

Getting and Keeping Health Coverage for Low-Income Californians: A Guide for Advocates March 2016



Jen Flory, Elizabeth Landsberg, Shirley Sanematsu,
and Mona Tawatao

Made Possible With Support From



California
Health Care
Foundation

Acknowledgments

Who We Are

Western Center on Law & Poverty fights for justice for low-income Californians by improving and transforming the public policy systems that touch their lives. We focus on health care, affordable housing, public benefits, racial equity and access to justice issues. Western Center uses a multi-pronged approach to improve the lives of Californians living in poverty. Our staff brings impact litigation in state and federal courts, educates policymakers and stakeholders, sponsors legislation, conducts budget advocacy, promotes better programs and policies at administrative agencies, and provides consultation and trainings to the State's legal services programs and community-based organizations. For more information about us, please see our website at www.wclp.org.

Acknowledgments

This guide was funded by a grant from the California Health Care Foundation. We are grateful to the foundation and Catherine Teare, our grant manager, for their unwavering support and flexibility throughout the process.

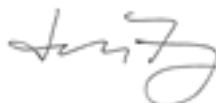
We express our deep appreciation for the team at Manatt Health, led by Alice Lam and including Melinda Dutton, Alexander Dworkowitz, and Rashi Kesarwani. Their health law expertise proved invaluable in reorganizing portions of the guide and reviewing drafts for consistency and technical accuracy.

We were also fortunate to have a great team of advocate reviewers who provided in-depth knowledge on specific subject areas: Kim Lewis, Cori Racela, and Abbi Coursolle of the National Health Law Program; Dan Brzovic of Disability Rights California; Julie Silas of Consumers Union; Donald Nollar of Maternal and Child Health Access; Lucy Quacinella of Multiforum Advocacy Solutions; Assmaa Elayyat of the California Welfare Directors Association; and Sonal Ambegaokar.

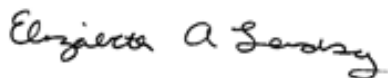
Special thanks as well to Western Center staff Suzie Convery, Aurora Colindres, Jason Rivera, Amanda Smith, and Paul Tepper for their assistance throughout the project. We are also grateful to Amalea Romero and Marina Anthony who assisted in drafting and cite checking portions of the guide while they were law clerks with us.

We also thank Jessica Fry, our graphic designer for this project who patiently worked with us to develop the look and feel of the guide.

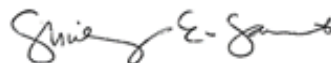
And finally, our humble recognition of Katie Murphy and Kim Lewis who wrote the original 2005 *Med-Cal Eligibility Guide* that was the backbone for this guide. Some of their original words are still here.



Jen Flory



Elizabeth Landsberg



Shirley Sanematsu



Mona Tawatao

Table of Contents

Overview of this Guide	<u>1</u>
Introduction to Part I: Eligibility Criteria At-A-Glance	<u>5</u>
A. Citizenship and Immigration Status	<u>6</u>
1. Mixed Status Families	<u>7</u>
B. Residency	<u>7</u>
C. Household and Income Requirements	<u>7</u>
1. Income Threshold and Income Counting	<u>7</u>
2. Household Determination	<u>9</u>
D. Age	<u>9</u>
E. Incarceration	<u>10</u>
F. Other Health Coverage	<u>10</u>
G. Tax Filing Status	<u>11</u>
H. Assets or Resources	<u>11</u>
I. Insurance Affordability Programs at a Glance	<u>13</u>
Chapter 1: Overarching Eligibility Issues for Medi-Cal	<u>15</u>
A. Citizenship and Immigration Status	<u>16</u>
1. Immigrants Eligible for Full-scope Medi-Cal	<u>16</u>
a. Qualified Immigrants	<u>16</u>
b. Lawfully Present and PRUCOL	<u>20</u>
2. Restricted Scope Medi-Cal	<u>21</u>
a. Services Covered Under Restricted Medi-Cal	<u>22</u>
b. Additional Programs Available Regardless of Immigration Status	<u>23</u>
B. Incarceration/Institutionalization	<u>24</u>
C. Residency	<u>26</u>

D. Other Health Coverage	<u>27</u>
E. Tax Filing Status	<u>28</u>
F. The Medi-Cal Hierarchy	<u>28</u>
Chapter 2. MAGI Medi-Cal Programs	<u>30</u>
A. Constructing Households	<u>31</u>
1. Tax Filer Rules	<u>32</u>
2. Non-Filer Rules	<u>33</u>
3. Counting Households with a Pregnant Woman	<u>34</u>
B. Counting Income	<u>34</u>
C. MAGI Medi-Cal Programs	<u>36</u>
1. Expansion Adults	<u>36</u>
2. Parents and Caretaker Relatives	<u>41</u>
3. Pregnant Women	<u>44</u>
a. MAGI Medi-Cal Programs for Pregnant Women	<u>44</u>
b. Medi-Cal Access Program (MCAP) for Pregnant Women and Newborns up to Age 2	<u>49</u>
4. Children: MAGI Medi-Cal, the Targeted Low-Income Children’s Program, and MCAP Infants and Babies	<u>54</u>
a. Infants: 0 to 1 year old	<u>57</u>
b. Children: Ages 1 to 6	<u>58</u>
c. Children: Ages 6 to 19	<u>59</u>
Chapter 3. Non-MAGI Medi-Cal	<u>62</u>
A. Non-MAGI Household and Income	<u>64</u>
B. Full-Scope Non-MAGI Medi-Cal for Seniors and Individuals with Disabilities	<u>65</u>
1. Categorically Linked Medi-Cal Based on Disability	<u>65</u>
a. Automatic Medi-Cal for Individuals Receiving Supplemental Security Income (SSI-b. linked Medi-Cal)	<u>65</u>
b. SSI 1619(b) Medi-Cal for Individuals who Lost SSI Because of Earnings from Work	<u>66</u>
2. Severely-Impaired Working Individual (SIWI) Program	<u>68</u>
3. Pickle Program	<u>69</u>
4. Disabled Adult Child (DAC) Medi-Cal	<u>71</u>
5. Disabled Widow/Widower Programs	<u>74</u>

6. Aged and Disabled Federal Poverty Level (A&D FPL) and Blind Federal Poverty Level (Blind FPL) Programs	<u>75</u>
a. Special Rules for A&D FPL and Blind FPL Programs	<u>82</u>
7. 250% Working Disabled Program (250% WDP)	<u>83</u>
8. Aged, Blind and Disabled – Medically Need (ABD-MN): Free and Share of Cost	<u>90</u>
C. Full-Scope Non-MAGI Medi-Cal for Children and Families	<u>98</u>
1. Automatic Eligibility Due to Receipt of Government Benefits	<u>99</u>
2. Children in Foster Care	<u>100</u>
3. Former Foster Youth Under Age 18 and Not Living with their Parents	<u>102</u>
4. Former Foster Youth 18 and Older	<u>102</u>
5. Transitional Medi-Cal (TMC)	<u>104</u>
6. Continuous Eligibility for Children	<u>106</u>
7. Deemed Eligibility for Newborns	<u>107</u>
8. Aid for Families with Dependent Children – Medically Needy	<u>108</u>
9. Medically Indigent	<u>110</u>
D. Limited Scope Medi-Cal Programs for Children	<u>111</u>
1. Minor Consent	<u>111</u>
2. Income Disregard Program for Pregnant Girls under Age 21	<u>112</u>
3. The Child Health and Disability Prevention (CHDP) Program	<u>113</u>
E. Medi-Cal Special Treatment Programs	<u>114</u>
1. Breast and Cervical Cancer Treatment Programs	<u>114</u>
2. Tuberculosis Program	<u>116</u>
3. Kidney Dialysis and Parenteral Hyperalimentation and Related Services	<u>117</u>
F. Medicare Savings Programs (MSPs)	<u>119</u>
1. Qualified Medicare Beneficiary (QMB or “Quimby”) Program	<u>121</u>
2. Specified Low-Income Medicare Beneficiaries (SLMB) Program	<u>122</u>
3. Qualified Individual (QI) Program	<u>123</u>
4. Qualified Disabled and Working Individual (QDWI) Program	<u>124</u>
G. Refugee Medical Assistance	<u>125</u>
Chapter 4. Covered California	<u>128</u>
A. Qualified Health Plans	<u>131</u>
1. Essential Health Benefits	<u>131</u>
2. Standard Benefit Design	<u>132</u>

B. Eligibility to Purchase Coverage Through Covered California	<u>135</u>
1. Citizenship and Immigration Status	<u>135</u>
2. Incarceration	<u>138</u>
3. Residency	<u>139</u>
4. Age	<u>140</u>
C. Eligibility for Financial Assistance	<u>140</u>
1. Lack of Minimum Essential Coverage	<u>141</u>
a. Months of Partial Coverage	<u>143</u>
b. Eligible But Not Enrolled	<u>144</u>
c. Special Rules Regarding Employer Coverage	<u>145</u>
i. Affordability and Value of Other Coverage	<u>145</u>
ii. Family Glitch	<u>146</u>
iii. The Enrolled Employee Exception	<u>146</u>
iv. COBRA	<u>147</u>
2. Income Threshold for Financial Assistance	<u>147</u>
a. Exceptions to the Lower Limit of Eligibility: Individuals Below 100%FPL	<u>148</u>
b. Income Counting: Modified Adjusted Gross Income (MAGI) Methodology	<u>148</u>
i. Household Size and Members	<u>150</u>
ii. Children	<u>150</u>
iii. Special Consideration for Pregnancy and Newborns	<u>151</u>
iv. Qualifying Relative Dependents	<u>151</u>
v. Spouses	<u>152</u>
vi. Family Members Who are Not Lawfully Present	<u>153</u>
3. Assets	<u>153</u>
4. Tax Filing Status	<u>153</u>
a. Must File Taxes for the Year that Premium Tax Credits are Received	<u>153</u>
b. Married Couples Must File a Joint Income Tax Return	<u>154</u>
i. Head of Household Exception	<u>155</u>
ii. Domestic Violence and Spousal Abandonment Exception	<u>155</u>
c. Individuals who are Dependents Cannot Themselves Take Premium Tax Credits	<u>156</u>
5. Enrollment in a Covered California Plan	<u>156</u>

D. Calculating Premium Tax Credits	<u>157</u>
1. Second Lowest Cost Silver Plan – The Benchmark Premium	<u>157</u>
2. Required Contribution Percentage	<u>158</u>
E. Premium Tax Credit Reconciliation	<u>160</u>
F. Cost-sharing Reductions	<u>162</u>
Introduction to Part II: Getting and Keeping Health Coverage	<u>165</u>
A. Application Channels	<u>165</u>
B. Verification Requirements	<u>166</u>
C. Starting Coverage	<u>166</u>
D. Plan Selection	<u>167</u>
E. Reporting Changes	<u>167</u>
F. Annual Renewal	<u>167</u>
G. Appeals	<u>168</u>
Chapter 5. Getting Onto Coverage	<u>171</u>
A. Applying for Medi-Cal, Covered California, and the Medi-Cal Access Program	<u>174</u>
1. Single Application, Multiple Application Pathways, “No Wrong Door”	<u>174</u>
a. Applying Online	<u>176</u>
b. Applying In-Person: County Offices and Community Partners	<u>177</u>
c. Applying by Phone: Covered California Service Center and Counties	<u>179</u>
d. Applying by Mail: The Single, Streamlined Paper Application	<u>179</u>
2. Expedited Coverage Pathways	<u>180</u>
a. Acceleration Enrollment (AE)	<u>180</u>
b. Deemed Eligible (DE) Infants	<u>181</u>
c. Hospital Presumptive Eligibility	<u>182</u>
d. Presumptive Eligibility (PE) for Pregnant Women	<u>184</u>
e. CHDP Gateway	<u>185</u>
f. Accelerated Eligibility (AE) for Federal Breast and Cervical Cancer Treatment Program (BCCTP)	<u>187</u>
g. Express Lane Enrollment (ELE)	<u>189</u>
h. Children in Foster Care	<u>190</u>
i. Former Foster Youth	<u>190</u>
j. Minor Consent Medi-Cal	<u>192</u>

k. Tuberculosis (TB) Program	<u>194</u>
3. Medi-Cal Connections with Public Benefits Programs	<u>194</u>
a. Programs Linked to Medi-Cal	<u>194</u>
b. Joint Application for health coverage and public benefits	<u>195</u>
4. Application Process and Eligibility for Inmates	<u>195</u>
B. Verifying Application Information	<u>196</u>
1. Overview of Process and Requirements	<u>196</u>
a. Medi-Cal	<u>196</u>
b. Medi-Cal Access Program	<u>197</u>
c. Covered California	<u>198</u>
2. Verification of Eligibility Criteria	<u>199</u>
a. Proving Identity	<u>199</u>
b. Citizenship and Immigration Status	<u>201</u>
i. Proof of Citizenship	<u>201</u>
ii. Proof of Lawful Immigration Status	<u>202</u>
iii. Resolving Citizenship or Immigration Inconsistencies	<u>202</u>
c. Incarceration	<u>205</u>
d. California State Residency	<u>205</u>
e. Income and Household Size	<u>206</u>
f. Pregnancy	<u>208</u>
g. Assets	<u>208</u>
h. Minimum Essential Coverage/Employer-Sponsored Coverage/ Other Coverage	<u>208</u>
C. When Coverage Starts	<u>210</u>
1. Medi-Cal	<u>211</u>
a. Retroactive Medi-Cal	<u>211</u>
b. Expedited Programs	<u>212</u>
2. Covered California	<u>212</u>
a. Covered California Open Enrollment	<u>212</u>
b. Covered California Special Enrollment	<u>213</u>
c. Covered California Coverage Effective Dates	<u>216</u>
3. MCAP	<u>218</u>
D. Plan Selection	<u>218</u>
1. Picking a Medi-Cal Plan	<u>219</u>
2. Picking a Covered California Plan	<u>220</u>

3. Picking an MCAP Plan	<u>221</u>
Chapter 6. Staying On	<u>222</u>
A. How to Keep Coverage	<u>225</u>
1. Changes in Circumstances	<u>226</u>
a. Medi-Cal	<u>226</u>
i. Beneficiary Obligation to Report	<u>226</u>
ii. Periodic Data Review	<u>227</u>
iii. Redetermination of Eligibility	<u>227</u>
iv. Relationship with Other Public Assistance Programs	<u>230</u>
b. Covered California	<u>232</u>
i. Enrollee Obligation to Report	<u>232</u>
ii. Semi-annual Data Review	<u>233</u>
iii. Additional Rules Regarding Redetermination Outcomes Due to Changes in Circumstances	<u>234</u>
c. Medi-Cal Access Program (MCAP)	<u>235</u>
2. Moving	<u>235</u>
a. Medi-Cal and Inter-County Transfers (ICTs)	<u>235</u>
i. The ICT Process	<u>236</u>
ii. Accessing Care during the ICT Process	<u>238</u>
b. Covered California: Inter-Regional Moves and Choosing a New Health Plan	<u>239</u>
i. Choosing a New Health Plan Due to a Move	<u>239</u>
ii. Avoiding Gaps in Coverage	<u>239</u>
3. Annual Renewal or Redetermination	<u>240</u>
a. Medi-Cal	<u>240</u>
i. Process for MAGI beneficiaries	<u>241</u>
ii. Process for Non-MAGI Beneficiaries	<u>244</u>
iii. Process for Households that Have Both MAGI and Non-MAGI Members	<u>249</u>
iv. SB 87 and Medi-Cal Eligibility Reviews	<u>249</u>
v. 90 Day Right to “Cure” or Reinstate Medi-Cal after Termination.	<u>251</u>
vi. Process When There is a Loss of Contact	<u>251</u>
vii. Special Processes for Certain Categories of Medi-Cal Beneficiaries	<u>252</u>

1) Former Foster Youth up to Age 26	<u>252</u>
2) “Mega Mandatory” Groups	<u>253</u>
3) Deemed Eligible (DE) Infants	<u>254</u>
4) Foster Children Returning Home	<u>254</u>
5) Minor Consent	<u>255</u>
6) Transitional Medi-Cal	<u>255</u>
7) Breast & Cervical Cancer Treatment Programs	<u>256</u>
8) Refugee Medical Assistance	<u>257</u>
b. Covered California	<u>257</u>
i. Open Enrollment	<u>258</u>
ii. Notice Requirements	<u>258</u>
iii. Redetermination for Financial Assistance	<u>260</u>
c. Redetermination for Mixed Coverage Families	<u>265</u>
d. Redetermination for MCAP	<u>267</u>
B. Due Process Rights	<u>267</u>
1. Medi-Cal Eligibility Appeals	<u>268</u>
a. Notice: Content and Timing Requirements	<u>268</u>
b. Requesting a Fair Hearing	<u>270</u>
c. Expedited Hearings	<u>272</u>
d. Retaining Benefits During the Fair Hearing Process – Aid Paid	<u>273</u>
Pending	
e. Informal Resolution	<u>274</u>
f. Dismissals	<u>275</u>
g. Setting and Notice of Hearing; Position Statement	<u>276</u>
h. The Fair Hearing	<u>277</u>
i. After the Fair Hearing	<u>279</u>
2. Covered California Eligibility Appeals	<u>280</u>
a. Notice: Content and Time Requirements	<u>282</u>
b. Request for Hearing	<u>283</u>
c. Expedited Appeals	<u>285</u>
d. Eligibility Pending Appeal – Continuing Enrollment	<u>286</u>
e. Informal Resolution	<u>287</u>
f. Notification of Hearing and Position Statement	<u>289</u>
g. The Fair Hearing	<u>290</u>
h. Hearing Decision and Other Post-Hearing Processes	<u>291</u>

3. Dual Agency Appeals	<u>293</u>
a. Shared Appeals Entity	<u>293</u>
b. Informal Resolution Process	<u>294</u>
c. The Fair Hearing	<u>294</u>
4. Medi-Cal Access Program (MCAP) Eligibility Appeals	<u>295</u>
C. Moving Between Programs	<u>296</u>
1. Covered California to Medi-Cal	<u>297</u>
2. Medi-Cal to Covered California	<u>299</u>
Introduction to Part III: Health Care Services for the Remaining Uninsured and Underinsured	<u>301</u>
Chapter 7: Counties' Legal Obligation to Provide Care to Remaining Uninsured Residents	<u>304</u>
A. Financial eligibility criteria	<u>306</u>
B. Cost-Sharing	<u>310</u>
C. Timing	<u>311</u>
D. Residency	<u>312</u>
E. Programmatic Eligibility	<u>314</u>
F. Recouping Expenses	<u>315</u>
G. Scope of Services	<u>316</u>
Chapter 8: Options for Hospital Bills	<u>317</u>
A. The Hospital Fair Pricing Act	<u>318</u>
1. Bills that are Eligible for Financial Assistance	<u>318</u>
2. Charity Care and Discount Payment Plans	<u>319</u>
3. Minimum Standards for Financial Eligibility	<u>319</u>
4. Financial Assistance Notification Requirements	<u>320</u>
a. The Written Policy	<u>321</u>
b. Finding Hospital Financial Assistance Policies	<u>321</u>
c. Requirements for Emergency Physicians	<u>322</u>
5. Applying for a Discount	<u>322</u>
6. Reasonable Payment Plans	<u>324</u>
7. Collection Practices	<u>325</u>
B. New IRS Regulations for Non-Profit Hospitals on Hospital Financial Assistance	<u>327</u>

List of Common Acronyms	<u>329</u>
Glossary	<u>334</u>
Appendices	
A. 2016 Health Coverage Income Guidelines	<u>350</u>
B. Immigration Barriers to Applying for Health Coverage Programs	<u>351</u>
C. Comparison of Covered CA and Medi-Cal Hearing Processes	<u>354</u>
D. Where to Go for Help - A Resource List	<u>357</u>
E. Useful Links	<u>359</u>

OVERVIEW OF THIS GUIDE

Background

In 2005, Western Center on Law & Poverty published its *Medi-Cal Eligibility Guide: How to Get and Keep Low-Income Health Coverage* to help advocates around the state have ready access to the relevant statutes, regulations, and guidance needed to ensure access to the Medi-Cal program. Over the years, program changes have occurred, reminding us of the need to update the guide. With the implementation of the Affordable Care Act in 2014 – including the expansion of the Medi-Cal program and the newly available subsidized plans through Covered California – suddenly, not only was the guide out-of-date, it was nearly obsolete.

When we started this project, we thought we would be producing a second edition of the Medi-Cal Eligibility Guide. However, due to the drastic changes in program requirements, income counting methodology, groups of eligible people, and newly available resources, this second edition has really become an eligibility guide for the primary low-income health programs in California. While several of the descriptions of specific Medi-Cal programs and procedures will be familiar, we have significantly reorganized sections and added information on the new Modified Adjusted Gross Income (MAGI) methodology, the new Medi-Cal programs for previously ineligible populations, Covered California, and options for the remaining uninsured.

Programs Covered by This Guide

As a result of the Affordable Care Act, several structural changes took place in health care programs available to low-income Californians. This guide covers the programs that are collectively known as “Insurance Affordability Programs,” as well as some programs available to the remaining uninsured. Insurance affordability programs include Medi-Cal, the Children’s Health Insurance Program (CHIP), and premium tax credits and cost-sharing reductions available to individuals enrolled in Covered California health plans.¹

1. Govt. Code § 100501.1(a).

Medi-Cal is now largely divided into MAGI programs that use the Affordable Care Act's new income counting rules and non-MAGI programs that use the old income counting rules or do not count income at all.

In California, CHIP includes the former Healthy Families program, which was transferred into the Medi-Cal program in 2013 as the Targeted Low-Income Children's Program and is now being rebranded as "Medi-Cal for Families." Medi-Cal for Families operates as part of the Medi-Cal program, following the same rules and procedures as any other Medi-Cal program. We have fully integrated any discussion of the program in this manual into the general Medi-Cal discussion.

CHIP also included Access for Infants & Mothers (AIM), a program for moderate income pregnant women which is now being administered by the Medi-Cal program as the Medi-Cal Access Program (MCAP). Despite its move to Medi-Cal, it still functions as a separate program with its own application and is not yet administered through county social services agencies as other Medi-Cal programs; it may be further integrated into Medi-Cal in the future. We have included MCAP in our discussions of the Medi-Cal program, though have noted where program requirements differ.

Like those in CHIP, enrollees in the Low-Income Health Programs administered by most counties in California were also transitioned into the Medi-Cal program on January 1, 2014. Thus, while county indigent health programs still exist and are discussed in their own chapter, many former recipients now receive Medi-Cal in the new expansion adult group.

Finally, Covered California is California's new program offering subsidized health insurance for Californians who are outside of the Medi-Cal income limits, yet are still low-to-moderate income. Covered California shares the MAGI income counting rules with MAGI Medi-Cal, with a few exceptions, though otherwise has distinct eligibility rules.

Organization of this Guide

Part I of the guide walks through the basic eligibility requirements of Medi-Cal and

Covered California. The introduction gives an overview of the factors that determine eligibility and gives direction on where to find more information for each program. Chapter 1 outlines the eligibility requirements that are common to all Medi-Cal programs. Chapter 2 covers the Medi-Cal programs that use the MAGI methodology, known as MAGI Medi-Cal. Chapter 3 covers the non-MAGI Medi-Cal programs that use a different criteria for determining financial eligibility than MAGI, use no income criteria but rely on links to other programs, or offer only limited services. Chapter 4 covers Covered California program rules.

Part II of the guide covers the procedures required to enroll in or maintain coverage through Medi-Cal or Covered California. Chapter 5 covers enrollment, including timelines, procedures, and choosing a health plan. Chapter 6 covers requirements to report changes, renew coverage, and what to do when coverage is threatened.

Part III of the guide describes two of the options for the remaining uninsured and underinsured to pay for health services. Chapter 7 covers the obligations of counties to provide services through safety net programs. Chapter 8 covers eligibility rules for reducing hospital bills for patients who cannot afford to pay, whether due to not having coverage or having coverage that is unaffordable.

What the Guide Does Not Cover

This guide does not cover many of the access to care issues that arise after enrolling in a health program, including managed care regulations and protections. Nor does it cover other issues individuals may face with providers, such as balance billing or the availability of linguistically appropriate services. In addition, while CHIP programs, as discussed above, are insurance affordability programs, the three CHIP-funded County Children's Health Initiatives that operate in San Francisco, San Mateo, and Santa Clara counties are not included due to the local nature of those programs. Similarly, there are other local children's programs and programs with very limited services, such as cancer screening, that may be available in some areas and are not addressed in this guide.

Finally, as a guide is only as good on the day it was published, please note that as we drafted this guide, many of the regulations were still in temporary or emergency form and some are yet to be written. As state and federal agencies continue with the full implementation of the Affordable Care Act, new guidance is constantly released. Even when the Affordable Care Act is fully implemented, state law in California is constantly in flux. Legal services advocates should be sure to use the footnoted references as a starting point rather than a final answer. Inevitably, portions of the guide will be out of date as events or policies change. Please contact us if you notice errors or omissions we can correct in later versions, or if you have questions or suggestions for improvements.

Introduction to Part I: Eligibility Criteria At-A-Glance

Three primary “Insurance Affordability Programs” provide health coverage to low and moderate income Californians:¹

- Medi-Cal – California’s Medicaid program;
- The Medi-Cal Access Program – a separate CHIP (Children’s Health Insurance Program) for pregnant women; and
- Covered California – California’s Exchange, or online health insurance marketplace.

Medi-Cal is the program for California’s lowest income individuals. Medi-Cal has different rules for individuals based on coverage categories. MAGI Medi-Cal programs cover adults under age 65, parents and caretaker relatives, pregnant women, and children, using the Modified Adjusted Gross Income (MAGI) methodology. MAGI Medi-Cal programs include the childless adult expansion program (including the former Low-Income Health Program (LIHP)); the Medi-Cal Access Program (MCAP – former Access for Infants and Mothers program (AIM))² and the Targeted Low-Income Children’s Program/ Medi-Cal for Families (TLICP, former Healthy Families Program). Non-MAGI Medi-Cal covers people in other government benefits programs and special populations, such as individuals who are over 65, individuals with disabilities who do not qualify for MAGI Medi-Cal, former foster youth, and children enrolled in certain programs designed to keep children in coverage at vulnerable times.

Covered California picks up where Medi-Cal leaves off, offering subsidized health insurance to low-to-moderate income Californians, up to \$80,360 for a family of 3 in 2016. Individuals who enroll in Covered California health plans may receive

-
1. Three counties, San Francisco, San Mateo, and Santa Clara also have County Children’s Health Insurance Programs (C-CHIP) which are also technically Insurance Affordability Programs as they are funded by federal CHIP funds. This guide does not cover eligibility for these three local programs.
 2. Although the Medi-Cal Access Program (MCAP) is now administered by DHCS, it is separate from Medi-Cal and currently does not provide access to Medi-Cal’s benefits or provider networks. Because MCAP is an important source of affordable coverage for pregnant women, this guide covers MCAP together with Medi-Cal, pointing out differences along the way. See Chapter 2 for a complete description of the program.

financial assistance in the form of advanced premium tax credits to offset the cost of purchasing insurance. At lower income levels, individuals qualify for more heavily subsidized health plans that have lower deductibles and co-payments than are offered to their higher income counterparts.

In general, individuals must meet certain rules to be eligible to enroll in Insurance Affordability Programs, which include:

- citizenship or immigration status;
- state residency; and
- income and household determination requirements.

Some programs also consider:

- age;
- incarceration;
- availability of other health coverage;
- tax filing status; and
- assets.

A. Citizenship and Immigration Status

Concerns about immigration status may cause confusion across programs and dissuade eligible people from applying for services. Medi-Cal is available in some form to all immigrants – regardless of status – as long as they meet all other eligibility requirements. For example, even undocumented immigrants may be eligible for emergency Medi-Cal benefits. Covered California, on the other hand, is only available to certain immigrants defined as “lawfully present,” which includes virtually all immigrants with a documented status, except those who have Deferred Action for Childhood Arrival (DACA) status.³ For a good rule of thumb, immigration status determines the *scope* of services in Medi-Cal, not whether someone is eligible. In Covered California, immigration status determines *who* gets services. MCAP has no citizenship or immigration status requirements; it provides comprehensive benefits to all enrollees, regardless of the pregnant woman’s status. U.S. citizens and nationals

3. 10 CCR § 6410 (referencing 45 C.F.R. § 1552.2).

are eligible for all three programs.

1. Mixed Status Families

Given both the complicated nature of immigrant eligibility for health programs and the mixed immigration statuses of many Californian families, members of the same family may find themselves eligible for different programs. A few rules to keep in mind:

- Only persons who are seeking services are required to provide citizenship and immigration status information. Persons who are not seeking services, even if applying for another family member, do not need to prove their citizenship or immigration status.
- Citizenship and immigration status information is only used to determine eligibility for the health program the person is applying for and not otherwise used for immigration enforcement purposes.⁴

For Medi-Cal immigration rules, see Chapter 1, Section A.

For Covered California immigration rules, see Chapter 5, Section B.1.

B. Residency

Only California residents are eligible for Medi-Cal, MCAP or Covered California.

For Medi-Cal and MCAP residency rules, see Chapter 1, Section C.

For Covered California residency rules, see Chapter 4, Section B.3.

C. Household and Income Requirements

1. Income Threshold and Income Counting

In order to determine whether an individual's income qualifies her for a particular program, first you must know what income methodology the program uses.

4. U.S. Immigration and Customs Enforcement, "Clarification of Existing Practices Related to Certain Health Care Information" (Oct. 25, 2013), <http://www.ice.gov/doclib/ero-outreach/pdf/ice-aca-memo.pdf>.

The MAGI rules apply to the MAGI Medi-Cal programs – the newly eligible adults (“expansion adults” age 19-64),⁵ pregnant women,⁶ parents and caretaker relatives,⁷ and children, which includes the CHIP-funded Targeted Low-Income Children’s Program,⁸ premium tax credits and cost sharing reductions offered through Covered California; and MCAP for pregnant women. Advocates are also encouraged to consult *Advocate’s Guide to MAGI*, published by the National Health Law Program.⁹ The MAGI rules count income based largely on how it would be reported for federal income taxes.

If an individual does not qualify for Medi-Cal under the MAGI rules, the individual may nevertheless qualify for Medi-Cal because they are aged, blind, or disabled, a foster child or a former foster child, a refugee, or seeking care for a particular medical condition that is covered under a limited scope program. These programs are known collectively as “Non-MAGI Medi-Cal” and they have their own income rules, and, in some cases, no income limitations at all. Prior to health reform, many Medi-Cal programs also required a deprivation test, meaning that households had to include a child deprived of parental support due to a parent being deceased, absent, incapacitated, unemployed or underemployed. That rule no longer exists for any Medi-Cal program, whether MAGI or Non-MAGI.¹⁰

For general MAGI income counting rules (MAGI Medi-Cal, MCAP, and Covered California), see Chapter 4, Section C.2.b.

For MAGI Medi-Cal and MCAP exceptions to the MAGI income counting rules, see Chapter 2, Section B.

For Non-MAGI Medi-Cal income counting rules, see individual program sections in Chapter 3.

5. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

6. 42 U.S.C. § 1396a(e)(5)-(6).

7. 42 U.S.C. §§ 1396a(a)(10)(i)(I), 1396u-1(a).

8. 42 U.S.C. § 1396a(l)(2)(C). For CHIP, see 42 U.S.C. §§ 1397bb(b)(1)(B)(v), 1396a(e)(14)(A); 42 C.F.R. § 457.315(a).

9. Available on National Health Law Program’s website at www.healthlaw.org/publications/search-publications/agmagi#.Ved4KPIViko.

10. ABX1-1 amended Welfare and Institutions Code § 14005.30 (b)(2) in 2013. See also ACWDL 14-28 (July 7, 2014).

2. Household

Because the income thresholds for each program are based on the federal poverty level for the household size, advocates must know the household rules of the program.

For Medi-Cal and MCAP, the household size is determined for each individual. Different households may exist within a single family, depending on each member's familial and tax relationships to each other. MAGI Medi-Cal programs and MCAP generally use tax rules for households (or "nonfiler" rules for those who do not file taxes) whereas non-MAGI Medi-Cal programs use the pre-ACA household rules.

For Covered California, household size is based on tax relationships and the household includes the taxpayer and all members claimed on their federal income tax return. Different households may exist within a single family, depending on the tax relationships to one another.

For MAGI Medi-Cal and MCAP household rules, see Chapter 2, Section A.

For Non-MAGI Medi-Cal household rules, see individual program sections in Chapter 3.

For Covered California household rules, see Chapter 4, Section C.2.b.

D. Age

In general, MAGI Medi-Cal programs are limited to persons under age 65, though caretaker relatives may be older and the children's programs have their own limits. Non-MAGI Medi-Cal programs are available to a variety of ages depending on the program – some serve persons over 65 in particular. MCAP has no age rule. Individuals of any age may purchase a Covered California plan; however, because Medicare beneficiaries are ineligible (see Other Health Coverage), few older than 64 purchase Covered California (recent immigrants are exceptions).

For MAGI Medi-Cal age rules, see individual program sections in Chapter 2.

For Non-MAGI Medi-Cal age rules, see individual program sections in Chapter 3.

For Covered California age rules, see Chapter 4, Section B.4.

E. Incarceration

Incarceration is treated differently in Medi-Cal than in Covered California. Incarceration is not a factor of eligibility for Medi-Cal but, in general, Medi-Cal will not pay for services for incarcerated individuals.¹¹ Individuals who have Medi-Cal and become incarcerated have their Medi-Cal suspended.¹² Incarceration is a condition of eligibility for Covered California.¹³ Individuals who are incarcerated are not eligible for enrollment in a Covered California plan and, if individuals who have Covered California become incarcerated, they will have their Covered California plans cancelled and then get a Special Enrollment Period when they are released.

For Medi-Cal incarceration rules, see Chapter 1, Section B.

For Covered California incarceration rules, see Chapter 4, Section B.2.

F. Other Health Coverage

Access to or enrollment in other health coverage affects eligibility for Medi-Cal, MCAP, and Covered California in different ways. People enrolled in other health coverage are still eligible for Medi-Cal, though the Medi-Cal program requires that the other health coverage be used before Medi-Cal will cover services.

Enrollment in other health insurance can prevent eligibility for MCAP unless the other coverage insufficiently covers maternity services.¹⁴ See Chapter 2, Section C.3.b.

Enrollment in other health coverage can preclude an applicant from enrolling in a Covered California plan entirely (if enrolled in Medicare) or can prevent someone from getting premium tax credits (if enrolled in most other kinds of coverage).¹⁵ In most cases, the individual need only be *eligible* for other health coverage to exclude someone from enrolling in Covered California.¹⁶

11. 42 U.S.C. § 1396d(a)(29)(A); 42 C.F.R. §§ 435.1009-1010.

12. Welf. & Inst. Code § 14011.10; ACWDL 14-26 (May 6, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-26.pdf>.

13. 42 U.S.C. § 18032(f)(1)(B); 45 C.F.R. § 155.305(a)(2); 10 CCR § 6472(d).

14. 10 CCR § 2699.201(d)(1)(T) and (V).

15. 26 U.S.C. § 36B(c)(2)(B); 26 C.F.R. § 1.36B-2(a)(2); 10 CCR § 6474(c)(1)(B)(2).

16. See 26 U.S.C. § 36B(c)(2)(B); 26 C.F.R. § 1.36B-2(a)(2).

For Medi-Cal rules about Other Health Coverage, see Chapter 1, Section D.

For Covered California rules about other health coverage, see Chapter 4, Section C.1.

G. Tax Filing Status

Individuals who do not file taxes can still enroll in Medi-Cal or MCAP.¹⁷ Non tax-filers can also enroll in Covered California, but in order to receive premium tax credits for coverage through Covered California, individuals must file taxes for the year they receive credits.¹⁸ For married couples, if either receives premium tax credits, the couple must file a joint tax return or they are ineligible for the credits and will have to pay them back.¹⁹

For Covered California rules on tax filing status, see Chapter 4, Section C.4.

H. Assets or Resources

In an effort to simplify program rules, the MAGI methodology does not consider assets or resources other than income. Thus applications for MAGI Medi-Cal, MCAP, and Covered California do not have any questions about bank accounts, homes, cars, property, etc.

On the other hand, most non-MAGI programs that count income still have limits on what resources an individual may have besides income to qualify for Medi-Cal. However, like everything else with the non-MAGI programs, the rules vary by program. For example, the Medicare Savings Programs (QMB, SLMB, etc.) have a countable resource limit of \$4,000 for an individual and \$6,000 for a married couple, while the 250% Working Disabled Program has a resource limit of \$2,000 for an individual and \$3,000 for a couple. In general, non-MAGI programs that do not count income, such as the program for Former Foster Youth or the Minor Consent program, do not look at resources either.

17. 42 C.F.R. § 435.603(f)(3).

18. 26 C.F.R. § 1.6011-8; 10 CCR § 6476(d)(2)(A).

19. 26 U.S.C. § 36B(c)(1)(C); 26 C.F.R. § 1.36B-2(b)(2) (referencing temporary regulation at 26 C.F.R. § 1.36B-2T); 45 C.F.R. § 155.310(d)(2)(ii)(B); 10 CCR § 6476(d)(2)(B).

For Non-MAGI assets rules, see individual programs in Chapter 3.

Special Note on the Individual Mandate: The Affordable Care Act now requires that most people have some form of full scope health coverage, known as “minimum essential coverage” or be assessed a tax penalty. As this is a guide covering eligibility for health programs, we do not detail all of the exceptions to the individual mandate (e.g., persons who are not required to file taxes, undocumented immigrants, persons facing hardship, persons in Medi-Cal coverage that is not full-scope, or persons with short gaps in coverage), nor do we outline the processes by which an individual may claim an exemption to the individual mandate when filing taxes.

For specific information on the current exemptions to the individual mandate, go to <https://www.healthcare.gov/health-coverage-exemptions/exemptions-from-the-fee/> or see the instructions to the current IRS form 8965.²⁰ In short, the health insurance offered through Covered California and MCAP is always minimum essential coverage. Full-scope Medi-Cal is also minimum essential coverage, and currently persons enrolled in Medi-Cal programs that do not meet the minimum essential coverage standard (e.g., Medi-Cal with a Share of Cost) can apply for a hardship exemption on that basis.²¹

20. See *also* 26 U.S.C. § 5000A, 45 C.F.R. § 155.605, and 26 C.F.R. § 1.5000A-3. CMS can extend certain exemptions via guidance under the hardship exemption, which are then found in the tax form instructions. See e.g., CMS, State Health Official Letter # 14-002, “Minimum Essential Coverage,” pp. 10-11 (Nov. 7, 2014), <http://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf>.

21. *Id.* Individuals need only file for the hardship exemption if they are required to file taxes and another simpler exemption is not available. Some exemptions require only a self-declaration rather than filling out an exemption form.

I. Insurance Affordability Programs at a Glance

General Comparison of Eligibility Rules²²

Eligibility Criteria	MAGI Medi-Cal	Non-MAGI Medi-Cal	MCAP	Covered CA with Subsidies
Citizenship/ Immigration Status	Citizenship or immigration status determines the scope of benefits	Citizenship or immigration status determines the scope of benefits	No citizenship or immigration status test	Only citizens, nationals, and lawfully present immigrants (except DACA) can enroll
Residency	Must be a California resident	Must be a California resident	Must be a California resident	Must be a California resident
Income Counting	Modified Adjusted Gross Income rules with Medicaid exceptions	Varies by program – often tied to rules of other benefits programs such as SSI	Modified Adjusted Gross Income rules with Medicaid exceptions	Modified Adjusted Gross Income rules
Income Threshold	Adults: 138% FPL Pregnant women: 213% FPL Children: 266% FPL	Varies by program	Over 213% through 322% FPL	100-400% FPL (and immigrants under 100% FPL)
Household Composition	Tax filer/Non-Filer rules	Medi-Cal Budget Unit	Tax filer/Non-Filer rules	Tax filer rules
Age	Must be under age 65 (except caretaker relatives)	Programs available for all ages	No age limits	No age limits

22. Some special Medi-Cal programs for specific populations do not entirely fit the pattern, such the Breast & Cervical Cancer Treatment Program (BCCTP) and the Family PACT program.

Eligibility Criteria	MAGI Medi-Cal	Non-MAGI Medi-Cal	MCAP	Covered CA with Subsidies
Incarceration	Enrollment in Medi-Cal suspended while incarcerated (though Medi-Cal does pay certain hospital expenses for inmates)	Enrollment in Medi-Cal suspended while incarcerated (though Medi-Cal does pay certain hospital expenses for inmates)	No program rules on incarceration	Cannot be enrolled while incarcerated
Effect of other health coverage	Must use other coverage first	Must use other coverage first	Cannot have other coverage unless maternity coverage is insufficient	Cannot have minimum essential coverage and get premium tax credits. Medicare enrollees cannot enroll at all
Tax Filing	Do not have to file taxes	Do not have to file taxes	Do not have to file taxes	Do not have to file taxes, but must file taxes in order to receive tax credits. Married couples must file jointly with certain exceptions
Assets	No assets test	Most programs have limits on assets	No assets test	No assets test
Fulfills the Individual Mandate of the Affordable Care Act?	Full-scope programs and Pregnancy-Related Medi-Cal do	Only full-scope programs; not Share of Cost Medi-Cal or limited service programs.	Yes	Yes

Chapter 1: Overarching Eligibility for Medi-Cal

Chapter 1: Overarching Eligibility Issues for Medi-Cal

A. Citizenship and Immigration Status

1. Immigrants Eligible for Full-scope Medi-Cal

- a. Qualified Immigrants
- b. Lawfully Present and PRUCOL

2. Restricted Scope Medi-Cal

- a. Services Covered Under Restricted Medi-Cal
- b. Additional Programs Available Regardless of Immigration Status

B. Incarceration/Institutionalization

C. Residency

D. Other Health Coverage

E. Tax Filing Status

F. The Medi-Cal Hierarchy

1. Overarching Eligibility Issues for Medi-Cal

A. Citizenship and Immigration Status

Regardless of citizenship or immigration status, anyone can apply for and receive some form of Medi-Cal, provided they meet all other Medi-Cal eligibility criteria. In general, U.S. citizens,¹ nationals,² and individuals who are lawfully residing in the United States are eligible for full-scope Medi-Cal. Individuals who do not have lawful status (or who fail to provide verification of status) are eligible for restricted-scope Medi-Cal, which covers emergency services as well as certain other services described below. For information regarding the verification of citizenship and immigration status under Medi-Cal and Covered California, see Chapter 5, Section B.2.b.

1. Immigrants Eligible for Full-scope Medi-Cal

In general, individuals who are lawfully present in the United States are eligible for full-scope Medi-Cal.³ For Medi-Cal eligibility purposes, they are either considered “qualified” immigrants or individuals who are Permanently Residing Under the Color of Law (PRUCOL).

a. Qualified Immigrants

“Qualified” immigrants is a federal statutory designation of immigrants eligible for

-
1. “Citizens” includes U.S. born citizens and naturalized citizens. See Chapter 5, Section B.2.b.i for differences in demonstrating citizenship among the two categories.
 2. “Nationals” is a specific term for individuals born in American Samoa or certain inhabitants of the Commonwealth of the Northern Mariana Islands. Medi-Cal policy referencing citizens often includes nationals as well as will this guide unless specified otherwise. See, e.g., ACWDL 07-12 (Jun. 4, 2007), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c07-12.pdf>.
 3. 42 C.F.R. § 435.406(a)(2); 22 CCR § 50301. Note that additional categories of lawfully present immigrants have since been added as discussed below.

“federal public benefits,” such as Medicaid.⁴

Individuals with the following immigration statuses are considered “qualified.”⁵

- Lawful Permanent Residents (LPRs or “green card holders”);
- Refugees, asylees, or individuals granted withholding of deportation/removal, conditional entry (in effect prior to Apr. 1, 1980), or paroled into the U.S. for at least one year; Cuban and Haitian entrants;
- Battered spouses and children with a pending or approved:⁶
 - Self-petition for an immigrant visa or visa petition by a spouse or parent who is either a U.S. citizen or LPR, or
 - Application for cancellation of removal/suspension of deportation, where the need for the benefit has a substantial connection to the battery or cruelty (parent/child of such battered child/spouse are also “qualified”);
- Victims of Severe Forms of Trafficking and their derivative beneficiaries who have obtained a T-visa or whose application for a T-visa sets forth a *prima*

4. 8 U.S.C. §§ 1611 and 1641. These were enacted as part of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act changes (PRWORA), Pub. L. No. 104–193, 110 Stat. 2105 (Aug. 22, 1996). 22 CCR § 50302.2. Federal matching funds are provided to DHCS for Medi-Cal beneficiaries who are considered “qualified” and are either exempt or have met the “5-year bar.” 8 U.S.C. § 1613.

5. The complete list of “qualified” immigrants includes those listed at 8 U.S.C. § 1641 and Trafficking Victims as a result of) the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. No. 106–386, § 107 (Oct. 28, 2000) and the Trafficking Victims Protection Reauthorization Act of 2003, Pub. L. No. 108–193, § 4(a)(2) (Dec. 19, 2003). See *also* “Table: A Quick Guide to Immigrant Eligibility for Affordable Care Act (ACA) and Key Federal Means-tested Programs,” National Immigration Law Center, September 2015, available at: <https://www.nilc.org/document.html?id=844>.

6. These immigrants are commonly referred to as “VAWA” immigrants because they are able to seek immigration relief from the Department of Homeland Security under the Violence Against Women Act (VAWA). VAWA is not an immigration status, but the basis on which an individual is granted lawful permanent residency. Immigrants who have begun this process are eligible.

facie case.⁷

“Non-qualified” immigrants are individuals whose immigration status is not listed within the “qualified” category.⁸ Immigrants who are “non-qualified” for federal public benefits include both individuals who are lawfully present and who are considered undocumented.⁹

-
7. *Medi-Cal Eligibility Procedures Manual* 24B16-17. Victims of Severe Forms of Trafficking are not listed as qualified, but under the Trafficking Victims Protection Act of 2000 (22 U.S.C. §§ 7101 *et seq.*) they have been deemed eligible for the same services as refugees. The Trafficking Victims Protection Reauthorization Act of 2003 provided benefits to derivative beneficiaries of T-visa applications as well (spouses and children of adult victims; parents and minor siblings of child victims). If an immigrant’s application or petition under VAWA is not yet approved, a preliminary *prima facie* case determination from USCIS is sufficient for purposes of receiving government benefits.
 8. 8 U.S.C. § 1611. Non-qualified immigrants are not eligible for the following federal public benefits: Medicaid, CHIP, TANF, SNAP, and SSI. Yet they remain eligible for Emergency Medicaid (Restricted Medi-Cal in California), public health, and many other federal programs that are not defined as a “federal public benefit.” For more information on federal immigrant eligibility rules, see *Guide to Immigrant Eligibility for Federal Programs*, 4th ed., National Immigration Law Center.
 9. For example, individuals with Temporary Protected Status (TPS) are in the U.S. lawfully, but they are considered “non-qualified” for federal benefit purposes because their status is not listed among the “qualified” immigrants.

Special Note on the 5-year Bar

Most immigrants who are considered “qualified” are also subject to a waiting period, commonly known as “the 5-year bar,” in order to be eligible for “federal public benefits.”¹⁰ California has taken up the option to provide full-scope Medicaid or CHIP coverage to “lawfully residing” immigrant children and pregnant women without any waiting period and access federal funds to support this coverage.¹¹ In addition, California currently uses state funds to provide full-scope Medi-Cal to other “qualified” immigrants during the 5-year bar, *i.e.*, non-pregnant adults, as well as other “lawfully present” immigrants who are otherwise eligible for Medi-Cal.¹²

Currently, “qualified” immigrants in the 5-year bar, ages 21-64, without children, with incomes below 138% FPL are enrolled in full-scope Medi-Cal. Starting in 2017, these immigrants will be given the option to dually enroll in Covered California and Medi-Cal via the *Newly Qualified Immigrant Wrap Program*. Covered California will be the primary insurance, and Medi-Cal will cover benefits not included in Covered California, such as adult dental.¹³ DHCS will pay the premiums and out-of-pocket costs of these individuals. Those who do not enroll dually in Covered California

-
10. 8 U.S.C § 1613. “Qualified” immigrants who have met or are exempt from the 5 year bar are eligible for federal funding under Medicaid. The 5-year bar does not apply to refugees, asylees, battered spouses and children, and “non-qualified” immigrants. 8 U.S.C. § 1613. For more details, see Department of Health and Human Services Centers for Medicare and Medicaid Services “Questions and Answers on the Five-Year Bar,” available at: http://niwaplibrary.wcl.american.edu/public-benefits/benefits-for-qualified-immigrants/c_Public%20Benefits%205year%20bar_6.23.04OVW11.15.04.pdf/at_download/file.
 11. 42 U.S.C. §§ 1396b(v)(4) and 1397gg(e)(1)(J); CMS, State Health Official Letter #10-006, “Medicaid and CHIP Coverage of “Lawfully Residing” Children and Pregnant Women,” (Jul. 1, 2010), <http://downloads.cms.gov/cmmsgov/archived-downloads/SMDL/downloads/sho10006.pdf>. Immigrants who are considered “lawfully residing” under this state option include all “qualified” immigrants and “non-qualified” immigrants who are lawfully present in the U.S. For a summary of “lawfully residing” immigration categories, see “‘Lawfully Residing’ Children and Pregnant Women Eligible for Medicaid and CHIP,” National Immigration Law Center, September 2012, available at: <https://www.nilc.org/document.html?id=34>.
 12. See State Plan Amendment 09-014, CA DHCS, (May 25, 2010) available at: <http://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA%2009-014.pdf>.
 13. Welf. & Inst. Code § 14102.

will have their Medi-Cal benefits reduced to restricted scope benefits. All other “qualified” immigrants who have been in the United States less than five years, such as parents and children, will continue to receive full-scope Medi-Cal, provided they meet the other eligibility requirements.

b. Lawfully Present and PRUCOL

Since 1996, most immigrants who were considered “lawfully present” in the U.S. for immigration purposes, whether they were “qualified” or not, have been eligible for full-scope Medi-Cal benefits in California. Coverage for these full-scope eligible immigrants, commonly referred to as PRUCOL, meaning Permanently Residing (in the United States) Under Color of Law,¹⁴ have been historically paid for with state funds, since these immigrants are not federally qualified. However, the Affordable Care Act’s definition of those who are “lawfully present” now includes many, but not all, immigration status categories under the definition of PRUCOL, e.g., Deferred Action for Childhood Arrivals (DACA) status.¹⁵ Nonetheless, while individuals with valid, non-immigrant visas are considered “lawfully present” for purposes of Covered California and APTCs, they are currently not given full-scope Medi-Cal benefits.¹⁶ Examples of immigrants who are eligible for full-scope Medi-Cal under PRUCOL include individuals who are:

- Paroled (by an immigration court) for less than one year;
- Subject to an order of supervision;
- Granted a stay of deportation;

14. The state definition is found at 22 CCR § 50301.3 and varies from the former federal regulation that was found at 42 C.F.R. § 435.408 until removed effective July 12, 2006. Although federal funding no longer covers some of these individuals, the state has chosen to continue to provide care for the individuals on the list who are not also deemed “qualified.” Article 7 in the *Medi-Cal Eligibility Procedures Manual* as well as all forms referring to PRUCOL status are still valid.

15. 45 C.F.R. § 152.2 (lawfully present); MEDIL 14-45 (Aug. 6, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-45.pdf>.

16. DHCS has no clear policy guidance on its denial of full-scope benefits to many non-immigrant visa holders. See question 7 of its Citizenship/Immigration FAQ at <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Medi-CalFAQs2014b.aspx>. While use of Medi-Cal is generally not a problem for immigrants (see section on Public Charge in Appendix B.), given the unsettled policy in this area and different nature of a non-immigrant visa, individuals planning on renewing a non-immigrant visa should seek immigration advice prior to applying for full-scope Medi-Cal.

- Granted indefinite voluntary departure;
- Granted voluntary departure while awaiting the issuance of a visa;
- Granted a suspension of deportation; or
- In deferred action status.

In addition, individuals may be PRUCOL who have:

- An approved immediate relative visa petition;
- Filed for adjustment to LPR status;
- Continuously resided in the United States since before January 1, 1972;
- Applied for a T-visa (victim of trafficking);¹⁷
- Applied for or granted a U-visa (victims of domestic violence or other serious crimes);¹⁸ or
- A good faith belief that a) they are known to the Department of Homeland Security, and b) DHS does not intend to deport them because of their immigration status or individual circumstances.¹⁹

2. Restricted Scope Medi-Cal

Individuals who are not lawfully present but who otherwise meet Medi-Cal eligibility criteria are eligible for restricted scope Medi-Cal, often referred to as Emergency Medi-Cal.²⁰ Eligible beneficiaries receive a Benefits Identification Card (BIC) similar to beneficiaries with full-scope Medi-Cal, but their Medi-Cal aid code only allows them to access certain services, discussed below. Unlike many other Medi-Cal beneficiaries, individuals enrolled in restricted scope Medi-Cal do not enroll in managed care plans; they access Medi-Cal services only on a fee-for-service basis.²¹

17. Welf. & Inst. Code §§ 14005.2 and 18945(b). Individuals granted T-visas are considered “qualified” immigrants, but individuals whose T-visa application is pending are considered eligible as PRUCOL.

18. Welf. & Inst. Code §§ 14005.2 and 18945(b).

19. This is known as the “catch-all” category of PRUCOL, the last box on the MC-13. Because immigration laws continually evolve, an individual may have a status that is not specifically listed but are considered lawfully present by USCIS. Thus, individuals whose specific status is not listed, but can claim they have a good faith belief they are known to USCIS and there are no steps being taken to deport them, can check this category. Individuals claiming PRUCOL based on their individual circumstances must document those circumstances on the G-485 SAVE form and may need to provide additional documentation with their application, e.g., medical certification.

20. Applicants who fail to verify their citizenship or immigration status may also be placed in restricted scope.

21. See Chapter 5, Section D.1.

Note: Health for All Kids (SB 75). As part of California’s 2015-2016 budget process, Medi-Cal was expanded to provide health coverage for all otherwise eligible children under age 19 regardless of immigration status.²² As of press time, this new program is still in the implementation phase and children who were previously eligible for only restricted scope Medi-Cal due to their immigration status should be transferred into full-scope Medi-Cal starting in May 2016. Previously unenrolled children and children enrolled in local programs such as Healthy Kids may enroll as well. Information regarding the implementation of this program is available at www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/sb-75.aspx.

a. Services Covered Under Restricted Medi-Cal

- **Emergency medical services:** Any medical services needed to treat a medical condition that is acute or severe enough that the absence of immediate medical attention is expected to result in serious jeopardy of health, impairment of bodily functions, or dysfunction of any bodily organ or part. This can include services such as kidney dialysis that are provided outside of a hospital emergency department.²³
- **Pregnancy-related services:** In addition to prenatal care, labor and delivery, and abortion services, pregnancy-related services include all Medi-Cal services that are medically necessary as determined by the treating provider during either the pregnancy or the 60-day postpartum period. Medi-Cal’s

22. Welf. & Inst. Code § 14007.8 enacted as SB 75 (2015-2016 budget) and SB 4 in 2015.

23. 42 U.S.C. § 1396b(v)(3); 42 C.F.R. § 440.225; Welf. & Inst. Code § 14007.5(d). Note that “emergency medical services” are not limited to hospital emergency departments, as the definition permits ongoing treatment or inpatient care if required to prevent serious injury or death. For example, individuals with restricted-scope Medi-Cal may be eligible for kidney dialysis, including related hospital, physician, medical transportation services, medical supplies or drugs related to the treatment of renal failure or complications with dialysis. *Crespin v. Kizer* 226 Cal. App. 3rd 498 (1990); ACWDL 88-84 (December 12, 1988). Aid Code 55 covers non-PRUCOL immigrants without satisfactory immigration status.

dental services are also included.²⁴ Family planning is covered during the postpartum period.²⁵

- **Long-term care:** Some restricted-scope beneficiaries are eligible for Medi-Cal based on their medical condition requiring long-term care in a nursing home.²⁶

b. Additional Programs Available Regardless of Immigration Status

- **Medi-Cal Access Program (MCAP):**²⁷ MCAP provides full-scope services to pregnant women with incomes over 213% through 322% FPL regardless of immigration status.²⁸
- **Breast and Cervical Cancer Treatment Program (BCCTP):** The *State-only* BCCTP provides time-limited Medi-Cal benefits *only for* breast or cervical cancer-related treatment to “not qualified” immigrants (including undocumented individuals) of any age who do not have insurance or have too little insurance.²⁹ Time-limited benefits are cancer-related services for up to 18 months for breast cancer and 24 months for cervical cancer. See Chapters 3, Section D.1.

24. See DHCS’s Medi-Cal Dental Provider Program Handbook, p. 4-10, available at <http://www.denti-cal.ca.gov/WSI/Publications.jsp?fname=ProvManual>.

25. Welf. & Inst. Code § 14007.7. See *also*, fn. 50 in Chapter 2.

26. *Crespin v. Belshe*, Alameda County Superior Court, No. 636714-5 (state’s motion to dissolve permanent injunction prohibiting state from cutting long-term care services to undocumented on basis of Welf. & Inst. Code § 14007.65 denied); see *also Crespin v. Kizer*, 226 Cal. App. 3rd 498 (1990).

27. The Medi-Cal Access Program used to be the Access for Infants and Mothers (AIM) program. Ins. Code §§ 12695 *et seq.*; and 10 CCR §§ 1699.100, *et seq.* As part of the Governor’s 2014-1015 Budget, AIM was transitioned from the Managed Risk Medical Insurance Board to the Department of Health Care Services (DHCS) and renamed the Medi-Cal Access Program (MCAP). Welf. & Inst. Code §§ 15800 *et seq.* In addition to state funding, California receives federal funding to provide prenatal care to immigrant women through MCAP. See 42 C.F.R. § 457.10; CMS, State Health Official Letter #09-006, “CHIPRA #2” (May 11, 2009), <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/sho051109.pdf>; CA CHIP Amendment CS9, available at: <http://www.dhcs.ca.gov/formsandpubs/laws/Documents/CS9ocr.pdf>.

28. Even though MCAP is administered by DHCS and includes “Medi-Cal” in its title, MCAP is not a Medi-Cal program and does not provide access to Medi-Cal’s benefits or provider networks. MCAP is a Children’s Health Insurance Program, also known as CHIP.

29. Health & Safety Code §§ 104161-104163.

- **Child Health and Disability Prevention Program:** The CHDP program provides free initial, periodic and inter-periodic (according to a “periodicity schedule”) medical health screens, immunizations and follow up county medical treatment to children and youth with family income up to 213% FPL.³⁰
- **Child Health and Disability Prevention (CHDP) Gateway Program:** Children due for a periodic screening under the CHDP Program may be temporarily enrolled in full-scope “presumptive eligibility” Medi-Cal through the CHDP Gateway program up to two times a year.³¹ See Chapter 5, Section A.2.e.
- **Minor Consent Services:** Minors may get sensitive services such as pregnancy, substance abuse, and mental health services without parental consent and without providing documentation of immigration status.³² See Chapter 3, Section C.1.
- **Health for All Kids (SB 75):** The expansion of Medi-Cal to undocumented children in 2016 will create parallel aid codes that allow children under age 19 to access full-scope Medi-Cal services in programs that previously offered them only restricted benefits.³³

B. Incarceration/Institutionalization

Federal Medicaid law specifically precludes payment for most medical services to inmates of public institutions, which could include correctional facilities for adults or children.³⁴ Individuals who are on house arrest, parole, probation, or are assigned community service are not living in a correctional facility, thus they are not considered inmates and Medi-Cal will still pay for their care.³⁵

Medi-Cal does allow payment for acute inpatient hospital services for inmates of

30. Health & Safety Code §§ 124030 *et seq.*; Medi-Cal Provider Manual, *Child Health and Disability Program (CHDP) Eligibility: CHDP Services*.

31. ACWDL 03-33 (Jan. 9, 2003), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c03-03.pdf>; MEDIL 15-26 (Aug. 28, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-26.pdf>; CHDP Provider Information Notice, 15-03.

32. *Medi-Cal Eligibility Procedures Manual*, 4V-2.

33. See Welf. & Inst. Code § 14007.8 enacted as SB 75 (2015-2016 budget) and SB 4 in 2015. Information on the implementation of this new program can be found at DHCS’s SB 75 webpage at <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/SB-75.aspx>.

34. 42 U.S.C. § 1396d(a)(29)(A); 42 C.F.R. §§ 435.1009 - 1010.

35. 42 C.F.R. § 435.1010; 22 CCR § 50273. See also ACWDL 93-41 (Jul. 7, 1993).

county and state prisons who are eligible for Medi-Cal and who are hospitalized off the grounds of the correctional facility during their incarceration. This program is known as the Medi-Cal Inmate Eligibility Program (MCIEP).³⁶ Inmates who are enrolled in MCIEP do not receive full Medi-Cal benefits; their Medi-Cal services are limited to the services related to their hospitalization.

Individuals who are already on Medi-Cal at the time of their incarceration have their full Medi-Cal suspended for up to one year.³⁷ For information on applying for or reinstating Medi-Cal upon leaving a public institution, see Chapter 5, Section A.4.

Some children who have been removed from their homes are also not eligible for Medi-Cal if they are inmates of a public institution, such as a correctional non-medical facility.³⁸ This Medi-Cal eligibility bar is complicated; however, it is narrowly applied. There are many groups of children that the bar does not apply to. The following groups may be eligible for full scope Medi-Cal:

- Children in a local agency facility pending foster care placement;³⁹
- Children residing at a facility for vocational training or for educational purposes;⁴⁰
- Minors in juvenile detention centers on probation with a suitable placement order;⁴¹
 - Children at a medical institution or mental health institution;⁴²
 - Children in a public institution for a temporary period pending more suitable placement;⁴³ and

36. Penal Code § 5072; Welf. & Inst. Code §§ 14053.7 and 14053.8. See also ACWDL 14-26 (May 6, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-26.pdf>; ACWDL 11-27 (Jun. 24, 2011), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c11-27.pdf>.

37. Welf. & Inst. Code § 14011.10; ACWDL 14-26 (May 6, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-26.pdf>.

38. 42 U.S.C. § 1396d(a)(27); 42 CFR §§ 435.1008-1009; 22 CCR §§ 50271, 50273, 50046-50052.5. See also *Medi-Cal Eligibility Procedures Manual*, 6D.

39. 22 CCR §§ 50046 and 50273; *Medi-Cal Eligibility Procedures Manual*, 6D-2.

40. *Id.*

41. *Id.* See 22 CCR §§ 50273(c)(5) – (8); *Medi-Cal Eligibility Procedures Manual*, 6D-1.

42. 42 C.F.R. §§ 435.1008-1009; 22 CCR §§ 50048-49, 50273(c)(11); *Medi-Cal Eligibility Procedures Manual*, 6D-1.

43. 22 CCR § 50046; *Medi-Cal Eligibility Procedures Manual*, 6D-1 – 6D-2.

- Children at nonprofit private child-care institutions.⁴⁴

C. Residency

California residency is required to receive Medi-Cal and MCAP; however, there is no minimum amount of time an individual must reside in California to establish residence.⁴⁵ Individuals may not be denied eligibility based on residency if they have just moved to the state or if they temporarily leave the state.⁴⁶ To establish residency, an individual age 21 or over must live in California and either have an intent to reside in the state or have a job commitment or be seeking employment in California.⁴⁷ Children under age 21 may use where they reside or the residency of the parent or caretaker with whom they live to determine residency.⁴⁸ Other individuals who may be California residents include those without fixed addresses, individuals who are incapable of indicating their intent to reside in California, as well as individuals who have been institutionalized out-of-state by their parents or an agent of the state.⁴⁹ For information on verifying residency, see Chapter 5, Section B.2.d.

Immigration status may not be used to deny state residency.⁵⁰ For example, individuals who were lawfully present in the U.S. with unexpired, non-immigrant visas⁵¹ had been previously denied Medi-Cal because DHCS claimed the terms of the visa issued by USCIS prevented them from establishing state residency.⁵² Yet based on Medi-Cal's definition of state residency, non-immigrants may have an *intent to reside* in California for the length of their visa or beyond and there is no minimum

44. 42 C.F.R. §§ 435.1008-1009.

45. 42 C.F.R. §§ 435.403; Welf. & Inst. Code § 14007; 22 CCR § 50320. Residency requirements for the Medi-Cal Access Program (MCAP) for pregnant women are at Ins. Code § 12698(a) and 10 CCR § 2699.100(v).

46. 42 C.F.R. §§ 435.403(j)(1) and (3); Welf. & Inst. Code § 14007; 22 CCR § 50320. For MCAP, Ins. Code § 12698(a) and 10 CCR § 2699.100(v).

47. 42 C.F.R. § 435.403(h); 22 CCR § 50320(b).

48. 42 C.F.R. § 435.403(i); 22 CCR § 50320(c).

49. 42 C.F.R. §§ 435.403; Welf. & Inst. Code § 14007.15.

50. 42 C.F.R. § 435.956(c)(2).

51. Non-immigrant visas include individuals granted worker, student, tourist, or business visas for example. For a complete list of non-immigrant visas, see the Immigration and Naturalization Act, 8 U.S.C. § 1101(a)(15).

52. Individuals with expired non-immigrant visas are no longer lawfully present and are considered undocumented immigrants.

time requirement.⁵³

D. Other Health Coverage

Individuals with other health coverage may be eligible for Medi-Cal, but they must apply for and use other health coverage that they have or that is available to them.⁵⁴ Medi-Cal beneficiaries who are enrolled in managed care are also subject to this requirement due to current contracting provisions,⁵⁵ which can make coordination difficult between the Medi-Cal managed care plan and the other health coverage plan.

California is obligated to seek other sources of health coverage and to collect payment from liable third parties.⁵⁶ As such, California requires that applicants and beneficiaries assign rights to medical support and help locate liable third parties, even going so far as to helping to establish paternity of children born outside of marriage so that the state may seek payment for medical services provided to the child.⁵⁷

Exceptions: The Medi-Cal Access Program, a separate program administered by DHCS, is only available to insured women whose insurance does not cover maternity services or with maternity-only deductibles or co-payments greater than \$500. For more information on MCAP, see Chapter 2, Section C.3.b. Similarly, the

53. Non-immigrants with valid visas can claim state residency for Medi-Cal purposes, but should first be advised to seek legal advice because there may be immigration consequences depending on the type of visa. Individuals who are lawfully present yet denied Medi-Cal due to immigration status may enroll in Covered California even if below 100% FPL. See Chapter 4, Section C.2.a.

54. 42 U.S.C. § 1396a(a)(25); Welf. & Inst. Code § 10020; 22 CCR § 50763(a). Note that the California regulations specify that Medi-Cal applicants and beneficiaries shall “apply for, and/or retain any available health care coverage when no cost is involved” but DHCS regularly requires beneficiaries to use other health coverage with co-pays and deductibles. See *also* Welf. & Inst. Code § 14023.7 (regarding provider obligations to bill private health insurance); Welf. & Inst. Code § 14023 (regarding penalties for failure to disclose entitlement to other health coverage.).

55. See 22 CCR § 50761 allowing this arrangement via the contract.

56. 42 U.S.C. § 1396a(a)(25); 42 C.F.R. §§ 433.137-433.140.

57. Welf. & Inst. Code § 14008.6. However the regulations do provide good cause exceptions where doing so would cause harm to the child, parent or other caretaker relative. 22 CCR § 50771.5(b).

federal Breast & Cervical Cancer Treatment Program is only available to women with no other creditable coverage that covers her breast or cervical cancer treatment. Women applying for the state-only Breast & Cervical Cancer Treatment Program (BCCTP) must be uninsured or underinsured. For more information on BCCTP, see Chapter 3, Section E.1.

E. Tax Filing Status

Medi-Cal beneficiaries are not required to file a federal income tax return and many Medi-Cal beneficiaries have household income well below the minimum income level at which a U.S. citizen or resident must file an income tax return.⁵⁸ Some beneficiaries may still choose to file taxes to collect other federal tax credits. With the implementation of the Modified Adjusted Gross Income (MAGI) income counting methodology, this has been a source of confusion for some county eligibility workers. However, Medi-Cal does not require applicants or beneficiaries to file taxes and, in fact, has special “non-filer” rules for determining the household size for those who do not file taxes. See Chapter 2, Section A for information on the tax filer and non-filer rules.

F. The Medi-Cal Hierarchy

In evaluating an individual for Medi-Cal, the general principle is to place the individual in the most beneficial aid code for which the individual is eligible. For example, if someone is eligible for a program that offers free Medi-Cal and a program that offers Medi-Cal with a Share of Cost, the individual should be put in the free Medi-Cal program. Because MAGI Medi-Cal programs do not need an assets (or disability) determination to maintain eligibility, they are thought to be more beneficial than non-MAGI programs as it is easier to automatically renew eligibility in a MAGI program. Nonetheless, some non-MAGI programs, which DHCS refers to as the “Mega-Mandatory” programs, do not require applicants or recipients to do anything because they are linked to other public benefits programs and the eligibility determination in the other program suffices for Medi-Cal as well. Individuals who

58. 26 C.F.R. § 151-1 covers the personal exemption amount and is inflation adjusted annually by the IRS and posted on the IRS website. For example, a married couple under age 65 earning less than \$20,300 did not need to file an income tax return in 2014 unless they were seeking a refund of taxes paid.

are in these programs, e.g., SSI-linked Medi-Cal, CalWORKS-linked Medi-Cal, should stay in those programs as they do not have to do anything to keep their Medi-Cal as long as they are in the other program. For more information on the Mega-Mandatory programs and aid codes, see DHCS All County Welfare Director's Letter 14-35.

Chapter 2: MAGI Medi-Cal Programs

Chapter 2. MAGI Medi-Cal Programs

A. Constructing Households

1. Tax Filer Rules
2. Non-Filer Rules
3. Counting Households with a Pregnant Woman

B. Counting Income

C. MAGI Medi-Cal Programs

- a. Expansion Adults
2. Parents and Caretaker Relatives
3. Pregnant Women
 - a. MAGI Medi-Cal Programs for Pregnant Women
 - b. Medi-Cal Access Program (MCAP) for Pregnant Women and Newborns up to Age 2
4. Children: MAGI Medi-Cal, the Targeted Low-Income Children's Program, and MCAP Infants and Babies
 - a. Infants: 0 to 1 year old
 - b. Children: Ages 1 to 6
 - c. Children: Ages 6 to 19

2. MAGI Medi-Cal Programs

The Affordable Care Act introduced a new methodology – Modified Adjusted Gross Income (MAGI) – to define a family’s size and count income in order to determine eligibility for insurance affordability programs.¹ As a result, household determination and income counting rules are largely aligned among Medi-Cal, the Medi-Cal Access Program (MCAP, the low-cost health insurance for moderate income pregnant women), and Covered California, with some exceptions. See Chapter 4, Section C.2 for a discussion of MAGI and Covered California.

For Medi-Cal, the MAGI rules apply to the following programs: Expansion Adults (adults aged 19 through 64); Parents and Caretaker Relatives; Pregnant Women; and Children.² In general, unless an individual gets Medi-Cal through a linked program such as SSI or CalWORKs, or due to former foster youth status, Medi-Cal eligibility is reviewed for the MAGI programs before looking to the Non-MAGI programs.

While the Medi-Cal consumer protection programs Transitional Medi-Cal and Continuous Eligibility for Children are not MAGI programs, they are mentioned throughout this chapter because they are critical eligibility extenders for families that allow those in MAGI Parents/Caretaker Relatives and MAGI Medi-Cal Children’s programs who are leaving Medi-Cal due to increased income to remain on Medi-Cal for up to 12 months. Complete descriptions of these programs are found in Chapter 3.

A. Constructing Households

To determine Medi-Cal eligibility, advocates must understand whose income counts and what income counts. To understand whose income counts, start with the

-
1. 42 U.S.C. § 1396a(e)(14); Welf. & Inst. Code § 14005.64.
 2. Medi-Cal’s Tuberculosis Program and the Refugee Medical Assistance program also now use the MAGI income methodology. See Welf. & Inst. Code 14005.20(b)(2) and ACWDL 15-16 (Mar. 20, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-16.pdf>. These programs, however, are not considered MAGI Medi-Cal in the Medi-Cal hierarchy because they are limited in scope or duration and should only be used when an individual is not eligible for any other form of free Medi-Cal. For that reason, we have included them in Chapter 3 as Non-MAGI Medi-Cal programs despite their adoption of MAGI income rules.

construction of the household. Because many Medi-Cal households are not required to file taxes as their income is below the filing threshold, the MAGI Medi-Cal rules are divided broadly into “tax filer” and “non-filer” rules.³ Regardless of whether a family files taxes or not, individuals in the same household may actually have different household sizes for the purpose of the Medi-Cal application.

1. Tax Filer Rules

Tax filer rules apply to individuals who expect to file a federal income tax return and, with some exceptions, individuals who will be claimed as dependents on a federal tax return for the taxable year.⁴ Tax filer rules apply to individuals who will still file taxes even if they are not required to do so.

For filers, the household consists of the tax filer and anyone the filer expects to claim as a dependent.⁵ In addition, married couples living together should always include the spouse in the household, regardless of whether they will be filing jointly or not.⁶ For dependents who are the biological, adopted or step children of the tax filer, the household consists of the tax filer, the tax filer’s spouse, and all of the tax filer’s dependents.

There are limited exceptions to the tax filer rules. A tax dependent who meets one of the following exceptions must use the *non-filer* rules:⁷

1. The dependent is not the spouse or a biological, adopted, or step-child of the taxpayer;
2. The dependent is a child under the age of 19 (or 21 if a full time student living at home) who lives with both parents and the parents plan on filing taxes separately; or

3. Household rules are at 42 C.F.R. § 435.603(d) and (f). DHCS has created a flow chart describing the rules available at http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/Co-OPS-Sup/MAGI-MCal-HHSizeFlowChart-v1_2-20140815.pdf.

4. 42 C.F.R. § 435.603(f)(1).

5. *Id.*

6. Although MAGI Medi-Cal has rules on household construction for tax filers, just as there is no requirement to file taxes, there is also no requirement to file a joint return if married in order to receive Medi-Cal as there is for Covered California.

7. 42 C.F.R. § 435.603(f)(2).

3. The dependent is a child under the age of 19 (or 21 if a full time student living at home) and a parent of the child both does not live with the child and is claiming the child on his or her tax return.

Given the different household counting rules that apply for tax filers and their dependents, it is possible for tax dependents to have a different household size than the individual who claims them. For example, a single parent living with only one child that they do not claim on their taxes would have a household of one. The child would follow the rules below and have a household of two.

2. Non-Filer Rules

Non-filers are individuals who do not expect to file a federal income tax return for the taxable year and do not expect to be claimed as a tax dependent on a federal income tax return.⁸

For non-filers (and tax dependents who fall in one of the non-filer exceptions), the household consists of any of the following who *live* with the individual:⁹

1. The individual;
2. The individual's spouse (do not count unmarried partners);
3. The individual's children who are under age 19 or age 21 if a full time student¹⁰ (do not count a child who is not a biological, step, or adopted child); and
4. For individuals under age 19 or 21 if a full time student, parents in the home and siblings in the home who are under age 19 or 21 if full-time students.

Again, it is important to construct the household from the perspective of each individual involved as each individual may have a different household size.

8. 42 C.F.R. § 435.603(f)(3).

9. *Id.* Note that in this section child, parent, and sibling includes “natural, adopted, and step.”

10. 42 C.F.R. § 435.603(f)(3)(iv). For the adoption of the full-time student option, see California's State Plan Amendment incorporating MAGI-Based Income Methodologies, SPA 13-0023-MM, available at <http://www.dhcs.ca.gov/formsandpubs/laws/Documents/Approved%20SPA%2013-0023.pdf>.

3. Counting Households with a Pregnant Woman

Pregnant women are treated differently for Medi-Cal and MCAP than for Covered California. Medi-Cal and MCAP count the number of children a woman is expecting as part of the household, so in most cases, a single pregnant woman with no other children would count as a household of two, or three if she is expecting twins, four if she is expecting triplets, etc.¹¹ This is true whether the woman is the filer or non-filer, or another household member, assuming that she has reported the pregnancy. Pregnancy is reported through self-declaration.¹²

B. Counting Income

MAGI Medi-Cal and MCAP use largely the same MAGI methodology that is used by Covered California for counting income. Taxable income, Social Security benefits, tax-exempt interest and foreign earned income are all included. Because many Medi-Cal beneficiaries either do not file or have not yet filed taxes, Medi-Cal applicants will also have to construct what their taxable income would be if they did file taxes and may need to consult the first page of IRS form 1040 to determine their adjusted gross income.

For a complete explanation of the general MAGI income rules, see Chapter 4, Section C.2.

There are several ways in which MAGI for Medi-Cal and MCAP is treated differently than for Covered California:

- Special Types of Income:
 - Lump sums of income (*i.e.*, gambling or lottery winnings, awards, backpay, etc.) are counted only in the month received for Medi-Cal.¹³

11. 42 C.F.R. § 435.603(b) and California's State Plan Amendment incorporating MAGI-Based Income Methodologies, SPA 13-0023-MM.

12. Welf. & Inst. Code § 14011.15(d).

13. 42 C.F.R. § 435.603(e)(1); MEDIL 15-03 (Feb. 27, 2015) p. 10, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-03.pdf>. Note that some lump sums, such as insurance settlements for personal injury or educational scholarships used for educational expenses, are not counted at all.

Thus, no matter the size of the lump sum of income, a person would lose Medi-Cal for only the month received and could go back on the next month provided the rest of the household income is below the income eligibility limit. For MCAP, lump sums are only relevant at the time of application, in that they would be counted as income if received during that month. Lump sums of income received after a woman is already on MCAP would not impact her eligibility just as any other increases do not. MCAP eligibility is a “point-in-time” determination, meaning that once a woman’s eligibility for MCAP is established, her coverage continues throughout her pregnancy and through the second month following the end of her pregnancy.

- Scholarships or fellowship grants for education expenses (not living expenses) are excluded from income.¹⁴
- American Indians and Alaskan Natives can exclude several tribal-related sources of income deriving from trusts, sale of tribal or reservation land or resources, and scholarships from the Bureau of Indian Affairs.¹⁵
- Monthly vs. Annual income: MAGI Medi-Cal rules allow counties to base eligibility on monthly rather than annual income. If an applicant provides both monthly and annual income, counties are instructed to divide the annual income by 12, compare it to the monthly amount also provided, and use the lower of the two amounts.¹⁶

Advocacy Tip: DHCS issued a chart to aid county workers in counting MAGI income that summarizes what income counts, what income should be excluded, the allowable deductions from adjusted gross income, and how to handle certain lump sum exceptions that advocates may find useful. This can be found attached to Medi-Cal Eligibility Division Information Letter 15-03.¹⁷

14. 42 C.F.R. § 435.603(e)(2); MEDIL 15-03, p. 10, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-03.pdf>.

15. 42 C.F.R. § 435.603(e)(3); MEDIL 15-03, p. 11, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-03.pdf>.

16. ACWDL 15-06 (Jan. 21, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-06.pdf>.

17. MEDIL 15-03 is found at <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-03.pdf>.

C. MAGI Medi-Cal Programs

The four MAGI Medi-Cal Programs – Expansion Adults, Parents and Caretaker Relatives, Pregnant Women, and Children – comprise the majority of the Medi-Cal population.¹⁸ These programs have varying eligibility criteria, such as different income thresholds and age limits. However, under the MAGI methodology, none of these programs have limits on assets or resources.

1. Expansion Adults

Pursuant to the Affordable Care Act’s Medicaid expansion provision for adults,¹⁹ in June 2013 California enacted legislation expanding Medi-Cal eligibility to adults without dependent children.²⁰ Under those laws, adults aged 19 through 64, who are not pregnant, not eligible for Medicare, and with incomes below 138% of the FPL became eligible for Medi-Cal as of January 1, 2014.²¹ These Medicaid “Expansion

-
18. Except for the Expansion Adult program, which was newly created by the ACA, the beneficiaries covered by these programs were eligible for Medi-Cal under the pre-ACA Medi-Cal rules for the Social Security Act 1931(b); the FPL Percentage programs for pregnant women and children; the Medically Needy and Medically Indigent programs; and the Targeted Low Income Children’s Program (formerly known in California as the Healthy Families program).
 19. The Supreme Court’s decision in *National Federation of Independent Business (NFIB) v. Sebelius* (567 U.S. ____ (2012), 132 S.Ct. 2566) upheld the ACA’s adult expansion group as a new mandatory coverage group. But the practical impact of the Court’s decision made the ACA’s Medicaid expansion optional for states because states that do not to implement the expansion lose only ACA Medicaid expansion funds, as opposed to losing all Medicaid funding.
 20. ABx 11 (Perez/Pan); Welf. & Inst. Code § 14005.60. California was an early adopter of the ACA’s expansion of Medicaid to non-disabled adults without dependent children. Under an 1115 Medicaid Waiver known as the “Bridge to Reform,” California began expanding coverage in 2011 to low-income “childless adults” through county-based Low Income Health Programs (LIHPs). By 2013, LIHPs covered approximately 660,000 people in fifty-three counties. Five counties – Fresno, Merced, Stanislaus, San Luis Obispo, and Santa Barbara – did not establish a LIHP. LIHPs ended December 31, 2013, with the majority of LIHP enrollees transitioned to Medi-Cal as expansion adults in January 2014. LIHP enrollees were assigned aid code L1 when they transitioned to Medi-Cal, and if they remained eligible under the Expansion Adult category were to be moved to aid code M1 going forward. ACWDL 14-01 (Jan. 9, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-01.pdf>.
 21. Aid code M1 (full-scope, no-cost Medi-Cal for expansion adults); aid code M2 (emergency, pregnancy related and long term care services to undocumented expansion adults); aid code P3 (hospital presumptive eligibility for expansion adults).

