

DATE: November 2, 2023

Medi-Cal Eligibility Division Information

Letter No.: I 23-49E

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

SUBJECT: ERRATA TO MEDIL I 23-49

Purpose

The purpose of this Medi-Cal Eligibility Division Information Letter (MEDIL) errata is to provide updated guidance to MEDIL I 23-49 regarding approved Section 1902(e)(14)(A) strategy, specifically regarding expanding the use of reasonable explanation and self-attested information received on the renewal packet. Guidance in this letter takes effect immediately.

Corrections to MEDIL I 23-19 are recorded using the following:

- ~~strike through~~ for deleted language
- **underline and bolding** for adding new language

Below is the language from MEDIL I 23-49, with the revisions located on page 1, 2 and 6.

The purpose of this Medi-Cal Eligibility Division Information Letter (MEDIL) is to instruct counties on the Centers for Medicare & Medicaid Services (CMS) approval for additional strategies requested by the Department of Health Care Services (DHCS) to assist during the continuous coverage unwinding period.

Background

On June 13, 2023, CMS published additional “Strategies to Prevent Procedural Terminations” that states may request to assist in addressing the challenges as part of the transition to routine operations. CMS can authorize these strategies under Section 1902(e)(14)(A) of the Social Security Act (“1902(e)(14)(A) Strategies”). To identify further opportunities beyond these strategies, DHCS worked with the County Welfare Director’s Association (CWDA) and counties. However, for the strategies detailed in this letter, CMS has identified existing authority can be leveraged and an 1902(e)(14)(A) waiver is not needed.

On June 29, 2023, DHCS requested CMS approval of the county-identified flexibilities. On September 22, 2023, CMS approved two of DHCS’ additional flexibility requests detailed above. **On October 24, 2023, CMS approved an additional county**

requested waiver under 1902(e)(14) that allows for the use of self-attested income information as verification when received on the renewal packet. This MEDIL outlines the flexibility strategies that were approved.

The flexibilities are effective at the publication of this letter and will continue throughout the continuous coverage unwinding period. The flexibilities apply to all Medi-Cal and Children's Health Insurance Program populations.

Ex Parte and Renewal Packet Requirement Flexibility

As a reminder, ex parte is a mandatory process involving the review of available information in an active case file, along with review of any other available information from other public assistance programs or data sources available to the county. During the renewal process, ex parte is critical in identifying information already available to the county. However, in instances where ex parte is not successful, counties must send the Medi-Cal members an annual renewal form.

Per [42 CFR § 435.916](#) as a condition of eligibility, Medi-Cal members who receive an annual renewal form must sign and return their renewal form (via any allowable modality). This means that situations occur where counties are able to complete a renewal via ex parte from receipt of information received after a packet is generated, but must wait for the return of the packet from the member before eligibility can be redetermined.

The renewal packet requirement unwinding flexibility allows counties to complete the annual redetermination via ex parte (if successful), even after a renewal packet is sent to a Medi-Cal member. This means even if the renewal packet was generated and sent, if the county is able to verify any missing or pending information, the renewal can be completed without waiting for the Medi-Cal member to sign and return the form. Similar to other unwinding flexibilities, this is only to be applied for positive or neutral changes in eligibility, as a negative action (such as a discontinuance, moving from no share of cost (SOC) to SOC, or an increase in SOC) cannot be taken based solely off an ex parte review without verification.

If missing or pending information is received during the 90-day cure period, but the packet is not received, counties may also apply this flexibility and complete the renewal process if all required information, aside from the renewal packet is received.

This waiver will assist in streamlining the renewal process by reducing paperwork burdens on Medi-Cal members and county eligibility workers, and minimizing procedural terminations for individuals who do not complete the renewal packet.

Ex Parte and Renewal Packet Requirement Flexibility Examples

Example #1: Renewal Packet Not Returned But Ex Parte Completed

- Member A is MAGI eligible and due for their annual renewal in February 2024.
- Member A is ran through auto ex parte in CalHEERS and is unable to be electronically verified through the federal data services hub (FDSH) due to income that appears not reasonably compatible with the self-reported amount. The self-attested income does not meet any waiver criteria.
- A renewal packet is generated by the system and sent to the member.
- One week after the packet is mailed, the county eligibility worker receives an income verification that aligns with the self-attested income information and is under the Medi-Cal limits.

Outcome: After review of the case, where income verification was the only item missing and needed to complete an ex parte renewal, the county eligibility worker is able to apply the renewal packet waiver, and the county is able to verify the income and complete the renewal without any further documentation needed.

Example #2: Renewal Packet Not Returned And Ex Parte Not Completed

- Member B is Non-MAGI eligible and due for their annual renewal in February 2024.
- Member B's case information is reviewed by the county eligibility worker, and ex parte is not successful as no waivers are able to be applied and updated paystubs are needed to confirm income.
- A renewal packet is generated and sent to the member.
- The packet is not returned and the county eligibility worker follows existing processes to contact the member and remind them to complete and return the packet and required verifications.
- Prior to termination for failure to complete the redetermination, the county eligibility worker receives an income verification. The worker reviews the verification – it is for a different employer and is unclear on the frequency of pay. The worker is unable to input the correct amount to determine eligibility and verify against the self-attested amount.

Outcome: The county eligibility worker is unable to complete ex parte as the verification provided is not sufficient to take additional action. Since Member B made a good faith effort to contact the county, the county eligibility worker would again request the needed

information to complete the determination. The renewal packet waiver would not apply, as the information provided does not satisfy ex parte review.

