426-1 ADDED 10/15

Background to Affordable Care Act and MAGI Medi-Cal

The Patient Protection and Affordable Care Act, 2010 (Pub L. 111-148), March 23, 2010 consolidated with the Health Care and Education Reconciliation Act (Pub L. 111-152) March 30, 2010, also known as the Affordable Care Act (ACA), expands the options available to individuals and small businesses that need help paying for the cost of health insurance. Individuals who do not have health insurance coverage or cannot afford coverage through their employers can apply for help through various health Insurance Affordability Programs (IAPs).

The Modified Adjusted Gross Income (MAGI) California Medical Assistance Program (Medi-Cal) provides zero Share of Cost (SOC) Medi-Cal to eligible individuals without any assets or resources test. MAGI Medi-Cal replaces income counting methods previously used in Medi-Cal with a more simplified method and significantly expands Medi-Cal benefits to include eligible individuals ages 19 to 64. MAGI Medi-Cal has two components: income and household composition. They are compared to the applicable Federal Poverty Level (FPL) to determine which IAPs may be available.

(42 U.S.C. §§ 1396a(a)(10)(A)(i)(VIII), (e)(14)(C); 42 C.F.R. §§ 435.119, 435.603(d)(4), (g)(1); 45 C.F.R. § 155.305(c); Gov't Code §§ 100500-100503; California Department of Health Care Services, Short Doyle Aide Code Master Chart (October 28, 2013) p. 24, at <http://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/10_28_2013_SD%20II%20Aid%20Code%20Master%20Chart%20for%20MHS-DMC.pdf> [as of November 25, 2014].)

426-1A ADDED 10/15

Insurance Affordability Program (IAP)

The term "Insurance Affordability Program" means one of the following:

(1) The Medi-Cal program;

(2) The Optional Targeted Low-Income Children (OTLIC) Medi-Cal program;

(3) A Qualified Health Plan (QHP) through Covered California with Advance Payments of Premium Tax Credit (APTC); or

(4) A QHP through Covered California with Cost-Sharing Reduction (CSR).

(42 C.F.R. § 435.4; Welf. & Inst. Code § 14057; 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(XIV), 1396a(r)(2); 1396d(u)(2)(B); &1397jj(b); Welf. & Inst. Code § 14005.26; Cal. State Plan Amdt. 13-005 (May 31, 2013).)

426-1B ADDED 10/15

Ineligible for APTC and CSR if Eligible for MAGI Medi-Cal

An individual who is eligible for MAGI Medi-Cal or other Minimum Essential Coverage (MEC) is not eligible for Advance Payments of Premium Tax Credit (APTC) or Cost-Sharing Reduction (CSR) assistance through Covered California.

(26 U.S.C. § 36B(b)(1), (c)(2)(B); 26 C.F.R. §§ 1.36B-2(a)(2), 45 C.F.R. § 155.305(f)(1)(ii)(B); Cal. Code Regs, tit. 10, § 6474, subd. (c)(1)(B).)

426-1C ADDED 10/15

MAGI Med-Cal Recipients Must Enroll in Available Managed Care

MAGI Medi-Cal eligible individuals shall enroll in a Medi-Cal managed care health plan if available in their county of residence, unless granted a medical exemption request to disenroll from managed care. If a Medi-Cal managed care plan is not available in an individual's county, services shall be provided under the Medi-Cal fee-for-service delivery system until a managed health care plan becomes available.

(Welf. & Inst. Code § 14005.60, subd. (c); Cal. Code of Regs., tit. 22, §§ 53887, 53923.5.)

426-2A ADDED 10/15

MAGI Medi-Cal Eligibility, Adults 19 to 64

Medi-Cal coverage is provided to eligible individuals ages 19 to 64, with Modified Adjusted Gross Income (MAGI) at or below 138% of the Federal Poverty Level (FPL) (5% disregard added to the 133% FPL limit), provided the individuals are not entitled to or enrolled for Medicare benefits under part A or B. (Aid Codes M1 and M2 are the aid codes for this category for adults 19-64 who are not considered parents or caretaker relatives.)

(42 U.S.C. § 1396a(a)(10)(A)(i)(VIII); 42 C.F.R. §§ 435.119, 435.603(d)(4); 45 C.F.R. § 155.305(c); Welf. & Inst. Code § 14005.64, subd. (b); California Department of Healthcare Services, All County Welfare Director's Letter (ACWDL) No. 14-15 (March 28, 2014), attaching DHCS ACA Medicaid and Exchange AID CODE List, version 1.0 (January 31, 2014).)

426-2B ADDED 10/15

MAGI Medi-Cal Eligibility for Children (including OTLIC)

Children under age 19 with household Modified Adjusted Gross Income (MAGI) up to 266 percent of the Federal Poverty Level (FPL) are eligible for full-scope benefits in MAGI Medi-Cal with no share of cost. Depending on the age and income of the child, a child may receive MAGI Medi-Cal under the Optional Targeted Low-Income Children (OTLIC) program, which is a part of MAGI Medi-Cal for children. Premiums of $13 per child, up to a maximum of $39 per family, apply for children ages 1-19 with household MAGI income between 160% and 266% of the Federal Poverty Level. Children in OTLIC MAGI Medi-Cal will be in Aid Codes T0 – T9. Children with lower incomes will be in a variety of additional MAGI Medi-Cal aid codes.

(42 U.S.C. §§ 1396a(a)(10)(A)(ii)(XIV), 1396a(r)(2); 1396d(u)(2)(B); &1397jj(b); 45 C.F.R. § 155.305(c); Welf. & Inst. Code § 14005.26; Cal. State Plan Amdt. 13-005 (May 31, 2013); California Department of Healthcare Services, All County Welfare Director's Letter (ACWDL) No. 14-15 (March 28, 2014), attaching DHCS ACA Medicaid and Exchange AID CODE List, version 1.0 (January 31, 2014); ACWDL No. 14-21 (April 25, 2014); Center for Medicare and Medicaid Services, State Medicaid & CHIP Policies for 2014 (Oct. 2013) <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/california.html> [as of June 2, 2015].)

426-2C ADDED 10/15

Parent/Caretaker Relatives

A parent or caretaker relative (and if living with the parent/caretaker relative, his or her spouse) qualifies for MAGI Medi-Cal with Modified Adjusted Gross Income up to 109% of the Federal Poverty Level. (Aid Code M3) A parent or caretaker relative may also qualify for Medi-Cal with Modified Adjusted Gross Income up to 138% of the Federal Poverty Level if he or she meets the qualifications for eligibility for adults ages 19 to 64. (Aid Codes M3 and M4 are used for this category.)

(42 U.S.C. § 1396a(a)(10)(A)(i)(VIII); 42 C.F.R. §§ 435.110, 435.119 & 435.603(d)(4); 45 C.F.R. § 155.305(c); Welf. & Inst. Code § 14055; California Department of Healthcare Services, All County Welfare Director's Letter (ACWDL) No. 14-15 (March 28, 2014), attaching DHCS ACA Medicaid and Exchange AID CODE List, version 1.0 (January 31, 2014); ACWDL No. 14-21 (April 25, 2014).)

426-2D ADDED 10/15

Caretaker Relative, Definition

"Caretaker relative" means a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care, and who is one of the following:

(1) The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, great grandparent, uncle, aunt, nephew, niece, great-great grandparent, great uncle or aunt, first cousin, great-great-great grandparent, great-great uncle or aunt, or first cousin once removed.

(2) The spouse or registered domestic partner of one of the relatives identified in paragraph (1), even after the marriage is terminated by death or divorce or the domestic partnership has been legally terminated.

(42 C.F.R. § 435.4; Welf. & Inst. Code § 14055.)

426-2E ADDED 10/15

Pregnant Women

A pregnant woman is eligible for either full-scope Medi-Cal or Medi-Cal with limited-scope benefits, depending on her income, as follows:

1. A pregnant woman with household income at or below 138% of the Federal Poverty Level (FPL) is eligible for full scope MAGI Medi-Cal with no Share of Cost. Her eligibility for MAGI Medi-Cal is not limited to the period of her pregnancy or 60 days post-partum, but will continue unless she has a change in circumstances (such as a change in income or household size).

2. A pregnant woman with income above 138% FPL may be eligible for full-scope Medi-Cal with no Share of Cost if she qualifies under the eligibility rules for MAGI Medi-Cal for children, including the Optional Targeted Low Income Children program (for pregnant women under age 19 with MAGI income up to 266% FPL). (Aid Codes T1 & T2)

3. A pregnant woman who is a former foster care youth may be eligible for full-scope Medi-Cal with no Share of Cost if she meets the requirements of that program, up to age 26. (Aid Code 4M.)

4. A pregnant woman with household income above 138% FPL, up to household income at or below 213% FPL, who does not qualify for full-scope Medi-Cal, is eligible for limited-scope Medi-Cal, which covers pregnancy-related services (family planning, pregnancy-related and post-partum services) and emergency services.

5. Limited-scope Medi-Cal benefits do not qualify as Minimum Essential Coverage. Therefore, a pregnant woman who is eligible for limited-scope Medi-Cal is also eligible to enroll in a Covered California Qualified Health Plan, and may be eligible for two types of premium subsidies for her Covered California plan: Advance Payments of Premium Tax Credit (APTC)); and Cost-Sharing Reduction (CSR), if she has income between 100% FPL and 250% FPL; and APTC only if she has income between 251% FPL and 400% FPL . A pregnant woman who is eligible for limited-scope Medi-Cal benefits is not required to enroll in limited-scope Medi-Cal. She may choose to enroll only in a Covered California Qualified Health Plan (with premium subsidies and cost sharing reduction, if she qualifies for those subsidies), or she may enroll in both a Covered California Qualified Health Plan and limited-scope, pregnancy-related Medi-Cal.

Since limited-scope Medi-Cal benefits do not qualify as Minimum Essential Coverage, a pregnant woman who enrolls only in limited-scope Medi-Cal and does not also enroll in a Covered California Qualified Health Plan (or other coverage that qualifies as Minimum Essential Coverage) could be required to pay penalties to the IRS for not having Minimum Essential Coverage, unless she applies for and obtains a hardship exemption.

(42 U.S.C. §§ 1396a(a)(10)(A)(i)(IV), 1396a(a)(10)(A)(ii)(IX), 1396a(l)(1)(A); 26 C.F.R. § 1.5000A-2(b)(2)(iii); 42 C.F.R. §§ 435.116, 435.119; 45 C.F.R. § 155.305(c); Welf. & Inst. Code §§ 14005.22 & 14005.225; California Department of Healthcare Services Medi-Cal Eligibility Division Information Letter (MEDIL) 14-05 (Jan. 17, 2014); California Department of Healthcare Services Medi-Cal Eligibility Division Information Letter (MEDIL) 14-31 (June 4, 2014); California Department of Healthcare Services, All County Welfare Director's Letter (ACWDL) No. 14-15 (March 28, 2014), attaching DHCS ACA Medicaid and Exchange AID CODE List, version 1.0 (Jan. 31, 2014); California Department of Healthcare Services, Medi-Cal Eligibility Division Information Letter (MEDIL) I 15-25 (Aug. 19, 2015); Department of Health and Human Services, Centers for Medicare and Medicaid Services, Letter approving full-scope Medi-Cal benefits for pregnant women up to 138% FPL, July 31, 2015 <http://www.dhcs.ca.gov/provgovpart/Documents/CA_Approval_Ltr_7_31_15.pdf> [as of August 13, 2015]; Minimum Essential Coverage, HHS Centers for Medicare & Medicaid Services, SHO #14–002 (Nov. 7, 2014) at pp. 6-7 & 10-11; Guidance on Hardship Exemptions for Persons Meeting Certain Criteria, HHS Centers for Medicare & Medicaid Services, (March 20, 2015).)

426-2F ADDED 10/15

Limited-Scope Medi-Cal for Pregnant Women Do Not Constitute Minimum Essential Coverage

Limited scope Medi-Cal does not constitute Minimum Essential Coverage (MEC). A pregnant woman who enrolls only in limited-scope Medi-Cal and does not also enroll in a Covered California Qualified Health Plan (or other coverage that qualifies as Minimum Essential Coverage) could be subject to paying penalties to the IRS for not having Minimum Essential Coverage, unless she applies for and obtains a hardship exemption.

(26 C.F.R. § 1.5000A-2(b)(2)(iii); Welf. & Inst. Code § 14005.37; California Department of Healthcare Services, All County Welfare Directors' Letter (ACWDL) 14-18 at pp. 3-4 (April 8, 2014); Minimum Essential Coverage, HHS Centers for Medicare & Medicaid Services, SHO #14–002 (Nov. 7, 2014) at pp. 6-7 & 10-11; Guidance on Hardship Exemptions for Persons Meeting Certain Criteria, HHS Centers for Medicare & Medicaid Services, (March 20, 2015).)

426-2G ADDED 10/15

Women Who Report Pregnancy as a Change in Circumstance

If a woman does not report that she is pregnant at the time of her Medi-Cal application and enrolls in Medi-Cal, and later reports pregnancy as a change in circumstance, the woman shall remain in her Medi-Cal coverage group (provided there are no other changes that would make her ineligible for coverage).

(California Department of Healthcare Services Medi-Cal Eligibility Division Information Letter (MEDIL) No. 14-31 (June 4, 2014).)

426-2H ADDED 10/15

Individuals Not Evaluated Using MAGI Methods

The Modified Adjusted Gross Income (MAGI) method of evaluating an individual's household composition, income and eligibility for Medi-Cal does not apply to certain groups, including the following:

1. Individuals whose eligibility does not require a determination of income by the California Department of Health Care Services or by the County, including, but not limited to, individuals receiving federal Supplemental Security Income (SSI) and individuals for whom the state relies on a finding of income made by another agency (known as an "Express Lane" agency).

2. Individuals who are age 65 or older when age is a condition of eligibility;

3. Individuals whose eligibility is being determined on the basis of being blind or disabled;

4. Individuals who request coverage for long-term services and supports;

5. Individuals who are being evaluated for eligibility for Medicare cost sharing assistance; and

6. Individuals who are being evaluated for coverage as medically needy.

(42 C.F.R. § 435.603(j).)

426-2I ADDED 10/15

Former Foster Care Children, not Evaluated Using MAGI Methods

An individual who was in foster care on his or her 18th birthday, in any state, is eligible for Medi-Cal until his or her 26th birthday. An individual in this group does not go through a Modified Adjusted Gross Income evaluation, and all income is disregarded. (Aid Code 4M)

(42 U.S.C. § 1396a(a)(10)(A)(i)(IX); California Department of Healthcare Services Medi-Cal Eligibility Division Information Letter (MEDIL) No. 14-05 (Jan. 17, 2014).)

426-3A ADDED 10/15

CalHEERS

The California Healthcare, Eligibility, Enrollment and Retention System (CalHEERS) is an automated system jointly managed by the Department of Health Care Services (DHCS) and Covered California and is designed to handle all applications for healthcare benefits, including all Medi-Cal programs, Advanced Payments of Premium Tax Credit (APTC) and Cost-Sharing Reductions (CSR) for enrollment into a Qualified Health Plan (QHP) through Covered California, and unsubsidized enrollment into a QHP through Covered California.

