41. State/County Administered Health Insurance Programs

41.1 Access for Infants and Mothers Program (AIM)

Overview

AIM is a health insurance program established in California for pregnant women and infants. AIM is not a Medi-Cal program; it is administered by the California Managed Risk Medical Insurance Board.

AIM provides full coverage private health insurance at low cost to pregnant women during pregnancy and for sixty calendar days following pregnancy and to the newborn through age one. For an additional fee the newborn will be covered until age two. However, other family members are not eligible for AIM.

The State's toll-free phone number for AIM is 1-800-433-2611 available Monday-Friday 8AM to 8PM and Saturday 8AM to 5PM.

Purpose

The objective of the AIM program is to increase access to perinatal care and health care by providing affordable coverage to the uninsured population of low-income pregnant women and infants who do not qualify for Medi-Cal due to income which would require the payment of a share of cost.

Eligibility Criteria

To qualify for AIM an applicant must meet the following criteria:

- Must be pregnant (but not more than 30 weeks) at the time of application.
- Must be a California resident for at least six continuous months prior to application.
- Must have family income between 200% + $1 and 300% of the Federal Poverty Level at time of application.
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- Must not be a Medi-Cal or Medicare beneficiary at the time of application.

**Note:**
Medi-Cal recipients with an unmet SOC Medi-Cal who have not been certified on MEDS are not considered to be Medi-Cal beneficiaries at the time of application. Therefore, persons determined to be eligible with a SOC who meet all other AIM criteria may apply for the AIM program.

- Must not have maternity benefits through private insurance.

**Important:**
AIM does not have an asset test (there is no property limit).

**Note:**
Aliens eligible for full-scope Medi-Cal benefits can apply for AIM. OBRA aliens have restricted benefits and cannot apply.

**41.1.1 Income/Property Criteria**

**Limits**

To qualify for AIM, family income must be between 200% + $1 and 300% of the FPL amount and is determined by the family size.

**Family size**

Family size is calculated by counting the number of persons living in the home, as defined in the segment titled “Total Family Income”. A pregnant woman is counted as two.

**Total Family Income**

Total family income is defined as the total annual income of all adult family members who live in the home as follows:

- The pregnant woman.
- The father of the unborn child (if married).
- The unmarried father of the unborn child (only if the parents are living together and already have a mutual child).
- Any children/stepchildren over 21 years of age.
Examples

Income includes the following:

- Money, wages, salaries and unearned income (before any deductions).
- Net receipts from self-employment.

Verification of income

Income verification must be sent with the application and can be any of the following:

- Last year's federal income tax forms.
- Last year's federal/state W-2 income forms.
- 3 consecutive months of paycheck stubs from this year or last year.
- A letter from an employer indicating annual income from this year or last year.

Note:
Verification submitted must be for the same period for all family members or the application will not be processed.

Example:
If one member of the family provides verification of last year's income, tax forms, pay stubs, etc., all family members must provide verification of last year's income.

AIM Subscriber Contribution Chart

The AIM Subscriber Contribution Table, or a subscriber's contribution, based on income and family size, is located in [Refer to “Reserved for Future Use,” page 2-1.]

Property

AIM has no asset test. Property limits are not considered, nor verified.
41.1.2 Subscriber Contribution

Payments

The subscriber contribution is divided into two parts. Payment of the first part begins when a cashier's check or money order made payable to the “State of California Access for Infants and Mothers” for $50 and must be sent with the application. The application will be returned, if this payment is not sent. A coupon book will be issued to allow payment of the remainder of the 2% of income contribution over a 12 month period.

Note:
If the application is rejected, the $50 payment will be returned.

Discount

A $50 discount will be received if the applicant submits the full 2% of income subscriber contribution with the application.

Mandatory Payment

The subscriber must agree to pay the entire first part of the Payment subscriber contribution to become enrolled in the program. This is a mandatory payment even if the mother and infant disenroll from the program, at a later date.

Penalty

If the subscriber does not pay the contribution within the monthly periods of time, reminder notices will be sent and the subscriber will be reported to a credit reporting agency.

The subscriber will not be disenrolled from the program for non-payment of the contribution, but the report to the credit agency will impact their ability to buy a house, a car or apply for a credit card.

Second Payment

If the subscriber wants to continue the enrollment of the infant until age two, the second part of the subscriber contribution is a payment of $100 when the infant reaches age one.
Note:
If the newborn is disenrolled before the first birthday, there is no responsibility to pay the second part of the subscriber contribution.

Discount

The $100 amount will be reduced to $50 if proof is submitted that the infant is up-to-date on his/her immunizations.

41.1.3 Care Providers/Covered Services

Participants

In Santa Clara County, subscribers may choose from the following health care providers who have contracted with the state to provide covered benefits for AIM:

• California Care Providers as follows:
  a. Good Samaritan Medical Group
  b. San Jose Medical Group

Note:
California Care is the HMO for Blue Cross of California.

• Kaiser

Coverage

Not all contractors provide the same scope of benefits. Applicants can call this toll-free number (1-800-289-6574) for more help in making a selection prior to applying.

41.1.4 Application Review

Where Located

The application is found in the AIM informational booklet. It should be carefully removed and completed as follows:
Section 1

This section requires some basic information on the pregnant woman applicant. If a question is not applicable, write “N/A”.

Section 2

There are two groups of care providers in Santa Clara County. Not all contractors provide the same scope of benefits. Applicants can call this toll-free number (1-800-289-6574) for more help in making a selection prior to applying.

The AIM booklet also contains a listing of the AIM providers, listed by county location.

Section 3

Part A must be completed by the pregnant woman applicant.

Part B must be completed as follows:

- If married, list the spouse and all children or stepchildren over the age of 21 who are living in the home.

- If unmarried, list the father of the unborn child, ONLY if:
  
  a. He lives with you, and
  
  b. You already have another mutual child.

Note:

The unmarried father's income does not count unless there is already a mutual child even if he is living in the home.

Important:

[Refer to “Income/Property Criteria,” page 41-2] Review what income must be listed, for whom, and the needed documentation. If there is no income, the “no income” box in the “Type of Income Documentation Enclosed” section must be checked.

Part C must include all unmarried children and stepchildren under age 21 that live in the home.
Note:
If more space is needed to list persons in Part B or C, the application may be photocopied or the applicant may write down the exact same information on a piece of paper.

Section 4

All the declarations are required by state law or regulations and each must be initialed to be enrolled.

Section 5

The applicant must read the Authorization and “Conditions of Enrollment” particularly the bold print line regarding agreement to pay before signing and dating the bottom of the application.

Pregnancy Certification

The application will not be accepted without a pregnancy certification form completed or, as a substitute, a verification which lists:

• The pregnant woman's name.
• That she is pregnant.
• The provider's Name, Address, and Medical License Number.

Note:
The pregnancy verification can be written on a prescription form.

AIM Application Assistance Fee

The AIM program will pay an application assistance fee of $50 to our Agency for assisting a pregnant woman in filling out the application, only if she is enrolled.

Checklist

The application packet must be reviewed for the following:

• Fully completed and signed application.
• Pregnancy verification.
• Income Documentation for all adult family members, from the same year and/or the same three months.
Reminder:
If there is no income documentation for an adult family member listed on the application, the “no income” box must be checked on the “Type of Documentation” line in Section 3, Part B.

- Cashiers Check of Money Order for $50.00 (or for the entire estimated subscriber contribution and receive a $50.00 discount) made payable to the “State of California Access for Infants and Mothers”.

Note:
If any of the above items are incomplete or not enclosed, the application will be sent back to the applicant and not processed. If the application is not processed, the $50 payment will be returned to the applicant.

EW Notification
If Medi-Cal with a share-of-cost is established in intake, the AIM applicant must be instructed to report to her Medi-Cal Eligibility Worker when AIM coverage is approved.

Mail To
When an EW assists the client in completing an application for AIM, the worker must place all items required for a complete application packet (as listed in the “Checklist” section above) in an envelope, address it as follows, and mail to:

California Access for Infants and Mothers Program
P.O. Box 15559
Sacramento, CA 95852-0559

The program was implemented in January, 1992, beginning with nine counties, seven in the Bay Area, Los Angeles and Orange County. Enrollment capacity statewide is limited to a certain number of pregnant women and is based on funds appropriated for the program.
41.2 Presumptive Eligibility for Pregnant Women  
(Proc 5M)

41.2.1 Background

Presumptive Eligibility (PE) for pregnant women is a federal option contained in Section 1920 of the Social Security Act. The passage of Assembly Bill (AB) 501 (Chapter 1127, Statutes of 1992) authorized the Department of Health Care Services (DHCS) to implement PE for pregnant women in California. Most other states have some type of PE program for pregnant women.

Overview

The PE program provides low income pregnant women with immediate, temporary Medi-Cal coverage, limited to ambulatory prenatal care, while their regular Medi-Cal (or CalWORKs) application is pending.

The intent of the PE program is to enable pregnant women to begin prenatal care as soon as possible. Early prenatal care helps reduce the rate of infant mortality and low birth weight babies.

A pregnant woman eligible for PE is certified for the month of application and the following month. She is instructed by the provider to apply for regular Medi-Cal (or CalWORKs) before the end of her PE period.

41.2.2 Eligibility Criteria

Who is Eligible

- Any California resident who believes that they are pregnant qualifies for PE.

- Family income must be at or below 200% of the Federal Poverty Level (FPL).

- “Family income” means gross income of the applicant and/or spouse. If under 21, unmarried and living with her parents, the parents’ income also counts.

- The client's statement regarding family income is sufficient to determine eligibility. Verification of income is not required.
• There are no other eligibility requirements. There are no property limits for PE.

Note:
Applicants who have a Medi-Cal or CalWORKs application pending, but whose eligibility has not yet been determined, may apply for PE.

Period of Eligibility

A woman enrolled in the PE program is eligible for coverage for the month of the PE application through the last day of the following month. This eligibility period is the “first good through” period on the Proof of Eligibility card. The client is required to apply for Medi-Cal before her “first good through” date expires.

<table>
<thead>
<tr>
<th>IF THE CLIENT...</th>
<th>THEN...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submits a Medi-Cal application before or during the PE period,</td>
<td>She is eligible for an extension in coverage under the PE program until a Medi-Cal determination is made.</td>
</tr>
<tr>
<td>Does not apply for Medi-Cal or does not cooperate with the eligibility determination process,</td>
<td>She cannot receive an extension or apply for the PE program again with the same pregnancy.</td>
</tr>
<tr>
<td>Is determined not eligible for Medi-Cal,</td>
<td>PE benefits continue only through the end of the “final good through” period on her PE Proof of Eligibility card.</td>
</tr>
<tr>
<td>Is determined eligible for Medi-Cal,</td>
<td>She must use the plastic Benefits Identification Card (BIC) as soon as she receives it for all services instead of the PE card.</td>
</tr>
</tbody>
</table>

Note:
It is critical that EWs take immediate and timely action to complete the eligibility determination before the PE period expires.

