



TOBY DOUGLAS
Director

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
Governor

September 16, 2013

Medi-Cal Eligibility Division Information Letter No.: I 13-12

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

SUBJECT: AFFORDABLE CARE ACT FOLLOW-UP GUIDANCE

The Department of Health Care Services (DHCS) is providing this follow-up guidance as a result of recently enacted state law, Senate Bill (SB) x1 1 and Assembly Bill (AB) x1 1 Statutes of 2013, as well as recent guidance provided by the federal Centers for Medicare & Medicaid Services (CMS) on the Affordable Care Act of 2010 (ACA). This letter provides various ACA related policy guidance to counties and Statewide Automated Welfare Systems (SAWS) based on the analysis of state law, proposed federal regulations, and discussions with CMS as ACA policy and guidance continue to develop. This letter provides the counties and SAWS with high-level policy guidance where possible, and also identifies policy areas where insufficient federal regulations or guidance limit DHCS' ability to provide such policy guidance to counties and SAWS. Furthermore, this letter supersedes and obsoletes Medi-Cal Eligibility Division Information Letter (MEDIL) 13-03.

ACA requirements described in this letter pertain to Medi-Cal eligibility policies and procedures that need to be implemented no later than either October 1, 2013, or January 1, 2014, depending on the requirement. To further define these requirements, State statute has been enacted via the aforementioned AB x1 1 and SB x1 1, and will be followed by policy guidance in the form of All-County Welfare Directors' Letters (ACWDLs) and state regulations. Given the timing of implementation, this follow-up guidance is being provided to inform preparatory steps towards implementation.

The Single Streamlined Paper Application

Effective October 1, 2013, the single, streamlined paper application, as prescribed in Welfare and Institutions Code 15926 (c)(1), will be used to apply for Medi-Cal. The single streamlined paper application is a joint application that will be used by applicants to apply for all health insurance affordability programs including:

- Modified Adjusted Gross Income (MAGI) Medi-Cal
- Non-MAGI Medi-Cal,
- Advanced Premium Tax Credits (APTCs),
- Cost Sharing Reductions (CSRs)
- Unsubsidized coverage

The statute authorizes the continued use of existing paper Medi-Cal applications, including but not limited to, the MC 210, MC 321, SAWS 1, and SAWS 2 until January 1, 2016, if such an application is presented at a county office. If, after January 1, 2014, a county is presented with a paper application for Medi-Cal eligibility, other than the single streamlined paper application or a CMS-approved alternative, counties must use the application information to complete the MAGI determination and/or ask for additional information in any modality to enable the MAGI determination to be completed in a timely manner. Printing of MC 210s and 321s will cease at some date prior to January 1, 2014.

Effective January 1, 2014, applicants who are determined to be ineligible for MAGI Medi-Cal, but may potentially be eligible for Non-MAGI Medi-Cal, shall be provided with non-MAGI supplemental application form(s) currently in development by DHCS. These supplemental forms will be used to collect the necessary data elements for Non-MAGI Medi-Cal eligibility determinations when the applicant has completed the single streamlined application. This MEDIL provides some initial guidance on the use of supplemental forms for individuals completing the single streamlined application who desire an eligibility determination on a basis other than MAGI. Further information regarding non-MAGI supplemental application forms will be forthcoming.

The California Department of Social Services (CDSS) is working to revise the SAWS 2 to capture data elements necessary to perform a Medi-Cal determination and will be requesting CMS approval of a revised SAWS 2. The revised form, the SAWS 2 Plus, will be an application to apply for Medi-Cal, CalFRESH, and CalWORKS. Once CDSS receives approval of the SAWS 2 Plus, counties may use the SAWS 2 Plus after January 1, 2014.

Applications and Supplemental Forms

Under ACA, applicants can file an application for all health insurance affordability program types via multiple access channels which include but are not limited to:

- in person at a county office
- in person with a certified assister
- phone-in
- county call center
- SAWS online application portals
- Covered California online portal
- quick-sort phone transfers from Covered CA
- fax
- mail-in

Any health insurance affordability program application submitted locally to the county must be accepted and processed for the appropriate program. If the application is for APTC/CSR only, counties must assume responsibility for the application by accepting and processing it for APTC/CSR eligibility prior to transferring case information or documents to Covered California.

