

County of Los Angeles Department of Public Social Services



MEDI-CAL PROGRAM FACT SHEET

Overview

Medi-Cal is under the jurisdiction of the Department of Health Care Services (DHCS). The Medi-Cal program provides comprehensive medical coverage to certain public assistance recipients and other eligible persons who are unable to afford the cost of their medical care. Individuals receiving public assistance from Supplemental Security Income/State Supplementary Payment (SSI/SSP), Foster Care, and CalWORKs are automatically eligible for Medi-Cal benefits. Other individuals who are aged, disabled, or in a skilled nursing facility may be eligible for benefits under the **Medi-Cal Assistance Only (MAO)** programs.

As a result of the implementation of Health Care Reform (HCR) on January 1, 2014, the Medi-Cal program has been separated into **Modified Adjusted Gross Income (MAGI)** Medi-Cal and Non-MAGI Medi-Cal. Non-MAGI Medi-Cal refers to eligibility programs that existed prior to the implementation of HCR, and continue to provide medical benefits under pre-HCR regulations. MAGI Medi-Cal includes the following new categories: childless adults between the ages of 19 and 64 who are not blind or disabled; pregnant women; parents/caretaker relatives; and children up to age 19. Eligibility for these individuals is based on reported income. Property and resources are not counted under MAGI Medi-Cal. Additionally, implementation of the new MAGI categories eliminated certain programs such as the 1931 (b) program.

Requirements for Medi-Cal Eligibility

The following basic requirements must be met for Medi-Cal eligibility:

• <u>Residency</u>

The person must be a California resident, with the intent to reside in the State of California.

• <u>Citizenship/Immigration Status</u>

To receive full-scope coverage, an individual must be a U.S. citizen or a non-citizen with satisfactory immigration status. The Deficit Reduction Act (DRA) of 2005 requires that individuals declaring U.S. citizenship or U.S. national status must provide original or certified copies of documents that verify their U.S. citizenship <u>and</u> identity. As of January 2010, this requirement may be met by matching a person's information with Social Security Administration (SSA) records. As of January 2014, this information may also be matched through the Federal Data Hub (HUB). Non-citizens without satisfactory immigration status and citizens without proof of citizenship may receive coverage that is limited to emergency, skilled nursing, and pregnancy related care.

Due to the implementation of Senate Bill (SB) 75 in May 2016, all children under 19 years of age are eligible to full-scope Medi-Cal (MC) regardless of immigration status.

<u>Requirements for Medi-Cal Eligibility</u> (continued)

<u>Resources and Property</u>

MAGI Medi-Cal - Resources and Property are not considered in the eligibility determination.

Non-MAGI Medi-Cal - An applicant's non-excluded resources must not exceed the limits, based on family size, as shown below:

1 person\$2,000 2 persons\$3,000 3 persons\$3,150 4 persons\$3,300	5 persons\$3,450 6 persons\$3,600 7 persons\$3,750 8 persons\$3,900	9 persons\$4,050 10 or more\$4,200
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The person's principal residence is not considered in determining resources and eligibility. The individual may also exempt other real property if it is utilized and the net market value (assessed value less encumbrances) does not exceed \$6,000. The value of other real property that exceeds \$6,000 is applied to the family's total resources. Other personal property, such as cash, bank accounts, and non-exempt vehicles are also included in the total resource valuation.

For MAO, the family may choose one vehicle for exemption, regardless of its use. A vehicle used as a home is also exempt for this program. Individuals with resources valued in excess of the limit for their household size are not eligible.

For married persons who need Medi-Cal because one spouse receives long-term inpatient care, the law allows the spouse, at home, to retain a portion of the combined community and separate property. The 2014 Community Spouse Resource Allowance (CSRA) is \$117,240. The CSRA is adjusted annually based on the federal Consumer Price Index.

What is the Cost of Medical Care?

MAGI Medi-Cal

Under MAGI Medi-Cal, there are no costs associated with receiving Medi-Cal benefits. MAGI Medi-Cal beneficiaries are eligible to receive full-scope Medi-Cal benefits without a cost; with the exception of the <u>Optional Targeted Low-Income Children</u> (OTLIC) Program. There are also no co-payments or out-of-pocket costs associated with receiving benefits under MAGI Medi-Cal.

