

Health Reform Community Forum FAQs – March and May Forums

California’s Health Benefit Exchange – “Covered California”

1) *What is the enrollment period for Covered California?*

The initial open enrollment period is from October 1 – March 31, 2014 for plans beginning January 1, 2014. Subsequently, open enrollment will be October 15 - December 7 for plans beginning in 2015 and beyond.

2) *If open enrollment period is missed, then what are the options for coverage?*

If an individual experiences a qualifying event outside of open enrollment (loss of job, gains a dependent, loses a spouse), then he/she can apply to the Exchange during this “special enrollment” period. Additionally, a person can purchase health insurance outside the Exchange on the individual market (i.e. how someone would apply for coverage today). However, they will not be eligible for a subsidy.

Medi-Cal accepts applications for individuals under 138% of the Federal Poverty Level (FPL) all year.

3) *Please explain the “penalty” when someone is not enrolled in any health insurance plan.*

The federal Affordable Care Act (ACA) requires most individuals to have public or private health insurance by January 2014 or face financial penalties. The penalty phases in over three years and becomes increasingly severe. In 2014, the penalty will be 1% of annual income or \$95, whichever is greater. By 2016 the penalty will be 2.5% of income or \$695, whichever is greater. The penalty will be assessed based on the number of months without coverage. The penalty will remain at 2.5% of income, or \$695 (whichever is greater), unless Congress changes the law.

To make sure you are covered in 2014, you must enroll in a health plan before March 31, 2014. The next open enrollment period begins in October 2014 for coverage in 2015. You cannot enroll at any time except during open enrollment periods unless you qualify for special enrollment (see Question 2).

4) *Who is exempt from the ACA’s “Individual Mandate” to purchase health insurance?*

Below is a list of proposed exemptions. Final federal regulations on exemptions (through the Health Exchange and through the IRS) will be published in Fall 2013.

- If the cost of your premium would be more than 8% of your income

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- Taxpayers with income below the filing threshold, or 100% FPL
- Members of Indian Tribes
- Hardship
- Individuals who experience a coverage gap of 3 months or less
- Religious conscience
- Member of a health care sharing ministry
- Incarcerated individuals
- Individuals who are not lawfully present in the US

5) If an employee's cost of an employer-based health insurance plan is 9.5% or more of his or her income, can that individual apply for health insurance through the Exchange? Would the employer pay a penalty fee for this person?

Yes. If an employer offers coverage that does not cover at least 60% of the cost of covered services for a typical population (a "bronze" plan) or the premium for the coverage would exceed 9.5% of a worker's income, then the employee can obtain coverage in the Exchange and be eligible for a tax credit subsidy.

The employer will pay a penalty \$2,000 per employee, not counting the first 30 employees (i.e. for an employer with 75 employees, the maximum penalty would be \$2000 multiplied by 45). Please note that penalties apply only to employers with more than 50 employees (a "large employer"). Employers with less than 50 employees may provide insurance to their employees, but will not be required to pay a fee if they do not.

6) How does the tax credit work? Does someone have to be enrolled in Covered California, or can it be anywhere?

A person that is 138-400% of the federal poverty level will receive a tax credit to purchase health insurance on California's Health Benefit Exchange (i.e. Covered California). A person can only receive the tax credit subsidy for plans offered through the Exchange. A person can opt to purchase health insurance outside the Exchange (and avoid a federal tax penalty); however, they will not receive a tax credit to help with their premium.

Consumers have the option of receiving a tax credit from the IRS at the end of the year, when they file his/her taxes, or receiving a monthly tax credit that goes directly to their insurance company to automatically reduce their monthly premium contribution.

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7) Are rates for coverage under the Exchange flexible if there are major income changes?

If an individual's income changes over the year, his/her premium amount stays the same. However, the individual's tax credit will be adjusted accordingly, and therefore their contribution amount toward their premium will change.

Any change of income that is not noted to Covered California will be reconciled when you file your tax returns – consumers will either owe money, or will receive a tax credit. If your income decreases, you should notify Covered California as soon as possible and they will help adjust your monthly tax credit that goes toward your premium, so that your contribution is less.

8) If someone has an individual health plan with a healthcare organization, should they apply for Covered California on their own?

