



CWDA

# Medi-Cal Eligibility Primer

February 1, 2007



# Medi-Cal Eligibility Primer

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## I. Counties Determine Initial and Ongoing Medi-Cal Eligibility



## I. Counties Determine Initial and Ongoing Medi-Cal Eligibility

Medi-Cal eligibility operations are run by the state's 58 county human services departments, with oversight from the California Department of Health Services (DHS).

Counties receive funding from the state to conduct eligibility determinations and annual redeterminations and to maintain each case throughout the year. The funding ratio for these activities is 50 percent state General Fund and 50 percent federal matching funds.

### Funding Increased As Program Expanded, Grew More Complex

In 1998-99, Medi-Cal eligibility operations cost California \$562 million (\$280 million General Fund), and the total caseload in the program was 5 million. In 2005-06, \$1.175 billion (\$587 million General Fund) was allocated to counties, with a projected caseload of 6.68 million. Attachment 1 provides a timeline for the increase in expenditures, with information about what changes were occurring in the program at each point in time.

Generally, increases in spending for program eligibility are directly tied to legislatively enacted program expansions, lawsuits that required additional activities on the part of county eligibility staff, and other new program complexities. Examples of these changes include:

- Implementing Medi-Cal changes enacted as part of the Healthy Families program created in the late 1990s, including the joint application, mail-in applications and a "bridge" program intended to help close gaps between Medi-Cal and Healthy Families.
- Processing a massive backlog of cases related to the creation of a major new Medi-Cal program related to welfare reform, the 1931(b) program, and subsequent legislation enacted to expand eligibility for that program.
- Significant expansions in coverage for the aged, blind and disabled population, one of the fastest-growing groups of Medi-Cal beneficiaries.
- The *Craig v. Bonta* lawsuit, which created a backlog of tens of thousands of beneficiaries leaving the SSI program who were required to be given a full Medi-Cal eligibility determination prior to losing their SSI-linked Medi-Cal coverage.
- Creation of new avenues for accelerated enrollment of children into the program, including the Single Point of Entry and the CHDP Gateway.
- Implementing a new requirement that county Medi-Cal staff determine eligibility for every In-Home Supportive Services (IHSS) case.

## Medi-Cal and Healthy Families: A Comparison

The complexity of the Medi-Cal program is perhaps best illustrated by comparing it to the relatively simple Healthy Families program. Attachment 2 lists the key eligibility components of each program, such as the number of programs in Medi-Cal (122 aid codes under numerous program categories) vs. Healthy Families (1 benefit package under which all recipients obtain coverage); the documentation required from applicants; and additional requirements in order to continue receiving coverage. Some of the information from this attachment is summarized in the table below.

### QUICK COMPARISON OF MEDI-CAL AND HEALTHY FAMILIES ELIGIBILITY

| Medi-Cal   | Healthy Families   |
|--|--|
| <u>Applications may be received via:</u>   |  |
| Single Point of Entry<br>CHDP Gateway<br>Walk-in at county office<br>Other county-administered programs<br>Referral from Healthy Families<br>Free School Lunch program (pilot)   | Single Point of Entry<br>CHDP Gateway<br>Referral from Medi-Cal  |
| <u>Documentation required for:</u>   |  |
| U.S. citizenship or immigration status<br>Income and certain assets<br>Deductions<br>California residency<br>Pregnancy   | U.S. citizenship or immigration status<br>Income<br>Deductions   |
| <u>Separate programs:</u>  |  |
| <b>122 separate aid codes</b> under multiple programs.   | <b>One program</b> for children up to age 19 who are ineligible for no-cost Medi-Cal and have family income below 250% of the federal poverty level. |
| <u>State-required follow-up information provided to applicant:</u>   |  |
| Sample:<br>Share of cost brochure<br>"Your Rights" and "Medi-Cal: What it Means To You" booklets<br>Brochures on services such as WIC<br>Information Notices regarding different programs within Medi-Cal<br>Voter Registration Information<br>Citizenship/Immigration Information | Healthy Families Handbook<br>Welcome Letter<br>Welcome Phone Call  |
| <u>Additional requirements:</u>  |  |
| 10-day reporting requirement for certain changes<br>Mid-year status report<br>Annual, client-completed redetermination form (most counties cannot pre-fill client information)   | No interim reporting<br>Annual pre-filled redetermination form   |

<sup>1</sup>American Indian and Alaskan Natives do not pay premiums.

Despite the relative simplicity of the Healthy Families eligibility process, it is important to note that that Medi-Cal has advantages over Healthy Families.

- No-cost Medi-Cal has no premiums or copayments. Healthy Families enrollees pay premiums of \$4 to \$15 per month per child, up to a maximum of \$45 per family, per month. Copayments of \$5 are required for most Healthy Families services, with the exception of immunizations and preventive care.
- Medi-Cal coverage is broader for special needs children. While the basic benefit packages are similar, Healthy Families does not offer Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefits, while Medi-Cal does. These are important benefits for children because they offer a comprehensive and preventive set of services that are intended to promote child health and development as well as treat diagnosed illnesses – especially illnesses that could be ameliorated with early treatment. Under EPSDT, children are entitled to all Medicaid-covered services they need, regardless of any benefit restrictions imposed on adult beneficiaries.
- Medi-Cal provides greater due process. Medi-Cal appeals follow a mandated set of steps, with benefits provided pending the outcome of the appeal and an opportunity to request a hearing before an administrative law judge. In contrast, the Healthy Families process is primarily a paper-based process; initial appeals are handled by the eligibility contractor and recipients are not entitled to a hearing except under certain circumstances.