Non-MAGI Medi-Cal

The amount that a family or an individual has to pay for Medi-Cal benefits is determined by the amount of available income that remains after appropriate exclusions and deductions are allowed. Based on income, families and individuals may be eligible to receive Medi-Cal benefits at <u>no cost</u> or <u>with a cost</u>. While there are no income limits for Medi-Cal eligibility, income that remains after all State-allowed deductions are applied must be paid or obligated toward the individual or family monthly medical expense before Medi-Cal will cover expenses.

Non-MAGI Medi-Cal (continued)

This amount to be paid or obligated is called a Share-of-Cost (SOC). Unlike a monthly medical premium, the SOC must <u>only</u> be paid or obligated if Medi-Cal coverage is needed during the service month. Each time a beneficiary receives medical services, the service provider will check the eligibility status to determine how much, if any, is obligated to be paid.

In certain cases, where a third party may be responsible for an individual's injury or illness, DHCS will attempt to recover the cost of medical treatment from the responsible party. For persons with Medi-Cal and Medicare, the primary payer is Medicare and the secondary payer is Medi-Cal.

Subsidized Health Insurance Coverage

Individuals or families that are not eligible under MAGI or Non-MAGI Medi-Cal may potentially be eligible to subsidized health care coverage through Covered California. Subsidized coverage is available in the form of an Advanced Premium Tax Credit (APTC) or Cost Sharing Reduction (CSR) subsidies. APTC provides a tax credit, which is used to reduce monthly health insurance premiums. CSR subsidies reduce out-of-pocket are applied to expenses, such as co-payments and other medical expenses at the time services are provided. Individuals or families with income between 100% and up to 400% of the Federal Poverty Level (FPL) are eligible to receive subsidized coverage.

Which Services are Covered?

Individuals who are eligible to receive full-scope Medi-Cal benefits are entitled to a comprehensive range of health care services, dental care (see Denti-Cal), and prescription drugs (both in and out of a hospital or nursing home) from health care providers who participate in the program. This includes hospice care to alleviate pain and suffering of individuals with a diagnosed life expectancy of six months or less.

Pregnant women may be entitled to benefits that include pregnancy-related services and 60 days of postpartum services at zero SOC. Medi-Cal benefits limited to pregnancy-related services, which include labor and delivery of an infant, and emergency medical services, are available to non-citizens who do not have satisfactory immigration status or citizens with unverified proof of citizenship, if otherwise eligible.

Note: Effective August 1, 2015, pregnant women (U.S. citizen or a non-citizen with satisfactory immigration status), with incomes from 0% to138 % FPL may be eligible to full-scope MAGI Medi-Cal coverage.

DHCS establishes which services are authorized. Before providing and billing for certain benefits, providers of Medi-Cal services may need to obtain authorization from the Medi-Cal Consultant at DHCS. Prior authorization is required for things such as: some dental services, prescription drugs not on the State-approved list, hearing aids, some sickroom equipment, prosthetic and orthodontic appliances, non-emergency hospitalization, nursing home services, and intermediate facility care.

Denti-Cal

Dental services are currently provided as one of the many benefits under the Medi-Cal program. As of May 1, 2014, dental benefits are now available for adults 21 and older.

Denti-Cal (continued)

These benefits cover:

- Exams and x-rays
- Cleanings
- Fluoride treatments
- Fillings
- Anterior root canals (front teeth)
- Prefabricated crowns
- Full dentures
- Other medically necessary dental services

Retroactive Coverage

An applicant may be eligible for Medi-Cal coverage for services received in any of the three months immediately prior to the month of application if all requirements are met for those past months. A beneficiary who is eligible for benefits on the first day of the month is entitled to services for the entire month.

How are Services Received?

A Benefits Identification Card (BIC) is issued to each beneficiary. The BIC must be shown to the provider each time medical services are received. The provider will use the BIC to determine the individual's Medi-Cal eligibility status and SOC obligation. The BIC should be retained even if benefits are subsequently discontinued. In the event that benefits are restored at a later date or upon reapplication, the BIC is reactivated for the beneficiary's use.