If a person is currently purchasing private health insurance (i.e. they do not receive it through an employer or are not on Medi-Cal), beginning in 2014 they will be able to purchase their insurance on Covered California. The benefit of doing this is that if they are under 400% of the federal poverty level they will be provided with a subsidy to help with the cost of their premium. The person can still choose to continue purchasing their insurance how they are currently; however, they will not be able to use a subsidy to do this.

9) If an individual has coverage through his or her employer can they still apply for Covered California to compare and opt out of their employer coverage?

No, a person cannot opt out of their employer coverage to go purchase insurance on the Exchange unless it fails to meet requirements (see Question 5). They may opt out of their employer coverage and purchase insurance outside of Covered California, as they can do currently.

10) Can you say more how Covered California will affect providers? Will there be more providers to handle the influx of new eligible patients?

Managed care companies are currently contracting with additional providers. For instance, in Alameda County, Alameda Alliance for Health (one of the two Medi-Cal Managed Care plans) is currently expanding their Medi-Cal provider network.

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11) Have call centers been established? Will they be handled by each county? What will the phone numbers be?

There will be three state call centers in California: Concord (Contra Costa), Fresno, and Rancho Cordova (Sacramento). The phone numbers for the call centers have not been released, and will open once people are able to begin enrollment on October 1, 2013.

These state call centers will transfer likely Medi-Cal eligible beneficiaries to the appropriate county call centers to complete Medi-Cal applications.

12) Can people opt out of Medi-Cal and go directly through Covered California to purchase health insurance for themselves and their families?

Per federal law, if you are currently a Medi-Cal enrollee or you are eligible for Medi-Cal, you are not eligible to purchase subsidized coverage through Covered California. The family can purchase health insurance outside of Covered California on the individual market, just like how families can currently purchase health insurance.

13) How will the 65+ population be served by Covered California and Medi-Cal?

Individuals age 65 years and older are not eligible to purchase insurance through Covered California. The rules for Medi-Cal for this population will remain the same. They may also apply for Medicare.

CalHEERS

14) What is this new technology called “CalHEERS”?

CalHEERS stands for California Healthcare Eligibility, Enrollment and Retention System. CalHEERS is essentially the computer system behind the Exchange (aka Covered California). It is a computer program that allows prospective consumers to enter their personal and income data and receive information about plans they are eligible for and what they cost. It will also determine preliminary eligibility for Advanced Premium Tax Credits (APTC), MAGI Medi-Cal, and Non-MAGI Medi-Cal.

Covered California awarded Accenture the contract to develop the CalHEERS system.

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15) Who is managing the county conversation with the CalHEERS development team?

Covered California has provided money to counties to hire an individual to be the liaison between their conversations around the development of CalHEERS and how that program will interact with the counties and their SAWS systems (CalWIN in Alameda County). SSA leaders, with support from the California Welfare Directors Association (CWDA), are in constant communication with Covered California to make sure we are updated on its progress and how counties hope it will be developed.

16) Does or will the CalHEERS portal help to identify the eligibility of other benefits programs?

CalHEERS will have one question that asks: Would anyone in the household like a referral to the local Health and Human Services Agency for any of the following programs: CalWORKS and/or CalFresh?

If a consumer selects that box, the information will be forward to an eligibility worker, who will follow up with the consumer regarding their eligibility.

17) If CalHEERS interfaces with INS, what will happen to the undocumented individuals that go through CalHEERS?

Undocumented individuals will not be able to purchase health insurance through Covered California. However, undocumented individuals who are tax filers may apply for coverage for their eligible dependents (whom they claim on their tax return) who are legal permanent residents or citizens.

CalHEERS will interface with the IRS, Social Security Administration and the Department of Homeland Security. To date, there has been very little information as to how these entities will treat applications submitted by undocumented individuals. As undocumented individuals are able to receive a tax identification number and file taxes, it remains to be seen if there will be changes in current treatment of these undocumented individuals and families.

Differences Between MAGI and Non-MAGI

18) What are the differences between MAGI and Non-MAGI Medi-Cal?

MAGI: MAGI is an abbreviation for Modified Adjusted Gross Income and is an income methodology used by the Internal Revenue Service (IRS). It will be a new way that income is determined for certain Medi-Cal beneficiaries, beginning on January 1, 2104.