### Medi-Cal Program is Efficient Compared to Other States

Despite its complexity, California's Medi-Cal program continues to be one of the most efficient, as shown by the chart below.

#### FFY 2004 MEDICAID ADMINISTRATIVE COSTS IN 8 LARGEST STATES

| STATE          | NUMBER OF<br>MEDICAID<br>RECIPIENTS<br>(FFY 2003) | REPORTED<br>MEDICAID<br>ADMINISTRATION<br>COSTS<br>(FFY 2004) | ADMIN<br>DOLLARS<br>PER<br>RECIPIENT | \$ DIFFERENCE<br>BETWEEN STATE<br>AND NATIONAL<br>AVERAGE |
|----------------|---|---|--------------------------------------|---|
| PA             | 1,786,300   | \$ 641,151,201  | \$ 359                               | \$ 134  |
| TN             | 1,651,500   | \$ 499,732,186  | \$ 303                               | \$ 78   |
| CA             | 10,042,800  | \$ 2,334,800,657  | \$ 232                               | \$ 7  |
| <b>Average</b> | -   | -   | <b>\$ 225</b>                        | -   |
| IL             | 2,177,300   | \$ 490,798,210  | \$ 225                               | -   |
| NY             | 4,583,000   | \$ 999,465,815  | \$ 218                               | (\$ 7)  |
| FL             | 2,841,100   | \$ 460,377,199  | \$ 162                               | (\$ 63)   |
| OH             | 1,938,800   | \$ 309,538,807  | \$ 160                               | (\$ 65)   |
| TX             | 3,660,700   | \$ 504,268,375  | \$ 138                               | (\$ 87)   |

For Federal Fiscal Year 2004 (the most recent federal claims data available), California, Illinois and New York were in the middle of the eight largest states' per-recipient spending on Medicaid administrative activities – all three states were within \$7 of the average. This spending category includes, but is not limited to, spending on initial and ongoing eligibility determinations.

Pennsylvania and Tennessee were well above the average, at \$359 and \$303 per recipient, respectively. Florida, Ohio and Texas were below the average.

In the chart, note that the “administrative spending” category contains spending directly related to eligibility determination, as well as other spending not contained in any other specific category. True eligibility determination costs were therefore lower than these numbers, but cannot be separated out using the federal data reports.

### Counties Operate Under Several Performance Standards

The cost of operating Medi-Cal eligibility programs is paid for by the state and federal government, each with a 50 percent share. Until 2000-01, counties received annual funding increases to reflect their actual costs, based on surveys completed by each county for both the Medi-Cal program and the human services programs that counties administer on behalf of the state. At that time, these “cost of doing business” increases were suspended due to the state’s poor economy, instituting a freeze on program costs. County Medi-Cal operations funding was additionally cut by six percent in 2002-03, also due to the poor economy.

The results of the freeze and subsequent cut were dramatic. The state saw a rise in the number of Medi-Cal recipients that could not be explained by an increase in applications or recent program expansions. The Department of Health Services concluded that delays in processing annual redeterminations were keeping ineligible recipients on the program longer.

In January 2003, the Administration submitted a budget proposal to the Legislature to restore the provision of annual cost increases for county Medi-Cal operations, in exchange for the enactment of several performance measures that counties would be measured against. The Legislature worked with the state and CWDA to craft a compromise proposal that created several performance standards, summarized in the chart on the next page.

The Medi-Cal budget for 2003-2004 assumed that costs would be reduced by a total of \$376 million in that fiscal year based upon increased funding for the counties and the requirement that counties timely perform eligibility determinations and annual RVs.

While all 58 counties are subject to these performance standards, the state worked with CWDA to establish a formal reporting cycle for the 25 largest counties, representing about 95 percent of the statewide caseload.

## COUNTY PERFORMANCE STANDARDS

### Application Processing Standards

90% of the general applications that are complete and without applicant errors must be completed within 45 days.

90% of the applications for Medi-Cal based on disability shall be completed within 90 days, excluding delays by the state.

### Annual Redetermination Processing Standards

90% of annual redeterminations must be begun by the recipient's anniversary date.

90% of redeterminations must be completed within 60 days of the recipient's annual redetermination date for redeterminations based on forms that are complete and are returned to the county by the recipient in a timely manner.

90% of annual redeterminations where the form has not been returned to the county by the recipient must be completed by sending a discontinuance notice to the recipient within 45 days of the form's original due date.

Each reporting cycle last two years, with all counties reporting in the first year and only those counties that are out of compliance with one or more measures reporting in the second year. The reports are based on cases reviewed during one month of the year, chosen by the county to allow for sufficient time to prepare the report prior to the January 15 submission deadline.

Counties that are out of compliance with one or more measures must enter into a Corrective Action Plan for improving performance and submit interim reports to the state to demonstrate progress toward compliance as well as sustained performance on the measures that they successfully met on the initial report.

If a Corrective Action county fails to improve its performance to the satisfaction of the Department of Health Services, it could be penalized up to 2 percent of its annual Medi-Cal eligibility allocation for the following year. These funds may be restored by the department if it determines that sufficient improvement is made by the county. If the county does not meet the standards and performance criteria, the department may reduce the allocation by an additional two percent for each year thereafter in which sufficient improvement has not been made.

