



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



EDMUND G. BROWN JR.  
GOVERNOR

November 16, 2012

TO: ALL COUNTY WELFARE DIRECTORS  
ALL COUNTY WELFARE ADMINISTRATIVE OFFICERS  
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS  
ALL COUNTY HEALTH EXECUTIVES  
ALL COUNTY MENTAL HEALTH DIRECTORS  
ALL COUNTY MEDS LIAISONS

SUBJECT: Targeted Low-Income Children's Program

Letter No.: 12-33

The purpose of this All County Welfare Directors Letter (ACWDL) is to inform counties of the changes to the Medi-Cal program pursuant to Assembly Bill (AB) 1494 (Chapter 28, Statutes of 2012) which provides for the transition of children from the current Children's Health Insurance Program, known as the Healthy Families Program (HFP), to the Medi-Cal program. Medi-Cal will cover these children under the optional targeted low-income coverage group, pursuant to the federal Social Security Act, Section 1902 (a)(10)(ii)(XIV). For purposes of this guidance, this new coverage group is named the Targeted Low-Income Children's Program (TLICP). Upon the implementation of the transition, occurring in four phases and beginning no sooner than January 1, 2013, the HFP will stop enrolling new children and these children will be subsequently covered under the Medi-Cal program. The Department of Health Care Services (DHCS) intends to begin the transition of the HFP children into the Medi-Cal program no sooner than January 1, 2013. As the children transition to the Medi-Cal program, their Medi-Cal eligibility will be temporarily granted based on their last known annual eligibility date under the HFP. Granting temporary eligibility allows for a smooth transfer to the Medi-Cal program without the need for the family to reapply for Medi-Cal at the time of transition.

TLICP will create a new bright line of income eligibility for children zero to 19 years of age, at 250 percent of the Federal Poverty Level (FPL). The enabling legislation also gives DHCS the ability to implement a premium payment program pursuant to §1916A of the federal Social Security Act for children with incomes greater than 150 percent of the FPL. In accordance with Section 14005.26 of the Welfare & Institutions (W&I) Code, monthly premium amounts shall equal thirteen dollars (\$13) per child with a maximum family contribution of thirty-nine dollars (\$39) per month (i.e. \$13 per month/one child,

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\$26 per month/two children, and \$39 per month/for three or more children) in families with incomes above 150 percent and up to and including 250 percent of the FPL.

Pursuant to ACWDL 91-82, health insurance premiums are not allowed as a deduction against income for members of the Medi-Cal family budget unit; the calculated premiums for TLICP is the result of the eligibility determination and is the Medicaid cost sharing obligation of the family.

The chart below represents the current Medi-Cal FPL, the Medi-Cal FPL for TLICP, and those FPL incomes subject to premium payments.

<b>Age of Child<sup>1</sup></b>	<b>Current Medi-Cal FPL Limits</b>	<b>Medi-Cal Targeted Low-Income Children's Program FPL Limits</b>	<b>Medi-Cal FPL Subject to Premiums</b>
0 – 1	Up to 200 percent	Above 200 percent and up to and including 250 percent of the FPL	Not Applicable
1 – 6	Up to 133 percent	Above 133 percent and up to and including 250 percent of the FPL	Applicable for incomes above 150 percent and up to and including 250 percent of the FPL
6 – 19	Up to 100 percent	Above 100 percent and up to and including 250 percent of the FPL	Applicable for incomes above 150 percent and up to and including 250 percent of the FPL

## **Current Processes**

### Medi-Cal Mail-in and Health-e App Applications

The Single Point of Entry (SPE), administered by MAXIMUS, the administrative vendor under contract with the Managed Risk Medical Insurance Board (MRMIB), receives mailed in and on-line applications. SPE also conducts Medi-Cal Eligibility Data System (MEDS) file clearance of HFP applicants and Medi-Cal screenings for children under age 19. SPE bases the screenings on business rule criteria provided by DHCS. In accordance with DHCS screening criteria, children screened and presumed eligible for no cost, full-scope, Medi-Cal receive accelerated enrollment (aid code 8E) at SPE for Medi-Cal until the county makes a determination of eligibility. MAXIMUS then forwards these applications to the county offices for eligibility determinations based on the child's county of residence.

<sup>1</sup> Eligible up to the month of the 1<sup>st</sup>, 6<sup>th</sup>, or 19<sup>th</sup> birthday; or continues beyond the 1<sup>st</sup>, 6<sup>th</sup>, or 19<sup>th</sup> birthday when in an inpatient status which began prior to the 1<sup>st</sup>, 6<sup>th</sup>, or 19<sup>th</sup> birthday.

