Introduction to Medi-Cal Eligibility

Medi-Cal — California's Medicaid program — provides health coverage for 1 in 3 of the state's residents, making it a critical and essential part of the state's health care framework. But despite its broad reach, not everyone is eligible for Medi-Cal. Because the program is jointly funded by the federal and state governments, individuals must meet specific eligibility requirements to qualify for the program.

Who Does Medi-Cal Cover?

- Low-income families with children
- Pregnant women
- Low-income adults and children
- Seniors 65 and older
- People with disabilities
- People needing community-based long-term care or care in nursing facilities
- Eligible undocumented individuals regardless of age

What Drives Medi-Cal Eligibility?

Medi-Cal eligibility depends on several key criteria:

- **Age** — Medi-Cal eligibility factors may vary by age.
- **Financial criteria** — Considers household size and income to determine eligibility.
- **Categorical criteria** — In some cases, eligibility is tied to eligibility for or engagement in other federal or state programs, such as cash assistance, foster care, SSI/SSP and other social services programs.
- **Other Demographic or Situational Information** — Considers whether an individual has children, is pregnant, blind or disabled, or needs long-term care services.
- **Residence** — Only California residents are eligible.

Eligibility Pathways

MAGI vs. Non-MAGI

- There are two main ways individuals can qualify for Medi-Cal — one based on Modified Adjusted Gross Income, or **MAGI**, and another that does not use MAGI to determine eligibility, which is referred to as the **Non-MAGI** pathway.
- Both MAGI and Non-MAGI pathways offer the same benefits.

** Depending on their income, some individuals and households may qualify for Non-MAGI Medi-Cal with a "share of cost," which is the amount of out-of-pocket spending that must be met every month before Medi-Cal will pay for services received in that month. MAGI Medi-Cal does not have a share of cost option.

What is MAGI?

The MAGI pathway uses federal income tax rules to determine Medi-Cal eligibility based on how an individual and others in their household file taxes and report income. Applicants' assets or resources are not used to determine eligibility.

Who may qualify:

- Children under age 19
- Parents and caretakers of minor children
- Adults aged 19-64
- Pregnant individuals

What is Non-MAGI?

Some people do not qualify under the MAGI pathway but may qualify under Non-MAGI rules. The non-MAGI pathway is a collection of additional programs in Medi-Cal that offer different ways for individuals in a household to qualify for coverage.

Who may qualify:

- Adults aged 65 and older
- People with disabilities or who are blind
- Children under age 21
- Parent/Caretaker relatives of age-eligible children
- Adults or children in a long-term care facility or nursing home
- Individuals enrolled in Medicare
- Individuals with certain conditions, such as breast and cervical cancer
- Individuals who are categorically eligible for Medi-Cal due to enrollment in another program, such as SSI/SSP, CalWORKs or foster care.

** Non-MAGI programs count household size and income differently than the MAGI pathway and may have other differences, depending on the circumstances of each household.

Presumptive Eligibility

In addition to MAGI and Non-MAGI, another common pathway is presumptive eligibility, which grants temporary and immediate eligibility under certain circumstances.

Example: A pregnant woman at a hospital requests immediate coverage to ensure that she can access prenatal care services. If she appears eligible for Medi-Cal, she is temporarily enrolled and can receive paid services during the month of application and the following month. Coverage is available for up to 60 days while she is applying for permanent Medi-Cal. A full Medi-Cal application must be filed separately and assessed for eligibility for coverage to become ongoing.

How Do People Apply for Medi-Cal?

Direct application to the county online, in person at a county social services office or by phone or mail.

Online, by phone or by mail through Covered California, California's individual health insurance marketplace.

Applying for other state or federal programs that provide categorical eligibility for Medi-Cal.

Applying for presumptive eligibility at a participating provider's office, clinic or hospital.

How is Eligibility Maintained and Renewed?

- Beneficiaries are required to report when certain changes occur, such as changes to address, family size or income, which can be done in person, by phone, through the mail and online. County social service agencies determine if the changes affect eligibility. If the county finds the household is still eligible, the annual renewal date is moved forward by another 12 months.
- **Eligibility must be redetermined at least once every 12 months** to verify that the beneficiary still meets Medi-Cal's eligibility criteria.
- If a person does not respond to a request for additional information to renew their coverage, he/she will likely be discontinued from the program. Coverage can be reinstated if the needed information is provided within 90 days after being discontinued and eligibility is verified.

The Medi-Cal program provides important benefits and services to California's most vulnerable populations; determining and maintaining eligibility are important steps toward accessing vital health care services and promoting positive health outcomes.