The counties are now in the second two-year cycle of reporting. Eight of the 25 largest counties entered in Corrective Action Plans. Four of these counties reported that they were below 90 percent on one measure, while the other four reported being out of compliance on two measures.

## Information Technology Plays Major Role

County staff use one of four computer systems to assist in determining eligibility for Medi-Cal. These systems are similar, but differ in their capabilities due in large part to the timing when each was originally programmed.

### FOUR COUNTY COMPUTER SYSTEMS

LEADER – Used by Los Angeles County.

ISAWS – The oldest system, used by 35 mostly small counties. Changes typically require more complex and costly programming because the system uses older programming techniques. Counties using ISAWS include Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Monterey, Napa, Nevada, Plumas, San Benito, San Joaquin, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne and Yuba.

C-IV – Four counties use this system, though the ISAWS counties will migrate to C-IV over the next two years. It is a more modern system that requires less complex programming to change, and has greater data analysis capacity than ISAWS. The counties currently using C-IV are Merced, Riverside, San Bernardino and Stanislaus.

CalWIN – The last system to be fully implemented, CalWIN also uses more modern programming techniques than ISAWS. The 18 counties using CalWIN are Alameda, Contra Costa, Fresno, Orange, Placer, Sacramento, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Tulare, Ventura and Yolo.

These four systems send and receive information from the state's overarching data system known as MEDS. The MEDS system regulates eligibility and is used not only by the county eligibility system but also by providers who check eligibility against the MEDS database and by the state to track data regarding the number and type of Medi-Cal beneficiaries and their usage of benefits. The MEDS system is immense and aging, which can make it difficult to rapidly accommodate program changes.

All eligibility for Medi-Cal is governed by "aid codes" stored within MEDS. At this time, more than 120 aid codes exist to convey the benefits for which a Medi-Cal beneficiary is eligible (full-scope benefits without restrictions, emergency only benefits for an undocumented non-citizen, benefits with a share of cost for someone whose income is above the limits for a program, etc.) and under which program they are receiving those benefits (1931(b) for Families, one of the Percent Programs for children, Long-Term Care, etc.).

Over time, it is hoped that the use of newer technology such as the Internet will give county staff the ability to work more closely with those families that need extra assistance to complete the eligibility process and retain coverage in the future.

Several counties have begun using on-line applications for Medi-Cal and other benefits. Some of the difficulties with rolling out these systems statewide have been (1) the sheer complexity of the Medi-Cal program, which makes programming time-consuming and (2) the fact that add-on systems not integrated with the four county consortia require that applications be printed out and re-typed, making these systems relatively inefficient.

#### C-IV WEB APPLICATION PROJECT

The C-IV consortium is working on an Internet-based application for Food Stamps, funded by a grant from the U.S. Department of Agriculture, which will send data directly into the C-IV system, avoiding the need to print out and re-type the information into the system at the county end. The goal is to ultimately expand this application to include Medi-Cal and Cal-WORKs.



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## II. Medi-Cal Has Many Entry Points



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People seeking coverage under Medi-Cal can enter the system in a number of ways.

In general, applications received from sources outside the county human services office are ultimately routed to the county in which the applicant resides for a full eligibility determination. County eligibility workers follow up with the applicant to seek additional information that may be required and use automation systems to assist with the eligibility determination process. The counties are overseen by the California Department of Health Services, which issues instructional letters, policies and procedures governing the operation of the program.

### APPLYING FOR MEDI-CAL

#### Through County Human Services

- Each county human services department accepts applications in person and also works with applicants to begin the process by mail or over the phone.
- Many counties have restructured their departments to enable much, if not all, of the process to be conducted without the applicant setting foot in a welfare office.
- Some counties have staff at local hospitals and clinics to conduct eligibility activities in the field. Because dedicated funding for these activities was cut during the most recent budget crisis, the number of outstationed workers has been reduced in recent years.

#### Through the Mail

- Applications can be mailed to the Single Point of Entry operated by the Managed Risk Medical Insurance Board (MRMIB), which contracts with Maximus to receive and review mail-in applications and route them to either the appropriate county human services department or to the Healthy Families program (also operated by Maximus under contract with MRMIB), depending on the information on the application.

#### At a Doctor's Office

- Children receiving care at a Child Health and Disability Prevention Program (CHDP) provider can be found temporarily eligible for coverage through the CHDP Gateway. The family must submit a full application for benefits in order to continue receiving Medi-Cal after the initial coverage period.

#### In the Community

- Trained Certified Application Assisters (CAAs) located at community-based organizations throughout the state help applicants fill out required documents and provide supporting information. It is generally believed that CAAs submit more complete, accurate applications than people who fill out applications without help.

In addition to processing initial eligibility, the counties also are responsible for ongoing eligibility operations. This includes handling inter-county transfers when recipients move, updating recipient information such as address and telephone, adding and removing children and adults from a case when household composition changes, processing state-required mid-year status reports from most adults in the program and processing federally required annual redeterminations.

Thirty-one counties operate, are implementing or are planning Children's Health Initiatives (CHIs), which conduct outreach to needy families without health coverage and route information to Medi-Cal, Healthy Families or the county's coverage program, as appropriate.

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### III. Medi-Cal Offers Coverage Under Numerous Programs



### III. Medi-Cal Offers Coverage Under Numerous Programs

Medi-Cal provides health coverage under multiple programs for children; families; adults with certain medical conditions; and adults who are aged, blind and disabled. The most commonly used programs are summarized below. Appendix 1 has a complete listing, taken from the California Health Care Foundation's *Guide to Medi-Cal Programs*, 2006 edition.

