Glossary

Accelerated Enrollment (AE): A special program through which a child applies through the Single Streamlined Application can get Medi-Cal very quickly if an initial screen of his/her application indicates s/he is likely to be eligible for free Medi-Cal. AE is also available in the federal BCCTP.

Adjusted Gross Income: Income from taxable sources minus specific allowable deductions and labelled "adjusted gross income" on IRS forms 1040, 1040-A, and 1040-EZ. For the longer forms (1040 and 1040-A), it is generally the last item on page 1 and repeated again at the top of page 2. Do not confuse with the line "taxable income" which comes after all allowable deductions and exemptions are made.

Advanced Premium Tax Credit (APTC): Payment of the tax credits authorized by Section 36B of the Internal Revenue Code and implementing regulations, which are sent directly to the Covered California Qualified Health Plan of an eligible individual on a monthly basis to pay a portion of the individual's health premium. See 10 CCR § 6410

Adverse Action: "An action taken by a county department which discontinues Medi-Cal eligibility or increases an MFBU's share of cost." 22 CCR § 50015

Affordable: A term of art in evaluating employer-sponsored plans to determine eligibility for Covered California financial assistance. If the amount of premiums that an employee must pay per year exceeds 9.5% of his or her income, that plan is not affordable. If it is less than 9.5% of income, it is affordable.

Affordable Care Act (ACA): The federal Patient Protection and Affordable Care Act of 2010 (Pub.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Pub.L. 111-152). Signed by President Barack Obama on March 23, 2010.

Aged: A Medi-Cal term for a person who is 65 years old or older.

Aid Code: A Medi-Cal aid code is "'[t]he two-digit number which indicates the aid category under which a person is eligible." 22 CCR § 50018.

Access for Infants and Mothers (AIM): See Medi-Cal Access Program (MCAP).

Aid Paid Pending: If a beneficiary requests a fair hearing before the date a county takes action to reduce, adjust, or terminate Medi-Cal, the beneficiary will continue to get Medi-Cal pending the fair hearing decision.

Appellant: A person appealing a determination related to eligibility made by Covered California.

Annual Redetermination: Every 12 months, Medi-Cal beneficiaries' eligibility is reviewed by the county to determine if they remain eligible for ongoing Medi-Cal coverage.

Applicant: "The individual or family making, or on whose behalf is made, an application, request for restoration of aid, or reapplication." 22 CCR § 50021.

Assets: See Property.

Beneficiary: "A person who has been determined eligible for Medi-Cal." 22 CCR § 50024.

Benefits Identification Card (BIC): The physical card a beneficiary receives from Medi-Cal and presents to providers as proof of coverage.

Breast and Cervical Cancer Treatment Program (BCCTP): A Medi-Cal special treatment program through which persons diagnosed with breast or cervical cancer can get full-scope or cancer-related coverage.

CalFresh: California's Supplemental Nutrition Assistance Program formerly known as the "food stamp" program.

California Healthcare Eligibility, Enrollment and Retention System (CalHEERS): The electronic portal or system through which consumers may apply for Medi-Cal or Covered California and manage their Medi-Cal or Covered California accounts.

Caretaker Relative (CR): "A relative who provides care and supervision to a child, if there is no natural or adoptive parent in the home." 22 CCR § 50085.

Conditional Withdrawal: A withdrawal of a Medi-Cal or Covered California appeal subject to certain conditions that the appellant or claimant and applicable agency have agreed upon being satisfied.

Categorical Linkage: A person receiving cash assistance through CalWORKs or SSI receives Medi-Cal automatically because s/he is in the category of persons receiving that cash assistance and "linked" to Medi-Cal on that basis.

Charity Care: A form of hospital financial assistance to uninsured patients that releases the patient from liability for the hospital bill.

Claimant: A person pursuing a Medi-Cal appeal.

Conditional Withdrawal: A withdrawal of a Medi-Cal or Covered California appeal subject to certain conditions that the appellant or claimant and applicable agency have agreed upon being satisfied.

Child Health and Disability Prevention Program (CHDP): "The community based program for early identification and referral for treatment of persons under 21 years with potentially handicapping conditions." 22 CCP § 50031.

