Welcome

How this Webcast Works:
Will be able to view after the broadcast at:
http://hbex.coveredca.com/agents/webinars/
Additionally we will provide a .pdf of this presentation

Introductions:

Crystal Haswell is the Chief of the Outreach and Enrollment Unit within the Medi-Cal Eligibility Division at DHCS. Part of her team's responsibility is to facilitate and develop training for CECs and Agents, as well as validate and coordinate the in-person application assistance payments to CEEs and Agents for approved Medi-Cal applications.

Wanda Mikuni is a project manager in the Outreach and Enrollment Unit at DHCS. She is responsible for the implementation and management of outreach, enrollment, and education efforts of the Medi-Cal populations.

David Mora is a contract manager for the Local Initiative Unit in the Medi-Cal Managed Care Division (MMCD) of DHCS. Currently he performs oversight, monitoring and compliance of the participating Medi-Cal managed care plans. David

began in MMCD more than seven years ago. He first worked as an analyst in the Office of the Ombudsman. He was also the lead analyst for the Rural Regional County managed care expansion last year and provides training and mentorship for new contract managers.

Harold Higgins is a Health Program Specialist II with the California Department of Health Care Services. Since 2010, he has served as the Medi-Cal Eligibility Division (MCED) expert adviser and specialist for the development, implementation, and policy consultation regarding implementing in California the Medicaid eligibility and retention policies of the Affordable Care Act (ACA) of 2010. Prior to his current assignment, Mr. Higgins served as the MCED subject matter expert concerning Medicaid income counting methodologies and Medicaid coverage groups.

John Zapata is Chief of the Residency and County Unit in the Medi-Cal Eligibility Division within the California Department of Health Care Services. Mr. Zapata's areas of responsibility for eligibility policy development within the Medi-Cal program include immigration status requirements, citizenship verification, California residency, institutional status and other areas. Mr. Zapata received a bachelor's degree in Urban Studies and Planning from the University of California, San Diego in 1983 and a Master of Public Affairs from the Lyndon B. Johnson School of Public Affairs, University of Texas at Austin. In his spare time, Mr. Zapata directs a church choir and sings with the Sacramento Choral Society and Orchestra.

Course Objectives

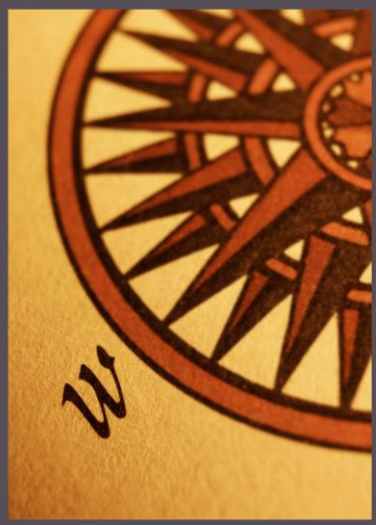
The purpose of the *Medi-Cal Essentials* course is to:

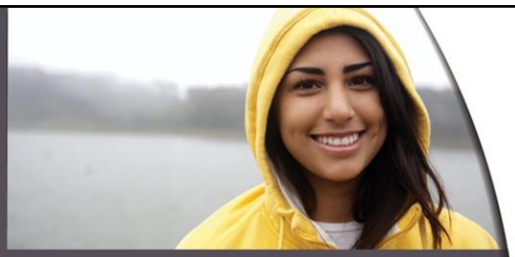
- Describe the changes to Medi-Cal under the Patient Protection and Affordable Care Act (ACA)
- Review the new, simplified eligibility requirements
- Assist with Medi-Cal enrollment through CoveredCA.com
- Answer common FAQs and provide solutions for known issues
- Describe Agent and Certified Enrollment Counselor (CEC) compensation

Course Outline

The ***Medi-Cal Essentials*** course contains the following lessons:

- Medi-Cal Overview
- Medi-Cal Eligibility
- Medi-Cal Enrollment
- Known Issues
- Enrollment Assistance Payment





Medi-Cal Overview

- *Program Highlights*
- *Simplified Application Process*
- *Expansion with ACA*
- *Benefits and Services*
- *Managed Care Plans*
- *FAQs*

DHCS Department of HealthCareServices

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Program Highlights

- **Medi-Cal is California's Medicaid program**
  - Public Health Insurance program
  - Covering low-income individuals since 1966
  - Currently there are > 10 million enrolled in California

Program Highlights

Medi-Cal provides health care services at no or low cost to patients:

- 100% Federally financed with decreasing support to 90% over time
- Administered by the Department of Healthcare Services (DHCS)
- Enrollment is managed through each California county

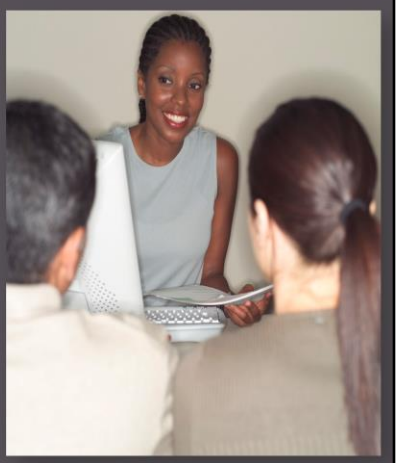
Consumers do not have to wait for a special enrollment period to apply for Medi-Cal through CoveredCA.com.

"No Wrong Door"

- **There is no wrong door when applying for Medi-Cal:**
  - In person at the county social services office where you reside
  - Over the telephone or through mail
  - In person with a Certified Enrollment Counselor or Agent
  - Electronically through Covered California at CoveredCA.com

Expansion with ACA

- **Simplified procedures for Medi-Cal eligibility:**
  - Eligibility based solely on income and family size for adults ages 19-64 (not based on assets or "Asset Test")
  - Previously, the asset limit was $2000 for one person and $3000 for a couple with increases for more family members
- **More people eligible:**
  - 1.5 million more Californians eligible
  - Former foster youth under age 26 are eligible regardless of income
  - Seniors and those with disabilities retain eligibility



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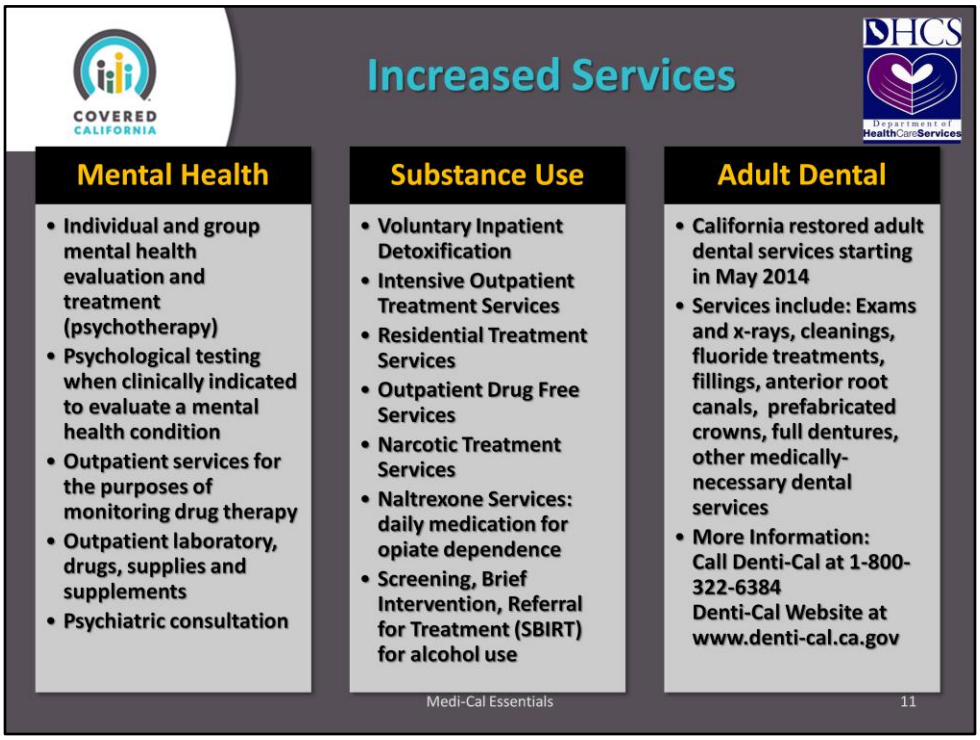
Essential Health Benefits (EHBs)
DHCS
Department of HealthCareServices
10 Essential Health Benefits Provided by Medi-Cal *
Ambulatory patient services
Emergency services
Hospitalization
Maternity and newborn care
Mental Health and Substance Use Disorder Services including Behavioral Health Treatment
Prescription Drugs
Rehabilitative and Habilitative Services and devices
Laboratory services
Preventive and wellness services and chronic disease management
Pediatric services (including oral and vision care)
* These categories of benefits are also available via Covered California, although individual services provided under each category may vary between Covered California and Medi-Cal.
Medi-Cal Essentials
10



Mental Health and Substance Abuse services are approved through DHCS and not the Managed Care provider.

Who is eligible for the expanded outpatient mental health services?

All Medi-Cal beneficiaries, whether in fee-for-service or a managed care plan, are eligible for these outpatient services when medically necessary. The services are provided to beneficiaries who have mild to moderate impairment resulting from a mental disorder.

The expanded outpatient mental health services are distinct from Specialty Mental Health Services. Medi-Cal beneficiaries who have a significant impairment resulting from a mental disorder may qualify for Specialty Mental Health Services provided through the county Mental Health Plan.

Can a beneficiary self-refer for outpatient mental health services, which are not an emergency?

A beneficiary can contact his primary care provider or the managed care plan to be directed to a mental health provider for these services as needed. Some mental disorders can be treated by the primary care provider. Therefore a good first step is for the beneficiary to first see the primary care provider.

What should a beneficiary do if he needs emergency psychiatric services?

The beneficiary can call 911 or go the nearest emergency room. The beneficiary will be evaluated and referred for further mental health treatment and follow-up services which are medically necessary.

How can a beneficiary access Specialty Mental Health Services?

A beneficiary who is identified as having a significant impairment from a mental health disorder will be referred to and can access Specialty Mental Health Services provided by the county Mental Health Plan. In order to qualify for these services, a beneficiary must meet criteria designated in a regulatory statute. Eligibility is determined when the patient is assessed by a mental health professional.

Is there a limit to the Medi-Cal program's outpatient mental health services?

There is no limit to these services, as long as the beneficiary meets the medical necessity criteria.

Where is the alcohol, screening and brief intervention (SBIRT) service offered?

This service is offered by the primary care physicians. If a beneficiary is identified as being at risk for alcohol use disorder, the beneficiary will receive advice or counseling at the primary care office. When a possible alcohol use disorder is identified, the beneficiary will be referred to county services for further evaluation and treatment.