If the Single Streamlined Application is not available in paper format for pre-enrollment on October 1, 2013, use the SAWS 2 Plus form. If neither form is available for pre-enrollment use on October 1, 2013, use any of the current application forms, including but not limited to, the MC 210, MC 321, or SAWS 2 with the appropriate supplement, as indicated in the "Application and Supplemental Form Usage" table on page 4.

Counties are to process eligibility using the application that was submitted in conjunction with the appropriate supplement as indicated in the "Application and Supplemental Form Usage" table below. Counties are not to deny the application and request the applicant to complete a new form or start the application process again.

The existing property supplements, MC 210PS or MC 322, can be used with the Single Streamlined Application to collect the property information required to complete a Non-MAGI Medi-Cal determination.

The following draft supplemental forms are for use in conjunction with the various applications until such time that DHCS releases the final versions of each form:

MC 210 ACA Income and Deduction Supplement (DRAFT)

This supplement includes additional income and deduction information which is not included on the Single Streamlined Application and is to only be used in limited circumstances. This information should be collected from individuals who have completed the Single Streamline Application for MAGI purposes and subsequently want to seek an eligibility determination for Pre-ACA and Non-MAGI Medi-Cal programs.

Request for Tax Household Information (RFTHI) (DRAFT)

This supplement includes additional tax household and federal data hub consent information which is not included on current Medi-Cal applications. This information needs to be collected in order to determine eligibility for MAGI or APTC programs for individuals currently enrolled in Medi-Cal. DHCS, in collaboration with the counties/California Welfare Director’s Association (CWDA) is working on finalizing this form. For purposes of training until the final form is released by DHCS, counties may use the RFTHI (DRAFT) that has been created by CWDA.

Note: Counties may obtain the needed information on the RFTHI (DRAFT), MC 210 ACA Income and Deduction Supplement (DRAFT) or existing Medi-Cal property supplement forms over the phone. If the county is unable to contact the applicant by phone, the forms can be requested by mail.

Application and Supplemental Form Usage		
	Now Path (Pre-ACA) October – December 2013 or Non-MAGI January 1, 2014 Forward	Later Path (MAGI) January 1, 2014 Forward
Application	Supplement Required for pre-ACA or Non-MAGI in 2014	Supplement Required for MAGI
MC 210	None	RFTHI ¹
SAWS 2	None	RFTHI
Single Streamlined Application	MC 210 ACA Income and Deduction Supplement (DRAFT) ² and MC 210 PS or MC 322	None
SAWS 2 Plus	None	None
MC 321	MC 371 and MC 322 if necessary	RFTHI and MC 371
Health E App	MC 371 and MC 322 if necessary	RFTHI and MC 371

¹ As noted in this chart, counties may use the RFTHI (DRAFT) as created by CWDA until DHCS releases the final form.

² As noted in this chart, counties may use the MC 210 ACA Income and Deduction Supplement (DRAFT) form until the final form is released by DHCS.

SAWS online	None	RFTHI
CalHEERS online	MC 210 ACA Income and Deduction Supplement (DRAFT) and MC 201 PS or MC 322	None

Note: Counties must continue to use supplemental forms such as the MC 210A, MC 13, etc. as appropriate, with all application forms, when processing eligibility, pending further guidance from DHCS on the use of such forms.

Applications Forwarded from the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) to SAWS for Processing

While applications can be received by counties directly, ACA provides for four conditions in which an application for insurance affordability programs should be forwarded to counties for determining eligibility on a basis other than MAGI:

1. Individuals excepted from MAGI methodology:
 - Individual is aged 65 or older when the individual is not eligible under MAGI.
 - Individual is blind or disabled when the individual is not eligible under MAGI.
 - Individual is enrolled in Medicare, but only for the purpose of determining eligibility for Medicare Savings Programs, including Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary and Qualified Individual.
 - Individual is requesting Long-Term Care (LTC) or Home and Community Based Waiver services or resides in LTC facility.

2. Individuals found income eligible for APTCs, but not income eligible for MAGI-based Medi-Cal, and indicated on the single streamlined application potential eligibility for Medi-Cal on a basis other than MAGI:
 - Individual is aged 65 years old or older.
 - Individual is blind or disabled.
 - Individual claims blindness or a disability, for purposes of submitting a disability determination package.

3. Individuals found MAGI Medi-Cal eligible, but indicated on the application a basis (linkage) other than MAGI and request an eligibility determination on a basis other than MAGI:
 - Individual is aged 65 years old or older.
 - Individual is blind or disabled.

