35. State/County Administered Health Insurance Programs

35.1 MC Access Program (MCAP) Formerly AIM

MCAP is a health insurance program established in California for pregnant individuals and infants. MCAP is not a Medi-Cal program; it is administered by the Department of Health Care Services (DHCS).

MCAP provides full coverage private health insurance at low cost to pregnant individuals regardless of their immigration status during pregnancy and for sixty calendar days following pregnancy. MCAP newborns are covered through age one and for an additional fee the newborn will be covered until age two; however all other family members are not eligible for MCAP.

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

Eligibility Criteria

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

- Must be pregnant at the time of application.
- Must be a California resident with intent to remain.
- Must have family income between 213% and 322% of the Federal Poverty Level at time of application.
- Must not be a Medi-Cal or Medicare recipient at the time of application.

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

- Must Not have maternity benefits through private insurance.

  Exception: Applicants may have other health coverage with a maternity-only deductible or copayment greater than $500 and still be eligible for MCAP.

35.1.1 Cost

MCAP subscribers must pay 1.5% of their Modified Adjusted Gross Income. This is a total cost, not a monthly premium. Individuals have the option to pay the total cost upfront or make monthly payments for one year. A $50 discount will be given to individuals who pay the full 1.5% upfront.

Once accepted into MCAP, individuals will receive monthly billing statements. Payments can be made to:

MC Access Program
P.O. Box 7191
Pasadena, CA 91109-7191

1-800-433-2611

Individuals whose payments are more than 90 days late will be reported to credit agencies.

Individuals are required to pay the full 1.5% even if they cancel MCAP mid-year unless their pregnancy is terminated in the first trimester.

35.1.2 Care Providers/Covered Services

In Santa Clara County, subscribers must enroll in the MC Managed Care Anthem Blue Cross HMO Plan. Once the individual is enrolled, a Blue Cross Provider Directory will be mailed so the individual can choose their provider.

Individuals who enrolled in MCAP after July 1, 2017 are eligible for the same services offered in a MC Managed Care Plan. The individual will be mailed an MC Benefits Identification Card (BIC).

EW Notification

If MC with a SOC is established at intake, the MCAP applicant must be instructed to report to her MC EW when MCAP coverage is approved.

35.1.3 MCAP Transition to MC

Pregnant individuals who report a decrease in income below 213% were previously automatically transitioned to MC. Individuals now have the option of maintaining their MCAP coverage until the end of their pregnancy to allow for continuity of care and avoid gaps in coverage.

Pregnant individuals have the ability to select MCAP or MC coverage by using the Keep or Switch link on the **Consumer Home** in CalHEERS. The Keep or Switch link only appears when there is a pregnancy reported. Refer to Job Aid: Keep or Switch.

The EW or Service Center Representative (SCR) may return the client to their previous coverage if the client switched coverage in error. A reminder and attestation check box informs the EW or SCR that returning the client to their previous eligibility does not reactivate enrollment and that manual coordination with the MCAP administrators (MAXIMUS) or County of Responsibility is required to reactivate coverage and prevent gaps in coverage. The [Save] button activates once the user has checked: “I have coordinated the enrollment”.

Before the individual can transition from MAGI MC back to MCAP, the worker must confirm that:

- The Unsolicited DER containing the MCAP to MAGI MC transition has been processed in CalWIN.
- CalHEERS Eligibility results have been loaded and authorized by the EW.
- MAGI MC eligibility results have been sent and processed by MEDS.

Notice of Action

If a client is returned to MCAP by CalHEERS administrative override, CalWIN will not call the BRE if there is no data change. After processing the case, the EW must select *Yes* in the ***Call BRE without Data Change*** field in the **Collect Case Summary Detail** window before running EDBC. Once there is a successful interface between CalWIN and CalHEERS, the MAGI MC Termination Notice of Action will be created.

35.2 Presumptive Eligibility for Pregnant Individuals

The Presumptive Eligibility (PE) program provides low income pregnant individuals with immediate, temporary MC coverage, limited to ambulatory prenatal care, while their regular MC (or CalWORKs) application is pending.

The intent of the PE program is to enable pregnant individuals 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 individual eligible for PE is certified for the month of application and the following month. She is instructed by the provider to apply for regular MC (or CalWORKs) before the end of her PE period.

35.2.1 Eligibility Criteria

Who is Eligible

- Any California resident who believes that they are pregnant qualifies for PE.
- Family income must be at or below 213% 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 an MC or CalWORKs application pending, but whose eligibility has not yet been determined, may apply for PE.

Period of Eligibility

The enrollment period begins on the day in which the individual is determined eligible for the PE4PW program. If the individual does not submit an MC application prior to the PE end date, PE ends on the last day of the following month in which the individual was determined eligible. If the individual does submit an MC application prior to the PE end date, PE coverage ends on the day in which MC eligibility is approved or denied.

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 MC, 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 MC under the Minor Consent Program.

35.2.2 PE Covered Services

PE benefits for pregnant individuals cover most outpatient 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.

35.2.3 PE Enrollment

The California Medicaid Management Information Systems' (CA-MMIS) Online Portal for Qualified Providers (QPs) was established to assist in the Presumptive Eligibility for Pregnant Women (PE4PW) Program to assist applicants applying for PE. When the PE4PW application has been submitted through the Online Portal, an electronic data match of the applicant's information determines if the applicant is currently receiving MC benefits through the MC Eligibility Data System (MEDS). If the applicant is not currently receiving benefits from MC, MEDS will provide a response to the system with an immediate PE4PW eligibility determination in real time.