Is there a limit to the alcohol, screening and brief intervention service (SBIRT) service?

SBIRT is a service offered once a year. Beneficiaries are screened yearly and provided up to three brief (5 to 10 minutes) counseling sessions per year. If a beneficiary needs additional evaluation or treatment, the beneficiary is referred to the county alcohol and drug program.

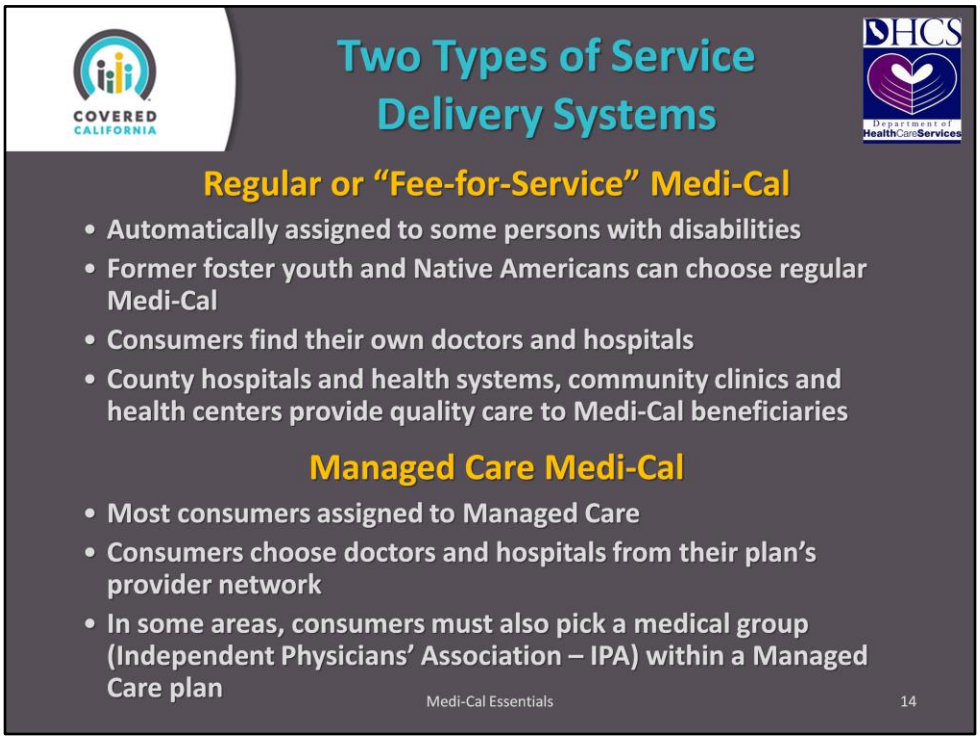
If a pregnant woman applies for coverage on CoveredCA.com, does not qualify for Medi-Cal online, with an income >213% <322% below the FPL, Covered California forwards her contact information to the Medi-Cal Access Program. The Medi-Cal Access Program will contact her directly and ask her if she would like to apply.

Additional Programs: Former Foster Youth

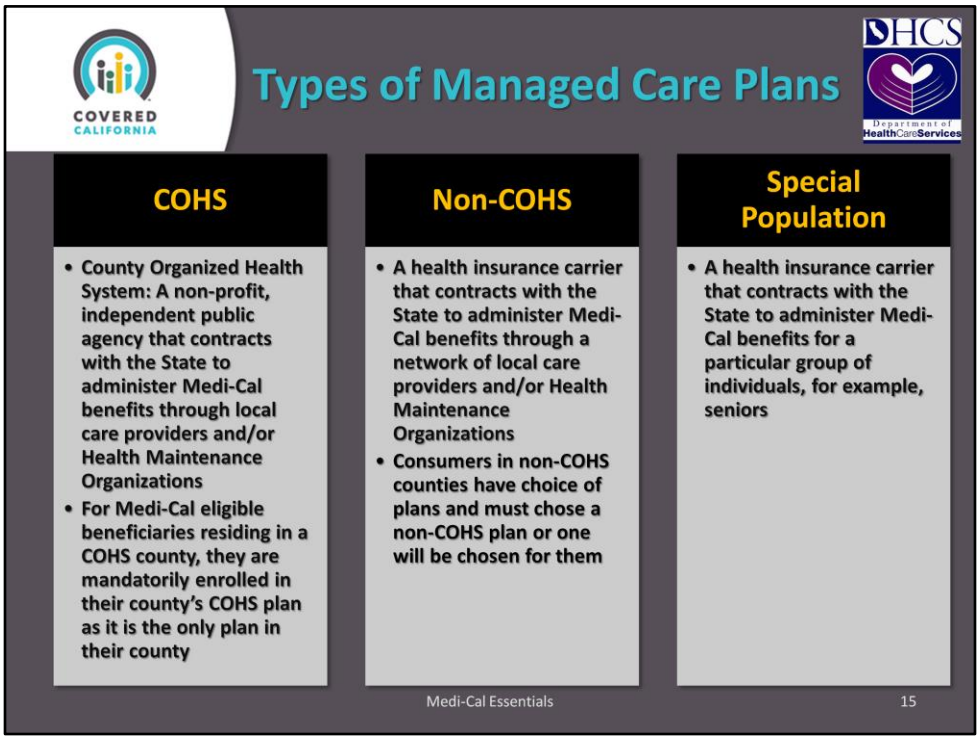
Former Foster Youth are eligible for no-cost full-scope Medi-Cal if they are:

- Under the age of 26; and,
- In foster care and Medicaid (in any state) on their 18th birthday (or later)
- No income or assets test
- Can self-attest to foster youth status to start the process
- Complete MC 250A application available at: http://www.dhcs.ca.gov/formsandpubs/forms/Forms/mc250a.pdf (No need to fill out a full application)

For additional information regarding Former Foster Youth eligibility please visit: www.coveredtil26.org



- FFS was the most common type of Medi-Cal delivery system; as recently as 2010 the majority of Medi-Cal beneficiaries were in FFS. If a consumer has been in Medi-Cal before, there is a good chance that they were in FFS.
- The FFS delivery system is statewide, and beneficiaries can access any provider in the state who accepts Medi-Cal FFS.
- FFS is beneficiary driven; they go to the doctor when they want to and only access the services they believe they need. Some beneficiaries like this flexibility but it leaves a gap in preventative care and services may only be sought once a condition has developed and extensive treatment is needed.
- Since Medi-Cal managed care began expanding in 2010, enrollment into managed care plans now outnumbers FFS enrollment.
- In managed care, coordination of services is done through a Primary Care Provider, which every member has either by choice or assignment. This allows for more preventative care and less duplication of services.
- Managed care members can only see network providers; getting services from out-of-network providers must be approved by the plan or it will not be covered by the plan.



Non-COHS plans:

- May be commercial or Local Initiative (LI) plans. LIs are non-profit, independent public agencies, similar to a COHS plan without the mandatory enrollment.
- Most Non-COHS counties will offer a choice of at least two Medi-Cal managed care plans.
- In Non-COHS counties, some Medi-Cal beneficiaries are voluntary and some are mandatory. Those who are voluntary can choose to either enroll in a plan or go into FFS. Those who are mandatory can choose from any of the Medi-Cal managed care plans that operate in their residence county. If there is no affirmative choice at the time of enrollment, they are assigned to a plan. Medi-Cal beneficiaries can change plans at any time.
- Special Population plans are health plans that contract with DHCS to offer medical services for certain Medi-Cal populations. They are only available is certain counties.
- Senior Care Action Network or "SCAN" plans are Medicare advantage Special Needs Plans for seniors who have both Medicare and Medi-Cal and who reside in Los Angeles, San Bernardino, and Riverside counties. SCAN provides all Medi-Cal services, including home and community based services to members assessed at the Nursing Facility Level of Care and nursing home custodial care, following the member in the nursing facility. The eligibility criteria for SCAN specifies that a member be at least 65 years of age, have Medicare A and B, have full scope Medi-Cal with no share of cost and live in SCAN's approved service areas of Los Angeles, Riverside, and San Bernardino counties. SCAN does not enroll individuals with End Stage Renal Disease.

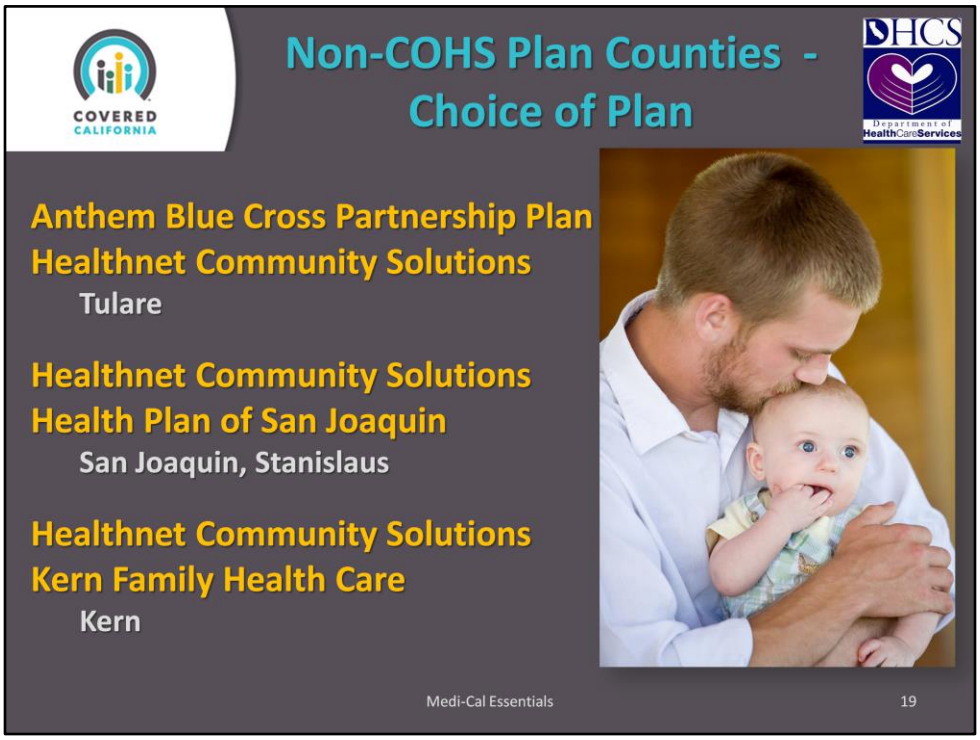
- The Program of All-inclusive Care for the Elderly, or “PACE”, is a health plan for frail seniors that coordinates the care of each member based on their individual needs with the goal of enabling older individuals to remain living in their community. Beneficiaries must be 55 years of age or older, meet the requirement for skilled nursing home care, live in a service area (county and zip code) served by a PACE program, and are able to live in the community without jeopardizing their health or safety.
- Other special populations served by these plans include Medi-Cal beneficiaries who are HIV-positive, and Medi-Cal managed care children with behavioral health needs.

