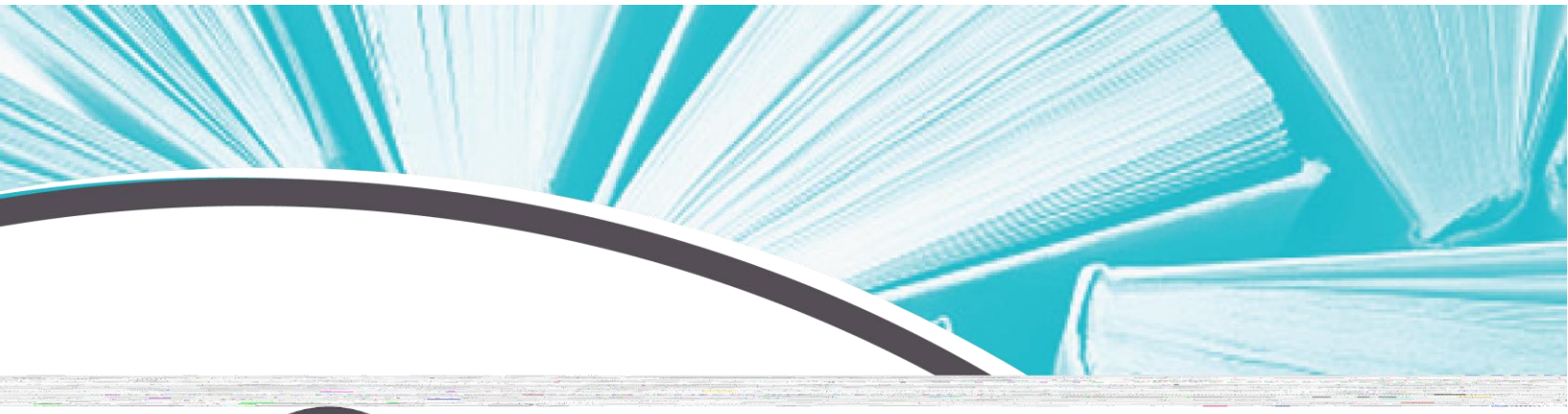

COVERED CALIFORNIA

Medi-Cal Eligibility, Benefits and Options

Advanced Study Course Participant Guide

Version 1.0

COURSE OBJECTIVES

- ✓ Describe Medi-Cal eligibility requirements
- ✓ Understand the difference between MAGI Medi-Cal and non-MAGI Medi-Cal
- ✓ Describe Medi-Cal benefits and costs
- ✓ Describe the enrollment and application process
- ✓ Describe temporary coverage programs
- ✓ Describe Medi-Cal children's programs

1. MEDI-CAL OVERVIEW

Medicaid known as Medi-Cal in California, is a federal- and state-funded public program that offers health insurance and long-term care to low-income individuals, including children, parents, pregnant women, people with disabilities and seniors. States take primary responsibility for administering the program, but must do so within federal requirements. The Medi-Cal program is governed by the Department of HealthCare Services (DHCS), and each county in California is responsible for operation of the program at the local level.

To qualify for Medi-Cal, individuals must meet both financial and non-financial criteria, such as citizenship and immigration requirements. Originally, Medi-Cal primarily offered health insurance only to individuals who also qualified for financial assistance, such as families on welfare and people with disabilities on Supplemental Security Income (SSI). However, in recent decades Medi-Cal has increasingly become a source of insurance for children and some parents from low to moderate-income working families. Until passage of the Patient Protection and Affordable Care Act (ACA), it offered little or no coverage to adults without children.

There are many ways in which individuals and families can qualify for Medi-Cal. Some of these targeted Medi-Cal programs include:

- **Optional Targeted Low Income Children's Program (OTLICP)** provides children under the age of 19, in families with incomes up to 266% of the Federal Poverty Level (FPL), with full-scope Medi-Cal benefits.
- **Breast and Cervical Cancer Treatment Program** provides adults with breast cancer with incomes up to 200% of the FPL, with restricted- or full-scope Medi-Cal benefits.
- **Aged, Blind & Disabled Program** provides individuals over the age of 65, or individuals who qualify as disabled by the Social Security Administration, with no-cost Medi-Cal benefits.
- **250% Working Disabled Program** provides working disabled individuals with incomes below 250% of the FPL, with low-cost Medi-Cal benefits.
- **Medicare Savings Programs** provide qualified individuals, with limited income and resources, assistance paying some or all of Medicare's premiums and may pay Medicare deductibles and coinsurance.

The Federal Poverty Level (FPL) is the minimum amount of gross income (before taxes) that a household needs for food, clothing, transportation, shelter, and other necessities. The federal Department of Health and Human Services (DHHS) determines the FPL each year, which varies by family size and is adjusted for inflation. The FPL guidelines are released each year in late January and become effective on the date they are posted in the Federal Register. They are released January 1st and adopted by Medi-Cal and must public programs on April 1st of each

year. They are effective until March 31st of the subsequent year to set income eligibility limits for its different programs.

THE DIFFERENCES BETWEEN MEDICARE AND MEDI-CAL

Medicare is a federally governed health insurance program. Medi-Cal, California's Medicaid program, is an assistance program governed by the State of California and financed by the state and federal governments.

Medicare

Medicare is the federally funded health insurance program for:

- People age 65 and older
- Certain younger people under age 65 with certain disabilities or who are blind
- People of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)
- There are four parts of Medicare that cover specific services:
- Medicare Part A (hospital insurance)
- Medicare Part B (medical insurance)
- Medicare Part C (Medicare Advantage Plans)
- Medicare Part D (prescription drug coverage)
- The application for Medicare is located at the Social Security office in your area

Medi-Cal

Medi-Cal is California's Medicaid program, which is financed by the State and federal government. Medi-Cal is a public health insurance program that provides needed healthcare services for low-income individuals including:

- Families with children
- Seniors
- Persons with disabilities
- Foster care
- Pregnant women
- Low-income people with specific diseases such as tuberculosis, breast cancer or HIV/AIDS

"Medi-Medi" or "Dual Eligible"

Some people qualify for both Medicare and Medi-Cal. People who qualify for both programs are called 'dual eligible' or "Medi-Medi." Medi-Cal is sometimes used to help pay for Medicare premiums.

2. MEDI-CAL EXPANSION

Under the ACA, states were able to decide whether to expand Medi-Cal to all adults, including parents and adults without children, up to 138% of the FPL. The Medi-Cal expansion in California has significantly expanded eligibility for all adults ages 19-64, but especially for adults

without children in their families (childless adult). Prior to the federal law, non-disabled adults in this group were not eligible themselves for Medi-Cal benefits, but had to have "linkage," in most cases to an eligible child, to access benefits. The expansion has also consolidated many current coverage groups into three major categories:

1. Parents and other caretaker relatives
2. Pregnant women
3. Infants and children

The expansion of Medi-Cal for adults is one way the ACA is increasing access to health insurance. Prior to 2014, Medi-Cal coverage for adults was limited to those who met income and eligibility standards and who:

- Had a deprived child living at home (parents and caretaker relatives)
- Had blindness or a disability
- Were over the age of 65
- Were pregnant

After 2014, Medi-Cal coverage included adults who were at or below 138% of the FPL who do not have children living with them (childless adult).

The other main way Medi-Cal expanded was to change income eligibility requirements. Like Covered California, Medi-Cal now uses household size and Modified Adjusted Gross Income (MAGI) as a simplified method of determining program eligibility. Previously, Medi-Cal eligibility was based also on the "asset test". Now, individuals seeking Medi-Cal benefits will fall into one of two major groups: MAGI and non-MAGI groups.

MAGI MEDI-CAL

MAGI Medi-Cal refers to Medi-Cal programs that follow MAGI rules for determining income eligibility. The following table outlines income eligibilities for MAGI groups, please note each program has other eligibility criteria:

MAGI Group	Eligible Population	Income Limit
Adults	Between the ages of 19 and 64 (not pregnant at the time of application) Low Income Health Program (LIHP) beneficiaries automatically transitioned into Medi-Cal will fall under the adult category	Up to 138% of the FPL
Parents and caretaker relatives	Parents and caretaker relatives (including those over the age of 65) of a dependent child	Up to 109% of the FPL
Children	Infants and children under age 19 Includes children automatically transitioned from the Healthy Families Program into OTLICP	• Infants (< 2 years old): Up to 266% of the FPL • Infants born to mothers in Medi-Cal Access Program, formerly Access for Infants and Mothers (AIM), with incomes up to 322% of the FPL
Pregnant women	Pregnant and post-partum women eligible for pregnancy-related services or full-scope benefits	• Up to 213% of the FPL are eligible for restricted-scope Medi-Cal (if undocumented) • Up to 138% of the FPL are eligible for full-scope Medi-Cal • From 214% – 322% of the FPL are eligible for Medi-Cal Access Program • From 100% - 400% of the FPL can also choose to enroll in Covered California and receive financial assistance

Example: Jason is a 24 year-old recent college graduate that lives at home with his parents. He files his own taxes and earns an estimated $1,061 a month (109% of the FPL) through his part-time job. Jason can qualify for MAGI Medi-Cal under the adult category because he has no dependents, is between the ages of 19-64 and is under the income limit.