### Healthy Families Program

At SPE, MAXIMUS forwards the applications that are not screened for no-cost Medi-Cal to the HFP for an eligibility determination. The administrative vendor enrolls eligible children in HFP health plans and collects health plan premiums for children based on the HFP FPL guidelines.

### County Received Applications

Initial applications received through the county go through file clearance for processing and the county determines Medi-Cal Program eligibility. At the initial Medi-Cal determination of children under the age of 19, the county forwards the application to HFP if the county determines the income is above the FPL limits for no-cost Medi-Cal eligibility.

If at annual Medi-Cal redetermination (RV), the county determines the family to have a share-of-cost (SOC), the worker issues (with parental consent) a one-month extension of no cost Medi-Cal using aid code 7X to the HFP for the Medi-Cal eligible child with a SOC. The county then forwards the child's case information to HFP for a review and eligibility determination.

### Access for Infants and Mothers (AIM)

The AIM Program, established in 1992, provides medically necessary services to pregnant women with incomes between 200 and 300 percent of poverty through participating health plans. Eligibility for the AIM Program requires the pregnant woman to have no maternity insurance, or have health insurance with a high (over \$500) maternity-only deductible, and to have a family income too high to qualify for no-cost Medi-Cal. Babies born to AIM Program subscribers, referred to as "AIM-linked infants", are automatically eligible for enrollment in HFP for one year without review of the family's income. Family income at the first HFP annual review for the baby must be within the AIM Program guidelines for continued HFP eligibility for the second year of coverage. AIM-linked infants enrolled in HFP are subject to the premiums imposed under HFP. Pursuant to federal requirements, children in families with income levels above 250 percent and up to and including 300 percent FPL are not considered to be targeted low-income children for purposes of Medicaid eligibility (Medi-Cal in California).

### **New Processes**

With the exception of the AIM-linked babies as noted below there will be no new enrollments into HFP upon the implementation of transitioning the HFP enrolled children to Medi-Cal. DHCS will contract with MAXIMUS to continue SPE operations. All new applications as well as information received for redeterminations, except as described later in this document, by SPE will be sent to child's county of residence for a Medi-Cal determination.

#### AIM-Linked Infants

The HFP transition of children to Medi-Cal does not change the current policy of ensuring health coverage for all infants with family incomes that meet the income eligibility standard that was in effect in the AIM Program at the time the infant's mother became eligible.

AIM-linked infants with family incomes up to 250 percent FPL will enroll in TLICP. At the end of the 12 month eligibility period, the county redetermines program eligibility. The AIM-linked infant will be disenrolled from Medi-Cal if the family income exceeds 250 percent FPL and the county refers the infant to HFP, using existing bridging processes for such referrals.

HFP will continue to cover all AIM-linked infants at income levels above 250 percent FPL up to 300 percent FPL throughout Fiscal Year 2012-2013, whether they are born in that fiscal year or are in their second year of AIM eligibility. There will be further discussions with the Legislature during the upcoming 2013-2014 Budget Year to address the AIM program. As warranted, DHCS will provide additional updates as they become available on the AIM program.

#### Annual Eligibility Redeterminations (AER) for Transitioning HFP Children

To ensure a seamless process and to minimize impacts to families, MAXIMUS will undertake the following actions during the HFP transition year:

- HFP AERs due in January, February, and March 2013  
Using the existing policies and procedures of the HFP, MAXIMUS will initiate the renewal process for children who have AERs due to take place in January, February, and March of 2013. MAXIMUS has sent or will send HFP renewal packages during the months of October, November, and December 2012 to these families.

If information returns for a child identified to transition during this time period, MAXIMUS will complete the AER process and based on the updated eligibility information, and the child will be placed in the appropriate transition aid code.

The next redetermination for these children is in the corresponding month of 2014 whereby the county will have responsibility for the next redetermination unless there is a change in circumstances. To the extent received by MAXIMUS, they will send reported changes or premium re-evaluations to the county for evaluation and handling, using existing processes or established electronic transmission of information (once processes are operational). The electronic transmission of information between MAXIMUS and the county consortia will come under a separate guidance.

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- Renewals due April 2013 through December 2013

MAXIMUS will send out renewal packages using a modified pre-populated form specific to the Medi-Cal program. The time frame for mailing these Medi-Cal renewal packages will be consistent with the current Medi-Cal processes for sending out renewal requests. Within ten (10) business days, MAXIMUS will review the forms returned by the beneficiary to ensure all forms are returned complete. After making five attempts within the 10 day timeframe, MAXIMUS forwards the forms from the beneficiary to the counties for a determination of completeness using existing mailing processes or establishing electronic transmission of information (once processes are operational). Upon receipt of the documentation from MAXIMUS, the counties will have three (3) business days to determine that the application received was complete and that begins the annual renewal process. In addition, MAXIMUS has the responsibility to include information for the counties related to the number of renewal packages mailed and returned in a transmittal format as confirmation of non-receipt for the county for audit and appeal purposes.