For those Medi-Cal eligible beneficiaries residing in a COHS county, they will mandatorily be enrolled in their County's COHS plan as it is the only plan in that county.

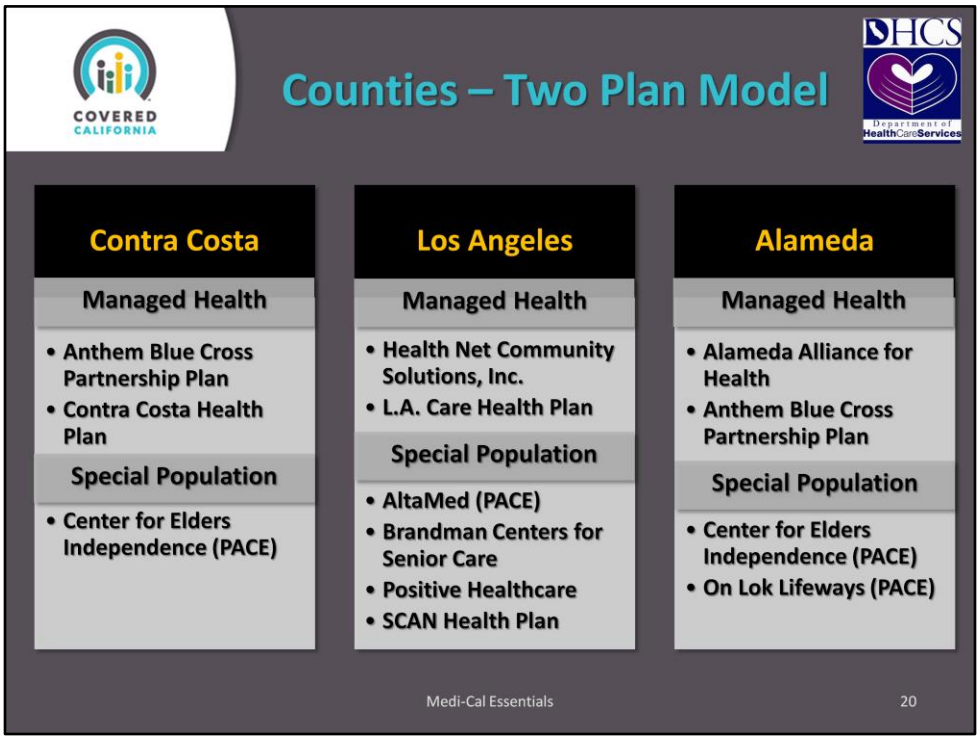
- All Medi-Cal beneficiaries that reside in these counties are automatically enrolled into the COHS plan upon receiving Medi-Cal eligibility.
- Partnership was the only COHS plan to add counties to their service area with the recent expansion of Medi-Cal managed care in rural counties. They added eight counties on September 1, 2013. They are now the largest COHS plan in California in terms of service area. Beneficiaries in these rural expansion counties had only received Medi-Cal through the FFS delivery system before the managed care expansion.
- CalOptima is the largest COHS plan in terms of enrollment, with over 580,000 members. The way they manage this large membership is through subcontracting with other health networks to provide Medi-Cal services to some of their members. They currently subcontract with 11 other health networks: one HMO (Kaiser); three Physician Hospital Consortia (Family Choice Health Network, Children's Hospital of Orange County (CHOC) Health Alliance, and AMVI Care Health Network), and seven physician groups (AltaMed, Arta Western Health Network, Monarch Family Health Care, Noble Mid-Orange County, Prospect Medical Group, Talbert Medical Group, and United Care Medical Group)

- San Benito was one of the counties where Medi-Cal managed care recently expanded, beginning on November 1, 2013. Previous to this, the only Medi-Cal delivery system was FFS.
- Even though there is only one plan in San Benito, it is not a COHS plan because the Medi-Cal plan operating there is a commercial plan, not county run. Also, enrollment is not mandatory for all groups.
- Beneficiaries have a choice between Anthem Blue Cross and FFS.

Consumers residing in these counties need to choose a plan during the plan selection process.
All of these counties used to be FFS only. Managed care expanded here and these plans began operating November 1, 2013.



Consumers residing in these counties need to choose a plan during the plan selection process.



Consumers residing in these counties need to choose a plan during the plan selection process.

- These are also “Two-Plan” counties, where a commercial plan and LI are both available for Medi-Cal enrollment.
- These counties also have Specialty plans operating in them for those populations targeted by these plans (Seniors, Seniors with Medicare, HIV positive beneficiaries).

Consumers residing in these counties need to choose a plan during the plan selection process.

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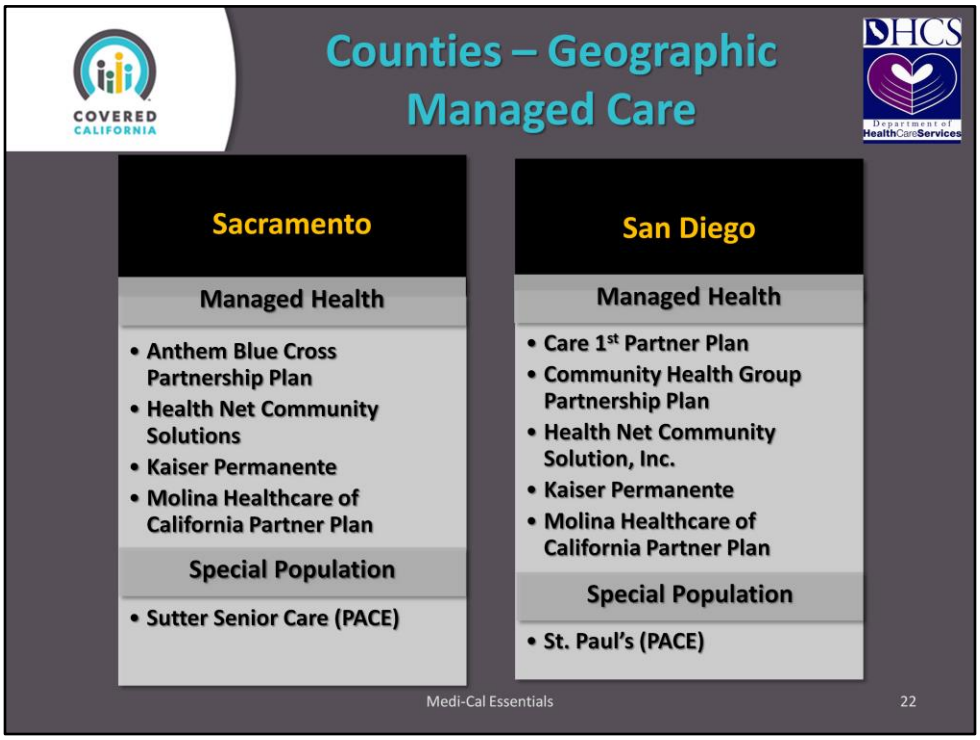


Consumers residing in these counties need to choose a plan during the plan selection process.

These are Geographic Managed Care, or "GMC" counties, where there are multiple commercial plans available for Medi-Cal enrollment. There are no LI or other government-run Medi-Cal managed care plans.

These counties also have Specialty plans operating in them for those populations targeted by these plans (Seniors).

FAQs

Is Medi-Cal free?

Typically there are no monthly premiums, deductibles, prescription costs, or co-payments. Coverage for *some* children in *higher income families* may cost $13 per month, with a $39 limit per family. Also, Pay-for-Service Medi-Cal recipients may be charged $1 by their pharmacy for refills.

FAQs

Does a current Medi-Cal recipient need to reapply through Covered California?

No. All current recipients retain their Medi-Cal coverage. Medi-Cal does require an annual redetermination for all beneficiaries.

When I was uninsured, are my medical bills prior to my Medi-Cal acceptance paid by Medi-Cal?

Medi-Cal will pay for your medical bills for three months prior to your acceptance into Medi-Cal.

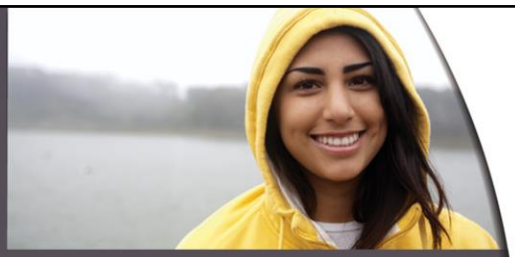
FAQs

Who do you contact if there are any questions regarding Medi-Cal?

Medi-Cal2014@dhcs.ca.gov

The consumer can also contact their assigned 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



Medi-Cal Eligibility

- *How is Eligibility Determined?*
- *Modified Adjusted Gross Income (MAGI)*
- *Federal Poverty Level (FPL)*
- *Residency Requirements*
- *Immigration Status*
- *Eligibility Examples*
- *FAQs*

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How is Eligibility Determined?

Simplified Eligibility:

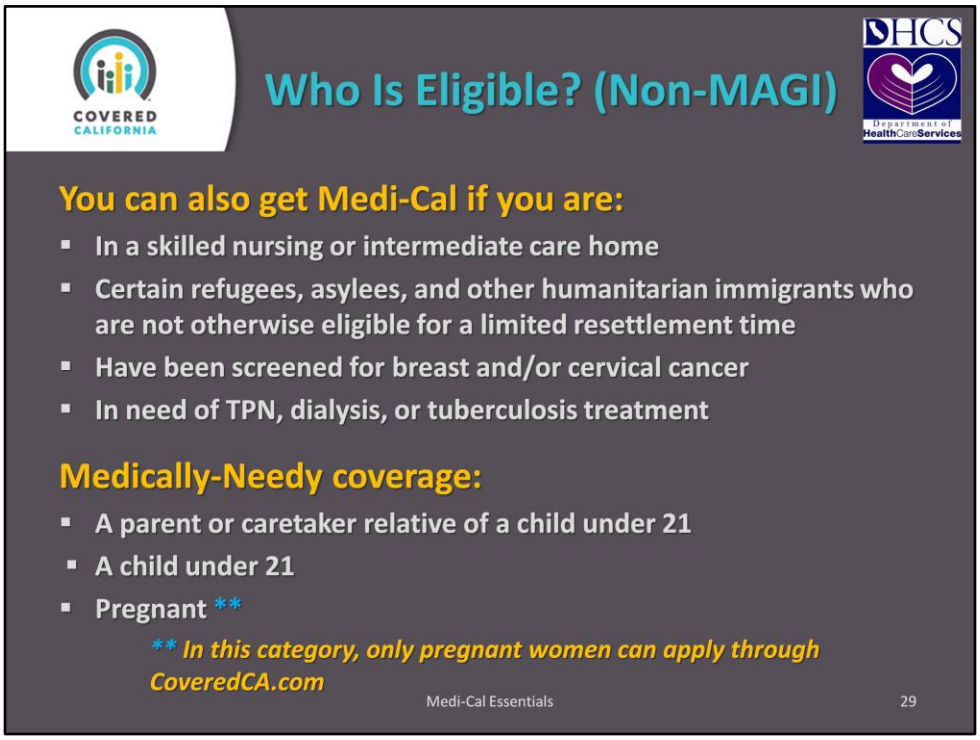
- For most applicants, eligibility is based on Current Monthly Income, Household Size, and Age of applicants
- Current Monthly income is defined by the consumers' Modified Adjusted Gross Income (MAGI) and the Federal Poverty Level (FPL)
- Elimination of the Asset/Property Test
- California State Residency
- Immigration Status

Non-MAGI Eligibility

Eligibility is *not* based on MAGI for individuals who are:

- Participation in a linked program (for example, SSI/SSP or CalWORKS)
- Receiving Title I-VE Foster Care and Adoption Assistance
- Over 65 years old, blind, or disabled*

** You must also meet income and asset tests to qualify. Household size and income are counted differently.*



Total parenteral nutrition (TPN) A solution containing all the required nutrients including protein, fat, calories, vitamins, and minerals, is injected over the course of several hours, into a vein. TPN provides a complete and balanced source of nutrients for patients who cannot consume a normal diet.