NON-MAGI-MEDI-CAL

Non-MAGI Medi-Cal refers to existing Medi-Cal programs that do not follow MAGI rules for determining income eligibility. Need based tests (or asset tests) are required for determining eligibility for non-MAGI Medi-Cal consumers.

Non-MAGI categories include, but are not limited to, the following individuals:

- Ages 65 and older who are not a parent/caretaker relative

- Blind or disabled, according to Social Security Administration rules
- Social Security Income (SSI)/State Supplementary Payment (SSP) recipients
- Enrolled in Refugee Cash Assistance
- Medicare recipients who are not a parent/caretaker relative
- Medicare Savings Program participants
- Enrolled in California Work Opportunity and Responsibility to Kids (CalWORKs)
- Enrolled in a foster care or adoption assistance program
- Persons needing dialysis, tuberculosis services Parenteral Hyper Alimentation treatment and/or breast or cervical cancer treatment

Example: Paul just celebrated his 65th birthday in May. He does not live with or have primary responsibility for any children. He applied for Covered California in January and was found eligible for MAGI Medi-Cal due to his age and income at the time of application. Once Paul turned 65, he contacted Medi-Cal to report a change in his eligibility and applied for Medicare benefits. Paul may now qualify for non-MAGI Medi-Cal to help pay for Medicare coverage.

3. Medi-Cal Benefits

Medi-Cal pays for a variety of medical, mental health, vision and dental services for children and adults. Individuals will be eligible for either full-scope or restricted-scope benefits. When an individual is determined eligible for Medi-Cal, the eligibility date is the application submission date and eligibility begins the first day of the month in which the individual applied. For example, a consumer who applies on the 10th of the month and is found eligible will receive coverage for benefits effective the first of that month.

Full Scope Benefits

Full-scope benefits includes medical services, dental services pharmacy and vision services, as well as durable medical equipment and medical supplies. All Medi-Cal health plans provide the 10 essential health benefits required by the ACA. These are a set of core services identified to ensure consumers have access to necessary health benefits and to create standardization among health plans. Full-scope Medi-Cal is considered minimal essential coverage. Therefore, individuals who have full-scope Medi-Cal are not subject to the tax penalty for not having health insurance. Full-scope Medi-Cal benefits for adults include the following:

Medical	Pharmacy and Vision	Durable Medical Equipment and Services
• Clinic services • Drug and alcohol treatment • Inpatient/outpatient services • Long-term care. Personal care services and home and community-based waiver services • Mental health • Physician-administered drugs • Physician services • Podiatry services* • Acupuncture* • Medical transportation	• Prescription drug coverage • Eye exams and tests • Orthotics and prosthetics	• Wheelchairs • Wheelchair repair • Hearing aids • Batteries for pacemakers • Chiropractic • Therapies: occupational, physical and speech

*Services may not be available for all

As a result of the ACA, mental health and drug and alcohol treatment services have increased, and adult dental services were restored in May 2014. The benefits offered are shown below:

Mental Health	Drug and Alcohol Treatment	Adult Dental
• Individual and group mental health evaluation and treatment (psychotherapy) • Psychological testing when clinically indicated to evaluate a mental health condition • Outpatient services for the purposes of monitoring drug therapy • Outpatient laboratory, drugs, supplies and supplements • Psychiatric consultation	• Voluntary inpatient detoxification • Intensive outpatient treatment services • Residential treatment services • Outpatient drug free services • Narcotic treatment services • Naltrexone services: daily medical for opiate dependence • Screening, Brief Intervention Referral for Treatment (SBIRT) for alcohol use	• Exams and x-rays • Cleanings • Fluoride treatments • Fillings • Anterior root canals (front teeth) • Prefabricated crowns • Full dentures • Other medically necessary dental services

Full-scope Medi-Cal benefits for children and young adults under age 21 include the following:

Medical	Pharmacy	Dental and Vision
• Physician, medical and surgical services • Preventive health care exams • Immunizations • Well-child services • Medically necessary hospitalization • Inpatient and outpatient services • Family planning services • Laboratory and x-ray services • Mental health services • Occupational, physical and speech therapies	• Prescription drug coverage	• Vision benefits, including an eye exam and eyeglasses every 24 months • Dental benefits, including preventive and diagnostic services

RESTRICTED SCOPE BENEFITS

Restricted-scope benefits include emergency services and prenatal care. Emergency services are defined as those necessary for the treatment of an emergency medical condition (not related to an organ transplant procedure but including renal dialysis services and emergency labor and delivery) and medical care directly related to the emergency. An emergency medical condition can be defined as:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Examples of emergency medical conditions can be open wounds, broken bones, difficulty breathing, loss of consciousness, high fever and chest pains.

Program-related (or limited-scope) benefits are based on the Medi-Cal program that is providing the benefits. For some programs it pertains to a specific condition like pregnancy-related coverage. For others program-related can mean a specific set of benefits offered to a targeted population like the Aged, Blind and Disabled Program.

Pregnancy-related coverage is a type of limited-scope Medi-Cal. Pregnancy-related is defined as anything that is either caused by or will affect the outcome of a pregnancy. Therefore, most medical needs of pregnant women will be covered. Pregnant women also are entitled to benefits such as labor and delivery and up to 60 days post-partum coverage (after birth), in addition to certain dental benefits, including cleaning and treatment for gingivitis.

Restricted and limited-scope benefits are not considered minimal essential coverage under the ACA. Therefore, individuals who have restricted or limited-scope Medi-Cal may be required to pay the shared responsibility tax penalty for not having health insurance.

CHILDREN'S BENEFITS

For Medi-Cal program eligibility purposes, children are defined as under the age of 19. Children may qualify under the OTLICP program with an income up to 266% of the FPL. Under Medically Needy coverage, children are defined as under age 21 unless they can be considered an adult, such is the case with an emancipated minor who is handling his or her own financial affairs. For Medi-Cal benefit purposes children are defined as up to the age of 21. For example, a child under the age of 21 will have full-scope benefits despite which Medi-Cal program they qualify for.

Example: Maria is an 18 year old Medi-Cal beneficiary under OTLICP. She is able to access full-scope benefits, including dental and vision services. When Maria turns 19 she will no longer qualify for OTLICP. She will then be determined for MAGI Medi-Cal as an adult with an income limit of 138% of the FPL. If Maria qualifies she will remain in MAGI Medi-Cal with full-scope benefits and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) until she turns 21. Upon Maria's 21st birthday her benefits package will shift to the adult Medi-Cal benefits package, which does not EPSDT.

4. APPLYING FOR MEDI-CAL BENEFITS

The first step in obtaining Medi-Cal benefits begins with the individual completing a single, streamlined online application through Covered California's website (CoveredCA.com). However, applicants can apply in the way that works best for them, including:

- In-person with an individual certified by Covered California to perform enrollment assistance, such as a Certified Enrollment Counselor or other Covered California in-person assister
- In-person with an Eligibility Worker at a local County Social Services office
- Online at: www.CoveredCA.com
- By contacting the Covered California Service Center at 1.800.300.1506
- By US Postal mail

CoveredCA.com determines eligibility only for MAGI Medi-Cal and Covered California health plans. The information provided by the individual is verified electronically by a federal hub. Once eligibility has been determined for Medi-Cal, the individual's information will be forwarded to their local County Social Services office.

When an individual is determined eligible for Medi-Cal, the eligibility date is the application submission date and eligibility begins the first day of the month in which the individual applied.

Parents with children already enrolled in Medi-Cal must still include their children on the application. CoveredCA.com will verify any existing Medi-Cal participants as part of the eligibility process. Children are given accelerated enrollment while an application for their parents is being processed. When an individual is determined eligible for Medi-Cal, eligibility begins the first day of the moth in which the individual applied.

Individuals over the age of 65, along with certain disabled individuals are usually eligible for Medicare, and should be directed to enroll in Medicare. If an individual is not eligible for Medicare, they may be eligible for Medi-Cal or a Covered California health plan. These individuals should be referred to the local County Social Services office, as there are many non-MAGI programs for individuals who also have Medicare coverage. Individuals over the age of 65, who are disabled and qualify for Medi-Cal and Medicare are known as "dual eligibles" (or Medi-Medi). Medicare supplemental insurance (Medigap) plans are not offered through Covered California.

Note for consumers who reside in: San Francisco, San Mateo and Santa Clara:

In these three counties only, if there is an application for coverage on CoveredCA.com, and the children do not qualify for Medi-Cal online, and the household income falls within 267% to 322% of the federal poverty level (FPL), the applicant should re-apply directly through their local county social services office.