Individuals who receive CalWORKs, SSI/SSP, Foster Care and Adoption Assistance are automatically eligible for Medi-Cal. Note that new federal citizenship documentation requirements will likely impact the automatic eligibility granted to CalWORKs recipients; this change is discussed in greater depth under "Major Issues" below.

#### Programs for Families

##### Section 1931(b) For Families

This program combines the eligibility criteria for CalWORKs, Food Stamps, and the pre-CalWORKs Aid to Families with Dependent Children (AFDC) program to ensure that families who were eligible for Medi-Cal under the old AFDC program continue to be eligible for Medi-Cal after the implementation of CalWORKs. States were given the option by Congress to use less restrictive financial requirements to expand coverage to more families, which California did take advantage of to a large extent.

#### Children's Programs

##### Percent Programs

These three programs provide coverage for children whose families fall under a certain federal poverty level. Eligibility is based on age. Infants up to age 1 are covered up to 200 percent of federal poverty; children aged 1 until their 6th birthdays are covered up to 133 percent of federal poverty; and children aged 6 until their 19<sup>th</sup> birthdays are covered up to 100 percent of federal poverty. See the federal poverty level charts for 2007 in Attachment 3.

##### Accelerated Enrollment

Children are immediately enrolled in Medi-Cal when they apply through certain avenues, while their final eligibility is determined by the county in which they live. These include children whose parents mail a joint Medi-Cal/Healthy Families application to the Single Point of Entry (SPE) and who appear eligible for no-cost Medi-Cal based on a screen conducted by the SPE.

##### Medi-Cal to Healthy Families Bridging Program

When a child is receiving Medi-Cal without a share of cost and is determined to be no longer eligible for this coverage, but appears to be eligible for Healthy Families, he or she is given up to one month of transitional coverage while the county forwards their information to the Healthy Families vendor to be processed as an application for that program.

## Children's Programs, cont.

### Minor Consent

The Minor Consent program allows minors under age 21 who are unmarried and living with a parent or guardian to receive specific services without the consent of their parents. These services include substance abuse and mental health treatment; family planning, abortion and pregnancy/prenatal services; and treatment for sexually transmitted diseases and sexual assault.

Child Health and Disability Prevention Program (CHDP). This program provides early and periodic screening, diagnosis and referral for potentially handicapping conditions for children and youths. All children under 21 years of age who are eligible for Medi-Cal qualify for CHDP services. These services include health assessments and a variety of laboratory tests, depending on the age and history of the patient. Children can begin receiving coverage at their doctor's office for a 60-day period based on their answers to a short screening form. The parent or guardian is given a full Medi-Cal application to fill out and submit. If an application is not submitted within the 60 days of initial coverage, the child will be discontinued from Medi-Cal.

### Continuous Eligibility for Children (CEC)

This program ensures that all children receive 12 months of eligibility once they are determined eligible for Medi-Cal, even if their parents lose coverage during that time period. When a child is moved into CEC, their benefits continue until the next scheduled annual redetermination date.

## Pregnancy-Related Programs

### Income Disregard Program

Provides pregnancy-related services, family planning and postpartum care for 60 days after birth or the end of pregnancy for women whose family income is up to 200 percent of the federal poverty level.

### Presumptive Eligibility Program

Allows providers to presume that a pregnant woman is eligible for Medi-Cal based on her answers to screening questions about income and residency. The woman must later submit a complete application for an eligibility determination by the county, or her coverage will be discontinued.

## Senior and Disabled Programs

### Aged/Disabled Federal Poverty Level Program

This program covers adults over 65 and adults and children with disabilities who meet income guidelines and the Social Security Administration's standard for disability but are not eligible for SSI/SSP.

## Senior and Disabled Programs, cont.

### Aged/Disabled Medically Needy Program

Provides coverage, generally with a share of cost, to individuals who meet the Social Security Administration definition of disabled but whose income is too high to qualify them for the Aged/Disabled Federal Poverty Limit program or any other no-cost Medi-Cal program.

### Long-Term Care Program

Long-term care covers services in medical or nursing facilities and personal care services in a person's home. Long-term care is not an individual Medi-Cal program, but rather a set of services provided under different aid codes. The eligibility criteria for persons in institutions differ from those for non-institutionalized recipients. For example, a married couple in which one person is institutionalized is allowed to have more assets than they would under other Medi-Cal coverage programs if both were living at home.

### 250% Working Disabled Program

This program allows people with disabilities who are employed to earn up to 250% of the federal poverty level and still receive medical care. Individuals in this program pay monthly premiums on a sliding scale.

### In-Home Supportive Services (IHSS) Program

Individuals receive services through IHSS to help them remain independently at home rather than enter a nursing facility. Adults and children with disabilities are eligible for the program. Individuals applying for IHSS services who are not eligible for SSI/SSP must have a Medi-Cal eligibility determination conducted by county Medi-Cal staff. This is required because the state finances a substantial percentage of the IHSS program through a Medicaid waiver received in 2004-05 from the federal government.