Adults,” also commonly referred to as “childless adults,” represent the largest expansion of Medicaid eligibility since the program began in 1965.²²

Age: Expansion Adults must be at least 19 years old and under age 65.²³

Beneficiaries who turn 65 while they are enrolled in Medi-Cal as an Expansion Adult must be evaluated for eligibility in all other Medi-Cal programs, *i.e.*, non-MAGI programs such as for the aged, blind or disabled, before they are disenrolled.²⁴

Income Limit: Expansion Adults must have incomes at or below 138% FPL, based on MAGI methodology.²⁵

Not Pregnant: Pregnant applicants are not Medi-Cal eligible as an Expansion Adult.²⁶ Pregnant applicants without children already in the home are evaluated under Medi-Cal categories that are specifically for pregnant women. See Section 3.

22. Note that “childless adults” is a misnomer. As the income limit for the Parents and Caretaker Relatives category (discussed below) is lower than the limit for the Expansion Adults, there are, in fact, adults who have children in the Expansion Adult group.

23. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII); 42 C.F.R. § 435.119(b)(1); Welf. & Inst. Code § 14005.60(a); MEDIL 13-12 (Sep. 16, 2013) at p. 6, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL%2013-12%20wAttach.pdf>.

24. Welf. & Inst. Code § 14005.37(d).

25. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII); 42 C.F.R. § 435.119(b)(5) (citing 133% FPL, but with an across the board 5% income disregard for MAGI, the income limit is 138% FPL); Welf. & Inst. Code §§ 14005.60(b) and 14005.64(b).

26. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII); 42 C.F.R. § 435.119(b)(2); Welf. & Inst. Code § 14005.60(a).

Advocacy Tip: The state is not obligated to track the pregnancy status of women once they are enrolled in the Expansion Adult group.²⁷ Therefore, if a woman is enrolled as an Expansion Adult and later becomes pregnant, she may remain in the Expansion Adult program so long as she meets the other eligibility criteria.²⁸ Effective August 1, 2015, otherwise eligible pregnant women qualify for full-scope Medi-Cal with income up to 138% FPL.²⁹ See Section 3. Thus, if a woman in the Expansion Adult category becomes pregnant and updates her on-line account or informs her county, she may remain in the Expansion Adult group instead of being moved to the aid code for full-scope Medi-Cal for pregnant women. This approach avoids a re-evaluation of eligibility for the whole household.³⁰

Eligibility for Medicare Part A or B: Expansion Adults must not be eligible for Medicare Part A or B.³¹

-
27. CMS "Medicaid and CHIP FAQs: Funding for the New Adult Group, Coverage of Former Foster Care Children and CHIP Financing" (Dec. 2013), Q.4 at p.2. <https://www.medicaid.gov/federal-policy-guidance/downloads/faq-12-27-13-fmap-foster-care-chip.pdf>.
28. *Id.* The state eligibility system CalHEERS was not originally programmed for this, which meant that a county had to take affirmative steps to prevent a pregnant woman from being terminated from the Expansion Adult program and her health plan and moved to fee-for-service under Pregnancy-Related Medi-Cal. MEDIL 14-31 (Jun. 4, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-31.pdf>. This defect in CalHEERS was corrected as of March 2015. See CalHEERS Change Release Notes #15.3.
29. Welf. & Inst. Code §§ 14005.22 and 14005.225; MEDIL 15-25 (Aug. 19, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-25.pdf>. Before August 1, 2015, the income eligibility limit for full-scope coverage under the “pregnant women” category was 60% FPL, while pregnant women over 60% FPL through 213% FPL were enrolled in the separate “low-income pregnant women” category for pregnancy-related care only. See, e.g., MEDIL 14-43 (Jul. 30, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-43.pdf>; see also, 42 U.S.C. § 1396a(a)(10)(A)(i)(IV) and (IX); 42 C.F.R. § 435.116(d)(1); and CMS SHO # 14-002, p. 3
30. More importantly, because beneficiaries in the Expansion Adult group typically receive services through managed care while beneficiaries in the Pregnancy-related group typically use the fee-for-service network, not requiring a woman to switch when she becomes pregnant makes continuity of care easier. For a chart of which programs are managed care and which ones use the fee-for-service network, see <http://www.dhcs.ca.gov/services/Documents/AidCodeChart.pdf>.
31. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII); 42 C.F.R. § 435.119(b)(3).

Eligibility under other Medi-Cal Coverage Programs: Expansion Adults must not be eligible under another Medi-Cal mandatory coverage group.³² For example, under this requirement a woman who otherwise meets all of the other eligibility criteria but is also a stepparent of a child living in the home would not be eligible as an Expansion Adult, but under the Parents and Caretaker Relatives program so long as she meets the eligibility criteria for that program.³³ But note that people who meet the eligibility criteria of an optional Medicaid coverage group, such as the Aged, Blind and Disabled – Medically Needy program (which uses non-MAGI income counting and resource rules) and are also eligible for the Expansion Adult program have the right to choose the program that better suits their needs.³⁴

32. 42 C.F.R. § 435.119(b)(4).

33. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII); Welf. & Inst. Code § 14005.60(a); see *also* ACWDL 14-28 (Jul. 7, 2014), at p.4, example 6, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-28.pdf>.

34. CMS, Frequently Asked Questions, “Medicaid/CHIP Affordable Care Act Implementation FAQs: Eligibility Policy,” at Q.6 (May 22, 2012) (“[E]ligibility for the new adult group based on MAGI does not preclude eligibility for coverage under an optional group that might be otherwise excepted from MAGI methods”), <https://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Eligibility-Policy-FAQs.pdf>. Because the scope of services is identical in MAGI and non-MAGI Medi-Cal, moving to the MAGI group makes passive renewal more likely as there is no additional information required about assets when renewing. See Chapter 6 on Medi-Cal renewal processes.

Expansion Adult: Summary of Eligibility Criteria

Age Limit	<ul style="list-style-type: none"> • 19 years old to under age 65
Income Limit	<ul style="list-style-type: none"> • At or below 138% FPL
Pregnant?	<ul style="list-style-type: none"> • Ineligible for Expansion Adult Medi-Cal if pregnant at time of application; pregnant applicants are evaluated under Medi-Cal programs specifically for pregnant women.
Medicare Part A or B?	<ul style="list-style-type: none"> • Must not be eligible for Medicare Part A or B
Eligible Under other Medi-Cal Programs?	<ul style="list-style-type: none"> • Must be ineligible for all other Medi-Cal mandatory coverage group, <i>i.e.</i>, applicants eligible as a Former Foster Youth or as a Parent/Caretaker Relative must be enrolled in one of those aid codes, even though they may also meet all the eligibility requirements for the Expansion Adult aid code.
<p>Aid Codes: M1 for full-scope, no-cost Medi-Cal for expansion adults; M2 for emergency, pregnancy related and long term care services to undocumented expansion adults; P3 for hospital presumptive eligibility for expansion adults.</p>	

2. Parents and Caretaker Relatives

The MAGI Parents and Caretaker Relatives program is for persons who live with, and have primary responsibility for, a child or children. The MAGI Parents and Caretaker Relatives program is a consolidation of the pre-Affordable Care Act parent and caretaker relative groups, covering those who were eligible under the 1931(b), AFDC-Medically Needy, and Medically Indigent programs.³⁵

Linkage to Child: Individuals eligible under the Parents and Caretaker Relatives must:

- **Be related** to the child by blood, adoption, or marriage. Caretaker relatives can be, among others, parents, grandparents, great-grandparents, stepparents, siblings, stepsiblings, uncles and aunts, cousins, or spouses or registered domestic partners of one of these relatives.³⁶
- **Live** with the child;³⁷ and
- Assume **primary responsibility** for the child.³⁸

For purposes of establishing linkage to a child as a MAGI parent or caretaker relative, the child living with the parent or caretaker relative must be under 18 years old, unless she is 18 and a full-time student in a secondary school or the equivalent level of vocational or technical training and can expect to complete the program by the time she is 19 years old.³⁹ A pregnant woman *during the third trimester of her pregnancy* and with no other children may become eligible as a parent as

35. 42 C.F.R. § 435.110. The aid codes for Parents and Caretaker Relatives are M3 (full scope, no-cost Medi-Cal); M4 (emergency, pregnancy related and LTC services to undocumented parents/caretaker relatives); and P2 (hospital presumptive eligibility, full-scope, no-cost Medi-Cal coverage for parent/caretaker relatives).

36. Welf. & Inst. Code § 14055(a)(1) and (2).

37. Welf. & Inst. Code § 14055(a).

38. *Id.*

39. ACWDL 14-28 (Jul. 7, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-28.pdf>. Note that this definition of a child is different from the definition used when assessing eligibility under AFDC-Medically Needy program. For that program, a child is defined as a non-disabled individual who is under the age of 21 or a disabled individual under the age of 18. *Id.*

there is “linkage” through her expected child.⁴⁰ If the pregnant woman is married to the father of her unborn child and the couple live together, he must be included in the household but he is not eligible as a parent under the Parents and Caretaker Relatives category until the baby is born.

Advocacy Tip: In order to establish the link to Transitional Medi-Cal (see Chapter 3, Section C.5), pregnant women with no other children in the home who apply in their third trimester should be enrolled in full-scope Medi-Cal under the Parents /Caretaker group if their income is at or below 109% FPL, instead of being enrolled under the Pregnant Women’s full-scope 138% FPL expansion. See Section C.3 below. Women enrolled in the Expansion Adult program before becoming pregnant whose income are at or below 109% FPL at the time of reporting their pregnancy in their third trimester also have the option (but are not required) to move to the Parent/Caretaker group, which would establish linkage to Transitional Medi-Cal. Exercising this option could result, however, in a re-evaluation of eligibility for all household members. Finally, pregnant women enrolled in the pregnant women’s full-scope 138% FPL expansion group whose income drops to or below 109% FPL in the third trimester may similarly opt to move to the Parent/Caretaker group to establish the link to Transitional Medi-Cal, although this could also result in re-evaluating eligibility for the rest of the household.⁴¹

40. *Id.* at p.2. This is required under Section 1931(b), which was not repealed by the ACA, and which follows the federal welfare rules in effect in 1988 providing cash assistance to pregnant women starting only in the third trimester when no other children were in the home. See CMS, Frequently Asked Questions, “Medicaid/CHIP Affordable Care Act Implementation FAQs: Eligibility Policy,” (May 22, 2012), at Q.5 (“Coverage under section 1931 of the Act was not repealed with the ACA and will remain in effect...”), <https://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Eligibility-Policy-FAQs.pdf>; see also *Medi-Cal Eligibility Procedures Manual* 5S-3.

41. Continuity of care should also be kept in mind because beneficiaries in the Parent and Caretaker Relatives group typically receive services through managed care while beneficiaries in the Pregnancy-related group typically use the fee-for-service network. This decision may depend on the individual's needs or how services are administered in the county. For a chart of which programs are managed care and which ones use the fee-for-service network, see <http://www.dhcs.ca.gov/services/Documents/AidCodeChart.pdf>.

Age: There is no age limit for eligibility under the Parents and Caretaker Relatives group.

Income Limit: Those eligible under the Parents and Caretaker Relatives group must have incomes at or below 109% FPL.⁴²

Parents and Caretaker Relatives: Summary of Eligibility Criteria

<p>Linkage to a Child</p>	<p>Parents/caretaker relatives must:</p> <ul style="list-style-type: none"> • Be related to the child by blood, adoption or marriage (caretakers include but are not limited to, grandparents, great-grandparents, stepparents, siblings, etc.); • Live with the child; and • Assume primary responsibility.
<p>Age Limit</p>	<ul style="list-style-type: none"> • No age limit to be a parent or caretaker relative
<p>Income Limit</p>	<ul style="list-style-type: none"> • At or below 109% FPL
<p>Aid Codes: M3 for full scope, no-cost Medi-Cal ; M4 for emergency, pregnancy related and long term care services to undocumented parents/caretaker relatives ; P2 for hospital presumptive eligibility, full-scope, no-cost Medi-Cal coverage</p>	

42. The income limit of 109% FPL is the MAGI adjusted income from the pre-ACA income limit of 100% FPL for the 1931(b) program, per federal law requiring states implement MAGI income limits not less than what was in effect at the time the ACA was enacted. 42 U.S.C. § 1396(e)(14).

3. Pregnant Women

As previously discussed, a pregnant woman who has no other children can receive Medi-Cal under the Parent/Caretaker Relative category if she is in her third trimester of pregnancy (see Advocacy Tip in Section C.2 above). And a woman who is enrolled in Medi-Cal as an Expansion Adult and becomes pregnant may choose to remain in the Expansion Adult category so long as she continues to meet the other eligibility criteria.⁴³ See Advocacy Tip in Section C.1 above.

California also provides several MAGI programs specifically for pregnant women, depending on their income: full-scope Medi-Cal for pregnant women up to 138% FPL;⁴⁴ pregnancy-related Medi-Cal for undocumented pregnant women from 0 to 213% FPL, and pregnant women between 138% and 213% FPL, regardless of immigration status; and the Medi-Cal Access Program, or MCAP, for pregnant women with household income over 213% FPL and up to and including 322% FPL, regardless of immigration status.⁴⁵

a. MAGI Medi-Cal Programs for Pregnant Women

Under MAGI Medi-Cal programs for Pregnant Women, whether a pregnant woman qualifies for full-scope Medi-Cal or restricted-scope Medi-Cal is determined by her income and immigration status. Practically speaking, however, she should have access to all medically necessary services, as described below.

Pregnancy: A woman of any age may be eligible during any stage of her pregnancy.

43. A pregnant woman may also receive Medi-Cal through one of the many non-MAGI programs discussed in Chapter 3 of this guide. There is the Income Disregard for Pregnant Girls Under 21 and the Medically Indigent program, and if the woman has a disability she may also be eligible for the programs specifically for the disabled, such as the Aged, Blind or Disabled Medically Needy or Aged and Disabled FPL. Advocates should be aware of all of the different program options that may be available to a pregnant woman in order to ensure she is in the best program for her situation.

44. ACWDL 15-35 (Nov. 12, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-35.pdf>; MEDIL 15-25 (Aug. 19, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-25.pdf>.

45. MCAP was formerly known as the Access for Infants and Mothers (AIM) program. The Department of Health Care Services changed the name to MCAP in 2014. MCAP is funded with federal monies from the Children's Health Insurance Program (CHIP) and therefore is not technically a Medi-Cal program.

Women have “continuous eligibility” (CE) throughout the pregnancy and until the end of the post-partum period, regardless of changes in income or household composition. The post-partum period begins on the date the pregnancy ends and lasts until the end of the month in which the 60th day after the end of the pregnancy occurs.⁴⁶

A woman is not required to provide medical documentation of her pregnancy; she may self-attest that she is pregnant. The county must accept the self-attestation unless the information is not reasonably compatible with other information available to the county.⁴⁷

Age: There is no age limit for the Medi-Cal for Pregnant Women programs.

Income Limit: Pregnant women must have incomes below 213% FPL for the MAGI Medi-Cal Pregnant Women programs.

- **0 to 138% FPL: Full-Scope Medi-Cal.** As of August 1, 2015, pregnant women who are citizens or have satisfactory immigration status receive full-scope Medi-Cal. Pregnant women who are undocumented are eligible for pregnancy-related services, as well as emergency services, kidney dialysis, and long-term care.⁴⁸
- **Over 138% through 213% FPL: Pregnancy-Related Medi-Cal.** Pregnant women above 138% FPL and up to and including 213% FPL are eligible

46. 22 CCR §§ 50260 and 50262.3(a); ACWDL 91-66 (July 25, 1991), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c91-66.pdf>.

47. Welf. & Inst. Code § 14013.3(d)(1); CMS "Medicaid/CHIP Affordable Care Act Implementation, Answers to Frequently Asked Questions" (May 22, 2012), at Q.9. <https://www.medicare.gov/state-resource-center/FAQ-medicare-and-chip-affordable-care-act-implementation/downloads/Eligibility-Policy-FAQs.pdf>. In both Medicaid and CHIP-funded programs, states “must accept self-attestation of pregnancy unless the State has information that is not reasonably compatible with such attestation.” 42 C.F.R. §§ 435.956(e) and 457.380(e).

48. Welf. & Inst. Code §§ 14005.22 and 14005.225; ACWDL 15-35 (Nov. 12, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-35.pdf>; MEDIL 15-25 (Aug. 19, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-25.pdf>. The aid codes for pregnant women with 0-138% FPL are M7 (full-scope, no-cost Medi-Cal coverage to citizen/lawfully present pregnant women) and M8 (emergency, pregnancy-related and long-term services to undocumented pregnant women).

for Pregnancy-Related Services Medi-Cal, without regard to immigration status.⁴⁹ Benefits include all Medi-Cal services when medically necessary.⁵⁰ The federal government has determined that Pregnancy-Related Medi-Cal for women with income over 138% through 213% FPL constitutes Minimum Essential Coverage, including during the postpartum period.⁵¹

- Women enrolled in Pregnancy-Related Medi-Cal are not subject to tax penalties.⁵²

49. The aid codes for pregnant women with incomes above 138% FPL and up to and include 213% FPL in Pregnancy-Related Medi-Cal are M9 (pregnancy-related Medi-Cal coverage to citizen/lawfully present pregnant women) and M0 (pregnancy-related Medi-Cal coverage for undocumented pregnant women). ACWDL 15-35 (Nov. 12, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-35.pdf>.

50. At the time of writing, CMS had informed DHCS that Pregnancy-Related Medi-Cal qualified as minimum essential coverage (MEC) based on the state's policy that women in pregnancy-related Medi-Cal may access all medically necessary services; DHCS is still awaiting formal confirmation from CMS on the MEC issue but has issued IRS Form 1095-B to beneficiaries reflecting minimum essential coverage for months enrolled in this program. See *also*, 77 Fed. Reg. 12144, 17148 (March 2012), Preamble to 42 C.F.R. § 440.210(a)(2): "Because the health of a pregnant woman is intertwined with the health of her expected child, the scope of such services is necessarily comprehensive." See *also, id.*, at 17149: "If a State proposes not to cover certain services or items for pregnant women that it covers for other adults, the State must describe in a State plan amendment for the Secretary's approval its basis for determining that such services are not pregnancy-related." California's State Plan lists no exclusions for pregnant women. SPA #14-0021 (approved August 3, 2015), expanding full-scope eligibility under "pregnant women's" category from 60% through 109%, effective August 1, 2015: <http://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/medicaid-state-plan-amendments.html>. See *also*, CMS, State Health Official Letter # 14-002 (Nov. 7, 2014), p. 4. (Only "[c]overage which is determined equivalent to the full Medicaid benefits provided to other categorically needy pregnant beneficiaries will be recognized as MEC"). Cf. 22 CCR § 50262 (a)(2) and (c).

51. This was in question for some time but as described in footnote 50, DHCS has issued IRS Form 1095-B to beneficiaries in this aid code reflecting minimum essential coverage for the months enrolled in this program. We still await written guidance.

52. Prior to 2015, women needed to request an exemption. See CMS, State Health Official (SHO) # 14-002 (Nov. 7, 2014), pp. 10-11. Practically speaking, most women in this category in 2014 probably had no idea that their coverage was technically not minimum essential coverage.

Advocacy Tip: Before the expansion of full-scope Medi-Cal to pregnant women up to 138% and the determination that Pregnancy-Related Medi-Cal was considered minimum essential coverage, women eligible for Pregnancy-Related Medi-Cal were also being enrolled into Covered California, if otherwise eligible, since their Medi-Cal was not considered minimum essential coverage at that time. Those women are allowed to retain their Covered California with APTCs along with their Medi-Cal until the end of the postpartum period.⁵³

As of October 2015, dual enrollments for pregnant women in Medi-Cal and Covered California stopped. Pregnant applicants eligible for Medi-Cal must be enrolled only in Medi-Cal. Women who become pregnant after enrolling in Covered California may choose to either remain in Covered California with the APTC subsidy or switch to Medi-Cal, but they cannot be enrolled in both programs at the same time.⁵⁴

When determining household size to calculate a pregnant woman's income, the number of expected children is included as discussed above in Section A.3.⁵⁵ Therefore, a pregnant woman expecting one child and with no other children would count as a household of two and one would look at the income limits for a family of two when determining eligibility. And if the woman lives with her three existing children, their household would be considered a household of five, not four.

REMEMBER: Pregnant women in their third trimester with no other children in the home and with income up to 109% FPL may be eligible for Medi-Cal under the Parent and Caretaker Relative program. This is important even after the August 1, 2015 expansion to full-scope coverage for otherwise eligible pregnant women to 138% FPL because only enrollment in the Parent/Caretaker program provides linkage to Transitional Medi-Cal. It is also important for undocumented pregnant women, who

53. September 2015 communication with CMS and DHCS.

54. See CalHEERS Change Release Notes #15.9 for the change deployed to CalHEERS on 10/11/2015, p. 19, change request # 45773, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/AB1296/CalHEERS_Release_Notes_15_9_Revised.pdf; CMS SHO # 14-002 (Nov. 7, 2014), p. 5.

55. 22 CCR § 50030(b).

may also benefit from linkage to Transitional Medi-Cal for emergency, kidney dialysis, and long-term care services after their post-partum period ends.⁵⁶

AND ALSO REMEMBER: If a woman with income up to and including 138% FPL becomes pregnant while enrolled as a MAGI Expansion Adult (aid code M1), she may remain in that program. Similarly, women enrolled in the full-scope expansion to 138% FPL for pregnant women (aid code M7 or M8) whose income drops to 109% FPL or below may remain in that program or, to acquire the link to Transitional Medi-Cal, may choose to switch to the Parent/Caretaker group in their third trimester.

Advocacy Tip: At the end of the 60 days post-partum period, a woman's eligibility should not be cut off automatically because the woman may be eligible under other Medi-Cal programs, such as the Parent and Caretaker Relative program to 109% FPL, the Expansion Adult program to 138% FPL, Transitional Medi-Cal, or disability categories. The county must check her eligibility for all other Medi-Cal programs before she can be terminated from the program.⁵⁷ If she is not eligible for Medi-Cal on any basis, she may be eligible for subsidized coverage through Covered California and should be assisted in transitioning to a Covered California plan.⁵⁸

56. Women who chose this route, however, should be sure to understand how care is delivered in their county to Parents and Caretaker Relatives (generally managed care) versus Pregnant Women (generally fee for service) as they may need to exercise their rights to continuity of care or seek an exemption from enrollment into managed care.

57. Welf. & Inst. Code § 14005.37.

58. Welf. & Inst. Code § 15926(h)(1).

Medi-Cal Programs for Pregnant Women: Summary of Eligibility Criteria

Pregnancy	<ul style="list-style-type: none"> Any stage of pregnancy “Continuous eligibility” throughout pregnancy and post-partum period, regardless of changes in income or household
Age Limit	<ul style="list-style-type: none"> No age limit
Income Limits/ Immigration Status	<p><u>At or below 138% FPL</u></p> <ul style="list-style-type: none"> Full-scope Medi-Cal for U.S. Citizens and pregnant women with satisfactory immigration status Pregnancy-related* Medi-Cal for undocumented pregnant women <p><u>Over 138% to 213% FPL</u></p> <ul style="list-style-type: none"> Pregnancy-related* Medi-Cal for pregnant women, regardless of immigration status <p>*Pregnancy-related Medi-Cal benefits include all Medi-Cal services when medically necessary.</p>
<p>Aid Codes: M7 for full-scope, no-cost Medi-Cal coverage to citizen/lawfully present pregnant women up to 138% FPL; M8 for emergency, pregnancy-related and long-term services to undocumented pregnant women up to 138% FPL; M9 Pregnancy-Related Medi-Cal for citizen/lawfully present pregnant women over 138% through 213% FPL; M0 Pregnancy-Related Medi-Cal for undocumented pregnant women over 138% through 213% FPL.</p>	

b. Medi-Cal Access Program (MCAP) for Pregnant Women and Newborns up to Age 2⁵⁹

The Medi-Cal Access Program, or MCAP, provides low cost health insurance coverage to women with income over 213% FPL and up to and including 322% FPL. There is no immigration or citizenship requirement to be eligible for MCAP. MCAP is administered by DHCS through a private vendor in Sacramento, not the counties.

59. Materials for MCAP are available here: <http://mcap.dhcs.ca.gov/Downloads/>.

MCAP offers comprehensive coverage for a total cost of 1.5% of a woman's yearly MAGI income. Because the cost for MCAP is capped at 1.5% of yearly income and has no cost-sharing requirements, it is usually less expensive for a woman to enroll in MCAP than it would be to pay premiums for health insurance through Covered California. Payment for MCAP can be made all at once at a discount of \$50 off the total cost, or in monthly installments over 12 months. If income drops during the 12-month payment period, the woman can ask to have her MCAP payments reduced accordingly.⁶⁰ There are no copayments, deductibles, or coinsurance with MCAP coverage.

Like Medi-Cal's coverage for pregnant women, MCAP coverage includes services during the post-partum period, which lasts until the end of the month in which 60 days have passed since the pregnancy ended.⁶¹

60. The policy in 10 CCR § 2699.201(d)(1)(CC) that required full-payment for all 12 months regardless of an enrollee's reduced income or transfer to Medi-Cal is inconsistent with CHIP and was therefore dropped effective September 1, 2015. See http://mcap.dhcs.ca.gov/Downloads/MCAP_Contribution_Re-Evaluation_Form.aspx. Similarly, MCAP no longer allows MCAP health plans to retroactively disenroll a woman under 10 CCR § 2699.207(a)(1)(D) and (g). As of this writing, neither the regulations nor the Declaration at the end of the MCAP application have been updated to reflect this change.

61. 10 CCR §§ 2699.207(a)(1)(D) and 2699.209(b).

Babies born to MCAP women are automatically eligible for Medi-Cal! Babies born to women on MCAP are automatically eligible for Medi-Cal up to the age of one without an application and regardless of income.⁶² But if the MCAP mom's income at the time of application was over 266% FPL, then her newborn will have a monthly premium of \$13 to maintain coverage. Between the ages of one and two, MCAP babies remain eligible for Medi-Cal with household incomes up to 322% FPL.⁶³ In the MCAP babies' second year, families with income over 160% FPL pay premiums.⁶⁴ To enroll an MCAP-linked newborn to Medi-Cal at any time during the newborn's first year, families can call MCAP at 1-800-433-2611, or submit an Infant Registration Form, which can be found at http://mcap.dhcs.ca.gov/Downloads/Infant_Registration.aspx. Babies born to women on MCAP are also discussed in Section C.4 on MAGI Children.

While the state computer system CalHEERS was not originally programmed to determine eligibility for MCAP, as of October 2015 women who apply through Covered California will have eligibility determined for MCAP.

MCAP Eligibility Requirements

Pregnancy: Women of any age during any stage of her pregnancy meet the pregnancy requirement.⁶⁵ Medical documentation of pregnancy is not required; self-attestation to pregnancy is acceptable.

Income: MCAP pregnant women must have incomes between 213% FPL and 322%

62. Welf. & Inst. Code § 15832 (a)(2)(A). Aid codes E6 (MCAP infants 213% FPL and 266%FPL) and E7 (MCAP infants between 267% and 322% FPL). MCAP-linked infants whose family income exceeds 322% FPL during the first year are also placed in E7, as DHCS ignores income after the date of the mother's eligibility determination for MCAP up until the baby's first birthday, to see if the baby meets the eligibility criteria for a second year of coverage.

63. Welf. & Inst. Code § 15832 (a)(3)(B)(i).

64. *Id.*

65. Welf. & Inst. Code § 15832(a)(1)(A). MCAP used to impose a 30-week pregnancy limit for MCAP applicants. But as of March 1, 2015, a pregnant woman could be eligible for MCAP at any point in her pregnancy. See announcement on mcap.dhcs.ca.gov.

FPL.⁶⁶ Remember, the number of expected children is included for a pregnant woman when determining household size for calculating income.⁶⁷ Therefore, a pregnant woman with no other children or household members would count as a household of two and one would look at the income limits for a family of two when determining her eligibility, a woman pregnant with twins and no other household members would count as a household of three.

Eligibility for Medi-Cal: MCAP pregnant women must not be eligible for other Medi-Cal coverage.⁶⁸

Eligibility for Medicare Part A or Part B: MCAP pregnant women must not be eligible for Medicare Part A or B.⁶⁹

Enrollment in Private Insurance: A pregnant woman with private insurance is only eligible for MCAP if her private insurance does not cover maternity services or has very limited or costly maternity coverage.⁷⁰ Limited or costly maternity coverage is insurance with a separate maternity-only deductible or copayment greater than \$500.

Pregnant women who are eligible for Covered California must choose Covered California or MCAP; they cannot be enrolled in both. MCAP qualifies as minimum essential coverage to meet the individual mandate of the Affordable Care Act.⁷¹ But a woman who is enrolled in Covered California and becomes pregnant remains eligible for financial assistance; she will not be disenrolled unless she chooses to switch to MCAP.⁷²

66. Welf. & Inst. Code § 15832(a)(1)(B). The statute cites 208% and 317%FPL as the income limits for MCAP eligibility, but because MCAP uses the MAGI methodology, in practice these limits are supplemented by the across the board 5% income disregard that is applicable to all MAGI programs.

67. 22 CCR § 50030(b).

68. Welf. & Inst. Code § 15833.

69. *Id.*

70. Welf. & Inst. Code § 15834.

71. CMS, State Health Official Letter #14-002, “Minimum Essential Coverage” (Nov. 7, 2014), <http://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf>.

72. *Id.*

Advocacy Tip: MCAP is not as well-known as Medi-Cal or Covered California. Because the income range for MCAP – over 213% FPL through 322% FPL – overlaps with Covered California’s income criteria and the state did not include MCAP in CalHEERS until October 2015, some pregnant women who may have been eligible for MCAP may still be enrolled in Covered California into 2016, without knowing that they had a choice between the two. MCAP coverage is generally much less expensive than the cost of insurance through Covered California. A pregnant woman who is eligible for both Covered California and MCAP but is enrolled in Covered California may drop the Covered California coverage and change to MCAP during her pregnancy. However this decision should be evaluated carefully since she could not apply for MCAP until she had dropped her Covered CA, thus causing a gap in coverage. Conversely, if a woman wanted to change from MCAP to Covered California, she has that choice as well. For more information, she can call the MCAP toll-free number at (800) 433-2611.

**Medi-Cal Access Program (MCAP) for Pregnant Women:
Summary of Eligibility Criteria**

Pregnancy	<ul style="list-style-type: none"> Any stage of pregnancy
Income Limit	<ul style="list-style-type: none"> Over 213% FPL to 322% FPL
Immigration Status?	<ul style="list-style-type: none"> No citizenship or immigration requirement
Other Medi-Cal Eligibility?	<ul style="list-style-type: none"> Must not be eligible for other Medi-Cal programs
Medicare Part A or B?	<ul style="list-style-type: none"> Must not be eligible for Medicare Part A or B
Private insurance?	<ul style="list-style-type: none"> Only if the insurance does not cover maternity services or has a maternity-only deductible or copayment greater than \$500
<p>Aid Codes: E6 for MCAP infants 213% FPL - 266%FPL; E7 for MCAP infants between 267% - 322% FPL.</p>	

4. Children: MAGI Medi-Cal, the Targeted Low-Income Children’s Program, and MCAP Infants and Babies

The majority of children in Medi-Cal are in the MAGI Medi-Cal Children’s program, the Targeted Low-Income Children’s Program (TLICP), formerly known as the Healthy Families Program,⁷³ or are infants and babies born to mothers in the Medi-Cal Access

73. TLICP was moved into Medi-Cal in 2013 when California transitioned over 750,000 children from Healthy Families into Medi-Cal over a one-year period. Welf. & Inst. Code § 14005.27; ACWDL 12-33 (Nov. 16, 2012), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/12-33.pdf>. Sometime in 2015, DHCS began referring to TLICP as the Medi-Cal for Families Program. That name, however, is a misnomer as the program covers only children and not families.

Program (MCAP) for pregnant women⁷⁴ (see Section C.3.b and Chapter 6, Section A.1.c).

Together, the MAGI Children's program and TLICP provide Medi-Cal to children ages 0 to 19 years old with incomes up to 266% FPL,⁷⁵ and up to 21 year olds who are full-time students with income up to 133% FPL.⁷⁶ Babies from 0 to age 1 born to women in MCAP are eligible for Medi-Cal, without regard to income,⁷⁷ and from 1 to 2 years old are eligible for Medi-Cal with income up to and including 322% FPL.⁷⁸

74. Welf. & Inst. Code § 15832(a)(2)(A).

75. The state statute establishing the upper income limit for TLICP sets the limit at 261% FPL. Welf. & Inst. Code § 14005.26(b). But because the income is determined according to MAGI methodology, which provides for an across the board 5% income disregard (see Welf. & Inst. Code § 14005.64(b)), the upper income limit for children in TLICP is 266% FPL.

76. And do not forget that most children who lose their MAGI Medi-Cal eligibility due to increased income and those who are categorically eligible for Medi-Cal through CalWORKs, among others, may have their eligibility extended through the Continuous Eligibility for Children and the Transitional Medi-Cal (TMC) programs. Those programs are discussed in Chapter 3, Section C.5 and C.6..

77. Welf. & Inst. Code § 15832(a)(3)(A). While all newborns of women in MCAP are eligible for Medi-Cal regardless of income, because MCAP's eligibility for pregnant women goes up to 322% FPL, the majority of MCAP infants will have income below 322% FPL. It would be uncommon, though not improbable, for an MCAP newborn up to age 1 to have income above 322% FPL and be in Medi-Cal, as MCAP does not revisit an MCAP family's income until the babies' first birthday. See Welf. & Inst. Code § 15832(a)(3)(B); ACWDL 12-33 (Nov. 16, 2012), at p. 3, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/12-33.pdf>.

78. Welf. & Inst. § Code 15832(a)(3)(B)(i).

Background: The distinctions between the MAGI Children’s Program and TLICP are primarily for administrative and federal financial claiming purposes for the state. The MAGI Children’s program was created by the Affordable Care Act’s consolidation of various Medicaid programs so that infants and children up to age 19, or age 21 if a full-time student,⁷⁹ who were eligible under the pre-ACA 1931(b), Medically Needy, Medically Indigent, and the FPL Percentage programs, were combined under one children’s category as of January 1, 2014.⁸⁰ TLICP children and babies on MCAP, on the other hand, are part of the state’s Children’s Health Insurance Program (CHIP) and are funded by federal CHIP dollars as opposed to Medicaid money. So even though TLICP and MCAP children are Medi-Cal enrollees, they are tracked differently for federal claiming purposes.

Monthly Premiums for Some Children Aged 1 to 19 and Some MCAP Babies: Kids in the MAGI Medi-Cal Children’s program and TLICP aged 1 up to 19 with income from 161% and up to and including 266% FPL are required to pay monthly premiums to maintain their eligibility.⁸¹ Infants 0 to age 1 in MAGI Medi-Cal Children’s and TLICP have no premiums.

79. 42 C.F.R. § 435.603(f)(3)(iv). For the adoption of the full-time student option, see California’s State Plan Amendment incorporating MAGI-Based Income Methodologies, SPA 13-0023-MM, available at <http://www.dhcs.ca.gov/formsandpubs/laws/Documents/Approved%20SPA%2013-0023.pdf>.

80. 42 C.F.R. § 435.118. The Affordable Care Act’s other significant change for children was the elimination that a child be “deprived” to qualify for coverage. Before the ACA, all children, parents, and caretaker relatives were subject to what was known as the deprivation test to be eligible for Medi-Cal. The deprivation test is an old welfare rule that requires a family to have a “deprived child” in the home to get benefits, which means a child is deprived of parental support in some way. Deprivation of a child was established through the absence, death, incapacity, or the unemployment or underemployment of at least one parent in the child’s family. With the ACA and the adoption of the MAGI methodology, California eliminated deprivation as a Medi-Cal eligibility criterion. Welf. & Inst. Code § 14005.30(b)(2).

81. The State Plan Amendment to move TLICP (then known as Healthy Families) into Medi-Cal permits the state to impose premiums on children age 1 to 19 with incomes above 150% FPL and up to and include 250%FPL; infants under age 1 are not subject to a premium. See SPA 13-005, Attachment 4.18-F, page 4, approved Dec. 20, 2013, available at <http://www.dhcs.ca.gov/formsandpubs/laws/Pages/Approved13-005.aspx>. California later raised the income limit to collect premiums from families with income above 160% FPL and up to and including 266% FPL. Welf. & Inst. Code § 14005.26(d)(1)(B).

But MCAP infants age 0 to 1 have premiums if their mothers had incomes over 266% FPL at the time of applying for MCAP. And MCAP one-year olds with income between 161% and up to and including 322% FPL (the MCAP eligibility limit for babies aged 1-2) also pay premiums.⁸²

The premium for one child is \$13 per month. For families with more than one child, the premiums are capped at \$39 per family per month, *i.e.*, a family with two children in TLICP will pay \$26 per month in premiums, while a family with three or more children in the program pays \$39 per month.⁸³ Payments are due on the 20th of each month.⁸⁴

a. Infants: 0 to 1 year old

Age: Infants up to age 1.

Note that under federal law and state regulations, babies born to mothers who are enrolled in Medi-Cal are “deemed eligible” for Medi-Cal until at least their first birthday without a separate application.⁸⁵ For more information on Medi-Cal Deemed Eligibility for Infants, see Chapter 5, Section A.2.b. And infants born to women in MCAP are automatically eligible for Medi-Cal and are included in this category.

The period of deemed eligibility for Medi-Cal for an infant ends once the baby turns one year old, unless the baby is in the hospital. If the baby is receiving continuous inpatient services that began before the baby’s first birthday, the baby’s eligibility in the Children’s Infant to 1 year-old program continues until the baby is discharged from the hospital.⁸⁶ Upon discharge, the baby would be evaluated for eligibility in the Children Ages 1 to 6 program and other Med-Cal programs.

82. ACWDL 12-33, at p. 3 (“[MCAP]-linked infants enrolled in [TLICP] are subject to the premiums imposed under [TLICP].”)

83. Welf. & Inst. Code § 14005.26(d)(1)(B) and (d)(2)(A).

84. For information on how families can pay these premiums, go to <http://www.dhcs.ca.gov/services/Pages/Medi-CalPremiumPayments.aspx>.

85. 42 U.S.C. § 1396a(e)(4); 22 CCR § 50262.3.

86. 22 CCR § 50262(b)(2).

Income Limit: Infants in families with incomes up to 266% FPL are eligible for no-cost Medi-Cal. Infants born to women on MCAP are automatically eligible for Medi-Cal, but those with incomes above 266% FPL must pay monthly premiums to remain eligible.⁸⁷

b. Children: Ages 1 to 6

Age: Children must be between 1 year old and up to 6 years old.⁸⁸

Just as for the infant 0 to 1 year-old program, the period of eligibility for a child in this program ends on the child's 6th birthday, unless the child is receiving inpatient services. Children who are receiving inpatient services when they turn six will continue to qualify for this program until they are discharged.⁸⁹ Upon discharge they are evaluated for eligibility for the Children ages 6 to 19 program.

Income Limit: Children ages 1-6 in families with incomes up to 160% FPL are eligible for no-cost Medi-Cal;⁹⁰ children ages 1-6 in families with incomes between 160% FPL to 266% FPL are eligible for Medi-Cal with a monthly premium.⁹¹ Babies age 1 to 2 years old born to women in MCAP with incomes between 161% FPL and up to and

87. Welf. & Inst. Code § 15832(a)(3)(A); 22 CCR § 50262(a)(2). Aid codes P9 (MAGI Children full-scope, no-cost Medi-Cal coverage for infants up to age 1 and up to 208% FPL); P0 (MAGI Children emergency and long term care services to undocumented infants up to 1 year of age and up to 208% FPL); P1 (MAGI Children hospital presumptive eligibility provides full-scope, no-cost Medi-Cal coverage for infants ages 0 to 1 whose family income is 0 to 208% FPL); T5 (TLICP infant up to 1 year, full-scope, no-cost Medi-Cal to children with family income above 208% FPL to 266% FPL); T0 (TLICP infant up to 1 year, emergency and state-funded LTC to children with family income above 208% FPL to 266% FPL); E6 (MCAP infant above 213% to 266% FPL); E7 (MCAP infant above 266% to 322% FPL).

88. 22 CCR § 50262.5.

89. 22 CCR § 50262.5(b).

90. Aid code P7 (MAGI Children ages 1 to 6, full-scope no-cost Medi-Cal up to 142% FPL); aid code P8 (MAGI Children ages 1 to 6, emergency and LTC services to undocumented children up to 142% FPL); aid code T4 (TLICP children ages 1 to 6, full-scope no-cost Medi-Cal for children with family income is above 142% FPL to 160% FPL); aid codes T9 (TLCIP children ages 1 to 6 without satisfactory immigration status, emergency and LTC services with income above 142% FPL to 160% FPL).

91. Aid code T3 (TLICP children ages 1 to 6, full-scope no-cost Medi-Cal for children with family income from 160% FPL to 266% FPL); aid code T8 (TLICP children ages 1 to 6 without satisfactory immigration status, emergency and LTC services with family income from 160% to 266% FPL).

including 322% FPL are eligible for Medi-Cal with a monthly premium.⁹²

c. Children: Ages 6 to 19

Age: Children must be between 6 years old and up to 19 years old.⁹³

Income Limit: All children in families with incomes up to 160% FPL are eligible for no-cost Medi-Cal;⁹⁴ children in families with incomes at 161% to 266% FPL are eligible for Medi-Cal with a monthly premium.⁹⁵

92. Aid codes E6 (MCAP-linked infant above 213% FPL to 266%) and E7 (MCAP linked infant above 266% FPL to 322% FPL).

93. 22 CCR § 50262.6.

94. Aid code P5 (MAGI Children ages 6 to 19, full-scope no-cost Medi-Cal up to 133% FPL); P6 (MAGI Children ages 6 to 19, emergency, pregnancy and LTC services to undocumented children up to 133% FPL); T2 (TLICP children ages 6 to 19, full-scope no-cost Medi-Cal, income above 133% FPL to 160% FPL); T7 (TLICP children ages 6 to 19, without satisfactory immigration status, emergency, pregnancy related and LTC, income above 133% to 160% FPL).

95. Aid codes T1 (TLICP, ages 6 to 19, full-scope Medi-Cal, income 160% FPL to 266% FPL, with premium); T6 (TLICP children ages 6 to 19, restricted to emergency, pregnancy-related, and LTC, income 160% FPL to 266% FPL, with premium).

**MAGI Children, Targeted Low-Income Children’s Program, and MCAP:
Summary of Eligibility Criteria**

Age of Child	MAGI Children and TLICP Income Limits	Monthly Premium? <i>\$13/month per child; max. \$39/month per family</i>
0 to 1 year-old	MAGI Children: 0 to 208% FPL TLICP: 209% to 266% FPL MCAP: No income limit	MAGI Children/TLICP: Not applicable MCAP: Yes, for babies over 266% FPL
1 to 6 years old	MAGI Children: 0 to 142% FPL TLICP: 143% FPL to 266% FPL MCAP, ages 1-2: 0 to 322% FPL	MAGI Children: Not applicable TLICP: Yes, for 161% FPL to 266% FPL MCAP, ages 1-2: Yes, for 161% FPL to 322% FPL
6 to 19 years old	MAGI Children: 0 to 133% FPL TLICP: 134% FPL to 266% FPL	MAGI Children: Not applicable TLICP: Yes, for 161% FPL to 266% FPL
<p>Aid Codes: 0 to 1 year olds – MAGI Children: P9 (full-scope, citizen), P0 (restricted, undocumented), P1 (hospital PE); TLICP: T5 (full-scope, citizen, 208%-266% FPL), T0 (restricted, undocumented, (208%-266% FPL), H6 (hospital PE); MCAP: E6 (full-scope, 213%-266% FPL), E7 (full-scope, 266%-322% FPL).</p> <p>1 to 6 years old – MAGI Children: P7 (full scope, citizen, 0-142%), P8 (restricted, undocumented, 0-142%); TLICP: T4 (full scope, citizen, 142%-160%), T3 (full scope, citizen, 160%-266%, premiums), T9 (restricted, undocumented, 142%-160%), T8 (restricted, undocumented, 160%-266%, premiums), H9 (hospital PE, children 1-6, 142%-266%); MCAP: E6 (full-scope, 213%-266% FPL), E7 (full-scope, 266%-322% FPL).</p> <p>6 to 19 year olds – MAGI Children: P5 (full scope, citizen, 0-133%), P6 (restricted, undocumented, 0-133%), M5 (full scope, citizen, expansion child, 108%-133%), M6 (restricted, undocumented, expansion child, 108%-133%), H0 (hospital PE, children 6-19 108%-266%); TLICP: T2 (full scope, citizen, 133%-160%), T1 (full scope, citizen, 160%-266%, premiums), T7 (restricted, undocumented, 133%-160%), T6 (restricted, undocumented, 160-266%, premiums).</p>		

Note: Health for All Kids (SB 75): As part of California’s 2015-2016 budget process, Medi-Cal was expanded to provide full-scope health coverage for all otherwise eligible children under age 19 regardless of immigration status.⁹⁶ As of press time, this new program is still in the implementation phase and children who were previously eligible for only restricted scope Medi-Cal due to their immigration status should be transferred into full-scope Medi-Cal starting in May 2016. The Department of Health Care Services is creating additional aid codes that will parallel all restricted aid codes that contain undocumented children and transfer the children to full-scope services by changing their aid codes. Children not previously enrolled in Medi-Cal and children enrolled in local programs such as Healthy Kids may enroll in the expansion to full-scope Medi-Cal as well. Information regarding the implementation of this program is available at <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/sb-75.aspx>.

96. Welf. & Inst. Code § 14007.8 enacted as SB 75 (2015-2016 budget) and SB 4 in 2015.

Chapter 3: Non-MAGI Medi-Cal

Chapter 3. Non-MAGI Medi-Cal

A. Non-MAGI Household and Income

B. Full-Scope Non-MAGI Medi-Cal for Seniors and Individuals with Disabilities

1. Categorically Linked Medi-Cal Based on Disability
 - a. Automatic Medi-Cal for Individuals Receiving Supplemental Security Income (SSI-b. linked Medi-Cal)
 - b. SSI 1619(b) Medi-Cal for Individuals who Lost SSI Because of Earnings from Work
2. Severely-Impaired Working Individual (SIWI) Program
3. Pickle Program
4. Disabled Adult Child (DAC) Medi-Cal
5. Disabled Widow/Widower Programs
6. Aged and Disabled Federal Poverty Level (A&D FPL) and Blind Federal Poverty Level (Blind FPL) Programs
 - a. Special Rules for A&D FPL and Blind FPL Programs
7. 250% Working Disabled Program (250% WDP)
8. Aged, Blind and Disabled – Medically Need (ABD-MN): Free and Share of Cost

C. Full-Scope Non-MAGI Medi-Cal for Children and Families

1. Automatic Eligibility Due to Receipt of Government Benefits
2. Children in Foster Care
3. Former Foster Youth Under Age 18 and Not Living with their Parents
4. Former Foster Youth 18 and Older
5. Transitional Medi-Cal (TMC)
6. Continuous Eligibility for Children

Chapter 3: Non-MAGI Medi-Cal (cont'd)

7. Deemed Eligibility for Newborns
 8. Aid for Families with Dependent Children – Medically Needy
 9. Medically Indigent
- D. Limited Scope Medi-Cal Programs for Children
1. Minor Consent
 2. Income Disregard Program for Pregnant Girls under Age 21
 3. The Child Health and Disability Prevention (CHDP) Program
- E. Medi-Cal Special Treatment Programs
1. Breast and Cervical Cancer Treatment Programs
 2. Tuberculosis Program
 3. Kidney Dialysis and Parenteral Hyperalimentation and Related Services
- F. Medicare Savings Programs (MSPs)
1. Qualified Medicare Beneficiary (QMB or “Quimby”) Program
 2. Specified Low-Income Medicare Beneficiaries (SLMB) Program
 3. Qualified Individual (QI) Program
 4. Qualified Disabled and Working Individual (QDWI) Program
- G. Refugee Medical Assistance

3. Non-MAGI Medi-Cal

With the passage of the Affordable Care Act and the requirement that the Modified Adjusted Gross Income (MAGI) methodology be used for the Medi-Cal expansion adult population, parents and caretaker relatives, pregnant women, and children, the programs left in Medi-Cal that continue to use the myriad of pre-ACA rules are commonly referred to as simply “non-MAGI Medi-Cal.” The non-MAGI Medi-Cal programs generally serve low-income individuals who are seniors or have disabilities; children and families who are linked to Medi-Cal through other public benefit programs or are in special circumstances such as foster care; individuals in need of specific treatment such as kidney dialysis or breast or cervical cancer; and some refugees. Unlike MAGI Medi-Cal or Covered California, there is no uniform set of eligibility rules for the various non-MAGI Medi-Cal programs.

A. Non-MAGI Household and Income

In general, most non-MAGI programs have their own guidelines regarding income and which household members to count in determining income. The non-MAGI Medi-Cal programs that do not have specific income or household rules are those programs where enrollees are “categorically-linked” to Medi-Cal by virtue of their enrollment in another public assistance program. Individuals receiving Supplemental Security Income/State Supplementary Payments (SSI/SSP or SSI), CalWORKs, financial assistance for foster care, adoption assistance, or KinGAP do not need to go through another income determination process to receive Medi-Cal; they are automatically eligible. Foster youth are also automatically eligible for Medi-Cal, and under the Affordable Care Act, former foster youth are categorically eligible for Medi-Cal up to age 26 and therefore are also considered to be non-MAGI Medi-Cal.

The other non-MAGI Medi-Cal programs that are not categorically-linked to Medi-Cal require an income determination. There are separate rules for individuals who are considered eligible for SSI but do not receive the cash payment and individuals who are considered to be “medically needy” or “medically indigent.” These programs generally serve individuals over age 65 and persons with disabilities and have income and resource/assets limits that are different than the MAGI income rules. For eligibility based on disability, the programs often require a disability determination as well.

Finally, certain non-MAGI programs have no income rules at all, such as Minor Consent or Continuing Eligibility for Children.

In short, when it comes to non-MAGI Medi-Cal, advocates must look at each program separately for its income and household rules, if any.¹ The following chapter divides the non-MAGI programs into the following:

- Full-scope Medi-Cal coverage for seniors and individuals with disabilities;
- Full-scope Medi-Cal for children and families;
- Limited scope Medi-Cal for children;
- Medi-Cal special treatment programs;
- Medicare Savings Programs (MSPs); and
- Refugee Medical Assistance (RMA).

B. Full-Scope Non-MAGI Medi-Cal for Seniors and Individuals with Disabilities

1. Categorically Linked Medi-Cal Based on Disability

a. Automatic Medi-Cal for Individuals Receiving Supplemental Security Income (SSI-linked Medi-Cal)

An individual already receiving SSI/SSP or SSI is *categorically linked* to Medi-Cal, *i.e.*, the individual gets Medi-Cal automatically and does not need to apply or qualify

-
1. In addition to the non-MAGI Medi-Cal program eligibility rules summarized in this chapter, advocates should also be aware that beneficiaries or their spouses who receive long-term care services (LTC) may be subject to different rules. Because this manual focuses on eligibility rules as opposed to the benefits covered by the insurance affordability programs, the rules regarding LTC services are not covered here. For more information on LTC, see California Advocates for Nursing Home Reform's (CANHR's) website at <http://www.canhr.org/> under the "Medi-Cal for Long Term Care" tab, which provides an overview of Medi-Cal for long-term care beneficiaries.

separately for Medi-Cal coverage.² There are no separate eligibility rules for this Medi-Cal program – the only eligibility determination that is made is for SSI. A Medi-Cal card will be automatically sent in the mail after the SSI benefits begin.³

b. SSI 1619(b) Medi-Cal for Individuals who Lost SSI Because of Earnings from Work

The 1619(b) program provides for the continuation of Medi-Cal eligibility for people who lose SSI cash benefits because of earnings from work.⁴ Unlike other Medi-Cal programs, the state Department of Health Care Services does not administer this program; the federal Social Security Administration does. The Social Security Administration determines eligibility for 1619(b) status for people who received SSI in the month before they became ineligible for an SSI cash payment because of earnings from work. People who qualify for 1619(b) status are considered to be SSI recipients even though they do not qualify for an SSI cash payment, which is why their categorically-linked Medi-Cal continues.

-
2. 42 U.S.C. § 1396a(a)(10)(A)(i)(II); 42 C.F.R. § 435.120; 22 CCR §§ 50145(a), 50227(a)(2); aid codes 10 (SSI-Aged), 20 (SSI- Blind) and 60 (SSI-Disabled). Note that before payment for In-Home Supportive Services, or IHSS, was shifted to the Medi-Cal program in 2011, IHSS recipients were also treated as categorically-eligible for Medi-Cal. Categorical eligibility for IHSS recipients has ended; an individual must be otherwise eligible for Medi-Cal in order to qualify for IHSS services.
 3. While SSI benefits begin on the first of the month after application for SSI, Medi-Cal benefits for SSI-linked beneficiaries are retroactive to the first of the month of application for SSI. SSI-linked Medi-Cal beneficiaries are also eligible for three months of retroactive Medi-Cal from the month of the SSI application, in the same way that non-SSI linked Medi-Cal applicants are eligible for three months of retroactive eligibility. Beneficiaries with outstanding medical bills from these retro periods may submit those bills for reimbursement.
 4. 42 U.S.C. § 1382h(b); 20 C.F.R. §§ 416.266-269. Social Security Administration website has information on the 1619(b) program at <https://www.socialsecurity.gov/disabilityresearch/wi/1619b.htm>. Medi-Cal enrollees who receive 1619(b)-linked Medi-Cal are in the same aid codes as individuals who receive SSI – aid codes 10, 20 and 60. Because the Social Security Administration determines 1619(b) eligibility and effectively treats individuals in 1619(b) as still receiving SSI, the SSA does not inform the state that SSI has stopped. Therefore, you may encounter consumers who no longer receive SSI but are still properly in the SSI aid codes.

To qualify for the 1619(b) program, an individual must:

- Have been eligible for an SSI cash payment in the month before earned income caused the SSI cash payment to end;
- Meet the requirements for receiving an SSI cash payment except for earnings;
- Still meet all other SSI eligibility requirements, including disability requirements, countable unearned income requirements, *i.e.*, countable unearned income less than the SSI/SSP benefit payment rate, and countable resource requirements, *i.e.*, countable resources less than \$2,000 for an individual or \$3,000 for a married couple;
- Need Medi-Cal in order to work; and
- Have gross earned income that is insufficient to replace SSI, Medi-Cal, and any publicly funded attendant care; this is known as the “threshold amount.” The threshold amount is the measure the Social Security Administration uses to decide whether an individual’s earnings are high enough to replace their SSI and Medi-Cal benefits. The threshold amount is the sum of:
 - The amount of earnings that would cause the SSI cash payments to stop; plus
 - The average annual per capita Medi-Cal expenditure.

In 2016, the threshold amount in California is \$37,184; for beneficiaries who are blind it is \$38,504.⁵ This means that if an individual who formerly received SSI cash payments expects gross earnings in 2016 to be less than \$37,184 (or \$38,504 if the individual is blind), the Medi-Cal categorical linkage to SSI will continue. No new application is required.

If gross earnings are higher than the threshold amount, the individual may still be eligible for 1619(b) if the Social Security Administration can determine an individualized threshold amount. An individual may qualify to have an individualized threshold amount determination if the individual has any of the following:

- Work expenses related to a disability;

5. The Social Security Administration publishes a POMS (Program Operations Manual System) every year with each state’s per capita Medicaid expenditure and the amount of earnings that would cause the SSI cash payments to stop. The 2016 POMS is POM SI 02302.200, available at: <https://secure.ssa.gov/poms.nsf/lnx/0502302200>.

- A plan to achieve self-support;
- Publicly funded attendant or personal care (such as IHSS); or
- Medical expenses above the state per capita amount.

Proof of these expenses has to be provided to the Social Security Administration for 1619(b) status to continue.

Individuals no longer eligible for SSI

If the Social Security Administration (SSA) determines that an individual is no longer eligible for SSI or 1619(b) status, SSA sends notice of this determination to the state. The state then notifies the county so that the county can redetermine eligibility for Medi-Cal under other programs. The county must continue to provide full-scope Medi-Cal with no Share of Cost until the county determines whether the individual may remain eligible for Medi-Cal on another basis.⁶ There are specific procedures that the state and counties must follow to ensure that these individuals do not lose their Medi-Cal when they lose their SSI and to address beneficiaries' ongoing Medi-Cal eligibility.⁷

2. Severely-Impaired Working Individual (SIWI) Program

The Severely-Impaired Working Individual (SIWI) provides zero Share of Cost Medi-Cal to working SSI beneficiaries even if their earnings are too high to receive an SSI cash payment. SIWI operates in the same way as the Section 1619(b) program, but is administered by the Department of Health Care Services and the counties rather than by the Social Security Administration, and is available to individuals who are no longer eligible for SSI or the 1619(b) program.⁸

There are four requirements to be eligible for the SIWI Medi-Cal program. An individual must:

-
6. Welf. & Inst. Code § 14005.37; *Craig v. Bonta*, S.F. Superior Ct., No. CFF 02 500688.
 7. See, e.g., ACWDLs 07-24 (Nov. 9, 2007), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c07-24.pdf>; 03-53 (Nov. 14, 2003), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c03-52.pdf>; 02-54 (Nov. 8, 2002), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c02-54.pdf>.
 8. ACWDL 97-27 (Jun. 20, 1997) <http://www.dhas.ca.gov/services/medi-cal/eligibility/documents/97-27.php>; aid code 8G.

- Depend on Medi-Cal to continue working;
- Meet all non-disability requirements for regular SSI/SSP benefits, except for earnings;
- Not have sufficient earnings to replace SSI, Medi-Cal or a publicly-funded personal or attendant care that would be lost due to the individuals's earnings; and
- Have received SSI or Section 1619(b) Medi-Cal in the month immediately preceding the first month of eligibility for the SIWI program. Individuals who meet Section 1619(b) criteria and do not want to have their eligibility determined by the Social Security Administration may also be eligible for the SIWI program when they lose their SSI. For example, an individual who wants to receive Medi-Cal under a Home and Community-Based Services (HCBS) waiver may be eligible for the SIWI program and would need to have their eligibility determined through the Department of Health Care Services, not the Social Security Administration.

3. Pickle Program

The Pickle Program⁹ provides full-scope, no cost Medi-Cal to individuals who once received SSI but are currently not eligible for a monthly SSI cash payment because of Cost of Living Adjustment (COLA) increases in their Title II Social Security benefits. Title II Social Security benefits include retirement benefits, disability benefits, and survivors' benefits.

Advocacy Tip: If an individual is receiving Social Security Disabled Adult Child (DAC) benefits, follow the DAC Medi-Cal procedures described in the following section instead of the Pickle procedures. Eligibility for DAC Medi-Cal should always be evaluated before considering eligibility for Pickle Medi-Cal. This is because DAC Medi-Cal provides all of the protections of the Pickle Medi-Cal program and additional protections, as well.

9. The Pickle Program is named after its congressional sponsor, J.J. Pickle (D-Texas) and was enacted in 1977.

An individual is eligible for no-cost Medi-Cal under the Pickle Program if the individual:

- Received SSI and Social Security in the same month (in any month since 1977); and
- Was discontinued from SSI for any reason; and
- Is not currently eligible to receive SSI because of a Social Security benefits COLA, *i.e.*, Social Security benefit level is now too high to qualify him/her for SSI; and
- Meets other SSI eligibility requirements, except for income due to Social Security COLAs.¹⁰

Note: To qualify for the Pickle Program, a beneficiary does not have to show that they actually lost their SSI due to a Social Security COLA. Under *Lynch v. Rank*, individuals qualify by showing that “but for” the COLA increase, they would currently be eligible for SSI.

“Pickle measure.”

To see if an individual is eligible for the Pickle Program, first determine the Social Security grant level from the last time the individual received *both* SSI and Title II Social Security.¹¹ Compare that with the current Social Security grant level. The individual is Pickle eligible if they would now be eligible for SSI if they were receiving the *same* Title II Social Security benefits today as the individual received when they last qualified for both SSI and Title II. The Title II grant level from the last time the individual qualified (or could have) for both SSI and Title II continue indefinitely as the

10. 42 C.F.R. § 435.135; *Lynch v Rank*, 747 F.2d 528 (9th Cir. 1984), as modified by 763 F.2d 1098 (9th Cir. 1985); *see also* ACWDL 83-74 (Nov. 15, 1983) (if one spouse qualifies as Pickle eligible, do not count the Pickle-eligible individual’s income or include the individual as an ineligible member of the household.) Aid codes 16 (aged), 26 (blind), and 66 (disabled).

11. An individual who is Pickle-eligible loses SSI in January when the COLA goes into effect. The state publishes updated “Pickle measure” calculation charts and instructions as All County Welfare Directors Letters each year, usually shortly before the beginning of the year. These instructions are typically titled something along the lines of “January 2015 Social Security Title II and Title XVI Cost of Living Adjustments and Related Issues.” *See, e.g.*, ACWDL 15-08 (Feb. 29, 2015). The state was a few months’ late with the 2015 letter.

individual's "Pickle measure."¹²

Pickle and Deeming

The "Pickle measure" also applies to Title II Social Security benefits deemed to a Pickle-eligible Medi-Cal beneficiary from an ineligible spouse to a spouse living in the same household, or from an ineligible parent to a minor child living in the same household. This means that the amount of Title II Social Security COLAs is not deemed.¹³ This prevents a Medi-Cal beneficiary, who is otherwise Pickle eligible because of their own Social Security COLAs, from losing Medi-Cal because of someone else's Social Security COLAs. This is necessary to give the beneficiary the no Share of Cost Medi-Cal that they would have received if there had been no Social Security cost of living increases at all since they last received SSI.

Getting and Keeping "Pickle" Medi-Cal

Any individuals described above who qualify should be able to get Medi-Cal, either as a continuing benefit when they lose SSI or as new applicants for the Pickle Program. The county must redetermine an individual's eligibility under this program when they lose SSI. An individual should remain eligible as long as they meet all SSI eligibility rules except the income rule. As discussed above, the county is obligated to redetermine Medi-Cal eligibility in any case where an individual loses SSI.

4. Disabled Adult Child (DAC) Medi-Cal

This program provides full-scope, no cost Medi-Cal to qualifying adults who receive "Social Security Disabled Adult Child (DAC) benefits."¹⁴ An adult is entitled to receive Title II Disabled Adult Child benefits if that adult is unmarried; has a disability that began before the age of 22; and was dependent on his or her parent at the time of application, the time of the parent's death, or at the time the parent's own period of disability began.¹⁵ The standard for determining disability is the same as for the

12. Clearinghouse Review publishes an annual Pickle update by Gordon Bonnyman of the Tennessee Justice Center, which includes step-by-step instructions to screen an individual for Pickle eligibility. See "Screening for Medicaid Eligibility under the Pickle Amendment," posted at Sargent Shriver National Center on Poverty Law, <http://www.povertylaw.org/clearinghouse/pickle>.

13. 42 C.F.R. § 435.135(b); *Lynch v. Dawson*, 820 F.2d 1014 (9th Cir. 1987).

14. 42 U.S.C. § 402(d); 20 C.F.R. § 404.350; *Smolen v. Chater*, 80 F.3d 1283 (9th Cir. 1996).

15. 42 U.S.C. § 402(d)(1)(B); 42 C.F.R. § 404.350(a)(4).

Title II Social Security Disability Insurance (SSDI) program. To qualify as a Medi-Cal Disabled Adult Child an individual must be entitled to receive Title II Disabled Adult Child benefits and must have had and lost SSI because of eligibility for these Title II benefits.

Individuals first receive Social Security DAC payments at the time of the retirement, disability or death of a parent. When this occurs, an individual who is receiving SSI can begin receiving a DAC payment that is higher than the SSI payment rate. This makes the individual ineligible for SSI and for SSI-linked Medi-Cal. The DAC Medi-Cal program maintains the status quo with respect to Medi-Cal by continuing to provide categorical Medi-Cal so long as the individual would be eligible for SSI if the individual were not receiving the DAC Social Security payments. The DAC Medi-Cal program, like the Pickle program, also provides protection from loss of SSI-linked Medi-Cal caused by Social Security COLAs. This second part of the DAC Medi-Cal program is sometimes called the “Pickle DAC” or “pseudo Pickle DAC” program.

DAC Program Eligibility Requirements

Individuals who receive "Social Security DAC" benefits can qualify for full-scope, no-cost Medi-Cal if they:

- Received SSI in July 1987 or later;
- Initially qualified for Title II DAC benefits, or qualified for an increase in Title II DAC benefits, on or after June 1, 1987; and
- Would be eligible for SSI now but for either:
 - the current receipt of Title II DAC benefits which they first became eligible for while they were receiving SSI, or
 - the increase in Title II benefits because of COLAs since they last received both Title II benefits and SSI.¹⁶

16. 42 U.S.C. § 1383c(c); ACWDL 91-47 (May 9, 1991), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c91-47.pdf>. The ACWDL states that to be eligible for the DAC or DAC Pickle programs, the DAC beneficiary must have been discontinued from SSI/SSP as a result of either having begun receiving DAC benefits or receiving an increase in DAC benefits.

In order for an individual with Title II DAC benefits to continue to receive Medi-Cal with no Share of Cost, the Social Security Title II income is disregarded when calculating Medi-Cal eligibility.¹⁷ Under federal law, the individual is treated for Medicaid purposes as if they were still an SSI beneficiary.¹⁸

To determine if an individual who received both Title II Social Security DAC and SSI at some time in the past qualifies for the Medi-Cal DAC Program, compare their Title II grant level in 1987 with the current SSI grant level. If they would qualify for SSI now, *i.e.*, if their Title II DAC benefits were at the same level as when they last qualified for both benefits, then the individual is eligible for no-cost Medi-Cal through the Medi-Cal DAC program.¹⁹ The individual would also qualify for no-cost Medi-Cal if they became eligible for Title II DAC benefits after July 1987.²⁰

Note: When determining an individual's eligibility for no-cost Pickle or DAC Medi-Cal based on COLA's, you cannot deduct Medicare premiums from the person's Title II benefits. In other words, count the Title II benefits before any Medicare premium deductions are taken.

Getting and Keeping DAC Medi-Cal

Any individual described above who qualifies should be able to get Medi-Cal either as a continuing benefit when she loses SSI or, if later, as a new applicant under the Medi-Cal DAC Program. The state periodically sends counties lists of Title II DAC recipients whose SSI/SSP has been or is being terminated.²¹ The counties are required to contact the recipients to see if they need assistance in completing the forms required for the application process.²²

Eligible individuals should remain eligible as long as they meet all the other SSI

17. ACWDL 07-29 (Nov. 26, 2007), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c07-29.pdf>.

18. 42 U.S.C. § 1383c(c).

19. Increases in DAC benefits may occur due to COLA's, a reduction in the number of dependents drawing against the wage earner's amount, or the death of the wage earner.

20. ACWDL 91-47 (May 9, 1991), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c91-47.pdf>.

21. See, e.g., ACWDL 95-14 (Mar. 6, 1995), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/95-14.pdf>.

22. *Id.*

eligibility rules.

5. Disabled Widow/Widower Programs

This program provides full-scope, no-cost Medi-Cal to individuals with disabilities who lost SSI as a result of receiving Title II widow's or widower's benefits or surviving divorced spouse benefits alone or combined with other Title II benefits.²³

Generally, in order to qualify for this program, an individual must have been married to the deceased for at least nine months. However, the nine-month requirement does not apply in certain circumstances, such as when the spouse's death was an accident; the spouse died while serving on active duty in the armed forces; or the couple has a child in common under age 18.²⁴ Individuals may qualify for these benefits if they are age 60 or older or if they are 50 or older and have a disability that started no later than seven years after the spouse died (or seven years after the individual was last entitled to benefits).²⁵ In addition, an individual who remarries may lose their eligibility for these benefits, depending on the circumstances.²⁶

Widows/widowers disability benefits convert to early retirement benefits at age 60. However, an individual is eligible for Medicare after the conversion to early retirement benefits at age 60 if the individual meets the Title II SSDI disability criteria. In addition, the individual must meet the SSDI disability criteria in order to qualify for no-cost Medi-Cal under the Disabled Widow program. The individual will generally

23. 42 U.S.C. § 402(e) and (f); 20 C.F.R § 404.335; 42 C.F.R. § 435.138. Medicare benefits come with the disabled widow/widower benefits after the two-year waiting period, on top of the initial five-month wait period, so long as the individual meets the disability criteria for Title II Social Security disability benefits.

24. 20 C.F.R § 404.335(a). Other situations where the nine-month rule does not apply include: When the couple's marriage was delayed because the now-deceased spouse was in a previous marriage to an individual who was mentally incompetent and institutionalized (20 C.F.R. § 404.335(a)(2)(iv)); when the couple had been previously married to each other and the prior marriage lasted at least nine-months (20 C.F.R. § 404.335(a)(2)(iii)); when in the month before marriage the individual was entitled to any of these benefits or payments: widow's, father's, mother's, wife's husband's parent's or disable child's benefits (20 C.F.R. § 404.335(a)(4)).

25. 20 C.F.R § 404.335(c); ACWDL 93-02 (Jan. 12, 1993), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c93-02.pdf>.

26. 20 C.F.R § 404.335(e).

meet the disability criteria because of the requirement that the individual lose SSI because of receipt of widow/widower benefits. This is because SSI that is payable before the age of 65 is always based on disability.

Widow/Widower with Disabilities Program Requirements

Persons with disabilities who are widows, widowers and surviving divorced spouses and qualify for Social Security disability or early retirement benefits will be eligible for Medi-Cal if they:

- Are ineligible for Medicare Part A;
- Received SSI in the month prior to the month in which their widow/widower disability benefits or early retirement benefits began; and
- Would be eligible for SSI but for the receipt of the widow/widower benefits.²⁷

Getting and Keeping Widow/Widower with Disabilities Benefits

Individuals who qualify should continue to get Medi-Cal when they lose SSI, or as new applicants to Medi-Cal. They should remain eligible as long as they meet all the other SSI eligibility rules, and until they become entitled to Medicare Part A. As discussed above, counties are obligated to redetermine Medi-Cal eligibility in any case where an individual loses SSI or Medi-Cal under a particular Medi-Cal program.

6. Aged and Disabled Federal Poverty Level (A&D FPL) and Blind Federal Poverty Level (Blind FPL) Programs

The A&D FPL and the Blind FPL Programs provide no-cost, full-scope Medi-Cal to

27. 42 U.S.C. § 1383c(d). There is also a Disabled Widow/Widower program that provides no-cost Medi-Cal for individuals who received an increase in widow/widowers benefits due to a one-time increase in those benefits in January 1984. That one-time increase was due to the elimination of the additional early retirement reduction factor for individuals under age 60. This program does not apply to anyone who first filed an application for the program after June 30, 1988. See 42 U.S.C. § 1383c(b); 42 C.F.R. § 435.137; ACWDLs 93-02 (Jan. 12, 1993), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c93-02.pdf>; 88-74 (Sept. 21, 1988), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c88-74.pdf>; and 86-54 (Oct. 10, 1986), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c86-54.pdf>. Very few people qualified for this program.

low-income individuals who are either over the age of 65, or who have a disability.²⁸ Children and adults can qualify as disabled if they meet the Social Security Administration's (SSA) disability criteria.²⁹ Note that an individual who is in long-term care in a nursing facility is not eligible for this program.³⁰

Must be over 65 or have a disability. An individual must be *either* over the age of 65, or have a disability (including blindness under SSDI disability standards) to be eligible for the A&D FPL program, or blind under the SSI program standards to be eligible for the Blind FPL program.³¹

Individuals are considered *disabled* for the A&D FPL program if either:

- They are receiving Social Security Disability Insurance (SSDI) benefits (including Disable Adult Child and Widow/Widowers benefits), or
- They meet the disability requirements for SSI (including the SSDI definition of blindness) but do not receive SSI because their income exceeds the SSI limits. For adults, disability is defined as having a physical or mental impairment that

28. 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(X) and 1396a(m) (allowing states the option to adopt a program for seniors and individuals with disabilities); Welf. & Inst. Code § 14005.40. The aid codes are 1H for individuals who are aged and 6H for individuals with disabilities; 1U and 6U are aid codes for restricted scope Medi-Cal for individuals who are over age 65 or disabled, respectively. The Blind FPL aid code is 2H.

29. 42 U.S.C. § 1396a(m)(1); 42 U.S.C. § 1382c.

30. ACWDL 00-57 (Nov. 14, 2000), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/00-57.pdf>.

31. The Blind FPL program was enacted because the federal American Recovery and Investment Act (ARRA) prohibited states from cutting back certain categories of Medicaid eligibility. The July 1, 2009 reduction in SSI benefit payment rates would have resulted in one of these Medi-Cal cutbacks because individuals who lost SSI because of the reduction would have lost automatic zero Share of Cost Medi-Cal as well. The Blind FPL program was enacted in order to give zero Share of Cost Medi-Cal to people who are blind who lost Medi-Cal because of the SSI reduction.

prevents the individual from working;³² the impairment must be expected to last at least 12 months or to result in death. For children, they must meet the SSI eligibility rules for children,³³ which assess whether the child has a physical or mental impairment that results in marked and severe functional limitations.³⁴

Individuals who are blind who are receiving Title II benefits automatically meet the disability definition of the A&D FPL program.³⁵ Individuals who are not receiving Title II benefits will meet the disability definition for this program only if they meet the Title II definition of blindness, which is narrower than the SSI definition of blindness. Therefore, they must be referred to the Disability Determination Service Division-State Programs (DDSD-SP) to be evaluated for disability before benefits under the A&D FPL Program can be granted. DDSD-SP will evaluate for disability and will determine whether the individual meets the Title II definition of blindness.

Individuals who are blind who lost SSI due to benefit reductions in 2009, or who are new applicants for Medi-Cal and allege blindness, will be evaluated for the Blind FPL program using the SSI definition of blindness. If the new applicant is determined to meet the Title II definition of blindness, or becomes eligible for SSDI benefits, the individual will be transferred into the A&D FPL program.³⁶

Income Limits. To be eligible for the A&D FPL or the Blind FPL Medi-Cal programs, an applicant's countable income cannot exceed a level set by the state that is based on the Federal Poverty Level. The countable monthly income limit for an individual

32. In order to have a disability under SSDI disability standards, the individual must be unable to engage in "Substantial Gainful Activity" or "SGA" which means the individual cannot do work activity which involves significant physical or mental effort that is performed (or generally performed) for pay or profit. ACWDL 00-68 (Dec. 29, 2000), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/00-68.pdf>. The Disability Determination Service Division-State Programs, a division of the California Department of Social Services, is responsible for making disability determinations for Medi-Cal. See ACWDL 11-11 (Feb. 25, 2011), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c11-11.pdf>.

33. Welf. & Inst. Code § 14005.40(c)(1).

34. 42 U.S.C. § 1382c(a)(3)(C)(i).

35. ACWDL 00-68.

36. ACWDL 09-28 (June 17, 2009), at p. 3, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c09-28.pdf>.

adult or child is based upon the Federal Poverty Level (100% FPL), plus \$230.³⁷ The countable income limits for a married couple who are both applying for Medi-Cal, *i.e.*, the couple either both have disabilities or are over age 65, both are blind, or one is disabled or over 65 and the other is blind, is based upon 100% FPL, plus \$310, *or* the SSI/SSP level, whichever is higher.³⁸ In addition, for purposes of calculating countable income for those individuals who receive Social Security (Title II), their annual cost of living adjustment (COLA) shall be disregarded from January through March, *i.e.*, until the new FPL limits go into effect in April.³⁹

In 2015, under the A&D FPL program the monthly income limit for an individual was \$1,211 and \$1,638 for a couple.⁴⁰ For the Blind FPL program, the income limit was \$1,211 for an individual; \$1,666 for a couple where one individual is blind and the other is aged or disabled; and \$1,751 for a couple where both individuals are blind.⁴¹

Countable Income. The income of the applicant, the applicant's spouse living in the same household, and the parents when the applicant is a minor child living in the same household, is counted in determining the applicant's "countable" income.⁴² Note that under SSI rules, certain free assistance an individual gets from others like

37. Welf. & Inst. Code § 14005.40(c)(1). The Federal Poverty Level (FPL) is announced each February and is effective the following April 1st for one year.

38. *Id.* The SSI/SSP cash benefit levels change each year on January 1st. The SSI rate is based upon the Federal Benefit Rate (FBR) set by the Social Security Administration (SSA) and a State-only Supplemental Payment (SSP) is added to the FBR to get California's SSI/SSP benefit amount. See, e.g., ACWDL 15-08 (Feb. 9 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-08.pdf>. Note that the SSI couple rate for people who are aged or disabled is less than the A&D FPL level for a couple, so the A&D FPL level is applied. However, the SSI couple rate if one or both members of the couple are blind is greater than the A&D FPL level for a couple. Therefore, for the Blind FPL program, the SSI couple rates are used instead of the A&D FPL couple rates. There are two rates, one for a couple if both members are blind, and a lower rate for a couple if one member is blind and the other is over 65 or has a different disability. ACWDL 15-24 (July 15, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-24.pdf>.

39. Welf. & Inst. Code § 14005.40(f).

40. ACWDL 15-12 (Feb. 27, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-12.pdf>.

41. ACWDL 15-24.

42. ACWDL 01-18 (Mar. 16, 2001), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c01-18.pdf>.

rent or food – called “in-kind support” – counts as income.⁴³ However, under these Medi-Cal programs, in-kind support and maintenance is determined using Medi-Cal rules.⁴⁴ This means that an item is not counted as income unless the entire item of need is provided to the Medi-Cal beneficiary.⁴⁵ For example, if a non-applicant spouse gets support to cover some but not all of a monthly utility bill, then the amount of that assistance is not considered in-kind support; it would only qualify as in-kind support if the entire utility bill were covered.

No spend-down. Individuals whose countable income (after exclusions and deductions, see below) is above the A&D FPL or the Blind FPL income limits cannot “spend down” their income to become eligible. Instead, those individuals will have to be considered under the Aged, Blind & Disabled – Medically Needy (ABD-MN) Share of Cost program, where they will be required to pay a Share of Cost before Medi-Cal will cover services. Because the income limit for A&D FPL is significantly higher than the limit for the ABD-MN program, an applicant who has countable income even one dollar over the A&D FPL income limit will only be able to qualify under the ABD-MN program and will owe a Share of Cost of hundreds of dollars, rather than receiving free Medi-Cal.⁴⁶ For a discussion of the ABD-MN Share of Cost Medi-Cal Program and Share of Cost, see section B.8 below.

Income Exclusions or Deductions

There are numerous income exclusions and deductions available under A&D FPL and Blind FPL programs that may lower an individual’s countable income.⁴⁷ These programs follow medically needy rules regarding income exclusions and deductions.⁴⁸ This means that an individual gets all of the SSI exclusions and

43. 20 C.F.R. §§ 416.1102, 416.1103(a)(3)-(5), (b)(2); 22 CCR §§ 50509 and 50511. Note that the definition of in-kind income is different in the “deemed SSI” programs, which use SSI methodologies for determining income in all respects. For example, clothing does not count as in-kind income under the SSI program or the Medi-Cal “deemed SSI” programs.

44. 22 CCR § 50509.

45. 22 CCR § 50509(b).

46. This unfair result is sometimes referred to as the A&D FPL “cliff,” meaning the individual who is only slightly above the A&D FPL limit (and therefore ineligible for A&D FPL Medi-Cal) pays a high penalty (a high SOC in the ABD-MN program) that is much more than the number of dollars s/he is above the A&D FPL income limit.

47. 20 C.F.R. §§ 416.1112, 416.1124. Note that applicants cannot deduct In-Home Supportive Services (IHSS) expenses.

48. 42 U.S.C. § 1396a(m).

deductions and any additional Medi-Cal exclusions and deductions applicable to the program. The following monthly income exclusions and deductions are available, among others:

- Unearned income:⁴⁹ \$20 is excluded per month.
- Earned income:⁵⁰
 - \$65 is excluded per month plus one-half (1/2) of the remainder of gross monthly earned income (e.g., \$565 gross monthly wages results in \$250 in countable monthly income; $565 - 65 = 500$; $500 \div 2 = 250$). **Note:** Married couples can only use the 65 + ½ deduction once.
 - Any unused portion of the \$20 unearned income deduction above (i.e., if less than \$20 of unearned income is excluded, whatever amount up to \$20 is left is the unused portion).
 - Income-related work expenses (IRWEs).⁵¹
- The cost of any health insurance premiums.⁵²
- A \$315 Personal Care Services (PCS) deduction for individuals residing in board of care homes⁵³

49. 20 C.F.R. § 416.1121 (unearned income defined).

50. 20 C.F.R. § 416.1110 (earned income defined).

51. These are out-of-pocket work expenses that an individual needs to become or remain employed, e.g., maintenance on a specialized van; attendant care services to get ready for work; transportation costs; medical devices; work related equipment. 20 C.F.R. § 416.976 and 22 CCR § 50045.1.

52. 22 CCR § 50555.2.

53. Welf. & Inst, Code § 14005.40 (g)(1)(C) and (2); ACWDL 01-18, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c01-18.pdf>. (the PCS deduction is an income disregard that applies to a resident of a licensed community care facility (in lieu of the board and care deduction) when the PCS deduction is greater than the board and care deduction).

Advocacy Tip: Help your clients avoid a Share of Cost of hundreds of dollars in the ABD-MN program by aggressively using these exclusions and deductions so that they qualify for no-cost A&D FPL. A helpful tip is for your client to buy a Medi-Gap or other private health insurance product, including dental or vision insurance. Clients can deduct the cost of that policy or product and that may help them get under the strict income limit in the A&D FPL and Blind FPL programs. If your client purchases private health insurance with coverage that duplicates Medi-Cal coverage, the private health coverage would be billed first and then Medi-Cal would pay for the services it covers after the private health carrier pays or denies a claim.

