHE?**

Yes, counties should continue to evaluate all Medicare eligible individuals for MSP program eligibility as instructed in [ACWDL 08-21](#), and when requested.

- 10. Are counties only required to process returned 1095-B MEDS alerts once the PHE ends?**

Counties should be working these alerts now. These alerts pertain to updating contact information.

G. Verifications

- 1. Are there any flexibilities surrounding verification requirements for current medical expense application towards share of cost under Hunt vs. Kizer? Can counties accept verbal attestation to avoid the beneficiary or their authorized representative (AR) from having to return to a drug store or provider to obtain the needed information?**

Yes, counties may accept self-attestation to verify incurred medical expenses for purposes of determining eligibility for coverage as described in Title 42 Code of Federal Regulations (C.F.R.) Section 435.121(e) and 42 C.F.R. Section

435.831(d). Counties can permit individuals, consistent with 42 C.F.R. Section 435.945, to self-attest to the amounts of their incurred medical expenses. This would allow individuals to avoid the collection and submission of documentation of their incurred medical expenses. Counties can permit this on a temporary basis through the duration of the PHE. Counties are expected to document such self-attestation in the case file.

H. Requested Changes for Mixed Households

- 1. In cases where an individual reports an increase in income that does not result in a change in MAGI/Optional Targeted Low Income Children Program (OTLICP) eligibility for the child, but would result in a change for the advanced premium tax credit (APTC) for the parents, what action does DHCS recommend? Should counties update the income so the individual can adjust their APTC and avoid a potential tax penalty next year?**

An APTC individual that reports a change to the county should be treated as someone requesting a change to their APTC case. The individual can report the change themselves in the Covered CA portal or the county can apply the change. Please note that no negative action can occur on any Medi-Cal household members. This may mean that the county has to make the change directly in California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), or not run EDBC after MAGI is requested and the case is updated with the new information in CalHEERS, or complete a manual override to maintain eligibility. Counties should not apply changes to an APTC case that are not reported directly from the individual such as information found in IEVS.

I. Presumptive Eligibility

- 1. Is Presumptive Eligibility (PE) included in the Governor's PHE Executive Order? Are individuals aided on PE considered beneficiaries?**

Individuals on PE are not considered beneficiaries and are not subject to the Governor's PHE Executive Order. PE individuals are subject to the application processing rules when/if they apply for Medi-Cal.

J. Accelerated Enrollment

- 1. Can counties take negative action on an Accelerated Enrollment (AE) case if an individual fails to provide requested information? Or should counties let the 8E aid code continue to run and address it after the PHE is over?**

AE is very similar to presumptive eligibility. Individuals granted AE Medi-Cal are not considered beneficiaries. If the county encounters a situation where an individual is currently on AE and fails to provide requested information, the county can terminate eligibility.

K. Disaster Payments

- 1. How do we treat the Disaster Relief Assistance for Immigrants payments? Are these payments exempt, similar to the Recovery Rebates for Individuals?**

According to Title 22 California Code of Regulations (CCR) Section 50535.5 Disaster and Emergency assistance payments received from federal, state, and local government agencies, or disaster assistance organizations are exempt for both MAGI and Non-MAGI Medi-Cal programs.

- 2. What is the treatment of rental relief subsidies received through SB 91 (Chapter 2, Statutes of 2021)? Are the subsidies countable for property or as income?**

No, for MAGI, a tenant's rent liability that is forgiven by a landlord or rental subsidies received through SB 91 do not count as income.

For Non-MAGI, rental relief subsidies are treated as Disaster and Emergency Assistance Payments and are not counted as income or as resources for 12 months following receipt.

SB 91, in accordance with Section 501 of Subtitle A of Title V of Division N of the federal Consolidations Appropriations Act of 2021 (Public Law 116-260), exempts any income from assistance programs provided to tenants for purposes of Personal Income Tax or that is used to determine eligibility for any state program or local program that is financed wholly or in part by state funds.

L. Families First Coronavirus Response Act/Family Medical Leave Act Income

- 1. Please advise how Families First Coronavirus Response Act and Family Medical Leave Act income would be counted for both MAGI and Non-MAGI programs.**

For purposes of determining Medi-Cal eligibility, the taxable portion of wages received under the Families First Coronavirus Response Act (FFCRA) is counted. The FFCRA does not change the Family Medical Leave Act (FMLA) but rather requires employers of a certain size to provide paid sick leave and family leave to employees affected by Covid-19. Under Section 7001(c) and Section 7003(c) of the FFCRA, paid sick leave and paid family leave are wages as defined in Section 3121(a) and compensation as defined in Section 3231(e) of the Internal Revenue Code (IRC).