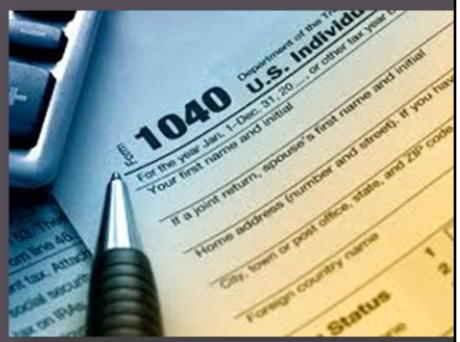
MAGI Eligibility

Medi-Cal eligibility is based on **MAGI** and the Federal Poverty Level (**FPL**) for:

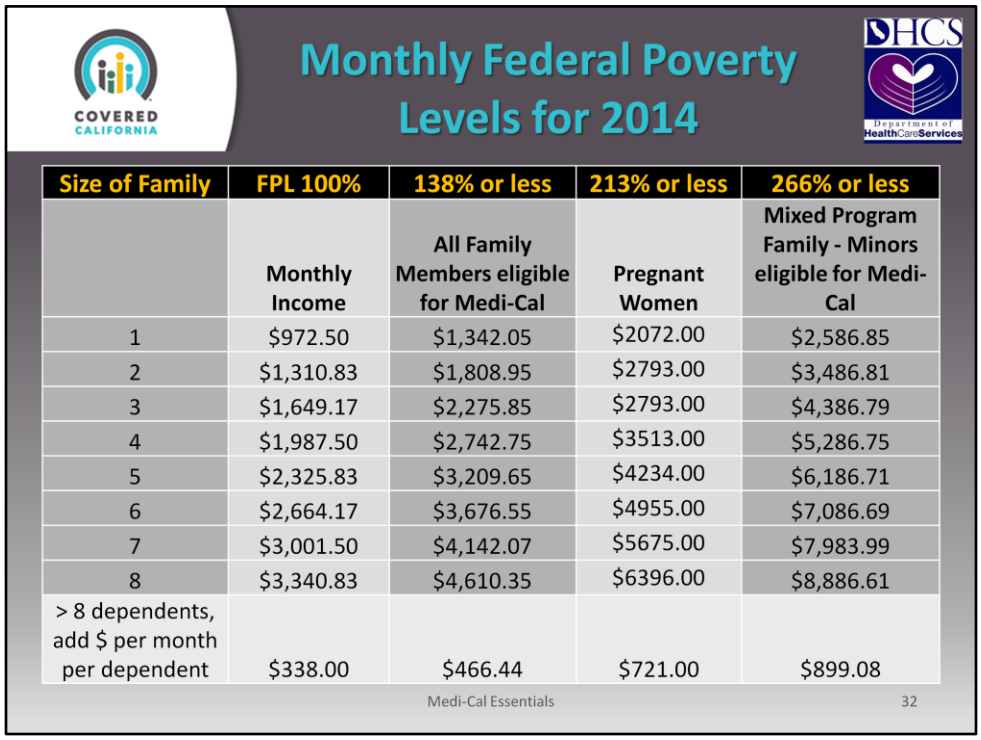
- Adults under age 65, with FPL ≤ 138%
- Children under age 19 with FPL ≤ 266%
- Pregnant women, with FPL ≤ 213%
- Parents and other caretaker relatives, with FPL ≤ 109%

Modified Adjusted Gross Income (MAGI)

- Modified Adjusted Gross Income (MAGI) is used to calculate eligibility for Covered California financial assistance and for Medi-Cal
- Eligibility is calculated by the household MAGI which is governed by IRS, Medicaid, and Treasury regulations



- For most consumers that apply for coverage, MAGI will be equal to their AGI (Adjusted Gross Income)



Refer to: http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-04.pdf for a complete description of all FPL categories.

How to Estimate Monthly MAGI

If your income and family size ***has not*** changed from last year:

1. From your last year's tax return:*

Line 4 from Form 1040EZ
Line 21 from Form 1040A
Line 37 from Form 1040

2. Divide by 12.

3. Compare to FPL Table for Medi-Cal eligibility.

** Some income is added back: Non-taxable interest income, non-taxable Social Security benefits, and non-taxable foreign earned income*

How to Estimate Monthly MAGI

If your income and family size ***has*** changed from last year:

1. Calculate monthly income from all household members.
2. Calculate deductions.
3. Compare to FPL Table for Medi-Cal eligibility.

Household Members – Included on Application

- You
- Your spouse
- Your unborn children (pregnant women/Medi-Cal only)
- Children living with you
- Any child or relative that is a qualifying dependent per tax law

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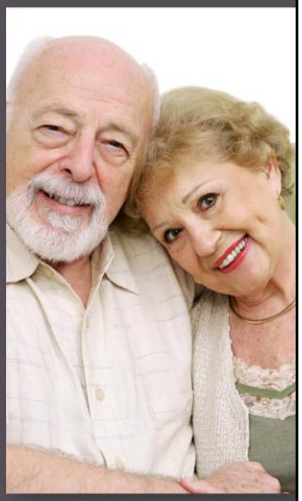
Note that Covered California only counts pregnancy as one person while Medi-Cal counts the mother plus the number of unborn children.

Household Members - Excluded

- Unmarried partner
- Unmarried partner's children if they are not your dependents
- Parents and other relatives who live with you, file their own tax returns, and are not your dependents



Refer to http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/Outreach_and_Enrollment(OE)/HmlessMCEnrllmntTlkit.pdf for more information on residency requirements for homeless.

Current policy temporarily suspends the requirement to provide paper verification of state residency if verification cannot be made electronically. If electronic verification cannot be made, the application will pass state residency without any further verification required.

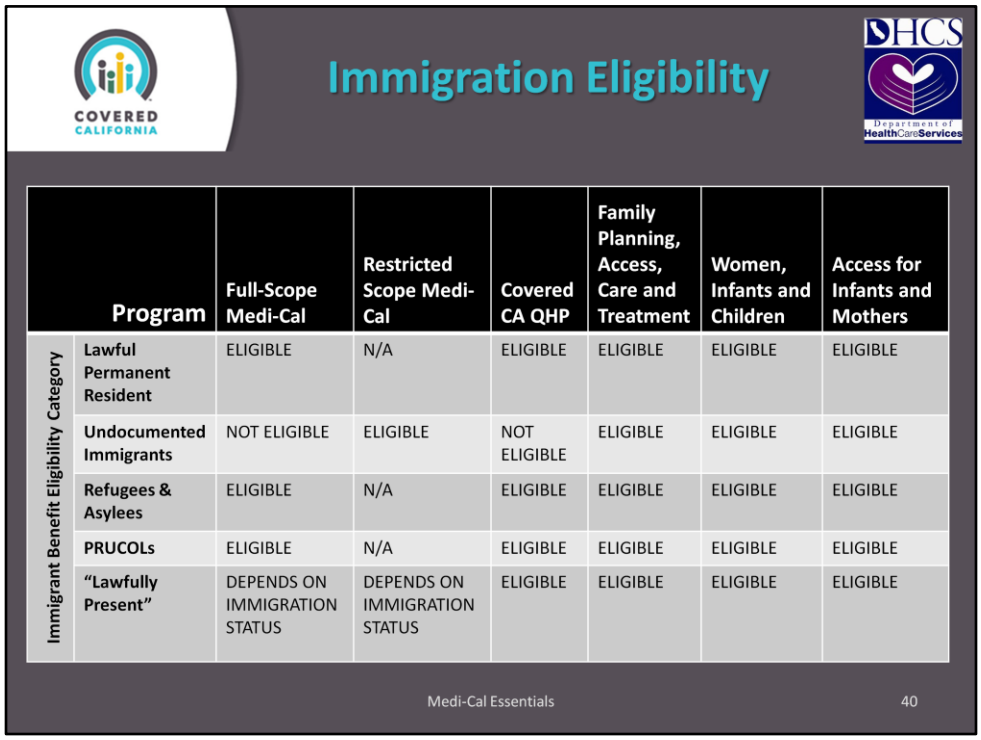
Satisfactory Immigration Status (SIS), for Medi-Cal purposes, means a noncitizen:

- Lawfully admitted for permanent status, or
- A noncitizen permanently residing in the U.S. under color of law (PRUCOL); or
- An amnesty noncitizen.

Immigration Status

Immigrants ***who do not meet SIS*** criteria, including but not limited to undocumented immigrants:

- May still be eligible for restricted scope Medi-Cal, if they meet all eligibility requirements.
- Restricted scope Medi-Cal covers emergency services, health care for pregnant women, and long-term care.
- May be also eligible for breast and cervical cancer treatment program.



