DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: April 1, 2025

TO: ALL COUNTY WELFARE DIRECTORS Letter No.:25-08
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: COUNTY MEDI-CAL PERFORMANCE DATA STANDARDS AND CALCULATIONS

REF: ACWDL 24-17

This letter provides additional details on the data sets used to assess performance measures and more information on how the Department of Health Care Services (DHCS) utilizes California Statewide Automated Welfare System (CalSAWS) data to assess performance standards.

Background
On November 25, 2024, DHCS published the All County Welfare Director's Letter (ACWDL) 24-17, notifying counties of the reinstatement of performance standards and enhancements used to evaluate these standards. 42 Code of Federal Regulations (CFR) 435.912, requires states to develop performance standards for determining, renewing, and redetermining eligibility in an efficient and timely manner for applicants or Medi-Cal members.

DHCS will implement a two-pronged process in the assessment of county performance:

1) Performance Standards:
The performance standard evaluates the timeliness of applications, annual redeterminations, and MEDS alert processing. DHCS will use data from Medi-Cal applications, Annual redeterminations, and Medi-Cal Eligibility Data System (MEDS) alert processing derived from CalSAWS to determine timeliness.

2) Focus Reviews:
Focused Reviews evaluate the timeliness and accuracy of eligibility determinations, annual redeterminations, and MEDS alert processing.

DHCS reviews performance standards data monthly. California performance standards are found in the Welfare and Institutions Code (WIC) 14154 (applications and annual redeterminations) and WIC 14154.5 (MEDS alert processing).

Performance Measures
Eligibility performance is measured using the following three standards: application processing, annual redetermination processing, and MEDS alert processing. Data is collected on a scheduled frequency and on the individual rather than case level.

This letter has three sections, each corresponding to a performance standard measurement: Application Processing, Annual Redetermination Processing, and MEDS Alerts Processing. If the data measures, calculations, or scope of oversight changes, DHCS will update the corresponding section(s).

If you have any questions, or if we can provide further information, please email DHCS at COMSCountyPerformanceStandardsQuestions@dhcs.ca.gov.

Sincerely,

Sarah Crow
Division Chief, Medi-Cal Eligibility
Department of Health Care Services
Enclosure *(if applicable)*

Section 1 - Application Processing
Medi-Cal application performance standards are governed by WIC 14154(d), which outlines the requirements for application processing as follows:

- Ninety percent of the general applications without applicant errors and are complete shall be completed within 45 days.
- Ninety percent of the applications for Medi-Cal based on disability shall be completed within 90 days, excluding delays by the state.

Note: Delays by the state are defined as Disability Determination Services Division (DDSD) caused delays.

In preparation for the reinstatement of county performance standards, DHCS will measure application processing using the CalSAWS dataset, which includes the Centers for Medicare and Medicaid Services (CMS) Performance Indicators (CMSPI) 12 data that DHCS receives monthly.

CMSPI Report Indicator 12
Indicator 12 of the CMSPI Report was developed to satisfy CMS' requirement to collect the processing time for all Medi-Cal applications during any given month, whether the applicant was found eligible or ineligible. The CMSPI Indicator 12 Report does not report California Work Opportunity and Responsibility to Kids (CalWORKs) applications, Inter-County Transfers (e-ICTs or ICTs), Craig vs. Bonta (CvB) referrals, or records transferred from Covered California to CalSAWS in a carry-forward status. The CMSPI Report Indicator 12 contains individual-level information.