Wages received under the FFCRA are not excluded from gross income as

“qualified disaster relief payments.” Although the COVID-19 outbreak is a “qualified disaster” for purposes of Section 139 the IRC, wages received under the FFCRA are not excludible qualified disaster relief payments because they are intended to replace wages or compensation that an individual would otherwise earn, rather than to serve as payments to offset any particular expenses that an individual would incur due to the COVID-19 PHE.

2. Under the Treatment of Cares Act, how do we identify the Employment Development Department Real Time income showing in MEDS? Would it be considered part of the Pandemic Unemployment Assistance and if so, how is it counted for Medi-Cal?

The income displayed on the EDD Real Time Match screen is either: Pandemic Unemployment Assistance, which extends unemployment benefits to individuals who exhausted their unemployment benefits or their Pandemic Emergency Unemployment Compensation, and whose households have been directly impacted by COVID-19; or Pandemic Emergency Unemployment Compensation, which is the 13-week extension of benefits paid for by the federal government when someone exhausts their regular state unemployment claim between March 29, 2020 and the end of 2020. Both of these types of unemployment insurance benefits (UIB) are considered countable income for Medi-Cal.

If the information on this screen matches what the customer has self-attested to with countable unemployment as outlined in ACWDL 20-09, then this screen can be used to verify their income. If it does not align with the self-attested UIB, then the county shall work with the customer to gather more information about the UIB type(s) they are receiving.

M. DHCS Reports

1. Will the counties continue to receive periodic data matching reports from DHCS during the emergency period? Should counties suspend the processing of other reports received from DHCS?

Yes, in accordance with House Resolution Bill (HR) 6201, DHCS will continue to deliver periodic data matching reports. For example, this would include reports such as the Income Eligibility Verification System (IEVS) the Public Assistance Reporting Information System (PARIS) and monthly Asset Verification Program (AVP) reports. Counties should keep these reports on file and delay renewal processing as directed by [MEDIL I 20-25](#) through the duration of the public health emergency.

Examples of the reports counties shall suspend processing include the Exception Eligibles report, the Disabled Adult Child(ren) Cleanup Effort reports, and the Married Filing Jointly Cleanup Effort reports.

N. Fair Hearings

1. **Will there be extensions for beneficiaries to request a fair hearing?**

In accordance with [MEDIL I 20-25](#), DHCS received federal approval from CMS, granting temporary flexibilities that extends timeframes to allow beneficiaries up to an additional 120 days, for a total of up to 210 days, to request a fair hearing for Medi-Cal eligibility or a Fee-For-Service appeal.

2. **Should the county take the action if a hearing decision orders a negative action during the executive order period?**

No, the county shall not take the negative action and the individual shall remain eligible until the COVID-19 PHE is terminated.

3. **Will Aid Paid Pending (APP) continue for individuals who are a no-show for their scheduled hearing?**

Yes, APP will continue for individuals who are a no-show to their scheduled hearing for the duration of the public health emergency as removing APP could be considered a negative action.

O. Premiums

1. **Will premium payments be waived or will they accumulate during the executive order period?**

Premium payments will be waived and will not accumulate during the public health emergency period when individuals notify Maximus or Third Party Liability that they are unable to pay due to impacts of the COVID-19 PHE.

P. Change in Scope

1. **Should individuals in the Young Adult Expansion (YAE) program who are aging out (turning 26) transition from full scope to limited scope before the end of the public health emergency?**

No, for all age-out scenarios within the YAE program, counties shall keep these individuals in full scope Medi-Cal coverage through the duration of the COVID-19 PHE.

2. **If an individual has made a declaration of citizenship or satisfactory immigration status and been assigned a Reasonable Opportunity Period**

(ROP) to provide proof, but fails to provide such proof within the ROP, should the county take a negative action to move the individual from full scope Medi-Cal to limited scope services before the end of the public health emergency?