In the event additional information is received by Maximus after the original documents were submitted to the county, MAXIMUS will send the additional information to the county using existing mailing processes or establishing electronic transmission of information (once processes are operational). As previously stated the electronic transmission of information between MAXIMUS and the county consortia will follow in a separate guidance. The counties will use the submitted information and any additional information required to make the Medi-Cal eligibility determination and place the child into the appropriate Medi-Cal aid code (which now includes TLICP) or discontinue the case, if applicable, using the existing Medi-Cal process including the use of SB 87.

Applications received by SPE

MAXIMUS will conduct MEDS file clearance and will review all submitted paper (mail-in) and electronic (Health-e-App) applications for completeness (i.e. all questions are answered, the application is signed and applicable supporting documentation, including income, is included with the application) prior to submission of the information to the county. To the extent the application is not complete, MAXIMUS has twenty (20) calendar days to contact the family to complete the application and/or provide the missing information before submitting the application to the county. To the extent MAXIMUS is unsuccessful in obtaining the required information; MAXIMUS will forward the incomplete application with all the information received. The time expended by MAXIMUS is included as part of the county's first 10-day request for information. The 45-day time clock begins from the date that SPE receives the application and not the date that the county receives the application.

MAXIMUS transmits the information received electronically. If the electronic process is not fully operational at the time of the HFP transition, SPE will send the information using the existing processes that are in place today until implementation of the electronic process.

#### Accelerated Enrollment (AE) at SPE

SPE grants AE to all applications received for children zero up to the month of their 19<sup>th</sup> birthday, which appear eligible for full scope Medi-Cal. AE is temporary fee-for-service, full-scope, no cost Medi-Cal for children under the age of 19 who are new to Medi-Cal, applied for Medi-Cal through SPE, and are likely eligible to Medi-Cal. SPE will continue to use the 8E aid code and will apply DHCS business rules for granting AE to children.

All applicants are eligible for AE except the following. Those:

- Who will be 19 years of age or over in the application month;
- With an active Medi-Cal case (eligibility status code < '999' in current or pending Medi-Cal Eligibility Data System (MEDS) month or in the application month);
- Without California residency;
- Whose application does not provide a county of residence or sufficient address information so that the county of residence can be determined;
- Whose application does not provide enough information so that a client identification number (CIN) can be assigned;
- Who are in the Healthy Families (HF) Bridging (7Y) or Medi-Cal Bridging (7X)<sup>2</sup> programs in the month of or the month prior to the month AE would be established;
- Who screen above 250 percent FPL and do not appear eligible for Medi-Cal;
- Whose application does not provide enough information at screening to establish eligibility; and
- Who have been reported as deceased on MEDS with a death date.

During the time period that the child is granted accelerated enrollment via the SPE, he/she will not be subject to premiums until the county has completed the eligibility determination process.

#### Accelerated Enrollment at Child Health and Disability Prevention (CHDP)

##### Gateway

The current HFP process for women enrolled in AIM is to sign up their babies into HFP right after birth to establish HFP eligibility. Currently there is no automated process to sign up the AIM eligible baby from the date of birth through the CHDP Gateway. If the AIM mom establishes eligibility for her infant through a CHDP provider, the CHDP Gateway establishes eligibility with the date of CHDP enrollment instead of from the infant's date of birth. As noted in the CHDP accelerated eligibility section, by redefining aid code 8X. Babies 0-2, above 250 percent FPL cannot be enrolled into TLICP. The

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<sup>2</sup> Currently counties use aid code 7X to bridge children from Medi-Cal to the HFP. There may be children who were placed in this aid code prior to the effective date of the transition and they would be the subject of this policy.

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CHDP provider will have to refer these infants to HFP so that the HFP can enroll the baby back to the date of birth.

DHCS has redefined the AE aid code, 8X for the CHDP Gateway Program. 8X was previously used to grant AE to the HFP to children through CHDP Gateway. This redefined aid code will now be used by CHDP Gateway to screen children to Medi-Cal under TLICP for children in families with incomes over 150 percent of the FPL. Below is a table defining the CHDP Gateway aid codes effective January 1, 2013.

Aid Code	Description
8U	CHDP Gateway Deemed
8V	CHDP Gateway Deemed SOC
8W	CHDP Gateway Medi-Cal up to 150 percent FPL
8X	CHDP Gateway Medi-Cal above 150 up to and including 250 percent FPL:

The CHDP Gateway application output verification messages will be changed to reflect the new program name and will not reflect eligibility for HFP except as so noted below under the AIM program. These changes at CHDP will be effective upon the implementation of the transition.