## Other Programs

### Medically Needy Program

This program serves individuals who are 65 or older, disabled, blind, parents/families who meet statutory deprivation requirements, or caretaker relatives. Individuals in the Medically Needy program do not receive cash assistance from another program like CalWORKs or SSI/SSP, usually because their income is too high to qualify. However, these individuals meet other requirements of these programs, such as age, blindness, disability or deprivation. Depending on their income level, individuals in this program may receive coverage at no cost to them or be required to pay a "share of cost."

### Transitional Programs

Various forms of transitional medical coverage are available for people who have lost cash assistance (CalWORKs, SSI or Foster Care) or Section 1931(b) Medi-Cal.



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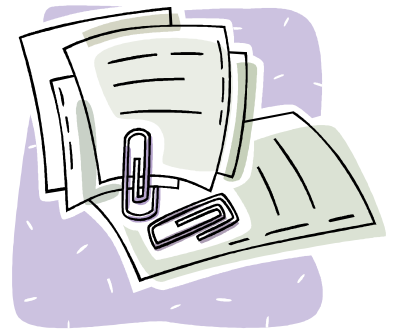
#### IV. Applicants and Beneficiaries Must Meet Numerous Requirements



## IV. Applicants and Beneficiaries Must Meet Numerous Requirements

### Paperwork/Documentation – the “Paper Chase.”

When a person applies for Medi-Cal, they receive a stack of paperwork to fill out and return to the county, along with numerous state- and federally-mandated notices containing information about Medi-Cal and also about the Women Infants and Children nutrition program, their ability to register to vote, and other programs and services for which they might be eligible. Depending on the circumstances of the family, they might also be required to fill out attachments to the application containing information about their assets, vehicles, other health coverage, and other items that could impact their eligibility for benefits. Appendix 2 contains a set of the documents that an applicant might receive as part of the application process, depending on their individual circumstances.



When applicants are informed of these requirements, it can sometimes take numerous attempts for them to properly fill out the forms and provide the required documents. The process of working with applicants to collect necessary documents can extend the eligibility determination process beyond the federally required 45 days for applications that are not based on disability.

### Periodic Documentation Requirements

Once a person begins receiving Medi-Cal benefits, they also must submit periodic documentation in order to retain those benefits. This includes a mid-year status report submitted six months after the person's eligibility date (required by state law), an annual redetermination of eligibility (required by federal law), and a requirement to report changes that could impact eligibility, such as address and household composition changes, within 10 days.

The mid-year status report requirement does not impact children under 21, pregnant women who are receiving only pregnancy-related benefits, and individuals who are aged, blind or disabled. For example, if a parent with two children, all of whom are receiving Medi-Cal, fails to turn in the required mid-year status report, the parent would be discontinued from the program while the children would continue to receive benefits until their next annual redetermination was due. Appendix 3 provides a sample of this report.

Mid-year status reports have been a controversial subject. Numerous bills have been introduced in recent years to eliminate the report, on the argument that the mid-year status report does not remove ineligible individuals from the Medi-Cal rolls, but serves only to punish those who, for whatever reason, fail to return the documentation in a timely manner. These bills have, thus far, failed passage, primarily due to concerns over the potential costs of eliminating the status report.

## Simplification Efforts

Several legislators have introduced bills over the past several years to allow applicants and/or beneficiaries to self-certify their income, assets or other information without requiring additional documentation. The federal government has actually encouraged states to explore these options, and a number of states have gone much further than California in doing so. Most of these bills have not been signed into law, but in 2006, Governor Schwarzenegger signed SB 437 (Escutia) which establishes a pilot project in two counties to allow for applicants and recipients of Medi-Cal to self-declare their income and assets. The pilots are limited to children and families receiving coverage. The bill also allows the Healthy Families program to use self-declaration process for beneficiaries completing their annual enrollment reviews, akin to the annual redetermination of eligibility for Medi-Cal.

To implement the SB 437 pilot, the Department of Health Services is currently soliciting interest from a selected group of counties with plans to choose the two participating counties in spring 2007. The counties must have a record for making eligibility determinations and annual redeterminations timely and of accurately and timely implementing programs. The two chosen counties can total no more than 10 percent of the statewide Medi-Cal caseload in the 1931(b), Medically Needy and percent programs.

The legislation also requires an evaluation of the pilot. DHS is soliciting interest from the University of California and California State University system for a researcher to conduct this evaluation. The department has met with advocates and CWDA about the bill's implementation and has committed to regular communication as the pilot counties are chosen and the program gets underway.

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## V. Major Issues Confronting Medi-Cal



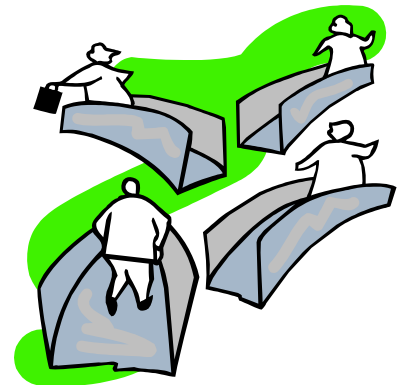
## V. Major Issues Confronting Medi-Cal

### Massive Complexity Has Proven Difficult to Simplify

While many efforts have been made in recent years, it has been difficult to simplify the massively complex Medi-Cal program. While on the surface it seems that combining the numerous programs that exist under the Medi-Cal umbrella would be a popular approach, each program has a constituency that could lose benefits if the simplification did not preserve their eligibility criteria.

For these reasons, even the simple-sounding concept of creating three basic programs – one for children and families, one for elder adults and persons with disabilities, and one for long-term care recipients, for example – leads to disagreements over the amount of income and assets that a beneficiary should be able to have.