No, individuals who were assigned a ROP to provide proof of citizenship or satisfactory immigration status but have failed to provide such proof within the ROP, must remain enrolled in full scope Medi-Cal until the termination of the COVID-19 PHE, even if their citizenship or satisfactory immigration status has not been verified.

- 3. If the county discovers an individual incorrectly declares citizenship or satisfactory immigration status information or is erroneously granted full scope coverage at application, should the county take negative action to move the individual from full scope Medi-Cal to limited scope services before the end of the public health emergency? (Updated)**

Previously counties were instructed to allow beneficiaries to remain in coverage regardless of whether the beneficiary was erroneously granted coverage in full scope Medi-Cal. Effective with the release of ACWDL 21-16, per CMS guidance, a person is only considered invalidly enrolled if the Medi-Cal eligibility determination was erroneously granted due to an agency error or fraud at application or at last redetermination (if such redetermination was completed **before March 18, 2020**). Agency error does not include errors resulting from a CEW not processing change in circumstances or renewals, nor does it include data entry errors made by the beneficiary. Per CMS guidance, a person can only be disenrolled based on fraud after a full administrative investigation into the suspected abused has taken place per 42 CFR 455.15 and 455.16. If eligibility was granted after the federal COVID-19 PHE began, the beneficiary must remain enrolled.

When counties identify a beneficiary who is not validly enrolled, the county must redetermine eligibility based on the process outlined in [ACWDL 21-16](#).

- 4. How should counties continue full-scope benefits once the 60-day postpartum period ends?**

Once a beneficiary finishes their 60-day postpartum period, they shall be transitioned to aid code 38 and remain on this aid code through the end of the COVID-19 PHE.

Q. Retroactive Medi-Cal

- 1. On MEDIL 20-18, question 25 has a note that the negative action may not apply to retroactive Medi-Cal requests since these individuals are not**

considered beneficiaries. If an individual request retroactive Medi-Cal but does not provide the verifications needed, can the county deny the request for retroactive benefits?

Yes, the county shall deny the request for retroactive coverage, since requests for retroactive Medi-Cal coverage are considered part of the application process and the individual is not considered a beneficiary for purposes of determining eligibility for retroactive months.

- 2. In ACWDL 21-16, there is a note that states that question 13 on MEDIL 21-04 regarding retroactive coverage is now obsolete. Does this mean that when an individual is approved for retroactive Medi-Cal, they are now considered beneficiaries and are subject to delayed negative action?**

Yes, in previous DHCS guidance, DHCS has stated that for months with retro eligibility, the person is considered an applicant and not a beneficiary. However, per CMS guidance (outlined in the Interim Final Rule), during the PHE, individuals who have retro eligibility Medi-Cal are protected if they are validly enrolled as of March 18, 2020. With the release of [ACWDL 21-16](#), if the individual was granted retroactive Medi-Cal eligibility, they must continue coverage throughout the end of the COVID-19 PHE.

If county workers have terminated any cases because only the retroactive months made the individual enrolled as of March 18, 2020, county workers are instructed to restore these cases immediately.

R. Inter-County Transfers

- 1. Should the annual renewal be completed for Inter-County Transfer (ICT) cases that have renewals that are either overdue or initiated, but the individual has not complied?**

Counties shall prioritize and complete ICT cases for renewals that are overdue or initiated where the client has not complied to ensure the individual has access to medical care through the duration of the PHE. The renewal date should remain the same. There shall be no delays in processing and the receiving county is responsible for handling the overdue renewal at the end of the COVID-19 PHE. Please continue to follow guidance outlined in MEDIL I 20-08 to delay discontinuance and negative actions as a result of annual renewals and reported change in circumstances, including verifications requested as part of the annual renewal and change in circumstance processing.

- 2. There are individual's currently in soft pause status who are requesting their case be transferred to a new county. Can a Sending County initiate an**

ICT, when one or more individuals on the Medi-Cal case are in soft pause status?

Yes, the Sending County must initiate a timely ICT when one or more individuals are in soft pause status and provide full documentation of the individual(s) eligibility status in soft pause cases in the ICT file sent to the Receiving County. The Receiving County will need to know the reason for soft pause, such as unable to discontinue due to the COVID-19 PHE or eligibility under a consumer protection program (CPP). When accepting the ICT, the Receiving County will have to continue the current aid code based on the soft pause and take the appropriate next steps for the case (i.e. sending the Non-MAGI screening packet, setting a task for the end of the COVID-19 PHE, etc.). In compliance with ICT mandates, the Sending and Receiving counties must coordinate the timely process of an ICT and prevent any break in aid or barriers to access to care for beneficiaries.

