

## General Overview of Medi-Cal Programs

### **What is Medi-Cal?**

Medi-Cal is a program that pays for medically necessary health, dental, vision and mental health services for many low-income people. It provides comprehensive medical benefits to all individuals who are receiving CalWORKs and Supplemental Security Income (SSI) and to some other individuals who have limited resources and income.

### **Who is this program for?**

Most Medi-Cal programs are for children under 21 years of age and adults 65 and older. However, there are many programs included under the Medi-Cal umbrella for adults between ages 21 and 65 who meet certain eligibility requirements. Sections 3, 4, 5 and 6 in this manual contain information on specific Medi-Cal programs and services for low-income adults.

However, not all low-income individuals or individuals needing healthcare can receive Medi-Cal services. Adults who do not qualify for Medi-Cal programs may be eligible for public or private programs described in Sections 6, 7 and 8.

### **What are the eligibility requirements?**

In addition to meeting the residency, income and resource guidelines, individuals must fall into certain categories or have specific health care needs as indicated below:

- Persons receiving foster care or adoption assistance
- Aged (65 or older), blind or disabled according to Social Security Administration rules
- Some families with dependent children (must meet deprivation criteria)
- Families in transition from CalWORKs to employment
- Persons needing dialysis, tuberculosis services, breast or cervical cancer treatment or nursing home care
- Certain refugees and asylees
- Pregnant women and children under 21 may qualify for Medi-Cal

Eligibility requirements vary by Medi-Cal program. In addition to the requirements listed above, income and resources (for some programs only) will also be considered when determining eligibility.

### **What are the residency and citizenship requirements?**

Applicants must be California residents to be eligible. Individuals with satisfactory immigration status or verified U.S. citizenship may be eligible for full-scope Medi-Cal at no cost and receive comprehensive services. Individuals who do not have satisfactory immigration status or verified U.S. citizenship may receive restricted or emergency Medi-Cal, which means that coverage is limited to pregnancy-related, nursing care and/or emergency care. Individuals living in California who fall under PRUCOL status (page 2-2) may be eligible for full-scope Medi-Cal.

## What is PRUCOL?

PRUCOL (**P**ermanently **R**esiding **U**nder the **C**olor **O**f **L**aw) is a status applied to aliens residing in the U.S. The United States Customs and Immigration Service (USCIS) is aware that these persons are currently living in the U.S. and must provide the person with a “notice of action” stating that the application has been received.

Families need to inform Medi-Cal that they meet the satisfactory immigration requirements under PRUCOL and provide proof of their status to be able to qualify for full-scope Medi-Cal. Medi-Cal will then provide them with the appropriate forms to complete the Medi-Cal application process. For additional information on PRUCOL, contact a local Department of Public Social Services (DPSS) office or contact the Coalition for Humane Immigrant Rights of Los Angeles (CHIRLA) at 1-888-624-4752.

## What benefits are covered?

Medi-Cal recipients who are eligible for no cost full-scope benefits receive comprehensive inpatient and outpatient health services and prescription drugs from Medi-Cal providers. Medical equipment and other benefits need prior approval. Some programs, such as restricted/emergency Medi-Cal and Minor Consent, cover only specific types of services, rather than full-scope coverage.

**NOTE:** Only some individuals are eligible for dental benefits. Please refer to the specific Medi-Cal program for more information.

## How are services delivered?

In Los Angeles County, Medi-Cal recipients receive services in one of two ways:

- Fee-for-Service (FFS) In Los Angeles County, Share of Cost Medi-Cal beneficiaries use fee-for-service Medi-Cal, which means they can go to any healthcare provider who participates in Medi-Cal and receive care. Individuals who are eligible for restricted or emergency only Medi-Cal, including certain pregnant women who are eligible for pregnancy services only, are not eligible to join a health plan and will also receive care under FFS.
- Managed Care Certain Medi-Cal recipients who receive full-scope services will receive benefits from managed care plans. Most children, pregnant women (who are eligible to receive full-scope benefits), or families linked to CalWORKs or who receive benefits under 1931(b), receive services through managed care. Families under managed care will need to choose a health plan. Health Care Options is the organization in Los Angeles County that assists families with managed care enrollment, disenrollment, and transfers.

