

Chapter 5: Getting Onto Coverage

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5. Getting Onto Coverage

A. Applying for Medi-Cal, Covered California, and the Medi-Cal Access Program

1. Single Application, Multiple Application Pathways, “No Wrong Door”

Under the Affordable Care Act, individuals have the right to apply for all health “insurance affordability programs” through the Single, Streamlined Application.¹ The Department of Health Care Services and Covered California jointly developed online and paper versions of the Single, Streamlined Application.² The elements of the application are laid out in Covered California regulations.³

Pre-ACA Applications

Though there is now a Single, Streamlined Application, if a county receives an old application form used prior to 2014, including the MC 210, MC 321, or SAWS 2, the county is required to process the application and request needed supplemental information.⁴

The insurance affordability programs are:⁵

- Medi-Cal;⁶

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1. Welf. & Inst. Code § 15926(b); 42 U.S.C. § 18083; 42 C.F.R. § 435.907. The SAWS 2 Plus application allows individuals to apply for CalWORKs, CalFresh and Medi-Cal through one application so if someone fills this out they do not also have to fill out the Single, Streamlined Application.
 2. 10 CCR § 6470.
 3. 10 CCR § 6470(c).
 4. Statute requires counties to accept the old applications until January 1, 2016 (see Welf. & Inst. Code § 15926 (c)(4)(G)) but DHCS has advised counties to continue to accept and process old applications though they have stopped printing them. See ACWDL 15-34 (Oct. 28, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-34.pdf>.
 5. Welf. & Inst. Code § 15926(a)(3); 42 C.F.R. § 435.4.
 6. Medi-Cal includes both MAGI and non-MAGI Medi-Cal programs. But to undergo an eligibility determination for non-MAGI Medi-Cal, applicants must submit supplemental information not required in the Single, Streamlined Application, such as assets information.

- The Children’s Health Insurance Program (CHIP), which includes:
 - Low-cost Medi-Cal for children who were previously in Healthy Families,⁷
 - County Children’s Health Initiative Program (C-CHIP),⁸ and
 - the Medi-Cal Access Program (MCAP);⁹ and
- Financial assistance (Advanced Premium Tax Credits (APTCs) and Cost-sharing Reductions (CSRs)) for health plans available through Covered California.

Individuals have the right to access and submit the Single, Streamlined Application online, in-person, by phone, mail, or fax. Once someone has applied through the Single, Streamlined Application the state is obligated to determine which of the insurance affordability programs the applicant is eligible.

A Special Note on MCAP

The rules for the Medi-Cal Access Program (MCAP – formerly AIM – Access for Infants and Mothers) were not initially included in the rules engine powering the Single, Streamlined Application. Consequently, pregnant women with incomes over 213% up through 322% FPL were incorrectly determined eligible for Covered California subsidies rather than MCAP or denied eligibility if undocumented. The MCAP eligibility rules were added to the business rules in October 2015 so that women should now get a correct eligibility determination.

Individuals seeking unsubsidized health coverage through Covered California may

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7. In 2013, California’s CHIP – known then as the Healthy Families Program – was transitioned into Medi-Cal and referred to as the Optional Targeted Low Income Children’s Program, or TLICP. Because CHIP children who are in Medi-Cal have to pay premiums and co-payments it is sometimes now referred to as “low-cost Medi-Cal” or “Medi-Cal for Families.”
 8. This guide does not cover C-CHIP programs as they are only available in San Francisco, San Mateo, and Santa Clara. They will be added to the online CalHEERS application in March 2016 to further achieve the goal of “no wrong door” in those counties.
 9. The Medi-Cal Access Program is a separate CHIP program for pregnant women with incomes over 213% up through 322% FPL. It was formerly called AIM – Access for Infants and Mothers. Undocumented women can qualify.

apply through these same venues. If they indicate up front that they do not want financial assistance, they will have an expedited application process because they will not need to submit certain financial information.

a. Applying Online

Individuals may apply for coverage online at the joint portal: www.coveredca.com.¹⁰ The website includes a number of shopping and enrollment functions and tools:

- “Shop and Compare,” which estimates whether individuals are eligible for free or low-cost Medi-Cal or subsidized Covered California coverage and the cost of available plans based on household size, income and zip code entered;
- Covered California plan selection;¹¹
- Connection with a Certified Enrollment Counselor (CEC) to help with the application; and
- Creation of an online account which can be updated.

The Covered California online application is available in English and in Spanish. Individuals may complete the entire application process online, unless information on the application cannot be electronically verified, in which case the applicant must submit additional documentation.

Individuals may also apply for health coverage as well as public benefits programs through the county online application portal at www.benefitscal.org. While there are no shop and compare tools, individuals can go to www.benefitscal.org to select their residence county and they will be routed to the appropriate portal for their county. The county portals will accept applications for CalFresh and CalWORKs in addition to Medi-Cal. Once the county eligibility worker reviews the case, it will be run through CalHEERS so the person gets evaluated for all insurance affordability programs, not just Medi-Cal, under this pathway.

10. Despite the name of the website, Covered California screens for Medi-Cal, MCAP, and soon C-CHIP programs where available.

11. Plan selection for Medi-Cal and the Medi-Cal Access Program will be added in the future. 42 U.S.C. § 1396a(a)(10)(A)(i)(IX).

CalHEERS, which stands for the California Healthcare Enrollment, Eligibility and Retention System, is the business rules engine (BRE) that powers the online joint application. CalHEERS contains the eligibility rules for MAGI Medi-Cal, CHIP (including MCAP and C-CHIP), and financial assistance for Covered California plans. It is important to know that the MAGI rules are only in CalHEERS; they are not in the counties' own benefits computer systems, so to be determined eligible for MAGI Medi-Cal a case has to be run through the CalHEERS BRE. If someone applies for coverage at a county, the county system will interface with CalHEERS for the MAGI calculation, as well as some verifications.

b. Applying In-Person: County Offices and Community Partners

Individuals may apply in-person by either going to a county social services office or seeking the help of a Certified Enrollment Counselor, an agent or a broker. Covered California does not itself have in-person application sites, but certifies and trains Certified Enrollment Counselors to assist with in-person applications. MCAP also does not have its own in-person application site but is included in Certified Enrollment Counselor trainings and contracts.

For some populations it is best to apply through the county to get the fastest and more reliably correct eligibility results including:

- ***People who want food assistance through CalFresh and/or cash assistance through CalWORKs in addition to health coverage.*** The county eligibility workers can help someone apply for all three at the same time. Such individuals can also apply for all three programs through www.benefitscal.org as noted above.
- ***People who were in foster care in any state when they turned 18.*** Former foster youth are automatically eligible for Medi-Cal until they turn

26.¹² Income and other eligibility rules do not matter for eligibility for this population. CalHEERS was initially built to require former foster youth to go through the full application process and asked unnecessary questions. That has largely been addressed in CalHEERS but the youth will have to give less information if they apply at the county. On the other hand, youth may be able to get Medi-Cal right away applying online if they do not mind having to answer some additional questions.

- ***Some immigrants.*** Some immigrants, including those who have DACA (Deferred Action for Childhood Arrivals) status or may be PRUCOL (Permanent Residence Under Color of Law) as well as refugees, may do better applying in person because there have been some problems in CalHEERS with immigrants and there are additional refugee programs that are only in the county systems.
- ***Non-MAGI Medi-Cal populations, including seniors and people with disabilities.*** Only *counties* can determine eligibility for non-MAGI Medi-Cal. The joint application includes questions to identify those potentially eligible for non-MAGI Medi-Cal and their cases are transferred to the county. Many non-MAGI programs require additional information about resources or disability status so this information can be provided all at once if an applicant applies at the county.¹³
- ***People who speak a language other than English or Spanish.*** The online application is only available in English and Spanish. The paper application is available in all the Medi-Cal threshold languages. Counties can provide language assistance and, on the Covered California website, people can search for a CEC who speaks their language.
- ***Anyone with an “immediate medical need.”*** Individuals with an immediate medical need require health services and would only get services if they have Medi-Cal. Pregnant women are among those who are considered to have an

12. 42 U.S.C. § 1396a(a)(10)(A)(i)(IX); Welf & Inst. Code § 14005.28(a); ACIN I-31-15 (July 22, 2015).

13. Individuals with disabilities should not be discouraged from applying for MAGI Medi-Cal, however, if they are under the income limit. They will not have to provide additional documentation of resources or disability status and may have an easier time renewing their Medi-Cal as well.

immediate medical need.¹⁴

c. Applying by Phone: Covered California Service Center and Counties

Individuals may apply by phone either by calling the Covered California Service Center at (800) 300-1506¹⁵ or their county social service office. Both the service center and counties take telephonic signatures by having the eligibility worker or customer service representative use one of the following methods:

- Check a box in SAWS attesting that the eligibility worker heard the applicant affirm the required elements for a signature;
- Record the entire interview; or
- Record the portion of the interview where the applicant affirms the required elements for a signature.

If an individual calls the Covered California service center to apply for coverage, the customer service representative will perform the “quick sort” – asking a few basic questions to see if the person is likely Medi-Cal eligible. If someone in the family is likely Medi-Cal eligible, Covered California will transfer the customer to their county through a “warm handoff” which involves getting the county worker on the phone for the individual.

d. Applying by Mail: The Single, Streamlined Paper Application

The paper Single, Streamlined Application may be downloaded from either the Covered California or the Medi-Cal website and is available in the twelve written Medi-Cal threshold languages: English, Arabic, Armenian, Chinese, Farsi, Hmong, Khmer, Korean, Russian, Spanish, Tagalog, and Vietnamese.¹⁶ Individuals may print

14. *Medi-Cal Eligibility Procedures Manual*, 4J-1, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/Article4-ApplicationProcess.pdf>.

15. This is the number for assistance in English. Covered California also has designated 800-numbers in the Medi-Cal threshold languages listed on their website <http://www.coveredca.com/get-help/contact/>.

16. Single Streamlined Application: <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/SingleStreamApps.aspx>.

out the application and send fully or partially completed applications to Covered California or a local county office for processing. Those who send in partially completed applications are able to get help filling out the rest of it by calling the Covered California Service Center or county.

Non-MAGI Applications

If an applicant answers a question on the Single, Streamlined Application indicating that they may be eligible for a non-MAGI program, e.g., indicating they are over 65 or have long-term care needs, their application is sent to the county to seek the needed supplemental information for a non-MAGI eligibility determination, such as assets/resources. There is a supplemental form that can be used with the Single, Streamlined Application to collect information needed to determine eligibility for non-MAGI Medi-Cal programs.¹⁷ If someone applies for health coverage using the previous Medi-Cal application – the MC 210 which is being phased out – the county can determine their eligibility for non-MAGI Medi-Cal programs.

