State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
Director

EDMUND G. BROWN JR.
Governor

Date: January 25, 2017

TO: ALL COUNTY WELFARE DIRECTORS Letter No.: 17-03
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS

SUBJECT: Revised Medi-Cal Hierarchy
(Reference: All County Welfare Directors Letters 99-02, 01-18 and 06-41; Medi-Cal Eligibility Division Information Letter I 13-03 and I 13-12)

The purpose of this All County Welfare Director's Letter (ACWDL) is to transmit the Medi-Cal hierarchy to be used when determining or redetermining Medi-Cal eligibility. It also clarifies when certain Medi-Cal or Medi-Cal Access Program (MCAP) and County Children's Health Insurance Program (CCHIP) applicants or beneficiaries may request processing under certain Medi-Cal eligibility groups and when they may not. This ACWDL supersedes any previous instruction in Medi-Cal Eligibility Division Information Letters, ACWDLs or any other guidance regarding the order of processing Medi-Cal eligibility.

Background

Federal law specifies that certain programs be determined before others when Medi-Cal eligibility is determined or redetermined. Before the implementation of the Affordable Care Act (ACA), the process consisted of evaluating which categorical/mandatory programs the individual might be eligible for before determining eligibility under optional categorical, Medically Needy or State-only programs. With the implementation of ACA, the previous hierarchy was revised, because the coverage groups have been expanded and certain Modified Adjusted Gross Income (MAGI) groups, such as the New Adult group, must be determined before or after other coverage groups. This letter contains instructions on the order in which Medi-Cal eligibility must now be determined. This letter also clarifies when MCAP and CCHIP applicants or beneficiaries may request processing under either Medi-Cal, MCAP, or CCHIP and when they may not.

Application of the Medi-Cal Hierarchy

At application, reported change of circumstances (including the start of Medicare eligibility) or annual redetermination, an applicant or beneficiary's Medi-Cal, MCAP or CCHIP eligibility (where applicable) will be determined by progressing through the Medi-Cal, MCAP and CCHIP hierarchy (see attached chart). The applicant/beneficiary may not be eligible for some groups after screening (for instance someone who is under 65 and is not claiming to be blind or to have a disability would not be eligible for the Pickle program as the applicant/beneficiary would have no way of meeting the eligibility criteria). Eligibility must be determined for each group where the applicant/beneficiary has potential Medi-Cal eligibility. When an applicant or beneficiary is eligible for more than one Medi-Cal program and one is more beneficial than others are, the applicant or beneficiary must be placed into the Medi-Cal program that is the most beneficial.

Mega Mandatory Groups

Mega Mandatory groups are those that are the categorical/mandatory programs required by federal law or where eligibility is determined by another program that automatically includes Medi-Cal eligibility as part of the determination, such as Foster Care. If the applicant or beneficiary has eligibility in one of the Mega Mandatory groups and a MAGI eligibility result is returned for that applicant/beneficiary, counties must not accept the MAGI result for that applicant/beneficiary as the basis for eligibility. While this should not occur for those applying through the portal, there may be situations where this occurs with cases processed through the county. That applicant or beneficiary will remain in the household for income and household size determination purposes, but must not be changed to a MAGI eligibility group.

For example: Andrea is married and has two children. Her spouse works part-time and files a tax return. Andrea is eligible for Pickle. Andrea's spouse and children will be evaluated for MAGI with a household of four, which includes Andrea. However, Andrea must not be moved to a MAGI aid code because her Pickle eligibility puts her in a Mega Mandatory category. For more information on the Pickle program, please reference the Pickle Handbook.

Once it is confirmed that the applicant/beneficiary does not have eligibility in the Mega Mandatory Medi-Cal programs, the next check would be a determination under the MAGI groups, including MCAP and CCHIP.

