Medi-Cal Explained FACT SHEET

Eligibility and Enrollment — Current Status and Challenges

Author: Don Novo, Principal, Health Management Associates

Introduction

FEDERAL LAW MANDATES the inclusion of certain populations in Medicaid, referred to as mandatory Medicaid eligibility groups, including children, pregnant women, and seniors and people with disabilities. Each state can opt to add additional population groups defined by statute. In California, some of these include low-income adults under age 65, those in the Breast and Cervical Cancer Treatment Program (BCCTP), and those who receive care in a nursing facility or receive long-term support services.

Medi-Cal eligibility is determined by financial, categorical, and nonfinancial factors. Financial requirements include income, and for some groups, assets, that fall within the program limits. Categorical requirements include being a member of a specific group, such as being a child under 21 years of age, a parent, a person with a disability, or a low-income adult under age 65. Nonfinancial factors include state residency and immigration status.

Populations

The Medi-Cal program has eight primary Medicaid eligibility groups (MEGs). Eligible Medi-Cal enrollees must fall into one of these MEGs to qualify for coverage, as identified in Table 1.

Eligibility Determinations

Medi-Cal uses a cascading eligibility determination process that allows applicants to enroll in the most comprehensive benefits package for which they qualify based on their individual and household circumstances. County eligibility workers use automated data-matching that include verification of earned and unearned income, verification of federal disability, Medicare status, and other elements of eligibility to expedite processing.

The Affordable Care Act (ACA) created a new Medicaid financial eligibility test called modified adjusted gross income (MAGI), based on federal tax rules for determining adjusted gross income. MAGI uses an across-the-board income methodology that eliminates many of the Medicaid program's previous income deductions for most adults, parents, children, and pregnant women.[1] Non-MAGI (pre-ACA) methodologies were retained for many populations, such as persons under age 65 and persons with disabilities, those in need of long-term care or long-term support services, or those age 65 and older. Eligibility for these categories of beneficiaries is determined using the traditional earned and unearned income adjustments and assets identified in Title XIX of the Social Security Act.[2]

County social service eligibility workers perform both initial and ongoing eligibility and redeterminations for all social service programs, including

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Table 1. Medicaid Eligibility Groups

MEGs or Medi-Cal Population(s)	Federal Statutory Authority	% of FPL	Enrollment	% of Total
ACA expansion adult — adults ages 19-64 (MCE)	§1902(a)(10)(A), §1905(y)(2)	≤138%	3,874,584	29%
Adoption/foster care	§1902(a)(10)(A)	None	166,788	1%
Children's Health Insurance Program (CHIP)	§2103	≤322% (children) ≤100% (adults)	1,320,900	10%
Long-term care	§1919(a)	≤300% FBR	52,991	<1%
Other	Various	N/A	116,593	1%
Parent/caretaker relative and child	§1902(e)(5)	≤109%	5,149,823	39%
Seniors and persons with disabilities (SPDs)	§1902(a)(10)(a), §1619(a)&(b)	≤133%	2,023,235	15%
Undocumented*	State-only program	≤138%	608,857	5%
Total enrollment (as of Jan. 2018)			13,313,771	100%

FBR = 2018 Federal Benefit Rate = $2,250; FPL = federal poverty level; MCE = Medicaid covered expansion.
* Restricted scope coverage for adults only (limited to emergency and pregnancy-related services). Children with undocumented immigration status are eligible for full scope coverage and dispersed throughout other aid categories.
Source: California Department of Health Care Services, April 2018.

California Work Opportunity and Responsibility to Kids (CalWORKs), CalFresh, and the Medi-Cal program. Historically, county social service agencies served as the access point for all Medi-Cal enrollment. However, the ACA created a "no wrong door" point of entry.[3, 4, 5]

The California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) is the automated eligibility system that serves as the consolidated system for eligibility, enrollment, and retention for Covered California and Medi-Cal.[6] CalHEERS shares information with California's 58 counties through the Statewide Automated Welfare System (SAWS). Collectively, these systems serve as the conduit to ensure eligibility and enrollment data are shared between Medi-Cal, county social service agencies, and Covered California.

