Chapter 2: MAGI Medi-Cal Programs

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2. MAGI Medi-Cal Programs

The Affordable Care Act introduced a new methodology – Modified Adjusted Gross Income (MAGI) – to define a family's size and count income in order to determine eligibility for insurance affordability programs.[1] As a result, household determination and income counting rules are largely aligned among Medi-Cal, the Medi-Cal Access Program (MCAP, the low-cost health insurance for moderate income pregnant women), and Covered California, with some exceptions. See Chapter 4, Section C.2 for a discussion of MAGI and Covered California.

For Medi-Cal, the MAGI rules apply to the following programs: Expansion Adults (adults aged 19 through 64); Parents and Caretaker Relatives; Pregnant Women; and Children.[2] In general, unless an individual gets Medi-Cal through a linked program such as SSI or CalWORKs, or due to former foster youth status, Medi-Cal eligibility is reviewed for the MAGI programs before looking to the Non-MAGI programs.

While the Medi-Cal consumer protection programs Transitional Medi-Cal and Continuous Eligibility for Children are not MAGI programs, they are mentioned throughout this chapter because they are critical eligibility extenders for families that allow those in MAGI Parents/Caretaker Relatives and MAGI Medi-Cal Children's programs who are leaving Medi-Cal due to increased income to remain on Medi-Cal for up to 12 months. Complete descriptions of these programs are found in Chapter 3.

A. Constructing Households

To determine Medi-Cal eligibility, advocates must understand whose income counts and what income counts. To understand whose income counts, start with the

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1. 42 U.S.C. § 1396a(e)(14); Welf. & Inst. Code § 14005.64.
2. Medi-Cal's Tuberculosis Program and the Refugee Medical Assistance program also now use the MAGI income methodology. See Welf. & Inst. Code 14005.20(b)(2) and ACWDL 15-16 (Mar. 20, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-16.pdf. These programs, however, are not considered MAGI Medi-Cal in the Medi-Cal hierarchy because they are limited in scope or duration and should only be used when an individual is not eligible for any other form of free Medi-Cal. For that reason, we have included them in Chapter 3 as Non-MAGI Medi-Cal programs despite their adoption of MAGI income rules.

construction of the household. Because many Medi-Cal households are not required to file taxes as their income is below the filing threshold, the MAGI Medi-Cal rules are divided broadly into "tax filer" and "non-filer" rules.[3] Regardless of whether a family files taxes or not, individuals in the same household may actually have different household sizes for the purpose of the Medi-Cal application.

1. Tax Filer Rules

Tax filer rules apply to individuals who expect to file a federal income tax return and, with some exceptions, individuals who will be claimed as dependents on a federal tax return for the taxable year.[4] Tax filer rules apply to individuals who will still file taxes even if they are not required to do so.

For filers, the household consists of the tax filer and anyone the filer expects to claim as a dependent.[5] In addition, married couples living together should always include the spouse in the household, regardless of whether they will be filing jointly or not.[6] For dependents who are the biological, adopted or step children of the tax filer, the household consists of the tax filer, the tax filer's spouse, and all of the tax filer's dependents.

There are limited exceptions to the tax filer rules. A tax dependent who meets one of the following exceptions must use the *non-filer* rules:[7]

1. The dependent is not the spouse or a biological, adopted, or step-child of the taxpayer;
2. The dependent is a child under the age of 19 (or 21 if a full time student living at home) who lives with both parents and the parents plan on filing taxes separately; or

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3. Household rules are at 42 C.F.R. § 435.603(d) and (f). DHCS has created a flow chart describing the rules available at http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/Co-OPS-Sup/MAGI-MCal-HHSizeFlowChart-v1_2-20140815.pdf.
4. 42 C.F.R. § 435.603(f)(1).
5. *Id.*
6. Although MAGI Medi-Cal has rules on household construction for tax filers, just as there is no requirement to file taxes, there is also no requirement to file a joint return if married in order to receive Medi-Cal as there is for Covered California.
7. 42 C.F.R. § 435.603(f)(2).

3. The dependent is a child under the age of 19 (or 21 if a full time student living at home) and a parent of the child both does not live with the child and is claiming the child on his or her tax return.

Given the different household counting rules that apply for tax filers and their dependents, it is possible for tax dependents to have a different household size than the individual who claims them. For example, a single parent living with only one child that they do not claim on their taxes would have a household of one. The child would follow the rules below and have a household of two.

2. Non-Filer Rules

Non-filers are individuals who do not expect to file a federal income tax return for the taxable year and do not expect to be claimed as a tax dependent on a federal income tax return.[8]

For non-filers (and tax dependents who fall in one of the non-filer exceptions), the household consists of any of the following who *live* with the individual:[9]

1. The individual;
2. The individual's spouse (do not count unmarried partners);
3. The individual's children who are under age 19 or age 21 if a full time student[10] (do not count a child who is not a biological, step, or adopted child); and
4. For individuals under age 19 or 21 if a full time student, parents in the home and siblings in the home who are under age 19 or 21 if full-time students.

Again, it is important to construct the household from the perspective of each individual involved as each individual may have a different household size.

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8. 42 C.F.R. § 435.603(f)(3).
9. *Id*. Note that in this section child, parent, and sibling includes "natural, adopted, and step."
10. 42 C.F.R. § 435.603(f)(3)(iv). For the adoption of the full-time student option, see California's State Plan Amendment incorporating MAGI-Based Income Methodologies, SPA 13-0023-MM, available at http://www.dhcs.ca.gov/formsandpubs/laws/Documents/Approved%20SPA%2013-0023.pdf.

3. Counting Households with a Pregnant Woman

Pregnant women are treated differently for Medi-Cal and MCAP than for Covered California. Medi-Cal and MCAP count the number of children a women is expecting as part of the household, so in most cases, a single pregnant woman with no other children would count as a household of two, or three if she is expecting twins, four if she is expecting triplets, etc.[11] This is true whether the woman is the filer or non-filer, or another household member, assuming that she has reported the pregnancy. Pregnancy is reported through self-declaration.[12]

B. Counting Income

MAGI Medi-Cal and MCAP use largely the same MAGI methodology that is used by Covered California for counting income. Taxable income, Social Security benefits, tax-exempt interest and foreign earned income are all included. Because many Medi-Cal beneficiaries either do not file or have not yet filed taxes, Medi-Cal applicants will also have to construct what their taxable income would be if they did file taxes and may need to consult the first page of IRS form 1040 to determine their adjusted gross income.

For a complete explanation of the general MAGI income rules, see Chapter 4, Section C.2.

There are several ways in which MAGI for Medi-Cal and MCAP is treated differently than for Covered California:

- Special Types of Income:
  - Lump sums of income (*i.e.*, gambling or lottery winnings, awards, backpay, etc.) are counted only in the month received for Medi-Cal.[13]

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11. 42 C.F.R. § 435.603(b) and California's State Plan Amendment incorporating MAGI-Based Income Methodologies, SPA 13-0023-MM.
12. Welf. & Inst. Code § 14011.15(d).
13. 42 C.F.R. § 435.603(e)(1); MEDIL 15-03 (Feb. 27, 2015) p. 10, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-03.pdf. Note that some lump sums, such as insurance settlements for personal injury or educational scholarships used for educational expenses, are not counted at all.