Most individuals who are entitled to zero SOC Medi-Cal are required to enroll in a managed care plan. These are private health organizations under contract with the State to provide comprehensive health care services to Medi-Cal beneficiaries. Once enrolled in a managed care plan, an individual must obtain his/her medical care through the plan except for emergencies, or medical services that are not covered by the plan. Certain other groups or persons who have a monthly SOC obligation may receive fee-for-service care from a qualified Medi-Cal provider.

MAGI Medi-Cal

Under the federal expansion of the Medi-Cal program, Medi-Cal eligibility is determined by utilizing the new MAGI methodology. Under the MAGI methodology, the reported tax household composition and income determines eligibility for MAGI Medi-Cal. Under MAGI Medi-Cal, the linkage requirement is no longer considered, and property and resources are exempt from the eligibility determination.

The MAGI categories include the following:

Adults - Childless individuals between the ages of 19-64 with income up to 138% of the FPL.

Parent/Caretaker Relatives – Individuals with children of their own, or with children for whom they are the designated caretaker relative with income up to 109% of the FPL.

Note: Parent/Caretaker relatives with incomes above 109%, but at or below 138% of the FPL may be eligible as Adults.

Pregnant Women – Pregnant women may be eligible to MAGI Medi-Cal benefits based on various income levels that offer both full-scope and pregnancy-related services only. The FPL ranges from 0% up 138% of the FPL for full-scope MAGI Medi-Cal. Pregnant women with income levels above 138% and up to 213% of the FPL are eligible for pregnancy related services only.

Children – Children may be eligible to one of two program categories, depending on age and household income. Under the Affordable Care Act (ACA), children are eligible to either full-scope or restricted benefits based on age, citizenship/immigration status, and the following FPLs:

- Infants 0-1 years of age/0%-208%
- Children 1-6 years of age/0%-142%
- Children 6-19 years of age/0%-133%

The second children's category includes the Optional Targeted Low-Income Children Program, which provides full-scope and restricted Medi-Cal benefits with or without a premium. Premium payments range from \$13 per child with a maximum of \$39 for 3 children or more in a household. Benefits under this category are also based on age, citizenship/immigration status, and the following FPLs:

- Infants 0-1 years of age/209%-266%
- Children 1-6 years of age/143%-160%
- Children 1-6 years of age/161%-266% (premium)
- Children 6-19 years of age/134%-160%
- Children 6-19 years of age/161%-266% (premium)

Non-MAGI Medi-Cal

The following Non-MAGI Programs provide Medi-Cal at zero SOC to certain eligible individuals:

Aged & Disabled Federal Poverty Level (A&D FPL) Program - Provides zero SOC Medi-Cal to income-eligible aged, disabled, or blind persons. To be eligible for this program, the individual must be at least 65 years of age or be considered disabled or blind by SSA criteria, have resources below the MAO limits (see <u>Resources</u>, page 2), and have net countable income at or below 100% of the FPL.

Long Term Care (LTC) – Provides services to individuals receiving inpatient medical care from a long-term health care facility that is expected to last at least one full calendar month after the month of admission. It covers services not covered under other Medi-Cal programs. There are special income and property exemptions under Medi-Cal LTC program.

Former Foster Youth (FFY) Medi-Cal Program - Provides for *automatic*, continuing, full-scope Medi-Cal coverage with no SOC for youth who were receiving Medi-Cal in foster care under the responsibility of any State or tribe on their 18th birthday or at a later age. Income and/or resources are not counted and there is no annual renewal requirement. Medi-Cal coverage continues until the FFY's 26th birthday as long as he/she maintains residency in California. The FFY Medi-Cal program also apply to youth who were <u>not</u> receiving Med-Cal benefits while in foster care on their 18th birthday and are between ages of 18 to 21.

SPECIAL PROGRAMS FOR FAMILIES, WOMEN, AND CHILDREN

The following programs provide Medi-Cal at zero SOC to certain eligible women, families, and children.