If the applicant is determined eligible for PE4PW, the client will be assigned aid code 7G and the QP will print out the eligibility determination and the *Immediate Need Eligibility Document*. The client must present the *Immediate Need Eligibility Document* to MC providers for service during the PE4PW eligibility period. PE4PW clients do not receive a plastic BIC. A BIC will only be sent to the client if she applies for and is subsequently determined eligible for MC benefits.

Note:

Applicants with a negative pregnancy test result or otherwise found to be not pregnant by the QP will not receive an *Immediate Need Eligibility Document*. MEDS will place the applicant in aid code 7F.

PE4PW QPs are required to provide clients of the program with an MC application. PE4PW clients must submit a completed application no later than the last day of the month following the month in which PE4PW was granted. When the application is submitted during the PE4PW period, PE4PW coverage can be extended pending the MC determination (approval or denial).

Santa Clara County QPs

A list of QPs for Santa Clara County is located under the MC Reference Materials page of the Program Bureau Intranet.

35.2.4 MEDS

MEDS will be programmed to automatically terminate all PE4PW benefits for clients who reach the 60-day limit unless MEDS has a record of a pending IAP application. If MEDS shows a pending HX-18 transaction (Covered California application) or EW-18 transaction (county application), MEDS will **not** automatically terminate PE4PW benefits until a determination has been given to the application with either an HX-20 or EW-20.

35.2.5 Aid Codes

The following are the aid codes for the PE4PW program.

Table 95: Aid Codes

Aid Code	Who Qualifies
7F	Valid for pregnancy test, initial visit, and services linked with the initial visit. Individuals placed in 7F have pregnancy test results that are negative or have been found not to be pregnant by the QP.
7G	Valid for specific prenatal care services. Individuals placed in 7G have self-attested to the pregnancy or have a pregnancy test result that is positive. QP issues a paper *Immediate Need Eligibility Document*.

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

Table 35-1: PE and Medi-Cal Application Process

Step	Who	Action
1.	Pregnant Individual	Obtains medical care, and does not have MC or other health insurance for prenatal care.
2.	PE Provider	• Explains the PE program. • Gives patient the PE Patient Fact Sheet. • Gives patient the MC 263 PE Pregnancy packet. • Completes PE determination (income screening using the Federal Poverty Level chart and pregnancy testing). • Issues a PE *Immediate Need Eligibility Document* to the eligible patient. • Bills MC for services.
3.	Pregnant Individual Who Is PE Eligible	• Receives an *Immediate Need Eligibility Document* from the QP, which is good for outpatient prenatal care only. • Is advised to apply for MC at a district office/outstationed clinic to get ongoing coverage including labor and delivery before the end of her eligibility for PE.

Table 35-1: PE and Medi-Cal Application Process

Step	Who	Action
4.	PE Recipient	Applies for MC (or CalWORKs).
5.	CST at Social Services	• Processes client's request for MC (or CalWORKs), following normal procedures. • Screens the pregnant individual for immediate need, following district office procedures.
6.	EW	• Determines if MC eligibility will be cleared before the end of the initial PE period. The PE recipient is eligible for PE for as long as her MC (or CalWORKs) application is pending. • Processes application for MC (or CalWORKs). • Advises client to stop using her PE card when her regular no SOC MC BIC is received. • No further action for PE is required when MC is denied or SOC MC is approved.

35.2.6 Retroactive Coverage

Some individuals may have received health care services that were not covered under the PE program, or prior to their application for PE or MC. EWs must inquire about the need for retroactive coverage for medical bills incurred in the three months prior to the date of application.

35.2.7 Non-County Resident

Occasionally, a pregnant individual may be determined eligible for PE in this county, but is not a county resident. If a PE applicant applies for MC (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.

35.2.8 Immediate Need Eligibility Document Replacement

If a PE recipient requests a replacement for a lost, stolen or destroyed Immediate Need Eligibility Document, EWs should refer her back to the provider who gave her the original document.

35.3 County Children's Health Initiative (CCHIP)

CCHIP is a health insurance program in Santa Clara, San Francisco, and San Mateo counties. CCHIP provides medical, dental, and vision coverage to children age 0-19 with family income between 266% and 322% of the Federal Poverty Level (FPL).

To be eligible for CCHIP, individuals must:

- Be a resident of Santa Clara County
- Be age 0-19
- Be uninsured and ineligible for MC
- Be a United States Citizen, National, or Lawfully Present Immigrant
- Not have employer-sponsored coverage available

EWs are not responsible for case management of CCHIP. The CalHEERS system will complete the eligibility determinations for CCHIP and transmit the eligibility results to the Department of Health Cares Services contractor MAXIMUS. MAXIMUS is responsible for CCHIP program enrollment, ongoing case management, premium billing and collection for CCHIP enrollees.

For CCHIP enrollment questions, clients may contact the dedicated MAXIMUS CCHIP line at 1-833-912-2447.

35.3.1 Client Contribution

Families are required to pay a portion of the health coverage cost to participate in CCHIP. The remainder of the cost is paid for by the State and Federal government. The family's required contribution depends on the household size and income, but ranges from $21 per month to a maximum of $63 per month.

A co-payment may be required for some services, depending on the family income. The maximum out of pocket amount for services in one benefit year is $250 per household. There are no copays for immunizations or preventative services and prescriptions.

35.3.2 Application

There is no separate application for CCHIP. Clients can apply anytime online, by phone, by mail, or in person.

