

Low Income Health Program

(For Discussion Purposes Only)

Low Income Health Program (LIHP)

- With respect to the receipt of federal funding, the MCE differs from the HCCI. Under the MCE, there is broader range of covered services and no cap on federal funding. In contrast, under HCCI, the range of covered services is narrower and there is a cap on federal funding.

Eligibility and Enrollment Processes

- For both the MCE and HCCI programs, eligible individuals may not be otherwise eligible for Medicaid or CHIP, must be non-pregnant, and must meet income eligibility standards that are determined on a county-by-county basis, with variation in the eligibility standards between counties within ranges established under this Demonstration.
 - **Definitions**
 - MCE Applicants – are non-pregnant individuals between 19 and 64 years of age who are not enrolled in Medicaid or CHIP and who appear to have family incomes at or below 133 percent of the FPL.
 - New MCE Recipients - Are individuals between 19 and 64 years of age who have family incomes at or below 133 percent of the FPL.
 - Existing MCE Recipients - Includes certain individuals whose income is at or below 133 percent of the FPL, and who were enrolled in the “Medi-Cal Hospital/Uninsured Care Waiver at the effective date of this Demonstration, but who do not meet the income eligibility requirements under the Demonstration for the Low Income Health program in their county of residence.
 - HCCI Applicants - are non-pregnant individuals between 19 and 64 years of age who appear to have family incomes above 133 through 200 percent of the FPL (or less based on participating county standards), are not enrolled in Medicaid or CHIP, do not have third party coverage, who have completed a written application for HCCI in a participating county and who have not had an eligibility determination.
 - New HCCI Recipients - Are individuals between 19 and 64 years of age who have family incomes above 133 through 200 percent of the FPL(or less based on participating county standards), are not enrolled in Medicaid or CHIP, do not have third party coverage, and

who have been determined to be eligible for enrollment into a participating county; and

- Existing HCCI Recipients - Includes certain individuals whose income is above 133 through 200 percent of the FPL, and who were enrolled in the “Medi-Cal Hospital/Uninsured Care Waiver” at the effective date of this Demonstration, but who do not meet the income eligibility requirements under the Demonstration for the Low Income Health Program in their county of residence.

Initial Eligibility Determination

- The determination by a participating county as to whether an applicant meets the eligibility standards for the MCE or HCCI programs, using applicable methodologies or procedures in effect in the county under this Demonstration, As set forth below, a county may determine an individual eligible subject to a waiting list.

Enrollment Caps

- In cases where a county determines, based on advance budget projections that it cannot continue to enroll applicants without exceeding the funding available for the county program, the county can establish enrollment caps for the HCCI program.
- If, notwithstanding enrollment caps that totally close new enrollment in the HCCI program, the county estimates that it will still exceed available funding, the county can establish enrollment caps for the MCE population.

Wait Lists for MCE and HCCI Applicants

- The State may employ county based wait lists when a county has established enrollment caps pursuant to the preceding paragraph, as a method of managing individual applicant enrollment into a county based HCCI or MCE program.
- Outreach for those on the Wait Lists - The State will ensure that county based outreach is conducted for those individuals on a wait list, for at least 6 months.

Eligibility Determinations

- Eligibility determinations for the MCE and HCCI populations will be made by individuals who are employed under merit system principles by the State or local governments, including local health departments.
- Counties will develop eligibility income standards, methodologies and procedures for the MCE and HCCI populations.

Eligibility Redeterminations

- Recipients enrolled in a MCE or HCCI program must have an eligibility redetermination at least once every 12 months.

Retroactive Eligibility

- Retroactive eligibility up to 3 months prior to the date of application may be extended to the MCE population, at county option, similar to the retroactive eligibility under the State plan.

Disenrollment of Recipients

- MCE population – Recipients will be disenrolled: In accordance with Medicaid law and policy; or if they no longer reside in the county participating in the MCE program.
- HCCI population – Recipients will be disenrolled if they: Exceed income limits allowed for the program at redetermination; Voluntarily withdraw from the program No longer reside in the County participating in the HCCI Become incarcerated or are institutionalized in an IMD; Attain age 65; Are no longer living; or Obtain other health coverage.

Standard Low Income Health Program Benefits

- MCE population core benefits to the extent available under the California State Plan:
 - Medical equipment and supplies;
 - Emergency Care Services (including transportation);
 - Acute Inpatient Hospital Services;
 - Laboratory Services;
 - Mental health benefits as described in STCs 0 and 0;
 - Prior-authorized Non-Emergency Medical Transportation (when medically necessary, required for obtaining medical care and provided for the lowest cost mode available);
 - Outpatient Hospital Services;
 - Physical Therapy;
 - Physician services (including specialty care);
 - Podiatry;
 - Prescription and limited non-prescription medications;
 - Prosthetic and orthotic appliances and devices; and
 - Radiology.
- HCCI population core benefits:

- Medical equipment and supplies;
- Emergency Care Services;
- Acute Inpatient Hospital Services;
- Laboratory Services;
- Outpatient Hospital Services;
- Physical Therapy;
- Physician services;
- Prescription and limited non-prescription medications;
- Prosthetic and orthotic appliances and devices; and
- Radiology.