Deduction for Non-Applicant Household Members. If there are other family members living in the home who are not applying for benefits, deduct a Maintenance Need Allowance, also known as the Maintenance Need Income Limit or MNIL, from the household’s countable income for each non-applicant. Non-applicant children, however, are included in the ineligible spouse’s MNIL.⁵⁴

Maintenance Income Need Level (MNIL)

Family Size	MNIL	Family Size	MNIL
1	\$600	6	\$1,417
2 (1 adult + 1 child)	\$750	7	\$1,550
2 Adults	\$934	8	\$1,692
3	\$934	9	\$1,825
4	\$1,100	10	\$1,959
5	\$1,259		

54. *Id.*

Advocacy Tip: Don't forget to deduct the MNIL from the countable household income for anyone living in the household who is not applying for the A&D FPL or Blind FPL programs.

Example: A woman who is disabled lives with her husband and three children. The husband earns \$4005 per month and there is no other family income. Countable income is \$1960 ($\$4005 - \$20 - \$65 = \3920 ; $3920 \div 2 = \$1960$). Then deduct the MNIL for four (\$1100) family members who are not eligible and the resulting income of \$860 is below the income limit.

Resource Limits. The maximum value of non-exempt property a beneficiary can have to be eligible for A&D FPL or Blind FPL Medi-Cal is \$2000 for an individual and \$3000 for a married couple.⁵⁵

Exempt resources. Certain property an individual has does not count against the resource limits.⁵⁶ Some of those exemptions are:

- The individual's primary residence;
- Clothing, household goods and other personal items;
- One car;
- Certain items necessary for self-employment (e.g., building, inventory or bank account) or that are used on the job (e.g., tools or a second car).

a. Special Rules for A&D FPL and Blind FPL Programs

Individuals No Longer Eligible for SSI. If beneficiaries are determined by the Social Security Administration to no longer meet SSI eligibility standards due to excess

55. 20 C.F.R. § 416.1205.

56. 20 C.F.R. §§ 416.1210 (effective 3/9/05) for a list of excluded resources; 20 CFR §§ 416.1216, 416.1218.

income or other non-disability related reasons, the counties must redetermine their eligibility under the A&D and Blind FPL programs and all other Medi-Cal programs, pursuant to a court order in the case of *Craig v. Bonta*.⁵⁷ The state and counties must follow specific procedures to ensure that these people do not lose their Medi-Cal when they lose their SSI and to address each beneficiary's ongoing Medi-Cal eligibility.⁵⁸ The counties should first determine whether the individual is eligible for Disabled Adult Child or Disabled Widow(er)s Medi-Cal, then Pickle Medi-Cal, then A&D FPL Medi-Cal, then Blind FPL Medi-Cal, in that order.

Individuals who Allege a Disability. If a child or adult who is determined to be no longer eligible for a specific Medi-Cal program states they have a disability, the county must review their eligibility for this and other Medi-Cal programs based upon disability. All the beneficiary has to do is allege a disability, either in writing or orally, and Medi-Cal coverage must continue until the disability evaluation is complete and final.⁵⁹ Counties should provide these individuals with any paperwork necessary to consider their eligibility based upon disability and send the application to the Disability Determination Service Division-State Programs (DDSD-SP), the state agency responsible for determining disability for Medi-Cal purposes.

7. 250% Working Disabled Program (250% WDP)⁶⁰

The 250% Working Disabled Program (250% WDP) provides full-scope Medi-Cal to individuals who:

- Have countable income below 250% FPL;

57. *Craig v. Bonta*, S.F. Superior Ct. No. CFF 02 500688 (2003); see also, e.g., ACWDLs 07-24 (Nov. 9, 2007), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c07-24.pdf>; 03-53 (Nov. 14, 2003), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c03-52.pdf>; 02-54 (Nov. 8, 2002), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c02-54.pdf>.

58. *Id.*

59. ACWDL 01-36 (June 19, 2001), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c01-36.pdf>.

60. Federal law gives states the option of providing Medicaid benefits to individuals with family income below 250% FPL who would be entitled to SSI but for the fact that their income is too high to qualify for SSI. 42 U.S.C. § 1396a(a)(10)(A)(ii)(XIII). California has exercised its option to establish Medicaid benefits for the working persons with disabilities. Welf. & Inst. Code § 14007.9(a)(1).

- Meet the Social Security definition of “disabled;”
- Have countable resources below the limits allowed under SSI (\$2,000 for an individual and \$3,000 for a married couple);⁶¹
- Are U.S. citizens or have satisfactory immigration status; and
- Are working.

Individuals who qualify can obtain full-scope Medi-Cal benefits by paying monthly premiums under a schedule based upon their countable (non-exempt) income.⁶²

Advocacy Tip: If an individual has a disability and is working, then consider eligibility under the 250% Working Disabled Program before considering the ABD-MN Share of Cost Program because the monthly premiums will likely be less than the Share of Cost obligation under the ABD-MN program. Also, the Social Security Administration’s requirement that an individual be unable to participate in “Substantial Gainful Activity” (SGA) to qualify for SSDI benefits does not apply to this program.⁶³

Another benefit of the 250% WDP is it allows enrollees to retain their earned income so they may accrue resources and not lose their eligibility. See the description of this unique benefit of the program in the “Exempting Retained Earned Income” later in this section.

Working Individuals

An individual must be working to qualify for this program. Applicants are considered working if they have *any* monthly earnings from work – there is no minimum amount of hours or pay. Work may also include earned in-kind income, if the earned in-kind

61. The 250% WDP is a “deemed SSI eligible” program. 42 U.S.C. § 1396a(a)(10)(A)(ii)(XIII). Therefore, SSI methodologies for determining income and resources apply, and SSI income and resource exclusions apply with additional exclusions provided under state Medi-Cal law.

62. Welf. & Inst. Code § 14007.9(c), (d)(a)(1) (which exercises a federal Medicaid option under 42 U.S.C. §§1396r-1a and 1396a(a)(10)(A)(ii)(XIII)). ACWDL 00-16, (Mar. 16, 2000), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c00-16.pdf>. Aid code: 6G (full-scope). There is no restricted scope 250% Working Disabled Program for undocumented immigrants.

63. Welf. & Inst. Code § 14007.9(a)(2)(1)(B).

is the only earnings.⁶⁴ An applicant must provide proof of employment and proof of earnings.⁶⁵

Once enrolled in the 250% Working Disable Program, an individual can be temporarily unemployed and still remain on the program. For more information regarding periods of unemployment, see “Rules for Maintaining Eligibility” below.

Individuals Who are Disabled

An individual must meet the Social Security definition of disability, without regard to the “substantial gainful activity” component of the federal definition, in order to qualify for this program.⁶⁶ This means an individual must have a medically determinable physical or mental impairment that has lasted or is expected to last for at least one year which would qualify that individual to receive SSI or SSDI.⁶⁷

Income Limits

To qualify for Medi-Cal under the 250% WDP, an unmarried individual’s *countable* income (income minus allowable exclusions) must be below the 250% of the federal poverty level for a household of one.⁶⁸ If an individual is married and their spouse’s income is deemed to them (or both spouses are applying), then countable income must be below 250% FPL for a household of two.⁶⁹ In addition, an individual must have countable income below the SSI/SSP benefit payment rate after excluding earnings from countable income.

Income Exclusions

The SSI income exclusions apply, with one important exception: **all** disability-based income is deducted.⁷⁰ This means that disability-based income – such as workers’ compensation, SDI, or other Social Security benefits, and state and private disability

64. ACWDL 00-51 (Sept. 27, 2000) at p. 6, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/00-51.pdf>.

65. ACWDL 00-51, at p. 3. Proof of employment includes but is not limited to pay stubs, written verification of employment from an employer, contracts, or 1099 IRS forms.

66. Welf. & Inst. Code § 14007.9(a)(2)(1)(B).

67. 42 U.S.C. § 1382c(a)(3).

68. Welf. & Inst. Code § 14007.9(a)(1)(A).

69. *Id.*

70. 42 C.F.R. § 435.831(b)(2); Welf. & Inst. Code § 14007.9(b)(1). See section B.6 for the SSI income deductions and exclusions.

income – is not counted in determining an individual’s eligibility for the 250% WDP. An individual’s Title II Social Security Disability Insurance that converts to Social Security Retirement when that individual reaches retirement age is also not counted.⁷¹

Income Deeming

Only count the income of the applicant (except for disability income) and the spouse, if the applicant is married. If the applicant is a child, count the parent’s income.

In-Kind Support and Maintenance: Special rules count the value of food, clothing, or shelter given to the individual (or paid for) by another.⁷² Shelter includes room, rent, gas, electricity, water, sewer, and garbage collection services.⁷³

Advocacy Tip: Counties must first determine eligibility for MAGI Medi-Cal for each family member, including for working persons with disabilities before looking at the 250% Working Disabled Program. Family members who are eligible for the 250% WDP are their own households, even if they are a child. They are treated as an “other public assistance” exception, i.e., the individual and his or her income are not included in the family’s household when determining other family members’ eligibility for Medi-Cal. However, a 250% WDP-eligible married couple is grouped together in the same household.

71. Welf. & Inst. Code § 14007.9(b)(5); ACWDL 11-38 (Nov. 9, 2011), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c11-38.pdf>. The exemption of disability income that converts to retirement income is limited to Social Security disability benefits and is not applicable to other public or private retirement entities, such as when an individual receives disability from the California Public Retirement System but then qualifies for Social Security income based on retirement.

72. ACWDL 00-51 at p. 4; see also ACWDL 00-16 (Mar. 16, 2000), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c00-16.pdf>.

73. *Medi-Cal Eligibility Procedures Manual*, 5R-6.

Resource Limit

The 250% Working Disabled Program has the same resource limits as the SSI program.⁷⁴ This means that the maximum value of non-exempt property an individual can have is \$2,000 for an individual and \$3,000 for a married couple.⁷⁵

Special Property Deduction: Individual retirement accounts (IRAs) or other retirement plans (e.g. Keogh's or 401(k) plans) *do not count* as property even if the individual has access to them.⁷⁶

Exempt Property: Because the 250% Working Disabled Program follows SSI's rules for excluding resources as well as Medi-Cal rules providing additional exclusions, property that is considered exempt under SSI is also considered exempt under 250% WDP.⁷⁷ Some of those exemptions are:

- The individual's primary residence;
- Clothing and personal items;
- One car; and
- Certain items necessary for self-employment (e.g., building, inventory or bank account) or that are used on the job (e.g., tools, or a second car).

Exempting Retained Earned Income: Money that is earned from working while enrolled in the 250% WDP can be exempted from the program's resource limits of \$2000 for an individual and \$3000 for a couple.⁷⁸ This money is exempt so long as the money is put into a separately identifiable account from the enrollee's checking and savings account that are counted as resources under the Medi-Cal program.⁷⁹ There is no limit on the amount of earned income an individual can keep in the separately identifiable account.⁸⁰ ***This means that an individual enrolled in the 250% WDP is able to build assets without jeopardizing eligibility.*** An individual who loses 250% WDP eligibility but continues to receive Medi-Cal in a program

74. Welf. & Inst. Code § 14007.9(a)(3).

75. 20 C.F.R. § 416.1205(c).

76. Welf. & Inst. Code § 14007.9(b)(2).

77. See 20 C.F.R. § 416.1210 for a list of excluded resources.

78. Welf. & Inst. Code § 14007.9(b)(4); ACWDL 11-38.

79. *Id.*

80. ACWDL 11-38, p. 3.

that requires age, blindness or disability as the basis for eligibility will keep these additional property exclusions.⁸¹

Premium Costs

All eligible individuals for the 250% Working Disabled Program must pay premiums based upon their countable income.⁸² There is a minimum premium of \$20 per individual per month and a maximum premium of \$250 per individual per month.⁸³ The following chart outlines the various premiums based upon countable income.⁸⁴

250% Working Disabled Program Premiums

Countable Monthly Income	Monthly Premium: Individual	Monthly Premium: Married Couple
\$1 - \$600	\$20	\$30
\$601 - \$700	\$25	\$40
\$701 - \$900	\$50	\$75
\$901 - \$1100	\$75	\$100
\$1101 - \$1300	\$100	\$150
\$1301 - \$1500	\$125	\$200
\$1501 - \$1700	\$150	\$225
\$1701 - \$1900	\$175	\$275
\$1901 - \$2100	\$200	\$300
\$2100 – up to 250% FPL for 2	\$250	\$375

Premium payments are due by the 10th of each month. 250% WDP enrollees may pay their premiums via electronic fund transfer (EFT) for free to the Department of Health Care Services at www.paycalifornia.com, or by mailing payment to DHCS.⁸⁵

81. Welf. & Inst. Code § 14007.9(c); ACWDL 11-38.

82. Welf. & Inst. Code § 14007.9(d).

83. Welf. & Inst. Code § 14007.9(d)(f)(1).

84. ACWDL 00-16, Enclosure 3 at p. 10; *Medi-Cal Eligibility Procedures Manual*, 5R-5.

85. Welf. & Inst. Code § 14007.9(g). For more information on how enrollees may pay their premiums, see Medi-Cal form MC 0384 (Rev. 12/12).

An individual may be disenrolled from the program for failure to pay the required premiums for two consecutive months.⁸⁶

Rules for Maintaining Eligibility

As long as a low-income adult or child meets the disability criteria, is working, meets the income and resource limits, and pays the monthly premium, they should remain eligible for the program.

Beneficiaries in the 250% Working Disabled Program may experience periods of unemployment and still retain their eligibility. Breaks in employment are limited to 26 weeks total during an annual eligibility time period, and an enrollee must continue to pay premiums during those times to retain their eligibility (although counties are not responsible for enforcing the collection of premium payments during the period of unemployment).⁸⁷

As is the case with other Medi-Cal programs, if an individual loses eligibility for 250% WDP then the county must always undertake a review to determine whether the individual is eligible for Medi-Cal on any other basis.⁸⁸

Advocacy Tip: If an individual who is receiving SSI loses their eligibility due to increased earnings, make sure the county has redetermined the individual's eligibility for Medi-Cal both under the A&D FPL Program and the 250% WDP.

86. ACWDL 00-16, p. 3.

87. Welf. & Inst. Code § 14007.9(a)(2); ACWDL 11-38 (Nov. 9, 2011), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c11-38.pdf>.

88. ACWDL 00-51, p. 5. If beneficiaries lose eligibility for the 250% WDP and they have retirement accounts such as IRAs or 401k accounts, those accounts will continue to be exempt as resources, meaning they will not be considered countable resources, if the beneficiaries are found to be otherwise eligible for other Medi-Cal programs that require age, blindness or disability as the basis for eligibility. Welf. & Inst. Code § 14007.9(c); ACWDL 11-38 at p.4.

8. Aged, Blind and Disabled – Medically Needy (ABD-MN): Free and Share of Cost

Individuals who are over age 65 or disabled can receive Medi-Cal under the Aged, Blind and Disabled Medically Needy (ABD-MN) program⁸⁹ if the individual:

- Does not want to receive SSI;⁹⁰
- Is not eligible for SSI because the individual does not meet an SSI eligibility condition that does not apply to the Medi-Cal program;⁹¹ or
- Has an application pending for SSI.⁹²

Individuals who qualify as ABD-MN usually do not get free Medi-Cal, but rather have to pay a “Share of Cost” (SOC).⁹³ This means that they must “spend down” their income to a specific Medi-Cal eligibility level each month that they use Medi-Cal in order for their Medi-Cal coverage to take effect. Share of Cost is explained later in this section.

The county must refer individuals who may be eligible for SSI, and who agree to apply for that program, to the Social Security Administration for a determination of SSI/SSP eligibility.⁹⁴ Pending the SSI/SSP determination, the county department shall determine eligibility under any other program for which the individual may be eligible.⁹⁵ This includes the ABD-MN program.

89. 42 U.S.C. § 1396a(a)(10)(C); 42 C.F.R. §§ 435.300 *et seq.*, 435.800 *et seq.* and 436.800 *et seq.*; Welf. & Inst. Code §§ 14005.7(c), 14005.9 and 14051; 22 CCR §§ 50203; 50401 *et seq.*; 50501 *et seq.*; 50549 *et seq.*; 50555.1. Note: For rules regarding the deeming of income from parents to a disabled child to determine if the child is eligible for SSI, go to <http://www.disabilityrightsca.org/pubs/PublicationsSocialSecurity.htm>.

90. 22 CCR § 50203. This is an “optional categorically needy” program under federal law. 42 C.F.R. § 435.210.

91. *Id.* This is a “mandatory categorically needy” program under federal law. 42 C.F.R. § 435.122.

92. *Id.*

93. ABD-MN aid codes with no Share of Cost: 14 (Aged), 24 (Blind), 64 (disabled); C1 (restricted, aged), C3 (restricted, blind), C7 (restricted, disabled). ABD-MN aid codes with Share of Cost: 17 (aged), 27 (blind), 67 (disabled); C2 (restricted, aged), C4 (restricted, blind), C8 (restricted, disabled).

94. 22 CCR § 50153(b)(3).

95. 22 CCR § 50153(b)(3)(b).

Advocacy Tip: If someone loses SSI, or is ineligible for SSI for some reason other than general, categorical or financial eligibility, check the Medi-Cal regulations, Medi-Cal Eligibility Procedures Manual, and ACWDLs to see if that eligibility condition under SSI exists in the Medi-Cal program. If it does not, the individual may receive Medi-Cal under this program. For example, so called “fugitive felons” are ineligible for SSI benefits under some circumstances, but remain eligible for Medi-Cal. Therefore, if the county has terminated Medi-Cal or refuses to take a Medi-Cal application because the individual is ineligible for SSI, insist on the application being processed; it may turn out that the individual was determined ineligible for SSI due to a requirement that does not exist under Medi-Cal, and therefore the individual could be entitled to Medi-Cal after all.

Income

To qualify for Medi-Cal under the ABD-MN Program without a SOC, a household’s *countable income* (income minus allowable deductions) must be below the Maintenance Needs Income Level (MNIL) for the household’s size. See the MNIL chart later in this section. If the household’s income limit is above the MNIL, the beneficiary will have a Share of Cost.

Income Exemptions

Certain income does not count in determining ABN-MN eligibility. The ABD-MN program follows the SSI income exemption rules.⁹⁶ Exempt income includes, among others:

- Public Assistance, including social services, foster care payments and public housing assistance;⁹⁷

96. 42 C.F.R. §§ 435.811(c) and 435.831(b)(2); 22 CCR §§ 50521 through 50544. 20 C.F.R. §§ 416.1102 and 416.1103 set out the SSI income counting rules. See *also* the discussion above for the A&D FPL Program, which also follows the SSI rules.

97. 22 CCR §§ 50525 (public assistance), 50527 (social services), 50531 (foster care), 50529 (Section 8 or federal HUD housing assistance), 50535 (relocation assistance).

- Voluntary job training programs and assistance;⁹⁸
- Public education loans, work study payments grants and educational expenses;⁹⁹
- Property tax refunds or rebates and earned income tax credits;¹⁰⁰
- Renters assistance;¹⁰¹
- One-third of child-support received for a child with disabilities;¹⁰² and
- Wages placed in a cafeteria plan to pay medical expenses or child care.¹⁰³

Income Deductions

Not all non-exempt income is considered when determining an individual's income for purposes of the ABD-MN program. Instead, individuals are allowed to take certain deductions that reduce the amount of countable income. The ABD-MN program also follows the SSI income exclusion rules and more generous Medi-Cal rules.¹⁰⁴ The following monthly exclusions are available:

- \$20 from either earned or unearned income – this is called the \$20 “any income” deduction;¹⁰⁵
- Earned income deductions;
- Any unused portion of the \$20 “any income” deduction;¹⁰⁶ (described above)
- \$65, plus one-half of the remainder of gross earned income;¹⁰⁷
 - Impairment-Related Work Expenses (IRWE's) for people who are disabled under the SSI standard (the IRWE deduction is taken after subtracting one-half of the remainder, as described above).

98. 22 CCR §§ 50530 (Dept. of Rehab training grant), 50538 -41 (other programs).

99. 22 CCR §§ 50533 and 50546.

100. 22 CCR §§ 50523 and 50543.5.

101. 22 CCR §§ 50523.5 (assistance from the California Franchise Tax Board), 50535 (relocation funds). See *also* 50454.5(a)(1) (renters credit among the type of assistance that may be provided by the California Franchise Tax Board).

102. 22 CCR § 50549.1

103. 20 C.F.R. § 404.1053.

104. 42 C.F.R. §§ 435.811 and 435.831(b)(2); 20 C.F.R. §§ 416.1102, 416.1103; 22 CCR §§ 50519 and 50545-50555.2; see *also* the discussion above for the A&D FPL Program, which also follows the SSI rules.

105. 22 CCR § 50549.2.

106. 22 CCR § 50551.2.

107. 22 CCR § 50551.3. Note that Temporary Workers Compensation, State Disability Income (SDI) and Unemployment Insurance (UI) are treated as unearned income. 22 CCR § 50507.

- The Blind Work Expense (BWE) deduction, which is a deduction for all work expenses available to those who are blind under the SSI standards (the BWE deduction is taken before subtraction of the one-half the remainder, as described above).
- Health benefit/insurance premiums;¹⁰⁸
- MNIL: The family’s monthly maintenance need income level (see MNIL chart later in this section).

Income Deeming: *Sneede/Gamma* Rules

“Income deeming” refers to the rules on whether to count the income of others to determine an individual’s non-MAGI Medi-Cal eligibility. There are two important court cases regarding Medi-Cal deeming. The first is *Sneede*, in which the court addressed when and how another individual’s income can count in determining an individual’s Medi-Cal eligibility.¹⁰⁹

When there are income earners in the home who are children or who are adults other than an applicant’s parent or spouse, their income must not count in determining the applicant’s income eligibility.¹¹⁰ The reason is that the legal obligation to support runs only between spouses, and between parents and their children, and not, for example, between siblings or between stepchildren and stepparent.¹¹¹ For example, if a child applicant’s 10-year-old brother earns money from a paper route, that money is not available to the applicant and should not be counted against the applicant. Likewise, if an applicant’s stepmom is in the home and she works, her earnings are not considered available for the support of the applicant. In contrast, in the case where the applicant is married the spouse’s income will be considered if the spouse is in the same household. Similarly, in the case of a child applicant, the parent’s income is counted if the parent is in the same

108. 42 C.F.R. § 435.831(e)(1); 22 CCR § 50555.2.

109. *Sneede v. Kizer*, 728 F.Supp. 607 (N.D. Cal. 1990).

110. 42 U.S.C. § 1396a(a)(17)(D); 42 C.F.R. § 435.602(a)(1).

111. The Affordable Care Act’s adoption of MAGI methodology did not change the income deeming rules regarding stepparents and stepchildren in the non-MAGI programs. Therefore, in the MAGI Medi-Cal programs a stepparent’s income is deemed to a stepchild, while in the non-MAGI programs a stepparent’s income would not be deemed to the stepchild under the *Sneede* rule.

household with the child.¹¹²

However, even if another individual's income can be deemed to the applicant, not all of that income is considered available to the applicant. The *Gamma* court held that a parent or spouse can first deduct a "personal need allowance" from her income for her own living expenses before income is deemed to family members for whom she is legally responsible.¹¹³

When to use **Sneede** and **Gamma** Rules

Sneede/Gamma procedures are only applicable if the combined income of the family makes the family ineligible for free Medi-Cal **and** one of the following is true:

- One of the children has their own income or;
- A stepparent or an unmarried parent lives in the home; or
- A caretaker relative cares for the child seeking Medi-Cal.

Therefore, an adult applicant would only count her income and the income of her spouse, if they are in the same household. And if the applicant is a child, the income of the parent would be counted to the child if the parent lives with the child.

If a child has her own income, special prorated income limits apply and *Sneede* procedures must be applied to the Medically Needy eligibility determination, where the child is kept in a separate mini-budget unit (called a MBU).¹¹⁴ In addition, if more than one individual in the family is aged, blind or disabled, the income deductions (discussed above) are subtracted from the combined nonexempt income of all aged, blind and disabled medically needy individuals in the household and the spouse or parents of these individuals. Finally, if income from a family member is deemed to be available to one family member applicant, it cannot be counted again in determining

112. In these cases, these individuals would be considered part of the same Medi-Cal Family Budget Unit (MFBU). See 22 CCR §§ 50351, 50371, 50373, 50557.

113. *Gamma v. Belshe*, No. C94-0852 (N.D.Cal 1995) reprinted at *Medicare & Medicaid Guide* (CCH), ¶ 40,003.

114. 22 CCR §§ 50381(a), 50558(a), (b).

another family member’s eligibility.¹¹⁵

Resource Limits

The ABD-MN program follows the SSI resource rules, but also has more generous limits and exclusions.¹¹⁶ In order to qualify for ABD-MN, the family’s property must be below certain property limits (see chart below).¹¹⁷ In addition, applicants who are over the property/resource limit at the time they submit their application have until the end of the month to reduce their property to the resource limits.¹¹⁸ This is called the “spend down” of resources. If an applicant successfully spends down to the resource limit before the end of the month of application, they will be eligible for Medi-Cal for that entire month.¹¹⁹

Aged, Blind and Disabled-Medically Needy: Property Limits

Family Size	Property Limits
1	\$2,000
2	\$3,000
3	\$3,150
4	\$3,300
Per Add'l Individual	Add \$150

-
115. 22 CCR §§ 50555.1, 50557(b). For more guidance on how to apply the *Sneede/Gamma* rules, see the Health Consumer Alliance’s fact sheets on income deeming, which can be found at <http://healthconsumer.org/publications.htm>. Note these fact sheets are pre-Affordable Care Act when the *Sneede/Gamma* rules were used by more families. Now, MAGI Medi-Cal allows access to free care for more family members at higher incomes than the ABD-MN Medi-Cal Program. Those who are not MAGI Medi-Cal eligible may find more generous benefits through a Covered California plan with financial assistance than a Medi-Cal Share of Cost program in many circumstances. Nonetheless, if an individual finds the cost-sharing in Covered California to be too expensive for their particular health care needs (or is over age 65), it is worth checking if the *Sneede/Gamma* rules work to their benefit.
116. 42 C.F.R. § 435.840(b). See 22 CCR §§ 50418 and 50425 – 50489 for the types of property that are considered exempt and not included in determining eligibility.
117. 22 CCR § 50420(a).
118. 22 CCR § 50420(c)(1).
119. *Id.*

Resource Exemptions

Some property does not count as a resource for this program. Exempt property includes, but is not limited to:¹²⁰

- Primary residence (home);¹²¹
- One car (plus a second car if it is used for work to produce income – not just to get to and from work);¹²²
- Household items and personal effects (including furniture, appliances, clothing and some jewelry);¹²³
- Equipment and property necessary for self-support while at work or in own business;¹²⁴ and
- Retirement accounts (IRA's, programs through work) of parents who are ineligible family members, *i.e.*, not eligible for or electing Medi-Cal.¹²⁵

Medi-Cal “Share of Cost”

As previously mentioned, individuals who qualify as ABD-MN usually do not get free Medi-Cal, but rather have what is known as a Share of Cost (SOC). Share of Cost is a sliding-scale monthly payment based on the income above the Medi-Cal income level for free care for the medically needy, known as the Maintenance Needs Income Level (MNIL).¹²⁶ If an applicant's income is below the Maintenance Need Income Level for her family size, she qualifies for free ABD-MN, meaning she has no Share of Cost. Medi-Cal Share of Cost programs do not count as *minimum essential coverage* for purposes of the individual mandate of the Affordable Care Act. Currently, there is an exemption for individuals in Medi-Cal Share of Cost programs to avoid the tax penalty imposed on individuals without minimum essential coverage. Nonetheless,

120. See 20 C.F.R. §§ 416.1210, 416.1212, 416.1216, and 416.1218; 22 CCR §§ 50418 and 50425 – 50489.

121. 20 C.F.R. § 416.1212; 22 CCR § 50425.

122. 20 C.F.R. §§ 416.1218, 416.1220.

123. 20 C.F.R. § 416.1216; 22 CCR §§ 50465, 50467.

124. 20 C.F.R. § 416.1220.

125. ACWDL 02-51 (October 18, 2002), at p. 2, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c02-51.pdf>.

126. The MNILs are fixed amounts according to family size that have not been changed in California since 1989. See, e.g., ACWDL 92-49 (July 23, 1992), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c92-49.pdf>.

persons under age 65 should check whether a Covered California plan with financial assistance would better serve their needs.

Family Maintenance Income Need Level (MNIL)

Family Size	MNIL	Family Size	MNIL
1	\$600	6	\$1,417
2 (1 adult + 1 child)	\$750	7	\$1,550
2 Adults	\$934	8	\$1,692
3	\$934	9	\$1,825
4	\$1,100	10	\$1,959
5	\$1,259		

Each month, individuals who are above their MNIL must “spend down” their income by paying for medical expenses on their own until they meet their SOC for that month. After meeting the SOC for the month, Medi-Cal will pay for the remainder of the covered services in that month. SOC is a dollar-for-dollar amount; if the beneficiary is \$70 over the MNIL, the SOC is \$70. If the beneficiary is over \$71, the SOC is \$71. Medi-Cal with a SOC is not to be confused with a monthly premium; unlike a premium, SOC is not owed in months the beneficiary does not seek services.

Advocacy Tip: Always first look to see if the individual or family qualifies for a free Medi-Cal program, such one of the MAGI Medi-Cal programs. Income standards in these programs are more generous and there is no Share of Cost for the beneficiary. If the individual is disabled and working, then look at eligibility under the 250% Working Disabled Program, which typically has a smaller premium than the Share of Cost owed under the ABD-MN program. Finally, in many instances, a Covered California plan with financial assistance would be cheaper than enrollment in the ABD-MN program, depending on the Share of Cost and whether certain services provided only through Medi-Cal were needed.

Determining Share of Cost

If an applicant's countable family income exceeds the Maintenance Need Income Level, the applicant will have a Share of Cost. As discussed above, the family's *countable income* is determined by subtracting any allowable exempt income and deductions from total income. The amount by which the *countable income* exceeds the Maintenance Need Income Level, based upon the number of people in the family, is the Share of Cost.¹²⁷

Example: If a family of 4 has a monthly countable income of \$2,000 and a Maintenance Need Income Level of \$1,100, the family must incur a \$900 Share of Cost ($\$2,000 - \$1,100 = \900) before Medi-Cal will cover their medical care in any month they seek care from Medi-Cal coverage.

Beneficiaries can meet their Share of Cost obligation amount by either paying for, or agreeing to pay for costs incurred for medical goods and services (even services or supplies Medi-Cal would not cover).¹²⁸

Continued Eligibility for ABD- MN Benefits

As long as an individual is age 65 or older or meets the disability criteria, and also meets the income and resource limits, they should remain eligible for the program. The individual's Share of Cost may also fluctuate depending on family size, income, or deductions, so it is important for the individual to report any change right away to the county eligibility worker.

C. Full-Scope Non-MAGI Medi-Cal for Children and Families

Most children and families are now found eligible for Medi-Cal under MAGI rules. However, there are still some programs that do not use the MAGI methodology to determine a child or parent's eligibility for Medi-Cal – largely because these programs are not reliant on income determinations at all, but rather connection to another program. The following non-MAGI programs provide full-scope no-cost Medi-Cal for children or families.

127. 22 CCR § 50653.

128. 42 C.F.R. § 435.831(i)(1)(ii); 22 CCR § 50655; see also *Johnson v Rank*, 110 F.R.D. 99 (N.D. Cal 1986).

1. Automatic Eligibility Due to Receipt of Government Benefits

Just as for individuals receiving SSI, families receiving welfare cash assistance and children receiving assistance because they no longer live with their biological parents are linked to Medi-Cal by their eligibility for those programs. Children and families who receive the following types of state or federal government benefits are categorically-linked to Medi-Cal and are automatically eligible for full-scope Medi-Cal:

- **Federal foster care benefits:**¹²⁹ These benefits are also called *Youakim* if the child is placed with a relative.
- **Adoption Assistance Payments (AAP):**¹³⁰ Federal benefits for children with “special needs.”
- **CalWORKs:**¹³¹ State welfare cash assistance.
- **State foster care benefits:** For children who do not meet the eligibility requirements of federal foster care.¹³² For example, children do not have to be removed from their home by a court order to be eligible for state foster

-
129. 42 U.S.C. §§ 672; 1396a(a)(10)(A)(i)(I); 42 C.F.R. § 435.115(e)(2). Generally, a child’s eligibility for federal funding under Title IV-E of the Social Security Act which covers federal foster care benefits is based on whether the child was eligible for Aid to Families with Dependent Children (AFDC) while living with a parent in the month prior to the Dependency Court petition being filed or the signing of a Voluntary Placement Agreement. 42 U.S.C. § 672(a)(1)(B), (a)(3)(A). Under the holding of *Rosales v. Thompson*, 321 F.3d 835 (9th Cir. 2003), a child can still meet this requirement if that child lived with a relative at any time during the six months prior to the petition being filed in Dependency Court or the Voluntary Placement Agreement being signed. “Youakim” is the term used if the child is federally eligible for federal foster care funding and living with a relative; it comes from the case *Youakim v. Miller*, 425 U.S. 231 (1976). It is the relative’s version of federal foster care funding. These children receive Medi-Cal in Aid Codes 42, 46, and 49 (for non-minor dependents aged 18 up to 21). ACWDL 12-03 (Jan. 10, 2012).
130. The Adoption Assistance Program is a cash grant program to facilitate the adoption of children who are hard to place who would require permanent foster care placement without this assistance. 42 U.S.C. §§ 673(a)(1)(B), 1396a(a)(10)(A)(i)(I), 42 C.F.R. § 435.115(e)(1). These children receive Medi-Cal in Aid Codes 03, 04, 06, 07, and 4A. 42 U.S.C. §§ 673(a)(1)(B), 1396a(a)(10)(A)(i)(I), 42 CFR § 435.115(e)(1) and ACWDLs 12-03 (Jan. 10, 2012); 08-30E (Feb. 25, 2009), and 00-22 (Apr. 10, 2000).
131. Welf. & Inst. Code § 14005.30(a)(2); 22 CCR §§ 50525, 50528. The CalWORKs-linked aid codes are 30, 31, 32, 33, 35, 3A, 3C, 3D, 3E, 3F, 3G, 3H, 3L, 3M, 3P, 3U, 3W, and K1.
132. Welf. & Inst. Code § 11401; 22 CCR § 50531. These children receive Medi-Cal in Aid Code 40, 43, 45, 4C, 4H, 4L, 4K, 4N, 4P, 4R, and 5K (for non-minor dependents aged 18 up to 21).

care benefits.¹³³

- **Kin-GAP:** State cash assistance to certain children under 18 who were dependents in the foster care system and who are now living with relatives who have obtained a guardianship.¹³⁴ Kin-GAP children receive cash benefits at an amount identical to the basic federal foster care rate.¹³⁵

2. Children in Foster Care

Most children who have been abandoned by their parents or removed from their parents' custody are eligible for free Medi-Cal regardless of their immigration status, with very limited exceptions (although immigration status can affect the scope of Medi-Cal benefits). The process by which a child becomes eligible, however, can be affected by how the child came to live outside the parents' home. If a child was removed from the parents' custody by a court order due to allegations of abuse, neglect, or abandonment, the child does not have to separately apply for Medi-Cal. For children in the foster care system, the county must either apply for them or help them apply.

Once eligible, there is no reason that a child in foster care should lose his or her Medi-Cal eligibility while in foster care, other than death.

133. *Id.* at (c) or (d).

134. Welf. & Inst. Code §§ 11363-11366; ACWDL 00-22 (Apr. 10, 2000), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c00-22.pdf>. These children receive Medi-Cal in Aid Codes 4F, 4G, 4S, 4T, and 4W.

135. Welf. & Inst. Code § 11364; DSS ACL 99-97, p.2 (Nov. 4, 1999).

Immigrant Children in Foster Care: Immigrant children who are in foster care are subject to the same rules and requirements as immigrant children who are not in foster care. Until Health for All Kids (SB 75) is implemented in 2016 and all otherwise eligible children are granted full-scope Medi-Cal regardless of immigration status, advocates should keep the following rules in mind:¹³⁶ Children who are either qualified immigrants or permanently residing under color of law (PRUCOL) immigrants are eligible for full-scope Medi-Cal if they meet all eligibility requirements. Children who do not have immigration documentation are eligible for restricted Medi-Cal if they meet all eligibility requirements. Counties and attorneys can help undocumented children in foster care apply for “Special Immigrant Juvenile Status.”¹³⁷ Children who have applied for Special Immigrant Juvenile Status are considered PRUCOL immigrants because they have permission to remain in the United States. Once granted Special Immigrant Juvenile Status, they will receive a green card. For a more detailed discussion of immigration status and its effect on Medi-Cal eligibility, see Chapter 1.

Special Rule Regarding Children in Foster Care and Managed Care Plans

Children in foster care are not required to enroll in a Medi-Cal managed care plan, and are not included in a mandatory managed care enrollment category unless they reside in a county with a County Operated Health System, where enrollment in managed care is mandatory and fee-for-service providers difficult to find.¹³⁸ For children outside a County Operated Health System county, the Department of Children and Family Services may enroll a foster care child in managed care if the agency, in consultation with the child’s caregiver, determines that such enrollment

-
136. See Chapter 1, Section A.2 for an explanation of the new Health for All Kids program which will allow undocumented children access to the same Medi-Cal programs as other children.
137. 8 U.S.C. § 1101(a)(27)(J); 8 C.F.R. § 204.11. See *also* State Plan Amendment 13-0026MM (effective January 1, 2014).
138. Welf. & Inst. Code § 14093.09; see *also* ACWDLs 00-13, p.2 (Mar. 22, 2000), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c00-13.pdf> and ACWDL 97-02 (Jan. 13, 1997), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/97-02.pdf>. COHS counties are Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura and Yolo.

is in the best interest of the child.¹³⁹ However, specialty mental health services are provided entirely by a managed care system. The child must have those services arranged and authorized through the County Mental Health Plan in their county of origin, even if those services are provided in the placement county.¹⁴⁰

3. Former Foster Youth Under Age 18 and Not Living with their Parents

All other children who used to be in foster care but no longer live with their parents are still likely to be Medi-Cal eligible because only the child's income counts toward that child's eligibility.¹⁴¹ Public assistance cash grants that the child receives, such as CalWORKs and SSI,¹⁴² do not count as income for Medi-Cal eligibility purposes.

4. Former Foster Youth 18 and Older

Before the Affordable Care Act, children who aged out of foster care on their 18th birthdays were entitled to Medi-Cal under the Former Foster Care Children's (FFCC) Program until they turned 21.¹⁴³ The Affordable Care Act extends Medicaid eligibility to former foster youth to age 26.¹⁴⁴

As of January 1, 2014, youth who were in foster care on their 18th birthday and received Medi-Cal while in foster care are eligible for Medi-Cal up to age 26.¹⁴⁵ Former foster youth are eligible for Medi-Cal regardless of their income, resources,

139. Welf. & Inst. Code § 14093.09(a).

140. Welf. & Inst. Code §§ 5777.7, 11376, and 11380.9; Department of Mental Health Info. Notice 09-06 (May 4, 2009).

141. *Sneede v. Kizer*, 728 F. Supp. 607 (N.D. Cal. 1990); *Medi-Cal Eligibility Procedures Manual*, Article 8F.

142. 22 CCR §§ 50525, 50528.

143. See ACWDLs 00-61 (Nov. 22, 2000), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/00-61.pdf> and 00-41 (Aug. 14, 2000), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/00-41.pdf> for information on Medi-Cal eligibility for former foster youth prior to the Affordable Care Act.

144. 42 U.S.C. § 1396a(a)(10)(A)(i)(IX); Proposed 42 C.F.R. § 435.150.

145. 42 U.S.C. § 1396a(a)(10)(A)(i)(IX); Welf. & Inst. Code § 14005.28(a); ACWDL 14-41 (Feb. 5, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-41.pdf>; MEDIL 14-05 (Jan. 17, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-05.pdf>; MEDIL 13-07 (Jun. 28, 2013), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL%2013-06.pdf>.

other insurance, and living arrangements (unless they are institutionalized or incarcerated). Even if they have significant resources, income, insurance from work, or live at home, they are still eligible for this program.¹⁴⁶ Former foster children qualify for full-scope Medi-Cal until age 26 regardless of their immigration status.¹⁴⁷ This extended coverage to age 26 is also available to former foster youth who turned 18 in foster care in another state and have subsequently moved to California.¹⁴⁸ However, if the former foster youth was not receiving Medi-Cal (or Medicaid in her state of origin) while in foster care, that individual can only receive Medi-Cal under the FFCC Program up to age 21.¹⁴⁹

Individuals in foster care on their 18th birthday are to be automatically enrolled in Medi-Cal under the FFCC Program, Aid Code 4M, without any interruption in coverage, without requiring a new application, and without having to provide additional information.¹⁵⁰ Former foster youth who did not get automatically enrolled in Medi-Cal should go to their local county office and get enrolled using the simplified, one-page application for former foster youth.¹⁵¹ For more information regarding former foster youth getting Medi-Cal, see Chapter 5 section A.2.i.

146. See, e.g., ACWDL 14-41, at Qs. 6 and 7.

147. ACWDL 15-29 (Sept. 16, 2015) at p.3, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-29.pdf> (instructing counties that in the rare case when a former foster youth exits foster care without immigration status for federal Medicaid eligibility, the former foster youth should submit a Statement of Citizenship, Alienage and Immigration Status (MC 13 form) and upon receipt of the individual's attestation counties are to enroll the individual in full-scope Medi-Cal Aid Code 4M).

148. *Id.* ACWDL 14-41, at Q. 4.

149. 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVII); proposed 42 C.F.R. § 435.226; ACWDL 14-41 (describing the population of former foster care youth who did not receive Medicaid in foster care as the “optional coverage group” and the former foster youth who were in foster care at age 18 and received Medicaid as the “mandatory coverage group”).

150. Welf. & Inst. Code § 14005.28(a)(1); ACIN I-31-15 (July 22, 2015); ACWDL 14-41; MEDIL I 14-05; MEDIL 13-07. Individuals who were previously enrolled in aid codes 40, 42, 43, 45, 46, 49, 4C, 4H, 4L, 4N, or 5K are all eligible under the ACA FFCC extension with aid code 4M up to the age of 26. MEDIL 14-05.

151. As of January 2014, the California Healthcare Enrollment, Eligibility and Retention System (CalHEERS) was not programmed to disregard income determinations for former foster youth. MEDIL 14-05. A system fix was scheduled to go live September 2015 to ensure that former foster youth who apply online through Covered California or otherwise have their information run through CalHEERS will receive correct eligibility determinations. And as of March 2016, former foster youth will be allowed to skip unnecessary questions such as about income and taxes on the online application.

5. Transitional Medi-Cal (TMC)

Transitional Medi-Cal allows families who are leaving welfare or are no longer eligible for Medi-Cal due to increased earnings to keep their Medi-Cal benefits for up to one year.¹⁵² Transitional Medi-Cal is a critical Medi-Cal eligibility extender for families, but is only available to parents, caretaker relatives, and children who are enrolled in the MAGI Parents and Caretaker Relatives, MAGI Children or CalWORKs-linked programs. This is because Transitional Medi-Cal is available to families who receive Medi-Cal under the provisions of Section 1931(b) of the Medicaid statute, which the Affordable Care Act consolidated into the MAGI Parent/Caretaker Relative and Children's categories, or through CalWORKs.¹⁵³

As soon as a county eligibility worker determines that a family will lose Medi-Cal due to increased income and they are in Parent or Caretaker Relative aid codes, the MAGI Medi-Cal Children's aid codes (not TLICP aid codes), or a CalWORKs aid code, the county must automatically transfer the family into the Transitional Med-Cal program to ensure there is no break in coverage.¹⁵⁴

Leaving Welfare or Medi-Cal: To qualify for Transitional Medi-Cal, a family must be losing CalWORKs or Medi-Cal eligibility as a Parent/Caretaker Relative or the MAGI Medi-Cal Children's aid codes for one of the following reasons:

1. Increased earnings from employment;
2. Loss of earned income disregards; or
3. Increased hours of employment.¹⁵⁵

152. 42 U.S.C. §§ 602(a)(37); 1396a(e)(1)(B) and 1396r-6; Welf. & Inst. Code §§ 14005.75, 14005.76, 14005.8-14005.89. TMC was established by Congress and the Reagan Administration in 1988 as a work incentive to allow families leaving welfare to keep Medi-Cal for up to one year even if their earnings go over the welfare income limit. The purpose of TMC was to encourage families leaving welfare to work and remain employed by continuing their Medi-Cal coverage.

153. CMS, Frequently Asked Questions, "Medicaid/CHIP Affordable Care Act Implementation FAQs: Eligibility Policy," at Q.5 (May 22, 2012) (stating that the ACA did not repeal § 1931 and that it continues under the ACA through the MAGI Medi-Cal programs for parents, caretaker relatives, pregnant women, and children).

154. Welf. & Inst. § Code 14005.8(a)(1).

155. Welf. & Inst. Code § 14005.8(a)(1).

A family must have received CalWORKs or Medi-Cal for at least three months of the six months immediately prior to the month in which the family became ineligible.¹⁵⁶

Age: To be eligible a family must have a child living in the home who is under age 18, or under 19 if the child is enrolled in school and expected to graduate before her 19th birthday.¹⁵⁷ There is no age limit for a parent or caretaker relative to receive Transitional Medi-Cal.

Income: For the first six months of Transitional Medi-Cal, there is no income limit.¹⁵⁸ After the initial six months, the family can stay on Transitional Medi-Cal if its countable income is below 185% FPL.¹⁵⁹

Advocacy Tip: If a beneficiary does not receive a notice about her right to receive Transitional Medi-Cal, or how to continue to receive it after the initial six months, her Medi-Cal has likely been improperly terminated. The termination should be appealed. And Transitional Medi-Cal cannot be terminated until the county determines whether the family is eligible on another basis.

156. *Id.*

157. *Medi-Cal Eligibility Procedures Manual*, 5B-4.

158. Welf. & Inst. Code § 14005.8(a)(1). Aid codes 39 (full scope TMC, initial 6 months) and 3T (restricted scope TMC for undocumented, initial 6 months).

159. Welf. & Inst. Code § 14005.8(a)(c); *Medi-Cal Eligibility Procedures Manual*, 5B-4. Aid codes 59 (full-scope TMC, second 6 months) and 5T (restricted scope TMC for undocumented, second 6 months).

6. Continuous Eligibility for Children

Children who receive free, full-scope Medi-Cal are guaranteed to keep that coverage until their next scheduled Annual Redetermination date¹⁶⁰ or 19th birthday, whichever comes first, even if their families' income goes up or their family experiences other changes that would otherwise make them ineligible or require payment of a Share of Cost (SOC) or premium.¹⁶¹ Continuous Eligibility for Children is not available to children who are in the Minor Consent program (for a discussion of Minor Consent, see Section D.1 below).¹⁶²

- Common examples when CEC would help a child keep free Medi-Cal include:
- Countable household income increases
- Household composition changes, e.g., same income covers fewer people.

There are three aid codes for children in CEC: 7J for children who are citizens or have satisfactory immigration status, 7K for undocumented children, and 06 for children losing federal Adoption Assistance Payments prior to their 18th birthday.

Counties' implementation of these aid codes has been inconsistent; a child may be receiving ongoing Medi-Cal through CEC but remain in the previous aid code. Advocates should make sure that children who are inappropriately kept in the previous aid code do not lose Medi-Cal or get a Share of Cost or premium before the next scheduled annual redetermination date.

160. The annual redetermination date is when the county reevaluates ongoing eligibility for all Medi-Cal recipients. The date is set by the application date and occurs every 12 months. 42 C.F.R. §§ 435.916(b) and 435.930(b); Welf. & Inst. Code § 14012; 22 CCR § 50189. See Chapter 6, Section A.3 for a complete description of the process.

161. 42 U.S.C. § 1396a(e)(12); Welf. & Inst. Code § 14005.25; ACWDL 14-05 (Feb. 20, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-05-w-attach.pdf>. Continuous Eligibility for Children is available to children enrolled in the MAGI Medi-Cal Children's program, the Targeted Low-Income Children's Program (TLICP), and for children in the following non-MAGI programs: categorically linked through SSI or CalWORKS; the Pickle program; the federal poverty level program for the disabled (A&D FPL); and the 250% Working Disabled Program. *Id.* at p. 2.

162. ACWDL 01-01 (Jan. 8, 2001), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c01-01.pdf>.

Advocacy Tip: Infants under the age of one do not need CEC if they were born to Medi-Cal eligible mothers because they are guaranteed coverage until their first birthday under Deemed Eligibility (DE) for Newborns. See Section C.7 below. There should be no practical impact on your clients. The only infants under age one who would need CEC are those who were born to mothers not eligible for Medi-Cal, such as those who become eligible after birth. A child who becomes eligible at two months of age would not have an annual redetermination until the age of 14 months, not on her first birthday.¹⁶³

At the scheduled annual redetermination, the CEC period ends. If a child is found eligible for ongoing full-scope, no-cost Medi-Cal, a new CEC period begins and the child is guaranteed another 12 months of free Medi-Cal until the next scheduled annual redetermination.¹⁶⁴ If the child is found to be ineligible for no-cost Medi-Cal, the child may be eligible for a program that requires payment, such as the Targeted Low-Income Children Program (which requires a premium for some enrollees, depending on their age and income), a Share of Cost program, or a qualified health plan offered through Covered California.¹⁶⁵

7. Deemed Eligibility for Newborns

Infants who are born to mothers who are eligible and receiving Medi-Cal at the time of birth may be enrolled in Medi-Cal without an application.¹⁶⁶ See Chapter 5, Section A.2.b for information on getting onto Medi-Cal through the Deemed Eligibility

163. This is the example provided in ACWDL 01-01, p.5 (Jan. 8, 2001) (ACWDL 01-01 is superseded where it conflicts with ACWDL 14-05, which it does not in this example).

164. ACWDL 14-05.

165. *Id.*

166. 42 U.S.C. § 1396a(e)(4); 22 CCR § 50262.3 also regulates the deemed eligibility program but it reflects an old version of 42 U.S.C. § 1396(e)(4) and is out-of-date. See ACWDL 09-17 (Apr. 3, 2009), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c09-17.pdf>.

Program. Deemed eligible infants are enrolled in Medi-Cal Aid Code 8U.¹⁶⁷

8. Aid for Families with Dependent Children – Medically Needy

Another medically needy program is the Aid for Families with Dependent Children – Medically Needy (AFDC-MN).¹⁶⁸ This program covers children and some parents and caretaker relatives whose income exceeds the limits of the MAGI Parents and Caretaker Relatives and the MAGI Children’s programs, discussed in Chapter 2. As in the Aged, Blind and Disabled – Medically Needy program, beneficiaries in the AFDC-MN program with countable incomes over the Medically Needy Income Level (MNIL) have to pay a Share of Cost. With the advent of MAGI and the elimination of the asset test, the only families who would be in the AFDC-MN program would have a Share of Cost. If an individual’s income is so low they qualify for free AFDC-MN, they would qualify for a MAGI program.

Because the Affordable Care Act eliminated the asset test for most Medi-Cal beneficiaries and the income limits for the MAGI Parents/Caretaker Relatives and Children’s are higher than the limits these populations were subject to pre-ACA, the number of beneficiaries who would use this program is relatively small.

Age. To be eligible for AFDC-MN, children must be under age 21; there is no age limit for parents and caretaker relatives. Parents and caretaker relatives must live with the children for the family to be eligible for this program.¹⁶⁹

Income. With the advent of the Affordable Care Act, no family should be in the AFDC-Medically Needy program without a share of cost. With a Share of Cost, there is no income limit *per se*, as any income over the MNIL is reflected dollar-for-dollar as

167. Note, Aid Code 8V provides Share of Cost deemed eligibility for infants born to mothers in a Share of Cost program. Hopefully with changes to programs available to pregnant women, including the integration of the former AIM program into the Medi-Cal Access Program for pregnant women and the availability of coverage via Covered California, this aid code will not be needed now that Share of Cost Medi-Cal is not considered minimum essential coverage.

168. Welf. & Inst. Code § 14005.7.

169. ACWDL 14-28 (Jul. 7, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-28.pdf>. The pre-ACA eligibility requirement that children be “deprived” was eliminated as of January 1, 2014.

the individual's Share of Cost.

To determine a family's income for AFDC-MN, the applicant's family is divided into a Medi-Cal Family Budget Unit (MFBU) in order to determine the income and resource limit for the family's size. The basic Medi-Cal Family Budget Unit rules are:¹⁷⁰

- Include everyone living in the home not receiving SSI or CalWORKs, regardless of whether they are eligible for or want to receive Medi-Cal
- Parents and all children (including 18 to 20 year olds and the unborn) make up the basic Medi-Cal Family Budget Unit;
- Stepparents are in the same Medi-Cal Family Budget Unit with the family (unless the only individuals who want Medi-Cal are the separate children of the other parent);
- The Medi-Cal Family Budget Unit must have at least one child who is under 21 or a fetus.¹⁷¹

For a list of ineligible and excluded household members from the Medi-Cal Family Budget Unit, see 22 CCR §§ 50379 and 50381.

Special Income Rules. If a child has her own income, special prorated income limits apply and a *Sneede* Medically Needy counting procedure is used. See the income deeming discussion in Section B.8 above for information regarding *Sneede*. In addition, if more than one individual in the family is aged, blind or disabled, the income deductions (discussed below) are subtracted from the combined nonexempt income of all aged, blind and disabled Medically Needy individuals in the household and the spouse or parents of those individuals. Finally, if income from a family member is used to determine income eligibility for one family member, e.g., “deeming” to a spouse, it cannot be counted again for another family member’s eligibility, e.g., a child.¹⁷²

Income Deductions and Exemptions. Medically Needy beneficiaries can take any exemptions and deductions allowed in the former AFDC case assistance program,

170. 22 CCR § 50373.

171. For children who alternate between parents and households, see 22 CCR § 50374.

172. 22 CCR § 50555.1

as well as deductions for amounts paid for Medicare and other health insurance payments.¹⁷³

The following monthly income deductions may be taken:

- \$90 in earned income, per worker;
- Dependent care costs, which are subtracted from earned income;
 - maximum \$200 per child under 2 years;
 - maximum \$175 if older child or disabled;
- Court-ordered child or spousal support paid by the beneficiary;
- \$50 in child or spousal support received by the beneficiary;
- Education expenses (including tuition, books, fees, supplies, travel, child care); and
- Health insurance premiums.

Resources. The property limit is based on family size. It is \$2000 for one, \$3000 for two, and \$150 for each additional Medi-Cal Family Budget Unit member. Exempt resources include a home, one car, clothing, essential property for employment, *i.e.*, tools of the trade, business property, and certain other items.¹⁷⁴

9. Medically Indigent

The Medically Indigent program is a state-only program that provides coverage to children and pregnant women who would otherwise be eligible for Medically Needy or the former Section 1931(b) program (now MAGI Parents and Caretaker Relatives and MAGI Children's), but fail to meet one of the categorical requirements. However, since the implementation of the Affordable Care Act and other health reforms in California, this program has drastically decreased in importance because most of the

173. Welf. & Inst. Code §§ 11200 *et seq.*, and 14005.7(d). The income exemptions can be found at 22 CCR §§ 50523, 50523.5, 50454.5, 50525, 50527, 50529, 50535, 50531, 50533, 50544, 50543, 50543.5.

174. ACWDL 99-03 (Jan. 20, 1999), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/99-03.pdf>.

categorical requirements no longer exist, such as the “deprivation test,”¹⁷⁵ and more generous income limits are available in other programs. The regulations for these programs have not been updated, but are at 22 California Code of Regulations § 50251.

Given the more generous MAGI rules that apply to these populations, practically speaking, the Medically Indigent programs will only apply to children over 266% FPL or pregnant women over 322% FPL who cannot get into a Covered California plan due to open enrollment limitations or immigration status.¹⁷⁶ Because those income limits are far above the Maintenance Need Income Limits (MNIL) – see the MNIL chart in Section B.8 above – any person who is in the Medically Indigent program will have a very high Share of Cost.

D. Limited Scope Medi-Cal Programs for Children

1. Minor Consent

The Minor Consent Program (also called “Sensitive Services”) provides children under age 21 with limited and specific Medi-Cal benefits without regard to family income. Those benefits are: pregnancy related services, family planning, treatment for sexual assault, rape, or sexually transmitted diseases, drug and alcohol abuse treatment, and outpatient mental health services, including counseling.¹⁷⁷ The minor can consent to and receive these services confidentially, *i.e.*, without their parent’s consent or knowledge.¹⁷⁸

175. Welf. & Inst. Code § 14005.30(b)(2). The deprivation test is an old welfare rule that requires a family to have a “deprived child” in the home to get benefits, which means a child is deprived of parental support in some way. Deprivation of a child was established through the absence, death, incapacity, or the unemployment or underemployment of at least one parent in the child’s family. With the ACA and the adoption of the MAGI methodology, California eliminated deprivation as a Medi-Cal eligibility criterion.

176. Aid codes include 82, 83, 86, 87, D1, and C9, though note the codes 83, 87, and D1 with a Share of Cost are the only ones likely to be used, given the expansion of other Medi-Cal programs under health reform.

177. Welf. & Inst. Code § 14010; Fam. Code §§ 6924-6929; 22 CCR §§ 501471, 50157(f)(3), 50167(a)(6)(D)(4), 50195(d), 50063.5; ACWDL 97-29 (June 23, 1997); ACWDL 94-63 (Aug. 8, 1994); Aid Codes 7M, 7N, and 7P.

178. See Health & Safety Code §§ 1231110 and 1231115(a) (regarding confidentiality of treatment).

All children under age 21 are eligible; however there are specific age limits for some services:

- Only children age 12 and older can consent to outpatient mental health services, services related to sexually transmitted diseases and their prevention, and drug and alcohol abuse treatment.¹⁷⁹
- Children under age 12 can consent to family planning, treatment for sexual assault or rape, and pregnancy related services.¹⁸⁰

Income and resources: No income or resources of a child’s parents are counted in determining eligibility for Minor Consent Medi-Cal.

For a minor to be eligible for the Minor Consent Medi-Cal Program, the child must be considered to be living in the home of a parent. A child need not be physically living in the home with their parent(s). If they are temporarily living with a relative or friend, they may be eligible if their parents are legally and financially responsible for the minor.¹⁸¹ If the child is not considered to be living in the home of a parent, the county must process the child’s application and determine eligibility as if the child were an adult if the child appears to be competent, in which case the child may be entitled to full-scope Medi-Cal.¹⁸²

2. Income Disregard Program for Pregnant Girls under Age 21 Program

This program provides pregnancy-related Medi-Cal without a Share of Cost to pregnant young women and teens who live with their parent/s and who would not otherwise qualify for Medi-Cal because they are over-income due to their parents’

179. 22 CCR § 50063.5; Fam. Code § 6924 (mental health care can be provided to children age 12 and older “who are mature enough to participate intelligently and which is needed to protect the child from harming themselves or others because the children are the alleged victims of incest or child abuse.”); Fam. Code § 6926 also include STD prevention services; ACWDL 12-03 (Jan. 10, 2012).

180. 22 CCR § 50063.5.

181. Medi-Cal Eligibility Procedural Manual, 4V-2.

182. 22 CCR § 50147.1(e).

income.¹⁸³ To qualify, the pregnant applicant must be under 21 years old; unmarried; live with a parent/s and be claimed as a dependent by the parent/s; and not file her own taxes.¹⁸⁴

3. The Child Health and Disability Prevention (CHDP) Program

CHDP is a program that provides free initial, periodic and inter-periodic (called “periodicity schedule”) medical health screens and limited medical treatment to children.¹⁸⁵ Children who are not otherwise eligible for Medi-Cal can qualify for the program up until the middle of first grade or if they are under 19 years old and their family income is at or below 266% of FPL.¹⁸⁶ CHDP services include preventative health screens such as physical and dental exams, “well baby” and “well child” exams, vision and hearing tests, immunizations, nutrition screening, lead screening and referrals for further diagnosis and treatment, if necessary. CHDP health providers often provide the health exams required for enrollment in school. To get CHDP services, an individual must see a doctor, clinic or other health care provider who is in the CHDP program. To find a medical provider in the CHDP program, an individual should call the local CHDP phone number in their county.¹⁸⁷

183. State Plan Amendment #13-029 (approved Jan. 14, 2014, effective Dec. 31, 2013). Aid codes 44 (restricted, citizens and immigrant with satisfactory immigration status) and 48 (restricted, undocumented). This Income Disregard program stems from the pre-Affordable Care Act Medi-Cal programs known as the Federal Poverty Level (FPL) Percentage Programs for Pregnant Women and Children, which had no asset test. Welf. & Inst. Code §§ 14148, 14148.75. With the advent of the ACA and the MAGI methodology, the majority of beneficiaries in the FPL Percentage Programs moved to the MAGI Parent/Caretaker Relative, Pregnant Women, and Children’s programs, except for some young women who were ineligible for those programs due to parental income. As a result of efforts by advocates, the state created this Income Disregard Program for Unmarried Pregnant Women under Age 21 to ensure those young women and girls have access to services.

184. *Id.* at Attachment 2.2-A, Supplement 1.

185. Health & Safety Code §§ 124025-124110.

186. CHDP Provider Manual, Eligibility at p. 1 (Dec. 2014). With the advent of the ACA, the upper income eligibility limit for CHDP was raised from 200% FPL to 266% FPL. At the time of publication of this guide, the state regulation on CHDP, 17 CCR § 6830(b), still has 200% FPL as the limit but has been superseded by DHCS guidance.

187. To find the phone number for the local CHDP program go to www.dhcs.ca.gov/services/chdp/Pages/CountyOffices.aspx.

Advocacy Tip: CHDP and CHDP Gateway (See Chapter 5, Section A.2.e) are different programs with different scope of services. Children who qualify for the CHDP Gateway get the full scope of services covered by Medi-Cal. This includes doctor's visits, hospital services, medications, dental care, mental health care, vision care (eye glasses), x-rays, lab tests, and specialty care, among other services.

E. Medi-Cal Special Treatment Programs

1. Breast and Cervical Cancer Treatment Programs

California has two Breast & Cervical Cancer Treatment Programs (BCCTPs) for low-income individuals with incomes under 200% of the Federal Poverty Level who have been diagnosed with breast or cervical cancer.¹⁸⁸ One is a federal Medicaid optional program that provides women with immediate, full-scope, no-cost Medi-Cal, which is commonly referred to as Federal BCCTP.¹⁸⁹ The other is a state-only funded program, commonly referred to as State BCCTP, which provides time-limited, cancer-related Medi-Cal services to low-income uninsured or underinsured individuals.¹⁹⁰

Age, Gender and Immigration Status: An individual's age, gender, and immigration status, as well as whether the individual has other health coverage, determine whether the individual qualifies for the federal program with full-scope Medi-Cal benefits or the state-funded program with a time-limited cancer treatment-only benefit. For a more detailed discussion of immigration issues, see Chapter 1, Section A.

-
188. See *generally* ACWDL 06-09 (Feb. 24, 2006), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c06-09.pdf> (providing an overview of California's implementation of BCCTP).
189. Welf. & Inst. Code § 14007.71 (exercising a federal Medicaid option under 42 U.S.C. §1396a(a)(10)(A)(ii)(XVIII)). Aid Codes: OM, ON, and OP. Aid Code OW is for women who no longer meet federal eligibility requirements and who will continue to receive transitional full-scope Medi-Cal services until the county completes an eligibility determination for other Medi-Cal programs.
190. Health & Safety Code §§ 104160, et seq. (creating a State-funded only BCCTP program for individuals who are determined ineligible for the federal BCCTP). Aid codes: OR, OT, OU, and OV (limited in scope and duration).

- **Federal BCCTP:** Only women under age 65 who are citizens¹⁹¹ or qualified immigrants (including PRUCOL) with no other health coverage may qualify for full-scope, no cost Medi-Cal under the federal BCCTP.¹⁹²
- **State BCCTP:** Women of any age with breast or cervical cancer and men of any age with breast cancer who are citizens, qualified immigrants, or are without satisfactory immigration status, may be eligible for the time limited, cancer-treatment only Medi-Cal, even if they have other health coverage.¹⁹³

Income: Both the Federal and the State BCCTPs require an individual's monthly income to be at or below 200% of the Federal Poverty Level for the family size.¹⁹⁴

Property or Resource Limits: Property or asset limits do not apply to either the Federal or State BCCTP. If all eligibility requirements are met, an individual is eligible for BCCTP no matter how much property the individual has.

Other Health Coverage: The Federal and State BCCTPs have different requirements concerning the availability of other health coverage.

- **Federal BCCTP:** In order for a woman to be eligible, she must have no other *creditable health coverage*.¹⁹⁵ Health insurance coverage counts as creditable coverage even if the deductibles, co-pays or coinsurance costs are high. But, if the other health coverage does not include coverage for treatment of breast or cervical cancer, then it is not considered creditable

191. Consumers who declare they are United States citizens or nationals and are applying for or receiving benefits through Federal BCCTP need to satisfy federal Deficit Reduction Act of 2005 (DRA) documentation requirements. See ACWDL 08-25 (Aug. 1, 2008), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c08-25.pdf> (describing the procedure for processing evidence of citizenship for BCCTP under the DRA).

192. The federal statute authorizing the optional BCCTP limits coverage to women under age 65 without "creditable coverage." 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVIII), (aa).

193. ACWDL 06-09 at p.2.

194. Welf. & Inst. Code § 14007.71(a) (requiring an individual under the federal program to meet the requirements of Health & Safety Code § 104162(c), which imposes the income limitation); Health & Safety Code § 104162(c), (d).

195. 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVIII), (aa)(4).

health coverage and the woman can be eligible for the federal program.¹⁹⁶

- **State BCCTP:** People can be eligible for the program if they are either uninsured or underinsured. “Underinsured” means either:
 1. The individual has health insurance that covers breast or cervical cancer treatment, but the sum of the individual’s insurance deductible, premiums, and expected co-payments in the initial 12-month period that breast or cervical cancer treatment services are needed exceeds \$750;

or
 2. The individual has Share of Cost or restricted scope Medi-Cal.¹⁹⁷

2. Tuberculosis Program

The Tuberculosis Program provides outpatient medical services related to the diagnosis and treatment of a TB infection for individuals who have either active TB (contagious) or are infected with TB (non-contagious) and who do not qualify for Medi-Cal on another basis without a Share of Cost.¹⁹⁸

TB infected: In order to qualify for the Tuberculosis program, an individual must be infected with TB, meaning that a physician must indicate a positive diagnosis or suspect there is a TB infection.¹⁹⁹

Income and resources: Before the Affordable Care Act, eligibility for the TB Program was based on the income and resources limits applied to individuals with disabilities under Medi-Cal and generally followed SSI rules.²⁰⁰ But as of January 1, 2014, the

196. Section 2701 of the Public Health Service Act contained the definition of “creditable coverage.” See 42 U.S.C. § 300gg(c)(1) (2006). The Affordable Care Act eliminated the statutory definition of the term but nevertheless followed the definition of “creditable coverage” as it existed prior to the passage of the law. See Affordable Care Act § 1101.

197. Health & Safety Code § 104161(g); ACWDL 06-09 at p.2; see *also* Health & Safety Code § 104162.1 (where the individual is underinsured, the State will only pay for the individual’s breast and/or cervical cancer treatment co-payments, premiums and deductibles or for treatment services not otherwise covered by the other health insurance).

198. Welf. & Inst. Code § 14005.20 (which exercises a federal Medicaid option available under §13603 of OBRA, amending 42 U.S.C. § 1396a(a)(10)(A)(ii)(XII)); 22 CCR §§ 51187 and 51187.1; *Medi-Cal Eligibility Procedures Manual*, 5N-2; Aid Code 7H.

199. 42 U.S.C. §1396a(z)(1)(A); 22 CCR § 51187(b).

200. Welf. & Inst. Code § 14005.20(b)(1).

TB program moved to the MAGI methodology to determine the income limit and resources applied to individuals with disability under Medi-Cal.²⁰¹

An individual remains eligible for this program as long as the TB infection and the need for treatment continue.

3. Kidney Dialysis and Parenteral Hyperalimentation and Related Services

Medi-Cal's Special Treatment Programs provide kidney dialysis or parenteral hyperalimentation (also called Total Parenteral Nutrition or "TPN") services to individuals who need them but do not otherwise qualify for Medi-Cal or would receive the services with a Share of Cost.²⁰² Unlike other Medi-Cal programs, this Special Treatment Program looks at an individual's annual net worth to determine financial eligibility. Eligible individuals with non-exempt net worth under \$5,000 receive dialysis and TPN services at no cost, while those with non-exempt net worth at or above \$5,000 are obligated to pay a percentage of the treatment costs for services not covered by other insurance or other government programs.²⁰³

- **Kidney Dialysis:** This special treatment program provides kidney dialysis, including full-care, self-care or home-care dialysis and related services. Treatment includes hospital and physician services related to the treatment of renal failure, related lab tests, medical supplies, and drugs.²⁰⁴ Unlike most programs, the kidney dialysis program is available to undocumented immigrants pursuant to a court order.²⁰⁵ For a more detailed discussion of immigration status issues, see Chapter 1, Section A.
- **Hyperalimentation/TPN Program:** TPN provides total nutrient replacement

201. Welf. & Inst. Code § 14005.20(b)(2).

202. Welf. & Inst. Code §§ 14140 to 14144.5; 22 CCR §§ 50264; 50801 to 50831; *Medi-Cal Eligibility Procedures Manual*, Article 17. Medi-Cal maintains two varieties of Special Treatment Programs. The first is known as "Special Treatment Programs-Only," which is for individuals who would otherwise be Medi-Cal eligible as Medically Needy except they are over the property limit. The second variety is the "Special Treatment Programs-Supplement," which is for individuals in need of dialysis or TPN services who have Medi-Cal with a Share of Cost through the Medically Needy program.

203. Welf. & Inst. Code §§ 14142, 14142.5.

204. *Medi-Cal Eligibility Procedures Manual*, 17A-1.

205. *Crespin v. Kizer*, 226 Cal. App. 3d 498 (1990). Aid Code 55 covers non-PRUCOL immigrants without satisfactory immigration status.

through a catheter positioned in the chest for individuals who, for whatever reason, are unable to eat and digest food.²⁰⁶

Eligibility Requirements

Individuals in need of special treatment: To qualify, an individual must need either dialysis or TPN and must not otherwise qualify for Medi-Cal.²⁰⁷ Individuals who need dialysis and are under age 65 are not eligible for Medi-Cal's dialysis treatment if they are eligible for Medicare dialysis coverage (this limitation does not apply to an individual in need of TPN).²⁰⁸

Income/Resources: Income and resources are assessed as an individual's annual non-exempt net worth. Annual net worth is the combination of non-exempt property/resources and gross income.²⁰⁹ Consumers with an annual non-exempt net worth less than \$5,000 are eligible for dialysis and related services or TPN and related services at no-cost.²¹⁰ Individuals with an annual non-exempt net worth of \$5,000 or more can still qualify for the program if they agree to pay a Share of Cost, although they cannot do so if their non-exempt net worth exceeds \$250,000.²¹¹

The following resources are exempt and therefore not taken into account when determining net worth:

- One motor vehicle used for transportation of a family member;
- The first \$40,000 of market value of the applicant's home;
- The first \$1,000 paid for life insurance placed in burial trust;
- Wedding/engagement rings, heirlooms, clothing, household furnishings and equipment; and
- Equipment, supplies and material needed for employment, for self-support, or for an approved plan of rehabilitation or self-care necessary for employment

206. *Medi-Cal Eligibility Procedures Manual*, 17A-1.

207. 22 CCR § 50817(b)(1), (2).

208. 22 CCR § 50817(b)(3).

209. Welf. & Inst. Code §§ 14140(a), 14142, 14142.5; 22 CCR § 50825.

210. Welf. & Inst. Code §§ 14142(a), 14142.5(a).

211. Welf. & Inst. Code §§ 14142(b), 14142.5(b).

(e.g. a wheelchair lift van).²¹²

Beneficiaries' Cost-sharing Obligation: If a beneficiary's annual nonexempt net worth is over \$5,000 but under \$250,000, then the beneficiary is responsible for cost sharing in the amount of 2% of annual nonexempt net worth.²¹³

Whose resources count: *For adults:* The resources of the applicant and the applicant's spouse count in determining net worth. *For children:* The child's parents' income counts if the child is under age 21, unmarried, and living with his/her parents.²¹⁴

Ongoing Eligibility for Medi-Cal Special Treatment Programs: Eligibility for these programs will only exist as long as the particular treatment is needed, or in the case of dialysis, until Medicare eligibility is established. However, before terminating benefits, the county must redetermine eligibility for other Medi-Cal programs.²¹⁵

F. Medicare Savings Programs (MSPs)

The Medicare Savings Programs (MSPs) are special categories of Medi-Cal eligibility for individuals who are Medicare eligible and have limited income and resources. This benefit is limited to paying the Medicare premiums and in some cases the Medicare deductibles, coinsurance and copayments of those who qualify. In other words, the state pays these individuals' Medicare out-of-pocket costs but is not obligated to provide additional Medi-Cal benefits unless the individual qualifies for Medi-Cal on another basis.

An individual does not have to qualify for any other Medi-Cal program to be eligible for an MSP. For example, an individual may have countable resources that are higher

212. 22 CCR § 50825(c).

213. Welf. & Inst. Code §§ 14142(b), 14142.5(b); 22 CCR § 50827(d)(2).

214. 22 CCR § 50825(b).

215. Welf. & Inst. Code § 14005.37.

than other non-MAGI Medi-Cal programs allow (for example, \$2,000 for an individual) but countable resources that are less than the MSP allows. See below for the applicable MSP resource limit. If the individual meets all MSP eligibility requirements, the individual will be eligible for MSP even though the individual is not eligible for Medi-Cal under any other Medi-Cal category.

The MSP programs are very important for people who have Medi-Cal with a Share of Cost because the Medically Needy Medi-Cal program no longer pays the Medicare Part B premium for this group. The MSP program will pay the Medicare Part B premium instead. Medi-Cal payment of the Medicare Part B premium is called “buy-in” and is currently available only for people who receive full-scope Medi-Cal with no Share of Cost.

Advocacy tip: If you are aware of an individual with a Share of Cost for Medi-Cal, explore with the individual the possibility of applying for an MSP. This will save them the cost of the Medicare Part B premium, which is usually deducted from the individual’s Social Security check. It’s usually best not to dis-enroll from Medicare Part B because there may be a penalty at the time of reenrollment in the form of a higher Part B premium.

There are currently four MSP categories:

- 1) Qualified Medicare Beneficiary;
- 2) Specified Low-Income Medicare Beneficiary;
- 3) Qualified Individual; and
- 4) Qualified Disabled and Working Individual.

Each category has slightly different rules but the eligibility for each is based upon income as a percentage of the Federal Poverty Level.²¹⁶

Immigration status requirements: Other than United States citizens, only Lawful

216. See, e.g., ACWDL 15-14 (Mar. 11, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-14.pdf>. These are updated annually.

Permanent Residents who have resided in the United States continuously for at least five years are eligible to “buy in” to the Medicare program, *i.e.*, secure Medicare without having sufficient work history.²¹⁷ This is an exception to the normal Medi-Cal eligibility rules that allow many other immigrants to receive services Medi-Cal is only making payment to Medicare, not administering its own health services program.

1. Qualified Medicare Beneficiary (QMB or “Quimby”) Program

The QMB Program pays the cost of both the Part A²¹⁸ and Part B²¹⁹ premiums for Medicare, as well as all Medicare co-payments and deductibles.²²⁰ QMB beneficiaries therefore pay no Part A or Part B premiums, no annual deductible and

217. 22 CCR §§ 50773(a)(2) and 50775(a).

218. Part A Medicare covers inpatient hospital services, including: drugs, blood, supplies, appliances and equipment, tests and lab work, nursing facility care following hospitalization, home health care following hospitalization (up to 100 visits per year, including speech therapy, physical and occupational therapy, medical supplies and durable medical equipment, and hospice care). Part A is available without cost to individuals who qualify for Medicare. See 42 U.S.C. § 426. However, Part A Medicare is available on a voluntary buy-in basis for individuals who are ineligible for Medicare because of where they worked or because they never worked. See 42 U.S.C. § 1395i–2. The cost of the Part A premium in 2015 is \$407 per month for those individual with less than 30 quarters of Medicare-covered employment. These amounts change each year on January 1. See Medicare website: www.medicare.org for more information.

219. Part B Medicare covers outpatient services: doctors’ services, outpatient medical and surgical services, and supplies (including mental health services and outpatient clinic services), outpatient hospital services and supplies, durable medical equipment, blood, certain cancer screenings (prostate, mammograms, colonoscopy, etc.), diabetes services, glaucoma testing, Pap tests and Pelvic examinations, vaccinations, and home health care services not covered by Part A. Individuals who qualify for Part A may purchase Part B. Those who do not qualify for Part A can still purchase Part B coverage if they are age 65 or older and are citizens or have satisfactory immigration status and have resided in the US continuously over the past 5 years. See 42 U.S.C. § 1395o. The cost of the Part B premium is \$104.90 per month in 2015. These numbers change annually on January 1st. See the Medicare website (www.medicare.org) for more information.

220. 42 U.S.C. § 1396a(a)(10)(E)(i). For Part A in 2015, there is a \$1,260 deductible for hospitalization during the first 60 days and \$315 per day coinsurance for days 61-90 and \$630 for days 91-150. ACWDL 15-13E (Apr. 15, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-13.pdf> . These amounts change annually on January 1st.

no cost sharing. Medi-Cal pays the premium and other cost sharing.²²¹

To qualify as a QMB, an individual must:

- Be entitled to Medicare Part A insurance (whether the premium is free or through enrollment and payment of the monthly premium);²²²
- Have **countable income** of not more than 100% FPL;²²³ and
- Have **countable resources** of not more than \$7,280 (\$10,930 for a married couple) in 2015.²²⁴

QMB beneficiaries may also be entitled to full-scope Medi-Cal benefits if they qualify under another Medi-Cal eligibility category. Most QMB beneficiaries will qualify under the A&D FPL Program. See Section B.6.

2. Specified Low-Income Medicare Beneficiaries (SLMB) Program

The SLMB Program is an MSP that pays Part B premiums for Medicare beneficiaries. SLMB beneficiaries pay no Part B premiums, which is \$104.90 for all Medicare beneficiaries in 2015.²²⁵ Also, a SLMB beneficiary may be awarded benefits retroactively for up to three months prior to the month of application if she was eligible during those months.²²⁶

To qualify as a SLMB, an individual must:

221. 42 U.S.C. §§ 1396a(a)(10)(E)(i); 1396d(p)(3). QMB's relief from cost sharing is available for all Medicare benefits, regardless of whether those benefits are offered under Medi-Cal. Benefits are available in the first month after eligibility is determined.

222. 42 U.S.C. § 1396d(p)(1)(A).

223. 42 U.S.C. § 1396d(p)(1)(B), (p)(2). Certain income is not counted. All programs follow the SSI rules in determining countable income. See Section B.6 for the SSI income rules.

224. 42 U.S.C. § 1396d(p)(1)(C). ACWDL 15-13E. Federal law sets the MSP property limits at three times the SSI property limit, plus an annual percentage increase equal to the increase in the Consumer Price Index. Certain resources are not counted like a home, a car, household possessions, some burial funds and life insurance; See earlier discussion in Section B.6. All MSP programs follow the SSI rules in determining countable resources.

225. 42 U.S.C. §§ 1396a(a)(10)(E)(iii); 1396d(p)(3)(A)(i); ACWDL 15-13E.

226. *Medi-Cal Eligibility Procedures Manual*, 5J-1.

- Be eligible for Medicare Part A insurance (whether the premium is free or through enrollment and payment of the monthly premium);
- Have *countable income* between 100% and 120% of the FPL;²²⁷ and
- Have *countable resources* of not more than \$7,280 (\$10,930 for a married couple).²²⁸

SLMB beneficiaries can also receive full-scope Medi-Cal benefits if they qualify under another Medi-Cal eligibility category. The SLMB program also aids individuals whose resources are too high to qualify for the A&D FPL Program or the 250% Working Disabled Program, which both provide full-scope Medi-Cal. See Section B.6 and B.7 above.

3. Qualified Individual (QI) Program

The QI Program (or QI-1 Program) is a Medicare Savings Program that covers Part B premiums for Medicare beneficiaries.²²⁹ The QI program is similar to the SLMB program; the primary difference is that the QI program applies to beneficiaries with slightly higher incomes than those who qualify for the SLMB program. Beneficiaries may receive benefits for 3 months prior to the month of application if they were eligible during those months.

To qualify as a QI, an individual must:

- Be eligible for Medicare Part B insurance (whether the premium is free or through enrollment and payment of the monthly premium);

227. 42 U.S.C. § 1396a(a)(10)(E)(iii). Certain income is not counted. All MSP programs follow the SSI rules in determining countable income found in Section B.6 above.

228. 42 U.S.C. §§ 1396a(a)(10)(E)(iii) and 1396d(p)(1)(C); ACWDL 15-13E. Federal law sets the MSP property limits at three times the SSI property limit, plus an annual percentage increase equal to the increase in the Consumer Price Index. Certain resources are not counted like a home, a car, household possessions, some burial funds and life insurance. All MSP programs follow the SSI rules in determining countable resources.

229. 42 U.S.C. §§ 1396a(a)(10)(E)(iv), 1396(p)(3)(A)(ii). QI, also called “QI-1” is an expansion of the SLMB program authorized by Congress in the Balanced Budget Act (BBA) of 1997. QI is not an open entitlement, which means that once the state’s annual allotment for QI funds is expended, no other individuals can get the benefit.

- Have *countable income* between 120% and 135% of the FPL;²³⁰ and
- Have *countable resources* of not more than \$7,280 (\$10,930 for a married couple).²³¹

QI beneficiaries are *not* eligible to receive full-scope Medi-Cal benefits.²³² This program is no longer a temporary program, but it is not an entitlement.²³³ Total funding for the program is limited. A new application must be filed each year, and applications are accepted on a first-come, first-served basis, with priority given to prior-year recipients.