2. Expedited Coverage Pathways

A number of pathways are available for immediate access to Medi-Cal coverage. Some of these pathways are only available to particular populations, while others provide temporary coverage based on preliminary information while the individual completes a full application.

a. Accelerated Enrollment (AE)

Accelerated Enrollment allows children under the age of 19 who apply through the Single, Streamlined Application and are likely eligible for Medi-Cal to be enrolled right away in temporary, fee-for-service Medi-Cal while the county makes a final

17. Welf & Inst. Code § 15926(c)(2). For the non-MAGI screening packet, see page 11 of ACWDL 14-18 (Apr. 18, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf>.

Medi-Cal eligibility determination.¹⁸ If the county determines the child eligible, AE is discontinued and Medi-Cal is continued in the appropriate aid code with no interruption in benefits.¹⁹ AE is not time-limited and continues until the county completes the eligibility determination and either terminates AE at the end of that month if the child is ineligible for ongoing Medi-Cal or transfers the case into the appropriate aid code for ongoing Medi-Cal.

Children do not need to be citizens or immigrants otherwise eligible for full-scope Medi-Cal to get AE. Documentation showing citizenship or immigration status is not needed for the initial AE screen, but will be necessary to determine ongoing Medi-Cal eligibility. However, children who appear in the State's computer system ("MEDS") to only be eligible for restricted-scope Medi-Cal are not eligible for AE.

The child's Medi-Cal will be in Aid Code 8E. AE is full-month eligibility. This means that if a child gets Medi-Cal in AE on March 10th, for example, they have Medi-Cal from March 1st to the 31st. This includes coverage of services provided after a determination of eligibility for ongoing Medi-Cal is completed, as well as for services provided before the AE was processed. AE also includes a retroactive coverage period of up to three months prior to the month of application, if requested and if the child was Medi-Cal eligible in those months. If a county determines ongoing eligibility, the case will not be transferred into the appropriate ongoing aid code until the first of the following month.

b. Deemed Eligible (DE) Infants

Under federal law, newborns born to mothers on Medi-Cal are "deemed eligible" (DE)

18. Welf. & Inst. Code § 14011.6; ACWDL 02-36 (Apr. 18, 2002), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c02-36.pdf>. Both this code section and the ACWDL refer to the "single point of entry" which was the processing entity for the old Medi-Cal/Healthy Families children's health coverage application. That has been replaced by the Single, Streamlined Application.

19. ACWDL 02-36 (Apr. 18, 2002), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c02-36.pdf>.

for Medi-Cal for their first year of life.²⁰ They must be enrolled in Medi-Cal without an application.²¹

To enroll a baby through DE, a parent, provider or other person at the family's request notifies the county that the baby was born. This can be done by telephone, through use of the Newborn Referral Form,²² the CHDP Gateway (see Section A.2.e. below), or other contact with the county advising of the baby's name, sex and date of birth and the mother's Medi-Cal information.²³ No other information or verification is needed; if the county finds the mother had Medi-Cal on the baby's date of birth, the baby is automatically enrolled. Even if the baby is no longer living with the mother when the county is advised of the birth, if the mother was on Medi-Cal on the day of birth, the baby must be enrolled in Medi-Cal.²⁴ The baby is eligible for Medi-Cal until their first birthday at which time the county must determine whether the baby continues to be eligible. Even if the mother loses Medi-Cal in the baby's first year, the baby remains eligible during the whole first year.

DE infants can also be identified through the CHDP Gateway.²⁵ When that happens, the infant is automatically enrolled in on-going Medi-Cal, with their own final Medi-Cal eligibility number, in real time.²⁶ See Section A.2.e.

c. Hospital Presumptive Eligibility²⁷

Certain hospitals may provide "presumptive eligibility" determinations for individuals

20. 42 U.S.C. § 1396a(e)(4); ACWDLs 09-17 (Apr. 12, 2009) <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c09-17.pdf>, 03-49 (Oct. 6, 2003), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c03-49.pdf>, and 91-79 (Nov. 4, 1991), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c91-79.pdf>.

21. *Id.*; 22 CCR § 50262.3.

22. The Newborn Referral Form, MC 330 (1/15), can be downloaded at: http://www.dhcs.ca.gov/formsandpubs/forms/Forms/MCED/MC_Forms/MC330_Eng.pdf

23. ACWDL 03-49.

24. ACWDL 09-17.

25. ACWDL 05-02 (Feb. 17, 2005), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c05-03.pdf>.

26. ACWDL 04-02 (February 14, 2004), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c04-02.pdf>. See page 2 of the ACWDL for "permanent modification" to the CHDP Gateway to identify and enroll deemed eligible infants.

27. DHCS ACA Hospital Presumptive Eligibility (PE) Program resources: http://files.medi-cal.ca.gov/pubsdoco/aca/aca_HPE_landing.asp.

eligible for MAGI Medi-Cal: children, pregnant women, parents, caretaker relatives, expansion adults, and former foster youth. These determinations enable temporary but immediate enrollment into Medi-Cal based on preliminary information.²⁸

Hospitals must be Medi-Cal providers approved by the Department of Health Care Services to make presumptive eligibility determinations. Individuals complete the Hospital PE Application – a one-page form attesting to income, household size and state residency – either in paper form or with a hospital staff member entering the information electronically. Hospitals submit application information through the Hospital PE Application Web Portal for processing – checking that applicants do not show in the Medi-Cal Eligibility Data System (MEDS) as having coverage and that they meet the basic eligibility criteria. Hospitals should receive a real-time eligibility response indicating approval or denial of presumptive eligibility. If applicants are eligible, they are given an “Immediate Need Eligibility Document,” which functions as a Medi-Cal card. These individuals receive full scope Medi-Cal benefits.

Temporary Medi-Cal eligibility through Hospital PE lasts up to 60 days, beginning the first day of the month the Hospital PE application is approved and ending the last day of the following month. MEDS automatically terminates Hospital PE eligibility on the last day of the following month in which the PE determination was made unless the individual has filled out a full Medi-Cal application and the county has sent a transaction to MEDS documenting that application.²⁹ Once the full Medi-Cal application is submitted the presumptive eligibility is extended until the application is processed.

Enrollment in the Hospital PE program is limited to one enrollment in a twelve-month period except that pregnant women may access the program once in a twelve-month period per pregnancy for ambulatory prenatal services.

28. 42 U.S.C. § 1396a(a)(47); 42 C.F.R. § 435.1110; Welf. & Inst. Code § 14011.66; ACWDL 14-14 (Mar. 27, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-14.pdf>.

29. ACWDL 14-14; MEDIL 14-48 (Oct. 1, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-48.pdf>.

d. Presumptive Eligibility (PE) for Pregnant Women

Low-income, pregnant women and teens may also access immediate, temporary Medi-Cal coverage for prenatal care based on preliminary information.³⁰

Pregnant women and teens complete the PE for Pregnancy Application (MC 263) – attesting to basic information on residency and income – at the office of their prenatal provider. As with the full Medi-Cal application, each expected child counts as a family member, so a pregnant woman is always at least a household of two, and a woman, for example, who is carrying twins and is married would be counted as a family of four in determining the applicable household size and income level for eligibility.³¹ There is no verification; self-attestation is sufficient. Pregnant women and teens who are presumptively eligible receive a temporary eligibility card from the provider to cover presumptive eligibility benefits. PE Medi-Cal covers pregnancy tests, ambulatory (out-patient) prenatal care, prescription drugs for conditions related to pregnancy, out-patient abortion procedures and dental services. Services not covered under presumptive eligibility include: inpatient services, family planning and delivery. If a pregnant woman needs a procedure that is not a PE benefit, she should apply for Medi-Cal and make it retroactive to cover any months (up to three months back) in which she received services.

Presumptive Eligibility for pregnant women initially lasts for the month in which it is given through the end of the following month. As long as the pregnant woman has submitted a Medi-Cal application, the provider may extend her PE period for another two months as many times as necessary until the Medi-Cal application is either approved or denied.

Pregnant teenagers can get Presumptive Eligibility. If they are living by themselves, only their income will count. If they are living with their parents, their income will be counted as well. Teens living with parents whose household income are over 213% FPL may still qualify under the Parental Income Disregard Program for Women under

30. 42 U.S.C. § 1396r-1; Welf. & Inst. Code § 14148.7; ACWDLs 95-74 (Nov. 23, 1995), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c95-74.pdf> and 93-78 (Oct. 27, 1993), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c93-78.pdf>.

31. See Chapter 2, Section A for more on household counting rules.

21 needing pregnancy-related care.³² A teenager living with her parents who wishes to receive confidential services, can apply for the Minor Consent program. See Chapter 3, Section D.1.

The PE for Pregnancy Program was operated completely on paper until November 1, 2015. As of November 1 there is an electronic Prenatal Gateway.³³ Providers will have to convert to this e-system by February 1, 2016.

e. CHDP Gateway

CHDP is the Child Health and Disability Prevention Program. See Chapter 3, Section D.3 for a description of the CHDP program itself. The CHDP “Gateway” provides children with immediate, free, temporary full-scope Medi-Cal through presumptive eligibility when providers pre-enroll them at the time of a “periodic visit” for preventive screenings through an electronic application process at a health care provider’s office.³⁴

Families complete the Pre-Enrollment Application (DHCS 4073) with CHDP providers. The application form is a one-page form that asks for the child’s name, household size, family income and information about the parents. There are no questions about immigration status on the application but children who are identified in MEDS as only eligible for restricted-scope Medi-Cal because of immigration status are not eligible to be pre-enrolled in Medi-Cal through the CHDP Gateway.³⁵ However, they are still entitled to CHDP services. There is no verification as part of the CHDP Gateway; self-attestation of information is sufficient. CHDP providers submit the pre-enrollment applications through the CHDP Gateway electronic interface. Eligible children will be given an Immediate Need Document, a receipt showing their eligibility for Medi-Cal

32. ACWDL 03-34E, (Aug. 3, 2004), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c03-34e.pdf>. See Chapter 3, Section D.2 for a description of the Parental Income Disregard program.

33. See the Presumptive Eligibility website for more information about recent program changes: <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/PE.aspx>.

34. Welf. & Inst. Code § 14011.7; ACWDL 03-33 (Jun. 18, 2003), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c03-33.pdf>.

35. This is expected to change with the implementation of SB 75 in May 2016 that extends full-scope Medi-Cal to all children regardless of immigration status, though details of the implementation were not finalized at the date of publication.

that they can use for services. Children will also receive a temporary Medi-Cal card in the mail.³⁶

Coverage consists of full-scope Medi-Cal and lasts for the month in which it is given through the end of the following month. Families must fill out a full Medi-Cal application before the end of the second month to continue the child's Medi-Cal benefits beyond the initial period.³⁷ Those that have submitted the full Medi-Cal application will have their children's coverage extended until an eligibility determination is made.