CalSAWS CMSPI Report Indicator 12 Data Definitions

County Code	The Identification number of the responsible county, (1-58).
County Name	The name of the county responsible for processing the application.
Case Number	The applicant's case number.
First Name	The applicant's first name.
Middle Name	The applicant's middle name.
Last Name	The applicant's last name.
Date of Birth	The applicant's date of birth.
Client Index Number (CIN)	This data element identifies a permanent and unique Client Index Number (CIN) assigned to every Health Services recipient via the daily MEDS batch update process; the one exception being for those cases represented by skeleton

	records. Once assigned, the CIN never changes, even when a later change is made to the MEDS-ID (from Pseudo to Social Security Number [SSN]).
MAGI vs non-MAGI	The financial methodology used to determine eligibility.
Application Received Date	The date the county received the application that resulted in an eligibility determination during the reporting month.
Determination Date	The date the eligibility determination was made during the reporting month.
Determination Result	The status of the eligibility determination is “Approved” or “Denied”.
Aid Code	The approved applicant’s Medi-Cal or CHIP aid code.
Days Processed	The number of days it took to make the final eligibility determination.
Disability Flag	Indicates whether a disability is claimed or whether the health history in CalSAWS indicates a disability: Y (yes) or N (no). The status of this flag is not considered when calculating 45-day timeliness standards because the individual under review is not being evaluated for coverage on the basis of a disability. The status of this flag is considered when calculating the 90-day timeliness standard in the event the individual under review was denied eligibility and, thus, no final aid code was assigned.
Incomplete Application (IA)	If the application is incomplete or has errors, Y (yes) or N (no).
DDSD Delay	Indicates if the application is delayed by Disability Determination Services Division (DDSD); Y (yes) or N (no).

DHCS defines the complete Medi-Cal application as follows:

Application completeness and applications without errors have the same meaning.

“Complete” means that all non-optional questions on the application form were answered and that all verifications requested from the applicant have been received, and that no further action is required from the applicant, and only county action is required because the county has the information necessary to make a disposition of eligibility or ineligibility. The Single Streamlined application for Insurance Affordability Programs identifies optional application questions.

Note: Counties must perform an ex parte review prior to requesting any documents from the applicant.

Performance Standards Data Dashboard - Application Processing

The data dashboard will display application processing timeliness rates that are compiled over twelve months, representing activities during the calendar year, from January 1 through December 31. The measures are stratified by county and with statewide totals at the bottom. The application processing measures section of the data dashboard separates applications by non-disabled individuals subject to the 45-day processing limit and those disabled individuals subject to the 90-day processing limit. The following measures are represented on the data dashboard:

45-Day Performance Standard:

Performance Standard: 45-Day Processing	Ninety percent of non-disability applications shall be completed within 45 days.
Operational Definition	Includes both MAGI and Non-MAGI (Aged, Aged Medically Needy (MN), and Aid to Families with Dependent Children (AFDC)) individual level determinations of eligibility and ineligibility. Identified by the presence of a non-disability aid code for determinations of eligibility. Both MAGI and Non-MAGI determinations of ineligibility (no aid code outcome present), which are identified by MAGI determination type or by non-MAGI determination type when the disability indicator flag is not set, does not indicate "Yes." Does not include new applications for coverage groups, such as SSI/SSP, CalWORKs, foster care, or other programs for which DHCS does not complete the determination of eligibility. It does not include applications transferred to CalSAWS as a result of a reported

	change of circumstances, such as transfers from Covered California in a "carry forward" status, Craig v. Bonta, and intercounty transfers.
Measure: Number of Non-Disability Based Individuals with Complete, Error-Free Applications	The number of non-disability-based individuals who submitted complete, error-free applications. In accordance with WIC 14154(d)(1), DHCS excludes individuals who submitted incomplete applications and applications with errors that caused a processing delay beyond 45 days.
Measure: Number of non-Disability Based Individuals Completed Within 45 Days	The number of non-disability-based individuals whose applications were finalized within 45 days of receipt of the application.
Measure: Percentage of non-Disability Based Individuals Complete Within 45 Days	Percentage of individual Medi-Cal applications processed within 45 days for non-disability applications.
Definition: Application Completeness (MAGI and Non-MAGI)	Application completeness and applications without errors have the same meaning. "Complete" means that all non-optional questions on the application form were answered and that all verifications requested from the applicant have been received, and that no further action is required from the applicant, and only county action is required because the county has the information necessary to make a disposition of eligibility or ineligibility. The Single Streamlined Application for Insurance Affordability Programs identifies optional application questions.