(Welf. & Inst. Code, § 14015.5, subd. (f)(2); Cal. Code Regs, tit. 10, § 6410.)

426-3B ADDED 10/15

One Application to Collect Information and Determine Eligibility

A Single, Streamlined Application (SSApp) must be used to determine eligibility and to collect information necessary for enrollment in all Insurance Affordability Programs (IAP), including Modified Adjusted Gross Income (MAGI) Medi-Cal, Non-MAGI Medi-Cal, Advance Payments of Premium Tax Credit (APTC) and Cost Sharing Reduction (CSR) subsidies, as well as unsubsidized coverage into a Qualified Health Plan (QHP) through Covered California.

(42 U.S.C. § 18083(a) & (b); 42 C.F.R. § 435.907(b); 45 C.F.R. § 155.405(a), (b); Welf. & Inst. Code § 15926, subd. (c); Cal. Code Regs, tit. 10, § 6470, subd. (a); Medi-Cal Eligibility Division Information Letter No. I 13-12 (September 16, 2013) p. 2; Cal. Dept. of Social Services, All County Letter (ACL) No. 14-14 (Feb. 7, 2014) p. 5.)

426-3C ADDED 10/15

Applicants Who Seek Any IAPs Must Be Evaluated for All IAPs

An applicant's request for an eligibility determination for one Insurance Affordability Program (IAP) is deemed a request for all IAPs, including Modified Adjusted Gross Income (MAGI) Medi-Cal, Non-MAGI Medi-Cal, Advance Payments of Premium Tax Credit (APTC) and Cost Sharing Reduction (CSR) subsidies. An applicant is not permitted to choose the IAPs for which he or she will be evaluated. If an applicant requests any of the IAPs, the applicant must be evaluated for all IAPs.

(42 U.S.C. § 18083 (a); 45 C.F.R. § 155.310(b); Cal. Code Regs, tit. 10, § 6476, subd. (b).)

426-3D ADDED 10/15

County Duties to Perform Other Evaluations if Applicant Not Eligible for MAGI Medi-Cal

The counties will submit applications to the CalHEERS Business Rules Engine (BRE), which will evaluate eligibility for Modified Adjusted Gross Income (MAGI) Medi-Cal, Advance Payments of Premium Tax Credit (APTC) and Cost Sharing Reduction (CSR). Applicants who are determined to be ineligible for MAGI Medi-Cal, but may be potentially eligible for Non-MAGI Medi-Cal, shall be referred to the counties. The counties shall provide such applicants with a Non-MAGI supplemental application form, which will be used to collect the necessary data elements for Non-MAGI Medi-Cal eligibility determinations.

If the county determines an applicant is eligible for Non-MAGI Medi-Cal with a Share of Cost (SOC), the applicant will have the option of enrolling in SOC Medi-Cal, SOC Medi-Cal along with a Covered California Qualified Health Plan (QHP) with APTC and/or CSR, or enrolling only in a Covered California QHP with APTC and/or CSR.

However, the federal Internal Revenue Service (IRS) and the federal Department of Health and Human Services (HHS) have determined that Medi-Cal with a Share of Cost does not qualify as Minimum Essential Coverage, and enrollment in Medi-Cal with a Share of Cost does not protect the enrollee from federal penalties for failing to enroll in Minimum Essential Coverage. For calendar year 2014 only, the IRS provided blanket relief from penalties for all individuals who were enrolled in Medi-Cal with a Share of Cost.

Beginning January 1, 2015, however, the IRS is no longer providing blanket relief from penalties. Instead, a person who enrolls only in Medi-Cal with a Share of Cost and does not also enroll in other Minimum Essential Coverage, such as a Covered California Qualified Health Plan, Medicare Part A (if eligible), or other qualifying coverage, must apply individually for a hardship exemption and be granted such an exemption, or the IRS may impose a penalty for not having Minimum Essential Coverage. Effective January 1, 2015, individuals enrolled in Medi-Cal with a Share of Cost who apply for a hardship exemption will qualify for a hardship exemption for the entire calendar year if they meet their spend-down requirement for at least one budget period in that calendar year.

(26 U.S.C. § 5000A(a)-(c); 26 C.F.R. § 1.5000A-2(b)(2)(v); 45 C.F.R. § 155.605(g)(1)(iii); California Department of Healthcare Services, Medi-Cal Eligibility Division Information Letter No. I 13-03 (May 16, 2013); California Department of Healthcare Services, Medi-Cal Eligibility Division Information Letter No. I 13-12 (September 16, 2013) pp. 2-3; All County Welfare Director's Letter (ACWDL) No. 14-18 (April 8, 2014) pp. 3-4, 9; Welf. & Inst. Code §§ 14005.32, 14005.37; Section 5000A Transition Relief for Individuals with Certain Government-Sponsored Limited-Benefit Health Coverage, Notice 2014-10, Internal Revenue Bulletin 2014-9 (Feb. 24, 2014) pp. 605-06; Minimum Essential Coverage, HHS Centers for Medicare & Medicaid Services, SHO No. 14–002 (Nov. 7, 2014) pp. 6-7 & 10-11; Guidance on Hardship Exemptions for Persons Meeting Certain Criteria, HHS Centers for Medicare & Medicaid Services (March 20, 2015).)

426-3E ADDED 10/15

Covered California to Transmit Applications to Counties in Three Days

When an applicant submits the application to Covered California, Covered California will make an initial determination of Modified Adjusted Gross Income (MAGI)-based Medi-Cal eligibility. If Covered California determines an applicant eligible for MAGI-based Medi-Cal, including the Optional Targeted Low-Income Children Program, Covered California must notify and transmit to the applicant's resident county all information that is necessary for the county to provide the applicant with coverage. Covered California must transmit the information to the county within three business days from the date of the eligibility determination.

(45 C.F.R. § 155.310(d)(3); Welf. & Inst. Code § 14015.5, subd. (c); Cal. Code Regs., tit. 10, § 6476, subds. (e), (f).)

426-3F ADDED 10/15

Applications that Covered California Must Forward to Counties

Covered California must forward to the counties for eligibility determinations the applications from the following individuals:

1. Individuals excepted from MAGI methodology:
    a. Individual is aged 65 or older;
    b. Individual is blind or disabled when the individual is not eligible under MAGI;
    c. 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; and
    d. 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:
    a. Individual is aged 65 years old or older;
    b. Individual is blind or disabled; and
    c. 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 other than MAGI and request an eligibility determination on a basis other than MAGI; and

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

(Welf. & Inst. Code § 15926, subd. (h)(2); Medi-Cal Eligibility Division Information Letter (MEDIL)No. I 13-12 (September 16, 2013) pp. 5-6.)

426-4A ADDED 10/15

Application Methods

Individuals may apply for healthcare benefits by mail, fax, telephone, online, or in person at county offices or with certified assisters. Individuals may submit their applications either to the county or to Covered California. The county must accept quick-sort phone transfers from Covered California.

(Cal. Code Regs., tit. 10, § 6470, subd. (j); 42 U.S.C. § 18083(b)(1); 45 C.F.R. § 155.405(c)(2); Welf. & Inst. Code § 15926, subd. (b); Medi-Cal Eligibility Division Information Letter (MEDIL) No.: I 13-12 (September 16, 2013) p. 3.)

426-4B ADDED 10/15

Continued Use of Certain Existing Applications until January 1, 2016

The county must accept any paper applications in existence prior to January 1, 2014 as an application for Medi-Cal, including the MC 210, the MC 321, and the SAWS 1 and SAWS 2 until January 1, 2016. The county must request any additional information needed from the applicant to complete the eligibility determination process.

(Welf. & Inst. Code § 15926, subd. (c)(4)(G); Medi-Cal Eligibility Division Information Letter (MEDIL) No.: I 13-12 (September 16, 2013) p. 2.)

426-4C ADDED 10/15

Application Content

An applicant must provide the information, documentation, and declarations required on the single streamlined application and sign and date the application under penalty of perjury. Electronic, including telephonically recorded, signatures and handwritten signatures transmitted via any electronic transmission must be accepted. The information, documentation and declaration required are set forth in the California Code of Regulations, title 10, section 6470,

subdivisions (c), (d) and (e). Covered California, the counties, or any other entity accepting and processing applications may not require an applicant to provide any forms, documents, or other information or undergo verification that is duplicative or otherwise unnecessary.

(42 U.S.C. § 18083(b)(2); 42 C.F.R. § 435.907(e), (f); Welf. & Inst. Code § 15926, subd. (h)(1); Cal. Code Regs, tit. 10, § 6470, subd. (b).)

426-4D ADDED 10/15

Requirement to Provide Social Security Number

An applicant must provide a Social Security Number (SSN), unless the applicant:

1. Is not eligible to receive an SSN;
2. Does not have an SSN and may only be issued an SSN for a valid non-work reason, including for purposes of receiving public assistance in a program that requires an SSN; or
3. Refuses to obtain an SSN due to well-established religious objections.

An applicant who does not provide a SSN shall still be evaluated for restricted-scope Medi-Cal.

(42 U.S.C. § 1320b-7(a)(1); 42 C.F.R. § 435.910(a), (h); Welf. & Inst. Code §§ 14007.5, subd. (d), 15926, subd. (c)(4)(B); Cal. Code Regs, tit. 22, § 50187, subds. (a), (b).)

426-4E ADDED 10/15

County Duty to Assist Applicants Who Cannot Recall, or Do Not Have, Social Security Numbers

If the applicant cannot recall the applicant's Social Security Number (SSN) or has not been issued an SSN, the county must help the applicant do the following:

1. Complete the SSN application;
2. Obtain evidence to establish the age, citizenship or alien status, and the applicant's true identity; and
3. Either send the SSN application to the Social Security Administration (SSA) or request SSA to provide the applicant's SSN.

(42 C.F.R. § 435.910(e).)

426-4F ADDED 10/15

Requests for Social Security Numbers from Non-Applicants

The county may request a non-applicant's Social Security Number if the county informs the applicant that provision of such Social Security Number is voluntary and that the county will only use the information to determine the applicant's eligibility for Medi-Cal and other Insurance Affordability Programs.

(42 C.F.R. § 435.907(e).)

426-4G ADDED 10/15

No Face-to-Face Interview Required

The county may not require an applicant to attend a face-to-face interview as part of the application process for MAGI Medi-Cal.

(42 C.F.R. § 435.907(d); Welf. & Inst. Code §§ 14011.1, subd. (d), 14011.15, subd. (e).)

426-4H ADDED 10/15

Timeline to Determine Eligibility

For Modified Adjusted Gross Income (MAGI) Medi-Cal applications, the county department shall complete the determination of eligibility as quickly as possible, but not later than 45 days following the date the application, reapplication or request for restoration is filed. For Non-MAGI Medi-Cal applications on the basis of disability, the timeline is 90 days.

(42 U.S.C. 1396a(a)(8); 42 C.F.R. § 435.912(a); Welf. & Inst. Code § 15926, subd. (e); Cal. Code Regs., tit. 22, § 50177.)

426-5A ADDED 10/15

MAGI Medi-Cal Effective Date of Eligibility

The beginning date of eligibility for Modified Adjusted Gross Income (MAGI) Medi-Cal applicants shall be the first day of the month of application if all eligibility requirements for MAGI Medi-Cal are met during that month, or if the eligibility requirements are not met during the month of application, the first day of the month in which the MAGI Medi-Cal eligibility requirements are met, but not earlier than January 1, 2014.

(Cal. Code Regs., tit. 22, § 50193; 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).)

426-5B ADDED 10/15

Retroactive Medi-Cal Eligibility

If an applicant requests retroactive Modified Adjusted Gross Income (MAGI) or Non-MAGI Medi-Cal coverage, the applicant may be eligible for MAGI or Non-MAGI Medi-Cal in any of the three months immediately preceding the month of application or reapplication if all of the MAGI or Non-MAGI Medi-Cal eligibility requirements are met in that month, but for MAGI Medi-Cal, not earlier than January 1, 2014. The applicant may request retroactive coverage on the application, on the statement of facts, or by a separate written request. An applicant who seeks retroactive coverage must apply for retroactive coverage within one year of the month for which the applicant requests retroactive coverage.

(Cal. Code Regs., tit. 22, §§ 50148, 50197, subd. (a); 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).)

426-5C ADDED 10/15

No Break in Coverage

During the processing of an application, renewal, or a transition due to a change in circumstances, the county and Covered California must ensure that all Insurance Affordability Program (IAP) applicants and recipients, who meet all program eligibility requirements and comply with all necessary requests for information, move between programs without any breaks in coverage. During the process, the county and Covered California must not require applicants and recipients to provide any forms, documents, or other information or undergo verification that is duplicative or otherwise unnecessary. The individual must be informed about how to obtain information on the status of his or her application, renewal, or transfer to another program at any time, and the information must be promptly provided when requested.

(Welf. & Inst. Code § 15926, subd. (h)(1).)

426-5D ADDED 10/15

County of Responsibility

The county of responsibility is the county responsible for determining the initial and continuing Medi-Cal eligibility for a person or family. The county of responsibility is generally the county in which the person's or family's residence is located, or the county of physical presence if the residence is unclear.

(Cal. Code Regs., tit. 22 §§ 50120, 50123, 50125.)

426-5E ADDED 10/15

Application in County Other Than County of Responsibility

The county in which a person applies for Medi-Cal shall accept the application from such person on behalf of the county of responsibility. The information shall be forwarded to the county of responsibility no later than 15 days from the date of application. The county in which the person applies may, with the consent of the applicant or beneficiary, become the county of responsibility for determining initial eligibility and initiating an Inter-County transfer.

(Cal. Code Regs., tit. 22 § 50135.)

426-6A ADDED 10/15

Inter-County Transfers (ICTs), Ongoing Eligibility with No Interruption in Benefits

The following rules apply to Medi-Cal Inter-County Transfers (ICTs):

- Counties must ensure all Medi-Cal cases remain active throughout the Inter-County transfer period with no interruption in benefits. Medi-Cal is a statewide program; counties may not terminate Medi-Cal benefits when a beneficiary moves from one county to another until an effective date of benefits for the beneficiary in the new county is confirmed.

- Counties may neither ask nor require a beneficiary to reapply for Medi-Cal benefits or apply for a redetermination of eligibility in the new county of residence solely due to the change in county residence.

- Counties shall not require the beneficiary to undergo any redetermination procedures during the Inter-County transfer. Inter-County transfer is a transfer of county responsibility for the beneficiary's case record. A redetermination of eligibility is not part of the Inter-County transfer process.

- Counties shall not require the beneficiary to complete a new application or cooperate with a full eligibility review in the new county until the next annual redetermination date as determined by the beneficiary's old county of residence.

(All-County Welfare Directors Letter (ACWDL) No. 03-12, February 21, 2003.)