Anyone eligible for or enrolled in full scope Medi-Cal is ineligible to purchase health coverage through Covered California with financial assistance. However, an individual may decline Medi-Cal and purchase a health plan through Covered California at full cost without financial assistance.

WHO CAN APPLY ON BEHALF OF AN INDIVIDUAL?

When an individual is unable to apply on their own behalf, spouses, legal guardians, a caretaker relative, a person who has knowledge of the applicant's circumstances, hospital staff, or a public agency representative may apply on their behalf. Applicants can also authorize representatives who have certain rights and can make decisions on their behalf.

ENROLLMENT PERIOD

Applicants who are eligible for Medi-Cal may apply for coverage at any time throughout the year. There is no special enrollment period for Medi-Cal and there is no enrollment deadline.

However, if some household members are enrolling in Medi-Cal and others in a Covered California health plan, enrollment in Covered California must occur during the open enrollment period (unless a qualifying event allows for an application to be submitted during special enrollment). Since full-scope Medi-Cal is considered minimum essential coverage, the loss of Medi-Cal is a qualifying event that would allow enrollment in CoveredCA.com during the special enrollment period. Individuals who are eligible for Medi-Cal and fail to enroll will be subject to the penalty for being uninsured.

Some individuals may be eligible for payment of their medical bills up to three months prior to the date of their Medi-Cal application through retroactive benefits. A request for retroactive eligibility can only be submitted at the County Social Services office. Individuals whose application requires resolution regarding citizenship or immigration status will be classified as conditionally eligible for Medi-Cal.

For more information on eligibility, contact the county's Health and Human Services Agency at http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx.

APPLICATION PROCESSING TIMES

The Medi-Cal eligibility determination process is completed as quickly as possible, but no later than:

- 45 days following the date the application or reapplication is filed
- 90 days following the date the application or reapplication is filed when eligibility requires establishing disability or blindness

The 45/90 day time period starts on the date of the application, including mail-in applications. Applications are excluded from the 45/90 day processing requirement if the individual provides partial information or fails to comply with requests for additional information or verification documentation. If an individual does not receive their Medi-Cal Benefits Identification Card within 45 days they can file an appeal with the local County Social Services office to receive an eligibility determination decision.

- During the 45/90 day application evaluation period, if an individual needs immediate care, they can make a request at the local County Social Services office. Alternatively, presumptive eligibility may be granted through hospitals, providers and clinics to certain groups, such as pregnant women, children and former foster care youth. If an individual wishes to withdraw a submitted Medi-Cal application, they must do so in writing to the County Social Services office.

5. Eligibility for MAGI Medi-Cal

Modified Adjusted Gross Income (MAGI) Medi-Cal is an income based program that does not consider assets when determining eligibility. Like all other Medi-Cal programs, California residency and immigration status will determine the benefits received. Technically, the ACA changed the threshold for the Medi-Cal expansion population to 133% of the FPL. However, California chose to add that 5% of a person's income be "disregarded" when calculating their income level, effectively bringing the threshold up to 138% of the FPL. Disregarding income or assets means not counting it for the purposes of determining eligibility. MAGI Medi-Cal calculates household income and family size differently than non-MAGI Medi-Cal determination.

MAGI Medi-Cal Eligibility Determination Process

The following three-step process is used to determine whether an individual is eligible for MAGI Medi-Cal:

1. **Identify the members of the individual's family**

   Individuals will be required to answer a series of questions about themselves and family members applying for coverage. Based on their responses, Covered California will know the tax relationship between family members (i.e., whether they are tax filers or tax dependents).

   When determining Medi-Cal eligibility, the online application also asks whether or not the household agrees to file a federal income tax return for the year they will receive coverage (the benefit year). Depending on the individual's answer, a specific set of household rules will be applied after which the online application will proceed to step two.

2. **Add the total income of qualified household members**

   A household's total income for the current benefit year is used to evaluate Medi-Cal eligibility.

3. **Compare total household income to the Federal Poverty Level***

Family Size	60% FPL MAGI Medi-Cal for Pregnant Women full-scope	109% FPL MAGI Medi-Cal for Parents & Caretaker Relatives	138% FPL MAGI Medi-Cal for Adults ages 19-64	160% FPL MAGI Medi-Cal OTLICP for children - not required to pay a premium	213% FPL MAGI Medi-Cal for Pregnant Women, restricted -scope	266% FPL MAGI Medi-Cal OTLICP for children 0 to 19 years old
1	$ 7,002	$ 12,721	$ 16,105	$ 18,672	$ 24,858	$ 31,043
2	$ 9,438	$ 17,146	$ 21,708	$ 25,168	$ 33,505	$ 41,842
3	$ 11,874	$ 21,572	$ 27,311	$ 31,664	$ 42,153	$ 52,642
4	$14,310	$ 25,997	$ 32,913	$ 38,160	$ 50,801	$ 63,441
5	$ 16,746	$ 30,422	$ 38,516	$ 44,656	$ 59,449	$ 74,241
6	$ 19,182	$ 34,848	$ 44,119	$ 51,152	$ 68,097	$ 85,041
Each add. person adds	$ 2,436	$ 4,426	$ 5,603	$ 6,496	$ 8,648	$ 10,800

*Effective April 1, 2014 - March 31, 2015

Regulations require Medi-Cal and Covered California utilize different FPL income limits. April of every year, Medi-Cal uses FPL guidelines that are released in January. The dollar amount goes up every year to adjust for inflation and other items. Covered California uses FPL guidelines for the current year until the open enrollment period. Therefore, to qualify for Medi-Cal an applicant's income must be at or below the current limit of 138% of the FLP. Yet, the Covered California income guideline of 400% of the FPL to qualify for financial assistance is based on the previous FPL guidelines. The online application system has both thresholds in the system so it will correctly determine the income limits for Medi-Cal or Covered California.

MAGI Medi-Cal Household Size Determination

MAGI Medi-Cal household size is determined on an individual basis, meaning the family size of each family member will be determined separately. In some cases members of the same family will have different family sizes. Medi-Cal households are determined based on a person's family and tax relationships, as well as their living arrangements. When people complete their tax returns, these factors are considered based on the calendar year that just ended. In general, there are 3 sets of rules that Medi-Cal applies when determining household size and depends on whether someone is a tax filer, a tax dependent, or neither a tax filer nor a tax dependent.

1. **Household Size Determination Rules for Tax Filers**

   If the applicant is a tax filer and is not claimed as a dependent by another tax flier, their household size will include:

   - The tax filer

- The spouse
- Everyone the tax filer claims as a dependent
- Your unborn child (pregnant women/Medi-Cal Only)*

*Note that Covered California only counts pregnancy as one person while Medi-Cal counts the mother plus the number of unborn children.

Married couples who live together are always counted in each other's household regardless of whether they file a joint or separate return.

Example: Eva and David are married and have a young daughter named Silvia. Eva's mother Isabel lives with them. Eva and David file taxes jointly and claim Silvia as their dependent. Isabel files her own taxes.

- Eva's and David's MAGI family size are the same and will consist of themselves (tax filers), each other (spouse) and their dependent child, Silvia; for a total of 3
- Silvia's MAGI family size is the same as the tax filers claiming her; for a total of 3
- Isabel's MAGI family size is just herself; for a total of 1

2. Household Size Determination Rules for Tax Dependents

For tax dependents, the household size is the same as that of the tax filer who claims the individual as a tax dependent. However, there are 3 exceptions to this rule:

- Individuals who expect to be claimed as a dependent by someone other than a spouse or parent
- Children (under 19) living with both parents, whose parents do not expect to file a joint tax return
- Children (under 19) who expect to be claimed as a dependent by a non-custodial parent

A dependent child is biological, adopted, or stepchild under the age of 21 and enrolled in school full-time. If a dependent child is not enrolled in school full-time they will be considered a dependent only until the age of 19. Tax dependents that live in Mexico or Canada are still considered dependents if they meet all other tax dependent requirements.

Example: Using the example above, only in this case Eva and David file taxes separately, and David claims Silvia as his dependent.

- David's MAGI family will consist of himself (tax filer), Eva (spouse) and Silvia (his dependent child); for a total of 3
- Eva's MAGI family size will consist of herself (tax filer) and David (spouse); for a total of 2
- Silvia's MAGI family size is determined using the non-tax filer/tax dependent rules. Included in Silvia's household is Silva, David (father) and Eva (mother) for a total of 3

Isabel's MAGI family size is just herself; for a total of 1

3. Household Size Determination Rules for Individuals who are not a Tax Filer Nor a Tax Dependent

The household rules for this category differ based on whether the individual is an adult or child.

- If the individual is an adult, the household includes the individual plus, if living with the individual, his or her spouse and children who are under 19 years old or under age 21 if a full-time student
- If the individual is a child under 19 years old, or under age 21 if a full-time student, the household includes the child and any siblings under 19 years old or under age 21 if a full-time student, and parents who live with the child

Example: Using the example above, where Eva and David file taxes jointly, but claim Isabel as their dependent.