Another pathway to Medi-Cal enrollment is presumptive eligibility (PE), by which qualified hospitals and clinics can provide temporary Medi-Cal eligibility using a special on-site application for those who may be eligible for Medi-Cal.[7] The PE program provides qualified persons with immediate access to temporary, no-cost Medi-Cal while they are applying for permanent Medi-Cal or other health coverage. During the period of PE coverage, the individual must apply to maintain ongoing Medi-Cal coverage.

Table 2. MAGI and Non-MAGI Populations

MAGI	Non-MAGI
■ Children under 19 ■ Parents or caretaker relatives ■ Pregnant and postpartum women ■ Former foster care children ■ Low-income adults ages 19-64	■ Children under 21 ■ Parents or caretaker relatives ■ Eligible as a result of another program determination (CalWORKs, foster care, SSI) ■ Seniors (65 or over) and persons with disabilities (SPDs) ■ Individuals with long-term care needs ■ Adults with Medicare or Medicare cost-sharing assistance ■ Adults in long-term care ■ Persons eligible as Share of Cost or Medically Needy

By federal and state statute, eligibility must be determined within 90 days for applicants who apply based on disability, and 45 days for all others. The 90- and 45-day requirements may be extended when an applicant can demonstrate good cause or where the receipt of necessary eligibility information was delayed for reasons beyond the control of either the applicant or the county.

Plan Enrollment

Most Medi-Cal beneficiaries under 65 years of age and without Medicare are required to enroll in a Medi-Cal managed care health plan. Individuals receiving care for a complex medical condition may be temporarily exempted from managed care health plan enrollment.[8]

Medi-Cal health plan choices vary based on the managed care model offered within a Medi-Cal enrollee's county of residence. Most Medi-Cal–eligible Two Plan and Geographic Managed Care (GMC) counties offer enrollees two or more health plan choices. Enrollees who reside in a county served by a County Organized Health System (COHS) are mandatorily enrolled in their county's single COHS health plan, without the choice of more than one health plan enrollment option. Another publication in this series, *The Medi-Cal Program: An Overview* provides greater details on all of the Medi-Cal managed care models.

Role of Health Care Options

Health Care Options (HCO) is Medi-Cal's enrollment broker; its role is to help ensure access to health care services by providing Medi-Cal beneficiaries with information about the managed care health and dental plans offered in the beneficiary's county of residence. After determining that an applicant is eligible for Medi-Cal, HCO mails a health plan selection package to those new Medi-Cal enrollees who are required to enroll in a Medi-Cal managed care health plan. HCO helps beneficiaries to select a plan and facilitates timely plan enrollment by mail, phone, or in person at a county social services office. If the beneficiary does not select a health plan within 30 days after receiving a health plan selection package, HCO chooses a plan for the beneficiary based on rules set by DHCS.
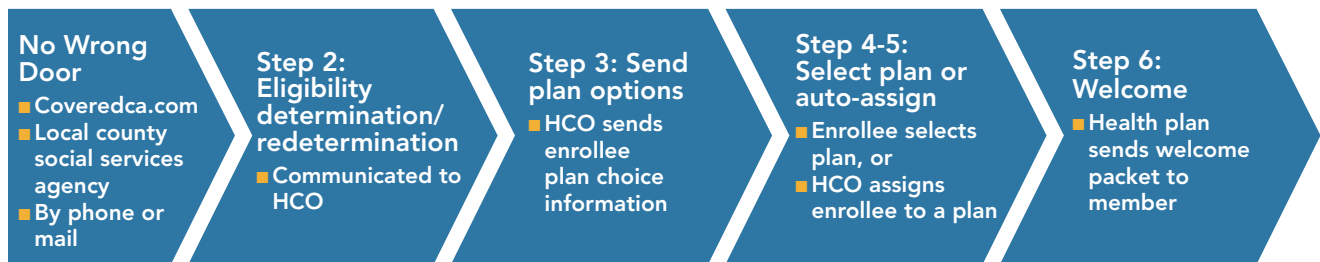
Ability to Change Plans

Medi-Cal enrollees who reside in a Two Plan or GMC model county can change their health plan assignment at any time and for any reason. Most requests to change health plans are effective the first day of the month following the request.

