DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

DATE: February 12, 2025

TO: ALL COUNTY WELFARE DIRECTORS Letter No.: 25-03
ALL COUNTY WELFARE ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS
ALL COUNTY MEDS LIAISONS

SUBJECT: NON-COMPLIANCE WITH MEDI-CAL ELIGIBILITY REQUIREMENTS AND THE ELIMINATION OF THE REQUIREMENT TO APPLY FOR OTHER BENEFITS
(Reference: Welfare & Institutions Code § 14005.37 and 14011.2; Title 22 California Code of Regulations § 50168, 50185, 50186, 50187, 50763, 50771, and 50777; All County Welfare Directors Letters 05-08, 08-07, 13-12, 14-18, 14-22, 15-26, 15-27, 16-04, 16-24, 17-03, 17-32, 20-04, 22-12 24-03, 24-06, 24-11, 24-19, Medi-Cal Eligibility Division Information Letter 16-04, 23-44, 23-57)

PURPOSE

The purpose of this All County Welfare Directors Letter (ACWDL) is to provide updated policies to ensure alignment with a Centers for Medicare and Medicaid Services (CMS) rule change eliminating the requirement that individuals apply for certain other benefits as a condition of Medi-Cal eligibility under Code of Federal Regulations (CFR), title 42, sections §§ 435.608 and 436.608. Due to the extensive revisions and updates, ACWDL 19-13 is now considered obsolete. This ACWDL will provide guidance on required county actions when Medi-Cal applicants and members fail to comply with the remaining requirements. This letter is not inclusive of all eligibility requirements for the Medi-Cal program and is only intended to provide updated guidance.

BACKGROUND

On April 2, 2024, CMS released the second part of a two-part final rule *Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes*. This rule contains several significant changes to Medi-Cal application, eligibility, enrollment, and renewal processes.

Effective June 1, 2025, Medi-Cal applicants and members are no longer required to apply for unconditionally available income for all Medi-Cal programs including the County Children's Health Initiative Program, under title 42 CFR §§ sections 435.608 and 436.608. For further guidance and for more information on complying with the CMS final

rule *Remove the Requirement to Apply for Other Benefits*, county eligibility workers (CEW) can refer to ACWDL 24-19. For information on the order in which Medi-Cal eligibility is determined, please reference ACWDL 17-03.

MEDI-CAL APPLICANT/ MEMBER REQUIREMENTS

In accordance with this rule change on the elimination to require individuals to apply for unconditionally available income, certain requirements remain. Those include:

- The requirement to apply for Medicare,
- The requirement to apply for Veteran's Health Benefits,
- The requirement to provide information about Third Party Liabilities,
- The requirement to provide information about Other Health Coverage (OHC),
- The requirement to apply for or provide a Social Security Number (SSN), and
- The requirement to comply with medical support enforcement (MSE) except for any applicable good cause exceptions described under CCR, title 22, section 50771.5 and CFR, title 42, section § 435.610. For more information on MSE, please refer to ACWDL 20-04 and ACWDL 24-19.

For each of the requirements outlined above, approval of eligibility may not be delayed if the individual is otherwise eligible for Medi-Cal. This means that for a new applicant or member seeking or renewing Medi-Cal eligibility, if the only item(s) pending is one or more of the requirements outlined above, eligibility must be approved pending the outcome of compliance with the requirement. Requirements for these groups are explained in greater detail in the sections below.

The following types of applicants/members may not have their Medi-Cal discontinued for their or other household member's failure to comply with the requirements to apply for the benefits listed above:

- A child who has been enrolled in Medi-Cal for 12 consecutive months with Continuous Eligibility for Children (CEC), whether through Accelerated Enrollment or otherwise (for more information on CEC, please see ACWDL 24-03);
- A Deemed Eligible infant under the age of one;
- A pregnant individual who had Medi-Cal for the pregnancy and who is still within their 12-month postpartum period;
- A foster child or former foster youth under age 26;
- Individuals who were required to apply for unconditionally available income prior to this updated guidance and who choose to no longer maintain those benefits; or

- A pregnant individual or an individual in their 12-month postpartum period who fails to comply with MSE requirements.
    - Note: The Section 1902(e)(14)(A) waiver allowed counties to suspend, as a condition of Medi-Cal eligibility, the requirement of the Medi-Cal applicant or member to cooperate with the MSE process. Until DHCS issues additional guidance, counties should continue to apply the waiver introduced during the continuous coverage unwinding that pauses this requirement. Please see Medi-Cal Eligibility Division Information Letter (MEDIL) I 23-44 for additional information. DHCS will provide additional guidance in the future when the unwinding waivers and flexibilities end and if any are expected to continue.