- Individual claims blindness or a disability, for purposes of submitting a disability determination package.

4. Individuals, who request a full Medi-Cal determination.

In reference to previous guidance concerning the four conditions in which an application for insurance affordability programs should be forwarded to counties for determining eligibility on a basis other than MAGI, DHCS is working to finalize policy direction regarding former foster care children, age 18-25. Pursuant to ACA, there are some requirements for this coverage group that DHCS is seeking further clarification on from CMS. Once developed and finalized, this new policy would be effective January 1, 2014. DHCS will work collaboratively with the counties in developing this policy.

MAGI Changes to Medi-Cal Programs

SAWS systems changes and/or county “work-around”, will need to be implemented for certain coverage groups subject to MAGI methods, effective January 1, 2014. ACA provisions require the use of MAGI financial methods, which include the use of MAGI income methods and the elimination of asset tests, when determining financial eligibility for certain coverage groups. However, due to the ACA grandfathering provision, SAWS must retain until December 2014, programming of current financial methods and noticing associated with the following coverage groups:

- 1931(b)
- Pregnant Women’s Federal Poverty Level Program
- Children’s Federal Poverty Level Program for Infants
- Children’s Federal Poverty Level Program, Ages 1-5
- Children’s Federal Poverty Level Program, Ages 6-18
- Optional Targeted Low-Income Children’s Program, Ages 0-19

Effective January 1, 2014, the new adult group, as prescribed in Section 1902(a)(10)(A)(i)(VII) of ACA, Medi-Cal eligibility will expand to individuals:

- Age 19 or older and under age 65,
- Are not pregnant,
- Are not entitled to or enrolled for Medicare benefits under part A or B,
- Are not otherwise eligible for and enrolled for mandatory coverage under a Medicaid State Plan,
- Have a household income at or below 138 percent of the Federal Poverty Level for the applicable family size.

MAGI methodology will be the only income methodology used to determine eligibility for the new adult group. Counties will be responsible for the ongoing case management of all beneficiaries determined eligible for the new adult group. This includes, but is not limited to, performing periodic data verifications, initiating annual redeterminations, and processing changes in circumstances.

To facilitate the creation of the new adult group, the following new aid codes have been established.

- Aid Code M1: Full Scope Medi-Cal
- Aid Code M2: Restricted Scope Medi-Cal

Additional aid codes are under development due to the collapsing of coverage groups subject to the use of MAGI and future guidance will be forthcoming from DHCS on this matter. In addition, for all programs subject to the use of MAGI methodology, ACA changes household composition rules to be based on tax filing status. Therefore, individuals in a household do not necessarily have to live under the same roof to be included in the household of a tax filer.

Annual Redetermination Process (ARV)

Effective January 1, 2014, the ARV process, as described in ACWDL 06-16, 06-17, and 11-23, will no longer be used to conduct MAGI Medi-Cal ARVs. Medi-Cal beneficiaries scheduled to return a completed ARV packet before January 1, 2014, shall be required to receive and submit a complete ARV packet in order to continue being Medi-Cal eligible in accordance with existing eligibility rules. Counties shall continue to work ARVs received in January, 2014, as receipt is within the 30-day cure period.

On January 1, 2014, a new Medi-Cal ARV process will be implemented that conforms to ACA requirements. The new ARV process will use an ex parte review of available information to determine continued eligibility in the Medi-Cal program without requiring the beneficiary to complete an ARV packet or submit any documentation. Paper documentation may be required in the event that the ex parte review and electronic process does not provide the required information needed to reestablish Medi-Cal eligibility for another 12 month period.

As prescribed in Welfare and Institutions Code (W&I), Section 14005.37, Medi-Cal annual redeterminations scheduled between January 1, 2014, and March 31, 2014, will be postponed for three months contingent upon federal approval. The timeline for working annual redeterminations will be as follows:

- January 2014 annual redeterminations will be conducted in April 2014.

- February 2014 annual redeterminations will be conducted in May 2014.
- March 2014 annual redeterminations will be conducted in June 2014.

This means that in the month of April 2014 through June 2014 counties will be working two months of annual redeterminations simultaneously. DHCS will issue guidance on the new ARV process in the near future.