During the time period that the child is granted accelerated enrollment via CHDP, he/she will not be subject to premiums until the county has completed the eligibility determination process.

#### Bridging Aid Code 7X– Medi-Cal to HFP

This section pertains to AIM-linked infants only. Counties will need to track children between the ages of 0-2 in each phase of the transition from HFP. To determine if a child is an AIM-linked infant, counties will need their automated system to check for the aid code 0C prior to the transition aid code of 5C or 5D. If the child has 0C prior to the transition aid code, then this is an AIM-linked infant. As mentioned before in the section on AIM these children have eligibility up to 300 percent FPL until the age of 2 to the AIM program.

If at RV, the county determines an AIM-linked child is above 250 percent FPL during their annual Medi-Cal redetermination, the county will need to forward the child's case information back to MAXIMUS for reenrollment to the HF AIM program using the current county process for referrals.

When at AER the family's income exceeds 250 of the FPL and there is an AIM-linked infant in the household, the county may with the current HFP referral process use aid code 7X to bridge the infant to HFP for the continuation of benefits under the HFP program. Note that this bridging applies only to AIM-linked infants and does not apply to

all children under 2 years of age with incomes above 250 percent and up to and including 300 percent of the FPL.

If the AIM-linked child's family income increases prior to the Medi-Cal redetermination or the HFP AER, that infant has coverage under the Continuous Eligibility for Children (CEC) Program.

Request to Add non HFP Child to MC at HFP AER

At any time during the HFP AER, the household requests to add a related child the county will follow the same procedures as they do now when adding family members to the case. ACWDL 11-23 clarifies that a MC 210RV allows the beneficiary to add a person to his/her Medi-Cal case at Annual Redetermination. The county may request additional information/verification of the new person to establish eligibility. Evaluation of Medi-Cal Program eligibility should follow the Medi-Cal hierarchy, which includes TLICP.

Request to Add non-HFP Child prior to HFP Child's AER

Counties would continue to follow the current Medi-Cal application or add person process when the household requests to add a related child. Evaluation of Medi-Cal eligibility should follow the Medi-Cal hierarchy, which includes TLICP. The county shall evaluate the HFP child at the time of the non HFP child's application, to determine Medi-Cal eligibility. If adding the non HFP child to the case results in a change that would otherwise move the HFP child to a Medi-Cal share-of-cost (SOC), premium payment, or program ineligibility, the HFP child will continue with no SOC Medi-Cal until his/her AER date. When the HFP child reaches the end of their AER, the county may then notify the family that this child now has the family SOC, family premium, or is now ineligible.

**Aid Codes**

The side-by-side tables below displays current Medi-Cal FPL Children's Programs aid codes with descriptions and the new corresponding Medi-Cal TLICP aid codes with descriptions of the population that each serve. Five new aid codes were created for the TLICP: H1, H2, H3, H4, and H5.



Current Medi-Cal FPL Children's Programs		New Medi-Cal Targeted Low-Income Children's Program	
Aid Code	Description	Aid Code	Description
47	200 Percent FPL Infant (Income Disregard Program – Infant). Provides full Medi-Cal benefits to eligible infants up to 1 year old or continues beyond 1 year when inpatient status which began before first birthday continues and family income is at or below 200 percent of the FPL.	H1	<p>TLICP for infants. Provides full scope, no-cost Medi-Cal for infants who are U.S. citizens, have satisfactory immigration status, or awaiting citizenship verification<sup>3</sup>. Coverage is up to the month of their first birthday or continues beyond one year when in an inpatient status that began before the first birthday. Family income is above 200 percent and up to and including 250 percent of the FPL. (M-CHIP)</p> <p>Includes infants up to the month of their first birthday from a family with an income above 200 up to and including 250 percent of the FPL, born to a mother enrolled in AIM.</p>
OC	<p>AIM – Infants enrolled in HFP.</p> <p>Infants from a family with an income up to and including 200 percent of the FPL, born to a mother enrolled in AIM. The infant's enrollment in the HF Program is based on their mother's participation in AIM. AIM eligibility is from birth up to 2 years of age.</p>		
72	133 Percent Program Provides full Medi-Cal benefits to eligible children age 1 through age 6 or beyond age 6 when inpatient status began before 6 <sup>th</sup> birthday, continues and family income is at or below 133 percent of the FPL.		
8P	133 Percent Excess Property Child Provides full-scope Medi-Cal benefits to eligible children ages 1 up to 6 or beyond 6 years when inpatient status, which began before 6 <sup>th</sup> birthday, continues, and family income is at or below 133 percent of the FPL.	H2	<p>TLICP provides full scope, no-cost Medi-Cal coverage to children with U.S. citizenship, satisfactory immigration status, or awaiting citizenship verification<sup>4</sup>; ages 1 through the month of the 6<sup>th</sup> birthday or continues when in an inpatient status which began before the 6<sup>th</sup> birthday for family income above 133 percent of FPL up to and including 150 percent of FPL. (M-CHIP)</p>