4. Qualified Disabled and Working Individual (QDWI) Program

The QDWI Program pays beneficiaries' Medicare Part A premiums. The QDWI program is available for individuals with disabilities, in a work incentive program, and no longer eligible for Medicare Part A at no cost because they lost Title II and premium-free Medicare benefits when their earned income exceeded the required Substantial Gainful Activity (SGA) limit.²³⁴ They cannot be otherwise eligible for Medi-Cal. The QDWI program pays for Part A premiums (\$407 per month in 2015); it does not pay for Part B.

To qualify as a QDWI, an individual must:

- Have a disability;
- Be under age 65;

230. 42 U.S.C. §§ 1396a(a)(10)(E)(iv) and 1396u-3(b)(3). Certain income is not counted. All MSP programs follow the SSI rules in determining countable income.

231. 42 U.S.C. §§ 1396a(a)(10)(E)(iv), 1396d(p)(1)(C). All MSP programs follow the SSI rules in determining countable resources found in Section B.6 above.

232. 42 U.S.C. § 1396a(a)(10)(E)(iv).

233. PL No. 114-10 § 211 (2005); 42 U.S.C. § 1396u-3(b)(3).

234. The vocational portion of the disability definition requires that the individual be “unable to engage in any substantial gainful activity.” See 42 U.S.C. § 1382c(a)(3). Generally, when an individual earns over a specified monthly amount, they are considered to be engaging in a SGA (the monthly SGA limit for individuals who are not blind in 2015 is \$1090). Authority for the QDWI program can be found in 42 U.S.C. §§ 1396a(a)(10)(E)(ii); 1396d(s); Welf. & Inst. Code § 14005.11; ACWDL 90-48 (June 6, 1990), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c90-48.pdf>; *Medi-Cal Eligibility Procedures Manual*, Article 5I.

- Be eligible for Medicare as a working disabled individual (sometimes referred to as a work incentive program);²³⁵
- No longer be eligible for Medicare Part A at no cost;
- Have **countable income** under 200% of the FPL;²³⁶ and
- Have **countable resources** of not more than \$4,000 (\$6,000 for a married couple).²³⁷

QWDI beneficiaries are not eligible to receive full-scope Medi-Cal benefits and cannot be otherwise Medi-Cal eligible.²³⁸

Getting On and Keeping MSPs

Medicare beneficiaries who qualify must apply at the local county welfare department by completing the state application form.²³⁹ People who qualify for the QMB, SLMB and the QDWI programs should remain eligible indefinitely as long they meet the eligibility income and resource requirements.²⁴⁰ The QI program is not an open entitlement program, which means that once the state’s annual allotment for QI funds is used, no other individuals can get the benefit. Individuals who qualify for the QI program will only remain eligible for one year so long as they meet the income and resource requirements; they must reapply for the benefit every year. QI recipients who reapply are given priority over new applicants.

G. Refugee Medical Assistance

Refugees, asylees, Cuban/Haitian entrants, and Victims of a Severe Form of

235. Medicare rules addressing when a working individual who is disabled under age 65 may qualify for Medicare despite engaging in “substantial gain activity” are found at 42 U.S.C. § 426(b) and 42 C.F.R. §§ 406.12(e), 406.20(c)(3).

236. 42 U.S.C. § 1396d(s)(2). Certain income is not counted. All MSP programs follow the SSI rules in determining countable income found in Section B.6 above.

237. 42 U.S.C. § 1396d(s)(3) (“resources ... do not exceed twice the maximum amount of resources that an individual or a couple may have and obtain benefits for supplemental security income benefits...”). Certain resources are not counted. All MSP programs follow the SSI rules in determining countable resources found in Section B.6 above.

238. 42 U.S.C. § 1396d(s)(4).

239. ACWDLs 08-21 (May 15, 2008), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c08-21.pdf> and 01-48 (Aug. 27, 2001), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c01-48.pdf>.

240. 42 C.F.R. § 435.930(b).

Trafficking are eligible for eight months of full-scope Medi-Cal under the Refugee Medical Assistance (RMA) program if they do not otherwise qualify for Medi-Cal²⁴¹ and have an income under 200% of the Federal Poverty Level (FPL).²⁴² Because the Medi-Cal expansion made coverage available to Expansion Adults under 138% FPL, effectively the RMA program applies to eligible immigrants between 138% to 200% FPL. Because some refugees with incomes below 138% FPL are also receiving Refugee Cash Assistance and the codes have not yet been de-linked, they are in the related RCA code rather than the M1 code for newly eligible adults.²⁴³ Additionally, eligible immigrants with incomes over 200% FPL are eligible for Refugee Medical Assistance with a Share of Cost,²⁴⁴ although financial assistance through Covered California is typically a better option for those immigrants.

While RMAs uses MAGI income rules, the income of the refugee's sponsor, in-kind services and shelter provided by a sponsor or resettlement agency, income earned after the date of application, and Refugee Cash Assistance are all excluded income.²⁴⁵ There is no asset test for this program. Although Refugee Medical Assistance is funded by the federal Office of Refugee Resettlement²⁴⁶ rather than the Centers for Medicare and Medicaid Services, Refugee Medical Assistance recipients must receive the same level of health services as all other Medicaid recipients.²⁴⁷

The eight-month eligibility period begins on the date of entrance for refugees, the date asylum was granted for asylees and Cuban/Haitian entrants, and the date of

241. 45 C.F.R. § 400.100(a)(1); 22 CCR § 50257(a). A separate regulatory provision requires medical assistance to be provided to Cuban and Haitian entrants to the same extent it is provided to refugees. 45 C.F.R. § 401.12. Asylees and trafficking victims do not have refugee status but are treated as refugees by law and therefore are eligible for the RMA program. ACWDL 14-16 (Apr. 1, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-16.pdf>.

242. 45 C.F.R. § 400.101(a)(2); *Medi-Cal Eligibility Procedures Manual*, 24B-3.

243. See ACWDL 15-16 (Mar. 20, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-16.pdf> and ACWDL 14-16 for information on transitioning Refugee Medical Assistance beneficiaries into the M1 adult expansion aid code or moving to Covered California as necessary at the end of the RMA period.

244. 45 C.F.R. § 400.103. *Medi-Cal Eligibility Procedures Manual*, 24B-3. Share of Cost programs in general are not minimum essential coverage that meet the individual mandate and the high cost sharing makes them unaffordable to most.

245. *Medi-Cal Eligibility Procedures Manual*, 24B-4; ACWDL 15-16, p.2.

246. ORR is part of the Administration for Children and Families.

247. 45 C.F.R. § 400.105.

certification for Victims of a Severe Form of Trafficking.²⁴⁸ Thus for these individuals, it is important they enroll as soon as possible.

Because Refugee Medical Assistance is governed by the Refugee Resettlement Act rather than the Medicaid Act, there are a few differences. The purpose of the Refugee Resettlement Act is to assist refugees in resettling in the U.S.,²⁴⁹ and at one time, refugees were eligible for 36 months of health care. Some of the sentiment to ensure that refugees have access to medical care during the length of their resettlement period, regardless of what changes might occur, still exists in the program. Once enrolled in Refugee Medical Assistance, individuals may not be cut off until the end of the eight-month eligibility period, even if their income increases.²⁵⁰ In addition, those enrolled in both Refugee Medical Assistance and Refugee Cash Assistance cannot be cut off of Refugee Medical Assistance before the end of the eight months just because they lose their cash assistance.²⁵¹ Finally, although Refugee Medical Assistance is a federal program, recipients should still have their eligibility for other Medi-Cal programs redetermined before being completely terminated from Medi-Cal or being transferred to Covered California.²⁵²

248. ACWDL 14-16, p. 2; *Medi-Cal Eligibility Procedures Manual*, 24B-1.

249. See 8 U.S.C. § 1522 and 45 C.F.R. § 400.1(b).

250. 45 C.F.R. § 400.104.

251. *Medi-Cal Eligibility Procedures Manual*, 24B-4.

252. See 45 C.F.R. § 400.93(b) and (d); *Medi-Cal Eligibility Procedures Manual*, 24B-11; ACWDL 15-16, p. 3.

Chapter 4: Covered California

Chapter 4. Covered California

A. Qualified Health Plans

1. Essential Health Benefits
2. Standard Benefit Design

B. Eligibility to Purchase Coverage Through Covered California

1. Citizenship and Immigration Status
2. Incarceration
3. Residency
4. Age

C. Eligibility for Financial Assistance

1. Lack of Minimum Essential Coverage

- a. Months of Partial Coverage
- b. Eligible But Not Enrolled
- c. Special Rules Regarding Employer Coverage
 - i. Affordability and Value of Other Coverage
 - ii. Family Glitch
 - iii. The Enrolled Employee Exception
 - iv. COBRA

2. Income Threshold for Financial Assistance

- a. Exceptions to the Lower Limit of Eligibility: Individuals Below 100%FPL
- b. Income Counting: Modified Adjusted Gross Income (MAGI) Methodology

Chapter 4: Covered California (cont'd)

- i. Household Size and Members
- ii. Children
- iii. Special Consideration for Pregnancy and Newborns
- iv. Qualifying Relative Dependents
- v. Spouses
- vi. Family Members Who are Not Lawfully Present.

3. Assets

4. Tax Filing Status

- a. Must File Taxes for the Year that Premium Tax Credits are Received
- b. Married Couples Must File a Joint Income Tax Return
 - i. Head of Household Exception
 - ii. Domestic Violence and Spousal Abandonment Exception
- c. Individuals who are Dependents Cannot Themselves Take Premium Tax Credits

5. Enrollment in a Covered California Plan

D. Calculating Premium Tax Credits

- 1. Second Lowest Cost Silver Plan – The Benchmark Premium
- 2. Required Contribution Percentage

E. Premium Tax Credit Reconciliation

F. Cost-sharing Reductions

4. Covered California

Covered California is the trade name for the California Health Benefit Exchange – California’s state-based health insurance exchange established under the Affordable Care Act.¹ Californians can buy a health plan that offers comprehensive health benefits through Covered California, and some are eligible for financial assistance in the form of tax credits or cheaper out-of-pocket costs. Health plans sold by Covered California have strict requirements as to what medical services they cover and what enrollees must pay for those services. Once individuals are found eligible to purchase a plan or get financial assistance, they must pick their plan and make the first premium payment before they are actually enrolled in coverage (see Chapter 5, Section C.2). Enrollees who choose to receive their premium tax credits in advance – sent directly to their health plan to help pay their monthly premium – must file a form with their federal income tax return to reconcile the amount of premium tax credits received for the year with their actual income for that year.

Legal Authority for Covered California: Covered California manages the federal tax credit established by the Affordable Care Act for Californians. While the federal Department of Health and Human Services regulates many of the actions of Covered California itself, several of the finer points regarding eligibility rules are codified in federal tax regulations at 26 C.F.R. § 1.36b-1, *et seq.* Fortunately the California regulations on eligibility, enrollment, and appeals, found in Title 10, Chapter 12 of the California Code of Regulations, do a good job of referencing the relevant federal authority at the end of each section. It is often easier to start with the California regulations, as they are better known to Covered California staff, and then look to the federal authorizing regulations and statutes when further research is needed. As the California regulations have been promulgated on an emergency basis with short timeframes, to be sure you are using the most recent set of regulations, we recommend going to www.healthexchange.ca.gov and clicking on “Regulations” in the Resources tab.

1. See Gov’t Code §§ 100500-100521 establishing the Exchange. 10 CCR § 6410 states that the California Health Benefit Exchange may be referred to and do business as “Covered California.” See *also* 42 U.S.C. § 18031 (providing for the establishment of state-based exchanges). After the passage of the Affordable Care Act, CMS started using the term “marketplace” instead of “exchange,” but the term “marketplace” is not broadly used in California.

A. Qualified Health Plans

Before discussing how individuals become eligible to enroll in Covered California plans and get financial assistance, some explanation of what individuals are purchasing is helpful. Individuals enrolling through Covered California are buying a “Qualified Health Plan.” A Qualified Health Plan is a health plan that meets Covered California’s requirements and contracts with Covered California to be sold on the state health care exchange.

1. Essential Health Benefits

Qualified Health Plans, like all plans now sold on the individual market in California, must provide the following essential health benefits, as defined by the Affordable Care Act and California statute and regulation:

- 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; and
- Pediatric services (including oral and vision care).²

State law also requires Qualified Health Plans offered through Covered California to include additional benefits, including, in certain cases, acupuncture, nonemergency ambulance transportation, and durable medical equipment.³ Thus, advocates

2. 42 U.S.C. § 18022; 45 C.F.R. §§ 156.100 and 156.115.

3. Health & Safety Code § 1367.005(a)(2)(A)(v); 28 CCR § 1300.67.005(c), (d). Essential Health Benefits are codified in California’s Insurance Code § 10112.27 and Health and Safety Code § 1367.005. The most detailed list incorporating all of these is in 28 CCR § 1300.67.005.

looking to get a specific service covered for a client should look not only to the health plan’s Evidence of Coverage documents, but to the California statutes and regulations specifying the types of services that are mandatory.

2. Standard Benefit Design

In addition to the essential health benefits, the plans also must meet federal actuarial standards so that each plan offers a pre-defined percentage actuarial value.⁴ As provided by the Affordable Care Act, plans are divided into metal tiers, with each tier offering a different value⁵:

Metal Tier Level	Actuarial Value (average percentage the plan pays toward the total cost of services)
Platinum	90%
Gold	80%
Silver	70%
Bronze	60%

The premium price is heavily affected by the actuarial value of the plan. In other words, in a Bronze plan, where the *enrollee* is expected to pay, on average, 40% of the cost of care, premiums are significantly cheaper than in a Platinum plan, where the enrollee pays, on average, only 10% of the cost of care.

Another way to evaluate how much a plan will cost an enrollee is to look at what is known as the “total cost of care.” The total cost of care considers not only the

-
4. 42 U.S.C. § 18022(d). The actuarial value is what enrollees who buy the plan pay on average in out-of-pocket expenses and may vary for any individual. Nonetheless, the percentage should help guide how much enrollees can expect their health insurance to pay. Alternatively, it may be easier to look at the maximum out-of-pocket cost of a plan to determine what enrollees can expect to pay during the plan year if they end up needing to use their insurance for any significant medical issues. For example, in 2016 the maximum out-of-pocket cost for a Bronze plan through Covered California was \$6,500 for an individual.
 5. 42 U.S.C. § 18022(d); 45 C.F.R. § 156.140; Health & Safety Code § 1367.008(a); Ins. Code § 10112.295(a).

premium, but the deductible (how much enrollees must pay before many services are covered), copayments and coinsurance for each visit, copayments or coinsurance for prescription medications, and the maximum out-of-pocket cost (the most a enrollee would have to pay in a plan year if all services are provided in the plan's network).

For example, in 2016 the deductible for a Bronze plan was \$6,000 and the maximum out-of-pocket cost was \$6,500. This means that enrollees have to pay up front \$6,000 toward their care before the plan will pay for most medical services.⁶ Once the enrollee reaches the maximum out-of-pocket cost by paying \$6,500 for care received in the plan's network, the plan must pay for all other in-network care that year. A Platinum plan on the other hand, has no deductible, so the plan will pay a significant portion of all medical care received. The maximum out-of-pocket for a Platinum plan is \$4,000 for any care received in network.⁷

Each individual's specific health care needs will impact which type of plan will cost the most. An individual who uses three to four brand name medications per month and visits a doctor just as often may find a Platinum plan to be the most affordable option; while the premium may be higher in Platinum, the out-of-pocket costs likely would be lower. An individual who does not use many health care services and is buying a plan for "just in case," may find that a Bronze plan, with its lower premium, is the best option.⁸ For lower-income individuals, the Silver plans with additional cost-sharing reductions are almost always the cheapest plans as they are higher value plans without the large deductibles, as discussed in Section F at the end of this chapter.

-
6. A limited number of doctor visits and preventive services are covered prior to meeting the deductible. Note that currently only Silver and Bronze plans have deductibles, and Silver plans cover more services before the deductible is paid.
 7. See 10 CCR § 6460 for further detail on what costs enrollees must pay for specific services.
 8. Anyone choosing Bronze, however, should be prepared for the high deductible if services are needed.

Advocacy Tip: Covered California went one step further than required under federal law and standardized not only the actuarial values of the plans themselves, but also the benefits in the Qualified Health Plans, so that one Bronze HMO plan will have the same covered services and the same co-payments and deductibles as any other Bronze HMO plan. The Covered California Board approves the standard plan benefit design by regulation the year prior to the plan year. When helping clients deal with unexpected bills, reviewing the charts in the regulation can help determine how the charges were assessed and if they are accurate.

The standard plan design for 2016 is found at 10 CCR § 6460, but due to the nature of the charts that are attached to the regulation describing the design, the regulations are better viewed directly on Covered California's website than in a search engine like Westlaw.⁹

Premium rates are also set based on geographic region and age of the individual. California has 19 regions¹⁰ and the choice of plans available in each region varies, with rates in the southern or metropolitan areas being cheaper on average than those in northern or rural areas. The Affordable Care Act limits how much older individuals can be charged for care, so that charges are no more than three times that of what younger individuals are charged.¹¹ Note that age, region, and whether the plan covers an individual or family are the only factors that insurers can now use to set premiums – no longer can they consider gender, tobacco use, or preexisting medical conditions.¹²

-
9. Rather than the Covered California consumer website for enrolling in Covered California, go to the agency website at www.healthexchange.ca.gov and click on Resources and then Regulations from the pull down menu to get a copy of the Standard Benefit Design Regulations for the year in question.
 10. Ins. Code §§ 10753.14(a)(2), 10965.9(a)(2); Health & Safety Code §§ 1357.512(a)(2), 1399.855(a)(2).
 11. 42 U.S.C. § 300gg(a)(1)(A)(iii); 45 C.F.R. § 147.102(a)(1)(iii); Ins. Code §§ 10753.14(a)(1), 10965.9(a)(1); Health & Safety Code §§ 1357.512(a)(1), 1399.855(a)(1).
 12. Ins. Code §§ 10753.14(a), 10965.9(a); Health & Safety Code §§ 1357.512(a), 1399.855(a). 45 C.F.R. § 147.102(a)(1)(iv) allows for discriminating rates for tobacco users but California's legislation enacting the Affordable Care Act's rate setting protections excluded the consideration of tobacco use. See ABX1-2 (Pan), statutes of 2013, preamble.

B. Eligibility to Purchase Coverage Through Covered California

Individuals who would like to purchase a Qualified Health Plan through Covered California must be 1) U.S. citizens, nationals, or lawfully present immigrants, 2) not incarcerated, and 3) residents of California. If individuals do not meet one of these criteria, specifically if they are not U.S. citizens or lawfully present, they may be able to purchase the same plans outside of Covered California in the off-Exchange individual market.¹³ Since financial assistance is only available through Covered California plans, individuals buying individual market products outside of the Exchange pay full price – a tough option for low-income Californians.

1. Citizenship and Immigration Status

Unlike Medi-Cal, where immigration status only affects the *scope* of benefits, in Covered California, immigration status affects *who* gets benefits. Under federal law, only California residents who are U.S. citizens,¹⁴ nationals, or who are “lawfully present” as defined in the Affordable Care Act are eligible to enroll in Covered California plans.¹⁵

Lawfully present immigrants include:¹⁶

- Lawful Permanent Resident (LPR/Green Card holder);
- Asylee;
- Refugee;
- Cuban/Haitian Entrant;
- Paroled into the U.S.;¹⁷

13. All health plans selling on the Exchange must offer the same product in the off-Exchange individual market. 42 U.S.C. § 18021(a)(1)(C)(iii).

14. Citizens include persons born in the United States and those who later naturalize or derive citizenship.

15. 10 CCR § 6472(c); 45 C.F.R. § 155.305(a)(1). California regulations follow the federal definition of “lawfully present.” See 10 CCR § 6410 (referencing 45 C.F.R. § 152.2).

16. 45 C.F.R. § 152.2. For additional details, see “Lawfully Present under the Affordable Care Act,” National Immigration Law Center, September 2012, available at www.nilc.org/lawfullypresent.html.

17. Except when paroled for prosecution, for deferred inspection or pending removal proceedings.

- Conditional Entrant Granted before 1980;
- Battered Spouse, Child and Parent;
- Victim of Trafficking and his/her Spouse, Child, Sibling or Parent;
- Granted Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture;
- Individual with Non-immigrant Status/Lawful Temporary Residents;¹⁸
- Temporary Protected Status;
- Deferred Enforced Departure;
- Deferred Action Status (Exception: Deferred Action for Childhood Arrivals (DACA) is not an eligible immigration status for applying for health insurance);¹⁹
- Administrative order staying removal issued by the Department of Homeland Security;
- Member of a federally-recognized Indian tribe or American Indian Born in Canada; or
- Resident of American Samoa.

Applicants for the following statuses are also eligible:

- Temporary Protected Status with Employment Authorization;
- Special Immigrant Juvenile Status;
- Victim of Trafficking Visa;
- Adjustment to LPR Status;
- Asylum;²⁰ or
- Withholding of Deportation, or Withholding of Removal, under the immigration

18. Includes temporary worker visas (such as H1, H-2A, H-2B), student visas, U-visa, T-visa, and other visas, and citizens of Micronesia, the Marshall Islands, and Palau.

19. See 45 C.F.R. § 152.2(8). Although individuals with Deferred Action for Childhood Arrivals are considered lawfully present under immigration law, the Obama administration specifically excluded this group from the definition of “lawfully present” for purposes of the Affordable Care Act. See *also* Q.1 USCIS’ FAQ on DACA available at www.uscis.gov/humanitarian/consideration-deferred-action-childhood-arrivals-process/frequently-asked-questions. This rationale will likely be applied to Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA), should that program ever be implemented. DAPA is currently enjoined from implementation by court order.

20. Must have been either granted employment authorization or are under the age of 14 and have had an application pending for at least 180 days.

laws or under the Convention against Torture (CAT).²¹

Persons with the following immigration status who also have an employment authorization document are also eligible:

- Registry Applicants;
- Order of Supervision;
- Applicant for Cancellation of Removal or Suspension of Deportation;
- Applicant for Legalization under Immigration Reform and Control Act (IRCA);
or
- Legalization under the LIFE Act.

The categories of immigrants who are considered lawfully present for purposes of enrollment in a Covered California plan are similar to the eligibility categories for full-scope Medi-Cal, but are narrower in some cases. For example, individuals with Deferred Action for Childhood Arrivals (DACA) status are not considered “lawfully present” for purposes of Covered California and premium tax credit eligibility, but are “lawfully present” for purposes of full-scope Medi-Cal.²² See Chapter 1 for more information about lawfully present under Medi-Cal.

21. Must have been either granted employment authorization or are under the age of 14 and have had an application pending for at least 180 days.

22. MEDIL 14-45 (Aug. 6, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-45.pdf>.

Note on Newly Qualified Immigrants: California supplements its Medi-Cal program to avoid the “five year bar,” a federal provision that precludes new immigrants from receiving federal benefits.²³ Currently immigrants who are age 21-64, without children, and are subject to the five-year bar may enroll in Medi-Cal if they otherwise meet Medi-Cal eligibility requirements. Starting in 2017, these immigrants will be dually enrolled in Covered California and Medi-Cal. Covered California will be the primary insurance, and Medi-Cal will cover benefits not included in Covered California, such as adult dental.²⁴ DHCS will pay the premiums and out-of-pocket costs of these individuals. Those who do not enroll in Covered California will have their benefits limited to restricted scope Medi-Cal. All other immigrants who have been in the United States less than five years, such as parents and children, will continue to receive full scope Medi-Cal services.

2. Incarceration

Individuals cannot enroll in a Covered California health plan if they are incarcerated, unless they are incarcerated pending the disposition of charges, *i.e.*, if they are awaiting trial or sentencing.²⁵ Advocates may wonder why anyone would apply for health insurance while incarcerated, since they could not use the services to access care outside of the prison health system and prisons are required to cover the health care needs of inmates. Nonetheless, this eligibility condition may affect some individuals seeking coverage; for example, individuals can face barriers if an electronic verification of incarceration status says they are in prison when they actually are not. See Chapter 5, Section B on verification procedures. Persons who are released from prison are entitled to buy coverage through Covered California during a 60-day special enrollment period that begins from the time they are released.²⁶

23. 8 U.S.C. § 1613.

24. Welf. & Inst. Code § 14102.

25. 42 U.S.C. § 18032(f)(1)(B); 45 C.F.R. § 155.305(a)(2); 10 CCR § 6472(d).

26. 45 C.F.R. § 155.420(c)(1); Health & Safety Code § 1399.849(d)(1)(D); 10 CCR § 6504(a)(8) and (f). See Chapter 5, Section C.2.b, subsection b, "Covered California Special Enrollment."

3. Residency

Only residents of California can purchase insurance through Covered California.²⁷ To meet the residency requirement, a person age 21 or over must live in California and either have an intent to reside in the state, have a job commitment, or be seeking employment in California.²⁸ Children under age 21 may use where they reside or the residency of the parent or caretaker with whom they live to determine residency.²⁹ A homeless individual can have California residency; a fixed address is not required.³⁰ Persons who move to California are entitled to enroll in Covered California during a 60-day special enrollment period.³¹

Covered California also requires that people live in the service area or region in which they are receiving services – in other words, if someone lives in Alameda County (Region 6), they have to enroll in a Region 6 plan, even though the person works in and would prefer to access health services in San Francisco County (Region 4).³² There are special rules for individuals under age 21 that allow them to pick either the service area connected to the residency of their parent or caretaker or the region where they actually reside, as in the case of a student living away from home.³³ Similar rules apply for households where not all members live in the same service area – they may in enroll in any of the service areas that one of the tax filers lives in.³⁴ Finally, for persons who are institutionalized out of state or do not otherwise fit the other scenarios, the Medicaid residency rules apply.³⁵

27. 45 C.F.R. § 155.305(a)(3).

28. 45 C.F.R. § 155.305(a)(3)(i).

29. 45 C.F.R. § 155.305(a)(3)(ii).

30. 45 C.F.R. § 155.305(a)(3)(i)(A); 10 CCR § 6472(e)(1)(A).

31. 45 C.F.R. § 155.420(c), (d)(7); 10 CCR § 6504(a)(8) and (f). See Chapter 5, Section C.2.b.

32. 45 C.F.R. § 155.305(a)(3)(i); 10 CCR § 6472(e)(1).

33. 45 C.F.R. § 155.305(a)(3)(ii); 10 CCR § 6472(e)(2).

34. 45 C.F.R. § 155.305(a)(3)(iv); 10 CCR § 6472(e)(4). An example would be persons under age 26 who can enroll in their parents plan, yet they need not live with their parents to do so. See 45 C.F.R. § 147.120.

35. 45 C.F.R. § 155.305(a)(3)(iii); 10 CCR § 6472(e)(3). The Medicaid residency regulations are at 42 C.F.R. § 435.403.

4. Age

Individuals of any age can purchase a plan through Covered California, though practically speaking, eligibility for Medicare precludes most people over age 65 from enrolling.³⁶

Catastrophic plans (high deductible plans with little or no coverage until the deductible is paid) sold by Covered California have additional requirements – applicants must be under age 30 or have received an exemption due to the affordability of available plans.³⁷ Advocates helping individuals understand the different available products should point out that there is minimal difference both in pricing and in product between catastrophic plans and Bronze plans, so individuals who are seeking financial exemptions to purchase a cheaper catastrophic plan might be wasting their time. Individuals also cannot get financial assistance to purchase a catastrophic plan.

C. Eligibility for Financial Assistance

The previously discussed rules are only to *purchase* a Covered California plan. In order to be eligible for financial assistance – premium tax credits³⁸ and cost-sharing reductions³⁹ – individuals must also lack minimum essential coverage, be income eligible, and agree to certain tax filing requirements.⁴⁰

Individuals who qualify for financial assistance get a tax credit to offset the cost

36. See question A.1 of the Aug. 1, 2014 Medicare and the Marketplace FAQ (available at <http://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Overview1.html>): “Consistent with the longstanding prohibitions on the sale and issuance of duplicate coverage to Medicare beneficiaries (section 1882(d) of the Social Security Act), it is illegal to knowingly sell or issue an Individual Marketplace Qualified Health Plan (or an individual market policy outside the Marketplace) to a Medicare beneficiary. This prohibition does not apply in the SHOP market, or to employer coverage outside of the SHOP market.” The FAQ itself is updated from time to time. See *also* the discussion on Minimum Essential Coverage in section C.1 below.

37. 42 U.S.C. § 18022(e)(2); 45 C.F.R. § 155.305(h); 10 CCR § 6472(f).

38. Premium tax credits are also known as “advanced premium tax credits (APTCs)” when taken in advance or simply “premium assistance” on Covered California materials.

39. Cost sharing reductions are also known by the abbreviation “CSRs” or “help with out-of-pocket costs” on Covered California materials.

40. 26 U.S.C. § 36B(c); 26 C.F.R. § 1.36b-2(a), (b); 10 CCR § 6474.

of their health insurance premiums. The Affordable Care Act allows enrollees to take the tax credit in advance – called advanced premium tax credits – or wait until filing taxes the following year. When they take the tax credit in advance, the federal government pays a part of the full tax credit directly to the health plan each month, reducing the amount of money the enrollee has to pay in premiums each month. Because it is a tax credit taken in advance based on an estimate of the tax household’s modified adjusted gross income, the advanced premium tax credits must be reconciled when filing taxes the next year.

Advocacy Tip: Enrollees who are uncertain about their income estimate may be well served by taking a smaller amount of premium tax credits each month in advance so they are not at risk of owing money come tax time. The Covered California website includes a sliding bar that allows enrollees to choose how much of the tax credit to take ahead of time.

1. Lack of Minimum Essential Coverage

Individuals must show that they do not have other minimum essential coverage in order to qualify for financial assistance through Covered California.⁴¹ Minimum essential coverage includes:⁴²

- Medicare Part A and Medicare Advantage plans;
- Full-scope Medi-Cal programs, including the Targeted Low-Income Children’s Program (former Healthy Families program),⁴³ Medi-Cal Access Program (MCAP – former AIM program), and Refugee Medical Assistance programs

41. 26 U.S.C. § 36B(c)(2)(B); 26 C.F.R. § 1.36B-2(a)(2); 10 CCR § 6474(c)(1)(B)(2).

42. 26 U.S.C. § 5000A(f); 26 C.F.R. § 1.5000A-2.

43. Starting sometime in 2015, the Department of Health Care Services began referring to TLICP as “Medi-Cal for Families.”

- administered by Medi-Cal;⁴⁴
- TRICARE;
- Comprehensive health care offered by the Veterans Administration;⁴⁵
- Coverage provided to Peace Corps volunteers;
- Coverage under the Nonappropriated Fund Health Benefit Program from the Department of Defense;
- Self-funded health coverage offered to students by universities for plan or policy years that began on or before Dec. 31, 2014 (for later plan or policy years, sponsors of these programs may apply to HHS to be recognized as minimum essential coverage);⁴⁶
- State high risk pool coverage established on or before November 26, 2014 in any state;⁴⁷
- Most employer-sponsored health plans, including COBRA and retiree coverage;
- Plans purchased on the individual market;
- Grandfathered health plans; and

44. Medicaid coverage is typically treated as minimum essential coverage. 26 C.F.R. § 1.5000A-2(b)(1)(ii). However, if the Medicaid coverage consists solely of “excepted benefits” than it is not considered minimum essential coverage. 26 C.F.R. § 1.5000A-2(g). Coverage that only provides certain types of benefits, such as dental policies, long-term care coverage, or coverage limited to minor consent services, are “excepted benefits” and therefore are not minimum essential coverage. 42 U.S.C. § 300gg-91(c)(2). In addition, coverage for medically needy individuals is considered minimum essential coverage only if the individual has no share of cost. 26 C.F.R. § 1.5000A-2(b)(2)(v); MEDIL 14-02 (Jan. 9, 2014), <http://www.dhcs.ca.gov/services/medicaid/eligibility/Documents/MEDIL2014/MEDIL14-02.pdf>; CMS, State Medicaid Director Letter #14-002, “Minimum Essential Coverage” (Nov. 7, 2014), <http://www.medicare.gov/federal-policy-guidance/downloads/sho-14-002.pdf> (the regulations have been slightly reordered since this guidance was published). Persons in these programs, such as Medi-Cal share of cost, should be permitted to enroll in Covered California. Medi-Cal programs for pregnant women that were previously considered “limited scope” (as opposed to restricted scope programs for undocumented women) are now considered minimum essential coverage as they provide all medically necessary services. Note that the Medi-Cal Access Program (formerly AIM, Access for Infants and Mothers) is not technically a Medicaid program, but is a CHIP program administered by Medi-Cal. Nonetheless it is minimum essential coverage.

45. See 26 C.F.R. § 1.5000A-2(b)(1)(v) for specific programs.

46. CMS, “Minimum Essential Coverage,” available at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/minimum-essential-coverage.html>.

47. *Id.*

- Other plans as designated by HHS.⁴⁸

As discussed below, for most forms of government program coverage and employer sponsored coverage, simply being eligible for the program is enough to make an individual *ineligible* for financial assistance through Covered California.⁴⁹ For other types of minimum essential coverage, such as plans purchased on the individual market, an individual has the option of deciding whether to keep the other coverage or enroll in a Covered California plan with financial assistance, provided the individual has not already entered into a health insurance contract or is able to end such a contract.

Note that because certain Medi-Cal programs are *not* minimum essential coverage, (namely Medi-Cal Share of Cost⁵⁰ programs and programs with limited scope of services such as Minor Consent), individuals enrolled in these programs can simultaneously enroll in a Covered California plan with advanced premium tax credits so long as they meet Covered California's eligibility criteria. Medi-Cal only covers what Covered California does not, such as In-Home Supportive Services, adult dental, or long-term care, so individuals should check provider networks before picking a Covered California plan for most regular health services.

a. Months of Partial Coverage

Individuals have minimum essential coverage for purposes of determining eligibility for premium tax credits only in months that they have the other coverage for the entire month.⁵¹ In other words, if someone is enrolled in a Qualified Health Plan as of the first day of the month but becomes eligible for Medi-Cal or coverage through a

48. 26 U.S.C. § 5000A(f).

49. 26 C.F.R. § 1.36B-2(c)(2)-(3).

50. Persons who meet their Share of Cost for the month have minimum essential coverage and thus cannot continue to receive premium tax credits or be enrolled in a plan with cost-sharing reductions. 26 C.F.R. § 1.5000A-2(b)(2)(v); MEDIL 14-02 (Jan. 9, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-02.pdf>; CMS, State Health Official Letter #14-002, “Minimum Essential Coverage” (Nov. 7, 2014), <http://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf>. Note that such dually enrolled individuals will be using Covered California before Medi-Cal given Medi-Cal program rules. How such programs should work together for persons needing services such as IHSS has not yet been fully explained in guidance or regulation.

51. 26 U.S.C. § 36B(c)(2)(A); 26 C.F.R. § 1.36B-3(c).

job part way through the month, they are still eligible for premium tax credits for the rest of that month. This prevents people from having to cancel their coverage early or needing to repay advanced premium tax credits for partial months.

b. Eligible but Not Enrolled

For most government programs such as Medi-Cal and Medicare, individuals are required to enroll in the government program if they are eligible. Even if not actually enrolled, they are treated as enrolled and denied Covered California financial assistance.⁵² There is an obligation to complete an application for the government program by the end of the third full calendar month that they would be eligible.⁵³ If they are denied coverage, even if wrongfully, or coverage is delayed, they may be enrolled in a Covered California plan and receive advanced premium tax credits until the month after the eligibility determination is made for the government program.⁵⁴

The federal regulations found at 26 C.F.R. § 1.36B-2(c)(2) have numerous examples as to how this plays out and are worth looking at when questions of the timing for enrollment in public programs come up. The regulations and examples make clear that enrollees in Covered California plans who later become Medi-Cal eligible are able to keep taking advanced premium tax credits until the month after they receive their notice of Medi-Cal eligibility. In this scenario, enrollees don't have to pay back premium assistance for the month during which they applied for Medi-Cal or any period during which they are retroactively determined to have been Medi-Cal eligible.

Reminder: Medi-Cal eligibility only makes individuals ineligible for premium tax credits; they may still enroll in Covered California plans without the credits. While few Medi-Cal-eligible individuals can afford the full price of a Covered California plan, there is no legal reason why they cannot purchase one.

52. See 26 U.S.C. § 5000A(a); 26 C.F.R. § 1.36B-2(c)(2).

53. 26 C.F.R. § 1.36B-2(c)(2)(ii).

54. 26 C.F.R. § 1.36B-2(c)(2)(iv) and (v).

Veterans programs are treated differently. The individual is only considered to have minimum essential coverage if actually enrolled in a comprehensive health program – not if the veteran is just using VA services for a particular service-related injury.⁵⁵

c. Special Rules Regarding Employer Coverage

Advocates should be aware that there are several special rules regarding employer coverage that determine both whether an employee or family member can enroll in Covered California and whether the employee has minimum essential coverage. Just as with most government benefits, if an employee has the opportunity to enroll in a plan that would be minimum essential coverage, the employee cannot enroll in a Covered California plan with financial assistance.

i. Affordability and Value of Other Coverage

Employer-sponsored coverage is considered minimum essential coverage if it is affordable and offers “minimum value.”

An employer plan is considered *affordable* if the amount that the employee must pay for self-only coverage is no more than the maximum required contribution percentage of the total tax household’s taxable income, which is currently set at 9.66%.⁵⁶ In other words, premiums that are less than roughly ten percent of an employee’s income are considered affordable. See Section D.2 for more information on calculating required contribution percentages. Employees who do not have an offer of affordable coverage from an employer can instead enroll in a Covered California plan with financial assistance.

Even if the employer plan meets the affordability test, advocates should check to

55. 26 C.F.R. § 1.36B-2(c)(2)(iii). 26 U.S.C. § 5000A(f)(1)(A)(v) gives the Secretaries of Veterans Affairs and Health & Humans Services the authority to determine which veterans programs meet the minimum essential coverage standard. Currently the Veterans Affairs website identifies the following three programs as meeting minimum essential coverage: the Veteran’s health care program, the Civilian Health and Medical program (CHAMPVA), and the spina bifida health care program. <http://www.va.gov/health/aca/EnrolledVeterans.asp>.

56. 26 U.S.C. § 36B(c)(2)(C)(i); 26 C.F.R. § 1.36B-2(c)(3)(v)(A)(1).

be sure that the plan also offers *minimum value*.⁵⁷ In order to be of minimum value, the plan must cover at least 60% of the expected total allowed costs for service (as measured actuarially, rather than on an individual basis).⁵⁸ Employees who are offered employer plans that do not meet the minimum value test can instead enroll in a Covered California plan with financial assistance.

If the employer plan meets the affordability test and is of minimal value, the employee can still enroll in a Covered California plan, but not with financial assistance.

ii. Family Glitch

An employer's offer of minimum essential coverage to a spouse or dependents can make those individuals ineligible for financial assistance through Covered California. When an employer offers spouse or dependent coverage, the affordability is determined by the cost of the employee's self-only coverage.⁵⁹ In other words, if the premium for the employee's self-only coverage is affordable, but dependent coverage is offered to the employee at a significantly higher rate that the employee cannot afford, the dependent coverage is still considered affordable. In this case, the employee may still purchase insurance for a spouse or dependents on Covered California if that is the better deal, but the family members will not get financial assistance.

iii. The Enrolled Employee Exception

Employees *actually enrolled* in employer plans are considered to have minimum essential coverage for the full months they are enrolled, even if those plans are not affordable or do not have minimum value.⁶⁰ Employees must drop their employer's health plan to change to a Covered California plan and can do so only during open

57. 26 U.S.C. § 36B(c)(2)(C)(ii); 26 C.F.R. § 1.36B-2(c)(3)(vi); 10 CCR § 6410.

58. *Id.* Advocates will need to check a plan's Evidence of Coverage or other documents to know the actuarial value.

59. 26 U.S.C. § 36B(c)(2)(C)(i); 26 C.F.R. § 1.36B-2(c)(3)(v)(A)(1)-(2); 26 C.F.R. § 1.36B-2T(c)(3)(v)(C) as updated by IRS Rev. Proc. 2014-62.

60. 26 C.F.R. § 1.36B-2(c)(3)(vii).

enrollment or when the contract ends via special enrollment.⁶¹

iv. COBRA

While COBRA coverage is not evaluated on affordability and minimum value like employer coverage, enrolling in COBRA does preclude enrollment in Covered California with financial assistance. Nonetheless, given the gap in coverage that can occur while waiting for coverage in a Covered California plan, an individual can enroll in both a Covered California plan with financial assistance and COBRA, provided the individual cancels COBRA once they start receiving financial assistance through Covered California.⁶² This can help avoid a 1-2 month gap in coverage. For more information on Covered California enrollment when losing coverage, see Chapter 5, Section C.2.b on Special Enrollment.

2. Income Threshold for Financial Assistance

Individuals with household income between 100% FPL and up to and including 400% FPL are income eligible for financial assistance through Covered California.⁶³

Most adults with household incomes up to 138% FPL in California are eligible for Medi-Cal (for children, the income standard is set at 266% FPL), and as described above, eligibility for Medi-Cal precludes eligibility for Covered California. In the vast majority of cases, an individual must have household income above 138% FPL to qualify for premium tax credits – and most children must be in families with incomes above 266% FPL in order to obtain premium tax credits.⁶⁴

61. See 26 C.F.R. § 1.36B-2(c)(3)(vii), including the examples in (C), and 26 C.F.R. § 1.36B-2(c)(3)(iii)(C), Example (ii).

62. The notes to the final federal rules and guidance from the Department of Labor make it clear that individuals can elect both COBRA coverage and Exchange-based coverage, provided they cancel their COBRA coverage as soon as the Exchange-based coverage goes into effect. See 79 FR 30297 (May 27, 2014) or Q4 of the Dept of Labor Guidance at <http://www.dol.gov/ebsa/faqs/faq-consumer-cobra.html>.

63. 26 U.S.C. § 36B(c)(1)(A); 26 C.F.R. § 1.36B-2(b); 10 CCR § 6474(c)(1)(A).

64. Certain lawfully present immigrants who are not eligible for full-scope Medi-Cal due to their immigrant status and are below 100% FPL will be treated as at 100% FPL and eligible for Covered California. 26 U.S.C. § 36B(c)(1)(B)(ii); 26 C.F.R. § 1.36B-2(b)(5); 45 C.F.R. § 155.305(f)(2); 10 CCR § 6474(c)(2).

**a. Exceptions to the Lower Limit of Eligibility:
Individuals Below 100% FPL**

Persons below 100% FPL can be eligible for Covered California tax credits in two scenarios:

- Lawfully present immigrants who are ineligible for Medi-Cal may obtain tax credits.⁶⁵
- A person may receive a tax credit if (1) the person enrolls in a plan through Covered California; (2) Covered California estimates that the person's household income will be between 100-400% FPL; (3) the person receives premium tax credits; and (4) the person is otherwise eligible for Covered California.⁶⁶

Enrollees in the second scenario do not have to pay back their tax credits because their income was lower than expected, though they should report changes in income within 30 days of the change, which in many cases will move them to the Medi-Cal program.⁶⁷ Even in these situations, Medi-Cal still would have been the better deal because the premium tax credit does not fully pay for the individual's Covered California premium. Unlike Medi-Cal, which is free, an individual in Covered California still has a required contribution toward the premium payment and cost sharing when services are received.

**b. Income Counting: Modified Adjusted Gross Income (MAGI)
Methodology**

The first step in determining if the amount of income qualifies an individual for financial assistance is to determine when to start counting the income. For persons applying for financial help through Covered California, the income that matters is the income for the entire calendar year. In other words, if someone applies in 2015 for coverage starting January 2016, it is the full 2016-year income that will be reported

65. 26 U.S.C. § 36B(c)(1)(B)(ii); 26 C.F.R. § 1.36B-2(b)(5); 45 C.F.R. § 155.305(f)(2); 10 CCR § 6474(c)(2).

66. 26 C.F.R. § 1.36B-2(b)(6)-(7).

67. 45 C.F.R. § 155.330(b); 10 CCR § 6496(b).

on the 2016 personal income federal tax return in early 2017 that counts toward Covered California eligibility.⁶⁸

This requires families to project at the time they apply what they think their income will be for the entire calendar year. Families with fluctuating income must project what their income will be for the calendar year, but if a change is not expected, then income can be calculated by multiplying the current monthly income by 12.

In the simplest of cases, determination of household income under the MAGI rules starts with the household federal income tax form, the 1040EZ,⁶⁹ the 1040A, or the 1040, and looking to the line labeled “Adjusted Gross Income” (the “AGI” in MAGI - lines 4, 21, and 37 respectively on the 2015 forms).⁷⁰ The Adjusted Gross Income of all household members *required* to file a tax return must be included.⁷¹

The MAGI rules also add a few additional sources of income that must be included that are normally excluded from taxes: excluded foreign income, tax-exempt interest, and non-taxable Social Security income.⁷² The excluded foreign income refers specifically to income excluded for American citizens and residents living abroad that is filed on IRS form 2555⁷³ – someone applying for benefits would only have this type of income during the year that person moves to or from the United States.

If a family has not filed taxes, advocates should still look at the IRS Form 1040 and write in what is known about the family’s income to determine the Adjusted Gross Income. And for families that have filed, advocates should ask to look at their IRS Form 1040 from the previous year and ask whether the income is the same. As mentioned above, Covered California program rules look to the projected income for the calendar year.

68. 45 C.F.R. § 155.305(f).

69. While the 1040EZ may be used to estimate income for the next year, once enrolled in Covered California, households can no longer use the 1040EZ form as premium tax credits require the filing of supplemental tax forms as discussed below.

70. 42 U.S.C. § 1396(e)(14)(G); 26 U.S.C. § 36B.

71. 26 U.S.C. § 36B(d)(2)(A); 26 C.F.R. § 1.36B-1(e)(1). Thus for children, their income is only included if they earn enough to have to file.

72. 26 U.S.C. § 36B(d)(2)(B); 26 C.F.R. § 1.36B-1(e)(2).

73. 26 U.S.C. § 36B(d)(2)(B)(i) and 26 C.F.R. § 1.36B-1(e)(2)(i) reference 26 U.S.C. § 911. This income exclusion is obtained by filing IRS Form 2555 or 2555EZ as part of a tax return.

i. Household Size and Members

For Covered California, the household or family size can affect whether an individual is eligible for premium tax credits and cost-sharing reductions, and if so, the amount of those tax credits and reductions. Determining the household size affects both how much income is included and the family's income relative to the federal poverty level (FPL). A taxpayer's household size equals the number of individuals for whom the taxpayer may claim a deduction under federal tax law.⁷⁴ The taxpayer may claim deductions for him or herself, a spouse, and dependents who are not claimed as dependents by other taxpayers. Dependents can include the taxpayer's qualifying children and qualifying relatives.⁷⁵

ii. Children

A qualifying child dependent for tax filing is a child residing in the United States, Canada, or Mexico under 19 (or under 24 if a full-time student) at the end of the calendar year who is the taxpayer's child (whether natural, adopted, step, or foster); brother; sister; stepbrother; stepsister; half-brother; half-sister; or one of their descendants, and

- lives with the taxpayer for more than one-half of the taxable year;
- has not provided over one-half of their own support for the taxable year; and
- has not filed a joint tax return with a spouse in that taxable year.⁷⁶

The age requirement is waived for adult children who are permanently disabled.⁷⁷ The requirement to live with the taxpayer is waived for full-time students, so long as they are not part of another tax household.⁷⁸ When two parents can claim the child but do not file a joint tax return, the child is considered the qualifying child of the

74. 26 U.S.C. § 36B(d)(1).

75. 26 U.S.C. § 152(a). See also 26 U.S.C. § 36B(d)(1); 26 C.F.R. §§ 1.36B-1(d), (f), and 1.36B-2(b)(3).

76. 26 U.S.C. § 152(b), (c); 26 C.F.R. §§ 1.152-1, 1.152-2(a). Whether a child is a tax dependent is not the same rule as whether a child can enroll on their parents' health insurance policy. A child need not be a tax dependent (or even live with a parent) to enroll in their parents' health plan if under age 26. 42 U.S.C. § 300gg-14; 45 C.F.R. § 147.120.

77. 26 U.S.C. § 152(c)(3)(B).

78. 26 C.F.R. §§ 1.152-1(c), 1.152-3(b).

parent with whom the child lives with more during the tax year. If the child lives with both parents equally, the child is considered the qualifying child of the parent with the highest adjusted gross income.⁷⁹ The parent claiming the child is known as the custodial parent. The custodial parent can choose to not claim the qualifying child as a dependent by signing IRS Form 8332. The non-custodial parent must attach this form to the return for that taxable year and may include the child in the household when claiming for premium tax credits.⁸⁰

iii. Special Consideration for Pregnancy and Newborns

For purposes of Covered California, a baby is not considered to be part of the household until birth, but then the baby counts as part of the household for the entire year. In other words, a single woman with no other children who gives birth in December cannot report her child as part of her household until the child is actually born. From the time she gets pregnant until the baby's birth, her eligibility for premium tax credits will be based on a family of one. But, once her child is born, the child becomes part of her household for tax purposes, including premium tax credits, for the entire year, making her a family of two for the full year. This means that the baby's birth will increase the amount of premium tax credits she is eligible for. Although she would not have been able to apply as a two-person family until after the birth of her child, when she files taxes and reconciles her premium tax credits, she may be eligible for more tax credits than she got in advance, based on her new household of two. She will likely be due tax credits unless her income was significantly more than estimated when she applied.

iv. Qualifying Relative Dependents

A taxpayer's qualifying relative dependent is an individual residing in the United States, Canada, or Mexico, for whom the taxpayer has provided over half of the relative's support, who has not filed jointly with a spouse, and who does not meet the definition of a qualifying child. The relative dependent must also have earned less than the exemption amount – the threshold amount for determining whether

79. 26 U.S.C. § 152(c)(4)(B); 26 C.F.R. § 1.152-4(a).

80. 26 U.S.C. § 152(e); 26 C.F.R. § 1.152-4(b).

someone must file a federal tax return at all.⁸¹ The qualifying relative must be related to the taxpayer as a:

- child or a descendant of a child;
- brother, sister, stepbrother, or stepsister;
- father or mother, or an ancestor of either;
- stepfather or stepmother;
- son or daughter of a brother or sister of the taxpayer;
- brother or sister of the father or mother of the taxpayer;
- son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law; or
- anyone, other than the taxpayer's spouse, who lives with the taxpayer during the entire taxable year and is a member of the taxpayer's household.⁸²

Note that domestic partners are not dependents for purposes of premium tax credits unless one partner is claiming the other as a qualifying relative dependent under this definition.⁸³

v. Spouses

A spouse is part of the taxpayer's household. If a taxpayer has a spouse, they must file a joint tax return for persons in the household to qualify for premium tax credits unless an exception applies.⁸⁴ Similar to other IRS household rules (for example, the birth of a child), whether someone is married or not depends on their status at the end of the entire calendar year, unless their spouse died during the year.⁸⁵

81. See IRS Pubs. 17 or 501 for the current exemption amounts for dependents. These publications are updated every year with a table "Filing Requirements for Dependents." Exemption amounts depend on marital status, age (under or over 65) and whether or not the dependent is blind. There are also additional exemptions for a dependent's SSI (never taxed), or if the dependent's only income is social security or railroad retirement income. If the dependent has Social Security income and other income, the rules are found in IRS Pub. 915.

82. 26 U.S.C. § 152(b), (d); 26 C.F.R. §§ 1.152-1, 1.152-2(a).

83. 10 CCR § 6410.

84. 26 U.S.C. § 36B(c)(1)(C); 26 C.F.R. §§ 1.36B-4T(b)(3), 1.36B-2T(a)(2); 10 CCR § 6476(d)(2)(B).

85. 26 U.S.C. § 7703(a)(1). In other words, widows or widowers are considered married for the year their spouse died. Everyone else is considered married only if they were married by December 31 of that year.

Individuals who are separated from their spouses are still considered married unless they legally separate under a decree of divorce or separate maintenance.⁸⁶ For example, a couple who is separated for all of 2015, but whose divorce is not finalized until January of 2016, must still jointly file their tax return for 2015 in order to claim premium tax credits for 2015, unless they have a decree of separate maintenance. For exceptions to this rule see Section C.4 below.

vi. Family Members who are Not Lawfully Present

A household includes individuals who are not lawfully present in the United States,⁸⁷ but members of the family who are not lawfully present are excluded from the family in calculating household size. Their income, however, is included in counting income.⁸⁸

3. Assets

Because Covered California uses the MAGI methodology, just like MAGI Medi-Cal, there is no assets test. Covered California does not ask for information about money in savings or retirement accounts or property owned to determine eligibility for financial assistance.

4. Tax Filing Status

a. Must File Taxes for the Year that Premium Tax Credits are Received

Individuals who have never filed taxes can sign up for a Covered California plan with advanced premium tax credits, but they must file a federal income tax return

86. 26 U.S.C. § 7703(a)(2).

87. 26 U.S.C. § 36B(e)(1)(B)(i)(I); 26 C.F.R. §§ 1.36B-1(d), 1.36B-3(l)(1). In other words, if someone has an exemption from the individual mandate, they can still be part of the household unless the exemption is based on unlawful presence.

88. 26 U.S.C. § 36B(e)(1)(B)(i)(II); 26 C.F.R. 1.36B-3(l)(2). Note that qualifying dependents living in Canada or Mexico are not unlawfully present in the United States. They should not be excluded.

for each calendar year that they received advanced premium tax credits.⁸⁹ Initially, some individuals were wrongly turned away from enrolling in Covered California plans because they had not previously filed, but the income tax requirement only exists to ensure that enrollees who take advanced premium tax credits receive the correct amount of those tax credits. This tax-filing requirement applies even to those enrollees who do not have taxable income for the year.

In subsequent years, individuals must attest to having met their tax-filing obligation in order to continue receiving advanced premium tax credits.⁹⁰ The IRS forwards information to Covered California on who filed taxes, though this information does not contain persons who may have filed taxes with an Individual Taxpayer Identification Number (ITIN) rather than a Social Security number. Covered California is currently allowing individuals to attest that they have filed their taxes to avoid losing access to advanced premium tax credits. Because the tax-filing requirement is only a condition of eligibility for premium tax credits, individuals that do not meet the tax-filing requirement may continue enrollment in a qualified health plan without premium tax credits. They may be subject to IRS fines or penalties, however.

b. Married Couples Must File a Joint Income Tax Return

If at least one of the married partners signs up for a Covered California plan with advanced premium tax credits, the couple must file a joint income tax return.⁹¹ There are three exceptions to this rule: spouses who can claim head of household, spouses who are victims of domestic violence, and spouses who have been abandoned.⁹² Currently, these are the only exceptions – others who took premium tax credits and do not file jointly must repay all of their advanced premium credits at tax time.

89. 26 C.F.R. § 1.6011-8; 10 CCR § 6476(d)(2)(A).

90. 10 CCR § 6470(d)(5).

91. 26 U.S.C. § 36B(c)(1)(C); 26 C.F.R. § 1.36B-2(b)(2) (referencing temporary regulation at 26 C.F.R. § 1.36B-2T); 45 C.F.R. § 155.310(d)(2)(ii)(B); 10 CCR § 6476(d)(2)(B).

92. Current regulations regarding domestic violence and spousal abandonment are found at 26 C.F.R. § 1.36B-2T(b)(2) and require that the spouse claiming abuse or abandonment certify meeting the criteria, e.g., the spouse cannot file due to abuse or being unable to locate the other spouse. 26 U.S.C. § 7703 and 26 C.F.R. § 1.7703-1(b) consider an individual not living with their spouse, but raising their child (living with person claiming more than 50% of the year and providing more than 50% of the cost of care) to be not married for purposes of the tax code. This person can file without the spouse, under the status “head of household.”

i. Head of Household Exception

The first exception is for married individuals who are eligible to file as a head of household. Such individuals:

- Maintain the principal place of residence for more than one half of the year for a dependent child or relative;
- Contribute over half of the cost of maintaining the household; and
- During the last six months of the taxable year, the individual's spouse was not a member of the individual's household.

Individuals meeting the above criteria can file taxes separately from their spouse as “Head of Household.”⁹³ Typically only one spouse can be considered “head of household,” unless the absent spouse also has a different qualifying dependent. Without another qualifying dependent, the absent spouse will be ineligible for premium tax credits altogether because the absent spouse is not filing jointly and cannot claim head of household status.

ii. Domestic Violence and Spousal Abandonment Exception

Starting January 1, 2014 through July 24, 2017, a married taxpayer can still get premium tax credits if they are unable to file a joint return due to domestic abuse or spousal abandonment. The spouses must be living apart at the time the return is filed.⁹⁴ Domestic abuse includes physical, psychological, sexual, or emotional abuse, including efforts to control, isolate, humiliate, and intimidate, or to undermine the victim's ability to reason independently. Depending on the facts and circumstances, abuse of the victim's child or another family member living in the household may constitute abuse of the victim.⁹⁵ A taxpayer is a victim of spousal abandonment if the taxpayer is unable to locate their spouse after reasonable diligence.⁹⁶ Either of these

93. 26 U.S.C. §§ 2(b)(1), (c), 7703; 26 C.F.R. §§ 1.2-2(b)-(e), 1.7703-1(b).

94. 26 C.F.R. § 1.36B-2T(b)(2)(ii). Note that these are temporary regulations.

95. 26 C.F.R. § 1.36B-2T(b)(2)(iii).

96. 26 C.F.R. § 1.36B-2T(b)(2)(iv).

exceptions may only be claimed for three consecutive years.⁹⁷

c. Individuals who are Dependents Cannot Take Premium Tax Credits

While individuals who are dependents can be part of a tax household and the primary filer in the household can get premium tax credits on their behalf, the dependent individuals themselves cannot independently take premium tax credits.⁹⁸ This is most likely to be an issue for young adults – if the young adult is not a legal dependent, the young person can take premium tax credits by filing their own taxes. If the young adult is a legal dependent, it is the parents (or other primary tax filer claiming the person) who take the tax credit. As discussed above, the young adult does not have to be a dependent to be included in the parents' policy – in that case, the credits are calculated separately.

5. Enrollment in a Covered California Plan

Individuals must enroll in a Qualified Health Plan through Covered California to be eligible for premium tax credits.⁹⁹ But advocates should note that the inverse of this is also true: individuals who enroll in a plan through Covered California without premium tax credits and realize later that they were eligible can claim those premium tax credits when they file at tax time. This is important to remember when an individual is not currently eligible for a Covered California plan, but might be in the future. For example, if the plan offered by a individual's employer is barely affordable, the individual might decide to enroll in a Covered California unsubsidized plan instead. At the end of the year if the individual's income turns out to be less than estimated – so much so that the employer's plan is no longer affordable – the individual can then take the tax credits when filing their federal income tax return.

Similarly, individuals who are not sure whether their final adjusted gross income for the year will be less than 400% FPL can enroll in a Covered California plan without

97. 26 C.F.R. § 1.36B-2T(b)(2)(v).

98. 26 U.S.C. § 36B(c)(1)(D); 26 C.F.R. § 1.36B-2(b)(3). See *also* discussion in Section D.1 on calculating the second lowest cost silver premiums for households that share a plan.

99. 42 U.S.C. § 18071(b)(1); 45 C.F.R. § 155.305(f)(3); 10 CCR § 6470(b).

taking any tax credits. They can then take the premium tax credits, if they qualify, at tax time. These strategies may not be realistic for many individuals because the individual would be required to pay the entire cost of the unsubsidized premium during the year.

D. Calculating Premium Tax Credits

Premium tax credits (which become *advanced* premium tax credits when taken before filing taxes) are calculated based on the premium cost of the *second lowest cost silver plan* available to that person and the *required contribution percentage* the person can be charged based on the individual's household income.¹⁰⁰ If the premium assistance amount is higher than the amount the individual actually must pay in premiums, the individual is entitled only to the amount actually paid.¹⁰¹

1. Second Lowest Cost Silver Plan – The Benchmark Premium

The second lowest cost silver plan premium, or the *benchmark premium*, is the cost of the second lowest cost silver premium that is actually available to the individual or family applying when age and region are factored in.¹⁰² If the whole family enrolls, but enrolls in separate plans, the applicable benchmark premium is the second lowest cost silver plan that would cover the whole family, even if that is not the plan they actually choose.¹⁰³

If more than one household enrolls under a single policy, the second lowest cost silver plan premium must be determined separately for each household. For example, if a couple includes on their health plan their 25-year old child who is no longer a dependent, two separate households would be considered to have enrolled under the policy: one household consisting of the parents, and the other household consisting of the child. The couple would determine the second lowest cost silver plan premium based on a policy available to the two of them (as a household of two in their region) and the 25-year old adult child would determine his second

100. 26 U.S.C. § 36B(b)(2); 26 C.F.R. §1.36B-3(d); 10 CCR § 6474(c)(4).

101. 26 U.S.C. § 36B(b)(2); 26 C.F.R. §1.36B-3(d); 10 CCR § 6474(c)(4).

102. 26 U.S.C. § 36B(b)(3)(B); 26 C.F.R. § 1.36B-3(f).

103. 26 C.F.R. § 1.36B-3(f)(7), Example 6.

lowest cost premium based on a policy available to him (as a household of one in his region). If both households are eligible for premium tax credits, they could use the advanced premium tax credit amount available to each for a single policy.¹⁰⁴

At the time of enrollment, both the lowest cost and second lowest cost plan must be open for enrollment to the individual in order to count as the second lowest cost silver premium; but if the plan stops accepting new enrollees or ceases altogether, that plan cannot be used to calculate the premium tax credits for incoming applicants.¹⁰⁵

2. Required Contribution Percentage

The required contribution percentage (or the *expected contribution or applicable percentage*) is based on a person's household income as a percentage of the federal poverty level (FPL). The FPL table that applies is the one in effect during open enrollment for the plan year, which is the previous year's FPL table. For example, for 2016 plans the FPL table in effect was the 2015 FPL table. Once the household income is known, a sliding scale is applied to determine the specific applicable percentage for the individual. The chart below provides the range of applicable percentages as they correspond to the federal poverty level. Persons earning under 400% of the federal poverty level are expected to pay an amount of their income indexed annually by the IRS on their health care premiums.¹⁰⁶

104. 26 C.F.R. § 1.36B-3(h)(2). While the law allows this it may take special assistance to actually enroll with the correct amount.

105. 26 C.F.R. § 1.36B-3(f)(6); see *also* 26 C.F.R. § 1.36(f)(7), Examples 13, 14, and 15.

106. 26 U.S.C. § 36B(b)(3)(A); 26 C.F.R. § 1.36B-3(g). 2015 numbers are found in IRS Rev. Proc. 2014-37, 2016 in IRS Rev. Proc. 2014-62. For a breakdown of all the percentages within the tier, either divide the range by the number of percentage points, *i.e.*, for the tier 150-200% FPL in 2014, divide 2.3 (6.3-4) by 50 (200-150) and add that number (.046) to each percentage point (150 = 4%, 151 = 4.046%, 152 = 4.092%, etc.) Alternatively, use an online premium tax calculator or check the tax table for the applicable figure found in the instructions to IRS Form 8962. The IRS rounds to the nearest hundredth of a percent as provided in 26 C.F.R. § 1.36B-3(g)(3), Example 1.

Income	Required Contribution Percentage	2015%	2016 %
Up to 133% FPL	2% of income	2.01%	2.03%
133 up to 150% FPL	3–4% of income	3.02-4.02%	3.05-4.07%
150 up to 200% FPL	4–6.3% of income	4.02%-6.34%	4.07-6.41%
200 up to 250% FPL	6.3-8.05% of income	6.34-8.10%	6.41-8.18%
250 up to 300% FPL	8.05-9.5% of income	8.10%-9.56%	8.18%-9.66%
300 up to 400% FPL	9.5% of income	9.56%	9.66%

Applying the two rules together is how the premium tax credit is established. If the benchmark premium costs more than the required contribution of the individual's monthly household income, then a premium tax credit is available.¹⁰⁷

For example, an individual earning \$23,340 in 2015 (200% of the applicable 2014 federal poverty level) would have a required contribution percentage of 6.34% (using the applicable 2015 table): \$1479.76 a year or \$123.31 a month. If the second lowest cost monthly premium available to that person in their area were \$250 a month, they would have a monthly premium tax credit of \$126.69 that they could use to help pay for the premium of any Covered California plan available sold in their region.¹⁰⁸

Remember: For purposes of determining household size, immigrants who are not lawfully present are excluded from the family size when figuring out the premium tax credits, but any income earned by them is included.¹⁰⁹

107. 26 U.S.C. § 36B(b)(2).

108. Although the second lowest cost silver premium is used to calculate the premium tax credit, there is no requirement that someone purchase a silver plan to use it.

109. 26 U.S.C. § 36B(e); 26 C.F.R. § 1.36B-3(l); 10 CCR § 6482(a).

E. Premium Tax Credit Reconciliation

Because advanced premium tax credits are based on an estimation of a household's adjusted gross income that is only finalized the following year during tax time, reconciliation is needed to re-account for any amounts over or underpaid. In general, if a family earned less than anticipated, they would be due additional tax credits for the difference. If they earned more, they likely would have to pay additional taxes.¹¹⁰ However, there are limits on the amount that must be repaid if the advanced credits they received exceeded the credits to which they were entitled. For tax year 2014, the limit on repayment was based on the following chart, which will be adjusted according to a cost-of-living adjustment and published by the IRS every year:¹¹¹

2014 Maximum Tax Repayment Amounts

% of FPL	Single	Married, Filing Jointly
<200%	\$300	\$600
200<300%	\$750	\$1,500
300<400%	\$1,250	\$2,500
>400%	Full Reconciliation	

In other words, a married couple earning less than 200% of the federal poverty level would be required to repay up to \$600 of advanced premium tax credits that were taken in excess. A single mother of two earning over 400% of the federal poverty level would be required to repay *all* advanced premium tax credits received that were in excess of the amount the mother was entitled to.

110. 26 U.S.C. § 36B(f); 26 C.F.R. § 1.36B-4(a); 10 CCR § 6410.

111. 26 U.S.C. § 36B(f)(2)(B); 26 C.F.R. § 1.36B-4(a)(3)(ii). The amounts were not indexed for 2015 and remain the same.

Practically speaking, enrollees reconcile after Covered California sends in IRS Form 1095-A in January after the plan year ends. Form 1095-A shows how much the second lowest cost silver plan was, the amount of advanced premium tax credits taken, the months enrolled in the plan, and the cost of the premium. Enrollees use the information on form 1095-A to fill out IRS Form 8962 that compares the household's modified adjusted gross income to the advanced premium tax credits taken to find the amount owed or to be returned. IRS Form 8962 is filed with the household 1040 or 1040A income tax return. Enrollees who take advanced premium tax credits or who want premium tax credits cannot use IRS Form 1040EZ because there is no way to attach IRS Form 8962 to the 1040EZ form.

The instructions on IRS Form 8962 walk through the reconciliation process, including some of the special rules for couples that marry or divorce during the plan year. Those instructions also address special scenarios, such as where a dependent is claimed by a different household than anticipated or reflected on the 1095-A form, or households that share a 1095-A form with people who are not part of the tax household.¹¹² IRS Form 8962 has both annual and monthly reconciliation methods – households who maintained the same coverage for all 12 months use the monthly method, and households with any change in coverage or coverage for less than a full year reconcile each month to appropriately pro rate the premium tax credit.

Enrollees with complicated reconciliation issues should be advised to seek a tax professional such as at a VITA clinic. Health advocates should have a general understanding of how reconciliation works and may want to look at IRS Form 8962 to better understand it, but in general may want to avoid giving specific tax advice.¹¹³

On the other hand, health advocates can advise individuals who are not certain about their income estimation that they do not have to take the full amount of advanced premium tax credits for which they are found eligible. By taking less during the year, if their income does turn out to be higher than estimated, they will have less to repay. Similarly, households earning close to 400% FPL should be warned that if their income is above 400% FPL at tax time, they will have to repay all premium tax credits received – no matter how large.

112. See the full reconciliation regulations at 26 C.F.R. §1.36B-4 and §1.36B-4T.

113. The form is available from the IRS website: <http://www.irs.gov/pub/irs-pdf/f8962.pdf>.

F. Cost-sharing Reductions

In addition to premium tax credits, another form of financial assistance is available to lower income enrollees in the form of *cost-sharing reductions*, such as lower deductibles, co-pays, and co-insurance. Eligibility for cost-sharing reductions is determined in the same way as for premium tax credits, but individuals face two additional requirements in order to qualify for a cost-sharing reduction. First, Covered California must determine that the individual is in a household that is expected to earn less than 250% of the federal poverty level during the year.¹¹⁴ Second, unlike premium tax credits, individuals *must* enroll in a Silver plan to get cost-sharing reductions, unless they are an American Indian or Alaskan Native.¹¹⁵

The cost-sharing reductions raise the actuarial value of the Silver plans available to the individual. For example, when an eligible individual purchases a Silver 94 plan (a silver plan which, on average, covers 94% of costs), the individual gets a plan with benefits that are more generous than a platinum plan, but pays for a plan that costs the same as a silver plan.

114. 45 C.F.R. § 155.305(g)(1)(i)(C); 10 CCR § 6474(d)(1)(C).

115. 45 C.F.R. § 155.305(g)(1)(ii); 10 CCR § 6474(d)(2). See note 118 below for information on the American Indian/Alaskan native exception that allows for cost-sharing regardless of the plan chosen.

The following chart shows the eligibility range for the cost-sharing reduction plans, *i.e., enhanced Silver plans*):¹¹⁶

Income	Actuarial Value (AV) with Cost-sharing Reduction
100–150% FPL ¹¹⁷	Plan covers 94% AV
150–200% FPL	Plan covers 87% AV
200–250% FPL	Plan covers 73% AV
American Indians/Alaskan Natives up to 300% FPL or receiving services from an Indian Health provider. ¹¹⁸	Plan covers 100% AV

Advocacy Tip: In some regions, individuals who are eligible for cost-sharing reductions will not get premium tax credits because the premiums in their area are lower than their expected contribution to those premiums. This does not mean they are not eligible for cost-sharing reductions because they still meet the criteria for premium tax credits.¹¹⁹

Policies that cover individuals with different household incomes, for example a parent and adult child who is not a dependent, will only be eligible for cost-sharing

116. 42 U.S.C. § 18071(c)(1)(B).
 117. Lawful immigrants earning less than 100% FPL who are eligible for Covered California solely because they are ineligible for Medi-Cal are also eligible for Silver 94 plans. 26 U.S.C. § 36B(c)(1)(B); 45 C.F.R. § 155.305(f)(2); 10 CCR § 6474(c)(2).
 118. 42 U.S.C. § 18071(d); 45 C.F.R. § 155.350(b); 10 CCR § 6494. American Indians and Alaskan Natives must be members of federally-recognized tribes to enroll in 100% cost sharing plans, but others may be eligible for care through Indian Service providers. See <http://www.ihs.gov/aca/faq/#q5> for further explanation of the special rules for American Indians and Alaskan Natives.
 119. 45 C.F.R. § 155.305(g)(1)(B), and 10 CCR § 6474(d)(1)(A) only require that applicants meet the premium tax credit eligibility criteria and make no reference to the computation of available credits.

reductions at the level of the household with the higher income.¹²⁰ In other words, one family member cannot bootstrap another into a more beneficial policy.

Unlike premium tax credits, there is no reconciliation process for cost-sharing reductions. Therefore, if an enrollee who benefitted from cost-sharing reductions sees an increase in income that makes the enrollee ineligible for cost-sharing reductions, the enrollee will not have to pay back the value of the reductions when they file their taxes.

120. 45 C.F.R. § 155.305(g)(3); 10 CCR § 6474(d)(4). “Household income” is defined at 26 U.S.C § 36B(d)(2) and 26 C.F.R. § 1.36B-1(e).

Introduction to Part II: Getting and Keeping Health Coverage

In addition to the rules for eligibility for Medi-Cal, the Medi-Cal Access Program (MCAP), or a Covered California health plan, there are rules governing the process for enrollment into and retaining coverage for these programs. While advocates have engaged in successful legislative and policy advocacy to remove many barriers and have pursued litigation to fix procedures that were too burdensome, there are still hoops to jump through to obtain and maintain coverage in public health programs in California.

A. Application Channels

The Affordable Care Act attempted to simplify applying for the “insurance affordability programs” (Medi-Cal, MCAP¹, and Covered California) through the development of an online and paper single streamlined application for all programs and the creation of a “no wrong door” policy allowing applicants to go to a variety of places to apply. Individuals can apply online, by phone, in person or by mail. Many Medi-Cal programs also have expedited coverage channels for certain populations (such as Presumptive Eligibility for Pregnant Women or Accelerated Enrollment for Children) or for certain conditions (such as Accelerated Enrollment for the Federal Breast and Cervical Cancer Treatment Program) or in certain locations (such as Hospital Presumptive Eligibility for individuals receiving hospital services). Additionally, some people receive Medi-Cal due to their enrollment in another public benefits program and do not need to submit an application (such as CalWORKS and SSI). Nonetheless, some channels have proven easier for some populations. For example, for someone over age 65, in most cases applying through the county will be faster than using the Single Streamlined Application as they can submit a property supplement at the same time they submit their application; this information is required to make an eligibility determination, but is not on the Single Streamlined Application because many programs do not have a property limit.

For information about application channels, see Chapter 5, Section A.

1. The Medi-Cal Access Program is included as a CHIP program. The former Healthy Families program is now a part of Medi-Cal. C-CHIP programs (local children’s insurance programs in three counties) are also being added to the online application but are not covered in this guide due to the limited, local scope of the programs.

B. Verification Requirements

When reviewing an application for eligibility, the Covered California and Medi-Cal programs must verify the contents of the application. Depending on the element, verification may be handled through self-attestation (accepting what the application states unless there is information to the contrary), electronic verification by checking other federal, state, or county databases, or require documentation. In general, for the elements that cannot be verified through self-attestation, the program will try electronic verification first, and, if that does not work, will request documentation. However, applicants may also submit documentation with their application online, via mail, or in person.

For information about verification requirements, see Chapter 5, Section B.

C. Starting Coverage

For Medi-Cal, coverage generally begins the first day of the month when the application is submitted. If an applicant would have been eligible in the months preceding the application, the applicant may also request retroactive Medi-Cal coverage for medical bills in the three months preceding the month of application. Medi-Cal also has presumptive eligibility programs designed to grant instant eligibility for a limited time from the date requested, but the applicant must submit a full application to receive ongoing and retroactive coverage. Coverage starts after the application is processed for the Medi-Cal Access Program² and Covered California health plans. In addition, applicants can only enroll during open enrollment or a special enrollment period for Covered California health plans and must pay their first premium to effectuate coverage.

For information on starting coverage, see Chapter 5, Section C.

-
2. MCAP has very limited reimbursement for up to \$125 in services received prior to enrollment.

D. Plan Selection

In general, a Medi-Cal applicant is first enrolled in fee-for-service Medi-Cal and later sent a health plan choice packet, provided that the applicant is required to or chooses to enroll in a managed care plan and the county of residence has more than one managed care plan. Prior to enrolling in a managed care plan, the individual accesses services through Medi-Cal's fee-for-service network. Medi-Cal members who are required to be in a managed care plan and do not choose one are "defaulted" into a plan by Medi-Cal.

For the Medi-Cal Access Program and Covered California, applicants pick a health plan when they apply.

For information on plan selection, see Chapter 5, Section D.

E. Reporting Changes

Medi-Cal beneficiaries must report changes that affect their eligibility, such as income or household size, within 10 days. Medi-Cal Access Program beneficiaries must report within 30 days when they give birth so that the duration of the coverage may be determined. Covered California enrollees must report changes that affect their eligibility for enrollment or financial assistance within 30 days.

For information on reporting changes, see Chapter 6, Section A.1.

F. Annual Renewal³

Medi-Cal beneficiaries must have their eligibility redetermined every 12 months from the last time their eligibility was reviewed. Thus, individuals have annual redetermination dates throughout the year. For MAGI Medi-Cal if the county has access to information showing a beneficiary is eligible they receive a form laying out the information upon which their continued eligibility is based and told to inform Medi-Cal if the information is wrong. Otherwise, they do not need to return any

-
3. There is no annual redetermination for the Medi-Cal Access Program because it does not last for more than one year.

information. If the counties do not have sufficient information to automatically renew a beneficiary they receive a pre-populated form with information that the county has. The beneficiary sends any additional or changed information needed. For non-MAGI Medi-Cal, while the program is also moving towards pre-populated forms, because assets must always be verified, there is no automatic verification.

Covered California enrollees can update their income and other eligibility elements, as well as pick a different health plan, during the rolling renewal period that starts just before open enrollment for the next calendar year. Thus, everyone in Covered California renews at more or less the same time. Enrollees who do not participate in the renewal process will be kept in their same health plan, provided it is still on the market and Covered California has permission to verify their income with the IRS.

For information on annual renewals, see Chapter 6, Section A.3.

G. Appeals

For either Medi-Cal or Covered California, individuals may appeal when they disagree with an eligibility determination or when they are terminated from the program. Each program outlines specific requirements of the notices, has specific timelines for requesting appeals, and allows for appeals to be resolved prior to the hearing or on an expedited nature where necessary.

For information on appeals, see Chapter 6, Section B.

Program Comparisons

	MAGI Medi-Cal	Non-MAGI Medi-Cal	MCAP	Covered California
Best Ways to Apply Directly	Single Streamlined Application: Online (CalHEERS) or mailed; County Office; or with the help of Certified Enrollment Counselor.	County Office in person or by mail – can use the Single Streamlined Application but should submit with property supplement if possible. Many also get Medi-Cal automatically via another public program.	Online via CalHEERS; or with the help of Certified Enrollment Counselor.	Single Streamlined Application: Online (CalHEERS), Covered California Service Center (phone), or with help of Certified Enrollment Counselor.
Required Verification Prior to Starting Coverage	Income (Residency is not currently verified but may be) Conditional enrollment pending immigration/citizenship status.	Income, assets, and possibly residency. Conditional enrollment pending immigration/citizenship status.	Income	None. Conditional enrollment pending immigration/citizenship status and income. If income verification is not resolved, can move to unsubsidized coverage.
Coverage Start	The 1 st of the month of application + 3 months prior if eligible	The 1 st of the month of application + 3 months prior if eligible	Up to 20 days after complete application is received. ⁴	Not earlier than the month <i>after</i> enrollment, but depends on date enrolled and payment of premium. If applying during Open Enrollment in November, no coverage until January 1 at earliest.

Enrollment Period	Can apply any time.	Can apply any time.	Can apply any time	Enroll during open enrollment or if a qualifying life event gives a special enrollment period.
Plan Selection	After enrollment.	After enrollment.	With application	With application and must pay first premium to enroll.
Change Reporting	Within 10 days of change.	Within 10 days of change	Within 30 days of the end of pregnancy (to reduce contribution) or birth of child (to determine last day of benefits.	Within 30 days of change.
Annual Renewal Process	County renews “ex-parte” if possible. Otherwise, sends pre-populated form and requests needed information.	County renews “ex parte” if possible. Beneficiary must also send in renewal forms with income and assets information.	N/A for mother. Special rules for baby which require income verification.	Covered California redetermines APTC/CSR eligibility if tax information is available and passively renews enrollee into same plan if the enrollee does not choose another plan.
Appeals	Appeal through DSS State Fair Hearing Division.	Appeal through DSS State Fair Hearing Division.	Two levels of informal appeal followed by appeal through DSS State Hearing Division.	Appeal through DSS State Fair Hearing Division.

- 10 CCR §§ 2699.203(a)(up to 10 days to determine eligibility); 2699.209(a)(up to 10 calendar days until coverage goes into effect).

Chapter 5: Getting Onto Coverage

Chapter 5. Getting Onto Coverage

A. Applying for Medi-Cal, Covered California, and the Medi-Cal Access Program

1. Single Application, Multiple Application Pathways, “No Wrong Door”
 - a. Applying Online
 - b. Applying In-Person: County Offices and Community Partners
 - c. Applying by Phone: Covered California Service Center and Counties
 - d. Applying by Mail: The Single, Streamlined Paper Application
2. Expedited Coverage Pathways
 - a. Acceleration Enrollment (AE)
 - b. Deemed Eligible (DE) Infants
 - c. Hospital Presumptive Eligibility
 - d. Presumptive Eligibility (PE) for Pregnant Women
 - e. CHDP Gateway
 - f. Accelerated Eligibility (AE) for Federal Breast and Cervical Cancer Treatment Program (BCCTP)
 - g. Express Lane Enrollment (ELE)
 - h. Children in Foster Care
 - i. Former Foster Youth
 - j. Minor Consent Medi-Cal
 - k. Tuberculosis (TB) Program
3. Medi-Cal Connections with Public Benefits Programs
 - a. Programs Linked to Medi-Cal
 - b. Joint Application for health coverage and public benefits

Chapter 5: Getting Onto Coverage (cont'd)

4. Application Process and Eligibility for Inmates

B. Verifying Application Information

1. Overview of Process and Requirements

- a. Medi-Cal
- b. Medi-Cal Access Program
- c. Covered California

2. Verification of Eligibility Criteria

- a. Proving Identity
- b. Citizenship and Immigration Status
 - i. Proof of Citizenship
 - ii. Proof of Lawful Immigration Status
 - iii. Resolving Citizenship or Immigration Inconsistencies
- c. Incarceration
- d. California State Residency
- e. Income and Household Size
- f. Pregnancy
- g. Assets
- h. Minimum Essential Coverage/Employer-Sponsored Coverage/ Other Coverage

C. When Coverage Starts

1. Medi-Cal

- a. Retroactive Medi-Cal
- b. Expedited Programs

2. Covered California

- a. Covered California Open Enrollment
- b. Covered California Special Enrollment
- c. Covered California Coverage Effective Dates

3. MCAP

Chapter 5: Getting Onto Coverage (cont'd)

D. Plan Selection

1. Picking a Medi-Cal Plan
2. Picking a Covered California Plan
3. Picking an MCAP Plan

5. Getting Onto Coverage

A. Applying for Medi-Cal, Covered California, and the Medi-Cal Access Program

1. Single Application, Multiple Application Pathways, “No Wrong Door”

Under the Affordable Care Act, individuals have the right to apply for all health “insurance affordability programs” through the Single, Streamlined Application.¹ The Department of Health Care Services and Covered California jointly developed online and paper versions of the Single, Streamlined Application.² The elements of the application are laid out in Covered California regulations.³

Pre-ACA Applications

Though there is now a Single, Streamlined Application, if a county receives an old application form used prior to 2014, including the MC 210, MC 321, or SAWS 2, the county is required to process the application and request needed supplemental information.⁴

The insurance affordability programs are:⁵

- Medi-Cal;⁶

-
1. Welf. & Inst. Code § 15926(b); 42 U.S.C. § 18083; 42 C.F.R. § 435.907. The SAWS 2 Plus application allows individuals to apply for CalWORKs, CalFresh and Medi-Cal through one application so if someone fills this out they do not also have to fill out the Single, Streamlined Application.
 2. 10 CCR § 6470.
 3. 10 CCR § 6470(c).
 4. Statute requires counties to accept the old applications until January 1, 2016 (see Welf. & Inst. Code § 15926 (c)(4)(G)) but DHCS has advised counties to continue to accept and process old applications though they have stopped printing them. See ACWDL 15-34 (Oct. 28, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-34.pdf>.
 5. Welf. & Inst. Code § 15926(a)(3); 42 C.F.R. § 435.4.
 6. Medi-Cal includes both MAGI and non-MAGI Medi-Cal programs. But to undergo an eligibility determination for non-MAGI Medi-Cal, applicants must submit supplemental information not required in the Single, Streamlined Application, such as assets information.