Requirement to Apply for Medicare

In accordance with California Code of Regulations (CCR), title 22, sections 50763(a)(1) and 50777, Medi-Cal applicants and members must, as a condition of eligibility, apply for any other available health coverage, including Medicare, if they qualify and when no cost is involved. If accepting the coverage would result in a premium or cost to the individual, they are not required to accept the coverage. The requirement is limited to applying for Medicare Parts A and B, not necessarily accepting it when costs are involved. Therefore, Medi-Cal members are not required to accept coverage due to costs. Counties shall inform applicants and members of their requirement to apply for Medicare if they are either citizens of the United States or are immigrants lawfully present in the United States for at least five years, in accordance with CCR, Title 22, Sections §§ 50775 and 50777, meet at least one of the following conditions:

- Applicants and members who are 64 and 9 months of age or older;
- Applicants and members in the month they turn 65;
- Applicants and members who are over 65 and it is past their initial enrollment period. An individual's initial enrollment period for Medicare is a total of seven months: three months prior to their 65th birthday, the month of their 65th birthday, and the three months after their 65th birthday. The county shall inform the individual that they are required to apply during the next Medicare open enrollment period which occurs annually from January 1 through March 31, with benefits effective July 1.
- Applicants and members who are eligible for Medicare prior to turning age 65. This includes:
    - Individuals applying on the basis of disability, including blindness, unless the county can obtain verification of receipt of Social Security Title II disability payments. For those receiving Social Security Title II disability payments, Medicare enrollment is automatic beginning with the 25th

month of receipt of this benefit and application for Medicare is not required.
- Individuals applying for the dialysis special treatment program, or individuals that the county is aware are receiving dialysis-related health care services, unless the county can obtain verification of receipt of Medicare Part A benefits. For individuals in need of dialysis who are enrolled in Medicare Part A, Medicare Part B enrollment is deemed to be automatic, and an application is not required.

With the expansion of Medi-Cal eligibility, Medi-Cal members who qualify for full-scope Medi-Cal must also meet all the criteria outlined above for the county to request that they apply for Medicare.

Under Title 22, CCR, Sections 50168 and 50777, Medi-Cal applicants and members have 60 days to provide proof of their Medicare approval or denial from the date they are notified of the need to apply for Medicare. The county may proceed with the eligibility determination if this information is available through an ex parte review.

If an applicant or member does not receive their Medicare approval or denial within 60 days, they are required to provide to the county proof of Medicare approval or denial within 10 days of receipt from the Social Security Administration (SSA). This means that if an individual informs the county that they have not yet received their approval or denial during the 60-day period, counties must allow the individual additional time to obtain it. 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. As a best practice, counties should consider allowing an additional 30 days for applicants or members to submit the required information, provided they are actively working with the county. This approach ensures a cooperative process and accommodates individuals who may need more time while waiting for SSA's reply.

An applicant who is required to apply for Medicare, and who is otherwise eligible for Medi-Cal must be made eligible pending the outcome of the requirement to apply for Medicare. The county process for obtaining this information from the applicant or member is provided below in the Required County Actions section of this letter.

Requirement to Provide Information about Other Health Coverage (OHC)

In accordance with Title 22, CCR, Sections 50185 and 50763, Medi-Cal applicants and members must, as a condition of eligibility:

- report to the county on the availability of OHC at the time of application, reapplication, or redetermination; and

- report to the county any change in the availability of OHC no later than 10 calendar days from the date the member was notified of the change by the employer or insurer.

The Department of Health Care Services (DHCS) currently receives OHC data from health insurance carriers, the Department of Child Support Services, the SSA, California Children's Services, and other automated systems through a data matching process. The entities that share OHC data with DHCS are referred to as Current Trading Partners and the OHC information they share is stored in the individual's Medi-Cal Eligibility Data System (MEDS) record.

According to ACWDL 13-12, counties must only add OHC records to MEDS when:

- The applicant or member provides information that the OHC they have is not on the list of Current Trading Partners (http://dhcs.ca.gov/OHC).
- The applicant or member has OHC that is not showing in MEDS and wants their OHC added to their record.