Continuous Eligibility for Children (CEC) - Protects zero SOC eligibility for children for up to 12 consecutive months. The SOC protection starts from the initial month of zero SOC eligibility determined at application or at the annual renewal. During the CEC guarantee period, any changes in the family's income or resources which would cause the child to have a SOC or be totally ineligible are disregarded until the next annual redetermination or the child's 19th birthday, whichever occurs first. CEC will protect the child from discontinuance, even if resource changes affect the other family members.

Deemed Eligibility - Provides that infants born to women eligible for and receiving Medi-Cal at the time of the child's birth, are automatically deemed eligible for one year without a separate Medi-Cal application. The birth verification or a Social Security Number (SSN) are not required for the child until age one. This program also provides that such infants shall remain eligible, regardless of any increases in the family's income or resources until the child reaches age one.

Transitional Medi-Cal Program - Provides up to 12 months of zero SOC benefits to families who have lost eligibility to CalWORKs benefits due to increased hours of employment or increased earnings of the caretaker/relative or primary wage earner. Certain eligibility requirements must be met.

Four-Month Continuing Medi-Cal - Allows families who have lost eligibility to CalWORKs benefits due to receipt of, or an increase in child support or alimony to receive no-cost full-scope benefits under certain conditions for four additional months.

SPECIAL PROGRAMS FOR ADULTS

Pickle Amendment Benefits - Under the Pickle Amendment to the Social Security Act, Medi-Cal benefits, at zero SOC, are available to persons who have lost their eligibility for SSI cash benefits due to cost-of-living adjustments in their regular Social Security Disability or Retirement benefits. To be eligible, an individual's countable income must be less than the current SSI payment level, after all cost of living adjustments subsequent to SSI ineligibility due to increased SSA benefits have been disregarded. This program was expanded to include Disabled Adult Children and Disabled Widow(ers).

OTHER SPECIAL PROGRAMS

The programs listed below provide financial or medical assistance to persons who may or may not otherwise be eligible for Medi-Cal benefits.

Child Health and Disability Prevention Program (CHDP) - CHDP is a State and federally mandated program which provides preventive health care to children ages 0-20 who receive Medi-Cal. Children, ages 0-19, who do not receive Medi-Cal but have family income equal to or less than 200% of the FPL, are also eligible for these services.

Eligible children receive services that include periodic assessments and referrals for diagnosis and treatment of suspected health care problems. The primary goal of the program is to keep children and teens healthy through regular check-ups and to find health problems before they become more serious. In Los Angeles County, CHDP services are provided by CHDP-certified fee-for-service providers, Medi-Cal Managed Care providers, County Public Health Centers, and certain prepaid health plans. In Long Beach and Pasadena, the City of Long Beach Health and Human Services and the City of Pasadena Public Health Department also provide these services.

Minor Consent Services - This program provides confidential services to minors related to sexual assault, pregnancy-related services, family planning, sexually transmitted diseases, drug and alcohol abuse, outpatient mental health treatment, and counseling.

250% Working Disabled Program - This program extends Medi-Cal comprehensive services to working, disabled individuals, subject to payment of a monthly premium. Applicants must meet SSI eligibility rules, although their countable net income can be as high as 250% of the FPL. The County determines eligibility and premiums are collected by the State. The monthly premium is set using a sliding scale based on individual income.

Dialysis and Related Services - Limited Medi-Cal coverage is provided to individuals who are ineligible due to property, who need life-sustaining dialysis and related services. Individuals may be obligated to pay a percentage of the treatment costs for services not covered by other health insurance or government programs.

Organ Transplant: Anti-rejection Medication - Allows Medi-Cal beneficiaries to receive up to two years of anti-rejection medication following an organ transplant. The medication is provided at no cost to the beneficiary.

Health Insurance Premium Payment (HIPP) Program - Under the HIPP Program, DHCS will pay health insurance premiums on behalf of certain MAO beneficiaries who have high-cost medical conditions. The Department of Public Social Services (DPSS) refers potentially eligible clients to DHCS for possible participation in the program.

Medicare Savings Programs (MSP)- The Medicare Catastrophic Coverage Act of 1988 requires that States pay the Medicare Part A and Part B cost-sharing expenses of qualified low-income Medicare beneficiaries that include premiums, deductibles, and co-insurance fees.