Cost Sharing Reduction (CSR): A form of financial assistance available through Covered California for consumers between 100-250% FPL who enroll in Enhanced Silver plans. If a consumer choses an Enhanced Silver plan, the plan comes with reduced deductibles, co-payments, and out-of-pocket maximums making the plan more valuable than what the consumer could otherwise purchase for that price. See 10 CCR § 6410.

Continuous Eligibility for Children (CEC): A program through which any child under age 19 who has free Medi-Cal with no Share of Cost can keep free Medi-Cal until his/her next scheduled annual redetermination or 19th birthday, whichever comes first, even if the family's income goes up or other circumstances change in a way that would otherwise require the child to pay a share of cost.

Countable Income: The amount of income reached by subtracting all income that is considered exempt and all amounts a family is allowed to deduct (or disregard). This amount is then measured against the income limit for the family size to determine if the family is eligible, ineligible, or eligible with a Share of Cost.

County: In this guide, County is often used as shorthand for the County Welfare Department, County Social Services Agency, or other agency in the County that is responsible for administering the County's Medi-Cal program.

Covered California: California's trade name for its Health Benefit Exchange. The Health Benefit Exchange is the program set up by the Affordable Care Act where eligible consumers can purchase subsidized health insurance.

Cuban/Haitian Entrant: Generally most Cubans and Haitians, including parolees and asylum seekers, who are neither lawful permanent residents or have a final nonappealable order of removal are entrants. See the Refugee Education Assistance Act or 1980, §501(e) for the exact definition.

Deductible: The amount a health plan enrollee must pay per year in out-of-pocket expenses before a health plan will start paying for services. Some services, such as preventive care, are not subject to the deductible. Premium payments, services received out-of-network, and services not covered by the health plan do not count towards the deductible.

Deduction: A deduction is an amount (usually of income) that an applicant or beneficiary may subtract from his/her gross income to determine how much of his/her income counts in determining Medi-Cal eligibility. "Deduction" and "disregard" are used interchangeably.

Deemed Eligibility for Newborns (DE): A special program that guarantees that a baby born to a mother who is eligible for Medi-Cal is automatically eligible for and gets to keep Medi-Cal at least until his/her first birthday.

Deeming: See Sneede/Gamma. Medi-Cal non-MAGI income deeming rules to determine whose income and property count toward an applicant's eligibility.

Department of Health Care Services (DHCS): DHCS is the state agency solely responsible for the administration of the Medi-Cal program.

Department of Homeland Security (DHS): The federal DHS is the department that houses the U.S. Citizenship and Immigration Services (USCIS) and Immigration and Customs Enforcement (ICE). Instead of referring to INS, immigration practitioners now generally refer to DHS, USCIS, or ICE, depending on the context. Some immigration responsibilities, however, are still housed in the Department of Justice.

Disability: For Medi-Cal purposes, a disabled person is an individual who has met the criteria set by the Social Security Administration (SSA). An individual must have a severe physical and/or mental problem that is expected to last for at least 12 months (or result in death) and prevent the person from being able to work or engage in "substantial gainful activity."

Disabled Adult Children (DAC): Disabled Adult Children are people over age 18 who were born with some kind of disabling condition or who became disabled before age 22 and whose SSI/SSP benefits were discontinued because of the receipt of or increase in Social Security (Title II) benefits. DACs are entitled to Social Security benefits from a parents' work history.

Discontinuance: See Termination.

Discount Payment Plan: A form of hospital financial assistance to the uninsured and underinsured that allows for patient to pay a reduced rate in installments.

Disregard: See Deduction.

Dual Eligible: A term used to describe a person who receives both Medi-Cal and Medicare. They are also called "Medi-Medi."

Exemption: Something that does not count in determining a person's or family's eligibility, such as income or property that is not counted when determining if a person or family has income or property under the limits for their family size. A person can also be exempt from a particular procedure or rule, which means they do not have to meet that requirement.

Ex Parte Process: The part of the Medi-Cal eligibility review that a county initiates itself and does on its own prior to contacting the beneficiary, using available and appropriate government databases and sources.

Fair Hearing: A beneficiary has a right to a hearing before an impartial arbiter anytime the county takes an adverse action to terminate, reduce, deny, or suspend benefits.