As a result of the data matching process, counties shall not request additional OHC information from applicants and members unless the applicant or member:

- Informs the county they have OHC that is not on the list of Current Trading Partners and/or not on MEDS; and
- Does not initially provide enough information for counties to add the OHC to the MEDS record.

Additionally, the county is not required to obtain OHC information when reporting the OHC could endanger an applicant or member or create a barrier to care, such as when:

- A child is in foster care or removed from the home pending evaluation of foster care status;
- A child is in an Adoption Assistance Program or Kin-GAP aid code;
- An applicant or member is a victim of domestic violence or human trafficking;
- Medical support is being enforced by the local child support agency;
- The OHC is limited to a specific geographic service area and the applicant or member lives outside that area; or
- The OHC requires use of specified provider(s), and the member lives more than 60 miles or 60 minutes travel time from the specified provider(s).

Additional information about when OHC information must be obtained by the county; required to be provided by the applicant or member when the county should request

removal of OHC and the process for updating OHC information in MEDS can be found in ACWDL 13-12.

An applicant who is required to provide information about OHC, and who is otherwise eligible for Medi-Cal, must be made eligible pending the outcome of the requirement to provide information about OHC. The county process for obtaining this information from the applicant or member is provided below in the Required County Actions section of this letter.

Requirement to Provide Veteran's Health Benefits Information

In accordance with Title 22, CCR, Sections 50185 and 50763, Medi-Cal applicants and members must, as a condition of eligibility, apply for and/or retain OHC when there is no premium cost to the applicant or member, such as insurance available to veterans of U.S. military service or their dependents.

An applicant who is required to apply for veteran's health benefits**,** and who is otherwise eligible for Medi-Cal, must be made eligible pending the outcome of the requirement to apply for veteran's health benefits. For more information about the referral process to the County Veterans Service Offices (CVSO) for U.S. military veterans, please see ACWDL 16-04 and ACWDL 05-08. The county process for obtaining this information from the applicant or member is provided below in the Required County Actions section of this letter.

As a reminder, Medi-Cal applicants or members who are veterans are only required to apply for veteran's health benefits and are not required to apply for veteran's income benefits. A confirmation of eligibility for veteran's income benefits does not mean the applicant or member is required to apply for those benefits as a condition of Medi-Cal eligibility. The county would not need to pursue any additional actions related to the veteran's income benefits. In addition, the elimination of the requirement to apply for other benefits, such as veteran's income, does not preclude the ex parte process by using the MC 05 to verify the veteran's income.

Requirement to Provide Information about Third Party Liabilities

In accordance with Title 22, CCR, Section 50771, Medi-Cal applicants and members must, as a condition of eligibility:

- report to the county on services received as the result of an accident or injury caused by a third party;

- furnish DHCS with an assignment of rights to receive payment for those services provided as a result of an accident or injury caused by a third party, if those services will be billed to Medi-Cal.

Applicants and members who indicate they have a lawsuit or other claim due to injury or accident, are required to cooperate with the county in obtaining information regarding third party liabilities. Counties are still required to submit proper notification to DHCS when a member receives a settlement, judgment, award, or workers' compensation. Online forms used to report information to DHCS may be found here.

An applicant who is required to cooperate with the county in obtaining information regarding third party liabilities, and who is otherwise eligible for Medi-Cal, must be made eligible pending the outcome of the requirement to cooperate. The county process for obtaining this information from the applicant or member is provided below in the Required County Actions section of this letter.

Requirement to Apply for or Provide a Social Security Number

In accordance with Title 22, CCR, Sections 50168 and 50187 and California Welfare and Institutions Code (W&I Code) section 14011.2, Medi-Cal applicants and members must, as a condition of eligibility, apply for and provide a SSN if:

- They are requesting or already have Medi-Cal benefits; and
- They declare they are a citizen or national of the United States have satisfactory immigration status.

An applicant or member does not have to provide an SSN if they have not declared that they are a citizen or national of the United States or have satisfactory immigration status. Per MEDIL I 23-57, noncitizen Medi-Cal applicants and members who are not lawfully present are not required to apply for or provide an SSN as a condition of full scope Medi-Cal eligibility.