35.3.3 CCHIP Managed Care Enrollment

Children eligible for CCHIP may enroll in either of the county's two managed care plans:

- Santa Clara Family Health plan
- Anthem Blue Cross of California

For assistance with enrolling in or disenrolling from a plan, clients may call Health Care Options at 1-800-430-4263.

35.3.4 CCHIP Q&A

Question 1: Does CCHIP meet MEC?

Answer 1: Yes CCHIP meets MEC.

Question 2: Can a client have both CCHP and Non-MAGI MC without a SOC?

Answer 2: No, the FPLs are not the same for CCHIP and zero SOC Non-MAGI MC.

Question 3: Can a client have both CCHIP and Non-MAGI MC with a SOC?

Answer 3: No, a client cannot have both CCHIP and SOC MC.

Question 4: Can a client have both CCHIP and MAGI MC?

Answer 4: No, the FPL programs are not the same.

Question 5: Can a client have CCHIP and CPTC?

Answer 5: No, if a client is eligible for CCHIP, they are not eligible for subsidized coverage, APTC, or CSR. The client can choose QHP instead of CCHIP, at the full plan cost.

Question 6: What aid code will the client receive for CCHIP and where will it appear in MEDS?

Answer 6: The CCHIP aid code is 2C and will appear in MEDS on a special segment.

Question 7: What is the EW responsibility for CCHIP clients?

Answer 7: EWs are not responsible for case management with CCHIP. The client will receive notification of eligibility, discontinuance from the program, and annual renewal determination from the CalHEERS system. However, the no "wrong door" policy applies to CCHIP. EWs must assist clients with the application online, in person, by phone, or by mail.

EWs will not confirm enrollment in CCHIP, confirmation comes directly from MAXIMUS.

If a client provides verifications to the EW, the EW will save the documents in IDM and update the CalWIN case with the verification status. If verifications remain pending, MAXIMUS will follow up with the client.

Question 8: What notifications will the client receive when they are approved, denied, or discontinued from CCHIP?

Answer 8: Eligibility and/or denial notices for CCHIP and/or APTC will come from Covered California. The client will receive notification of enrollment, start date of coverage, or discontinuance from MAXIMUS.

Question 9: Will the client be automatically enrolled in CCHIP once the determination is made in CalHEERS or is there a batch process?

Answer 9: Eligibility for CCHIP is determined with aid code 2C. Enrollment is completed by MAXIMUS.

Question 10: What happens when the client's income increases above 322%?

Answer 10: CCHIP children will receive 12 months of uninterrupted coverage. If the income increases above the limit, the child will remain active on CCHIP until the end of the certification year.

35.4 Accelerated Enrollment (AE)

When an application is received through the Online Covered CA portal, individuals who appear to be eligible for no cost MC based on their self-attested information are enrolled into the AE program. The AE Program allows individuals to have immediate access to medical services until eligibility for regular MC benefits is determined. Covered CA forwards the application via "External Referral Data" (ERD) to the residence county for an MC determination.

35.4.1 Scope of Coverage and Aid Code

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

- AE begins the first day of the month AE was established.

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

Important:

Under NO circumstances should an individual be denied MC due to the fact that he/she has an active (8E) MEDS record.

35.4.2 Ineligible for AE

AE does not apply to individuals who:

- Have an active MC 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 MC or whose AE screening indicates that they are not likely eligible for no-cost MC
- Do not appear eligible for no-cost MC

35.4.3 Informing Notices

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

- An informing notice generates through Covered CA notifying the AE eligibles their application has been referred to the county for a Medi-Cal determination.
- AE coverage ends when a full MC eligibility determination is completed and the individuals MC has either been approved or denied. A 10-day Notice of Action (NOA) is NOT required to stop AE.

35.4.4 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 35-2: AE MEDS Record

Field	Code(s)
Eligibility Status Code	001-499
Government Responsibility Code	"1" (County Responsibility)
Other Health Coverage Information	"N" for none or "V" for various
County ID format	• Residence County Number "43" • Aid Code (8E); '9'; and • Client Index Number (CIN) Example: [43-8E-9123456-7-8D]

35.4.5 Termination of AE

AE ends when MEDS receives information that the individuals MC has either been approved or denied. MEDS automatically terminates AE at the end of the MEDS month in which the EW generates an MC 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:

If ...	Then...
A denial is reported to MEDS prior to the end of the calendar month,	MEDS will discontinue AE the last day of the calendar month. The AE termination date will be the denial date. A ten-day NOA is not required to terminate AE.
The application is approved prior to MEDS Cut-Off,	Both the AE Aid Code and the regular MC Aid Code will show on the MEDS screen in their corresponding segments for the current month. The AE Aid Code will automatically terminate at the end of the month while the regular MC Aid Code continues.
If the application is approved after MEDS Cut-Off and on or before the end of the calendar month,	MEDS will show the new ongoing MC 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.

35.5 CHDP Gateway Program

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 MC 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 MC if they applied.

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.

35.5.1 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 MC based upon income screening for zero SOC MC).

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" (DHCS 4073) via the internet or a point-of-service (POS) device, and existing eligibility for MC is automatically checked through MEDS. The DHCS 4073 is the electronic internet-based application used by CHDP providers to complete pre-enrollment into MC 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 MC 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 MC for the month of screening and the following month in one of the Aid Codes below:

Aid Code	Description
8W	CHDP Gateway MC up to 150% FPL
8X	CHDP Gateway MC above 150% up to and including 250% FPL
8Y	A child currently eligible on MEDS in an Aid Code linked to undocumented immigration status. (CHDP STATE-ONLY PROGRAM)

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).