- The Children’s Health Insurance Program (CHIP), which includes:
 - Low-cost Medi-Cal for children who were previously in Healthy Families,⁷
 - County Children’s Health Initiative Program (C-CHIP),⁸ and
 - the Medi-Cal Access Program (MCAP);⁹ and
- Financial assistance (Advanced Premium Tax Credits (APTCs) and Cost-sharing Reductions (CSRs)) for health plans available through Covered California.

Individuals have the right to access and submit the Single, Streamlined Application online, in-person, by phone, mail, or fax. Once someone has applied through the Single, Streamlined Application the state is obligated to determine which of the insurance affordability programs the applicant is eligible.

A Special Note on MCAP

The rules for the Medi-Cal Access Program (MCAP – formerly AIM – Access for Infants and Mothers) were not initially included in the rules engine powering the Single, Streamlined Application. Consequently, pregnant women with incomes over 213% up through 322% FPL were incorrectly determined eligible for Covered California subsidies rather than MCAP or denied eligibility if undocumented. The MCAP eligibility rules were added to the business rules in October 2015 so that women should now get a correct eligibility determination.

Individuals seeking unsubsidized health coverage through Covered California may

-
7. In 2013, California’s CHIP – known then as the Healthy Families Program – was transitioned into Medi-Cal and referred to as the Optional Targeted Low Income Children’s Program, or TLICP. Because CHIP children who are in Medi-Cal have to pay premiums and co-payments it is sometimes now referred to as “low-cost Medi-Cal” or “Medi-Cal for Families.”
 8. This guide does not cover C-CHIP programs as they are only available in San Francisco, San Mateo, and Santa Clara. They will be added to the online CalHEERS application in March 2016 to further achieve the goal of “no wrong door” in those counties.
 9. The Medi-Cal Access Program is a separate CHIP program for pregnant women with incomes over 213% up through 322% FPL. It was formerly called AIM – Access for Infants and Mothers. Undocumented women can qualify.

apply through these same venues. If they indicate up front that they do not want financial assistance, they will have an expedited application process because they will not need to submit certain financial information.

a. Applying Online

Individuals may apply for coverage online at the joint portal: www.coveredca.com.¹⁰ The website includes a number of shopping and enrollment functions and tools:

- “Shop and Compare,” which estimates whether individuals are eligible for free or low-cost Medi-Cal or subsidized Covered California coverage and the cost of available plans based on household size, income and zip code entered;
- Covered California plan selection;¹¹
- Connection with a Certified Enrollment Counselor (CEC) to help with the application; and
- Creation of an online account which can be updated.

The Covered California online application is available in English and in Spanish. Individuals may complete the entire application process online, unless information on the application cannot be electronically verified, in which case the applicant must submit additional documentation.

Individuals may also apply for health coverage as well as public benefits programs through the county online application portal at www.benefitscal.org. While there are no shop and compare tools, individuals can go to www.benefitscal.org to select their residence county and they will be routed to the appropriate portal for their county. The county portals will accept applications for CalFresh and CalWORKs in addition to Medi-Cal. Once the county eligibility worker reviews the case, it will be run through CalHEERS so the person gets evaluated for all insurance affordability programs, not just Medi-Cal, under this pathway.

10. Despite the name of the website, Covered California screens for Medi-Cal, MCAP, and soon C-CHIP programs where available.

11. Plan selection for Medi-Cal and the Medi-Cal Access Program will be added in the future. 42 U.S.C. § 1396a(a)(10)(A)(i)(IX).

CalHEERS, which stands for the California Healthcare Enrollment, Eligibility and Retention System, is the business rules engine (BRE) that powers the online joint application. CalHEERS contains the eligibility rules for MAGI Medi-Cal, CHIP (including MCAP and C-CHIP), and financial assistance for Covered California plans. It is important to know that the MAGI rules are only in CalHEERS; they are not in the counties' own benefits computer systems, so to be determined eligible for MAGI Medi-Cal a case has to be run through the CalHEERS BRE. If someone applies for coverage at a county, the county system will interface with CalHEERS for the MAGI calculation, as well as some verifications.

b. Applying In-Person: County Offices and Community Partners

Individuals may apply in-person by either going to a county social services office or seeking the help of a Certified Enrollment Counselor, an agent or a broker. Covered California does not itself have in-person application sites, but certifies and trains Certified Enrollment Counselors to assist with in-person applications. MCAP also does not have its own in-person application site but is included in Certified Enrollment Counselor trainings and contracts.

For some populations it is best to apply through the county to get the fastest and more reliably correct eligibility results including:

- ***People who want food assistance through CalFresh and/or cash assistance through CalWORKs in addition to health coverage.*** The county eligibility workers can help someone apply for all three at the same time. Such individuals can also apply for all three programs through www.benefitscal.org as noted above.
- ***People who were in foster care in any state when they turned 18.*** Former foster youth are automatically eligible for Medi-Cal until they turn

26.¹² Income and other eligibility rules do not matter for eligibility for this population. CalHEERS was initially built to require former foster youth to go through the full application process and asked unnecessary questions. That has largely been addressed in CalHEERS but the youth will have to give less information if they apply at the county. On the other hand, youth may be able to get Medi-Cal right away applying online if they do not mind having to answer some additional questions.

- ***Some immigrants.*** Some immigrants, including those who have DACA (Deferred Action for Childhood Arrivals) status or may be PRUCOL (Permanent Residence Under Color of Law) as well as refugees, may do better applying in person because there have been some problems in CalHEERS with immigrants and there are additional refugee programs that are only in the county systems.
- ***Non-MAGI Medi-Cal populations, including seniors and people with disabilities.*** Only *counties* can determine eligibility for non-MAGI Medi-Cal. The joint application includes questions to identify those potentially eligible for non-MAGI Medi-Cal and their cases are transferred to the county. Many non-MAGI programs require additional information about resources or disability status so this information can be provided all at once if an applicant applies at the county.¹³
- ***People who speak a language other than English or Spanish.*** The online application is only available in English and Spanish. The paper application is available in all the Medi-Cal threshold languages. Counties can provide language assistance and, on the Covered California website, people can search for a CEC who speaks their language.
- ***Anyone with an “immediate medical need.”*** Individuals with an immediate medical need require health services and would only get services if they have Medi-Cal. Pregnant women are among those who are considered to have an

12. 42 U.S.C. § 1396a(a)(10)(A)(i)(IX); Welf & Inst. Code § 14005.28(a); ACIN I-31-15 (July 22, 2015).

13. Individuals with disabilities should not be discouraged from applying for MAGI Medi-Cal, however, if they are under the income limit. They will not have to provide additional documentation of resources or disability status and may have an easier time renewing their Medi-Cal as well.

immediate medical need.¹⁴

c. Applying by Phone: Covered California Service Center and Counties

Individuals may apply by phone either by calling the Covered California Service Center at (800) 300-1506¹⁵ or their county social service office. Both the service center and counties take telephonic signatures by having the eligibility worker or customer service representative use one of the following methods:

- Check a box in SAWS attesting that the eligibility worker heard the applicant affirm the required elements for a signature;
- Record the entire interview; or
- Record the portion of the interview where the applicant affirms the required elements for a signature.

If an individual calls the Covered California service center to apply for coverage, the customer service representative will perform the “quick sort” – asking a few basic questions to see if the person is likely Medi-Cal eligible. If someone in the family is likely Medi-Cal eligible, Covered California will transfer the customer to their county through a “warm handoff” which involves getting the county worker on the phone for the individual.

d. Applying by Mail: The Single, Streamlined Paper Application

The paper Single, Streamlined Application may be downloaded from either the Covered California or the Medi-Cal website and is available in the twelve written Medi-Cal threshold languages: English, Arabic, Armenian, Chinese, Farsi, Hmong, Khmer, Korean, Russian, Spanish, Tagalog, and Vietnamese.¹⁶ Individuals may print

14. *Medi-Cal Eligibility Procedures Manual*, 4J-1, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/Article4-ApplicationProcess.pdf>.

15. This is the number for assistance in English. Covered California also has designated 800-numbers in the Medi-Cal threshold languages listed on their website <http://www.coveredca.com/get-help/contact/>.

16. Single Streamlined Application: <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/SingleStreamApps.aspx>.

out the application and send fully or partially completed applications to Covered California or a local county office for processing. Those who send in partially completed applications are able to get help filling out the rest of it by calling the Covered California Service Center or county.

Non-MAGI Applications

If an applicant answers a question on the Single, Streamlined Application indicating that they may be eligible for a non-MAGI program, e.g., indicating they are over 65 or have long-term care needs, their application is sent to the county to seek the needed supplemental information for a non-MAGI eligibility determination, such as assets/resources. There is a supplemental form that can be used with the Single, Streamlined Application to collect information needed to determine eligibility for non-MAGI Medi-Cal programs.¹⁷ If someone applies for health coverage using the previous Medi-Cal application – the MC 210 which is being phased out – the county can determine their eligibility for non-MAGI Medi-Cal programs.

2. Expedited Coverage Pathways

A number of pathways are available for immediate access to Medi-Cal coverage. Some of these pathways are only available to particular populations, while others provide temporary coverage based on preliminary information while the individual completes a full application.

a. Accelerated Enrollment (AE)

Accelerated Enrollment allows children under the age of 19 who apply through the Single, Streamlined Application and are likely eligible for Medi-Cal to be enrolled right away in temporary, fee-for-service Medi-Cal while the county makes a final

17. Welf & Inst. Code § 15926(c)(2). For the non-MAGI screening packet, see page 11 of ACWDL 14-18 (Apr. 18, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf>.

Medi-Cal eligibility determination.¹⁸ If the county determines the child eligible, AE is discontinued and Medi-Cal is continued in the appropriate aid code with no interruption in benefits.¹⁹ AE is not time-limited and continues until the county completes the eligibility determination and either terminates AE at the end of that month if the child is ineligible for ongoing Medi-Cal or transfers the case into the appropriate aid code for ongoing Medi-Cal.

Children do not need to be citizens or immigrants otherwise eligible for full-scope Medi-Cal to get AE. Documentation showing citizenship or immigration status is not needed for the initial AE screen, but will be necessary to determine ongoing Medi-Cal eligibility. However, children who appear in the State's computer system ("MEDS") to only be eligible for restricted-scope Medi-Cal are not eligible for AE.

The child's Medi-Cal will be in Aid Code 8E. AE is full-month eligibility. This means that if a child gets Medi-Cal in AE on March 10th, for example, they have Medi-Cal from March 1st to the 31st. This includes coverage of services provided after a determination of eligibility for ongoing Medi-Cal is completed, as well as for services provided before the AE was processed. AE also includes a retroactive coverage period of up to three months prior to the month of application, if requested and if the child was Medi-Cal eligible in those months. If a county determines ongoing eligibility, the case will not be transferred into the appropriate ongoing aid code until the first of the following month.

b. Deemed Eligible (DE) Infants

Under federal law, newborns born to mothers on Medi-Cal are "deemed eligible" (DE)

18. Welf. & Inst. Code § 14011.6; ACWDL 02-36 (Apr. 18, 2002), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c02-36.pdf>. Both this code section and the ACWDL refer to the "single point of entry" which was the processing entity for the old Medi-Cal/Healthy Families children's health coverage application. That has been replaced by the Single, Streamlined Application.

19. ACWDL 02-36 (Apr. 18, 2002), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c02-36.pdf>.

for Medi-Cal for their first year of life.²⁰ They must be enrolled in Medi-Cal without an application.²¹

To enroll a baby through DE, a parent, provider or other person at the family's request notifies the county that the baby was born. This can be done by telephone, through use of the Newborn Referral Form,²² the CHDP Gateway (see Section A.2.e. below), or other contact with the county advising of the baby's name, sex and date of birth and the mother's Medi-Cal information.²³ No other information or verification is needed; if the county finds the mother had Medi-Cal on the baby's date of birth, the baby is automatically enrolled. Even if the baby is no longer living with the mother when the county is advised of the birth, if the mother was on Medi-Cal on the day of birth, the baby must be enrolled in Medi-Cal.²⁴ The baby is eligible for Medi-Cal until their first birthday at which time the county must determine whether the baby continues to be eligible. Even if the mother loses Medi-Cal in the baby's first year, the baby remains eligible during the whole first year.

DE infants can also be identified through the CHDP Gateway.²⁵ When that happens, the infant is automatically enrolled in on-going Medi-Cal, with their own final Medi-Cal eligibility number, in real time.²⁶ See Section A.2.e.

c. Hospital Presumptive Eligibility²⁷

Certain hospitals may provide "presumptive eligibility" determinations for individuals

20. 42 U.S.C. § 1396a(e)(4); ACWDLs 09-17 (Apr. 12, 2009) <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c09-17.pdf>, 03-49 (Oct. 6, 2003), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c03-49.pdf>, and 91-79 (Nov. 4, 1991), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c91-79.pdf>.

21. *Id.*; 22 CCR § 50262.3.

22. The Newborn Referral Form, MC 330 (1/15), can be downloaded at: http://www.dhcs.ca.gov/formsandpubs/forms/Forms/MCED/MC_Forms/MC330_Eng.pdf

23. ACWDL 03-49.

24. ACWDL 09-17.

25. ACWDL 05-02 (Feb. 17, 2005), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c05-03.pdf>.

26. ACWDL 04-02 (February 14, 2004), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c04-02.pdf>. See page 2 of the ACWDL for "permanent modification" to the CHDP Gateway to identify and enroll deemed eligible infants.

27. DHCS ACA Hospital Presumptive Eligibility (PE) Program resources: http://files.medi-cal.ca.gov/pubsdoco/aca/aca_HPE_landing.asp.

eligible for MAGI Medi-Cal: children, pregnant women, parents, caretaker relatives, expansion adults, and former foster youth. These determinations enable temporary but immediate enrollment into Medi-Cal based on preliminary information.²⁸

Hospitals must be Medi-Cal providers approved by the Department of Health Care Services to make presumptive eligibility determinations. Individuals complete the Hospital PE Application – a one-page form attesting to income, household size and state residency – either in paper form or with a hospital staff member entering the information electronically. Hospitals submit application information through the Hospital PE Application Web Portal for processing – checking that applicants do not show in the Medi-Cal Eligibility Data System (MEDS) as having coverage and that they meet the basic eligibility criteria. Hospitals should receive a real-time eligibility response indicating approval or denial of presumptive eligibility. If applicants are eligible, they are given an “Immediate Need Eligibility Document,” which functions as a Medi-Cal card. These individuals receive full scope Medi-Cal benefits.

Temporary Medi-Cal eligibility through Hospital PE lasts up to 60 days, beginning the first day of the month the Hospital PE application is approved and ending the last day of the following month. MEDS automatically terminates Hospital PE eligibility on the last day of the following month in which the PE determination was made unless the individual has filled out a full Medi-Cal application and the county has sent a transaction to MEDS documenting that application.²⁹ Once the full Medi-Cal application is submitted the presumptive eligibility is extended until the application is processed.

Enrollment in the Hospital PE program is limited to one enrollment in a twelve-month period except that pregnant women may access the program once in a twelve-month period per pregnancy for ambulatory prenatal services.

28. 42 U.S.C. § 1396a(a)(47); 42 C.F.R. § 435.1110; Welf. & Inst. Code § 14011.66; ACWDL 14-14 (Mar. 27, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-14.pdf>.

29. ACWDL 14-14; MEDIL 14-48 (Oct. 1, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-48.pdf>.

d. Presumptive Eligibility (PE) for Pregnant Women

Low-income, pregnant women and teens may also access immediate, temporary Medi-Cal coverage for prenatal care based on preliminary information.³⁰

Pregnant women and teens complete the PE for Pregnancy Application (MC 263) – attesting to basic information on residency and income – at the office of their prenatal provider. As with the full Medi-Cal application, each expected child counts as a family member, so a pregnant woman is always at least a household of two, and a woman, for example, who is carrying twins and is married would be counted as a family of four in determining the applicable household size and income level for eligibility.³¹ There is no verification; self-attestation is sufficient. Pregnant women and teens who are presumptively eligible receive a temporary eligibility card from the provider to cover presumptive eligibility benefits. PE Medi-Cal covers pregnancy tests, ambulatory (out-patient) prenatal care, prescription drugs for conditions related to pregnancy, out-patient abortion procedures and dental services. Services not covered under presumptive eligibility include: inpatient services, family planning and delivery. If a pregnant woman needs a procedure that is not a PE benefit, she should apply for Medi-Cal and make it retroactive to cover any months (up to three months back) in which she received services.

Presumptive Eligibility for pregnant women initially lasts for the month in which it is given through the end of the following month. As long as the pregnant woman has submitted a Medi-Cal application, the provider may extend her PE period for another two months as many times as necessary until the Medi-Cal application is either approved or denied.

Pregnant teenagers can get Presumptive Eligibility. If they are living by themselves, only their income will count. If they are living with their parents, their income will be counted as well. Teens living with parents whose household income are over 213% FPL may still qualify under the Parental Income Disregard Program for Women under

30. 42 U.S.C. § 1396r-1; Welf. & Inst. Code § 14148.7; ACWDLs 95-74 (Nov. 23, 1995), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c95-74.pdf> and 93-78 (Oct. 27, 1993), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c93-78.pdf>.

31. See Chapter 2, Section A for more on household counting rules.

21 needing pregnancy-related care.³² A teenager living with her parents who wishes to receive confidential services, can apply for the Minor Consent program. See Chapter 3, Section D.1.

The PE for Pregnancy Program was operated completely on paper until November 1, 2015. As of November 1 there is an electronic Prenatal Gateway.³³ Providers will have to convert to this e-system by February 1, 2016.

e. CHDP Gateway

CHDP is the Child Health and Disability Prevention Program. See Chapter 3, Section D.3 for a description of the CHDP program itself. The CHDP “Gateway” provides children with immediate, free, temporary full-scope Medi-Cal through presumptive eligibility when providers pre-enroll them at the time of a “periodic visit” for preventive screenings through an electronic application process at a health care provider’s office.³⁴

Families complete the Pre-Enrollment Application (DHCS 4073) with CHDP providers. The application form is a one-page form that asks for the child’s name, household size, family income and information about the parents. There are no questions about immigration status on the application but children who are identified in MEDS as only eligible for restricted-scope Medi-Cal because of immigration status are not eligible to be pre-enrolled in Medi-Cal through the CHDP Gateway.³⁵ However, they are still entitled to CHDP services. There is no verification as part of the CHDP Gateway; self-attestation of information is sufficient. CHDP providers submit the pre-enrollment applications through the CHDP Gateway electronic interface. Eligible children will be given an Immediate Need Document, a receipt showing their eligibility for Medi-Cal

32. ACWDL 03-34E, (Aug. 3, 2004), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c03-34e.pdf>. See Chapter 3, Section D.2 for a description of the Parental Income Disregard program.

33. See the Presumptive Eligibility website for more information about recent program changes: <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/PE.aspx>.

34. Welf. & Inst. Code § 14011.7; ACWDL 03-33 (Jun. 18, 2003), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c03-33.pdf>.

35. This is expected to change with the implementation of SB 75 in May 2016 that extends full-scope Medi-Cal to all children regardless of immigrations status, though details of the implementation were not finalized at the date of publication.

that they can use for services. Children will also receive a temporary Medi-Cal card in the mail.³⁶

Coverage consists of full-scope Medi-Cal and lasts for the month in which it is given through the end of the following month. Families must fill out a full Medi-Cal application before the end of the second month to continue the child's Medi-Cal benefits beyond the initial period.³⁷ Those that have submitted the full Medi-Cal application will have their children's coverage extended until an eligibility determination is made.

If a child meets the eligibility requirements for the Gateway program and the child's record in the MEDS computer system shows that the child has other health coverage (or OHC), the Other Health Coverage will *not* be used to deny payment or request for services from a Medi-Cal provider as it does in other scenarios where the beneficiary has additional coverage.³⁸ The state will override the OHC code in MEDS during the months that the child is pre-enrolled through the Gateway program to ensure that the child will be able to receive Medi-Cal covered services regardless of the OHC status and so that the provider will be paid. This override will then be removed by MEDS in the month after the child is determined eligible or ineligible for ongoing Medi-Cal.³⁹

Deemed Eligible infants⁴⁰ can also be identified through the CHDP Gateway. When that happens, the infant is automatically enrolled in on-going Medi-Cal, with their own final Medi-Cal eligibility number, in real time.⁴¹

Effective July 31, 2015, a child may be pre-enrolled into full-scope Medi-Cal through the CHDP Gateway only two times a year.⁴² The practical effect is to limit opportunities for infants under the age of 18 months to enroll in temporary full-scope

36. ACWDL 03-33, p. 5.

37. *Id.* at p.3.

38. *Id.* at p. 7.

39. *Id.* at pp. 7 & 8.

40. See Section A.2.a above.

41. ACWDL 05-02 (Feb. 17, 2005), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c05-03.pdf>.

42. MEDIL 15-26 (Aug. 28, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-26.pdf>; CHDP Provider Information Notice (August 12, 2015).

Medi-Cal or, if under 12 months, be screened for deemed eligibility, since all other children qualify for only one CHDP visit a year based on the periodicity schedule.⁴³

f. Accelerated Eligibility (AE) for Federal Breast and Cervical Cancer Treatment Program (BCCTP)

California has two Breast and Cervical Cancer Treatment Programs (BCCTPs) for low-income persons who have been diagnosed with breast or cervical cancer. One is a federal Medicaid optional program that provides women with immediate, full-scope, no-cost Medi-Cal, which is commonly referred to as Federal BCCTP.⁴⁴ The other is a state-only funded program, commonly known as State BCCTP, which provides time-limited, cancer-related Medi-Cal to low-income uninsured or underinsured women and men.⁴⁵ See Chapter 3, Section E.1 for more information regarding the eligibility criteria for both BCCTPs.

Unlike other Medi-Cal programs, a person cannot apply for BCCTP at a county welfare office or through Covered California.⁴⁶ Eligible applicants are screened and enrolled into BCCTP by authorized health care providers, who file an online application on behalf of the applicant. The application is then evaluated by a state eligibility specialist at the Department of Health Care Services.

Only providers who participate in either of the following cancer detection programs may enroll applicants in BCCTP:

- Every Woman Counts (EWC), or
- Family Planning Access Care and Treatment (Family PACT).⁴⁷

If a person has been diagnosed with breast or cervical cancer but the provider is not

43. <http://www.dhcs.ca.gov/services/chdp/Documents/HealthPeriodicity.pdf>.

44. Welf. & Inst. Code § 14007.71.

45. Health & Safety Code §§ 104161, et seq.

46. If a person applying for Medi-Cal at a county office appears to be eligible for BCCTP, the county worker should refer the person to the BCCTP toll-free number 1-800-824-0088. ACWDL 06-09 (Feb. 24, 2006) at p.6, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c06-09.pdf>. Note that this is also DCHS's toll-free line for information regarding presumptive eligibility for Medi-Cal for pregnant women.

47. ACWDL 06-09.

with Every Woman Counts or Family PACT, the person must still see an Every Woman Counts or Family PACT provider who can confirm the diagnosis and submit the BCCTP application through an online, Internet-based application process.⁴⁸

Advocacy Tip: To find a provider who participates in Every Woman Counts or Family PACT: Call the Department of Health Care Services' Every Woman Counts referral line at 1-800-511-2300.

The provider submits the online application on behalf of the applicant and then the provider receives a confirmation document that indicates eligibility. If the person appears to be eligible for *Federal* BCCTP, she will be granted Accelerated Eligibility (AE).⁴⁹ Accelerated Eligibility allows an eligible woman to be immediately enrolled in temporary full-scope no-cost Medi-Cal and receive a Benefits Identification Card (BIC) in the mail within four business days.⁵⁰ She will remain enrolled until the state or county makes a final determination of her eligibility for BCCTP, *unless* she indicates on the online application that she does not want continuing Medi-Cal, in which case the AE coverage will end on the last day of the following month.

Advocacy tip: A person must answer “yes” to the question on the online application asking if the person wants continuing Medi-Cal, so that their full-scope Medi-Cal will continue under AE until the state determines them ineligible.

When an individual applies and does not appear to be eligible for Federal BCCTP, then an eligibility specialist at the Department of Health Care Services will complete

48. Medi-Cal Informational Notice 372 (Sept. 2009).

49. There is no Accelerated Enrollment for state-only BCCTP.

50. Welf. & Inst. Code § 14007.71(a). Once enrolled through AE, the person can use the confirmation document received at the time of the online application to obtain medical services. ACWDL 06-09 at p.6. The Aid Codes for AE through Federal BCCTP are OM (eligibility limited to two months) and ON (continuing eligibility under AE while a Federal BCCTP eligibility determination is made).

an eligibility determination for State BCCTP and establish the appropriate time limited coverage and scope of benefits in order for the person's coverage to begin.⁵¹

g. Express Lane Enrollment (ELE)

The Department of Health Care Services obtained a waiver under a federal option to enroll some people who are receiving CalFresh benefits into Medi-Cal for twelve months without requiring any additional information.⁵² To qualify the person must be under the age of 65, neither blind nor disabled, and not receiving Medi-Cal or Medicare. The aid codes are 7U for adults 19-64 and 7W for children under the age of 19.

In 2014, the Department of Health Care Services mailed notices to people receiving CalFresh but not Medi-Cal informing them of their ability to opt into Medi-Cal by phone, by mail, or online. People receiving CalFresh benefits can also opt into Medi-Cal at a county social services office. Medi-Cal coverage is effective on the first day of the month they opt into coverage. Someone who did not receive the mailing but who has CalFresh can request Medi-Cal coverage and the county should process that request, again without asking for any additional information.

The CalFresh application and recertification form, CF 285, allows applicants and beneficiaries applying for or renewing CalFresh to check a box that they want the information used to determine their Medi-Cal eligibility. CF 285 forms received by counties where the applicant or beneficiary checked the Medi-Cal box are to be treated as an Express Lane application and the person should get Medi-Cal if they are under 65 years and are eligible for CalFresh. On the SAWS2Plus application for multiple programs (CalFresh, CalWORKs and Medi-Cal), someone can check in the "Medi-Cal Health Care" question 6 that they want Medi-Cal, can skip the health care-specific questions, and will receive ELE Medi-Cal if they are found eligible for CalFresh. If the applicant chooses that route and is found ineligible for CalFresh, they will have Medi-Cal for at least a year and, at renewal, the county will send them

51. Health & Safety Code §§ 104162(e) and 104162.2.

52. CMS State Health Official Letter #13-003, "Facilitating Medicaid and CHIP Enrollment and Renewal in 2014" (May 17, 2013), <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-003.pdf>; Welf. & Inst. Code § 14005.66; ACWDL 14-06 (Feb. 21, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-06.pdf>.

a Request for Tax Household Information (RFTHI) form to determine their eligibility for Medi-Cal.

If someone who enrolled into Medi-Cal through Express Lane Eligibility loses their CalFresh, the county should send them a RFTHI form to process their eligibility for MAGI Medi-Cal. The person stays in Express Lane Enrollment Medi-Cal while the form is being processed. By the person's twelfth month of Express Lane Enrollment Medi-Cal eligibility, the county must do a Medi-Cal redetermination and determine their eligibility under the Medi-Cal rules rather than simply relying on CalFresh enrollment.

h. Children in Foster Care

The County is responsible for ensuring that the health care needs of children in its foster care program are met. Children in foster care should be granted expedited Medi-Cal eligibility upon removal from their homes so they can quickly access any needed health care.⁵³ If the child was already on Medi-Cal when removed from home but does not have access to their Medi-Cal card, the county must issue immediate proof of Medi-Cal eligibility or a new Medi-Cal Benefits Identification Card (BIC) at the request of the child's foster care worker or foster parent.⁵⁴ For children who are not in foster care, the County must process the Medi-Cal application within 45 days.⁵⁵

i. Former Foster Youth

Since January 1, 2014, individuals in foster care on their 18th birthday must

53. Welf.& Inst. Code § 14007.45 (which exercises a federal Medicaid option under 42 U.S.C. § 1396r-1a); ACWDL 01-41 (Jul. 25, 2001), at p. 2, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c01-36.pdf> ("Each county should appoint a Foster Care Coordinator in the Medi-Cal eligibility agency to ensure that foster care workers and child protective service workers who are involved in the removal of a child from the home, have a contact within the eligibility agency to expedite the issuance of proof of eligibility for the child.")

Some counties have adopted their own policies to issue Medi-Cal cards within 24 hours.

54. ACWDL 01-41. Also, foster care children are eligible for 12 months of Continuous Eligibility for Children (see Chapter 3, Section C.16). ACWDL 02-20 (Apr. 5, 2002), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/02-20c.pdf>.

55. 42 C.F.R. § 435.911; 22 CCR § 50177(a)(1).

automatically be enrolled in Medi-Cal under the Former Foster Care Children's (FFCC) Program, without any interruption in coverage, without requiring a new application, and without having to provide additional information.⁵⁶ Foster youth who are about to exit the foster care system are to be screened to ensure that their Medi-Cal coverage is active; that they are moved to aid code 4M once they exit foster care and have a Medi-Cal Benefits Identification Card (BIC); and are informed of their right to stay on Medi-Cal until they are 26.⁵⁷

If an individual has previously aged out of the FFCC Program aid code 4M when the program ended at age 21, but is under age 26, they still qualify until the month of their 26th birthday.⁵⁸ In an effort to maintain coverage for the approximately 1,000 former foster youth who were going to age out of the FFCC Program at age 21 prior to January 1, 2014, the state created a "bridge" where former foster youth who turned 21 years old between July 1, 2013 and December 31, 2013 were to retain their Medi-Cal Aid Code 4M coverage.⁵⁹

Individuals eligible for coverage must meet the following criteria:

- Were in foster care on their 18th birthday,
- Are not enrolled in the foster care system,
- Are not in Medi-Cal, and
- Are under the age of 26.

56. Welf. & Inst. Code § 14005.28(a)(1); ACIN I-31-15 (Jul. 22, 2015), <http://www.dss.cahwnet.gov/lettersnotices/EntRes/getinfo/acin/2015/I-31-15.pdf>; ACWDL 14-41 (Feb. 5, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-41.pdf>; MEDIL 14-05 (Jan. 17, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-05.pdf>; MEDIL 13-07 (Jun. 28, 2013), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL%2013-07.pdf>. Individuals who were previously enrolled in aid codes 40, 42, 43, 45, 46, 49, 4C,4H, 4L, 4N, or 5K are all eligible under the ACA FFCC extension with aid code 4M up to the age of 26.

57. ACIN I-31-15.

58. MEDIL 14-05.

59. MEDIL 13-07.

They may apply online through Covered California⁶⁰ or go to their local county office and identify themselves as a former foster youth. Such applicants may use the simplified one-page Medi-Cal application form MC 250A specifically for former foster youth, or the county worker may obtain the necessary information verbally, over the phone, electronically, by mail or fax.⁶¹ Applicants may self-attest to having been in foster care at age 18 and should be immediately enrolled in coverage.⁶² The county has 30 days to verify prior foster care status from any county, state (if not California) or tribe where the individual was in foster care and that the child was enrolled in Medicaid at the time of aging out of foster care.⁶³

j. Minor Consent Medi-Cal

A child under 21 who lives at home with a parent may obtain the limited-scope Minor Consent Medi-Cal by applying for the program benefit at the county welfare office and by completing a form called Request for Eligibility for Limited Services (MC 4026) and the Statement of Facts (the MC 210).⁶⁴ The minor must contact the eligibility worker each month to continue the services and fill out an MC 4026 form, though the

60. The California Healthcare Enrollment, Eligibility and Retention System (CalHEERS) was not initially programmed to disregard income determinations for former foster youth, so in 2014 and through much of 2015 former foster youth were advised to apply for coverage at the county instead. MEDIL 14-05. But in October 2015, a system fix was made to CalHEERS so that former foster youth could apply online and have their eligibility determined for the FFCC Program. And as of February 2016, former foster youth will be allowed to skip unnecessary questions such as about income and taxes on the online application.

61. ACWDL 14-41 (Feb. 5, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-41.pdf>; MEDIL I 14-05 (Jan. 17, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-05.pdf>.

62. ACWDL 14-41. “Prior foster care status can be attested to by the FFCC applicant at the time of application and verified later by the county. If the individual applies as a FFCC applicant, the county is to immediately determine the individual eligible for FFCC program based on self-attestation.”

63. ACWDL 14-41; MEDIL 14-05.

64. 22 CCR § 50147.1(b); *Medi-Cal Eligibility Procedures Manual*, 4V-2. While the MC 210 is no longer generally in use, this is an easier application to use than the Single Streamlined Application and some counties at least have copies on hand to use for Minor Consent Services applications. But it may soon no longer be accepted for this purpose. See Chapter 3, Section D.1 for the scope of services covered by the Minor Consent Program (pregnancy related services, family planning, treatment for sexual assault, rape, sexually transmitted diseases, drug and alcohol abuse treatment, and outpatient mental health services, including counseling).

minor need not sign the form every month.⁶⁵

To obtain mental health counseling services a minor must request these services through the County Mental Health Plan, which is responsible for authorizing all mental health services for Medi-Cal beneficiaries in California.⁶⁶

Advocacy Tip: To receive mental health services under the Minor Consent program, the minor should call the the County Mental Health Plan Access Line in their county and request an assessment or evaluation under Medi-Cal Minor Consent (also called “Sensitive Services”). If the County Mental Health Plan refuses to schedule such an assessment, the advocate should file a grievance.

No notices or mail should be sent to the minor’s home address. The child can provide the county with an alternative address to send information to, if necessary. However, applicants receive a paper Medi-Cal card that gets reactivated monthly and notices of action are issued by the worker in person, so there is no real need for an alternative address.

The minor should not need to present identification documents, a social Security number, pregnancy verification or proof of residency. Documentation of immigration status is not required for Minor Consent Medi-Cal.⁶⁷ Income and property verification are required for minors who are employed or who have bank accounts.⁶⁸ Minors do

65. *Medi-Cal Eligibility Procedures Manual*, 4V-4.

66. See DMH Information Notice 98-09, (July 3, 1998), <http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice98-09.pdf>; also note 22 CCR § 50147.1(c), which sets forth a specific process by which a minor must obtain a statement from a mental health provider indicating that they meet specific criteria for the treatment is, in essence, obsolete because Medi-Cal mental health services are “carved out” from other health services (*i.e.*, there is a separate managed care system) and all persons seeking mental health services must request these services from the County Mental Health Plan (MHP). For more information on the mental health managed care carve out for Medi-Cal, visit the Disability Rights California website at www.disabilityrightsca.org, *e.g.*, Publication # 5495.01, January 2014).

67. *Medi-Cal Eligibility Procedures Manual*, 4V-2.

68. See *Medi-Cal Eligibility Procedures Manual*, 4V-3.

not have to provide verification for accounts they do not have access to.⁶⁹

Family Planning Services. For family planning services, a minor can seek services through Family Planning, Access, Care and Treatment program (Family PACT), a government program that provides free and confidential family planning services. Call 1-800-541-5555 for more information or to find a provider. For more information about Family PACT, visit the website at <http://www.familypact.org/>.

k. Tuberculosis (TB) Program

There is a special application form for the Tuberculosis Program, MC 274 TB, which is available at the county welfare offices and at providers' offices. On the application, the physician or her designated staff must certify that the individual is infected with tuberculosis. Most applications are submitted by community clinics where tuberculosis infected patients are seen. For more information on the TB program, see Chapter 3, Section E.2.

3. Medi-Cal Connections with Public Benefits Programs

a. Programs Linked to Medi-Cal

Eligibility for some programs, e.g., CalWORKs and SSI, automatically make someone eligible for Medi-Cal. If a family receives CalWORKs benefits they receive Medi-Cal without having to file a health care application.⁷⁰ Similarly, if a person is already receiving SSI or IHSS they are categorically linked to Medi-Cal so they automatically get Medi-Cal without having to apply separately.⁷¹ People on CalWORKs, SSI or IHSS will get a Medi-Cal card, welcome packet, and health plan choice packet.

69. *Id.*

70. Welf. & Inst. Code § 14005.30.

71. 42 U.S.C. § 1396a(a)(10)(A)(i)(II); 42 C.F.R. § 435.120 (SSI); Welf & Inst. Code § 12305 (IHSS).

If someone loses their cash aid through CalWORKs or SSI, the county must determine whether they are still eligible for Medi-Cal before terminating their coverage.⁷² Most families that are leaving CalWORKs should have their Medi-Cal eligibility extended for at least 6-months through the Transitional Medi-Cal program. For information regarding Transitional Medi-Cal, see Chapter 3, Section C.5.

b. Joint Application for Health Coverage and Public Benefits

The SAWS2 PLUS Application can be used to apply for Medi-Cal, CalWORKs and CalFresh on one application. It replaces the old SAWS2 form by including the tax household questions needed for MAGI income determinations. People can also apply online for Medi-Cal, CalWORKs and CalFresh simultaneously at www.benefitscal.org.

4. Application Process and Eligibility for Inmates

Medi-Cal beneficiaries who become inmates at public institutions have their Medi-Cal enrollment suspended temporarily, for up to one year, and then unsuspending when they are released.⁷³ In addition, assistance with applying for health coverage is provided when inmates in public institutions are close to being released.⁷⁴

An agreement between the Department of Health Care Services and the California Department of Corrections and Rehabilitation requires that the corrections department assist inmates with filling out the paper Single, Streamlined Application 60-90 days before the scheduled release. Inmate applicants designate the

72. Welf. & Inst. Code § 14005.37; *Craig v. Bonta*, S.F. Superior Ct., No. CFF 02 500688; ACL 03-52 (Oct. 6, 2003), <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl03/pdf/03-52.pdf>; ACL 03-25 (May 29, 2003), <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl03/pdf/03-25.pdf>; ACL ,03-24 (May 20, 2003), <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl03/pdf/03-24.pdf>; ACL 02-54 (Jul. 18, 2002), <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl02/pdf/02-54.pdf>; ACL 02-45 (Jun 25, 2002), <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl02/pdf/02-45.pdf>. The county will also screen for other insurance affordability programs so if someone is over income for Medi-Cal the county will advise if they are eligible for MCAP or Covered California.

73. Welf. & Inst. Code § 14011.10.

74. Penal Code § 4011.11; ACWDLs 14-24 (May 6, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-24.pdf> and 09-16 (Apr. 1, 2009), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c09-16.pdf>.

corrections department representative as their Authorized Representative for the application and the corrections department submits the application to the county with a cover letter designating it as a pre-release application for special handling. If determined eligible, a Medi-Cal Beneficiary Identification Card (BIC) is issued while the applicant is still an inmate to allow them to access services as soon as they are released.⁷⁵ Similar application processes are used locally for jail inmates who require services during incarceration or post-release.

B. Verifying Application Information

When an individual applies for health coverage through the Single, Streamlined Application they are told that the information on the application will be verified using state and federal databases.⁷⁶ The state CalHEERS system links to a federal Data Services Hub (“federal verification hub”) and applications are sent through that hub to attempt to verify income, Social Security number, and citizenship or immigration status. The federal verification hub links to the Internal Revenue Service, the Social Security Administration and the Department of Homeland Security. CalHEERS and the county eligibility systems also link to some state data sources used to verify application elements. Below we discuss how various application elements are verified and which ones allow self-attestation. If an applicant is allowed to self-attest information it means that the applicant’s reporting of information on an application is sufficient and documentation is not needed. Applications must be accepted without verification.⁷⁷

1. Overview of Process and Requirements

a. Medi-Cal

Applicants are not to be asked for verification of information that can be obtained through one of the electronic databases to which CalHEERS links.⁷⁸ For Medi-Cal, in addition to running the electronic verifications, the county must conduct an *ex parte*

75. *Id.*

76. 10 CCR § 6470(e)(3).

77. 10 CCR § 6504(e).

78. Welf. & Inst. Code § 14013.3(b).

check on data to which they have access including a family member's Medi-Cal file, or the applicant or family member's information with Covered California, CalFresh or CalWORKs, before requesting documentation from an applicant.⁷⁹

If citizenship or immigration status cannot be verified but the applicant is otherwise eligible, the individual is granted full-scope benefits and provided with a "reasonable opportunity period" to supply additional information.⁸⁰ During this period, the counties send at least two ten-day requests to the applicant requesting verification information.

Applicants whose immigration status are not verified should have their scope of benefits revised by the county from full-scope Medi-Cal to restricted-scope Medi-Cal rather than have their Medi-Cal terminated.⁸¹ If they are subsequently able to provide proof of their immigration status, the county should change their scope of benefits to full scope.⁸²

For all other eligibility criteria that cannot be verified, the applicant is sent a notice requesting additional information to continue processing the application. Individuals can fax or mail requested documentation to their county social services office. They can also upload documents on the Covered California website.

b. Medi-Cal Access Program

MCAP regulations require only verification of income.⁸³ If electronic verification of

79. Welf. & Inst. Code § 14013.3(b).

80. Welf & Inst Code § 14007.5; 22 CCR § 50301.5; ACWDL 07-12 (Jun. 4, 2007), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c07-12.pdf>.

81. MEDIL 14-21 (Mar. 25, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-21.pdf>.

82. *Id.*

83. See 10 CCR § 2699.201. MCAP's governing statutes now lie at Welfare and Institutions Codes sections starting at Section 15810. The MCAP regulations however have not been updated since DHCS began administering the program and electronic verification via CalHEERS became available. Although the regulations seem to require paper documentation of income, once MCAP was moved into CalHEERS, it has been treated like the other insurance affordability programs and an attempt to electronically verify income is made prior to requesting paper documentation. MCAP is available regardless of immigration status, so no verification of qualified status is needed.

income is not available, individuals must provide paper documentation. All other information on the application requires only self-attestation.⁸⁴

c. Covered California

If information on an application is not available or reasonably compatible with information verified through CalHEERS, Covered California uses the following process to attempt to resolve the lack of data or inconsistency.

First, Covered California must make a “reasonable effort” to identify and address the causes of the lack of electronic information or the inconsistency, including typographical or other clerical errors, by contacting the applicant to confirm the accuracy of the information on the application.⁸⁵ If this does not address the problem, Covered California must send the applicant a notice about the inconsistency and request documentation to resolve it.⁸⁶ The applicant has 95 days to provide the information.⁸⁷ This time period can be extended if the applicant has made a good faith effort to obtain the information.⁸⁸ Applicants, with or without an application assistor’s help, can upload documents to their online account, send Covered California a copy via fax, or mail the documents to Covered California. Applicants should never mail the original version of the documents requested.

If applicants need more than 95 days, or if they do not have the document requested, they can call the Service Center and explain that they need additional time. After the documents are received by Covered California, the individual will be notified by a message in their online account. If there is a problem with an individual’s document or the electronic verification process again, a Covered California representative will contact them by mail or telephone to continue to resolve the problem.

84. *Id.*

85. 10 CCR § 6492(a)(1).

86. 10 CCR § 6492(a)(2). Notices may be sent to applicants via e-mail or to their CoveredCA.com account instead of U.S. mail. Covered California must contact the applicant with the communication method chosen by the applicant. See 42 C.F.R. § 435.918 and 45 C.F.R. § 155.230(d).

87. 10 CCR § 6492(a)(2).

88. 10 CCR § 6492(a)(3).

Pending resolution of the disputed eligibility element, Covered California must process the application based on the applicant's attested information and grant eligibility if the applicant is otherwise eligible.⁸⁹ During the reasonable opportunity period, the CalHEERS system should allow the applicant to select and enroll in a plan.

If the applicant is eligible for premium tax credits and cost-sharing reductions, their premium payment should incorporate the advanced premium tax credit amount based on the applicant's attested income and the applicant should be allowed to enroll in the cost-sharing reduction plan that corresponds to their income. If verification is pending, Covered California must inform the applicant that if they are later found ineligible for premium tax credits, they will have to report the advanced premium tax credits received at tax filing and may be required to re-pay the amount they received.⁹⁰

If, at the end of the reasonable opportunity period, the missing or incomplete information has not been verified, Covered California will make an eligibility determination based on the information on the application and from the electronic data sources and advise the applicant of this determination.⁹¹ For inconsistencies not involving immigration or citizenship, Covered California can, on a case-by-case basis, rely on the attested information on the application if the applicant cannot access documentation.⁹²

2. Verification of Eligibility Criteria⁹³

a. Proving Identity

89. 10 CCR § 6492(a)(4).

90. 10 CCR § 6492(a)(4)(B). The IRS limits the amount of repayment required for those with incomes below 400% of the federal poverty level. 26 U.S.C. § 36B(f)(2)(B); 26 C.F.R. § 1.36B-4(a)(3)(ii). See Chapter 4 for more on the reconciliation process for premium tax credits.

91. 10 CCR § 6492(a)(5).

92. 10 CCR § 6492(b).

93. CMS, "Medicaid/CHIP MAGI-based Eligibility Verification Plan," <http://www.medicaid.gov/medicaid-chip-program-information/program-information/eligibility-verification-policies/downloads/california-verification-plan-template-final.pdf>.

When applying for health coverage through any of the venues, an applicant must first prove their identity – a process referred to as “Remote Identity Proofing.” For individuals applying through the paper application, they must sign their application under penalty of perjury, including that they are who they say they are.⁹⁴ When applying through any other venues, applicants must first agree to have their identity verified.⁹⁵ The verification can be done in one of two ways. One option is for the applicant to present information proving her identity in person, by mail or uploading the documentation. For example, the applicant could show someone, send in or upload a driver’s license or valid identification card with a photo. The regulations specify what types of documentation can be submitted.⁹⁶

The other option to verify identity is to go through the Federal Data Service Hub Remote Identity Proofing Service.⁹⁷ This is a separate service that uses credit information to ask individuals a series of personal questions that help identify that the applicant is who they say they are such as questions about previous addresses or accounts. A credit check is not actually run but the credit security questions are used. If the online service cannot verify the applicant’s identity, they will have to prove their identity in an alternative way before they can complete the application.⁹⁸ For those who cannot verify their identity through the online service, they can fill-out a paper application or verify their identity in person.⁹⁹

Once the applicant completes the identity verification process, they can continue the application for themselves and their household.¹⁰⁰ The rest of the household will not have to go through identity verification.¹⁰¹ Advocates assisting individuals who have no banking record or are very recent immigrants to the United States should advise them of the other options for verifying identity as Remote Identity Proofing is more difficult for these groups.

94. 10 CCR § 6464(b).

95. 10 CCR § 6464(c)(1).

96. 10 CCR § 6464(c)(2)(A).

97. 10 CCR § 6464(c)(2)(B).

98. 10 CCR § 6464(c)(3).

99. 10 CCR § 6464(c)(3)(B), (C).

100. 10 CCR § 6464(d).

101. *Id.*

b. Citizenship and Immigration Status

Individual seeking financial assistance from Covered California or enrollment in most full-scope Medi-Cal programs must provide proof of citizenship or lawful immigration status.¹⁰² In addition, individuals who are applying for certain health coverage programs must provide a Social Security number to be eligible and as proof of identity in order for Covered California to access their federal electronic data.¹⁰³ These two separate eligibility requirements apply only to individuals in the household who are seeking coverage.

Note on Non-Applicants: In most cases, individuals applying on behalf of another household member are considered non-applicants and are not required to provide their Social Security number nor attest to and provide proof of citizenship or lawful status.¹⁰⁴ However, non-applicants may be required to provide their Social Security number in order to have their identity electronically verified, or in certain cases, verify household income.¹⁰⁵ See "Proving Identity" section above.

i. Proof of Citizenship

Most U.S. citizens who are applying for health coverage can have their citizenship

102. 45 C.F.R. § 155.305(a)(1); 42 C.F.R. § 435.406. Residents of California who do not have lawful immigration status may apply for Restricted Medi-Cal without providing a SSN or attesting to lawful status. As of the date of publication, DHCS is currently working on implementing Health Care for All Children, which would allow undocumented children under age 19 to enroll in full-scope Medi-Cal. See Welf. & Inst. Code 14007.8 enacted by (SB) 75 (Chapter 18, Statutes of 2015) and amended by SB 4 (Chapter 709, Statutes of 2015).

103. 45 C.F.R. § 155.315(b); 42 C.F.R. § 435.910. If an individual has not been issued a SSN number yet, Medi-Cal must assist the applicant in completing an application for a SSN. 42 C.F.R. § 435.910(e)(1)

104. 45 C.F.R. § 155.310(a)(3); 42 CFR § 435.907(e)(3).

105. Non-applicants who attest to having a Social Security number and having filed taxes for the year that data would be used to verify household income must provide their number to Covered California. 45 C.F.R. § 155.305(f)(6). Non-applicants may voluntarily provide their Social Security number in order to verify household income, but must first be informed that providing their SSN is voluntary and will only be used to determine eligibility for those who are applying. 42 C.F.R. § 435.907(e)(3)(iii).

status electronically verified through the Social Security Administration database using only their Social Security numbers.¹⁰⁶ Naturalized citizens can be verified through either the SSA database or through the U.S. Department of Homeland Security database.¹⁰⁷ A range of documents may be used to document citizenship, including a naturalization or birth certificate or passport if available.¹⁰⁸

ii. Proof of Lawful Immigration Status

Applicants with lawful immigration status should provide their USCIS number (formerly known as the Alien Registration Number or “A-Number”) and can indicate the specific type of immigration document they have as proof of that status, if they have one.¹⁰⁹ If the document they have that proves their immigration status is not listed among the choices on the application, the applicant should indicate “Other.”

Reminder: Some immigrants who are not considered lawfully present for Covered California may be eligible under full-scope Medi-Cal. For example, individuals with Deferred Action for Childhood Arrivals (DACA) status are not considered “lawfully present” for purposes of Covered California and financial assistance eligibility, but are eligible for full-scope Medi-Cal under the PRUCOL rules. See Chapter 1, Section A.

iii. Resolving Citizenship or Immigration Inconsistencies

106. 45 C.F.R. § 155.315(c) (Covered California). For Medi-Cal, see Welf. & Inst Code § 14011.2 directing department to seek exception to the process outlined in 42 C.F.R. § 435.407; ACWDL 09-65 (Dec. 31, 2009), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c09-65.pdf>.

107. 45 C.F.R. § 155.315(c)(2). Naturalized citizens should not be required to provide a copy of their naturalization certificate in order to apply; they may provide the document only when electronic verification is not successful and are provided a “reasonable opportunity period” to do so. 42 C.F.R. § 435.952(c).

108. 42 C.F.R. § 435.407 (providing a specific tier of acceptable documents that can be used to prove U.S. Citizenship). See also ACWDL 07-12 (Jun. 4, 2007), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c07-12.pdf>. Covered California has a list of acceptable citizenship documents available at www.coveredca.com/FAQs/Request-for-Verification-CLP/PDFs/Document-List.pdf.

109. Lists of acceptable immigration documentation can be found in MEDIL 14-21 (March 25, 2014); Covered California’s list is at www.coveredca.com/FAQs/Request-for-Verification-CLP/PDFs/Document-List.pdf; a federal list is at Healthcare.gov with links to images of documents at www.healthcare.gov/help/immigration-document-types/.

If the electronic data match fails to verify citizenship or a qualified immigration status, applicants to Medi-Cal and Covered California can still enroll on a conditional basis, but must take additional steps to verify their immigration status within 90 days, known as the reasonable opportunity period.¹¹⁰ The process differs depending on which program the applicant appears eligible.

For Medi-Cal, if the immigration status is not automatically verified through the federal hub, the county can use an alternate verification request known as the SAVE process.¹¹¹ County workers use the information in the application to do a data match with the U.S. Citizenship and Immigration Services. Unless there is no other way to verify status, applicants no longer have to turn in paper documentation of their status.¹¹² Medi-Cal has released a Medi-Cal Eligibility Division Information Letter (MEDIL) with an attachment of sample documents that show many of the immigration documents that can be used to demonstrate status and where to find the appropriate information on the documents.¹¹³ While it is not a comprehensive list, it will help advocates in the most common immigration situations. Persons whose citizenship

-
110. 10 CCR §6478(c)(3) (allowing at an initial 90-day period for Covered California, followed by extensions as necessary); 45 C.F.R. 155.315(c)(3); 42 C.F.R. § 435.952(d); MEDIL 14-21 (Jul. 21, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-41.pdf> (90-day reasonable opportunity period); ACWDL 09-65 (Dec. 31, 2009), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c09-65.pdf> (extending reasonable opportunity period for to 90 days); ACWDL 92-48 (Aug 7, 1992), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c92-48.pdf> (establishing conditional eligibility pending immigration status due to *Ruiz v. Kizer* lawsuit).
111. SAVE stands for Systematic Alien Verification for Entitlements and is an information service administered by U.S. Citizenship and Immigration Services.
112. 42 CFR 435.952(c). Note that neither the *Medi-Cal Eligibility Procedures Manual 7G-2 – 7G-3* or Welf. & Inst. Code § 14007 have been updated to reflect this change that passed as part of health reform. Until the California regulations are updated, MEDIL 14-21 is the only instruction to counties on how to process immigration verification. In some cases, such as for Medi-Cal applicants who are eligible for registry because they have resided continuously in the United States since before January 1, 1972, there is no electronic verification available, but the immigrant can show proof of continuous residence.
113. MEDIL 14-41 (Jul. 21, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-41.pdf>.

status is not automatically verified may provide documentation of citizenship.¹¹⁴

Medi-Cal may not deny full-scope benefits without first trying the available automatic processes and offering a 90-day reasonable opportunity period.¹¹⁵

Applicants who are otherwise eligible for Medi-Cal, but whose status cannot be verified either electronically or via documentation, should have their scope of benefits revised by the county from full-scope Medi-Cal to Restricted-Scope Medi-Cal rather than have their application denied.¹¹⁶ If they are subsequently able to provide proof of their immigration status, the county should change their scope of benefits to full-scope.¹¹⁷

For Covered California, if the electronic data match does not work, applicants must send in documentation of citizenship or immigration status during the 90-day reasonable opportunity period – Covered California does not have an alternate SAVE process for immigration status. If the inconsistency is not resolved at the end of 90 days (which can be extended on case-by case basis), Covered California must provide enrollees written notice that their application will be denied and that they will be disenrolled from their Covered California plan by the first of the following month.¹¹⁸ Applicants have the right to appeal this denial like any other application denial.

MCAP has no citizenship or immigration verification requirements.

114. 42 U.S.C. 1320b–7(d)(4)(A) (Section 1137 of the SSA Act). 42 C.F.R. §435.952(d); ACWDLs 09-65 (Dec. 31, 2009), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c09-65.pdf> (extending period to 90 days), and 07-12 (Jun. 4, 2007), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c07-12.pdf> (listing acceptable documents).

115. MEDIL 14-21 (Mar. 25, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-21.pdf>. 42 U.S.C. 1320b–7(d)(4)(A) (Section 1137 of the SSA Act). 42 C.F.R. § 435.952(d); ACWDL 09-65 (extending period for citizenship verification to 90 days).

116. *Id.*

117. *Id.*

118. 10 CCR § 6492(b); 45 C.F.R. § 155.315(g); 10 CCR § 6492(a)(5)(B) (stating notice will be a 5 day notice by reference to §66476(h)). Though note that the parallel 45 C.F.R. § 155.310(g) only says “timely written notice.”

c. Incarceration

As discussed earlier in Section A.4, individuals will have their Medi-Cal suspended for up to one year while they are incarcerated; they can also receive Medi-Cal benefits if they are receiving hospital inpatient services, if they are off prison grounds for 24 hours or longer.

Individuals are not eligible for Covered California if they are incarcerated.¹¹⁹ For Covered California the definition of incarcerated is “confined, after the disposition of charges, in a jail, prison, or similar penal institution or correctional facility.”¹²⁰ CalHEERS electronically verifies whether someone is incarcerated or, if the sources are not available, accepts self-attestation.¹²¹ If the verified information conflicts with the information on the application, the applicant is asked for verification documentation.

d. California State Residency

While state law requires California residency be verified for Medi-Cal eligibility, the Department of Health Care Services has issued guidance suspending this verification requirement.¹²² This means that currently Medi-Cal applicants self-attest on their application that they are California residents without further verification.¹²³

Covered California applicants also self-attest to California residency, and the self-attestation is accepted unless other information on the application or information available to Covered California indicates the self-attestation is not reasonably

119. 10 CCR § 6472(d).

120. 10 CCR § 6410.

121. 10 CCR § 6478(e)(1).

122. MEDIL 14-44 (Aug. 1, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-44.pdf>; MEDIL 14-29 (May 16, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-29.pdf>; MEDIL 14-20 (Mar. 18, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-20.pdf>.

123. Note that DHCS checks its records against the Public Assistance Reporting Information System (PARIS) which checks for out-of-state individuals. Beneficiaries can be discontinued if they fail to verify residency if PARIS shows them residing in another state.

compatible.¹²⁴ An applicant's immigration status may not be used to determine whether an applicant is a California resident.¹²⁵ In other words, if an applicant is on a temporary immigrant visa, such as a student visa, Covered California should not determine that the individual is not a resident of California.

e. Income and Household Size

Applicants report income and tax household size on their application, which is then checked against data sources using the federal verification hub.

For Medi-Cal, if the income information submitted by the individual is "reasonably compatible" with the information obtained through the electronic data sources, e.g., IRS, state wage data, unemployment, Social Security, Medi-Cal accepts the amount listed on the application.¹²⁶ The two amounts are "reasonably compatible" for Medi-Cal in any of the following circumstances:

- Both show the individual's income above the relevant income standard;
- Both show the individual's income is at or below the relevant income standard; or
- The individual states their income is above the income standard and the information obtained by the state shows the individual's income is at or below the relevant income standard.¹²⁷ In this case, the individual must be told that the income information they provided was higher than the information the state obtained through electronic verification and the individual may request to have their income determined at the lower, verified amount.¹²⁸

If the income information obtained through electronic verification is not reasonably compatible with the information provided by the individual, the individual must provide additional information that explains the discrepancy, such as pay stubs or other documentation regarding income.¹²⁹

124. 10 CCR § 6478(d).

125. *Id.*

126. Welf. & Inst. Code § 14013.3(c)(1).

127. Welf. & Inst. Code § 14013.3(c)(3).

128. Welf. & Inst. Code § 14013.3(c)(4).

129. Welf. & Inst. Code § 14013.3(c)(2).

For Covered California, income information is checked against an applicant's previous year's tax return through the IRS database. If the applicant says that the income and tax household size on their last year's tax return represents an accurate projection of their income and household size for the benefit year for which they are applying for coverage, Covered California uses that tax information.¹³⁰ Covered California accepts self-attestation of income and household size if tax data is unavailable or the applicant attests that a change in income or household size has occurred or is reasonably expected to occur such that the tax data is not accurate for this benefit year.¹³¹ If, however, Covered California finds that the application's attested income and household size are not reasonably compatible with other information from the applicant or information Covered California has other than the tax data, then the attestation will be verified against state electronic data sources. If state sources are unavailable, the applicant must submit documentation to support their attested income.¹³²

There is an alternative verification process for individuals who attest to projected household income.¹³³ If their projected income is no more than 10% below the income on their most recent tax return, it must be accepted without further verification. If the projected annual income is more than 10% below the latest tax income or if the tax data is unavailable, the applicant's attested income is verified with state data sources or by requesting documentation from the applicant.¹³⁴

When income cannot be verified electronically, Covered California notifies applicants of what information is needed and gives them 90 days to provide it.¹³⁵ If the applicant does not provide the information within 90 days, Covered California uses the information available through electronic databases to determine their eligibility.¹³⁶

For MCAP, if income cannot be electronically verified, paper documentation is

130. 10 CCR § 6482 (d)(2), (e)(2).

131. 10 CCR §§ 6482 (d)(3), (e)(3) and 6484.

132. 10 CCR § 6482 (d)(4), (e)(4).

133. 10 CCR § 6486.

134. 10 CCR § 6486 (c).

135. 10 CCR § 6492(a). The 95 days may be extended on a case-by-case basis.

136. 10 CCR § 6492(a)(5).

requested.¹³⁷

f. Pregnancy

Medi-Cal accepts self-attestation that a woman applying for coverage is pregnant “unless the department has information that is not reasonably compatible with the attestation” in which case the woman can be asked to provide information to explain the discrepancy.¹³⁸

Covered California accepts self-attestation that a woman applying for coverage is pregnant. MCAP also accepts self-attestation of pregnancy.

g. Assets

MAGI Medi-Cal programs (including MCAP) and Covered California have no eligibility requirements related to assets – sometimes also called “property” or “resources.” However, as discussed in Chapter 3 many of the non-MAGI Medi-Cal programs do have an assets limit. Medi-Cal uses a form called the "MC 210 PS: Property Supplement" to gather information about an applicant’s assets.¹³⁹ For assets listed on the form, individuals must attach verifying documentation such as bank statements. For real estate, if it is the primary residence where the applicant lives, the applicant notes the address on the form but does not have to verify it. For other property, verifications are required to determine whether the property can be exempt.

h. Minimum Essential Coverage/Employer-Sponsored Coverage/ Other Coverage

The Single, Streamlined Application asks applicants whether they have other health coverage. Applicants self-attest whether they are covered by other insurance or

137. 10 CCR § 2699.201. Although the regulations seem to require paper documentation of income, once MCAP was moved into CalHEERS, it has been treated like the other insurance affordability programs and an attempt to electronically verify income is made prior to requesting paper documentation.

138. Welf. & Inst. Code § 14013.3(d).

139. Available at <http://www.dhcs.ca.gov/formsandpubs/forms/Forms/mc210ps.pdf>.

have other insurance available.

In general, having other health coverage has no impact on whether someone is eligible for Medi-Cal, though having Medicare can preclude eligibility in certain categories such as the Expansion Adults category in MAGI Medi-Cal.¹⁴⁰ However, because Medi-Cal is always the “payer of last resort” the Department of Health Services does verify whether an applicant has other health coverage using electronic databases. For more information on other health coverage see Chapter 1, Section D.

Individuals are not eligible for subsidized coverage in Covered California if they have health coverage that qualifies as Minimum Essential Coverage (MEC). Individuals are also not eligible for subsidized coverage if they are eligible for affordable employer-sponsored coverage.¹⁴¹ Covered California accepts self-attestation of eligibility for employer-sponsored coverage unless it is not reasonably compatible with other information.¹⁴² Covered California verifies whether an applicant has minimum essential coverage by checking the CalHEERS and county eligibility systems to see whether the applicant has Medi-Cal (including CHIP-funded Medi-Cal) and using other databases to check for employer-based health coverage.¹⁴³

140. Someone with Medicare could be eligible for a number of other Medicare-specific programs such as the Medicare Savings Programs.

141. IRS Code § 36B(c)(2)(C)(i). See Chapter 4 for a full explanation of these rules.

142. 10 CCR § 6490. Previously, Covered California accepted self-attestation regarding the status of available employer coverage but should start verifying with employers in 2016. See 10 CCR § 6490(e); 45 C.F.R. § 155.320(d).

143. 10 CCR § 6480; *but see* 10 CCR § 6480(e) and 45 C.F.R. § 155.320(d).

Advocacy Tip: Medi-Cal and Other Health Coverage

While being enrolled in other health coverage (OHC) precludes someone from being eligible for premium subsidies in Covered California, having other health coverage is not an eligibility bar to Medi-Cal.¹⁴⁴ Many people have employer-based coverage and Medi-Cal, for example. If they are otherwise eligible for Medi-Cal, having another source of health coverage is not a problem. The application asks about other health coverage and it will be noted in the individual's Medi-Cal file in the Other Health Coverage data field. Medi-Cal is always the payer of last resort so if someone does have Medi-Cal and other health coverage, their other coverage is their primary coverage and must be used before Medi-Cal will pay. It is still important to go to a Medi-Cal doctor. If someone with Medi-Cal and other coverage goes to a doctor who accepts both of their types of coverage, the doctor cannot bill them for any co-pays.

C. When Coverage Starts

Individuals can *apply* for Medi-Cal and Covered California anytime and can *enroll* in Medi-Cal anytime. But individuals can only *enroll* in Covered California during an annual open enrollment or a special enrollment period. Individuals may also apply for and enroll in MCAP at any time during their pregnancy.¹⁴⁵ Below we discuss when coverage starts for the different programs and how to select a health plan.

-
144. The Medi-Cal Access Program (MCAP) and the Breast and Cervical Cancer Treatment Program (BCCTP) are an exception to this rule depending on the scope of the other health coverage. This means generally people cannot enroll in MCAP or BCCTP if they have other health coverage. For more information on MCAP see Chapter 2, Section C.3.b. For more information on BCCTP see Chapter 3, Section E.1. Individuals are also not eligible for the Expansion Adult MAGI Medi-Cal program if they have Medicare.
145. 10 CCR § 2699.200. Note that the 30-week pregnancy limit for MCAP applicants referred to in subdivision (d)(1)(H) of the state regulation was abolished in 2015. As of March 1, 2015, a pregnant woman could be eligible for MCAP at any point in her pregnancy. To date the regulations have not been updated, though language regarding the 30-week limit has been removed from the MCAP website.

1. Medi-Cal

Medi-Cal eligibility determinations must be made within 45 days from the date of application, or 90 days when the application is based on disability.¹⁴⁶ Medi-Cal is full-month coverage so that once Medi-Cal is granted the coverage is for the full calendar month that includes the application date. For example, if the applicant applies on July 6 and is found eligible her coverage extends to the entire month of July. This means if she received services covered by Medi-Cal as early as July 1st she or her providers can seek payment from Medi-Cal.

Once an applicant is determined eligible they will receive their Medi-Cal card, called a Beneficiary Identification Card (BIC),¹⁴⁷ as well as a “welcome packet” and, for most people, a health plan choice packet.

a. Retroactive Medi-Cal

An applicant can receive Medi-Cal coverage (and payment for Medi-Cal covered benefits received) for up to three calendar months preceding the month of application if they would have been eligible for Medi-Cal during those months.¹⁴⁸ Applicants can apply for retroactive Medi-Cal on the Medi-Cal application or after applying for Medi-Cal or CalWORKs by indicating the request on the application or by separate written request.¹⁴⁹ Retroactive Medi-Cal can be requested for up to one year after the date of application¹⁵⁰ so if there are outstanding bills, the Medi-Cal member should submit them to Medi-Cal for reimbursement or ask the provider to bill Medi-Cal.

146. 42 C.F.R. § 435.911; Welf. & Inst. Code § 14154(d)(1); 22 CCR § 50177.

147. Welf. & Inst. Code §§ 14017.7, 14017.8. Note that an individual is only sent a BIC if one has not been issued to that person previously. If the person was previously assigned a BIC, it is re-activated. If the beneficiary needs to request a new card, they can contact the county. Additionally, beneficiaries can request a paper BIC from the county so they do not have to wait for the plastic card to arrive in the mail if they have an urgent need.

148. Welf. & Inst. Code §§ 14019, 14019.6; 22 CCR § 50197; MEDIL 14-27 (May 15, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-27.pdf>.

149. 22 CCR § 50148(a)(2).

150. 22 CCR § 50148(b).

b. Expedited Programs

As discussed above there are several expedited ways to get Medi-Cal including Accelerated Enrollment (AE) for Children, Presumptive Eligibility (PE) for Pregnant Women, Hospital Presumptive Eligibility, and the CHDP Gateway. With each of these pathways, coverage starts the day the abbreviated application is approved – not at the beginning of the month as is the general Medi-Cal rule. Individuals who have earlier bills in the same month should submit their complete Medi-Cal application before the end of the month to ensure that those bills can be covered as well. See Section A.2 earlier in this chapter for a more detailed discussion of expedited coverage programs.

2. Covered California

While people can apply for Covered California coverage anytime they can only *enroll* in Covered California during the annual open enrollment period or a special enrollment period.¹⁵¹ They should receive an eligibility determination within 10 days from the date of a completed paper application and in real time (meaning while they are still on the computer) for an electronic application, if administratively feasible.¹⁵²

a. Covered California Open Enrollment

For plan year 2016 and thereafter, the annual open enrollment period starts November 1 and runs through January 31.¹⁵³

During open enrollment, for coverage to be effective by January 1st, plan selection must be made by December 15,¹⁵⁴ and plan payment must be received by December 28 (the fourth remaining business day of the month) (e.g., December 28th in 2015).¹⁵⁵

151. 10 CCR § 6470 (k).

152. 10 CCR § 6476(f).

153. 45 C.F.R. § 155.400(e)(2); Health & Safety Code § 1399.849 (c). Note: This open enrollment period also applies to buying health coverage in the individual market “outside” Covered California. *Id.*; Ins. Code § 10965.3(c).

154. 45 C.F.R. § 155.410(f); 10 CCR § 6502(f).

155. 45 C.F.R. § 155.400(e); 10 CCR § 6502(g), including the definition of “premium due date” in 10 CCR § 6410.

When the applicant selects a plan during the first 15 days of any subsequent month and payment is received by the plan on the “premium due date” (fourth remaining business day of the month), coverage starts no later than the first day of the following month.¹⁵⁶ If the plan is selected after the 15th of the month, however, coverage is effective the first day of the second month following payment.¹⁵⁷ This would mean a month without coverage which could be quite significant for someone with medical needs. Note that if an applicant would qualify for special enrollment during this time, there are certain circumstances when coverage can start sooner, such as when losing other health coverage.¹⁵⁸

b. Covered California Special Enrollment

Once open enrollment has closed, individuals must have a “triggering event” (also known as a “qualifying life event”) in order to enroll or change from one Covered California plan to another. If there is no triggering event, individuals are not able to enroll in coverage until the next open enrollment period. In other words, at this stage eligibility to enroll is a two-step process: 1) Is the individual eligible for special enrollment?; and 2) Is the individual eligible for Covered California?

Advocate Tip: For special enrollment, do not take “no” for an answer for step 1. Individuals can submit documentation of circumstances that require Covered California to adjudicate whether the applicant is eligible for a special enrollment period. Sometimes, customer service center representatives tell applicants that they do not qualify for special enrollment. As a result, the individual does not actually apply for Covered California. The individual (or advocate) should give a brief explanation as to why they qualify for special enrollment and proceed on to the application. If not, even if the individual appeals the denial, there is little that an administrative law judge can do, except tell the person to go back and apply again, as there is no application denial to adjudicate.

156. 45 C.F.R. § 155,410(f); 10 CCR § 6502(f); 10 CCR § 6502(g) including the definition of “premium due date” in 10 CCR § 6410.

157. *Id.*

158. See Section C.2.b on special enrollment below.

The following “triggering events” qualify someone for a special enrollment period in Covered California:¹⁵⁹

1. Loss of Minimum Essential Coverage.¹⁶⁰ This includes:
 - Loss of eligibility for employer coverage, e.g., loss of a job or a reduction in work hours that causes loss of access to employer-sponsored health plan;
 - Loss of eligibility for Medi-Cal, CHIP, Medicare or other government-sponsored health coverage (including loss of Medi-Cal with a Share of Cost);¹⁶¹
 - Exhaustion of COBRA coverage;
 - Cancellation of non-group plan;
 - Reaches the lifetime limit on plan benefits;
 - Loss of eligibility for student health plan;
 - Divorce, legal separation or dissolution of domestic partnership resulting in loss of coverage;
 - No longer eligible as a dependent under current plan;
 - Death (*i.e.*, of another person in the family) resulting in loss of coverage such as when the employee with the link to employer-sponsored coverage dies;
 - Decertification of current Covered California coverage;
 - No longer living, working, or residing in the area of the health plan;
 - Termination of employer contributions to employee’s health coverage;

159. 45 C.F.R. § 155.420(d); Health & Safety Code § 1399.849(d); 10 CCR § 6504(a) and (b). Note that both the Covered California regulations, which rely largely on the federal Affordable Care Act regulations, and the Department of Managed Health Care regulations, which apply to most California health plans, apply special enrollment periods.

160. 45 C.F.R. § 155.420(d)(1)(i); Health & Safety Code § 1399.849(d)(1)(A); 10 CCR § 6504(a)(1)(A) and (b). Two exceptions to the rule that the coverage must be minimum essential coverage include loss of pregnancy-only Medi-Cal coverage and loss of medically needy Medi-Cal coverage in a month that the share-of-cost is met. 45 C.F.R. § 155.420(d)(1)(iii) and (iv); 10 CCR 6504(a)(1)(C) and (D). See *also* CMS’s guidance on certain types of Medicaid coverage as minimum essential coverage: <http://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf>.

161. Although Medi-Cal with a Share of Cost has been determined to not be minimum essential coverage, 10 CCR § 6504(a)(1)(D) allows for special enrollment.

and

- Newly eligible for the premium tax credit due to discontinuation or change to employer-sponsored plan resulting in plan no longer being considered MEC.¹⁶²

Note: “Loss of MEC” does not include loss of coverage due to failure to pay premiums timely, including COBRA or loss of coverage for cause, such as based on an intentional misrepresentation.¹⁶³

2. Gains or becomes a dependent including through adoption, placement for adoption or placement in foster care.¹⁶⁴
3. Is mandated to be covered as a dependent pursuant to a court order.¹⁶⁵
4. Loses a dependent or is no longer considered a dependent through divorce, legal separation, or dissolution of domestic partnership.¹⁶⁶
5. Has been released from incarceration.¹⁶⁷
6. Health plan substantially violated a material provision of the health coverage contract.¹⁶⁸
7. Gains citizenship or Lawful Permanent Resident status.¹⁶⁹
8. Error on enrollment or non-enrollment by Covered California.¹⁷⁰
9. Change in eligibility for payment assistance (premium assistance/cost sharing reductions, if already enrolled in a QHP through Covered California).¹⁷¹

162. 26 U.S.C. § 5000A; 26 C.F.R. § 54.9801-6(a)(3); 29 C.F.R. § 1163; 45 C.F.R. § 155.420(d)(6)(iii); 10 CCR § 6504(a)(7).

163. 26 C.F.R. § 54.9801-2; 45 C.F.R. § 155.420(e)(1); Health & Safety Code § 1399.849(d)(1)(A)(iii); 10 CCR § 6504(b)(3); 10 CCR § 6504(c)(1).

164. 45 C.F.R. § 155.420(d)(2); Health & Safety Code § 1399.849(d)(1)(B); 10 CCR § 6504(a)(2).

165. 45 C.F.R. § 155.420(d)(2); Health & Safety Code § 1399.849(d)(1)(C); 10 CCR § 6504(a)(2)

166. 45 C.F.R. § 155.420(d)(2); Health & Safety Code § 1399.849(d)(1)(C); 10 CCR § 6504(a)(2)(B).

167. Health & Safety Code § 1399.849(d)(1)(D); 10 CCR § 6504(a)(8).

168. 45 C.F.R. § 155.420(d)(5); Health & Safety Code § 1399.849(d)(1)(E); 10 CCR § 6504(a)(5).

169. 45 C.F.R. § 155.420(d)(3); 10 CCR § 6504(a)(3). It is difficult to become a citizen without having a previous lawful status, but is possible if claiming such status through lineage.

170. 45 C.F.R. § 155.420(d)(4); Health & Safety Code § 1399.849(d)(1)(H); 10 CCR § 6504(a)(4).

171. 45 CFR § 155.420(d)(6); 10 CCR § 6504(a)(6). Note that Covered California interprets this to only allow for changes in plan, not to newly enroll based on language in the state and federal regulations referring to the *enrollee* rather than the *individual* as in other sections. Thus, if you are already in a plan you can change to a new plan but you can't newly enroll in a plan when your income decreases.

10. Existing employer plan no longer affordable.¹⁷²
11. Access to new health plan due to a permanent move.¹⁷³
12. Native American exception (can change Covered California plans once a month).¹⁷⁴
13. Member of the reserve forces of the U.S. military or California National Guard returning from active duty.¹⁷⁵
14. Exceptional circumstances (such as loss of exemption, court order to cover child's health care, domestic abuse or spousal abandonment).¹⁷⁶

For most triggering events, people have 60 days from the date of the event to select a Covered California plan, except there are longer periods for some triggering events. For example, for loss of coverage an applicant can select a plan starting 60 days before the coverage ends to 60 days after.¹⁷⁷

Advocacy Tip: Even though people have 60 days to pick a plan, waiting beyond the month they lose eligibility in their current health coverage will mean going without coverage. For individuals losing coverage, including Medi-Cal, the usual rule by which someone has to pick a plan by the 15th of the month for coverage to be effective does not apply. Rather their coverage will be effective the first of the month after they made their health plan choice – even after the 15th of the month. See Covered California Coverage Effective Dates below.

c. Covered California Coverage Effective Dates

In general, if the plan is selected within the first 15 days of the month, coverage is effective the first day of the following month. If the plan is selected after the 15th day of the month, coverage is effective the first day of the second month following the

172. 45 C.F.R. § 155.420(d)(6)(iii); 10 CCR § 6504(a)(7). See also 10 CCR § 6504(b)(2).

173. 45 C.F.R. § 155.420(d)(7); Health & Safety Code § 1399.849(d)(1)(F); 10 CCR § 6504(a)(8).

174. 45 C.F.R. § 155.420(d)(8); 10 CCR § 6504(a)(9).

175. Health & Safety Code § 1399.849(d)(1)(I).

176. 45 C.F.R. § 155.420(d)(9); 10 CCR § 6504(a)(10).

177. 45 C.F.R. § 155.420(c); Health & Safety Code § 1399.849(d)(2); 10 CCR § 6504(f).

payment.¹⁷⁸ For some triggering events, like the birth or adoption of a baby or loss of coverage, there are special coverage dates that allow coverage to start sooner. The chart below shows the other coverage effective dates.

Covered California Effective Dates of Coverage¹⁷⁹

Event	Coverage Effective Dates
<p><i>Standard Rule</i></p> <ul style="list-style-type: none"> • Plan selection occurring on the 1st through the 15th of the month • Plan selection occurring on the 16th through the last day of the month 	<ul style="list-style-type: none"> • First day of the following month • First day of the second following month
Loss of coverage	First day of the month following loss of coverage if the plan selection is made by the date of coverage loss, or first day of the month following plan selection if the plan selection is made after the coverage loss.
Marriage or entry into domestic partnership	First day of the month following plan selection.
Birth, adoption, or placement for adoption	Date of birth, adoption, or placement, or the first day of the month following the date of birth, adoption, or placement at the enrollee’s option.
Gaining a dependent or becoming a dependent through a child support order or other court order	The date the court order is effective, or the standard rule (<i>i.e.</i> , the 15th day rule based on the plan selection date), at the enrollee’s option.

178. 45 C.F.R. § 155.320(b)(1); 22 CCR § 6504(g).

179. 45 C.F.R. § 155.320(b)(2); Health & Safety Code § 1399.849(e); 10 CCR § 6504(h).

Loss or death of dependent or enrollee	First day of the month following the plan selection.
<p>Other qualifying life events:</p> <ul style="list-style-type: none"> • The health plan violated its contract • Exceptional circumstances • Misconduct or misinformation • Misrepresentation or erroneous enrollment • A contracting provider left the network while the enrollee was receiving specified services 	The date of the event or the standard rule, as determined by Covered California on a case by case basis.

3. MCAP

MCAP coverage starts 10 calendar days after the date the application is approved.¹⁸⁰

D. Plan Selection

Most Medi-Cal beneficiaries and all Covered California and MCAP members enroll into and receive their services through a health plan. For those choosing among health plans some considerations include:

- Whether the plan includes the consumer’s doctor or other important provider. Check the plan’s provider directories and call the provider to confirm they accept the plan. Specify whether it’s the Med-Cal or Covered California product offered by the plan because the provider networks for plans are generally different for Medi-Cal, Covered California, MCAP and the commercial market.
- Whether the plan covers prescription drugs that the member takes. Check the health plan formulary or call the health plan.

180. 10 CCR § 2699.209(a).

- The cost of the plan in the case of Covered California. Consider cost sharing including per visit co-pays, prescription drug co-pays and deductibles in addition to the monthly premium cost.
- Quality ratings for the plans which can be found at the Office of the Patient Advocate: www.opa.ca.gov

Advocacy Tip: In general, if a Medi-Cal beneficiary does not pick a plan, the applicant will be defaulted into a plan – meaning they will be assigned by the state to a plan. If a Covered California enrollee does not pick a plan, the applicant will not be enrolled into coverage at all. In MCAP, for counties with a plan choice, the woman must pick a plan or she will not have coverage.

1. Picking a Medi-Cal Plan¹⁸¹

Most but not all Medi-Cal members must enroll in a Medi-Cal health plan. Medi-Cal members must enroll in a plan except for the following groups: those in foster care or receiving adoption assistance, as well as former foster youth; those with other health coverage (OHC), including Medicare – except in counties with the dual demonstration project; pregnant women up to 213% FPL who are in Pregnancy-Related Medi-Cal; and those who have Medi-Cal with a Share-of-Cost.

