CCALAC
Community Clinic Association of Los Angeles County

2024 Enrollment Refresher Training

October 29, 2024

Presented by
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Member Driven. Patient Focused.

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Community Clinic Association of Los Angeles County

Maternal and Child Health Access

Through direct support, individual advocacy, policy change and health care workforce transformation,
MCHA is building a California where women, pregnant people and families are supported, and everyone can be healthy.
www.mchaccess.org

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Income Guidelines

Effective January 1, 2024 through December 31, 2024 for MAGI Programs
Non-MAGI income levels effective April 1, 2024 through March 31, 2025

Number Persons	**Medi-Cal** Maintenance Need Level to calculate Share-of-Cost (SOC) and Non-MAGI Medically Needy	100% **Federal Poverty Level**	109% **Medi-Cal,** MAGI Parents and & Caretaker Relatives*	**138% FPL Medi-Cal** MAGI Adults* 19-64 & Non-MAGI Aged & Disabled**+	**213% FPL Medi-Cal,** MAGI, Pregnancy	250% **Medi-Cal,** Non-MAGI, 250% FPL Working Disabled **Covered CA** Cost-Sharing Reductions	**266% FPL Medi-Cal,** MAGI -TLICP Children 0 to 19 Children's Presumptive Eligibility (CPE)	**322% FPL** Medi-Cal Access Program **(MCAP)** 214 - 322% FPL and MCAP Infants Medi-Cal with income up to 322% FPL	**400% FPL Covered CA** Premium Tax Credits*
1	$600	$1255	$1368	$1732		$3138	$3339		$5020
2	$934+	$1704	$1858	$2352	$3630	$4260	$4533	$ 5487	$6816
3	$934	$2152	$2346	$2970	$4584	$5380	$5725	$ 6930	$8608
4	$1100	$2600	$2834	$3588	$5538	$6500	$6916	$ 8372	$10400
5	$1259	$3049	$3324	$4208	$6495	$7623	$8111	$ 9818	$12196
6	$1417	$3497	$3812	$4826	$7449	$8742	$9303	$ 11261	$13988
Additional person, add:	$14	$449	$ 490	$ 620	$957	$1123	$1195	$1446	$1796
	+Pregnant person or adult and one child use: $750, 2 adults use: $934			+New Non-MAGI Income limits are effective 4/1/24					*People with income over 400% FPL may qualify for subsidies to lower premiums to 8.5 % of income

Medi-Cal Program Eligibility

- California Residency -
  - Definition- I live and intend to reside (live) in California, or
    I live and work or intend to work in California

- Income

California Eliminated Medi-Cal's Asset Test on January 1, 2024!

Medi-Cal, MAGI Income

Modified Adjusted Gross Income (MAGI)

Income Calculation for people under age 65 without Medicare.

Taxable Income, (**Adjusted Gross Income** found on line 11 on IRS Form 1040)

PLUS, the following incomes if your client has them:

Tax Exempt Interest Income

- **Non-Taxable SS Benefits**
- **Foreign Earned Income IRS - f2555 = MAGI**

Not all income types are taxable!
www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/Co-OPS-Sup/Income_Deductions_Chart_010119.pdf

Medi-Cal, Non-MAGI Income Deductions

For People aged 65 and older or Disabled of any age with Medicare

From **Unearned** Income:

Subtract $20.00

Unearned Income:
Social Security Checks
Pension
Rental income

From **Gross Earned** Income:

1. Subtract $65.00
2. Divide the result by 2

Earned Income:
Employment

Medi-Cal Renewals

Home / Keep Your Medi-Cal

Annual Redetermination Sequencing of Activities

85 Days Prior: Ex-Parte Review Completed

60-75 Days Prior: Annual Renewal Packet Mailed (when applicable)

10 Days Prior: Notice of Action Sent

Last Day of Eligibility: Final Day of Eligibility for Discontinued Beneficiaries

Ex-Parte Review

Before a renewal is sent, an internal review, called Ex-Parte is conducted to see if there is information available to auto-renew the Medi-Cal case.