Minor Consent

PE does not include Minor Consent services. A minor’s need for confidentiality is not protected under the PE program.

A minor under 21 years, applying for PE and living with her parent(s) must provide information on her total family income to the best of her knowledge. If the minor does not want her parents to know she is applying for Medi-Cal, or is unable to provide her family income, the PE provider cannot offer her PE. The provider would instead refer her to a Social Services Agency district office or outstationed clinic to apply for Medi-Cal under the Minor Consent Program.
41.2.3 PE Covered Services

PE benefits for pregnant women cover most ambulatory prenatal services including those provided on an outpatient basis at a hospital emergency room for:

- Vaginal bleeding
- Prescription needs
- Dental benefits
- Laboratory services determined by the physician to be pregnancy related, and
- Therapeutic abortion or termination of pregnancy.

**Note:**
The above is not a comprehensive list of PE services. Clients who have questions regarding covered services should be directed to their provider.

PE does NOT cover:

- Sterilization
- Family Planning
- Hospitalization
- Labor and delivery
- Some laboratory services
- Medical and dental services unrelated to pregnancy.

41.2.4 PE Enrollment

Enrollment into the PE program is through a participating Qualified Provider (QP). QPs enroll patients into the program using the “PE for Pregnancy” (MC 263) enrollment packet.

**PE Enrollment Forms**

The “Presumptive Eligibility (PE) for Pregnancy” (MC 263) includes the following:

- Provider Instructions Presumptive Eligibility for Pregnant Women Program (PE for Pregnancy – Proof of Eligibility)
- Application for Presumptive Eligibility Only (PE for Pregnancy – Application)
- Application for Medi-Cal Program Only (PE for Pregnancy – Medi-Cal Application).

When a pregnant woman is determined eligible for PE, the provider immediately issues a temporary paper PE card to her.
Note:
If the client wishes to apply for CalWORKs, a SAWS 1 must be completed.

41.2.5 PE Application Process for Medi-Cal

As part of the PE application process, the patient completes the “Application for Medi-Cal Program Only” (MC 263 PE for Pregnancy) form. The QP may offer to fax this completed application directly to the county Social Services Agency using the fax number listed on the PE for Pregnant Women website (408-295-9248).

The MC 263 may also be submitted by mail or in-person. A SAWS 1 is not required when the client is applying for Medi-Cal only. The MC 263 must be date-stamped for the client to give to the PE provider to verify the date of application, should she need to extend her PE eligibility period. The information on the MC 263 must be used to preserve the client’s application date and a Medi-Cal application (MC 210) must be given or mailed to the client for completion. The date of application is the date the MC 263 or SAWS 1 is received and date stamped.

Note:
Use the earliest ‘Fax date’ or ‘date stamp’ as the date of application.

The following chart provides an overview of the PE and Medi-Cal (or CalWORKs) application process:

<table>
<thead>
<tr>
<th>Step</th>
<th>Who</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Pregnant Woman</td>
<td>Obtains medical care, and does not have Medi-Cal or other health insurance for prenatal care.</td>
</tr>
</tbody>
</table>
| 2.   | PE Provider | • Explains the PE program.  
• Gives patient the PE Patient Fact Sheet.  
• Gives patient the MC 263 PE For Pregnancy packet.  
• Completes PE determination (income screening using the Federal Poverty Level chart and pregnancy testing).  
• Issues a PE Proof of Eligibility card to the eligible patient.  
• Bills Medi-Cal for services. |
| 3.   | Pregnant Woman Who Is PE Eligible | • Receives a temporary paper PE card immediately from the QP, which is good for ambulatory prenatal care only.  
• Is advised to apply for Medi-Cal at a district office/outstationed clinic to get ongoing coverage including labor and delivery before the end of her eligibility for PE. |

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#### Forms used in the enrollment process are available at the following website:

**http://files.medi-cal.ca.gov/pubsdoco/forms.asp**

<table>
<thead>
<tr>
<th>Step</th>
<th>Who</th>
<th>Action</th>
</tr>
</thead>
</table>
| 4.   | PE Beneficiary Applies for Medi-Cal (or CalWORKs) Before the End of Her PE Period | May bring with her any of the following items to the Receptionist or EW, which indicates she may be receiving PE:  
  - MC 263 PE For Pregnancy - PROOF OF ELIGIBILITY card.  
  - “Application for Medi-Cal Program Only”  
  (MC 263 PE For Pregnancy - MEDI-CAL APPLICATION)  
  NOTE: The PE client who applies for Medi-Cal (or CalWORKs) after her PE period ends is treated as any other applicant. There are no special procedures to follow. |
| 5.   | CST at Social Services                   | Processes client's request for Medi-Cal (or CalWORKs), following normal procedures, except:  
  - The client who applies for Medi-Cal only and submits a completed MC 263 PE For Pregnancy - Medi-Cal Application is not required to complete a SAWS 1. A completed MC 263 PE For Pregnancy - Medi-Cal Application must be accepted and a date-stamped copy returned to the client.  
  NOTE: The application date is:  
  - The date client comes into the office and the MC 263 is date stamped, or  
  - The date the county receives the MC 263 by Fax/mail, or  
  - The date the SAWS 1 is date-stamped.  
  Screens the pregnant woman for immediate need, following district office procedures. |
| 6.   | EW                                       | • Determines if Medi-Cal eligibility will be cleared before the end of the initial PE period. The PE recipient is eligible for PE for as long as her Medi-Cal (or CalWORKs) application is pending.  
  • Processes application for Medi-Cal (or CalWORKs).  
  NOTE: Be sure to evaluate for the 200% Income Disregard program or any other applicable Medi-Cal programs, including retro Medi-Cal. PE provides limited prenatal services, and does not replace any of the regular Medi-Cal programs.  
  • Advises client to stop using her PE card when her regular no SOC Medi-Cal BIC is received.  
  • No further action for PE is required when Medi-Cal is denied or SOC Medi-Cal is approved. |
41.2.6 Retroactive Coverage

Some beneficiaries may have received health care services that were not covered under the PE program, or prior to their application for PE or Medi-Cal. EWs should be especially attentive to inquiring about the need for retroactive coverage for medical bills incurred in the three months prior to the date of application.

The client must also be informed of the following:

- The client can apply for retroactive Medi-Cal coverage within one year of the month for which coverage is needed.
- The client does not have to apply for or be approved for ongoing Medi-Cal in order to apply for retroactive coverage.

41.2.7 Other

Non-County Resident

Occasionally, a pregnant woman may be determined eligible for PE in this county, but is not a county resident. If a PE applicant applies for Medi-Cal (or CalWORKs), but is determined not to be a resident of Santa Clara County, the EW must take a courtesy application and send the information to the applicant’s county of residence for an eligibility determination.

PE Card Replacement

If a PE recipient requests a replacement for a lost, stolen or destroyed PE card, staff should refer her back to the provider who gave her the original PE card. The PE provider is responsible for replacing the PE card.

General Information

EWs may refer pregnant women to the DHCS website for information on the PE program. Pregnant women can find out how to enroll as a patient to obtain immediate prenatal care coverage.

Information for providers, including the Qualified Provider Application for PE Participation, county fax numbers, Federal Poverty Level charts, links to the PE Manual, and how to order forms can be found at:

http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/PE.aspx
41.3 Healthy Families Program (HFP)

41.3.1 Background

The enactment of the Assembly Bill (AB) 1494 (Chapter 28, Statutes of 2012) will transition children from the Healthy Families Program (HFP), to the Medi-Cal program. Upon implementation of the transition, which will occur in four phases and begin no sooner than January 1, 2013, the HFP will stop enrolling new children, with the exception of AIM-linked children, and these children will be subsequently covered under the Medi-Cal program.

DHCS will use the last known Managed Risk Medical Insurance Board (MRMIB) HFP eligibility review to give temporary Medi-Cal eligibility to these children. Granting temporary eligibility allows for a smooth transfer to the Medi-Cal program without the need to reapply for Medi-Cal at the time of transition.

41.3.2 Effective Dates

The State will begin transitioning children from the HFP no sooner than January 1, 2013. The last phase of the transition will begin no sooner than September 1, 2013.

Transition Phases

The chart below shows the transition phases.

<table>
<thead>
<tr>
<th>Transition Phase</th>
<th>Start Date</th>
<th>Cases Transitioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1A</td>
<td>No sooner than January 2013</td>
<td>Individuals currently enrolled in a HFP health plan that is also a Medi-Cal managed care plan will be enrolled in the same plan, unless they choose a different Medi-Cal Managed Care plan.</td>
</tr>
<tr>
<td>Phase 1B</td>
<td>No sooner than March 2013</td>
<td></td>
</tr>
<tr>
<td>Phase 2</td>
<td>No sooner than April 2013</td>
<td>Individuals currently enrolled in a HFP health plan that is a subcontractor of a Medi-Cal Managed Care plan will be enrolled in a Medi-Cal managed care plan that includes the individual’s current plan.</td>
</tr>
</tbody>
</table>
Approximately 32,000 children currently in HFP in Santa Clara County will be transitioning to Medi-Cal in two phases, phase 1A and phase 2.

- Phase 1A includes 22,000 children enrolled in HFP plans that are also a Medi-Cal managed care plans. (Children enrolled in Anthem Blue Cross or Santa Clara Family Health Plan) These children will start transitioning no sooner than January 1, 2013.

- Phase 2 includes 10,000 children enrolled in HFP plans that is a subcontractor of a Medi-Cal managed health care plan (Children enrolled in Kaiser). These children will start transitioning no sooner than April 1, 2013.

### 41.3.3 Transition

#### Transition Aid Codes

HFP children will remain in HFP aid code 9H (0C for AIM-linked infants) until their transition phase. Children due to be transitioned will be placed into one of two temporary aid codes in MEDS-5C or 5D. The county must perform the Medi-Cal determination within one year of the HFP annual eligibility review (AER).

- Aid code 5C provides full scope Medi-Cal coverage without premium payment to children with family income at or below 150% FPL.

- Aid code 5D provides full scope Medi-Cal coverage with a premium payment to children with family income above 150% FPL and up to 250%FPL.