426-6B ADDED 10/15

Inter-County Transfers, Duties of Sending County

When a beneficiary reports a permanent change of county residence or reports that he or she is living in another county for an indefinite period, the Sending County must initiate an Inter-County transfer to the Receiving County within seven calendar days. Among other actions, the Sending County must notify the Receiving County in writing of the case transfer, complete an address

change in the county system and in Medi-Cal Eligibility Data System (MEDS) records, and send an Inter-County Transfer notice to the beneficiary.

(All-County Welfare Directors Letter (ACWDL) No. 03-12, February 21, 2003.)

426-6C ADDED 10/15

Inter-County Transfers, Duties of Receiving County

When a Sending County notifies a Receiving County of an Inter-County Transfer, the Receiving County must complete the Inter-County Transfer no later than the first of the month after the 30-day Inter-County transfer notification from the Sending County. The beneficiary shall not be required to complete a new application. The Receiving County shall not conduct a full eligibility review until the next annual redetermination date unless there is a change in circumstances that affects Medi-Cal eligibility.

Among other actions, the Receiving County must verify the beneficiary's current address and active Medi-Cal status on Medi-Cal Eligibility Data System (MEDS), initiate action to continue Medi-Cal benefits for the beneficiary in the Receiving County, notify the Sending County caseworker of the effective date of Medi-Cal benefits for the beneficiary so that the Sending County can take action to terminate benefits, and send a Notice of Action to the beneficiary of the effective date of Medi-Cal benefits in the Receiving County, including the new caseworker's name, telephone number, and work hours.

(All-County Welfare Directors Letter (ACWDL) No. 03-12, February 21, 2003.)

426-6D ADDED 10/15

Inter-County Transfers, Sending County Termination Date and Receiving County Effective Date

The Sending County's termination date must be on the last day of the month and the Receiving County's effective date of benefits must be on the first day of the month following the Sending County's termination date, with no gap in coverage.

(All-County Welfare Directors Letter (ACWDL) No. 03-12, February 21, 2003.)

427-1A ADDED 10/15

Requirement for Citizenship or Satisfactory Immigration Status

To be eligible for full-scope Medi-Cal benefits, an applicant or beneficiary shall have satisfactory citizenship or immigration status as follows:

(1) A citizen of the United States;

(2) A national of the United States from American Samoa or Swain's Island;

(3) An alien lawfully admitted for permanent residence;

(4) An alien permanently residing in the United States under color of law (PRUCOL); or

(5) Certain amnesty aliens.

Applicants who do not meet this requirement may still receive restricted scope Medi-Cal.

(8 U.S.C. § 1641; 42 U.S.C. § 1396b(v)(1); 42 C.F.R. § 435.406; Welf. & Inst. Code § 14007.5; Cal. Code Regs., tit. 22 § 50301, subd. (b).)

427-1B ADDED 10/15

Residency Requirement

California residence is a requirement for the California Medical Assistance Program (Medi-Cal), although no period of residence in California shall be required. An adult applicant must be living in California with the intention to reside in the state (including individuals who do not have a fixed address); or must have entered the state with a job commitment or to seek employment.

(42 C.F.R. § 435.403(a); Welf. & Inst. Code §§ 14007, 14007.15, subd. (a).)

427-1C ADDED 10/15

Residency Out-of-State

A recipient who maintains a residence outside of California for at least two months shall not be eligible for Medi-Cal where the county has made inquiry of the recipient and the recipient has not responded to the inquiry by clearly showing that he or she has

(1) not established residence elsewhere; or

(2) been prevented by illness or other good cause from returning to the state.

(Welf. & Inst. Code § 14007.6, subd. (a).)

427-1D ADDED 10/15

Reapplication by Out-of-State Recipient After Reestablishing Residency

If a recipient whose Medi-Cal benefits were terminated due to establishing residency out-of-state reapplies, Medi-Cal benefits must be restored, provided all other eligibility criteria are met and the recipient is considered a resident.

(Welf. & Inst. Code §§ 14007.6, subd. (b); 14007.15.)

427-1E ADDED
7/16Consumer protection programs such as Continuous Eligibility for Children (CEC) and Transitional Medical Care, do not apply to data entry errors. In some cases, this means the individuals may be moved into less advantageous Medi-Cal program or coverage through Covered California or may be discontinued once timely notice can be provided. Additionally, these individuals may be moved into a more advantageous program immediately. If necessary, counties may be required to complete an online MEDS transaction to provide the more advantageous eligibility until CalHEERS is able to move the person into the new aid code and the necessary transactions can be sent.
(ACWDL 16-16, July 5, 2016, p. 3)

427-1F ADDED
7/16In accordance with All County Welfare Directors Letter (ACWDL) 14-05, Continuous Eligibility for Children (CEC), children under age 19 who are approved for MAGI Medi-Cal are eligible to receive CEC when there is a change that would disadvantage the child or when there is a loss of contact with the family.

In the situation where certain individuals in a case household are found eligible or conditionally eligible while others remain in a pending eligibility status, when the family provides verification of income, counties must submit the information to CalHEERS to update eligibility for the whole case. If the verification provided would disadvantage the eligible or conditionally eligible child (other than a child in AE), per ACWDL 14-05, the county will place the child in the appropriate CEC aid code until their upcoming annual redetermination date, or the county shall follow the soft pause procedures outlined in ACWDL 14-18 and ACWDL 14-32, at which time he or she would be reassessed for ongoing eligibility. If no verification of income is provided after due process and there is a loss of contact with the family, the county shall place the child in the appropriate CEC aid code until their upcoming annual redetermination date and the pending adults shall be denied, as per current policy.

(ACWDL 16-16, July 5, 2016, p. 3)

427-1G ADDED
7/16Children granted presumptive eligibility through Accelerated Enrollment (AE) in aid code 8E are described by CalHEERS as conditionally eligible and are provided the AE eligibility immediately. However, for purposes of the final eligibility determination and appropriate NOA, children in AE are considered to be in a pending status until the county makes a final determination of eligibility. AE policy has not changed and if children in AE are determined to be ineligible, they are to be denied and not discontinued. The denial will result in a termination of the AE in MEDS at the end of the current month. Children who are initially granted AE and later found to be eligible shall be approved effective the application month.

(ACWDL 16-16, July 5, 2016, p. 3)

427-1H ADDED
7/16It is the Department of Health Care Services (DHCS) policy that individuals who are determined conditionally eligible by CalHEERS are to be considered as eligible awaiting appropriate verification to move to an eligible status.

(Welfare and Institutions Code, Section 14015.5; ACWDL 16-16, July 5, 2016)

427-1I ADDED
7/16Individuals who are determined Medi-Cal eligible by the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) are to be considered as eligible, even if other members of the household are pending Medi-Cal eligibility.

(Welfare and Institutions Code, Section 14015.5; ACWDL 16-16, July 5, 2016)

427-2A ADDED 10/15

Financial Eligibility Overview for MAGI-Based Medi-Cal

Financial eligibility for Modified Adjusted Gross Income (MAGI) Medi-Cal is based on household composition and household income. Each applicant's financial eligibility is determined individually for that applicant, using the following steps:

1. Who is in the applicant's MAGI Medi-Cal household (MAGI household composition);
2. Whose Income is counted; and
3. Which income is counted.

(42 C.F.R. § 435.603.)

427-2B

ADDED 10/15
MAGI Medi-Cal Household Composition When determining eligibility for MAGI Medi-Cal, household composition means the number of persons counted as members of an individual's household under Modified Adjusted Gross Income (MAGI) Medi-Cal

eligibility rules.

Each person's household composition is determined individually, based upon relationships and the tax filing status of each person. Depending on these factors, each person's household composition is determined using either the "Basic Rule" or the "Non-Filer Rule." (42 C.F.R. § 435.603(f).)

All citations in this chart are to 42 C.F.R. § 435.603(f). The category numbers in this chart are provided for convenience when using the chart, and are not found in the federal regulations.

"Applicant" means each person listed on the application, reviewed individually.

If the individual is . . .	**Then, the Medi-Cal MAGI Household includes:**
1. Tax Filer – the person who files a tax return [(f)(1)] • The spouse also counts as a tax filer, if they filed jointly. • Cannot be categorized as a tax filer if	Follow the Basic rule [(f)(1),(2) & (4)] • Tax filer + spouse, and all of the filer's tax dependents. Include spouse, if living together,

claimed as anyone's dependent.	even if not filing jointly.
2. Tax Dependent – Child of the Tax Filer [(f)(2)] • Son or daughter of tax filer (any age) • Broader than IRS qualifying child standard. • For children not covered by a Category 5 exception	
3. Tax Dependent – Other. [(f)(2)(i)] • A person *other than* the spouse or biological, adopted or step child who expects to be claimed as a tax dependent by the tax filer.	Follow the Non-Filer Rule [(f)(2) & (3)]: • The applicant, her spouse and minor children, PLUS • If the applicant is a minor child, also include her parents and minor siblings. • Only include
4. Non-filer: [(f)(3)] – A person who: • Does not file taxes	

AND • Is not claimed as a dependent	these persons if living with the applicant.
5. Children with Exceptions: If a child (<19/21 if a student) is claimed: • By only 1 parent and living with both parents but parents not file jointly [(f)(2)(ii)], OR • By non-custodial parent [(f)(2)(iii)] *(A child with exceptions cannot be a category 2 tax dependent)*	For this rule, "minor" means under age 19, or under 21 if a full-time student

(42 C.F.R. § 435.603(b) & (f).)

427-2C ADDED 10/15

Household Size - Pregnant Woman

In any household that includes a pregnant woman, the household includes the pregnant woman plus the number of children that she is expected to deliver.

(42 C.F.R. § 435.603(b); Cal. State Plan Amdt. 13-0023 (September 30, 2013) p. 5.)

427-2D ADDED 10/15

Married Couples Living Together

A married couple is not required to file a joint tax return to be eligible for Modified Adjusted Gross Income (MAGI) Medi-Cal. For a married couple living together, each spouse's household includes the other spouse, regardless of whether they expect to file a joint tax return.

(42 C.F.R. § 435.603(f)(4).)

427-3A ADDED 10/15

Basic Rule for Individual Taxpayers Not Claimed as Tax Dependents

The MAGI Medi-Cal household of an individual who expects to file a tax return for the taxable year in which the individual is seeking benefits, and who does not expect to be claimed as a tax dependent by another taxpayer, consists of the individual, the individual's spouse if living together, and all persons whom such individual expects to claim as a tax dependent.

(42 C.F.R. § 435.603(f)(1), (3), (4); Cal. State Plan Amdt. 13-0023 (September 30, 2013) p.6.)

427-3B ADDED 10/15

Basic Rule for Child of any Age Claimed as Dependent by Taxpayer(s) Who Is (Are) Child's Parent

Generally, for a child (son or daughter of any age), who expects to be claimed as a tax dependent by the child's parent(s), the child's household for MAGI Medi-Cal is the household of the taxpayer claiming that child as a tax dependent. This rule applies if the child meets either the requirements to be claimed as a "qualifying child" tax dependent or the requirements to be claimed as a "qualifying relative" tax dependent. This rule does not apply if the child falls within either of the two exceptions specified in 42 C.F.R. & 435.603(f)(2)(ii) & (iii).

(42 C.F.R. § 435.603(f)(2).)

427-3C ADDED 10/15

Individuals Other Than a Spouse or Child Claimed as Dependents by Taxpayers

For an individual who expects to be claimed as a tax dependent by another taxpayer, but who is not the taxpayer's spouse or biological, adopted, or step child, the individual's MAGI Medi-Cal household consists of the individual and the following persons, if living with the individual,

1. The individual's spouse;

2. The individual's natural, adopted and step children (under age 19, or age 21 if full-time students); and

3. If the individual is a minor (under age 19, or age 21 if full-time student), the individual's household shall include the individual's natural, adopted and step parents and natural, adoptive and step siblings (under age 19, or age 21 if full-time students).

(42 C.F.R. § 435.603(f)(2)(i), (f)(3); Cal. State Plan Amdt. 13-0023 (September 30, 2013) p. 6.)

427-3D ADDED 10/15

Child Claimed as Tax Dependent by Only One Parent and Living with Both Parents Who Do Not File a Joint Tax Return

The MAGI Medi-Cal household of a child (under age 19, or age 21 if full-time student) who expects to be claimed as a tax dependent by only one parent, and who is living with both parents who do not file a joint tax return, consists of the child and the following individuals, if living with the child:

1. The child's spouse;

2. The child's natural, adopted and step-children (under age 19, or age 21 if full-time students);

3. The child's parents; and

4. The child's natural, adoptive and step siblings (under age 19, or age 21 if full-time students).

(42 C.F.R. § 435.603(f)(2)(ii), (f)(3); Cal. State Plan Amdt. 13-0023 (September 30, 2013) p. 6.)

427-3E ADDED 10/15

Child Claimed as Tax Dependent by Non-Custodial Parent

If a child (under age 19, or age 21 if full-time student) expects to be claimed as a tax dependent by a non-custodial parent, the child's MAGI Medi-Cal household consists of the child and the following individuals, if living with the child:

1. The child's spouse;

2. The child's natural, adopted and step-children (under age 19, or age 21 if full-time students);

3. The child's parents; and

4. The child's natural, adoptive and step siblings (under age 19, or age 21 if full-time students).

(42 C.F.R. § 435.603(f)(2)(iii), (f)(3); Cal. State Plan Amdt. 13-0023 (September 30, 2013) p. 6.)

427-3F ADDED 10/15

Individuals Who Do Not File Taxes and Who Are Not Claimed as Dependents

The MAGI Medi-Cal household of an individual who does not expect to file a tax return and who does not expect to be claimed as a tax dependent consists of the individual and the following persons, if living with the individual:

(1) The individual's spouse;

(2) The individual's natural, adopted and step children (under age 19, or age 21 if full-time students); and

(3) If the individual is a minor (under age 19, or age 21 if full-time student), the individual's household shall include the individual's natural, adopted and step parents and natural, adoptive and step siblings (under age 19, or age 21 if full-time students).

(42 C.F.R. § 435.603(f)(3).)

427-3G ADDED 10/15

Who Taxpayers May Claim as Dependents

Dependents are the taxpayer's qualifying children and qualifying relatives.

(26 U.S.C. §§ 151, 152.)

427-3H ADDED 10/15

Qualifying Child

A taxpayer's qualifying child means an individual,

(1) who is the taxpayer's natural child, adopted child, stepchild, foster child, brother, sister, stepbrother, stepsister, half-brother, half-sister, or one of their descendants;

(2) who lives with the taxpayer for more than one-half of the taxable year;

(3) who is under age 19, or under age 24 (if a full time student), at the close of the calendar year in which the taxable year begins, and younger than the tax filer (and the taxpayer's spouse, if married filing jointly); these age requirements are deemed met for individuals who are permanently and totally disabled, as defined in federal law;

(4) who has not provided over one-half of such individual's own support for the taxable year;

(5) who has not filed a joint tax return with the individual's spouse in that taxable year; and

(6) who is a U.S. citizen or national, U.S. resident alien, or a resident of Canada or Mexico.