Thus, no matter the size of the lump sum of income, a person would lose Medi-Cal for only the month received and could go back on the next month provided the rest of the household income is below the income eligibility limit. For MCAP, lump sums are only relevant at the time of application, in that they would be counted as income if received during that month. Lump sums of income received after a woman is already on MCAP would not impact her eligibility just as any other increases do not. MCAP eligibility is a "point-in-time" determination, meaning that once a woman's eligibility for MCAP is established, her coverage continues throughout her pregnancy and through the second month following the end of her pregnancy.

- Scholarships or fellowship grants for education expenses (not living expenses) are excluded from income.[14]
- American Indians and Alaskan Natives can exclude several tribal-related sources of income deriving from trusts, sale of tribal or reservation land or resources, and scholarships from the Bureau of Indian Affairs.[15]

- Monthly vs. Annual income: MAGI Medi-Cal rules allow counties to base eligibility on monthly rather than annual income. If an applicant provides both monthly and annual income, counties are instructed to divide the annual income by 12, compare it to the monthly amount also provided, and use the lower of the two amounts.[16]

Advocacy Tip: DHCS issued a chart to aid county workers in counting MAGI income that summarizes what income counts, what income should be excluded, the allowable deductions from adjusted gross income, and how to handle certain lump sum exceptions that advocates may find useful. This can be found attached to Medi-Cal Eligibility Division Information Letter 15-03.[17]

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14. 42 C.F.R. § 435.603(e)(2); MEDIL 15-03, p. 10, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-03.pdf.
15. 42 C.F.R. § 435.603(e)(3); MEDIL 15-03, p. 11, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-03.pdf.
16. ACWDL 15-06 (Jan. 21, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-06.pdf.
17. MEDIL 15-03 is found at http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-03.pdf.

C. MAGI Medi-Cal Programs

The four MAGI Medi-Cal Programs – Expansion Adults, Parents and Caretaker Relatives, Pregnant Women, and Children – comprise the majority of the Medi-Cal population.[18] These programs have varying eligibility criteria, such as different income thresholds and age limits. However, under the MAGI methodology, none of these programs have limits on assets or resources.

1. Expansion Adults

Pursuant to the Affordable Care Act's Medicaid expansion provision for adults,[19] in June 2013 California enacted legislation expanding Medi-Cal eligibility to adults without dependent children.[20] Under those laws, adults aged 19 through 64, who are not pregnant, not eligible for Medicare, and with incomes below 138% of the FPL became eligible for Medi-Cal as of January 1, 2014.[21] These Medicaid "Expansion

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18. Except for the Expansion Adult program, which was newly created by the ACA, the beneficiaries covered by these programs were eligible for Medi-Cal under the pre-ACA Medi-Cal rules for the Social Security Act 1931(b); the FPL Percentage programs for pregnant women and children; the Medically Needy and Medically Indigent programs; and the Targeted Low Income Children's Program (formerly known in California as the Healthy Families program).
19. The Supreme Court's decision in *National Federation of Independent Business (NFIB) v. Sebelius* (567 U.S. ___ (2012), 132 S.Ct. 2566) upheld the ACA's adult expansion group as a new mandatory coverage group. But the practical impact of the Court's decision made the ACA's Medicaid expansion optional for states because states that do not to implement the expansion lose only ACA Medicaid expansion funds, as opposed to losing all Medicaid funding.
20. ABx 1 1 (Perez/Pan); Welf. & Inst. Code § 14005.60. California was an early adopter of the ACA's expansion of Medicaid to non-disabled adults without dependent children. Under an 1115 Medicaid Waiver known as the "Bridge to Reform," California began expanding coverage in 2011 to low-income "childless adults" through county-based Low Income Health Programs (LIHPs). By 2013, LIHPs covered approximately 660,000 people in fifty-three counties. Five counties – Fresno, Merced, Stanislaus, San Luis Obispo, and Santa Barbara — did not establish a LIHP. LIHPs ended December 31, 2013, with the majority of LIHP enrollees transitioned to Medi-Cal as expansion adults in January 2014. LIHP enrollees were assigned aid code L1 when they transitioned to Medi-Cal, and if they remained eligible under the Expansion Adult category were to be moved to aid code M1 going forward. ACWDL 14-01 (Jan. 9, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-01.pdf.
21. Aid code M1 (full-scope, no-cost Medi-Cal for expansion adults); aid code M2 (emergency, pregnancy related and long term care services to undocumented expansion adults); aid code P3 (hospital presumptive eligibility for expansion adults).

Adults," also commonly referred to as "childless adults," represent the largest expansion of Medicaid eligibility since the program began in 1965.[22]

Age: Expansion Adults must be at least 19 years old and under age 65.[23] Beneficiaries who turn 65 while they are enrolled in Medi-Cal as an Expansion Adult must be evaluated for eligibility in all other Medi-Cal programs, *i.e.*, non-MAGI programs such as for the aged, blind or disabled, before they are disenrolled.[24]

Income Limit: Expansion Adults must have incomes at or below 138% FPL, based on MAGI methodology.[25]

Not Pregnant: Pregnant applicants are not Medi-Cal eligible as an Expansion Adult.[26] Pregnant applicants without children already in the home are evaluated under Medi-Cal categories that are specifically for pregnant women. See Section 3.

22. Note that "childless adults" is a misnomer. As the income limit for the Parents and Caretaker Relatives category (discussed below) is lower than the limit for the Expansion Adults, there are, in fact, adults who have children in the Expansion Adult group.
23. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII); 42 C.F.R. § 435.119(b)(1); Welf. & Inst. Code § 14005.60(a); MEDIL 13-12 (Sep. 16, 2013) at p. 6, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL%20I13-12%20wAttach.pdf.
24. Welf. & Inst. Code § 14005.37(d).
25. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII); 42 C.F.R. § 435.119(b)(5) (citing 133% FPL, but with an across the board 5% income disregard for MAGI, the income limit is 138% FPL); Welf. & Inst. Code §§ 14005.60(b) and 14005.64(b).
26. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII); 42 C.F.R. § 435.119(b)(2); Welf. & Inst. Code § 14005.60(a).