**NOTE:** Starting in June 2011, most seniors and persons with disabilities with Medi-Cal only (not Medicare) will be required to enroll in a Medi-Cal Health Plan. Beneficiaries have begun to receive notifications based on the month of their birthday to explain the changes. The transition will take place over a 12-month period starting in June 2011. For more information about these changes, visit: <http://www.dhcs.ca.gov/individuals/Pages/MMCDSPDBenInfCounty.aspx>.

Families and individuals who are enrolled in managed care will receive packets from Health Care Options for health plan enrollment. They will need to choose health and dental plans (only certain individuals are eligible for dental benefits) within 30 days of receiving their packets and should receive information and health plan cards from their health plan providers within 45 days.

In Los Angeles County, Medi-Cal managed care operates under a Two Plan Model, meaning that there is a commercial plan and a local initiative plan available to managed care recipients. The Commercial Plan is Health Net and its partner, Molina Healthcare. The Local Initiative is L.A. Care Health Plan and its partners, Blue Cross of California Partnership Plan, Inc., Community Health Plan, Care 1st Partner Plan, LLC, and Kaiser Permanente of California, LLC.

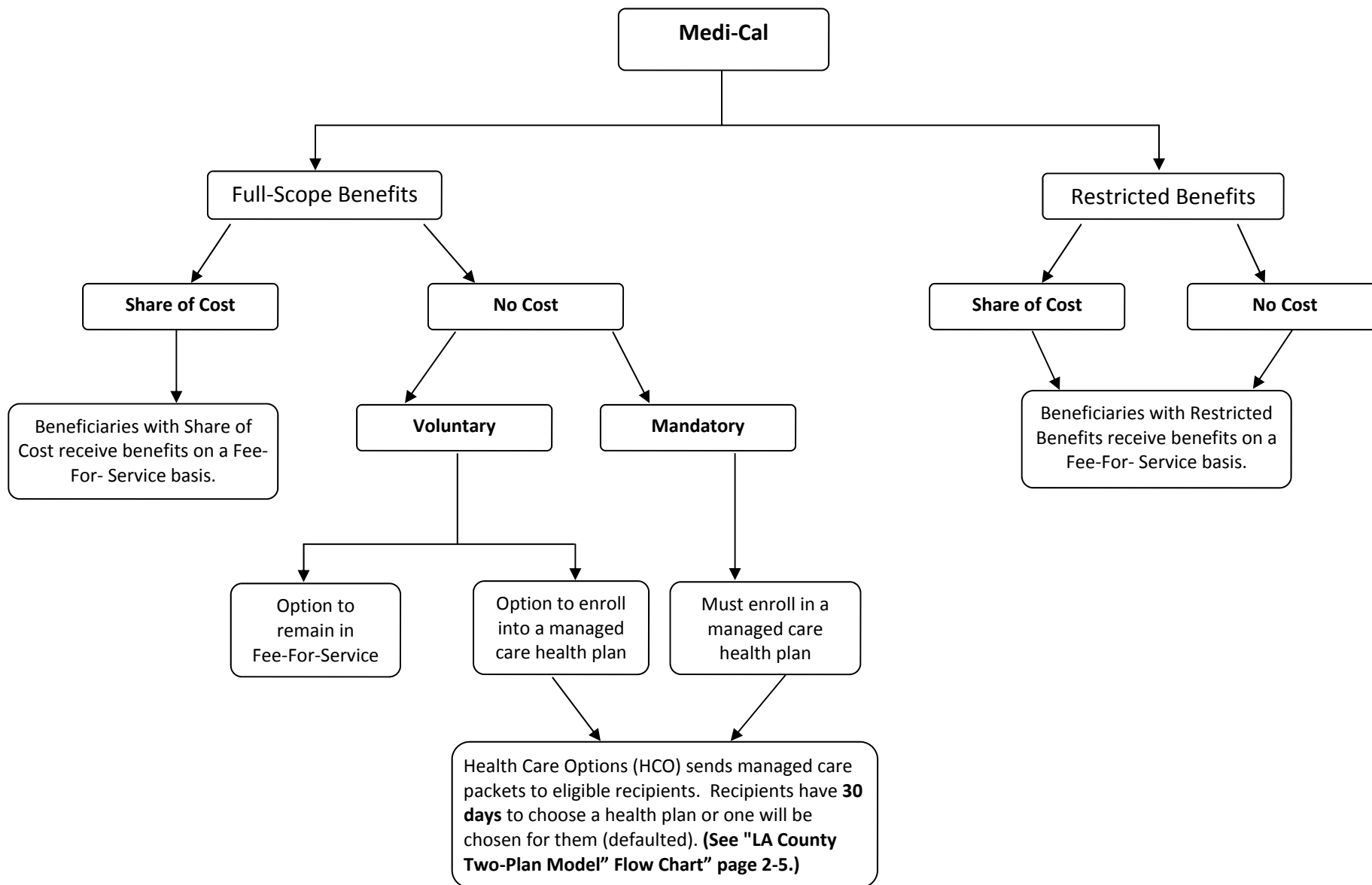
The service delivery method a Medi-Cal enrollee receives is determined by the Aid Code assigned by Medi-Cal. Dependent upon their aid code, certain enrollees are eligible to choose either fee-for-service or managed care.