(26 U.S.C. § 152(a), (b), (c); 26 C.F.R. §§ 1.152-1, 1.152-2(a).)

427-3I ADDED 10/15

Special Qualifying Child Rule for Individuals with Disability

If at any time during the taxable year, an individual is permanently and totally disabled, as defined under federal tax law (26 U.S.C. § 22(e)(3)), that individual is deemed to have met the age criteria for a qualifying child.

(26 U.S.C. § 152(c)(3)(B).)

427-3J ADDED 10/15

Parent and Non-Parent Taxpayers that Can Claim the Qualifying Child

When two or more taxpayers can claim a deduction for a child, that child will be considered a qualifying child and dependent of the taxpayer who is the child's parent. If the child's parent is deceased or unknown, the child will be considered a qualifying child and dependent of the taxpayer with the highest adjusted gross income in the taxable year.

(26 U.S.C. § 152(c)(4)(A).)

427-3K ADDED 10/15

Two Parent Taxpayers that Can Claim the Qualifying Child

When two parents may claim the child, the child will be considered a qualifying child and dependent of the parent with whom the child lives for the longest period of time during the taxable year. If the child lives with both parents equally, the child will be considered a qualifying child and dependent of the parent with the highest adjusted gross income.

(26 U.S.C. § 152(c)(4)(B); 26 C.F.R. § 1.152-4(a).)

427-3L ADDED 10/15

Two Parent Taxpayers that Can Claim the Qualifying Child

A custodial parent with whom the child lives the longest during the taxable year may release the claim to exemption by signing IRS Form 8332 and declaring the intent to not claim the qualifying child as a dependent. The non-custodial parent must attach the form to his or her tax return for that taxable year.

(26 U.S.C. § 152(e); 26 C.F.R. § 1.152-4(b).)

427-3M ADDED 10/15

Qualifying Relative

A taxpayer's qualifying relative and dependent means an individual:

(1) who is the taxpayer's

a. child or a descendant of a child;

b. brother, sister, stepbrother, or stepsister;

c. father or mother, or an ancestor of either;

d. stepfather or stepmother;

e. son or daughter of a brother or sister of the taxpayer;

f. brother or sister of the father or mother of the taxpayer;

g. son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law; or

h. anyone, other than the taxpayer's spouse, who lives with the taxpayer during the entire taxable year and is a member of the taxpayer's household (may include the taxpayer's unmarried same sex partner and registered domestic partner);

(2) whose gross income during the taxable year is less than the exemption amount ($4,000 for calendar year 2015); this amount does not include income that an individual with a disability earns from a sheltered workshop where the individual receives medical care;

(3) for whom the taxpayer has provided over one-half of such individual's support for the taxable year;

(4) who is not any taxpayer's qualifying child;

(5) who has not filed a joint tax return with the individual's spouse in that taxable year; and

(6) who is a U.S. citizen or national, U.S. resident alien, or a resident of Canada or Mexico.

(26 U.S.C. § 152(a), (b), (d); 26 C.F.R. §§ 1.152-1, 1.152-2(a).)

427-3N ADDED 10/15

Qualifying Relative

Household income is determined individually for each applicant seeking benefits, using the following steps:

1. Determine whose income is included:

   Determine whose income is included by including the Modified Adjusted Gross Income (MAGI) for all of the applicant's MAGI Medi-Cal household members, except that under some circumstances, the income of tax dependents who are below the tax filing threshold is not included.

2. Determine which income is included:

   For all household members whose income is included, calculate the Modified Adjusted Gross Income (MAGI) by combining the types of income used to calculate Adjusted Gross Income on a tax return and then adding tax-exempt interest, non-taxable Social Security, and income earned abroad.

(42 C.F.R. § 435.603(d) & (e).)

427-4A ADDED 10/15

Household Income Overview

For purposes of Modified Adjusted Gross Income (MAGI) Medi-Cal eligibility, the household income of an individual is the sum of the MAGI-based income of every individual who is included in the individual's MAGI household, with the following exceptions:

(1) The MAGI-based income of a child who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax return for the taxable year in which eligibility for Medi-Cal is being determined is not included in household income, whether or not the child files a tax return.

(2) The MAGI-based income of a tax dependent, other than a spouse or child of the taxpayer who claims the tax dependent, who is not expected to be required to file a tax return for the taxable year in which eligibility for Medi-Cal is being determined, is not included in the household income of the taxpayer, whether or not such tax dependent files a tax return.

An individual is required to file a tax return if the individual's relevant income exceeds the applicable Tax Filing Threshold. The tax filing thresholds for individuals claimed as tax dependents are set forth in the Tax Filing Threshold Chart for Tax Dependents (IRS Publication 501, Table 2).

If a spouse is a member of an individual's MAGI household, the spouse's income is always included if the spouses are living together, whether or not the spouse files a tax return.

(42 C.F.R. § 435.603(d); 435.603(f)(i); IRS Publication 501, *Exemptions, Standard Deduction, and Filing Information for Use in Preparing 2014 Returns* (2014), Table 2 <http://www.irs.gov/uac/About-Publication-501> [as of August 12, 2015].)

427-4B ADDED 10/15

Determine Whose Income is Included

For purposes of Modified Adjusted Gross Income (MAGI) Medi-Cal eligibility, the household income of an individual is the sum of the MAGI-based income of every individual who is included in the individual's MAGI household, with the following exceptions:

(1) The MAGI-based income of a child who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax return for the taxable year in which eligibility for Medi-Cal is being determined is not included in household income, whether or not the child files a tax return.

(2) The MAGI-based income of a tax dependent, other than a spouse or child of the taxpayer who claims the tax dependent, who is not expected to be required to file a tax return for the taxable year in which eligibility for Medi-Cal is being determined, is not included in the household income of the taxpayer, whether or not such tax dependent files a tax return.

An individual is required to file a tax return if the individual's relevant income exceeds the applicable Tax Filing Threshold. The tax filing thresholds for individuals claimed as tax dependents are set forth in the Tax Filing Threshold Chart for Tax Dependents (IRS Publication 501, Table 2).

If a spouse is a member of an individual's MAGI household, the spouse's income is always included if the spouses are living together, whether or not the spouse files a tax return.

(42 C.F.R. § 435.603(d); 435.603(f)(i); IRS Publication 501, *Exemptions, Standard Deduction, and Filing Information for Use in Preparing 2014 Returns* (2014), Table 2 <http://www.irs.gov/uac/About-Publication-501> [as of August 12, 2015].)

427-4C___ADDED 10/15

Tax Filing Thresholds – Individuals Claimed as Dependents

A U.S. citizen or resident alien who is claimed as a dependent by another taxpayer must file an income tax return if the annual income met the relevant threshold, as shown below.

1. Use only taxable portions of income to determine filing threshold: When determining whether a tax dependent must file a tax return, compare the ***taxable*** portion of the dependent's earned, unearned, and gross income to the tax filing table for dependents. IRS rules define these terms as follows:

    a. Unearned income includes taxable interest, ordinary dividends, and capital gain distributions. It also includes unemployment compensation, *taxable* social security benefits, pensions, annuities, and distributions of unearned income from a trust.

    b. Earned income includes salaries, wages, tips, professional fees, and *taxable* scholarship and fellowship grants.

    c. Gross income is the total of the unearned and earned income.

2. Social Security benefits received by dependents: If a dependent receives social security benefits that are ***not taxable***, the dependent has zero unearned income, because the IRS only counts "taxable" social security as "unearned income." Most of the time, the social security benefits received by a dependent who is applying for MAGI Medi-Cal are not taxable. If a dependent's social security benefits are not taxable, do not consider the dependent's social security benefits when reviewing the tax filing table.

3. Tax dependent status: The IRS tax filing table for dependents includes a cautionary reminder that if a person's gross income was $3,950 or more, that person usually cannot be claimed as a dependent unless the person meets the requirements to be a "qualifying child" (including the requirement to be under age 19, or under age 24 if a student, unless the child is disabled). For example, if a child is over these age limits and is not disabled, a parent cannot claim the child as a dependent under the "qualifying child" rules. However, the parent may claim the child as a dependent under the "qualifying relative" rules, but *only if* the child's gross income was less than $3,950 and *also* if the parent and child meet the other requirements for "qualifying relative" status. For details, see Exemptions for Dependents (IRS publication 501, page 11 & following).

4. Different filing rules apply, depending on marital status, age, and whether dependent is blind: The IRS provides different filing thresholds depending on whether a dependent is single or married, over or under age 65, or blind. In MAGI Medi-Cal hearings, most dependents are single, under age 65, and not blind.

(26 U.S.C. § 6012; 26 C.F.R. § 1.1-1; IRS Publication 501, *Exemptions, Standard Deduction, and Filing Information for Use in Preparing 2014 Returns* (2014), Table 2, <http://www.irs.gov/uac/About-Publication-501> [as of Aug. 12, 2015]; see also 26 U.S.C. § 86 (rules for determining whether social security benefits are taxable.)

427-4D___ADDED 10/15

2014 Tax Filing Thresholds – Individuals Claimed as Tax Dependents

For 2014, the tax filing thresholds for individuals claimed as tax dependents by another taxpayer are as follows:

(1) Single Dependent, Under Age 65, not Blind:

The individual must file a tax return if **any** of the following apply:

a. Unearned income was more than $1,000;

b. Earned income was more than $6,200;

c. Gross income was more than the larger of

i. $1,000, or

ii. Earned income (up to $5,850) plus $350.

(2) Single Dependent, Age 65 or Older, or Blind:

The individual must file a tax return if **any** of the following apply:

a. Unearned income was more than $2,550 ($4,100 if 65 or older **and** blind);

b. Earned income was more than $7,750 ($9,300 if 65 or older **and** blind);

c. Gross income was more than the larger of

i. $2,550 ($4,100 if 65 or older **and** blind), or

ii. Earned income (up to $5,850) plus $1,900 ($3,450 if 65 or older **and** blind).

(3) Married Dependent, Under Age 65, not Blind:

The individual must file a tax return if **any** of the following apply:

a. Gross income was at least $5 and spouse files a separate return and itemizes deductions.

b. Unearned income was more than $1,000;

c. Earned income was more than $6,200;

d. Gross income was more than the larger of

i. $1,000, or

ii. Earned income (up to $5,850) plus $350.

(4) Married Dependent, Age 65 or Older, or Blind:

The individual must file a tax return if **any** of the following apply:

a. Gross income was at least $5 and spouse files a separate return and itemizes deductions.

b. Unearned income was more than $2,200 ($3,400 if 65 or older **and** blind);

c. Earned income was more than $7,400 ($8,600 if 65 or older **and** blind);

d. Gross income was more than the larger of

i. $2,200 ($3,400 if 65 or older **and** blind), or

ii. Earned income (up to $5,850) plus $1,550 ($2,750 if 65 or older **and** blind).

(26 U.S.C. § 6012; 26 C.F.R. § 1.1-1; IRS Publication 501, *Exemptions, Standard Deduction, and Filing Information for Use in Preparing 2014 Returns* (2014), Table 2, <http://www.irs.gov/uac/About-Publication-501> [as of May 14, 2015]; see also 26 U.S.C. § 86 (rules for determining whether social security benefits are taxable.)

427-4E ADDED 10/15

Modified Adjusted Gross Income, General Definition

"Modified" Adjusted Gross Income (MAGI) is the income calculation method used to determine eligibility for MAGI Medi-Cal. MAGI income calculation rules require starting with an individual's Adjusted Gross Income (determined based on tax filing rules), and then "modifying" the Adjusted Gross Income by adding the following three types of income:

(1) Foreign earned income excluded from gross income as permitted under federal tax law (26 U.S.C. § 911(a));

(2) Tax exempt interest; and

(3) Non-taxable social security retirement, survivors and disability benefits, and tier 1 railroad retirement benefits.

Although the "MAGI" modification only adds an individual's *non-taxable* social security retirement, survivors and disability benefits, and tier 1 railroad retirement benefits, the MAGI income calculation will always include *100%* of an individual's social security retirement, survivors and disability benefits, and tier 1 railroad retirement benefits, because the taxable social security benefits are included in the individual's Adjusted Gross Income, and the non-taxable social security benefits are added as the "modification" to the Adjusted Gross Income. (NOTE that this rule applies once it has been determined that the individual's income must be included in the relevant MAGI household income. If it has been determined that an individual's income will not be counted in MAGI household income, then none of the individual's MAGI income is included.)

In addition to the above three MAGI modifications, the following additional adjustments must be made when calculating MAGI Medi-Cal income, where applicable:

(1) An amount received as a lump sum is counted as income only in the month received;

(2) Scholarships, awards or fellowship grants used for education purposes and not for living expenses are excluded from income; and

(3) Certain American Indian/Alaska Native Corporation income is excluded.

(26 U.S.C. § 36B (d)(2)(B); 26 C.F.R. § 1.36B-1(e)(2); 42 C.F.R. § 435.603(e).)

427-4F ADDED 10/15

Adjusted Gross Income (AGI), General Definition

Adjusted Gross Income (AGI) means "gross income," as defined in tax rules, minus certain deductions that tax rules allow a taxpayer to take before calculating the "Adjusted Gross Income" line on the tax return. These Adjusted Gross Income deductions are taken before the taxpayer takes his or her Schedule A deductions or Standard Deduction.

Thus, the first step in calculating Adjusted Gross Income is to determine the taxpayer's "Gross Income," using tax rules. The next step is to determine whether the taxpayer is entitled to take any of the Adjusted Gross Income deductions.

(26 U.S.C. §§ 62, 162(l), 164(f); 26 C.F.R. § 1.62-1(c); IRS Form 1040 Instructions for 2014 < http://www.irs.gov/pub/irs-pdf/i1040.pdf > [as of August 13, 2015] pp. 30-37.)

427-4G ADDED 10/15

Gross Income - General

MAGI Medi-Cal eligibility is based on Modified Adjusted Gross Income, which uses "Adjusted Gross Income" as its starting point. The starting point for determining "Adjusted Gross Income" is to determine an individual's "Gross Income," as defined in tax rules.

Tax rules define "Gross Income" as income that is not exempt from tax.

Gross Income includes compensation for services (i.e. fees, wages, commissions, and fringe benefits), gross business or partnership income, rental income, financial gain from exchange of property, royalties, interest, dividend, annuities, alimony, pension, distribution from a life insurance, estate or trust, unemployment benefits, and tax refunds.

(26 U.S.C. §§ 61, 85; 26 C.F.R. § 1.61-1; *Hyde v. Commission* (2011) Tax Court Memo 2011-104, 101 T.C.M. (CCH) 1502; IRS Publication 501, *Exemptions, Standard Deduction, and Filing Information for Use in Preparing 2013 Returns* (2013), Table. 1.)