Family Planning, Access, Care, and Treatment (Family PACT): A program funded by Medi-Cal that provides family planning services to women and men who are not otherwise eligible for free Medi-Cal and whose incomes are under 200% of the Federal Poverty Level.

Federal Poverty Level (FPL): "An income level based on the official poverty line as defined by the federal Office of Management and Budget and revised annually or at any shorter interval that the Secretary of Health and Human Services deems feasible and desirable." 22 CCR § 50041.5; see also 10 CCR § 6410.

Fee for Service (FFS): A method of receiving and paying for care where a beneficiary can get services from any Medi-Cal provider and the Medi-Cal program pays that provider based on the services rendered. FFS Medi-Cal describes all Medi-Cal services rendered outside of a managed care plan or system

Four-Month Continuing: A family can receive up to four months of additional Medi-Cal when they lose free coverage due to increased collection of child or spousal support.

Full-Scope: Beneficiaries who have satisfactory immigration status receive full-scope Medi-Cal, which means the full package of health care benefits available in the Medi-Cal program.

In-Home Supportive Services (IHSS): A program run by the state that provides personal assistance services to persons with disabilities to enable them to live independently instead of needing to live in a nursing home or other institutional setting.

In-Kind Income: Income that counts for Medi-Cal eligibility when an applicant or beneficiary receives a full month's item of need, such as housing or food, at no cost to himself/herself.

Insurance Affordability Programs: Medi-Cal, subsidized Covered California and Children's Health Insurance Programs (CHIP) including the Medi-Cal Access Program (former AIM program), the Optional Low-Income Children's Program (former Healthy Families Program) that is now part of Medi-Cal and county C-CHIP programs. See Welf. & Inst. Code § 15926(c).

Inter-County Transfer (ICT): The process by which a county is required to transfer a beneficiary's Medi-Cal case to a new county with no interruption in benefits if the beneficiary moves from one county to another.

Lawful Permanent Resident (LPR): An immigrant with a visa that legal entitles him or her to live and work in the United States indefinitely, also known as a "green card holder."

Lawfully Present Immigrants: A term that includes all immigrants with documented status except those in Deferred Action for Childhood Arrivals (DACA) and DAPA status and defines immigrant eligibility for Covered California.

Linked: A term used to describe persons who receive Medi-Cal because they are "linked" to a cash assistance program such as CalWORKs or SSI. In other words, they meet the eligibility requirements of the cash assistance program although it is not necessary that they be receiving the cash assistance. Another use of the term is when a parent or relative gets Medi-Cal because they are "linked" to his/her child, *i.e.*,they qualify for MAGI Parents/Caretaker Relatives program.

MAGI: Modified Adjusted Gross Income. This is a particular income counting methodology used to determine eligibility for Covered California and some Medi-Cal programs. It is based on the adjusted gross income on a tax return with some additional sources of income added. See 42 CFR 435.603§(e); Welf. and Inst. Code § 14005.64(a)-(c).

MAGI Medi-Cal: Medi-Cal programs that use the Modified Adjusted Gross Income methodology to determine financial eligibility.

Maintenance Need Level (MNL, MNIL, or MNA): The amount used in the Medically Needy programs to determine whether a person receives free Medi-Cal if they are under the income limit, or Medi-Cal with a Share of Cost if their income exceeds the limit. It is assumed that this is the amount a person would need to cover basic living expenses. Maintenance Need Income Level (MNIL) is an income limit, also called Maintenance Need Level (MNL), while the Maintenance Need Allowance (MNA) is an amount attributed to a person's needs when determining family members' eligibility.

Managed Care: A method of receiving and paying for care where the beneficiary is enrolled in a health plan and receives services through that plan, which coordinates the beneficiary's care and gets paid a capitated rate for each beneficiary regardless of how many services the person actually uses.

Maximum Out-of-Pocket Cost: The most that a health plan enrollee can pay per year in out-of-pocket expenses (excluding premium payments) for covered health services received in-network or in an emergency. Once the out-of-pocket cost is reached, the health plan must cover all in-network and emergency services.

Medicaid: The federal public health coverage program that sets rules and requirements for states to follow in their health programs for low-income residents; California's Medicaid program is called Medi-Cal.