**What happens next?**

After families or individuals have been enrolled in Medi-Cal, they should receive informational packets from the program that provides information on benefits, membership services phone numbers, directory listings of the participating providers and membership cards.

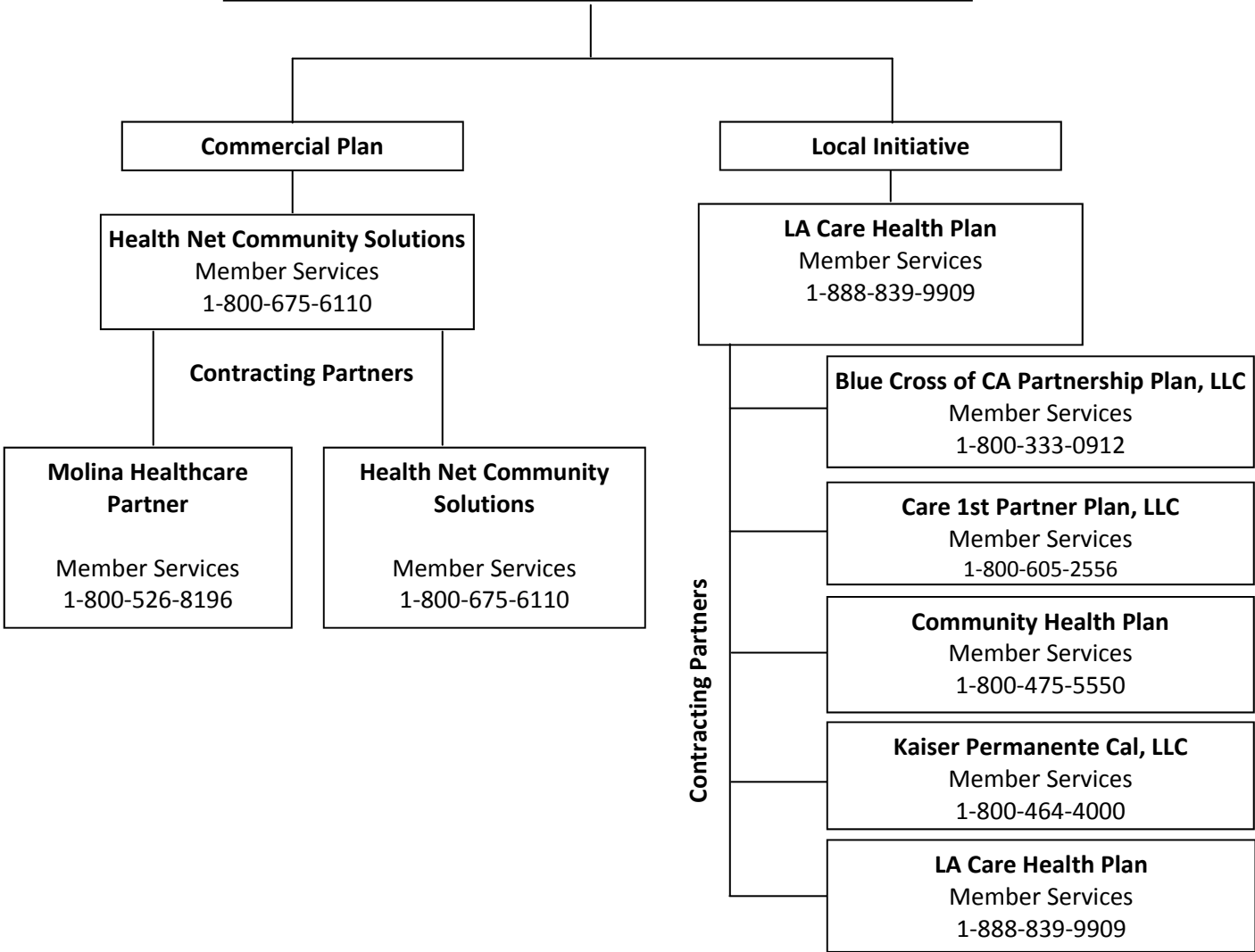
The following three pages provide additional information on how Medi-Cal is organized in Los Angeles County. Contact information is provided on the following pages.