<sup>3</sup>Refer to All County Welfare Directors Letter 09-65, December 31, 2009, SSN Data Match For Verification Of Citizenship and Identity For Purposes Of Medi-Cal Eligibility

<sup>4</sup> ibid

Current Medi-Cal FPL Programs		New Medi-Cal Targeted Low-Income Children's Program	
Aid Code	Description	Aid Code	Description
7A	100 Percent Child Provides full benefits to otherwise eligible children, ages 6 and up to 19 or beyond 19 when inpatient status began before the 19 <sup>th</sup> birthday and family income is at or below 100 percent of the FPL.	H4	TLICP provides full scope, no-cost Medi-Cal coverage to children with U.S. citizenship, satisfactory immigration status, or awaiting citizenship verification <sup>5</sup> ages 6 through the month of the 19 <sup>th</sup> birthday or continues when in an inpatient status which began before the 19 <sup>th</sup> birthday for family income above 100 percent up to and including 150 percent of the FPL (M-CHIP).
8R	100 Percent Excess Property Child Provides full-scope benefits to otherwise eligible children, ages 6 to and up to 19 or beyond 19 when inpatient status begins before the 19 <sup>th</sup> birthday and family income is at or below 100 percent of the FPL.		

Aid Code	Targeted Low-Income Children's Program - Premium Payment Aid Codes with Description
H3	TLICP – full scope, subject to premium payment. Provides full-scope coverage based on a premium payment to children with U.S. citizenship, satisfactory immigration status, or awaiting citizenship verification <sup>6</sup> from age 1 to the month of their 6 <sup>th</sup> birthday or continues when in an inpatient status which began before the 6 <sup>th</sup> birthday, with family income above 150 percent up to and including 250 percent of the FPL. (M-CHIP)  Includes infants age 1 up to the month of their 2 <sup>nd</sup> birthday from a family with an income above 200 up to and including 250 percent of the FPL, born to a mother enrolled in AIM.
H5	TLICP – full scope, subject to premium payment. Provides full-scope coverage based on a premium payment to children with U.S. citizenship, satisfactory immigration status, or awaiting citizenship verification <sup>7</sup> from age 6 to the month of their 19 <sup>th</sup> birthday or continues when in an inpatient status which began before the 19 <sup>th</sup> birthday, with family income above 150 percent up to and including 250 percent of the FPL. (M-CHIP)

<sup>5</sup> ibid<sup>6</sup> ibid<sup>7</sup> ibid

### **Effective Date**

The effective date for implementation of aid codes H1, H2, H3, H4, and H5, will be upon implementation of the transition but no sooner than January 1, 2013.

### **Retroactive Coverage**

Retroactive eligibility is not available for TLICP aid codes H1, H2, H3, H4, and H5 for the months of October, November, and December 2012 to cover medical expenses in the three months prior to the implementation date of the program. Therefore, between January and March 2013, when a family with children in these aid codes requests Medi-Cal retroactive coverage, counties need to assess eligibility for other Medi-Cal programs in existence on October, November, or December 2012<sup>8</sup>. Eligibility for these programs will involve the need to assess for resources thus this additional information will be needed from families if retroactive eligibility is requested.

Retroactive eligibility will phase in for the TLICP aid codes of H1, H2, H3, H4, and H5 over the first three months as follows:

Individuals eligible for H1, H2, H3, H4 or H5 in:	Retro coverage for H1, H2, H3, H4 or H5
January 2013	No coverage prior to January 2013
February 2013	January 2013
March 2013	January and February 2013
April 2013	January, February, and March 2013

Beginning April 2013, counties will assess retroactive eligibility for all Medi-Cal programs including TLICP.

### **Medi-Cal Delivery Systems**

For new applications, counties will continue to utilize existing enrollment processes for individuals subject to mandatory managed care enrollment, based on their county of residence. All other individuals will be covered by the Medi-Cal Fee-for-Service (FFS) delivery system. Children transitioned to Medi-Cal from the HFP will be enrolled into managed care or FFS, based on their applicable transition phase in accordance with ACWDL 12-30, page 2.

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<sup>8</sup>Retroactive eligibility is not available through the HFP as they cannot accept new enrollees after January 1, 2013.

