

Chapter 17: Other Related (non-Medi-Cal) Programs

If a person or family is not eligible for Medi-Cal, there are a number of other public health programs that may be able to provide coverage for appropriate healthcare services. In addition, people can have Medi-Cal coverage as well as coverage through certain other programs such as Medicare, California Children Services (CCS), and AIDS Drug Assistance Program (ADAP) (as described below).

Advocacy Tip ► First try to establish eligibility for no share of cost Medi-Cal eligibility. If a person is not eligible for Medi-Cal without a share of cost, then look to other healthcare programs that might involve some cost.

Medicare

Medicare is a federal health insurance program. To be eligible for Medicare, an individual must be 65 years of age or older and eligible for Social Security or must be under 65 years of age, permanently disabled and have been receiving Social Security Disability Insurance payments for two years. Medicare also covers individuals with particular illnesses including some individuals on continuing dialysis for kidney failure, those in need of a kidney transplant, and those who have ALS.¹

Unlike Medi-Cal, there are no income or asset requirements for individuals to be eligible for Medicare. Medicare covers individuals who meet the eligibility requirements, not families. Beneficiaries may also have other health insurance, including private health insurance or Medi-Cal.

Unlike Medi-Cal, which is a federal-state partnership program, Medicare is completely federal, and the state has little to do with Medicare administration or rules. At the federal level, the Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services oversees both programs.

There are four different programs within Medicare: Parts A, B, C and D.

- Part A is hospital insurance and provided to those who qualify for Medicare without a premium.
- Part B provides coverage for doctors' visits and preventive care. To receive Part B benefits, beneficiaries must pay a monthly premium. If a person is low-income and has difficulty paying the monthly premium for Part B, she may be eligible for assistance from the state through a Medicare Savings Program which may pay her Part B premium and possibly other costs that Medicare does not cover. For more information on Medicare Savings Programs see Chapter 9.

¹ ALS is commonly referred to as Lou Gehrig's disease.

- Part C does not, in itself, cover additional services to Medicare beneficiaries, but offers beneficiaries an option to enroll in Medicare Advantage Plans. Medicare Advantage Plans are private managed care plans that contract with CMS to provide Medicare beneficiaries with healthcare benefits through a managed care model as opposed to through Medicare's traditional fee-for-service model.

Medicare Part D provides prescription drug coverage to beneficiaries and was added to Medicare in January of 2006. As opposed to Parts A and B of Medicare which offer both fee-for-service and private insurance options, Part D benefits may only be obtained through private prescription drug plans. Beneficiaries choose between a large number of different private companies' ("sponsors") drug plans for coverage. Each of these plans has its own formulary, drug utilization requirements (e.g. prior authorization or monthly quantity limits) and set their own monthly premiums and cost sharing amounts.

The Part D plans must cover at least two medications in pre-set drug categories or classes. However, there are six categories in which they are prohibited from offering drug coverage. These include drugs available to the beneficiary under Parts A or B, even if the beneficiary is not enrolled in that Part; barbiturates; benzodiazepines; fertility drugs; weight loss or weight gain drugs; and drugs for cosmetic or hair growth purposes. Individuals may enroll in Medicare Part D when they become eligible for Medicare. They can change Part D plans during the open enrollment period, which is November 15 through December 31 of each year. Part D beneficiaries may face a gap in coverage, which is commonly referred to as the "doughnut hole," which occurs when a beneficiary has obtained drugs through her Part D plan totaling a certain amount in costs and before she reaches the catastrophic coverage benefit of the program. Part D costs, including premiums, co-payments, deductibles, and the extent of the "doughnut hole" change annually.

Advocacy tip ► A Medicare beneficiary may enroll in a Medicare Part D prescription drug plan or change her plan online at the Medicare Web site at www.medicare.gov. Before attempting to use the Web site, the beneficiary should have a list of all of her medications (both chemical and trade name, as well as generic), the dosage for each medication, the frequency she takes each medication, information, if available, about whether she is able to tolerate the generic version or take another medication for the same condition, and also which pharmacies she prefers to use.

Low-Income individuals may qualify for what is referred to as the Low-Income Subsidy (LIS) or "Extra Help." An individual with the LIS will pay no or a reduced premium, and she will have reduced co-payments. Beneficiaries with the LIS coverage will not experience the "doughnut hole." Applications for LIS are available at www.medicare.gov, at the Social Security office, and also through the county welfare office.

Dual eligibles or "Medi-Medi's," individuals who qualify for both Medicare and Medi-Cal, receive almost all of their prescription drugs from their Medicare Part D plan instead of from Medi-Cal. These individuals should be automatically enrolled in the Low-Income Subsidy. Dual eligibles may get medications that are expressly excluded under Medicare Part D (see above) covered under Medi-Cal. However, if a dual eligible wishes to

get a medication that Part D could cover, but her prescription drug plan does not cover, she cannot get that drug through her Medi-Cal coverage.