- Eva's and David's MAGI family size are the same and will consist of themselves (tax filers), each other (spouse) and their dependents (Silvia and Isabel); for a total of 4
- Silvia's MAGI family size is the same as the tax filers claiming her; for a total of 4
- Isabel's MAGI family size is just herself; for a total of 1

Parents, children and siblings include adopted children, biological children, and stepfamilies.

The IRS does not allow unborn children to be claimed as tax dependents. Therefore, for the purpose of calculating household size for Covered California Advanced Premium Tax Credit (APTC)/Cost-Sharing Reduction (CSR), a pregnant woman is counted as one person. However, Medi-Cal has special rules for counting pregnant women that include the number of children expected. Thus, a pregnant woman expecting twins in her third trimester could be counted as one person under the Covered California APTC/CSR rules and as three people under Medi-Cal rules.

Household members that are excluded from the household size determination are:

1. Unmarried partners
2. Unmarried partner's children if they are not tax dependents of the tax filer,
3. Parents and other relatives who live in the household, file their own taxes, and are not dependents of the tax filer.

Changes to household size should be reported to Medi-Cal within 10 days through CoveredCA.com or by calling the local County Social Services office.

For more information on MAGI Medi-Cal household size determination visit:

http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/County-Operations-Support/MAGI-MCal-HHSizeFlowChart-v1_2-20140815.pdf

MAGI Medi-Cal Household Income Determination

A household's MAGI is used to determine eligibility for subsidized health insurance through Covered California and for income-based Medi-Cal (MAGI Medi-Cal). The Adjusted Gross Income (AGI) is used to calculate MAGI. Individuals can find their AGI on the following federal tax return lines:

- Line 4, Form 1040EZ
- Line 21, Form 1040A
- Line 37, Form 1040

To perform MAGI calculations, certain types of income are added to AGI:

- Non-taxable Social Security benefits (Line 20a minus 20b, Form 1040)
- Tax-exempt interest (Line 8b, Form 1040)

- Foreign earned income and housing expenses for Americans living abroad (calculated on Form 2555)
- Lump sum payments (e.g., gifts, prizes, income, and property tax refunds) are counted only in the month received

The following sources of income are excluded when determining MAGI for Medi-Cal eligibility:

- Scholarships, awards, or fellowship grants used for educational purposes, but not used for living expenses
- Certain American Indian and Alaska Native income derived from:
  - Distributions
  - Payments
  - Ownership interests
  - Real property usage rights
  - Student financial assistance

Any changes to household income should be reported to Medi-Cal within 10 days through CoveredCA.com or by calling the local County Social Services office.

CALCULATING MAGI

It is important to understand all sources of income that will be counted in MAGI, as certain types of income may be deducted or not included. The following table describes sources of income as they relate to MAGI:

What is included in MAGI?	What is deducted from MAGI?	What is not included in MAGI?

• Taxable wages, salaries, self-employment income, tips, and commissions
• Gross interest and taxable ordinary dividends
• Taxable amount of a pension, annuity, or IRA distribution
• Social Security benefits
• Business income (or losses)
• Farm income (or losses)
• Capital gains and other gains (or losses)
• Unemployment compensation
• Alimony received
• Income (or losses) from rental real estate, royalties, and partnerships
• Taxable refunds, credits, or offsets of state and local income taxes
• Other taxable income
	• Certain allowable self-employment expenses
	• Student loan interest deductions
	• Educator expenses
	• IRA deductions
	• Moving expenses
	• Penalty on early withdrawal of savings
	• Health savings account deductions
	• Alimony paid
	• Certain business expenses of reservists, performing artists, and fee-basis government officials
		• Foster Care payments
		• Veterans' disability payments
		• Workers' compensation payments
		• Child support received
		• Supplemental Security Income (SSI)
		• Also not included in MAGI, because these items are already subtracted from W-2 wages and salaries, are pre-tax contributions for:
		  ○ Child care
		  ○ Commuting
		  ○ Employer-sponsored health insurance
		  ○ Flexible spending accounts
		  ○ Retirement plans such as a 401(k) or 403(b)

PROJECTING SELF-EMPLOYMENT INCOME FOR MAGI

If a self-employed individual has worked less than a year, or not long enough to file a tax return in the previous year, a projection of annual self-employment income can be made by:

1. Adding together gross self-employment income and any profit made from selling business property or equipment during the time the business has been in operation within the last year
2. Subtracting business expenses allowed by the IRS

3. Divide by the number of months employed then multiply by twelve to get projected annual income

Self-employment income for the current benefit year also can be determined by using the income and deductions claimed on the previous year's taxes (Form 1040, Line 12 of Schedule C), if an individual worked long enough to file a federal tax return for the previous year, and it is representative of their current income.

MAGI Verification Documentation

Covered California requires individuals to provide the following:

- Attest to their current or projected income for the current benefit year
- If an individual's income varies from month to month, income should be based on a monthly average of expected earnings for the current benefit year (projected average annual income). To make this income estimate, individuals should take the following factors into consideration:
  - Their income pattern over the last year
  - The actual income they received in the last month
  - The ability to provide a statement of anticipated income, which can be presented as a self-affidavit letter of income

If an individual's attested income is not reasonably consistent with available federal data, or if income information is not available, the individual has 90 days to provide documentation to resolve the inconsistency (i.e. by presenting current paystubs or the previous year's tax return).

Optional Targeted Low-Income Children's Program

The Optional Targeted Low-Income Children's Program (OTLICP) offers healthcare coverage for children previously in the Healthy Families Program (HFP) that were transition into Medi-Cal. OTLICP provides full-scope Medi-Cal benefits at no- or low-cost to children with eligible immigration status and household income up to 266% of the FPL.

Cost is based on the family's household income. Children are eligible at no cost with an income limit at or below 160% of the FPL. Families with incomes greater than 160% of the FPL will be subject to a health insurance premium of:

- **$13** per month for 1 child
- **$26** per month for 2 children
- **$39** per month for 3 or more children

Medi-Cal Access Program, formerly Access for Infants and Mothers (AIM), includes infants whose mother's income is above 266% up to and including 322% FPL. These infants are registered into the DHCS Medi-Cal Access Infant Program back to their date of birth once registered by the mother, plan, provider, or hospital. The infant is eligible for up to two years of coverage through the Medi-Cal Access Infant Program as long as the family income stays within the Medi-Cal Access Program's income eligibility levels at the one year renewal.

For more information on OTLICP please visit:
http://www.dhcs.ca.gov/services/pages/healthyfamiliestransition.aspx.

MAGI Medi-Cal for Pregnant Women

Pregnant women qualify for MAGI Medi-Cal up to 213% of the FPL with different coverage levels. Pregnant women with income:

- Up to 60% of the FPL are eligible for full-scope Medi-Cal benefits.

Above 60% up to and including 213% of the FPL are eligible for limited-scope Medi-Cal (pregnancy-related only benefits). Pregnant women may transition to the MAGI parent/caretaker group (full-scope Medi-Cal) during their 3rd trimester if they meet the income requirements (0 up to 109% of the FPL). Women will remain eligible for full-scope or limited-scope Medi-Cal for pregnant women until the end of the post-partum period that ends at the last day of the month in which the 60th day occurs.

CALIFORNIA RESIDENCY REQUIREMENTS

To be eligible for Medi-Cal an individual must reside in the state of California. Residency is established if an individual is physically present and living in California and:

- Intends to remain permanently or for an indefinite period or the tourist visa expires
- Entered the state with a job commitment or to seek employment, whether or not currently employed (i.e. individual immigrating to the US to seek employment)

Individuals will attest to their address on the online application, which will be verified. If further address verification is required the following are currently acceptable types of proof of residency for Medi-Cal:

- A recent California rent or mortgage receipt or utility bill in the individual's name
- A current California motor vehicle driver's license or California Identification Card issued by the Department of Motor Vehicles in the individual's name
- A current California motor vehicle registration in the individual's name
- A document showing that the individual is employed in this state or is seeking employment in the state
- A document showing that the individual has registered with a private employment service in this state
- Evidence that the individual has enrolled his or her children in a school in this state
- Evidence that the individual is receiving public assistance in this state
- Evidence of registration to vote in this state
- A declaration by the individual under penalty of perjury that he or she intends to reside in this state and does not have a fixed address and cannot provide any of the documents previously identified
- A declaration by the individual under penalty of perjury that he or she has entered the state with a job commitment or is seeking employment in the state and cannot provide any of the previously identified documents

As a result of the Medi-Cal expansion in California, nearly all individuals who are experiencing homelessness or living in supportive housing are eligible to enroll in Medi-Cal. A homeless individual may provide a written statement indicating that they are a resident of the state, do not have a fixed address and cannot provide any other documents. For more information on residency requirement for the homeless please visit: http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/OE/HmlessMCEnrllmntTlkit.pdf

6. Citizenship and Immigration Status Requirements

IMPORTANT NOTE

United States Citizenship and Immigration Services (USCIS) will not use the information about individuals or members of their household, obtained through the CoveredCA.com application for purposes of determining eligibility for health coverage, as a basis for pursuing a civil immigration enforcement action against individuals or their families. Whether the information is provided by a federal agency to the Department of Homeland Security or the information is provided to ICE by another source it will only be used for the purpose of verifying immigration status.