	Note: Counties must perform an ex parte review prior to requesting any documents from the applicant.
Calculation	Numerator: Number of non-disability-based individuals with complete, error-free applications processed within 45 days Denominator: Number of non-disability-based individuals with complete, error-free applications.
Data Source	CalSAWS provides Centers for Medicare and Medicaid Services (CMS) Performance Indicator 12, Client Index Number (CIN) Level Dataset.
Data Source Frequency	Received monthly from CalSAWS on or about the 8th of the month.
Data Set Availability	Currently available to counties on the CalSAWS SharePoint site on or about the 8th of the month. Upon implementation of CA-270511, the first generated report is expected to be available in May 2025. At this time, counties will be able to access the report through the CalSAWS Web Application and will no longer need to go to the CalSAWS Web Portal.
County Validation	DHCS requests that counties validate the data on or before the 18th of each month and inform DHCS of any discrepancies noted by the county.

90-Day Performance Standard:

Performance Standard: 90 Day Processing	Ninety percent of disability applications shall be completed within 90 days
Operational Definition	Includes non-MAGI (blind and disabled) individual level determinations of eligibility

	and ineligibility. Identified by the presence of a blind or disability aid code for determinations of eligibility. For non-MAGI determinations of ineligibility (no aid code outcome), identified by a non-MAGI determination type, when the disability indicator flag is set or indicates "Yes". It does not include new applications for coverage groups, such as SSI/SSP, CalWORKs, foster care, or other programs for which DHCS does not complete the determination of eligibility. It does not include applications transferred to CalSAWS as a result of a reported change of circumstances, such as transfers from Covered California in a "carry forward" status, Craig v. Bonta, and Intercounty transfers.
Measure: Number of Disability Based Individuals with Complete, Error-Free Applications	Number of individual Medi-Cal applications processed within 90 days for disability applications (blind and disabled). In accordance with WIC 14154(d)(1), DHCS excludes incomplete applications and applications with errors, and State Disability Determination Services delays that caused a delay beyond 90 days.
Measure: Number of Disability Based Individuals Completed Within 90 Days	Number of disability-based individuals whose applications were finalized within 90 days of receipt of the application.
Measure: Percentage of Disability Based Individuals Completed Within 90 Days	Percentage of individual Medi-Cal applications processed within 90 days for disability applications.
Definition: Application Completeness (Non-MAGI)	Application completeness and applications without errors have the same meaning.

	"Complete" means that all non-optional questions on the application form were answered and that all verifications requested from the applicant have been received, and that no further action is required from the applicant, and only county action is required because the county has the information necessary to make a disposition of eligibility or ineligibility. The Single Streamlined Application for Insurance Affordability Programs identifies optional application questions. Note: Counties must perform an ex parte review prior to requesting any documents from the applicant.
Calculation	Numerator: Number of Disability based individuals with complete, error-free applications and excluding DDSD caused delays that are processed within 90 days Denominator: Number of Disability based individuals with complete, error free applications and excluding DDSD caused delays.
Data Source	CalSAWS provided Centers for Medicare and Medicaid Services (CMS) Performance Indicator 12, Client Index Number (CIN) Level Dataset.
Data Source Frequency	Received monthly from CalSAWS on or about the 8th of the month.
Data Set Availability	Currently available to counties at the CalSAWS SharePoint site on or about the 8th of the month. Upon implementation of CA-270511, the first generated report is expected to be available in May 2025. At this time, counties will be able to access the report through the CalSAWS Web

	Application and will no longer need to go to the CalSAWS Web Portal.
County Validation	DHCS requests that counties validate on or before the 18th of each month and inform DHCS of any discrepancies noted by the county.

Section 2 - Annual Redetermination Processing

Medi-Cal Annual Redetermination Processing performance standards are governed by WIC § 14154(d)(3). However, due to the outdated language in sections A and C of the WIC § 14154(d)(3), DHCS will monitor section B only. WIC § 14154(d)(3)(B) requires:

- Ninety percent of the annual redeterminations shall be completed within 60 days of the recipient's annual redetermination date for those redeterminations based on forms that are complete and have been returned to the county by the recipient in a timely manner.