MAGI

In determining MAGI eligibility, Children's Federal Poverty Level (FPL) coverage groups, Parent/Caretaker and Pregnant Women's/Infants groups come before the New Adult Group, MCAP, CCHIP and the Optional Targeted Low Income Children's groups. After

eligibility for the MAGI Medi-Cal, MCAP and CCHIP groups has been determined and the applicant/beneficiary does not qualify, the applicant/beneficiary may be determined for other optional categorical Medically Needy and state-only Medi-Cal groups, and should be evaluated for Advanced Premium Tax Credit (APTC) eligibility if the applicant/beneficiary is not eligible for a Medi-Cal program, MCAP, CCHIP or other health coverage like Medicare that is federally-designated minimum essential coverage (MEC). Medi-Cal with a share-of-cost (SOC) is not considered MEC. Although the children's MAGI Optional Targeted Low Income Children's program is an Optional Categorical group, it must be evaluated before Non-MAGI Optional Categorical and Medically Needy/Medically Indigent programs for children.

Pregnant applicants in the Medi-Cal income range (up to 213 percent FPL) are enrolled into Medi-Cal. Pregnant applicants with an income above 213 percent FPL up to and including 322 percent FPL are enrolled in MCAP (formerly the Access for Infants and Mothers or AIM program) which is funded by the Children's Health Insurance Program. Therefore, an applicant is evaluated for MCAP before APTCs. However, federal guidance provides that pregnant applicants, as well as women enrolled in Covered CA with APTCs who become pregnant and who have income within the MCAP range, have the option to enroll in either of these two programs and, if enrolled in Covered CA, move from Covered CA to MCAP during pregnancy and the post-partum period. See Centers for Medicare and Medicaid Services State Health Official Letter # 14-002 (Nov. 7, 2014). MAXIMUS, Inc. (Maximus) case manages MCAP for the Department of Health Care Services. Counties should coordinate with Maximus on MCAP eligibility and redetermination issues.

As a reminder, Home and Community-Based Services (HCBS) Waiver and Long-Term Care (LTC) benefits and services are provided to beneficiaries under the MAGI coverage groups without time limits and no change in aid code if eligible.

Medicare Savings Programs (MSPs)

The MSPs, which include the Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB), Qualifying Individual (QI 1), and Qualified Working Disabled Individual (QWDI), are mandatory groups. QMB and SLMB can occur concurrently with other Medi-Cal eligibility and applicants/beneficiaries found eligible for QMB and SLMB might be evaluated for other Medi-Cal programs and given concurrent eligibility where appropriate. QI 1 may not occur when the applicant/beneficiary is otherwise Medi-Cal eligible for no-SOC benefits but applicants/beneficiaries with Medically Needy SOC eligibility may be eligible in months when their SOC is not met. QWDI may not occur with any other Medi-Cal eligibility, even eligibility for Medi-Cal with a SOC. The MSPs must be evaluated for all Medicare-eligible applicants and beneficiaries that apparently qualify no matter if they have other Medi-Cal eligibility, as specified above, including beneficiaries who become eligible for Medicare in the New Adult group. The

New Adult group beneficiary, who is eligible to receive Medicare, must be transitioned out of the New Adult group with eligibility determined elsewhere in the hierarchy.

Optional Categorical Groups and the Medically Needy

Optional categorical programs are programs allowed, but not required in federal law. California has chosen several optional categorical programs including the MAGI Optional Targeted Low Income Children's program (OTLIC), the Non-MAGI Aged and Disabled FPL Program, Blind FPL Program and 250 percent Working Disabled Program, among others. The majority of optional categorical programs operating under Medi-Cal are non-MAGI programs.

The Medically Needy program is a non-MAGI program that allows beneficiaries, who are otherwise eligible except for income, to spend down excess income on qualified medical expenses (known as SOC) in order to become eligible for Medi-Cal coverage.