# Voluntary and Mandatory Medi-Cal Beneficiary Flow Chart



# Los Angeles County Two Plan Model

<b>MAXIMUS Health Care Options</b>	
Armenian	1-800-840-5032
Cambodian	1-800-430-5005
Chinese	1-800-430-6006
English	1-800-430-4263
Farsi	1-800-840-5034
Hmong	1-800-430-2022
Lao	1-800-430-4091
Russian	1-800-430-7007
Spanish	1-800-430-3003
Vietnamese	1-800-430-8008



## Medi-Cal Key Players in Los Angeles County

### Department of Public Social Services (DPSS)

Determines Medi-Cal eligibility



Once Medi-Cal eligibility has been determined and family members are in managed care Medi-Cal, they will receive a welcome packet from the agency below.

### Health Care Options (HCO)

Assists in enrolling eligible members into a health plan. HCO processes health plan enrollment, disenrollment, transfers between LA County's two main plans and Medical Exemption requests. For questions or problems call 1-800-430-4263.



Once families have selected their desired health plans, the family members who are enrolled in Medi-Cal should familiarize themselves with the member service departments of their selected health plans.

### Member Services at the Health Plan

This is the department that family members can contact if they are having problems or delays when trying to access their healthcare services. See page 2-5 for phone numbers.

**What is the cost?**

Applicants who are not eligible for no cost Medi-Cal may be eligible for Share of Cost (SOC) Medi-Cal, which means that families or individuals must pay an amount each month for services before Medi-Cal pays. Under SOC Medi-Cal, there are no income limits for eligibility for those who meet program requirements, but the Share of Cost sometimes can be very high. The share of cost applies only to months when Medi-Cal services are received. If no Medi-Cal services are received during a certain month, families do not pay the share of cost.