## **Premiums**

Pursuant to AB 1494, W&I Code §14005.26, DHCS shall exercise the option pursuant to Section 1916A of the federal Social Security Act (42 U.S.C. Section 1396o-1) to impose premiums for individuals with family income above 150 percent and up to and including 250 percent of the FPL. This includes the application of an income disregard between 200 and 250 percent of the FPL. Effective January 1, 2013, when the county worker processes an application, whether forwarded from SPE or received directly at the county or completes an annual redetermination, if the county worker determines the family income is above 150 percent the FPL, a notification will be made to MAXIMUS for collection of the premium and non-eligibility case maintenance. DHCS has a “one-way” reconciliation process with MAXIMUS – a monthly extract of all HF records in MEDS is sent to MAXIMUS.

In order to facilitate premium payment reporting to MAXIMUS, DHCS will add premium payment aid codes (5D, H3, H5) to the HF aid codes that are extracted from MEDS for MAXIMUS. Therefore, as counties report premium payment aid codes (H3 and H5) to MEDS (new eligibility, ongoing eligibility and terminated eligibility), these updates are then reported to MAXIMUS via the HFRECON file. The frequency of the MEDS HFRECON file may need to change from monthly to semi-monthly.

The county eligible worker will maintain and perform all eligibility-related case maintenance for children with incomes up to 150 percent of the FPL. These cases will not be subject to premiums and the county should not forward information to MAXIMUS for these children.

Because the corporate title of MAXIMUS will not be used on any materials going to beneficiaries, when discussing or referencing any needed contact information for a beneficiary on matters pertaining to premiums or premium payments, such references shall be to the “Medi-Cal Premium Payment Section.”

Beneficiaries will make payment arrangements with the Medi-Cal Premium Payment Section at MAXIMUS. The Medi-Cal Premium Payment Section at MAXIMUS has the responsibility for payment arrangements, acceptable payment methods, billing cycles, premium discounts, refunds, etc. In addition, the Medi-Cal Premium Payment Section at MAXIMUS provides an instruction about premium payment policies and how MAXIMUS handles premium payments for families subject to premiums. The county will not be a designated entity to accept premium payments. If a beneficiary has a question about the premium payment, the beneficiary is to be directed to contact the Medi-Cal Premium Payment Section at MAXIMUS concerning their premium payments. This contact information will be noted on their premium informing materials and billing statements. In the event an urgent question is received by the county concerning payment of premiums, the county will have a liaison within the Medi-Cal Premium Payment Section and may communicate with the liaison on behalf of the beneficiary, within the administration of the Medi-Cal Program.

### MAXIMUS Responsibility

MAXIMUS has responsibility for the following:

- Maintaining non-eligibility case files of beneficiaries with premiums and scheduling payment notifications.
- Collecting premiums by
  - Cash, check, Western Union
  - Electronic funds transfer, and
  - Credit card transactions (one-time or recurring).
- Establishing and maintaining billing procedures:
  - Billing notices,
  - Billing reminders, and
  - Applying premium discounts.
- Sending notices of overdue payments, missed payments, etc.
  - Follow up calls/mailings.
- Notifying counties of past due payments to trigger the county's process for disenrollment/noticing if applicable (expiration of grace period at 60 days).
- Providing lists to counties of clients with payments in arrears, those reconciling past due payments, and those who reconciled missed payments.
- Granting refunds when applicable.
- Providing a means to settle billing disputes that are not elevated to a state hearing process.
- Initiating premium collection or premium reimbursements following a state hearing or appeal process.
- Closing the MAXIMUS premium case upon direction from counties when the county reports income below 150 percent FPL, the beneficiary is no longer eligible for Medi-Cal, or no longer required to pay premiums.

### Premium Collection

When a beneficiary misses a premium payment and falls behind in making the family contributions for thirty (30) calendar days, the Medi-Cal Premium Payment Section will send an overdue reminder notice to the family regarding payment due (monthly billing statement). The notice and billing statement specifies the amount past due, payment date, and potential discontinuance language for non-payment of premiums. If the beneficiary does not make a payment on the past due amount within an additional fifteen (15) calendar days, the Medi-Cal Premium Payment Section sends an additional reminder notice, including a monthly billing statement, which identifies the amount past due, payment due date, and potential disenrollment language for failure to pay premiums. For any collected past due premiums, they will be applied to the outstanding balance owed. For example, if a family pays \$26 dollars per month in premiums, has a balance due of \$78 to cover three months in arrears, and they pay \$52, the \$52 will be applied to the two most outstanding months. The Medi-Cal Premium Payment Section

shall also contact the beneficiary by telephone to remind the beneficiary of the impending disenrollment. These steps taken by the Medi-Cal Premium Payment Section are in addition to the steps taken by the county in the SB 87 process (and may be taken simultaneously) for non-payment of premiums.