A deemed infant who was born to an individual covered by Medi-Cal in the month of delivery is eligible for Medi-Cal even if the infant's SSN has not been provided. According to the Medi-Cal Eligibility Procedures Manual, Section 5H, the parent should be informed of the need to provide an SSN for the infant by the age of one year. However, the county shall not delay or deny the infant's Medi-Cal eligibility because an SSN has not been provided during the infant's first year.

For more information on SSN requirements for Medi-Cal applicants and members, counties can reference MEDIL 23-57.

Applicants and members who are required to provide an SSN, other than deemed infants, have 60 days from the date of Medi-Cal application to provide proof of their SSN or SSN application. Additionally, once an SSN provided by an applicant or member has been verified, the applicant/member shall not be required to provide the SSN again, even if they are transferring to or applying in a new county. An applicant who is required to provide an SSN or proof of SSN application, and who is otherwise eligible for Medi-Cal, must be made eligible for full-scope Medi-Cal benefits pending verification of the SSN or proof of SSN application. The county process for obtaining this information from the applicant or member is provided in the Required County Actions section below.

Required County Actions

Application Process

When it is determined that a Modified Adjusted Gross Income (MAGI) or Non-MAGI applicant must comply with any of the eligibility requirements described in this ACWDL, the county must request compliance during the Second Contact application process (see ACWDL 08-07 and ACWDL 22-12) only when other items of verification or information are also needed to confirm Medi-Cal eligibility. Additionally, the county must only deny an application for failure to provide the required information or action after the Second Contact Request for Information process has ended.

Once an applicant has complied with all other eligibility requirements, eligibility may not be delayed pending the outcome of the request to comply with the requirements outlined in this ACWDL. This means that if all other eligibility requirements are met after either the first or second contact, the application would be processed, and eligibility granted pending the outcome of the request to comply with the requirements outlined in this ACWDL. The requirement to not delay eligibility also applies to:

- A new application that is received for an individual who was previously denied or discontinued from Medi-Cal for non-compliance with any of the requirements in this ACWDL, regardless of whether it is during the 90-Day Cure Period;
- A new application that is received for an individual who was previously denied or discontinued from Medi-Cal for non-compliance with any of the requirements in this ACWDL, who is requesting retroactive coverage; and
- An individual referred from Covered California to the county in Carry Forward Status (CFS) who was previously denied or discontinued from Medi-Cal for non-compliance with any of the requirements in this ACWDL. Per ACWDL 17-07, CFS referrals are to be treated as new applications.

Only the individual who fails to comply with the requirements outlined in this ACWDL should be denied. Other household members' eligibility should be unaffected by the non-compliance. As a reminder, Title 22 of the CCR, Section 50185(d) requires that counties assist the applicant or member as necessary in complying with requests to gather information required in the application process or in the determination of continuing eligibility.

Example 1: A MAGI applicant has pending eligibility due to income earned from their employer that is not reasonably compatible. The applicant has indicated they are a U.S. military veteran. The county follows the Second Contact process to request a reasonable explanation or other form of income verification and inform the applicant of their need to comply with the CVSO in applying for veteran's health benefits. The county sends the completed Military Verification and Referral Form MC 05 to the CVSO. After the county performs the appropriate contact requirements, the applicant does not provide a reasonable explanation or income verification. The county has confirmed with the CVSO that the applicant has not cooperated with applying for veteran's health benefits. The county sends a denial notice of action (NOA) with their appeal rights, informing the applicant of the specific verification and information that was not received in accordance with ACWDL 15-26. The NOA informs the applicant that either a reasonable explanation or income verification, and proof of application for veteran's health benefits were not provided.

Example 2: A Non-MAGI applicant has pending eligibility due to income verification that is needed. The applicant has indicated they are involved in a lawsuit due to injury or accident. The county follows the Second Contact process to request income verification and third party liability information with the appropriate amount of time to return the requested information for each request. After the first contact, the applicant provides the verification and is found eligible for Non-MAGI Medi-Cal. Eligibility is approved and the county sends the approval NOA with appeal rights. Once the individual becomes a member, the county informs the individual of the need to provide information about third party liability following the process outlined in the Member Process section below.

Example 3 : The county receives a referral from Covered California for an individual in CFS as a result of reported decrease in income that has been electronically verified. The county determines the individual was previously discontinued from Medi-Cal as a result of a failure to apply for veteran's health benefits. As the individual's eligibility has been determined and they are not required to comply with any requirement other than the need to apply for veteran's health benefits, the county accepts the Medi-Cal eligibility, lifts the CFS flag and sends the approval NOA with appeal rights. Once the individual becomes a member, the county informs the individual of the need to

cooperate with the CVSO in providing information for veteran's health benefits following the process outlined in the Member Process section below.