Citizenship or eligible immigration status is not a requirement for Medi-Cal eligibility. However, it will determine the type of services an individual may access. Undocumented immigrants are eligible only for restricted-scope Medi-Cal benefits. To be eligible for full-scope Medi-Cal benefits an individual must have satisfactory immigration status which includes, but it not limited to:

Immigrants eligible for Medi-Cal benefits effective January 1, 2014	
	Lawful Permanent Residents (LPR)
Applicants for adjustment to LPR status with approved visa petition	Individuals granted conditional entry into the US
Asylees	Individuals granted withholding of deportation or removal
Refugees	Individuals paroled in the US for at least one year
Cuban and Haitian entrants	DACA (Deferred Action for Childhood Arrival) residents
Battered spouses and children who have an approved self-petition for an immigrant visa under the Violence Against Women Act (VAWA)	Immigrants who would have been eligible before January 1, 2014 for benefits under the Refugee Medical Assistance (RMA) Program
Victims of trafficking	PRUCOL residents (Permanently Residing Under the Color of Law)

Example: A person that works, attends school and files taxes in the US but is living in Mexico, is not eligible because all individuals must reside in California. In addition, to be eligible for full-scope Medi-Cal benefits, the individual must also have appropriate immigration status.

Unlike the federal requirements for Medicaid, to be eligible for Medi-Cal, there is not a five-year waiting period for qualified aliens. For example, under current Medi-Cal policy, eligible green card holders can receive full-scope Medi-Cal benefits in California even if they have been in the US for less than five years. When the application is submitted, individuals can upload proof of residency and immigration documentation immediately or have the option to provide supporting documentation within 90 days of submitting the application.

For more information on immigration classifications and a comprehensive list of “lawfully present” individuals please visit: www.nilc.org/document.html?id=809.

IMMIGRATION STATUS AND DOCUMENTATION

The following table includes common documents that may be provided by US citizens, US nationals and lawfully present individuals to document citizenship or immigration status. Documentation type to upload must be in Word, Excel, PDF, JPG and TIF formats with a 5MB limit. Consumers can fax the documents to Covered California at 916-636-3400, however processing times may be increased.

Status Definition	Valid Documentation	Program Eligibility
US Citizen or US National		
Born in the US or a person who owes permanent allegiance to the US (e.g. those born in American Samoa or Swains Island)	• Social Security Number	• Covered California health plan, with or without financial assistance • Full-scope Medi-Cal
US Naturalized Citizen		
Person has been naturalized as a US citizen (became a US citizen after birth)	• Certificate of Naturalization (N-550 or N-570) • Certificate of US Citizenship (N-560 or N-561)	• Covered California health plan, with or without financial assistance • Full-scope Medi-Cal

Status Definition	Valid Documentation	Program Eligibility
Lawfully Present Individuals		

• Qualified non-citizens/ immigrants:
  ○ Lawful permanent residents (LPR/Green Card Holders)
  ○ Asylees
  ○ Refugees
  ○ Cuban/Haitian entrants
  ○ Individuals paroled into the
	Depending on individual's situation:
	• Green card number (Resident Alien Number) with expiration date (I-551)
	• Reentry Permit (I-327)
	• Refugee Travel Document (I-571)
	• Employment Authorization Card (I-766)
	• Machine Readable Immigrant Visa (with
		• Covered California health plan, with or without financial assistance
		• Full-scope Medi-Cal for:
		  ○ Individuals up to 21 years of age
		  ○ Pregnant individuals with income up to 60% of the FPL
		  ○ Children in families with income up to 266% of the FPL
		  ○ Parents, seniors, and persons with disabilities
		  ○ Parents and caretakers with income up to 138% of the FPL

Status Definition	Valid Documentation	Program Eligibility
US for at least one year ○ Individuals with conditional entry granted before 1980 ○ Battered non-citizens, spouses, children, or parents ○ Victims of trafficking along with their spouses, children, siblings, or parents, or individuals with a pending application for a victim of trafficking visa ○ Individuals granted withholding of deportation ○ Members of federally recognized Indian tribes or American Indians born in Canada • Humanitarian statuses or circumstances (including Temporary Protected Status, Special Juvenile Status, asylum applicants, Convention Against Torture, victims of trafficking)	temporary I-551 language) • Temporary I-551 Stamp (on passport or I-94/I-94A) • Arrival/Departure Record (I-94/I-94A) • Arrival/Departure Record in foreign passport (I-94) • Foreign Passport • Certificate of Eligibility for Nonimmigrant Student Status (I-20) • Certificate of Eligibility for Exchange Visitor Status (DS2019) • Notice of Action (I-797) • Document indicating membership in a federally recognized Indian tribe or American Indian born in Canada • Certification from US Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR) • Office of Refugee Resettlement (ORR) eligibility letter (if under 18) • Document indicating withholding of removal • Administrative order staying removal issued by the Department of Homeland Security • Alien number (also called alien registration number or	○ Adults without children, ages 19 to 64, with income up to 138% of the FPL • Pregnancy-only Medi-Cal for: ○ Qualified immigrants who are pregnant with income between 60% - 213% of the FPL

Status Definition	Valid Documentation	Program Eligibility
• Valid non-immigrant visas • Legal status conferred by other laws (temporary resident status, LIFE Act, Family Unity individuals) • Individual with a work or student visa who intends to become a permanent resident of California	USCIS number) or 1-94 number	

Status Definition	Valid Documentation	Program Eligibility
Temporary residents (who do not intend to reside in California)		
• Foreign visitors • Students with temporary visas • Individuals with temporary visas	• Employment Authorization Card (I-766) • Temporary I-551 Stamp (on passport, I-94, or I-94A) • Arrival/Departure Record (I-94, I-94A) issued by USCIS • Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20) • Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)	• Covered California health plan, with or without financial assistance. Must reside in California for, and file taxes in, the benefit year. • Restricted-scope Medi-Cal

Helpful Resources

For more information on the legal requirements for lawful presence, including the definition of "qualified immigrants," go to:

- http://www.law.cornell.edu/cfr/text/45/152.2
- http://www.law.cornell.edu/uscode/text/8/1641

Another helpful resource is the following report: "**Lawfully Present Individuals Eligible under the Affordable Care Act**," published by the National Immigration Law Center (September 2012): www.nilc.org/document.html?id=809.

PRUCOL AND DACA

There are 16 immigration statuses that may qualify as permanently residing in the United States Under Color of Law (PRUCOL):

1. A conditional entrant admitted to the US before April 1, 1980
2. An alien paroled into the US, including Cuban/Haitian entrants
3. An alien subject to an Order of Supervision
4. An alien granted an indefinite stay of deportation
5. An alien granted an indefinite voluntary departure
6. An alien on whose behalf an immediate relative petition (INS Form I-130) has been approved and who is entitled to voluntary departure
7. An alien who has properly filed an application for lawful permanent resident status
8. An alien granted a stay of deportation for a specific period
9. An alien granted asylum
10. An refugee admitted to the US since April 1, 1980
11. An alien granted voluntary departure who is awaiting issuance of a visa
12. An alien in deferred action status
13. An alien who entered and has continuously resided in the US since before January 1, 1972, who would be eligible for an adjustment of status to lawful permanent resident pursuant to INA Section 249 (eligible as a Registry Alien)
14. An alien granted a suspension of deportation whose departure USCIS does not contemplate enforcing
15. An alien granted withholding of deportation pursuant to INA Section 243(h)
16. An alien, not in one of the above categories, who can show that (1) USCIS knows they are in the US; and (2) USCIS does not intend to deport them, either because of the person's status category or individual circumstances

Deferred Action for Childhood Arrival (DACA) individuals fall under deferred action status. DACA status is for certain individuals who came to the US as children and meet several guidelines, and who may request consideration of deferred action for a period of two years, subject to renewal. They are also eligible for work authorization.

Note: Some legal permanent resident cards do not have an Alien Number or Card Number. When completing the application, you will be asked to enter this information. Please enter the following values:

Alien Number: 999999999

Card Number: ZZZ9999999999

Expiration Date: 12/31/9999

Applicants can upload a copy of the Legal Permanent Resident card or the county will request proof of immigration status if no electronic match is found.

Status	Valid Documentation	Program Eligibility
• Permanently Residing Under the Color of Law (PRUCOL) • Deferred Action for Childhood Arrival (DACA)	• PRUCOL - documentation from United States Citizenship and Immigration Services (USCIS) showing PRUCOL status (I-94 or I-210 letter) • DACA –I-797 Notice of Action or employment authorization document (EAD)	Full-scope Medi-Cal

For more information on DACA please visit: http://www.nilc.org/acadacafaq.html.