The optional categorical programs are determined only after an applicant/beneficiary has been determined ineligible for any Mega Mandatory or MAGI Medi-Cal programs. The Medically Needy program is determined only after an applicant/beneficiary has been determined ineligible for Mega Mandatory, MAGI Medi-Cal programs including OTLIC, Optional Categorical groups, the MCAP program, and CCHIP in participating counties.

NOTE: Applicants or beneficiaries who are eligible for MAGI, but who are also potentially eligible for Optional categorical or Medically Needy, may choose to have eligibility determined under those programs if they can establish linkage through disability, age or blindness, and are willing to provide all information necessary to complete a non-MAGI Medi-Cal determination.

As a reminder, LTC services can be provided through the MAGI and Optional Categorical coverage groups, if eligible; however, for the Non-MAGI Optional Categorical coverage groups, once LTC status is achieved, pursuant to ACWDL 90-01, (see Section 50056 of the letter), individuals must be transitioned to the Medically Needy program where the SOC is calculated. While HCBS services are provided in the Mega Mandatory, MAGI groups including OTLIC and Non-MAGI Optional Categorical coverage groups, if the applicant/beneficiary is not eligible under those groups Medi-Cal eligibility under the Non-MAGI Optional Categorical groups and Medically Needy program is determined using institutional deeming rules.

Applicants or beneficiaries with disabilities can enroll in MAGI Medi-Cal if not in a linked Mega Mandatory program and other MAGI eligibility criteria are met (for instance, income under 138 percent FPL). To be eligible for disability based Medi-Cal, the applicant/beneficiary must have a finding of disability either by the Social Security Administration or by Medi-Cal. However, an applicant/beneficiary who has a finding of

disability, either by the Social Security Administration or Medi-Cal, but who has not yet begun receiving Medicare, may still be eligible for the MAGI New Adult group or MCAP until they begin receiving Medicare.

State-Only Groups

State-only programs are programs California has chosen to implement that do not receive federal funds. These programs are the last categories for which the applicant's/beneficiary's eligibility is determined. Many of the state-only programs have limited benefits targeted to specific conditions or circumstances, such as the Medically Indigent LTC program or the Dialysis/Total Parenteral Nutrition programs. Since there is no federal funding, these programs are the last to be determined in the hierarchy. In addition, if beneficiaries subsequently become potentially eligible for federally funded programs, these beneficiaries must have their eligibility redetermined and should then be placed in federally funded programs if otherwise eligible.

Presumptive Eligibility (PE), Express Lane Enrollment and Accelerated Enrollment (AE)

AE for children, PE for children and pregnant women, the Breast and Cervical Cancer Treatment Program, and Hospital PE programs are not considered in the hierarchy as these programs require a final eligibility determination and are not considered to be coverage groups. Similarly, Express Lane enrollment, and other temporary systems implemented to quickly enroll applicants for health insurance, are not considered coverage groups.

Consumer Protection Programs (CPPs)

CPPs, such as Continuance Eligibility for Children, Transitional Medi-Cal, Four Month Continuing, and Continuous Eligibility for Pregnant Women are also not subject to the hierarchy as the order a beneficiary is determined for CPPs depends on the beneficiary's circumstances. The order they are determined will be the subject of a future ACWDL.

If you have questions regarding this letter or the attached hierarchy table, please contact Leanna Pierson at (916) 327-0408 or by email at Leanna.Pierson@dhcs.ca.gov or Sharyl Shanen-Raya at (916) 552-9449 or by email at Sharyl.Shanen-Raya@dhcs.ca.gov.