	Program	Full-Scope Medi-Cal	Restricted Scope Medi-Cal	Covered CA QHP	Family Planning, Access, Care and Treatment	Women, Infants and Children	Access for Infants and Mothers
Immigrant Benefit Eligibility Category	Lawful Permanent Resident	ELIGIBLE	N/A	ELIGIBLE	ELIGIBLE	ELIGIBLE	ELIGIBLE
	Undocumented Immigrants	NOT ELIGIBLE	ELIGIBLE	NOT ELIGIBLE	ELIGIBLE	ELIGIBLE	ELIGIBLE
	Refugees & Asylees	ELIGIBLE	N/A	ELIGIBLE	ELIGIBLE	ELIGIBLE	ELIGIBLE
	PRUCOLs	ELIGIBLE	N/A	ELIGIBLE	ELIGIBLE	ELIGIBLE	ELIGIBLE
	"Lawfully Present"	DEPENDS ON IMMIGRATION STATUS	DEPENDS ON IMMIGRATION STATUS	ELIGIBLE	ELIGIBLE	ELIGIBLE	ELIGIBLE

Examples of two types of "Lawfully Present" individuals and the resulting eligibility differences: a lawfully permanent resident is eligible for full scope Medi-Cal while a Visa holder is eligible for Restricted Scope.

Immigration Eligibility

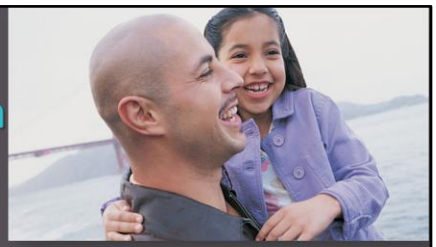
Program		Full-Scope Medi-Cal	Restricted Scope Medi-Cal	Covered CA QHP	Family Planning, Access, Care and Treatment	Women, Infants and Children	Access for Infants and Mothers
Immigrant Benefit Eligibility Category	**Deferred Action for Childhood Arrivals (DACA)**	ELIGIBLE	N/A	NOT ELIGIBLE	ELIGIBLE	ELIGIBLE	ELIGIBLE
	Survivors of Human Trafficking or Serious Crimes	ELIGIBLE	N/A	ELIGIBLE	ELIGIBLE	ELIGIBLE	ELIGIBLE
	Other Non-immigrant Visa Holders	NOT ELIGIBLE	ELIGIBLE	Depends	Depends	Depends	Depends

Mixed Program Families

Families may find that some household members qualify for Medi-Cal while other family members qualify for premium assistance and cost-sharing subsidies through Covered California.

For example, there are families with children eligible for Medi-Cal and parents eligible for premium assistance because children are eligible for Medi-Cal at significantly higher income levels (< 266 % FPL) than for adults (< 138% FPL).

Example 1 – Mixed Program



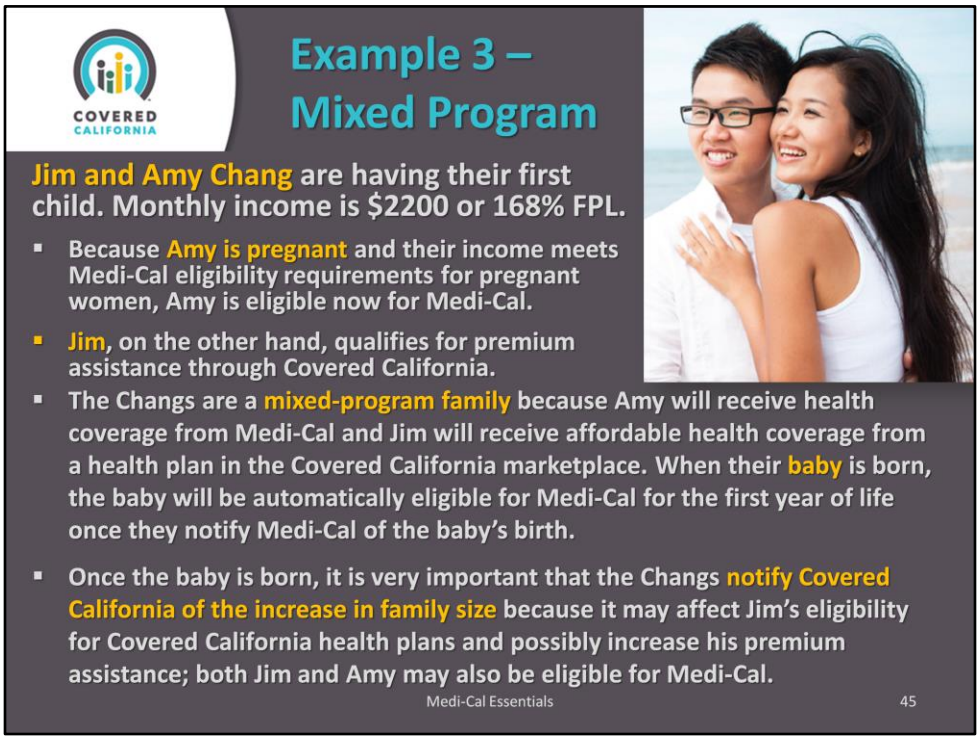
Anthony, a 35-year old father, has one minor dependent (under age 19) and projects his yearly household income for 2014 to be $40,000 ($3333 per month or approximately 260% of the Federal Poverty Level). Anthony lives in El Dorado Hills (95762).

- **Anthony:** is eligible for a Covered California health plan with premium assistance. Anthony selects the lowest premium Silver-level health plan (full cost $378). Anthony pays $274 a month, after applying the $104 of premium assistance.
- **Anthony's Child:** Anthony's child is eligible for low-cost Medi-Cal coverage. For Anthony's zip code, his child may receive Medi-Cal coverage from Anthem Blue Cross, Kaiser Permanente, or California Health & Wellness at $13 per month.
- **Anthony** selects the lowest premium Silver-level plan for himself and a Medi-Cal plan for his child, bringing his total premium for himself and child to $287 per month.

Example 2 – Mixed Program

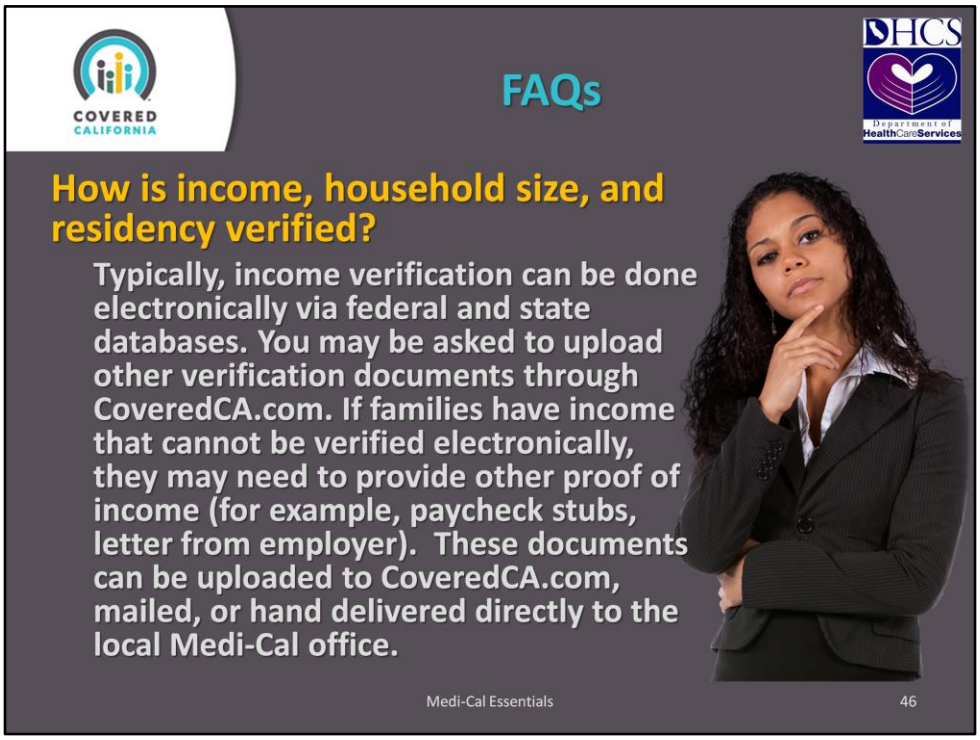
The Aquino Family wants health coverage. The parents, Joe and Angela, are currently uninsured but their two children are enrolled in Medi-Cal. Monthly income $4500 or 226% of FPL.

- Joe and Angela are **eligible for premium assistance** if they enroll in a private health plan through Covered California.
- Joe and Angela's **children will continue to have Medi-Cal coverage** through a Medi-Cal managed care health plan.
- Joe and Angela may be able to enroll in the **same health plan their children** are in depending on what Medi-Cal plans and Covered California plans are available in their county.



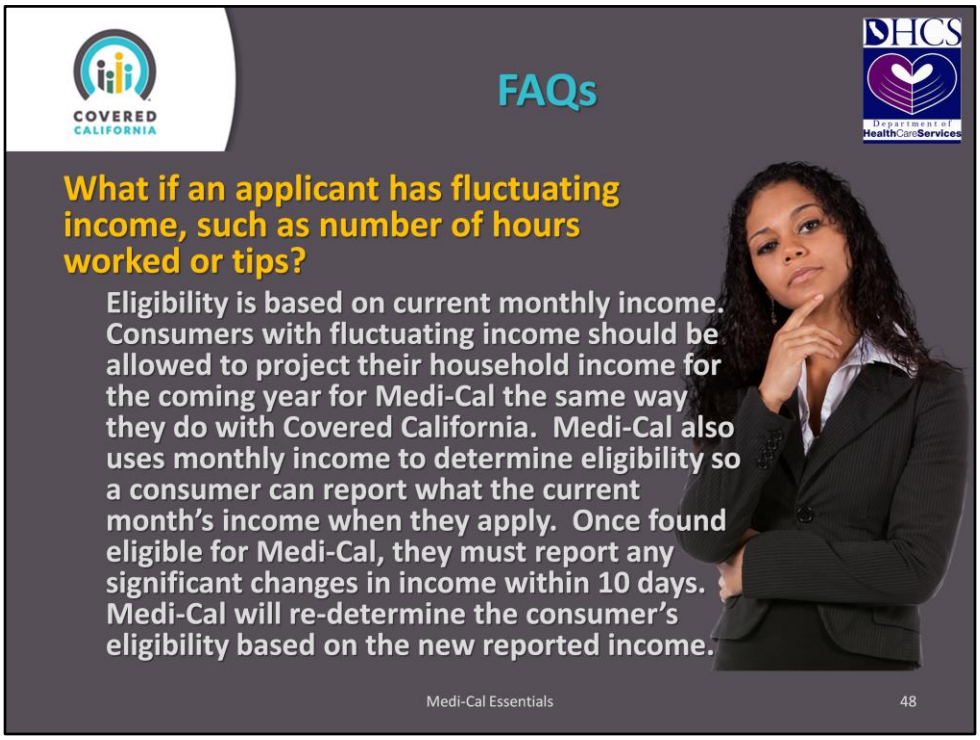
If Amy is not receiving MEC through Medi-Cal, she can also apply for a Covered California plan.