If the Child is...	Then the Child Receives...
Not known to MEDS, or has SOC MC,	• A CHDP Exam • Temporary full-scope MC
Known to MEDS - Currently active on restricted benefits,	• Emergency /Pregnancy Only MC • CHDP exam • Not eligible for temporary full-scope MC
Known to MEDS - Currently active on full scope zero SOC MC,	• CHDP Exam • A referral to MC Managed Care 800# and to the local CHDP Program 800# for information about child health services.
Not eligible for a CHDP Exam,	No pre-enrollment into MC.

Children Without Satisfactory Immigration Status (SIS)

Children who are currently active on MEDS in a restricted MC Aid Code due to undocumented immigration status cannot be pre-enrolled in MC 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 MC

A child who is already receiving MC with a SOC and has met his/her SOC in the month of the CHDP visit is already MC 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 35-3: CHDP Eligibility and OHC

If...	Then...
The child is determined eligible under the CHDP accelerated enrollment aid code 8W or 8X,	The OHC indicator code is changed to "N" regardless of whether MEDS shows an active OHC code.
The child is determined eligible under the State-only CHDP Aid Code 8Y and MEDS shows an active OHC code,	The MEDS OHC code is changed to an 'A' (pay and chase).

CHDP Eligibility and Retroactive MC

Individuals applying for MC through the Gateway may request retroactive MC 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 MC

If the applicant indicates on the CHDP application that he or she wants to apply for MC for the child, SPE sends an MC 321 HFP to the parents of children who are pre-enrolled in MC 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 35-4: Eligibility Determination for MC

If the Completed Application is...	Then...
Returned to SPE within the initial two months of presumptive eligibility, and that information is reported to MEDS,	SPE conducts a full file clearance and reports to MEDS that the application has been received.
	SPE extends the pre-enrollment period, and the child continues to receive full-scope, zero SOC MC coverage until eligibility for ongoing MC is determined.

Table 35-4: Eligibility Determination for MC

If the Completed Application is...	Then...
	SPE screens the application and sends to the county for an eligibility determination.
	SPE sends an informing notice to the client explaining that pre-enrollment has been extended until eligibility for MC is determined. This notice is available in 11 languages.
Not returned to SPE within the initial two months of presumptive eligibility,	The child's eligibility for full scope zero SOC coverage is not extended beyond the second month. **Note:** There is no requirement to provide a 10-day NOA when pre-enrollment ends.
Submitted directly to the Intake office, instead of mailed to SPE,	The Intake EW must ensure that: • Receipt of the application is reported to MEDS via an AP 18 on-line transaction, for the child's pre-enrollment eligibility to be extended. • The application is processed following existing procedures.

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 MC 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 MC is completed for the child, the EW must send the appropriate MC approval or denial NOA.

35.6 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 MC 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 EW prior to denying or discontinuing MC 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 MC 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 MC 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.

35.6.1 Federal BCCTP

The federally-funded BCCTP provides full scope, no share of cost (SOC) MC benefits to uninsured individuals under age 65 who are US citizens or lawful immigrants, have no health insurance coverage and are found to be in need of treatment for breast and/or cervical cancer. Individuals who meet all federal BCCTP requirements remain eligible for the duration of the treatment period.

Ineligibility for federal BCCTP

An individual becomes ineligible for federal BCCTP when any of the following occurs:

- Has turned 65 years of age
- Has obtained creditable insurance coverage, Medi-Cal with a SOC, Medicare, employer provided insurance, or a Covered California Plan, etc.
- No longer needs treatment for breast and/or cervical cancer as determined by her treating physician.

Note:

The Federal BCCTP allows eligibility for beneficiaries who have MC 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 MC (i.e., undocumented aliens, pregnant individuals, etc.).

Federal BCCTP Health Insurance Coverage Limitations

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

- Medicare
- Group health plan
- MC (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.

35.6.2 State-Funded BCCTP

California BCCTP was created to address coverage beyond the limitations of the federal law.

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.

On January 2019, AB1810 eliminated the time limit and provides continued coverage through the duration of the treatment if an individual with a diagnosis of breast and/or cervical cancer meets all BCCTP eligibility requirements. It also applies to individuals diagnosed with a reoccurence of breast and/or cervical cancer.

The State-funded BCCTP covers individuals:

Table 35-5: BCCTP Individuals

Who:	Defined as:
Are uninsured	Individuals who do not have no-cost MC, Medicare or private health insurance

Table 35-5: BCCTP Individuals

Who:	Defined as:
Underinsured	• Individuals with share-of-cost MC, Advanced Premium Tax Credits (APTC), and/or a Qualified Health Plan (QHP) through Covered California. • Individuals 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.)
Meet Residency Requirements	• Are residents of California
Meet Income Guidelines	• Are at or below 200% Federal Poverty Level (based on family Size)
Require treatment	• In need of breast and/or cervical cancer treatment

35.6.3 Referrals to BCCTP

When making a BCCTP referral, the EW must:

Table 35-6: Referrals to BCCTP

Step	Action
1.	Initiate the referral on the first day of contact by the beneficiary or applicant. Do not delay in sending any referrals to BCCTP.
2.	Complete the BCCTP referral form “County Referral to the Breast and Cervical Cancer Treatment Program” (MC 373). Include the following information: • Name and contact information (including phone extension) of the EW making the referral. • Provide current and available information at the time of the referral that would assist in determining BCCTP eligibility. • If available, any pertinent documents must be sent with the MC373 referral, e.g., pathology report, front and back of identification card, LPR card, and income verification, etc. Send via secure, encrypted email to: BCCTP@dhcs.gov or via fax at (916) 440-4593 **Note:** Do not include any Personally Identifiably Information (PII) in the Subject Line of an email as the subject lines are not encrypted in the same manner as the body of the email.
3.	Notify the applicant/recipient that a referral was sent to BCCTP for an eligibility determination
4.	If the client has no other linkage to MC benefits and would otherwise be denied or discontinued, add a Special Indicator, “Batch AU Exception- MC” in CalWIN.
5.	Document 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 MC.