Mid-year Status Report (MSR)

As prescribed in W&I Code, Section 14011.16, effective January 1, 2014, MSR requirements, as prescribed in ACWDL 09-32, are eliminated for all Medi-Cal beneficiaries. Medi-Cal beneficiaries scheduled to return a completed MSR form before January 1, 2014, as prescribed in the above mentioned ACWDL, shall be required to submit a complete MSR form in order to continue receiving Medi-Cal benefits. If the beneficiary does not return the completed MSR, the beneficiary should be discontinued in accordance with ACWDL 09-32. Counties will continue to work an MSR returned in January, 2014, as if it were submitted timely, as the returned MSR falls within the 30 day cure period. Counties/SAWS shall ensure MSRs are not sent to beneficiaries who would have an MSR due January 1, 2014, or later.

Reporting Requirements

Pursuant to W&I Code, Section 14102.5, DHCS shall, in collaboration with the Covered California (The Exchange), counties, advocates, and SAWS consortia, develop and prepare one or more reports issued on at least a quarterly basis on enrollment for all insurance affordability programs. This data is to be made publicly available within 30 days after the end of each quarter. DHCS is obtaining the majority of necessary eligibility reports from CalHEERS; however, DHCS has determined there will be some required reports that will need to be obtained from the counties/SAWS. DHCS is currently participating in ongoing meetings with the counties/SAWS to define requirements and agreed upon format and transmission protocols. Additional details regarding the reporting requirements will be contained in a future ACWDL.

Additionally there are federal reporting requirements that must be submitted to the federal CMS beginning at the end of September. DHCS has engaged in discussions with CWDA regarding the required data elements and will look to leverage data elements from readily available sources such as the Medi-Cal Eligibility Data System and/or CalHEERS, to the extent possible, to meet these requirements. It is anticipated that there may be some data elements that the SAWS must directly report to DHCS and, as this is determined, additional guidance will be forthcoming from DHCS.

Policy Areas Pending Future Federal Guidance:

- Case management/handling of mixed households (Medi-Cal/APTC).
- Final verification plan and impact to SAWS/county business processes.
- Whether medically needy with a Share of Cost is minimum essential coverage.
- Business processes associated with continuing the Medi-Cal/CalWORKS linkage.
- Transitional Medi-Cal.
- Notice of Action content and triggers.
- Outreach to potential Exchange/Medi-Cal eligible, CalFresh, California Children's Services, etc.
- Case management of mixed cases and mass updates.
- Renewal processing for MAGI and non-MAGI eligibility.
- Periodic verification processing for MAGI and non-MAGI eligibility.
- Handling of appeals after adjudication.
- Handling of CalWORKS timed-out adults.
- Final ACA aid codes.

If you have any questions or concerns, please contact Harold Higgins of the Medi-Cal Eligibility Division, at (916) 327-0412 or email at harold.higgins@dhcs.ca.gov.

Sincerely,

Original Signed by

René Mollow, MSN, RN
Deputy Director
Health Care Benefits and Eligibility

Attachments

Request for Tax Household Information (RFTHI) (DRAFT)

Please contact us if you need this form in another language, large print, or other format

- How to complete this form:
1. Answer all of the questions on the form. Use ink and print your answers. If you need more space, attach a separate sheet to this form.
 2. Read the information about you and each member of your household, including tax dependents. Add any missing information. If any information has changed, write in the correct information.
 3. Sign the form on the page 3
 4. **Return this form by XX.** Use the postage paid envelope to return the form. If you do not return the form by this deadline, you will lose your Med-Cal coverage.

- What we need:
- We need information about each person living in your household or listed on your tax return, including:
- Those who get Medi-Cal now
 - Those who do not have Medi-Cal now but would like to apply, and
 - Those who live in the household and do not have Medi-Cal but do not want to apply.

If you do not qualify for Medi-Cal: If you do not qualify for Medi-Cal, we will check to see if you qualify for other kinds of health coverage. We may send your information to another program so they can see if you qualify.

Need Help?: Call your Medi-Cal Agency at XXX-XXX-XXXX.
(TTY: XXX-XXX-XXXX)
You can call Monday to Friday 8:00am- 5:00pm

You must fill out this one of these forms for each person in your household and return it to the county to keep your Medi-Cal!