**Example:**

Phase 1A transition starts on 01/01/2013. ONLY children in Phase 1A will receive aid code 5C or 5D. The remaining HFP children retain the HFP aid code until their transition phase.

---

### Transition Phase Table

<table>
<thead>
<tr>
<th>Transition Phase</th>
<th>Start Date</th>
<th>Cases Transitioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 3</td>
<td>No sooner than August 2013</td>
<td>Individuals currently enrolled in a HFP plan that is not also a Medi-Cal managed care plan and does not contract or subcontract with a Medi-Cal Managed Care plan will be enrolled in a new Medi-Cal managed care plan in the county.</td>
</tr>
<tr>
<td>Phase 4</td>
<td>No sooner than January 2013</td>
<td>Individuals currently in a county that has not implemented Medi-Cal Managed Care</td>
</tr>
</tbody>
</table>
Transitioned children remain in the applicable transition aid code until the date of the child’s HFP Annual Eligibility Review (AER), there is a change in circumstance that warrants a Medi-Cal review of eligibility or if the child is in an existing Medi-Cal case and the family’s Medi-Cal Redetermination (RD) occurs sooner than the child’s HFP AER.

**Premiums**

Children assigned 5D continue to pay premiums to the HFP Payment Section during their transition eligibility period until their next AER, if there is a change in circumstance that warrants a Medi-Cal review of eligibility, or if the child is in an existing Medi-Cal case at the family Medi-Cal Redetermination (RD) that occurs sooner than the child’s HFP AER month.

Once a Medi-Cal determination is made, these children will either continue with the same premium, a lower premium, or not pay a premium.

### 41.3.4 Medi-Cal Determinations

The timing of the Medi-Cal determination depends upon the individual circumstances of the child transitioning from the HFP. Some HFP children may already be in a Medi-Cal case with other family members. Others may not have any association with a Medi-Cal case.

When a child in transitional aid code 5C or 5D is also in an open Medi-Cal case with other family members and that case has a Medi-Cal RD date that occurs prior to the child’s HFP AER date, Medi-Cal determinations for the HFP child will be completed at the family Medi-Cal RD date and not wait until the child’s HFP AER date.

When a child in aid code 5C or 5D is also in an open Medi-Cal case with other family members and the child’s HFP AER is before the Medi-Cal family’s RD date, the EW will add the child and evaluate the Medi-Cal case with the child without having to wait for the Medi-Cal RD date.

If a child in aid code 5C, 5D does not have a Medi-Cal case, no action is required until the HFP AER date. At the HFP AER date, the EW will open a Medi-Cal case and determine if the child is Medi-Cal eligible.
Continuous Eligibility for Children (CEC)

If the family Medi-Cal RD, or adding the child to the Medi-Cal case as an “add a child” results in a change that would move the HFP child to a Medi-Cal share-of-cost (SOC), premium payment, or program ineligibility, the child is eligible for CEC and continues with no SOC Medi-Cal until his/her AER.

Continuous eligibility also protects the child from non financial reasons for discontinuance, even if those changes adversely affect other family members, except for:

- Death
- Child reaches the age limit
- Child loses California residency or
- The child/guardian or representative of the child requests disenrollment

Reminder:
Non-payment of premium is not a reason for CEC.

41.3.5 Transition Process

For HFP AERs due in January, February and March, 2013 MAXIMUS has sent renewal packages during the months of October, November, and December 2012 to these families. If HFP AER packets are returned MAXIMUS will complete the AER process and based on the updated eligibility information place these children in the appropriate transition aid code. The next redetermination for these children is in the corresponding month of 2014 (January, February or March) when the county will have responsibility to complete the redetermination unless there is a change in circumstances before the RD date.

For HFP AERs due in April through December 2013, MAXIMUS will send out renewal packages using a modified pre-populated form specific to the Medi-Cal program. The time frame for mailing these Medi-Cal renewal packages will be consistent with the current Medi-Cal processes. Within 10 business days, MAXIMUS will review the forms returned by the beneficiary for completeness. If AER is incomplete MAXIMUS will make five attempts to contact the family within the 10 day time frame. After 10 days MAXIMUS will forward the forms to the county. Upon receipt of the documentation from MAXIMUS, the county will have 3 business days to determine that the application received was complete and that begins the annual renewal process. In addition, MAXIMUS will provide to the county information related to the number of renewal packages mailed but not returned as confirmation of non-receipt for the county for audit and appeal purposes MAXIMUS will also send to the county any additional information if received from the
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beneficiary after original documents were sent. The EW will use the submitted documents and any additional information required to make the Medi-Cal eligibility determination and place the child into the appropriate Medi-Cal aid code.

41.3.6 Informing Notices

Prior to each phase of the transition, the State will mail notifications to the affected families. Those transitioning in Phase 1 were mailed a 60-day notification in November 2012, and a reminder notification in December 2012.

Welcome Packet

The State will send a Medi-Cal welcome packet to transitioning HFP families prior to the effective date of their transition.

The welcome packet includes:

- PUB 68, Medi-Cal What It Means To You
- MC 003 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program information
- MC 219, Important Information for Persons Requesting Medi-Cal
- Multilingual notice – request for assistance.
- Important Information about dental benefits
- A list of counties with telephone office contact information for Medi-Cal inquires.

Beneficiary Identification Cards

The State will be sending Beneficiary Identification Cards (BICs) only to children who received a BIC prior to 2011. Children who received a BIC in 2011 or 2012 will not get a new one.
With the exception of the AIM-linked babies there will be no new enrollments into HFP upon the implementation of transitioning the HFP children to Medi-Cal. The Single Point of Entry (SPE) will remain in existence and will continue to accept mail-in applications and applications submitted through the Health-e-App system.

The Single Point of Entry will:

- Conduct a MEDS clearance to determine if the child already has an open Medi-Cal case which would make them ineligible for accelerated enrollment (AE).
- Review for completeness, and if an application is not complete, request any missing information from the family.
- Screen for likely Medi-Cal eligibility and grant AE to children who screen as eligible and whose family incomes are below 250% FPL.
- Forward all applications to the county for eligibility determination.

MAXIMUS has 20 calendar days to contact the family to complete the application and/or provide the missing information before submitting the application to the county. After 20 days MAXIMUS will forward the incomplete application to the county.

Reminder:

Application date is the date that SPE receives the application and not the date that the county receives the application.

Accelerated Enrollment (AE)

SPE grants AE, a temporary full-scope, no cost Medi-Cal to all applications received for children zero up to the month of their 19th birthday, which appear eligible for full scope Medi-Cal and whose family incomes are below 250% FPL. SPE will continue to use the 8E aid code for AE.

During the time period that the child is granted AE, he/she will not be subject to premiums until the EW has completed the eligibility determination process.
41.4 Healthy Kids

Description

Healthy Kids is a locally funded health insurance program established to provide low cost/no cost comprehensive health coverage to uninsured children in Santa Clara County who do not qualify for Medi-Cal. For those unable to pay there is a premium assistance fund.

Healthy Kids is administered by Santa Clara Family Health Plan (SCFHP), and is not available through any other managed care health plan. A separate application is used for families applying for Healthy Kids.

Healthy Kids is entirely funded with local money. Funding for this program has been received from Santa Clara County’s tobacco settlement distribution, Proposition 10 money, the City of San Jose, the Santa Clara Family Health Foundation and other sources. There is no state or federal financial participation.

Additional information about the Healthy Kids Program can be found on the Healthy Kids Website: www.CHIkids.org.

Purpose

Healthy Kids Insurance is the essential component in helping to reach the goal of making health care coverage accessible to all children in Santa Clara County through the Children’s Health Initiative.

Scope of Coverage

Healthy Kids offers the following benefits:

- Full medical coverage (including prescriptions)
- Inpatient care
- Physician visits
- Well-baby visits
- Prevention services
- Health education
- Dental care
- Vision services
- Mental health and alcohol and substance abuse care.
A child who is enrolled in Healthy Kids is a member of the Santa Clara Family Health Plan and receives his/her care through the Plan’s network of doctors, clinics and hospitals.

There is a monthly health insurance premium ranging from $4 to $15 per child, but not more than $45 for three or more children. In addition to the monthly premium, some services require a copayment to the service provider at the time of service. Some services (such as preventive care services) are free. No individual charge will exceed $5.00.

Eligibility Criteria

To qualify for Healthy Kids, children must meet all of the following criteria:

- Reside in Santa Clara County
- Be under age 19
- Be ineligible for Medi-Cal
- Have net non-exempt family income at or below 300% of the FPL
- Have no other health insurance coverage.

Note:
Children who receive only restricted Medi-Cal benefits may qualify for Healthy Kids, however, children who currently receive full-scope Medi-Cal benefits with a share-of-cost are not eligible for enrollment.

41.5 Santa Clara County Children’s Health Initiative

41.5.1 Overview

The Children’s Health Initiative (CHI) was implemented in January 2001, with the goal of providing access to no-cost/low-cost comprehensive health insurance coverage for an estimated 71,000 uninsured children in Santa Clara County with family income at or below 300% of the federal poverty level (FPL). CHI included Medi-Cal, Healthy Families (ended 12/21/13) and our local program, Healthy Kids.

In an effort to remove barriers to health insurance for low income families, Medi-Cal programs and procedures were expanded to enable more families and children to access these programs by simplifying the application forms, expediting the enrollment process and increased outreach efforts.
The Children’s Health Initiative (CHI) is a result of a county-wide collaboration. Partners include Santa Clara County Social Services Agency, Santa Clara Valley Health and Hospital Systems, Santa Clara Family Health Plan, Health Trust, Alum Rock School District, People Acting in Community Together (PACT), Working Partnerships, Casa en Casa, Resources for Families and Communities and others.

The Children’s Health Initiative is an extensive outreach and enrollment plan that strives to reach out to families and help them apply for the appropriate health insurance program for their child(ren) utilizing a seamless process to determine eligibility for one of the following children’s health coverage programs:

- Medi-Cal Targeted Low Income Children’s Program - If net non-exempt family income is at or below 250% of the FPL,
- Healthy Kids - If net non-exempt family income is at or below 300% of the FPL.

Families are contacted through various outreach methods; media ad campaigns, flyers, word of mouth, encouragement by doctors during a visit, phone calls, etc.

**Toll-Free Number**

A toll-free telephone information line has been established for the Children’s Health Initiative. The phone line is a collaborative effort and is staffed by employees from Santa Clara Valley Health and Hospital Systems and Santa Clara County Social Services Agency.

The toll-free number is: 1-888-244-5222.