DHCS will measure annual redetermination standards using the Renewal Master Request (RMR) dataset provided by CalSAWS. The RMR is received monthly but delayed by approximately 120 days to account for the 90-day Cure Period.

RMR Report
The RMR report contains annual redetermination data on the total number of redeterminations processed, including redeterminations that resulted in continued eligibility, discontinuances, the reason for discontinuance, and the number of days for fully processed redeterminations. The RMR data provides information at both the case and individual levels for MAGI and non-MAGI programs processed by the county. The data is organized into two separate sets: one for cases and one for individuals. These two data sets are located in different tabs within the RMR.

Case Level Data (First Tab)
The "case level" tab contains data on cases with active eligibility that have an annual redetermination due during the reporting month. Cases with cash-linked eligibility are not captured in this dataset. Mixed cases that include cash-linked individuals and non-cash-linked individuals are captured in the dataset. Non-cash-linked individuals are captured in the Individual Level Tab. Case-level data does not break out MAGI and non-MAGI populations.

Definition

Renewals Due This Month*	The total number of annual redeterminations due in the reporting month.

*Renewals Due This Month: Include all active cases in which an annual redetermination was due for the month.

Individual Level Data (Second Tab)
The “individual level” tab includes annual redeterminations due during the reporting month for individuals with active eligibility, excluding those with cash-based or linked eligibility. Individuals with annual redeterminations due are categorized based on the MAGI or non-MAGI aid code assigned at the time the "Renewal Due" month begins. For example, if an individual is non-MAGI eligible when the annual redetermination is due, CalSAWS will report the annual redetermination as non-MAGI, even if Medi-Cal eligibility continues under MAGI or non-MAGI. CalSAWS should report the annual redetermination according to the primary aid code. The primary aid code is the aid code that ranks highest in the Medi-Cal aid code hierarchy – please refer to ACWDL 17-03 for more information on the aid code hierarchy.

CalSAWS RMR Data Definitions

Total number of Renewals Due	The total number of annual redeterminations due during the reporting month.
Incomplete Renewal Packet	The total number of incomplete annual redetermination packets as reported by the county.
Total Number Completed	The total number of annual redeterminations due that were completed for the reporting month. This includes records with continued eligibility to include both auto and manual ex parte, and discontinued records. Note: Annual redeterminations completed after the *Month 3 Post-Due Month* will not be included in the *Total Number Completed.*
Month Due	The total number of annual redeterminations that were completed during or before the month they are due.

Month 1 Post-Due Month	The total number of annual redeterminations completed 1 month after the renewal month.
Month2 Post-Due Month	The total number of annual redeterminations completed 2 months after the renewal month.
Month 3 Post-Due Month	The total number of annual redeterminations completed 3 months after the renewal month.
Total Number of Renewals Completed Resulting in Continued Eligibility	The total number of annual redeterminations that resulted in continued eligibility. The number includes auto ex-parte, manual ex-parte, and manual renewals.
Auto Ex-Parte	The total number of completed annual redeterminations using the Federal Data Services Hub (FDSH).
Manual Ex-Parte	The total number of annual redeterminations completed by the county by manually verifying data from the Medi-Cal member's record, such as Income and Eligibility Verification System (IEVS), CalWORKs, and CalFresh data. For non-MAGI, this includes verifying stable income.
Beneficiary Provided Information	The total number of annual redeterminations completed using information provided by the Medi-Cal member.
Total Number of Renewals Completed Resulting in Discontinuance	Total number of completed annual redeterminations that resulted in the discontinuance from the Medi-Cal program.
Failure to Respond	The total number of completed annual redeterminations that resulted in discontinuance due to Failure to Respond.
Over Income	Total number of completed annual redeterminations that resulted in discontinuance as a result of excess over income.
Other Reasons	The total number of completed annual redeterminations that resulted in discontinuance for reasons other than Failure to Respond or Over Income.