The Medi-Cal Premium Payment Section will notify the county when the beneficiary has not paid premiums for sixty (60) days and there was no response to the nonpayment notice from the beneficiary. When the county receives the information from the Medi-Cal Premium Payment Section, the county initiates the SB 87 process for the potential discontinuation to determine if there is eligibility for another Medi-Cal program. If the county determines there is no other eligibility for Medi-Cal other than paying a premium, the county discontinues the case with a timely notice.

#### Premium Collection for AIM-linked children

AIM-linked infants, because of existing program rules, have a ninety (90) day grace period which will be used for those who transition to Medi-Cal. The Medi-Cal Premium Payment Section will notify the county when the beneficiary has not paid premiums after the grace period of 90 days and there was no response to the nonpayment notice from the beneficiary. When the county receives the information from the Medi-Cal Premium Payment Section, the county initiates the SB 87 process to determine if there is eligibility for another Medi-Cal program. If after the SB 87 process the county determines there is no other eligibility for Medi-Cal other than paying a premium, the county discontinues the case with a timely notice.

### **Hearing Process**

Counties will continue to follow the current hearing process when the beneficiary has an eligibility dispute. Please refer to ACWDLs 80-48, 85-02, 87-02 and any other pertinent ACWDL for hearings.

### **Eligibility for New Applicants**

#### Medi-Cal Hierarchy

Once the county completes the Medi-Cal eligibility process, children will be placed in the appropriate Medi-Cal program according to the Medi-Cal Program hierarchy.

Because TLICP is an optional program (pursuant to federal Medicaid provisions) it falls after the FPL programs (which are mandatory coverage groups under federal Medicaid requirements). The TLICP will coincide with the 250 percent Working Disabled, the Aged and Disabled FPL and the FPL Blind programs, which are similarly, situated optional coverage groups.

### Continuous Eligibility for Children

Pursuant to 1902(e)(12) of the federal Social Security Act, States are permitted to implement a period of Continued Eligibility for Children (CEC) under an age specified by the State, but not to exceed 19 years of age. Continuous eligibility ends with the earlier of the time the individual exceeds the state-established age, the end of a period (not to exceed 12 months) following initial ongoing eligibility or at the annual Medi-Cal RV date. The child has eligibility to CEC, except for:

- the death of the child,
- when child reaches the age limit,
- loses California residency, or
- the child/guardian or representative of the child requests disenrollment.

CEC also protects the child from nonfinancial reasons for discontinuance, even if those changes adversely affect other family members.

Counties should be aware that there are two aid codes designated for CEC; 7J and 7K. Please refer to the CEC ACWDLs. The following examples describe how CEC covers transitioning and transitioned children to Medi-Cal.

Children who were previously eligible to a no cost or share-of-cost Medi-Cal aid code and now are eligible under the TLICP will be subject to the same policies pertaining to continuous eligibility for children pursuant to ACWDLs 01-01 and 08-55. The process for determining CEC is no different. If a change happens to a family currently eligible for Medi-Cal and that change causes the family to exceed 150 percent FPL the child has CEC coverage until the Medi-Cal RV.

AIM linked children on Medi-Cal in aid code 0C whose incomes increase above 250 percent FPL; see section in this ACWDL on the Bridging Aid Code 7X Medi-Cal to Healthy Families Program.

### **Transitioning From Aid Codes 5C/5D to the H Series Aid Codes**

#### Medi-Cal case with other family members and Medi-Cal redetermination (RV) prior to the HFP AER

When the Medi-Cal RV results in a change that would move the HFP child to a Medi-Cal share-of-cost (SOC), premium payment, or program ineligibility, the child continues with no SOC Medi-Cal until his/her AER date. When the child reaches the end of their AER, the county may then notify the family that this child now has the family SOC, family premium, or is now ineligible.

#### HFP AER prior to Medi-Cal RV

If the transitioning child is in a Medi-Cal family in the TLICP and the child's HFP AER occurs prior to the family's Medi-Cal RV, the county **may** add the child to the case and evaluate the Medi-Cal case with the child without having to wait for the Medi-Cal RV

date. However, this does not mean that the county moves the Medi-Cal RV date. The case keeps its Medi-Cal RV date and the county does a redetermination for Medi-Cal at that time.

#### No Medi-Cal Case

As stated in ACWDL 12-30, if a transitioning HFP child in aid code 5C or 5D does not have a Medi-Cal case; the county is not required to take an action until the HFP AER date. At the HFP AER date, the county will open a Medi-Cal case and determine if the child is Medi-Cal eligible. If there are other family members and the members request Medi-Cal then the county follows the same procedures as now when adding family members to the case.