(Chart page 1 of 2)

Table 35-6: Referrals to BCCTP

Step	Action
6.	Transfer an intake case to continuing pending BCCTP/DDSD decisions.

(Chart page 2 of 2)

35.6.4 Referring BCCTP Applicants to DDSD

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 35-7: Referring BCCTP Applicants to DDSD

Step	Action
1.	Determine if the applicant meets all the criteria for a disability evaluation.
2.	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. **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.	If the applicant does not meet the DDSD criteria, and there is no linkage to MC, refer the individual to BCCTP without a disability packet. Keep MC pending.
4.	If the applicant is a male or a woman 65 years or older, not eligible for MC, deny MC and also send a referral for State-funded BCCTP.

Simultaneously referring an individual to BCCTP and DDSD will allow the federally BCCTP eligible individuals to receive MC benefits, including Accelerated Eligibility if eligible, while their disability determination is being reviewed. BCCTP will contact the applicant to determine if the individuals 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.

35.6.5 Referring Individuals

If an MC recipient is no longer eligible for his/her existing MC program either at the annual redetermination or when the recipient reports a change in circumstances, and they declare 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 MC program, including federal BCCTP.

In order to follow the SB 87 process, the EW must:

Table 35-8: SB 87 Process

Step	Action
1.	Determine if the recipient meets the DDSD criteria to send a referral.
2.	Refer the recipient 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 recipient 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 MC program.
5.	Do not discontinue MC benefits for an individual under 65 years of age until BCCTP determination is received. If a DDSD referral was made, also wait for the DDSD decision.

35.6.6 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.

Aid Codes for Individuals (only) Who Are Less Than 65 Years of Age

Table 35-9: Aid Codes For Individuals Who Are Less Than 65

Aid Code	Funding	Description
0U	Federal/ State Funded	Restricted MC Services and State-Funded Cancer Treatment and Related Services for Women Without SIS This category provides restricted services for females (only) under 65 years old, who do not have SIS, and who do not have other 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. Individuals must have income below 200% of the Federal Poverty Level (FPL). These individuals may receive subsequent periods of eligibility if diagnosed with recurring breast/cervical cancer and still meet all other eligibility requirements. NOTE: This aid code does not provide Minimum Essential Coverage (MEC). This aid coded includes: • MC emergency services, • State-Funded BCCTP services • Pregnancy or postpartum Services, and • LTC MC Services.
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 MC 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 MC emergency services and state-only MC 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 MC limited to two months only (the month of application and the month after) because the individual did not request ongoing MC.
0N	State	Presumptive Eligibility (PE) - Two-Month Limit This is a temporary, full-scope, no-SOC MC coverage for women with no health insurance coverage. BCCTP applicants are granted for two months of PE with a termination date populated in MEDS. When a BCCTP beneficiary applies for Medi-Cal and MEDS shows a Medi-Cal application registration has been completed, the termination date will automatically be removed. Once the final Medi-Cal determination is completed, then Aid Code 0N will be automatically terminated.

Aid Codes for Males or Females

Table 35-10: Aid Codes for Females or Males

Aid Code	Funding	Description
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 relates services to females 65 years old or older, regardless of immigration status, who do not have health insurance coverage • Provides coverage limited to breast cancer treatment and related services for males of any age or immigration status (regardless of age or immigration status) and who do not have health insurance coverage. Individuals must have income below 200% of the Federal Poverty Level (FPL). These individuals may receive subsequent periods of eligibility if diagnosed with recurring breast/cervical cancer and still meet all other eligibility requirements. This aid code does not provide Minimum Essential Coverage (MEC).
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. Individuals must have income below 200% of the Federal Poverty Level (FPL).
OW	Federal	Transitional full-scope MC 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 MC 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.

Table 35-10: Aid Codes for Females or Males

Aid Code	Funding	Description
0Y	State	Transitional restricted MC and State-funded cancer treatment and related services to beneficiaries terminated from aid code 0U because they have turned 65 years of age, have no creditable health coverage, 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 18 or 24 months of State-funded BCCTP, when State-funded BCCTP ends, the beneficiary will be placed in aid code 0L until the EW makes a determination.
0L	State	Transitional restricted MC for beneficiaries who: • Terminated from aid code 0U because they are no longer in need of treatment for breast and/or cervical cancer; • Terminated from aid code 0U because they acquired creditable health coverage, but their out-of-pocket expenses will not exceed $750 in the next 12-month period. • Terminated from aid code 0V because they have obtained age 65, acquired creditable health coverage, or are no longer in need of treatment for breast and/or cervical cancer, • Have exhausted their 18 or 24 months of State-funded BCCTP coverage pending a determination while in interim aid code 0X or 0Y.