Medi-Cal Eligibility Data System (MEDS): Statewide computer system that stores Medi-Cal eligibility and demographic information.

Medically Indigent: Persons who get Medi-Cal, usually with a Share of Cost, who fail the income or deprivation test or other specific categorical requirements, but are otherwise eligible.

Medically Needy: Persons who receive Medi-Cal with or without a Share of Cost based on whether their countable incomes fall below or exceed the Maintenance Need Income Level (MNIL).

Medicare: A federal health insurance program that provides health coverage for U.S. residents who are 65 or older or who are permanently disabled regardless of the person's income.

Medicare Savings Plan (MSP): Special programs through which persons can get Medicare premiums and payments paid by Medi-Cal. Those programs are the Qualified Medicare Beneficiary Program (QMB), the Specified as Low-Income Medicare Beneficiary Program (SLMB), the Qualified Individual Program (QI), and the Qualified Disabled & Working Individuals Program (QWDI).

Medi-Cal: California's Medicaid program providing low-cost and no-cost health coverage for low-income residents.

Medi-Cal Access Program (MCAP): A program administered by the state that provides prenatal care and delivery to mothers and full health services to newborns up to age 1 for women with income over 213% and up to and including 322% the Federal Poverty Level. Formerly known as the Access for Infants and Mothers (AIM) Program.

Medi-Cal Family Budget Unit (MFBU): An MFBU is used to combine family members and their income to determine eligibility. it includes all family members not receiving cash aid whose income is included when calculating Medi-Cal eligibility. If a family member is ineligible for assistance, but still legally responsible for those in the MFBU, then the person is included in the MFBU. 22 CCR § 50060.

Medi-Cal Only: "A person's or family's eligibility for Medi-Cal benefits that has been determined independently of an eligibility determination for any other aid or benefit program" (22 CCR § 50060.5) such as CalWORKs or Supplemental Security Income (SSI).

Medi-Medi: See Dual Eligible.

Mini Budget Unit (MBU): An MBU is a subunit of the MFBU and is used to determine eligibility under Sneede rules and procedures.

Minimum Essential Coverage: A requirement of the Affordable Care Act is that all individuals, with exceptions, must have health coverage that is minimum essential coverage. Minimum essential coverage is defined in statute as most employer coverage, full-coverage government-sponsored programs, and plans sold on the individual market.

Minimum Value: An evaluation of employer-sponsored coverage to determine whether an employee is eligible for Covered California. Plans that do not cover at least 60% of expected total costs are not minimum value.

Minor Consent Services: Services a minor can consent to on his/her own (without requiring consent of a parent) related to sexual assault, drug or alcohol abuse, pregnancy, family planning, venereal disease, or sexually transmitted diseases and mental health counseling. See 22 CCR § 50063.5.

No Longer Disabled: A special program through which children who were receiving SSI as of August 22, 1996 when the disability definition changed can still get Medi-Cal if the reason they are not otherwise eligible is due to the change in disability definition.

Non-Immigrant: A person in the United States based on a temporary visa such as a student, tourist, or work visa.

Non-MAGI Medi-Cal: Medi-Cal programs that do not use the Modified Adjusted Gross Income methodology.

Non Filer: A person who does not file taxes and is not the dependent of someone who does.

Notice of Action (NOA): The official notice the County must send to a beneficiary anytime the County is taking any action to start, stop, or change the beneficiary's Medi-Cal eligibility.

Open Enrollment: The time of year when a qualified individual can enroll or change coverage in a Qualified Health Plan through Covered California without needing a qualifying event. See Health and Safety Code § 1399.849(c)(1) and Insurance Code § 10965.3(c)(1).

Out-of-Pocket Costs: Costs that a health plan enrollee is responsible for besides premium payments. These include co-payments and co-insurance amounts that are paid when services are received.

Permanently Residing Under Color of Law (PRUCOL): There are several categories of immigration status that Medi-Cal deems satisfactory to receive full-scope Medi-Cal because the Immigration Agency knows the beneficiary is in the United States but is taking no steps to deport him/her due to his/her special status.

Pickle: A special program through which a person can get Medi-Cal because s/he received SSI and Social Security benefits in the same month but was discontinued from SSI for any reason.