If a child meets the eligibility requirements for the Gateway program and the child's record in the MEDS computer system shows that the child has other health coverage (or OHC), the Other Health Coverage will *not* be used to deny payment or request for services from a Medi-Cal provider as it does in other scenarios where the beneficiary has additional coverage.³⁸ The state will override the OHC code in MEDS during the months that the child is pre-enrolled through the Gateway program to ensure that the child will be able to receive Medi-Cal covered services regardless of the OHC status and so that the provider will be paid. This override will then be removed by MEDS in the month after the child is determined eligible or ineligible for ongoing Medi-Cal.³⁹

Deemed Eligible infants⁴⁰ can also be identified through the CHDP Gateway. When that happens, the infant is automatically enrolled in on-going Medi-Cal, with their own final Medi-Cal eligibility number, in real time.⁴¹

Effective July 31, 2015, a child may be pre-enrolled into full-scope Medi-Cal through the CHDP Gateway only two times a year.⁴² The practical effect is to limit opportunities for infants under the age of 18 months to enroll in temporary full-scope

36. ACWDL 03-33, p. 5.

37. *Id.* at p.3.

38. *Id.* at p. 7.

39. *Id.* at pp. 7 & 8.

40. See Section A.2.a above.

41. ACWDL 05-02 (Feb. 17, 2005), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c05-03.pdf>.

42. MEDIL 15-26 (Aug. 28, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-26.pdf>; CHDP Provider Information Notice (August 12, 2015).

Medi-Cal or, if under 12 months, be screened for deemed eligibility, since all other children qualify for only one CHDP visit a year based on the periodicity schedule.⁴³

f. Accelerated Eligibility (AE) for Federal Breast and Cervical Cancer Treatment Program (BCCTP)

California has two Breast and Cervical Cancer Treatment Programs (BCCTPs) for low-income persons who have been diagnosed with breast or cervical cancer. One is a federal Medicaid optional program that provides women with immediate, full-scope, no-cost Medi-Cal, which is commonly referred to as Federal BCCTP.⁴⁴ The other is a state-only funded program, commonly known as State BCCTP, which provides time-limited, cancer-related Medi-Cal to low-income uninsured or underinsured women and men.⁴⁵ See Chapter 3, Section E.1 for more information regarding the eligibility criteria for both BCCTPs.

Unlike other Medi-Cal programs, a person cannot apply for BCCTP at a county welfare office or through Covered California.⁴⁶ Eligible applicants are screened and enrolled into BCCTP by authorized health care providers, who file an online application on behalf of the applicant. The application is then evaluated by a state eligibility specialist at the Department of Health Care Services.

Only providers who participate in either of the following cancer detection programs may enroll applicants in BCCTP:

- Every Woman Counts (EWC), or
- Family Planning Access Care and Treatment (Family PACT).⁴⁷

If a person has been diagnosed with breast or cervical cancer but the provider is not

43. <http://www.dhcs.ca.gov/services/chdp/Documents/HealthPeriodicity.pdf>.

44. Welf. & Inst. Code § 14007.71.

45. Health & Safety Code §§ 104161, et seq.

46. If a person applying for Medi-Cal at a county office appears to be eligible for BCCTP, the county worker should refer the person to the BCCTP toll-free number 1-800-824-0088. ACWDL 06-09 (Feb. 24, 2006) at p.6, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c06-09.pdf>. Note that this is also DCHS's toll-free line for information regarding presumptive eligibility for Medi-Cal for pregnant women.

47. ACWDL 06-09.

with Every Woman Counts or Family PACT, the person must still see an Every Woman Counts or Family PACT provider who can confirm the diagnosis and submit the BCCTP application through an online, Internet-based application process.⁴⁸

Advocacy Tip: To find a provider who participates in Every Woman Counts or Family PACT: Call the Department of Health Care Services' Every Woman Counts referral line at 1-800-511-2300.

The provider submits the online application on behalf of the applicant and then the provider receives a confirmation document that indicates eligibility. If the person appears to be eligible for *Federal* BCCTP, she will be granted Accelerated Eligibility (AE).⁴⁹ Accelerated Eligibility allows an eligible woman to be immediately enrolled in temporary full-scope no-cost Medi-Cal and receive a Benefits Identification Card (BIC) in the mail within four business days.⁵⁰ She will remain enrolled until the state or county makes a final determination of her eligibility for BCCTP, *unless* she indicates on the online application that she does not want continuing Medi-Cal, in which case the AE coverage will end on the last day of the following month.

Advocacy tip: A person must answer “yes” to the question on the online application asking if the person wants continuing Medi-Cal, so that their full-scope Medi-Cal will continue under AE until the state determines them ineligible.

When an individual applies and does not appear to be eligible for Federal BCCTP, then an eligibility specialist at the Department of Health Care Services will complete

48. Medi-Cal Informational Notice 372 (Sept. 2009).

49. There is no Accelerated Enrollment for state-only BCCTP.

50. Welf. & Inst. Code § 14007.71(a). Once enrolled through AE, the person can use the confirmation document received at the time of the online application to obtain medical services. ACWDL 06-09 at p.6. The Aid Codes for AE through Federal BCCTP are OM (eligibility limited to two months) and ON (continuing eligibility under AE while a Federal BCCTP eligibility determination is made).

an eligibility determination for State BCCTP and establish the appropriate time limited coverage and scope of benefits in order for the person's coverage to begin.⁵¹

g. Express Lane Enrollment (ELE)

The Department of Health Care Services obtained a waiver under a federal option to enroll some people who are receiving CalFresh benefits into Medi-Cal for twelve months without requiring any additional information.⁵² To qualify the person must be under the age of 65, neither blind nor disabled, and not receiving Medi-Cal or Medicare. The aid codes are 7U for adults 19-64 and 7W for children under the age of 19.

In 2014, the Department of Health Care Services mailed notices to people receiving CalFresh but not Medi-Cal informing them of their ability to opt into Medi-Cal by phone, by mail, or online. People receiving CalFresh benefits can also opt into Medi-Cal at a county social services office. Medi-Cal coverage is effective on the first day of the month they opt into coverage. Someone who did not receive the mailing but who has CalFresh can request Medi-Cal coverage and the county should process that request, again without asking for any additional information.

The CalFresh application and recertification form, CF 285, allows applicants and beneficiaries applying for or renewing CalFresh to check a box that they want the information used to determine their Medi-Cal eligibility. CF 285 forms received by counties where the applicant or beneficiary checked the Medi-Cal box are to be treated as an Express Lane application and the person should get Medi-Cal if they are under 65 years and are eligible for CalFresh. On the SAWS2Plus application for multiple programs (CalFresh, CalWORKs and Medi-Cal), someone can check in the "Medi-Cal Health Care" question 6 that they want Medi-Cal, can skip the health care-specific questions, and will receive ELE Medi-Cal if they are found eligible for CalFresh. If the applicant chooses that route and is found ineligible for CalFresh, they will have Medi-Cal for at least a year and, at renewal, the county will send them

51. Health & Safety Code §§ 104162(e) and 104162.2.

52. CMS State Health Official Letter #13-003, "Facilitating Medicaid and CHIP Enrollment and Renewal in 2014" (May 17, 2013), <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-003.pdf>; Welf. & Inst. Code § 14005.66; ACWDL 14-06 (Feb. 21, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-06.pdf>.

a Request for Tax Household Information (RFTHI) form to determine their eligibility for Medi-Cal.

If someone who enrolled into Medi-Cal through Express Lane Eligibility loses their CalFresh, the county should send them a RFTHI form to process their eligibility for MAGI Medi-Cal. The person stays in Express Lane Enrollment Medi-Cal while the form is being processed. By the person's twelfth month of Express Lane Enrollment Medi-Cal eligibility, the county must do a Medi-Cal redetermination and determine their eligibility under the Medi-Cal rules rather than simply relying on CalFresh enrollment.

h. Children in Foster Care

The County is responsible for ensuring that the health care needs of children in its foster care program are met. Children in foster care should be granted expedited Medi-Cal eligibility upon removal from their homes so they can quickly access any needed health care.⁵³ If the child was already on Medi-Cal when removed from home but does not have access to their Medi-Cal card, the county must issue immediate proof of Medi-Cal eligibility or a new Medi-Cal Benefits Identification Card (BIC) at the request of the child's foster care worker or foster parent.⁵⁴ For children who are not in foster care, the County must process the Medi-Cal application within 45 days.⁵⁵

i. Former Foster Youth

Since January 1, 2014, individuals in foster care on their 18th birthday must

53. Welf.& Inst. Code § 14007.45 (which exercises a federal Medicaid option under 42 U.S.C. § 1396r-1a); ACWDL 01-41 (Jul. 25, 2001), at p. 2, <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c01-36.pdf> ("Each county should appoint a Foster Care Coordinator in the Medi-Cal eligibility agency to ensure that foster care workers and child protective service workers who are involved in the removal of a child from the home, have a contact within the eligibility agency to expedite the issuance of proof of eligibility for the child.")

Some counties have adopted their own policies to issue Medi-Cal cards within 24 hours.

54. ACWDL 01-41. Also, foster care children are eligible for 12 months of Continuous Eligibility for Children (see Chapter 3, Section C.16). ACWDL 02-20 (Apr. 5, 2002), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/02-20c.pdf>.

55. 42 C.F.R. § 435.911; 22 CCR § 50177(a)(1).

automatically be enrolled in Medi-Cal under the Former Foster Care Children's (FFCC) Program, without any interruption in coverage, without requiring a new application, and without having to provide additional information.⁵⁶ Foster youth who are about to exit the foster care system are to be screened to ensure that their Medi-Cal coverage is active; that they are moved to aid code 4M once they exit foster care and have a Medi-Cal Benefits Identification Card (BIC); and are informed of their right to stay on Medi-Cal until they are 26.⁵⁷

If an individual has previously aged out of the FFCC Program aid code 4M when the program ended at age 21, but is under age 26, they still qualify until the month of their 26th birthday.⁵⁸ In an effort to maintain coverage for the approximately 1,000 former foster youth who were going to age out of the FFCC Program at age 21 prior to January 1, 2014, the state created a "bridge" where former foster youth who turned 21 years old between July 1, 2013 and December 31, 2013 were to retain their Medi-Cal Aid Code 4M coverage.⁵⁹

Individuals eligible for coverage must meet the following criteria:

- Were in foster care on their 18th birthday,
- Are not enrolled in the foster care system,
- Are not in Medi-Cal, and
- Are under the age of 26.

56. Welf. & Inst. Code § 14005.28(a)(1); ACIN I-31-15 (Jul. 22, 2015), <http://www.dss.cahwnet.gov/lettersnotices/EntRes/getinfo/acin/2015/I-31-15.pdf>; ACWDL 14-41 (Feb. 5, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-41.pdf>; MEDIL 14-05 (Jan. 17, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-05.pdf>; MEDIL 13-07 (Jun. 28, 2013), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL%2013-07.pdf>. Individuals who were previously enrolled in aid codes 40, 42, 43, 45, 46, 49, 4C,4H, 4L, 4N, or 5K are all eligible under the ACA FFCC extension with aid code 4M up to the age of 26.