Example #3: Discontinued Member Provides Required Information During 90-Day Cure Period

- Member C and D are Non-MAGI eligible and due for their annual renewal in February 2024.
- Member C and D's case information is reviewed by the county eligibility worker, and ex parte is not successful as no waivers are able to be applied and updated paystubs are needed to confirm income.
- Member C and D do not complete the renewal process and are discontinued for failure to complete determination.
- During the 90-Day Cure Period, income verification is received that supports the self-attested information for both Member C and D.

Outcome: After review of the case, the county eligibility worker is able to apply the renewal packet waiver. The county is able to verify the income and complete the renewal redetermination for Member C and D during the 90-day Cure Period without receipt of the renewal packet.

Example #4: Renewal Packet Not Returned But Ex Parte Completed Through Verification Provided to Another Public Assistance Program.

- Member E is MAGI eligible and due for their annual renewal in February 2024.
- Member E is unable to be electronically verified through the FDSH due to income that appears not reasonably compatible with the self-reported amount. The self-attested income does not meet any waiver criteria.
- During the renewal period, Member E provides an updated income verification to another public assistance program. The Medi-Cal renewal packet is not provided.

Outcome: After review of the case, the county eligibility worker is able to apply the renewal packet waiver since the county is able to verify the income. A renewal packet is not required to complete the renewal process.

Example #5: Partial Information Received During Renewal Process

- Members F and G are MAGI eligible and due for their annual renewal in February 2024. They claim two mutual children as dependents, Child A and Child B.
 - Member F has employment income and Member G has self-employment income which totals over 100% FPL.

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- The household is unable to be electronically verified through the FDSH for Members F and G due to income that appears not reasonably compatible with the self-reported amount. Both children are electronically verified. The self-attested income does not meet any waiver criteria.
- A renewal packet is generated by the system and sent to Members F and G. Both children have a successful renewal and no further information is needed for their eligibility determination.
- During the renewal period, Member F provides an updated income verification but does not provide updated information for Member G. The renewal packet is not provided.

Outcome: After review of the case, the county eligibility worker is not able to apply the renewal packet waiver. Since all income verifications were not received and electronic verification was not successful, the county eligibility worker would proceed with current business processes to request for the missing information (income verification and renewal packet).

Expanded Allowance of Reasonable Explanation And Self-Attestation of Income at Renewal

To further assist Medi-Cal applicants, members, and county eligibility workers in streamlining processes and allowing more flexibility with verification, [ACWDL 22-22](#) introduced the Reasonable Explanation policy. This policy allows Medi-Cal applicants and members to provide, when applicable, an explanation that reasonably explains an income discrepancy when income is unable to be electronically verified. This statement can be obtained verbally or written, but must meet the criteria and be obtained via modalities detailed in the policy letter. Typically, this involves a county eligibility worker identifying the need for a reasonable explanation and following up with the applicant or member via their preferred contact modality.

This unwinding flexibility, as approved, allows for further allowance to apply reasonable explanation when a Medi-Cal member indicates any changes or clarifications to income on their renewal form, without requiring income verification. For example, if the pre-populated renewal form indicates an individual was employed and lists the income amount, a member may cross that information out and instead clarify on the form that they lost their job and no longer have income.

County eligibility workers have discretion to determine if the information meets the criteria in [ACWDL 22-22](#) to serve as a reasonable explanation without requiring income verification. However, the parameters below help serve as a guideline when determining application of this flexibility:

- The information provided must reasonably explain the discrepancy.
 - For example, a change in the household or employment status may reasonably explain income not verifying.
- There must be sufficient information provided to continue with the eligibility determination.
 - For example, if a member crosses out pre-populated income on the renewal form but does not provide any other information to explain why the income was inaccurate such as a job change, there is not sufficient information to reasonably explain the discrepancy.

Effective October 1st, renewals received without a reasonable explanation or new income verification can use self-attested information under the 1902(e)(14)(A) Self-Attestation of Income Waiver.

This waiver will allow the acceptance of self-attestation of income for instances where:

- **the renewal packet is required,**
- **no income waivers are applicable, and**
- **utilization of the self-attested income will not lead to a negative action (discontinuance or moving from no share-of-cost (SOC) to SOC).**

Counties must still follow normal business processes to verify all other required non-financial eligibility criteria.

This waiver will streamline processing when the renewal packet is required to complete the eligibility determination and received with new self-attested income information without income verification or a reasonable explanation.

Additionally, when utilized, counties may leverage the journal template below:

“The [Name of Flexibility] waiver was applied while processing the continuous coverage unwinding renewal based on CMS waiver approval under Section 1902(e)(14)(A).” The [Name of Individuals] self-attested income of [Name and Amount of Income] included with the renewal was used without any additional administrative verifications.”

Documentation of Unwinding Flexibilities

In conjunction with standard application or renewal case notes, counties must ensure that proper narratives are included within the SAWS case file when any of the Section 1902(e)(14)(A) waivers or other unwinding flexibilities are applied to a Medi-Cal member

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or household. Counties must ensure the case narratives describe what flexibility was applied and for whom. Templates are available in this errata and via [MEDIL I 23-06](#).

DHCS will provide additional guidance when the unwinding flexibilities end.

If you have any questions, or if we can provide further information, please contact Kathryn Floto by phone at (916) 345-8076 or by email at Kathryn.Floto@dhcs.ca.gov.

Original Signed By,

Yingjia Huang
Assistant Deputy Director
Health Care and Benefits
Department of Health Care Services