- Information or verification in the beneficiary's Medi-Cal, CalWORKs, and CalFresh case files.
- Information or verification accessed through any available electronic databases or electronic verification.

Cases that are auto-renewed do not require any action from the client.

Notice of Action - Snippet

"Your Medi-Cal is renewed for the next year. We checked to see if you can still get Medi-Cal. We must check once a year. To decide, we used information you gave us or that is available to us. Based on this information, you will have Medi-Cal for the next year. We will check again in one year to see if you can keep getting Medi-Cal."

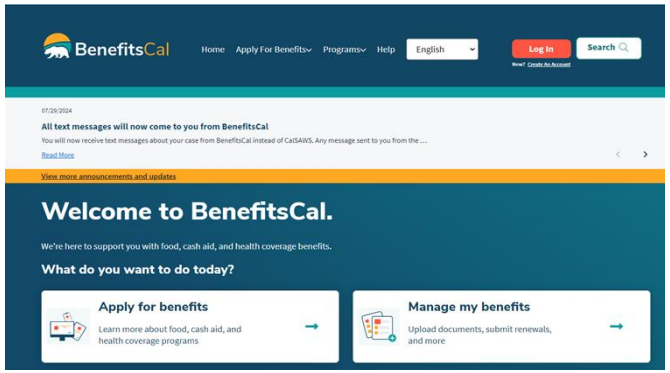
Statewide Ex-Parte Rate

- Prior to March 2020, California had an average 41% auto ex-parte rate statewide.
- August 2024 renewals - auto ex-parte success rate was 69.5% statewide.

Auto-Renewal Unsuccessful

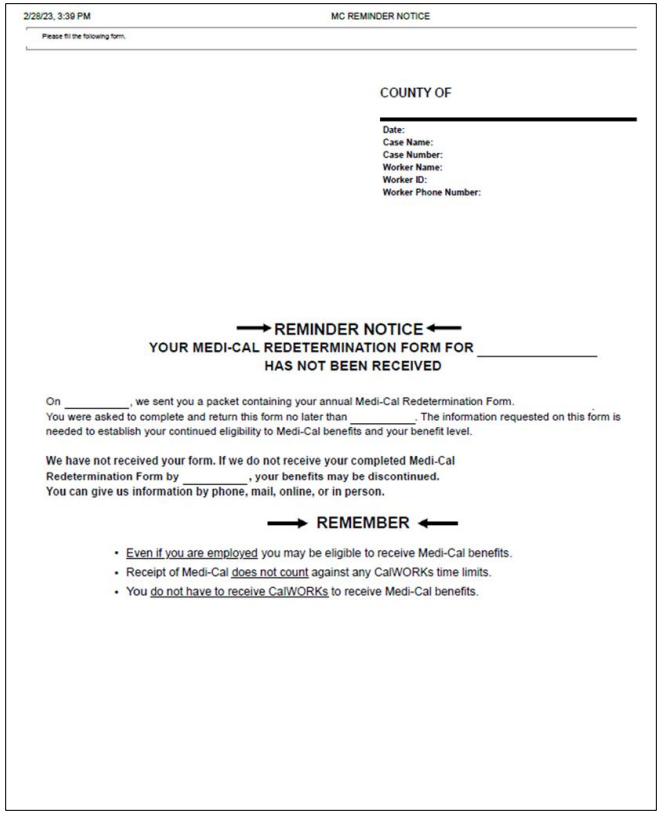
- Pre-populated Medi-Cal Renewal Form is mailed to clients who did not Auto-Renew.
- Mailed in a yellow envelope

- Renewal forms can be completed online in BenefitsCal.com
  Note: if you create an account and link a case, it may take up to 24 hours for the redetermination to show up in the system.



Reminder Notice

An additional phone contact is required before the 10-day notice is mailed out.



2/28/23, 3:39 PM MC REMINDER NOTICE

Please fill the following form.