**41.5.2 CHI Screening Process at Intake**

**Role of the Application Assistor**

CAAs and EWs assist applicants with the following:

- Screening applicants for the appropriate program based on the family’s net non-exempt income
- Assisting applicants with completion of the joint “Medi-Cal for Pregnant Women and Children/Healthy Families Application” (MC 321 HFP) and the Healthy Kids Application
- Gathering verifications
- Determining the health insurance premium amount
• Assisting the family with enrollment in a Health Care Plan and choice of a Health Care Provider

• Assembling the application packet and ensuring it is forwarded to the appropriate location for processing.
Based on the family's income, the application forms are forwarded to:

- Social Services Agency or Single Point of Entry for a Medi-Cal eligibility determination, or
- Santa Clara Family Health Plan for a Healthy Kids eligibility determination.

Because there is a limited pool of funding available for Healthy Kids, it is important that every child who qualifies for Medi-Cal be enrolled in that program first.

### 41.5.3 CHI Screening Process at Redetermination

**Role of the Continuing EW**

Retention efforts to keep children insured are essential in attaining the CHI goal of providing comprehensive health insurance to all children residing in Santa Clara County with family income at or below 300% of the FPL. Continuing EWs must review children for all CHI programs when appropriate.

**IMPORTANT:**
“Continuous Eligibility for Children” (CEC) rules allow children under 19 to remain on zero SOC Medi-Cal, regardless of changes in family circumstances, until the next redetermination (RD). Therefore, CHI reviews are typically completed at the annual RD.

A CHI review is completed at RD when the case contains a child under 19 who meets ALL of the following conditions:

- Has no other health coverage (OHC), including Healthy Kids, AND
- The family’s net non-exempt income is at or below 300% of the FPL, AND
- Is NOT eligible for full scope zero SOC Medi-Cal.

A CHI review is NOT required when the child remains eligible for any zero SOC Medi-Cal program.
**41.5.4 CHI Review Process**

EWs are to follow the procedures below when a CHI review is required:

<table>
<thead>
<tr>
<th>STEP</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Determine the scope of Medi-Cal coverage</td>
</tr>
<tr>
<td></td>
<td><strong>IF the child is eligible for...</strong> <strong>THEN...</strong></td>
</tr>
<tr>
<td></td>
<td>Full Scope, • Go to Step 2.</td>
</tr>
<tr>
<td></td>
<td>Restricted, • Go to Step 3.</td>
</tr>
<tr>
<td>2.</td>
<td>Determine the net family income.</td>
</tr>
<tr>
<td></td>
<td><strong>IF the income is...</strong> <strong>THEN...</strong></td>
</tr>
<tr>
<td></td>
<td>Above the Maintenance Need Level, but at or below 250% of the FPL, • Set up the appropriate Medi-Cal program.</td>
</tr>
<tr>
<td></td>
<td>Between 250% and 300% of the FPL, • Go to Step 3.</td>
</tr>
<tr>
<td>3.</td>
<td>Determine if the child is pregnant.</td>
</tr>
<tr>
<td></td>
<td><strong>IF the child is...</strong> <strong>THEN...</strong></td>
</tr>
<tr>
<td></td>
<td>NOT Pregnant, Go to Step 4.</td>
</tr>
<tr>
<td></td>
<td>Pregnant, Restricted Medi-Cal covers the pregnancy. Wait until after the delivery to complete the CHI review and referral to Healthy Kids.(^a)</td>
</tr>
<tr>
<td>4.</td>
<td>Determine the type of Medi-Cal the child received in the month prior to RD.</td>
</tr>
<tr>
<td></td>
<td><strong>IF the child received...</strong> <strong>THEN...</strong></td>
</tr>
<tr>
<td></td>
<td>Full-scope zero SOC Medi-Cal, Assist with the Healthy Kids application process.</td>
</tr>
<tr>
<td></td>
<td>Restricted Medi-Cal with or without a SOC Assist with the Healthy Kids application process.</td>
</tr>
<tr>
<td></td>
<td>Full-scope SOC Medi-Cal, The child is considered insured and is not eligible for Healthy Kids. Complete the Medi-Cal RD process to determine ongoing Medi-Cal eligibility.</td>
</tr>
</tbody>
</table>

\(^a\) Children born to a mother on Medi-Cal qualify for Continued Eligibility (one year of zero SOC Medi-Cal).
41.5.5 Release of Information

With the implementation of the Children’s Health Initiative, it is necessary for Social Services Agency to share Medi-Cal information with the Healthy Kids Programs.

A “Consent to Exchange/Release Information” (SC 115) was developed to allow the sharing of specific eligibility data among the two programs.

Exception:

Information concerning medical records and/or minor consent eligibility CANNOT be released.

The SC 115 must be completed by all Medi-Cal applicants who are applying for children under age 19 and annually at redetermination thereafter. Both the client and the EW must sign the form. The original must be filed in the case record with the application (on Fastener One, Top), and a copy given to the client.

CAAs will also require applicants to complete an SC 115. The original signed consent form will be attached to the Medi-Cal application when submitted to Social Services for processing.

If the client refuses to sign the SC 115, then information cannot be shared between the different programs. The eligibility determination is not impacted if the client does not sign the release form.

41.5.6 CHI Forms and Materials

Forms used by EWs and CAAs when processing applications and redeterminations for the Medi-Cal and Healthy Kids Programs are listed below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Number</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>MC/HF Joint Application</td>
<td>MC 321</td>
<td>Completed by Applicant with Assistance from EW</td>
</tr>
<tr>
<td>Healthy Kids Application</td>
<td>N/A</td>
<td>Completed by Applicant with Assistance from EW</td>
</tr>
<tr>
<td>CAA Reference Manual</td>
<td>N/A</td>
<td>Reference Guide for EWs</td>
</tr>
<tr>
<td>Income Calculation Sheet for Medi-Cal</td>
<td>N/A</td>
<td>Budget Worksheet for EWs</td>
</tr>
<tr>
<td>Santa Clara Family Health Plan Provider Listing</td>
<td>N/A</td>
<td>Reference Guide for EWs</td>
</tr>
<tr>
<td>Blue Cross Provider Listing</td>
<td>N/A</td>
<td>Reference Guide for EWs</td>
</tr>
</tbody>
</table>
41.6 Accelerated Enrollment (AE) for Children

When an application is received by the Single Point of Entry (SPE), certain children who appear to be eligible for no cost Medi-Cal under one of the Federal Poverty Level (FPL) programs are enrolled into the AE program. The AE Program allows children to have immediate access to medical services until eligibility for regular Medi-Cal benefits is determined. SPE then forwards the application to the residence county for a Medi-Cal determination.

In Santa Clara County, mail-in applications from the SPE are sent to the designated Office for processing.

41.6.1 Scope of Coverage and Aid Code

AE provides temporary, full-scope, no cost coverage while eligibility for Medi-Cal is being determined.

- AE begins the first day of the month that SPE receives the application.

- Children who qualify for AE are assigned Aid Code 8E and MEDS generates the mailing of a Benefits Identification Card (BIC) to the child’s home.

EWs must evaluate the level of Medi-Cal benefits based on the child’s immigration status. SPE does not evaluate immigration status when establishing AE.

Note:
Children on AE receive fee-for-service Medi-Cal.

Important:
Under NO circumstances should a child be denied Medi-Cal due to the fact that he/she has an active (8E) MEDS record.
41.6.2 Children Ineligible for AE

AE does not apply to children who:

• Will be 19 years of age or over in the application month
• Have an active Medi-Cal MEDS record
• Do not have California residency
• Are included on an application that does not provide enough information at screening to establish eligibility
• Are included on an application that does not provide enough information for a Client Identification Number (CIN) to be assigned
• Have not requested Medi-Cal or whose SPE screening indicates that they are not likely eligible for no-cost Medi-Cal
• Do not appear eligible for no-cost Medi-Cal
• Have been reported as deceased on MEDS (a death date is present).

41.6.3 Informing Notices

AE is NOT considered full Medi-Cal eligibility, therefore, there are no appeal rights or Notice of Action (NOA) requirements during this period.

• SPE sends an informing notice for all children determined eligible for AE. The notice explains that a BIC will be issued for the child, and how to use the BIC to access services.
• AE stops when a full Medi-Cal eligibility determination is completed and the child’s Medi-Cal has either been approved or denied. A 10-day Notice of Action (NOA) is NOT required to stop AE.

41.6.4 AE MEDS Record

AE eligibility is viewed on the Special Program 1 [INQ1] MEDS screen. An AE record on MEDS will have the following information:

<table>
<thead>
<tr>
<th>Field</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility Status Code</td>
<td>001-499</td>
</tr>
<tr>
<td>Government Responsibility Code</td>
<td>“1” (County Responsibility)</td>
</tr>
</tbody>
</table>
41.6.5 Reporting Approvals to MEDS

Medi-Cal approvals are currently reported to MEDS through the CalWIN batch process. No EW action is needed, except to monitor and confirm eligibility on MEDS and ensure that the AE record is captured and that a duplicate record is not created.

41.6.6 Termination of AE

AE ends when MEDS receives information that the child’s Medi-Cal has either been approved or denied. MEDS automatically terminates AE at the end of the MEDS month in which the EW generates a Medi-Cal approval or denial transaction, and it is reported to MEDS by CalWIN via interface.

AE Time frames and MEDS Cut-Off

The following information is reflected on MEDS when action is taken to terminate AE:

<table>
<thead>
<tr>
<th>If ...</th>
<th>Then...</th>
</tr>
</thead>
<tbody>
<tr>
<td>A denial is reported to MEDS prior to the end of the calendar month,</td>
<td>MEDS will discontinue AE the last day of the calendar month.</td>
</tr>
<tr>
<td></td>
<td>The AE termination date will be the denial date.</td>
</tr>
<tr>
<td></td>
<td>A ten-day NOA is not required to terminate AE.</td>
</tr>
<tr>
<td>The application is approved prior to MEDS Cut-Off,</td>
<td>Both the AE Aid Code and the regular Medi-Cal Aid Code will show on the MEDS screen in their corresponding segments for the current month.</td>
</tr>
<tr>
<td></td>
<td>The AE Aid Code will automatically terminate at the end of the month while the regular Medi-Cal Aid Code continues.</td>
</tr>
</tbody>
</table>
Medi-Cal Handbook

State/County Administered Health Insurance Programs

41.7 CHDP Gateway Program

41.7.1 Background

The Child Health and Disability Prevention (CHDP) Program provides preventive health assessments to 2.1 million children statewide. Services are limited to physical examinations, vision and hearing screening, laboratory tests, and immunizations. Approximately half of these children are Medi-Cal beneficiaries. The remaining children are from families with income at or below 200% of the federal poverty level (FPL) and whose CHDP services are covered by state-only funds. It is estimated that many of these children would be eligible for Medi-Cal if they applied.