Advocacy Tip: The state is not obligated to track the pregnancy status of women once they are enrolled in the Expansion Adult group.[27] Therefore, if a woman is enrolled as an Expansion Adult and later becomes pregnant, she may remain in the Expansion Adult program so long as she meets the other eligibility criteria.[28] Effective August 1, 2015, otherwise eligible pregnant women qualify for full-scope Medi-Cal with income up to 138% FPL.[29] See Section 3. Thus, if a woman in the Expansion Adult category becomes pregnant and updates her on-line account or informs her county, she may remain in the Expansion Adult group instead of being moved to the aid code for full-scope Medi-Cal for pregnant women. This approach avoids a re-evaluation of eligibility for the whole household.[30]

Eligibility for Medicare Part A or B: Expansion Adults must not be eligible for Medicare Part A or B.[31]

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27. CMS "Medicaid and CHIP FAQs: Funding for the New Adult Group, Coverage of Former Foster Care Children and CHIP Financing" (Dec. 2013), Q.4 at p.2. https://www.medicaid.gov/federal-policy-guidance/downloads/faq-12-27-13-fmap-foster-care-chip.pdf.
28. *Id.* The state eligibility system CalHEERS was not originally programmed for this, which meant that a county had to take affirmative steps to prevent a pregnant woman from being terminated from the Expansion Adult program and her health plan and moved to fee-for-service under Pregnancy-Related Medi-Cal. MEDIL 14-31 (Jun. 4, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-31.pdf. This defect in CalHEERS was corrected as of March 2015. *See* CalHEERS Change Release Notes #15.3.
29. Welf. & Inst. Code §§ 14005.22 and 14005.225; MEDIL 15-25 (Aug. 19, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-25.pdf. Before August 1, 2015, the income eligibility limit for full-scope coverage under the "pregnant women" category was 60% FPL, while pregnant women over 60% FPL through 213% FPL were enrolled in the separate "low-income pregnant women" category for pregnancy-related care only. *See, e.g.,* MEDIL 14-43 (Jul. 30, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-43.pdf; *see also,* 42 U.S.C. § 1396a(a)(10)(A)(i)(IV) and (IX); 42 C.F.R. § 435.116(d)(1); and CMS SHO # 14-002, p. 3
30. More importantly, because beneficiaries in the Expansion Adult group typically receive services through managed care while beneficiaries in the Pregnancy-related group typically use the fee-for-service network, not requiring a woman to switch when she becomes pregnant makes continuity of care easier. For a chart of which programs are managed care and which ones use the fee-for-service network, see http://www.dhcs.ca.gov/services/Documents/AidCodeChart.pdf.
31. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII); 42 C.F.R. § 435.119(b)(3).

Eligibility under other Medi-Cal Coverage Programs: Expansion Adults must not be eligible under another Medi-Cal mandatory coverage group.[32] For example, under this requirement a woman who otherwise meets all of the other eligibility criteria but is also a stepparent of a child living in the home would not be eligible as an Expansion Adult, but under the Parents and Caretaker Relatives program so long as she meets the eligibility criteria for that program.[33] But note that people who meet the eligibility criteria of an optional Medicaid coverage group, such as the Aged, Blind and Disabled – Medically Needy program (which uses non-MAGI income counting and resource rules) and are also eligible for the Expansion Adult program have the right to choose the program that better suits their needs.[34]

32. 42 C.F.R. § 435.119(b)(4).
33. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII); Welf. & Inst. Code § 14005.60(a); *see also* ACWDL 14-28 (Jul. 7, 2014), at p.4, example 6, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-28.pdf.
34. CMS, Frequently Asked Questions, "Medicaid/CHIP Affordable Care Act Implementation FAQs: Eligibility Policy," at Q.6 (May 22, 2012) ("[E]ligibility for the new adult group based on MAGI does not preclude eligibility for coverage under an optional group that might be otherwise excepted from MAGI methods"), https://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Eligibility-Policy-FAQs.pdf. Because the scope of services is identical in MAGI and non-MAGI Medi-Cal, moving to the MAGI group makes passive renewal more likely as there is no additional information required about assets when renewing. *See* Chapter 6 on Medi-Cal renewal processes.

Expansion Adult: Summary of Eligibility Criteria

Age Limit	• 19 years old to under age 65
Income Limit	• At or below 138% FPL
Pregnant?	• Ineligible for Expansion Adult Medi-Cal if pregnant at time of application; pregnant applicants are evaluated under Medi-Cal programs specifically for pregnant women.
Medicare Part A or B?	• Must not be eligible for Medicare Part A or B
Eligible Under other Medi-Cal Programs?	• Must be ineligible for all other Medi-Cal mandatory coverage group, *i.e.*, applicants eligible as a Former Foster Youth or as a Parent/Caretaker Relative must be enrolled in one of those aid codes, even though they may also meet all the eligibility requirements for the Expansion Adult aid code.
Aid Codes: M1 for full-scope, no-cost Medi-Cal for expansion adults; M2 for emergency, pregnancy related and long term care services to undocumented expansion adults; P3 for hospital presumptive eligibility for expansion adults.	

2. Parents and Caretaker Relatives

The MAGI Parents and Caretaker Relatives program is for persons who live with, and have primary responsibility for, a child or children. The MAGI Parents and Caretaker Relatives program is a consolidation of the pre-Affordable Care Act parent and caretaker relative groups, covering those who were eligible under the 1931(b), AFDC-Medically Needy, and Medically Indigent programs.[35]

Linkage to Child: Individuals eligible under the Parents and Caretaker Relatives must:

- **Be related** to the child by blood, adoption, or marriage. Caretaker relatives can be, among others, parents, grandparents, great-grandparents, stepparents, siblings, stepsiblings, uncles and aunts, cousins, or spouses or registered domestic partners of one of these relatives.[36]
- **Live** with the child; [37] and
- Assume **primary responsibility** for the child.[38]

For purposes of establishing linkage to a child as a MAGI parent or caretaker relative, the child living with the parent or caretaker relative must be under 18 years old, unless she is 18 and a full-time student in a secondary school or the equivalent level of vocational or technical training and can expect to complete the program by the time she is 19 years old.[39] A pregnant woman *during the third trimester of her pregnancy* and with no other children may become eligible as a parent as

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35. 42 C.F.R. § 435.110. The aid codes for Parents and Caretaker Relatives are M3 (full scope, no-cost Medi-Cal); M4 (emergency, pregnancy related and LTC services to undocumented parents/caretaker relatives); and P2 (hospital presumptive eligibility, full-scope, no-cost Medi-Cal coverage for parent/caretaker relatives).
36. Welf. & Inst. Code § 14055(a)(1) and (2).
37. Welf. & Inst. Code § 14055(a).
38. *Id.*
39. ACWDL 14-28 (Jul. 7, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-28.pdf. Note that this definition of a child is different from the definition used when assessing eligibility under AFDC-Medically Needy program. For that program, a child is defined as a non-disabled individual who is under the age of 21 or a disabled individual under the age of 18. *Id.*

there is "linkage" through her expected child.[40] If the pregnant woman is married to the father of her unborn child and the couple live together, he must be included in the household but he is not eligible as a parent under the Parents and Caretaker Relatives category until the baby is born.

