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

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

Date: February 10, 2014

TO: ALL COUNTY WELFARE DIRECTORS Letter No. 14-03
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS

SUBJECT: 2014 Renewals: Converting Pre-ACA Medi-Cal Beneficiaries to MAGI Medi-Cal

The Department of Health Care Services (DHCS) is providing guidance as a result of Assembly Bill (AB) x1 1, Chapter 3, 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 is to provide the Statewide Automated Welfare Systems (SAWS) and counties with policy guidance.

This guidance is focused on implementing Medi-Cal annual redeterminations to convert beneficiaries from Pre-ACA (Pre-Affordable Care Act) Medi-Cal to Modified Adjusted Gross Income (MAGI) Medi-Cal in 2014.

This ACWDL overrides previous ACWDLs on the Medi-Cal annual renewal process including ACWDLs 06-16, 06-17, and 11-23.

Background

As prescribed in Welfare and Institutions Code (WIC) Section 14005.37, the Medi-Cal annual redetermination process for those individuals subject to Medi-Cal benefits on the basis of MAGI, shall be streamlined and simplified. Medi-Cal beneficiaries will have their annual redeterminations conducted via an “ex parte” review of available information to the greatest extent possible.

An “ex parte” review refers to an upfront review of current beneficiary data and information by the eligibility worker before asking the beneficiary for additional data. An ex parte review may be able to provide for an upfront renewal of Medi-Cal benefits without a beneficiary ever having to complete an annual redetermination packet. Such action furthers the process principles of being streamlined and simplified.

While in the future, the ex parte review is to occur prior to seeking any information from the beneficiary, and beneficiaries from whom information is needed will receive a pre-populated redetermination form, a slightly different process must be followed for existing Pre-ACA Medi-Cal beneficiaries whose annual redeterminations are due after January 2014. For these Pre-ACA Medi-Cal beneficiaries, the first ex parte review process would automatically fail due to the fact that there is not enough information known about the beneficiary's tax household and tax income to conduct a MAGI eligibility determination. To determine MAGI eligibility for pre-ACA beneficiaries, current information about federal tax household and income is needed.

Specifically, MAGI Medi-Cal is based upon IRS tax rules, but IRS information is not known for Pre-ACA Medi-Cal beneficiaries. Therefore, counties are required to collect additional information on Pre-ACA Medi-Cal beneficiaries in order to complete the beneficiary's 2014 annual redetermination. Many Medi-Cal beneficiaries are not required to file taxes because their income is so low. For those beneficiaries, the state still needs to determine the MAGI household and determine current income.

Medi-Cal Annual Redetermination Process Will Begin May 2014
The Medi-Cal annual redetermination process, as prescribed below in this letter, shall begin for individuals with redeterminations due in May 2014. Counties shall ensure they do not process Medi-Cal annual redeterminations for individuals who would have otherwise been due for redetermination from January 2014 through April 2014. Those who had redeterminations due from January through April will be moved according to the below schedule.

Beginning with annual redeterminations due in May 2014, Medi-Cal annual redeterminations for 2014 only will be processed according to the following timeline:

- January and May annual redeterminations in May
- February and June annual redeterminations in June
- March and July annual redeterminations in July
- April and August annual redeterminations in August

Request For Tax Household Information (RFTHI) Redetermination Packet
Counties are hereby instructed to use the RFTHI Redetermination Packet. The RFTHI Redetermination Packet collects the necessary income and tax household information that is missing from their current Medi-Cal case in order to conduct a MAGI eligibility determination.

The beneficiary is not required to physically return the RFTHI Redetermination Packet. The beneficiary can provide the information requested in the packet by mail, by fax, in person, or over the phone.

The RFTHI Redetermination Packet is shown as Attachment A of this letter. This packet consists of the following components:

1. Cover Letter - The cover letter explains to a Medi-Cal beneficiary the change to the Medi-Cal annual redetermination process as prescribed in the ACA.
2. Instructions Page - The instructions page explains to the beneficiary how to complete the form.
3. RFTHI Form - This is the main annual redetermination form. One of these forms must be completed, or the information must otherwise be provided, by each member of the household; however, only the head of household must complete Section 9 and sign the form.
4. RFTHI Supplemental Form – This form supplements the RFTHI form. This form must be completed, or information otherwise provided, once for the entire household. Only one Supplemental Form per household is required.