For a helpful primer on Medicare Part D coverage for dual eligibles, see the NHeLP publication, *Medicare Part D and Dual Eligibles: A Guide for California Advocates*, available on the www.healthlaw.org Web site.

Healthy Families

California's State Children's Health Insurance Program (SCHIP) is called Healthy Families. Healthy Families provides low-cost comprehensive health coverage to children up to age 19 in families with incomes up to 250% of Federal Poverty Level (FPL) who do not qualify for free Medi-Cal and do not have private insurance. Children can have other dental and vision coverage, but not other health coverage. Children must be residents of California and must be either U.S. citizens or qualified legal immigrants.² Despite the name of the program, Healthy Families only covers children, not their parents or caretakers, unless the parent is also under age 19.

Children can apply for the program through the joint Healthy Families and Medi-Cal application described in Chapter 6 of this manual. Certified Application Assistants can assist families at no cost. While family income must be below 250% to qualify, a number of sources of income are exempt, including: income from a legal guardian, stepparent, foster parent or caretaker relative, SSI, CalWORKs, General Relief, foster care payments, grants & scholarships, earnings of a child who is under age 14 or attending school, loans, and some other government benefits. There are no resource or property limits. If the child was previously enrolled in a private health plan, there is a 90-day waiting period for Healthy Families eligibility.

Advocacy tip ► There is no retroactive coverage through Healthy Families; however, if a child has recent medical bills, the family should apply for both Medi-Cal and Healthy Families. If the child is found eligible for Medi-Cal with a share of cost, this coverage can help to pay for medical expenses in the three months prior to application.

Services are provided only through managed care plans, and families must either choose a plan or they will be automatically assigned to one. Families can change plans during their first three months of enrollment or during the annual open enrollment period. The health plans must cover basic services, which include office visits, prescription drugs, hospital inpatient care, emergency health care services, maternity services, vision care, and dental coverage. Covered services covered are based on those in the benefits package for California state employees. Some services are “carved out” of Healthy Families. While plans cover basic mental health needs, the county department of mental health covers any specialized mental health services for seriously emotionally disturbed children. California Children Services provides health care and case management for children and youth under age 21 with certain medically disabling conditions.

² See Chapter 2 for a definition of “qualified legal immigrant.”

Families must pay a premium for enrolled children to remain eligible. These payments range from \$4 per child to a maximum of \$45 per family. Families will receive a free month if they pay three months in advance. There is a \$5 co-payment for non-preventive services with a \$250 yearly cap.³

The program is administered by the Managed Risk Medical Insurance Board (MRMIB) and eligibility and enrollment processing is contracted to a private vendor, currently Maximus. Healthy Families beneficiaries are tracked by aid code 9H. For more information on the Healthy Families program, call 1-800-880-5305 (8 a.m. to 8 p.m. Monday through Friday) or visit www.healthyfamilies.ca.gov or www.mrmib.ca.gov.

Access for Infants and Mothers (AIM)

The AIM program, administered by the state of California, provides health coverage to pregnant women and their newborns/infants with family income between 200 and 300% FPL. Services include prenatal visits, hospital delivery, and 60 day postpartum care. Newborn children through two years of age are eligible for Healthy Families coverage. AIM is open to women who are uninsured or underinsured, as long as they are not eligible for no share of cost Medi-Cal or have Medicare Part A or B. Coverage is not free—it costs 1.5% of the subscriber's adjusted annual income. AIM is administered by MRMIB. You can get more information about AIM by calling 1-800-433-2611 or by visiting www.aim.ca.gov.

California Children's Services (CCS)

The CCS program, administered by the state and counties, provides funding for medical care for eligible, low- and moderate-income children who have certain serious medical problems, including acute injury and illness, genetic diseases, chronic conditions or physical disabilities, congenital defects and major injuries due to violence and accidents.⁴ CCS covers medical services including physician services, hospital care, laboratory work, x-rays, rehabilitation services, pharmaceuticals, equipment, and case management. Every county has a CCS office that can be reached by calling the county health department. Although CCS is not a Medi-Cal program, CCS beneficiaries are assigned to aid codes 9K, 9M, 9N, or 9R. CCS is open to undocumented children, and children in families with \$40,000 or less in annual income. Children may be enrolled in Medi-Cal or Healthy Families and also receive care from CCS. For more information, see the CCS Web site at: www.dhcs.ca.gov/services/ccs/Pages/default.aspx.