Advocacy Tip: In order to establish the link to Transitional Medi-Cal (see Chapter 3, Section C.5), pregnant women with no other children in the home who apply in their third trimester should be enrolled in full-scope Medi-Cal under the Parents /Caretaker group if their income is at or below 109% FPL, instead of being enrolled under the Pregnant Women's full-scope 138% FPL expansion. See Section C.3 below. Women enrolled in the Expansion Adult program before becoming pregnant whose income are at or below 109% FPL at the time of reporting their pregnancy in their third trimester also have the option (but are not required) to move to the Parent/Caretaker group, which would establish linkage to Transitional Medi-Cal. Exercising this option could result, however, in a re-evaluation of eligibility for all household members. Finally, pregnant women enrolled in the pregnant women's full-scope 138% FPL expansion group whose income drops to or below 109% FPL in the third trimester may similarly opt to move to the Parent/Caretaker group to establish the link to Transitional Medi-Cal, although this could also result in re-evaluating eligibility for the rest of the household.[41]

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40. *Id.* at p.2. This is required under Section 1931(b), which was not repealed by the ACA, and which follows the federal welfare rules in effect in 1988 providing cash assistance to pregnant women starting only in the third trimester when no other children were in the home. *See* CMS, Frequently Asked Questions, "Medicaid/CHIP Affordable Care Act Implementation FAQs: Eligibility Policy," (May 22, 2012), at Q.5 ("Coverage under section 1931 of the Act was not repealed with the ACA and will remain in effect..."), https://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Eligibility-Policy-FAQs.pdf; *see also Medi-Cal Eligibility Procedures Manual 5S-3*.
41. Continuity of care should also be kept in mind because beneficiaries in the Parent and Caretaker Relatives group typically receive services through managed care while beneficiaries in the Pregnancy-related group typically use the fee-for-service network. This decision may depend on the individual's needs or how services are administered in the county. For a chart of which programs are managed care and which ones use the fee-for-service network, see http://www.dhcs.ca.gov/services/Documents/AidCodeChart.pdf.

Age: There is no age limit for eligibility under the Parents and Caretaker Relatives group.

Income Limit: Those eligible under the Parents and Caretaker Relatives group must have incomes at or below 109% FPL.[42]

Parents and Caretaker Relatives: Summary of Eligibility Criteria

Linkage to a Child	Parents/caretaker relatives must: • Be related to the child by blood, adoption or marriage (caretakers include but are not limited to, grandparents, great-grandparents, stepparents, siblings, etc.); • Live with the child; and • Assume primary responsibility.
Age Limit	• No age limit to be a parent or caretaker relative
Income Limit	• At or below 109% FPL
Aid Codes: M3 for full scope, no-cost Medi-Cal ; M4 for emergency, pregnancy related and long term care services to undocumented parents/caretaker relatives ; P2 for hospital presumptive eligibility, full-scope, no-cost Medi-Cal coverage	

42. The income limit of 109% FPL is the MAGI adjusted income from the pre-ACA income limit of 100% FPL for the 1931(b) program, per federal law requiring states implement MAGI income limits not less than what was in effect at the time the ACA was enacted. 42 U.S.C. § 1396(e)(14).

3. Pregnant Women

As previously discussed, a pregnant woman who has no other children can receive Medi-Cal under the Parent/Caretaker Relative category if she is in her third trimester of pregnancy (see Advocacy Tip in Section C.2 above). And a woman who is enrolled in Medi-Cal as an Expansion Adult and becomes pregnant may choose to remain in the Expansion Adult category so long as she continues to meet the other eligibility criteria.[43] See Advocacy Tip in Section C.1 above.

California also provides several MAGI programs specifically for pregnant women, depending on their income: full-scope Medi-Cal for pregnant women up to 138% FPL;[44] pregnancy-related Medi-Cal for undocumented pregnant women from 0 to 213% FPL, and pregnant women between 138% and 213% FPL, regardless of immigration status; and the Medi-Cal Access Program, or MCAP, for pregnant women with household income over 213% FPL and up to and including 322% FPL, regardless of immigration status.[45]

a. MAGI Medi-Cal Programs for Pregnant Women

Under MAGI Medi-Cal programs for Pregnant Women, whether a pregnant woman qualifies for full-scope Medi-Cal or restricted-scope Medi-Cal is determined by her income and immigration status. Practically speaking, however, she should have access to all medically necessary services, as described below.

Pregnancy: A woman of any age may be eligible during any stage of her pregnancy.

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43. A pregnant woman may also receive Medi-Cal through one of the many non-MAGI programs discussed in Chapter 3 of this guide. There is the Income Disregard for Pregnant Girls Under 21 and the Medically Indigent program, and if the woman has a disability she may also be eligible for the programs specifically for the disabled, such as the Aged, Blind or Disabled Medically Needy or Aged and Disabled FPL. Advocates should be aware of all of the different program options that may be available to a pregnant woman in order to ensure she is in the best program for her situation.
44. ACWDL 15-35 (Nov. 12, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-35.pdf; MEDIL 15-25 (Aug. 19, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-25.pdf.
45. MCAP was formerly known as the Access for Infants and Mothers (AIM) program. The Department of Health Care Services changed the name to MCAP in 2014. MCAP is funded with federal monies from the Children's Health Insurance Program (CHIP) and therefore is not technically a Medi-Cal program.

Women have "continuous eligibility" (CE) throughout the pregnancy and until the end of the post-partum period, regardless of changes in income or household composition. The post-partum period begins on the date the pregnancy ends and lasts until the end of the month in which the 60th day after the end of the pregnancy occurs.[46]

A woman is not required to provide medical documentation of her pregnancy; she may self-attest that she is pregnant. The county must accept the self-attestation unless the information is not reasonably compatible with other information available to the county.[47]

Age: There is no age limit for the Medi-Cal for Pregnant Women programs.

Income Limit: Pregnant women must have incomes below 213% FPL for the MAGI Medi-Cal Pregnant Women programs.

- ***0 to 138% FPL: Full-Scope Medi-Cal***. As of August 1, 2015, pregnant women who are citizens or have satisfactory immigration status receive full-scope Medi-Cal. Pregnant women who are undocumented are eligible for pregnancy-related services, as well as emergency services, kidney dialysis, and long-term care.[48]
- ***Over 138% through 213% FPL: Pregnancy-Related Medi-Cal.*** Pregnant women above 138% FPL and up to and including 213% FPL are eligible

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46. 22 CCR §§ 50260 and 50262.3(a); ACWDL 91-66 (July 25, 1991), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c91-66.pdf.
47. Welf. & Inst. Code § 14013.3(d)(1); CMS "Medicaid/CHIP Affordable Care Act Implementation, Answers to Frequently Asked Questions" (May 22, 2012), at Q.9. https://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Eligibility-Policy-FAQs.pdf. In both Medicaid and CHIP-funded programs, states "must accept self-attestation of pregnancy unless the State has information that is not reasonably compatible with such attestation." 42 C.F.R. §§ 435.956(e) and 457.380(e).
48. Welf. & Inst. Code §§ 14005.22 and 14005.225; ACWDL 15-35 (Nov. 12, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-35.pdf; MEDIL 15-25 (Aug. 19, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-25.pdf. The aid codes for pregnant women with 0-138% FPL are M7 (full-scope, no-cost Medi-Cal coverage to citizen/lawfully present pregnant women) and M8 (emergency, pregnancy-related and long-term services to undocumented pregnant women).

for Pregnancy-Related Services Medi-Cal, without regard to immigration status.[49] Benefits include all Medi-Cal services when medically necessary.[50] The federal government has determined that Pregnancy-Related Medi-Cal for women with income over 138% through 213% FPL constitutes Minimum Essential Coverage, including during the postpartum period.[51]

- Women enrolled in Pregnancy-Related Medi-Cal are not subject to tax penalties.[52]