**How is share of cost determined?**

Share of cost is determined by subtracting the Medi-Cal Maintenance Need Level (MNL) amount, according to family size, from the monthly family income after allowed deductions. The BIC (Benefits Identification Card) issued to Medi-Cal recipients will allow providers to get information about the SOC that must be paid by the recipient before Medi-Cal will pay.

The following table shows the monthly maintenance need level by family size.

Family Size	Monthly Maintenance Need Level
1	\$600
2 (one adult, one child)	\$750
2 (adults)	\$934
3	\$934
4	\$1100
5	\$1259
6	\$1417
Each additional person	Add \$14

For example, a family of four with a net monthly income of \$1,500 (after allowed deductions) would have a monthly share of cost of \$400 (net monthly income \$1,500, minus MNL for a family of four \$1,100, leaves a \$400 share of cost).

**Are there resources limits?**

Resources are items that a family may own and can include cars, houses, jewelry, savings or checking accounts, etc. Some Medi-Cal programs look at applicants’ resources. In order to be eligible for those programs, applicants’ resources must fall within approved limits. Most Medi-Cal programs use the **Resource Limit Chart** to determine resources (see chart on page 2-8).

Families do not have to count the house they reside in. Resource limits for a family of one is different for 1931(b) and other Medi-Cal Programs. Please see the chart on page 2-8 for more information.

## **Resource Limit Chart**

<b>Number in Family</b>	<b>Resource Limit (value of things owned)</b>	<b>Number in Family</b>	<b>Resource Limit (value of things owned)</b>
1*	\$2,000	6	\$3,600
2	\$3,000	7	\$3,750
3	\$3,150	8	\$3,900
4	\$3,300	9	\$4,050
5	\$3,450	10 or more	\$4,200

*\*For Medi-Cal 1931(b), a family of 1 has a resource limit of \$3,000.*

There are special rules that apply to individuals who own their own businesses, and resource limits are different for the 1931(b) program and for families where one spouse is in long-term inpatient care. For example, under 1931(b), the value of a vehicle is taken into account, and households with one or two family members have the same resource limit of \$3,000 (see page 3-4 for more detailed information on Medi-Cal 1931(b)). Families should report all of their property and resources even though some things may not count.

### **What about other insurance?**

Individuals and families are allowed to have private health insurance in addition to Medi-Cal coverage. Medi-Cal will pay last and will not cover co-payments or deductibles but will cover any eligible services not covered by private insurance. For example, a person who is covered by private insurance but whose coverage does not include pregnancy could use private insurance for other services but use Medi-Cal for pregnancy-related services. Some Medi-Cal programs cover dental services, while many private plans do not.

### **How to apply:**

Interested applicants can find a district DPSS office in their area by looking in the local white pages under County Government to request mail-in applications, apply by phone or make appointments. They may also apply online: <https://www.dpssbenefits.lacounty.gov>. Applications may also be completed at community and county clinics, hospitals, some school sites and other locations where on-site Medi-Cal eligibility staff are located. Eligibility workers will help applicants make certain that all forms have been completed and verification documents submitted. Different programs may have different applications.

- **Who can apply on behalf of the applicant?**  
When a person is unable to apply on his/her own behalf, spouses, legal guardians, friends, neighbors, hospital staff or public agency representatives may apply on their behalf. Applicants can name authorized representatives who have certain rights but cannot represent clients in all situations.
- **How long does it take for a Medi-Cal application to be processed?**  
The date of application is the date on which the application is received by the DPSS office. Application processing time is no more than **90 days** for applicants who apply on the basis of disability, **45 days** for others. Los Angeles County has set a processing goal of no more than 30 business days.

- What is Retroactive Medi-Cal?

Beneficiaries may apply for Retroactive Medi-Cal for payment of medical bills incurred during the three-month period prior to application if they met Medi-Cal eligibility requirements during that time period.

**Contact information:**

For information or to receive an application for Medi-Cal, call 1-888-747-1222 or visit [www.dhs.ca.gov/publications/forms/](http://www.dhs.ca.gov/publications/forms/) to download a Medi-Cal application.