Reinstatements During the 90-day Cure Period	The total number of individuals who had their Medi-Cal eligibility re-instated during the 90-day Cure Period.

As a reminder, WIC § 14154(d)(3)(B) states that 90% of annual redeterminations shall be completed within 60 days of the recipient's annual redetermination date for those redeterminations based on completed forms returned to the county in a timely manner. Therefore, DHCS considers annual redeterminations adjudicated within two months after the redetermination due month.

The performance standard is calculated by adding the three columns titled 1) “Month Due” (C) + “Month 1 Post-Due Month” (D) + “Month 2 Post-Due Month” (E). Then divide the sum of the three columns (C, D, and E) by the column titled “Total Number of Renewals Due” (A). Below is a snippet of the RMR. The columns used for calculating the performance standards have an asterisk.

Total Number of Renewals Due	**Incomplete Renewal Packet**	**Completion Timeframe** Continued and Discontinued Eligibility					
		Total Number Completed (B=C+D+E+F) & (B=G+K)	Month Due	Month 1 Post Due Month	Month 2 Post-Due Month	Month 3 Post-Due Month	
(A)*		(B)	(C)*	(D)*	(E)*	(F)	

Reporting Schedule
The report is due to DHCS on the 8th of the submission month according to the following timetable:

Renewal Due Month	**Renewals Processed Months**	**CalSAWS Submission Deadline (**8th of the submission month**)**
January	January - April	May
February	February – May	June
March	March - June	July
April	April – July	August
May	May-August	September
June	June – September	October

July	July – October	November
August	August – November	December
September	September – December	January
October	October – January	February
November	November – February	March
December	December – March	April

The annual redetermination date is defined as the last day of the annual redetermination due month. The redetermination packet is considered timely if it is received by the last date of the redetermination due month.

Performance Standards Data Dashboard - Annual Redetermination Processing

The data dashboard will display annual redetermination timeliness rates that are compiled over twelve months, representing activities during the calendar year, from January 1 through December 31. The measures are stratified by county and with statewide totals at the bottom. The annual redetermination processing measures of the data dashboard represent the percentage of redeterminations due that are complete no later than two months after the redetermination due month. The following measures are represented on the data dashboard:

Performance Standard Ninety Percent	Ninety percent of annual redeterminations due shall be completed within two months of the annual redetermination due month for those redeterminations based on complete forms that have been returned to the county in a timely manner.
Operational Definition	Includes both MAGI and Non-MAGI individual level annual redeterminations of eligibility and ineligibility. Does not include redeterminations as a result of a reported change of circumstance. For example, reported change (increase of income), anticipated change (change in age), or transfers from Covered California or Social Security Administration as a result of no longer qualifying for CalWORKs or SSI/SSP.
Measure: Number of Individuals Due for Annual Redetermination	Number of Individuals due for annual redetermination. In accordance with WIC 14154(d)(3)(B), DHCS excludes those individuals with incomplete annual redetermination forms that were received by the county no later than the last day of the annual redetermination due month which caused a delay beyond two months after the annual redetermination due month.

Measure: Number Completed Within Two Months of The Redetermination Due Month	Number of individuals whose annual redetermination was complete within two months of the redetermination due month.
Measure: Percentage of Annual Redeterminations Complete	Percentage of annual redeterminations complete within two months after the annual redetermination due month.
Definition: Annual redetermination forms timeliness and completeness	All required annual redetermination forms have been provided to the county by the last day of the annual redetermination due month. The forms received are complete, and no further action is required of the beneficiary; the county has all the required information to determine eligibility. CalSAWS pulls this information from the CalSAWS reporting page.
Calculation	Numerator: The sum of the number completed during the due month, first-month post-due month, and second-month post-due month. Denominator: Number of annual redeterminations due.
Data Source	CalSAWS provides the Renewal Master Request data set.
Data Source Frequency	Received monthly from CalSAWS on or about the 8th of the month. This dataset is lagged about 120 days to capture all 90-day cure period activities.
Data Set Availability	Available to counties at the CalSAWS SharePoint site on or about the 8th of the month
County Validation	DHCS requests that counties validate on or before the 18th of each month and inform DHCS of any discrepancies noted by the county.