Original Signed By

Sandra Williams, Chief
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Attachment

MEDI-CAL HIERARCHY
MEGA MANDATORY
Supplemental Security Income/State Supplementary Payment (SSI/SSP) 10, 20, 60
Tile IV-E Foster Care 42, 49
State-Only (Cash) Foster Care 40, 43, 4K, 5K
Foster Care-Medi-Cal Only 45, 46
Title IV-E Adoption Assistance 03, 07
State Only (Cash) Adoption Assistance 04
Adoption Assistance-Medi-Cal Only 06, 4A
Title IV-E Kinship Guardianship Assistance Program (Kin-GAP) 4F, 4S, 4T
State Only (Cash) Kin-GAP 4G, 4W
Former Foster Care 4M
Pickle 16, 26, 66
Disabled Adult Child (DAC) 6A, 6C
Disabled Widow/Widower 36
Medicare Savings Programs (MSP) 80 (QMB), 8C (SLMB), 8D (QI1), 8A (QWDI)
MAGI
MAGI Infant's and Children's Groups Full Scope: M5, P5, P7, P8 (also includes California Work Opportunity and Responsibility to Kids-CalWORKs: 30, 31, 32, 33, 35, 3A, 3C, 3D, 3E, 3F, 3G, 3H, 3L, 3M, 3P, 3R, 3S, 3U, 3W, 4H, 4N, 4P, 4R) Note: Even though there are restricted aid codes for this category children receiving restricted services were transitioned to full scope coverage effective May 1, 2016
MAGI Parent-Caretaker Relative Full Scope: M3 Restricted: M4 (also includes CalWORKs: 30, 31, 32, 33, 35, 3A, 3C, 3D, 3E, 3F, 3G, 3H, 3L, 3M, 3P, 3R, 3S, 3U, 3W, 4H, 4N, 4P, 4R)
MAGI Pregnant Woman (full-scope and Restricted) Full Scope: M7, Restricted: M8
MAGI Pregnant Woman (Services limited to all medically necessary pregnancy-related services and services for other conditions that might complicate the pregnancy) M9, M0

MEDI-CAL HIERARCHY CONTINUED
MAGI New Adult Group Full Scope: M1, Restricted: M2
MAGI Optional Targeted Low Income Child Full Scope: T1, T2, T3, T5 Note: Even though there are restricted aid codes for this category, children receiving restricted services were transitioned to full scope coverage effective 5/1/2016.
MCAP Pregnant Women 0D, 0G
MCAP linked Infant and Child E6, E7
CCHIP 2C (only in participating counties, indicator aid code only)
Non-MAGI-Optional Categorical
Aged and Disabled (A&D) Federal Poverty Level (FPL) Program Full Scope: 1H, 6H Restricted: 1U, 6U
Blind FPL Program Full Scope: 2H, Restricted: None
250 Percent Working Disabled Program (250% WDP) 6G
Tuberculosis Program Limited Services: 7H
NON-MAGI-Medically Needy/Medically Indigent
Aged, Blind or Disabled (ABD) Medically Needy (MN) Full Scope: No Share of Cost (SOC) -14, 24, 64, SOC-17, 27, 67 Restricted: No SOC-58, C1, C3, C7, SOC-58, C2, C4, C8 LTC Full Scope: 13, 23, 63 Restricted: No SOC-D2, D4, D6 SOC-D3, D5, D7
Aid to Families with Dependent Children (AFDC) MN Full Scope: No SOC-34 SOC 37 Restricted: No SOC-58, C5 SOC 58, C6
Medically Indigent (MI) Child Full Scope: No SOC-82 SOC-83 Restricted: No SOC-58, C9 SOC-58, D1
MI Pregnant Woman Full Scope: No SOC-86 SOC-87 Restricted: No SOC-58, 5F, D8 SOC-58, 5F, D9
Breast and Cervical Cancer Treatment Program (BCCTP) Federal Full Scope: 0P, 0W Restricted: 0L, 0U, 0V
NON-MAGI (State Only)
BCCTP (State Only) 0R, 0T, 0X, 0Y
MI Long Term Care (State Only) 53
Dialysis Only Program 71
Total Parenteral Nutrition 73
Anti-Rejection Medicine 77

MEDI-CAL HIERARCHY CONTINUED
60-Day Postpartum 76