57. ACIN I-31-15.

58. MEDIL 14-05.

59. MEDIL 13-07.

They may apply online through Covered California⁶⁰ or go to their local county office and identify themselves as a former foster youth. Such applicants may use the simplified one-page Medi-Cal application form MC 250A specifically for former foster youth, or the county worker may obtain the necessary information verbally, over the phone, electronically, by mail or fax.⁶¹ Applicants may self-attest to having been in foster care at age 18 and should be immediately enrolled in coverage.⁶² The county has 30 days to verify prior foster care status from any county, state (if not California) or tribe where the individual was in foster care and that the child was enrolled in Medicaid at the time of aging out of foster care.⁶³

j. Minor Consent Medi-Cal

A child under 21 who lives at home with a parent may obtain the limited-scope Minor Consent Medi-Cal by applying for the program benefit at the county welfare office and by completing a form called Request for Eligibility for Limited Services (MC 4026) and the Statement of Facts (the MC 210).⁶⁴ The minor must contact the eligibility worker each month to continue the services and fill out an MC 4026 form, though the

60. The California Healthcare Enrollment, Eligibility and Retention System (CalHEERS) was not initially programmed to disregard income determinations for former foster youth, so in 2014 and through much of 2015 former foster youth were advised to apply for coverage at the county instead. MEDIL 14-05. But in October 2015, a system fix was made to CalHEERS so that former foster youth could apply online and have their eligibility determined for the FFCC Program. And as of February 2016, former foster youth will be allowed to skip unnecessary questions such as about income and taxes on the online application.

61. ACWDL 14-41 (Feb. 5, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-41.pdf>; MEDIL I 14-05 (Jan. 17, 2015), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-05.pdf>.

62. ACWDL 14-41. “Prior foster care status can be attested to by the FFCC applicant at the time of application and verified later by the county. If the individual applies as a FFCC applicant, the county is to immediately determine the individual eligible for FFCC program based on self-attestation.”

63. ACWDL 14-41; MEDIL 14-05.

64. 22 CCR § 50147.1(b); *Medi-Cal Eligibility Procedures Manual*, 4V-2. While the MC 210 is no longer generally in use, this is an easier application to use than the Single Streamlined Application and some counties at least have copies on hand to use for Minor Consent Services applications. But it may soon no longer be accepted for this purpose. See Chapter 3, Section D.1 for the scope of services covered by the Minor Consent Program (pregnancy related services, family planning, treatment for sexual assault, rape, sexually transmitted diseases, drug and alcohol abuse treatment, and outpatient mental health services, including counseling).

minor need not sign the form every month.⁶⁵

To obtain mental health counseling services a minor must request these services through the County Mental Health Plan, which is responsible for authorizing all mental health services for Medi-Cal beneficiaries in California.⁶⁶

Advocacy Tip: To receive mental health services under the Minor Consent program, the minor should call the the County Mental Health Plan Access Line in their county and request an assessment or evaluation under Medi-Cal Minor Consent (also called “Sensitive Services”). If the County Mental Health Plan refuses to schedule such an assessment, the advocate should file a grievance.

No notices or mail should be sent to the minor’s home address. The child can provide the county with an alternative address to send information to, if necessary. However, applicants receive a paper Medi-Cal card that gets reactivated monthly and notices of action are issued by the worker in person, so there is no real need for an alternative address.

The minor should not need to present identification documents, a social Security number, pregnancy verification or proof of residency. Documentation of immigration status is not required for Minor Consent Medi-Cal.⁶⁷ Income and property verification are required for minors who are employed or who have bank accounts.⁶⁸ Minors do

65. *Medi-Cal Eligibility Procedures Manual*, 4V-4.

66. See DMH Information Notice 98-09, (July 3, 1998), <http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice98-09.pdf>; also note 22 CCR § 50147.1(c), which sets forth a specific process by which a minor must obtain a statement from a mental health provider indicating that they meet specific criteria for the treatment is, in essence, obsolete because Medi-Cal mental health services are “carved out” from other health services (*i.e.*, there is a separate managed care system) and all persons seeking mental health services must request these services from the County Mental Health Plan (MHP). For more information on the mental health managed care carve out for Medi-Cal, visit the Disability Rights California website at www.disabilityrightsca.org, *e.g.*, Publication # 5495.01, January 2014).

67. *Medi-Cal Eligibility Procedures Manual*, 4V-2.

68. See *Medi-Cal Eligibility Procedures Manual*, 4V-3.

not have to provide verification for accounts they do not have access to.⁶⁹

Family Planning Services. For family planning services, a minor can seek services through Family Planning, Access, Care and Treatment program (Family PACT), a government program that provides free and confidential family planning services. Call 1-800-541-5555 for more information or to find a provider. For more information about Family PACT, visit the website at <http://www.familypact.org/>.

k. Tuberculosis (TB) Program

There is a special application form for the Tuberculosis Program, MC 274 TB, which is available at the county welfare offices and at providers' offices. On the application, the physician or her designated staff must certify that the individual is infected with tuberculosis. Most applications are submitted by community clinics where tuberculosis infected patients are seen. For more information on the TB program, see Chapter 3, Section E.2.

3. Medi-Cal Connections with Public Benefits Programs

a. Programs Linked to Medi-Cal

Eligibility for some programs, e.g., CalWORKs and SSI, automatically make someone eligible for Medi-Cal. If a family receives CalWORKs benefits they receive Medi-Cal without having to file a health care application.⁷⁰ Similarly, if a person is already receiving SSI or IHSS they are categorically linked to Medi-Cal so they automatically get Medi-Cal without having to apply separately.⁷¹ People on CalWORKs, SSI or IHSS will get a Medi-Cal card, welcome packet, and health plan choice packet.

69. *Id.*

70. Welf. & Inst. Code § 14005.30.

71. 42 U.S.C. § 1396a(a)(10)(A)(i)(II); 42 C.F.R. § 435.120 (SSI); Welf & Inst. Code § 12305 (IHSS).

If someone loses their cash aid through CalWORKs or SSI, the county must determine whether they are still eligible for Medi-Cal before terminating their coverage.⁷² Most families that are leaving CalWORKs should have their Medi-Cal eligibility extended for at least 6-months through the Transitional Medi-Cal program. For information regarding Transitional Medi-Cal, see Chapter 3, Section C.5.

b. Joint Application for Health Coverage and Public Benefits

The SAWS2 PLUS Application can be used to apply for Medi-Cal, CalWORKs and CalFresh on one application. It replaces the old SAWS2 form by including the tax household questions needed for MAGI income determinations. People can also apply online for Medi-Cal, CalWORKs and CalFresh simultaneously at www.benefitscal.org.

4. Application Process and Eligibility for Inmates

Medi-Cal beneficiaries who become inmates at public institutions have their Medi-Cal enrollment suspended temporarily, for up to one year, and then unsuspended when they are released.⁷³ In addition, assistance with applying for health coverage is provided when inmates in public institutions are close to being released.⁷⁴

An agreement between the Department of Health Care Services and the California Department of Corrections and Rehabilitation requires that the corrections department assist inmates with filling out the paper Single, Streamlined Application 60-90 days before the scheduled release. Inmate applicants designate the

72. Welf. & Inst. Code § 14005.37; *Craig v. Bonta*, S.F. Superior Ct., No. CFF 02 500688; ACL 03-52 (Oct. 6, 2003), <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl03/pdf/03-52.pdf>; ACL 03-25 (May 29, 2003), <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl03/pdf/03-25.pdf>; ACL 03-24 (May 20, 2003), <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl03/pdf/03-24.pdf>; ACL 02-54 (Jul. 18, 2002), <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl02/pdf/02-54.pdf>; ACL 02-45 (Jun 25, 2002), <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl02/pdf/02-45.pdf>. The county will also screen for other insurance affordability programs so if someone is over income for Medi-Cal the county will advise if they are eligible for MCAP or Covered California.

73. Welf. & Inst. Code § 14011.10.

74. Penal Code § 4011.11; ACWDLs 14-24 (May 6, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-24.pdf> and 09-16 (Apr. 1, 2009), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c09-16.pdf>.

corrections department representative as their Authorized Representative for the application and the corrections department submits the application to the county with a cover letter designating it as a pre-release application for special handling. If determined eligible, a Medi-Cal Beneficiary Identification Card (BIC) is issued while the applicant is still an inmate to allow them to access services as soon as they are released.⁷⁵ Similar application processes are used locally for jail inmates who require services during incarceration or post-release.

B. Verifying Application Information

When an individual applies for health coverage through the Single, Streamlined Application they are told that the information on the application will be verified using state and federal databases.⁷⁶ The state CalHEERS system links to a federal Data Services Hub (“federal verification hub”) and applications are sent through that hub to attempt to verify income, Social Security number, and citizenship or immigration status. The federal verification hub links to the Internal Revenue Service, the Social Security Administration and the Department of Homeland Security. CalHEERS and the county eligibility systems also link to some state data sources used to verify application elements. Below we discuss how various application elements are verified and which ones allow self-attestation. If an applicant is allowed to self-attest information it means that the applicant’s reporting of information on an application is sufficient and documentation is not needed. Applications must be accepted without verification.⁷⁷

1. Overview of Process and Requirements

a. Medi-Cal

Applicants are not to be asked for verification of information that can be obtained through one of the electronic databases to which CalHEERS links.⁷⁸ For Medi-Cal, in addition to running the electronic verifications, the county must conduct an *ex parte*

75. *Id.*

76. 10 CCR § 6470(e)(3).

77. 10 CCR § 6504(e).

78. Welf. & Inst. Code § 14013.3(b).

check on data to which they have access including a family member's Medi-Cal file, or the applicant or family member's information with Covered California, CalFresh or CalWORKs, before requesting documentation from an applicant.⁷⁹

If citizenship or immigration status cannot be verified but the applicant is otherwise eligible, the individual is granted full-scope benefits and provided with a "reasonable opportunity period" to supply additional information.⁸⁰ During this period, the counties send at least two ten-day requests to the applicant requesting verification information.

Applicants whose immigration status are not verified should have their scope of benefits revised by the county from full-scope Medi-Cal to restricted-scope Medi-Cal rather than have their Medi-Cal terminated.⁸¹ If they are subsequently able to provide proof of their immigration status, the county should change their scope of benefits to full scope.⁸²

For all other eligibility criteria that cannot be verified, the applicant is sent a notice requesting additional information to continue processing the application. Individuals can fax or mail requested documentation to their county social services office. They can also upload documents on the Covered California website.

b. Medi-Cal Access Program

MCAP regulations require only verification of income.⁸³ If electronic verification of

79. Welf. & Inst. Code § 14013.3(b).

80. Welf & Inst Code § 14007.5; 22 CCR § 50301.5; ACWDL 07-12 (Jun. 4, 2007), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c07-12.pdf>.

81. MEDIL 14-21 (Mar. 25, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-21.pdf>.

82. *Id.*

83. See 10 CCR § 2699.201. MCAP's governing statutes now lie at Welfare and Institutions Codes sections starting at Section 15810. The MCAP regulations however have not been updated since DHCS began administering the program and electronic verification via CalHEERS became available. Although the regulations seem to require paper documentation of income, once MCAP was moved into CalHEERS, it has been treated like the other insurance affordability programs and an attempt to electronically verify income is made prior to requesting paper documentation. MCAP is available regardless of immigration status, so no verification of qualified status is needed.

income is not available, individuals must provide paper documentation. All other information on the application requires only self-attestation.⁸⁴

c. Covered California

If information on an application is not available or reasonably compatible with information verified through CalHEERS, Covered California uses the following process to attempt to resolve the lack of data or inconsistency.