Pregnancy-Related Services: Pregnancy-related medical care, including labor, delivery, care up to 60-days postpartum and family planning.

Premium Tax Credits: The primary form of assistance available through Covered California. This is a tax credit that can be taken in advance, throughout the year, to help pay for insurance. Also known as Advance Premium Tax Credits (APTCs) or premium assistance.

Property: The possessions a person owns that are counted and valued to determine whether an applicant is low-income enough to qualify for Medi-Cal.13 The words "assets" and "resources" are used interchangeably with "property." 22 CCR § §50073 and 50074.

Public Charge: A determinination that an immigrant has become or is likely to become primarily dependent on the government for subsistence.

Qualified Disabled & Working Individual Program (QWDI): This program allows certain disabled individuals who lost their Medicare Part A Benefits due to returning to work to get their Medicare Part A premiums paid by Medi-Cal.

Qualifying Event: A life event that allows someone to enroll in or change Covered California plans outside of Open Enrollment. Also known as a "triggering event."

Qualified Health Plan: A health plan offered through Covered California. All qualified health plans must cover "essential health benefits" as defined by federal and state statute and regulation.

Qualified Individual: A person who resides in California and who is seeking to enroll in a qualified health plan offered through Covered California.

Qualified Immigrant: Categories of immigrants eligible for federal public benefits (including Medi-Cal) if they meet all other eligibility requirements.

Qualified Individual Program (QI): This program allows certain low-income individuals who lost their free Medicare Part A premium benefit because of a return to work to get Part A premiums paid for by Medi-Cal.

Qualified Medicare Beneficiary Program (QMB): This program allows certain low-income Medicare beneficiaries to get Medi-Cal to pay for both their Medicare Part A and Part B premiums, as well as co-payments.

Recipient: A person who is receiving Medi-Cal.

Redetermination: The process through which a county eligibility worker evaluates a beneficiary's eligibility for ongoing Medi-Cal coverage, usually due to a change in circumstances or new information provided on a reporting form.

Refugee Medical Assistance (RMA): A special program through which refugees, asylees, Cuban and Haitian entrants, and victims of trafficking get full-scope Medi-Cal for 8 months if they do not fit into any other Medi-Cal category.

Relative: "A mother, father, grandfather, grandmother, son, daughter, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, niece, half-brother, half- sister, any such person of a preceding or succeeding generation denoted by a prefix of grand, great or great-great or the suffix in-law." 22 CCR § 50084.

Reasonable Payment Plan: A hospital bill payment plan for patients who qualify for financial assistance that takes into account a patient's income and expenses. If the hospital and patient cannot agree on what is reasonable, the Hospital Fair Pricing Act provides a statutory formula.

Reconciliation: The process by which someone who received premium tax credits from Covered California determines whether more payment is due or a refund is due when filing annual taxes. Because advanced premium tax credits are necessarily determined based upon estimated income, more or less will generally be due once final annual income is determined. Reconciliation can also be used by households who did not take tax credits in advance but are eligible for them when filing taxes.

Required Contribution Percentage: The maximum amount of income that a household is expected to contribute to health insurance premiums. This is used in determining how much premium tax credits a household is entitled to.

Residence: The place in which a person or family lives or is physically present if the person or family has no present intention of leaving.

Resources: See Property.

Restricted Services: A person who is ineligible for full-scope Medi-Cal due to unsatisfactory immigration status can receive limited services including emergency services, pregnancy-related services, and kidney dialysis.

Retroactive Medi-Cal: A beneficiary may receive Medi-Cal for any of the three months immediately prior to application if s/he meets all eligibility requirements in those months.

Section 1931(b): A former Medi-Cal program that provided free Medi-Cal to low-income children, pregnant women, parents, and caretaker relatives whether or not they receive cash assistance in the CalWORKs welfare program. This program was named after the authorizing section in the Social Security Act and was the most generous program for most families because it allowed families to deduct a significant amount of earnings to become and remain eligible. The Affordable Care Act collapsed the mandatory categorically needy groups covered by 1931(b) program - children, pregnant women, parents and caretaker relatives - into MAGI Medi-Cal programs.