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49. The aid codes for pregnant women with incomes above 138% FPL and up to and include 213% FPL in Pregnancy-Related Medi-Cal are M9 (pregnancy-related Medi-Cal coverage to citizen/lawfully present pregnant women) and M0 (pregnancy-related Medi-Cal coverage for undocumented pregnant women). ACWDL 15-35 (Nov. 12, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-35.pdf.
50. At the time of writing, CMS had informed DHCS that Pregnancy-Related Medi-Cal qualified as minimum essential coverage (MEC) based on the state's policy that women in pregnancy-related Medi-Cal may access all medically necessary services; DHCS is still awaiting formal confirmation from CMS on the MEC issue but has issued IRS Form 1095-B to beneficiaries reflecting minimum essential coverage for months enrolled in this program. *See also*, 77 Fed. Reg. 12144, 17148 (March 2012), Preamble to 42 C.F.R. § 440.210(a)(2): "Because the health of a pregnant woman is intertwined with the health of her expected child, the scope of such services is necessarily comprehensive." *See also, id.,* at 17149: "If a State proposes not to cover certain services or items for pregnant women that it covers for other adults, the State must describe in a State plan amendment for the Secretary's approval its basis for determining that such services are not pregnancy-related." California's State Plan lists no exclusions for pregnant women. SPA #14-0021 (approved August 3, 2015), expanding full-scope eligibility under "pregnant women's" category from 60% through 109%, effective August 1, 2015: http://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/medicaid-state-plan-amendments.html. *See also*, CMS, State Health Official Letter # 14-002 (Nov. 7, 2014), p. 4. (Only "[c]overage which is determined equivalent to the full Medicaid benefits provided to other categorically needy pregnant beneficiaries will be recognized as MEC"). *Cf.* 22 CCR § 50262 (a)(2) and (c).
51. This was in question for some time but as described in footnote 50, DHCS has issued IRS Form 1095-B to beneficiaries in this aid code reflecting minimum essential coverage for the months enrolled in this program. We still await written guidance.
52. Prior to 2015, women needed to request an exemption. *See* CMS, State Health Official (SHO) # 14-002 (Nov. 7, 2014), pp. 10-11. Practically speaking, most women in this category in 2014 probably had no idea that there coverage was technically not minimum essential coverage.

Advocacy Tip: Before the expansion of full-scope Medi-Cal to pregnant women up to 138% and the determination that Pregnancy-Related Medi-Cal was considered minimum essential coverage , women eligible for Pregnancy-Related Medi-Cal were also being enrolled into Covered California, if otherwise eligible, since their Medi-Cal was not considered minimum essential coverage at that time. Those women are allowed to retain their Covered California with APTCs along with their Medi-Cal until the end of the postpartum period.[53]

As of October 2015, dual enrollments for pregnant women in Medi-Cal and Covered California stopped. Pregnant applicants eligible for Medi-Cal must be enrolled only in Medi-Cal. Women who become pregnant after enrolling in Covered California may choose to either remain in Covered California with the APTC subsidy or switch to Medi-Cal, but they cannot be enrolled in both programs at the same time.[54]

When determining household size to calculate a pregnant woman's income, the number of expected children is included as discussed above in Section A.3.[55] Therefore, a pregnant woman expecting one child and with no other children would count as a household of two and one would look at the income limits for a family of two when determining eligibility. And if the woman lives with her three existing children, their household would be considered a household of five, not four.

REMEMBER: Pregnant women in their third trimester with no other children in the home and with income up to 109% FPL may be eligible for Medi-Cal under the Parent and Caretaker Relative program. This is important even after the August 1, 2015 expansion to full-scope coverage for otherwise eligible pregnant women to 138% FPL because only enrollment in the Parent/Caretaker program provides linkage to Transitional Medi-Cal. It is also important for undocumented pregnant women, who

53. September 2015 communication with CMS and DHCS.
54. *See* CalHEERS Change Release Notes #15.9 for the change deployed to CalHEERS on 10/11/2015, p. 19, change request # 45773, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/AB1296/CalHEERS_Release_Notes_15_9_Revised.pdf; CMS SHO # 14-002 (Nov. 7, 2014), p. 5.
55. 22 CCR § 50030(b).

may also benefit from linkage to Transitional Medi-Cal for emergency, kidney dialysis, and long-term care services after their post-partum period ends.[56]

AND ALSO REMEMBER: If a woman with income up to and including 138% FPL becomes pregnant while enrolled as a MAGI Expansion Adult (aid code M1), she may remain in that program. Similarly, women enrolled in the full-scope expansion to 138% FPL for pregnant women (aid code M7 or M8) whose income drops to 109% FPL or below may remain in that program or, to acquire the link to Transitional Medi-Cal, may choose to switch to the Parent/Caretaker group in their third trimester.

Advocacy Tip: At the end of the 60 days post-partum period, a woman's eligibility should not be cut off automatically because the woman may be eligible under other Medi-Cal programs, such as the Parent and Caretaker Relative program to 109% FPL, the Expansion Adult program to 138% FPL, Transitional Medi-Cal, or disability categories. The county must check her eligibility for all other Medi-Cal programs before she can be terminated from the program.[57] If she is not eligible for Medi-Cal on any basis, she may be eligible for subsidized coverage through Covered California and should be assisted in transitioning to a Covered California plan.[58]

56. Women who chose this route, however, should be sure to understand how care is delivered in their county to Parents and Caretaker Relatives (generally managed care) versus Pregnant Women (generally fee for service) as they may need to exercise their rights to continuity of care or seek an exemption from enrollment into managed care.
57. Welf. & Inst. Code § 14005.37.
58. Welf. & Inst. Code § 15926(h)(1).

Medi-Cal Programs for Pregnant Women: Summary of Eligibility Criteria

Pregnancy	• Any stage of pregnancy • "Continuous eligibility" throughout pregnancy and post-partum period, regardless of changes in income or household
Age Limit	• No age limit
Income Limits/ Immigration Status	At or below 138% FPL • Full-scope Medi-Cal for U.S. Citizens and pregnant women with satisfactory immigration status • Pregnancy-related* Medi-Cal for undocumented pregnant women Over 138% to 213% FPL • Pregnancy-related* Medi-Cal for pregnant women, regardless of immigration status *Pregnancy-related Medi-Cal benefits include all Medi-Cal services when medically necessary.
Aid Codes: M7 for full-scope, no-cost Medi-Cal coverage to citizen/lawfully present pregnant women up to 138% FPL; M8 for emergency, pregnancy-related and long-term services to undocumented pregnant women up to 138% FPL; M9 Pregnancy-Related Medi-Cal for citizen/lawfully present pregnant women over 138% through 213% FPL; M0 Pregnancy-Related Medi-Cal for undocumented pregnant women over 138% through 213% FPL.	

b. Medi-Cal Access Program (MCAP) for Pregnant Women and Newborns up to Age 2[59]

The Medi-Cal Access Program, or MCAP, provides low cost health insurance coverage to women with income over 213% FPL and up to and including 322% FPL. There is no immigration or citizenship requirement to be eligible for MCAP. MCAP is administered by DHCS through a private vendor in Sacramento, not the counties.

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59. Materials for MCAP are available here: http://mcap.dhcs.ca.gov/Downloads/.