CEC will **NOT** cover nonpayment of premiums as outlined in the premium collection section of this letter. Premiums are a condition for eligibility, failure to pay premiums and the inability to be found eligible under any other Medi-Cal program will result in program disenrollment similar to that of residency.

#### **Reporting**

Under the requirement by AB 1494, the county must process 90 percent of the aforementioned cases within 10 working days of receiving the applications from SPE. For purposes of this performance standard the 10-day processing time begins upon receipt of the application from SPE, and is not based on the initial application date.

For applications that are submitted directly to the counties, the county will continue to be required to meet the current performance standards as indicated in ACWDL 12-29.

Another provision of W&I Code §14005.26 also requires that when the county receives an application with children that also includes adults and the adults require additional information beyond the information provided for the children, the county shall process the eligibility for the children without delay while gathering the necessary information to process eligibility for the adults.

Note that the Transition ACWDL (12-30) erroneously indicated that data reports required by law included the reporting of information on annual redetermination forms. This is not the case. Please refer to ACWDL 12-29. An erratum will be issued separately.



## **Notices of Actions and SB87**

### Approval

When the county determines that a child has eligibility to TLICP, the approval Notice of Action (NOA) should include the following language: in its entirety.

Beginning, \_\_\_\_ (date) \_\_\_\_\_ your child(ren) listed on this notice is eligible to receive full-scope Medi-Cal benefits. Your eligibility is determined by your income, in addition to other program requirements.

If your family's income or circumstances change, you must report this to your worker within ten (10) days. The name and phone number of your worker is listed above on this notice.

The laws which require this action are Welfare & Institutions Code Section 14000, 14005, 14016, 14016.2 14023, 14023.7 and 14124.90.

### Approval with Premiums

When the county determines that a child has eligibility to the TLICP with a premium, the approval Notice of Action (NOA) should include the following language in its entirety:

Beginning, \_\_\_\_ (date) \_\_\_\_ your child(ren) listed on this notice has full scope Medi-Cal benefits. You must pay a monthly premium for the child(ren) listed on this notice in order to remain eligible for this Medi-Cal benefit. The monthly premium for a child is determined by income.

You will receive a separate letter and billing statement from the Medi-Cal Premium Payment Section with the monthly premium amount you must pay and your payment options. To continue your enrollment under this program, you must pay the monthly premium that is due.

If your family's income or circumstances change, you must report this to your worker within ten (10) days. The name and phone number of your worker is listed above on this notice.

The laws which require this action are Welfare & Institutions Code Section 14005.26.

November 16, 2012

Denial/Discontinuances

When the county denies an application or determines that a child no longer has eligibility to TLICP with or without a premium, the denial or discontinuance Notice of Action (NOA) should include the following language in its entirety:

- ☐ Your application for Medi-Cal, dated \_\_\_\_\_,  
has been denied (Month Day Year)
- ☐ Your child's eligibility to receive Medi-Cal will be discontinued effective the  
last day of \_\_\_\_\_.  
(Month Day Year)

**The reason for this denial/discontinuance is:**

Use current available language and enter the current language reason for denial when FPL is 150 percent FPL and below: such as:

"Your family's income is over the allowable limit,"

**For discontinuance for non-payment of premiums:**

Premiums have not been paid for the child named above, for two consecutive months. After case evaluation, the child was not found eligible for any other Medi-Cal program. Therefore, your child's Medi-Cal eligibility will be discontinued.

The regulations which require this action are (please see below).

If you have any questions about this action or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone your worker. Your worker's name and telephone number is above. If you wish to pay the premiums and remain eligible for Medi-Cal, please contact the Medi-Cal Premium Payment Section at (800) 880-5305 to arrange for premium payments.

Please remember that this action pertains only to the circumstances you reported to us and that you may reapply at any time.

November 16, 2012

#### Denial/Discontinuance Regulations

When the action is a denial, use the current appropriate regulation depending upon the denial reason. For example, a child that is over income for TLICP and whose family does not wish to provide property information would be denied because, *“There is insufficient information available to make an eligibility determination, after the county department has made a reasonable effort to obtain the necessary information.” This language is not meant to replace the current language for failure to provide. It is only a placeholder.*

In this case the regulation is 22 CFR 50175.

When the action is discontinuance from the TLICP, the law which governs the action is Welfare and Institutions Code, Section 14005.26

#### **Contacts**

If you have any questions concerning this letter or require additional information pertaining to deemed eligibility of children or this ACWDL, please contact Ms. Sherilyn Walden at [Sherilyn.Walden@dhcs.ca.gov](mailto:Sherilyn.Walden@dhcs.ca.gov) or call (916) 552-9472.

Original signed by

Azadeh Fares, Chief (Acting)  
Medi-Cal Eligibility Division