In January 2014, there will be a new Medi-Cal population which will be in the MAGI Medi-Cal category. These are individuals 19-64 years old. They must simply meet the income requirement of less than 138% of the Federal Poverty Level (FPL), or pay a share of cost depending on the program. These individuals

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will no longer have to pass an asset test. Assets can include cash, checking and savings accounts, stocks, bonds, life insurance, etc.

In addition to the new MAGI Medi-Cal population (individuals age 19-64 at no more than 138% FPL), the MAGI income methodology will also be used for children ages 0-19 (up to 250% FPL), parents and adult caretakers with linkage through a qualifying child (up to 138% FPL), and pregnant women (up to 138% FPL for full-scope Medi-Cal, 138-200% FPL for pregnancy services). These beneficiaries may have a Share of Cost or specific premium amount depending on their income level and program.

Non-MAGI: The Non-MAGI Medi-Cal population includes those low-income individuals who must be linked to Medi-Cal through a specific category - CalWORKS, SSI, aged, blind, disabled, foster care, or adoption assistance. Then, they must pass an asset test (no more than \$2000/individual or \$3000/couple). The asset test still exists for this subset of individuals because Medi-Cal for this population has a different benefit package and/or may be linked to other services (SSI income, etc.) Lastly, they must meet the income requirement (under 138% FPL), or pay a Share of Cost depending on the program (a share of cost occurs when the individual or household exceeds the 138% FPL threshold and therefore have to pay a portion of their premium).

19) What is the Federal Poverty Level (FPL) breakdown for MAGI and Non-MAGI population?

Non-MAGI income methodology uses the net income of the individual or family after deductions, disregards and exemptions to determine financial eligibility to the Medi-Cal program. MAGI income methodology uses the adjusted gross income of the individual or family as reported to the IRS and allows a 5% across-the-board disregard. Therefore a consumer with income at 138% FPL may be eligible for Medi-Cal, given that the 5% disregard drops them down to the 133% FPL level.

Family Size, % of FPL and Monthly Income for 2013

Family Size	100% Monthly	133% Monthly	138% Monthly	150% Monthly	175% Monthly	200% Monthly	250% Monthly
1	958	1,274	1,322	1,437	1,676	1,915	2,394
2	1,293	1,720	1,784	1,939	2,262	2,585	3,232
3	1,628	2,165	2,246	2,442	2,849	3,255	4,069
4	1,963	2,611	2,709	2,944	3,435	3,925	4,907
5	2,298	3,056	3,171	3,447	4,021	4,595	5,744
6	2,633	3,502	3,633	3,949	4,607	5,265	6,582
7	2,968	3,947	4,096	4,452	5,194	5,935	7,419
8	3,303	4,393	4,558	4,954	5,780	6,605	8,257

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20) If someone is aged, blind, or disabled, and under 138% of the FPL, but above the asset test, where do they fall?

Disabled or blind individuals aged 19-64 (whose income is under 138% of FPL, but assets exceed the limit) would qualify for MAGI Medi-Cal. Those over 65 whose income exceeds the asset test are not eligible for MAGI Medi-Cal. However, they may qualify for Medicare and be eligible for one of the Medicare Savings Programs, such as Qualified Medicare Beneficiary Program (QMB) or Specified Low-Income Medicare Beneficiary Program (SLMB).

21) Can Non-MAGI Medi-Cal recipients transition into the MAGI Medi-Cal category?

Yes. When a CalWORKS-linked child ages out of Non-MAGI Medi-Cal (eligible through the month they turn 19), he or she will be eligible to move to the new MAGI Medi-Cal for individuals ages 19-64 if they continue to meet the income requirements.

22) What will happen with the Non-MAGI population (65 + & disabled) who do not qualify for extra help because their income exceeds the Medicare Savings Program limits? Will they be able to receive additional help? Will they still have an asset test?

The aged and disabled population will be covered under Non-MAGI Medi-Cal and are subject to the asset test. This population is subject to a share of cost. The share of cost will be based on the individual's income and maintenance need level. This group may also choose to pay for private insurance to help with costs if they do not also qualify for a Medicare Savings Program. Individuals who are aged and disabled will not qualify for MAGI Medi-Cal as this new program is for adults age 19-64.