MCAP offers comprehensive coverage for a total cost of 1.5% of a woman's yearly MAGI income. Because the cost for MCAP is capped at 1.5% of yearly income and has no cost-sharing requirements, it is usually less expensive for a woman to enroll in MCAP than it would be to pay premiums for health insurance through Covered California. Payment for MCAP can be made all at once at a discount of $50 off the total cost, or in monthly installments over 12 months. If income drops during the 12-month payment period, the woman can ask to have her MCAP payments reduced accordingly.[60] There are no copayments, deductibles, or coinsurance with MCAP coverage.

Like Medi-Cal's coverage for pregnant women, MCAP coverage includes services during the post-partum period, which lasts until the end of the month in which 60 days have passed since the pregnancy ended.[61]

60. The policy in 10 CCR § 2699.201(d)(1)(CC) that required full-payment for all 12 months regardless of an enrollee's reduced income or transfer to Medi-Cal is inconsistent with CHIP and was therefore dropped effective September 1, 2015. *See http://mcap.dhcs.ca.gov/Downloads/MCAP_Contribution_Re-Evaluation_Form.aspx*. Similarly, MCAP no longer allows MCAP health plans to retroactively disenroll a woman under 10 CCR § 2699.207(a)(1)(D) and (g). As of this writing, neither the regulations nor the Declaration at the end of the MCAP application have been updated to reflect this change.
61. 10 CCR §§ 2699.207(a)(1)(D) and 2699.209(b).

Babies born to MCAP women are automatically eligible for Medi-Cal! Babies born to women on MCAP are automatically eligible for Medi-Cal up to the age of one without an application and regardless of income.[62] But if the MCAP mom's income at the time of application was over 266% FPL, then her newborn will have a monthly premium of $13 to maintain coverage. Between the ages of one and two, MCAP babies remain eligible for Medi-Cal with household incomes up to 322% FPL. [63] In the MCAP babies' second year, families with income over 160% FPL pay premiums.[64] To enroll an MCAP-linked newborn to Medi-Cal at any time during the newborn's first year, families can call MCAP at 1-800-433-2611, or submit an Infant Registration Form, which can be found at http://mcap.dhcs.ca.gov/Downloads/Infant_Registration.aspx. Babies born to women on MCAP are also discussed in Section C.4 on MAGI Children.

While the state computer system CalHEERS was not originally programmed to determine eligibility for MCAP, as of October 2015 women who apply through Covered California will have eligibility determined for MCAP.

MCAP Eligibility Requirements

Pregnancy: Women of any age during any stage of her pregnancy meet the pregnancy requirement.[65] Medical documentation of pregnancy is not required; self-attestation to pregnancy is acceptable.

Income: MCAP pregnant women must have incomes between 213% FPL and 322%

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62. Welf. & Inst. Code § 15832 (a)(2)(A). Aid codes E6 (MCAP infants 213% FPL and 266%FPL) and E7 (MCAP infants between 267% and 322% FPL). MCAP-linked infants whose family income exceeds 322% FPL during the first year are also placed in E7, as DHCS ignores income after the date of the mother's eligibility determination for MCAP up until the baby's first birthday, to see if the baby meets the eligibility criteria for a second year of coverage.
63. Welf. & Inst. Code § 15832 (a)(3)(B)(i).
64. *Id.*
65. Welf. & Inst. Code § 15832(a)(1)(A). MCAP used to impose a 30-week pregnancy limit for MCAP applicants. But as of March 1, 2015, a pregnant woman could be eligible for MCAP at any point in her pregnancy. See announcement on mcap.dhcs.ca.gov.

FPL.[66] Remember, the number of expected children is included for a pregnant woman when determining household size for calculating income.[67] Therefore, a pregnant woman with no other children or household members would count as a household of two and one would look at the income limits for a family of two when determining her eligibility, a woman pregnant with twins and no other household members would count as a household of three.

Eligibility for Medi-Cal: MCAP pregnant women must not be eligible for other Medi-Cal coverage.[68]

Eligibility for Medicare Part A or Part B: MCAP pregnant women must not be eligible for Medicare Part A or B.[69]

Enrollment in Private Insurance: A pregnant woman with private insurance is only eligible for MCAP if her private insurance does not cover maternity services or has very limited or costly maternity coverage.[70] Limited or costly maternity coverage is insurance with a separate maternity-only deductible or copayment greater than $500.

Pregnant women who are eligible for Covered California must choose Covered California or MCAP; they cannot be enrolled in both. MCAP qualifies as minimum essential coverage to meet the individual mandate of the Affordable Care Act.[71] But a woman who is enrolled in Covered California and becomes pregnant remains eligible for financial assitance; she will not be disenrolled unless she chooses to switch to MCAP.[72]

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66. Welf. & Inst. Code § 15832(a)(1)(B). The statute cites 208% and 317%FPL as the income limits for MCAP eligibility, but because MCAP uses the MAGI methodology, in practice these limits are supplemented by the across the board 5% income disregard that is applicable to all MAGI programs.
67. 22 CCR § 50030(b).
68. Welf. & Inst. Code § 15833.
69. *Id.*
70. Welf. & Inst. Code § 15834.
71. CMS, State Health Official Letter #14-002, "Minimum Essential Coverage" (Nov. 7, 2014), http://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf.
72. *Id.*

Advocacy Tip: MCAP is not as well-known as Medi-Cal or Covered California. Because the income range for MCAP – over 213% FPL through 322% FPL – overlaps with Covered California's income criteria and the state did not include MCAP in CalHEERS until October 2015, some pregnant women who may have been eligible for MCAP may still be enrolled in Covered California into 2016, without knowing that they had a choice between the two. MCAP coverage is generally much less expensive than the cost of insurance through Covered California. A pregnant woman who is eligible for both Covered California and MCAP but is enrolled in Covered California may drop the Covered California coverage and change to MCAP during her pregnancy. However this decision should be evaluated carefully since she could not apply for MCAP until she had dropped her Covered CA, thus causing a gap in coverage. Conversely, if a woman wanted to change from MCAP to Covered California, she has that choice as well. For more information, she can call the MCAP toll-free number at (800) 433-2611.

Medi-Cal Access Program (MCAP) for Pregnant Women:
Summary of Eligibility Criteria

Pregnancy	• Any stage of pregnancy
Income Limit	• Over 213% FPL to 322% FPL
Immigration Status?	• No citizenship or immigration requirement
Other Medi-Cal Eligibility?	• Must not be eligible for other Medi-Cal programs
Medicare Part A or B?	• Must not be eligible for Medicare Part A or B
Private insurance?	• Only if the insurance does not cover maternity services or has a maternity-only deductible or copayment greater than $500
Aid Codes: E6 for MCAP infants 213% FPL - 266%FPL; E7 for MCAP infants between 267% - 322% FPL.	

4. Children: MAGI Medi-Cal, the Targeted Low-Income Children's Program, and MCAP Infants and Babies

The majority of children in Medi-Cal are in the MAGI Medi-Cal Children's program, the Targeted Low-Income Children's Program (TLICP), formerly known as the Healthy Families Program,[73] or are infants and babies born to mothers in the Medi-Cal Access

73. TLICP was moved into Medi-Cal in 2013 when California transitioned over 750,000 children from Healthy Families into Medi-Cal over a one-year period. Welf. & Inst. Code § 14005.27; ACWDL 12-33 (Nov. 16, 2012), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/12-33.pdf. Sometime in 2015, DHCS began referring to TLICP as the Medi-Cal for Families Program. That name, however, is a misnomer as the program covers only children and not families.