427-4G1 ADDED 10/15

Gross Income - Self-Employment Income

Income from self-employment is calculated based on the taxpayer's net business profit (or loss), as shown on the Schedule C (calculated by reducing gross revenue from self-employment by allowable deductible expenses).

(26 U.S.C. § 1402(a); IRS Form 1040, Schedule C, <http://www.irs.gov/pub/irs-pdf/f1040sc.pdf> [as of September 3, 2015]; IRS Form 1040, Instructions, <www.irs.gov/pub/irs-pdf/i1040gi.pdf> [as of September 3, 2015].)

427-4H ADDED 10/15

Gross Income - Social Security Benefits

If it has been determined that an individual's income must be included when determining the income of a MAGI household (using the rules in 42 C.F.R. section 435.603(d)(1) and (d)(2)), then the *total* amount of the individual's social security retirement, survivors and disability benefits, and tier 1 railroad retirement benefits, will always be included in calculating that individual's *Modified* Adjusted Gross Income, since the *total* MAGI calculation includes *both* taxable and non-taxable Social Security benefits.

When it is necessary to determine the *taxable* portion (*gross income* portion) of an individual's social security benefits, the following federal tax rule is used:

Gross income includes social security retirement, survivors and disability benefits, and tier one railroad retirement benefits, only in the following circumstances:

(1) The social security beneficiary was married, lived with the spouse at any time during the taxable year, but filing separately; or

(2) One half of the social security beneficiary's social security benefits plus other gross income and any tax exempt interest is more than $25,000 (for calendar year 2014) ($32,000 if married filing jointly).

(26 U.S.C. § 86; *Maki v. Commissioner* (1996) Tax Court Memo 1996-209, RIA TC Memo P 96209, 71 T.C.M. (CCH) 2933.)

427-4I ADDED 10/15

Gross Income - Workers' Compensation

Gross income does not include workers' compensation. Workers' compensation for purposes of this paragraph does not include retirement plan benefits received based on age, length of service, or prior contributions to the plan, even if the retirement was due to an occupational sickness or injury.

(26 U.S.C. § 104; 26 C.F.R. § 1.104-1(b); IRS Publication 17 (November 26, 2013) p. 53; IRS Publication 525 (December 31, 2013) pp. 18-19.)

427-4J ADDED 10/15

Gross Income - Veteran's Benefits

Veterans' benefits paid under any law, regulation, or administrative practice, administered by the Department of Veterans Affairs (VA) are not included in gross income. The following amounts paid to veterans or their families are not taxable:

- Education, training, and subsistence allowances.
- Disability compensation and pension payments for disabilities paid either to veterans or their families.
- Grants for homes designed for wheelchair living.
- Grants for motor vehicles for veterans who lost their sight or the use of their limbs.
- Veterans' insurance proceeds and dividends paid either to veterans or their beneficiaries, including the proceeds of a veteran's endowment policy paid before death.
- Interest on insurance dividends you leave on deposit with the VA.
- Benefits under a dependent-care assistance program.

- The death gratuity paid to a survivor of a member of the Armed Forces who died after September 10, 2001.
- Payments made under the compensated work therapy program.
- Any bonus payment by a state or political subdivision because of service in a combat zone.

Military pensions and disability benefits, however, are included in gross income, if they are:

1. Retirement benefits based on age or years of service; and
2. Disability pension benefits based on years of service, except when the pension qualifies for exclusion for service-connected disability.

(26 U.S.C. §§ 104, 122, 134; IRS Publication 17 (2014) pp. 51-53; IRS Publication 525 (2014) pp. 15-16.)

427-4K ADDED 10/15

Gross Income - Child Support

Gross income does not include child support.

(26 U.S.C. § 71(c).)

427-4L ADDED 10/15

Gross Income - IHSS Wages Included; WPCS Wages Are Excluded

Generally, an applicant's IHSS wages are taxable gross income and therefore are included in Modified Adjusted Gross Income (MAGI).

An applicant's wages from providing personal care services are excluded from the applicant's MAGI under California Department of Healthcare Services Medi-Cal Eligibility Division Information Letter (MEDIL) No. 15-03 and federal tax law (26 U.S.C. § 131) when all three conditions are met:

1. The applicant receives wages through the Waiver Personal Care Services (WPCS) program for providing personal care services to a Medi-Cal beneficiary who is a waiver participant.
    a. A provider under WPCS receives Time Reports showing the hours approved under WPCS. Providers who also receive wages through an In Home Supportive Services (IHSS) program receive two Time Reports: one from IHSS and one from WPCS. (WAIVER PERSONAL CARE SERVICES FREQUENTLY ASKED

QUESTIONS Department of Health Care Services In-Home Operations Branch, <http://www.dhcs.ca.gov/services/ltc/Documents/WPC_Frequently_Asked_Questions.pdf> [as of August 11, 2015] p. 3.)

2. The applicant and the WPCS recipient live in the same home.

3. The applicant's exempt wages are for providing personal care services to no more than 5 WPCS recipients age 19 or higher, or 10 WPCS recipients under age 19.

(26 U.S.C. §§ 36B(d)(2)(B), 131; Internal Revenue Bulletin: 2014-4, January 21, 2014, Notice 2014–7, Foster care payment, Medicaid waivers <http://www.irs.gov/irb/2014-4_IRB/ar06.html#d0e425> [as of August 11, 2015]; California Department of Healthcare Services Medi-Cal Eligibility Division Information Letter (MEDIL) No. 15-03 (Jan. 27, 2015).)

427-4M___ADDED 10/15

Gross Income - Constructive Receipt of Income

Although the taxpayer may not have the income in his or her possession, the taxpayer has constructively received it in the taxable year during which the income is made available so that the taxpayer may access the income during that taxable year. The taxpayer, however, has not constructively received the income if the taxpayer cannot access the income, or if the access is subject to substantial limitations.

(26 C.F.R. § 1.451-2(a).)

427-4N___ADDED 10/15

Conversion of Weekly or Biweekly Income to Monthly Income

Income shall be converted to monthly income by multiplying weekly income by 4.33 or biweekly income by 2.167 if the beneficiary wishes to receive Medi-Cal for more than two months, and if the beneficiary is to receive the income for a full month.

(Cal. Code of Regs., tit. 22, § 50517.)

427-4O___ADDED 10/15

Adjusted Gross Income (AGI) - Deductions

Adjusted Gross Income (AGI) means gross income minus the following deductions:

(1) Educator expenses up to $250;

(2) Certain business expenses of reservists, performing artists, and fee-basis government officials;

(3) Losses from sale or exchange of property;

(4) Deductions attributable to expenses related to production of rental income and to depletion and depreciation of improvement related to mines, oil and gas wells, other natural deposits, and timber;

(5) Deductions of life tenants and income beneficiaries of property;

(6) Pension, profit-sharing, and annuity plans of self-employed individuals;

(7) Qualified retirement savings;

(8) Penalty on early withdrawal of savings (excluding the ten-percent early distribution penalty that applies to any distribution from retirement account that occurs before age 59.5);

(9) Alimony paid;

(10) Reforestation expenses;

(11) Certain required repayment of supplemental unemployment compensation benefits;

(12) Jury duty pay remitted to the employer;

(13) Deduction for clean-fuel vehicle and refueling property;

(14) Moving expenses;

(15) Archer MSAs (Medical Savings Accounts);

(16) Student loan interest deduction of up to $2,500;

(17) Qualified college tuition and related expenses up to $4,000 in taxable year;

(18) Health saving account deduction;

(19) Costs involving discrimination suits;

(20) Attorneys' fees relating to awards to whistleblowers;

(21) Deductible part of self-employment tax; and

(22) Self-employment health insurance deduction.

(26 U.S.C. §§ 62, 162(l), 164(f); 26 C.F.R. § 1.62-1(c); IRS Form 1040 Instructions for 2014 < http://www.irs.gov/pub/irs-pdf/i1040.pdf > [as of August 13, 2015] pp. 30-37; IRS Publication 970 <www.irs.gov/pub/irs-pdf/p970.pdf> [as of September 4, 2015] pp. 37-43.)

427-4P ADDED 10/15

AGI – Moving Expense Deduction

A taxpayer may deduct moving expenses if

(1) new employment is at least 50 miles farther from the taxpayer's old home than previous employment; or if the taxpayer was not previously employed, new employment must be at least 50 miles from the old home; and

(2) the taxpayer works full time for at least 30 weeks during the 12-month period following the move.

(26 U.S.C. § 62(a)(15); 26 C.F.R. § 1.62-1(c).)

427-4Q ADDED 10/15

Five-Percent Income Disregard

A five-percent income disregard will apply in determining whether a MAGI Medi-Cal applicant's household income is below the relevant MAGI Medi-Cal income eligibility limit. California has incorporated the five-percent disregard into the income thresholds used to determine MAGI Medi-Cal eligibility. For example, for most adults age 19-64, five percent has been added to the MAGI eligibility limit of 133 percent of the Federal Poverty Level (FPL), and those adult applicants are eligible for MAGI Medi-Cal if the applicant's MAGI Medi-Cal household income is at or below 138 percent of the FPL. No other income disregards apply.

(42 U.S.C. §§ 1396a(e)(14)(C), 1396(e)(I)(1); 42 C.F.R. § 435.603(d)(4), (g)(2); Welf. & Inst. Code § 14005.64(b).)

427-4R ADDED 10/15

No Assets or Resources Test

No assets or resources test will apply in determining MAGI Medi-Cal eligibility.

(42 C.F.R. § 435.603(g)(1).)

427-5A ADDED 10/15

Applicants Use Current Monthly Income and Family Size, Which May Be Prorated

Financial eligibility for MAGI Medi-Cal applicants, and other individuals not receiving Medi-Cal at the point at which eligibility for Medi-Cal is being determined, must be based on current monthly household income and family size.

In determining current monthly household income and family size**,** the agency may adopt a reasonable method to include a prorated portion of reasonably predictable future income, to account for a predictable increase or decrease in future income, or both, as evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income. Such future increase or decrease in income or family size must be verified in the same manner as other income and eligibility factors.

(42 C.F.R. §§ 435.603(h)(1) & (h)(3); Welf. & Inst. Code § 14005.65; Cal. State Plan Amdt. 13-0023 (September 30, 2013), p. 5.)

427-5B ADDED 10/15

Beneficiaries May Use Projected Annual Income and Family Size, Remainder of Calendar Year

MAGI Medi-Cal beneficiaries may use projected annual household income to determine Medi-Cal eligibility for the remainder of the calendar year, if the current monthly income would render the beneficiary ineligible due to an increase in income.

In determining current monthly household income and family size**,** the agency may adopt a reasonable method to include a prorated portion of reasonably predictable future income, to account for a predictable increase or decrease in future income, or both, as evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income. Such future increase or decrease in income or family size must be verified in the same manner as other income and eligibility factors.

(42 C.F.R. §§ 435.603(h)(2) & (h)(3); Welf. & Inst. Code § 14005.65; Cal. State Plan Amdt. 13-0023 (September 30, 2013), p. 5.)

ADDED 10/15

MAGI Medi-Cal, 2015 Federal Poverty Level Applicable Beginning January 1, 2015

For MAGI Medi-Cal cases, the Federal Poverty Level (FPL) that applies is the one in effect for the budget period used to determine an individual's eligibility.

The 2015 FPL chart is used for MAGI Medi-Cal budget periods beginning January 1, 2015. The 2015 FPL chart is as follows:

Federal Poverty Guidelines 2015
(Rounded to the nearest dollar)

	ANNUAL FPL	MONTHLY FPL						
MAGI Household Size	100% FPL	100% FPL	60% FPL	109%	138%	160%	213%	266%
1	$11,770	$981	$589	$1,070	$1,354	$1,570	$2,090	$2,610
2	$15,930	$1,328	$797	$1,447	$1,833	$2,125	$2,829	$3,532
3	$20,090	$1,674	$1,004	$1,825	$2,310	$2,678	$3,566	$4,454
4	$24,250	$2,021	$1,213	$2,203	$2,789	$3,234	$4,305	$5,376
Each Add'l	$4,160	$347						

(42 U.S.C. § 9902(2); 42 C.F.R. § 435.4; ACWDL 15-14 (March 11, 2015).)

427-5D

ADDED 10/15

MAGI Medi-Cal, Federal Poverty Level Applicable April 1, 2014 through December31, 2014

For MAGI Medi-Cal cases, the Federal Poverty Level (FPL) that applies is the one in effect for the budget period used to determine an individual's eligibility.

The 2014 FPL chart is used for MAGI Medi-Cal budget periods from April 1, 2014, through December 31, 2014. The 2014 FPL chart is as follows:

Federal Poverty Guidelines 2014
(Rounded to the nearest dollar)

	ANNUAL FPL	MONTHLY FPL

MAGI Household Size	100% FPL	100% FPL	60% FPL	109%	138%	160%	213%	266%
1	$11,670	$973	$584	$1,061	$1,343	$1,556	$2,072	$2,587
2	$15,730	$1,311	$787	$1,429	$1,809	$2,098	$2,793	$3,487
3	$15,730	$1,650	$990	$1,798	$2,276	$2,639	$3,513	$4,387
4	$19,790	$1,988	$1,193	$2,167	$2,743	$3,180	$4,234	$5,287
Each Add'l	$4,060	$339						

(42 U.S.C. § 9902(2); 42 C.F.R. § 435.4; ACWDL 14-04 (February 19, 2014).)

427-5E

ADDED 10/15

MAGI Medi-Cal, Federal Poverty Level Applicable Jan. 1, 2014 through March 31, 2014

For MAGI Medi-Cal cases, the Federal Poverty Level (FPL) that applies is the one in effect for the budget period used to determine an individual's eligibility.

The 2013 FPL chart is used for MAGI Medi-Cal budget periods from January 1, 2014, through March 31, 2014. The 2013 FPL chart is as follows:

Federal Poverty Guidelines 2013 (Rounded to the nearest dollar)								
	ANNUAL FPL	MONTHLY FPL						
MAGI Household Size	100% FPL	100% FPL	60% FPL	109%	138%	160%	213%	266%
1	$11,490	$958	$574	$1,044	$1,321	$1,532	$2,039	$2,547
2	$15,510	$1,293	$776	$1,409	$1,784	$2,068	$2,753	$3,438
3	$19,530	$1,628	$977	$1,774	$2,246	$2,604	$3,467	$4,329
4	$23,550	$1,963	$1,178	$2,139	$2,708	$3,140	$4,180	$5,220
Each Add'l	$4,020	$335						

(42 U.S.C. § 9902(2); 42 C.F.R. § 435.4; ACWDL 13-09 (March 18, 2013).)

427-5F ADDED 10/15

Medi-Cal Process If Applicant is Initially Found Ineligible for Both Medi-Cal and APTC

If the applicant is determined ineligible for Medi-Cal using the Medi-Cal household income rules (including the requirement to determine eligibility based on current monthly income); and

If the applicant's projected annual household income is determined to be less than 100 percent of the Federal Poverty Level using the rules that apply to determining eligibility for Advance Payments of Premium Tax Credit (APTC) (making the applicant ineligible for APTC to subsidize a Covered California plan); then

The applicant's Medi-Cal eligibility must be determined using the household income rules that apply for determining eligibility for APTC.

