SACRAMENTO COUNTY

Medi-Cal Eligibility and Enrollment Overview

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March 2017

Who Is Eligible for Medi-Cal?

- **Low Income** – Different income limits based on program, age, and family size.
- **California Residency** – Must be physically present and have intent to stay permanently.
- **Citizens**
- **Immigrants** – Immigration status determines whether eligible for full-scope or restricted-scope benefits.

Immigrants

- Eligible for Full Scope Benefits:
  - Lawful Permanent Residents (LPR)
  - Refugees, Asylees, etc.
  - PRUCOL (Permanent Residence Under Color of Law)
    - Includes Deferred Action for Childhood Arrivals (DACA)
  - Undocumented children under age 19 (SB 75)

- Eligible for Restricted Scope Benefits (emergency, pregnancy-related, and long-term care):
  - Undocumented
  - Temporary Visas

Paths to Eligibility

1. MAGI (Modified Adjusted Gross Income) – Eligibility based primarily on income.

2. Non-MAGI Medi-Cal (or traditional Medi-Cal) – Eligibility based on "linkage" to certain categories, such as SSI and AFDC. Childless non-disabled adults are excluded.

MAGI Medi-Cal

- Income: Taxable income plus specific additions.
- Household: Includes tax filer and dependents.
- Income limits: Based on Federal Poverty Level (FPL).
  - For adults, household income must be ≤ 138% FPL.
  - For children, household income must be ≤ 266% FPL.
- Assets: No limit.
- Age: Under age 65 (unless a caretaker relative).

Non-MAGI Medi-Cal

- Categorically linked: Aged, blind, disabled, under 21, pregnant, or the caretaker relative of a child.
- Assets: Countable assets must be within limits.
  - Exemptions include primary residence and one vehicle.
- Income: Countable income ≤ Maintenance Need for zero share of cost.
  - $600 for an individual; $1,100 for family of four.
  - Some special programs have higher income limits.

Key Differences

Concept	MAGI Medi-Cal	Non-MAGI Medi-Cal
Household	Tax filing household	Relationship-based
Assets	No limit	Under $2,000 for family of one; increases with family size.
Income Limit	Based on FPL	Based on Maintenance need
Monthly Premium	Children between 160% – 266% FPL have a $13 premium.	No premiums (Exception: 250% Working Disabled Program).
Other Health Coverage	Not allowed, if the coverage meets minimum essential coverage.	Allowed. Other coverage is primary, Medi-Cal pays last.

Medi-Cal Share of Cost (SOC)

- Non-MAGI Medi-Cal only: Share of cost = income in excess of the Maintenance Need.
- Pay/obligate: Medi-Cal covers expenses after share of cost is met. Works like a deductible.
- MAGI Medi-Cal: No share of cost. If above income limit, individual is evaluated for exchange program.
- Minimum Essential Coverage: Medi-Cal with a share of cost does *not* meet criteria unless SOC fully met. Possible tax penalty.

How to Apply

- Online
  - www.mybenefitscalwin.org
  - www.coveredca.com
- Phone
- Fax
- Mail
- In Person at Sacramento County Department of Human Assistance (DHA).

Hospital Presumptive Eligibility

- Temporary Medi-Cal for uninsured individuals seeking hospital services.
- Hospital must be a qualified provider.
- Applicant self-attests to basic eligibility criteria.
- Real time determination completed via application portal.
- Eligibility ends the last day of the following month, unless a Medi-Cal application has been submitted.

Application Tips

- Medi-Cal applications are accepted year-round (no open enrollment period).
- Applicant may request up to 3 months of retroactive coverage.
- Income and non-financial eligibility information is verified electronically when possible.
- Eligibility must be renewed annually.
- Assistance is available through Certified Enrollment Counselors located at community based agencies.

Application Disposition

Notice of Action (NOA) – County or Covered California sends an informing notice upon approval or denial.

- Approved – State issues a Benefits Identification Card (BIC). If system shows prior issuance, old BIC is reactivated.
- Denied – NOA provides appeal rights.

Health Care Options (HCO)

- HCO – Agency that processes Medi-Cal Managed Care enrollment and disenrollment.
- Enrollment Packet – HCO sends to those eligible to enroll in Managed Care. Packet includes:
  - Health Plan information
  - Enrollment form
  - Postage paid envelope
- Assistance – HCO offers free information sessions at DHA offices. HCO will also assist by phone.
- Default – Plan must be selected within 30 days, or a plan will be assigned through a default process.

Managed Care Plan

- Upon enrollment, the Plan sends the member an ID card and health plan information.

- Member must select a Primary Care Provider or will be assigned.

Mandatory Enrollment

Enrollment in a Managed Care Plan is mandatory for most beneficiaries in full scope Medi-Cal:

- Families – Children and caretaker relatives.
- Adult Expansion – Age 19-64 without children.
- Non-Duals – Seniors & Persons with Disabilities (SPD) who do not have Medicare.

Voluntary Enrollment

- Duals – Managed Care enrollment is voluntary for SPDs with both Medi-Cal and Medicare (Medi-Medi)
- Child Welfare Services involvement – Children in Foster Care, Adoption Assistance Program (AAP), or Kin-GAP Program.
- Breast and Cervical Cancer Treatment Program (BCCTP) – full scope aid codes only.

Fee-For-Service (FFS) Only

- Some beneficiaries are not eligible to enroll in a Managed Care Plan and must find providers who accept FFS ("straight") Medi-Cal:
  - Restricted scope
  - Share of Cost
  - Long Term Care
  - Hospital Presumptive – until full application approved.
  - Members of a health plan through private insurance.

- Members enrolling in Managed Care are FFS from date of Medi-Cal approval until Plan is in effect.

Disenrollment

- Members may change plans at any time. A new Plan Choice Form is required. It can take up to 45 days for new plan to be effective.

- Common reasons for disenrollment:
  - Moved out of county
  - Entered Long Term Care
  - Increased income
  - Obtained other health coverage

Questions?