Section 3 - MEDS Alert Processing

Regular reconciliation of county and state Medi-Cal eligibility data is essential for addressing discrepancies between county systems and MEDS and identifying any processing or procedural issues within the systems.

W&I Code Section 14154.5 mandates that counties process MEDS alerts promptly and consistently to minimize data discrepancies between MEDS and CalSAWS. MEDS alerts notify counties and other partners about potential or existing discrepancies in MEDS records.

MEDS Alerts processing performance standards require counties to process MEDS alerts that affect eligibility, share of cost, and records that exist on the county's files but not in MEDS.

A. Ninety percent of non-reconciliation MEDS Alerts should be processed by the timeframes indicated below.
B. Ninety-five percent of reconciliation MEDS Alerts should be processed by the timeframes indicated below.

MEDS alerts received by the 10th working day of the month shall be processed in time for the change to be effective at the beginning of the following month. Any worker alert that affects the eligibility or the share of cost that is received after the 10th working day of the month shall be processed in time for the change to be effective at the beginning of the month after the following month. Counties may refer to ACWDL 23-14E for the list of MEDS Alerts that will be monitored under the performance standards.

DHCS will monitor the processing of MEDS alerts using data generated by MEDS, and the CalSAWS-generated MEDS Alert dataset, which is received monthly.

MEDS-generated alert data includes current and unresolved MEDS alerts. These alerts are transmitted to CalSAWS for assignment to a County Eligibility Worker (CEW) for processing. In CalSAWS, the dataset includes both outstanding and processed alerts.

Alerts are categorized based on how frequently they are generated in MEDS and their impact on eligibility. Category 1 alerts are the most common and have the most immediate negative effects on eligibility, with subsequent categories representing alerts that have less immediate negative impacts on eligibility.

MEDS alerts are generated daily through various independent processes and are categorized as follows:

Category 1: Daily update process.
Category 2: Monthly MEDS renewal process.
Category 3: Quarterly reconciliation process.
Category 4: Periodic data matching.

CalSAWS MEDS Alert Data Definitions (SIRFRA 1380)

Alert Number	The MEDS Alert number that was generated.
Alert Completion Indicator	CEW selected a manual indicator indicating the alert was resolved; Y (yes), or N (no).
Alert Completion Date	The date the CEW marked the alert as resolved.
CIN	This data element identifies a permanent and unique Client Index Number (CIN) assigned to every Health Services recipient via the daily MEDS batch update process; the one exception being for those cases represented by skeleton records. Once assigned, the CIN never changes, even when a later change is made to the MEDS-ID (from Pseudo to Social Security Number [SSN]).
County ID Number	The county identification number, (1-58).
MEDS ID	The member's MEDS Identification number.
CCN	Covered California case number. Note: DHCS does not utilize this information and will remove this item in a future release.
Aid Code	The Medi-Cal aid code assigned to the individual.
MEDS Creation Date	The date MEDS created the alert.
Alert Created in CalSAWS	The date the MEDS alert was created in CalSAWS.
Alert Create Timestamp	The date and time stamp alert were created in CalSAWS.
MEDS Alert Available to Worker	The first business day CalSAWS made the alert available to the CEW.