Setting the bar too low could lead to eligibility reductions and freeze out individuals who would be eligible for one of the programs in existence today; setting the bar too high could lead to substantial costs.



Suggestions that CWDA has put on the table in the past include the following.

- Enhancing Retention: Eliminate Mid-Year Status Report  
Retaining eligible children on Medi-Cal and Healthy Families is vital in order to ensure continuing coverage for children; motivating, encouraging and assisting families in following through during the eligibility process is pivotal to retention. In order to enhance counties' ability to retain families in coverage, we have recommended elimination of the mid-year status report requirement for adults.

The mid-year status report does not appear to be a cost-effective means of ensuring program integrity and presents a barrier to some eligible adults retaining coverage. Further, there is evidence that some families assume that their children have lost coverage when the parent is terminated for failing to provide the required information, thus resulting in coverage lapses for these children even though they are technically still eligible for services.

- Smoothing Transitions Between Programs  
CWDA recommended that the Legislature allow counties to facilitate the enrollment of children into Healthy Families when they are found to be ineligible for no-cost Medi-Cal. Legislators agreed, enacting a new accelerated enrollment program for children as part of the 2005-06 Budget Act, followed by an expansion of the concept contained in SB 437 (Escutia, Statutes of 2007). While this new program has not yet been implemented, we are hopeful that making these programs as seamless as possible can reduce the chances that any child falls through the cracks.

For adults with disabilities, a similar need exists related to the currently established "maintenance need level" that is used to determine whether a Medi-Cal beneficiary must pay a share of cost before becoming eligible for health care coverage, and also to determine the amount of that share of cost. Under current law, the maintenance need level is intended to be set at the lowest level that still allows medically needy persons to meet their basic needs for food, clothing, and shelter and also pay a share of cost for health care. However, because the maintenance need level has not been increased since 1989, many beneficiaries whose income increases slightly above the level suddenly face a substantial share of cost for Medi-Cal services.

The disabled and elderly are especially vulnerable. For example, a single elderly person receiving SSA of \$1067 or less qualifies for zero share-of-cost Medi-Cal under the Aged and Disabled Federal Poverty Program. If they start receiving a dollar more in social security income bringing their income to \$1068, they would have a \$448 share of cost to pay each month before Medi-Cal would cover any of their medical expenses. Figuring out some way to increase the maintenance need level or otherwise smooth out this drastic shift from zero share of cost to several hundred dollars would be extremely beneficial to the well-being of elder adults and people with disabilities.

- Starting Down the Road to Simplification

Recognizing that incremental, short-term simplification efforts can play an important part of a longer-term strategy of program simplification, we have recommend aligning the federal poverty level "percent programs" for children aged 1 to 19 at 133 percent of the federal poverty level. This would expand no-cost Medi-Cal coverage for children aged 6 to 19, who currently are covered up to 100 percent of the federal poverty level.

This is similar to the "bright line" contained in the Governor's health care reform proposal, but at a slightly higher poverty level (133 percent vs. his proposed 100 percent). Aligning coverage within families to the extent possible will help to avoid the problem of "split" families, in which some children are enrolled in Medi-Cal and others are enrolled in Healthy Families. Multiple programs, multiple doctors, different coverage levels, and different copayments can lead to confusion for families and inadequate preventive and ongoing care for children.

## New Citizenship Documentation Requirements

The Federal Deficit Reduction Act of 2005, signed into law in February 2006, requires all applicants for and recipients of federal Medicaid benefits to submit proof of identity and citizenship. Current beneficiaries will be able to retain coverage while they provide the information, as long as they are working in good faith with counties to obtain the necessary documents. Applicants will not be eligible for full-scope benefits until they provide the documentation. This requirement is expected to affect up to 6.5 million current California beneficiaries and tens of thousands of applicants each year.

The federal law became effective July 1, 2006, and California is in the process of implementing the requirement. The state sent out a draft All-County Welfare Directors Letter in mid-2006, requesting feedback from stakeholders including counties, providers and advocates. Hundreds of pages of comments were received. A second draft was released on February 7, and stakeholders will have an opportunity to comment verbally at a meeting on February 22. Counties have been instructed not to seek documentation from beneficiaries or applicants until the final instructions are released.

In the meantime, the Department of Health Services has been using county data and its internal birth certificate data to match as many current beneficiaries as possible, which would fulfill the citizenship requirement (these individuals would still have to provide proof of identity). An estimated 1.6 million of the 3.4 million beneficiaries subject to the requirement have been matched with state vital records files, leaving 5 million that will need to provide both proof of identity and citizenship.

This new requirement has far-reaching implications for adults and children applying for or receiving Medi-Cal benefits. Key issues include:

- Original Documents Required

The federal guidance thus far has been strict about requiring that the state (in California, the counties) view original documents such as the actual driver's license or certified copy of a birth certificate, rather than accepting copies through the mail. This will increase foot traffic in county offices, as it is unlikely that an applicant or beneficiary will want to send these original documents through the mail.

Counties have been moving toward a more client-friendly environment where applications can be made by phone or mail without necessitating a trip to the welfare office; this new requirement represents a step away from these types of services. There has been discussion about enabling providers and/or certified application assisters to submit copies to the counties with signatures attesting that they reviewed original documents, but it is not clear whether the state's instructions will allow for this.