First, Covered California must make a “reasonable effort” to identify and address the causes of the lack of electronic information or the inconsistency, including typographical or other clerical errors, by contacting the applicant to confirm the accuracy of the information on the application.⁸⁵ If this does not address the problem, Covered California must send the applicant a notice about the inconsistency and request documentation to resolve it.⁸⁶ The applicant has 95 days to provide the information.⁸⁷ This time period can be extended if the applicant has made a good faith effort to obtain the information.⁸⁸ Applicants, with or without an application assistor’s help, can upload documents to their online account, send Covered California a copy via fax, or mail the documents to Covered California. Applicants should never mail the original version of the documents requested.

If applicants need more than 95 days, or if they do not have the document requested, they can call the Service Center and explain that they need additional time. After the documents are received by Covered California, the individual will be notified by a message in their online account. If there is a problem with an individual’s document or the electronic verification process again, a Covered California representative will contact them by mail or telephone to continue to resolve the problem.

84. *Id.*

85. 10 CCR § 6492(a)(1).

86. 10 CCR § 6492(a)(2). Notices may be sent to applicants via e-mail or to their CoveredCA.com account instead of U.S. mail. Covered California must contact the applicant with the communication method chosen by the applicant. See 42 C.F.R. § 435.918 and 45 C.F.R. § 155.230(d).

87. 10 CCR § 6492(a)(2).

88. 10 CCR § 6492(a)(3).

Pending resolution of the disputed eligibility element, Covered California must process the application based on the applicant's attested information and grant eligibility if the applicant is otherwise eligible.⁸⁹ During the reasonable opportunity period, the CalHEERS system should allow the applicant to select and enroll in a plan.

If the applicant is eligible for premium tax credits and cost-sharing reductions, their premium payment should incorporate the advanced premium tax credit amount based on the applicant's attested income and the applicant should be allowed to enroll in the cost-sharing reduction plan that corresponds to their income. If verification is pending, Covered California must inform the applicant that if they are later found ineligible for premium tax credits, they will have to report the advanced premium tax credits received at tax filing and may be required to re-pay the amount they received.⁹⁰

If, at the end of the reasonable opportunity period, the missing or incomplete information has not been verified, Covered California will make an eligibility determination based on the information on the application and from the electronic data sources and advise the applicant of this determination.⁹¹ For inconsistencies not involving immigration or citizenship, Covered California can, on a case-by-case basis, rely on the attested information on the application if the applicant cannot access documentation.⁹²

2. Verification of Eligibility Criteria⁹³

a. Proving Identity

89. 10 CCR § 6492(a)(4).

90. 10 CCR § 6492(a)(4)(B). The IRS limits the amount of repayment required for those with incomes below 400% of the federal poverty level. 26 U.S.C. § 36B(f)(2)(B); 26 C.F.R. § 1.36B-4(a)(3)(ii). See Chapter 4 for more on the reconciliation process for premium tax credits.

91. 10 CCR § 6492(a)(5).

92. 10 CCR § 6492(b).

93. CMS, "Medicaid/CHIP MAGI-based Eligibility Verification Plan," <http://www.medicaid.gov/medicaid-chip-program-information/program-information/eligibility-verification-policies/downloads/california-verification-plan-template-final.pdf>.

When applying for health coverage through any of the venues, an applicant must first prove their identity – a process referred to as “Remote Identity Proofing.” For individuals applying through the paper application, they must sign their application under penalty of perjury, including that they are who they say they are.⁹⁴ When applying through any other venues, applicants must first agree to have their identity verified.⁹⁵ The verification can be done in one of two ways. One option is for the applicant to present information proving her identity in person, by mail or uploading the documentation. For example, the applicant could show someone, send in or upload a driver’s license or valid identification card with a photo. The regulations specify what types of documentation can be submitted.⁹⁶

The other option to verify identity is to go through the Federal Data Service Hub Remote Identity Proofing Service.⁹⁷ This is a separate service that uses credit information to ask individuals a series of personal questions that help identify that the applicant is who they say they are such as questions about previous addresses or accounts. A credit check is not actually run but the credit security questions are used. If the online service cannot verify the applicant’s identity, they will have to prove their identity in an alternative way before they can complete the application.⁹⁸ For those who cannot verify their identity through the online service, they can fill-out a paper application or verify their identity in person.⁹⁹

Once the applicant completes the identity verification process, they can continue the application for themselves and their household.¹⁰⁰ The rest of the household will not have to go through identity verification.¹⁰¹ Advocates assisting individuals who have no banking record or are very recent immigrants to the United States should advise them of the other options for verifying identity as Remote Identity Proofing is more difficult for these groups.

94. 10 CCR § 6464(b).

95. 10 CCR § 6464(c)(1).

96. 10 CCR § 6464(c)(2)(A).

97. 10 CCR § 6464(c)(2)(B).

98. 10 CCR § 6464(c)(3).

99. 10 CCR § 6464(c)(3)(B), (C).

100. 10 CCR § 6464(d).

101. *Id.*

b. Citizenship and Immigration Status

Individual seeking financial assistance from Covered California or enrollment in most full-scope Medi-Cal programs must provide proof of citizenship or lawful immigration status.¹⁰² In addition, individuals who are applying for certain health coverage programs must provide a Social Security number to be eligible and as proof of identity in order for Covered California to access their federal electronic data.¹⁰³ These two separate eligibility requirements apply only to individuals in the household who are seeking coverage.

Note on Non-Applicants: In most cases, individuals applying on behalf of another household member are considered non-applicants and are not required to provide their Social Security number nor attest to and provide proof of citizenship or lawful status.¹⁰⁴ However, non-applicants may be required to provide their Social Security number in order to have their identity electronically verified, or in certain cases, verify household income.¹⁰⁵ See "Proving Identity" section above.

i. Proof of Citizenship

Most U.S. citizens who are applying for health coverage can have their citizenship

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102. 45 C.F.R. § 155.305(a)(1); 42 C.F.R. § 435.406. Residents of California who do not have lawful immigration status may apply for Restricted Medi-Cal without providing a SSN or attesting to lawful status. As of the date of publication, DHCS is currently working on implementing Health Care for All Children, which would allow undocumented children under age 19 to enroll in full-scope Medi-Cal. See Welf. & Inst. Code 14007.8 enacted by (SB) 75 (Chapter 18, Statutes of 2015) and amended by SB 4 (Chapter 709, Statutes of 2015).
103. 45 C.F.R. § 155.315(b); 42 C.F.R. § 435.910. If an individual has not been issued a SSN number yet, Medi-Cal must assist the applicant in completing an application for a SSN. 42 C.F.R. § 435.910(e)(1)
104. 45 C.F.R. § 155.310(a)(3); 42 CFR § 435.907(e)(3).
105. Non-applicants who attest to having a Social Security number and having filed taxes for the year that data would be used to verify household income must provide their number to Covered California. 45 C.F.R. § 155.305(f)(6). Non-applicants may voluntarily provide their Social Security number in order to verify household income, but must first be informed that providing their SSN is voluntary and will only be used to determine eligibility for those who are applying. 42 C.F.R. § 435.907(e)(3)(iii).

status electronically verified through the Social Security Administration database using only their Social Security numbers.¹⁰⁶ Naturalized citizens can be verified through either the SSA database or through the U.S. Department of Homeland Security database.¹⁰⁷ A range of documents may be used to document citizenship, including a naturalization or birth certificate or passport if available.¹⁰⁸

ii. Proof of Lawful Immigration Status

Applicants with lawful immigration status should provide their USCIS number (formerly known as the Alien Registration Number or “A-Number”) and can indicate the specific type of immigration document they have as proof of that status, if they have one.¹⁰⁹ If the document they have that proves their immigration status is not listed among the choices on the application, the applicant should indicate “Other.”

Reminder: Some immigrants who are not considered lawfully present for Covered California may be eligible under full-scope Medi-Cal. For example, individuals with Deferred Action for Childhood Arrivals (DACA) status are not considered “lawfully present” for purposes of Covered California and financial assistance eligibility, but are eligible for full-scope Medi-Cal under the PRUCOL rules. See Chapter 1, Section A.

iii. Resolving Citizenship or Immigration Inconsistencies

106. 45 C.F.R. § 155.315(c) (Covered California). For Medi-Cal, see Welf. & Inst Code § 14011.2 directing department to seek exception to the process outlined in 42 C.F.R. § 435.407; ACWDL 09-65 (Dec. 31, 2009), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c09-65.pdf>.

107. 45 C.F.R. § 155.315(c)(2). Naturalized citizens should not be required to provide a copy of their naturalization certificate in order to apply; they may provide the document only when electronic verification is not successful and are provided a “reasonable opportunity period” to do so. 42 C.F.R. § 435.952(c).

108. 42 C.F.R. § 435.407 (providing a specific tier of acceptable documents that can be used to prove U.S. Citizenship). See also ACWDL 07-12 (Jun. 4, 2007), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c07-12.pdf>. Covered California has a list of acceptable citizenship documents available at www.coveredca.com/FAQs/Request-for-Verification-CLP/PDFs/Document-List.pdf.

109. Lists of acceptable immigration documentation can be found in MEDIL 14-21 (March 25, 2014); Covered California’s list is at www.coveredca.com/FAQs/Request-for-Verification-CLP/PDFs/Document-List.pdf; a federal list is at Healthcare.gov with links to images of documents at www.healthcare.gov/help/immigration-document-types/.

If the electronic data match fails to verify citizenship or a qualified immigration status, applicants to Medi-Cal and Covered California can still enroll on a conditional basis, but must take additional steps to verify their immigration status within 90 days, known as the reasonable opportunity period.¹¹⁰ The process differs depending on which program the applicant appears eligible.

