



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



EDMUND G. BROWN JR.  
Governor

May 16, 2013

Medi-Cal Eligibility Division Information Letter No.: I 13-03

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 of 2010 – Initial Guidance

The Department of Health Care Services (DHCS) has been working closely with the federal Centers for Medicare & Medicaid Services (CMS) on the Affordable Care Act of 2010 (ACA) regarding the required Medicaid eligibility changes. There are various ACA related policy changes DHCS would like to provide high-level policy guidance to counties and Statewide Automated Welfare Systems (SAWS) based on analysis of federal regulations and discussions with CMS as they plan for implementation. There are various ACA related policy changes where DHCS cannot provide policy guidance at this time pending final federal guidance and interpretation of ACA requirements and enabling state statute. 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.

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, counties and SAWS can expect state statute to be enacted, followed by policy guidance in the form of All-County Welfare Directors' Letters (ACWDLs) and state regulations. Given the timing of implementation, this initial 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 Medi-Cal (for the subject both to Modified Adjusted Gross Income (MAGI) and non-MAGI), Advanced Premium Tax Credits (APTCs), Cost Sharing Reductions (CSRs) and unsubsidized coverage. Continued use of other existing paper Medi-Cal applications, including but not limited to, the MC 210, MC 321, SAWS 1, and SAWS 2 after January 1, 2014, would require modifications to gather additional data necessary to perform a MAGI eligibility determination. In addition, DHCS would need to obtain approval from CMS prior to using an alternative application beyond January 1, 2014. Printing of MC 210s and 321s will cease at some date prior to January 1, 2014. 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.

The California Department of Social Services (CDSS) is working to revise the SAWS 2 to capture data elements necessary to perform a MAGI determination and will be requesting CMS approval of a revised SAWS 2. Once CDSS receives approval of the revised SAWS 2, counties may use the revised SAWS 2 after January 1, 2014.

Applicants, who are determined to be ineligible for MAGI Medi-Cal, but may be potentially eligible for non-MAGI Medi-Cal, shall be provided with a 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. Further information regarding non-MAGI supplemental application forms will be forthcoming.

**Applications the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) Will Forward 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 identified as a former foster care child, age 18 to 25.
  - Individual is enrolled in Medicare, but only for the purpose of determine 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 requests 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.

Note: DHCS is currently analyzing proposed federal regulations, released on January 22, 2013, that include provisions regarding applications for Medicaid determinations. Given the proposed nature of the regulations, DHCS will provide future high level policy guidance on this matter in the future.

### **MAGI Changes to Medi-Cal Programs**

SAWS systems changes and/or county “work-arounds”, 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
- 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. These aid codes shall be programmed and operational in all county systems no later than October 1, 2013.

- 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. Because counties will be performing the case management of MAGI Medi-Cal cases, SAWS will need to be programmed to accommodate this change in household composition rules. SAWS must provide technical documentation to DHCS demonstrating SAWS has the ability to perform case management of MAGI Medi-Cal cases using the new MAGI tax filing household construct.

#### **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. Counties shall not send existing ARV packets to beneficiaries, who have an ARV due January 1, 2014, or later.

On January 1, 2014, a new Medi-Cal ARV process will be implemented that conforms to ACA requirements. The new ARV process will require counties to perform an electronic verification of the beneficiary's existing income and demographic data with the federal data hub. Counties will access the federal data hub through an Electronic Health Information Transfer (E-HIT) from SAWS to CalHEERS. If the electronic verification does not result in a "reasonable compatibility" issue, counties will be required to notify the beneficiary the ARV was performed and the basis of the beneficiary's continuing eligibility. Should the electronic verification result in a "reasonable compatibility" issue, counties will be required to follow steps to be outlined in future guidance that will include the use of a prepopulated renewal form and the federally-approved DHCS verification plan.

#### **Mid-year Status Report (MSR)**

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 aforementioned 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.

### **SNEEDE v. KIZER**

Effective January 1, 2014, Sneeede v. Kizer and Gamma v. Belshé procedures continue to apply when determining financial eligibility for the non-MAGI based Medically Needy Program. Current Medi-Cal coverage groups that will be subject to MAGI methodologies, as described above, are not subject to Sneeede v. Kizer and Gamma v. Belshé eligibility rules. Counties should only include the income and property of the non-MAGI Medi-Cal Family Budget Unit (MFBU) members. If the non-MAGI MFBU is found to have excess property, or a share of cost, and a Sneeede class member is included in the non-MAGI MFBU, then the county would determine if any of those individuals were eligible after breaking the non-MAGI MFBU into the mini-budget units in accordance with the Sneeede Procedures contained in Article 8 of the Medi-Cal Eligibility Manual, Procedures Section 8F.

### **Reporting Requirements**

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 SAWS to define requirements and agree upon format and transmission protocols. Additional detail regarding the reporting requirements will be contained in a future ACWDL.

### **Continuous Eligibility for Children (CEC)**

CEC eligibility for children under 19 years of age does not change with the implementation of the ACA. During the eligibility period, if a child's Medi-Cal eligibility changes from MAGI Medi-Cal to APTC/CSR eligibility or ineligibility, the child shall be placed in CEC until his/her next scheduled annual renewal. Counties will call the CalHEERS business rules engine in the event there is a change of circumstances that may affect eligibility. If the family is determined APTC/CSR eligible or there is ineligibility, the child would be protected under CEC. A child who is currently eligible for Disabled Federal Poverty Level or Pickle (or other Non-MAGI Programs without a share of cost) would also be protected by CEC. Because eligibility rules for MAGI and non-MAGI reside in two different systems, CEC design discussions are underway for CEC configuration within CalHEERS and SAWS to afford CEC protection based a child's change in circumstance and their basis for income eligibility (MAGI vs non-MAGI).

A child's CEC period may only end for the following reasons: loss of California residency, death, voluntary withdrawal, a request for discontinuance, whereabouts unknown, incarceration, or a child turns 19 years of age.

**Policy Areas Pending Future Federal Guidance:**

- Final data elements of the single streamlined application and prepopulated renewal forms.
- Case management/handling of mixed households (Medi-Cal/APTC).
- Final verification plan and impact to SAWS/county business processes.
- Whether medically needy with a SOC is minimum essential coverage.
- Business processes associated with continuing the Medi-Cal/CalWORKS linkage.
- Transitional Medi-Cal.
- Impact of open enrollment period on SAWS/counties.
- Notice of Action content and triggers.
- Senate Bill 87/Ex parte requirements.
- Outreach to potential Exchange/Medi-Cal eligible, CalFresh, CCS, 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.
- Policy for where potential applicants are directed to mail applications (County verses CalHEERS service center).
- Final ACA aid codes.

If you have any questions or concerns, please contact Harold Higgins, Medi-Cal Eligibility Division, by phone (916) 327-0412 or email [harold.higgins@dhcs.ca.gov](mailto:harold.higgins@dhcs.ca.gov).

Sincerely,

**Original Signed By**

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Health Care Benefits and Eligibility