(42 C.F.R. § 435.603(i).)

427-6A ADDED 10/15

MAGI Medi-Cal Annual Redetermination Requirement

A county must redetermine an individual's Medi-Cal eligibility, including Modified Adjusted Gross Income (MAGI) Medi-Cal eligibility, every 12 months.

(42 C.F.R. § 435.916(a); Welf. & Inst. Code §14005.37(a); All-County Welfare Directors' Letter (ACWDL) No. 14-32 (September 19, 2014).)

427-6B ADDED 10/15

Annual Redetermination, County and CalHEERS Ex Parte Review of Records

When conducting the annual redetermination, the County must first attempt to establish ongoing eligibility by conducting an ex parte review of available information, without beneficiary contact. The ex parte review starts with the most recent or last known information in the beneficiary's active Medi-Cal case file or other information available to the county about the beneficiary and/or the beneficiary's immediate family members in case files that are open or were closed in the last 90 days, including, but not limited to, information from CalWORKs, CalFresh, Covered California, state and federal databases, other state and federal data records, and other sources of relevant information that are reasonably available. Information received or reported previously will be considered up to date, as if reported during the annual redetermination, and used as current monthly information for the eligibility redetermination.

The county must submit this information to the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) for the MAGI Medi-Cal eligibility determination.

(42 C.F.R. § 435.916(a); Welf. & Inst. Code § 14005.37, subd. (e); All-County Welfare Directors' Letter (ACWDL) No. 14-32 (September 19, 2014) pp. 1-3.)

427-6C ADDED 10/15

Annual Redetermination, Ex Parte Review Confirms Eligibility

If the ex parte review during the redetermination process confirms MAGI Medi-Cal eligibility, the county shall not contact the beneficiary to request information or send an annual redetermination form to the beneficiary. The county must send a Notice of Action (NOA) confirming eligibility for another year. The NOA must include the MAGI household size and income amount that the County used to redetermine eligibility. The NOA must explain that if the information is correct, the beneficiary does not need to take any action. Finally, the NOA must explain that if the information is incorrect, the beneficiary must contact the county within 90 days to provide the most current information. If the beneficiary reports a correction, the county shall process the corrected information as a change in circumstance.

(42 C.F.R. § 435.916(a); Welf. & Inst. Code § 14005.37, subd. (e); All-County Welfare Directors' Letter (ACWDL) No. 14-32 (September 19, 2014) p. 3.)

427-6D ADDED 10/15

Annual Redetermination, Request Information If CalHEERS Cannot Confirm Eligibility

If CalHEERS cannot confirm a beneficiary's continued MAGI Medi-Cal eligibility via the ex parte review, the county must send the beneficiary the MC 0216 form, a Pre-Populated MAGI Medi-Cal Annual Renewal form. The form must be populated to ask only for the information that could not otherwise be verified. The form must notify the beneficiary that he or she has 60 days in which to return the form. If the beneficiary does not respond, the county must make at least one attempt to contact the beneficiary during the 60 days to request the needed information.

(42 C.F.R. § 435.916(a); Welf. & Inst. Code § 14005.37, subd. (f); All-County Welfare Directors' Letter (ACWDL) No. 14-32 (September 19, 2014) pp. 3-4.)

427-6E ADDED 10/15

Annual Redetermination, Medi-Cal Discontinued If Beneficiary Does Not Provide Information

If the county has sent the beneficiary the Pre-Populated MAGI Medi-Cal Annual Renewal form, and if the beneficiary does not provide the requested information after 60 days, the beneficiary shall be discontinued from MAGI Medi-Cal for lack of cooperation. The county shall send the beneficiary a timely and adequate discontinuance Notice of Action (NOA) explaining the basis of termination. An adequate NOA must advise the beneficiary that he or she has 90 days from the date of termination to provide the missing information and have their benefits reinstated. The

NOA must explain what specific information or verification(s) are missing and needed to redetermine eligibility.

(Welf. & Inst. Code § 14005.37, subd. (f); All-County Welfare Directors' Letter (ACWDL) No. 14-32 (September 19, 2014) p. 5; *Korean Community Center of the East Bay v. Kent* (Super. Ct. Alameda County, No. RG14748387).)

427-6F ADDED 10/15

Annual Redetermination, Further Evaluation If Beneficiary Provides Requested Information

If the county has sent the beneficiary the Pre-Populated MAGI Medi-Cal Annual Renewal form, and if the beneficiary has provided information, but the information is not adequate to determine eligibility, the county shall attempt to work with the beneficiary to collect the necessary information.

If the beneficiary provides the information requested, the county will submit the information to CalHEERS to determine whether the beneficiary has continued MAGI Medi-Cal eligibility.

(Welf. & Inst. Code § 14005.37, subd. (f); All-County Welfare Directors' Letter (ACWDL) No. 14-32 (September 19, 2014) p. 5.)

427-6G ADDED 10/15

Annual Redetermination, Benefits Renewed If CalHEERS Confirms Beneficiary's Information

If the beneficiary has provided the information requested on the Pre-Populated MAGI Medi-Cal Annual Renewal form, and CalHEERS then confirms MAGI Medi-Cal eligibility, the county must send the beneficiary a Notice of Action (NOA), notifying the beneficiary that he or she is eligible for a new 12-month period. The NOA must include the MAGI household size and income amount that the County used to redetermine eligibility. The NOA must explain that if the information is correct, the beneficiary does not need to take any action. Finally, the NOA must explain that if the information is incorrect, the beneficiary must contact the county within 90 days to provide the most current information. If the beneficiary reports a correction, the county shall process the corrected information as a change in circumstance.

(All-County Welfare Directors' Letter (ACWDL) No. 14-32 (September 19, 2014) p. 5.)

427-6H ADDED 10/15

Annual Redetermination, CalHEERS Determines Beneficiary Not Eligible for MAGI Medi-Cal

If the beneficiary has provided the information requested on the Pre-Populated MAGI Medi-Cal Annual Renewal form, and CalHEERS determines that the beneficiary is no longer eligible for MAGI Medi-Cal, and if the beneficiary has a potential linkage to a Non-MAGI Medi-Cal program, the county shall evaluate the beneficiary using the Non-MAGI Medi-Cal rules. If necessary, the county shall send the beneficiary the Non-MAGI Screening Packet, asking only for information not already available to the county, and giving the beneficiary 30 days to respond.

(1) Inadequate Information for Non-MAGI Medi-Cal Evaluation: Medi-Cal Discontinued

If the county does not have adequate information to perform the Non-MAGI Medi-Cal evaluation through the ex parte process, and the beneficiary does not provide the requested information, the county shall send a timely and adequate discontinuance Notice of Action (NOA) explaining the basis of termination. An adequate NOA must advise the beneficiary that he or she has 90 days from the date of termination to provide the missing information and have their benefits reinstated. The NOA must explain what specific information or verification(s) are missing and needed to redetermine eligibility. If the beneficiary does not make a timely appeal and request aid paid pending, the county shall discontinue Medi-Cal benefits and shall immediately evaluate the beneficiary for APTC and forward to Covered California.

(2) Adequate Information, Non-MAGI Medi-Cal Review Conducted

If the county has enough information via the ex parte review, or the beneficiary provides the requested information, the county shall determine eligibility for Non-MAGI Medi-Cal.

(a) Eligible for Non-MAGI Medi-Cal

If the county finds the beneficiary eligible for a Non-MAGI Medi-Cal program, the county shall send the beneficiary an appropriate Notice of Action.

(b) Eligible for Non-MAGI Medi-Cal with a Share of Cost

If the beneficiary is eligible only for Medi-Cal with a Share of Cost (SOC), the county shall immediately use the CalHEERS Business Rules Engine (BRE) to determine the beneficiary's eligibility for APTC/CSR. The beneficiary does not need to request this determination, and it is the county's responsibility to conduct this determination once the beneficiary is determined to have a Share of Cost. Individuals have the option of having SOC Medi-Cal, SOC Medi-Cal and APTC/CSR, or APTC/CSR. If the individual is found eligible for APTC/CSR, the individual can choose to enroll in the program or not.

However, the federal Internal Revenue Service (IRS) and the federal Department of Health and Human Services (HHS) have determined that Medi-Cal with a Share of Cost does not qualify as Minimum Essential Coverage, and enrollment in Medi-Cal with a Share of Cost does not protect the enrollee from federal penalties for failing to enroll in Minimum Essential Coverage. For calendar year 2014 only, the IRS

provided blanket relief from penalties for all individuals who were enrolled in Medi-Cal with a Share of Cost.

Beginning January 1, 2015, however, the IRS is no longer providing blanket relief from penalties. Instead, a person who enrolls only in Medi-Cal with a Share of Cost and does not also enroll in other Minimum Essential Coverage, such as a Covered California Qualified Health Plan, Medicare Part A (if eligible), or other qualifying coverage, must apply individually for a hardship exemption and be granted such an exemption, or the IRS may impose a penalty for not having Minimum Essential Coverage. Effective January 1, 2015, individuals enrolled in Medi-Cal with a Share of Cost who apply for a hardship exemption will qualify for a hardship exemption for the entire calendar year if they meet their spend-down requirement for at least one budget period in that calendar year.

(c) Ineligible for Non-MAGI Medi-Cal

If the county finds that the beneficiary is not eligible for a Non-MAGI Medi-Cal program, the county shall immediately use the CalHEERS Business Rules Engine (BRE) to determine the beneficiary's eligibility for APTC/CSR.

If the beneficiary is found eligible for APTC/CSR, the County must assist the individual in completing the enrollment process into APTC/CSR, including assisting with health plan selection, if so requested.

Once the beneficiary's eligibility determination for APTC/CSR is complete, the county shall send the beneficiary a timely Medi-Cal discontinuance notice and discontinue the beneficiary's Medi-Cal benefits. The county and Covered California shall ensure that the beneficiary moves between programs without a break in coverage, provided the beneficiary meets all eligibility requirements and complies with all necessary requests for information.

(26 U.S.C. § 5000A(a)-(c); 26 C.F.R. § 1.5000A-2(b)(2)(v); 45 C.F.R. § 155.605(g)(1)(iii); Welf. & Inst. Code § 14005.37 & 15926(h)(1); California Department of Healthcare Services, All-County Welfare Directors' Letter (ACWDL) No. 14-18 (April 8, 2014); California Department of Healthcare Services, All-County Welfare Directors' Letter (ACWDL) No. 14-32 (September 19, 2014); *Korean Community Center of the East Bay v. Kent* (Super. Ct. Alameda County, No. RG14748387); Section 5000A Transition Relief for Individuals with Certain Government-Sponsored Limited-Benefit Health Coverage, Notice 2014-10, Internal Revenue Bulletin 2014-9 (Feb. 24, 2014) pp. 605-06; Minimum Essential Coverage, HHS Centers for Medicare & Medicaid Services, SHO #14–002 (Nov. 7, 2014) at pp. 6-7 & 10-11; Guidance on Hardship Exemptions for Persons Meeting Certain Criteria, HHS Centers for Medicare & Medicaid Services, (March 20, 2015).)

427-6I ADDED 10/15

Beneficiary Must Report Changes in Circumstances Affecting Medi-Cal Eligibility within 10 Days

A beneficiary must report, within 10 days, any change in circumstances that may affect Medi-Cal eligibility.

(42 C.F.R. § 435.916(c); Welf. & Inst. Code § 14005.37, subd. (h).)

427-6J ADDED 10/15

County Duty to Redetermine when Beneficiary Reports Change in Circumstances

If the county receives information about a beneficiary's change in circumstances, the county must promptly redetermine eligibility.

(42 C.F.R. § 435.916(d); Welf. & Inst. Code § 14005.37, subds. (a), (e), (g).)

427-6K ADDED 10/15

Change of Circumstances, County and CalHEERS Ex Parte Review of Records

When conducting a redetermination after a beneficiary reports a change in circumstances, the County must first must conduct an ex parte review of available information, starting with the most recent or last known information in the beneficiary's active Medi-Cal case file or other information available to the county about the beneficiary and/or the beneficiary's immediate family members in case files that are open or were closed in the last 90 days, including, but not limited to, information from CalWORKs, CalFresh, Covered California, state and federal databases, other state and federal data records, and other sources of relevant information that are reasonably available.

The county must submit this information to California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) for a MAGI Medi-Cal eligibility determination.

(42 C.F.R. § 435.916(a); Welf. & Inst. Code § 14005.37, subd. (e).)

427-6L ADDED 10/15

Change of Circumstances, Ex Parte Review Confirms Eligibility

If, based on the ex parte review, the county determines that the change in circumstances does not affect the beneficiary's eligibility status, the county shall not send the beneficiary a notice.

(Welf. & Inst. Code § 14005.37, subd. (e)(4).)

427-6M ADDED 10/15

Change of Circumstances, Request Information If CalHEERS Cannot Confirm Eligibility

During a change of circumstances review, if the county cannot confirm a beneficiary's continued MAGI Medi-Cal eligibility via the ex parte review, the county must send the beneficiary a form that is prepopulated with the information the county has obtained. The form must be populated to ask only for the information that could not otherwise be verified. The form must request only information related to the change in circumstances. The form must notify the beneficiary that he or she has 30 days in which to return the form. If the beneficiary does not respond, the county must make at least one attempt to contact the beneficiary during the 30 days to request the needed information.

(Welf. & Inst. Code § 14005.37, subd. (g).)

427-6N ADDED 10/15

Change of Circumstances, Medi-Cal Discontinued if Beneficiary Does Not Provide Information

If the county has requested information during a change of circumstances review, and if the beneficiary does not provide the requested information within 30 days, the county must send a timely and adequate 10-day notice of termination of Medi-Cal eligibility. An adequate notice must advise the beneficiary that he or she has 90 days from the date of termination to provide the missing information and have their benefits reinstated. The notice must explain what specific information or verification(s) are missing and needed to redetermine eligibility.

(Welf. & Inst. Code § 14005.37, subd. (g)(3); *Korean Community Center of the East Bay v. Kent* (Super. Ct. Alameda County, No. RG14748387).)

427-6O ADDED 10/15

Change of Circumstances, Further Evaluation If Beneficiary Provides Requested Information

If the county has sent the beneficiary the Pre-Populated form, and if the beneficiary has provided information, but the information is not adequate to determine eligibility, the county shall attempt to work with the beneficiary to collect the necessary information.

If the beneficiary provides the information requested, the county will submit the information to CalHEERS to determine whether the beneficiary has continued MAGI Medi-Cal eligibility.

(Welf. & Inst. Code § 14005.37, subd. (g)(3); California Department of Healthcare Services, All County Welfare Directors' Letter (ACWDL) No. 14-18 (April 8, 2014);); California Department of Healthcare Services, All-County Welfare Directors' Letter (ACWDL) No. 14-32 (September 19, 2014).)