Child Health and Disability Prevention (CHDP)

The CHDP program, administered by the state and counties, covers preventive health screening examinations including physical exams, hearing, vision exams and immunizations for children with family incomes of less than 200% FPL.⁵ Children must be

³ Cal. Ins. Code § 12693 *et seq.* and Cal. Code Regs. tit. 10, § 2699.6500 *et seq.*

⁴ For a list of CCS eligible conditions, see www.dhcs.ca.gov/services/ccs/Pages/medicaleligibility.aspx. Health & Safety Code §§ 123800 *et seq.* See also PAI's service rights manual, California Children Services (CCS) at www.pai-ca.org.

⁵ Health & Safety Code §§ 124025 *et seq.* and 17 CCR § 6800 *et seq.*

California residents to qualify, but there is no required immigration status for the child or the family. Using CHDP does have immigration consequences for the family or the child.

States are required to cover these services to Medi-Cal beneficiaries under age 21 under the federal EPSDT program described in Chapter 12 of this manual. Children who are not eligible for Medi-Cal nevertheless may receive CHDP services until 19 years of age. CHDP is often the source for paying for regular check-ups for children, medical exams in order to enroll in public schools, or medical exams required for participation in some sporting activities.

CHDP became a gateway to Medi-Cal and Healthy Family services in July 2003 with an automated application initiated by the CHDP provider that provides up to two months of immediate eligibility while the family completes the application for continued coverage under one of the programs. Although CHDP is not a Medi-Cal program, CHDP beneficiaries are assigned to aid codes 8W, 8X or 8Y. For more information about CHDP, visit the Web site: www.dhcs.ca.gov/services/chdp/Pages/default.aspx.

County Medical Services Program (CMSP)

CMSP is a county medical assistance program serving the indigent adult population in thirty-four rural counties.⁶ CMSP is designed to fulfill these counties' obligations to care for their indigent adult residents who have no other source of medical insurance.⁷ The program was created in 1983 and is currently administered by Blue Cross Life and Health, but the County Health Services Program determines eligibility. CMSP is designed to provide a safety net for individuals who otherwise could not obtain medical or dental care.

Individuals can apply for CMSP at the county welfare office and, in some counties, at hospitals. In order to obtain full scope benefits, an applicant must be a U.S. citizen or have satisfactory immigration status. Applicants cannot be eligible for Medi-Cal. CMSP county residents with undetermined immigration status may be able to obtain emergency services. An applicant must provide documentation to verify her income and assets, and have less than \$2,000 in liquid assets during the month in which she is applying. A family of two can have \$3,000, and \$150 is added per additional family member. The value of the primary residence and one car are exempt. As with Medi-Cal, individuals can spend down their resources to meet the property limit.

Once enrolled, an individual may be eligible for two, three, or six months. After that time period, she must reapply for continued benefits. An individual must also reapply if she moves to another county even if that county has a similar CMSP program. Coverage typically begins the month of application and there is no retroactive coverage.

The medical benefits CMSP clients receive include medically necessary services, with the exception of pregnancy-related services, long-term care and services provided by chiropractors, acupuncturists, and psychologists. Small co-payments may be required.

⁶ Information in this section comes from the County Medical Services Program brochure on www.healthconsumer.org.

⁷ Cal. Welf. & Inst. Code § 17000.

CMSP programs are funded by state and county funds. In CMSP counties, most Medi-Cal providers are also CMSP providers. Applicants and beneficiaries do have appeal rights. Aid codes 50, 84, 85, 88 and 89 and 8F are used by many counties for billing and tracking purposes. For more information, see the CMSP Web site at: www.cmspcounties.org/.

Genetically Handicapped Persons Program (GHPP)

GHPP provides health coverage for adults who have specific genetic diseases, including cystic fibrosis, hemophilia, sickle cell disease, Huntington's disease, Friedreich's Ataxia, Joseph's disease, Von Hippel-Landau syndrome, and metabolic disorders such as Wilson's disease, disorders of lactate and pyruvate metabolism, and others.⁸ Children under age 21 with qualifying conditions receive services through CCS. The program does not have an income limit, though higher income individuals or families may need to pay an annual enrollment fee based on income and family size. Aid code 9J is used for tracking. GHPP can cover services in addition to a person's Medi-Cal, Medicare, or private insurance coverage. A person may obtain the application at the GHPP Web site and send the application to the Sacramento GHPP office:

www.dhcs.ca.gov/services/ghpp/Pages/default.aspx .