When someone enrolls in Medi-Cal they are initially in Fee-for-Service (FFS) Medi-Cal and can go to any doctor that contracts directly with Medi-Cal. Along with their Medi-Cal welcome packets, new Medi-Cal members receive a health plan “choice packet” with information about the health plan choices in their county. This includes provider directories for their geographic region and a choice form for the individual to indicate their preferred primary care doctor. They have 30 days to pick a plan and doctor and are given a 30 day extension if they request the provider directory for the entire plan

181. DHCS’s Health Care Options Branch oversees and administers enrollment activities with the support of the statewide enrollment broker, Maximus. Plan enrollment informational materials are available at http://www.healthcareoptions.dhcs.ca.gov/HCO_CSP/HCO_Program/default.aspx.

service area.¹⁸² Individuals who do not choose a plan are assigned a plan by Medi-Cal.¹⁸³ Plans must ensure that members choose a primary care doctor within 30 days of plan enrollment or assign them a doctor within 40 days if they have not selected one.¹⁸⁴ Members who are dissatisfied with their doctor or plan can change doctors or plans anytime.¹⁸⁵

Medi-Cal members who would generally have to enroll in a Medi-Cal plan can seek a Medical Exemption Request (MER) if they are receiving services from a fee-for-service provider for a complex condition or if they are an American Indian or receiving services from Indian Health Services.¹⁸⁶

There are different models of Medi-Cal managed care, which vary depending on the county where the beneficiary resides.¹⁸⁷

Medi-Cal Managed Care Models

Model	Description
Geographic Managed Care	Choice of several commercial plans
Two-Plan	Choice of a local initiative plan run by the county or a commercial plan
County-Organized Health System	One plan serving the whole county
Regional Model	Choice of two commercial plans

2. Picking a Covered California Plan

182. Welf. & Inst. Code §§ 14087.305 and 14089.

183. Welf. & Inst. Code §§ 14087.305(e) and 14089(5).

184. Welf. & Inst. Code §§ 14087.305(f) and 14089(6).

185. Welf. & Inst. Code §§ 14087.305(g) and 14089(7).

186. 22 CCR §§ 53887 (Two-Plan Model); 53923.5 (GMC).

187. Welf. & Inst. Code §§ 14087, 14089; 22 CCR §§ 53921, 53882, and 53921.5

Individuals with an online account can select a Covered California plan online. The “Find a Plan” section starts with applicants indicating their frequency of use of medical services and prescriptions. This is used to provide information about which plans would be least expensive for the household.

The "Plan Comparison" page shows custom results for the applicant based on the preferences listed in the application. All plans available in the applicant’s area are listed, with closest matches to the applicant’s preferences and needs listed first. There are a series of expandable sections on the Plan Comparison tool that provide details of services offered by each plan. The summary section shows the estimated costs, including both the premium and out-of-pocket costs, based on the previous page’s answers about how often the applicant uses medical services. Quality ratings for each plan are also included.

There is a plan booklet each year listing the Covered California health plans which can be downloaded from the website. Individuals can also select a plan by calling the Covered California Service Center or working with their certified enrollment counselor, agent or broker.

3. Picking an MCAP Plan

In most counties (48) there is only one MCAP plan and in ten counties there is a choice between two plans.¹⁸⁸ After a woman is deemed eligible for MCAP she receives a letter and phone contacts about how to select an MCAP plan. If she is in one of the counties with a choice of plans she must select one or she will not be enrolled into MCAP. She will receive a notice denying her MCAP for failure to choose a plan.

188. Information about MCAP plans is available at http://mcap.dhcs.ca.gov/Plans_Providers/Health_Plans.aspx. The Department of Health Care Services is currently looking to replace the MCAP network with the existing Medi-Cal plans for further integration of the programs. Presumably all enrolled women would be permitted to stay with whichever plan they enrolled in during a transition period to the extent the plans are different.

Chapter 6: Staying On

Chapter 6. Staying On

A. How to Keep Coverage

1. Changes in Circumstances

a. Medi-Cal

- i. Beneficiary Obligation to Report
- ii. Periodic Data Review
- iii. Redetermination of Eligibility
- iv. Relationship with Other Public Assistance Programs

b. Covered California

- i. Enrollee Obligation to Report
- ii. Semi-annual Data Review
- iii. Additional Rules Regarding Redetermination Outcomes
Due to Changes in Circumstances

c. Medi-Cal Access Program (MCAP)

2. Moving

a. Medi-Cal and Inter-County Transfers (ICTs)

- i. The ICT Process
- ii. Accessing Care during the ICT Process

b. Covered California: Inter-Regional Moves and Choosing a New Health Plan

- i. Choosing a New Health Plan Due to a Move
- ii. Avoiding Gaps in Coverage

3. Annual Renewal or Redetermination

a. Medi-Cal

- i. Process for MAGI beneficiaries

Chapter 6: Staying On (cont'd)

- ii. Process for Non-MAGI Beneficiaries
- iii. Process for Households that Have Both MAGI and Non-MAGI Members
- iv. SB 87 and Medi-Cal Eligibility Reviews
- v. 90 Day Right to “Cure” or Reinstate Medi-Cal after Termination.
- vi. Process When There is a Loss of Contact
- vii. Special Processes for Certain Categories of Medi-Cal Beneficiaries
 - 1) Former Foster Youth up to Age 26
 - 2) “Mega Mandatory” Groups
 - 3) Deemed Eligible (DE) Infants
 - 4) Foster Children Returning Home
 - 5) Minor Consent
 - 6) Transitional Medi-Cal
 - 7) Breast & Cervical Cancer Treatment Programs
 - 8) Refugee Medical Assistance

- b. Covered California
 - i. Open Enrollment
 - ii. Notice Requirements
 - iii. Redetermination for Financial Assistance
- c. Redetermination for Mixed Coverage Families
- d. Redetermination for MCAP

B. Due Process Rights

- 1. Medi-Cal Eligibility Appeals
 - a. Notice: Content and Timing Requirements
 - b. Requesting a Fair Hearing
 - c. Expedited Hearings
 - d. Retaining Benefits During the Fair Hearing Process – Aid Paid Pending
 - e. Informal Resolution

Chapter 6: Staying On (cont'd)

- f. Dismissals
 - g. Setting and Notice of Hearing; Position Statement
 - h. The Fair Hearing
 - i. After the Fair Hearing
 - 2. Covered California Eligibility Appeals
 - a. Notice: Content and Time Requirements
 - b. Request for Hearing
 - c. Expedited Appeals
 - d. Eligibility Pending Appeal – Continuing Enrollment
 - e. Informal Resolution
 - f. Notification of Hearing and Position Statement
 - g. The Fair Hearing
 - h. Hearing Decision and Other Post-Hearing Processes
 - 3. Dual Agency Appeals
 - a. Shared Appeals Entity
 - b. Informal Resolution Process
 - c. The Fair Hearing
 - 4. Medi-Cal Access Program (MCAP) Eligibility Appeals
- C. Moving Between Programs
 - 1. Covered California to Medi-Cal
 - 2. Medi-Cal to Covered California

6. Staying On

A. How to Keep Coverage

Individuals who have been found eligible and are enrolled in Medi-Cal or Covered California with financial assistance (premium tax credits or cost-sharing reductions) must have their eligibility redetermined every 12 months in order to retain coverage for the next year.¹ If during the 12-month period new information that affects eligibility becomes available to the county or Covered California – either reported by the individual or accessed through other electronic data sources – a beneficiary or enrollee will automatically have their eligibility for the insurance affordability program redetermined based on the new information.

As a result of a redetermination, a Medi-Cal beneficiary or Covered California enrollee with financial assistance could:

- Remain eligible for the same program, e.g., remain on Medi-Cal under the same basis of eligibility;
- Remain eligible for the same insurance affordability program, but be eligible for a higher or lower cost premium plan due to a change in income;
- Become eligible for a different insurance affordability program entirely, e.g., move from Medi-Cal to Covered California; or
- Become ineligible for all insurance affordability programs.

A Medi-Cal beneficiary or Covered California enrollee found to be ineligible for their existing insurance affordability program must be automatically determined for eligibility for other programs, rather than reapplying to the other program.²

-
1. While this guide also covers the Medi-Cal Access Program, women in the program do not have an annual determination as the program ends 60 days after the birth of the baby, nor are they reassessed for the program when their income changes. See Section A.3.d for the renewal rules for babies born on the Medi-Cal Access Program.
 2. 42 C.F.R. § 435.916(f); 45 C.F.R. § 155.335(f); 10 CCR §§ 6472, 6474; ACWDL 14-18 (Apr. 8, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attach.pdf>.

1. Changes in Circumstances

Changes in income, family composition and other types of household changes may affect a Medi-Cal beneficiary's or Covered California enrollee's continuing eligibility for coverage. These changes could relate to

- Income;
- Household composition (e.g., birth, death, adoption);
- Moving;
- Immigration status;
- Incarceration; or
- Access to other health coverage.

In general, Medi-Cal beneficiaries and Covered California enrollees are required to report any changes affecting eligibility during the 12-month period. In addition, the county/state may receive information periodically from data sources that could trigger a redetermination.

a. Medi-Cal

i. Beneficiary Obligation to Report

Beneficiaries must report to the county any change in their circumstances that may affect their Medi-Cal eligibility within ten calendar days of the change.³ The primary types of changes that affect eligibility are changes in income or household composition.⁴ Beneficiaries may report changes via website (logging into their account in CalHEERS at www.coveredca.com), telephone, fax, mail, in person or any other commonly available electronic means authorized by the county or DHCS.⁵

3. Welf. & Inst. Code § 14005.37(h).

4. See ACWDL 14-22 (Apr. 25, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-22.pdf>.

5. 42 C.F.R. § 435.907(a); Welf. & Inst. Code § 14005.37(q).

Advocacy Tip: The website www.coveredca.gov is part of CalHEERS, the California Healthcare Eligibility, Enrollment and Retention System, and is a portal through which one can apply for Medi-Cal or Covered California. The system also maintains accounts through which consumers can manage their Medi-Cal or Covered California coverage. If someone applied for Medi-Cal through the county, however, due to remaining technical issues with the system, they might not be able to access CalHEERS without assistance from the county. Consumers should also beware that going into one's CalHEERS account and changing information might trigger a redetermination!

ii. Periodic Data Review

The county may periodically access the federal data hub, along with other state databases, such as the Department of Motor Vehicles or the Franchise Tax Board, along with the county's own system for administering benefits between annual eligibility redeterminations to obtain more current eligibility information, such as income.

iii. Redetermination of Eligibility

The county must determine a beneficiary's ongoing eligibility upon learning of a change potentially affecting eligibility from the beneficiary or from its own review as follows:⁶

- Determine if the change in circumstances affects eligibility. For example, a change of address may not affect eligibility for Medi-Cal, but a change in household size might. If there is no change in eligibility based on the new information, no other action is needed.⁷ Another example: If income increases \$100/month, but the annual household income remains below the eligibility limit, the individual remains eligible for the same program so no further action is needed.
- If the county determines that the change in circumstances may affect

6. Welf. & Inst. Code § 14005.37(g) and its subdivisions, unless otherwise indicated.

7. Welf. & Inst. Code § (e)(2)(4).

eligibility, the county must attempt to gather all eligibility information using the *ex parte* process - a review of all available data resources such as the beneficiary's CalWORKs file or the federal data services hub.

- If the *ex parte* process does not provide the county the information it needs to find the beneficiary still eligible, the county shall ask the beneficiary for the information it needs. To request information from a beneficiary, the county must use a pre-populated form containing the information that the county already has and that requests *only* the information needed from the beneficiary to renew eligibility.⁸ The beneficiary has 30 days from the date the pre-populated form is mailed to respond. The beneficiary must be allowed to provide the information requested on the pre-populated form by mail, phone, in person, or any other commonly available electronic means authorized by the county or DHCS.
- During this 30-day period, the county must try to contact the beneficiary by phone, in writing or other commonly available electronic means at least once in an effort to obtain the necessary information. If the beneficiary has identified a preferred method of contact, the county must use that method, otherwise, the county must use reasonable efforts to determine the best method of contact.⁹
- **If the beneficiary responds**, the county must determine if the beneficiary remains eligible based on the information provided by the beneficiary. If they remain eligible, the county completes the redetermination and sends written notice to the beneficiary. The beneficiary's next renewal date should be reset to 12 months from the date the county determines the beneficiary is eligible.¹⁰
 - In evaluating information regarding changed circumstances, the county must follow the SB 87 process described at Section A.3.a.iv below and in Welfare & Institutions Code 14005.37 subsection (d) and evaluate the beneficiary for eligibility for *all* Medi-Cal programs (MAGI

8. At publication of this manual, the computer-generated prepopulated form contemplated by the redetermination statute was not yet in operation, thus counties were sending beneficiaries other forms requesting the documents necessary to determine ongoing eligibility.

9. Welf. & Inst. Code § 14005.37(t).

10. Welf. & Inst. Code § 14005.37(n).

and non-MAGI) before terminating the beneficiary from Medi-Cal.¹¹ If based on the new information the beneficiary is found not eligible for any Medi-Cal program (if they are over income due to an increase in income or change in family composition, for example) the county must determine eligibility for Covered California with financial assistance.¹² If eligible, the county should assist the individual with enrollment into Covered California and, if requested, with Covered California plan selection.¹³ After completing the beneficiary's eligibility determination for Covered California, the county is required to send the beneficiary a ten-day Notice of Action terminating their Medi-Cal.¹⁴ Note that the county is supposed to take any steps necessary to ensure that a Covered California-eligible beneficiary being discontinued from Medi-Cal can transition to Covered California without a break in coverage.¹⁵ Beneficiaries found eligible for Share of Cost Medi-Cal must also be evaluated for Covered California financial assistance.¹⁶ Beneficiaries eligible for Covered California have the choice of having just Share of Cost Medi-Cal, Covered California, or both.¹⁷

- **If the beneficiary does not provide the necessary information** to the county within the 30-day period, the county may send the beneficiary a ten-day Notice of Action of terminating Medi-Cal.¹⁸ At this point in the

-
11. Welf. & Inst. Code § 14005.37(d); ACWDL 14-18 at pp. 1- 2, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf>.
 12. *Id.* at pp. 4, 9. Remember, however, many parents and children can move into Transitional Medi-Cal or Continuous Eligibility for children when the family's income increases. See Chapter 3, Sections C.5 and C.6.
 13. *Id.* at p. 4.
 14. The requirements for the Notice of Action are set forth in ACWDL 15-33 (Oct, 9, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-33.pdf>.
 15. Welf. & Inst. Code § 15926(h).
 16. ACWDL 14-18 at pp. 3 – 4, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf>.
 17. *Id.*, p. 3. Share of Cost Medi-Cal is not considered minimum essential coverage, but note that persons with Share of Cost Medi-Cal and no other coverage may meet the criteria for a Covered California Special Enrollment Period and are currently eligible for an exemption from the individual mandate. 10 CCR § 6504 § (a)(1)(D); MEDIL 15-29 (Oct. 22, 2015), p. 2, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-29.pdf>. See also Instructions for IRS Form 8965 for 2015, p. 3 available at <https://www.irs.gov/pub/irs-pdf/i8965.pdf>.
 18. Welf. & Inst. Code § 14005.37(g)(3); ACWDL 14-18 at p. 2, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf>.

process, the county is required to immediately evaluate the beneficiary for premium tax credits and forward the case to Covered California.¹⁹ At the end of the ten days, the beneficiary may be discontinued or terminated from Medi-Cal; however, if the beneficiary provides the requested information prior to the termination date, the county must rescind the termination action and conduct an eligibility evaluation and redetermination.²⁰

- If terminated, the beneficiary still has 90 days from termination to “cure” or provide the information requested and if they do so, the county must treat the information as if it was received timely.²¹ Note that the “good cause” rule regarding submitting information even beyond the 90 days applies.²² See also Section B.1 later in this chapter for the Medi-Cal notice and hearing rights, including the right to continue receiving Medi-Cal pending appeal (aid paid pending).

Note that these rules generally apply to both MAGI and Non-MAGI Medi-Cal beneficiaries.²³

Also note that the county can terminate without doing a redetermination only when it has proof that the beneficiary cannot be eligible for Medi-Cal such as proof that the beneficiary died or moved out of state.²⁴

iv. Relationship with Other Public Assistance Programs

If a Medi-Cal beneficiary is enrolled in another public assistance program such as

19. ACWDL 14-18, at p. 4, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf>.

20. *Id.*

21. *Id.* See also Welf. & Inst. Code § 14005.37(i).

22. ACWDL 14-35 (Sep. 29, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf>, pp. 5 – 6. See 22 CCR § 50175(c).

23. ACWDL 14-18, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf>. See ACWDL 14-18 for more detail on these rules and where the processes that the county must follow differ for MAGI versus Non-MAGI Medi-Cal. The section in this manual on annual redeterminations for MAGI and Non-MAGI beneficiaries, found *infra* at Section A.3.a., also contains additional detail.

24. Welf. & Inst. Code § 14005.39.

CalFresh²⁵ and reports a change to that program that would affect their Medi-Cal eligibility, the county should conduct a Medi-Cal eligibility redetermination using the information the beneficiary provided to the other program, without requesting additional information from the beneficiary.²⁶ If the beneficiary remains Medi-Cal eligible, the beneficiary must be granted a new 12-month eligibility period.²⁷

Counties may align a beneficiary's annual Medi-Cal redetermination date with their CalFresh redetermination date so long as the resulting Medi-Cal annual redetermination date (discussed below) is set for no less and no more than 12 months out.²⁸

Advocacy Tips: Advise your clients to give the county their updated addresses anytime they move so the county has their most current information. Even if they remain in the same city or county, they should report their new address.

Advise your clients to respond to requests for information from Medi-Cal by phone, fax, or mail as soon as possible. If they are past the deadline to respond, advise them to still respond as there is a 90-day cure period as well as good faith exceptions if they were unable to respond for a reason.

Ensure your clients' language access rights are enforced. If your client is terminated from Medi-Cal and is still eligible, but the renewal forms or Notice of Action that were sent are not in your client's primary language, you can assert that the termination is not valid because your client did not receive proper notice.²⁹ The county must reinstate eligibility and reissue the forms or Notice of Action in your client's primary language before the client can be lawfully terminated from Medi-Cal. See Section B.1.a later in this chapter.

25. CalFresh is California's Supplemental Nutrition Assistance Program, which gives eligible persons electronic benefits to purchase many foods. See Welf. & Inst. Code §§ 18900 et seq.

26. ACWDL 14-22 at pp. 2-3, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-22.pdf>.

27. Welf. & Inst. Code § 14005.37(n).

28. ACWDL 14-22 at p.3, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-22.pdf>.

29. See 42 U.S.C. § 1396u-2; 42 C.F.R. § 438.10(c); Welf. & Inst. Code §§ 14005.37(p), 15926(k).

b. Covered California

i. Enrollee Obligation to Report

Enrollees are required to report to Covered California any changes that affect eligibility within 30 days of such change.³⁰ Similar to Medi-Cal, changes that should be reported include³¹

- Income;
- Tax household composition;
- Moving;
- Immigration status;
- Incarceration; and
- Access to other health coverage.

Enrollees may report changes online through Covered California’s website, or by phone, fax, mail or in person.³² However, an enrollee has no obligation to report changes in income that do not affect the amount of the enrollee’s premium tax credits or level of cost-sharing reductions.³³

After obtaining updated information from the enrollee, Covered California must first verify the information per the procedures used when the initial application was processed.³⁴ These verification procedures are discussed in detail in Chapter 5, Section B.

30. 45 C.F.R. § 155.330(b)(1); 10 CCR §§ 6496(b) and 6498(g). Enrollees of unsubsidized coverage who experience a change of circumstances should report the change, but in general, there should be no change in their coverage during the year. Further, enrollees who have not requested an eligibility determination for insurance affordability programs do not have to report changes affecting eligibility for such programs. 45 C.F.R. § 155.330(b)(2); 10 CCR § 6496(c). Unsubsidized enrollees whose income decreases and who would like to apply for financial assistance during the year may do so. See 10 CCR § 6504(a)(6).

31. 10 CCR §§ 6472, 6474. See Ch. 4 regarding eligibility for premium tax credits and minimum essential coverage.

32. *Id.* 10 CCR §§ 6496(b) and 6498(g).

33. 45 C.F.R. § 155.330(b)(3); 10 CCR § 6496(d).

34. 45 C.F.R. § 155.330(c); 10 CCR § 6496(e); 10 CCR §§ 6478 through 6492.

Once Covered California verifies the change in information reported by an enrollee, it must redetermine the enrollee's eligibility for enrollment in the existing plan or, if applicable, for eligibility for financial assistance.³⁵ Covered California must notify the enrollee of the outcome of the redetermination within five business days of the redetermination.³⁶ For an enrollee's rights regarding adverse actions resulting from redetermination, see Section B.2.a later in this chapter.

ii. Semi-annual Data Review

Covered California is required to examine available data sources twice a year to determine if an enrollee has died and if the enrollee is receiving advanced premium tax credits or cost-sharing reductions, and whether the enrollee has been determined eligible for Medicare, Medi-Cal, or a CHIP.³⁷ Covered California must use a different redetermination process when the changes are reported by an enrollee or qualified individual versus when changes are identified based on information through semi-annual data review.

Covered California must follow this process if the semi-annual data review results in updated information about death, or eligibility for Medicare, Medi-Cal, or CHIP:³⁸

- Notify the enrollee about the updated (changed) information and the projected outcome of the eligibility redetermination after considering the new information;
- Give the enrollee 30 days to notify Covered California if the information is inaccurate;
- If the enrollee responds within 30 days to contest the updated information, Covered California must treat the information as an inconsistency and provide the enrollee a reasonable opportunity period to resolve the problem; and³⁹
- If the enrollee does not respond within 30 days, Covered California must

35. 45 C.F.R. § 155.330(e)(1)(i); 10 CCR § 6496(h)(1), referencing §§ 6472 and 6474. Such redetermination may affect the eligibility of other household members for insurance affordability programs, including Medi-Cal.

36. 45 C.F.R. § 155.330(e)(1)(ii), 10 CCR § 6496(h)(2), referencing § 6476(h).

37. 45 C.F.R. § 155.330(d)(1); 10 CCR § 6496(g).

38. 45 C.F.R. § 155.330(e)(2)(i); 10 CCR § 6496(i).

39. See 10 CCR § 6492 for procedures to resolve inconsistencies.

complete the redetermination based on the information found and send notice of the final outcome.

iii. Additional Rules Regarding Redetermination Outcomes Due to Changes in Circumstances

For a redetermination that results in a change in cost-sharing reductions, the enrollee should be determined eligible for the category of cost-sharing reductions that corresponds to her expected annual household income for the current benefit year.⁴⁰ A redetermination during the benefit year that results in a change in eligibility for cost-sharing reductions or becoming newly eligible or ineligible for premium tax credits is a qualifying event for a Special Enrollment Period, allowing that enrollee to change plans.⁴¹

Advocacy Tip: If an enrollee in a cost-sharing reduction plan reports a change that would change their eligibility for cost-sharing reductions, the change will require the enrollee to change health plans. Thus, so long as the enrollee complies with the obligation to report that change within 30 days, if they have an important medical appointment scheduled, they may want to wait until after that appointment to notify Covered California of the change to avoid billing problems. Another thing to consider is that any out-of-pocket expenses attributed to the previous plan must be credited to the new plan in order to calculate annual deductibles or maximum out-of-pocket limits.⁴²

Any change in coverage that results from a new eligibility determination would begin either the first of the following month or the second month depending on whether Covered California was notified of the change before or after the 15th of the month.⁴³

40. 45 C.F.R. § 155.330(g)(2); 10 CCR § 6496(n).

41. 10 CCR § 6504(a)(6).

42. 45 C.F.R. § 156.425(b); 10 CCR § 6506(d)(9)D).

43. 10 CCR § 6496(k), (l).

c. Medi-Cal Access Program (MCAP)

While there is no “redetermination” process for MCAP, *per se*, advocates should be aware of the following reporting obligations:

- If a woman's pregnancy ends during the first trimester, she may have her contribution reduced to one-third of the original cost by notifying MCAP within 30 days of the date the pregnancy ended.⁴⁴
- The baby's birth must be reported within 30 days so MCAP can determine the last valid day of eligible benefits, which is the end of the month in which the 60th day after birth occurs.⁴⁵
- Drops in income should be reported so that women can have their monthly contribution reconsidered or be moved into Medi-Cal.⁴⁶
- Drops in income should be reported for babies in their second year of MCAP so as to assess whether the MCAP premium can be eliminated.

2. Moving

a. Medi-Cal and Inter-County Transfers (ICTs)

Medi-Cal is a statewide benefit and is “portable” from county to county. Portability means that when Medi-Cal beneficiaries move to a new county, they *do not* have to re-apply for Medi-Cal in their new county of residence and there should be *no interruption* in their coverage.

But because the Medi-Cal program is administered at the county level, a beneficiary's Medi-Cal case must be transferred from the current county of residence to the

44. 10 CCR § 2699.400(a)(5).

45. 10 CCR § 2699.209(b).

46. This is a recent change to the MCAP program as of October 2015. The form to change the monthly premium amount can be found at http://mcap.dhcs.ca.gov/Downloads/MCAP_Contribution_Re-Evaluation_Form.aspx.

new county of residence. This process is called an Inter-County Transfer (ICT).⁴⁷ Because the majority of Medi-Cal beneficiaries receive their health services through managed care plans that are organized at the county level, Medi-Cal managed care beneficiaries who move to a different county will also likely have to enroll in a new managed care plan. Both the ICT process and how beneficiaries can help ensure they are able to access services when they move are discussed below.

i. The ICT Process

When beneficiaries move and inform⁴⁸ either the county they are leaving (known in ICT terms as the “Sending County”) or the county they are moving to (the “Receiving County”) of the new address, the two counties must work together to transfer the case with no interruption in benefits and without having to re-apply.⁴⁹

Ideally, Medi-Cal beneficiaries will report an upcoming change of address to their county workers in their Sending County before they move so their Medi-Cal case may be activated in the Receiving County by the time they relocate. State policy guidance directs Sending Counties to initiate the transfer process with the Receiving County within seven calendar days.⁵⁰ During that time, the Sending County sends an ICT Informing Notice to the beneficiary about the address change and the initiation

47. The state regulations on ICTs are at Title 22 of the California Code of Regulations, Sections 50136 to 50138. But it is important to note that portions of those regulations have been superseded by ACWDL 03-12 (Feb. 21, 2003), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c03-12.pdf>. For example, according to Section 50136(a)(1) and (3), an ICT triggers a redetermination of eligibility. But following federal guidance, ACWDL 03-12 provides that an ICT does not automatically trigger a redetermination, and that a redetermination is only required if the move coincides with a change in circumstance that may impact eligibility, such as a change in income or a change in the number of people in the family’s household.

48. At the time this manual was being drafted, DHCS issued guidance to counties to accept address change information received from Medi-Cal managed care plans when the beneficiary approved the updated contact information or the county can otherwise verify the updated contact information. ACWDL 15-30 (Sept. 22, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-30.pdf>. Presumably that means an ICT may be triggered not only when a beneficiary informs a county of a move, but also when a Medi-Cal managed care plan notifies a county of a beneficiary’s move to a different county.

49. ACWDL 03-12, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c03-12.pdf>.

50. *Id.* at p. 3.

of the transfer process with the Receiving County; enters the address change in the county's system, and completes the online transaction in the state's Medi-Cal Eligibility Data System (MEDS) so the MEDS record reflects the consumer's correct new residence county code and address; notifies the Receiving County of the impending transfer; and sends the Receiving County the ICT form and packet.⁵¹

But an ICT may also be triggered when Medi-Cal beneficiaries inform their Receiving County that they will be moving, have moved, or otherwise request Medi-Cal in their Receiving County. In that scenario, the Receiving County must contact the beneficiary's caseworker in the Sending County and request that a transfer be initiated.⁵² The Sending County then processes the transfer, *i.e.*, sends an Informing Notice to the beneficiary; completes the address change in the county's system; sends the Receiving County the ICT form and packet, etc.

Once the Receiving County has been notified of the transfer, it must complete the ICT process no later than the first of the month after the 30-day ICT notification period.⁵³ The 30 days begin on the date the Sending County mailed or electronically sent the ICT notification and ICT packet to the Receiving County.⁵⁴

During the transfer process, the Sending County retains responsibility for the beneficiary's Medi-Cal benefits and case record.⁵⁵ The Receiving County completes the transfer process by reviewing the case documents, notifying the Sending County of the effective date of Medi-Cal benefits in the new county so the case worker in the Sending County can close out the case, and sending a Notice of Action to the beneficiary at the new address to inform the beneficiary of the beneficiary's new casework name, phone number and office hours.⁵⁶ The ICT process is considered completed at the county-level once the Receiving County has the case active in its county system and the beneficiary's new address and county code is in MEDS.⁵⁷

51. *Id.* at pp. 3-4.

52. *Id.* at p. 5.

53. *Id.*

54. ACWDL 04-14 (Apr. 30, 2004), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c04-14.pdf> at p. 7. A list of the documents for the ICT packet the Sending County sends to the Receiving County is in Section IV of ACWDL 03-12 at page 7.

55. *Id.* at p.9, Section V.

56. ACWDL 03-12, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c03-12.pdf>.

57. ACWDL 04-14, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c04-14.pdf>.

Advocacy Tip: An ICT does not immediately trigger a redetermination of eligibility for Medi-Cal, even if the move coincides with other life changes that may affect eligibility. If there are no changes other than the move itself, there is no change in the beneficiary's eligibility and no need for any redetermination.⁵⁸ In situations where the beneficiary experiences other changes along with the move such as a new job and change in income, or a change in the number of people in the household, the Receiving County must not delay transfer of the beneficiary's Medi-Cal case. The Receiving County will redetermine the beneficiary's eligibility only once the transfer is complete.

ii. Accessing Care During the ICT Process

While the transfer is being processed, the Medi-Cal beneficiary will receive fee for service Medi-Cal, meaning the consumer can access services from any provider that accepts fee for service Medi-Cal rather than through a managed care plan.⁵⁹ In situations where beneficiaries who are moving and need to be disenrolled immediately from their managed care plan in order to access services, they may contact Health Care Options or the Office of the Ombudsman and request an emergency disenrollment.⁶⁰

For an ICT where an emergency disenrollment from a health plan is not needed, once the transfer is complete and the Receiving County has changed the county code in MEDS, the managed care enrollment process may begin. If the beneficiary is a mandatory managed care beneficiary, such as a MAGI expansion adult, and moves to a County Organized Health System county where there is only one health plan, the beneficiary will be automatically enrolled in the county's plan. But if the receiving county is a Geographic Managed Care county or a Two-Plan model county, the beneficiary will be placed in fee for service during the transfer and the change in county residence code will trigger Health Care Options to send the consumer health plan information. Voluntary managed care beneficiaries can remain in fee for service Medi-Cal.

58. *Id.*

59. *Id.* at p. 11.

60. *Id.* at p. 10.

b. Covered California: Inter-Regional Moves and Choosing a New Health Plan

As discussed in more detail in Chapter 4, health insurance plans offered through Covered California are organized by region. As of 2016, the state is divided into 19 regions, with different health plans and premium rates across the regions. If Covered California enrollees move, they may have to change health plans and their rates may change.

i. Choosing a New Health Plan Due to a Move

Moving is a qualifying “life event” that triggers a special enrollment period, which allows enrollees to change health plans outside of open enrollment. For a complete discussion of special enrollment for Covered California plans, see Chapter 5, Section C.2.b.

When they move, Covered California enrollees can change plans online by going to the Covered California website at www.coveredca.com. They can also call the Covered California Service Center at (800) 300-1506, or get help from a Covered California Certified Enrollment Counselor, Covered California Certified Insurance Agent, Certified Plan Based Enroller, or county eligibility worker.

ii. Avoiding Gaps in Coverage

To avoid gaps in health coverage, it is important to remember that in general the start date for coverage depends on the date of enrollment. If consumers enroll by the 15th day of the month, their coverage will start on the first day of the next month. If consumers enroll after the 15th day of the month, their coverage will start on the first day of the second following month. For example, a consumer who enrolls on June 13 will start their coverage on July 1. A consumer who enrolls on June 16 will start their coverage on August 1. The Special Enrollment rules do have exceptions for certain circumstances, including loss of Medi-Cal.⁶¹

61. See Chapter 5, Section C.2.b.

3. Annual Renewal or Redetermination

In addition to eligibility reviews or redeterminations prompted by changes in an individual's circumstances, Medi-Cal beneficiaries and Covered California enrollees must have their eligibility redetermined for coverage every 12 months.⁶²

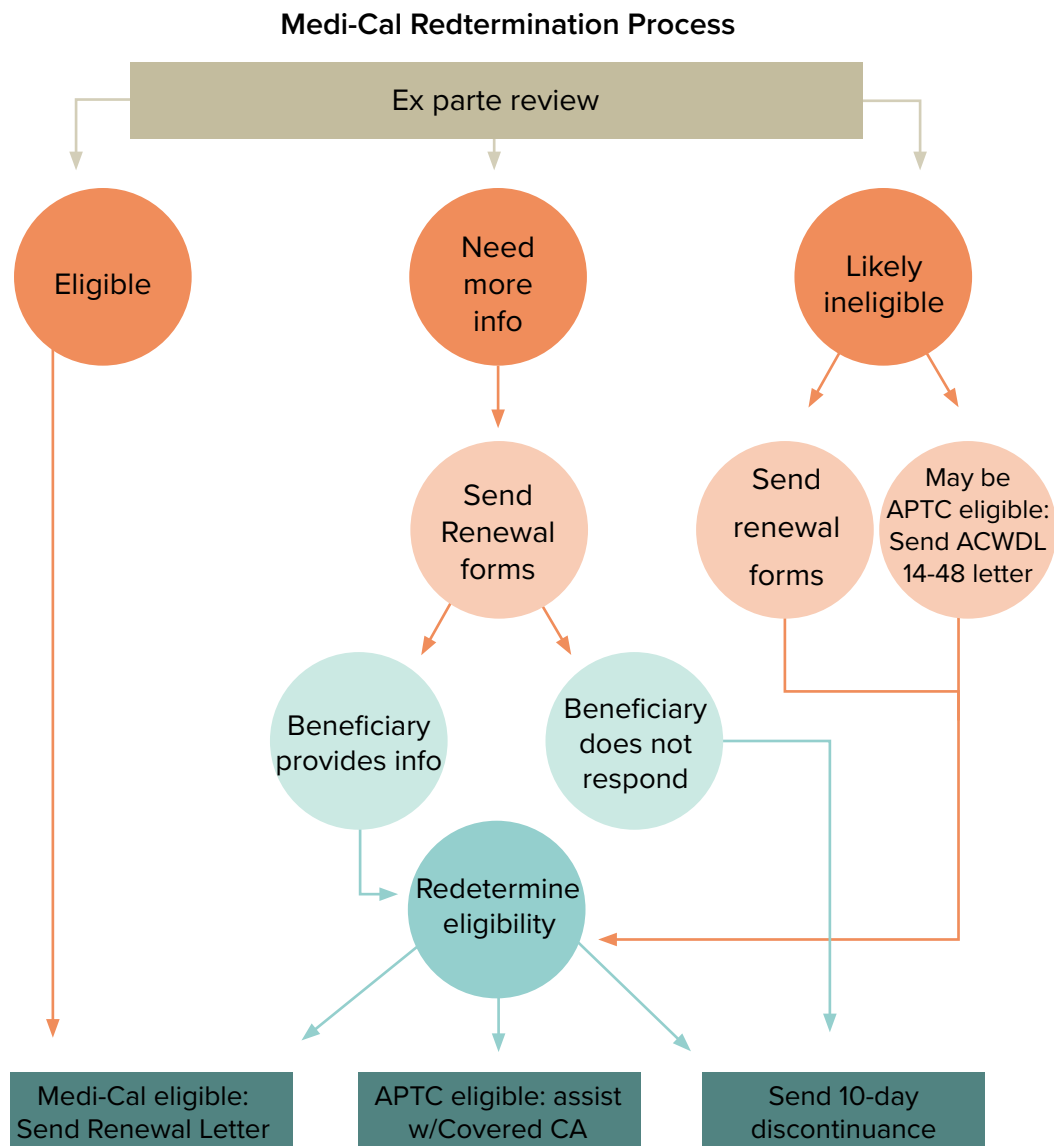
a. Medi-Cal

All Medi-Cal beneficiaries must have their eligibility redetermined once every 12 months, either on the anniversary of their initial application date or their most recent redetermination of eligibility.⁶³ There are differences among the processes for MAGI and non-MAGI beneficiaries and for households with both MAGI and non-MAGI members. The following chart illustrates the overall process and the narrative that follows details the redetermination processes for MAGI and non-MAGI beneficiaries.⁶⁴

62. 42 C.F.R. § 435.916(f); 45 C.F.R. § 155.335(f); 10 CCR §§ 6472, 6474; ACWDL 14-18, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf>.

63. 42 C.F.R. § 435.916; Welf. & Inst. Code § 14005.37(a) and (n).

64. The chart was created by Cori Racela of the National Health Law Program.



i. Process for MAGI beneficiaries

- At least 65 days before the annual redetermination date, the county does an *ex parte* review — a review using data resources available to the county such as the beneficiary’s CalWORKS file or the federal data services hub.⁶⁵
- If the county can establish eligibility based on information obtained *ex parte*, it sends the beneficiary a Notice of Action stating that eligibility continues

65. 42 C.F.R. § 435.916 (a)(2); Welf. & Inst. Code § 14005.37(e)(1); ACWDL 14-32 (Sep. 9, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_attchmnt.pdf, p. 2.

for another year and no additional information is required.⁶⁶ The notice must include the MAGI household size and income used to determine eligibility.

- If the information in the notice is incorrect, the beneficiary has 90 days to provide the county with correct information.⁶⁷
- If the county cannot redetermine eligibility with the information obtained *ex parte* or the information obtained is not reasonably compatible to find the beneficiary still eligible, the county may ask the beneficiary only for the information needed to renew eligibility. Beneficiaries should not be asked to re-confirm all eligibility criteria.
- The county sends the beneficiary a Pre-Populated MAGI Medi-Cal Annual Renewal form (Form MC 216).⁶⁸ This form contains the information that the county already has and thus asks the beneficiary only for the remaining information that is necessary to establish eligibility.⁶⁹
- The beneficiary has 60 days from the date the pre-populated form is mailed to respond.⁷⁰ The beneficiary must be allowed to provide the information requested on the MC 216 form by mail, phone, in person, or any other commonly available electronic means authorized by the county or DHCS.⁷¹
- The county must attempt to contact the beneficiary at least once in an effort to obtain the needed information, ideally at least 30 days after sending the pre-populated MC 216 form.⁷² If the beneficiary has identified a preferred method of contact, the county must use that method; otherwise, the county must use reasonable efforts to determine the best method of contact.⁷³
- **If the beneficiary responds**, the county must follow the SB 87 process

66. 42 C.F.R. § 435.916 (a)(2); Welf. & Inst. Code § 14005.37(e)(2); ACWDL 14-32, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_attchmnt.pdf, p. 3.

67. 42 C.F.R. § 435.916 (a)(3)(iii); Welf. & Inst. Code § 14005.37(e)(2). The county will redetermine eligibility based on the new information provided by the beneficiary and reconfirm by NOA if the beneficiary is still eligible.

68. 42 C.F.R. § 435.916 (a)(3); Welf. & Inst. Code § 14005.37(f)(2); ACWDL 14-32, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_attchmnt.pdf, p. 3.

69. *Id.*

70. Welf. & Inst. Code § 14005.37(f)(2); ACWDL 14-32, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_attchmnt.pdf, p. 4.

71. Welf. & Inst. Code § 14005.37(f)(1)(B).

72. *Id.* at (f)(1)(D)(2); ACWDL 14-32, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_attchmnt.pdf, p. 4.

73. Welf. & Inst. Code § 14005.37(t).

described at Section A.3.a.iv and Welfare & Institutions Code Section 14005.37 subsection (d) and evaluate the beneficiary for eligibility for *all* Medi-Cal programs (e.g., non-MAGI) before terminating the beneficiary from Medi-Cal.⁷⁴ If based on the information provided to the county the beneficiary is found not eligible for any Medi-Cal program (if they are over income due to an increase in income or change in family composition, for example) the county should determine eligibility for financial assistance through Covered California.⁷⁵ If eligible, the county should assist the individual with the enrollment process and, if requested, with Covered California plan selection.⁷⁶ After completing the beneficiary's eligibility determination for Covered California financial assistance, the county is required to send the beneficiary a ten-day Notice of Action terminating their Medi-Cal.⁷⁷ Note that the county is required to take any steps necessary to ensure that a Covered California-eligible beneficiary being discontinued from Medi-Cal can transition to Covered California without a break in coverage.⁷⁸ Further, beneficiaries found eligible for Share of Cost Medi-Cal must be evaluated for financial assistance through Covered California.⁷⁹ Beneficiaries eligible for Covered California have the choice of having just Share of Cost Medi-Cal, Covered California, or both.⁸⁰

- If, after the county follows the proper redetermination procedures outlined above and the **beneficiary does not respond**, the county may send the beneficiary a ten-day Notice of Action terminating Medi-Cal.⁸¹ At this point in

74. Welf. & Inst. Code § 14005.37(d); ACWDL 14-18, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf>, pp. 1- 2.

75. *Id.* at pp. 4, 9.

76. *Id.* at p.4.

77. The requirements for such a NOA are set forth in ACWDL 15-33 (Oct. 9, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-33.pdf>.

78. Welf. & Inst. Code § 15926(h).

79. ACWDL 14-18, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf>, pp. 3 – 4.

80. *Id.*, p. 3. Share of Cost Medi-Cal is not considered minimum essential coverage, but note that persons with Share of Cost Medi-Cal and no other coverage may meet the criteria for a Covered California Special Enrollment Period and are currently eligible for an exemption from the individual mandate. 10 CCR § 6504 § (a)(1)(D); MEDIL 15-29 (Oct. 22, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-29.pdf>, p. 2. See also Instructions for IRS Form 8965 for 2015, p. 3 available at <https://www.irs.gov/pub/irs-pdf/i8965.pdf>.

81. Welf. & Inst. Code § 14005.37(f)(3); ACWDL 14-32, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_attchmnt.pdf, p. 5.

the process, the county is required to immediately evaluate the beneficiary for Covered California financial assistance and forward the case to Covered California.⁸² At the end of the ten days, the beneficiary may be terminated from Medi-Cal, but if the beneficiary provides the requested information prior to the termination date, the county must rescind the termination action and work the case.⁸³

- If terminated, the beneficiary still has 90 days from termination to “cure” and provide the information requested. If they do so, the county must treat the information as if it was received timely.⁸⁴ Note that the “good cause” rule regarding submitting information even beyond the 90 days applies.⁸⁵ See also Section B.1 in this chapter for Medi-Cal notice and hearing rights, including the right to continue receiving Medi-Cal pending appeal (aid paid pending).
- The notice must comply with ACWDL 13-13 on Medi-Cal Notice of Action Policy, and all of the federal and state regulations upon which the notice is based. See Section B.1.a later in this chapter.

ii. Process for Non-MAGI Beneficiaries

- **Screening for MAGI:** For non-MAGI beneficiaries the county must first do an *ex parte* review of the case file or other electronic data sources to see if any individual in the household should now be considered as MAGI eligible, such as a parent, or adult with income below 138% FPL. The county must review any Request for Tax Household Information that may be in the case file or others sources that may indicate MAGI eligibility.⁸⁶ If an individual is potentially MAGI eligible, then the county should evaluate her *ex parte* utilizing the MAGI processes outlined earlier in Section A.3.a.i. The county may request tax information from data sources or from the beneficiary via the Request for Household Tax Information form, which the beneficiary has 30

82. ACWDL 14-18 (Apr. 8, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf>, p. 4

83. *Id.*

84. *Id.* See also Welf. & Inst. Code § 14005.37(i).

85. See 22 CCR § 50175(c).

86. ACWDL 14-35, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf>, p. 1.

days to complete and return.⁸⁷ However, generally, the county may not send or use that form for individuals who are enrolled in Medi-Cal programs for the aged, blind, or disabled.⁸⁸ Even absent a Request for Household Tax Information form, the county may simply use annual projected income and non-tax filer MAGI household rules to determine MAGI eligibility. If the case has one or more non-MAGI individuals, counties must complete the *ex parte* determination using the steps that follow, as applicable.⁸⁹ If any household member is in long term care, see below for next steps.

- **Ex parte Review:** For the non-MAGI beneficiaries, the county must first gather available information *ex parte* (on its own without contacting the beneficiary), e.g., from the beneficiary’s Medi-Cal, CalWORKs and CalFresh files and those of immediate family members that are open or that were closed in the prior 90 days from the federal hub and other state databases.⁹⁰ If based on the *ex parte* review there is sufficient information to establish continuing Medi-Cal eligibility, the county must send the beneficiary a Notice of Action stating that her eligibility continues and the basis for such determination.⁹¹
- **Resource/Asset Review:** The county must also review resources/assets at redetermination for non-MAGI beneficiaries. (See Chapter 3 of this manual for non-MAGI Medi-Cal asset limits.)

Beyond *ex parte* review

- If there is not enough information to complete the redetermination *ex parte* the county must request the missing information using the MC 210 RV “Medi-Cal Annual Redetermination” form.⁹² Because the county will likely need to redetermine a non-MAGI beneficiary’s resources, it should send the “Additional Income and Property Information Needed for Medi-

87. ACWDL 14-18, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf>, pp. 5 – 9.

88. ACWDL 15-03 (Jan. 20, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-03.pdf>.

89. *Id.*

90. Welf. & Inst. Code § 14005.37(e); ACWDL 14-35, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf>, p. 2.

91. Welf. & Inst. Code § 14005.37(e)

92. ACWDL 14-35, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf>, p. 2.

Cal” (MC 604) form along with the MC 210 RV form.⁹³ **For households with a family member in long term care**, the county sends both the MC 210 RV “Medi-Cal Annual Redetermination” and a “Redetermination for Medi-Cal Beneficiaries (Long-Term Care in own MFBU [Medi-Cal Family Budget Unit])” MC 262 form.⁹⁴

- The beneficiary has 60 days from the date of mailing to provide the requested information by phone, fax, in person or by mail.⁹⁵ There is a good cause exception if the beneficiary does not respond within the 60 days.⁹⁶
- The county must attempt to contact the beneficiary at least once during these 60 days to request the needed information.⁹⁷ If the beneficiary has identified a preferred method of contact, the county must use that method; otherwise, the county must use reasonable efforts to determine the best method of contact.⁹⁸
- If the county needs more information to make a property (asset) determination, it mails a “Property Settlement” form (MC 210 PS) to which the beneficiary has 30 days to respond.⁹⁹ At this stage, it is possible that the county will find potential MAGI eligibility. If this happens, the county sends the beneficiary a Request for Household Tax Information which the beneficiary has 30 days to complete and return. Then the county proceeds in accordance with the MAGI annual redetermination process described earlier in Section A.3.a.i.¹⁰⁰
- If the beneficiary remains eligible for non-MAGI Medi-Cal, the county

93. Form revised in 2014: available at: [http://www.dhcs.ca.gov/formsandpubs/forms/Forms/MC%20600/MC_604_IPS_ENG_0514%20\(2\).pdf](http://www.dhcs.ca.gov/formsandpubs/forms/Forms/MC%20600/MC_604_IPS_ENG_0514%20(2).pdf)

94. ACWDL 14-35, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf>, p. 3.

95. Welf. & Inst. Code § 14005.37(f).

96. ACWDL 14-35, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf>. The circumstances constituting good cause are found at 22 CCR § 50175(c).

97. Welf. & Inst. Code § 14005.37(f)(2), ACWDL 14-35, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf>, p. 3,

98. Welf. & Inst. Code § 14005.37(t).

99. ACWDL 14-35, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf>, p. 3.

100. *Id.* See also ACWDL 14-32 (Sep. 19, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_attchmnt.pdf.

must send the beneficiary a Notice of Action stating that her eligibility continues and the basis for such determination.¹⁰¹

- **If an individual provides the information necessary for redetermining eligibility** and is determined to be ineligible for non-MAGI Medi-Cal, the county must follow the SB 87 process described at Section A.3.a.iv and Welfare & Institutions Code Section 14005.37 subsection (d) and evaluate the beneficiary for eligibility for *all* Medi-Cal programs (e.g., MAGI) before terminating the beneficiary from Medi-Cal.¹⁰² If based on the information provided to the county the beneficiary is found not eligible for any Medi-Cal program (if they are over income due to an increase in income or change in family composition, for example) the county is required to determine eligibility for Covered California financial assistance benefits.¹⁰³ If eligible, the county should assist the individual with enrollment, and, if requested, with Covered California plan selection.¹⁰⁴ After completing the beneficiary's eligibility determination for Covered California, the county is supposed to send the beneficiary a ten-day Notice of Action terminating her Medi-Cal.¹⁰⁵ Note that the county is required to take any steps necessary to ensure that a Covered California-eligible beneficiary being discontinued from Medi-Cal can transition to Covered California without a break in coverage.¹⁰⁶ Further, beneficiaries found eligible for Share of Cost Medi-Cal must be evaluated for financial assistance through Covered California.¹⁰⁷ Beneficiaries eligible for Covered California have the choice of having

101. Welf. & Inst. Code § 14005.37(e)

102. ACWDL 14-18, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf>, pp. 1- 2.

103. *Id.* at pp. 9.

104. *Id.* at p.4. Note that although this section of ACWDL 14-18 references the MAGI redetermination process, there is no reason that it should not apply to non-MAGI as well.

105. The requirements for the Notice of Action are set forth in ACWDL 15-33, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-33.pdf>.

106. Welf. & Inst. Code § 15926(h).

107. ACWDL 14-18, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf>, pp. 3 – 4.

- just Share of Cost Medi-Cal, Covered California, or both.¹⁰⁸
- If after the county follows the proper redetermination procedures outlines above, the **beneficiary does not respond**, the county may send the beneficiary a ten-day Notice of Action terminating Medi-Cal.¹⁰⁹ At this point in the process, the county is required to immediately evaluate the beneficiary for Covered California financial assistance and forward the case to Covered California.¹¹⁰ At the end of the ten days, the beneficiary may be terminated from Medi-Cal, but if the beneficiary provides the requested information prior to the termination date, the county must rescind the termination action and work the case.
 - If terminated, the beneficiary still has 90 days from termination to “cure” and provide the information requested and if they do so, the county must treat the information as if it was received timely.¹¹¹ Note that the “good cause” rule applies for information submitted beyond the 90 days.¹¹² See Section B.1 later in this chapter for Medi-Cal notice and hearing rights, including the right to continue receiving Medi-Cal pending appeal (aid paid pending).
 - The notice must comply with ACWDL 13-13 on Medi-Cal Notice of Action Policy, and all of the federal and state regulations upon which the notice is based. See Section B.1.a.

108. *Id.*, p. 3. Share of Cost Medi-Cal is not considered minimum essential coverage, but note that persons with Share of Cost Medi-Cal and no other coverage may meet the criteria for a Covered California Special Enrollment Period and are currently eligible for an exemption from the individual mandate. 10 CCR § 6504 § (a)(1)(D); MEDIL 15-29 (Oct. 22, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-29.pdf>, p. 2. See also Instructions for IRS Form 8965 for 2015, p. 3 available at <https://www.irs.gov/pub/irs-pdf/i8965.pdf>.

109. Welf. & Inst. Code § 14005.37(f)(3).

110. ACWDL 14-18, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf>, p. 9.

111. *Id.* See also Welf. & Inst. Code § 14005.37(i).

112. ACWDL 14-35, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf>, pp. 5 – 6. See 22 CCR § 50175(c).

iii. Process for Households that Have Both MAGI and Non-MAGI Members

The county must follow both the MAGI and non-MAGI redetermination processes.¹¹³ *Ex parte* redetermination is the first step the county must take.¹¹⁴ The county should designate non-MAGI household members as “non-applying” household members of the tax filing unit to achieve an accurate MAGI determination. MAGI household members should be designated as “ineligible” household members to achieve an accurate non-MAGI determination.¹¹⁵ If eligibility cannot be established *ex parte*, the county may request more information from MAGI household members using the pre-populated MAGI redetermination form (MC 216 RV) and from non-MAGI household members using the “Additional Income and Property Information Needed for Medi-Cal” form (MC 604 IPS).¹¹⁶

If any family member is in long term care, the county should mail both the pre-populated MAGI redetermination form (MC 210 RV) and the “Additional Income and Property Information Needed for Medi-Cal” form (MC 604 IPS).¹¹⁷

Once determined eligible, the annual redetermination date for both MAGI and non-MAGI beneficiaries is reset for another 12 months.¹¹⁸

iv. SB 87 and Medi-Cal Eligibility Reviews

In 2001, the Legislature enacted SB 87, which requires counties to evaluate beneficiaries to see if they are eligible for all other Medi-Cal programs before terminating them from Medi-Cal. The implementation of the Affordable Care Act and Medi-Cal expansion did not change this important county obligation and, in fact

113. See ACWDLs 14-32, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_atthmnt.pdf and 14-35, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf>.

114. ACWDL 14-35, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf>, p.4.

115. *Id.*

116. *Id.* at 4.

117. *Id.*

118. Welf. & Inst. Code § 14005.37(a).

expanded the obligation to provide even more protections for beneficiaries.¹¹⁹ Before Medi-Cal beneficiaries can be terminated from Medi-Cal, where beneficiaries have provided information necessary to redetermine eligibility, counties must evaluate them for potential eligibility for all Medi-Cal programs and for Covered California, including advanced premium tax credits and cost-sharing reductions.¹²⁰

- **MAGI Medi-Cal Beneficiaries.** If the county determines, based on the *ex parte* review and request for additional information during the annual review, that a MAGI beneficiary is no longer eligible under MAGI rules, the county must determine if they could have “potential linkage” to non-MAGI Medi-Cal.¹²¹ DHCS has interpreted this potential linkage rule to mean that generally, if a beneficiary is between the ages of 22 and 64 and is not disabled, not a parent/caretaker, not pregnant and not in long term care, then the beneficiary is *not* potentially linked to non-MAGI. In any case, if the beneficiary requests to be reviewed for non-MAGI eligibility, the county must do so.¹²²
- **Non-MAGI Medi-Cal Beneficiaries.** If the county determines, based on the *ex parte* review and request for additional information during the annual review, that a beneficiary is no longer eligible under non-MAGI eligibility rules (e.g., excess resources), the beneficiary must be evaluated for MAGI Medi-Cal.¹²³

The county’s obligation to evaluate a beneficiary who it has determined is no longer eligible for any Medi-Cal program and is eligible for Covered California and APTCs and to assist such an individual with the transition to Covered California is discussed in Section C later in this chapter.

119. Welf. & Inst. Code § 14005.37(d)

120. 42 C.F.R. § 435.916(f); ACWDL 14-18, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf>.

121. Welf. & Inst. Code § 14005.37(d)(A) [sic], ACWDL 14-18, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf>.

122. Welf. & Inst. Code § 14005.37(d)(B)[sic].

123. Welf. & Inst. Code § 14005.37(d).

v. 90 Day Right to “Cure” or Reinstate Medi-Cal after Termination.

If a beneficiary is terminated from Medi-Cal because the county does not have sufficient information to make an eligibility determination, a beneficiary has 90 days from the date of termination to reinstate Medi-Cal benefits.¹²⁴ The beneficiary must be informed of this right and what needs to be done, e.g., what alleged missing information needs to be submitted to the county, to cure her termination in the termination notice.¹²⁵ If the beneficiary provides the necessary information within the 90 days, the county must redetermine eligibility and rescind the termination as though the beneficiary provided the information in a timely manner.¹²⁶ Further, the “good cause” rule applies to information submitted after the 90 days.¹²⁷

Advocacy Tip: If a beneficiary is terminated from Medi-Cal, they and anyone acting on their behalf should always explore the option of using the cure or reinstatement process to get back on Medi-Cal.

vi. Process When There is a Loss of Contact

If the MAGI Medi-Cal Annual Renewal Form (MC 216) is returned to the county with a “return to sender” or “no forwarding address,” before proceeding with steps to terminate the beneficiary, the county must first check all available sources to determine if any household member may be a deemed infant or former foster youth.¹²⁸ If so, the county must follow the procedures in Section A.3.a.viii. 1 and

-
124. Welf. & Inst. Code § 14005.37(i); ACWDL 14-32, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_atthmnt.pdf, p. 5.
125. ACWDL 15-27 (Jul. 31, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-27.pdf>; MEDIL 15-21 (Aug. 13, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-21.pdf>.
126. Welf. & Inst. Code § 14005.37(i).
127. ACWDL 14-35, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_atthmnt.pdf, pp. 5 – 6. The circumstances constituting good cause are found at 22 CCR § 50175(c).
128. Welf. & Inst. Code § 14005.37(g)(2); ACWDL 14-32, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_atthmnt.pdf, p. 6.

3. If not, the county must do an *ex parte* review of available information on the beneficiary or his or her family members, and then, if necessary, must attempt to contact the beneficiary by email, phone or other means available to the county according to the beneficiary's preferred mode of contact, if such mode has been identified.¹²⁹ If all required attempts to contact the beneficiary fail, the county must send a ten day notice of termination with all required appeal rights and document the inability to make appropriate contact in the case file.¹³⁰

vii. Special Processes for Certain Categories of Medi-Cal Beneficiaries

1) Former Foster Youth up to Age 26

Former foster youth should be automatically renewed by the county based on *ex parte* information. Income or resources are not counted for eligibility purposes for this population until they age out of the program.¹³¹ They should not be sent a pre-populated form MC 216 unless they are part of a household in which the information is needed to redetermine other members.¹³² Further, former foster youth up to age 26 may not be terminated from Medi-Cal due to a loss of contact with the county.¹³³ If the county cannot contact the beneficiary, the county must ensure the beneficiary is in fee-for-service Medi-Cal until contact is reestablished or the county receives information that would require discontinuance from Medi-Cal such as death or loss of California residency.¹³⁴ Once the beneficiary turns 26, the county must evaluate the individual for other insurance affordability programs, including MAGI Medi-Cal.

129. *Id.*

130. *Id.*

131. However, the former foster youth's income is counted as part of the household income when determining eligibility for other household members. See eligibility rules for former foster youths in Chapter 3.

132. Welf. & Inst. Code § 14005.28(a)(3); ACWDL 14-32, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_attchmnt.pdf, p. 6

133. ACWDL 14-32, p. 6.

134. *Id.*, pp. 6 – 7.

Advocacy Tip: Note that a family with a member who is a former foster youth may get a renewal packet. In that case, the former foster youth will not have to renew, but the other family members will.¹³⁵ The former foster youth should stay on Medi-Cal regardless of whether they return the packet, but their income is needed to determine eligibility for the rest of the household.

2) “Mega Mandatory” Groups

Annual redeterminations for Medi-Cal beneficiaries in what are referred to as the “Mega Mandatory” coverage groups should be conducted in accordance with the rules that existed for these groups before the rules under the ACA went into effect. These groups include cash aid recipients, Pickle, Disabled Adult Children, Disabled Widows/ers, Foster Care, Former Foster Care, Kin-Gap and Adoption Assistance groups.¹³⁶ Medi-Cal eligibility in these categories must be preserved as long as the beneficiary remains eligible for them because eligibility for these groups is higher on the Medi-Cal hierarchy than MAGI mandatory coverage, and their eligibility for Medi-Cal is largely derivative from their eligibility for the other program.¹³⁷ Thus, generally, so long as a beneficiary remains in a Mega Mandatory category, they should not have to be redetermined, unless they lose eligibility for the other program, and should not be evaluated for MAGI and hence, should not be sent a Request for Tax Household Information form.

Mega-Mandatory individuals in a household with members other than themselves must be included as “not applying” within the tax household for any household members who are MAGI. On the other hand, Mega-Mandatory individuals are *not* included in the Medi-Cal Family Budget Unit for non-MAGI eligibility redeterminations.¹³⁸ Counties must ensure that redeterminations for family members in households with Mega-Mandatory beneficiaries do not effect the eligibility of those beneficiaries.

135. *Id.*, p. 6.

136. ACWDL 14-35, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf>, p. 5.

137. *Id.*

138. *Id.*

3) Deemed Eligible (DE) Infants

Deemed Eligible infants whose eligibility is Medi-Cal linked must have their eligibility redetermined at their first birthday, even if the rest of the household's annual redetermination date is at a later date. If the newborn is still eligible for no-cost Medi-Cal, a 12-month Continuous Eligibility for Children period will begin.¹³⁹ See Chapter 3, Section C.6. If the newborn is not eligible for free Medi-Cal, the county will evaluate the newborn for Medi-Cal with a premium via the Optional Targeted Low-Income Children's Program (formerly Healthy Families) or Covered California.

Infants who are eligible for Medi-Cal in their first year because they are MCAP-linked may be eligible for MCAP for a second year if the household income remains below 322%. See Chapter 2, Section C.3.b. and C.4.b.

4) Foster Children Returning Home

Once a child leaves foster care before their 18th birthday, they remain eligible for Medi-Cal until the next scheduled annual redetermination. This is called Continuous Eligibility for Children and is described in more detail in Chapter 3, Section C.6. Continuous Eligibility for Children also applies to situations where a child has run away from their foster care home or whose whereabouts are otherwise unknown.¹⁴⁰

For example, after a child in foster care is returned home, they should remain eligible for Medi-Cal without interruption, regardless of the birth parent's financial circumstances, until at least the annual redetermination (the end of the continuous eligibility period) when eligibility will be reviewed by the county. If at annual redetermination, the entire household's income is within Medi-Cal limits, the youth is eligible for no-cost Medi-Cal for another 12-month period.¹⁴¹

139. 42 U.S.C. § 1396a(e)(4). Note that 22 CCR § 50262.3 also regulates the deemed eligibility program but it reflects an old version of 42 U.S.C. § 1396(e)(4) and is out-of-date. See ACWDL 09-17 (Apr. 13, 2009), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c09-17.pdf>.

140. ACL 02-59 (Aug. 5, 2002), <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl02/pdf/02-59.pdf>.

141. ACDWL 02-20 (Apr. 5, 2002), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/02-20c.pdf>.

5) Minor Consent

As the Minor Consent program is a limited-scope and temporary program, the standard redetermination rules do not apply. Currently, counties only issue eligibility for the Minor Consent Program on a month-to-month basis. The minor will receive their Medi-Cal benefits card in person at the same time services are requested. The eligibility should continue each month as long as the child meets the eligibility criteria (See Chapter 3, Section D.1) and is in need of the services.

6) Transitional Medi-Cal

During the first six months on Transitional Medi-Cal, families qualify regardless of income.¹⁴² However, to remain on Transitional Medi-Cal for an additional six month period, the household income may not exceed 185% of the federal poverty level.¹⁴³ In the sixth month, the household must complete a status form (provided by the county) to enable the county to assess, based on earnings information for months four through six, if the family is qualified for another six months.¹⁴⁴ The beneficiary must return the completed form to the county by the 21st day of the seventh month and must submit another earnings status report by the 21st day of the tenth month for months seven through nine.¹⁴⁵ If the beneficiary fails to submit the status form timely, the county sends a ten-day termination notice of action unless the county determines the beneficiary had good cause for filing late.¹⁴⁶ If the beneficiary submits forms timely, but the county determines that the household is no longer eligible for Transitional Medi-Cal, the county must evaluate the household and should not terminate Medi-Cal unless there is no eligibility for any other Medi-Cal program.¹⁴⁷ This redetermination must take place before termination of Transitional Medi-Cal so that if the beneficiary is eligible for another Medi-Cal program, there is no break in aid.¹⁴⁸

142. See Ch 3, Section C.5 of this manual for a description of Transitional Medi-Cal.

143. *Id.*

144. *Medi-Cal Eligibility Procedures Manual*, 5B, p. 8, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c288.pdf>.

145. *Id.*

146. *Id.*

147. *Id.*

148. *Id.* at p.12.

7) Breast & Cervical Cancer Treatment Programs

Consumers in Federal and State BCCTPs must report any changes that may affect their eligibility to a state BCCTP eligibility specialist within ten calendar days.¹⁴⁹ How long a person remains eligible for the BCCTP depends on which program the person qualifies for, the federal or state-only program:

- **Federal BCCTP:** Once an applicant is placed into the federal BCCTP program through Accelerated Eligibility (AE), they will continue to receive full-scope benefits until the state or county determines her to be no longer eligible for Medi-Cal on any other basis.¹⁵⁰
- **State BCCTP:** This is a time-limited program that only covers services related to breast and/or cervical cancer treatment, therefore coverage ends when 18 months of breast cancer treatment or 24 months of cervical cancer treatment are rendered.¹⁵¹ At the end of the BCCTP period, the county must redetermine eligibility for all insurance affordability programs, including other Medi-Cal categories.

149. ACWDL 06-09 (Feb. 24, 2006), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c06-09.pdf>, pp. 7 and 9.

150. Welf. & Inst. Code § 14007.71(e); ACWDL 06-09, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c06-09.pdf>, at p.7 (“If a beneficiary is found to no longer qualify for federal BCCTP ... the case may be sent to the beneficiary’s county of residence for a determination of Medi-Cal eligibility under any other program”). See *also* ACWDL 06-25 (Aug. 2, 2006), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c06-25.pdf> (describing the process for how consumers terminated from Federal BCCTP are placed in an interim Medi-Cal aid code while the county assesses eligibility under other Medi-Cal programs). The interim aid code OW is for women who no longer meet federal eligibility requirements and will continue to receive transitional Medi-Cal full-scope Medi-Cal services until the county completes an eligibility determination for other Medi-Cal programs.

151. Welf. & Inst. Code § 104161.1.

Advocacy Tip: A person may qualify for more than one period of state-only BCCTP coverage if they have a “new tissue diagnosis,” have been screened and diagnosed with this more recent qualifying cancer condition by an Every Woman Counts or Family PACT provider, and meets the other remaining State BCCTP eligibility requirements.¹⁵² A former or current State BCCTP beneficiary who later meets all eligibility requirements for Federal BCCTP, *i.e.*, a woman under 65 who gains satisfactory immigration status, may qualify for Federal BCCTP without requiring a new tissue diagnosis.

8) Refugee Medical Assistance

For most Medi-Cal programs, including time limited programs such as state-only BCCTP, redetermination occurs at the end of the eligibility period. For Refugee Medical Assistance, because the funding is time limited by the federal Office of Refugee Resettlement who regularly audits the state to make sure funding is not extended, counties begin the redetermination process two months before the end of the eight-month eligibility period. At the end of the eight months, the recipient will be transferred to another Medi-Cal program, Covered California, or terminated.¹⁵³

b. Covered California

There are two parts to annual renewal in Covered California: 1) An eligibility redetermination for enrollees who receive financial assistance that is similar to Medi-Cal beneficiaries, and 2) Re-enrollment into a plan for the next benefit year. Both parts of the annual renewal process occurs in the early fall prior to the annual open enrollment period.

152. ACWDL 06-09, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c06-09.pdf>, p.8.

153. See ACWDL 15-16 (Mar. 20, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-16.pdf> and ACWDL 14-16 (Apr. 1, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-16.pdf> for information on transitioning RMA beneficiaries into the M1 adult expansion aid code or moving to Covered California as necessary at the end of the RMA period.

i. Open Enrollment

An individual may enroll in a qualified health plan, or an enrollee may change plans only during the annual open enrollment period, except individuals in specified circumstances may enroll during special enrollment periods.¹⁵⁴ See Chapter 5 for information about Special Enrollment. For plan year 2016, the open enrollment period started on November 1, 2015 and ran through January 31, 2016. The open enrollment period for the exchange each year is adopted into federal and state regulations, generally following the dates used for the federal Exchange.¹⁵⁵

During the open enrollment period, all Covered California enrollees – whether or not they have financial assistance – have the opportunity to choose their coverage for the next benefit year.¹⁵⁶ They can choose to remain with the same health plan, change metal tiers (e.g., silver to bronze), change to another health plan, or terminate coverage.¹⁵⁷ If existing enrollees want a new plan to start on January 1st, they must change plans by December 15th.¹⁵⁸ If they miss that deadline, they have until the end of open enrollment to change plans or they will remain automatically re-enrolled in their current plan or a similar one if necessary. See Section A.3.b.iii. below for more on automatic plan re-enrollment.

ii. Notice Requirements

The open enrollment period is the time for new consumers to purchase Covered California coverage if they are newly eligible or were not able to qualify for a special enrollment period during the year. To reduce confusion, Covered California must notify current enrollees as well as qualified individuals – those who were determined

154. 10 CCR § 6502(a); see also 45 C.F.R. § 155.420; 10 CCR § 6504 (special enrollment periods).

155. Health & Safety Code § 1399.849(c)(1); Ins. Code § 10965.3(c)(1); 10 CCR § 6502(f). The federal Exchange (known as the federally-facilitated marketplace) is for states that do not administer their own Exchanges.

156. The one exception is if an enrollee qualifies for a special enrollment period during the year. For Medi-Cal beneficiaries enrolled in a health plan, they are able to change plans throughout the year and there is no similar open enrollment period in Medi-Cal. For more information, see Chapter 5 on Medi-Cal managed care enrollment.

157. They may actually terminate coverage at any time throughout the year.

158. See 10 CCR § 6498(e)(2)(A).

eligible for coverage but did not enroll – of the annual renewal process and the annual open enrollment period in a “single, coordinated notice,” no earlier than the first day of the month before the open enrollment period begins and no later than the first day of the open enrollment period.¹⁵⁹

The content requirements of the “single, coordinated” notice differ depending upon whether the individual is an existing enrollee or qualified individual, and whether the enrollee has requested an eligibility determination for financial assistance.¹⁶⁰ For qualified individuals not currently enrolled in a qualified health plan, the notice must include at least the following:¹⁶¹

- A description of the annual redetermination and renewal process;
- An explanation of the obligation to report changes to information affecting eligibility during the benefit year;
- Instructions on how to report a change to Covered California; and
- The open enrollment date and the last day on which plan selection may be made for coverage effective on January first of the following benefit year to avoid any coverage gap.¹⁶²

For existing Covered California enrollees who are receiving financial assistance for the current benefit year, the notice must include at least all of the above information plus the following:¹⁶³

- An explanation that the plan premiums and the amount of premium tax credits and the level of cost-sharing reductions, for which they may be eligible, may change each benefit year;
- A description of the reconciliation process for advanced premium tax credits;
- The data used in the enrollee’s most recent eligibility determination and the amount of monthly advanced premium tax credit and the level of cost-sharing reductions the enrollee has been receiving during the current benefit year;

159. 45 C.F.R. § 155.335(c); 10 CCR §§ 6498(f), 6502(e).

160. 45 C.F.R. § 155.335(d); 10 CCR § 6498(f)

161. See 10 CCR § 6498(e)(1) for specifics on this obligation.

162. 10 CCR § 6498(e)(1).

163. 10 CCR § 6498(e)(2).

- An explanation that if they do not complete the renewal process by December 15 of the current benefit year for coverage effective January first of the following benefit year, Covered California will redetermine eligibility and renew coverage for the following benefit year using the last information the enrollee provided to it; and
- An explanation that to obtain the most accurate eligibility determination, including for financial assistance, the enrollee must contact Covered California and update their information, or make a plan selection by the end of the open enrollment period.

For existing enrollees with unsubsidized coverage (who did not receive financial assistance), the notice must include at least all of the information Covered California is required to provide to qualified individuals not currently enrolled (see above) plus explain the following:¹⁶⁴

- That the plan premiums may change each benefit year;
- That unless the enrollee completes the renewal process by December 15 of the current benefit year for coverage effective January first of the following benefit year, Covered California will redetermine eligibility and renew coverage for the following benefit year using the most recent information (e.g., address, household members) the enrollee provided to Covered California; and
- That to obtain the most accurate eligibility determination, the enrollee must contact Covered California and update her information or make a plan selection by the end of the open enrollment period.

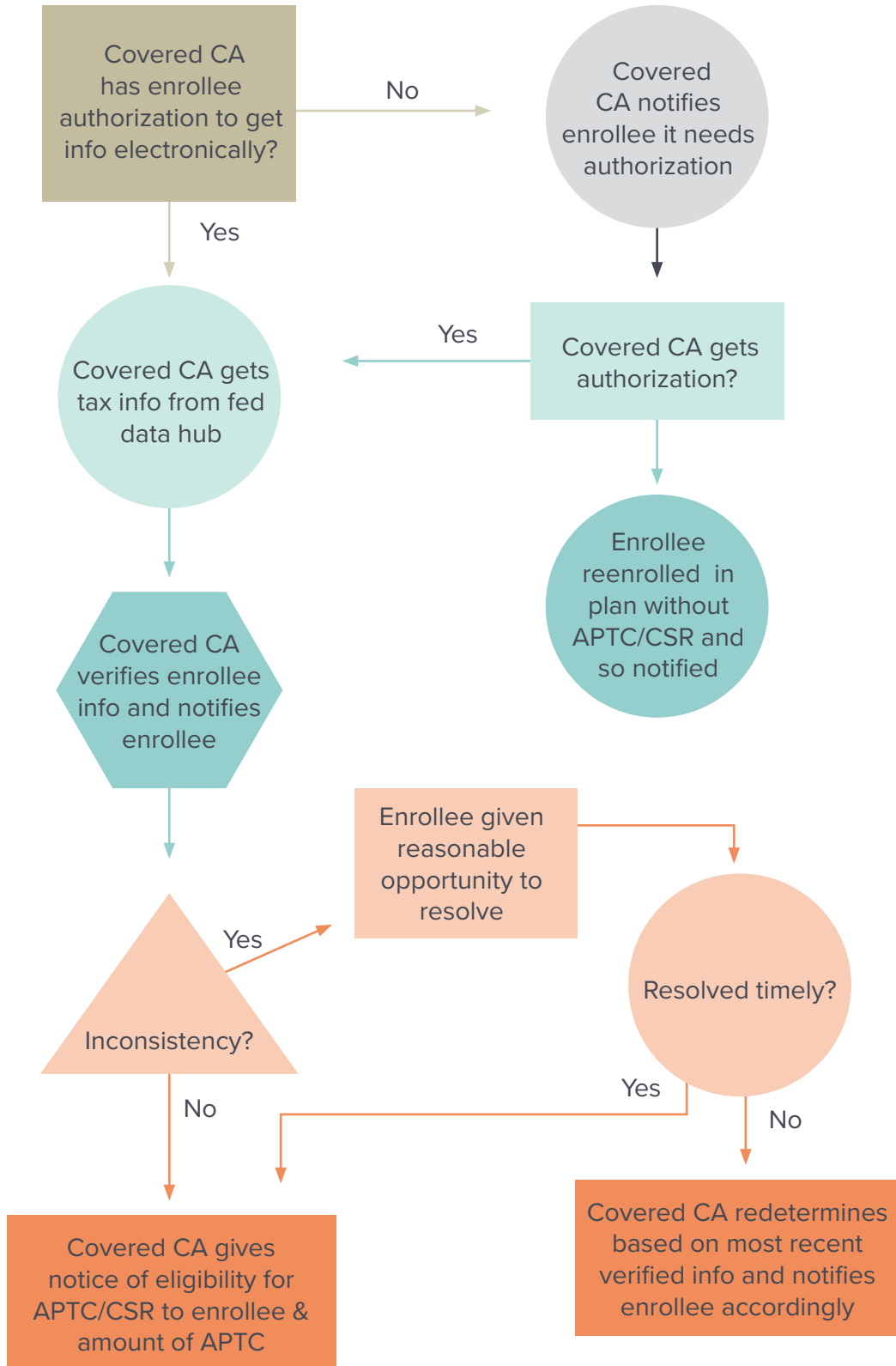
iii. Redetermination for Financial Assistance

Annual redetermination of eligibility for enrollees who receive financial assistance (Advanced Premium Tax Credits (APTCs) or Cost-sharing Reductions (CSRs)) begins before open enrollment so that Covered California can let enrollees know what financial assistance they are eligible for the next benefit year to help them choose a plan during open enrollment.¹⁶⁵ The following chart illustrates the beginning steps of this process and is followed by a detailed narrative description.

164. 10 CCR § 6498(e)(3).

165. 45 C.F.R. § 155.335 (a); 10 CCR § 6498(a).

Covered California Renewal



Step 1: Updating Electronic Data and Authorization

Covered California needs to obtain income tax information electronically via the federal data services hub to ensure the eligibility redetermination for financial assistance is based on enrollees most recently reported income. However, enrollees must provide Covered California authorization to access the annual household income per federal tax records.¹⁶⁶ Authorization may be provided by the enrollee at the time of the initial application for a period of one to five years.¹⁶⁷ If Covered California already has authorization from the enrollee at the time of annual redetermination, Covered California will automatically obtain the most recent federal tax information and amount of Social Security benefits (if applicable) from the federal data hub, as well as income data from state databases such as the Franchise Tax Board to begin the eligibility redetermination of their financial assistance.¹⁶⁸

If Covered California still needs authorization to check tax information beyond the initial year, Covered California will notify enrollees before the annual renewal process begins that their authorization is required to be able to redetermine their eligibility for APTCs and CSRs for the following plan year.¹⁶⁹

If Covered California is not provided this authorization by a specified date during the renewal period, Covered California is unable to redetermine eligibility for financial assistance, and the enrollee will not be able to receive financial assistance for the following year.¹⁷⁰ Due to automatic plan re-enrollment (discussed below), these

166. 10 CCR § 6498(b).

167. *Id.* However, the enrollee or qualified individual may decline to provide such authorization, may provide authorization for a period of less than five years, and may “[d]iscontinue, change or renew his or her authorization at any time.”

168. *Id.* at subsec. (c).

169. 10 CCR § 6498(d). Notice must be provided at least 30 days prior to the date of the first annual redetermination notice. Covered California can provide this notice earlier to allow more time for enrollees to respond and give authorization. *Id.* See also 10 CCR § 6498(f) for notice requirements.

170. 10 CCR § 6498; 45 C.F.R. § 155.335. Permission to access electronic records is required even if an enrollee can provide Covered California updated income because any information provided must be electronic verified before it can be used to redetermine eligibility. Thus, without this permission, Covered California cannot make any eligibility redetermination for financial assistance. 45 C.F.R. § 155.335(l). Ultimately, the goal for use of electronic records is to reduce the burden on consumers and have their eligibility redetermined every year electronically without any action required by the consumer.

enrollees will automatically be re-enrolled into their Covered California plan but will be required to pay the issuer the full amount of the premium for coverage starting January 1.

Step 2: Redetermining Eligibility

An enrollee must complete the renewal process within 34 days from the date of the annual redetermination notice.¹⁷¹ The enrollee may complete the redetermination process through the Covered California website, in person with an enrollment counselor, or by telephone.¹⁷²

Once an enrollee has updated her information, Covered California will electronically verify that information. If there is an inconsistency, Covered California must notify the enrollee and provide a reasonable opportunity to resolve the problem. Otherwise, Covered California will provide notice of eligibility for financial assistance for the next benefit year, and the amount of the premium tax credits.¹⁷³

If the enrollee or the qualified individual does not complete the renewal process within the prescribed 34 days, Covered California will proceed with redetermination of eligibility for financial assistance based on the most recent information the individual provided to it and renew the enrollee's coverage for the following benefit year.¹⁷⁴ Covered California must provide written notice of the eligibility determination within five business days of the determination.¹⁷⁵ Individuals have similar appeal rights when renewing their coverage as they do when initially applying for coverage.¹⁷⁶ If the enrollee does not actively update their information and choose a plan, Covered California must use the individual's most recent tax information and keep them in the same plan, if possible.¹⁷⁷

171. See 10 CCR § 6498(i) for all of the steps.

172. 10 CCR § 6498(i)(2). Because there is no paper renewal form, providing updated information by fax or mail is not available.

173. 10 CCR §§ 6476(h), 6498(j)(2).

174. 10 CCR § 6498(l)(1). In doing so, Covered California must adhere to the standards in subsection "l" of § 6498 and to the requirements of §§ 6472 and 6474 which cover eligibility requirements for enrollment in a plan through Covered California and eligibility requirements for financial assistance.

175. 10 CCR §§ 6476(h), 6498(j)(2).

176. 10 CCR § 6604(a)(2).

177. 10 CCR § 6498(l)(1).

Step 3: Automatic or “Passive” Plan Re-Enrollment

Plan re-enrollment occurs during open enrollment for all current Covered California enrollees – whether or not they receive financial assistance or have been redetermined eligible for financial assistance. Re-enrollment must be completed by December 15th for the new coverage to have an effective date of January 1st.

If Covered California is able to redetermine an enrollee’s financial assistance during this period, Covered California will also notify the health plan selected by the enrollee. Health plan issuers will then send a notice to its existing enrollees regarding the amount of the new premium, their updated advanced premium tax credit amount, and an updated Summary of Benefits and Coverage.¹⁷⁸

If the enrollee does not terminate coverage nor actively chooses a plan for the next benefit year by December 15th, Covered California and the health plan issuers will automatically enroll the individual in a plan most similar to their existing plan and metal tier to avoid a gap in coverage the following year.¹⁷⁹ If the enrollee is no longer eligible for a silver plan with cost-sharing reductions, they will be enrolled in a silver plan without cost-sharing reductions.¹⁸⁰ If the issuer of the existing plan is no longer offering any coverage under Covered California, Covered California may not automatically enroll the individual into a plan with another issuer. Instead, Covered California must notify the enrollee they must choose a new plan with a new issuer by the end of open enrollment or they will lose coverage for the following year.¹⁸¹

Other than this exception, most Covered California enrollees will be re-enrolled in a plan as of January 1st whether or not they selected a plan themselves. They may change plans until the end of the open enrollment period with the same effective dates as regular plan enrollment. However, after open enrollment ends, enrollees

178. 45 C.F.R. § 155.400(a); 45 C.F.R. 156.1255 (issuer); see also CMS Bulletin 16: Guidance for Issuers on 2016 Reenrollment in the Federally-facilitated Marketplace (FFM) (August 25, 2015), pp. 5-6 at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016AutoReenrollmentBulletin16.pdf>.