Share of Cost: "A person's or family's net income in excess of their maintenance need that must be paid or obligated toward the cost of health care services before the person or family may be certified and receive Medi-Cal." 22 CCR § 50090

Selected Low-Income Medicare Beneficaries Program (SLMB): This program allows certain low-income beneficiaries to get Medi-Cal to pay for their Medicare Part B premiums.

Single, Streamlined Application: The application used to apply for Medi-Cal, Medi-Cal Access Program (MCAP) for pregnant women, and insurance in Covered California – both subsidized and unsubsidized; the application is available online and in paper and can be submitted online, by phone, by mail or in person. 10 CCR § 6470.

Sneede/Gamma: Special income counting rules for non-MAGI programs about whose income counts in determining an applicant's eligibility, named after two lawsuits, *Sneede v. Kizer* and *Gamma v. Belshe*. Under these rules, the only persons whose income can be counted are the applicant's, his/her parents', and his/her spouse's, and a parent or spouse can deduct an allowance from their income for living expenses.

Social Security Administration (SSA): The federal agency that administers Social Security, Supplemental Security Income (SSI), and other Social Security benefits for the aged and disabled and qualified family members.

Social Security Disability Insurance (SSDI): A monthly cash benefit for disabled workers who have recent employment history (also called "Title II" benefits).

Special Enrollment Period (SEP): "Period duing which a qualified individual or enrollee who experiences certain qualifying events...may enroll in, or change enrollment in, a Qualified Health Plan through [Covered California] outside of the initial and annual open enrollment periods." 10 CCR § 6410.

Spend-down: An applicant or beneficiary's ability to reduce the amount of income or resources s/he has in excess of the allowed limits in order to get under the limit and therefore become eligible.

Standard Benefit Design: The deductibles, out-of-pocket maximums, co-payments, and coinsurance amounts of health plans offered through Covered California. Because the plan designs are standardized, the deductibles, etc., are the same in each metal tier level regardless of which company is selling it.

Statewide Automated Welfare Systems (SAWS): The statewide electronic business engine for Medi-Cal and other benefits programs.

Substantial Gainful Activity (SGA): In order to be considered disabled by the SSA, a person must not be able to perform work activity which involves significant physical or mental effort. It is referred to as engaging in "substantial gainful activity."

Supplemental Security Income (SSI): A cash assistance payment for persons who are over 65 or meet the disability definition used by the Social Security Administration and have sufficiently low income and resources.

Tax filer: An individual or couple who files an income tax return and no other taxpayer will be able to claim him, her or the couple as a tax dependent. See 10 CCR § 6410. For the Medi-Cal program, the person need only expect to file.

Temporary Assistance for Needy Families (TANF): The federal welfare program that replaced Aid to Families with Dependent Children (AFDC) which provides cash aid and employment assistance to poor families. CalWORKs is the name of California's TANF program.

Termination: When the County stops a beneficiary's Medi-Cal coverage. Terminations only occur at the end of a calendar month. "Termination" and "discontinuance" are used interchangeably.

Transitional Medi-Cal (TMC): Children, parents, and caretaker relatives who lose Section 1931(b) Medi-Cal and/or CalWORKs cash assistance due to increased earnings or increased hours worked by the Primary Wage Earner can receive up to 12 additional months of free Medi- Cal called Transitional Medi-Cal (TMC). The first 6 months are available regardless of income and families can receive additional 6 months if their countable incomes are less than 185% of the Federal Poverty Level.

Triggering Event: A life event that allows someone to enroll in or change Covered California plans outside of Open Enrollment. Also known as a "qualifying event."

Violence Against Women Act (VAWA): Spouses or children of U.S. citizens or LPRs who are permitted to petition for their own immigrant visas under the Violence Against Women Act of 1994 because their qualifying citizen or LPR family member has abused them. Such individuals are eligible for benefits whether the petition is pending or approved.

10-day Notice: Any time the County is reducing or terminating a beneficiary's Medi-Cal or assigning or adjusting a Share of Cost, the County must send a notice specifying the change and explaining the client's appeal rights at least 10 days before the action takes place.

90-Day Period to Cure: When beneficiaries turn in a required reporting form late but within 90 days of the due date, the County must evaluate eligibility as if the beneficiary turned the form in on time, and if ongoing eligibility is established, rescind any termination based on failure to return the form on time.