Program (MCAP) for pregnant women[74] (see Section C.3.b and Chapter 6, Section A.1.c).

Together, the MAGI Children's program and TLICP provide Medi-Cal to children ages 0 to 19 years old with incomes up to 266% FPL,[75] and up to 21 year olds who are full-time students with income up to 133% FPL.[76] Babies from 0 to age 1 born to women in MCAP are eligible for Medi-Cal, without regard to income,[77] and from 1 to 2 years old are eligible for Medi-Cal with income up to and including 322% FPL.[78]

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74. Welf. & Inst. Code § 15832(a)(2)(A).
75. The state statute establishing the upper income limit for TLICP sets the limit at 261% FPL. Welf. & Inst. Code § 14005.26(b). But because the income is determined according to MAGI methodology, which provides for an across the board 5% income disregard (see Welf. & Inst. Code § 14005.64(b)), the upper income limit for children in TLICP is 266% FPL.
76. And do not forget that most children who lose their MAGI Medi-Cal eligibility due to increased income and those who are categorically eligible for Medi-Cal through CalWORKs, among others, may have their eligibility extended through the Continuous Eligibility for Children and the Transitional Medi-Cal (TMC) programs. Those programs are discussed in Chapter 3, Section C.5 and C.6..
77. Welf. & Inst. Code § 15832(a)(3)(A). While all newborns of women in MCAP are eligible for Medi-Cal regardless of income, because MCAP's eligibility for pregnant women goes up to 322% FPL, the majority of MCAP infants will have income below 322% FPL. It would be uncommon, though not improbable, for an MCAP newborn up to age 1 to have income above 322% FPL and be in Medi-Cal, as MCAP does not revisit an MCAP family's income until the babies' first birthday. *See* Welf. & Inst. Code § 15832(a)(3)(B); ACWDL 12-33 (Nov. 16, 2012), at p. 3, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/12-33.pdf.
78. Welf. & Inst. § Code 15832(a)(3)(B)(i).

Background: The distinctions between the MAGI Children's Program and TLICP are primarily for administrative and federal financial claiming purposes for the state. The MAGI Children's program was created by the Affordable Care Act's consolidation of various Medicaid programs so that infants and children up to age 19, or age 21 if a full-time student,[79] who were eligible under the pre-ACA 1931(b), Medically Needy, Medically Indigent, and the FPL Percentage programs, were combined under one children's category as of January 1, 2014.[80] TLICP children and babies on MCAP, on the other hand, are part of the state's Children's Health Insurance Program (CHIP) and are funded by federal CHIP dollars as opposed to Medicaid money. So even though TLICP and MCAP children are Medi-Cal enrollees, they are tracked differently for federal claiming purposes.

Monthly Premiums for Some Children Aged 1 to 19 and Some MCAP Babies: Kids in the MAGI Medi-Cal Children's program and TLICP aged 1 up to 19 with income from 161% and up to and including 266% FPL are required to pay monthly premiums to maintain their eligibility.[81] Infants 0 to age 1 in MAGI Medi-Cal Children's and TLICP have no premiums.

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79. 42 C.F.R. § 435.603(f)(3)(iv). For the adoption of the full-time student option, see California's State Plan Amendment incorporating MAGI-Based Income Methodologies, SPA 13-0023-MM, available at http://www.dhcs.ca.gov/formsandpubs/laws/Documents/Approved%20SPA%2013-0023.pdf.
80. 42 C.F.R. § 435.118. The Affordable Care Act's other significant change for children was the elimination that a child be "deprived" to qualify for coverage. Before the ACA, all children, parents, and caretaker relatives were subject to what was known as the deprivation test to be eligible for Medi-Cal. The deprivation test is an old welfare rule that requires a family to have a "deprived child" in the home to get benefits, which means a child is deprived of parental support in some way. Deprivation of a child was established through the absence, death, incapacity, or the unemployment or underemployment of at least one parent in the child's family. With the ACA and the adoption of the MAGI methodology, California eliminated deprivation as a Medi-Cal eligibility criterion. Welf. & Inst. Code § 14005.30(b)(2).
81. The State Plan Amendment to move TLICP (then known as Healthy Families) into Medi-Cal permits the state to impose premiums on children age 1 to 19 with incomes above 150% FPL and up to and include 250%FPL; infants under age 1 are not subject to a premium. *See* SPA 13-005, Attachment 4.18-F, page 4, approved Dec. 20, 2013, available at http://www.dhcs.ca.gov/formsandpubs/laws/Pages/Approved13-005.aspx. California later raised the income limit to collect premiums from families with income above 160% FPL and up to and including 266% FPL. Welf. & Inst. Code § 14005.26(d)(1)(B).

But MCAP infants age 0 to 1 have premiums if their mothers had incomes over 266% FPL at the time of applying for MCAP. And MCAP one-year olds with income between 161% and up to and including 322% FPL (the MCAP eligibility limit for babies aged 1-2) also pay premiums.[82]

The premium for one child is $13 per month. For families with more than one child, the premiums are capped at $39 per family per month, *i.e.*, a family with two children in TLICP will pay $26 per month in premiums, while a family with three or more children in the program pays $39 per month.[83] Payments are due on the 20th of each month.[84]

a. Infants: 0 to 1 year old

Age: Infants up to age 1.

Note that under federal law and state regulations, babies born to mothers who are enrolled in Medi-Cal are "deemed eligible" for Medi-Cal until at least their first birthday without a separate application.[85] For more information on Medi-Cal Deemed Eligibility for Infants, see Chapter 5, Section A.2.b. And infants born to women in MCAP are automatically eligible for Medi-Cal and are included in this category.

The period of deemed eligibility for Medi-Cal for an infant ends once the baby turns one year old, unless the baby is in the hospital. If the baby is receiving continuous inpatient services that began before the baby's first birthday, the baby's eligibility in the Children's Infant to 1 year-old program continues until the baby is discharged from the hospital.[86] Upon discharge, the baby would be evaluated for eligibility in the Children Ages 1 to 6 program and other Med-Cal programs.

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82. ACWDL 12-33, at p. 3 ("[MCAP]-linked infants enrolled in [TLICP] are subject to the premiums imposed under [TLICP]."
83. Welf. & Inst. Code § 14005.26(d)(1)(B) and (d)(2)(A).
84. For information on how families can pay these premiums, go to http://www.dhcs.ca.gov/services/Pages/Medi-CalPremiumPayments.aspx.
85. 42 U.S.C. § 1396a(e)(4); 22 CCR § 50262.3.
86. 22 CCR § 50262(b)(2).

Income Limit: Infants in families with incomes up to 266% FPL are eligible for no-cost Medi-Cal. Infants born to women on MCAP are automatically eligible for Medi-Cal, but those with incomes above 266% FPL must pay monthly premiums to remain eligible.[87]

b. Children: Ages 1 to 6

Age: Children must be between 1 year old and up to 6 years old.[88]
Just as for the infant 0 to 1 year-old program, the period of eligibility for a child in this program ends on the child's 6th birthday, unless the child is receiving inpatient services. Children who are receiving inpatient services when they turn six will continue to qualify for this program until they are discharged.[89] Upon discharge they are evaluated for eligibility for the Children ages 6 to 19 program.