- Need for Funding to Address County Workload

The *2006-07 Budget Act* contains language requiring the state to estimate the cost of implementing the requirements and provide allocations to counties to enable them to implement timely. In fall 2006, CWDA provided the state with a statewide cost estimate based on the original draft letter and surveys of several counties. However, the state did not include any funding for these activities in the 2007-08 budget proposal released in January 2007.

We are concerned that counties will be unable to conduct this new work and continue to fulfill their existing performance requirements without knowledge of the level of funding available to them. We also have requested that counties be able to use their allocations to pay for original documents, such as birth certificates or passports, for individuals who have no funds of their own. Thus far, the department has indicated that counties will not be allowed to use their allocations for this purpose.

- Consequences for recipients and providers  
The state has indicated that it will provide emergency-only benefits for individuals who cannot provide the required proof of citizenship/identity, rather than discontinuing them from the program entirely. Even reducing benefits will have consequences for recipients and providers, as emergency-only benefits are very limited in scope. (Note that long-term care recipients who are dropped down to emergency coverage will be able to remain in nursing care, according to the department.)
- Consequences for other program areas  
CalWORKs, Food Stamps and In-Home Supportive Services (IHSS) and Long-Term Care recipients who receive Medi-Cal benefits will be required to meet the citizenship and identity documentation requirements. This will require coordination across programs. In the case of CalWORKs and Food Stamps, the new rules could create situations where someone is eligible for one program but not the other, changing current rules and practices for county eligibility staff and requiring automation system changes. In the IHSS and Long-Term Care programs, many recipients have cognitive impairments that will make it difficult for them to assist in the collection of necessary documents.
- Need for automation changes  
Both the MEDS system and the county consortia will require automation changes. The newer systems (CalWIN and C-IV) will be easier to reprogram; the oldest system, ISAWS, will be more difficult and time-consuming to automate. In all cases, reprogramming will take time and potentially require staff to do work manually for some months prior to the automation being completed.

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## VI. Attachments



## Attachment 1: County Medi-Cal Operations Funding: A Brief History

|   |  |
|---|--|
| <b>1998-99</b>  |  |
| Spending: \$562 million (\$280 million GF)  | Caseload: 5 million  |
| Increase over prior year due to <sup>1</sup> :<br>Shifting funds from CalWORKs to Medi-Cal in order to maximize federal funding.<br>Implementing 1931(b) and transitional programs for families leaving CalWORKs.           | Implementing Medi-Cal changes enacted as part of the Healthy Families program, including the joint application, mail-in applications and the bridge program. |
| <b>1999-00</b>  |  |
| Spending: \$661 million (\$330 million GF).   | Caseload: 5.1 million  |
| Increase over prior year due to <sup>2</sup> :<br>1931(b) backlog processing.<br>Increases to non-welfare caseloads.<br>Continued fund shift from CalWORKs.   | Asset test waiver for children.<br>Expansion of 1931(b) to 100% of FPL.<br>Expansion of 1931(b) asset limit.   |
| <b>2000-01</b>  |  |
| Spending: \$736 million (\$368 million GF).   | Caseload: 5.2 million  |
| Increase over prior year due to <sup>3</sup> :<br>1931(b) expansions.<br>12-month eligibility for children.<br>Elimination of quarterly status reports.<br>Implementation of SB 87 rules.                                   | Aged/blind/disabled coverage expansion.<br>Coverage for working persons with disabilities up to 250% FPL.  |
| <b>2001-02</b>  |  |
| Spending: \$793 million (\$396 million GF).   | Caseload: 5.9 million  |
| Increase over prior year due to <sup>4</sup> :<br>Coverage expansions for children; families; and the aged, blind and disabled.<br>Elimination of quarterly status reports.   | Continued implementation of quarterly reporting elimination and SB 87 rules.   |
| <b>2002-03</b>  |  |
| Spending: \$855 million (\$427 million GF).   | Caseload: 6.3 million  |
| Increase over prior year due to <sup>5</sup> :<br>Coverage expansions for children, families and the aged, blind and disabled.<br>Elimination of quarterly status reports.<br><i>Craig v. Bonta</i> lawsuit.                | Creation of CHDP Gateway.<br>Accelerated enrollment for children.<br>Eligibility redeterminations for families reaching CalWORKs time limits.                |
| <b>2003-04</b>  |  |
| Spending: \$974 million (\$487 million GF).   | Caseload: 6.51 million   |
| Increase over prior year due to:<br>Caseload increases.<br><br><i>Craig v. Bonta</i> lawsuit.<br><br>Restoration of cost-of-doing-business for county Medi-Cal operations, tied to new performance standards and penalties. | Eligibility redeterminations for families reaching CalWORKs time limits.<br>CHDP Gateway.<br>Institution of semi-annual status reporting.                    |

|   |  |
|---|--|
| <b>2004-05</b>  |  |
| Spending: \$1.088 billion (\$544 million GF).   | Caseload: 6.58 million   |
| Increase over prior year due to:<br>Caseload growth, especially aged, blind and disabled and CHDP Gateway.<br>Program expansions.<br>Cost-of-doing-business increase. | County Medi-Cal staff determining eligibility for In-Home Supportive Services (IHSS) recipients.<br><i>Craig v. Bonta</i> lawsuit. |
| <b>2005-06</b>  |  |
| Spending: \$1.175 billion (\$587 million GF) was allocated to counties in the current year.   | Projected Caseload: 6.68 million   |
| Increase over prior year due to:<br>Caseload growth.<br><i>Craig v. Bonta</i> , CHDP Gateway, IHSS determinations all continuing.                                     | Cost-of-doing-business increase.<br>Medicare Part D drug coverage.   |