Major Risk Medical Insurance Program (MRMIP)

This state program offers health insurance for Californians who are unable to obtain coverage in the individual health insurance market, usually due to a pre-existing condition. Those who qualify for the program will pay premiums and MRMIP will supplement those premiums to cover the cost of the program.⁹

To be eligible for the program, an individual: must be a resident of California; cannot be eligible to purchase any health insurance for continuation of benefits under COBRA; cannot be eligible for either Part A or Part B of Medicare; and must be "unable to obtain adequate health coverage." "Unable to obtain adequate health insurance" is indicated by denial of coverage within the last 12 months, involuntary termination of health insurance coverage in the last 12 months for reasons other than nonpayment, an offer of individual health coverage in which the premium is higher than that of the MRMIP subscriber rate for the individual's first choice participating health plan, or membership in a group of one who has been denied health insurance coverage in the last 12 months.¹⁰ If not currently eligible, individuals cannot be enrolled or placed on a waiting list for MRMIP, even if they anticipate becoming eligible.¹¹

⁸ The list of GHPP eligible conditions is available at: www.dhcs.ca.gov/services/ghpp/Pages/MedicalEligibility.aspx. Health & Safety Code §§ 125125 – 125199.

⁹ Information for this section came from California Major Risk Medical Insurance Program brochure available on www.healthconsumer.org.

¹⁰ Cal. Code Regs. tit. 10, § 2698.200.

¹¹ Cal. Code Regs. tit. 10, § 2698.201(f).

Slots in the MRMIP program are limited and there is frequently a waiting list.¹² MRMIP coverage can last up to 36 months, and then the individual receives a one-time opportunity for guaranteed purchase of health insurance. MRMIP works through private health plans who must comply with the basic requirements of the Knox-Keene Act, which governs managed care plans.¹³ The premium cost is shared between MRMIP and the participant and also includes co-payments.¹⁴ The program is administered by MRMIB. For more information on the MRMIP program, please see the Web site at: www.insurance.ca.gov/0100-consumers/0300-public-programs/0600-mrmip/ or the consumer brochure available at www.healthconsumer.org.

Medically Indigent Adult Program (MIA)

MIA is a county medical assistance program in the larger California counties. MIA serves the same population as the County Medical Services Program (CMSP). It is similar to the CMSP programs which include individuals who are not eligible for Medi-Cal, but who are unable to pay for their medical care. MIA programs are funded and administered by each individual county to fulfill the county's legal obligation to provide for the healthcare of indigent resident adults.¹⁵ Each county's program differs in scope and application process. A county program, however, may only have limited residency periods and must include some due process protections to program participants.

Children's Health Initiatives (CHIs)

The Children's Health Initiatives have been created in numerous counties throughout California to cover those children below 250% FPL, who are not eligible for Medi-Cal or Healthy Families, and often cover additional children up to 300% of FPL. CHI's are local programs with a variety of different application and eligibility requirements. Most receive a mixture of public and private funding.

AIDS Drug Assistance Program (ADAP)

AIDS Drugs Assistance Programs are state-based programs funded in part by Title II of the Ryan White CARE Act, which was created in 1990 by the U.S. Congress. ADAPs cover medications to treat HIV disease or prevent related serious deterioration of health. Drugs covered and eligibility criteria are determined state-by-state with a focus on serving low-income individuals.

California's ADAP covers HIV/AIDS medications to individuals at or below 400% of FPL. If a person's income is higher than 400% FPL but lower than \$50,000, a sliding scale co-payment is required based on annual state income tax liability. To be eligible, a person must be financially eligible, over 18 years of age, have an HIV or AIDS diagnosis, and have a prescription for a covered drug from a California physician. ADAP provides coverage even if a person has other health coverage if their insurance does not include drug

¹² Cal. Code Regs. tit. 10, § 2698.202(c).

¹³ Cal. Code Regs. tit. 10, § 2698.301(a).

¹⁴ Cal. Code Regs. tit. 10, § 2698.300.

¹⁵ Cal. Welf. & Inst. Code § 17000.

benefits or the co-payment plan is causing financial hardship. ADAP clients may also have Medi-Cal or Medicare. The state Office of AIDS runs the program in California. For information about eligibility, the ADAP drug formulary, or ADAP's interaction with the Medicare Part D program, visit the Office of AIDS Web site at:

www.dhs.ca.gov/aids/Programs/CARE/adap.htm. For local ADAP enrollment information call 888-311-7632 or visit their Web site at www.phsb.com/patient/ca_eligible.html.

The CARE/HIPP program also pays health insurance premiums for people who are disabled by HIV/AIDS, and who are at risk of losing private health insurance coverage. For more information on this program, see the fact sheet at:

www.dhs.ca.gov/aids/Programs/ProgramFactSheets/2517CAREHIPP1007.pdf. For more information about the CARE/HIPP and HIPP program under Medi-Cal, see Chapter 10.