For Medi-Cal, if the immigration status is not automatically verified through the federal hub, the county can use an alternate verification request known as the SAVE process.¹¹¹ County workers use the information in the application to do a data match with the U.S. Citizenship and Immigration Services. Unless there is no other way to verify status, applicants no longer have to turn in paper documentation of their status.¹¹² Medi-Cal has released a Medi-Cal Eligibility Division Information Letter (MEDIL) with an attachment of sample documents that show many of the immigration documents that can be used to demonstrate status and where to find the appropriate information on the documents.¹¹³ While it is not a comprehensive list, it will help advocates in the most common immigration situations. Persons whose citizenship

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110. 10 CCR §6478(c)(3) (allowing at an initial 90-day period for Covered California, followed by extensions as necessary); 45 C.F.R. 155.315(c)(3); 42 C.F.R. § 435.952(d); MEDIL 14-21 (Jul. 21, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-41.pdf> (90-day reasonable opportunity period); ACWDL 09-65 (Dec. 31, 2009), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c09-65.pdf> (extending reasonable opportunity period for to 90 days); ACWDL 92-48 (Aug 7, 1992), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c92-48.pdf> (establishing conditional eligibility pending immigration status due to *Ruiz v. Kizer* lawsuit).
111. SAVE stands for Systematic Alien Verification for Entitlements and is an information service administered by U.S. Citizenship and Immigration Services.
112. 42 CFR 435.952(c). Note that neither the *Medi-Cal Eligibility Procedures Manual 7G-2 – 7G-3* or Welf. & Inst. Code § 14007 have been updated to reflect this change that passed as part of health reform. Until the California regulations are updated, MEDIL 14-21 is the only instruction to counties on how to process immigration verification. In some cases, such as for Medi-Cal applicants who are eligible for registry because they have resided continuously in the United States since before January 1, 1972, there is no electronic verification available, but the immigrant can show proof of continuous residence.
113. MEDIL 14-41 (Jul. 21, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-41.pdf>.

status is not automatically verified may provide documentation of citizenship.¹¹⁴

Medi-Cal may not deny full-scope benefits without first trying the available automatic processes and offering a 90-day reasonable opportunity period.¹¹⁵

Applicants who are otherwise eligible for Medi-Cal, but whose status cannot be verified either electronically or via documentation, should have their scope of benefits revised by the county from full-scope Medi-Cal to Restricted-Scope Medi-Cal rather than have their application denied.¹¹⁶ If they are subsequently able to provide proof of their immigration status, the county should change their scope of benefits to full-scope.¹¹⁷

For Covered California, if the electronic data match does not work, applicants must send in documentation of citizenship or immigration status during the 90-day reasonable opportunity period – Covered California does not have an alternate SAVE process for immigration status. If the inconsistency is not resolved at the end of 90 days (which can be extended on case-by case basis), Covered California must provide enrollees written notice that their application will be denied and that they will be disenrolled from their Covered California plan by the first of the following month.¹¹⁸ Applicants have the right to appeal this denial like any other application denial.

MCAP has no citizenship or immigration verification requirements.

114. 42 U.S.C. 1320b–7(d)(4)(A) (Section 1137 of the SSA Act). 42 C.F.R. §435.952(d); ACWDLs 09-65 (Dec. 31, 2009), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c09-65.pdf> (extending period to 90 days), and 07-12 (Jun. 4, 2007), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c07-12.pdf> (listing acceptable documents).

115. MEDIL 14-21 (Mar. 25, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-21.pdf>. 42 U.S.C. 1320b–7(d)(4)(A) (Section 1137 of the SSA Act). 42 C.F.R. § 435.952(d); ACWDL 09-65 (extending period for citizenship verification to 90 days).

116. *Id.*

117. *Id.*

118. 10 CCR § 6492(b); 45 C.F.R. § 155.315(g); 10 CCR § 6492(a)(5)(B) (stating notice will be a 5 day notice by reference to §66476(h)). Though note that the parallel 45 C.F.R. § 155.310(g) only says “timely written notice.”

c. Incarceration

As discussed earlier in Section A.4, individuals will have their Medi-Cal suspended for up to one year while they are incarcerated; they can also receive Medi-Cal benefits if they are receiving hospital inpatient services, if they are off prison grounds for 24 hours or longer.

Individuals are not eligible for Covered California if they are incarcerated.¹¹⁹ For Covered California the definition of incarcerated is “confined, after the disposition of charges, in a jail, prison, or similar penal institution or correctional facility.”¹²⁰ CalHEERS electronically verifies whether someone is incarcerated or, if the sources are not available, accepts self-attestation.¹²¹ If the verified information conflicts with the information on the application, the applicant is asked for verification documentation.

d. California State Residency

While state law requires California residency be verified for Medi-Cal eligibility, the Department of Health Care Services has issued guidance suspending this verification requirement.¹²² This means that currently Medi-Cal applicants self-attest on their application that they are California residents without further verification.¹²³

Covered California applicants also self-attest to California residency, and the self-attestation is accepted unless other information on the application or information available to Covered California indicates the self-attestation is not reasonably

119. 10 CCR § 6472(d).

120. 10 CCR § 6410.

121. 10 CCR § 6478(e)(1).

122. MEDIL 14-44 (Aug. 1, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-44.pdf>; MEDIL 14-29 (May 16, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-29.pdf>; MEDIL 14-20 (Mar. 18, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-20.pdf>.

123. Note that DHCS checks its records against the Public Assistance Reporting Information System (PARIS) which checks for out-of-state individuals. Beneficiaries can be discontinued if they fail to verify residency if PARIS shows them residing in another state.

compatible.¹²⁴ An applicant's immigration status may not be used to determine whether an applicant is a California resident.¹²⁵ In other words, if an applicant is on a temporary immigrant visa, such as a student visa, Covered California should not determine that the individual is not a resident of California.

e. Income and Household Size

Applicants report income and tax household size on their application, which is then checked against data sources using the federal verification hub.

For Medi-Cal, if the income information submitted by the individual is “reasonably compatible” with the information obtained through the electronic data sources, e.g., IRS, state wage data, unemployment, Social Security, Medi-Cal accepts the amount listed on the application.¹²⁶ The two amounts are “reasonably compatible” for Medi-Cal in any of the following circumstances:

- Both show the individual's income above the relevant income standard;
- Both show the individual's income is at or below the relevant income standard; or
- The individual states their income is above the income standard and the information obtained by the state shows the individual's income is at or below the relevant income standard.¹²⁷ In this case, the individual must be told that the income information they provided was higher than the information the state obtained through electronic verification and the individual may request to have their income determined at the lower, verified amount.¹²⁸

If the income information obtained through electronic verification is not reasonably compatible with the information provided by the individual, the individual must provide additional information that explains the discrepancy, such as pay stubs or other documentation regarding income.¹²⁹

124. 10 CCR § 6478(d).

125. *Id.*

126. Welf. & Inst. Code § 14013.3(c)(1).

127. Welf. & Inst. Code § 14013.3(c)(3).

128. Welf. & Inst. Code § 14013.3(c)(4).

129. Welf. & Inst. Code § 14013.3(c)(2).

For Covered California, income information is checked against an applicant's previous year's tax return through the IRS database. If the applicant says that the income and tax household size on their last year's tax return represents an accurate projection of their income and household size for the benefit year for which they are applying for coverage, Covered California uses that tax information.¹³⁰ Covered California accepts self-attestation of income and household size if tax data is unavailable or the applicant attests that a change in income or household size has occurred or is reasonably expected to occur such that the tax data is not accurate for this benefit year.¹³¹ If, however, Covered California finds that the application's attested income and household size are not reasonably compatible with other information from the applicant or information Covered California has other than the tax data, then the attestation will be verified against state electronic data sources. If state sources are unavailable, the applicant must submit documentation to support their attested income.¹³²

There is an alternative verification process for individuals who attest to projected household income.¹³³ If their projected income is no more than 10% below the income on their most recent tax return, it must be accepted without further verification. If the projected annual income is more than 10% below the latest tax income or if the tax data is unavailable, the applicant's attested income is verified with state data sources or by requesting documentation from the applicant.¹³⁴

When income cannot be verified electronically, Covered California notifies applicants of what information is needed and gives them 90 days to provide it.¹³⁵ If the applicant does not provide the information within 90 days, Covered California uses the information available through electronic databases to determine their eligibility.¹³⁶

For MCAP, if income cannot be electronically verified, paper documentation is

130. 10 CCR § 6482 (d)(2), (e)(2).

131. 10 CCR §§ 6482 (d)(3), (e)(3) and 6484.

132. 10 CCR § 6482 (d)(4), (e)(4).

133. 10 CCR § 6486.

134. 10 CCR § 6486 (c).

135. 10 CCR § 6492(a). The 95 days may be extended on a case-by-case basis.

136. 10 CCR § 6492(a)(5).

requested.¹³⁷

f. Pregnancy

Medi-Cal accepts self-attestation that a woman applying for coverage is pregnant “unless the department has information that is not reasonably compatible with the attestation” in which case the woman can be asked to provide information to explain the discrepancy.¹³⁸

Covered California accepts self-attestation that a woman applying for coverage is pregnant. MCAP also accepts self-attestation of pregnancy.

g. Assets

MAGI Medi-Cal programs (including MCAP) and Covered California have no eligibility requirements related to assets – sometimes also called “property” or “resources.” However, as discussed in Chapter 3 many of the non-MAGI Medi-Cal programs do have an assets limit. Medi-Cal uses a form called the "MC 210 PS: Property Supplement" to gather information about an applicant’s assets.¹³⁹ For assets listed on the form, individuals must attach verifying documentation such as bank statements. For real estate, if it is the primary residence where the applicant lives, the applicant notes the address on the form but does not have to verify it. For other property, verifications are required to determine whether the property can be exempt.

h. Minimum Essential Coverage/Employer-Sponsored Coverage/ Other Coverage

The Single, Streamlined Application asks applicants whether they have other health coverage. Applicants self-attest whether they are covered by other insurance or

137. 10 CCR § 2699.201. Although the regulations seem to require paper documentation of income, once MCAP was moved into CalHEERS, it has been treated like the other insurance affordability programs and an attempt to electronically verify income is made prior to requesting paper documentation.

138. Welf. & Inst. Code § 14013.3(d).

139. Available at <http://www.dhcs.ca.gov/formsandpubs/forms/Forms/mc210ps.pdf>.

have other insurance available.

In general, having other health coverage has no impact on whether someone is eligible for Medi-Cal, though having Medicare can preclude eligibility in certain categories such as the Expansion Adults category in MAGI Medi-Cal.¹⁴⁰ However, because Medi-Cal is always the “payer of last resort” the Department of Health Services does verify whether an applicant has other health coverage using electronic databases. For more information on other health coverage see Chapter 1, Section D.

Individuals are not eligible for subsidized coverage in Covered California if they have health coverage that qualifies as Minimum Essential Coverage (MEC). Individuals are also not eligible for subsidized coverage if they are eligible for affordable employer-sponsored coverage.¹⁴¹ Covered California accepts self-attestation of eligibility for employer-sponsored coverage unless it is not reasonably compatible with other information.¹⁴² Covered California verifies whether an applicant has minimum essential coverage by checking the CalHEERS and county eligibility systems to see whether the applicant has Medi-Cal (including CHIP-funded Medi-Cal) and using other databases to check for employer-based health coverage.¹⁴³

140. Someone with Medicare could be eligible for a number of other Medicare-specific programs such as the Medicare Savings Programs.

141. IRS Code § 36B(c)(2)(C)(i). See Chapter 4 for a full explanation of these rules.

142. 10 CCR § 6490. Previously, Covered California accepted self-attestation regarding the status of available employer coverage but should start verifying with employers in 2016. See 10 CCR § 6490(e); 45 C.F.R. § 155.320(d).

143. 10 CCR § 6480; *but see* 10 CCR § 6480(e) and 45 C.F.R. § 155.320(d).