Effective 1/1/2015, Medi-Cal will pay the CC QHP premiums, co-pays, and deductibles if the pregnant women selects this “wrap” participation.



Current policy temporarily suspends the requirement to provide paper verification of state residency if verification cannot be made electronically. If electronic verification cannot be made, the application will pass state residency without any further verification required.

Covered California plans require 30-day notification.



Note that the CoveredCA.com application does not ask the "Does your income change month to month?" question, as does the paper application from Medi-Cal.

FAQs

How often is Medi-Cal eligibility re-determined?

On the anniversary month when eligibility was determined.

How can I be dis-enrolled in Medi-Cal prior to the annual re-determination?

Yes. If your income or household size changes during the year, you may lose your Medi-Cal coverage and be eligible to purchase new coverage as a qualifying event during either the special or open enrollment period.

FAQs

Is everyone 65 years and over be eligible for Medi-Cal?

- No, but many low-income people over 65 are eligible for Medi-Cal.
- MAGI Medi-Cal covers individuals 65 years and over if they are a parent or caretaker relative and are eligible for the MAGI parent/caretaker relative coverage group.
- For those not included in the parent/caretaker relative group, the county will re-determine these individuals for non-MAGI coverage groups prior to their 65th birthday.
- Seniors over 65 can have both Medicare and Medi-Cal at the same time. Medi-Cal can help pay for Medicare for some people.

FAQs

Are people over 65 eligible for APTC if they have Medicare?

No. People over 65 are eligible for APTC if they qualify, but not if they have Medicare. Remember, there are penalties for individuals who do not enroll in Medicare when they qualify.

FAQs

What is the Estate Recovery Program?

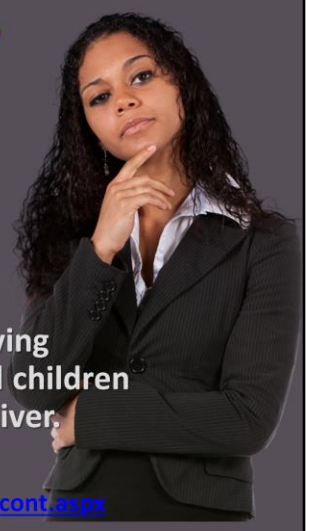
Upon your death, the State may recover from your estate all Medi-Cal costs of care you incurred:

- over the age of 55, or for
- nursing home or long term care you received prior to the age of 55.

Certain family members, including surviving spouses, children under 21, and disabled children can file for an exemption or hardship waiver.

For more information, please go to:

http://www.dhcs.ca.gov/services/Pages/TPLRD_ER_cont.aspx



FAQs

Can a consumer enroll in a Covered California health plan and receive Medi-Cal as a secondary insurer?

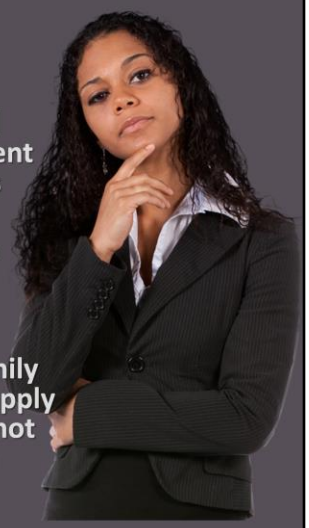
- Under federal law, anyone currently enrolled in Medi-Cal coverage that provides limited scope of services or coverage associated with a share-of-cost spend-down requirement, may also enroll in and purchase subsidized coverage through Covered California.
- Women with pregnancy-related Medi-Cal are not subject to tax penalties in 2014; undecided for 2015-on.
- Medi-Cal limited scope of services or share of cost coverage are not considered to meet the minimum essential coverage (MEC) requirement.

FAQs

Is loss of Medi-Cal coverage a qualifying event?

Yes. Because Medi-Cal is minimum essential coverage, loss of Medi-Cal is a qualifying event allowing a special enrollment period for this family to enroll in a Covered CA plan.

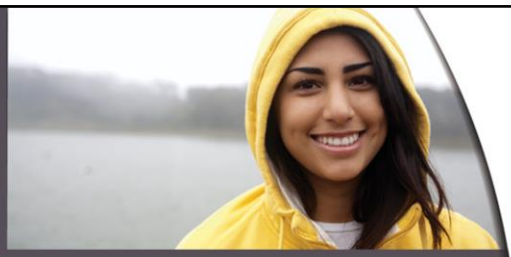
If a family's income increases so they are no longer eligible for Medi-Cal, Medi-Cal will inform them of their last date of Medi-Cal. Medi-Cal will then transfer the family's information to Covered California so the family can enroll in a Covered California plan and apply for premium assistance. The family should not be required to start a new application if the original application was entered in CoveredCA.com.



FAQs

Can a consumer decline Medi-Cal, enroll in a Covered California health plan, and receive the federal premium assistance?

Under federal law, anyone currently enrolled in or are eligible for Medi-Cal is ineligible to purchase subsidized coverage through Covered California. If eligible for Medi-Cal, health coverage can be purchased through Covered California, but with no premium assistance to reduce cost; full cost of the Covered California health care plan's premium must be paid.



Medi-Cal Enrollment

- *How to Apply*
- *Process Overview*
- *Help with the Application*
- *Verification Documents*
- *FAQs*

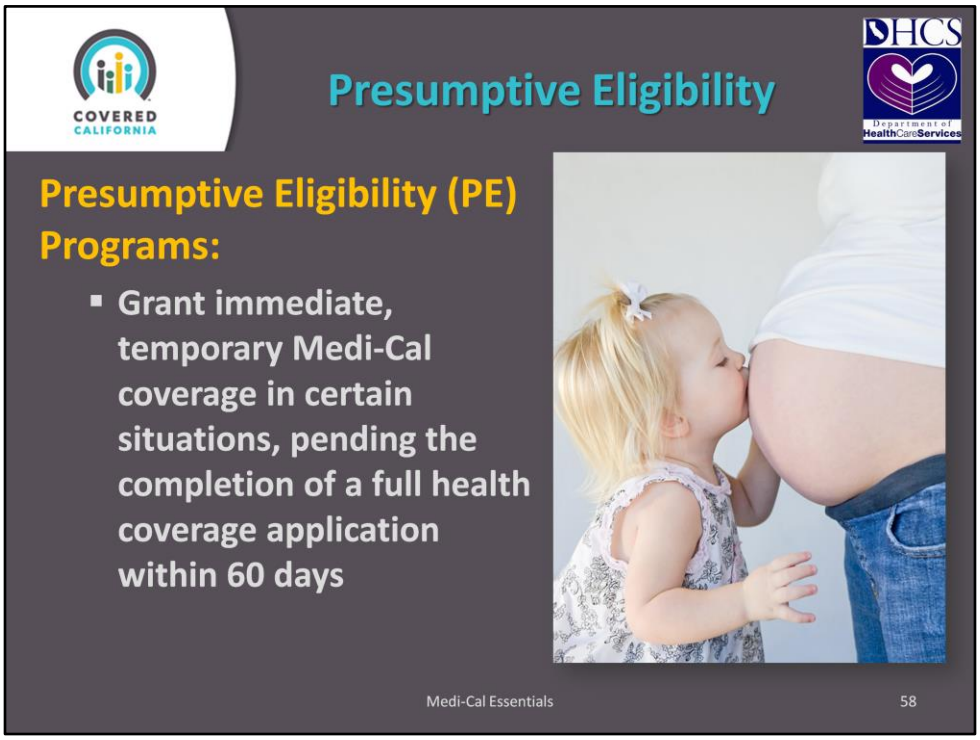
DHCS Department of HealthCareServices

COVERED CALIFORNIA

New Way to Apply

Online through CoveredCA.com

- Electronic processing and verification
- May not need to go into county social services office for verification
- Income or household changes can be made online
- Annual re-assessment may be done electronically



PE is granted without requiring the submission of an application. The submission of a completed application is due within 60 days of coverage. If consumers apply within the 60-day time requirement, PE will continue during adjudication. If a complete application is not submitted within 60 days, PE will be dropped.

Presumptive Eligibility Programs

- The **Hospital PE** program allows qualified hospitals to grant immediate, temporary Medi-Cal coverage to individuals
- The **PE for Pregnant Women** program allows qualified providers to grant immediate, temporary Medi-Cal coverage for ambulatory prenatal care and prescription drugs for conditions related to pregnancy for low-income, pregnant patients
- The **Child Health and Disability Prevention Program (CHDP)** allows qualified providers to grant to children immediate, temporary Medi-Cal coverage for full-scope of services provided by Medi-Cal.

PE providers enroll consumers, not the county or CoveredCA.com.

Express Lane

- Individuals receiving CalFRESH benefits are able to enroll in Medi-Cal without completing an application due to their income and residency already being verified by the CalFRESH program.

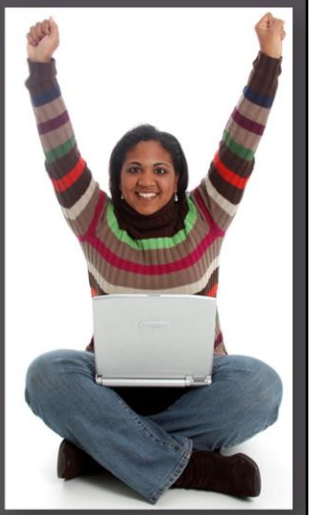
Applications are only received through the counties, not CoveredCA.com.

Eligibility may be granted or pended if electronic verification fails.

Children are not “pended”, though parents may be pended for income or state residency verification.

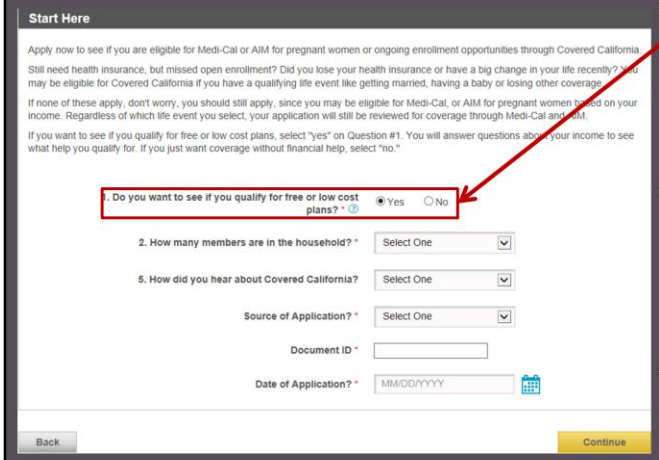
Application Process Overview CoveredCA.com

6. Applicant is informed of program acceptance on CoveredCA.com, is assigned a County Social Worker, and receives Medi-Cal card and welcome packet.
7. Applicant choses Managed Care provider, if needed. Current beneficiaries will be sent a choice packet in the mail to select a health plan.