ELIGIBILITY FOR UNDOCUMENTED IMMIGRANTS

Undocumented immigrants are not eligible for full-scope Medi-Cal benefits. However, if income and residency requirements are met, they are eligible for restricted-scope benefits as the following table outlines:

Status Definition	Valid Documentation	Program Eligibility
Undocumented Immigrants		

A foreign-born person who does not have a legal right to be or remain in the US	Not applicable	• Restricted-scope Medi-Cal:
		  ○ Emergency-related services
		  ○ State-funded long-term care (LTC)
		  ○ Pregnancy-related services:
		  ▪ Prenatal care
		  ▪ Labor and delivery
		  ▪ Up to 60 days of post-partum care
		  ▪ Family planning services
		• Long-term care/kidney dialysis
		• Medi-Cal Breast and Cervical Cancer Treatment Program (BCCTP)
		• Medi-Cal Access Program (MAP), formerly Access for Infants and Mothers (AIM)
		• Family Planning Access, Care, and Treatment (Family PACT)
		• Child Health and Disability Prevention Program (CHDP)

7. Non-MAGI Medi-Cal Asset Requirements

Assets and property are items a family may own, such as a car, house (other than the home in which the family resides), jewelry, savings and checking accounts. Medi-Cal uses the terms assets, property or resources interchangeably.

MAGI Medi-Cal programs do not take assets into consideration in determining eligibility. Non-MAGI Medi-Cal programs do take assets into consideration in the eligibility determination process. For the majority of non-MAGI Medi-Cal programs, the house in which the family lives and the family car are exempt. To be eligible for non-MAGI Medi-Cal, the family assets may not exceed certain limits to qualify for benefits.

Asset Limit Chart

Family Size	Asset Limit
1	$2,000
2	$3,000
3	$3,150
4	$3,300
5	$3,450
6	$3,600
7	$3,750
8	$3,900
9	$4,050
10 or more	$4,200
For more than 10 add $150 for each additional person.	

Example: Jonathan is a 70-year-old grandfather that is in need of health insurance. He has recently become a legal permanent resident and now qualifies for full-scope Medi-Cal benefits or to purchase coverage through Covered California. When Jonathan applied for coverage at CoveredCA.com, he was found ineligible for MAGI Medi-Cal and was directed to the coverage options through Covered California. Jonathan decided to request a full Medi-Cal determination and was found eligible for the Aged, Blind and Disabled Medi-Cal program (ABD). ABD requires an asset test for all beneficiaries. Jonathan reports his assets with a bank statement illustrating he has $1,500 in a savings account. Since Jonathan is under the asset limit of $2,000 for a family size of 1, and is projected to meet all other eligibility criteria of the program he qualifies for A&D FPL Medi-Cal.

For more information on Medi-Cal asset requirements please refer to the Department of Social Services Resource Guide (Medi-Cal Program Fact Sheet, page 119): http://www.ladpss.org/dpss/IGR/pdf/ResourceGuide2014links.pdf.

8. Medi-Cal Costs

Most individuals who enroll in Medi-Cal will access benefits at little to no cost. Typically there are no monthly premiums, deductibles, or co-payments. However, some Medi-Cal programs, like the OTLICP, have low monthly premiums for families with higher incomes. If a Medi-Cal

beneficiary's income is higher than the allowed income limits, they may be eligible for Medi-Cal with a Share of Cost (SOC).

MEDI-CAL SHARE OF COST

Share of Cost (SOC) means that the individual will have to pay a portion of their medical expenses out-of-pocket. In some instances, Medi-Cal beneficiaries must pay a fixed monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. A Medi-Cal beneficiary's SOC is similar to a private insurance plan's out-of-pocket deductible.

The SOC amount is calculated by the County Social Services office using the beneficiary's household monthly income and the Medi-Cal Maintenance Need Income Level (MNIL), which is a calculated amount that is needed monthly to pay for living expenses.

The following table shows the MNIL by family size:

Family Size	MNIL
1	$600
2 (one adult, one child)	$750
2 (adults)	$934
3	$934
4	$1,100
5	$1,259
6	$1,417

SOC Medi-Cal does not qualify as minimum essential coverage. Therefore, beneficiaries can request that their local County Social Services office review their case for MAGI Medi-Cal eligibility.

9. ADMINISTRATION OF MEDI-CAL BENEFITS

Medi-Cal provides high quality, accessible, and cost-effective health care through either fee-for-service (FFS) or managed care delivery systems. .

FEE-FOR-SERVICE

With fee-for-service (FFS), or "regular" Medi-Cal, a beneficiary can access benefits with any FFS Medi-Cal provider (i.e. doctors, clinics, hospitals or pharmacies). FFS Medi-Cal is automatically assigned to some persons with disabilities. For the most part, other FFS Medi-Cal beneficiaries will be enrolled in a temporary form of Medi-Cal benefits like presumptive eligibility. If and when the individual is determined eligible for a Medi-Cal program through a formal application they will be transitioned into managed care. Individuals who can choose to participate in FFS Medi-Cal are:

- Children in a foster care or adoption aid program
- Beneficiaries with a SOC
- Beneficiaries eligible for restricted-scope Medi-Cal
- Pregnant women with pregnancy related coverage in the MAGI Medi-Cal program up to 213% of the FPL
- Children enrolled in California Children's Services (CCS)

FFS is beneficiary driven, meaning an individual can go to the doctor when they want and only access the services they believe they need. Some beneficiaries like this flexibility, but it does leave a gap in preventive care. Often as a result, services may only be sought once a condition has developed and extensive treatment is needed.

MANAGED CARE

Medi-Cal managed care contracts for health care services through established networks of organized systems of care, which emphasize primary and preventive care. Since Medi-Cal managed care began expanding in 2011, enrollment in managed care plans outnumbers FFS enrollment. An individual eligible for managed care Medi-Cal must choose a health plan in their county within 45 days or a health plan will be assigned to them. In a County Organized Health System County (COHS), there is only one plan and beneficiaries are automatically assigned. In managed care, coordination of services is done through a Primary Care Provider (PCP), who every member chooses themselves or is assigned. This ensures more preventive care and less duplication of services. Managed care members generally see network providers; however, in certain situation they may get services from an out-of-network provider approved by the plan.

Most Medi-Cal beneficiaries with full-scope coverage not enrolled in temporary, presumptive eligibility will be mandated to enroll in managed care, with the exception of children in foster care or adoption assistance programs, and beneficiaries with a SOC or in long term care, except in a COHS County or one where the Coordinate Care Initiative has been implemented. Children enrolled in California Children's Services in the counties of Alameda, Los Angeles and San Diego have the option to enroll in managed care or FFS.

Most Medi-Cal beneficiaries with full-scope coverage not enrolled in temporary, presumptive eligibility will be mandated to enroll in managed care, with the exception of children in foster care or adoption assistance programs, and beneficiaries with a SOC or in long term care. except in a COHS County or one where the Coordinate Care Initiative has been implemented Children enrolled in California Children's Services in the counties of Alameda, Los Angeles and San Diego have the option to enroll in managed care or FFS.

For more information on Medi-Cal Managed Care please visit:
http://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx.

For a description of the six models of managed care in California, please visit:
http://www.dhcs.ca.gov/provgovpart/Documents/MMCDModelFactSheet.pdf

HEALTH PLAN SELECTION

Medi-Cal beneficiaries who are mandated or chose to be in managed care must enroll with a health insurance company who contracts with Medi-Cal to provide services except in a COHS County, where they are automatically enrolled in the single plan.. This means that many individuals who qualify for Medi-Cal may choose the health insurance plan they want. They can choose one plan for the entire family or choose a different plan for each family member.

Individuals will receive a Medi-Cal welcome package, except in a COHS County, that will include the Medi-Cal enrollment booklet and health plan choice form. The enrollment booklet includes important information such as plan provider directories with names of doctors and hospitals in the managed care health plan's network. Individuals should review the booklet carefully to select a health plan and PCP that meets their needs. Since a doctor's ability to take new Medi-Cal patients may vary, the most accurate way to determine if a health plan's network includes a healthcare professional is to call the doctor's office or desired health plan directly. Medi-Cal health plans are available to individuals based on their county of residence.

To view the Medi-Cal enrollment information by county please visit, http://www.healthcareoptions.dhcs.ca.gov/HCOCSP/Enrollment/Informing_Materials.aspx

Individuals enrolled in Medi-Cal may choose a health plan or change health plans at any time during the year. Changes take effect on the first day of the next month. For more information on how to enroll with a health plan or change a health plan call Medi-Cal Health Care Options at 1.800.430.4263 or go to, http://www.healthcareoptions.dhcs.ca.gov/ Mixed Program Family

Even though all family members apply for health coverage together, each member of the household is evaluated individually and it is possible that some members of the household qualify for Medi-Cal while others will qualify for a Covered California health plan with APTC, and possibly CSR, through Covered California. These families are considered mixed program families (MPF). Income limits for eligibility vary for different populations in Medi-Cal. For example, children and pregnant women qualify for Medi-Cal at higher incomes compared to childless adults.