Qualified Medicare Beneficiary Program (QMB) - Medi-Cal will help pay monthly Medicare Part A and Part B premiums plus deductible and co-insurance fees for certain aged and disabled persons. For Medicare Part A premium coverage under the QMB Program, eligible persons may have income up to 100% of the FPL.

Specified Low Income Medicare Beneficiary Program - Coverage is limited to the payment of Medicare Part B premium, <u>not</u> payment of Medicare Part A premium or the Part B deductibles or co-insurance fees. Individuals may have income above 100% but less than 120% of the FPL.

Qualifying Individual-1 (QI-1) Program - Coverage is limited to the payment of the Medicare Part B premium. It does not pay the Medicare Part A premium or the Part B deductibles, or co-insurance fees. To be eligible for the QI-1 Program, an individual's monthly countable income must be within the 121% - 135% of the FPL. This program has a sunset date of March 31, 2015; however, the QI-1 Program has been extended many times, therefore, we are to continue accepting applications and determining eligibility for the QI-1 Program until the DHCS notifies otherwise.

Qualified Disabled Working Individual (QWDI) Program – Coverage is limited to the payment of Medicare Part A Premium. The individual must be eligible to enroll in Part A, be under 65, have been entitled to disability insurance benefits under Title II, but lost these benefits due to earning which exceeded the Substantial Gainful Activity limit, and continues to have a disabling physical or mental condition, and is not otherwise eligible to Medicare. To be eligible for the QDWI Program, an individual's monthly countable income must be at or below 200% of the FPL.

Medicare Buy-In - Coverage is limited to the payment of Medicare Part B premiums by DHCS for certain eligible aged, blind or disabled Medi-Cal beneficiaries under the Medicare Buy-In agreement with the SSA. As a result of Senate Bill 853, for individuals with a SOC, Medicare Part B premium payment will only be paid after the SOC has been paid by the beneficiary.

Tuberculosis Program - This is an optional program for persons infected with tuberculosis who <u>do</u> <u>not</u> qualify for federally funded Medi-Cal programs. To be eligible, income and resource requirements are applied.

Breast and Cervical Cancer Treatment Program (BCCTP) - This program is administered by DHCS for affected individuals who do not meet the requirements for full-scope, no-cost Medi-Cal. Breast cancer treatment is available to both men and women, while the cervical cancer treatment is available to women only. County staff refers potentially eligible persons to BCCTP for evaluation. The State refers persons who are no longer eligible for BCCTP benefits to DPSS for determination of eligibility under other Medi-Cal programs. For enrollment information, individuals should call the toll-free number 1-800-824-0088.

Assisted Living Waiver Pilot Project (ALWPP) - ALWPP was a three-year pilot project created by State law, AB 499, in 2000. The project was designed to test the efficacy of assisted living as an alternative to LTC nursing provider site placement. The ALWPP is intended to provide options for older adults and individuals with disabilities who want to remain in a community-based setting. The waiver project was renewed in March 1, 2014 for another five years.

OTHER PATHS TO MEDI-CAL

Several programs have been developed by DHCS to facilitate children's access to Medi-Cal benefits and to expedite the application process.

These programs offer either no-cost Medi-Cal benefits for certain seemingly eligible children for a period of 60 days or until a determination of eligibility has been completed; or use an alternate application method to expedite the eligibility determination. The programs that offer expedited access to Medi-Cal benefits are:

CHDP Gateway - Allows potentially eligible children, 0 to 19 years of age, to enroll into temporary, no-cost Medi-Cal benefits through providers at the time of the CHDP examination. Applications must be submitted during the 60-day temporary enrollment period if benefits are to continue. If an application is not returned, the temporary benefit stops at the end of the 60-day period. The exception to this process rule is: no application is required for a CHDP Gateway enrolled infant born to а mother who was eligible to and receiving Medi-Cal in the infant's birth month. The infant remains eligible to receive the temporary benefits until age one or until eligibility under regular Medi-Cal programs has been completed.