COUNTY OF

Date:
Case Name:
Case Number:
Worker Name:
Worker ID:
Worker Phone Number:

→ REMINDER NOTICE ←
YOUR MEDI-CAL REDETERMINATION FORM FOR _____
HAS NOT BEEN RECEIVED

On _____, we sent you a packet containing your annual Medi-Cal Redetermination Form.
You were asked to complete and return this form no later than _____. The information requested on this form is needed to establish your continued eligibility to Medi-Cal benefits and your benefit level.

We have not received your form. If we do not receive your completed Medi-Cal Redetermination Form by _____, your benefits may be discontinued.
You can give us information by phone, mail, online, or in person.

→ REMEMBER ←

- Even if you are employed you may be eligible to receive Medi-Cal benefits.
- Receipt of Medi-Cal does not count against any CalWORKs time limits.
- You do not have to receive CalWORKs to receive Medi-Cal benefits.

10-day Termination Notice of Action

Request State Fair Hearing before the negative action occurs.

- Ask for "**Aid Paid Pending**" Benefits will continue pending review (Aid Paid Pending) if the hearing is filed within 10 days of receiving the NOA. This process allows the client to continue receiving services while the case is being reviewed.

90-day Cure Period

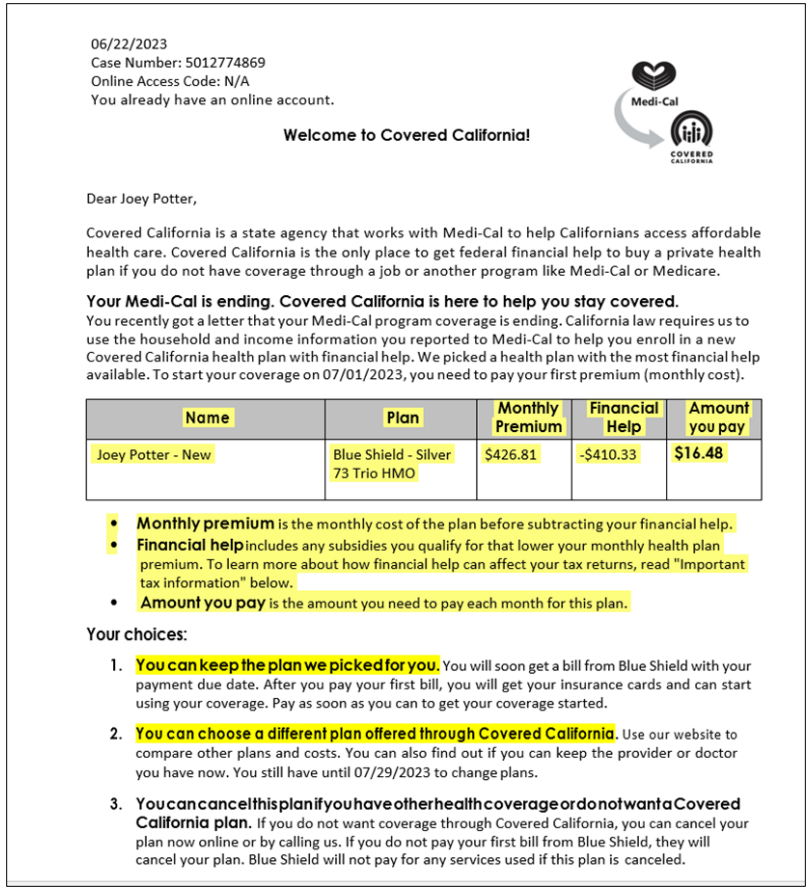
- When Medi-Cal ends, people have 90 days to turn in missing renewal info.
- County must accept info. as timely received and restore Medi-Cal without a gap in coverage.

https://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx

Over Income for Medi-Cal

Individuals no longer eligible for Medi-Cal due to excess income will be forwarded to Covered California.

- Clients are placed into a Silver metal health plan but have the option to change mental level and health plan as they wish.
- Clients have a 60-day window to enroll into Covered California.