Since eligibility criteria for each program is different, it may not be possible for the entire family to be enrolled in a single program. Many adults may be eligible for a Covered California plan with APTC at significantly lower income limits than their children who may be eligible for Medi-Cal – 138% for most adults to 266% FPL for children.

People who are eligible for Medi-Cal are not eligible for premium assistance with Covered California. Applicants who are eligible for Medi-Cal have the choice to, opt out of Medi-Cal and purchase a full-cost health plan through Covered California. By doing so, these individuals would be giving up high quality coverage at low or no cost for a health plan that requires monthly premiums and other out-of-pocket costs (i.e. co-insurance, deductibles, co-pays).

INCOME LIMITS

The program income limits vary for different coverage groups for Medi-Cal. For example, children and pregnant women qualify for Medi-Cal at higher income guidelines compared to childless adults.

The following table outlines the eligibility income guidelines for MAGI Medi-Cal groups:

Determining MAGI Medi-Cal Eligibility	
Population	**Income Limit (up to)**
Adults age 19-64	138% of the FPL
Parents and caretaker relatives	109% of the FPL
Pregnant women	213% of the FPL
Children	266% of the FPL

If a family's household income is above the limits for MAGI Medi-Cal the applicant will be determined for Covered California with or without APTC and CSRs.

Example: Derek and Michelle are married and seeking coverage for themselves and their 9 year old daughter, Sofia. Michelle is seven months pregnant and recently lost her employer-sponsored coverage due to a layoff. Derek is a landscaper and his projected annual income is $45,000 (225% of the FPL). When submitting their Covered California application the family will qualify for different programs. Derek will most likely qualify for Covered California with APTC and CSR, Michelle will qualify for pregnancy-related coverage through Medi-Cal and Sofia will

qualify for Medi-Cal's OTLICP. Adults age 19-64 (including parents and other caretaker relatives with income above 109% FPL). All programs offer different levels of coverage with different out-of-pocket expenses, and satisfy the individual mandate of minimal essential coverage.

Example: Jim and Stacy will soon be uninsured due to Jim's job loss and whose employer provided both him and his wife with employer-sponsored coverage. Their two children are enrolled in Medi-Cal. Jim and Stacy may be eligible for premium assistance if they enroll in a health plan through Covered California while their two children will continue to have coverage through a Medi-Cal managed care health plan. Jim and Stacy may be able to enroll in the same health plan as their children depending on what Medi-Cal and Covered California plans are available in their county.

Example: Roxanne is a 49 year old single mother with one dependent child, age 15. Her projected annual income for 2014 is $39,000 (248% of the FPL). If Roxanne applies for a health plan through Covered California her child will be eligible for Medi-Cal's OTLICP and she will be eligible for premium assistance through Covered California.

Individuals in a mixed program family will have different costs because Medi-Cal provides health coverage at low- or no-cost while Covered California health plans require a monthly premium and other out-of-pocket costs such as co-pays and coinsurance. A family's medical expenses with be determined by the amount of APTC received, the level of coverage a family chooses with Covered California (metal tier), and the Medi-Cal program they are eligible for.

10. Presumptive Eligibility Programs

Medi-Cal provides certain individuals with temporary and immediate coverage before they are formally determined eligible for a Medi-Cal program. These programs grant individuals with presumptive eligibility (PE), meaning they are presumed eligible without a full eligibility determination. However, a full Medi-Cal application must be submitted within 60 days of PE coverage or PE will be terminated. Depending on the program, Individuals are enrolled in PE by participating providers and not done through the County Social Services office or CoveredCA.com.

Presumptive Eligibility for Pregnant Women

Presumptive eligibility for pregnant women is a no-cost Medi-Cal program designed to provide immediate, temporary coverage for prenatal care to low-income pregnant women pending submission of a formal Medi-Cal application.

Any woman, who thinks she is pregnant, has a household income at or below 213% of the FPL, and does not have an existing Medi-Cal case may qualify for PE coverage. However, she must seek care through a participating PE provider. PE is temporary coverage good through the beneficiary's final eligibility determination for Medi-Cal.

PE covers specific outpatient prenatal care, outpatient abortion procedures, prescription drugs for conditions related to pregnancy, and limited lab and preventive dental services. However, it does not cover labor and delivery, family planning or inpatient care. Therefore, PE patients must submit a formal Medi-Cal application to continue receiving coverage. For questions about the PE program contact PE via email at PE@dhcs.ca.gov.

Hospital Presumptive Eligibility Program

On January 1, 2014, the hospital presumptive eligibility program began providing individuals with temporary, no-cost Medi-Cal benefits for up to 2 months. The following individuals may be eligible for hospital PE benefits:

- Children ages 0-18
- Parents and caretaker relatives
- Pregnant women
- Former foster care children age18 to 26, who were in foster care on their 18th birthday
- Adults ages 19-64, not pregnant, not on Medicare, and not part of any group described above
- Presumptive Eligibility for the Breast and Cervical Cancer Treatment Program

The Breast and Cervical Cancer Treatment Program (BCCTP) provides temporary full scope no-cost Medi-Cal for eligible low-income California women. Applications for presumptive eligibility through BCCTP are submitted by Cancer Detection Program (CDC).

Every Woman Counts (EWC) or Family Planning, Access, Care and Treatment (FPACT) enrolling providers through an internet gateway portal that interfaces directly to MEDS. The final eligibility determination is made by state BCCTP eligibility specialist.

To receive hospital PE benefits, an individual must submit a simplified application through participating hospitals. Individuals are determined and notified immediately of their PE determination. And will have the opportunity to complete the Covered California online application to ensure that their PE benefits do not expire after the initial PE coverage period. If an individual enrolls in Medi-Cal after seeking treatment at the hospital, Medi-Cal can pay for services received three months prior to the full Medi-Cal application date if the individual asks for retroactive coverage so that the Medi-Cal could pay for services received prior to application. Inquiries regarding the hospital PE program may be directed to DHCSHospitalPE@dhcs.ca.gov.

MEDI-CAL EXPRESS LANE ELIGIBILITY

Express lane eligibility is a result of federal guidance to streamline Medi-Cal enrollment for newly eligible adults and children who are part of other state programs. For example, newly eligible adults and children currently enrolled in the CalFresh program who are not receiving Medi-Cal may use express lane eligibility to expedite the Medi-Cal enrollment process.

A federal waiver allows DHCS to grant Medi-Cal expressly without the need for an application or a determination for 12 months by using CalFresh income eligibility. By being enrolled in CalFresh, income and residency has been established and DHCS will only need to conduct necessary citizenship and identity verification to comply with federal Medicaid regulations. For more information on express lane eligibility please visit: http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/ExpressLane.aspx

11. MEDI-CAL CHILDREN'S PROGRAMS

FORMER FOSTER CARE CHILDREN'S PROGRAM

Effective January 1, 2014 as part of the Medi-Cal expansion, the Former Foster Care Children's Program (FFCCP) extended coverage to youth, up to the age of 26, who were in foster care on their 18th birthday regardless of income. If an individual previously aged out of the FFCCP, but is under the age of 26, the individual still qualifies for no-cost, full-scope Medi-Cal benefits up to their 26th birthday. The FFCCP group does not go through MAGI income determination. Program eligibility is based solely on an individual's:

- Participation in foster care and Medicaid in ANY state on their 18th birthday
- Currently residing in the state of California
- Younger than the age of 26

Former foster care youth who meet the requirements are eligible to enroll in Medi-Cal, even if they:

- Were in foster care and Medicaid in another state
- Have children
- Are married
- Live with a relative, in an institution, group home, residential placement, or transitional living program
- Currently have health insurance through an employer, parent, or spouse
- Have income above 138% of the FPL, which generally is the income threshold for Medi-Cal eligibility

There is no open enrollment for this program and eligible individuals may apply at any time throughout the year at their local County Social Services office. The application is streamlined by using a MC 250A form, which is a simple one-page Medi-Cal application form specifically intended to screen for FFCCP. When a MC 250A form is submitted, the individual's participation in foster care on their 18th birthday will be verified. Once verification occurs the individual will be enrolled in FFCCP. If verification cannot be confirmed at the time of application, the individual must enroll based on self-attestation. The County Social Services office has 30 days to verify participation in foster care. Youth who were in foster care on their 18th birthday in California (proof of residency may be required), are not required to provide:

- Written proof of former foster care status
- Proof of income or tax filing status – former foster care youth qualify for no-cost Medi-Cal regardless of income or family size (unless applying for a spouse and/or children)

For those who were in foster care on their 18th birthday and lived in another state, verification will be made by:

- Documentation that confirms former foster care on or after their 18th birthday from a public agency
- Contacting the state in which the applicant was in foster care

Once admitted into the program, former foster care youth have the option to access Medi-Cal benefits through either fee-for-service or managed care. FFCCP individuals will remain eligible for Medi-Cal benefits automatically up to their 26th birthday and no redetermination is required.

