MEDI-CAL ELIGIBILITY AND MANAGED CARE PLAN ENROLLMENT FOR LONG-TERM CARE PROVIDERS

This resource for long-term care (LTC) providers explains Medi-Cal eligibility and managed care enrollment and offers guidance on how LTC providers can help members through these processes.

Applying for Medi-Cal

DHCS may take up to **45 days to process the Medi-Cal application,** or up to 90 days if the application is based on disability. Once approved, new members get a Medi-Cal Benefits Identification Card (BIC) and can use their benefits right away. The general verification process is as follows:

- The member or representative applies for Medi-Cal.
- The local county office may contact the member by mail or phone to verify eligibility criteria, (such as income, identity, or citizenship).
- Once approved, the member receives a notice confirming their Medi-Cal eligibility.
- The member gets their BIC and can use Medi-Cal Fee-for-Service (FFS) benefits until enrolled in a Medi-Cal managed care plan (MCP).
- Within 45 days of receiving the BIC, if there are multiple MCP options, the member will be sent information explaining their choices. They must select a MCP by the deadline in their "My Medi-Cal Choice Packet" or be automatically enrolled in a MCP.

LTC providers can determine a member's Medi-Cal eligibility by checking the member's eligibility record in the Automated Eligibility Verification System (AEVS). Providers can direct members and their representatives to additional eligibility resources available on the DHCS website.

Enrolling in a Medi-Cal MCP

Member Choice

A Medi-Cal member's MCP choice depends on their county of residence and whether they are "dually eligible" for both Medi-Cal and Medicare and already enrolled in a Medicare Advantage Plan. LTC providers should use AEVS to identify a member's assigned MCP. As illustrated in the table below, there are five managed care county models. Refer to the DHCS Medi-Cal MCPs by County and Medi-Cal MCP Model Fact Sheet for more information.

County Model	Model Description	Member Choice, if applicable
Geographic Managed Care (GMC)	DHCS contracts with multiple Knox-Keene licensed commercial MCPs serving defined geographical areas.	If a member resides in a GMC, Two-Plan, or Regional County and is **not** enrolled in a Medicare Advantage Plan with a matching MCP, the member can enroll in a MCP in the following ways: » **Mail** in the *My Medi-Cal Choice* form that comes with their *My Medi-Cal Choice* packet. » **Online** at Medi-Cal Health Care Options (HCO) through their login and member page. » **Over the Phone** with Medi-Cal HCO Customer Service at 1-800-430-4263 (TTY:1-800-430-7077) (Available 8 am – 6 pm, Monday to Friday). » **In-Person** at the member's local County Social Service Office. While the member is waiting for their *My Medi-Cal Choice*
Two-Plan	DHCS contracts with two Knox-Keene licensed MCPs, a county-authorized plan called a Local Initiative and a commercial MCP.	
Regional	DHCS contracts with two Knox-Keene licensed commercial MCPs serving two or more contiguous counties in the designated Rural Expansion Regional. This is a model for rural counties that have not elected to participate in the County-Organized Health Systems (COHS) or Two-Plan model.	

County Model	Model Description	Member Choice, if applicable
		packet and/or going through the process of choosing or enrolling in a MCP, they are enrolled in Medi-Cal FFS. **During this period, LTC providers should bill Medi-Cal FFS for any LTC services provided.** If a member lives in one of the 17 Medi-Cal matching plan policy counties and is enrolled in a Medicare Advantage plan with a matching MCP, they will be enrolled automatically in that matching MCP.
COHS	DHCS contracts with a MCP that is run by a county government entity and is the sole MCP operating in the county. COHS are exempt from federal MCP requirements, including plan choice and state Knox-Keene Act licensure requirements.	If the member lives in a COHS county or a Single Plan County, the member will be automatically enrolled in the COHS plan, Single plan, or Kaiser Permanente. If a member lives in one of the 17 Medi-Cal matching plan policy counties and is enrolled in a Medicare Advantage plan with a matching MCP, they will be enrolled automatically in that matching MCP.
Single Plan	DHCS contracts with a licensed MCP operating under the authorization or sponsorship of a county or local authority. The Single Plan is licensed under Knox-Keene Act.	

MCP Subcontracting

Delegation

Prime Plan	Delegated Plan
LA Care	Anthem
	Blue Shield Promise
Health Net	Molina

Some MCPs, referred to as prime plans, partner with other MCPs, referred to as delegate subcontractors, to help members get care.

During the LTC transition to managed care, DHCS used members' choice of primary care providers (PCP) in prime/delegate plan arrangements to assign them to a plan. If member's chosen PCP did not match their selected prime and delegate plan, they were enrolled in the plan that contracted with their PCP.