LAO Analysis of the 1999-00 Budget Bill;<sup>2</sup> LAO Analysis of the 2000-01 Budget Bill;<sup>3</sup> LAO Analysis of the 2001-02 Budget Bill;<sup>4</sup> LAO Analysis of the 2002-03 Budget Bill;<sup>5</sup> LAO Analysis of the 2003-04 Budget Bill

## Attachment 2: Medi-Cal Complexity, Healthy Families Simplicity

| Medi-Cal  | Healthy Families  |
|---|---|
| <u>Length of time to make eligibility determination:</u>  |   |
| 45 Days   | 10 Days   |
| <u>Applications may be received via:</u>  |   |
| Single Point of Entry<br>CHDP Gateway<br>Walk-in at county office<br>Other county-administered programs<br>Referral from Healthy Families<br>Free School Lunch program (pilot counties)   | Single Point of Entry<br>CHDP Gateway<br>Referral from Medi-Cal   |
| <u>Documentation required for:</u>  |   |
| U.S. citizenship or immigration status<br>Income<br>Deductions<br>California residency<br>Pregnancy   | U.S. citizenship or immigration status<br>Income<br>Deductions  |
| <u>Separate programs:</u> <sup>1</sup>  |   |
| <b>122 separate aid codes under multiple categories.</b><br><i>Major aid categories include:</i><br>1931(b)<br>1931(b) SneeDe<br>Transitional Medi-Cal/Four-Month Continuing<br>Medically Needy Only (Share of Cost)<br>Medically Needy Only SneeDe (Share of Cost)<br>Childrens Percentage Programs<br>200% for children 0 to 1<br>133% for children 1 to 6<br>100% for children 6 to 19<br>Former Foster Care Children<br>Minor Consent<br>Pregnancy Programs<br>Pickle<br>Aged/Disabled Federal Poverty Level Programs<br>250% Working Disabled<br>Disabled Adult Child Programs<br>Long-Term Care Programs<br>Specified Low-Income Medicare Beneficiaries | <b>One program</b> for children up to age 19 who are ineligible for no-cost Medi-Cal and with family income up to 250% of the federal poverty level.    |
| <u>Follow-up information/documentation required for eligibility:</u> <sup>2</sup>   |   |
| Statement of Citizenship/Immigration Status<br>Rights and Responsibilities<br>Other Health Coverage Form<br>Child Support Form (if a parent is absent)<br>Retroactive Coverage Form<br>Student Education Expenses<br>In-Kind Income/Housing Verification<br>Property/Resource Verification<br>Vocational/Work History<br>Authorization to Release Medical Information<br>Supplemental Statement of Facts<br>Motor Vehicle Worksheet   | Health plan information/choice of plan<br>Monthly premium<br>Documentation of status as American Indian or Alaska Native for waiver of premiums/copays. |

| <u>State-required follow-up information provided to applicant:</u>  |   |
|---|---|
| Share of cost only brochure<br>"Your Rights" brochure<br>"Medi-Cal: What it Means To You" booklet<br>EPSDT Brochure<br>CHDP Brochure<br>WIC Brochure<br>Medi-Cal Information Notice<br>Long-Term Care Information Notice<br>Transitional Medi-Cal Information Form<br>Mental Health Benefit Statement<br>Voter Registration Information/Form<br>Information Regarding Citizenship/Immigration<br>Mail-In Application Cover Letter | Healthy Families Handbook<br>Welcome Letter<br>Welcome Phone Call |
| <u>Additional requirements:</u>   |   |
| 10-day reporting requirement for certain changes<br>Annual, client-completed redetermination form (most counties cannot pre-fill client information)  | No interim reporting<br>Annual pre-filled redetermination form    |

<sup>1</sup>Which programs an application is reviewed for depends on type of applicant. The county works through each potential program in a pre-determined order until it finds the application eligible.

<sup>2</sup>Failure to provide required information could lead to delay or denial of benefits.

## Attachment 3: 2007 Federal Poverty Guideline

United States Department of Health and Human Services

| <b>Family Size</b> | <b>100 %</b> | <b>133%</b> | <b>150%</b> | <b>200%</b> | <b>250%</b> | <b>300%</b> |
|--------------------|--------------|-------------|-------------|-------------|-------------|-------------|
| 1                  | \$10,210     | \$13,579    | \$15,315    | \$20,420    | \$25,525    | \$30,630    |
| 2                  | 13,690       | 18,207      | 20,535      | 27,380      | 34,225      | 41,070      |
| 3                  | 17,170       | 22,836      | 25,755      | 34,340      | 42,925      | 51,510      |
| 4                  | 20,650       | 26,845      | 30,975      | 41,300      | 51,625      | 61,950      |



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## VII. Appendices Available for Separate Download



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Guide to Medi-Cal Programs  
*California Healthcare Foundation*

Can be downloaded at:

<http://www.chcf.org/documents/policy/medi-cal/101/GuideMediCalPrograms2006.pdf>

Medi-Cal Application Packet

This is a set of documents compiled by CWDA, available upon request.

Medi-Cal Mid-Year Status Report  
*California Department of Health Services*

Can be downloaded at:

<http://www.dhs.ca.gov/publications/forms/pdf/mc176s.pdf>