Former foster care youth who are unsure of their foster care status on their 18th birthday should call the Foster Care Ombudsman at 1.877.846.1602 or email: fosteryouthhelp@dss.ca.gov.

County-specific information for assistance can be found at:
http://www.childrennow.org/uploads/documents/Coveredtil26_CountyContactList.pdf .

To download and print a MC 250A form visit:
http://www.dhcs.ca.gov/formsandpubs/forms/Forms/mc250a2014.pdf .

CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

The Child Health and Disability Prevention (CHDP) is a federal and state supported heath program that provides a periodic health assessment for the early detection and prevention of disease and disabilities for low-income children and youth on a fee-for-service basis through a provider network consisting of private physicians, local health departments, community clinics, and some local school districts. Children enrolled in Medi-Cal managed care plans receive these services through their health plan provider network.

Children with emergency Medi-Cal with incomes up to 200% of the FPL are eligible from birth through the age of 18 for state funded CHDP services. Medi-Cal beneficiaries with incomes of up to 266% of the FPL are eligible up to the age of 21. If a child qualifies for CHDP, there is no cost for services to the family. CHDP assessments include:

- Health and developmental history
- Complete physical examination
- Oral health assessment
- Nutrition assessment
- Behavioral assessment
- Immunizations
- Vision screening
- Hearing screening
- Laboratory tests for anemia, blood, lead, tuberculosis, urine abnormalities, sexually transmitted diseases, and other problems as needed
- Health education and anticipatory guidance
- Care coordination and assistance with access to needed diagnostic and treatment services

To access CHDP families must contact a CHDP provider. To find providers please visit: http://www.dhcs.ca.gov/services/chdp/Pages/countyoffices.aspx.

Child Health and Disability Prevention Gateway

The Child Health and Disability Prevention Gateway is an online Medi-Cal application and enrollment process that occurs during a CHDP visit. CHDP providers can pre-enroll children into Medi-Cal during the child's visit. CHDP Gateway provides immediate temporary, full-scope, fee-for-service Medi-Cal benefits for the month of the visit and the following month.

CHDP providers may grant eligible children immediate, temporary Medi-Cal coverage under presumptive eligibility. Families must request and submit a formal Medi-Cal application to continue to receive services after the temporary coverage is over. For more information on CHDP Gateway please contact a CHDP provider:
http://www.dhcs.ca.gov/services/chdp/Pages/countyoffices.aspx

12. Additional Medi-Cal Information

Renewal and Redetermination

Medi-Cal eligibility is re-determined for all beneficiaries annually during the month in which an individual was found initially eligible. Starting in 2015, renewals will use a pre-populated form and only request information from the individual that is needed after reviewing their current file

If an individual's household size or income changes during the year, they may no longer be eligible for Medi-Cal but qualify to purchase a health plan through Covered California.

Redetermination form: http://www.dhcs.ca.gov/formsandpubs/forms/Forms/mc210rv-eng.pdf

Estate Recovery Program

Since Medi-Cal pays for medical care for some people whose savings and income are too low for them to pay for their own care, the cost of an individual's medical care, or the premiums paid

for care may be required to be repaid to Medi-Cal upon the individual's death. The costs that Medi-Cal will evaluate are those incurred over the age of 55 or for nursing home or long term care incurred prior to the age of 55. Medi-Cal will also not seek reimbursement for services that are also covered under Medicare if the beneficiary is enrolled in a Medicare Savings Program. Repayment is never more than the value of the assets the individual had at the time of death. The amount repaid will be used to pay for medical care for others who need it.

After receiving notification regarding the death of a person who was receiving Medi-Cal benefits, DHCS will decide whether or not the cost of services must be paid back. The amount that has been paid by Medi-Cal and what is left in the estate of the deceased who received services is taken into consideration when making this decision.

If an Application for Hardship Waiver is submitted within 60 days of the date on the Estate Recovery claim letter, DHCS will waive a claim for reimbursement against a beneficiary's estate under the following circumstances:

- During the lifetime of a surviving spouse
- For Medi-Cal benefits provided before the individual's 55th birthday (unless the individual is institutionalized)
- If the individual is survived by a child under 21 years old
- If the individual is survived by a child who is blind or disabled (as defined by the Federal Social Security Act)
- The result of reimbursement would cause substantial hardship to the dependents, heirs or survivors of the deceased individual

For more information on estate recovery please visit:
http://www.dhcs.ca.gov/formsandpubs/publications/Pages/BrochuresMedi-Cal.aspx

How Medi-Cal Eligibility Affects Eligibility for Premium Assistance

Individuals who are eligible for MAGI Medi-Cal are not eligible for a Covered California health plan with APTC or CSR. If an individual's income is on the border of the MAGI Medi-Cal income limit of 138% of the FPL it is possible that some months they will qualify for Medi-Cal and other months qualify for Covered California. In this case the individual would benefit from the bridge plan.

However, when the online application determines that an individual is not eligible for Medi-Cal, or at any point during the application process, the individual can choose to request a full non-MAGI Medi-Cal determination by DHCS. In some instances, the coverage available on a non-MAGI Medi-Cal basis might better fit an individual's health care needs.

While the non-MAGI Medi-Cal determination is pending, the individual can enroll temporarily in a Covered California health plan and use any premium assistance for which they qualify. It is important to know that if it turns out the consumer is not eligible for premium assistance they must re-pay the premium amount up to a certain dollar amount, as indicated below:

Income (for an individual)	Maximum Repayable Premium Amount
Below 200% of the FPL	$600
200 – 300% of the FPL	$1,500
301 – 400% of the FPL	$2,500

If DHCS determines that the individual is eligible for a Medi-Cal program, they would dis-enroll from the Covered California health plan and enroll in Medi-Cal.

BRIDGE PLAN

The Bridge Plan will be deployed sometime in 2014. The Bridge Plan will initially be available only to individuals that, due to eligibility changes, would transition from Medi-Cal or OTLICP to a Covered California health plan. Covered California will certify certain Medi-Cal managed care plans as Qualified Health Plans so they serve as "bridge" plans between Medi-Cal/OTLICP coverage and Covered California health insurance. This will allow individuals whose income is on the border of the income limit to change from Medi-Cal/OTLICP coverage to Covered California and stay with the same health insurance company and provider network to ensure continuity in care if they choose. It would also allow family members to be covered by a single health insurance company with a largely similar provider network. The Bridge Plan will offer low premiums for their marketplace eligible enrollees through contracts as Covered California health plans. These health plans will serve both Medi-Cal eligible individuals and some Covered California consumers.

PUBLIC CHARGE

The definition of a public charge is an individual who is likely to become primarily dependent on the government for support as demonstrated by either the receipt of public cash assistance for income maintenance, or institutionalization for long-term care at the government's expense. Using public benefits like Medi-Cal will not label an individual as a public charge unless Medi-Cal funds are used to pay for long-term care (in a nursing home or other institution). However, being labeled as a public charge can reflect negatively on individuals seeking to become US citizens or legal permanent residents. For more information on public charge and accessing public healthcare please visit: www.nilc.org/document.html?id=464.

USING MEDI-CAL AND OTHER INSURANCES

It is possible to have Medi-Cal and other types of health coverage. In most cases, when an individual is enrolled in Medi-Cal and private or employer-sponsored health insurance, Medi-Cal will pay for services not covered by the primary insurance. Under federal law, anyone currently enrolled in restricted-scope Med-Cal or with a SOC may purchase subsidized coverage through Covered California, because these forms of Medi-Cal are not considered minimal essential coverage under the ACA.

It is not possible to qualify for MAGI Med-Cal and Covered California with subsidized coverage at the same time. However, if a consumer is enrolled in a Covered California health plan and is subsequently determined to be eligible Medi-Cal, they will receive the tax credit for the time they were enrolled in the Covered California health plan.

13. CONCERNS OR COMPLAINTS

Individuals covered under regular (fee-for-service) Medi-Cal who have a complaint may contact their local County Social Services office for help. For a complete listing of offices and phone numbers, contact the Department of Health Care Services at 916.445.4171 or visit www.dhcs.ca.gov.

Individuals in a Medi-Cal managed care plan may contact either the Medi-Cal Managed Care Ombudsman at 1.888.452.8609, or the Department of Managed Health Care at 1.888.466.2219 to report a complaint.

For concerns or questions regarding applications submitted through CoveredCA.com, email Medi-Cal2014@dhcs.ca.gov.

Consumers can also contact their County Social Worker by following this link to find a list of local offices: http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices2.aspx