Note on 6. Applicants will also receive a Notice of Action in the mail (if mail was specified as preferred communication method) notifying applicants of eligibility. For applicants who applied through CoveredCA.com, the notice will also be displayed in their account.

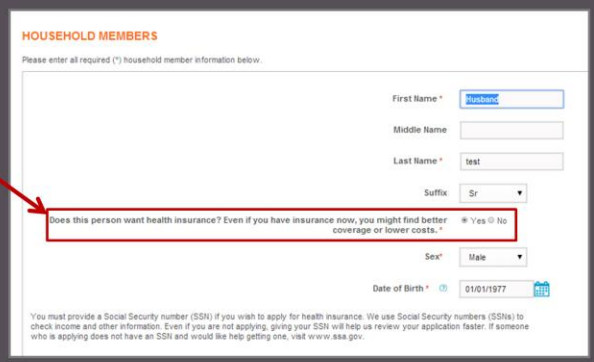
Tip 1: Start Here Page



- Always select **Yes** if Consumer wants financial help from Covered California or wants to enroll in Medi-Cal.
- Only check **No** if the consumer definitely does not want to receive premium assistance or Medi-Cal (if eligible).
- If the consumer began the application online, the Agent ***will not*** be able to view this response.

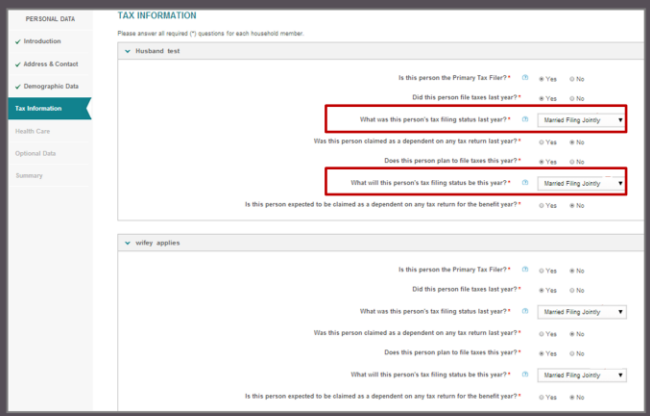
Tip 2: Household Members

- When submitting an application with children, answer **Yes** to this question. This will enable the system to process the parents' eligibility for Medi-Cal also.



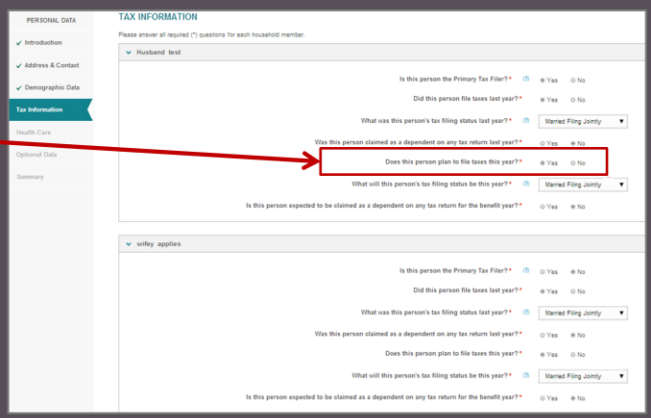
Tip 3: Tax Information

- Married couples must always choose **Married Filing Jointly** if they are on the same application.



Tip 4: Tax Information

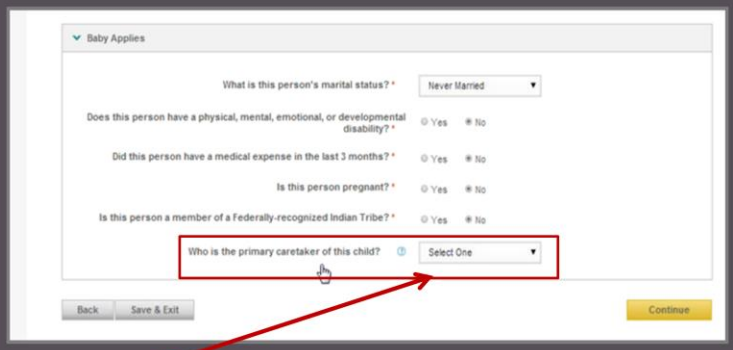
- In order to be eligible for tax credits, the **Primary Tax Filer** must check **Yes** to **Does this person plan to file taxes this year?**



Tip 5: Tax Information

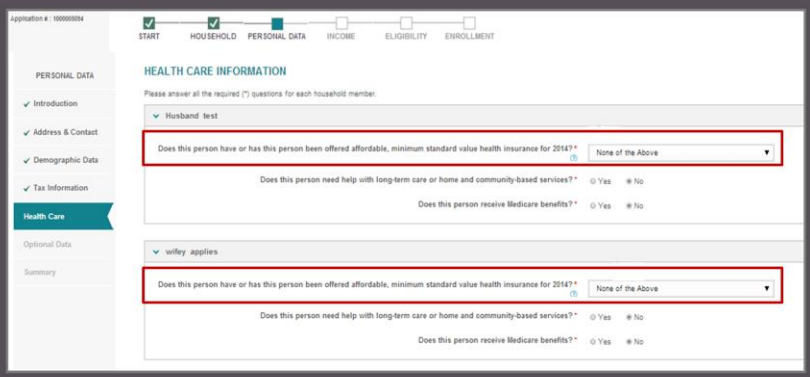
- The spouse **should *not*** be marked that they are claimed as a dependent.

Tip 6: Tax Information



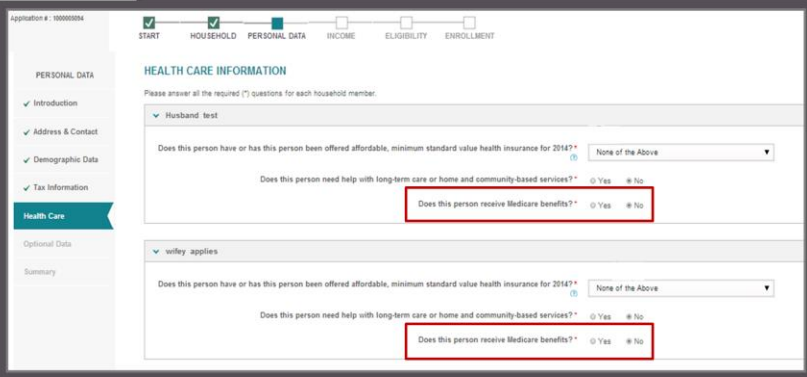
- **For children,** select the primary tax filer individual as the primary caretaker of the child from this drop down, to qualify the child for affordable, minimum standard value health insurance through Covered California.

Tip 7: Health Care Information



- Select **None of the above** in Health Care Information page to qualify for affordable, minimum standard value health insurance through Covered California.

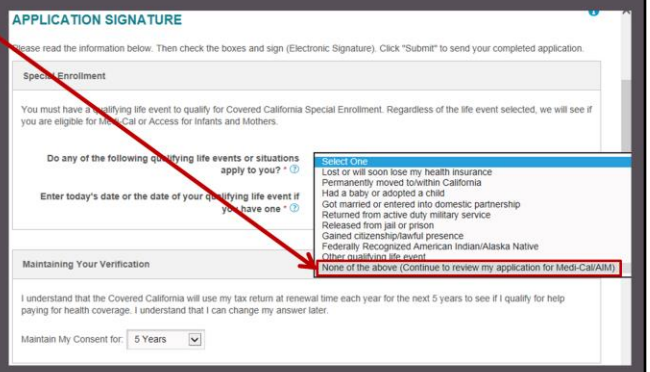
Tip 8: Health Care Information



- If the person receives **Medicare** benefits, they ***will not*** qualify through this application; they must go to the county social services office to apply.

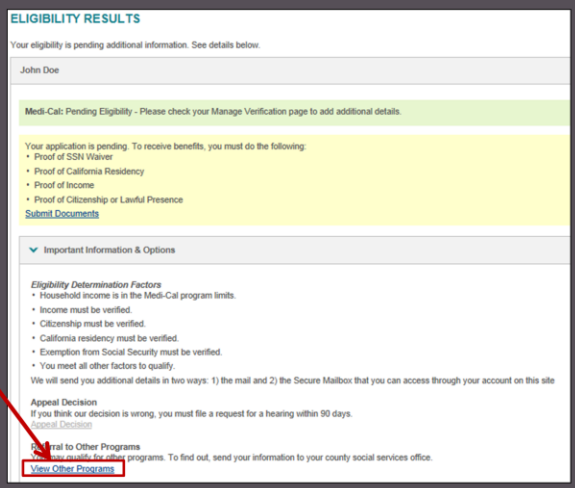
Tip 9: Application Signature

- New Applicants are required to provide the **Qualifying Life Event** during the Special Enrollment Period (SEP).
- Select **None of the above (Continue to review for my application for Medi-Cal/AIM)**.



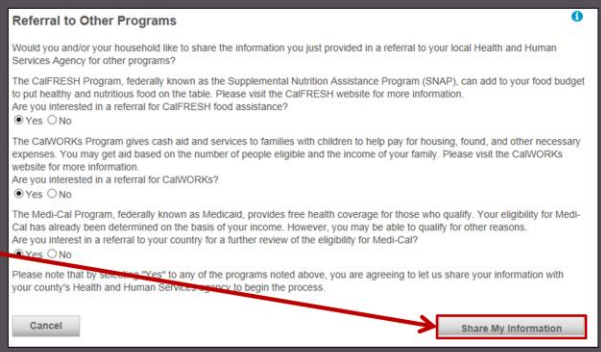
Tip 10: View Other Programs

- Applicants who may qualify for Medi-Cal will receive the option to apply for other programs available through DHCS. Click **View Other Programs**.



Tip 11: Referral to Other Programs

- Select **Yes** next to any or all programs to receive a referral.
- Click **Share My Information** to proceed.



Current policy temporarily suspends the requirement to provide paper verification of state residency if verification cannot be made electronically. If electronic verification cannot be made, the application will pass state residency without any further verification required.

FAQs?

How does Medi-Cal determine the eligibility date?

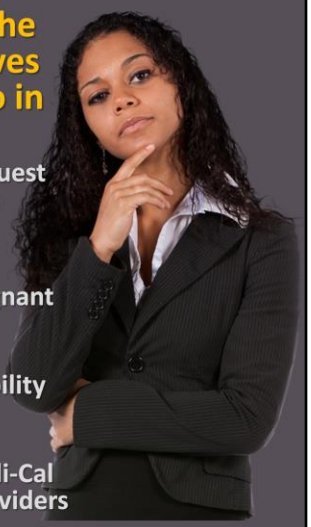
- The eligibility date is the application submission date and, if found eligible, coverage would go back to the first day of the month of submission. This is very important and different from Covered CA.
- Individuals with medical bills accrued 90 days prior to the application date can request retroactive eligibility to pay those bills. Retroactive eligibility can only be made at the county social services office.