35.6.7 Processing BCCTP Determinations

In most cases, prior to denying or discontinuing MC 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 MC eligibility determination for any other MC program. Send the appropriate MC denial 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 MC disability criteria, but a determination by BCCTP has not been received, the EW is not to deny or discontinue MC 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 MC 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 MC 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 MC programs, including the federal BCCTP. The NOA must include the following BCCTP denial paragraph:

Your application for MC 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 MC 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 MC benefits.

Processing Chart

The following is a chart to clarify the steps in processing an applicant for BCCTP prior to denial:

Table 35-11: Processing Chart

Question	If. . .	Then. . .
1. Is the applicant eligible for federal BCCTP?	YES	• BCCTP sends the approval NOA to the client with a copy to the EW. • The EW waits for the DDSD decision if a referral was made and a decision has not been received. • Deny MC if no DDSD referral was made. (No specific BCCTP language required on the NOA.)
	NO	• EW waits for the DDSD decision. Once the DDSD decision is received, follow steps in # 3 below. • EW sends a MC denial, including BCCTP denial if a DDSD referral was not sent.
2. Is the applicant eligible for State BCCTP?	YES	• BCCTP sends a letter to the applicant. • The EW follows step # 1 above. (The applicant is not eligible for federal BCCTP.)
	NO	• BCCTP will send a letter to the applicant. • The EW follows steps 1 and 3.

(Chart page 1 of 2)

Table 35-11: Processing Chart

Question	If. . .	Then. . .
3. Is the applicant considered disabled?	YES	The EW must take the following actions: • Approve disability-based MC if otherwise eligible. • Calls or faxes approval NOA to BCCTP. • Check MEDS for correct Aid Code.
	NO	• EW sends MC denial NOA including federal BCCTP denial if the applicant is not eligible for federal BCCTP, or only eligible for State BCCTP.

(Chart page 2 of 2)

MC Recipient Eligible for Federal BCCTP and NOA

If the MC recipient is found eligible for federal BCCTP, the State will issue a NOA to the recipient and copy the EW who made the referral. If BCCTP makes a favorable BCCTP determination prior to DDSD, the EW must 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 recipient and delay treatments.

Full Scope with a Disability Packet

If an individual 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 MC have been completed.

Restricted MC with a Disability Packet

If an individual on restricted MC 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 individual immediately.

If the individual is found not to have a disability, the worker must inform BCCTP and send a final discontinuance NOA for all MC 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 individual is still active in BCCTP (aid code 0N, 0P, 0W). If the individual is still federally active in BCCTP but is now also eligible for MC based upon disability, the worker must:

- Make the individual eligible for MC 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 MC 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 MC hierarchy of programs, BCCTP is the last program. In most cases, if an individual is eligible for disability-based MC and federal BCCTP, the EW would set up disability based MC and BCCTP will discontinue the program.

BCCTP Processing Chart for MC Beneficiaries

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

Below is a chart to clarify the BCCTP processing for a MC beneficiary:

Table 35-12: BCCTP Processing for a MC Recipient

Question	If. . .	Then. . .
1. Is the recipient eligible for federal BCCTP?	YES	• BCCTP sends the approval NOA with a copy to the EW. • If DDSD has not made a decision, discontinue MC effective the end of the current month. **Do not send a NOA.** • If no DDSD referral was made, discontinue MC.
	NO	• The recipient remains active until a decision is received from DDSD. • If no DDSD referral was sent, send a MC discontinuance NOA including BCCTP denial.

(Chart page 1 of 2)

Table 35-12: BCCTP Processing for a MC Recipient

Question	If. . .	Then. . .
2. Is the recipient determined disabled by DDSD? **Note:** Recipient **is** federally eligible for BCCTP	YES	• Check MEDS to determine if recipient is still active in aid code 0N, 0P, or 0W. • Approve linkage based MC effective the following month. • Send approval NOA. • Call or fax a copy of the approval NOA to BCCTP. • BCCTP will evaluate if recipient can continue with BCCTP benefits, i.e. SOC or restricted MC benefits.
	NO	• Discontinue MC. • Do not send a NOA. **Note:** The recipient is already receiving MC through BCCTP.
3. Is the recipient determined disabled by DDSD? **Note:** The recipient is **not** eligible for federal BCCTP	YES,	• Approve disability-based MC, if otherwise eligible.
	NO,	• Send a MC discontinuance NOA, including federal BCCTP denial. • Fax copy of NOA to BCCTP **Note:** BCCTP will proceed to process state BCCTP.

(Chart page 2 of 2)

35.6.8 MC 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 MC and/or federal BCCTP. The EW must add specific language to the discontinuance NOA prior to mailing it to the MC recipient who claims to have breast or cervical cancer. The language is as follows:

"Your application for MC 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 MC 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 MC notice is issued for an individual who is denied federal BCCTP, the EW must include the specific required BCCTP denial paragraph as written above.

35.6.9 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 must fax a copy of the MC approval NOA to BCCTP to indicate that the individual is eligible for MC and under which program.

35.6.10 Annual Redetermination (RD) for BCCTP Eligibility

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

35.6.11 State Hearings and Appeals

BCCTP recipients have the same hearing and appeal rights as any other MC recipient. When an MC applicant or recipient appeals a denial of MC 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 MC eligibility or otherwise uphold a NOA denying an applicant or terminating a female recipient from MC 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 MC disability, the ALJ will deny the appeal.

When the county receives a fair hearing request from a woman who was determined not eligible for MC, 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.