3. What should the county do if a beneficiary moves out of the county and they do not provide a new address in the receiving county?

If a county receives information that an individual no longer lives in the county that has responsibility for the case, the county must keep the individual enrolled until the beneficiary presents themselves to the county where the individual is receiving aid, or another county, and an ICT can be processed per Welfare & Institutions Code 10003. The county eligibility worker should contact the beneficiary to verify the changed county of residence, obtain their updated contact information, and facilitate an ICT .

S. Case Processing Actions Allowed during the COVID-19 PHE ACWDL

1. Do we continue to delay moving a child from a no premium to premium aid code during the public health emergency?

Per CMS guidance, moving a child from a no premium to a premium aid code is now an allowable action as long as there is no reduction in benefits. Continuous eligibility for children (CEC) should still be evaluated prior to making a change from premium to no-premium. County workers are also reminded to advise families of their right to request premium waivers during the PHE, and how to obtain a premium waiver.

2. If a redetermination that granted eligibility erroneously took place after March 18, 2020, can a negative action can be taken?

No. Per CMS guidance, a person is considered invalidly enrolled if the Medi-Cal eligibility determination was erroneously granted due to an administrative error or

fraud at application or at last redetermination (if **such redetermination was completed before March 18, 2020**). If eligibility was granted on or after March 18, 2020 when the federal COVID-19 PHE began, the beneficiary must remain enrolled.

- 3. In ACWDL 21-16, it states that CEWs shall only process change in circumstances that result in no change or positive change in eligibility and coverage for Medi-Cal beneficiaries who are validly enrolled. What should CEWs do if while processing a change in circumstance, they determine that the client and/or household was not validly enrolled?**

Discontinuing or performing a negative action for those who are invalidly enrolled are allowable actions during the federal COVID-19 PHE per CMS. Per [ACWDL 21-16](#), CEWs shall complete a redetermination of Medi-Cal eligibility (consistent with Welfare and Institutions Code 14005.37 and 42 CFR 435.916) when the county identifies a beneficiary is enrolled in a Medi-Cal program based on agency error, fraud, or abuse, . This includes the process of ex-parte, requesting verifications if applicable, and following the existing processes outlined in [ACWDL 14-18](#).

- 4. Tier 1 does not list the continuous eligibility for children (CEC) program. Are counties supposed to review for CEC when a reported change results in a child going from a non-premium aid code to a premium aid code or are counties no longer placing children in CEC?**

CEC protects children in the exact same level of coverage in between application/renewal and the next annual renewal. Therefore, moving a child to CEC would provide the same level of coverage and would be an allowable move during the COVID-19 PHE. However, in instances when the CEC period has expired, a child may be moved to another aid code, including from a non-premium to a premium aid code, as long as they maintain the same tier of coverage.

T. Other Reminders

- 1. How should counties verify individuals with no income?**

Counties shall follow the existing policy for verifying no income. When an individual reports no income, including when an individual self-attests to no income as a result of income ending, the CEW shall only request additional verifications if the individual's self-attested income is not verified through electronic sources such as with the Federal Data Services Hub (Welfare and Institutions Code (WIC) Section 14013.3) or other electronic sources. This applies to all individuals who self-attest to no income, including non-MAGI individuals who are included in the household composition.

If the self-attested income is not reasonably compatible, then the CEW shall attempt to administratively verify no income. Verification of income can be through employment contracts, paystubs, letters from the employer, unemployment denial letter, social security award letters, etc. As a reminder, counties shall accept a sworn statement that may be signed telephonically as outlined in [MEDIL I 20-25](#) for forms and verifications that usually require a wet signature during the public health emergency. Furthermore, if an applicant or beneficiary has recently lost employment or does not have access to a verification due to the COVID-19 PHE, the county shall offer the individual the opportunity to complete a telephonically signed, written affidavit attesting to the change in income or other item in need of verification.

Counties may provide the option of completing the written affidavit with a telephonic signature by asking the applicant or beneficiary, “If you do not have any verification available, you may complete a sworn statement and telephonically sign it over the phone. Would you like to complete one at this time?”