Advocacy Tip: Medi-Cal and Other Health Coverage

While being enrolled in other health coverage (OHC) precludes someone from being eligible for premium subsidies in Covered California, having other health coverage is not an eligibility bar to Medi-Cal.¹⁴⁴ Many people have employer-based coverage and Medi-Cal, for example. If they are otherwise eligible for Medi-Cal, having another source of health coverage is not a problem. The application asks about other health coverage and it will be noted in the individual's Medi-Cal file in the Other Health Coverage data field. Medi-Cal is always the payer of last resort so if someone does have Medi-Cal and other health coverage, their other coverage is their primary coverage and must be used before Medi-Cal will pay. It is still important to go to a Medi-Cal doctor. If someone with Medi-Cal and other coverage goes to a doctor who accepts both of their types of coverage, the doctor cannot bill them for any co-pays.

C. When Coverage Starts

Individuals can *apply* for Medi-Cal and Covered California anytime and can *enroll* in Medi-Cal anytime. But individuals can only *enroll* in Covered California during an annual open enrollment or a special enrollment period. Individuals may also apply for and enroll in MCAP at any time during their pregnancy.¹⁴⁵ Below we discuss when coverage starts for the different programs and how to select a health plan.

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144. The Medi-Cal Access Program (MCAP) and the Breast and Cervical Cancer Treatment Program (BCCTP) are an exception to this rule depending on the scope of the other health coverage. This means generally people cannot enroll in MCAP or BCCTP if they have other health coverage. For more information on MCAP see Chapter 2, Section C.3.b. For more information on BCCTP see Chapter 3, Section E.1. Individuals are also not eligible for the Expansion Adult MAGI Medi-Cal program if they have Medicare.
145. 10 CCR § 2699.200. Note that the 30-week pregnancy limit for MCAP applicants referred to in subdivision (d)(1)(H) of the state regulation was abolished in 2015. As of March 1, 2015, a pregnant woman could be eligible for MCAP at any point in her pregnancy. To date the regulations have not been updated, though language regarding the 30-week limit has been removed from the MCAP website.

1. Medi-Cal

Medi-Cal eligibility determinations must be made within 45 days from the date of application, or 90 days when the application is based on disability.¹⁴⁶ Medi-Cal is full-month coverage so that once Medi-Cal is granted the coverage is for the full calendar month that includes the application date. For example, if the applicant applies on July 6 and is found eligible her coverage extends to the entire month of July. This means if she received services covered by Medi-Cal as early as July 1st she or her providers can seek payment from Medi-Cal.

Once an applicant is determined eligible they will receive their Medi-Cal card, called a Beneficiary Identification Card (BIC),¹⁴⁷ as well as a “welcome packet” and, for most people, a health plan choice packet.

a. Retroactive Medi-Cal

An applicant can receive Medi-Cal coverage (and payment for Medi-Cal covered benefits received) for up to three calendar months preceding the month of application if they would have been eligible for Medi-Cal during those months.¹⁴⁸ Applicants can apply for retroactive Medi-Cal on the Medi-Cal application or after applying for Medi-Cal or CalWORKs by indicating the request on the application or by separate written request.¹⁴⁹ Retroactive Medi-Cal can be requested for up to one year after the date of application¹⁵⁰ so if there are outstanding bills, the Medi-Cal member should submit them to Medi-Cal for reimbursement or ask the provider to bill Medi-Cal.

146. 42 C.F.R. § 435.911; Welf. & Inst. Code § 14154(d)(1); 22 CCR § 50177.

147. Welf. & Inst. Code §§ 14017.7, 14017.8. Note that an individual is only sent a BIC if one has not been issued to that person previously. If the person was previously assigned a BIC, it is re-activated. If the beneficiary needs to request a new card, they can contact the county. Additionally, beneficiaries can request a paper BIC from the county so they do not have to wait for the plastic card to arrive in the mail if they have an urgent need.

148. Welf. & Inst. Code §§ 14019, 14019.6; 22 CCR § 50197; MEDIL 14-27 (May 15, 2014), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL14-27.pdf>.

149. 22 CCR § 50148(a)(2).

150. 22 CCR § 50148(b).

b. Expedited Programs

As discussed above there are several expedited ways to get Medi-Cal including Accelerated Enrollment (AE) for Children, Presumptive Eligibility (PE) for Pregnant Women, Hospital Presumptive Eligibility, and the CHDP Gateway. With each of these pathways, coverage starts the day the abbreviated application is approved – not at the beginning of the month as is the general Medi-Cal rule. Individuals who have earlier bills in the same month should submit their complete Medi-Cal application before the end of the month to ensure that those bills can be covered as well. See Section A.2 earlier in this chapter for a more detailed discussion of expedited coverage programs.

2. Covered California

While people can apply for Covered California coverage anytime they can only *enroll* in Covered California during the annual open enrollment period or a special enrollment period.¹⁵¹ They should receive an eligibility determination within 10 days from the date of a completed paper application and in real time (meaning while they are still on the computer) for an electronic application, if administratively feasible.¹⁵²

a. Covered California Open Enrollment

For plan year 2016 and thereafter, the annual open enrollment period starts November 1 and runs through January 31.¹⁵³

During open enrollment, for coverage to be effective by January 1st, plan selection must be made by December 15,¹⁵⁴ and plan payment must be received by December 28 (the fourth remaining business day of the month) (e.g., December 28th in 2015).¹⁵⁵

151. 10 CCR § 6470 (k).

152. 10 CCR § 6476(f).

153. 45 C.F.R. § 155.400(e)(2); Health & Safety Code § 1399.849 (c). Note: This open enrollment period also applies to buying health coverage in the individual market “outside” Covered California. *Id.*; Ins. Code § 10965.3(c).

154. 45 C.F.R. § 155.410(f); 10 CCR § 6502(f).

155. 45 C.F.R. § 155.400(e); 10 CCR § 6502(g), including the definition of “premium due date” in 10 CCR § 6410.

When the applicant selects a plan during the first 15 days of any subsequent month and payment is received by the plan on the “premium due date” (fourth remaining business day of the month), coverage starts no later than the first day of the following month.¹⁵⁶ If the plan is selected after the 15th of the month, however, coverage is effective the first day of the second month following payment.¹⁵⁷ This would mean a month without coverage which could be quite significant for someone with medical needs. Note that if an applicant would qualify for special enrollment during this time, there are certain circumstances when coverage can start sooner, such as when losing other health coverage.¹⁵⁸

b. Covered California Special Enrollment

Once open enrollment has closed, individuals must have a “triggering event” (also known as a “qualifying life event”) in order to enroll or change from one Covered California plan to another. If there is no triggering event, individuals are not able to enroll in coverage until the next open enrollment period. In other words, at this stage eligibility to enroll is a two-step process: 1) Is the individual eligible for special enrollment?; and 2) Is the individual eligible for Covered California?

Advocate Tip: For special enrollment, do not take “no” for an answer for step 1. Individuals can submit documentation of circumstances that require Covered California to adjudicate whether the applicant is eligible for a special enrollment period. Sometimes, customer service center representatives tell applicants that they do not qualify for special enrollment. As a result, the individual does not actually apply for Covered California. The individual (or advocate) should give a brief explanation as to why they qualify for special enrollment and proceed on to the application. If not, even if the individual appeals the denial, there is little that an administrative law judge can do, except tell the person to go back and apply again, as there is no application denial to adjudicate.

156. 45 C.F.R. § 155,410(f); 10 CCR § 6502(f); 10 CCR § 6502(g) including the definition of “premium due date” in 10 CCR § 6410.

157. *Id.*

158. See Section C.2.b on special enrollment below.

The following “triggering events” qualify someone for a special enrollment period in Covered California:¹⁵⁹

1. Loss of Minimum Essential Coverage.¹⁶⁰ This includes:
 - Loss of eligibility for employer coverage, e.g., loss of a job or a reduction in work hours that causes loss of access to employer-sponsored health plan;
 - Loss of eligibility for Medi-Cal, CHIP, Medicare or other government-sponsored health coverage (including loss of Medi-Cal with a Share of Cost);¹⁶¹
 - Exhaustion of COBRA coverage;
 - Cancellation of non-group plan;
 - Reaches the lifetime limit on plan benefits;
 - Loss of eligibility for student health plan;
 - Divorce, legal separation or dissolution of domestic partnership resulting in loss of coverage;
 - No longer eligible as a dependent under current plan;
 - Death (*i.e.*, of another person in the family) resulting in loss of coverage such as when the employee with the link to employer-sponsored coverage dies;
 - Decertification of current Covered California coverage;
 - No longer living, working, or residing in the area of the health plan;
 - Termination of employer contributions to employee’s health coverage;

159. 45 C.F.R. § 155.420(d); Health & Safety Code § 1399.849(d); 10 CCR § 6504(a) and (b). Note that both the Covered California regulations, which rely largely on the federal Affordable Care Act regulations, and the Department of Managed Health Care regulations, which apply to most California health plans, apply special enrollment periods.

160. 45 C.F.R. § 155.420(d)(1)(i); Health & Safety Code § 1399.849(d)(1)(A); 10 CCR § 6504(a)(1)(A) and (b). Two exceptions to the rule that the coverage must be minimum essential coverage include loss of pregnancy-only Medi-Cal coverage and loss of medically needy Medi-Cal coverage in a month that the share-of-cost is met. 45 C.F.R. § 155.420(d)(1)(iii) and (iv); 10 CCR 6504(a)(1)(C) and (D). See *also* CMS’s guidance on certain types of Medicaid coverage as minimum essential coverage: <http://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf>.

161. Although Medi-Cal with a Share of Cost has been determined to not be minimum essential coverage, 10 CCR § 6504(a)(1)(D) allows for special enrollment.

and

- Newly eligible for the premium tax credit due to discontinuation or change to employer-sponsored plan resulting in plan no longer being considered MEC.¹⁶²

Note: “Loss of MEC” does not include loss of coverage due to failure to pay premiums timely, including COBRA or loss of coverage for cause, such as based on an intentional misrepresentation.¹⁶³

2. Gains or becomes a dependent including through adoption, placement for adoption or placement in foster care.¹⁶⁴
3. Is mandated to be covered as a dependent pursuant to a court order.¹⁶⁵
4. Loses a dependent or is no longer considered a dependent through divorce, legal separation, or dissolution of domestic partnership.¹⁶⁶
5. Has been released from incarceration.¹⁶⁷
6. Health plan substantially violated a material provision of the health coverage contract.¹⁶⁸
7. Gains citizenship or Lawful Permanent Resident status.¹⁶⁹
8. Error on enrollment or non-enrollment by Covered California.¹⁷⁰
9. Change in eligibility for payment assistance (premium assistance/cost sharing reductions, if already enrolled in a QHP through Covered California).¹⁷¹

162. 26 U.S.C. § 5000A; 26 C.F.R. § 54.9801-6(a)(3); 29 C.F.R. § 1163; 45 C.F.R. § 155.420(d)(6)(iii); 10 CCR § 6504(a)(7).