## Assistor Tips!!!

- Screening adults for Medi-Cal program eligibility can be challenging because Medi-Cal follows a fixed priority in screening, first determining if there is a program for which the entire family qualifies in order to maximize benefits.

### Screening Priority for Medi-Cal Applications

- ↳ 1931(b)
- ↳ 1931(b) Sneeede (if applicable)
- ↳ Transitional Medi-Cal (TMC) (if previously received 1931(b) or CalWORKs)\*
- ↳ Continuous Eligibility for Children (CEC)\*
- ↳ Aged & Disabled Federal Poverty Level (A&D FPL)
- ↳ Regular Medi-Cal (Medically Needy and Medically Indigent)
- ↳ Regular Sneeede
- ↳ Percentage Programs (for children and pregnant women)
- ↳ Healthy Families (for children up to age 19)

\*For TMC and CEC, the application would have to be made during an existing eligibility period.

While Medi-Cal will screen first for the 1931(b) family programs, **approval for percentage programs for children and pregnant women should not be delayed** if resources/property is the only missing information. Medi-Cal should enroll those applicants in the appropriate percentage programs temporarily until they can be evaluated for the 1931(b) program.

- While income charts and guidelines can be helpful in guiding clients toward appropriate programs, there are various factors including immigration status, income deductions and exclusions, resources, and guidelines affecting step-families or families where children have their own incomes (Sneeede rules) that are taken into account when determining eligibility. In some cases, the assistor's most effective role may be in helping clients work with their eligibility workers to find the programs most appropriate for their specific circumstances, assisting clients during the application process and helping them understand communications from Medi-Cal.
- For access to All County Letters and All County Information Notices and answers to frequently asked questions about Social Services, visit [www.dhs.ca.gov/mcs/mcpd/MEB/ACLs/default.htm](http://www.dhs.ca.gov/mcs/mcpd/MEB/ACLs/default.htm).
- Remind adults to inform Medi-Cal of changes in address or other contact information and to pay attention to all communications from Medi-Cal and also their health plans if they are enrolled in managed care. Adults are required to fill out a Mid-Year Status Report (MSR) each six months for a determination of continued eligibility under Medi-Cal. Some individuals, including pregnant women, children and disabled recipients are exempt from the MSR requirement.



## Assistor Tips!!!

- Assistors may be able to help applicants check their eligibility status in one or both of the following ways:
  - Medi-Cal uses various computer systems to verify eligibility status. Although most of these systems are not available for use by assistors or recipients, assistors may be able to work with the Children’s Health and Disability Prevention (CHDP) Program and/or Medi-Cal provider staff to check the status of Medi-Cal applications through the Medi-Cal Point of System (POS) data system.

**Note:** Other data systems used to verify Medi-Cal eligibility status:

- SAEVS (Supplemental Automated Eligibility Verification System)\*
- LEADER (Los Angeles Eligibility Determination Evaluation Reporting System)
- MEDS (Medi-Cal Eligibility Data System)
- AEVS (Automated Eligibility Verification System)\*

\* This service can be used by non-providers. Call 1-800-427-1295 for more information.

- Applicants can fill out a form to designate assistors as their authorized representatives. Assistors can then contact applicants' eligibility workers to inquire about eligibility and case status. This form must be provided to the eligibility worker before information can be provided to the assistor.
- Families enrolled in Medi-Cal have a right to a State Fair Hearing if the health services they want or need are unfairly denied, delayed or stopped. Hearings must be requested within 90 days of the denied, delayed or stopped services. A request may be submitted in one of three ways:
  - 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 19-37, Sacramento, California 94244-2430
  - To the State Hearings Division at fax number (916) 229-4110

OR

You may make a toll-free call to request a State Hearing by calling:  
California Department of Social Services  
Public Inquiry and Response  
Phone 1-800-952-5253 (Voice)  
1-800-952-8349 (TDD)