For example, the table above indicates that in LA County, LA Care is a prime plan that delegates members to subcontractors Anthem Blue Cross and Blue Shield of California Promise Health Plan. Health Net is another prime plan that partners with Molina Healthcare. To find a member's assigned MCP, LTC providers can check AEVS, the prime plan's provider portal, member services, or the member's health plan ID card.

Participating Provider Groups (PPG) or Independent Practice Associations (IPA)

MCPs may subcontract services to a subset of providers called PPGs or IPAs. In some cases, providers may need to contract with and bill the PPG or IPA. Providers should check the Division of Financial Responsibility in their contract with the MCP to determine who to bill. To determine if a member has been assigned to a PPG or IPA and which one, providers can check the member's health plan ID card or the member's MCP portal.

Resources Provided to Members Newly Enrolled in a MCP

After a member is enrolled in a MCP, they will receive a confirmation letter from HCO confirming the MCP and effective MCP enrollment date. The member will also receive a welcome packet from their MCP with important information, including a Member Handbook (Evidence of Coverage (EOC)), Provider Directory, and notices about services. This may include form letters, Notices of Action (NOA), Notice of Adverse Benefit Determination (NABD), grievances or appeals, marketing materials, preventive health reminders, surveys, free language assistance notices, and newsletters.

All MCPs are required to post their Member Handbook and Provider Directory on their website. The MCP and HCO, the Medi-Cal Enrollment Broker, must ensure all member communication meets readability and suitability requirements and is approved by DHCS before distribution. The MCP and HCO will send this information in the manner preferred, including in alternate formats, such as Braille, large-print font, or audio.

How LTC Providers Can Support Medi-Cal Members

How can LTC providers support residents with applying for or maintaining Medi-Cal eligibility?

Anyone aware of a potential applicant's need to apply to Medi-Cal can do so to preserve the application date. Applicants who cannot act for themselves will not be denied or lose Medi-Cal coverage just because no one is assigned to act for them. If there is no spouse, conservator, guardian, or executor and the applicant is not considered competent, LTC providers may be able to act on a resident's behalf by contacting the local county social services office and explaining the applicant's situation. Refer to All County Welfare Directors' Letter 94-62 for more information.

How can a LTC provider support a member enrolling in a MCP?

The Choice Form indicates enrollment can be signed by "Head of Household or Authorized Representative." However, this does not have to be a legally determined Authorized Representative (AR), as indicated in DHCS Medi-Cal Eligibility Data System (MEDS), and can be a family member, LTC provider administrator, case manager, or social worker. A family member or other support person determined by the member can also sign the Choice Form.

Additionally, LTC providers can work with the Medi-Cal Enrollment Broker, HCO. In this process, an individual who is not a member's legal representative, also called an Enrollment Assistant, can assist the member with enrolling in a MCP over the phone.

How can LTC providers support members with enrollment when there is a change in their county of residence?

LTC providers should be familiar with the Intercounty Transfer (ICT) process to help members who want to change their permanent address. It is the member's responsibility to notify either the county they are moving from (sending county) or to (receiving county) about their address change. The member may report this in person, in writing, by phone, or online. They are informed of these options when they apply or during eligibility redetermination. Once notified, the county must start the ICT within seven business days and complete it within 30 days. If the member is disenrolled from their MCP in their sending county, they are still entitled to the full scope of benefits and will

receive these benefits through FFS in their receiving county until enrolled in a new MCP. LTC providers can help by acting as a liaison to ensure communication is clear and the member continues to receive care throughout the process. For more information on the ICT process, providers can review All County Welfare Directors' Letter 18-02E.

If a member cannot enroll in a MCP due to an address mismatch in MEDS, LTC providers should direct the member or their AR to contact their Local County Office to update their address. Members with a mismatched address in MEDS will remain in FFS until their address is updated. If the member has chosen a MCP, it will be saved in the enrollment system for up to 120 days while the update is made.

How can LTC providers support a member switching their MCP, if there is more than one plan offered in their county?

Members have the right to **change their MCP at any time** by contacting HCO. Upon receipt of a member's request to change their MCP, they will receive a confirmation letter in the mail within 1-3 business days following the MCP change. The MCP coverage change is effective the first of the month following the confirmation letter. LTC providers can support member MCP changes as an Enrollment Assistant in the same manner as they would during the initial enrollment process described above.

Questions and Resources

Questions about Medi-Cal eligibility can be directed to the member's Local County Office. Questions about member MCP enrollment should be directed to the respective MCP LTSS liaison.

LTC providers can find additional information in DHCS-published resources on each of the following webpages:

- Skilled Nursing Facility CalAIM Carve-In webpage
- Intermediate Care Facility for the Developmentally Disabled CalAIM Carve-In webpage
- Subacute Care Facility CalAIM Carve-In webpage