179. 45 C.F.R. §§ 155.335 (j) and 155.410(g); 10 CCR § 6498(l)(1). CMS provided exchanges details on how to determine which plan is most similar to last year’s plan to ensure enrollees are not inadvertently placed in a plan that is more expensive or less comprehensive than what coverage they currently have. See 45 CFR 155.335(j).

180. 10 CCR § 6498 (l)(2).

181. *Id.* at subsections (3) and (5).

may not change plans until the next open enrollment period unless they qualify for a special enrollment period.¹⁸² If they do finally report and authorize verification of their income, they will be able to start receiving the premium tax credits they are eligible for.

c. Redetermination for Mixed Coverage Families

For purposes of this section, a mixed coverage household means a household with at least one member in Modified Adjusted Gross Income (MAGI) Medi-Cal and at least one household member receiving Covered California benefits.

Household members in a mixed coverage family will have two different annual redetermination periods — one for Medi-Cal, which can take place at any time of the year so long as it is 12 months after the last time their eligibility was determined, and one for Covered California, which only takes place during open enrollment.¹⁸³ The annual redetermination notice that Covered California sends to enrollees should include information about which family members are required to renew and which members have Medi-Cal coverage and will need to renew separately with the county in order to avoid confusion.¹⁸⁴ Counties have jurisdiction for all mixed household redeterminations.¹⁸⁵ As a result, counties must assist with renewals for mixed households where changes are reported for Covered California that may affect Medi-Cal eligibility.¹⁸⁶

When a household has members whose Medi-Cal redetermination occurs before the Covered California redetermination period, the county will conduct the annual renewal process as described above for both MAGI and non-MAGI beneficiaries in the household. The county will enter the updated information for the household into county's eligibility determination system, redetermine eligibility for those members,

182. See Chapter 5, Section C.2.b.

183. ACWDL 14-38 (Oct. 23, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-38.pdf>, p. 1.

184. ACWDL 14-38, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-38.pdf>, p. 2.

185. Welf. & Inst. Code § 14005.37; ACWDL 14-38, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-38.pdf>, p. 8, citing Welf. & Inst. Code § 14015.7(b).

186. ACWDL 14-38, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-38.pdf>, p. 9.

and provide notice of renewal. The county will set the next annual redetermination date for 12 months for those members who have Medi-Cal.

The updated household information obtained by the county during the Medi-Cal determination is automatically entered into CalHEERS – the statewide eligibility system for Covered California and MAGI Medi-Cal. Covered California will consider this updated information as a change of circumstance if there have been changes that affect eligibility, and follow the redetermination process described above for the members of the household who are enrolled in Covered California. Covered California must notify the enrollees that their eligibility was reviewed again as a result of the new information and provide a written eligibility determination. The annual redetermination date for Covered California household members, however, is not changed.

If the Covered California annual redetermination period occurs before the Medi-Cal annual redetermination date, Covered California will conduct the annual redetermination process as described above for those household members who are enrolled in a Covered California plan. The household should provide Covered California with any updated eligibility information on-line or by phone as discussed earlier in Section A.3.b. Covered California will redetermine eligibility for the Covered California household members and provide a notice of renewal.

The updated information provided by the family or the federal data hub to Covered California will be automatically electronically shared with the county via the CalHEERS computer system and sent to the county's computer system. The county must consider any changed information that affects eligibility, such as a change in income or household size, as a change in circumstances and redetermine eligibility for the Medi-Cal members as described earlier in Section A.3.a.¹⁸⁷ This results in a re-setting of the annual redetermination date for the Medi-Cal household members to 12 months from the redetermination.¹⁸⁸

187. ACWDL 14-38, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-38.pdf>, p. 8.

188. 42 C.F.R. § 435.916(d)(1)(ii); Welf. & Inst. Code § 14005.37(n); ACWDL 14-38, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-38.pdf>, p. 8. See also ACWDL 14-22, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-22.pdf>.

d. Redetermination for MCAP

A woman on MCAP does not go through an annual redetermination because her coverage ends at the end of the month that is 60 days after her child was born.¹⁸⁹ Infants born to mothers who were on MCAP at the time may remain on MCAP for 12 months (or move to Medi-Cal if the household income drops).¹⁹⁰ At the end of the 12 months, the family is sent a request for income information. If the household income is below 322% FPL, the infant may remain enrolled in MCAP for another 12 months.¹⁹¹ At the end of the second 12 months, the infant is screened for Medi-Cal eligibility.¹⁹²

B. Due Process Rights

Medi-Cal applicants and beneficiaries have well-established due process rights that govern their legal rights to enroll or stay on the program. Likewise, the Affordable Care Act established rights for applicants and enrollees in plans administered by health benefit exchanges such as Covered California. The processes for consumers to appeal adverse actions related to Medi-Cal and to Covered California are closely aligned. Following federal and state mandates, the State established an appeals process for prospective and current Covered California and MCAP enrollees by enacting Assembly Bill 617 (Nazarian), which took effect on January 1, 2015.¹⁹³ Some of the statutory scheme created by AB 617 also amended the Medi-Cal hearing process.¹⁹⁴ This section discusses the Medi-Cal and Covered California appeals processes separately, specifying the parts of the processes that are the same as well as the points where they diverge, and also discusses some important aspects of dual agency (combined Medi-Cal and Covered California) appeals.

189. Welf. & Inst. Code § 15840.

190. Welf. & Inst. Code § 15832(a)(3)(A).

191. Welf. & Inst. Code § 15832(a)(3)(B).

192. Welf. & Inst. Code § 15832(a)(3)(C).

193. Stats. 2014, c. 869 (A.B.617), § 7, eff. Jan. 1, 2015.

194. See Welf. & Inst. Code §§ 10950, 10951, and 10960.

1. Medi-Cal Eligibility Appeals¹⁹⁵

Medi-Cal applicants and beneficiaries have due process notice and hearing rights when an adverse action is taken against them such as a Medi-Cal denial or termination, or a reduction in services or benefits.¹⁹⁶ Adverse actions also include increasing a household's share of cost.¹⁹⁷ This section focuses on the notice and appeals process for Medi-Cal eligibility denials and terminations. The Department of Health Care Services has delegated the provision of hearings to the Department of Social Services' State Hearings Division, who also conducts other benefits hearings such as hearings related to CalFRESH.¹⁹⁸ Non-MAGI Medi-Cal hearings continue to be handled by the regional offices of the State Hearings Division, while the MAGI Medi-Cal hearings are handled by the State Hearings Division's Affordable Care Act Bureau, which also handles Covered California appeals.

a. Notice: Content and Timing Requirements

The county must send the applicant or beneficiary a written Notice of Action before terminating, suspending, or reducing benefits.¹⁹⁹ The notice must give recipients timely and adequate notice of the proposed action.²⁰⁰ The notice must state the intended action, the reasons and legal authority for such action, an explanation of hearing rights and the right to representation, and how a beneficiary might receive continuing benefits while the appeal is pending or it is not adequate.²⁰¹ Where the intended action is to terminate benefits based on missing eligibility information,

195. This section relies in part on sections of Chapter 19 of the Health Consumer Alliance's Medi-Cal Overview (2008) authored by the National Health Law Program, which can be found at <http://healthconsumer.org/publications.htm#manuals>. Information has been expanded and updated as appropriate.

196. See *Goldberg v. Kelly*, 397 U.S. 254, 266 (1970) (procedural due process requires evidentiary hearing before public assistance payments to welfare recipient are discontinued.); 42 C.F.R. § 431.201; Welf. & Inst. Code § 51014.1; 22 CCR § 50015.

197. 22 CCR § 50015.

198. Welf. & Inst. Code § 10950 allows the Department of Health Care Services to contract with the Department of Social Services for the provision of state fair hearings. The delegation documents are available at <http://www.cdss.ca.gov/shd/PG1160.htm>.

199. 42 C.F.R. § 435.919(a); 22 CCR § 50179(a).

200. 42 C.F.R. § 435.919.

201. 42 C.F.R. § 431.206(b); 22 CCR §§ 50179(c), 51014(c); ACWDL 13-13 (May 14, 2013), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/13-13.pdf>, pp. 3 – 4.

the notice from the county must also advise the beneficiary of the right to reinstate benefits, or “cure,” after termination of Medi-Cal and how to exercise it.²⁰²

The county must send the beneficiary a notice regarding termination of Medi-Cal ten days prior to the date of intended termination.²⁰³ The ten days does not include the date of mailing or the effective date of the action.²⁰⁴

With regard to initial eligibility determinations, the county must determine eligibility and provide a notice of approval or denial within 45 days of the date of application, or 90 days if a disability determination is required.²⁰⁵

Advocacy Tip: Advocates should always consider asserting a notice argument when the clients do not receive the notices to which they are entitled or when the notices they receive are defective in terms of content or timeliness. Potential remedies for such defects include undoing the adverse action, requiring the county to restart the process, or reinstating aid paid pending.²⁰⁶

Notices of Action should be provided in the language indicated by the beneficiary to the county.²⁰⁷ DHCS should translate the notices into the Medi-Cal “threshold languages,” and counties must use DHCS's translated notices for applicants and

202. Welf & Inst. Code § 14005.37(i); 22 CCR § 50179(c)(7).

203. 42 C.F.R. § 431.213, 22 CCR § 50179(d). ACWDL 13-13, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/13-13.pdf>, p. 4. See also *Rivera v. Douglas*, No. RG14740911 (Cal. Superior Ct. (Alameda), August 14, 2015).

204. 22 CCR § 50179(d)(1); ACWDL 13-13, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/13-13.pdf>, p. 4; California Dept. of Social Services Manual of Policies & Procedures (“MPP”), § 22-072.4 available at <http://www.dss.cahwnet.gov/getinfo/pdf/4cfcman.pdf>.

205. 42 C.F.R. § 435.912(e); Welf. & Inst. Code § 15926(f)(5); 22 CCR § 50179(a) (notice of action required for eligibility decisions); 22 CCR § 50177(a) (promptness requirements for Medi-Cal eligibility decisions).

206. Welf. & Inst. Code § 10967.

207. Welf. & Inst. Code § 15926(k); ACWDL 13-13, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/13-13.pdf>, p. 8; ACWDL 10-03 (Jan. 12, 2010), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c10-03.pdf>, p. 6.

beneficiaries in their primary language, regardless of whether that language is a threshold language in a particular county.²⁰⁸ The current written threshold languages required for Medi-Cal are: Spanish, Vietnamese, Chinese,²⁰⁹ Korean, Russian, Armenian, Farsi, Khmer (Cambodian), Hmong, Arabic and Tagalog.

Advocacy Tip: Advocates should challenge notices that are not translated into a beneficiary’s primary language bearing in mind that the Department of Social Services Manual of Policies and Procedures’ definition of a language-compliant notice sets forth “a rebuttable presumption that a claimant chose to receive written communications in her primary language.”²¹⁰ Any hearing request made in response to a non-language compliant notice “shall be deemed to be a timely hearing request.”²¹¹ Further, “a case shall be postponed” if the Administrative Law Judge determines that a language-compliant notice was not provided, unless the claimant waives the language-compliant notice.²¹² Finally, a claimant can generally get aid reinstated retroactively, if they received a non-language-compliant notice that involves discontinuance, suspension, termination or reduction of aid.²¹³

b. Requesting a Fair Hearing

Medi-Cal applicants and beneficiaries have the right to challenge adverse actions, such as denials of eligibility or termination of benefits, through the fair hearing process. “Claimants,” as persons requesting a hearing are called, have 90 days from

208. ACWDL 13-13, p. 8. See also ACWDL 10-03, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c10-03.pdf> for additional guidance on language access requirements in Medi-Cal.

209. For spoken languages, Mandarin, Cantonese and Other Chinese are all threshold languages thereby the state and counties must employ a sufficient number of qualified bilingual persons to ensure provision of services in those languages. ACWDL 10-03 (Jan. 12, 2010), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c10-03.pdf>, p. 2.

210. MPP 22-001(l)(1)(a).

211. MPP 22-009.11.

212. MPP 22-049.522.

213. MPP 22-049.522.

the date of the mailing of the notice to request a hearing.²¹⁴ A claimant has the right to be represented in the hearing process by an “authorized representative,” who can be an advocate, attorney, or someone else the claimant chooses.²¹⁵ For good cause, the time to request a hearing can extend beyond 90 days for up to 180 days from the date of the adverse action.²¹⁶ However a notice is not required in order to request for a fair hearing. An individual may file a hearing request whenever they are not satisfied with the county’s action regarding their Medi-Cal or if their Medi-Cal application has not been determined quickly enough.²¹⁷

Advocacy Tip: If an applicant has been waiting for more than 45 days (or 90 days for applications requiring a disability determination) for an eligibility determination or if a beneficiary is not sure whether they got a notice, they should file for a fair hearing immediately. Note that applicants on the 45 day timeline who have received neither an eligibility determination nor a notice must be sent a Notice of Inaction informing them how to appeal; however, such applicants should not wait for such notice to request an eligibility hearing.²¹⁸ If the applicant has immediate health needs, file for an expedited hearing.²¹⁹

Beneficiaries terminated from Medi-Cal based on lack of information to redetermine eligibility also have 90 days from termination to “cure” the termination and get back on Medi-Cal by submitting to the county the information it claims is missing.²²⁰ When a termination is cured, an individual’s eligibility is restored back to the date of termination. Curing the termination may be a better way to resolve a problem related to incomplete information, even when the individual is sure they turned such

214. 42 C.F.R. §431.221(d), Welf. & Inst. Code § 10951. Note that the 90-day limit does not apply if the beneficiary gets no written notice or if the NOA is defective. *Morales v. McMahon*, 223 Cal.App.3d 184 (1990).

215. 42 C.F.R. § 435.923; MPP 22-085.

216. Welf. & Inst. Code § 10951(b).

217. Welf. & Inst. Code § 10950(a).

218. MEDIL 15-11 (Apr. 7, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-11.pdf>.

219. 45 CFR § 155.540(a); Gov’t Code § 100506.4(a)(2); 10 CCR § 6616(a); ACL 14-14 (Feb. 7, 2014), <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf>, p. 14.

220. Welf. & Inst. Code § 14005.37(i).

information in, because the cure process can be faster.

A request for hearing need only be “a clear expression by the applicant or beneficiary, or his authorized representative, that he wants the opportunity to present his case to a reviewing authority.”²²¹ No magic words are required. Generally, an individual may request a hearing by filling out the form on back of the notice called the “NA Back 9” and sending the completed form to the state Department of Social Services State Hearings Division or by making a request to the State Hearings Division.²²² There is a place on the NA Back 9 form to request an interpreter. In whatever form a request for a hearing is made, it should contain identifying information such as the requester’s name, address, phone number and Medi-Cal number (if already a beneficiary). It should make clear that it is a request for a Medi-Cal hearing and the reason for the request—why the claimant disagrees with the particular action or inaction at issue.²²³ The claimant should also state if they need an interpreter and identify the language needed.²²⁴ If a claimant requests help with filing a hearing request, the county or Covered California staff must provide such assistance.²²⁵

c. Expedited Hearings

Medi-Cal applicants or beneficiaries are entitled to an expedited appeals process “where there is immediate need for health services because a standard appeal could seriously jeopardize the appellant’s life, health, or the ability to attain, maintain, or regain maximum function.”²²⁶ A request for an expedited hearing solely on a Medi-Cal issue must be made to the Presiding Judge of the county’s regional State Hearings Division office by phone or facsimile.²²⁷ If a Covered California

221. 42 C.F.R. § 431.201.

222. ACWDL 13-13, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/13-13.pdf>, p. 9. The NA Back 9 must be on the back of all NOAs and is also available at <http://www.cdss.ca.gov/cdssweb/entres/forms/English/NABACK9.PDF>. Refer to this ACWDL for general NOA requirements.

223. MPP 22-004.211.

224. *Id.*

225. Gov’t. Code § 100506.4(c); 22 CCR § 50955.

226. Gov’t. Code § 100506.4(a)(2). See also ACL 13-40 (May 20, 2013), <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2013/13-40.pdf>, p. 2.

227. Phone numbers and other contact information regarding the foregoing are provided in Appendix D of this manual.

issue is involved, however, the request goes to the Affordable Care Act Bureau.²²⁸ The Presiding Judge may set up a three-way call between the county appeals representative and the claimant to get the information necessary to determine whether an expedited hearing is warranted. If the Presiding Judge decides to grant the request for expedited hearing, they must ensure the hearing is calendared on an expedited basis and send the claimant and county written notice within ten days of the request for an expedited hearing.²²⁹ If the request for expedited hearing is denied, notice of the denial must be provided within three days by phone or other common secure electronic means followed by notice in writing within five working days to the county and claimant. The matter must be set for fair hearing according to the regular hearing timelines.²³⁰

The Administrative Law Judge must issue a decision within five business days of closing the record.²³¹ Thereafter, the claimant may follow all of the procedures that apply when pursuing the regular hearing process.

d. Retaining Benefits During the Fair Hearing Process – Aid Paid Pending

Medi-Cal beneficiaries are allowed to keep their Medi-Cal during the fair hearing process under several conditions. In the case of a termination, reduction or suspension of existing eligibility, if a beneficiary requests a fair hearing within ten days from the date of the notice or before the intended action that is the subject of the notice takes place, Medi-Cal eligibility and benefits must be continued until the administrative law judge issues a hearing decision.²³² Eligibility and benefits maintained under these circumstances is called “aid paid pending.” Further, the Department of Health Care Services also has the option to reinstate services to a beneficiary who requests a hearing within ten days after the adverse action.²³³

228. ACL 14-14, <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf>, pp. 14-15.

229. *Id.*

230. Gov't. Code § 100506.4(a)(2). See also ACL 14-14, <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf>, pp. 14-15.

231. Gov't. Code § 100506.4(a)(2). See also ACL 14-14, <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf>, p. 3.

232. 42 C.F.R. §§ 431.230, 431.231(c) & (d); 22 CCR § 51014.2(a).

233. 42 C.F.R. § 431.231.

Finally, where there has been a failure to provide a proper, language compliant, and timely notice, a beneficiary who requests a hearing must be reinstated within ten days of the mailing of a proper notice and must receive aid paid pending.²³⁴

Advocacy Tip: Whenever possible, in the case of a termination, reduction or suspension of Medi-Cal coverage, the claimant or their representative should request a hearing within ten days of receiving the notice, even if it appears that the issue can be resolved informally, so that the claimant continues to receive Medi-Cal coverage while working to resolve the problem. Similarly, request aid paid pending in all cases where the notice is defective or no notice was sent.

e. Informal Resolution

Once an applicant or beneficiary requests a hearing to challenge an adverse action, county appeals workers must try to resolve disputes informally, at the lowest administrative level, to avoid unnecessary hearings.²³⁵ The county appeals worker initiates this process by reviewing an appeal request to determine whether the action being appealed is correct or incorrect.²³⁶ If incorrect, the county appeals worker must contact the claimant and attempt to resolve the case without a hearing if the claimant agrees. The informal resolution process is strictly voluntary and refusal to participate in it does not affect the claimant's hearing rights.²³⁷ The county appeals worker must also determine whether the appeal is a dual agency appeal that should also involve Covered California, and if so, notify Covered California; determine whether language services are required and arrange for them accordingly; and inform the claimant of other agencies that might resolve the issue.²³⁸

234. *Id.*, subsec. (c); MPP 22-049.523.

235. Gov't. Code § 100506.4(g)(1); MPP 22-073.23.

236. Gov't. Code § 100506.4(g)(8)(A); MPP 22-073.231.

237. Gov't. Code § 100506.4(g)(1), (5) and (8)(B); MPP 22-073.231.

238. Gov't. Code § 100506.4(g) and (8)(C) – (E). Dual agency appeals are appeals where it is not clear which program the individual is eligible for. The requirement to inform of other agencies that may resolve the issue is more common in a Covered California hearing due to the more limited jurisdiction of those hearings. See Section B.2.

For eligibility determinations based on MAGI, a claimant or their authorized representative may initiate the informal resolution process with whichever agency made the eligibility determination, either the county or Covered California.²³⁹

If the claimant and county appeals worker succeed in resolving the appeal, it is often through the conditional withdrawal process. The claimant may withdraw their hearing request any time before the Director of DHCS signs the hearing decision.²⁴⁰ Withdrawals may be unconditional or conditional.²⁴¹ *Unconditional withdrawals* result in an immediate dismissal of the appeal, but without prejudice, meaning that the claimant can file a new hearing request on the same issue as long as it is timely.²⁴² *Conditional withdrawals* must be accompanied by a written agreement signed by the claimant and the county that require the party or parties to complete the actions agreed upon to conditionally resolve the appeal within 30 days.²⁴³ Assuming the conditions are timely met, the appeal is dismissed. If the actions are not resolved within 30 days or if the claimant is unsatisfied with the resolution, the claimant can ask for a hearing within 90 days.²⁴⁴

If, after reviewing the appeal request, the county appeals worker determines that the action being appealed was correct or the claimant and county are not otherwise able to resolve the matter informally, the claimant's right to a hearing is preserved and the case can proceed to hearing.²⁴⁵

f. Dismissals

The Hearings Division must dismiss an appeal if the claimant withdraws the appeal

239. *Id.* subsection (g)(6). See the section of this manual on dual agency appeals at Section B.3.

240. MPP 22-054.21.

241. *Id.*

242. *Id.*

243. *Id.* For guidance on what constitutes adequate conditional withdrawal language, see ACL 14-14, <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf>, p. 11.

244. MPP 22-054.21(b)(3); ACL 14-14, <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf>, pp. 11-12.

245. Gov't. Code § 100506.4(g)(2); *Id.* at 22-073-232.

request or fails to appear at a scheduled hearing without good cause.²⁴⁶ For MAGI Medi-Cal appeals handled by the Affordable Care Act Bureau, the claimant has 30 days to request in writing and for good cause that the dismissal be vacated.²⁴⁷ For non-MAGI appeals heard in the regional offices, the claimant has only 15 days to make such a request.²⁴⁸ MAGI Medi-Cal appeals have specific notice requirements for dismissal notices; non-MAGI appeal dismissals are handled via hearing decision dismissing the case.²⁴⁹

g. Setting and Notice of Hearing; Position Statement

The State Hearings Division must set the hearing within 30 working days after the request is filed.²⁵⁰ The date of the hearing request is the date that the county receives the request.²⁵¹

At least 15 days before the hearing, the State Hearings Division must notify the appellant in writing either electronically or by hard copy, of the date, time, and location of the hearing.²⁵² Subject to agreements between the county and the claimant to the contrary, the hearing must be held in the county where the claimant resides.²⁵³ The notice must explain in what format the hearing will be held—phone, video conference, or in person. The notice must also advise the claimant of their right to request a hearing by phone, video conference, or in person, and include instructions on how to exercise this right.²⁵⁴ If the date, time, and location indicated would prevent the claimant from participating in the hearing, the State Hearings Division must make reasonable efforts to reset the hearing for a “reasonable” and “mutually convenient” date, time, and location.²⁵⁵ If the claimant is unable to attend the hearing at the hearing location because of poor health, the hearing can be held

246. 42 C.F.R. § 431.223.

247. ACL 14-14, <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf>, p. 13; see also MPP 22.053.113 (providing examples of good cause).

248. MPP 22-054.222; see also MPP 22.053.113 (providing examples of good cause).

249. AWCDL 14-14, <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf>, p.13; MPP 22-054.221.

250. Welf. & Inst. Code § 10952.

251. See ACL 14-14, <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf>, p. 10.

252. Gov't. Code § 100506.4(h)(2).

253. MPP 22-045.1.

254. *Id.*

255. *Id.*

in the claimant's home or other agreed upon location.²⁵⁶

At least two working days before the hearing, the county appeals worker must make available to the claimant a copy of a position statement that sets forth the issues in question at the fair hearing.²⁵⁷ The county must make it available electronically, if it can be done securely.²⁵⁸ If the county fails to make the position statement available in a timely fashion or decides to modify the statement, the hearing can be postponed, but only at the claimant's request and so as long as the claimant waives the right to obtain a decision on the hearing within the deadline that would otherwise apply.²⁵⁹ A postponement for this reason constitutes a postponement for good cause.

h. The Fair Hearing

Medi-Cal fair hearings are conducted by Administrative Law Judges of the State Hearings Division of the Department of Social Services.²⁶⁰ Hearings are held in at least one location in each county.²⁶¹

The hearing may be held via telephone or videoconference, or, if the claimant requests, in person.²⁶² There is also a home hearing alternative for people with disabilities who are unable to appear by telephone.²⁶³ The claimant must have the opportunity to review their appeal record, case file, and all documents to be used by the State Hearings Division at the hearing within a reasonable time before the

256. MPP 22-045.11.

257. Gov't. Code § 100506.4(h)(2); Welf. & Inst. Code § 10952.5.

258. Gov't. Code § 100506.4 (h)(1).

259. Welf. & Inst. Code § 10952.5. This leaves the claimant with the unsavory choice of moving forward with the hearing without knowing the position of the county ahead of time or waiting to have the hearing at all and further illustrates why asking for aid paid pending is so important.

260. Gov't. Code § 100506.4(h)(5); Welf. & Inst. Code §§ 10953, 10953.3.

261. For additional information on hearing sites, see the Department of Social Services webpage on hearings at <http://www.dss.cahwnet.gov/shd/PG1163.htm>.

262. Gov't. Code § 100506.4(h)(3).

263. ACL 14-14, <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf>, p. 8.

hearing as well as during the hearing.²⁶⁴

At the hearing, the Administrative Law Judge must allow the claimant to present evidence and bring witnesses in support of her appeal and to refute any evidence or testimony brought against her through cross-examination or otherwise.²⁶⁵

The claimant cannot be asked to provide information or documentation already provided during the informal resolution process at the hearing.²⁶⁶ The Department of Social Services must provide an interpreter if the claimant requests one or if the Administrative Law Judge determines an interpreter is necessary.²⁶⁷ The Administrative Law Judge must determine if the interpreter is certified or if not certified, examine the qualifications of the interpreter and assure objective interpretation.²⁶⁸ The Administrative Law Judge must review the appeal considering all relevant facts and evidence presented must be considered.²⁶⁹

Postponements and continuances of hearings, including those requested by claimants due to specified life emergencies such as a death in the family or personal illness or injury or due to process deficiencies, such as failure of the county to provide a timely position statement, must be handled in accordance with the state Department of Social Services' Manual of Policies and Procedures Section 22-053.

For more on the fair hearing process, including specific procedural rules during the hearing such as the use of witnesses and evidence, see the Health Consumer Alliance *Overview of the Medi-Cal Program*, Chapter 19, pp. 19-5 to 19 – 8 at <http://healthconsumer.org/Medi-CalOverview2008Ch19.pdf>, and the CDSS Manual of Policies and Procedures at <http://www.dss.cahwnet.gov/getinfo/pdf/4cfcman.pdf>, Sections 22-049 through 22-051.

264. Gov't. Code § 100506.4(h)(6); MPP 22-051. Note that the regulations governing Covered California fair hearings specify that the appellant may review the file at least two (2) business days before the hearing. 10 CCR § 6614(d). Claimants and persons acting on their behalf should assert the right to review the hearing documents at least as early as this.

265. Gov't. Code § 100506.4(h)(4).

266. Gov't. Code § 100506.4(g)(3).

267. MPP 22-049.6.

268. MPP 22-049.611-612.

269. Gov't. Code § 100506.4(h)(7).

i. After the Fair Hearing

The Administrative Law Judge must complete a hearing decision within 90 days of the filing of the fair hearing request.²⁷⁰ The decision must be in writing and sent to the claimant or authorized representative.²⁷¹ The decision must include “a decision with a plain language description of the effect of the decision on the [claimant’s] eligibility or enrollment, a summary of the facts relevant to the appeal, an identification of the legal basis for the decision, and the effective date of the decision[.]”²⁷²

A Medi-Cal hearing decision by an Administrative Law Judge is a proposed decision that gets sent to the Director of the Department of Health Care Services within 75 days after the fair hearing concludes.²⁷³ Within 30 days of receiving the proposed decision, the Director reviews it and either adopts or changes it or sets the matter for further hearing.²⁷⁴ If the Director fails to take action on the decision within 30 days of receiving it, it is deemed adopted.²⁷⁵ If the Director changes the decision, the “alternated” decision is sent to the claimant and county.²⁷⁶

If the decision is in favor of the claimant, the county must comply with the decision within 30 days.²⁷⁷ Any corrective payments that Medi-Cal must make to comply with the decision, either to beneficiaries or providers, must be made retroactive to the date that such payments should have been made.²⁷⁸

If the claimant receives an unfavorable hearing decision, they may seek a rehearing by sending a written request to the Rehearing Unit of the State Hearings Division

270. 42 C.F.R. § 431.244(f); Gov’t. Code § 100506.4.

271. 42 C.F.R. § 431.245.

272. Gov’t. Code § 100506.4(i).

273. Welf. & Inst. Code § 10958.

274. Welf. & Inst. Code § 10959.

275. *Id.*

276. *Id.*

277. Welf. & Inst. Code § 10961. See also 42 C.F.R. § 431.246 (regarding the requirement that “prompt” corrective action be taken if the hearing decision is favorable to the claimant, or if the agency decides in the claimant’s favor before the hearing.)

278. *Id.* Regarding DHCS’ obligation to make corrective payments to beneficiaries, see *Conlan v. Shewry*, 131 Cal. App. 4th 1354 (2005), *Conlan v. Bonta*, 102 Cal. App. 4th 745 (2002), and Welf. & Inst. Code § 14019.3.

within 30 days of receiving the decision.²⁷⁹ The request should state the date of the adverse decision, state why a rehearing should be granted and describe any additional evidence that will be submitted and explain why it was not submitted at the original hearing.²⁸⁰ The Director of the Department of Health Care Services must take action to grant or deny the request for rehearing within 15 days of receipt; otherwise the request is deemed denied.²⁸¹

Another option for a claimant who gets an adverse hearing decision is to seek judicial review of the adverse decision. This is done by filing a petition for writ of mandate in Superior Court within one year of receiving notice of the Director's final decision.²⁸² No filing fee is required and if the claimant prevails, they are entitled to attorney fees and costs.²⁸³ Going through the rehearing process is not required before going to court.²⁸⁴ Thus, a claimant who is unsuccessful at her initial fair hearing may seek a rehearing first and if unsuccessful may file a writ in court, or may go straight to court.

2. Covered California Eligibility Appeals

As with Medi-Cal appeals, the State Hearings Division of the California Department of Social Services handles Covered California appeals.²⁸⁵ While the rules governing the appeals hearing processes are the same or very similar in many places to those for Medi-Cal appeals, there are differences between the processes.²⁸⁶ Most

279. Welf. & Inst. Code § 10960.

280. MPP 22-065.

281. 42 C.F.R. § 431.232(b); Welf. & Inst. Code § 10960.

282. Welf. & Inst. Code § 10962. A writ of administrative mandamus (Cal. Code Proc. 1094.5) is an order from a California state judge reviews a final order of a state agency to determine if it is valid. It is a type of legal action against the state though it has its own procedure and terminology.

283. *Id.*

284. Welf. & Inst. Code § 10960(e).

285. Gov't. Code § 100506.3 (a); 10 CCR § 6600; ACL 14-14, <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf>, p. 6.

286. The Covered California appeals process is primarily governed by Subpart F of Part 155 of Title 45 of the Code of Federal Regulations and Article 7, the relevant provisions of Title 22 of the California Government Code, and Chapter 12 of Title 10 of the California Code of Regulations. Gov't Code §100506.3 (a). If the foregoing is not applicable, the Medi-Cal hearing processes at Welfare & Institutions Code Sections 10950, *et seq.* govern.

significantly, the appeals process is not handled by the counties, but by Covered California. Covered California eligibility appeals encompass not only eligibility to enroll or remain enrolled in a Covered California qualified health plan, but also eligibility for, or the amount of, advanced premium tax credits and cost-sharing reductions. In general, Covered California appeals do not cover complaints about the health plans themselves or service denials, though there are situations where there may be a connection to eligibility such as disputes with a plan when coverage should have begun.²⁸⁷

This section focuses on appeals of eligibility determinations made by Covered California, through the State Hearings Division. Note however that Covered California and the State Hearings Division also have the jurisdiction to hear appeals regarding certain determinations for exemptions from the health coverage mandate.²⁸⁸

An applicant for Covered California or an enrollee in a Covered California plan may appeal 1) any action or inaction related to the individual's eligibility for Covered California or enrollment in a Covered California plan, including eligibility to enroll during a special enrollment period; 2) any action or inaction related to eligibility for or the amount of premium tax credits or cost-sharing reductions; 3) an eligibility determination for an exemption from the individual mandate penalty; or 4) Covered California's failure to provide "timely or adequate notice of an eligibility determination or redetermination or an enrollment-related determination."²⁸⁹

287. Complaints about a health plan or a plan's denial of services are handled by the Department of Managed Health Care, or in limited situations, the Department of Insurance. Information is available at www.dmhc.ca.gov.

288. 45 C.F.R. § 155.505(b)(2); Gov't. Code § 100506.3(a). To date, these exemptions regarding the individual mandate are still being handled by the federal Health & Human Services administration though it is expected that exemption determinations will be handed over to the states that run their own Exchanges in the near future.

289. Gov't. Code § 100506.1. See *also* 45 CFR § 155.505. 10 CCR § 6602 also covers Covered California appeal requirements, however Government Code § 100506.1 governs. Note that decisions regarding special enrollment periods can be appealed per 45 C.F.R. § 155.505(b)(1)(i), which says that an appeal can be made of any eligibility decision based on 45 C.F.R. § 155.305(a)-(h). 45 C.F.R. § 155.305(b) covers eligibility for a qualified health plan based on enrollment periods. As noted above, to date, Health & Human Services is still handling exemption disputes.

a. Notice: Content and Time Requirements

Covered California must provide written notice to an applicant of any determination it makes regarding an applicant's eligibility to enroll in a qualified health plan or eligibility for financial assistance within five business days of making the determination.²⁹⁰

Likewise, Covered California must notify enrollees regarding ongoing eligibility to be enrolled in a qualified health plan and ongoing eligibility for or changes to levels of financial assistance within five business days of completing redetermination (either annual redetermination or redetermination due to the enrollee's changed circumstances).²⁹¹

These notices must be in writing and must include:

- an explanation of the action stated in the notice, e.g., eligibility or ineligibility for applicable programs;
- the effective date of the action, e.g., eligibility or termination;
- the factual bases upon which the action was made;
- the relevant regulations and other legal authority supporting the action;
- “[c]ontact information for available customer service resources, including legal aid and welfare rights offices”; and
- an explanation of appeal rights.²⁹²

The explanation of appeal rights must state specific information, including the ways by which an applicant or enrollee may request an appeal, and an explanation as to how eligibility may be maintained pending appeal.²⁹³

Covered California must provide an enrollee notice at least 14 days before the “effective date of termination” when terminating coverage.²⁹⁴

290. 45 C.F.R. § 155.310(g); 10 CCR § 6476(h).

291. 10 CCR §§ 6496(h)(2) and 6498(j)(2).

292. Gov't. Code § 100506.2(b); 10 CCR § 6454.

293. These content requirements are fully set forth at Government Code § 100506.2(b) and 10 CCR § 6604(b). See also 45 C.F.R. § 155.515(b).

294. 45 C.F.R. § 155.430(d)(1)(i); 10 CCR § 6506(d)(1).

All Covered California notices must be timely and accessible, provided at no cost to the individual, to persons with disabilities through use of auxiliary aids and services, and to persons who are limited English proficient through language services, including written translation.²⁹⁵

b. Request for Hearing

As with the Medi-Cal process, a Covered California applicant or enrollee has 90 days from the date of the notice of eligibility determination to request a hearing if they disagree with the outcome.²⁹⁶ The time can be extended for good cause for up to 180 days after the notice of eligibility determination.²⁹⁷

A person appealing a Covered California action is referred to as an “appellant” rather than a “claimant.”²⁹⁸ An appellant may submit an appeal request to Covered California or the State Hearings Division through the Covered California website, by telephone, fax, mail, or in person.²⁹⁹ Covered California and the State Hearings Division must assist an applicant or enrollee making an appeal request.³⁰⁰ Further, Covered California and the State Hearings Division are prohibited from interfering with an applicant’s or enrollee’s right to make an appeal.³⁰¹ If the appeal request is made to Covered California, Covered California must immediately transmit the appeal request and the appellant’s eligibility record to the State Hearings Division.³⁰² However, the date of the request is the date Covered California receives it.³⁰³

After Covered California or the State Hearings Division receives an appeal request, an Administrative Law Judge designated by the State Hearings Division must determine the validity of each appeal request, e.g., whether the appeal is within the

295. Welf. & Inst. Code § 15926(k); 10 CCR §§ 6452(c), 6454(b).

296. 45 C.F.R. § 155.520(b); Welf. & Inst. Code § 10951(a); 10 CCR § 6606(c).

297. 10 CCR § 6606(c), referencing Welf. & Inst. Code § 10951.

298. ACL 14-14, <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf>, pp. 1 -2.

299. 10 CCR §§ 6470(j) and 6606 (a). Hearing Request Form available at <https://www.coveredca.com/PDFs/HearingRequestFormCC.pdf>.

300. 45 C.F.R. § 155.520(a)(2); Gov’t. Code § 100506.4(c); 10 CCR § 6606(a).

301. 45 C.F.R. § 155.520(a)(3); Gov’t. Code § 100506.4(c); 10 CCR § 6606(a).

302. 10 CCR § 6602(g).

303. ACL 14-14, <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf>, p. 10.

Department of Social Services' jurisdiction and whether it is timely and whether there is good cause for the request, and, if untimely (submitted later than 90 days from the notice of eligibility determination), whether there is good cause for its untimeliness.³⁰⁴ The Administrative Law Judge must apply the "good cause" standard set forth in Welfare & Institutions Code Section 10591.³⁰⁵ The Administrative Law Judge making the validity or good cause determination must complete the determination expeditiously so that the State Hearings Division may send the required written acknowledgement notices to the appellant within the prescribed five day timeline discussed below. If the appellant disagrees with the decision on validity or good cause, they may make an appeal request to the Health and Human Services Agency within 30 days of the date of the appeal decision.³⁰⁶ This extra step to determine the validity of an appeal request before a hearing can be set is unique to the Covered California appeals process; it is not a requirement in the Medi-Cal process.

The State Hearings Division must send written notice to the appellant acknowledging receipt of the appeal within five business days.³⁰⁷ The notice must provide information to the appellant about:

- the opportunity for an informal hearing;
- the appellant's eligibility to continue receiving Covered California benefits pending appeal; and
- an explanation that any advanced premium tax credits paid on behalf of the

304. 42 C.F.R. § 155.520(a)(4) and (c); 10 CCR § 6602(c). Note that appeals based on denial of services, for example, are generally not within the Department of Social Services' jurisdiction, but generally must go through the appeal procedures provided through the Department of Managed Health Care or the Department of Insurance. Government Code § 100506.4(g)(8)(E) requires Covered California to refer an appellant to another agency that *may* be able to assist with their appeal if it cannot.

305. 10 CCR § 6606(c).

306. 10 CCR § 6606(d). The appeal form and instructions can be found at <https://www.healthcare.gov/downloads/marketplace-appeal-request-form-s.pdf>. At the time this manual was published, appeals could only be submitted by mail or phone. Further, there was uncertainty about how the HHS appeal process worked and based on anecdotal information, the authors determined it was infrequently used. Thus, while bearing in mind the 30 day deadline, applicants and their advocates should consider what steps might be taken other than appealing to HHS if an appeal is deemed not valid, such as quickly taking steps to cure whatever defects are in the appeal, if possible.

307. 10 CCR § 6606(e).

tax filer pending appeal is subject to reconciliation under the application federal laws and regulations.³⁰⁸

Except in the case of expedited appeals (discussed below), the Hearings Division must transmit via secure electronic interface notice of the appeal request and, if applicable, instructions to provide eligibility pending appeal to Covered California (and to the Department of Health Care Services,³⁰⁹ as applicable) within three days from receiving a valid appeal request.³¹⁰

Upon receipt of an appeal request that is determined not valid and without good cause for such defect, the written notice from the State Hearings Division to the appellant must state:

- that the appeal request has not been accepted;
- the nature of the defect in the appeal request; and
- if the defect specified is curable, that the appellant may cure the defect and resubmit the appeal request within 30 calendar days from the date on which the invalid appeal request was received.³¹¹

The State Hearings Division must treat as valid an amended appeal request that meets the applicable content and other requirements, e.g., that it is on a subject over which the Hearings Division has jurisdiction.³¹²

c. Expedited Appeals

“[W]here there is immediate need for health services because a standard appeal could seriously jeopardize the appellant’s life, health or the ability to attain, maintain or regain maximum function,” Covered California must provide a process for an

308. *Id.* See also 45 C.F.R. § 155.520.

309. In practice, the county would be the likely recipient of this notice and information as opposed to DHCS as counties administer Medi-Cal.

310. 10 CCR § 6606(e). See also 45 C.F.R. § 155.520(d)(1).

311. 10 CCR § 6606(f). See also 45 C.F.R. § 155.520(d)(2).

312. 10 CCR § 6606(f). See also 45 C.F.R. § 155.520(d)(2)(ii).

expedited appeal.³¹³ The hearing for an expedited appeal must be set on an expedited basis.³¹⁴ Specifically, the State Hearings Division must give the appellant written notice that her request is granted within ten days of approving such request and include the date, time, and type of the hearing, e.g., telephonic.³¹⁵ If an expedited appeal is granted, the decision must be issued “as expeditiously as possible”—no later than five business days after the expedited hearing, except if the appellant agrees to a delay to submit additional documents for the appeals record.³¹⁶ In turn, Covered California must act to implement the decision as expeditiously as possible. If an expedited appeal is denied, the State Hearings Division must notify the appellant within three days by phone or other commonly available secure electronic means, followed by a written notice within five business days, of the decision to deny the expedited appeal.³¹⁷ Thereafter, the appeal proceeds under the standard process.³¹⁸

d. Eligibility Pending Appeal – Continuing Enrollment

As with Medi-Cal, it is critical that enrollees and those acting on their behalf understand their rights regarding maintenance of Covered California coverage in a qualified health plan, including the same level and amount of financial assistance, while appealing an eligibility determination. This is called “continuing enrollment.”³¹⁹ It is akin to “aid paid pending” under Medi-Cal. Appellants challenging an eligibility redetermination by Covered California, or with the amount of approved financial assistance, may ask for continuing enrollment in the health plan as long as the individual is willing to continue paying their portion of the required premiums during

313. 45 C.F.R § 155.540(a), Gov’t. Code § 100506.4(a)(2); ACL 14-14, pp. 14-15. See *also* 10 CCR § 6616(a).

314. Gov’t. Code § 100506.4(a)(2), 10 CCR § 6616(c)(1)

315. 10 CCR § 6616(c). Further, within three business days of the date the appellant’s request for an expedited appeal is granted, the Hearings Division must provide notice via secure electronic interface to Covered California (and if applicable, say, in a dual agency appeal, to DHCS) stating that the request for an expedited appeal is granted and a hearing will be set on an expedited basis.

316. Gov’t. Code § 100506.4(a)(2).

317. Gov’t. Code § 100506.4(a)(2). See also 10 CCR § 6616(b).

318. *Id.*

319. 45 C.F.R. §155.525; 10 CCR § 6608; ACL 14-14 (Feb. 7, 2014), <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf>, pp. 7 - 8.

the appeal.³²⁰ Covered California must continue to consider the appellant eligible for the same level of premium tax credits as the level immediately before the redetermination or remain in the same cost-sharing reduction plan while the appeal is pending.³²¹ The trigger for “continuing enrollment” is the “receipt of a valid appeal request or notice.”³²²

If the appeal decision ultimately goes against the appellant, the appellant is liable for any premium tax credits received they were not eligible for, which could well be the entire premium tax credit amount received.³²³ Such amounts will be reconciled and ultimately collected through the reconciliation process when filing income taxes for the year.³²⁴

e. Informal Resolution

An appellant must be given the opportunity to pursue an informal resolution of their appeal prior to a hearing.³²⁵ This option is strictly voluntary and whether they pursue informal resolution or not does not affect their right to a hearing, nor delay the timeline setting the hearing.³²⁶ As part of the informal resolution process, a representative of Covered California must contact the appellant or their authorized representative and offer to discuss the challenged action, if the appellant agrees.³²⁷ For eligibility determinations based on MAGI, an appellant or their authorized representative may initiate the informal resolution process with whichever agency made the eligibility determination, either the county or Covered California.³²⁸

320. *Id.*

321. *Id.* Note that Government Code § 100506.5 states that Covered California should consider both enrollees and “applicants” eligible to maintain their APTC and CSR at the same level pending appeal, so advocates should look for situations in which applicants may be able to assert this right as well.

322. 45 C.F.R. § 155.525(a); 10 CCR § 6608(a).

323. Note there is no way to reconcile cost-sharing reductions, so these reductions in out-of-pocket costs are not paid back if the decision is unfavorable.

324. See 26 U.S.C. § 36B(f); 26 C.F.R. § 1.36B-4(a). For more on the reconciliation process, see Chapter 4, Section E.

325. Gov’t. Code § 100506.4 (g). See *also* 45 C.F.R. 155.535 and 10 CCR § 6612.

326. *Id.* at (g)(4) and (5).

327. Gov’t. Code § 100506.4(g)(1).

328. *Id.* subsection (g)(6).

In the informal resolution process, Covered California must follow these steps:

- review the file to determine whether the action appealed was appropriate and whether a hearing is needed;
- try to resolve the matter if the action that the individual is appealing was incorrect;
- determine whether a dual agency (both Medi-Cal and Covered California) appeal is required to resolve the problem at a hearing and notify the other agency thereof;
- determine whether interpretation services are necessary and make arrangements accordingly; and
- inform appellants of other agencies that may be available to help resolve the issue if it is an issue that Covered California does not have jurisdiction over.³²⁹

If the appellant is dissatisfied with the outcome of the informal resolution process, they need not accept it. They can reject the outcome and their right to a hearing is preserved.³³⁰ The case can then proceed to hearing.

If the appellant is satisfied with the outcome of the informal resolution process, they may withdraw the hearing request or may agree to a conditional withdrawal agreement that contains the terms and conditions that the appellant and Covered California have agreed to.³³¹ The conditional withdrawal must specify with sufficient detail and clarity what action Covered California or the county will take and what obligations the claimant and/or county has (as applicable).³³² For example, stating that Covered California or the county will “review” the matter is not sufficient. The Affordable Care Act Bureau requires that the conditional withdrawal “must instead say what Covered California or the county is re-reviewing and what *action* after review will be taken. . .”³³³ Under these circumstances, no hearing takes

329. *Id.* at (g)(8). Because Covered California does not have jurisdiction over most disputes with the health plans themselves, appellants disputing denials of services by the plans should be referred to the Department of Managed Health Care (or in limited cases to the Department of Insurance).

330. 45 C.F.R. § 155.535(a)(2); Gov’t Code § 100506.4 (g)(2).

331. See 10 CCR § 6610(a).

332. ACL 14-14, <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf>, p. 11.

333. *Id.*

place. Rather, both the appellant and Covered California must sign the conditional withdrawal, then Covered California will submit the conditional withdrawal request to State Hearings Division within five business days of the outcome of the informal process.³³⁴ The appeal may then be dismissed.³³⁵ If Covered California properly dismisses the appeal, the informal resolution decision is final and binding.³³⁶ However, the administrative dismissal may be set aside and the case reopened at appellant's request if there is showing of good cause.³³⁷

Covered California must send notice of the outcome of the informal resolution to the State Hearings Division by secure electronic interface within three business days of the outcome.³³⁸ Further, Covered California must provide a written notice to the appellant setting forth the outcome of the informal resolution process, the effective date of the outcome, if applicable, and a plain language description of the effect of the outcome on the appellant's appeal and eligibility within five business days of the date of the informal resolution decision.³³⁹

f. Notification of Hearing and Position Statement

The State Hearings Division must notify the appellant in writing either electronically or by hard copy, of the date, time and location of the hearing at least 15 days before the hearing.³⁴⁰ The notice must explain in what format the hearing will be held – phone or video conference or in person. The notice must also advise the appellant of her right to request a hearing by phone or video conference or in person and include instructions on how to exercise this right.³⁴¹ The State Hearings Division has to make reasonable efforts to reset the hearing for a “reasonable” and “mutually convenient” date, time and location if the appellant cannot make the date, time, or

334. 10 CCR § 6612(f)(1); ACL 14-14, <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf>, p. 11.

335. 10 CCR § 6610.

336. 10 CCR § 6612(f)(3); ACL 14-14, <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf>, p. 13.

337. 45 C.F.R. § 155.530(d); 10 CCR § 6610(a)(1)(C)(4); ACL 14-14, <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf>, p. 13.

338. 10 CCR § 6612(f)(2).

339. 10 CCR § 6612(f).

340. Gov't. Code § 100506.4(h)(2).

341. *Id.*

location on the notice.³⁴²

Covered California must provide a position statement to the appellant and all the case documents and case record from the informal process to the appellant, their representative if they have one, and the Hearings Division, at least two business days before the hearing.³⁴³ Additionally, Covered California must notify the appellant that the position statement will be available through the claimant's web portal, and, if applicable, will also give the appellant the contact information on how to obtain a copy of the statement from the county no less than two business days before the hearing.³⁴⁴ The additional requirements regarding provision of the position statement are the same as for Medi-Cal appeal hearings.³⁴⁵ See Section B.1.g.

g. The Fair Hearing

The hearing must be within 90 days from the date on which a valid appeal request is received, unless it is an expedited appeal.³⁴⁶ For expedited appeal timelines, see the earlier discussion at Section B.2.c. The hearing must be conducted by an impartial official who has not been directly involved in the action which is the subject of the appeal, namely, an Administrative Law Judge in the Department of Social Services' State Hearings Division.³⁴⁷

The hearing may be held via telephone or videoconference, or, if the appellant requests, in person.³⁴⁸ There is also a home hearing alternative for people with disabilities who are unable to appear by telephone.³⁴⁹ The appellant must have the opportunity to review her appeal record, case file and all documents to be used by the Hearings Division at the hearing at least two business days before the hearing

342. *Id.*

343. Gov't. Code § 100506.4 (h)(1); 10 CCR § 6612(e)(2); ACL 14-14, <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf>, p. 14.

344. ACL 14-14, p. 14.

345. *Id.* and Welf. & Inst. Code § 10952.5; ACL 14-14, p. 14.

346. 10 CCR § 6614(c)(1).

347. Gov't. Code § 100506.4 (h)(5); 10 CCR § 6614(c)(4).

348. Gov't. Code § 100506.4 (h)(3); 10 CCR § 6614(c)(5).

349. ACL 14-14, <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf>, p. 8.

as well as during the hearing.³⁵⁰ At the hearing, the Administrative Law Judge must allow the appellant to present evidence and bring witnesses in support of her appeal and to refute any evidence or testimony brought against her through cross-examination or otherwise.³⁵¹ The appellant cannot be asked to provide information or documentation that they already provided during the informal resolution process at the hearing.³⁵² The Administrative Law Judge must review the appeal considering all relevant facts and evidence presented.³⁵³

h. Hearing Decision and Other Post-Hearing Processes

The hearing decision must be made within 90 days of the date the appeal is filed.³⁵⁴

The decision must include:

- a decision;
- a plain language description of the effect of the decision on the appellant's eligibility or enrollment;
- a summary of the facts relevant to the appeal;
- the legal basis for the decision;
- the effective date of the decision, which the appellant may choose to have retroactive effect, assuming the decision to appellant is favorable;³⁵⁵
- appellant's right to pursue the appeal before the HHS appeals entity and process to do so;
- indication that the appeal decision is final, unless the appellant appeals to HHS; and
- appellant's right to judicial review of the decision under Section 1094.5 of the California Code of Civil Procedure.³⁵⁶

Upon adjudication of the appeal, the State Hearings Division must transmit the

350. 10 CCR § 6614(d). See *also* Gov't. Code § 100506.4(h)(6) (requiring an opportunity to review "at a reasonable time" before the hearing date).

351. Gov't. Code § 100506.4(h)(4). See *also* 10 CCR § 6614(d).

352. Gov't. Code § 100506.4(g)(3); 10 CCR § 6614(e)(1).

353. Gov't. Code § 100506.4(h)(7); 10 CCR § 6614(f).

354. Gov't. Code § 100506.4 (h)(7).

355. Gov't. Code § 100506.4 (i).

356. 10 CCR § 6618(a).

decision to Covered California by secure electronic means.³⁵⁷ Similar to the Medi-Cal appeals process, the decision must be transmitted to the Director of Covered California within 75 days after the fair hearing concludes.³⁵⁸ The Director and Covered California then follow the same process that Medi-Cal (the Department of Health Care Services) must follow as to whether to adopt or alternate the decision.³⁵⁹ See Section B.1.i. above.

Within 30 days, Covered California must implement the appeal decision.³⁶⁰ At the option of the appellant, the decision shall be effective prospectively to the date of the decision or another date chosen by the appellant, or retroactively to the date the incorrect eligibility determination was made.³⁶¹ Receipt of the decision may also compel Covered California to redetermine the eligibility of other members of the appellant's household, if their eligibility may be affected by the appeal decision.³⁶²

If the appellant disagrees with the hearing decision, within 30 days of the hearing decision notice, they may submit an appeal request to the federal Health and Human Services Agency.³⁶³

Alternatively, an appellant who disagrees with the hearing decision may seek judicial review by filing a writ in state court.³⁶⁴ There is no requirement to exhaust administrative remedies or mutual exclusion regarding these two options. The appellant need not appeal to the Health and Human Services Agency before exercising their right to seek judicial review; likewise, appealing to the Health and

357. Gov't. Code § 100506.4 (j).

358. Welf. & Inst. Code § 10958.

359. Welf. & Inst. Code § 10959. See also Covered California Delegation Order 15-100.

360. 10 CCR § 6618(c).

361. *Id.* at subsection (c)(1).

362. *Id.* at subsection (c)(2).

363. Gov't. Code § 100506.4 subsections (b) and (k). See also 45 C.F.R. § 155.520(c). Instructions on how to appeal, the appeals process and an appeal request form are available at <https://www.healthcare.gov/downloads/marketplace-appeal-request-form-s.pdf>. When this manual was published, the specifics of this process were not clear or well-publicized. The authors were aware of just a few instances in which appeals were made to HHS and did not know the outcomes. Further, at the time, the only ways by which an HHS appeal could be submitted were by mail and phone. If this remains the status quo, enrollees and their advocates may be well-advised to opt for judicial review if they wish to challenge a hearing decision, rather than file an appeal with HHS.

364. *Id.*, subsec. (l).

Human Services Agency does not preclude judicial review.³⁶⁵

3. Dual Agency Appeals

Eligibility disputes often arise for new applicants for health coverage who are close to the Medi-Cal/Covered California income thresholds and for persons already in Medi-Cal or enrolled in a Covered California plan whose income has changed in a way that places them close to these income thresholds. In these appeals that implicate both programs, advocates should consider filing a combined Medi-Cal and Covered California hearing appeal request. This is so that if an individual gets a hearing decision that they are not eligible for one program, they can get a simultaneous decision that they are eligible for the other program, rather than have to obtain two separate consecutive decisions that may delay or interrupt health care coverage.

This section covers some rules and procedures that may be helpful to know when pursuing a dual agency appeal. You should also read both the Medi-Cal and Covered California eligibility appeals sections above for guidance. You may also refer to the table at Appendix C comparing the Medi-Cal and Covered California appeals for additional guidance.

a. Shared Appeals Entity

In navigating the two sets of often overlapping statutory, regulatory and sub-regulatory authorities that may apply in a dual agency case, it may be helpful to keep the following in mind: 1) Sections 100506.2 and 100506.4 of the Government Code apply to the Medi-Cal eligibility fair hearing process to the extent these Government Code sections conflict with the Welfare and Institutions Code sections on fair hearings contained at Welfare and Institutions Code Sections 10950, *et seq.*,³⁶⁶ and 2) The Covered California appeals process is primarily governed by Subpart F of Part 155 of Title 45 of the Code of Federal Regulations, the relevant provisions of Article 7, Title 22 of the Government Code, and Chapter 12 of Title 10 of the California Code of Regulations; if the foregoing is not applicable, look to the Medi-Cal hearing

365. *Id.*

366. Welf. & Inst. Code § 10950(b)(1).

processes at Welfare & Institutions Code Sections 10950, *et seq.*³⁶⁷

b. Informal Resolution Process

It is not up to the claimant to know which type of hearing to ask for in the event that there is a dispute that implicates both agencies. If either agency determines on an informal process review that a dual agency appeal is required to resolve the matter, the determining agency must notice the other agency about the appeal if the latter has not already been included in the appeal request.³⁶⁸

For MAGI appeals, the agency that made the eligibility determination conducts the informal resolution process—the county for Medi-Cal and Covered California for itself.³⁶⁹ This means either agency can review a MAGI income determination during informal resolution. However, informal resolutions involving an issue related only to Covered California rules such as rules regarding special enrollment or employer offers of affordable coverage must remain with Covered California; those involving non-MAGI issues must be handled by the counties.³⁷⁰

c. The Fair Hearing

Where an appeal raises issues that involve both Medi-Cal and Covered California, the agencies are supposed to coordinate and decide whether all issues can be presented in one Statement of Position or whether the respective agencies will submit separate statements.³⁷¹ A coordinated statement is the preferred practice, according to the Hearings Division.³⁷²

In dual agency appeals, whenever possible, the County Hearing Representative is supposed to present the Medi-Cal case and the Covered California Hearings Representative is supposed to present the Covered California case at the same

367. Gov't. Code § 100506.3 (a).

368. Gov't. Code § 100506.4(g)(8)(C).

369. Gov't. Code § 100506.4(g)(6).

370. *Id.*

371. ACL 14-14, <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf>, p. 14.

372. *Id.*

hearing and may work cooperatively in presenting evidence.³⁷³

4. Medi-Cal Access Program (MCAP) Eligibility Appeals

At the time of publication of this manual, parts of the regulatory scheme for the Medi-Cal Access Program (MCAP) for pregnant women were in flux, including the program’s eligibility appeals processes, as administration of the program had recently been transferred from the Managed Risk Medical Insurance Board to the Department of Health Care Services.³⁷⁴ The following reflects what the authors believe is the most practical information on the MCAP eligibility appeals process at publication.

Technically, there are three levels of appeal. First, an applicant denied MCAP makes a written appeal within 60 days of denial to the “Executive Director-Benefits Appeal.” If the appeal is denied at this first level, the applicant is supposed to receive a denial letter advising of the basis for denial, the applicant’s right to take the appeal to the second level—MCAP directly—and the process for doing so. If the appeal is denied at the second level, MCAP should send the applicant a written denial letter advising the applicant of her right to a fair hearing before an Administrative Law Judge, the third and “formal” level of appeal.³⁷⁵ Once the hearing is before an Administrative Law Judge, the procedure should be similar to that of Medi-Cal or Covered California, though a state representative will be representing the MCAP program.

In reality, applicants denied coverage who wish to appeal might not move through these MCAP eligibility appeal levels sequentially. CalHEERS screening includes screening for MCAP if a woman is pregnant and over income for Medi-Cal. Thus, a pregnant woman might apply for health coverage on line and as the result of

373. *Id.* at p. 18.

374. This manual does not cover MCAP benefits appeals. The regulations covering such appeals can be found at 10 CCR § 2699.500, *et seq.*, but given that many MCAP processes were in flux at the time this manual was published, as with eligibility appeals, the regulations may not reflect the procedures utilized by MCAP in reality. It may be best to contact MCAP at 1-800-433-2611 immediately upon denial of benefits for information on how to proceed with an appeal.

375. As of publication, the processes surrounding this denial letter were unclear.

CalHEERS screening, be denied for both Medi-Cal and MCAP and then receive a notice advising her she is eligible for Covered California.³⁷⁶ If she appeals her Medi-Cal denial, her case will go to fair hearing before an Administrative Law Judge. Administrative Law Judges in the Affordable Care Act Bureau should review the eligibility determination as to both Medi-Cal and MCAP. On the other hand, the same form notice for women screened for MCAP eligibility contains a provision that explains how to proceed with a level one MCAP appeal. If the applicant decides to go that route, then she may end up going through the three levels of MCAP appeals.³⁷⁷

Caveat: While aspects of MCAP are in flux, the MCAP regulations on appeals³⁷⁸ and MCAP's (DHCS) website may not provide the most complete or accurate guidance on MCAP eligibility appeals. Therefore applicants and advocates may want to contact MCAP directly at 1-800-433-2611 for the most current information on the processes.

C. Moving Between Programs

State law requires that both Covered California and the counties make an eligibility determination for all insurance affordability programs, such as Medi-Cal or APTCs in Covered California.³⁷⁹ If eligibility of a recipient changes, then both agencies are required to facilitate a move between programs without a break in coverage.³⁸⁰

376. See Gov't. Code § 100506.2(b) regarding the required combined eligibility notice that must be issued for all insurance affordability programs, including MCAP, if applicable.

377. 10 CCR § 2699.500(b)(1). Appeals regarding disenrollment of a subscriber or infant are likewise made to the Executive Director. *Id.*, subsec. (b)(2). Appellants and advocates can go to this link for the address of the Executive Director: http://mcap.dhcs.ca.gov/My_MCAP/Appeals.aspx. Alternatively, they may search for "MCAP eligibility appeals" on the Internet (as the link to the MCAP appeals information on the DHCS website may change.)

378. 10 CCR § 2699.500, *et seq.*

379. Welf. & Inst. Code § 15926(h)(1).

380. *Id.*

1. Covered California to Medi-Cal

A Covered California enrollee may experience a drop in income due to job loss or a change in household composition such as the birth of child that causes her to become eligible for Medi-Cal. Technically, a person in this position does not have to move into Medi-Cal, but if they stay in Covered California, they are no longer eligible for the premium tax credit that would make their health plan premium affordable.³⁸¹ Thus, to meet the general obligation to have health insurance (the individual mandate), they will most likely need to enroll in Medi-Cal.

Generally, Covered California becomes aware of changes that make a person eligible for Medi-Cal either from the person reporting the change or from the annual redetermination process. Both trigger Covered California's obligation to determine if an enrollee or qualified individual is still eligible for Covered California.³⁸²

If as a result of the eligibility review process Covered California determines that an enrollee is no longer eligible, Covered California must provide an enrollee at least 14 days' notice before the "effective date of termination."³⁸³ If the enrollee appeals the termination, they have the right to remain covered and retain their benefits (premium tax credits and cost-sharing reductions) while the appeal is pending by requesting continued enrollment.³⁸⁴ However if they are ultimately deemed ineligible for Covered California, they may owe back premium tax credits during the reconciliation process.

As part of the eligibility redetermination process, Covered California must assess the enrollee's potential eligibility for Medi-Cal.³⁸⁵ If the enrollee is deemed potentially eligible for Medi-Cal, Covered California must send the case to the enrollee's county of residence for determination of eligibility for Medi-Cal.³⁸⁶

381. See Chapter 4, Section C.2.b of this manual.

382. 45 C.F.R. § 155.330(e)(1)(i) and (e)(2)(i); 10 CCR § 6496(h)(1) and (i).

383. 45 C.F.R. § 155.430(d)(1)(i); 10 CCR § 6506(d)(1).

384. 45 C.F.R. § 155.525; Gov't. Code § 100506.5; 10 CCR § 6608.

385. Welf. & Inst. Code § 15926(h).

386. ACWDL 15-01 (Jan. 7, 2015), p. 2, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-01.pdf>.

Covered California must send a notice to the enrollee explaining its finding of ineligibility for Covered California.³⁸⁷ Once the county makes an eligibility determination, it must also send a notice of action finding eligibility.³⁸⁸ Further, Covered California and the Department of Health Services are obligated to help the affected beneficiary make the transition without a gap in coverage and without requesting any information unnecessary to establishing eligibility for Medi-Cal.³⁸⁹

Consumers who face termination from Covered California and those acting on their behalf must consider all options, including ongoing Covered California eligibility and Medi-Cal eligibility, and the accompanying time requirements and continuing aid and appeal rights in order to avoid gaps in coverage.

Covered California enrollees who cannot keep making their premium payment and do not want to wait to be transferred to Medi-Cal also have the option of actively terminating their enrollment in the Covered California plan and applying for coverage through Medi-Cal. This strategy is not without its challenges as Covered California enrollees must generally provide at least 14 days notice to their plan that they want to terminate.³⁹⁰ Then, they must make sure to have completed a Medi-Cal application in the same month to avoid a gap in coverage. While they would then be covered from their application date, it could take up to 45 days to process the application, so they may have difficulty accessing services. Additionally, from a practical standpoint, trying to submit an application for one program while there is still an active case on the other program can cause technical challenges that also lead to delays in accessing care. Consumer advocates continue to press for improvements to this transition process.

2. Medi-Cal to Covered California

If the income of a person on Medi-Cal increases or a change in tax household composition places them above the applicable Medi-Cal eligibility income threshold, they may still qualify for Medi-Cal with a Share of Cost and also be eligible to enroll in

387. 45 C.F.R. § 155.310(g); 10 CCR § 6476(h).

388. 22 CCR § 50179(a).

389. Welf. & Inst. Code § 15926(h)(1).

390. 10 CCR § 6506(d).

a health plan and receive financial assistance through Covered California.

Counties become aware of such changes in income or other changes that may make a beneficiary ineligible for Medi-Cal when the beneficiary reports the change to the county, as beneficiaries are obligated to report changes that affect eligibility, or because the county discovers the change during an eligibility review or redetermination.

If the county determines that a beneficiary is no longer eligible for Medi-Cal, the county must issue a Notice of Action to the beneficiary ten days prior to the date of termination.³⁹¹ The beneficiary has the right to appeal the termination, and, if they do so within ten days of the Notice of Action, they can continue to be on Medi-Cal pending the outcome of the appeal, thus avoiding a gap in coverage.³⁹² If the beneficiary does not receive a notice or receives a deficient notice (see Section B.1.a. above) the beneficiary should immediately request an appeal with aid paid pending in order to buy time to contest the termination or enroll in a Covered California plan.

Applicable state law requires an entity making the eligibility determination to ensure that an eligible applicant “that meets all program eligibility requirements and complies with all necessary requests for information moves between programs **without any breaks in coverage** and without being required to provide any forms, documents, or other information or undergo verification that is duplicative or otherwise unnecessary.”³⁹³ The loss of Medi-Cal eligibility based on being over-income would not result in a gap if the affected person is able to select a Covered California plan before Medi-Cal ends; however, the mere ten day window between receipt of the notice and termination makes this very challenging.³⁹⁴ Thus, it is critical

391. 42 C.F.R. § 431.213; 22 CCR §§ 50179(d). The requirements for termination notices are discussed in detail at Section B.1.a of this Chapter.

392. 42 C.F.R. §§ 431.230, 431.231(c) & (d); 22 CCR § 51014.2(a). The right to “aid paid pending” during the Medi-Cal appeal process is discussed in Section B.1.d of this Chapter.

393. Welf. & Inst. Code § 15926(h)(1) (emphasis added).

394. Covered California special enrollment rules allow for coverage to start the next month when a plan is selected prior to the end of the previous coverage, in this case Medi-Cal. 10 CCR § 6504(h)(3)(A). To date, insufficient information is sent to terminated Medi-Cal beneficiaries to inform them how to enroll in an select a Covered California plan.

that counties, Covered California, and any advocate involved take every measure to ensure that the beneficiary being terminated from Medi-Cal is able to enroll in a plan without a gap in coverage.³⁹⁵ Again, consumer advocates continue to press for improvements to this process.

395. As of the date of publication of this manual, the transition process between programs was not automated. Thus, if an individual is discontinued from Medi-Cal based on an inadequate or defective notice of action, the individual or her advocate should request aid paid pending during the process of finding and enrolling in a Covered California plan.

Introduction to Part III: Health Care Services for the Remaining Uninsured and Underinsured

Despite the expansion of health care coverage that came with the Affordable Care Act, there are still many low-income Californians without access to health coverage. Some are ineligible for full-scope Medi-Cal or Covered California due to immigration status, while others still cannot afford the price of available insurance, whether through Covered California or an employer, or otherwise did not enroll during an open enrollment period.

This section of the guide covers two additional pieces of the safety net that are available for those left out of health reform: county indigent health programs and the Hospital Fair Pricing Act. Unlike Medi-Cal and Covered California, which are prime examples of federalism in action as they stem from federal law with an overlay of state authority, the county indigent health programs and the Hospital Fair Pricing Act are homegrown, with their roots in California state law. And while there are more localized health care programs for low to moderate income individuals in many counties and cities, as well as clinics offering sliding scale services, and public health programs that offer limited services such as cancer screenings, those options are beyond the scope of this guide given their local or limited nature.

County Indigent Health Programs. California state law requires each county be the provider of last resort health care services for individuals who have no other means to receive care. As an initial matter, these programs are not to be confused with the important but very different work of county public health departments, which typically focus on community health issues such as licensure and inspections of restaurants and housing, disaster preparedness, and tracking communicable diseases such as STD and tuberculosis.

County indigent health programs, on the other hand, provide safety net health care services to persons with no other means to get care. Commonly referred to as Section 17000 programs, based on the section of the Welfare & Institutions Code that requires them, each county may set its own eligibility criteria and any cost-sharing based on an analysis of the cost of living in their county and on a person's ability to pay for care. Counties do not have to provide a complete array of services, but

must provide at least “subsistence medical care,” and not just emergency services, so that individuals are not in pain or suffering. Some counties provide far more in their Section 17000 programs, including primary care and broad access to medical specialists.

See Chapter 7: Counties’ Legal Obligation to Provide Care to Remaining Uninsured Residents

Hospital Fair Pricing Act. California state law also requires that all hospitals have financial assistance policies for uninsured or underinsured persons earning less than 350% of the federal poverty level. Hospitals must notify patients of these policies at the time of billing and must make the policies and applications for financial assistance publicly available both at the hospital and on a state website containing all hospital policies and applications. While hospitals are only required to provide discounts charging no more than the highest government rate (generally the Medicare rate), many hospitals have far more generous policies and the majority offer free care to at least certain income levels.

See Chapter 8: Options for Hospital Bills

Programs for the Remaining Uninsured

	County Indigent Health Programs	Hospital Fair Pricing Act
Income Eligibility	Each county sets its own limits, but must be based on cost of basic needs to live in the county and actual ability to pay.	Must cover individuals with household income below 350% FPL.
Other Eligibility Requirements	May require lawful immigration status.	Must be uninsured or underinsured May have an assets test for free care only.
Services Covered	Subsistent medical care including emergency services and urgent dental services, though may require use of contracted facility for non-emergencies.	Only hospital bills and bills from ER doctors.
When Coverage Starts	Generally covers all services during the month of application and while enrolled.	Can request after services are received.

Chapter 7: Counties' Legal Obligation to Provide Care to Remaining Uninsured Residents

Chapter 7: Counties' Legal Obligation to Provide Care to Remaining Uninsured Residents

- A. Financial eligibility criteria
- B. Cost-Sharing
- C. Timing
- D. Residency
- E. Programmatic Eligibility
- F. Recouping Expenses
- G. Scope of Services

7. Counties' Legal Obligation to Provide Care to Remaining Uninsured Residents¹

After the full implementation of the Affordable Care Act – with the expansion of Medi-Cal to non-disabled adults with no dependent children, subsidized insurance through Covered California, and a single streamlined application and eligibility process – it is estimated there will still be anywhere from 2 to 4 million non-elderly Californians who lack health coverage.² For those who remain uninsured, pre-existing state law requires counties to provide safety net health care.

Welfare and Institutions Code section 17000 obligates counties to serve as the provider of “last resort” for indigent Californians who have no other means of support.

Welfare and Institutions Code § 17000: "Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives and friends, by their own means, or by state hospitals or other state or private institutions."³

1. This chapter is adapted from an advocate issue brief “Ensuring a Strong Safety Net for the Remaining Uninsured,” co-authored by Abbi Coursolle of the National Health Law Program and Shirley Sanematsu of the Western Center on Law & Poverty and published in March 2015 with funding from the Blue Shield of California Foundation. The full report is available at <http://wclp.org/resource/resources-1/>.
2. See, e.g., Bianca DiJulio et al, "Where are California's Uninsured Now? Wave 2 of the Kaiser Family Foundation California Longitudinal Panel Survey" (2014) (about 2.4 million in 2014), <http://kff.org/health-reform/report/where-are-californias-uninsured-now-wave-2-of-the-kaiser-family-foundation-california-longitudinal-panel-survey/>; Anthony Menacho et al., Health Access California, "Reorienting the Safety Net for the Remaining Uninsured 3" (2015) (2.7 to 3.4 million in 2015), available at <http://www.health-access.org/images/pdfs/CountySafetyNetReportSurveyResults3-12-15.pdf>; *UCLA Center for Health Policy Research & UC Berkeley Center for Labor Research and Education, CalSIM version 1.91 Statewide Data Book: 2015–2019* at 2 (2014) [hereinafter UCLA & UCB Study] (just over 4 million in 2015), available at <http://healthpolicy.ucla.edu/publications/Documents/PDF/2014/calsimdatabook-may2014.pdf>.
3. Welf. & Inst. Code § 17000; see *Welfare Rights v. Frank*, 25 Cal. App. 4th 415, 420-21 (1994) (describing the legislative history of the statute).

Section 17000 is designed to ensure that low-income Californians who are not eligible for health coverage programs like Medi-Cal or Covered California have access to a safety net that meets their subsistence health care needs. Over the years, the courts have interpreted Section 17000 to allow counties some discretion in the design and scope of their 17000 programs.

When working with an uninsured consumer, it is important for advocates to understand the basic requirements of Section 17000, as well as the eligibility criteria in the particular county where the consumer resides, the county's enrollment policies and practices, and the services the county covers. If the consumer is not eligible for the county's 17000 program, or the services covered by the county do not meet the subsistence needs of indigent residents, the information in this chapter can help advocates assess whether a county's program conforms with Section 17000's intent.

A. Financial Eligibility Criteria

California law gives counties discretion in setting their eligibility criteria for their Section 17000 programs.⁴ But that discretion is limited. Welfare and Institutions Code Section 10000 requires that Section 17000 services be provided “promptly and humanely” to satisfy the statutory purpose of “providing appropriate aid and services to all of [the state's] needy and distressed.”⁵ Thus, a county's discretion to set eligibility standards “can only be exercised within fixed boundaries . . . consistent, not in conflict with [§17000], and reasonably necessary to effectuate its purpose.”⁶ A threshold eligibility criterion that merits close scrutiny is the county's financial

-
4. Welf. & Inst. Code § 17001 (“The board of supervisors of each county, or the agency authorized by county charter, shall adopt standards of aid and care for the indigent and dependent poor of the county or city and county”).
 5. Welf. & Inst. Code § 10000 (“The purpose of this division is to provide for protection, care, and assistance to the people of the state in need thereof, and to promote the welfare and happiness of all of the people of the state by providing appropriate aid and services to all of its needy and distressed. It is the legislative intent that aid shall be administered and services provided promptly and humanely, with due regard for the preservation of family life, and without discrimination on account of ancestry, marital status, political affiliation, or any characteristic listed or defined in Section 11135 of the Government Code. That aid shall be so administered and services so provided, to the extent not in conflict with federal law, as to encourage self-respect, self-reliance, and the desire to be a good citizen, useful to society”).
 6. *Robbins v. Superior Court*, 38 Cal.3d 199, 405 (1985); see also *Mooney v. Pickett*, 4 Cal.3d 669, 679 (1971).

eligibility standards to qualify for care.

Section 17000 requires counties to provide health care to “all indigent” residents. With regard to assets, counties may establish their own policies regarding the property a person may have while receiving aid through Section 17000.⁷ Counties have generally adopted all or part of the pre-ACA Medi-Cal asset rules, such as allowing up to \$2,000 in assets for an individual and exempting one car and one’s home, but counties may adopt more restrictive policies.

With regard to income, income eligibility limits for indigent health programs span a wide range across California’s counties.⁸ For example, in 2014 three counties limited their programs to persons with income at or below 100% of the Federal Poverty Limit (\$11,880 a year for an individual in 2016), while at the high end one county reportedly had an income eligibility limit of 700% of the Federal Poverty Limit (\$83,160 a year for an individual in 2015).⁹ The majority of counties – 43 of 58 – set their upper income eligibility limits at 200% of the Federal Poverty Limit, or \$23,760 a year for an individual.¹⁰

Despite these widely disparate income limits, counties do not have unfettered discretion in setting income eligibility criteria. First, counties must not set their standards to such low levels that they would leave otherwise qualified residents

-
7. Welf. & Inst. Code § 17107; see also *id.* § 17111 (allowing recipients to be permitted to keep tools of his trade necessary to continue employment and a car of “reasonable value” in order to enable the aided person to become self-supporting).
 8. Menacho *et al.*, *supra* note 2 at 7-8; see also Cal. Dept. of Health Care Servs., *County Indigent Care Profile (2014)*, available at http://www.dhcs.ca.gov/provgovpart/Documents/AB%2085/County_Profiles_ADA.pdf.
 9. *Id.* The three counties with income eligibility limits of 100% of the Federal Poverty Limit are Merced, Placer and Santa Cruz; Ventura County reports an income eligibility limit of 700% FPL. See *id.*
 10. *Id.* The 43 counties with an income eligibility limit of 200% of the Federal Poverty Limit include eight individual counties - Alameda, Kern, Monterey, Orange, Riverside, San Joaquin, San Mateo, and Santa Barbara - and the 35 rural and/or small counties that make up the County Medical Services Program (CMSP) consortium. See *id.*

without subsistence medical care.¹¹ Section 17000’s mandate is not limited to assisting only the county’s most destitute individuals; the mandate to care for “all indigents” requires counties to provide care for residents who may have greater means, but who nevertheless are unable to pay for the costs of their own medically necessary care.¹²

A second and related limit on the counties’ discretion in setting income limits centers on a person’s ability to pay for care. A county’s income eligibility standard must take into account an individual’s actual ability to pay for the cost of subsistence care.¹³ A third limit on a county’s discretion to establish income criteria requires a county to take into account the cost of basic needs to live in the county, such as housing, utilities, food, transportation, etc., in setting income criteria that may be appropriate for residents.¹⁴ Thus, counties may not set their income eligibility levels so low that residents will not be able to afford subsistence living in the county after paying for medical care.¹⁵

One red flag regarding a county’s income eligibility criteria is a county that uses a “hard” income cap, meaning that if an uninsured person’s income exceeds it, she is absolutely barred from accessing Section 17000 services, regardless of her medical need or ability to pay. Such caps have been struck down as improper.¹⁶ A county “cannot be considered [a] ‘safety net’ or place of ‘last resort’ for subsistence medical care” if persons “suffering from serious injury or illness, but whose income is \$1 over the income cap...and cannot afford or cannot obtain insurance” are unable to access

-
11. *Hunt v. Superior Court*, 21 Cal.4th 984, 1014 (1999) (“[I]n determining a financial eligibility standard for [17000 county health services], the County must consider whether implementation of the standard would leave some residents incapacitated by age, disease, or accident, and whose condition is not relieved through other means, without subsistence medical care”).
 12. See, e.g., *Alford v. County of San Diego*, 151 Cal.App.4th 16, 29 (2007) (noting that “medically indigent persons” includes the “working poor”); *Goodall v. Brite*, 11 Cal.App.2d 540, 548 (1936) (holding that a county hospital must accept beyond the “pauper class” and accept persons “who can pay something towards their care and treatment”).
 13. *Hunt*, 21 Cal.4th at 1015.
 14. *Alford*, 151 Cal. App.4th at 35.
 15. See *id.*; see also *Hunt*, 21 Cal.4th at 1015.
 16. *Alford*, 151 Cal. App.4th at 35 (striking down San Diego’s flat income eligibility cap of \$1,078 a month, or 135% of the Federal Poverty Limit at the time, because the county failed to consider an individual’s ability to pay all or part of their subsistence medical care, even if the person was just \$1 over the cap).

§ 17000 care.¹⁷

Counties have several options to address this issue, such as having a Section 17000 program that includes a sliding scale fee or share of cost system based on an ability to pay analysis;¹⁸ providing reasonable policies and procedures for residents to request hardship exemptions from such limits; or setting their income eligibility criteria at such a level that persons above the level can afford to pay for care. Advocates should work with their counties to ensure that financial eligibility rules are reasonable and provide access to the remaining uninsured who will not otherwise be able to pay for care.

Advocacy Tip: Answering the series of questions below can help you assess whether a county's financial eligibility rules are reasonable.

- What are the income limits for someone to qualify for medically indigent services?
 - If the income eligibility limit is a percentage of the Federal Poverty Limit, does the county update the dollar amount equivalent every year on April 1?
- If there is an income eligibility limit, did the county do a study on the cost of basic necessities (housing, utilities, food, transportation, personal care, etc.) to live in the county in setting its income eligibility limit?
 - How current is the data the county used in assessing the cost of basic necessities? And is the data specific to the county?
- Is there an upper income eligibility cap, and if yes what is it?
- Does the county have an assets or resources eligibility requirement? If yes, what is it based on?
- Are there exemptions from any of the program's eligibility requirements? For example, is there a financial hardship exception to offset income that is otherwise over the income eligibility limit?
 - How does the county notify the general public and applicants for county indigent health of the availability of this exemption?
- When were the county's financial eligibility requirements last updated?
- How many people is your county serving in its 17000 program?

17. *Id.*

18. Section 17000 programs can include income-tiered categories for care, where services may be available at no cost to persons below a certain income level and some type of cost-sharing arrangement at higher income levels.

B. Cost-Sharing

In addition to setting of financial eligibility limits, some counties may include cost-sharing in their Section 17000 programs. Cost-sharing can take many forms and generally describes anytime a program charges a person for services, such as imposing a fee schedule for services, *i.e.*, \$5 for a primary care visit, \$10 for a specialist and \$20 for emergency room care. Another example of cost-sharing is when participants in a county health program who exceed a certain income or asset limit are required to spend the amount of money they have above the limit in order to access services, a practice commonly referred to as share of cost or spending-down.