*****Excluded Benefits** - Services and Benefits excluded from the MCE and HCCI core benefit plans include:

- Organ Transplants;
- Bariatric surgery; and
- Infertility related services (Eligible individuals requiring these services are to be seamlessly enrolled into the Family Planning, Access, Care and Treatment Program (F-PACT)).

Enhancements to Core Benefits

- Counties may provide benefits that include additional Medicaid eligible services above the minimum benefits and receive Federal funding. The State will submit such proposals to CMS for approval.

Denial of Services

- The LIHP program may exclude from the core benefits those services listed above, except medically necessary emergency care services for MCE populations, that are rendered by providers that are not in the provider network for the LIHP program.

Coverage of Out-of-Network Emergency Services

- Participating counties under the LIHP must provide coverage of emergency services provided in hospital emergency rooms for emergency medical conditions, and/or required post-stabilization care, regardless of whether the provider that furnishes the services is within the LIHP network.

LIHP Plan Materials

- LIHP programs will include in plan materials information about their ability to receive emergency and/or post-stabilization services in out-of-network hospitals as well as their right to not be liable for payment for these services. LIHP programs will ensure that beneficiary id cards indicate to emergency providers

that the LIHP program should be contacted for reimbursement and approval for post-stabilization services.

MCE Mental Health Benefit Criteria

- The MCE enrollee as described in paragraph entitled “Eligibility” must be diagnosed by a MCE participating provider, within their scope of practice, with a mental health diagnosis specified in the most recent version of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association.

Mental Health Benefits for MCE enrollees

- The State must offer a minimum evidence-based benefits package for mental health services under the Demonstration, to promote services in community-based settings with an emphasis on prevention and early intervention.
- Minimum Benefits Package - Each county will provide the minimum level of mental health benefits to enrollees:
 - Up to 10 days per year of acute inpatient hospitalization in an acute care hospital, psychiatric hospital, or psychiatric health facility.
 - Psychiatric pharmaceuticals. Up to 12 outpatient encounters per year. Outpatient encounters include assessment, individual or group therapy, crisis intervention, medication support and assessment. If a medically necessary need to extend treatment to an enrollee exists, the plan will optionally expand the service(s).
- Benefits beyond the Minimum. - Counties may provide benefits that include additional Medicaid eligible services above the minimum benefits and receive Federal funding. The State will submit such proposals to CMS for approval.
- Option to carve out Mental Health Benefits- Counties may opt to provide mental health services through a delivery system that is separate for the LIHP.

Cost Sharing Parameters for the LIHP Population

- MCE related enrollment fees and premiums must be discontinued for enrollees with family income at or below 133 percent of the FPL and newly participating MCE program counties must comply with Medicaid cost sharing limits for MCE and HCCI populations.
- Effective July 1, 2011. All cost-sharing must be in compliance with Medicaid requirements for State plan populations that are set forth in statute, regulation and policies and all HCCI enrollees must be limited to a 5% aggregate cost sharing limit per family.

Delivery Systems for the LIHP Population

If the State chooses to use a managed care delivery system to provide benefits to the LIHP population, any managed care delivery system which uses managed care organizations (MCOs), health-insuring organizations (HIOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs) or primary care case management systems (PCCMs) [collectively referred to as managed care entities] is subject to all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, except as expressly noted below and consistent with the Demonstration waiver and expenditure authorities. A county based delivery system with a closed network of providers will be considered a managed care delivery system.

Network Adequacy and Access Requirements for the LIHP Population

- Accessibility to primary health care services will be provided at a location within 60 minutes or 30 miles from each enrollee's place of residence.
- Specialty care access will be provided at a minimum within 30 business days of request.
- Penalty Provisions Related to Network Readiness and Adequacy. Failure to implement or operationalize the provisions listed in this STC will result in the loss of a percentage of the expenditure cap applicable to Safety Net Care Pool (SNCP) expenditures cap (not including HCCI expenditures)
- LIHP Credentialing and Cultural Competence
- Encounter Data. Each county LIHP managed care delivery system in the Demonstration will be responsible for the collection and reporting of all data on services furnished to Demonstration enrollees through encounter data or other methods as specified by the State.

Due Process

- By May 1, 2011, the State must implement standards and procedures for hearings and appeals by LIHP applicants and recipients. These standards and procedures shall not go into effect until approved by CMS. The State's proposed standards and procedures shall be submitted to CMS for review by January 1, 2011.