Performance Standards Data Dashboard - MEDS Alert Processing Measures

The data dashboard will display MEDS Alert timeliness rates that are complied over twelve months, representing activities during the calendar year, from January 1 through December 31. The metrics are stratified by county and with statewide totals at the

bottom. The MEDS Alert processing measures section of the data dashboard separates RECON alerts by non-RECON alerts as these two alert types have different performance standards. The following measures are represented on the data dashboard:

RECON Alerts:

Performance Standard: 95 Percent	If received on or before the tenth working day of the month, ninety five percent of the RECON alerts shall be processed by the last day of the month received. If received after the tenth working day of the month, ninety five percent of the RECON alerts shall be processed by the last day of the month following the month of receipt. DHCS utilizes the day the eligibility worker receives the alert to determine if the alert was received on, before, or after the 10th working day of the month.
Operational Definition	Includes RECON alerts identified in ACWDL 23-14E.
Measure: Number of RECON Alerts Received	Number of RECON alerts received
Measure: Number of Recon Alerts Completed	Number of Recon alerts completed.
Measure: Percent of RECON Alerts Processed	Percentage of individual RECON alerts processed.
Calculation	Numerator: Number of RECON alerts processed Denominator: Number of RECON alerts received
Data Source	DHCS utilizes a combination of MEDS data and CalSAWS data. DHCS provides CalSAWS with a MEDS alert input file consisting of all alerts contained in ACWDL 23-14E that were generated the prior month, and CalSAWS replies to this file with a data set indicating what day an alert was made available to the eligibility worker and what day the alert was processed or if the alert is unresolved. Unresolved alerts are carried over to the next month's report. For counties that process alerts in CalSAWS, CalSAWS utilizes the eligibility worker alert processed indicator to determine what day an alert was processed. For counties

	that process alerts directly in MEDS, DHCS utilizes the MEDS database to detect the date when an alert has been resolved and no longer regenerates.
Data Source Frequency	CalSAWS provided dataset is received monthly from CalSAWS on or about the 8th of the month.
Data Set Availability	Available to counties at the CalSAWS SharePoint site on or about the 8th of the month
County Validation	DHCS requests counties validate on or before the 18th of the month and inform DHCS of any discrepancies noted by the county.

Non-RECON Alerts:

Performance Standard: 90 Percent	If received on or before the tenth working day of the month, ninety percent of the non-RECON alerts shall be processed by the last day of the month received. If received after the tenth working day of the month, ninety percent of the non-RECON alerts shall be processed by the last day of the month following the month of receipt. DHCS utilizes the day the eligibility worker receives the alert to determine if the alert was received on, before, or after the 10th working day of the month.
Operational Definition	Includes non-RECON alerts identified in ACWDL 23-14E.
Measure: Number of non-RECON Alerts Received	Number of non-RECON alerts received
Measure: Number of non-RECON Alerts Completed	Number of non-RECON alerts completed.
Measure: Percent of non-RECON Alerts Processed	Percentage of non-RECON alerts processed.
Calculation	Numerator: Number of non-RECON alerts processed Denominator: Number of non-RECON alerts received
Data Source	DHCS utilizes a combination of MEDS data and CalSAWS data. DHCS provides CalSAWS with a MEDS alert input file consisting of all alerts contained in ACWDL 23-14E that were generated the prior month, and CalSAWS replies to this file

	with a data set indicating what day an alert was made available to the eligibility worker and what day the alert was processed or if the alert is unresolved. Unresolved alerts are carried over to the next month's report. For counties that process alerts in CalSAWS, CalSAWS utilizes the eligibility worker alert processed indicator to determine what day an alert was processed. For counties that process alerts directly in MEDS, DHCS utilizes the MEDS database to detect the date when an alert has been resolved and no longer regenerates.
Data Source Frequency	CalSAWS provided dataset is received monthly from CalSAWS on or about the 8th of the month.
Data Set Availability	Available to counties at the CalSAWS SharePoint site on or about the 8th of the month
County Validation	DHCS requests counties validate on or before the 18th of the month and inform DHCS of any discrepancies noted by the county.

Reconciliation (RECON) MEDS Alerts are notifications generated during the MEDS reconciliation process to inform counties of potential discrepancies or mismatches between CalSAWS and MEDS.

Non-reconciliation (non-RECON) MEDS Alerts are alerts generated by MEDS to inform counties of potential discrepancies but are not related to the quarterly reconciliation process.