Including cost-sharing arrangements in Section 17000 programs is permissible, but there are limits. First, counties are strictly prohibited by statute from charging fees as a prerequisite to receiving Section 17000 services. Specifically, “[n]o fee or charge shall be required of any persons before a county renders medically necessary services to persons entitled to services pursuant to § 17000.”¹⁹ In other words, counties may bill the consumer for 17000 services, but they may not deny people services if they are unable to pay.

And, like income eligibility limits, any cost-sharing system must be related to a person’s ability to pay for care.²⁰ This means that if a Section 17000 program requires participants over 100% of the Federal Poverty Level to pay according to a fee schedule, for example, the county must have a factual basis to assume all persons above that level can afford to pay the fees. In other words, counties may “implement a *reasonable* sliding fee schedule *based on ability to pay*.”²¹ Advocates should evaluate their counties’ cost-sharing rules to make sure they are up-to-date and reflect the current cost-of-living in the county.

19. Welf. & Inst. Code § 16804.1.

20. See, e.g., *Brown v. Crandall*, 198 Cal. App. 4th 1, 10 (2011) (noting that “the ability to pay for private health insurance does not necessarily demonstrate an ability to pay all of a substantial medical bill. . . . [but] whether a person can afford such care is a factual question that should be decided based on evidentiary proof”); *Poverty Resistance Center v. Hart*, 213 Cal.App.3d 295, 304 (1989) (“[F]actual premises which underpin a standard adopted under Section 17001 must be supported by evidence before the Board and by reasonable inference drawn therefrom”).

21. Welf. & Inst. Code § 16804.1(b) (emphasis added).

Advocacy Tip: Is there cost-sharing? Examples of cost-sharing include participant fees, co-pays, sliding scale fees, share of cost, or a percentage of the cost of care to receive services.

If there is cost-sharing, relevant questions include:

- What are the amounts of these fees?
- On what basis did the county develop its cost-sharing system?
- When was the cost-sharing scheme last updated?
- Does the county require participants to pay fees before receiving services?

C. Timing

Counties have substantial discretion in terms of when they will accept an application for their Section 17000 programs. For example, while some counties operate their programs to accept applications at any time, other counties will only accept applications from individuals who have an existing medical need.²² Such requirements are most likely consistent with the statutory mandate to relieve and support residents—those without an existing need are presumed not to require the county’s relief and support.²³ Counties may require residents to reapply for help or “renew” enrollment in a Section 17000 program on a regular basis.²⁴

Counties may be required to cover bills incurred in the past, but have some discretion to require residents to apply for help within a certain period after the bill was incurred.²⁵ Some counties use “coverage-like” programs to deliver care to indigent residents, which permits them to stay in the program for an entire year without a need to reapply or demonstrate medical need.²⁶ Advocates should work

22. See Health Access California, *supra* note 3, at 4.

23. See Welf. & Inst. Code § 17000.

24. See Health Access California, *supra* note 3, at 11.

25. See *McGrath v. Crandall*, No. A127890, 2011 WL 1085112, at *4 (Cal. Ct. App. Mar. 24, 2011) (remanding the question of whether a county is obligated to cover past bills).

26. Several counties chose this model following their experience with the Low Income Health Program, the bridge program and precursor to expanded Medi-Cal. See Health Access California, *supra* note 3, at 13.

with their counties to determine whether this type of program design is feasible to ensure broader access to health care coverage by those remaining uninsured.

D. Residency

Section 17000 limits eligibility for county health care services to individuals who are residents in the county where they are applying for aid. Residents of an Indian Reservation are considered residents of the county in which the Reservation is located.²⁷ Residence is defined in the law as “the place where one remains.”²⁸ Like the general rules governing residency in California, “residence” for the purposes of Section 17000 programs requires both physical location and intent to stay in a place.²⁹ Counties may not, however, refuse services to county residents simply because they don’t have a valid address, such as in the case of people who are homeless.³⁰ Similarly, a rule requiring applicants to reside in the county for a period of time before accessing services through the 17000 program is likely invalid.³¹

Section 17000 expressly limits the county’s obligation to support those who “*lawfully*” reside in the county. The term “*lawfully*” has been interpreted to allow counties to limit services to individuals with a satisfactory immigration status.³² Counties therefore have the discretion to aid undocumented immigrants and/or non-residents, although they are not required to do so.³³ Counties also have some discretion as to which specific immigration statuses they consider “*lawfully resident*.” At least one court suggests that counties may follow CalWORKS welfare rules with respect to immigration status, which are generally more restrictive than the immigration status rules for Medi-Cal and Covered California.³⁴

27. *Acosta v. San Diego Cnty.*, 126 Cal. App. 2d 455, 467 (1954).

28. Welf. & Inst. Code § 17101.

29. See *Nelson v. San Diego County Bd. Of Supervisors*, 190 Cal. App. 3d 25, 30 (1987). The general residence rules for the state are set forth at Government Code § 244.

30. *Nelson*, 190 Cal. App. 3d 25 at 31.

31. See *Mem’l Hosp. v. Maricopa Cnty.*, 415 U.S. 250, 269 (1974).

32. *Khasminskaya v. Lum*, 47 Cal. App. 4th 537, 543 (1996); *Bay General Community Hospital v. County of San Diego*, 156 Cal. App. 3d 944, 961 (1984).

33. Welf. & Inst. Code § 17003.

34. See *Khasminskaya*, 47 Cal. App. 4th at 543.

In California, all immigrants regardless of documentation status may be eligible for restricted-scope Medi-Cal, which provides for emergency care and certain pregnancy-related and long-term care services.³⁵ Immigrants who can establish PRUCOL (Permanently Residing Under Color of Law) status are eligible for full-scope Medi-Cal benefits.³⁶ In Covered California, immigrants are eligible to purchase a plan as long as they are “lawfully present.”³⁷ While there is significant overlap between the groups of immigrants who are eligible for Medi-Cal and those who are eligible for Covered California, there will be some immigrants whose immigration status qualifies them for full-scope Medi-Cal, but not Covered California, and vice versa.³⁸

For example, immigrants who hold work permits under the Deferred Action Childhood Arrival (DACA) executive order are potentially eligible for Medi-Cal through PRUCOL, but are not eligible for Covered California. If they are ineligible for Medi-Cal due to income, these DACA may be eligible for help from their county’s Section 17000 program. Advocates should be aware of their county’s rules regarding immigrant eligibility, and consider challenging policies that are overly restrictive.

Advocacy Tip: Relevant questions regarding a county's residency requirement include:

- Does the county require a person to reside in the county for a certain number of days to be considered a county resident?
- How does the county consider immigration status in its residency definition?
 - Which immigration statuses are eligible for the county’s program?
- Does the county’s program provide services to persons who are undocumented?

35. Welf. & Inst. Code §§ 14007.5(d); 14007.2; 14007.65.

36. Welf. & Inst. Code § 14007.5(b); id. § 11104 (eligibility of immigrants who are PRUCOL); see also Cal. Imm. Policy Center, "Health Program Eligibility Chart for California Immigrants," 2 n.3 (2013) (explaining PRUCOL), *available* at <http://www.caimmigrant.org/wp-content/uploads/2014/10/HPEligibilityChartforCAImmigrants.2013.pdf>;

37. 45 C.F.R. § 152.2 (defining “lawfully present”).

38. Nat’l Imm. Law Center, "Major Benefit Programs Available to Immigrants in California" at p. 3-4 (2014), *available* at <http://nilc.org/document.html?id=481>.

E. Programmatic Eligibility

Section 17000 limits a county's obligation to provide care to only those individuals who do not have another source of care for the services they request from a county. Practically speaking, this provision is usually used as a legal basis to require applicants for county programs to apply for Medi-Cal, Covered California or other potential sources of health coverage, including other private insurance (like COBRA or employer coverage) before the county will cover their health care costs.

A county's obligation to provide additional, but necessary, services to those enrolled in coverage depends on the type of coverage the person has. The statute explicitly relieves counties of any duty to provide health care to those persons who are enrolled in, or who are eligible for, Medi-Cal—even if a needed service is not covered by Medi-Cal.³⁹ Counties do have an obligation to provide health care to those who have a Medi-Cal application pending; it may recoup the cost of those services provided from the state Medi-Cal program if the Medi-Cal application is ultimately approved. However, a county may be obligated to cover medically necessary services that are not covered by a person's private insurance.⁴⁰

With regard to uninsured individuals who are eligible for subsidized Covered California plans but are not enrolled, the case law suggests that if subsidized Covered California plans are inaccessible to low-income Californians due to cost, counties could be required to offer services to this population.⁴¹ An alternative model might be for counties to subsidize residents' Covered California plan premiums, which might be more cost-effective than providing the services directly at full county cost. For those remaining uninsured individuals who missed the enrollment period to apply for subsidized insurance through Covered California, case law suggests that the county has an obligation to provide care at least until the person next has an opportunity to enroll.⁴² Advocates should seek the best mechanisms to ensure that those eligible for other affordable coverage options are swiftly enrolled, and to

39. Welf. & Inst. Code § 17030.

40. *Cf. McCormick. v. County of Alameda*, 193 Cal. App. 4th 201 (2011) (General Assistance, the cash aid counterpart to § 17000 health programs, must pay for services when CalWORKs provides no cash assistance).

41. *See id.*

42. *See id.*

provide interim services for those who miss an enrollment period.

Advocacy Tip: With the implementation of health reform and expanded coverage options, it is important to understand how a county's section 1700 program fills the gaps. What is the relationship between eligibility for county Section 17000 program health services and eligibility for Medi-Cal or subsidized insurance through Covered California? Does the county require applicants to prove ineligibility for these other two programs to be eligible for county indigent health services?

F. Recouping expenses

Counties may require residents to repay the cost of care provided to them through a Section 17000 program, by placing a lien on the recipient's property.⁴³ In addition, counties may seek repayment from any legally responsible relatives or immigration sponsors of those who receive care from a Section 17000 program.⁴⁴ The law contains detailed provisions concerning when a county may enforce such a lien to recoup the cost of care; those provisions are intended to protect consumers from onerous collections.⁴⁵ Other consumer debt collection protections may apply if the county attempts to collect on the lien.⁴⁶ Advocates should determine whether their county requires residents to sign a lien before receiving services from its Section 17000 program, and where this is the county practice, seek an evaluation of whether this is cost-effective. If not, counties should be asked to alter or eliminate the practice.

43. Welf. & Inst. Code § 17109.

44. See *id.* § 17300 (responsible relatives); *id.* § 17001.9 (sponsors of immigrants).

45. See *id.* §§ 17400-410; see also *Cnty. of San Diego v. Muniz*, 22 Cal. 3d 29 (1978).

46. See, e.g., *Joseph v. J.J. Mac Intyre Companies, L.L.C.*, 238 F. Supp. 2d 1158 (N.D. Cal. 2002).

G. Scope of Services

The kind of care counties must provide to their low-income residents is derived from the statutory obligation to “relieve and support.” That phrase has been interpreted to obligate counties to provide “subsistence medical care;” however, it has not been read to require counties to provide their low-income residents with a set benefits package.⁴⁷ This standard requires counties must provide “at least...medical services necessary for the treatment of acute life-and-limb threatening conditions and emergency medical services.”⁴⁸ In the case of emergency care, counties must pay for that care even if it is provided out-of-network or out-of-county.⁴⁹

But the counties’ obligation clearly extends beyond emergency care. Counties must provide “medically necessary care.”⁵⁰ And such care must be “sufficient to remedy substantial pain and infection.”⁵¹ Under this standard, counties have been found liable for urgent dental care to address abscesses, for example, but not routine preventive dental care.⁵² While some counties offer only a very limited scope of services in their Section 17000 programs, others offer preventive services and broad access to specialty care; some counties have even implemented innovations like medical homes, and integrated delivery for behavioral health services.⁵³ Advocates should evaluate whether the services offered by their county are “sufficient to remedy substantial pain and infection,” and also look for opportunities to work with counties to implement cost-effective innovations, including coverage of preventive services, better care coordination through medical homes, and improved integration with county behavioral health delivery systems.⁵⁴

47. *Hunt*, 21 Cal. 4th at 1012.

48. *Id.* at 1014.

49. *Fuchino v. Edwards-Buckley*, 196 Cal. App. 4th 1128 (2011).

50. *County of Alameda v. State Bd. of Control*, 14 Cal. App. 4th 1096, 1108 (1993).

51. *Cooke v. Superior Court*, 213 Cal. App. 3d 401, 404 (1989).

52. *Id.* at 415 (county is not required to ensure “good teeth and a picture-perfect smile in order to succeed in the workplace. . . [but it must provide a] level of care which remedies the pain and infection which petitioners have needlessly endured”); see also *Harris v. Bd. of Supervisors, Los Angeles Cnty.*, 366 F.3d 754, 765 (9th Cir. 2004) (county may not cut services in a way that will “deprive plaintiffs of medically necessary care, will endanger their health, and will lead to their unnecessary suffering”).

53. See Health Access California, *supra* note 3, at 13-14.

54. *Cooke*, 213 Cal. App.3d at 404.

Chapter 8: Options for Hospital Bills

Chapter 8: Options for Hospital Bills

A. The Hospital Fair Pricing Act

1. Bills that are Eligible for Financial Assistance
2. Charity Care and Discount Payment Plans
3. Minimum Standards for Financial Eligibility
4. Financial Assistance Notification Requirements
 - a. The Written Policy
 - b. Finding Hospital Financial Assistance Policies
 - c. Requirements for Emergency Physicians
5. Applying for a Discount
6. Reasonable Payment Plans
7. Collection Practices

B. New IRS Regulations for Non-Profit Hospitals on Hospital Financial Assistance

8. Options for Hospital Bills

A. The Hospital Fair Pricing Act

Uninsured or underinsured patients who are struggling to pay their hospital bills and who are not eligible for Medi-Cal or a county indigent program should consider seeking assistance under the Hospital Fair Pricing Act.¹ The Hospital Fair Pricing Act requires hospitals and emergency physicians to offer discount payment plans or charity care to patients in need. A hospital is required to make an effort to inform the patient of all discount payment programs available and negotiate a payment plan if necessary. If the patient and hospital are not able to come to an agreement, then the hospital must follow the reasonable payment plan formula identified in the statute.

1. Bills That are Eligible for Financial Assistance

Both hospital bills and bills from emergency physicians are covered in the Hospital Fair Pricing Act.² The law applies to all hospital bills, not just those for emergency services; thus outpatient and scheduled services provided in a hospital setting should also be covered. Advocates should be aware, however, that unless there is an emergency situation, hospitals are not required to treat patients who cannot show that they can pay for services.³ Bills from physicians who are not emergency physicians (anesthesiologists, cardiologists, etc.) are not covered by the Hospital Fair Pricing Act regardless of whether those bills relate to emergency services.

-
1. Health & Safety Code § 127400 *et seq.* Patients who are Medi-Cal eligible should be directed to apply for Medi-Cal, even if they have already received hospital services as Medi-Cal can cover services received up to three months prior to the month of application. Most county programs under Welf. & Inst. Code § 17000 also cover services received in the month of application.
 2. “Emergency physicians” are defined in Health & Safety Code § 127450(c) and include physicians contracted to provide emergency medical service in the emergency room, not other specialists who may be called in.
 3. The Emergency Medical Treatment & Active Labor Act (EMTALA) (aka the Patient Anti-Dumping Law) requires hospitals to treat anyone presenting in the emergency department with an emergency medical condition or in active labor. Hospitals that do not comply with EMTALA risk losing Medicare or Medicaid reimbursements. 42 U.S.C. § 1395dd. Nearly all hospitals depend on Medicare and Medicaid reimbursement, save for some military hospitals and Shriners hospitals that provide free children’s services.

2. Charity Care and Discount Payment Plans

Once a hospital makes a determination that a patient is eligible for financial assistance, the hospital may then offer the patient either charity care or a discount payment plan. Hospitals generally use the term charity care to describe full charity care or free hospital care.

A discount payment plan is offered when the hospital has determined that the patient does not qualify for full charity care (or the hospital does not offer full charity care), but is eligible for a discount and is required to pay only a part of the bill. A patient who qualifies is not required to pay more than the amount a government-sponsored health program (e.g. Medicare) would pay.⁴

The maximum amount an emergency physician may charge is 50% of the median of billed charges.⁵ If the emergency physician has sought reimbursement from the Maddy Emergency Medical Services Fund, then the physician may not continue billing or attempting to collect any amount for the bill.⁶

3. Minimum Standards for Financial Eligibility

All uninsured patients or patients with high medical costs *who are at or below 350 percent of the federal poverty level* are eligible for a hospital's charity care or discount payment policy.⁷ While uninsured patients are easy enough to identify, the protections also extend to insured patients with high medical costs, meaning those who have medical bills that exceed 10% of the patient's family income in the prior 12 months.⁸ If these expenses are not incurred at the hospital, the patient will have to show evidence of payment of other medical bills that bring the total amount billed to over 10% of the family income.⁹ The insured patients most likely to meet these

4. Health & Safety Code § 127405(d).

5. Health & Safety Code § 127452(b). The median of billed charges must be based on the FAIR Health, Inc. database: <http://fairhealthconsumer.org/medicalcostlookup.php>.

6. Health & Safety Code § 127452(c). The Maddy Fund is a fund to reimburse physicians for emergency services provided to patients who do not pay. Health & Safety Code § 1797.98a.

7. Health & Safety Code §§ 127405(a)(1)(A), 127452(a).

8. Health & Safety Code § 127400(g)(1)-(2).

9. Health & Safety Code § 127400(g)(2).

criteria are those with catastrophic type policies or high deductible policies such as Covered California Bronze policies.

For bills from emergency physicians, patients only qualify as underinsured if they both meet the 10% test described above and their coverage provides no discount on services from the emergency physician.¹⁰

Advocacy Tip: These are the minimum standards that hospitals and emergency physicians must incorporate into their policies. Hospital can, and many do, allow those with incomes over 350% FPL to qualify for their charity care or discount payment policies.¹¹ Similarly, hospitals have discretion to set what income levels, if any, get free care via charity care, what income levels get a discount, and what percentage of a discount is available. Hospitals are free to set their own policies provided they follow these minimum guidelines and the guidelines are available in a written policy. Some emergency physicians and even doctors not subject to the Hospital Fair Pricing Act will discount or write off a bill if the hospital has already found the patient eligible for financial assistance. Sending the other physicians the notification from the hospital that the bill has been drastically reduced or written off can help in the negotiation of these other bills since many of these other providers do not have billing staff who can make assessments of financial need.

4. Financial Assistance Notification Requirements

Hospitals and emergency physicians are required to make all reasonable efforts to obtain from the patient information on any insurance that may cover the patient's hospital bills.¹² If the patient does not provide evidence of third party coverage by the time of billing, the hospital or emergency physician (or assignee) must provide the patient with clear and conspicuous notices describing the charges, how to apply for government health care benefits, and the hospital's or physician's financial

10. Health & Safety Code § 127450(i). Most insurance policies do provide a discount, even those with high deductibles.,

11. Health & Safety Code § 127405(a)(1)(A).

12. Health & Safety Code §§ 127420(a), 127454(a).

assistance policies. The notices must also include a contact person or office and phone number that patients may use to obtain information on applying.¹³ Such notice must be provided in the language spoken by the patient if that language is spoken by 5% or more of the patients served by the hospital.¹⁴ Hospitals and emergency physician must also provide patients with a referral to a local consumer assistance center housed at legal services offices.¹⁵

a. The Written Policy

Each hospital must have an understandable written policy regarding discount payment plans and charity care.¹⁶ The written policy must include:

- A description of the process for determining patient eligibility, clearly stating the criteria based on income as a percentage of the federal poverty level;
- An extended payment plan option to allow discounted payments to be made over time;
- Notification that the terms of the payment plan can be negotiated between the hospital and patient, and that the hospital will use the reasonable payment plan formula if the hospital and patient are unable to agree on the terms (see section 6 below);
- The name of the designated executive level staff person to contact if a dispute arises;
- Notification that emergency physicians must also provide discounts to uninsured and underinsured patients with incomes below 350% FPL.¹⁷

b. Finding Hospital Financial Assistance Policies

Advocates who are having difficulty obtaining the policy from the hospital itself should know that these policies must be submitted to the Office of Statewide Health

13. Health & Safety Code §§ 127420(b), 127454(b).

14. See Health & Safety Code § 127410(a) referring to Insurance Code § 12693.30 which incorporates the Dymally-Alatorre Bilingual Services Act. See Government Code § 7290 et seq., specifically § 7296.2.

15. Health & Safety Code §§ 127420(b)(4), 127454(b)(4)(A).

16. Health & Safety Code § 127405(a)(1)(A).

17. Health & Safety Code § 127405(a)(1)(A)-(B).

Planning and Development (OSHPD) biennially or whenever a significant change is made, and OSHPD must make this information available to the public.¹⁸ OSHPD posts hospital financial assistance policies and applications on a searchable website so that patients can have access to the policies and compare them. This resource may be found at <https://syfphr.oshpd.ca.gov/>.

Advocacy Tip: If a hospital claims that its financial assistance policy has changed, you should hold them to the policy posted on the OSHPD website as this public posting is legally required.

c. Requirements for Emergency Physicians

Emergency physicians must also provide notice of their offered discounts. If the emergency physician uses the following notice in any billing, that emergency physician has complied with required notice requirement: “If you are uninsured or have high medical costs, please contact ____ (name of person responsible for discount payment policy) at ____ (area code and phone number) for information on discounts and programs for which you may be eligible, including the Medi-Cal program. If you have coverage, please tell us so that we may bill your plan.”¹⁹

Alternatively, the emergency physician can comply with the notice requirement by providing information about discounts upon request and printing on the bill the following in 14-point bold type: “If uninsured or high medical bill, call re: discount.”²⁰

5. Applying for a Discount

Patients do need to cooperate with the hospital to be eligible for discounted payments and provide documentation of income and health care coverage.²¹

18. Health & Safety Code § 127435. OSHPD has enacted regulations that govern how hospitals must submit their financial assistance policies and applications to the department. They may be found at 22 CCR § 96040 et seq.

19. Health & Safety Code § 127454(c)(1).

20. Health & Safety Code § 127454(c)(2).

21. Health & Safety Code §§ 127405(e), 127452(d).

However, for either charity care or discount payment plans, the hospital may only require patients to submit recent pay stubs or income tax returns.²² When determining eligibility for charity care only, hospitals may ask for information about all monetary assets, except for retirement or deferred compensation plans.²³ To verify the value of such monetary assets, a hospital may require a patient to provide authorization to obtain the patient's account information from financial or commercial institutions.²⁴ If a patient is only getting a discount from a hospital, monetary assets do not matter and the patient may not be required to divulge such information. Real property, such as a patient's home, should never matter. Additionally, hospitals may not include residency or immigration status requirements for eligibility; any requests for such information are inappropriate.

Emergency physicians may rely on the determination made by the hospital where the emergency care was provided or they may ask for recent pay stubs, income tax returns, or a self-attestation; emergency physicians are prohibited from asking for other types of documentation.²⁵

The information gathered from the documentation provided by the patient may not be used for collection activities by either the hospital or an emergency physician.²⁶

22. Health & Safety Code § 127405(e)(1).

23. Health & Safety Code § 127405(e)(2).

24. Health & Safety Code § 127405(e)(2).

25. Health & Safety Code § 127452(d)(1).

26. Health & Safety Code §§ 127405(e)(3), 127452(d)(2).

Advocacy Tip: If patients apply or have a pending application for another health coverage program at the time they apply for charity or discounted care at the hospital, the application does not, in and of itself, preclude eligibility.²⁷ Advocates should be aware though that many hospitals do require patients to apply for Medi-Cal and other programs before offering a discount and in fact are required to inform patients as to how they might apply for government sponsored programs and provide applications for such programs.²⁸ Patients who apply for Medi-Cal may still end up with a high share of cost or may be denied all together and therefore would still need assistance from the hospital.²⁹ Similarly, while it might be good practice for the hospital to inform the patient of the availability of Covered California policies, in most cases such coverage would not be available until after a plan is chosen and paid for, and therefore the plan would not cover the hospital bill in question.³⁰

6. Reasonable Payment Plans

If the hospital determines that the patient is eligible for a discount payment plan (but not eligible for charity care), the expected payment for a patient should be limited to the amount a hospital would expect to receive, in good faith, from government-sponsored health benefit programs the hospital participates in. If no established payment is provided by a government sponsored health benefit program for the service provided, the hospital should establish a discounted payment.

When the hospital and patient cannot agree on payment plan during the negotiation process, the hospital must offer a “reasonable payment plan” to all patients meeting the eligibility requirements. This payment plan will require that monthly payments do not exceed ten percent of a patient’s family income for a month, excluding

27. Health & Safety Code § 127420(b)(5)(C).

28. Health & Safety Code § 127420(b)(4). Emergency physicians must also notify patient that they may be eligible for a government-sponsored program but do not need to provide an application. Health & Safety Code § 127454(b)(3).

29. Some patients with a Medi-Cal share of cost would meet the definition of underinsured.

30. Of course, if it turns out a patient had been wrongly denied Covered California coverage recently, the patient may be able to get retroactive coverage through the appeals process.

deductions for essential living expenses.³¹

“Essential living expenses” are defined as expenses for any of the following: rent or housing payments and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses (including insurance, gas and repairs), installment payments, laundry and cleaning expenses, and other extraordinary expenses.³² Once such expenses are taken into account, the remaining 10% may be very low. Patients can, however, agree to pay more if they wish to, as many patients do not want to remain in debt for a long period of time.

Emergency physicians are also required to offer a negotiable extended payment plan. If the emergency physician and patient cannot reach an agreement on the amount of the payment, then the emergency physician must instead use a reasonable payment formula, similar to the methodology used for the hospitals, when determining the amount of the monthly payment. Emergency physicians are entitled to a \$10 a month minimum payment regardless of the amount a patient has left over for essential living expenses.³³

7. Collection Practices

Hospitals and emergency physicians must have a written policy about when and under whose authority patient debt is advanced for collection.³⁴ A hospital that uses an affiliate, subsidiary or external collection agency to collect debt must have an agreement with that entity requiring them to comply with the hospital’s reasonable payment plan.³⁵

Hospitals may not report patients who are not covered by insurance or who have medical costs that exceed 10% of their family’s annual income to a credit reporting agency. Hospitals also may not commence a lawsuit prior to 150 days after the

31. Health & Safety Code §§ 127405(b), 127455(f).

32. Health & Safety Code §§ 127400(i), 127450(k).

33. Health & Safety Code § 127455(f).

34. Health & Safety Code §§ 127425(a), 127455(a).

35. Health & Safety Code §§ 127425(b), 127455(b).

initial bill.³⁶ Hospitals cannot send a bill to a collection agency or other assignee if the patient is attempting to qualify for financial assistance, attempting to negotiate a payment plan, or is making regular partial payments, unless the referral to the outside agency also complies with these collection guidelines.³⁷

Hospitals or their assignees may not begin collection activities against a patient without first giving a statement of the availability of credit counseling services and a short written description of the patient's rights under state and federal fair debt collection laws.³⁸ Hospitals, emergency physicians, and their assignees cannot report the bill to credit reporting agencies while a patient is trying to settle a bill in good faith.³⁹ Hospitals, emergency physicians and their assignees also generally cannot use wage garnishments and liens on primary residences as a means of collecting hospital bills against patients who qualify for financial assistance.⁴⁰ Wage garnishments may only be used after a noticed motion to the court demonstrating that the patient has the ability to make payments on the judgment and a court holds a hearing regarding the patient's ability to pay in light of other obligations and medical services needed.⁴¹ The sale of a primary residence may only be forced after the patient and his or her spouse dies and the patient's children have reached age 18 and are able to care for themselves outside of the residence.⁴²

If a patient fails to make consecutive payments for 90 days and the provider wants to continue to seek payments from the patient, the hospital, emergency physician, or their assignee must contact the patient, by phone and in writing, informing the patient that the extended payment plan may be declared inoperative and give the patient the chance to renegotiate a plan.⁴³ Patients who can no longer make the payments under the original payment plan are allowed to renegotiate a payment plan.⁴⁴ However, if a patient fails to renegotiate a payment plan, the patient is still required to make all payments, pursuant to the reasonable payment plan. If the

36. Health & Safety Code §§ 127425(d), 127455(c).

37. Health & Safety Code §§127425(e), 127455(d).

38. Health & Safety Code § 127430.

39. Health & Safety Code §§127425(e), 127455(d).

40. Health & Safety Code §§ 127425(f)(1), 127455(e)(1).

41. Health & Safety Code §§ 127425(f)(2)(A), 127455(e)(2)(A).

42. Health & Safety Code §§ 127425(f)(2)(B), 127455(e)(2)(B).

43. Health & Safety Code §§ 127425(h), 127455(f).

44. Health & Safety Code §§ 127425(g), 127455(f).

patient continues to fail to make payments and the hospital, collection agency, or assignee declares the extended payment plan inoperative, it may then report the information to a consumer credit reporting agency or commence a civil action against the patient.⁴⁵

B. New IRS Regulations for Non-Profit Hospitals on Hospital Financial Assistance

As part of the Affordable Care Act, the IRS recently adopted a regulation regarding the financial assistance policies of non-profit hospitals. Hospitals had until the beginning of 2016 to come into compliance with the final regulations.⁴⁶

The IRS regulations are similar to the California Hospital Fair Pricing Act, but the IRS regulations only apply to non-profit hospitals. Hospitals that fail to comply may ultimately have their tax-exempt status revoked after a thorough investigation as to the history and nature of the failure – minor errors will not cause revocation of such status.⁴⁷

In general, the Hospital Fair Pricing Act is more prescriptive and thus more helpful for advocates. There are, however, a few additional requirements in the IRS regulations that do not exist in the Hospital Fair Pricing Act.

- The IRS regulations establish a time period during which a hospital *must* consider an application for financial assistance – 240 days after the first bill is sent.⁴⁸ The Hospital Fair Pricing Act is silent on this, though advocates have convinced hospitals to accept applications much later.
- The IRS regulations require hospitals to maintain a list of any providers delivering emergency or other medically necessary care in the hospital that specifies which providers are covered by the hospital facility's financial assistance policy and which are not.⁴⁹
- The IRS regulations require hospitals to maintain a list of all the actions the

45. Health & Safety Code §§ 127425(g), 127455(f).

46. 26 C.F.R. § 1.501(r)-7.

47. 26 C.F.R. § 1.501(r)-2.

48. 26 C.F.R. § 1.501(r)-1(b)(3).

49. 26 C.F.R. § 1.501(r)-4(b)(1)(iii)(F).

hospital may take to collect on the bill.⁵⁰

- The IRS regulations forbid deferring, denying, or requiring a payment before providing medically necessary care because of a patient's previous nonpayment of one or more bills covered under the hospital facility's financial assistance policy.⁵¹

The IRS regulations also have more specifics on methods of application, methods of contact, and reasonable attempts on the part of the hospital to determine eligibility.⁵² As these regulations are brand new, it is unclear how actively the IRS will enforce them, but it is another tool advocates should be aware of.

50. 26 C.F.R. § 1.501(r)-4(b)(1)(iii)(D), (b)(4)(ii).

51. 26 C.F.R. § 1.501(r)-6(b)(1)(iii).

52. See 26 C.F.R. § 1.501(r)-6.

List of Common Acronyms

AAP: Adoption Assistance Program

ABD: Aged, Blind, and Disabled

ABD-MN: Aged, Blind, and Disabled - Medically Needy Program

ACA: Affordable Care Act

ACL (or ACWDL): All County Letter (or All County Welfare Directors Letter)

A&D FPL: Aged and Disabled Federal Poverty Level Program

AE: Accelerated Enrollment

AFDC: Aid to Families with Dependent Children

AFDC-MN: Aid to Families with Dependent Children - Medically Needy Program

ALJ: Administrative Law Judge

APP: Aid Paid Pending

APTC: Advance Premium Tax Credit

AR: Authorized Representative or Annual Renewal

BCCTP: Breast and Cervical Cancer Treatment Program

BIC: Benefits Identification Card

CalFresh: California's "food stamp" program

CalHEERS: California Healthcare Eligibility Enrollment and Retention System

CalWIN: CalWorks Information Network - the county consortia IT system serving 18 counties

CalWORKs: California Work Opportunity and Responsibility to Kids - California's welfare to work program

CEC: Continuous Eligibility for Children

CCS: California Children's Services

CCR: California Code of Regulations

CDSS: California Department of Social Services

CFR: Code of Federal Regulations

CHDP: Child Health and Disability Prevention Program

C-IV: Consortia-IV- the IT consortia system serving 39 counties

COBRA: Consolidated Omnibus Budget Reconciliation Act (specifically, the provision that allows for the extension of employer-based coverage when leaving a job).

COLA: Cost of Living Adjustment

CSR: Cost Sharing Reduction

CWD: County Welfare Department OR Conditional Withdrawal

DAC: Disabled Adult Children

DACA: Deferred Action for Childhood Arrivals

DDSD: Disability Determination Service Division (formerly the DAPD - Disability Adult Programs Division)

DE: Deemed Eligibility for Newborns

DHCS: Department of Healthcare Services

DHS: Department of Health Services or Department of Homeland Security

DSS: Department of Social Services

ELE: Express Lane Eligibility

Family PACT: Family Planning, Access, Care, and Treatment

FC: Foster Care

FFCC Program: Former Foster Care Children Program

FFS: Fee for Service

FFY: Former Foster Youth

FPL: Federal Poverty Level

FPL-B: Federal Poverty Level - Blind

Hospital PE: Hospital Presumptive Eligibility

ICT: Inter-County Transfer

IEVS: Income and Eligibility Verification System

IHSS: In-Home Supportive Services

IRWE: Income-Related Work Expense

KinGAP: Kinship Guardian Assistance Program

LPR: Lawful Permanent Resident

LTC: Long Term Care

MAGI: Modified Adjusted Gross Income

MBU: Mini Budget Unit

MCAP: Medi-Cal Access Program (formerly Access for Infants and Mothers, or AIM)

MEC: Minimum Essential Coverage

MEDIL: Medi-Cal Eligibility Division Information Letters

MEDS: Medi-Cal Eligibility Data System

MFBU: Medi-Cal Family Budget Unit

MI: Medically Indigent

MN: Medically Needy

MNA: Maintenance Need Allowance

MPP: (Department of Social Services) Manual of Policies and Procedures

MNL (or MNIL): Maintenance Need (Income) Level

MRMIB: Managed Risk Medical Insurance Board (pronounced “Mr. Mib”)

NOA: Notice of Action

OBRA: Omnibus Budget Reconciliation Act

OMEA: Office of Marketplace Eligibility Appeals

OHC: Other Health Coverage

PA: Public Assistance

PRUCOL: Permanently Residing Under Color of Law

PRWORA: Personal Responsibility and Work Opportunity Reconciliation Act

QDWI: Qualified Disabled and Working Individual

QHP: Qualified Health Plan

QI: Qualified Individual

- QMB:** Qualified Medicare Beneficiary
- SAWS:** Statewide Automated Welfare System
- RMA:** Refugee Medical Assistance
- SB 87:** Senate Bill 87
- SGA:** Substantial Gainful Activity
- SHD:** State Hearings Division (of the California Department of Social Services)
- SIWI:** Severely-Impaired Working Individual
- SLMB:** Specified Low-Income Medicare Beneficiary
- SPE:** Single Point of Entry
- SOC:** Share of Cost
- SSDI:** Social Security Disability Income
- SSA:** Social Security Administration
- SSI/SSP:** Supplemental Security Income/ State Supplemental Program
- SSN:** Social Security Number
- TB:** Tuberculosis Program
- TLICP:** Targeted Low-Income Children's Program
- TMC:** Transitional Medi-Cal
- TPN:** Total Parenteral Nutrition
- UIB:** Unemployment Insurance Benefits
- USC:** United States Code
- VAWA:** Violence Against Women Act
- § 1931(b):** pre-ACA Section 1931(b) Medi-Cal program
- 250% WDP:** 250% Working Disabled Program

Glossary

Accelerated Enrollment (AE): A special program through which a child applies through the Single Streamlined Application can get Medi-Cal very quickly if an initial screen of his/her application indicates s/he is likely to be eligible for free Medi-Cal. AE is also available in the federal BCCTP.

Adjusted Gross Income: Income from taxable sources minus specific allowable deductions and labelled "adjusted gross income" on IRS forms 1040, 1040-A, and 1040-EZ. For the longer forms (1040 and 1040-A), it is generally the last item on page 1 and repeated again at the top of page 2. Do not confuse with the line "taxable income" which comes after all allowable deductions and exemptions are made.

Advanced Premium Tax Credit (APTC): Payment of the tax credits authorized by Section 36B of the Internal Revenue Code and implementing regulations, which are sent directly to the Covered California Qualified Health Plan of an eligible individual on a monthly basis to pay a portion of the individual's health premium. See 10 CCR § 6410

Adverse Action: "An action taken by a county department which discontinues Medi-Cal eligibility or increases an MFBU's share of cost." 22 CCR § 50015

Affordable: A term of art in evaluating employer-sponsored plans to determine eligibility for Covered California financial assistance. If the amount of premiums that an employee must pay per year exceeds 9.5% of his or her income, that plan is not affordable. If it is less than 9.5% of income, it is affordable.

Affordable Care Act (ACA): The federal Patient Protection and Affordable Care Act of 2010 (Pub.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Pub.L. 111-152). Signed by President Barack Obama on March 23, 2010.

Aged: A Medi-Cal term for a person who is 65 years old or older.

Aid Code: A Medi-Cal aid code is “[t]he two-digit number which indicates the aid category under which a person is eligible.” 22 CCR § 50018.

Access for Infants and Mothers (AIM): See Medi-Cal Access Program (MCAP).

Aid Paid Pending: If a beneficiary requests a fair hearing before the date a county takes action to reduce, adjust, or terminate Medi-Cal, the beneficiary will continue to get Medi-Cal pending the fair hearing decision.

Appellant: A person appealing a determination related to eligibility made by Covered California.

Annual Redetermination: Every 12 months, Medi-Cal beneficiaries’ eligibility is reviewed by the county to determine if they remain eligible for ongoing Medi-Cal coverage.

Applicant: “The individual or family making, or on whose behalf is made, an application, request for restoration of aid, or reapplication.” 22 CCR § 50021.

Assets: See Property.

Beneficiary: “A person who has been determined eligible for Medi-Cal.” 22 CCR § 50024.

Benefits Identification Card (BIC): The physical card a beneficiary receives from Medi-Cal and presents to providers as proof of coverage.

Breast and Cervical Cancer Treatment Program (BCCTP): A Medi-Cal special treatment program through which persons diagnosed with breast or cervical cancer can get full-scope or cancer-related coverage.

CalFresh: California's Supplemental Nutrition Assistance Program formerly known as the "food stamp" program.

California Healthcare Eligibility, Enrollment and Retention System (CalHEERS):

The electronic portal or system through which consumers may apply for Medi-Cal or Covered California and manage their Medi-Cal or Covered California accounts.

Caretaker Relative (CR): “A relative who provides care and supervision to a child, if there is no natural or adoptive parent in the home.” 22 CCR § 50085.

Conditional Withdrawal: A withdrawal of a Medi-Cal or Covered California appeal subject to certain conditions that the appellant or claimant and applicable agency have agreed upon being satisfied.

Categorical Linkage: A person receiving cash assistance through CalWORKs or SSI receives Medi-Cal automatically because s/he is in the category of persons receiving that cash assistance and “linked” to Medi-Cal on that basis.

Charity Care: A form of hospital financial assistance to uninsured patients that releases the patient from liability for the hospital bill.

Claimant: A person pursuing a Medi-Cal appeal.

Conditional Withdrawal: A withdrawal of a Medi-Cal or Covered California appeal subject to certain conditions that the appellant or claimant and applicable agency have agreed upon being satisfied.

Child Health and Disability Prevention Program (CHDP): “The community based program for early identification and referral for treatment of persons under 21 years with potentially handicapping conditions.” 22 CCP § 50031.

Cost Sharing Reduction (CSR): A form of financial assistance available through Covered California for consumers between 100-250% FPL who enroll in Enhanced Silver plans. If a consumer chooses an Enhanced Silver plan, the plan comes with reduced deductibles, co-payments, and out-of-pocket maximums making the plan more valuable than what the consumer could otherwise purchase for that price. See 10 CCR § 6410.

Continuous Eligibility for Children (CEC): A program through which any child under age 19 who has free Medi-Cal with no Share of Cost can keep free Medi-Cal until his/her next scheduled annual redetermination or 19th birthday, whichever comes first, even if the family's income goes up or other circumstances change in a way that would otherwise require the child to pay a share of cost.

Countable Income: The amount of income reached by subtracting all income that is considered exempt and all amounts a family is allowed to deduct (or disregard). This amount is then measured against the income limit for the family size to determine if the family is eligible, ineligible, or eligible with a Share of Cost.

County: In this guide, County is often used as shorthand for the County Welfare Department, County Social Services Agency, or other agency in the County that is responsible for administering the County's Medi-Cal program.

Covered California: California's trade name for its Health Benefit Exchange. The Health Benefit Exchange is the program set up by the Affordable Care Act where eligible consumers can purchase subsidized health insurance.

Cuban/Haitian Entrant: Generally most Cubans and Haitians, including parolees and asylum seekers, who are neither lawful permanent residents or have a final nonappealable order of removal are entrants. See the Refugee Education Assistance Act or 1980, §501(e) for the exact definition.

Deductible: The amount a health plan enrollee must pay per year in out-of-pocket expenses before a health plan will start paying for services. Some services, such as preventive care, are not subject to the deductible. Premium payments, services received out-of-network, and services not covered by the health plan do not count towards the deductible.

Deduction: A deduction is an amount (usually of income) that an applicant or beneficiary may subtract from his/her gross income to determine how much of his/her income counts in determining Medi-Cal eligibility. "Deduction" and "disregard" are used interchangeably.

Deemed Eligibility for Newborns (DE): A special program that guarantees that a baby born to a mother who is eligible for Medi-Cal is automatically eligible for and gets to keep Medi-Cal at least until his/her first birthday.

Deeming: See Sneed/Gamma. Medi-Cal non-MAGI income deeming rules to determine whose income and property count toward an applicant's eligibility.

Department of Health Care Services (DHCS): DHCS is the state agency solely responsible for the administration of the Medi-Cal program.

Department of Homeland Security (DHS): The federal DHS is the department that houses the U.S. Citizenship and Immigration Services (USCIS) and Immigration and Customs Enforcement (ICE). Instead of referring to INS, immigration practitioners now generally refer to DHS, USCIS, or ICE, depending on the context. Some immigration responsibilities, however, are still housed in the Department of Justice.

Disability: For Medi-Cal purposes, a disabled person is an individual who has met the criteria set by the Social Security Administration (SSA). An individual must have a severe physical and/or mental problem that is expected to last for at least 12 months (or result in death) and prevent the person from being able to work or engage in "substantial gainful activity."

Disabled Adult Children (DAC): Disabled Adult Children are people over age 18 who were born with some kind of disabling condition or who became disabled before age 22 and whose SSI/SSP benefits were discontinued because of the receipt of or increase in Social Security (Title II) benefits. DACs are entitled to Social Security benefits from a parents' work history.

Discontinuance: See Termination.

Discount Payment Plan: A form of hospital financial assistance to the uninsured and underinsured that allows for patient to pay a reduced rate in installments.

Disregard: See Deduction.

Dual Eligible: A term used to describe a person who receives both Medi-Cal and Medicare. They are also called “Medi-Medi.”

Exemption: Something that does not count in determining a person’s or family’s eligibility, such as income or property that is not counted when determining if a person or family has income or property under the limits for their family size. A person can also be exempt from a particular procedure or rule, which means they do not have to meet that requirement.

Ex Parte Process: The part of the Medi-Cal eligibility review that a county initiates itself and does on its own prior to contacting the beneficiary, using available and appropriate government databases and sources.

Fair Hearing: A beneficiary has a right to a hearing before an impartial arbiter anytime the county takes an adverse action to terminate, reduce, deny, or suspend benefits.

Family Planning, Access, Care, and Treatment (Family PACT): A program funded by Medi-Cal that provides family planning services to women and men who are not otherwise eligible for free Medi-Cal and whose incomes are under 200% of the Federal Poverty Level.

Federal Poverty Level (FPL): “An income level based on the official poverty line as defined by the federal Office of Management and Budget and revised annually or at any shorter interval that the Secretary of Health and Human Services deems feasible and desirable.” 22 CCR § 50041.5; see also 10 CCR § 6410.

Fee for Service (FFS): A method of receiving and paying for care where a beneficiary can get services from any Medi-Cal provider and the Medi-Cal program pays that provider based on the services rendered. FFS Medi-Cal describes all Medi-Cal services rendered outside of a managed care plan or system

Four-Month Continuing: A family can receive up to four months of additional Medi-Cal when they lose free coverage due to increased collection of child or spousal support.

Full-Scope: Beneficiaries who have satisfactory immigration status receive full-scope Medi-Cal, which means the full package of health care benefits available in the Medi-Cal program.

In-Home Supportive Services (IHSS): A program run by the state that provides personal assistance services to persons with disabilities to enable them to live independently instead of needing to live in a nursing home or other institutional setting.

In-Kind Income: Income that counts for Medi-Cal eligibility when an applicant or beneficiary receives a full month's item of need, such as housing or food, at no cost to himself/herself.

Insurance Affordability Programs: Medi-Cal, subsidized Covered California and Children's Health Insurance Programs (CHIP) including the Medi-Cal Access Program (former AIM program), the Optional Low-Income Children's Program (former Healthy Families Program) that is now part of Medi-Cal and county C-CHIP programs. See Welf. & Inst. Code § 15926(c).

Inter-County Transfer (ICT): The process by which a county is required to transfer a beneficiary's Medi-Cal case to a new county with no interruption in benefits if the beneficiary moves from one county to another.

Lawful Permanent Resident (LPR): An immigrant with a visa that legal entitles him or her to live and work in the United States indefinitely, also known as a "green card holder."

Lawfully Present Immigrants: A term that includes all immigrants with documented status except those in Deferred Action for Childhood Arrivals (DACA) and DAPA status and defines immigrant eligibility for Covered California.

Linked: A term used to describe persons who receive Medi-Cal because they are “linked” to a cash assistance program such as CalWORKs or SSI. In other words, they meet the eligibility requirements of the cash assistance program although it is not necessary that they be receiving the cash assistance. Another use of the term is when a parent or relative gets Medi-Cal because they are “linked” to his/her child, *i.e.*, they qualify for MAGI Parents/Caretaker Relatives program.

MAGI: Modified Adjusted Gross Income. This is a particular income counting methodology used to determine eligibility for Covered California and some Medi-Cal programs. It is based on the adjusted gross income on a tax return with some additional sources of income added. See 42 CFR 435.603§(e); Welf. and Inst. Code § 14005.64(a)-(c).

MAGI Medi-Cal: Medi-Cal programs that use the Modified Adjusted Gross Income methodology to determine financial eligibility.

Maintenance Need Level (MNL, MNIL, or MNA): The amount used in the Medically Needy programs to determine whether a person receives free Medi-Cal if they are under the income limit, or Medi-Cal with a Share of Cost if their income exceeds the limit. It is assumed that this is the amount a person would need to cover basic living expenses. Maintenance Need Income Level (MNIL) is an income limit, also called Maintenance Need Level (MNL), while the Maintenance Need Allowance (MNA) is an amount attributed to a person’s needs when determining family members’ eligibility.

Managed Care: A method of receiving and paying for care where the beneficiary is enrolled in a health plan and receives services through that plan, which coordinates the beneficiary’s care and gets paid a capitated rate for each beneficiary regardless of how many services the person actually uses.

Maximum Out-of-Pocket Cost: The most that a health plan enrollee can pay per year in out-of-pocket expenses (excluding premium payments) for covered health services received in-network or in an emergency. Once the out-of-pocket cost is reached, the health plan must cover all in-network and emergency services.

Medicaid: The federal public health coverage program that sets rules and requirements for states to follow in their health programs for low-income residents; California's Medicaid program is called Medi-Cal.

Medi-Cal Eligibility Data System (MEDS): Statewide computer system that stores Medi-Cal eligibility and demographic information.

Medically Indigent: Persons who get Medi-Cal, usually with a Share of Cost, who fail the income or deprivation test or other specific categorical requirements, but are otherwise eligible.

Medically Needy: Persons who receive Medi-Cal with or without a Share of Cost based on whether their countable incomes fall below or exceed the Maintenance Need Income Level (MNIL).

Medicare: A federal health insurance program that provides health coverage for U.S. residents who are 65 or older or who are permanently disabled regardless of the person's income.

Medicare Savings Plan (MSP): Special programs through which persons can get Medicare premiums and payments paid by Medi-Cal. Those programs are the Qualified Medicare Beneficiary Program (QMB), the Specified as Low-Income Medicare Beneficiary Program (SLMB), the Qualified Individual Program (QI), and the Qualified Disabled & Working Individuals Program (QWDI).

Medi-Cal: California's Medicaid program providing low-cost and no-cost health coverage for low-income residents.

Medi-Cal Access Program (MCAP): A program administered by the state that provides prenatal care and delivery to mothers and full health services to newborns up to age 1 for women with income over 213% and up to and including 322% the Federal Poverty Level. Formerly known as the Access for Infants and Mothers (AIM) Program.

Medi-Cal Family Budget Unit (MFBU): An MFBU is used to combine family members and their income to determine eligibility. It includes all family members not receiving cash aid whose income is included when calculating Medi-Cal eligibility. If a family member is ineligible for assistance, but still legally responsible for those in the MFBU, then the person is included in the MFBU. 22 CCR § 50060.

Medi-Cal Only: “A person’s or family’s eligibility for Medi-Cal benefits that has been determined independently of an eligibility determination for any other aid or benefit program” (22 CCR § 50060.5) such as CalWORKs or Supplemental Security Income (SSI).

Medi-Medi: See Dual Eligible.

Mini Budget Unit (MBU): An MBU is a subunit of the MFBU and is used to determine eligibility under Sneed rules and procedures.

Minimum Essential Coverage: A requirement of the Affordable Care Act is that all individuals, with exceptions, must have health coverage that is minimum essential coverage. Minimum essential coverage is defined in statute as most employer coverage, full-coverage government-sponsored programs, and plans sold on the individual market.

Minimum Value: An evaluation of employer-sponsored coverage to determine whether an employee is eligible for Covered California. Plans that do not cover at least 60% of expected total costs are not minimum value.

Minor Consent Services: Services a minor can consent to on his/her own (without requiring consent of a parent) related to sexual assault, drug or alcohol abuse, pregnancy, family planning, venereal disease, or sexually transmitted diseases and mental health counseling. See 22 CCR § 50063.5.

No Longer Disabled: A special program through which children who were receiving SSI as of August 22, 1996 when the disability definition changed can still get Medi-Cal if the reason they are not otherwise eligible is due to the change in disability definition.

Non-Immigrant: A person in the United States based on a temporary visa such as a student, tourist, or work visa.

Non-MAGI Medi-Cal: Medi-Cal programs that do not use the Modified Adjusted Gross Income methodology.

Non Filer: A person who does not file taxes and is not the dependent of someone who does.

Notice of Action (NOA): The official notice the County must send to a beneficiary anytime the County is taking any action to start, stop, or change the beneficiary's Medi-Cal eligibility.

Open Enrollment: The time of year when a qualified individual can enroll or change coverage in a Qualified Health Plan through Covered California without needing a qualifying event. See Health and Safety Code § 1399.849(c)(1) and Insurance Code § 10965.3(c)(1).

Out-of-Pocket Costs: Costs that a health plan enrollee is responsible for besides premium payments. These include co-payments and co-insurance amounts that are paid when services are received.

Permanently Residing Under Color of Law (PRUCOL): There are several categories of immigration status that Medi-Cal deems satisfactory to receive full-scope Medi-Cal because the Immigration Agency knows the beneficiary is in the United States but is taking no steps to deport him/her due to his/her special status.

Pickle: A special program through which a person can get Medi-Cal because s/he received SSI and Social Security benefits in the same month but was discontinued from SSI for any reason.

Pregnancy-Related Services: Pregnancy-related medical care, including labor, delivery, care up to 60-days postpartum and family planning.

Premium Tax Credits: The primary form of assistance available through Covered California. This is a tax credit that can be taken in advance, throughout the year, to help pay for insurance. Also known as Advance Premium Tax Credits (APTCs) or premium assistance.

Property: The possessions a person owns that are counted and valued to determine whether an applicant is low-income enough to qualify for Medi-Cal.¹³ The words “assets” and “resources” are used interchangeably with “property.” 22 CCR § 50073 and 50074.

Public Charge: A determination that an immigrant has become or is likely to become primarily dependent on the government for subsistence.

Qualified Disabled & Working Individual Program (QWDI): This program allows certain disabled individuals who lost their Medicare Part A Benefits due to returning to work to get their Medicare Part A premiums paid by Medi-Cal.

Qualifying Event: A life event that allows someone to enroll in or change Covered California plans outside of Open Enrollment. Also known as a "triggering event."

Qualified Health Plan: A health plan offered through Covered California. All qualified health plans must cover "essential health benefits" as defined by federal and state statute and regulation.

Qualified Individual: A person who resides in California and who is seeking to enroll in a qualified health plan offered through Covered California.

Qualified Immigrant: Categories of immigrants eligible for federal public benefits (including Medi-Cal) if they meet all other eligibility requirements.

Qualified Individual Program (QI): This program allows certain low-income individuals who lost their free Medicare Part A premium benefit because of a return to work to get Part A premiums paid for by Medi-Cal.

Qualified Medicare Beneficiary Program (QMB): This program allows certain low-income Medicare beneficiaries to get Medi-Cal to pay for both their Medicare Part A and Part B premiums, as well as co-payments.

Recipient: A person who is receiving Medi-Cal.

Redetermination: The process through which a county eligibility worker evaluates a beneficiary's eligibility for ongoing Medi-Cal coverage, usually due to a change in circumstances or new information provided on a reporting form.

Refugee Medical Assistance (RMA): A special program through which refugees, asylees, Cuban and Haitian entrants, and victims of trafficking get full-scope Medi-Cal for 8 months if they do not fit into any other Medi-Cal category.

Relative: "A mother, father, grandfather, grandmother, son, daughter, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, niece, half-brother, half-sister, any such person of a preceding or succeeding generation denoted by a prefix of grand, great or great-great or the suffix in-law." 22 CCR § 50084.

Reasonable Payment Plan: A hospital bill payment plan for patients who qualify for financial assistance that takes into account a patient's income and expenses. If the hospital and patient cannot agree on what is reasonable, the Hospital Fair Pricing Act provides a statutory formula.

Reconciliation: The process by which someone who received premium tax credits from Covered California determines whether more payment is due or a refund is due when filing annual taxes. Because advanced premium tax credits are necessarily determined based upon estimated income, more or less will generally be due once final annual income is determined. Reconciliation can also be used by households who did not take tax credits in advance but are eligible for them when filing taxes.

Required Contribution Percentage: The maximum amount of income that a household is expected to contribute to health insurance premiums. This is used in determining how much premium tax credits a household is entitled to.

Residence: The place in which a person or family lives or is physically present if the person or family has no present intention of leaving.

Resources: See Property.

Restricted Services: A person who is ineligible for full-scope Medi-Cal due to unsatisfactory immigration status can receive limited services including emergency services, pregnancy-related services, and kidney dialysis.

Retroactive Medi-Cal: A beneficiary may receive Medi-Cal for any of the three months immediately prior to application if s/he meets all eligibility requirements in those months.

Section 1931(b): A former Medi-Cal program that provided free Medi-Cal to low-income children, pregnant women, parents, and caretaker relatives whether or not they receive cash assistance in the CalWORKs welfare program. This program was named after the authorizing section in the Social Security Act and was the most generous program for most families because it allowed families to deduct a significant amount of earnings to become and remain eligible. The Affordable Care Act collapsed the mandatory categorically needy groups covered by 1931(b) program - children, pregnant women, parents and caretaker relatives - into MAGI Medi-Cal programs.

Share of Cost: “A person’s or family’s net income in excess of their maintenance need that must be paid or obligated toward the cost of health care services before the person or family may be certified and receive Medi-Cal.” 22 CCR § 50090

Selected Low-Income Medicare Beneficiaries Program (SLMB): This program allows certain low-income beneficiaries to get Medi-Cal to pay for their Medicare Part B premiums.

Single, Streamlined Application: The application used to apply for Medi-Cal, Medi-Cal Access Program (MCAP) for pregnant women, and insurance in Covered California – both subsidized and unsubsidized; the application is available online and in paper and can be submitted online, by phone, by mail or in person. 10 CCR § 6470.

Sneede/Gamma: Special income counting rules for non-MAGI programs about whose income counts in determining an applicant's eligibility, named after two lawsuits, *Sneede v. Kizer* and *Gamma v. Belshé*. Under these rules, the only persons whose income can be counted are the applicant's, his/her parents', and his/her spouse's, and a parent or spouse can deduct an allowance from their income for living expenses.

Social Security Administration (SSA): The federal agency that administers Social Security, Supplemental Security Income (SSI), and other Social Security benefits for the aged and disabled and qualified family members.

Social Security Disability Insurance (SSDI): A monthly cash benefit for disabled workers who have recent employment history (also called "Title II" benefits).

Special Enrollment Period (SEP): "Period during which a qualified individual or enrollee who experiences certain qualifying events...may enroll in, or change enrollment in, a Qualified Health Plan through [Covered California] outside of the initial and annual open enrollment periods." 10 CCR § 6410.

Spend-down: An applicant or beneficiary's ability to reduce the amount of income or resources s/he has in excess of the allowed limits in order to get under the limit and therefore become eligible.

Standard Benefit Design: The deductibles, out-of-pocket maximums, co-payments, and coinsurance amounts of health plans offered through Covered California. Because the plan designs are standardized, the deductibles, etc., are the same in each metal tier level regardless of which company is selling it.

Statewide Automated Welfare Systems (SAWS): The statewide electronic business engine for Medi-Cal and other benefits programs.

Substantial Gainful Activity (SGA): In order to be considered disabled by the SSA, a person must not be able to perform work activity which involves significant physical or mental effort. It is referred to as engaging in "substantial gainful activity."

Supplemental Security Income (SSI): A cash assistance payment for persons who are over 65 or meet the disability definition used by the Social Security Administration and have sufficiently low income and resources.

Tax filer: An individual or couple who files an income tax return and no other taxpayer will be able to claim him, her or the couple as a tax dependent. See 10 CCR § 6410. For the Medi-Cal program, the person need only expect to file.

Temporary Assistance for Needy Families (TANF): The federal welfare program that replaced Aid to Families with Dependent Children (AFDC) which provides cash aid and employment assistance to poor families. CalWORKs is the name of California's TANF program.

Termination: When the County stops a beneficiary's Medi-Cal coverage. Terminations only occur at the end of a calendar month. "Termination" and "discontinuance" are used interchangeably.

Transitional Medi-Cal (TMC): Children, parents, and caretaker relatives who lose Section 1931(b) Medi-Cal and/or CalWORKs cash assistance due to increased earnings or increased hours worked by the Primary Wage Earner can receive up to 12 additional months of free Medi-Cal called Transitional Medi-Cal (TMC). The first 6 months are available regardless of income and families can receive additional 6 months if their countable incomes are less than 185% of the Federal Poverty Level.

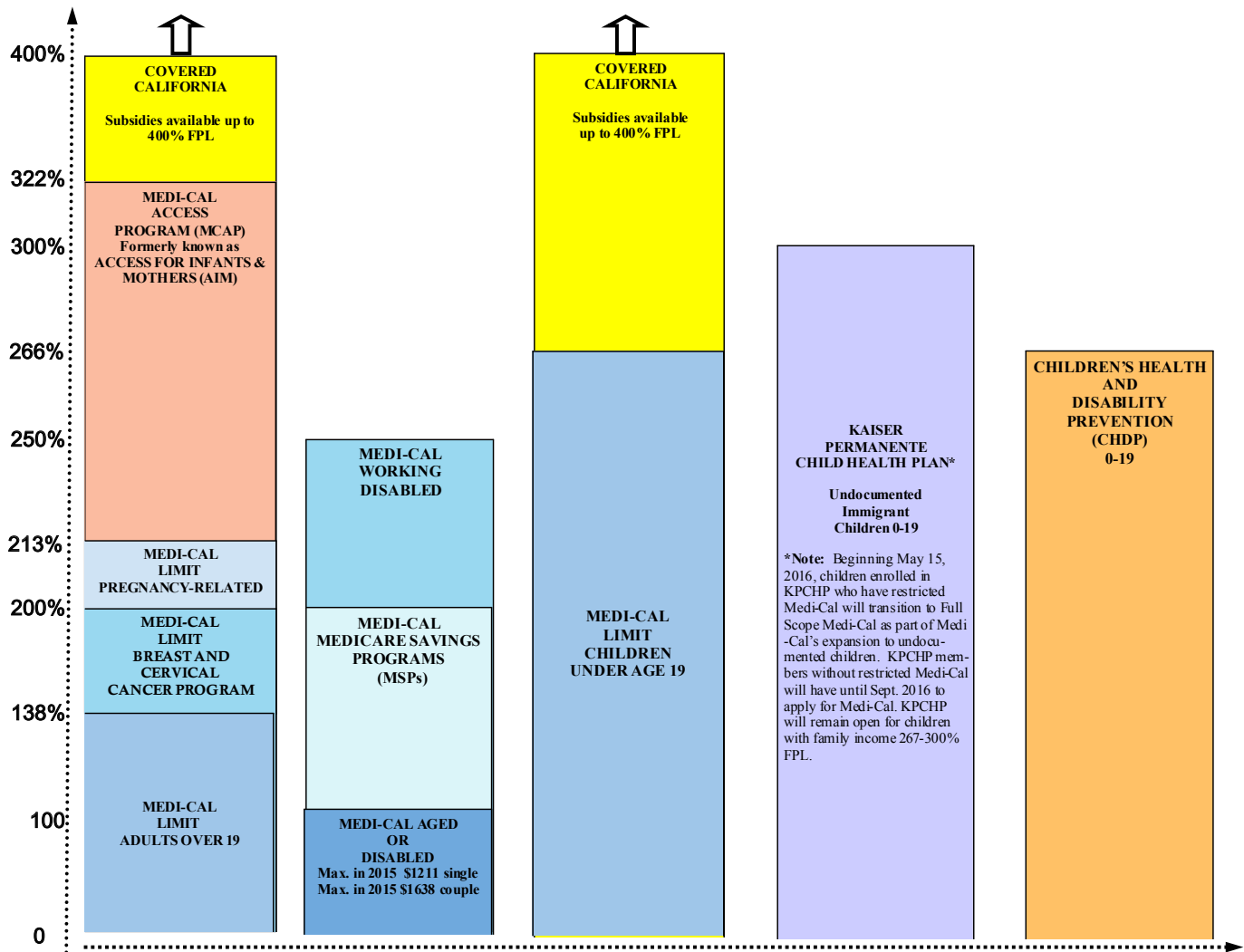
Triggering Event: A life event that allows someone to enroll in or change Covered California plans outside of Open Enrollment. Also known as a "qualifying event."

Violence Against Women Act (VAWA): Spouses or children of U.S. citizens or LPRs who are permitted to petition for their own immigrant visas under the Violence Against Women Act of 1994 because their qualifying citizen or LPR family member has abused them. Such individuals are eligible for benefits whether the petition is pending or approved.

10-day Notice: Any time the County is reducing or terminating a beneficiary's Medi-Cal or assigning or adjusting a Share of Cost, the County must send a notice specifying the change and explaining the client's appeal rights at least 10 days before the action takes place.

90-Day Period to Cure: When beneficiaries turn in a required reporting form late but within 90 days of the due date, the County must evaluate eligibility as if the beneficiary turned the form in on time, and if ongoing eligibility is established, rescind any termination based on failure to return the form on time.

Appendix A: 2016 Health Coverage Income Guidelines



©2006 Maternal and Child Health Access; reprinted and modified by Western Center on Law and Poverty with permission from MCHA, March 2016



Appendix B: Immigration Barriers to Applying for Health Coverage Programs

Many immigrants are reluctant to apply for health coverage programs because they are concerned that by doing so, they may harm their or their family members' immigration status or lead to deportation. These fears are often based on misinformation or myths, and may not be specifically identified as the reason they do not want to apply.

A. Confidentiality/Use of Immigration Status

Immigrants may be concerned that notifying Medi-Cal or Covered California that some members of the family do not have lawful status will result in deportation of those family members. Advocates should emphasize that information used to apply for health coverage programs is not shared with Immigration & Customs Enforcement (ICE).¹ Information provided when applying for coverage should only be required of applicants and used for purposes of determining eligibility.²

B. Public Charge

Immigrants who are lawfully present may raise a concern about harming their current immigration status or their chances of becoming a citizen later if they receive government benefits and are then considered a “public charge” by immigration authorities³. The “public charge” test by USCIS affects most, but not all, immigrants who are waiting to get their green card or who are applying for a visa.⁴ Some groups, such as refugees, asylees, or victims of domestic violence or trafficking, are

-
1. See ICE Memo, October 2013, available at <http://www.ice.gov/doclib/ero-outreach/pdf/ice-aca-memo.pdf>
 2. 42 C.F.R. § 435.907(e)(1); 45 C.F.R. 155.315(i); 45 C.F.R. § 155.260(a)(1)
 3. See USCIS fact sheet, available at <http://www.uscis.gov/news/fact-sheets/public-charge-fact-sheet>.
 4. The “public charge” test is used by the USCIS to determine whether an individual seeking LPR status or visa status may be likely to become in the future “primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance or institutionalization for long-term care at government expense.” USCIS reviews numerous factors – such as education, skills, health, in addition to receipt of public benefits, such as CalWORKS. Based on the totality of the circumstances test, USCIS will determine who may become a public charge and can deny the individual’s application for a visa or LPR status.

exempt from the public charge test when they apply for their green card. Immigrant families in which the applicants are naturalized U.S. citizens, lawful permanent residents or are U.S. citizen children of immigrant parents are not subject to the public charge test. Additionally, U.S. Citizenship and Immigration Services does permit immigrants subject to the public charge test to receive most health care or nutrition benefits without counting those against them.⁵ The one exception is receipt of long-term care services, which will be counted against the individual subject to the public charge test.⁶

C. Sponsor Liability

Most immigrants who have a green card (Lawful Permanent Resident status) were required to have a family member or employer sponsor them in their immigration application.⁷ Sponsors sign a contract with USCIS to agree to be financially responsible for the immigrant. If a sponsored immigrant receives government benefits, that government agency can require the sponsor to pay back the benefits received.⁸ However, sponsor liability does not apply if the applicant: a) is not required to have a sponsor;⁹ b) is a naturalized citizen, c) has worked 40 quarters, or d) is the US citizen child of the sponsored immigrant.¹⁰ In addition, sponsors are not

-
5. See <http://www.uscis.gov/news/fact-sheets/public-charge-fact-sheet> on the USCIS website for the official guidelines regarding public charge. For additional materials on public charge, visit the National Immigration Law Center's webpage on Public Charge at <https://www.nilc.org/pubcharge.html>.
 6. *Id.* Individuals who are eligible for Medi-Cal long-term care are likely to have little resources and high health risks, which are additional factors that would also make them more likely to be considered a public charge.
 7. See "Affidavit of Support," USCIS, available at <http://www.uscis.gov/green-card/green-card-processes-and-procedures/affidavit-support>. See also, "Sponsored Immigrants and Benefits in California," National Immigration Law Center, October 2006, available at <https://www.nilc.org/sponsoredimms&bens-ca.html>.
 8. A sponsor's household income may also be counted when a sponsored immigrant applies for certain government benefits. Sponsor deeming is not applicable for Medi-Cal or Covered California and premium tax credits.
 9. For a list of immigrants who are not required to have a sponsor, see "Consolidation of Policy Regarding USCIS Form I-864, Affidavit of Support (AFM Update AD06-20)," U.S. Citizenship and Immigration Services interoffice memo, (June 27, 2006), pg. 5, available at www.uscis.gov/USCIS/Laws/Memoranda/Static_Files_Memoranda/Archives%201998-2008/2006/affsuppafm062706.pdf.
 10. See also "Sponsored Immigrants and Benefits in California," National Immigration Law Center, October 2006, available at <https://www.nilc.org/sponsoredimms&bens-ca.html>.

held liable if a sponsored immigrant incurs out-of-pocket health expenses (unless the sponsor signs a provider's financial liability forms), receives only restricted scope Medi-Cal services, or receives earned benefits (e.g., a pension, Social Security) or tax credits – such as Covered California premium tax credits. Finally, government agencies must tell applicants if they will be asking for reimbursement from the sponsor and only after it creates a procedure for doing so, can they collect from the sponsor.¹¹ Currently, DHCS has no procedure to collect sponsor reimbursement for Medi-Cal, MCAP, or other health-related benefits.¹²

D. Other Barriers

Often recent events in the community such as a federal immigration raid, anti-immigrant stories in the media, or misinformation may deter eligible immigrants from applying for Medi-Cal or other health coverage. In addition, lack of language access or cultural competency and lack of literacy in their own language may also deter immigrants from seeking coverage for their family.

Most importantly, advocates should strongly advise against providing false information on an application for health coverage. Some immigrants may believe a social security number is required for everyone in the family to apply and provide a false social security number on the application. This could be considered fraud and could lead to problems with law or immigration enforcement. If other immigrants learn of this, they may mistakenly believe that applying for coverage was the cause of the problem, rather than the providing of false information. Thus, advocates should to explain when a social security number is required or only voluntary.

11. See “Affidavits of Support on Behalf of Immigrants: Final Rule,” 71 FR 35732 (June 21, 2006), available at www.gpo.gov/fdsys/pkg/FR-2006-06-21/pdf/06-5522.pdf.

12. See “Sponsored Immigrants and Benefits in California,” National Immigration Law Center, October 2006, available at: <https://www.nilc.org/sponsoredimmigrants&benefits-ca.html>. Covered California is private health insurance and tax credits are not considered a public benefit subject to sponsor liability. However, sponsors could be held liable for Medi-Cal if DHCS chooses to seek reimbursement from them in the future, but any reimbursement requested would only be the amounts incurred after that decision is in place, not retroactively. Note this is different from Medi-Cal estate recovery, which applies regardless of immigration or citizenship status.

Appendix C: Comparison of Covered California and Medi-Cal Fair Hearings Processes*

Covered California	Medi-Cal
Timelines	
<ul style="list-style-type: none"> Appeal within 90 days of receipt of eligibility determination notice (45 C.F.R. § 155.520(b), Welf. & Inst. Code (WIC) § 10951(a), 10 CCR § 6606 (c)) 	<ul style="list-style-type: none"> Same (42 C.F.R. § 431.221(d), WIC § 10951)
<ul style="list-style-type: none"> Informal resolution process included in statute and regulations (45 C.F.R. § 155.535, Gov't Code § 100506.4(g), 10 CCR § 6612) 	<ul style="list-style-type: none"> Informal resolution process included in statute and CDSS Manual (Gov't Code § 100506.4(g)(1); MPP, 22-073.23)
<ul style="list-style-type: none"> Notice of hearing 15 days prior to the hearing (Gov't Code § 100506.4(h)(2), 10 CCR § 6614(b)) 	<ul style="list-style-type: none"> Same (Gov't Code § 100506.4(h)(2))
<ul style="list-style-type: none"> Statement of position to appellant at least 2 business days prior to hearing (Gov't. Code § 100506.4(h)(1); 10 CCR § 6612(e)(2); ACL 14-14, p. 14) 	<ul style="list-style-type: none"> Same (Gov't. Code § 100506.4(h)(1); WIC § 10952.5)
<ul style="list-style-type: none"> Decision due 90 days from the date appeal is made (Gov't. Code § 100506.4(h)(7), 10 CCR § 6618(b)(1)) 	<ul style="list-style-type: none"> Same (42 C.F.R. § 431.244(f); Gov't. Code § 100506.4(h)(7))
<ul style="list-style-type: none"> Covered California Director may alternate the decision (WIC § 10959 per Delegation Order 15-100) 	<ul style="list-style-type: none"> DHCS Director may alternate the decision (WIC § 10959)

* Adapted from 2014 Health Consumer Alliance Chart

Covered California	Medi-Cal
Post-Decision Options	
<ul style="list-style-type: none"> • Appeal to HHS within 30 days of decision (45 C.F.R. § 155.520 (c), Gov't. Code § 100506.4 (b) & (k)) 	<ul style="list-style-type: none"> • Request for rehearing within 30 days of receiving decision (WIC § 10960)
<ul style="list-style-type: none"> • Seek judicial review via CCP § 1094.5 writ petition (Gov't. Code § 100506.4 (l), 10 CCR § 6618(a)(8)) 	<ul style="list-style-type: none"> • Same (WIC § 10962)
Expedited Decisions	
Sources: 45 C.F.R § 155.540(a), Gov't. Code § 100506.4(a)(2); 10 CCR § 6616(a); and ACL 14-14, pp. 14-15	Sources: Gov't. Code § 100506.4(a)(2); ACL 13-40; ACL 14-14
<ul style="list-style-type: none"> • “[T]here is immediate need for health services because a standard appeal could seriously jeopardize the appellant’s life, health or the ability to attain, maintain or regain maximum function” 	<ul style="list-style-type: none"> • Same
<ul style="list-style-type: none"> • Request goes to Affordable Care Act Bureau in DSS State Hearings Division 	<ul style="list-style-type: none"> • Request goes to Presiding Judge of Regional Office of State Hearings Division
<ul style="list-style-type: none"> • Decision to expedite must be made within 3 days of request 	<ul style="list-style-type: none"> • Presiding Judge can decide to expedite through 3-way call, often immediately upon request
<ul style="list-style-type: none"> • Hearing must be held within 10 days of request 	<ul style="list-style-type: none"> • Same
<ul style="list-style-type: none"> • Decision must be issued within 5 days of record closure 	<ul style="list-style-type: none"> • Same

Covered California	Medi-Cal
Other Distinctions	
<ul style="list-style-type: none"> Covered California is the respondent 	<ul style="list-style-type: none"> County is the respondent
<ul style="list-style-type: none"> Person filing the appeal is “appellant” (ACL 14-14, pp. 1, 2) 	<ul style="list-style-type: none"> Person filing appeal is “claimant”
<ul style="list-style-type: none"> Issue(s) must be “valid” to be appealed (42 C.F.R. § 155.520(a) (4) and (c), 10 CCR § 6602(c)) 	<ul style="list-style-type: none"> "Any action or inaction" (WIC § 10950)
<ul style="list-style-type: none"> Eligibility pending appeal (“continuing enrollment”) – appellant may request 90 days after NOA if agree to pay premium (45 C.F.R. §155.525, 10 CCR § 6608, ACL 14-14. pp. 7 – 8) 	<ul style="list-style-type: none"> Aid pending must be within 20 days of the NOA or before negative action takes effect (42 C.F.R. §§ 431.230, 431. 231(c) & (d); 22 CCR § 51014.2(a))

Appendix D: Where to Go for Help – A Resource List

A. Eligibility Issues

1. For someone to help with an application for Medi-Cal and Covered California find Certified Enrollment Entities at www.coveredca.com/get-help/local/.
2. Those with a Medi-Cal eligibility issue can contact the county social services office in their county for assistance.
3. Those with a Covered California eligibility issue can contact the Covered California Service Center for assistance at (800) 300-1506. Go to www.coveredca.com/get-help/contact/ for a list of designated numbers for the other languages. Covered California also has a Live Chat function at coveredca.custhelp.com/app/chat/chat_launch.
4. For issues with the Medi-Cal Access Program (MCAP) for pregnant women, call MCAP at (800) 433-2611.
5. To file a fair hearing for Medi-Cal or Covered California submit a request for a hearing to the Department of Social Services in one of these ways:
 - To the State Hearings Division at fax number (916) 651-5210 or (916) 651-2789.
 - Request a Hearing Online: <https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx>
 - By phone: (800) 952-5253 (Voice) / (800) 952-8349 (TDD)
 - To the county welfare department at the address shown on the Notice of Action.
 - To the California Department of Social Services, State Hearings Division, P.O. Box 944243, Mail Station 9-17-37, Sacramento, California 94244-2430.

B. Service Issues (such as problems accessing care or a billing issue)

1. For questions about or problems with a health plan contact the health plan member service number for assistance.
2. For issues that cannot be resolved with the health plan or for questions about health plans contact the California Department of Managed Health Care Help Center at (888) 466-2219 or online at www.HealthHelp.ca.gov.

3. For help switching Medi-Cal health plans or for problems with Medi-Cal health plans contact the Medi-Cal Ombudsman at (888) 452-8609 or MMCDOmbudsmanOffice@dhcs.ca.gov.

C. Consumer Advocacy

1. For help with an individual health care issue call the Health Consumer Alliance statewide line at (888) 804-3536 or visit www.healthconsumer.org.
2. For specialized help for those with Medicare call HICAP (the Health Insurance Counseling & Advocacy Program) (www.cahealthadvocates.org/) at (800) 434-0222.
3. Disability Rights California (www.disabilityrightsca.org) offers patient-rights advocacy, legal advice, representation, and other services with physical, psychiatric, and developmental disabilities at (800) 776-5746.
4. LawHelpCalifornia.org - referral information for California legal aid organizations, bar certified lawyer referral services and court services.
5. The American Bar Association's Lawyer Referral & Information Service at www.americanbar.org/groups/lawyer_referral.html and Consumer's Guide to Legal Help.
6. HospitalBillHelp.org - if you live in California and have problems related to a hospital bill, or need to find a hospital where you can get a fair price, this web site can help you understand your rights and options.
7. California Hospital Free and Discount Payment Programs: find out if you qualify for free or discounted care at a hospital near you.
8. Dial 2-1-1 information for California counties: community services in your county.

Appendix E: Useful Links

1. Department of Health Care Services

- Main Webpage: www.dhcs.ca.gov
- DHCS Organizational Chart and Contact Information:
www.dhcs.ca.gov/Pages/AboutUs.aspx
- All County Welfare Directors Letters (ACWDLs) and Medi-Cal Eligibility Division Information Letters (MEDIL): www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/ACWDLbyyear.aspx
- All County Welfare Directors Letters Master Index (subject matter index; unfortunately last updated in 2010):
www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/ACWDLMasterIndex.aspx
- County Operations Resources (resources DHCS distributed to counties to aid in understanding new MAGI and ACA rules):
www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/CO_Call_Log.aspx
- Stakeholder Engagement Page (information about various stakeholder groups):
www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/CSP.aspx
- Medi-Cal Managed Care All Plan, Policy, and Dual Plan Letters: www.dhcs.ca.gov/formsandpubs/Pages/MMCDPlanPolicyLtrs.aspx
- Medi-Cal Eligibility and Procedure Manual (somewhat out of date):
www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/MedEligProcManual.aspx
- Medi-Cal Provider Manuals (useful in finding specific information on which services are covered):
files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp
- Medi-Cal Access Program
mcap.dhcs.ca.gov/

2. Covered California

- Consumer website to start the single streamlined application (CalHEERS) and certain consumer documents such as appeal requests and FAQs:

www.coveredca.com

- California Health Benefit Exchange page to access Board meetings and materials, current regulations, and stakeholder meetings:

www.healthexchange.ca.gov

3. Department of Managed Health Care

DMHC regulates health plans, including many Medi-Cal health plans, and handles disputes regarding access to care or failure to cover for services for the plans it regulates. The website also contains full text of the Knox Keene Health Care Service Plan Act and regulations:

dmhc.ca.gov

The webpage dmhc.ca.gov/FileaComplaint redirects to the page with information on filing plan complaints or independent medical reviews for medical service denials.

4. County Medical Services Program

CMSP provides county-level health services for the remaining uninsured to the 35 rural counties that contract with it:

www.cmspcounties.org

5. Hospital Fair Pricing

Find hospital fair pricing policies and applications at: www.oshpd.ca.gov/hid/products/hospitals/fairpricing/

6. Additional Advocate Materials

a. Health Consumer Alliance

The HCA webpage, www.healthconsumer.org, has advocate guides and consumer fact sheets on many health topics for low-income consumers.

b. Western Center on Law & Poverty

The WCLP webpage, www.wclp.org, has healthcare practice tips, state budget and legislative updates, issue papers, and other healthcare advocates.

c. National Health Law Program

The NHeLP webpage, www.healthlaw.org, has advocate guides to many aspects of Medicaid and managed care, as well as other programs.

Two especially helpful publications:

- Advocate's Guide to MAGI – in depth explanation of MAGI household and income calculation rules: www.healthlaw.org/publications/agmagi
- The Advocate's Guide to the Medicaid Program – definitive guide to Medicaid (from a federal perspective). Latest edition pre-ACA, but still very helpful: www.medicaidguide.org.

d. Center for Budget Policy and Priorities

CBPP has a Health Reform Beyond the Basics webpage which is a good resource for understanding MAGI households, tax reconciliation, and other implementation of the Affordable Care Act at the federal level (some resources are specific to the federal marketplace rather than California: www.healthreformbeyondthebasics.org

e. National Immigration Law Center

NILC offers California-specific information on immigrant access to public benefits programs at www.nilc.org/benefitsca.

f. California Advocates for Nursing Home Reform

CANHR offers in-depth information on Medi-Cal long term care, nursing homes, and the Medi-Cal estate recovery rules at www.canhr.org.

g. Disability Rights California

DRC has information on access to health care benefits for persons with disabilities, including mental health treatment, responsibilities of providers and plans to offer accessible services, and information on dual eligibility for Medi-Cal and Medicare: www.disabilityrightsca.org/pubs/PublicationsIndex.htm

h. Maternal and Child Health Access

MCHA offers useful materials to advocates on programs for pregnant women and children in its section “Training Materials.” Some of the materials are Los Angeles county specific: www.mchaccess.org/training_materials.htm

i. Consumers Union

CU has information for California consumers on choosing Covered California health plans and understanding premium tax credits in its research library at consumersunion.org/research-policies/ . (Expand the section on “health” and choose “California.”)