The Future of HealthPAC

23) What is the future of the HealthPAC MCE, HCCI, and County programs after Health Care Reform and Medi-Cal expansion is implemented on January 1, 2014? Who are the other individuals, in addition to the undocumented, that will qualify for HealthPAC? Why would HealthPAC enroll someone eligible for Medi-Cal?

The eligibility criteria, including income levels, for HealthPAC in 2014 and beyond are still being determined and will be based on available funding. Currently HealthPAC is funded by: a) County general funds, b) State realignment funds, and c) Federal funds that expire in 2014. HealthPAC has not covered people who are eligible for Medi-Cal and still won't. Therefore, the three existing HealthPAC programs will be restructured to meet the needs of the remaining uninsured.

The Governor's budget proposes a state take back of a portion of 1991 realignment funding because under Medi-Cal Expansion, counties should have a smaller indigent population to care for. Counties have until December 2013 to select one of two methodologies from which a portion of state money to

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the counties for indigent and public health care will move to pay for other county human services programs.

\$300 million will be set aside for FY13-14 to represent what will be the aggregate savings the counties will return. Whatever amount Alameda County calculates as its savings under its selected methodology will impact the available funding sources for HealthPAC, and thus, eligibility.

24) How are patients in HealthPAC going to be informed they are now on Medi-Cal or the Exchange?

The State Department of Health Care Services is currently working on their communication strategy. The County has requested that the County also be permitted to send out information.

25) Will One-e-App go away? Will CBOs get advanced notice (6wks at least) on trainings?

HCSA is currently looking at options to simplify eligibility and enrollment. It is possible that One-e-App will go away; however One-e-App will continue to be used for at least the next year. CBOs will get advanced notice of any upcoming changes.

Eligibility and Enrollment in Alameda County

26) For someone enrolling in November, will the application be processed by January 1, or will the person have to complete a new application for Medi-Cal in 2014?

This person will not need to complete a new HealthPAC application, and the eligibility for HealthPAC will be from first day or the month that the application was started. If the person is approved for HealthPAC MCE, they will be transitioned to Medi-Cal as of January 1, 2014. The County staff is working to transition all HealthPAC MCE populations to Medi-Cal beginning January 1st, so the county advises enrollment into HealthPAC all through December 2013.

27) Can you address what will happen with the Medi-Medi population with health reform?

The Medi-Medi population refers to those individuals that receive Medi-Cal and Medicare benefits. These individuals are also called “Dual Eligible Beneficiaries.”

California will launch a three-year demonstration, of which Alameda County is part of, in January 2014 called Cal MediConnect to promote coordinated health care delivery to seniors and people with disabilities who are Dual Eligibles. Cal MediConnect is part of California’s larger Coordinated Care

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Initiative, which also includes moving all Medi-Cal beneficiaries to a Medi-Cal Managed Care Health Plan to receive their benefits, including Long Term Supports and Services.

For more information, see: <http://www.calduals.org/>

28) For individuals currently on HealthPAC MCE, what will they need to do to get on MAGI Medi-Cal? Can they apply via CalHEERS starting October 1st?

The county will be working to process and automatically transition all these people into Medi-Cal.

29) Will there be retroactive enrollment in Medi-Cal and/or Covered California? Will there still not be retroactive enrollment for HealthPAC? How many months back will the retroactive enrollment go?

Medi-Cal currently has retroactive enrollment. Covered California will not have retroactive enrollment; enrollment must occur during open enrollment. HealthPAC will not have retroactive enrollment; it will continue as it currently is.

30) What will happen to the newly documented that are between 200%-400% FPL?

This population will be eligible for insurance with tax credit subsidies on Covered California.

31) For a wounded service member who returns and requires fulltime care, will he and his spouse or parent caretaker be eligible for Medi-Cal or Covered California health plans when no longer covered by TRICARE even though he may have VA Health Care coverage?

The ACA does not impact VA Health Care, TRICARE or TRICARE for Life Benefits, in that nothing affects veterans' access to the care that they current are receiving. The ACA does, however, allow veterans receiving VA Health Care, or who are uninsured, to also enroll in an insurance plan through the Exchange to receive additional high-quality and affordable care.