Budget Act Trailer Bill AB 442 allows the CHDP Program to be utilized as a “gateway” to the Medi-Cal, for the purpose of maximizing enrollment of uninsured children into comprehensive health care coverage.

Note:
CHDP referral procedures have not changed. EWs must continue to inform families of the availability of CHDP screening for children under 19 years of age and ensure all cases containing children under age 21 are coded with the appropriate CDS entry.

41.7.2 Pre-Enrollment by CHDP Providers

The CHDP Gateway Program allows CHDP providers to pre-enroll children into temporary, full-scope, zero share-of-cost (SOC), fee-for-service Medi-Cal based upon income screening for zero SOC Medi-Cal.

<table>
<thead>
<tr>
<th>If ...</th>
<th>Then...</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the application is approved after MEDS Cut-Off and on or before the end of the calendar month,</td>
<td>MEDS will show the new ongoing Medi-Cal eligibility Aid Code on the [INQM] screen from the effective date, and AE will be terminated the last day of the calendar month. The AE termination date displayed on MEDS will be the date the transaction posted to MED.</td>
</tr>
</tbody>
</table>
CHDP Screening Process

When a child visits a CHDP provider’s office for a health assessment, the 250% income screening test is applied. If the child meets the income criteria and is under 19 years of age, the provider submits a “Child Health and Disability Prevention (CHDP) Program Pre-Enrollment Application” (DHS 4073) via the internet or a point-of-service (POS) device, and existing eligibility for Medi-Cal is automatically checked through MEDS. The DHS 4073 is the electronic internet-based application used by CHDP providers to complete pre-enrollment into Medi-Cal through the Gateway. In addition, a brochure explaining CHDP and the CHDP Gateway is provided to the client during the office visit.

Note: Children whose family income is above the applicable FPL limits for zero SOC Medi-Cal are not eligible for CHDP services or pre-enrollment through the CHDP Gateway.

CHDP Gateway Aid Codes

Children who meet the requirements to be pre-enrolled through the Gateway are automatically given full-scope, zero SOC Medi-Cal for the month of screening and the following month in one of the Aid Codes below:

<table>
<thead>
<tr>
<th>Aid Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8W</td>
<td>CHDP Gateway Medi-Cal up to 150% FPL</td>
</tr>
<tr>
<td>8X</td>
<td>CHDP Gateway Medi-Cal above 150% up to and including 250% FPL</td>
</tr>
<tr>
<td>8Y</td>
<td>A child currently eligible on MEDS in an Aid Code linked to undocumented immigration status. (CHDP STATE-ONLY PROGRAM)</td>
</tr>
</tbody>
</table>

Child Qualifies for Pre-Enrollment

When the electronic CHDP Gateway application is submitted to MEDS, and the child meets the pre-enrollment requirements, the CHDP provider receives an immediate response, indicating the child’s existing or newly assigned Client Index Number (CIN).

<table>
<thead>
<tr>
<th>If the Child is...</th>
<th>Then the Child Receives...</th>
</tr>
</thead>
</table>
| Not known to MEDS, or has SOC Medi-Cal, | • A CHDP Exam  
• Temporary full-scope Medi-Cal |
| Known to MEDS - Currently active on restricted benefits, | • Emergency /Pregnancy Only Medi-Cal  
• CHDP exam  
• Not eligible for temporary full-scope Medi-Cal |
State/County Administered Health Insurance Programs

Children Without Satisfactory Immigration Status (SIS)

Children who are currently active on MEDS in a restricted Medi-Cal Aid Code due to undocumented immigration status cannot be pre-enrolled in Medi-Cal through the CHDP Gateway. These children are only entitled to state-funded CHDP services, for the month of screening and the following month.

Note:
Undocumented children who are NOT currently active on MEDS may be pre-enrolled through the Gateway.

CHDP Eligibility and SOC Medi-Cal

A child who is already receiving Medi-Cal with a SOC and has met his/her SOC in the month of the CHDP visit is already Medi-Cal eligible and cannot be pre-enrolled for that month.

CHDP Eligibility and Other Health Coverage (OHC)

When MEDS indicates a child has OHC, the child is still pre-enrolled through the CHDP Gateway and is able to receive services regardless of their OHC status. A new MEDS enhancement overrides the OHC code on MEDS at the time of pre-enrollment through the CHDP Gateway as follows:

<table>
<thead>
<tr>
<th>If...</th>
<th>Then...</th>
</tr>
</thead>
<tbody>
<tr>
<td>The child is determined eligible under the CHDP accelerated enrollment aid code 8W or 8X,</td>
<td>The OHC indicator code is changed to “N” regardless of whether MEDS shows an active OHC code.</td>
</tr>
<tr>
<td>The child is determined eligible under the State-only CHDP Aid Code 8Y and MEDS shows an active OHC code,</td>
<td>The MEDS OHC code is changed to an ‘A’ (pay and chase).</td>
</tr>
</tbody>
</table>

CHDP Eligibility and Retroactive Medi-Cal

Individuals applying for Medi-Cal through the Gateway may request retroactive Medi-Cal coverage to cover the pre-enrollment period.
BIC Card

Children who are not known to MEDS at the time of pre-enrollment through the Gateway are automatically mailed a BIC card within two working days. If a BIC was previously issued to the child, a new BIC is not issued unless requested on the pre-enrollment application.

Eligibility Determination for Medi-Cal

If the applicant indicates on the CHDP application that s/he wants to apply for Medi-Cal for the child, SPE sends an MC 321 HFP to the parents of children who are pre-enrolled in Medi-Cal through the Gateway. The MC 321 HFP is sent in the appropriate language, along with a self-addressed, postage paid envelope with instructions to mail the application back to SPE for processing.

Parents are required to submit the completed application form to SPE for ongoing coverage to continue. The CHDP Gateway program application process is as follows:

<table>
<thead>
<tr>
<th>If the Completed Application is...</th>
<th>Then...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Returned to SPE within the initial two months of presumptive eligibility, and that information is reported to MEDS,</td>
<td>SPE conducts a full file clearance and reports to MEDS that the application has been received.</td>
</tr>
<tr>
<td></td>
<td>SPE extends the pre-enrollment period, and the child continues to receive full-scope, zero SOC Medi-Cal coverage until eligibility for ongoing Medi-Cal is determined.</td>
</tr>
<tr>
<td></td>
<td>SPE screens the application and sends to the county for an eligibility determination.</td>
</tr>
<tr>
<td></td>
<td>SPE sends an informing notice to the client explaining that pre-enrollment has been extended until eligibility for Medi-Cal is determined. This notice is available in 11 languages.</td>
</tr>
<tr>
<td>Not returned to SPE within the initial two months of presumptive eligibility,</td>
<td>The child’s eligibility for full scope zero SOC coverage is not extended beyond the second month.</td>
</tr>
<tr>
<td></td>
<td>NOTE: The child’s eligibility for full scope zero SOC coverage is not extended beyond the second month.</td>
</tr>
<tr>
<td></td>
<td>There is no requirement to provide a 10-day NOA when pre-enrollment ends.</td>
</tr>
</tbody>
</table>
Note:
A child can be eligible for an additional period of presumptive eligibility in the future, if CHDP services are requested again and they are in accordance with the allowable CHDP time frames.

Notice of Action

Pre-enrollment eligibility through the CHDP Gateway is granted before a full Medi-Cal eligibility determination is made; therefore, there are no appeal rights or notice of action (NOA) requirements for the pre-enrollment period. However, once an eligibility determination for Medi-Cal is completed for the child, the EW must send the appropriate Medi-Cal approval or denial NOA.

41.8 Breast and Cervical Cancer Treatment Program (BCCTP)

The BCCTP was implemented on January 1, 2002. BCCTP is both federal and state-funded. Eligibility determination and ongoing case maintenance is done by the Department of Health Care Services (DCHS). This program provides full-scope or restricted, no share-of-cost Medi-Cal to uninsured or under insured individuals who are screened through the Centers for Disease Control and Prevention (CDC) or by the National Breast and Cervical Cancer Early Detection Program; and are found to be in need of treatment including some precancerous conditions. In California, the authorized screening providers are those participating in either the Cancer Detection Programs: Every Woman Counts (EWC), or Family Planning, Access, Care and Treatment (FPACT) program.
BCCTP must be considered by the County prior to denying or discontinuing Medi-Cal benefits. At the time of application, redetermination or any time a change is reported that results in ineligibility, and the EW is aware or the applicant or recipient declares he/she has breast cancer or she has cervical cancer, the EW must send a referral to BCCTP and not take any action on the Medi-Cal benefits until a determination is received from BCCTP.

In order to make individuals aware that the BCCTP is available, a flyer, “Breast and Cervical Cancer Treatment Program (BCCTP)” (MC 372) must be included in all intake and redetermination packets.

The BCCTP provides an online, internet-based application process specifically designed to enable breast and/or cervical cancer patients to apply for BCCTP coverage right in an EWC or FPACT provider's office. Upon application, the enrolling provider gives the applicant the Confirmation Document (CD) and message text document. The CD tells the applicant whether they received Accelerated Enrollment (AE) or not and the message text document provides additional information about the BCCTP. Those determined eligible are sent a Medi-Cal BIC, if they do not already have one. If the applicant receives AE and does not have a BIC, the CD may be used until the BIC is received in the mail.

41.8.1 Every Woman Counts (EWC) Program

The Department of Health Care Services (DHCS), Every Woman Counts (EWC) Program, provides eligible women with free breast and cervical cancer screening services, such as mammograms, clinical breast exams, Pap tests, and Human Papillomavirus (HPV) tests (in combination with a Pap test). EWC also assists eligible women with enrollment into the Breast and Cervical Cancer Treatment Program (BCCTP).

Eligibility Criteria:

In order for women to be eligible for free EWC services, they must:

• Live in California,
• Have no or limited health insurance,
• Have health insurance with a co-payment or deductible they cannot afford
• Not be eligible for Medi-Cal,
• Have income up to 200 percent of the federal poverty level,
• Be at least 40 years of age for a clinical breast exam and a mammogram,
• Be at least 21 years of age for a Pap test.
Eligibility Workers (EWs) must share the *EWC Program Brochure* with women found ineligible for Medi-Cal, Covered California health plans, or other county medical coverage services.