Please note; the supplemental forms that are currently sent with the Medi-Cal annual redetermination packet continue to be sent with the RFTHI packet. The RFTHI packet is simply replacing the MC 210RV and MC 201PS packet with the RFTHI Redetermination Packet for 2014.

The Department will be issuing further guidance on the 2014 annual redetermination process very shortly.

If you have any questions, please contract Braden Oparowski by phone at (916) 552-9570 or by email at Braden.Oparowski@dhcs.ca.gov.

Original Signed By:

Tara Naisbitt, Chief
Medi-Cal Eligibility Division

County Logo

Important news about how to keep your Medi-Cal!

Beginning this year, Medi-Cal eligibility will be determined for most people using income tax rules and personal filing information. Medi-Cal will count the size of your household and your income based on your tax information. If you do not file taxes, you can still get Medi-Cal.

Because you have Medi-Cal now, we already know a lot about you. What we do not know is your tax household information. To get this information, we need you to fill out the forms that are enclosed with this letter.

We will use the information on these forms, along with the information we already know about you, to see if you still qualify for Medi-Cal. Please complete the forms for yourself and the family members either living with you or claimed on your tax return. Only the head of household (the person who files taxes) must complete Section 9 of the "**Request for Tax Household Information (RFTHI)**" form and sign the forms. You only have to fill out these forms this year as we move you from the current Medi-Cal rules to the new Medi-Cal rules. In the future, we will try to re-determine your eligibility each year based on the information we have without asking for anything more from you.

Since we will now use your tax information to determine Medi-Cal eligibility, we may be able to electronically check the information you give us to see if you are still eligible for Medi-Cal. If we are able to do so, we may not need any additional paper documents other than the enclosed forms. If we cannot check your information electronically, we will ask you for paper documents. You will only be asked to send paper documents for the information we could not check electronically.

If you are not eligible for Medi-Cal based on the new rules, you may still qualify for other Medi-Cal programs, but we must first check your eligibility based on tax information to see what type of Medi-Cal you are eligible for.

In order to see if you are still eligible for Medi-Cal, you must give us the information on the **Request for Tax Household Information (RFTHI**) form and the **RFTHI Supplemental Form.** You must give us this information for yourself and each person living with you or claimed on your tax return.

You must give us this information by _____.

There are three ways you can give us this information:

By mail:
You can give us this information by completing the forms sent with this letter. You must complete one RFTHI form for yourself and each person living with you or claimed on your tax return and one RFTHI Supplemental for your household. Please mail the forms to this address _____.

By phone:
You can give us this information over the phone by calling us at _____. When you call, you should have your most recent federal tax return available, if you file taxes.

In person:

County Logo

Important news about how to keep your Medi-Cal!

You can give us this information by visiting us at _____.

Remember, you must give us this information by _____ or you may lose your Medi-Cal benefits.

Comments 1/24/14

Request for Tax Household Information (RFTHI)

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 page 3
4. **Return this form by MM/DD/YYYY**. Use the postage paid envelope to return the form. IF you do not return the form by this deadline, you will lose your Medi-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 (866) 613-3777
TTY: (800) 660-4026
You can call Monday to Friday 8:00 A.M. – 5:00 P.M.

You must fill out one of these forms for <u>each person</u> in your household and return it to the County

Case Number (optional)	SSN or ATIN/ITIN
Individuals' 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 ☐ Twice a Month ☐ Semi Monthly ☐Monthly ☐ Yearly

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

Type of work: _____

Home much net income (profit once business expenses are paid) will you receive from 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 lost it within the last 12 months? ☐Yes ☐No

6. Were you or anyone else in your family who is age 26 or younger in foster care at the age of 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 for future years:

To make it easier to determine my eligibility for help applying 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 may opt out at any time.

☐ 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 1-800-300-1506 or visit coveredca.gov 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.bov/ocr/office/file.
- If I think Covered California has made a mistake. I can appeal its decision. To appeal means to tell someone at Cover 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 1-800-300-1506. 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 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

Need help? Call Covered California at 1-800-300-1506 (TTY: 888-889-4500). You can call Monday through Friday, 8:00 A.M. to 5:00 P.M.

Request For Tax Household Information (RFTHI) Supplemental Form
Complete this form for your household
Please copy this form if you need additional space.