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32) What is the eligibility criteria linked to citizenship/5-year permanent residency?

Legal Permanent Residents (LPRs) with any amount of residency and are 138-400% of the Federal Poverty Level (FPL) will be eligible to purchase health insurance on the Exchange and receive a subsidy. LPRs with more than 5 years residency and under 138% are eligible for Medi-Cal.

We are waiting for final budget details to determine the eligibility for Medi-Cal for LPRs with less than 5 years residency. Details to be forthcoming.

33) What is the projected processing time for new applications in October for newly-eligible MAGI Medi-Cal population and for the Exchange?

Below are the most recent draft answers regarding Covered California's recommended application processing times:

Complete online and telephone applications using CalHEERS will be processed in "real time" and within minutes. Complete paper or faxed applications that do not require resolution of any inconsistency will be processed within 10 calendar days of receipt. Incomplete paper or faxed applications that require follow-up as a result of missing information will be processed within 10 days of receipt.

All applications resulting in conditional eligibility for Covered California will allow the consumer at least 90 days to resolve the inconsistency. Consumers may submit a request to extend the 90 day reasonable opportunity period if they provide the reason why the consumer is unable to furnish documents or why documents do not exist to resolve the inconsistency. Consumer's justification is reviewed and must be approved within a recommended 15 day business processing timeframe.

34) How will experience and/or wait times change for undocumented immigrants and mixed status households?

Undocumented immigrants will not be eligible for a health plan on the Exchange. If they are under 200% FPL then they will still be eligible for HealthPAC in 2014 under current processes. Mixed status families should be treated the same when they apply for coverage in terms of processing times mentioned above (see Question 23).

35) Parents with a Medi-Cal Share of Cost are currently enrolled in HealthPAC County. What will they be eligible for in 2014 if it is income that identified them as Share of Cost, not their assets?

This depends on their income. If they are 0-138% of FPL, they will be eligible for Medi-Cal. If they are 138-200%, they will be eligible to enroll in Covered California and will be eligible for a premium subsidy.

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36) If you are over 400% FPL and uninsured, can you purchase on the Exchange?

Yes, you can. However, people over 400% will not be eligible for a tax credit subsidy.

37) Will Medi-Cal income guidelines go up to include more people?

The Medi-Cal income guidelines will be up to 138% of the federal poverty level for all age groups.

38) What coverage is available for individuals who are 138%-200%FPL and don't meet the 5 year country resident requirement?

So long as the person is a legal permanent resident, they will be able to purchase insurance through Covered California and will receive a subsidy.

39) How will same sex couples apply for health coverage?

Coverage through the Exchange is based on your federal income tax return. Same sex couples will apply for health insurance individually unless one partner is claimed as a dependent.

40) What will happen to applicants enrolled in HealthPAC HCCI if they cannot afford to pay the premiums through the Exchange?

HealthPAC HCCI beneficiaries will be eligible for the Exchange on January 1, 2014, where they will be eligible for a tax credit to help pay their monthly premiums. It is still to be determined whether they could get covered through HealthPAC.

41) Are there any changes to the frequency on proof of documentation required to maintain eligibility?

Covered California is still working with DHCS to determine if documents and data matching should occur semi-annually or quarterly.

42) Will currently enrolled Medi-Cal beneficiaries be automatically transferred to the new system (CalHEERS) or do they need to re-enroll?

Currently enrolled Medi-Cal beneficiaries will not be automatically transferred to CalHEERS, as their case management remains with the County SSA. However, the County SAWS system (Statewide Automated Welfare System that does eligibility and enrollment into benefits for counties; it is called CalWIN in

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Alameda County) will interface with CalHEERS (estimated start date of January 1, 2014). At renewal time, beneficiaries' information will automatically be sent to CalHEERS for selection into an Exchange-based health plan, should they no longer qualify for Medi-Cal.

43) With an influx of newly eligible participants, how will this affect the Medi-Cal application? How long will this process be? In Alameda County, will each applicant be assigned a worker?

SSA is currently discussing application formats and processes while we wait for Covered California to develop their single, streamlined application (which the newly eligible and the Exchange populations can use to apply for health coverage). Details of the Medi-Cal application processes will be available as SSA receives more information from Covered CA and DHCS about Medi-Cal application procedures.