Member Process

When it is determined that a MAGI or Non-MAGI member must comply with any of the requirements described in this ACWDL, the county must request compliance following the change in circumstance redetermination process outlined in W&I Code, Section 14005.37, ACWDL 14-18 and ACWDL 24-11 by completing the following steps:

- Complete an ex parte review using all available sources as required by W&I Code, Section 14005.37. This includes information from case files, including California Work Opportunity and Responsibility to Kids and CalFresh case files~~,~~ of the member or their immediate family members that are open or closed in the last 90 days, to determine if the individual has already complied with the requirement.
- Only after the CEW conducts an ex parte review and is unable to verify compliance, send out a Medi-Cal Request for Information form (MC 355) informing the individual of the need to comply with the requirement.
- Allow 30 days for the member to respond. Note: as described above, proof of application for SSN and Medicare have different response deadlines.
- Follow up with the client through their preferred method of communication within the 30-day period if the information is not received. As a best practice, counties should adopt a 15-day follow up timeframe between contact attempts.

If a member fails to provide proof that the requirement was met within the required timeframe, the county must take action to discontinue eligibility send a 10-day discontinuance NOA that includes the 90-day cure period language. The NOA must include the specific information or verification that was not provided in accordance with ACWDLs 17-32 and 15-27. If a member informs the county that an application was submitted to comply with the requirement, and the delay is a result of the entity making the decision, the member 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.

Only the individual who fails to comply with the requirements outlined in this ACWDL should be discontinued. Other household members should remain covered, if otherwise eligible. As a reminder, Title 22 of the CCR, Section 50185(d) requires that counties assist the applicant or member as necessary in complying with requests to gather

information required in the application process or in the determination of continuing eligibility.

Example 4: A Non-MAGI member with no Share-of-Cost will turn 65 on November 1, 2024. On August 1, 2024, the member is aged 64 and 9 months and is required to apply for Medicare as the Medicare will be at no cost. The county does an ex parte review and confirms there is no proof of approval or denial of Medicare in existing case files. The county sends the MC 355 on August 1, 2024, informing the member they must apply for Medicare and provides a due date of September 30, 2024. The county follows up with one additional contact during the 60 day time period. As of September 30th, the member has not provided proof of approval or denial from Medicare and has not informed the county they are still waiting for the outcome of their application for Medicare. The county sends a discontinuance NOA along with appeal rights informing the member that they did not provide proof of application for Medicare and have a 90-day cure period.

90-Day Cure Period

In accordance with W&I Code, Section 14005.37, an individual who is discontinued from Medi-Cal for failure to provide information or verification needed to confirm ongoing eligibility during a change in circumstance or annual renewal process must be provided a 90-day cure period. As a result, any time an individual is discontinued for failing to comply with the requirements in this ACWDL, a NOA must be provided to the individual ensuring the 90-day cure period language is provided. For updated 90-day cure period language please refer to MEDIL 16-04 and ACWDL 16-24. As a reminder, counties should ensure that the good cause regulations are followed if an individual presents proof outside of the 90-day cure period with good cause for not providing timely information. DHCS is working on additional guidance regarding the 90-day cure period, which will be released in the future.

Future Work Efforts

Previously, CR 119408, released June 2019 (CR 19.6), provided integrated functionality for CEWs to utilize the Statewide Automated Welfare System (SAWS) to send specific denial or discontinuance reasons to the California Healthcare, Eligibility, Enrollment, and Retention System (CalHEERS) for non-compliance with the requirements outlined above. The NOA with the appropriate denial or discontinuance reason are automatically generated by SAWS. Until SAWS removes the non-compliance reason related to applying for unconditionally available income, CEWs must not take action to deny or discontinue Medi-Cal coverage when an applicant or member fails to apply for the unconditionally available income benefits mentioned on the

previous page. CalSAWS will be updated accordingly in the next earliest release to remove this option and will inform counties upon completion.

County questions regarding policy guidance should be sent to MCED-Policy@dhcs.ca.gov.

Original Signed By

Sarah Crow, Chief
Medi-Cal Eligibility Division