163. 26 C.F.R. § 54.9801-2; 45 C.F.R. § 155.420(e)(1); Health & Safety Code § 1399.849(d)(1)(A)(iii); 10 CCR § 6504(b)(3); 10 CCR § 6504(c)(1).

164. 45 C.F.R. § 155.420(d)(2); Health & Safety Code § 1399.849(d)(1)(B); 10 CCR § 6504(a)(2).

165. 45 C.F.R. § 155.420(d)(2); Health & Safety Code § 1399.849(d)(1)(C); 10 CCR § 6504(a)(2)

166. 45 C.F.R. § 155.420(d)(2); Health & Safety Code § 1399.849(d)(1)(C); 10 CCR § 6504(a)(2)(B).

167. Health & Safety Code § 1399.849(d)(1)(D); 10 CCR § 6504(a)(8).

168. 45 C.F.R. § 155.420(d)(5); Health & Safety Code § 1399.849(d)(1)(E); 10 CCR § 6504(a)(5).

169. 45 C.F.R. § 155.420(d)(3); 10 CCR § 6504(a)(3). It is difficult to become a citizen without having a previous lawful status, but is possible if claiming such status through lineage.

170. 45 C.F.R. § 155.420(d)(4); Health & Safety Code § 1399.849(d)(1)(H); 10 CCR § 6504(a)(4).

171. 45 CFR § 155.420(d)(6); 10 CCR § 6504(a)(6). Note that Covered California interprets this to only allow for changes in plan, not to newly enroll based on language in the state and federal regulations referring to the *enrollee* rather than the *individual* as in other sections. Thus, if you are already in a plan you can change to a new plan but you can't newly enroll in a plan when your income decreases.

10. Existing employer plan no longer affordable.¹⁷²
11. Access to new health plan due to a permanent move.¹⁷³
12. Native American exception (can change Covered California plans once a month).¹⁷⁴
13. Member of the reserve forces of the U.S. military or California National Guard returning from active duty.¹⁷⁵
14. Exceptional circumstances (such as loss of exemption, court order to cover child's health care, domestic abuse or spousal abandonment).¹⁷⁶

For most triggering events, people have 60 days from the date of the event to select a Covered California plan, except there are longer periods for some triggering events. For example, for loss of coverage an applicant can select a plan starting 60 days before the coverage ends to 60 days after.¹⁷⁷

Advocacy Tip: Even though people have 60 days to pick a plan, waiting beyond the month they lose eligibility in their current health coverage will mean going without coverage. For individuals losing coverage, including Medi-Cal, the usual rule by which someone has to pick a plan by the 15th of the month for coverage to be effective does not apply. Rather their coverage will be effective the first of the month after they made their health plan choice – even after the 15th of the month. See Covered California Coverage Effective Dates below.

c. Covered California Coverage Effective Dates

In general, if the plan is selected within the first 15 days of the month, coverage is effective the first day of the following month. If the plan is selected after the 15th day of the month, coverage is effective the first day of the second month following the

172. 45 C.F.R. § 155.420(d)(6)(iii); 10 CCR § 6504(a)(7). See also 10 CCR § 6504(b)(2).

173. 45 C.F.R. § 155.420(d)(7); Health & Safety Code § 1399.849(d)(1)(F); 10 CCR § 6504(a)(8).

174. 45 C.F.R. § 155.420(d)(8); 10 CCR § 6504(a)(9).

175. Health & Safety Code § 1399.849(d)(1)(I).

176. 45 C.F.R. § 155.420(d)(9); 10 CCR § 6504(a)(10).

177. 45 C.F.R. § 155.420(c); Health & Safety Code § 1399.849(d)(2); 10 CCR § 6504(f).

payment.¹⁷⁸ For some triggering events, like the birth or adoption of a baby or loss of coverage, there are special coverage dates that allow coverage to start sooner. The chart below shows the other coverage effective dates.

Covered California Effective Dates of Coverage¹⁷⁹

Event	Coverage Effective Dates
<p><i>Standard Rule</i></p> <ul style="list-style-type: none"> • Plan selection occurring on the 1st through the 15th of the month • Plan selection occurring on the 16th through the last day of the month 	<ul style="list-style-type: none"> • First day of the following month • First day of the second following month
<p>Loss of coverage</p>	<p>First day of the month following loss of coverage if the plan selection is made by the date of coverage loss, or first day of the month following plan selection if the plan selection is made after the coverage loss.</p>
<p>Marriage or entry into domestic partnership</p>	<p>First day of the month following plan selection.</p>
<p>Birth, adoption, or placement for adoption</p>	<p>Date of birth, adoption, or placement, or the first day of the month following the date of birth, adoption, or placement at the enrollee’s option.</p>
<p>Gaining a dependent or becoming a dependent through a child support order or other court order</p>	<p>The date the court order is effective, or the standard rule (<i>i.e.</i>, the 15th day rule based on the plan selection date), at the enrollee’s option.</p>

178. 45 C.F.R. § 155.320(b)(1); 22 CCR § 6504(g).

179. 45 C.F.R. § 155.320(b)(2); Health & Safety Code § 1399.849(e); 10 CCR § 6504(h).

Loss or death of dependent or enrollee	First day of the month following the plan selection.
<p>Other qualifying life events:</p> <ul style="list-style-type: none"> • The health plan violated its contract • Exceptional circumstances • Misconduct or misinformation • Misrepresentation or erroneous enrollment • A contracting provider left the network while the enrollee was receiving specified services 	The date of the event or the standard rule, as determined by Covered California on a case by case basis.

3. MCAP

MCAP coverage starts 10 calendar days after the date the application is approved.¹⁸⁰

D. Plan Selection

Most Medi-Cal beneficiaries and all Covered California and MCAP members enroll into and receive their services through a health plan. For those choosing among health plans some considerations include:

- Whether the plan includes the consumer’s doctor or other important provider. Check the plan’s provider directories and call the provider to confirm they accept the plan. Specify whether it’s the Med-Cal or Covered California product offered by the plan because the provider networks for plans are generally different for Medi-Cal, Covered California, MCAP and the commercial market.
- Whether the plan covers prescription drugs that the member takes. Check the health plan formulary or call the health plan.

180. 10 CCR § 2699.209(a).

- The cost of the plan in the case of Covered California. Consider cost sharing including per visit co-pays, prescription drug co-pays and deductibles in addition to the monthly premium cost.
- Quality ratings for the plans which can be found at the Office of the Patient Advocate: www.opa.ca.gov

Advocacy Tip: In general, if a Medi-Cal beneficiary does not pick a plan, the applicant will be defaulted into a plan – meaning they will be assigned by the state to a plan. If a Covered California enrollee does not pick a plan, the applicant will not be enrolled into coverage at all. In MCAP, for counties with a plan choice, the woman must pick a plan or she will not have coverage.

1. Picking a Medi-Cal Plan¹⁸¹

Most but not all Medi-Cal members must enroll in a Medi-Cal health plan. Medi-Cal members must enroll in a plan except for the following groups: those in foster care or receiving adoption assistance, as well as former foster youth; those with other health coverage (OHC), including Medicare – except in counties with the dual demonstration project; pregnant women up to 213% FPL who are in Pregnancy-Related Medi-Cal; and those who have Medi-Cal with a Share-of-Cost.

When someone enrolls in Medi-Cal they are initially in Fee-for-Service (FFS) Medi-Cal and can go to any doctor that contracts directly with Medi-Cal. Along with their Medi-Cal welcome packets, new Medi-Cal members receive a health plan “choice packet” with information about the health plan choices in their county. This includes provider directories for their geographic region and a choice form for the individual to indicate their preferred primary care doctor. They have 30 days to pick a plan and doctor and are given a 30 day extension if they request the provider directory for the entire plan

181. DHCS’s Health Care Options Branch oversees and administers enrollment activities with the support of the statewide enrollment broker, Maximus. Plan enrollment informational materials are available at http://www.healthcareoptions.dhcs.ca.gov/HCO_CSP/HCO_Program/default.aspx.

service area.¹⁸² Individuals who do not choose a plan are assigned a plan by Medi-Cal.¹⁸³ Plans must ensure that members choose a primary care doctor within 30 days of plan enrollment or assign them a doctor within 40 days if they have not selected one.¹⁸⁴ Members who are dissatisfied with their doctor or plan can change doctors or plans anytime.¹⁸⁵

Medi-Cal members who would generally have to enroll in a Medi-Cal plan can seek a Medical Exemption Request (MER) if they are receiving services from a fee-for-service provider for a complex condition or if they are an American Indian or receiving services from Indian Health Services.¹⁸⁶

There are different models of Medi-Cal managed care, which vary depending on the county where the beneficiary resides.¹⁸⁷

Medi-Cal Managed Care Models

Model	Description
Geographic Managed Care	Choice of several commercial plans
Two-Plan	Choice of a local initiative plan run by the county or a commercial plan
County-Organized Health System	One plan serving the whole county
Regional Model	Choice of two commercial plans

2. Picking a Covered California Plan

182. Welf. & Inst. Code §§ 14087.305 and 14089.

183. Welf. & Inst. Code §§ 14087.305(e) and 14089(5).

184. Welf. & Inst. Code §§ 14087.305(f) and 14089(6).

185. Welf. & Inst. Code §§ 14087.305(g) and 14089(7).

186. 22 CCR §§ 53887 (Two-Plan Model); 53923.5 (GMC).

187. Welf. & Inst. Code §§ 14087, 14089; 22 CCR §§ 53921, 53882, and 53921.5

Individuals with an online account can select a Covered California plan online. The “Find a Plan” section starts with applicants indicating their frequency of use of medical services and prescriptions. This is used to provide information about which plans would be least expensive for the household.

The "Plan Comparison" page shows custom results for the applicant based on the preferences listed in the application. All plans available in the applicant’s area are listed, with closest matches to the applicant’s preferences and needs listed first. There are a series of expandable sections on the Plan Comparison tool that provide details of services offered by each plan. The summary section shows the estimated costs, including both the premium and out-of-pocket costs, based on the previous page’s answers about how often the applicant uses medical services. Quality ratings for each plan are also included.

There is a plan booklet each year listing the Covered California health plans which can be downloaded from the website. Individuals can also select a plan by calling the Covered California Service Center or working with their certified enrollment counselor, agent or broker.

3. Picking an MCAP Plan

In most counties (48) there is only one MCAP plan and in ten counties there is a choice between two plans.¹⁸⁸ After a woman is deemed eligible for MCAP she receives a letter and phone contacts about how to select an MCAP plan. If she is in one of the counties with a choice of plans she must select one or she will not be enrolled into MCAP. She will receive a notice denying her MCAP for failure to choose a plan.

188. Information about MCAP plans is available at http://mcap.dhcs.ca.gov/Plans_Providers/Health_Plans.aspx. The Department of Health Care Services is currently looking to replace the MCAP network with the existing Medi-Cal plans for further integration of the programs. Presumably all enrolled women would be permitted to stay with whichever plan they enrolled in during a transition period to the extent the plans are different.