Successes and Current Challenges

The Medi-Cal program developed a successful redetermination process in accordance with state legislation (ABX 1 1) that required the use of automated verifications and prepopulated redetermination forms. The streamlined processes allowed county social service agencies to process a backlog of pending applications and redeterminations from 2014 through 2016 following the significant increase in the Medi-Cal population due to the passage of the ACA. Available 2015 data indicate that counties processed roughly 75% of redeterminations within 90 days between January 2015 and September 2015.[9]

Figure 1. Medi-Cal Eligibility and Health Plan Assignment Process

No Wrong Door
- Coveredca.com
- Local county social services agency
- By phone or mail

Step 2: Eligibility determination/ redetermination
- Communicated to HCO

Step 3: Send plan options
- HCO sends enrollee plan choice information

Step 4-5: Select plan or auto-assign
- Enrollee selects plan, or
- HCO assigns enrollee to a plan

Step 6: Welcome
- Health plan sends welcome packet to member

Another success for Medi-Cal was the implementation of full-scope, state-funded Medi-Cal benefits to children under 19 years of age regardless of their immigration status. This effort was prompted by passage of SB 75 in 2016. DHCS and county social service agencies worked together with providers, enrollment assisters, and community-based organizations to facilitate communication and outreach efforts between local clinics and county human services departments to maximize this state-funded coverage expansion.

Significant increases in eligibility have also contributed to some program enrollment challenges. Last year, federal auditors found that, in 2014 and 2015, the state enrolled and made payments on behalf of beneficiaries who were later deemed ineligible.[10] The state agreed with most audit findings and detailed several corrective steps it had taken or planned to take to address the issues.

Looking Ahead

Going forward, policymakers continue to consider the potential impact of the Trump administration's proposed rule regarding the definition of "public charge" under federal immigration law.[11] The proposed rule, if finalized, is expected to cause a large number of immigrant parents to either not enroll or dis-enroll themselves and their children from safety-net programs like Medi-Cal, the Children's Health Insurance Program (CHIP), and other publicly funded health care programs, even though current eligibility for those programs would not change.

Endnotes

1. *Health Reform in Translation: What Is MAGI?* California Health Care Foundation, January 2014, www.chcf.org/wp-content/uploads/2017/12/PDF-HealthReformTranslationMAGI.pdf.

2. "Eligibility," Medicaid.gov, accessed November 28, 2018, www.medicaid.gov/medicaid/eligibility/index.html.

3. *Coverage Expansion Learning Collaborative: Streamlined Eligibility and Enrollment for Non-MAGI Populations*, Medicaid and CHIP (MAC) Learning Collaboratives, June 22, 2015, www.medicaid.gov/state-resource-center/mac-learning-collaboratives/downloads/non-magi-populations.pdf.

4. "Covered California - Single Streamlined Application," California Department of Health Care Services, last modified September 28, 2018, www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/SingleStreamApps.aspx.

5. "Medi-Cal Eligibility and Covered California - Frequently Asked Questions," California Department of Health Care Services, last modified September 28, 2018, www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Medi-CalFAQs2014a.aspx.

6. "California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), Office of Systems Integration, accessed November 28, 2018, http://osi.ca.gov/CalHEERS.shtml.

7. *Medicaid and CHIP FAQs: Implementing Hospital Presumptive Eligibility Programs*, Centers for Medicare & Medicaid Services, January 2014, www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-Implementation/Downloads/FAQs-by-Topic-Hospital-PE-01-23-14.pdf.

8. "Who Must Enroll," California Department of Health Care Services, accessed November 28, 2018, www.healthcare-options.dhcs.ca.gov/learn/who-must-enroll.

9. "Analysis of the Medi-Cal Budget," Legislative Analyst's Office, February 11, 2016, lao.ca.gov/Publications/Report/3350.

10. *California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements*, U.S. Department of Health and Human Services, February 2018, https://oig.hhs.gov/oas/reports/region9/91602023.pdf; *California Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements,* U.S. Department of Health and Human Services, December 2018, https://oig.hhs.gov/oas/reports/region9/91702002.pdf.

11. *Changing Public Charge Immigration Rules: The Potential Impact on Children Who Need Care*, California Health Care Foundation, October 23, 2018, www.chcf.org/publication/changing-public-charge-immigration-rules/.

Acknowledgment

About Health Management Associates

Medi-Cal Explained is an ongoing series on Medi-Cal for those who are new to the program, as well as those who need a refresher. To see other publications in this series, visit www.chcf.org/MC-explained.