**Note:**

The EWC Brochure is available for printing on the DHCS website listed below. ([http://www.dhcs.ca.gov/services/cancer/EWC/Pages/EducationalMaterials.aspx](http://www.dhcs.ca.gov/services/cancer/EWC/Pages/EducationalMaterials.aspx))

Women are able to call an automated referral line at (800) 511-2300 or use an Online Provider Locator ([http://dhcs.ca.gov/EveryWomanCounts](http://dhcs.ca.gov/EveryWomanCounts)) to find up to ten doctors or clinics in their area that provide these services. Both the automated referral line and the Online Provider Locator are available twenty-four hours a day, seven days a week.

### 41.8.2 Health Insurance Coverage

Individuals who have the following types of health insurance coverage are ineligible for BCCTP:

- Medicare
- Group health plan
- Medi-Cal (full-scope, no SOC)
- Armed Forces insurance
- State health risk pool
- Health insurance coverage - benefits consisting of medical care provided through:
  - Insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, or
  - Hospital or medical service plan contract, or
  - Health maintenance organization (HMO) contract offered by a health insurance company.
41.8.3 Federal BCCTP

The federally-funded BCCTP provides full scope, no share of cost (SOC) Medi-Cal benefits to uninsured women under age 65 who are citizens or lawful immigrants who have no health insurance coverage and who are found to be in need of treatment for breast and/or cervical cancer. A woman who meets all federal BCCTP requirements remains eligible for the duration of her period of treatment.

Note:
Federal rules only allow CDC (or CDC-approved) providers to screen women. Men are precluded from federal BCCTP.

Ineligibility for federal BCCTP

A woman becomes ineligible for federal BCCTP if she:

• Has turned 65 years of age
• Has obtained creditable insurance coverage, including but is not limited to full-scope, no share-of-cost Medi-Cal or Medicare
• No longer needs treatment for breast and/or cervical cancer as determined by her treating physician.

Note:
The federal BCCTP does allow eligibility for beneficiaries who have Medi-Cal with a SOC if they meet all other federal BCCTP eligibility criteria. state-funded BCCTP provides coverage to individuals who meet all non-federal BCCTP requirements, including those who are concurrently eligible for restricted Medi-Cal (e.g., undocumented aliens, pregnant women, etc.).

41.8.4 State-Funded BCCTP

Recognizing the need in California for breast and cervical cancer treatment coverage beyond the limitations of the federal law, a state-funded BCCTP is established. Under the state-funded BCCTP, the period of coverage is limited to 18 months for breast cancer and up to 24 months for cervical cancer.

The state-funded BCCTP program covers breast and/or cervical cancer patients needing treatment who have been determined ineligible for the federal BCCTP, such as:

• Women age 65 and over, regardless of immigration status;
• Women under 65 without satisfactory immigration status (SIS); or
• Men (breast cancer only) of any age or immigration status.
The state-funded BCCTP covers persons who are:

<table>
<thead>
<tr>
<th>Uninsured</th>
<th>Under Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons who do not have no-cost Medi-Cal, Medicare or private health insurance</td>
<td>• Persons with share-of-cost Medi-Cal</td>
</tr>
<tr>
<td></td>
<td>• Persons with existing comprehensive health insurance coverage (i.e., Medicare or private health insurance) that is inaccessible due to high premium, deductible and/or copayment costs (exceeding $750 in the 12-month period.)</td>
</tr>
</tbody>
</table>

41.8.5 Referrals to BCCTP

When making a BCCTP referral, the EW must:

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Call (916) 322-3410 and inform BCCTP that the referral is being faxed.</td>
</tr>
<tr>
<td>2.</td>
<td>Fax the referral form, “County Referral to the Breast and Cervical Cancer Treatment Program” (MC 373) to (916) 440-5693 and include the following:</td>
</tr>
<tr>
<td></td>
<td>• Full name of the person referred,</td>
</tr>
<tr>
<td></td>
<td>• Address of the person,</td>
</tr>
<tr>
<td></td>
<td>• Phone number of the person,</td>
</tr>
<tr>
<td></td>
<td>• CIN, current Aid Code and the case number, and</td>
</tr>
<tr>
<td></td>
<td>• Name and contact information of the EW making the referral.</td>
</tr>
<tr>
<td>3.</td>
<td>Notify the applicant/beneficiary that a referral was sent to BCCTP for an eligibility determination</td>
</tr>
<tr>
<td>4.</td>
<td>Add a Special Indicator, “BCCTP Pending,” in CalWIN.</td>
</tr>
<tr>
<td>5.</td>
<td>Document in Case Comments that a BCCTP and DDSD referrals were sent or only a BCCTP referral sent. Document the reason the applicant would have been denied or discontinued from Medi-Cal.</td>
</tr>
<tr>
<td>6.</td>
<td>Transfer an intake case to continuing pending BCCTP/DDSD decisions.</td>
</tr>
</tbody>
</table>
41.8.6 Referring Applicants

At application, if the individual will be denied and the EW is aware or the applicant declares to have breast or cervical cancer, the EW must:

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Determine if the applicant meets all the criteria for a disability evaluation.</td>
</tr>
<tr>
<td>2.</td>
<td>If the applicant meets the DDSD criteria, simultaneously refer the applicant to DDSD for a disability determination and to BCCTP for an eligibility determination. Make a notation on Box 10 of the DDSD referral form (MC 221) that the individual has been referred to BCCTP. <strong>Note:</strong> If the MC 221 does not indicate in Box 10 that the EW has made a referral to BCCTP, the DDSD analyst will fax the MC 221 to the EW indicating a BCCTP referral appears necessary. The EW must check the case file and verify if a referral has been made to BCCTP. If one has not been made, the EW must make the referral and inform DDSD.</td>
</tr>
<tr>
<td>3.</td>
<td>If the applicant does not meet the DDSD criteria, and there is no linkage to Medi-Cal, refer the individual to BCCTP without a disability packet. Keep Medi-Cal pending.</td>
</tr>
<tr>
<td>4.</td>
<td>If the applicant is a male or a woman 65 years or older, not eligible for Medi-Cal, deny Medi-Cal and also send a referral for State-funded BCCTP.</td>
</tr>
</tbody>
</table>

Simultaneously referring women to BCCTP will allow the federally BCCTP eligible women to receive Medi-Cal benefits, including Accelerated Eligibility if eligible, while their disability determination is being reviewed. BCCTP will contact the applicant to determine if she meets federal BCCTP requirements. The State will make a BCCTP eligibility determination and if found eligible will issue an approval Notice of Action (NOA) to the applicant and copy the EW who made the referral.

41.8.7 Referring Beneficiaries

If a Medi-Cal beneficiary is no longer eligible for his/her existing Medi-Cal program either at the annual redetermination or when the beneficiary reports a change in circumstances, and the beneficiary declares to have breast and/or cervical cancer, the EW must follow the SB 87 process to determine whether the individual is eligible for any other Medi-Cal program, including federal BCCTP.
In order to follow the SB 87 process, the EW must:

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Determine if the beneficiary meets the DDSD criteria to send a referral</td>
</tr>
</tbody>
</table>
| 2.   | Refer the beneficiary to DDSD for a disability determination, if applicable, **AND** send a referral to BCCTP. Make a notation on Box 10 of the MC 221 that a BCCTP referral has been made  
**Note:** If the MC 221 does not indicate in Box 10 that the EW has made a referral to BCCTP, the DDSD analyst will fax the MC 221 to the EW indicating a BCCTP referral appears necessary. The EW must check the case file and verify if a referral has been made to BCCTP. If one has not been made, the EW must make the referral and inform DDSD. |
| 3.   | Place the beneficiary in one of the SB 87 pending disability Aid Codes (6J, 6R, 5J, or 5R) while a disability determination is pending. |
| 4.   | If the individual does not meet the DDSD criteria, send a BCCTP referral without a DDSD packet.  
**Note:** A male or a 65 year-old or older female are not eligible for federal BCCTP, but EWs must still follow the SB 87 process to determine whether the individual is eligible for any other Medi-Cal program. |
| 5.   | Do not discontinue Medi-Cal benefits for a woman under 65 years of age until BCCTP determination is received. If a DDSD referral was made, also wait for the DDSD decision. |

### 41.8.8 BCCTP Categories

Seven aid codes are assigned to BCCTP and are viewable on MEDS secondary screens: INQ1, INQ2 or INQ3. There are an additional four interim aid codes.
## Medi-Cal Handbook

### State/County Administered Health Insurance Programs

#### Categories for Females (only) Who Are Less Than 65 Years of Age

<table>
<thead>
<tr>
<th>Aid Code</th>
<th>Funding</th>
<th>Description</th>
</tr>
</thead>
</table>
| 0U       | Federal/State Funded | Restricted Medi-Cal Services and State-Funded Cancer Treatment and Related Services for Women Without SIS  
This category provides restricted services for females (only) who do not have SIS. This category does not cover women with other comprehensive health insurance. The period of eligibility for this category is up to 18 months for breast cancer and up to 24 months for cervical cancer. |
| 0P       | Federal  | Federal BCCTP Eligibility Determined  
The period of eligibility for this aid code is the duration of treatment as long as all other federal BCCTP eligibility criteria continue to be met. This is a full-scope, no-SOC Medi-Cal for females (only) who have SIS and have no creditable health insurance coverage. |
| 0V       | Federal  | Continuing Restricted Services for 0U Eligibles  
The 0U eligibles must have exhausted their period of state-funded cancer treatment services, but still need treatment and still meet all federal BCCTP requirements except for immigration status. This category provides continuing Medi-Cal emergency services and state-only Medi-Cal pregnancy-related/LTC services without a SOC, for 0U beneficiaries whose 18 or 24 month period of state-funded cancer treatment coverage has ended but continue to need treatment and meet all other federal BCCT eligibility requirements except for immigration status. |
| 0M       | State    | Accelerated Eligibility (AE) - Two-Month Limit  
This category provides temporary, full-scope, no-SOC Medi-Cal limited to two months only (the month of application and the month after) because the individual did not request ongoing Medi-Cal. |
| 0N       | State    | AE Until a Determination of Federal BCCTP Eligibility is Determined  
This is a temporary, full-scope, no-SOC Medi-Cal coverage for women with no health insurance coverage. This AE continues while a federal BCCTP eligibility determination is made. Applicants who, at the time of their BCCTP application, have current eligibility in MEDS for a restricted Medi-Cal aid code (e.g., 58, 3V) will not be granted AE as their current status indicates they do not meet all federal BCCTP requirements. |
### Category for Males or Females