06/22/2023
Case Number: 5012774869
Online Access Code: N/A
You already have an online account.

Medi-Cal
COVERED CALIFORNIA

Welcome to Covered California!

Dear Joey Potter,

Covered California is a state agency that works with Medi-Cal to help Californians access affordable health care. Covered California is the only place to get federal financial help to buy a private health plan if you do not have coverage through a job or another program like Medi-Cal or Medicare.

Your Medi-Cal is ending. Covered California is here to help you stay covered.
You recently got a letter that your Medi-Cal program coverage is ending. California law requires us to use the household and income information you reported to Medi-Cal to help you enroll in a new Covered California health plan with financial help. We picked a health plan with the most financial help available. To start your coverage on 07/01/2023, you need to pay your first premium (monthly cost).

Name	Plan	Monthly Premium	Financial Help	Amount you pay
Joey Potter - New	Blue Shield - Silver 73 Trio HMO	$426.81	-$410.33	**$16.48**

- **Monthly premium** is the monthly cost of the plan before subtracting your financial help.
- **Financial help** includes any subsidies you qualify for that lower your monthly health plan premium. To learn more about how financial help can affect your tax returns, read "Important tax information" below.
- **Amount you pay** is the amount you need to pay each month for this plan.

Your choices:

1. **You can keep the plan we picked for you.** You will soon get a bill from Blue Shield with your payment due date. After you pay your first bill, you will get your insurance cards and can start using your coverage. Pay as soon as you can to get your coverage started.
2. **You can choose a different plan offered through Covered California.** Use our website to compare other plans and costs. You can also find out if you can keep the provider or doctor you have now. You still have until 07/29/2023 to change plans.
3. **You can cancel this plan if you have other health coverage or do not want a Covered California plan.** If you do not want coverage through Covered California, you can cancel your plan now online or by calling us. If you do not pay your first bill from Blue Shield, they will cancel your plan. Blue Shield will not pay for any services used if this plan is canceled.

Covered California Open Enrollment

Covered California

Covered California – DACA

- On May 3, 2024, the U.S. Department of Health and Human Services, published a final rule to modify the definition of "lawfully present" applicable to eligibility for enrollment in a Qualified Health Plan (QHP) through the Health Insurance Marketplace so that DACA recipients were no longer excluded from the definition.
- This rule will allow DACA recipients enroll through the Marketplace and be eligible for Advanced Premium Tax Credits (APTCs) and Cost Sharing Reductions (CSRs) starting during this year's open enrollment: November 1, 2024.
- Additionally, DACA recipients who apply for coverage through a Special Enrollment Period during November 2024 can have their Marketplace coverage begin as early as December 1, 2024
- With this status change, DACA recipients are subject to the state individual health coverage mandate.

Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/hhs-final-rule-clarifying-eligibility-deferred-action-childhood-arrivals-daca-recipients-and-certain

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Covered California 2025

- With income over 138% of the FPL beneficiaries are eligible for Advance Premium Tax Credits (APTC) /Subsidies
- Above 138% to 250% of the FPL = Cost Sharing Reductions, lower deductibles and co-pays (Enhanced Silver Plans)

Household Income Eligibility by Percentage of Federal Poverty Level (FPL)	2025 California Enhanced Cost-Sharing Reduction Product
100% up to 150%	Silver 94
Above 150% up to 200%	Silver 87
Above 200% up to 250%	Silver 73
Above 250%	Silver 73
American Indian/Alaska Native Above 300%	Silver 73

COVERED CALIFORNIA

2025 Patient-Centered Benefit Designs and Medical Cost Shares

Benefits in blue are NOT subject to a deductible. Benefits in blue with a white corner are subject to a deductible after the first three visits.