Express Lane Enrollment (ELE) - Allows eligible CalFresh beneficiaries, who meet ELE criteria, the ability to enroll into Medi-Cal without the need of submitting a Medi-Cal application. As part of a new HCR rule, CalFresh children and adults under the age of 65, who are not disabled, not receiving Medi-Cal or Medi-Care and who meet eligibility requirements for the CalFresh program, would also be eligible to receive up to 12 months of no cost Medi-Cal.

Hospital Presumptive Eligibility (HPE) – The program was implemented on January 1, 2014, providing temporary zero SOC Medi-Cal benefits for up to 60 days based on self-attested information. To qualify for this program, an individual must be a California resident, not currently enrolled in any insurance affordability program.

Hospital Presumptive Eligibility (HPE) (continued)

The individual must meet the income and household composition requirements for one of the following groups:

- Former Foster Care Children (ages 18-26),
- Children (ages 0-18),
- Parent/Caretaker Relatives,
- Pregnant Women, or
- Adults (ages 19-64 and not eligible for any other mandatory group).

The HPE Medi-Cal application is a one-page application which is reviewed by the authorized personnel in qualified participating hospitals. The HPE application is submitted online via the

Hospital PR portal allowing for a real-time eligibility determination. Enrollment to the HPE program is limited to one enrollment per 12-month period.

Low Income Subsidy Referrals

The "Medicare Improvements for Patients and Providers Act of 2008" (MIPPA), aimed at eliminating barriers to Medicare Savings Program (MSP) enrollments, requires the State to treat the Low Income Subsidy (LIS) applications for Medicare Part D as an application for the MSP. California has also elected to treat the LIS application as an application for Medi-Cal, for which an eligibility determination is required.

Medi-Cal Inmate Eligibility Program (MCIEP)

Inmates who are hospitalized off the grounds of the correctional facility for 24 hours or more for inpatient hospital services may apply for Medi-Cal benefits under the MCIEP. Pending release from incarceration, inmates approved for MCIEP are referred by the Department of Corrections and Rehabilitation (CDCR) to DPSS and re-evaluated for continued Medi-Cal eligibility without the completion of a new application.

Pre-Release Parole Program

Based on an agreement between DHCS and the CDCR, applications for adult inmates who are granted parole will be processed prior to their release. If the inmate is determined to be eligible, the CDCR is notified and a temporary BIC is issued in order for the parolee to access health care upon release.

Suspension of Medi-Cal Benefits for Incarcerated Juveniles

Senate Bill 1147 (SB 1147) was implemented in March 2011. The bill mandates that persons under age 21, who were Medi-Cal beneficiaries at the time of incarceration, are to have their Medi-Cal benefits suspended rather than terminated. The suspension is not to exceed 12 months and affects minors whose incarceration began on or after January 1, 2010. It also requires that Medi-Cal benefits for the incarcerated minor be restored without a new application on the day the eligible juvenile is no longer considered an inmate of a public institution, <u>if released within the 12-month period</u>.

Suspension of Medi-Cal Benefits for Inmates

Assembly Bill 720 (AB 720) amends the suspension requirements in Senate Bill 1147. AB 720 mandates that <u>all inmates</u> who were Medi-Cal beneficiaries at the time of incarceration are to have their Medi-Cal benefits suspended rather than terminated. The suspension is not to exceed 12 months and affects inmates whose incarceration began on or after January 1, 2014. It also requires that Medi-Cal benefits be restored, without a new application, on the day the eligible

Suspension of Medi-Cal Benefits for Inmates (continued)

individual is no longer considered an inmate of a public institution, <u>if released within the 12-month</u> <u>period</u>. AB 720 also requires counties to evaluate for ongoing eligibility when a State inmate receiving Medi-Cal is being released.

My Health LA (MHLA)

MHLA is a no-cost health care program for people who live in Los Angeles County. It is for individuals age 6 and older, whose family's income is at or below 138% of the FPL. MHLA is also free to individuals and families who do not have and cannot get health insurance. Health care services are provided by non-profit clinics called "Community Partners". There are 164 Community Partner clinics in the MHLA program throughout Los Angeles County.