<table>
<thead>
<tr>
<th>Aid Code</th>
<th>Funding</th>
<th>Description</th>
</tr>
</thead>
</table>
| 0T       | State   | Coverage Limited to Cancer Treatment and Related Services Only  
The period of eligibility for this aid code is up to 18 months for breast cancer or up to 24 months for cervical cancer.  
- Provides coverage limited to breast and/or cervical cancer treatment and related services regardless of immigration status, who do not have health insurance coverage  
- Provides coverage limited to breast cancer treatment and related services for males (regardless of age or immigration status) and who do not have health insurance coverage. |
| 0R       | State   | High-Cost Other Health Coverage-Coverage Limited to Cancer Treatment and Related Services Only  
Both males and females (regardless of age or immigration status) may qualify. This category provides payment of premiums, co-payments, deductibles, as well as coverage for breast and/or cervical cancer treatment and related services that are not covered by insurance. The insurance costs as determined by BCCTP Eligibility Specialist (ES), exceeds $750 in the 12-month period beginning on the date of eligibility determination for BCCTP. If the insurance costs during this 12-month period are determined by the ES to be $750 or less, the individual is not eligible for state-funded BCCTP coverage. The period of eligibility for this aid code is up to 18 months for breast cancer or up to 24 months for cervical cancer. |
| OW       | Federal | Transitional full-scope Medi-Cal coverage with no SOC to BCCTP beneficiaries terminated from aid code 0P because they have obtained age 65, acquired creditable health coverage, or are no longer in need of treatment for breast and/or cervical cancer. |
| 0X       | State   | Transitional restricted Medi-Cal and State-funded cancer treatment and related services to BCCTP beneficiaries terminated from aid code 0U because they have obtained creditable health coverage, but their out-of-pocket expenses for the health coverage will exceed $750 in the next 12-month period and have not exhausted the 18 or 24 months of State-funded eligibility.  
Note: If the EW does not make a determination before the end of the beneficiary’s 18 months (for breast cancer) or 24 months (for cervical cancer) of State-funded eligibility, when State-funded BCCTP ends, the beneficiary will be placed into aid code OL until the EW makes a determination. |
41.8.9 Processing BCCTP Determinations

In most cases, prior to denying or discontinuing Medi-Cal benefits, the EW must have both a BCCTP determination and a DDSD decision if a referral was made.

Applicants with a DDSD Referral

If the applicant is found not eligible for federal BCCTP or found eligible only for State BCCTP, the EW must wait for the disability determination from DDSD before making a final Medi-Cal eligibility determination for any other Medi-Cal program. Send the appropriate Medi-Cal denial notice of action (NOA). The NOA must include the BCCTP denial paragraph, if appropriate. BCCTP will send a letter to the applicant, copy the EW, regarding the determination of state-funded BCCTP.

When the EW receives the DDSD determination that the individual does not meet Medi-Cal disability criteria, but a determination by BCCTP has not been received, the EW is not to deny or discontinue Medi-Cal until the BCCTP decision is received.
Applicants without a DDSD Referral

If a DDSD referral was not made, BCCTP will determine eligibility for both federal and State BCCTP. Once that determination is made, BCCTP will notify the EW if the individual is not eligible for federal BCCTP. The EW will send the denial NOA of both the Medi-Cal and BCCTP programs. BCCTP will notify the individual, copy the EW, if the individual is not eligible for State BCCTP. BCCTP will only send an eligibility letter (not NOA) regarding the State BCCTP since the State BCCTP is not a Medi-Cal benefit.

Denial NOA

If the applicant is not eligible for federal BCCTP or eligible only for State BCCTP, the EW must send the final denial NOA for all Medi-Cal programs, including the federal BCCTP. The NOA must include the following BCCTP denial paragraph:

Your application for Medi-Cal has been denied, including for the Breast and Cervical Cancer Treatment Program (BCCTP). However, BCCTP will now review your case to determine if you are eligible for State-funded BCCTP. State-funded BCCTP is not a Medi-Cal Program. You will receive a separate letter from the BCCTP letting you know if you are eligible for State-funded BCCTP.

The State will send a letter to the applicant regarding the eligibility determination for State-funded BCCTP as these benefits are not considered Medi-Cal benefits.

Processing Chart

The following is a chart to clarify the steps in processing an applicant for BCCTP prior to denial:
<table>
<thead>
<tr>
<th>Question</th>
<th>If . . .</th>
<th>Then . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is the applicant eligible for federal BCCTP?</td>
<td>YES</td>
<td>• BCCTP sends the approval NOA to the client with a copy to the EW.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The EW waits for the DDSD decision if a referral was made and a decision has not been received.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Deny Medi-Cal if no DDSD referral was made. (No specific BCCTP language required on the NOA.)</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>• EW waits for the DDSD decision. Once the DDSD decision is received, follow steps in # 3 below.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• EW sends a Medi-Cal denial, including BCCTP denial if a DDSD referral was not sent.</td>
</tr>
<tr>
<td>2. Is the applicant eligible for State BCCTP?</td>
<td>YES</td>
<td>• BCCTP sends a letter to the applicant.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The EW follows step # 1 above. (The applicant is not eligible for federal BCCTP.)</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>• BCCTP will send a letter to the applicant.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The EW follows steps 1 and 3.</td>
</tr>
<tr>
<td>3. Is the applicant considered disabled?</td>
<td>YES</td>
<td>The EW must do the following actions:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Approve disability-based Medi-Cal if otherwise eligible.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Calls or faxes approval NOA to BCCTP.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Check MEDS for correct Aid Code.</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>• EW sends Medi-Cal denial NOA including federal BCCTP denial if the applicant is not eligible for federal BCCTP, or only eligible for State BCCTP.</td>
</tr>
</tbody>
</table>

**Medi-Cal Recipient Eligible for Federal BCCTP and NOA**

If the Medi-Cal recipient is found eligible for federal BCCTP, the State will issue a NOA to the beneficiary and copy the EW who made the referral. If BCCTP makes a favorable BCCTP determination prior to DDSD, the EW shall discontinue the alleged disability Aid Code (6J) effective the end of the current month. Do not send a discontinuance NOA so not to confuse the beneficiary and delay treatments.
Full Scope with a Disability Packet

If a beneficiary is not eligible for the federal BCCTP, the State will notify the EW. The individual must remain active in a pending disability Aid Code while a disability determination is pending. Upon receipt of the DDSD decision, the EW will take appropriate action. If the individual is found not to have a disability, the EW must inform BCCTP as soon as possible and send a discontinuance NOA including denial for BCCTP.

Note: 
BCCTP cannot determine eligibility for the State BCCTP until all eligibility determinations for Medi-Cal have been completed.

Restricted Medi-Cal with a Disability Packet

If a beneficiary in restricted Medi-Cal is determined not eligible for federal BCCTP, BCCTP will notify the EW. The individual must remain active in a pending disability aid codes (5J or 5R) while a disability determination is pending. BCCTP will proceed to make a determination for the State BCCTP. If the individual is found eligible for the State BCCTP, the State will notify the beneficiary immediately.

If the individual is found not to have a disability, the worker must inform BCCTP and send a final discontinuance NOA for all Medi-Cal programs, including the federal BCCTP.

Disability Determination for Applicant or Recipient Approved Federal BCCTP

When an individual is approved for federal BCCTP and the EW later receives a DDSD decision of disability, the EW must check MEDS to determine if the woman is still active in BCCTP (aid code ON, OP, OW). If the woman is still federally active in BCCTP but is now also eligible for Medi-Cal based upon disability, the worker shall:

• Make the woman eligible for Medi-Cal under the correct disability Aid Code effective the first of the following month and send the approval NOA.

• Fax a copy of the approval NOA to BCCTP to indicate that the individual is eligible for Medi-Cal and under which program.

BCCTP will evaluate if the individual must be terminated from BCCTP or if she may continue under BCCTP.
Note:  
In the Medi-Cal hierarchy of programs, BCCTP is the last program. In most cases, if a woman is eligible for disability-based Medi-Cal and federal BCCTP, the EW would set up disability based Medi-Cal and BCCTP will discontinue the program.

BCCTP Processing Chart for Medi-Cal Beneficiaries

For Medi-Cal recipients, BCCTP cannot make a determination of eligibility for State BCCTP until all eligibility determinations for Medi-Cal have been made.

Below is a chart to clarify the BCCTP processing for a Medi-Cal beneficiary:

<table>
<thead>
<tr>
<th>Question</th>
<th>If...</th>
<th>Then...</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is the recipient eligible for federal BCCTP?</td>
<td>YES</td>
<td>• BCCTP sends the approval NOA with a copy to the EW.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If DDSD has not made a decision, discontinue Medi-Cal effective the end of the current month. <strong>Do not send a NOA.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If no DDSD referral was made, discontinue Medi-Cal.</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>• The beneficiary remains active until a decision is received from DDSD.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If no DDSD referral was sent, send a Medi-Cal discontinuance NOA including BCCTP denial.</td>
</tr>
</tbody>
</table>

(Chart page 1 of 2)
41.8.10 Medi-Cal Discontinuance NOA

The discontinuance NOA must be issued once the BCCTP and or the DDSD determinations are received by the EW if the recipient is ineligible for Medi-Cal and/or federal BCCTP. The EW must add specific language to the discontinuance NOA prior to mailing it to the Medi-Cal recipient who claims to have breast or cervical cancer. The language is as follows:

“Your application for Medi-Cal has been denied, including for the Breast and Cervical Cancer Treatment Program (BCCTP). However, BCCTP will now review your case to determine if you are eligible for State-funded BCCTP. State-funded BCCTP is not a Medi-Cal program. You will receive a separate letter from the BCCTP letting you know if you are eligible for State-funded BCCTP.”
MC 351 and MC 239 A

Notices of Action MC 351 and MC 239 A have been revised to include the specific BCCTP required language. If another Medi-Cal notice is issued for an individual who is denied federal BCCTP, the EW must include the specific required BCCTP denial paragraph as written above.

41.8.11 Retroactive Benefits

If the original application to the county included a request for retroactive benefits and MEDS does not show coverage for the requested months, the EW shall fax a copy of the Medi-Cal approval NOA to BCCTP to indicate that the individual is eligible for Medi-Cal and under which Medi-Cal program.