Coverage Category	Minimum Coverage	Bronze	Silver	Silver 73 CA Enhanced CSR	Silver 87 CA Enhanced CSR	Silver 94 CA Enhanced CSR	Gold	Platinum
Percent of cost coverage	Covers 0% until out-of-pocket maximum is met	Covers 60% average annual cost	Covers 70% average annual cost	Covers 73% average annual cost	Covers 87% average annual cost	Covers 94% average annual cost	Covers 80% average annual cost	Covers 90% average annual cost
Cost-sharing Reduction Single Income Range	N/A	N/A	N/A	>$30,120 (Above 200% FPL)	$22,591 to $30,120 (>150% to ≤200% FPL)	up to $22,590 (100% to ≤150% FPL)	N/A	N/A
Free Preventive Care Visit	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care Visit	After first 3 non-preventive visits, full cost per instance until out-of-pocket maximum is met	$60	$50	$35	$15	$5	$35	$15
Urgent Care		$60	$50	$35	$15	$5	$35	$15
Specialist Visit	Full cost per service until out-of-pocket maximum is met	$95*	$90	$85	$25	$8	$65	$30
Emergency Room Facility		40% after deductible is met	$400	$350	$150	$50	$330	$150
Laboratory Tests		$40	$50	$50	$20	$8	$40	$15
X-Rays and Diagnostics		40% after deductible is met	$95	$95	$40	$8	$75	$30
Imaging			$325	$325	$100	$50	$75 copay or 25% coinsurance***	$75 copay or 10% coinsurance***
Tier 1 (Generic Drugs)	Full cost per script until out-of-pocket maximum is met	$19	$18	$15	$5	$3	$15	$7
Tier 2 (Preferred Drugs)		40% up to $500 per script after drug deductible is met	$60**	$55	$25	$10	$60	$16
Tier 3 (Non-preferred Drugs)			$90**	$85	$45	$15	$85	$25
Tier 4 (Specialty Drugs)			20% up to $250** per script	20% up to $250 per script	15% up to $150 per script	10% up to $150 per script	20% up to $250 per script	10% up to $250 per script
Medical Deductible - The amount you pay before the plan pays	N/A	Individual: $5,800 Family: $11,600	Individual: $5,400 Family: $10,800	N/A	N/A	N/A	N/A	N/A
Pharmacy Deductible - The amount you pay before the plan pays	N/A	Individual: $450 Family: $900	Individual: $50 Family: $100	N/A	N/A	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	$9,200 individual $18,400 family	$8,850 individual $17,700 family	$8,700 individual $17,400 family	$6,100 individual $12,200 family	$3,000 individual $6,000 family	$1,150 individual $2,300 family	$8,700 individual $17,400 family	$4,500 individual $9,000 family

The Newborn Gateway

- When a mother has Medi-Cal for the delivery, her newborn is automatically “deemed eligible” (DE) for Medi-Cal from the date of birth continuously to the first birthday, without needing to submit a Medi-Cal application.
- Infants whose mothers had coverage under the Medi-Cal Access Program (MCAP, income over 213% up to and including 322% of poverty) will also qualify for Medi-Cal or the Medi-Cal Access Infants Program (MCAIP)1 until age one without an application.

As of July 1st, 2024 hospitals and all other birth settings for Medi-Cal or MCAP deliveries are required to report births of newborns deemed eligible for Medi-Cal or Medi-Cal Access Program (MCAP) within 72 hours of birth or 24 hours of discharge from the hospital.

- Unique Medi-Cal/MCAIP number issued in real time
- The hospital or other birth setting must print the confirmation page with the newborn’s unique number and give it to the family.
- If the enrollment takes place after the mother and baby have left, the hospital or other provider must mail confirmation print out to the family. a copy of the eligibility

Newborn Gateway Issues

- Names not correct the Beneficiary Identification Card (BIC)
- Baby Ramirez is listed on the BIC
- Families have no idea - “what’s the newborn gateway?”

For Medi-Cal Cases: Los Angeles County Infant Registration Line (833) 735-9359

For MCAP Cases: These cases are held by the state, not county, call (800) 433-2611

Kaiser Community Health Care Program

The Community Health Care Program (CHCP) is for California residents who don't have access to any other health coverage, including Medi-Cal, Medicare, a job-based health plan, or coverage through Covered California.