427-6P___ADDED 10/15

Change of Circumstances, Beneficiary No Longer Eligible for MAGI Medi-Cal

If the county has requested information during a change of circumstances review, and if the beneficiary provides the requested information, and the county determines that the beneficiary is no longer eligible for MAGI Medi-Cal, and if the beneficiary has a potential linkage to a Non-MAGI Medi-Cal program, the county shall evaluate the beneficiary using the Non-MAGI Medi-Cal rules. If necessary, the county shall send the beneficiary the Non-MAGI Screening Packet, asking only for information not already available to the county, and giving the beneficiary 30 days to respond.

(1) Inadequate Information for Non-MAGI Medi-Cal Evaluation: Medi-Cal Discontinued:

If the county does not have adequate information to perform the Non-MAGI Medi-Cal evaluation via the ex parte review, and the beneficiary does not provide the requested information, the county shall send a timely and adequate discontinuance Notice of Action (NOA) explaining the basis of termination. An adequate NOA must advise the beneficiary that he or she has 90 days from the date of termination to provide the missing information and have their benefits reinstated. The NOA must explain what specific information or verification(s) are missing and needed to redetermine eligibility. If the beneficiary does not make a timely appeal and request aid paid pending, the county shall discontinue Medi-Cal benefits and shall immediately evaluate the beneficiary for APTC and forward to Covered California.

(2) Adequate Information, Non-MAGI Medi-Cal Review Conducted

If the county has enough information via the ex parte review, or the beneficiary provides the requested information, the county shall determine eligibility for Non-MAGI Medi-Cal.

(a) Eligible for Non-MAGI Medi-Cal

If the county finds the beneficiary eligible for a Non-MAGI Medi-Cal program, the county shall send the beneficiary an appropriate notice.

(b) Eligible for Non-MAGI Medi-Cal with a Share of Cost

If the beneficiary is eligible only for Medi-Cal with a Share of Cost (SOC), the county shall immediately use the CalHEERS Business Rules Engine (BRE) to determine the beneficiary's eligibility for APTC/CSR. The beneficiary does not need to request this determination, and it is the county's responsibility to conduct this determination once the beneficiary is determined to have a Share of Cost. Individuals have the option of having SOC Medi-Cal, SOC Medi-Cal and APTC/CSR, or APTC/CSR. If the individual is found eligible for APTC/CSR, the individual can choose to enroll in the program or not.

However, the federal Internal Revenue Service (IRS) and the federal Department of Health and Human Services (HHS) have determined that Medi-Cal with a Share of Cost does not qualify as Minimum Essential Coverage, and enrollment in Medi-Cal with a Share of Cost does not protect the enrollee from federal penalties for failing to enroll in Minimum Essential Coverage. For calendar year 2014 only, the IRS provided blanket relief from penalties for all individuals who were enrolled in Medi-Cal with a Share of Cost.

Beginning January 1, 2015, however, the IRS is no longer providing blanket relief from penalties. Instead, a person who enrolls only in Medi-Cal with a Share of Cost and does not also enroll in other Minimum Essential Coverage, such as a Covered California Qualified Health Plan, Medicare Part A (if eligible), or other qualifying coverage, must apply individually for a hardship exemption and be granted such an exemption, or the IRS may impose a penalty for not having Minimum Essential Coverage. Effective January 1, 2015, individuals enrolled in Medi-Cal with a Share of Cost who apply for a hardship exemption will qualify for a hardship exemption for the entire calendar year if they meet their spend-down requirement for at least one budget period in that calendar year.

(c) Ineligible for Non-MAGI Medi-Cal

If the county finds that the beneficiary is not eligible for a Non-MAGI Medi-Cal program, the county shall immediately use the CalHEERS Business Rules Engine (BRE) to determine the beneficiary's eligibility for APTC/CSR.

If the beneficiary is found eligible for APTC/CSR, the County must assist the individual in completing the enrollment process into APTC/CSR, including assisting with health plan selection, if so requested.

Once the beneficiary's eligibility determination for APTC/CSR is complete, the county shall send the beneficiary a timely Medi-Cal discontinuance notice and discontinue the beneficiary's Medi-Cal benefits. The county and Covered California shall ensure that the beneficiary moves between programs without a break in coverage, provided the beneficiary meets all eligibility requirements and complies with all necessary requests for information.

(26 U.S.C. § 5000A(a)-(c); 26 C.F.R. § 1.5000A-2(b)(2)(v); 42 C.F.R. § 435.916(d); 45 C.F.R. § 155.605(g)(1)(iii); Welf. & Inst. Code §§ 14005.37 & 15926(h)(1); California Department of Healthcare Services, All County Welfare Directors' Letter (ACWDL) No. 14-18 (April 8, 2014); California Department of Healthcare Services, All-County Welfare Directors' Letter (ACWDL) No. 14-32 (September 19, 2014); *Korean Community Center of the East Bay v. Kent* (Super. Ct. Alameda County, No. RG14748387); Section 5000A Transition Relief for Individuals with Certain Government-Sponsored Limited-Benefit Health Coverage, Notice 2014-10, Internal Revenue Bulletin 2014-9 (Feb. 24, 2014) pp. 605-06; Minimum Essential Coverage, HHS Centers for Medicare & Medicaid Services, SHO #14–002 (Nov. 7, 2014) at pp. 6-7 & 10-11; Guidance on Hardship Exemptions for Persons Meeting Certain Criteria, HHS Centers for Medicare & Medicaid Services, (March 20, 2015).)

427-6Q ADDED 10/15

90-Day Cure Period

If within 90 days of termination of a Medi-Cal beneficiary's eligibility or a change in eligibility status, the beneficiary submits to the county a signed and completed form or otherwise provides the needed information to the county, eligibility shall be redetermined by the county and if the beneficiary is found eligible, or the beneficiary's eligibility status has not changed, whichever applies, the termination shall be rescinded as though the form were submitted in a timely manner.

If, however, the information available to the county pursuant to the redetermination procedures above does not indicate a basis of eligibility, Medi-Cal benefits may be terminated so long as due process requirements have otherwise been met.

(Welf. & Inst. Code § 14005.37, subds. (i), (j); California Department of Healthcare Services, All County Welfare Directors' Letter (ACWDL) No. 14-18 (April 8, 2014) pp. 6-9.)

427-6R ADDED 10/15

Notification of Process to Cure

A Notice of Action (NOA) must include a statement, when appropriate, regarding the information or action necessary to reestablish eligibility or to determine a correct share of cost. An adequate NOA must advise the beneficiary that he or she has 90 days from the date of termination to provide a completed form or provide the missing information and have their benefits reinstated, known as the 90-day cure period. The NOA must explain what specific information or verification(s) are missing and needed to redetermine eligibility.

(Cal. Code Regs., tit. 22 § 50179, subd. (c)(7); Welf. & Inst. Code § 14005.37, subd. (i); California Department of Healthcare Services, All County Welfare Directors' Letter (ACWDL)

No. 14-18 (April 8, 2014) pp. 6-9; *Korean Community Center of the East Bay v. Kent* (Super. Ct. Alameda County, No. RG14748387).)

427-7A ADDED 10/15

Verification of U.S. Citizenship or Satisfactory Immigration Status

Applicants are not required to submit paper documentation of citizenship or immigration status to complete the application, but verification of citizenship or immigration status remains a requirement. The county shall provide full-scope Medi-Cal benefits to otherwise eligible individuals who attest to citizenship or satisfactory immigration status, while citizenship or immigration status is being verified.

An applicant who claims that he or she is a U.S. citizen or has satisfactory immigration status, on the single streamlined application or other Medi-Cal application, will have his or her citizenship or immigration status electronically verified via the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) through the federal data hub.

If an applicant's immigration status cannot be verified through CalHEERS through the federal data hub, or if the application information is not reasonably compatible with information in the federal data hub, the county must provide the applicant with 90 days to resolve the inconsistency.

(42 U.S.C. §§ 1396a(ee), 1396b(x); 42 C.F.R. §§ 435.407, 435.945(b), 435.952; Medi-Cal Eligibility Division Information Letter No. I 14-21 (March 25, 2014) pp. 1-2.)

427-7B ADDED 10/15

Immigration Status May Not be Used to Determine State Residency

Evidence of immigration status may not be used to determine that an individual is not a state resident.

(42 C.F.R. § 435.956(c)(2).)

427-7C ADDED 10/15

Indefinite Suspension of Paper Verification Requirements for Residency; Verify with Attestation

Paper verification of state residency status has been suspended until further notice. Counties shall consider residency to be verified if the applicant has attested to living within California by

verbal contact or by listing a California address on the application. The attestation may be from the individual, an adult in the individual's household or family, an authorized representative, or in case of a minor or an incapacitated individual, someone acting responsibly for the individual.

(42 C.F.R. §§ 435.945(a), 435.952, 435.956(c); Medi-Cal Eligibility Division Information Letter No. I 14-44 (August 1, 2014).)

427-7D ADDED 10/15

Self-Attestation of Age, Date of Birth and Household Size

The county may accept attestation of an individual or must accept reasonably compatible information to verify age, date of birth, and household size. The attestation may be from the individual, an adult in the individual's household or family, an authorized representative, or in the case of a minor or an incapacitated individual, someone acting responsibly for the individual.

(42 C.F.R. §§ 435.945(a), 435.956(f), 435.952.)

427-7E ADDED 10/15

Electronic Income Verification

When determining financial eligibility for Medi-Cal benefits, the county must obtain income information that is available electronically from state and federal agencies, and must determine whether that electronic information is, or is not, reasonably compatibly with the income information that an application or beneficiary provided as part of the application or redetermination process.

(42 C.F.R. § 435.948; Welf. & Inst. Code § 14013.3, subds. (a), (b).)

427-7F ADDED 10/15

Reasonable Compatibility, Definition

Information is "reasonably compatible" if any of the following applies:

(1) The electronic and application information are each above the applicable income standard;

(2) The electronic and application information are each at or below the applicable income standard; or

(3) The application information states that the individual's income is above the applicable income standard, and the electronic information states that the individual's income is at or below the applicable income standard. (In this case, the county must inform the individual that the income information that he or she provided was higher than the information that was electronically verified, and the individual may request a reconciliation of the difference.)

(Welf. & Inst. Code § 14013.3, subds. (c)(3).)

427-7G ADDED 10/15

Information Accepted if Reasonably Compatible

If the electronic information is reasonably compatible with the information provided by the individual, the county shall accept the information provided by the individual as accurate.

(Welf. & Inst. Code § 14013.3, subd. (c)(1).)

427-7H ADDED 10/15

Verification Process if Income Information is Not Reasonably Compatible

If CalHEERS has determined that income information provided by an applicant is not reasonably compatible with electronically-available information, the county shall first conduct an ex parte review to determine if the county has previously verified income. If the county has previously verified income, and that verified income accurately reflects the amount of income reported on the application, the county shall use the ex parte verified dollar amount in the county system as the verified dollar amount of income. A county shall treat previously verified income as accurately reflecting application income if both the ex parte verified income and application income are at or below the Modified Adjusted Gross Income Medi-Cal limits.

If the county does not have existing verification on record, or the ex parte verified income does not match application income, then the county must request paper verification.

(Welf. & Inst. Code § 14013.3, subd. (c)(2); Medi-Cal Eligibility Division Information Letter No.: I 14-16 (February 26, 2014) p. 1.; Medi-Cal Eligibility Division Information Letter No.: I 14-23 (April 24, 2014).)

427-7I ADDED 10/15

Pregnancy Verification

The county shall accept the attestation of the individual regarding whether she is pregnant unless the county has information that is not reasonably compatible with the attestation. If the information obtained by the county is not reasonably compatible with the information provided by or on behalf of the individual, the county shall require that the individual provide additional information that reasonably explains the discrepancy.

(Welf. & Inst. Code § 14013.3, subd. (d); 42 C.F.R. §§ 435.952, 435.956(e).)

427-7J ADDED 10/15

General Verification Requirement, Other than for Income and Pregnancy

If the county obtains information that is needed for an eligibility determination or redetermination (other than income or pregnancy information) that is not reasonably compatible with the information provided by or on behalf of the individual, the county shall require the individual to provide additional information that reasonably explains the discrepancy.

(42 C.F.R. § 435.952; Welf. & Inst. Code § 14013.3, subd. (e).)

427-7K ADDED 10/15

Additional Information or Documentation

The county shall not require an individual to furnish additional information or documentation unless the information required for an eligibility determination cannot be obtained electronically or the county found that the electronic information was not reasonably compatible with the information provided by the individual.

(42 C.F.R. § 435.952(c).)

427-7L ADDED 10/15

No Negative Action Without Seeking Additional Information or Documentation, and Providing Notice and Hearing Rights

The county may not deny or terminate eligibility or reduce benefits for any individual on the basis of information the county receives through the verification process, unless the county has sought additional information or documentation from the individual and given the individual proper notice and hearing rights.

(42 C.F.R. § 435.952(c).)

428-1A ADDED 10/15

Notice of Action Requirement

The county must provide an applicant with written notice of the county's decision on his or her application and, if Medi-Cal eligibility is denied, the reasons for the action, the specific regulation supporting the action, an explanation of his or her right to request a state hearing, and a statement, when appropriate, regarding the information or action necessary to reestablish eligibility or determine a correct share of cost. This notice is called the “Notice of Action” (NOA).

(42 C.F.R. §§ 435.913, 431.206(b)(1), 431.210; Cal. Code Regs., tit. 22 § 50179, subd. (c); All County Welfare Directors Letter No. 13-13 (May 14, 2013), p. 3.)

428-1B ADDED 10/15

Conditional Notices are Not Considered a NOA

Conditional notices which advise applicants or beneficiaries that eligibility will be denied or discontinued unless specified actions are taken by the applicants or beneficiaries do not meet the requirements of a Notice of Action.

(Cal. Code Regs., tit. 22 § 50179, subds. (a), (f).)

428-1C ADDED 10/15

Required Notice of Hearing Procedures

The Notice of Action must include the following information regarding the applicant’s right to a state hearing:

(1) The procedures for requesting a state hearing;

(2) The time limit within which a state hearing must be requested;

(3) The applicant’s right to represent him or herself, or use legal counsel, a relative, a friend, or other spokesperson; and

(4) The circumstances under which aid will be continued if the applicant requests a state hearing.

(42 C.F.R. §§ 431.206(b), 431.210(e); Cal. Code Regs., tit. 22 § 50179, subd. (c)(5), (6); All County Welfare Directors Letter No. 13-13 (May 14, 2013), p. 4.)

428-1D ADDED 10/15

NOA Must be Timely and Adequate

A county must give beneficiaries timely and adequate notice of the proposed action to terminate, discontinue, or suspend their eligibility or to reduce or discontinue services they may receive under Medi-Cal.

(42 C.F.R. § 435.919(a); All County Welfare Directors Letter No.: 13-13 (May 14, 2013), p. 4.)