FAQs

Medi-Cal may take 45 days to finalize the application before the consumer receives their card. What does the consumer do in the interim?

If a consumer needs care immediately, they can request immediate care through their county social services office. They can also use the following avenues:

- Some hospitals can provide presumptive eligibility Medi-Cal coverage for adults, pregnant women, children, and former foster care enrollees, regardless of coverage.
- Pregnant women can get presumptive eligibility Medi-Cal coverage from certain Medi-Cal providers and clinics.
- Children can get presumptive eligibility Medi-Cal coverage provided by enrolled Medi-Cal providers and clinics seeing children.



FAQs

What if a consumer has not received a card in 45 days?

Consumers who have been waiting more than 45 days can file for an appeal to receive a decision. If a consumer has an immediate health need, they should contact the county to get enrolled or request an expedited appeal if unsuccessful with the county.

FAQs

Is there any way to cancel an application that has already been submitted if the consumer changes their mind?

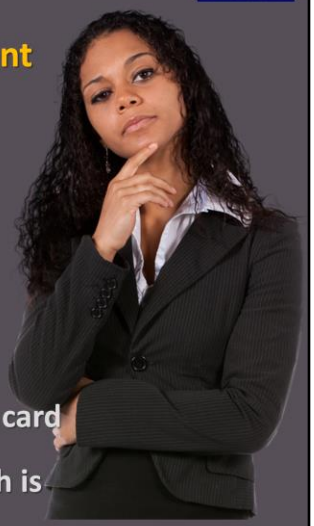
The "Withdraw Application" link is available on the consumer home page after an application has been submitted. With Medi-Cal, consumers must also write to their county social services office requesting to withdraw their application.

Examples are pregnancy only coverage and medically-needy coverage.

FAQs

An applicant has an old Legal Permanent Resident (LPR) Alien Card without a 9-character "Alien Number", no 13-character "Card Number", and no "Expiration Date". What should be entered in the required fields?

- Enter the following values:
  - Alien Number: 999999999
  - Card Number: ZZZ9999999999
  - Expiration Date: 12/31/9999
- Applicants can upload a copy of the LPR card or the county will request proof of immigration status if no electronic match is found.



FAQs

Can an Agent and an applicant work on application online at the same time?

No. Print a copy of the application and work with the consumer from your printed copy.

Can I view an applicant's Secure Mailbox in CoveredCA.com?

No.

FAQs

Can I upload verification documents for an applicant?

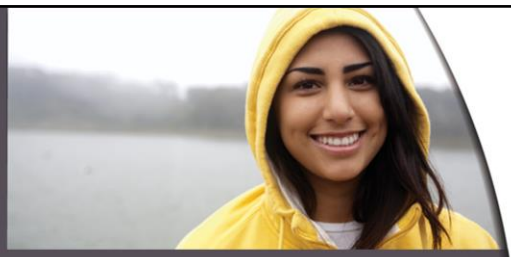
Yes, in Word, Excel, PDF, JPG, and TIF formats. File size limit is 5MB.

What if the consumer is unemployed and has no proof of income documents?

Consumers can provide a sworn statement (Attestation) of their income.

Can I email or fax the verification documents?

You cannot email the documents, but you can fax the documents to Covered California at 916-636-3400. Processing times may increase.

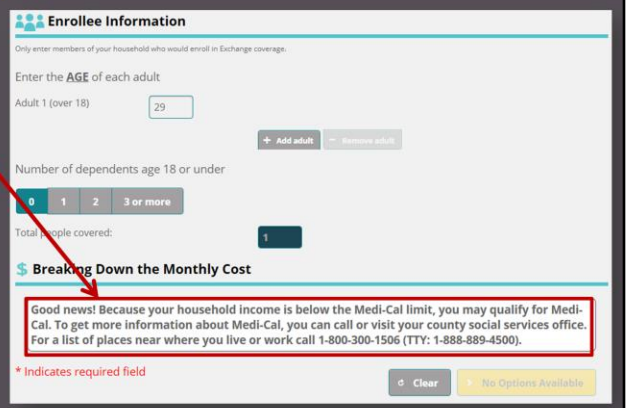


Known Issues

- *Shop and Compare*
- *Mixed Family – Does not Want Medi-Cal for Children*
- *Appeal Decision*
- *Uploading Documents Children Already on Medi-Cal*
- *Former Foster Youth*

Shop and Compare Tool Message

When using the **Shop and Compare Tool** on CoveredCA.com, a consumer may receive this message if their income and household size seem to meet Medi-Cal requirements. Consumers may believe that they cannot apply online.



Mixed Program Family – Does not Want Medi-Cal

If the children in the family are eligible for Medi-Cal but the parents do not want them on Medi-Cal, can they waive eligibility?

- **Solution 1 - No.**
  On the application, select **NO** ***"Would you like to see if you can get financial help paying for your health insurance?"*** No family members will be eligible for APTC; all premiums will be at full cost.

Mixed Program Family – Does not Want Medi-Cal

- **Solution 2 - Yes.**
  Fill out **two applications**. On **Application 1**, household size includes the parents and children, but select that the children do not want insurance. Select **YES "Would you like to see if you can get financial help paying for your health insurance?"** The parents will be eligible for APTC.

  On the children's application, **Application 2**, household size includes the parents and children, but select that the parents do not want insurance. Select **NO "Would you like to see if you can get financial help paying for your health insurance?"** The children will not be eligible for APTC; all premiums will be at full cost.

Upload Verification Documents for the Applicant

What do I do if I am having difficulty uploading the Verification documents?

- **Solution 1.** Some users have reported this problem when using Internet Explorer 8. Close IE8 and try another browser, such as, Google Chrome, Firefox, or Safari.
- **Solution 2.** Go to the "Manual Verifications" page in CalHEERS, select the individual, update the "Pending" status to "Pass" and "Redetermine Eligibility". Afterwards, either attempt to upload the documents or wait to send directly to the county worker handling the case.

Children Already on Medi-Cal

If the children are already on Medi-Cal, how does an applicant answer the question, **"Does this person want health insurance?"**

Answer **Yes** for the children so that the adults may qualify for MAGI Medi-Cal.

Appeal Decision

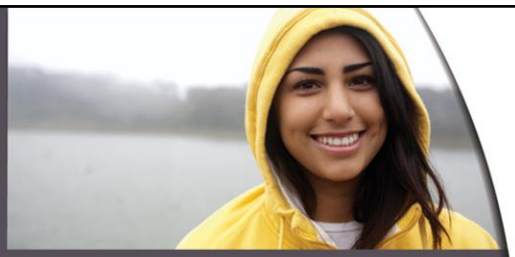
When the Appeal Decision link is selected, nothing happens. How can an Appeal be made?

The consumer needs to **contact** the **Service Center, Hearings Division of DPSS,** or their **local county social services office** to initiate the appeal.

Refer to and complete the Notice of Action Back 9 http://www.dss.cahwnet.gov/cdssweb/entres/forms/English/NABACK9.PDF to initiate an Appeal.

Former Foster Youth

- Former foster youth should apply for Medi-Cal coverage through the county directly, rather than through Covered California, using the one-page MC 250A form available at: http://www.dhcs.ca.gov/formsandpubs/forms/Forms/mc250a2014.pdf
- Expected CalHEERS programming changes will allow former foster youth to skip income and other questions that do not factor into their eligibility for coverage and will allow CalHEERS to determine eligibility for the Former Foster Care Children's Medi-Cal Program.



Enrollment Assistance Payment

- *Overview*
- *How Much Funding is Available?*
- *Payment Eligibility*
- *Who Pays?*
- *How and When?*
- *Payment Tracking*
- *FAQs*

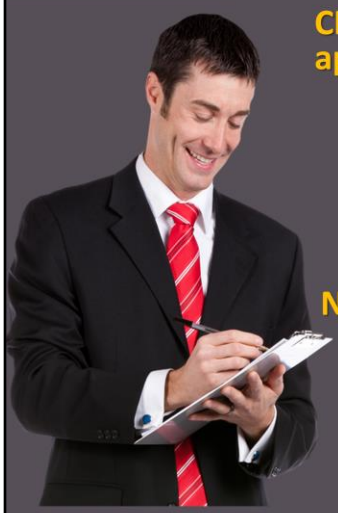
How Much Funding is Available?

- Assembly Bill 82 approved **$14 million** in private funds
- A federal match for a total of **$28 million** is expected
- Funding is estimated to pay for upwards of **450,000 approved applications**
- These funds will also cover **administrative costs**

Purpose

The purpose of this funding is to encourage access to health care services through Medi-Cal enrollment by providing in-person enrollment assistance payments **of $58 per approved Medi-Cal application** submitted by Certified Insurance Agents (CIA)s and CECs through Covered California.

Payment Eligibility



CIAs and CECs receive $58 for each approved Medi-Cal application when:

- Medi-Cal applicants are newly eligible for coverage pursuant to the federal Patient Protection and Affordable Care Act, or
- Applicants have not been enrolled in the Medi-Cal program during the previous 12 months prior to making the application.

Notes:

- Payment made for each approved application, not the number of applicants
- Mixed Program Family applications are not eligible for the $58 Medi-Cal enrollment assistance payment

Who Pays?

- The California Department of Health Care Services (DHCS) will transfer funding to Covered California.
- Covered California is responsible for distributing payments for Medi-Cal enrollment assistance.

How and When?

- Payments begin for approved Medi-Cal applications submitted by Agents or CECs to Covered California beginning July 2014.
- The first round of payments will be made for those applications that resulted in at least one newly eligible 19-64 year old on the application. Subsequent payments will be issued as soon as possible, including applications with children under 19 years old.
- Payments continue until the funds appropriated for this purpose run out.

FAQs?

Are $58 payments made for both online and paper Medi-Cal applications?

Yes. Only online applications submitted through CalHEERS are eligible for enrollment assistance payment. Paper applications must be submitted through Covered California ***only*** to be eligible for enrollment assistance payment.

FAQs?

Will CIAs and CECs receive reimbursement for completing Medi-Cal *renewal* applications?

No. Funding is specifically for enrollment purposes under AB 82, Section 70.

For Mixed Program Family applications, how are the commissions paid for the APTC plans and Medi-Cal?

Commissions are only paid for the APTC plans only and not the Medi-Cal enrollments.

Conclusion – Questions?

www.CoveredCA.com

http://hbex.coveredca.com/agents/webinars/

DHCS
Department of HealthCareServices

COVERED CALIFORNIA