- Enrolled in the Kaiser Permanente Platinum 90 HMO plan.
- Pay no monthly premium.
- Pay no of pocket costs for most covered services at Kaiser Permanente facilities.

Learn about Your Community Health Care Program Benefits

The Community Health Care Program (CHCP) provides health coverage for qualifying CA residents who don't have access to other health coverage.

CHCP members:

- Are enrolled in the Kaiser Permanente Platinum 90 HMO plan.
- Pay no monthly premium.
- Pay no of pocket costs for most covered services at Kaiser Permanente facilities.

Questions about Kaiser Permanente's Community Health Care Program? Call us toll free at

1-800-464-4000
TTY users call 711
24 hours a day
7 days a week
(closed major holidays)

Or visit your closest Kaiser Permanente facility

https://charitablehealth.kaiserpermanente.org/california/apply-now/

L. A. County Ability to Pay Program

For LA County residents, the "Ability to Pay Program" or "ATP".

It is no cost (free) for patients with income at or under 200% Federal Poverty Level (FPL) and a reduced cost, sliding scale for those over 200% FPL

Health Services
LOS ANGELES COUNTY

Ability To Pay (ATP) Program Cost Table
Effective 04/1/2024

STEP 1: Find your household size (please include all adults and children who live with you).

STEP 2: Next, find your monthly gross income amount under one of the FPL levels.

STEP 3: Follow the column down to the bottom chart to find out how much you will be asked to pay according to your household size and income for outpatient & emergency room (monthly cost), and inpatient services (per admission cost).

Federal Poverty Levels (FPL)	< = 200% FPL	201-300% FPL		301-350% FPL		351-400% FPL		401-500% FPL		501-600% FPL		601 +
Household Size	Less than or equal	More than	Less than	More than	Less than	More than	Less than	More than	Less than	More than	Less than	More than
1	$2,510	$2,511	$3,765	$3,766	$4,393	$4,394	$5,020	$5,021	$6,275	$6,276	$7,530	$7,531
2	$3,408	$3,409	$5,112	$5,113	$5,964	$5,965	$6,816	$6,817	$8,520	$8,521	$10,224	$10,225
3	$4,304	$4,305	$6,456	$6,457	$7,532	$7,533	$8,608	$8,609	$10,760	$10,761	$12,912	$12,913
4	$5,200	$5,201	$7,800	$7,801	$9,100	$9,101	$10,400	$10,401	$13,000	$13,001	$15,600	$15,601
5	$6,098	$6,099	$9,147	$9,148	$10,672	$10,673	$12,196	$12,197	$15,245	$15,246	$18,294	$18,295
6	$6,994	$6,995	$10,491	$10,492	$12,240	$12,241	$13,988	$13,989	$17,485	$17,486	$20,982	$20,983
7	$7,890	$7,891	$11,835	$11,836	$13,808	$13,809	$15,780	$15,781	$19,725	$19,726	$23,670	$23,671
8	$8,788	$8,789	$13,182	$13,183	$15,379	$15,380	$17,576	$17,577	$21,970	$21,971	$26,364	$26,365
9	$9,684	$9,685	$14,526	$14,527	$16,947	$16,948	$19,368	$19,369	$24,210	$24,211	$29,052	$29,053
10	$10,580	$10,581	$15,870	$15,871	$18,515	$18,516	$21,160	$21,161	$26,450	$26,451	$31,740	$31,741
Outpatient & Emergency Services (Monthly Cost)	$0	$20		$50		$80		$355		$435		$485
Inpatient Services (Per Admission Cost)	$0	$200		$700		$1,200		$2,500		$3,000		$3,500

DHS Policy 515 Financial Assistance Programs and Charity Care Policy details the Financial Assistance Programs (FAPs), requirements, and guidelines.

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Thank You!

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