428-1E ADDED 10/15

Adverse Action NOA Must be Mailed at Least 10 Days Prior to Effective Date

For an adverse action, the County must mail the Notice of Action at least ten calendar days prior to the first of the month in which the adverse action becomes effective, excluding the date of mailing.

(42 C.F.R. § 211; Cal. Code Regs., tit. 22 § 50179, subd. (d)(1); All County Welfare Directors Letter No. 13-13 (May 14, 2013) p. 4.)

428-1F ADDED 10/15

No 10-Day Notice Requirement For Non-Adverse Action NOA

For an action that is not an adverse action, the County must mail the Notice of Action in sufficient time to reach the beneficiary by the effective date of the action for discontinuances or increases in the Share of Costs.

Examples of discontinuances that are considered “non-adverse” actions include discontinuances due to death, or a beneficiary signing a written statement stating he or she no longer wishes to receive Medi-Cal benefits.

(42 C.F.R. § 431.213; Cal. Code Regs., tit. 22 § 50179, subd. (d)(2); All County Welfare Directors Letter (ACWDL) No.: 13-13 (May 14, 2013) pp. 5-6.)

428-1G ADDED 10/15

Five-Day Notice if Probable Fraud

In cases of probable fraud, a county may shorten the period of advance notice to five days before the date of action if the county has facts indicating the action should be taken because of probable fraud by the beneficiary and the facts have been verified, if possible, through secondary sources.

(42 C.F.R. § 431.214; All County Welfare Directors Letter (ACWDL) No. 13-13 (May 14, 2013) p. 6.)

428-1H ADDED 10/15

NOA Must be in the Case File

A copy of the Notice of Action (NOA) shall be placed in the case file.

(Cal. Code Regs., tit. 22 § 50179, subd. (b); All County Welfare Directors Letter (ACWDL) No. 13-13 (May 14, 2013), p. 3.)

428-2A ADDED 10/15

Right to Appeal

An individual may submit an appeal request in person, or by telephone, email, online, mail or fax to Covered California, counties or the California Department of Social Services State Hearings Division (SHD).

(Cal. Dept. of Social Services, All County Letter No. 14-14 (Feb. 7, 2014) p. 9.)

Covered California and the California Department of Social Services have entered into an Inter-Agency (IA) Agreement that authorizes the State Hearings Division (SHD) to conduct hearings based on consumer appeals that arise out of the Covered California application and enrollment process. The SHD will be handling all applicant appeals regarding eligibility, redetermination and timeliness of Covered California grants of federal tax credits or federal subsidies. The SHD will also continue to handle all Medi-Cal appeals, including MAGI Medi-Cal appeals, through the IA Agreement with the Department of Health Care Services.

(Cal. Code Regs., tit. 10, §§ 6600 & 6602; Cal. Dept. of Social Services, All County Letter (ACL) No. 14-14 (Feb. 7, 2014) pp. 6-8.)

428-2B ADDED 10/15

Right to Appeal If No Eligibility Decision within 45 Days of Application (*Rivera*)

In *Rivera v. Douglas*, the Court held if a Medi-Cal applicant has not received a decision on the application after 45 days, the applicant is "effectively being denied Medi-Cal benefits …." The Court ruled that the applicant is entitled to a hearing if the applicant has not received a decision on the Medi-Cal application within 45 days of the date of the application.

(*Rivera v. Douglas* [Department of Health Care Services], Alameda County Superior Court, Case No. RG1474091, Order Granting Petitioners' Motion for Preliminary Injunction (Jan. 20, 2015) p. 25; Medi-Cal Eligibility Division Information Letter (MEDIL) No.: l 15-11, April 7, 2015.)

428-2C ADDED 10/15

Authority for Retroactive Decisions

Appeal decisions shall state the effective date of the decision. The effective date of a decision may be retroactive, at the option of the appellant if the appellant is otherwise eligible.

(Gov. Code § 100506.4, subd. (i).)

428-2D ADDED 10/15

Eligibility for Aid Paid Pending Appeal Hearing

Continued Medi-Cal pending a hearing decision shall be provided if the beneficiary appeals in writing within 10 days of the mailing or personal delivery of the Notice of Action (NOA) or before the effective date of the action.

(42 C.F.R. §§ 431.230, 431.231(c), (d); Cal. Code Regs. tit. 22, § 51014.2, subd. (a).)

428-2E ADDED 10/15

Due Process Rights, MAGI Medi-Cal Appeals

Initial determinations of eligibility and redeterminations are subject to the same due process rights and substantive review as is provided in any Medi-Cal appeal, including Non-MAGI Medi-Cal appeals.

(Cal. Dept. of Social Services, All County Letter (ACL) No. 14-14 (Feb. 7, 2014) p. 8.)

428-2F ADDED 10/15

Counties' Role in Appeal Hearings

The counties are responsible for defending any MAGI Medi-Cal appeals, including any appeals of denials of MAGI Medi-Cal.

(Cal. Dept. of Social Services, All County Letter (ACL) No. 14-14 (Feb. 7, 2014) p. 8.)

428-2G ADDED 10/15

Dual Cases, Definition

Where a claimant/appellant's appeal raises issues that involve both Covered California and Medi-Cal, both Covered California and the County will be noticed for the hearing and will participate in the hearing. These cases are known as "dual cases."

(Cal. Dept. of Social Services, All County Letter (ACL) No. 14-14 (Feb. 7, 2014) pp. 14, 18.)

428-2H ADDED 10/15

Informal Resolution Process

Prior to the hearing, a representative of the entity that made the determination being appealed (county, Department of Health Care Services, or Covered California) must contact the appellant or the appellant's representative and offer to discuss the determination. This discussion is known as the 'informal resolution" process. The informal resolution process is voluntary, and neither an appellant's participation nor nonparticipation in the informal resolution process shall affect the appellant's right to a hearing.

(Gov. Code § 100506.4, subd. (g)(1), (4).)

428-2I ADDED 10/15

Dual Cases, Responsibility to Notify Other Agency

During the information resolution process prior to the hearing, the entity that made the determination being appealed (county, Department of Health Care Services, or Covered California) must determine whether a dual agency appeal is required to resolve the matter at the hearing and notice the other agency if not already included.

(Gov. Code § 100506.4, subds. (g)(1), (8)(C).)

428-2J ADDED 10/15

Dual Cases, Role of County and Covered California Representatives, Presentation of Evidence

Whenever possible, in a dual case the County Hearing Representative (CHR) will present the MAGI Medi-Cal or the Non-MAGI Med-Cal case and the Covered California Hearings Representative will present the Covered California case in the same hearing. Covered California and the counties may work cooperatively in presenting evidence at the hearing.

(Cal. Dept. of Social Services, All County Letter (ACL) No. 14-14 (Feb. 7, 2014) p. 18.)

428-2K ADDED 10/15

Mixed Coverage Household, Defined

A mixed coverage household is defined as a household with at least one member receiving MAGI Medi-Cal benefits and at least one member receiving Covered California benefits.

(California Department of Healthcare Services, All County Welfare Directors' Letter (ACWDL) No. 14-38 (October 23, 2014) p. 1.)

428-2L ADDED 10/15

Informal Resolution

Counties shall notify the State Hearings Division, Affordable Care Act Bureau, of any informal resolution reached with the claimant/appellant.

(Cal. Dept. of Social Services, All County Letter (ACL) No. 14-14 (Feb. 7, 2014) pp. 12-13.)

428-2M ADDED 10/15

Requests to Reopen After Dismissals

The claimant/appellant may request that an administrative dismissal be set aside and the case be re-opened upon a showing of good cause.

(Cal. Dept. of Social Services, All County Letter (ACL) No. 14-14 (Feb. 7, 2014) pp. 12-13.)

428-2N ADDED 10/15

Expedited Appeal Process

Federal and state Covered California regulations mandate an Expedited Appeals process for Covered California appeals where a claimant/appellant has an immediate need for health services and a standard appeal could seriously jeopardize the claimant/ appellant's life or health or ability to attain, maintain or regain maximum function.

In a dual case, Covered California shall notify the California Department of Social Services (CDSS) Affordable Care Act Bureau (ACAB) of the claimant/appellant's request for an expedited appeal. The ACAB Presiding Judge will determine if an expedited state hearing is required.

If the appeal involves MAGI or Non-MAGI Medi-Cal only issues, the request for an expedited hearing shall be submitted to the California Department of Social Services (CDSS) State Hearings Division (SHD) Presiding Judge or the county's regional offices.

(Cal. Code Regs., tit. 10, § 6616, subd. (a); 45 C.F.R. § 155.540(a); Cal. Dept. of Social Services, All County Letter (ACL) No. 14-14 (Feb. 7, 2014) pp. 14-15.)

428-2O ADDED 10/15

Expedited Appeal Decisions

The decision on an expedited case shall be issued as expeditiously as reasonably possible and no later than five business days from the close of the hearing record.

(Cal. Code Regs., tit. 10, § 6618, subd. (b)(2); Cal. Dept. of Social Services, All County Letter (ACL) No. 14-14 (Feb. 7, 2014) p. 15.)

428-2P ADDED 10/15

Written Withdrawals

Written unconditional or conditional withdrawals result in immediate dismissal of the appeal.

(Cal. Code Regs., tit. 10, § 6610, subd. (a)(1); Cal. Dept. of Social Services, All County Letter (ACL) No. 14-14 (Feb. 7, 2014) p. 11.)

428-2Q ADDED 10/15

Conditional Withdrawals

A request to withdraw a hearing based on a conditional withdrawal must be accompanied by the agreement signed (faxed or telephonic signature is allowed) by the claimant/appellant and Covered California or the county, as part of the informal resolution process. The agreement must specify what Covered California or the county is re-reviewing and the actions to be taken, after review, with sufficient detail that the obligations of the claimant/appellant and/or county (as applicable) are clear. The written agreement must be signed by all parties and received by the State Hearings Division (SHD) prior to the hearing. Upon receipt of a signed withdrawal, the appeal will be dismissed, subject to a good cause re-opening.

The action by Covered California or the counties should be taken as soon as practicable after receipt of the signed Conditional Withdrawal but no later than 30 days after the execution of the Conditional Withdrawal.

(Cal. Code Regs., tit. 10, § 6610, subd. (a)(1)(C); Cal. Dept. of Social Services, All County Letter (ACL) No. 14-14 (Feb. 7, 2014) pp. 11-12.)

428-2R ADDED 10/15

Verbal Unconditional Withdrawals

If a claimant/appellant makes a verbal unconditional withdrawal request directly to the California Department of Social Services (CDSS) State Hearings Division (SHD)'s Affordable Care Act Bureau (ACAB), after confirming the person's identity, the case will be dismissed. The SHD must send the claimant/appellant a written confirmation of the withdrawal within five business days from the date on which the claimant/appellant's verbal withdrawal is received. If the claimant/appellant does not contact the SHD within 15 calendar days of mailing the request for confirmation of withdrawal, the case shall be dismissed.

(Cal. Code Regs., tit. 10, § 6610, subd. (a)(1)(C); Cal. Dept. of Social Services, All County Letter (ACL) No. 14-14 (Feb. 7, 2014) p. 12.)

428-2S ADDED 10/15

Dismissal Due to Failure to Appear/Abandonment

If the claimant/appellant fails to appear at a scheduled hearing by him or herself, or by authorized representative, without good cause, the request for hearing shall be considered abandoned. The appeal will be dismissed and a written decision shall be issued dismissing the claim.

(Cal. Code Regs., tit. 10, § 6610, subd. (a)(2); Cal. Dept. of Soc. Serv. Manual of Pol. and Proced. § 22-054.22.)

428-2T ADDED 10/15

Dismissal if Appeal is Not Valid

An appeal will be dismissed if the claimant/appellant fails to submit a valid appeal request without good cause.

(Cal. Code Regs., tit. 10, § 6610, subd. (a)(3).)

428-2U ADDED 10/15

Dismissal If Claimant/Appellant Dies While Appeal Pending

An appeal will be dismissed if the claimant/appellant dies while the appeal is pending, unless the appeal affects the remaining members of the deceased claimant/appellant's household or the appeal can be carried forward by a representative of the deceased claimant/appellant's estate or by an hear of the deceased claimant/appellant's estate, if the estate is not in probate.

(Cal. Code Regs., tit. 10, § 6610, subd. (a)(4).)

428-2V ADDED 10/15

Notice of Dismissal

If an appeal is dismissed, the California Department of Social Services (CDSS) State Hearings Division (SHD)'s Affordable Care Act Bureau (ACAB) shall send written notice to the claimant/appellant within five days from the date of the dismissal. This notice shall include:

(1) The reason for the dismissal;

(2) An explanation of the dismissal's effect on the claimant/appellant's eligibility; and

(3) An explanation of how the claimant/appellant may show good cause as to why the appeal should be vacated.

(Cal. Code Regs., tit. 10, § 6610, subd. (c).)

428-2W ADDED 10/15

Dismissal Vacated for Good Cause

The California Department of Social Services (CDSS) State Hearings Division (SHD)'s Affordable Care Act Bureau (ACAB) must vacate a dismissal and proceed with the appeal if the claimant/appellant makes a written request within 30 calendar days of the date of the notice of the dismissal showing good cause why the dismissal should be vacated.

(Cal. Code Regs., tit. 10, § 6610, subd. (d)(1); Cal. Dept. of Social Services, All County Letter (ACL) No. 14-14 (Feb. 7, 2014) p. 13.)

428-2X ADDED 10/15

Denial of Request to Vacate Appeal - Notice to Claimant/Appellant

The California Department of Social Services (CDSS) State Hearings Division (SHD)'s Affordable Care Act Bureau (ACAB) must provide written notice of the denial of a request to vacate a dismissal to the claimant/appellant within five business days from the date of such denial, if the request is denied.

(Cal. Code Regs., tit. 10, § 6610, subd. (d)(2); Cal. Dept. of Social Services, All County Letter ACL) No. 14-14 (Feb. 7, 2014) p. 13.)

428-3A ADDED 10/15

Evidence Considered on Appeal

California Department of Social Services (CDSS) State Hearings Division (SHD) Administrative Law Judges (ALJs) must consider the information used to determine the claimant/appellant's eligibility, as well as any additional relevant evidence presented during the course of the appeals process, including at the hearing. The appeals entity must review the record "de novo" and must consider all relevant facts and evidence adduced during the appeal process. This standard of "de novo" review means that the appeals entity has authority to issue its own decision based on the evidence produced during the hearing process.

(Cal. Code Regs., tit. 10, § 6614, subds. (e), (f); Cal. Dept. of Social Services, All County Letter No. 14-14 (Feb. 7, 2014) p. 18.)

428-3B ADDED 10/15

Stipulations

The representatives for Covered California and the County have authority at the state hearing to make binding agreements and stipulations on behalf of the parties they are representing.

(Cal. Dept. of Soc. Serv. Manual of Pol. and Proced. § 22-073.37; Cal. Dept. of Social Services, All County Letter (ACL) No. 14-14 (Feb. 7, 2014) p. 11-12.)