44) What's the best number to call if the worker doesn't respond to applicants calls?

If clients need additional, personalized support they should call the Social Services Client Advocate at: (510) 383-2898. Clients may also call the Interactive Voice Response (IVR) number to receive automated information about their case at: 1 (888) 999-4772.

45) Are current Medi-Cal aid codes going to change?

There will be additional aid codes for the new MAGI populations. Currently, there is no information about whether current aid codes will disappear or change.

46) We currently have an Eligibility & Enrollment outreach worker from SSA at our site, will this change since so much is being moved around?

Alameda County SSA will continue its outreach work with CBOs for enrollment. Outreach SSA workers will continue at CBO sites so long there is a sufficient workload for the outreach worker.

Assister and Navigator Program

47) What are the Assister and Navigator Programs?

The Assister and Navigator Programs are programs where certain entities and their employees or volunteers can be trained, certified and registered with Covered California to help enroll individuals and families into health insurance on the Exchange.

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Assister entities will be compensated by the Exchange for successfully enrolling and renewing individuals in Exchange health plans during the initial enrollment period from October 2013 through March 2014 (\$58/successful application and \$25/successful renewal). Compensation may also be available through The California Endowment for Medi-Cal applications and renewals. The State is currently deciding whether or not to take up this offer. Details To Be Determined.

Navigator entities will help the Exchange outreach to specific groups still uninsured after the initial enrollment period. These entities will be sustained through the Exchange's operating costs and will be paid through a block grant, rather than a fee-for-enrollment program.

Insurance agents and health providers can use the CalHEERS system. Insurance agents and hospitals will not be compensated through Covered California for any application assistance due to the monetary incentive to enroll individuals in certain plans. However, community clinics will be able to receive compensation for application assistance.

48) What are the criteria for becoming an assister or navigator?

Assisters and Navigator Individuals must apply through a trained, certified, registered Assister or Navigator Entity. The Entity must be trained, certified and registered with Covered California (see question 19, above) and must approve the individual's request.

Please see the California Benefits Exchange web-site for more details:
<http://www.healthexchange.ca.gov/StakeHolders/Pages/Default.aspx>

49) When will Assister training occur?

This information has not yet been released by the State of California. According to their timeline, training will be available sometime in late summer 2013; however, Covered California is now estimating that the training will be in September 2013.

50) Why should a CBO choose to be an assister or navigator? (i.e which role is more appropriate for what type of organization)?

The assister program is designed for organizations that have the capacity to do one-on-one client work, as assisters will be helping individuals enroll in health insurance programs. The navigator program is focused on outreach.

Please see the California Benefits Exchange web-site for more details:
<http://www.healthexchange.ca.gov/StakeHolders/Pages/Default.aspx>

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51) Despite new access to healthcare, we will still have a large number of uninsured. With that in mind, will we redefine outreach to be more comprehensive and be more a marketing model?

Covered California is actively engaging community partners in an Education and Outreach movement. Organizations and other entities have applied for grants through Covered California to help outreach to California's current uninsured population. The Navigator and Assister Programs will help support these efforts. Navigator Entities will be selected after Initial Enrollment, as they will focus on those populations that remain uninsured after Health Reform begins in January 2014. Covered California emphasizes selecting organizations that show commitment to providing services and outreach to certain hard-to-reach segments of California.

52) Will assisters be expected to inform patients of CalFRESH and other programs patient may be eligible for, if CalFresh is linked to Medi-Cal eligibility software? Or is the Social Services Agency responsible?

Assisters will be expected to help clients select the referral option on the CalHEERS application (see Question 16, above).

53) What role are private providers (e.g. Kaiser) taking and will there be an impact on them?

Private health plans, such as Kaiser, will be offering health insurance programs to populations on the Exchange. A customer can choose from a variety of qualified health plans available based on scope of coverage and cost.

Kaiser is currently informing members who purchased private health insurance through them of the changes the health reform law will take. See: <http://healthreform.kaiserpermanente.org/en/your-guide-to-reform>.

54) What are the new job opportunities with health reform? How does one apply? How soon?