41.8.12 Annual Redetermination (RD) for BCCTP Eligibility

Annual RDs are performed by State Eligibility Specialists (ES) for those beneficiaries receiving full or restricted federal BCCTP benefits (in Aid Code 0P, 0U and 0V) to determine if there have been any changes in the beneficiary's circumstance (e.g., obtained health insurance coverage, no longer California resident, etc.) that may affect ongoing BCCTP eligibility and determine if the beneficiary is still in need of treatment. Currently, annual RDs are not required for state-funded BCCTP; however, the beneficiaries are required to report within ten calendar days any changes which may affect their eligibility.

41.8.13 State Hearings and Appeals

BCCTP beneficiaries have the same hearing and appeal rights as any other Medi-Cal beneficiary. When a Medi-Cal applicant or beneficiary appeals a denial of Medi-Cal eligibility and that appeal is based on her having, or declaring to have, breast and/or cervical cancer, Administrative Law Judges (ALJs) have been instructed that the case must be referred to BCCTP.

The case must be referred to BCCTP by the county if the ALJ renders a decision to the county and the county has previously not referred the case to BCCTP. If the decision is rendered to the DDSD and the MC 221 does not show that a referral to BCCTP has been made, the DDSD staff will fax the MC 221 to the county indicating a BCCTP referral appears necessary. The county must check the case file and verify if a referral has been made to the BCCTP. If one has not been made, the county must make the referral.
The ALJ cannot make a ruling on the individual’s Medi-Cal eligibility or otherwise uphold a NOA denying an applicant or terminating a female beneficiary from Medi-Cal until the federal BCCTP assessment is completed. If the case was not previously referred to BCCTP, the ALJ must pend the decision until the BCCTP determination is made. If BCCTP determines that the woman is federal BCCTP eligible, the ALJ will dismiss the case based on federal BCCTP eligibility. If BCCTP determines that the woman is not eligible for federal BCCTP, and the woman does not qualify for Medi-Cal disability, the ALJ will deny the appeal.

When the county receives a fair hearing request from a woman who was determined not eligible for Medi-Cal, including federal BCCTP, the county is to write a position statement for the hearing. As part of the position statement, the county must contact the BCCTP and receive a statement from BCCTP as to the details of why the applicant or beneficiary was not eligible for the federal BCCTP.

**41.8.14 Managed Care for BCCTP Beneficiaries**

Only the full-scope BCCTP beneficiaries (Aid Code 0P) may voluntarily enroll in managed care plans.

**41.8.15 Recipients Ineligible for BCCTP**

When a beneficiary is no longer eligible for federal, the BCCTP beneficiary will continue to receive the same level of benefits. BCCTP staff will place the beneficiary in an interim aid code in MEDS until an SB 87 process is completed and reported to MEDS by county staff.

BCCTP staff will send a notification (via facsimile) to the beneficiary’s county of residence for a county redetermination of ongoing Medi-Cal eligibility. If BCCTP staff has information that the beneficiary already has an opened Medi-Cal case at the county, such as SOC or restricted Medi-Cal, the BCCTP staff will include the county case information (i.e. case number and worker number per MEDS) on the County Notification form to facilitate the county redetermination process as the county case worker may not be aware of the change in the BCCTP beneficiary’s circumstances that generated the BCCTP discontinuance. BCCTP staff will send a copy of the BCCTP case record (by regular mail) which contains the following documents:
• BCCTP abbreviated Application
• BCCTP Rights and Responsibilities
• BCCTP Continuing Eligibility Redetermination Form if an Annual Redetermination was completed.
• Verification/documentation of immigration or citizen status.
• Copy of Social Security card or other identification, if available
• Statement of Citizenship, Alienage and Immigration Status Form (MC 13)
• MEDS screen showing “QE” if DRA has been met.
• BCCTP Medi-Cal Informing Notice advising of the pending discontinuance from federal BCCTP Medi-Cal.
• BCCTP Continuing Eligibility Redetermination Form if an Annual Redetermination was completed.

BCCTP sends a timely notice of action to terminate federal BCCTP and determines if the beneficiary is eligible for State-funded BCCTP.

**Time Frame**

The county must complete the eligibility review within 60 days from the date the BCCTP staff sends the referral notification via facsimile.

**41.8.16 Beneficiaries Ineligible for federal or state BCCTP**

Individuals who are no longer eligible for federal or state BCCTP will continue to receive full-scope Medi-Cal or restricted Medi-Cal benefits until a redetermination of Medi-Cal eligibility can be performed by county staff. On a monthly basis, these ineligible BCCTP individuals will come over in the “Exception Eligibles” (EE) tracking report.
The chart below outlines the process when a BCCTP beneficiary appears on the Exception Eligibles report.

<table>
<thead>
<tr>
<th>STEP</th>
<th>WHO</th>
<th>ACTION</th>
</tr>
</thead>
</table>
| 1    | BCCTP Staff               | • Terminates the beneficiary from the BCCTP aid code and places the correct interim aid code in MEDS.  
• Sends an Informational Notice to inform the beneficiary that he/she will continue to receive full-scope, no SOC or restricted Medi-Cal until the county makes a determination of his/her eligibility for any other Medi-Cal program.  
• Sends BCCTP County Notification form when a BCCTP case requires a county redetermination under another Medi-Cal Program.  
• Determines if beneficiary is eligible for State-funded BCCTP.  
• Sends a timely Notice of Action.  
Note: If the county determines the beneficiary is eligible for full-scope, no-cost Medi-Cal, the beneficiary will be terminated from the BCCTP and will not be placed into state-funded BCCTP. |
| 2    | Medical Program Coordinator | Forwards the referral packet to CCS Intake for processing.                                                                                                                                               |
| 3    | CCS Application Support   | Completes the application registration and case assignment following the current business process.                                                                                                        |
| 4    | EW                        | • Mails Medi-Cal Informing Notices including MC 007, MC 219, DHCS 7007, DHCS 7007A to the client.  
• Completes SB 87 process “Senate Bill (SB) 87 Process,” page 8-1.  
• Contacts the BCCTP staff (as indicated on the BCCTP County Notification form) to obtain clarification or additional information regarding the referral packet, as needed.  
• Approves or denies Medi-Cal benefits.  
**Note:** No special MEDS transaction is required to change a BCCTP interim aid code to another Medi-Cal program aid code. Our transaction will automatically terminate the beneficiary’s interim aid code. |
CalWIN Process

BCCTP staff-referred cases for a redetermination of ongoing Medi-Cal benefits are entered and processed in CalWIN just like any regular Medi-Cal application. The EW must review the CalWIN-determined annual RD and override if incorrect. CalWIN automatically sends the required AP18/EW20 to report the date the redetermination started and AP34/EW34 MEDS transaction to report the approval or denial via interface.
41.9 Health Care Coverage Assistance Program

Santa Clara Valley Health Hospital System (SCVHHS) provides several medical financial assistance programs and services to help Santa Clara County residents pay for the hospital/medical costs incurred with SCVHHS. Among the programs and services provided are:

- Ability to Pay Determination (APD)
- Valley Care
- Discount Program
- Waiver Program
- Inpatient Financial Services

If no insurance coverage is available, a financial counselor may assist with an application for Medi-Cal or other financial assistance program. The Financial Counselor will determine the program to which eligible based on the information provided on the Financial Assistance Application (FAA).

Emergency Services

Every person who needs emergency services will receive them regardless of their ability to pay; however, non-emergency services must be paid prior to receiving them if the patient is not a Santa Clara County resident. As part of the screening process, the patient will be asked about any active insurance coverage. Any co-pays will be collected.

Application:

Financial Assistance Applications may be obtained in person at:

SCVHHS
Patient Access Department
770 South Bascom Avenue, Door A
San Jose, CA 95128
Hours: M - F from 8 AM to 4 PM
Phone: 1-866-967-4677

Applicants may obtain the FAA on-line at www.scvmed.org/valleycare and e-mail the application to HHSVCAppl@hs.sccgov.org or fax to (408) 494-7848.
Verifications:

The following verifications are required to process the Financial Assistance Application and apply to all programs:

- Proof of residency
  - Rental/Lease contract
  - Mortgage statement
  - Utility bill
- Proof of Identity
  - Drivers License
  - Passport
  - Government issued ID
  - Work or school ID
- Proof of Income (Provide all that apply)
  - Check stubs (all stubs within 45 days from date of application)
  - Tax return (current tax year)
  - Award letter (SSA, Unemployment, Disability, Worker’s Comp)
  - Cash income statements (including tips)
  - Military benefits statement
  - Rental income receipts
- Proof of Assets
  - Bank account statements (last three months)
  - Investment account statements
- Proof of US citizenship (original copy)
  - US Passport
  - US Birth Certificate
  - Permanent Residency Card
  - Certificate of Naturalization or Citizenship
- Medi-Cal denial notice

Additional verifications may be required based on a variety of factors.

41.9.1 Ability to Pay Determination Program

The Ability to Pay Determination (APD) program was initiated at the Santa Clara Valley Medical Center (VMC) on March 1, 1983. The APD program is designed to bill poor and low income patients according to their ability to pay. APD has a co-pay that varies from $50 - $300 which is required prior to receiving services.

Who May Qualify for APD

An individual may qualify for APD if all of the following conditions are met:
• Received medical care, treatment or services at or arranged through VMC; and

• Is a resident of Santa Clara County; and

• NOT covered by or eligible for any other medical assistance program or other health insurance; and

• Income and family size are within APD guidelines.

**APD Period and Re-evaluation**

• APD Determination will cover six calendar months.

• Determination will be re-evaluated upon:

  • Any inpatient admission during the six month period.
  • Expiration of the six month period and a new request is submitted.
  • Request by the individual due to income or family size change.

### 41.9.2 Valley Care

Valley Care is a publicly funded health care program that gives people living in Santa Clara County basic health coverage. Valley Care is Santa Clara County’s Low Income Health Program (LIHP).

**Eligibility Criteria**

To be eligible for Valley Care, an applicant must be:

• Santa Clara County resident;
• Be between 19 - 64 years of age;
• Be a U.S. citizen or Lawful Permanent Resident for at least 5 years;
• Have family income at or below 75% of the federal poverty level (FPL).

### 41.9.3 Discount Program

The Discount Program is for individuals who do not qualify for Valley Care or APD. If they meet all eligibility criteria, their charges can be discounted by a percentage.

### 41.9.4 Waiver Program

The Waiver Program is for individuals who are not Santa Clara County residents. If they meet all eligibility criteria, a part of the cost may be waived.
41.9.5 Inpatient Financial Services

Inpatient Financial Services is application assistance provided by Financial Counselors to patients in the hospital who help them apply for Medi-Cal, APD, Valley Care, or other financial programs to help pay for the hospital costs.