35.6.12 Managed Care for BCCTP Beneficiaries

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

35.6.13 Recipients Ineligible for BCCTP

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

BCCTP referrals are emailed to the MC Program Coordinators and forwarded to the MC Benefits Assistance (MBA) for processing. The county must complete the eligibility review within 60 days from the date the BCCTP staff sends the referral.

35.6.14 Recipients Ineligible for federal or state BCCTP

Individuals who are no longer eligible for federal or state BCCTP will continue to receive full-scope MC or restricted MC benefits until a redetermination of MC 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 35-13: Recipients Ineligible for BCCTP

STEP	WHO	ACTION
1	BCCTP Staff	• Terminates the recipient from the BCCTP aid code and places the correct interim aid code in MEDS. • Sends an Informational Notice to inform the recipient that he/she will continue to receive full-scope, no SOC or restricted MC until the county makes a determination of his/her eligibility for any other MC program. • Sends BCCTP County Notification form when a BCCTP case requires a county redetermination under another MC Program. • Determines if beneficiary is eligible for State-funded BCCTP. • Sends a timely Notice of Action. **Note:** If the county determines the recipient is eligible for full-scope, no-cost MC, the recipient will be terminated from the BCCTP and will not be placed into state-funded BCCTP.
2	Medical Program Coordinator	Forwards the referral packet to MBA Intake for processing.

Table 35-13: Recipients Ineligible for BCCTP

STEP	WHO	ACTION
3	CCS Application Support	Completes the application registration and case assignment following the current business process.
4	EW	• Mails MC I Informing Notices including MC 007, MC 219, DHCS 7007, DHCS 7007A to the client. • Completes SB 87 process. • 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 MC benefits. **Note:** No special MEDS transaction is required to change a BCCTP interim aid code to another MC program aid code. The MC approval transaction will automatically terminate the recipient's interim aid code.

35.7 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 MC,
- 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.

EWs must share the *EWC Program Brochure* with women found ineligible for MC, 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)

Women are able to call an automated referral line at (800) 511-2300 or use an Online Provider Locater (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 Locater are available twenty-four hours a day, seven days a week.

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)
- Discount Program
- Waiver Program
- Inpatient Financial Services

If no insurance coverage is available, a financial counselor may assist with an application for MC 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 HHSVCApp@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

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

35.7.1 Ability to Pay Determination Program

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 quality 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.

35.7.2 Valley Care

Valley Care was a publicly funded health care program that provided individuals living in Santa Clara County basic health coverage. Valley Care was Santa Clara County's Low Income Health Program (LIHP). The LIHP program was discontinued in 2014.

35.7.3 Discount Program

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

35.7.4 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.

35.7.5 Inpatient Financial Services (informational flyer in ch 41 folder)

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

35.8 Family Planning, Access, Care and Treatment Program (Family PACT)

California residents can receive family planning services through the Family PACT Program, previously known as the State Only Family Planning Program (SOFP), when they meet the following criteria:

- No other health coverage which covers family planning, and

- Gross family income at or below 200% of the federal poverty level, and
- Unmet share of cost (this criteria applies only for MC clients).

Note:
There is no property limit or citizenship requirement for Family PACT.

The EW does not determine Family PACT Eligibility; healthcare providers determine Family PACT eligibility. The participating providers will enroll the eligible person in the Family PACT program, and issue a Health Access Programs (HAP) card for people who don't have a valid BIC; or add Family PACT eligibility to the MC BIC. The provider is responsible for the HAP card replacement. [Refer to Update 97-9]

35.9 COVID-19 Uninsured Group Program

As of March 18, 2020, the Department of Health Care Services (DHCS) was directed to provide Presumptive Eligibility (PE) for coronavirus disease 2019 (COVID-19) to uninsured individuals who need diagnostic testing, testing-related services, and treatment services, including all medically necessary care related to COVID-19, at no cost.

On August 28, 2020, DHCS implemented the COVID-19 Uninsured Group Program that extends PE period.

Applications for this program are processed by existing qualified providers, who currently evaluate eligibility for Child Health and Disability Prevention (CHDP), PE for Pregnant Women (PE4PW), and Hospital Presumptive Eligibility (HPE). The EW does not determine the PE for COVID-19 program.

35.9.1 Eligibility Criteria

To qualify for PE for COVID-19, individuals must:

- Be a California resident regardless of immigration status, income or resources, **and**
- Have no health insurance, or
- Have private insurance, but not covered for COVID-19 testing and treatment services including medical necessary care for COVID-19, or
- Be not eligible for any Medi-Cal programs (with the exception of individuals who have not met their Share of Cost), or
- Not have Medicare.

If an individual is determined to be eligible to CHDP, PE4PW, or HPE program, the individual will not qualify for the COVID-19 Uninsured Group program.

Period of Eligibility

The COVID-19 Uninsured Group Program covers COVID-19 diagnostic testing, testing-related services, and treatment services, including hospitalization and all medically necessary care, at no cost to the individual, for up to 12 months or the end of the public health emergency (PHE), whichever comes first.

Retroactive Eligibility

Applications for the COVID-19 Uninsured Group program can be retroactive to April 8, 2020. QPs can submit retroactive applications to COVID19Apps@dhcs.ca.gov for review and processing.

35.9.2 Aid Code in MEDS

Aid Code V2 is assigned in MEDS for the COVID-19 Uninsured Group program. MEDS will automatically terminate Aid Code V2 at the end of 12 month if no other Medi-Cal programs are evaluated.