Entities can become Assister or Navigator entities and can generally speaking be compensated by Covered California for their work. One must apply through the Covered California website, with applications being released sometime in Spring 2013. Details on becoming an Assister or Navigator can be found on the California Benefits Exchange web-site:

<http://www.healthexchange.ca.gov/StakeHolders/Pages/Default.aspx>

Additionally, health care careers are on the rise. Please contact the Alameda County Workforce Investment Board (AC WIB) for more information on the current job opportunities in this field:

<http://www.acwib.org/index.htm>

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55) How does Assister/Navigator program interact with the Medi-Cal Administrative Activities (MAA) program or CMAA reimbursement funding? Will we be able to count the time as MAA application, or is it only Fee for service?

Eligibility outreach and enrollment into Medi-Cal activities are eligible for reimbursement by the MAA program. However, to the extent that fees or payments for the Assister program are federal, those costs (covered by federal funding) would not be reimbursable under the MAA program.

56) How does the recent Covered California Outreach and Education Grant program differ from the Assister Program?

California provided funding to a number of entities for “Outreach and Education” regarding health reform implementation. This is intended to take place prior to open enrollment. The Assister Program is for one-on-one help to enroll individuals and families during this period. The Navigator Program will take place after open enrollment, and will give grants to entities to outreach specifically to difficult to reach populations that have not yet enrolled.

57) Can local veteran service organizations be assisters?

A list of assister entities can be found here:

<http://www.healthexchange.ca.gov/StakeHolders/Documents/Assisters%20Program%20Stakeholders%20Webinar%20Draft%20Regs-FINALSlide%20Deck05032013.pdf>

Veterans’ service organizations are eligible to become assisters, and will most likely qualify for payment if they are not considered agents, brokers, county health departments that provide health care services to consumers, hospitals, or other providers.

58) Will funding be available for CBOs to hire medical providers in order to prepare for the influx of patients?

There are not current grants for hiring staff, apart from the traditional programs established by the federal government through the National Health Service Corps. The National Health Service Corps received a \$300 million investment from the American Recovery and Reinvestment Act (ARRA), as well as a \$290 million investment from the Affordable Care Act (ACA).

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59) How can CBO's participate and/or support outreach and enrollment for new MAGI eligible clients?

CBOs can apply to become Covered California Assisters or Navigators when applications are released. Additionally, CBOs can provide resources to their clients about other organizations that are providing outreach and education on health reform. If a CBO elects not to become an Assister they can still unofficially help their clients enroll in coverage through CalHEERS and they will not be compensated for this work. CBOs can also refer clients to other Assister or public benefits entities for further information and support.

60) Are there additional funds for CBO's to perform outreach services for the County?

Outreach grants are not available through the County; however, outreach funding is available through the State of California through the Assister and Navigator Programs.

61) What is the time listed for Assisters Help Desk listed in the PST?

The time for the Assister's Help Desk is Monday-Friday 8am to 5pm, PST.

Scope of Services

62) Will coverage in HealthPAC change at all to help cover more Substance Use Disorder (SUD) services?

HealthPAC coverage currently mirrors Medi-Cal coverage. The scope of services for HealthPAC in 2014 is still to be determined, but will likely continue to mirror Medi-Cal.

63) Do we assume behavioral health is included in all plans for physical health?

State and federal laws require that health plans provide mental health and substance use benefits in a fashion similar to their coverage of other health services. The types and extent of services covered, copayments, and deductibles will vary among plans. As a result of parity legislation and the affordable care act, more people will have health coverage that includes mental health and substance use disorder services.

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64) Will Medi-Cal or Covered California cover dental services for adults?

Medi-Cal does not currently cover adult dental (outside of emergency dental). Partial restoration of dental benefits in the Medi-Cal Program is included as part of the Budget (as of June 18, 2013) beginning May 1, 2014. Services would include preventative care, exams, fluoride treatments, restorations, crowns, full dentures, and emergency care. Partial dentures are not included and root canals would be done on a case-by-case basis. Individuals newly eligible for Medi-Cal benefits will be covered 100% by the federal government. For existing eligibles, the State and federal government will split the cost.

Covered California is a marketplace with many different insurance options, some of which may provide dental benefits, others which will not. By April 2014 Covered California hopes to offer independent dental health plans for consumers to purchase.

65) Why is it still undecided about providing substance use disorder (SUD) services and how is this informed by Federal Parity Legislation?