Does anyone in the household have income that is not from a job?
Do not include child support payments, veteran's payments, or Supplemental Security Income (SSI). See Page 3 for additional information.

Does anyone in the household have income that is not from a job? ☐ **Yes** ***If yes***, who? _____ ***If yes,*** answer the questions below.

☐ **No** ***If no***, go to *"Does anyone in your household have deductions" on this page.*

Where does this income come from?	**How often does this person get this income?** *(check one)*	**How much?**
	☐ Hourly: How many hours per week?_____ ☐ Every two weeks ☐ Daily: How many days per week? _____ ☐ Twice a month ☐ Weekly ☐ Monthly ☐ One-time payment	**$**

Does anyone in the household have income that is not from a job? ☐ **Yes** ***If yes***, who? _____ ***If yes,*** answer the questions below.

☐ **No** ***If no***, go to *"Does anyone in your household have deductions" on this page.*

Where does this income come from?	**How often does this person get this income?** *(check one)*	**How much?**
	☐ Hourly: How many hours per week?_____ ☐ Every two weeks ☐ Daily: How many days per week? _____ ☐ Twice a month ☐ Weekly ☐ Monthly ☐ One-time payment	**$**

Does anyone in your household have deductions?
If you pay for certain things that can be deducted on a federal income tax return, telling us about them may lower the cost of health insurance. ***Do not include self-employment expenses****. See Page 3 for additional information.*

Does anyone in your household have deductions? ☐ **Yes** ***If yes***, who _____ ***If yes,*** answer the questions below.

☐ **No** ***If no***, go to "Additional information we need" on this page.

Type of deduction	**How often does this person get this deduction?** *(check one)*	**How much?**
☐ Alimony paid ☐ Student loan interest ☐ Other _____	☐ Hourly: How many hours per week?_____ ☐ Every two weeks ☐ Daily: How many days per week? _____ ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Quarterly ☐ One-time payment ☐ Yearly	**$**

Does anyone in your household have deductions? ☐ **Yes** ***If yes***, who _____ ***If yes,*** answer the questions below.

☐ **No** ***If no***, go to "Other eligibility information" on this page.

Type of deduction	**How often does this person get this deduction?** *(check one)*	**How much?**
☐ Alimony paid ☐ Student loan interest ☐ Other _____	☐ Hourly: How many hours per week?_____ ☐ Every two weeks ☐ Daily: How many days per week? _____ ☐ Twice a month ☐ Weekly ☐ Monthly ☐ Quarterly ☐ One-time payment ☐ Yearly	**$**

Additional information we need.
Please answer the questions below that apply to you or anyone in your household.

Is anyone in your household 19 to 20 years old and a full-time student? ☐ Yes ☐ No ***If yes,*** who? _____

Does anyone in your household have a physical, mental, emotional, or developmental disability? ☐ Yes ☐ No

If yes, who? _____

Does anyone in your household need help with long-term care or home and community-based services? ☐ Yes ☐ No

If yes, who? _____

Is anyone in your household pregnant? ☐ Yes ☐ No ***If yes,*** who? _____

If yes, what is your expected due date? _____ How many babies are expected? _____

Has anyone moved into or out of the home in the past 12 months? ☐ Yes ☐ No

If yes, who _____ What is your relationship to this person? _____

What language should we write you in? _____ What language do you want us to speak to you in? _____

If anyone in your household has changed their citizenship/immigration status in the past 12 months, list the name(s) below:

Name of Person (Include first and last name)	**New Immigration or Citizenship Status**

Examples of income not from a job

Use this list for “Does anyone have income that is not from a job?”

- Unemployment benefits
- Social Security benefits
- Retirement or pension income
- Rent or royalty income
- Alimony received
- Investment income
- Capital gains
- Farming or fishing income
- Canceled debts
- Court awards
- Jury duty pay
- Other income not from a job

Deductions

Use this list for “Does anyone in the household have deductions?”

- Certain self-employment expenses
- Student loan interest deduction
- Tuition and fees
- Educator expenses
- IRA contribution
- Moving expenses
- Penalty on early withdraw of savings
- Health savings account deduction
- Alimony paid
- Domestic production activities deduction
- Certain business expenses of reservists, performing artists, and fee-based government officials