Income Limit: Children ages 1-6 in families with incomes up to 160% FPL are eligible for no-cost Medi-Cal;[90] children ages 1-6 in families with incomes between 160% FPL to 266% FPL are eligible for Medi-Cal with a monthly premium.[91] Babies age 1 to 2 years old born to women in MCAP with incomes between 161% FPL and up to and

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87. Welf. & Inst. Code § 15832(a)(3)(A); 22 CCR § 50262(a)(2). Aid codes P9 (MAGI Children full-scope, no-cost Medi-Cal coverage for infants up to age 1 and up to 208% FPL); P0 (MAGI Children emergency and long term care services to undocumented infants up to 1 year of age and up to 208% FPL); P1 (MAGI Children hospital presumptive eligibility provides full-scope, no-cost Medi-Cal coverage for infants ages 0 to 1 whose family income is 0 to 208% FPL); T5 (TLICP infant up to 1 year, full-scope, no-cost Medi-Cal to children with family income above 208% FPL to 266% FPL); T0 (TLICP infant up to 1 year, emergency and state-funded LTC to children with family income above 208% FPL to 266% FPL); E6 (MCAP infant above 213% to 266% FPL); E7 (MCAP infant above 266% to 322% FPL).
88. 22 CCR § 50262.5.
89. 22 CCR § 50262.5(b).
90. Aid code P7 (MAGI Children ages 1 to 6, full-scope no-cost Medi-Cal up to 142% FPL); aid code P8 (MAGI Children ages 1 to 6, emergency and LTC services to undocumented children up to 142% FPL); aid code T4 (TLICP children ages 1 to 6, full-scope no-cost Medi-Cal for children with family income is above 142% FPL to 160% FPL); aid codes T9 (TLCIP children ages 1 to 6 without satisfactory immigration status, emergency and LTC services with income above 142% FPL to 160% FPL).
91. Aid code T3 (TLICP children ages 1 to 6, full-scope no-cost Medi-Cal for children with family income from 160% FPL to 266% FPL); aid code T8 (TLICP children ages 1 to 6 without satisfactory immigration status, emergency and LTC services with family income from 160% to 266% FPL).

including 322% FPL are eligible for Medi-Cal with a monthly premium.[92]

c. Children: Ages 6 to 19

Age: Children must be between 6 years old and up to 19 years old.[93]

Income Limit: All children in families with incomes up to 160% FPL are eligible for no-cost Medi-Cal;[94] children in families with incomes at 161% to 266% FPL are eligible for Medi-Cal with a monthly premium.[95]

92. Aid codes E6 (MCAP-linked infant above 213% FPL to 266%) and E7 (MCAP linked infant above 266% FPL to 322% FPL).
93. 22 CCR § 50262.6.
94. Aid code P5 (MAGI Children ages 6 to 19, full-scope no-cost Medi-Cal up to 133% FPL); P6 (MAGI Children ages 6 to 19, emergency, pregnancy and LTC services to undocumented children up to 133% FPL); T2 (TLICP children ages 6 to 19, full-scope no-cost Medi-Cal, income above 133% FPL to 160% FPL); T7 (TLICP children ages 6 to 19, without satisfactory immigration status, emergency, pregnancy related and LTC, income above 133% to 160% FPL).
95. Aid codes T1 (TLICP, ages 6 to 19, full-scope Medi-Cal, income 160% FPL to 266% FPL, with premium); T6 (TLICP children ages 6 to 19, restricted to emergency, pregnancy-related, and LTC, income 160% FPL to 266% FPL, with premium).

MAGI Children, Targeted Low-Income Children's Program, and MCAP: Summary of Eligibility Criteria

Age of Child	MAGI Children and TLICP Income Limits	Monthly Premium? *$13/month per child;* *max. $39/month per family*
0 to 1 year-old	**MAGI Children:** 0 to 208% FPL **TLICP:** 209% to 266% FPL **MCAP:** No income limit	**MAGI Children/TLICP:** Not applicable **MCAP:** Yes, for babies over 266% FPL
1 to 6 years old	**MAGI Children:** 0 to 142% FPL **TLICP:** 143% FPL to 266% FPL **MCAP, ages 1-2:** 0 to 322% FPL	**MAGI Children:** Not applicable **TLICP:** Yes, for 161% FPL to 266% FPL **MCAP, ages 1-2:** Yes, for 161% FPL to 322% FPL
6 to 19 years old	**MAGI Children:** 0 to 133% FPL **TLICP:** 134% FPL to 266% FPL	**MAGI Children:** Not applicable **TLICP:** Yes, for 161% FPL to 266% FPL

Aid Codes: 0 to 1 year olds – MAGI Children: P9 (full-scope, citizen), P0 (restricted, undocumented), P1 (hospital PE); TLICP: T5 (full-scope, citizen, 208%-266% FPL), T0 (restricted, undocumented, (208%-266% FPL), H6 (hospital PE); MCAP: E6 (full-scope, 213%-266% FPL), E7 (full-scope, 266%-322% FPL).
1 to 6 years old – MAGI Children: P7 (full scope, citizen, 0-142%), P8 (restricted, undocumented, 0-142%); TLICP: T4 (full scope, citizen, 142%-160%), T3 (full scope, citizen, 160%-266%, premiums), T9 (restricted, undocumented, 142%-160%), T8 (restricted, undocumented, 160%-266%, premiums), H9 (hospital PE, children 1-6, 142%-266%); MCAP: E6 (full-scope, 213%-266% FPL), E7 (full-scope, 266%-322% FPL).
6 to 19 year olds – MAGI Children: P5 (full scope, citizen, 0-133%), P6 (restricted, undocumented, 0-133%), M5 (full scope, citizen, expansion child, 108%-133%), M6 (restricted, undocumented, expansion child, 108%-133%), H0 (hospital PE, children 6-19 108%-266%); TLICP: T2 (full scope, citizen, 133%-160%), T1 (full scope, citizen, 160%-266%, premiums), T7 (restricted, undocumented, 133%-160%), T6 (restricted, undocumented, 160-266%, premiums).

Note: Health for All Kids (SB 75): As part of California's 2015-2016 budget process, Medi-Cal was expanded to provide full-scope health coverage for all otherwise eligible children under age 19 regardless of immigration status.[96] As of press time, this new program is still in the implementation phase and children who were previously eligible for only restricted scope Medi-Cal due to their immigration status should be transferred into full-scope Medi-Cal starting in May 2016. The Department of Health Care Services is creating additional aid codes that will parallel all restricted aid codes that contain undocumented children and transfer the children to full-scope services by changing their aid codes. Children not previously enrolled in Medi-Cal and children enrolled in local programs such as Healthy Kids may enroll in the expansion to full-scope Medi-Cal as well. Information regarding the implementation of this program is available at http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/sb-75.aspx.

96. Welf. & Inst. Code § 14007.8 enacted as SB 75 (2015-2016 budget) and SB 4 in 2015.