The federal Center for Medicare and Medicaid Services (CMS) disseminated preliminary guidelines in early 2013 for how Parity regulations should be applied to the Medicaid Expansion population. The guidelines were vague in several crucial areas relevant to substance use benefits, and a Final Rule with more details is not expected from CMS until late this calendar year. The lack of clarity has in the interim opened the door for debates, including in California where the Department of Health Care Services is in the midst of intense discussions with statewide county and provider associations regarding what the substance use benefits should be. The outcome of these discussions will then have to be approved by the State Legislature, the Governor, and ultimately CMS. We are all eager for the statewide definition of these benefits to be finalized soon so we can plan appropriately for January 2014. It is also likely that California will pursue a waiver from CMS that allows individual counties to opt for funding a more enhanced benefit than whatever should be decided upon as the basic statewide one. However, that type of waiver usually takes approximately 2-3 years to develop and get approved by CMS.

Dual Eligible and Medicare Beneficiary Questions

66) Can you explain the Medi-Medi program?

Medi-Medi is term used to describe an individual that is eligible for Medi-Cal and Medicare. They are also known as Dual Eligibles, and will be part of the Duals Demonstration Project under the Coordinated Care Initiative (part of the Affordable Care Act). Dual Eligible beneficiaries will move to a Managed Care Medi-Cal plan and will receive more coordinated care for all of their needs, including Long Term Services and Supports. For more information, please go to the Coordinated Care Initiative web-site:

<http://www.calduals.org/> .

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67) Will those 65+ on Medicare only receive help with lowering their Share of Cost, health premiums and copays through the health reform law?

There are currently Medi-Cal programs for the Aged, Blind and Disabled population that do not require them to pay a share cost. These programs do not go away in 2014. However, this may be a group that chooses to pay for private insurance.

There are also certain Medicare Savings Programs they may be eligible for. For more information see <http://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html>

68) How does the transition to a Medi-Cal Managed Care Plan under the Dual Eligible Demonstration impact in-patient and outpatient mental health services, including skilled nursing facilities?

Alameda County residents with both Medicare and Medi-Cal will be transitioning to managed care plans (Anthem Blue Cross and Alameda Alliance for Health) in the fall of 2013 as part of a demonstration program to evaluate the impact of this change. The managed care plans will be responsible for the Medicare portion of client mental health and substance use benefits.

Alameda County Behavioral Health Care Services (BHCS) will be responsible for the Medi-Cal specialty mental health and substance use disorder treatment benefits for these individuals. Anthem Blue Cross and Alameda Alliance for the Health have contracted with Beacon Health Strategies to help them manage the behavioral health benefits for their new dual eligible clients. BHCS is currently developing formal partnership agreements with Beacon and the health plans.

Part of this pilot program includes an effort to support the movement of individuals from more institutional settings such as skilled nursing facilities to less restrictive settings with appropriate long-term care supportive services. Providers of services to dual eligible individuals should anticipate potential changes to behavioral health service eligibility, covered services, and payment approaches for the dual eligible population in the next few years.

Other Questions

69) How will partnerships with county agencies work?

SSA and HCSA are committed to working together, and with our community partners, as health care reform rolls out over the next few years. We hope to keep our CBO partners informed and updated on any changes to the services they provide our clients, as well as how they can help us prepare for any and all of the upcoming changes to our business processes. Both SSA and HCSA welcome feedback, suggestions and partnership. To contact us, email healthreform@acgov.org.

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70) What will happen to FamilyPACT and Every Woman Counts?

Currently, the State of California has not made any changes to the FamilyPACT program. More details will be available after the Governor's May Budget Review and the passing of the completed budget by the California Legislature this summer.

71) What languages is the Health Reform 101 sheet translated into?

The "How to Enroll" sheet is translated into Spanish, Chinese, Vietnamese, Cambodian, and Farsi. We are working to have the sheet translated into Tagalog, Punjabi, Hindi and Urdu.

72) For the population who can't or won't be enrolled due to disability or lack of awareness, how will they be assisted and how will they avoid violation of not having health coverage? Will they still have to pay a penalty?

All individuals are mandated to have health care coverage in 2014. If they do not qualify for an exemption they will have to pay a penalty (see Question #3).