When an individual is currently active under aid code V2 and then, later, approved for one of the following other PE aid codes: CHDP, PE4PW, HPE, and BCCTP, MEDS will override aid code V2 to other PE aid code.

35.9.3 Frequently Asked Questions (FAQs)

Question 1: What is a Qualified Provider (QP)?

Answer 1: A QP is an approved Medi-Cal provider who participates as a QP, permitted under the approved California Medicaid State Plan in relation to PE programs.

Question 2: Can an individual who is not a California resident get coverage under the COVID-19 Uninsured Group program?

Answer 2: No, you must be a California resident to be eligible for the COVID-19 Uninsured Group program.

Question 3: How does a Qualified Provider access the COVID-19 Uninsured Group Application Portal?

Answer 3: To access the COVID-19 Uninsured Group Application Portal, follow the instructions below:

- *Access the Medi-Cal website at http://www.medi-cal.ca.gov/, select "Providers" and click the "Transactions" link.*
- *Enter your User ID (National Provider Identifier) and Password (Provider*

- *Identification Number) and click the "Submit" button.*
- *Click the "Prgms" tab.*
- *Click the "COVID-19 Uninsured Group Eligibility" link.*

Question 4: Which Internet browser should I use to access the COVID-19 Uninsured Group Application Portal?

Answer 4: Medi-Cal recommends that providers use the Chrome browser when accessing the COVID-19 Uninsured Group Application Portal to avoid any printing issues that may occur with other Internet browsers.

Question 5: How long does it take to receive the COVID-19 Uninsured Group determination?

Answer 5: The QP will be able to view the applicants COVID-19 Uninsured Group eligibility determination in the Point of Service (POS) system in real-time once eligibility is determined.

Question 6: What services are covered under the COVID-19 Uninsured Group program?

Answer 6: All medically necessary services for COVID-19 will be covered under the COVID- 19 Uninsured Group program. This includes medically necessary diagnostic testing, testing-related services, hospitalization and other treatment services provided at the associated office, clinic, or emergency room visit related to COVID-19. These services will be paid up to the maximum reimbursement fee-for-service (FFS) rate, in the FFS delivery system.

Question 7: Is a Social Security Number required to apply for the COVID-19 Uninsured Group?

Answer 7: If an individual has a Social Security Number (SSN), it must be provided on the Application for Coverage of COVID-19 Testing Costs form (MC 374).

Question 8: Is an individual's citizenship/immigration status verified when they apply for the new COVID-19 Uninsured Group?

Answer 8: Yes, an individual's citizenship/immigration status will be electronically verified. But status is not a condition of eligibility.

Question 9: Are telephonic signatures accepted for the new COVID-19 Uninsured Group Application?

Answer 9: Yes, in order to accept a telephonic signature, the following procedure must be followed:

- Read the consent language aloud to the individual/Authorized Representative as it is stated on the signature page of the COVID-19 Uninsured Group Application:

  By signing, I declare that what I say below is true and correct.

- *I have read and understood this PE for COVID-19 Medi-Cal Application.*
- *The information I provided is true, correct, and complete.*

- Ask that the individual/Authorized Representative verbally acknowledge their consent.
- In the signature line, write “Verbal consent – COVID-19”.
- Be sure to document and keep documentation for all verbal consent obtained.

35.10 Hearing Aid Coverage For Children Program (HACCP)

The “Hearing Aid Coverage for Children Program” (HACCP), authorized by Assembly Bill (AB) 89, is a state program for children under the age of 18, who are not currently eligible for, or enrolled in Medi-Cal or California Children’s Services (CCS), and who are in need of hearing aids and related services.

Note:

These benefits are also available to children whose health insurance does not cover hearing aids and related services.

The HACCP program is administrated by MAXIMUS; including the eligibility determination and ongoing case management. HACCP began accepting applications effective 07/21/2021.

35.10.1 HACCP Covered Services and Aid Code

HACCP utilizes existing Medi-Cal and CCS policies to guide the benefit structure including, but not limited to, coverage of:

- Hearing aid(s) and hearing aid replacement
- Hearing aid supplies/accessories
- Hearing aid-related audiology services
- Other related post-evaluation services

Coverage for these services is based on a referral from an enrolled Medi-Cal audiologist or hearing aid dispenser who will document the degree of hearing loss, medical necessity for the requested amplification method, name of the manufacturer, type of hearing aid authorized, and the number of units.

Children who qualify for HACCP are assigned Aid Code A1.

35.10.2 Eligibility Criteria

To qualify for HACCP, all criteria below must be met.

The child must be:

- Under the age of 18,
- In need of hearing aid and related services,
- Referred by an audiologist, otolaryngologist, or medical physician,
- Living in a household with an income of up to 600 percent of the Federal Poverty Level (FPL),
- Not otherwise eligible for Medi-Cal or CCS, or have an existing health insurance that does not cover hearing aid and related services

35.10.3 How to Apply for HACCP

The application for HACCP benefits is done through MAXIMUS and requires a referral from an audiologist, otolaryngologist, or physician. If an applicant is found not eligible for HACCP because they are meeting eligibility for Medi-Cal or CCS, MAXIMUS will include a copy of the Single Streamlined Application in the HACCP denial letter, and refer the applicant to the social services agency to apply for coverage; this application is to be processed as a regular walk-in application.

Applicants may obtain additional information by visiting the HACCP website, or by calling the HACCP Call Center a 1-833-956-2878. Applicants may also be provided with the HACCP flyer: English flyer Spanish Flyer.