Case Number (Optional)	SSN or ATIN/ITIN	
Individual's Name	Birth date (mm/dd/yyyy)	
Current street address, apartment number	City	ZIP code
Mailing address, if different from above	City	ZIP code

1. Is this person: Employed Self-Employed

2. If this person is currently employed, list all of the information about all types of income received including:

Employer Name: _____ Employer Address: _____

Employer Phone Number _____ Average Hours Worked Each Week _____

Wages/Tips (before taxes): _____ Hourly Every 2 Weeks Twice a Month Monthly Yearly

3. If this person is self-employed, answer the following questions:

Type of **Work**: -----

How much Net income (profits once business expenses are paid) will you get from this self-employment this month?: _____

4. For this person, do you plan to file a federal income tax return NEXT YEAR? Yes complete a-c No, skip to c

a. Will you file jointly with a spouse? NO Yes, Name of Spouse _____

b. Will you claim any dependents? NO Yes, Name of Dependents _____

c. Will you be claimed as a dependent on someone's tax return? NO Yes

 If Yes, list the name of the tax filer: _____ How is this person related to the tax filer? _____

5. Please answer the following questions only if this person is under the age of 21 and a full time student:

Did this person have health insurance through a job and lose it within the last three months? Yes No

6. Were you or anyone else in your family who is age 26 or younger in foster care at age 18? Yes No

7. Has this person's immigration or citizenship status changed in the past 12 months? Yes No

If yes, please explain what changed: _____

8. Is this person: Hispanic Latino Spanish American Indian or Alaskan Native White

Black or African American Filipino Chinese Japanese Cambodian Korean Vietnamese

Asian Indian Laotian Other Asian, specify: _____ Native Hawaiian

Guamanian or Chamorro Samoan Other or Mixed Race

9. Renewal of coverage in future years:

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next:

5 years (the maximum number of years allowed), or for a shorter number of years:

4 years

3 years

2 years

1 year

Don't use information from tax returns to renew my coverage.

****Note:** The income/tax filing information is required for all household members. If additional family members are employed or self-employed, questions 1-4 should be answered for these individuals as well.

Your rights and responsibilities

- I am signing this renewal form under penalty of perjury. That means that I have provided true answers to all the questions on this form to the best of my knowledge, and I know that I may be subject to penalties under federal law if I provide false or untrue information.
- I know that I must tell Covered California if anything changes and is different from what I wrote on this form. I can call xxx-xxx-xxxx or visit (web address) to report any changes. I understand that a change in my information might affect whether someone in my household qualifies for coverage.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting [hhs.gov/ocr/office/file](https://www.hhs.gov/ocr/office/file).
- If I think Covered California has made a mistake, I can appeal its decision. To appeal means to tell someone at Covered California that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting Covered California at XXX-XXX-XXXX. Someone from Covered California will explain anything about this application to me if I need that.
- I understand that if I do not qualify for Medi-Cal Covered California will check to see if I qualify for other kinds of health coverage. Covered California may send my information to another program so they can see if I qualify.

I declare, under penalty of perjury, under the laws of the State of California that all information provided on this form is true and correct.

Signature	Date
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Need help? Call Covered California at 800-XXX-XXXX (TTY: XXX-XXX-XXXX). You can call Monday through Friday, 8 a.m. to 5 p.m.

MC 210 ACA INCOME Supplement (DRAFT)

The information being requested below is to supplement income information you have provided on the Medi-Cal Single Streamlined Application to be determined for Medi-Cal using current income eligibility rules. Please review the income checklist below and indicate whether you, your spouse, or children under 21 that are living in the home collect income from any of these sources. You must provide verification of any income source which you answer "yes" to.

INCOME TYPE	INDICATE IF YES	IF YES, WHO RECIEVES?	AMOUNT	FREQUENCY
CHILD SUPPORT				
SPOUSAL SUPPORT				
VETERANS				
DISABILITY				
GIFTS				
LOANS				
GRANTS				

MC 210 ACA INCOME DEDUCTION Supplement (DRAFT)

The information being requested below is to supplement income deduction information that is not collected on the Medi-Cal Single Streamlined Application in order for you to be determined for Medi-Cal using current income eligibility rules. Please review the income deduction checklist below and indicate whether you, your spouse, or children under 21 that are living in the home pay any of the following expenses. You must provide verification of any deduction type to which you answer “yes” to.

INCOME TYPE	INDICATE IF YES	IF YES, WHO RECIEVES?	AMOUNT	FREQUENCY
CHILD SUPPORT				
SPOUSAL SUPPORT				
OTHER HEALTH COVERAGE				
MEDICARE				
CHILDCARE				
ADULT CARE				
EDUCATIONAL EXPENSES				