Chapter 6: Applying For Medi-Cal Benefits And Retroactive Benefits

Right to Apply

Regardless of the how they apply for Medicaid, individuals must be given an opportunity to apply without delay and must be allowed to bring a representative to assist or represent them during the application process. The eligibility process itself as well as the methods of determining eligibility developed by the Department of Health Care Services (DHCS) must be consistent with Title VI of the Civil Rights Act, the Americans with Disabilities Act, and section 504 of the Rehabilitation Act.

Applicants for the Medi-Cal program may apply in several different ways; they can complete an application at the DHCS or local Department of Public Social Services (DPSS) office, they can mail in an application or they can apply at certain hospitals and federally qualified health centers (FQHCs). Additionally, pregnant women and children can complete a short-form application at disproportionate share (DSH) hospitals and FQHCs. This function is called “outstationing.” Also, county juvenile detention facilities must assist with completing a Medi-Cal application while a youth is in detention so that eligible wards may leave detention with Medi-Cal eligibility approved.

A written application must be completed by the applicant or a person acting on her behalf. Applicants will be asked for a social security number and should furnish it or explain that they are applying for one. Others in the household who are not applying for Medi-Cal benefits do not need to provide a Social Security number and should not be asked for one.

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1 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.906.
2 42 C.F.R. § 435.908.
5 42 U.S.C. § 1396a(a)(55); 42 C.F.R. §§ 435.904, 435.907(c). See 56 Fed. Reg. 65,490 (Dec. 17, 1991) (model Medicaid short form); CMS, State Medicaid Manual §§ 2905-2913; CMS, State Medicaid Director Letter No. 01-009 (Jan. 18, 2001). See also Cal. Welf. & Inst. Code § 14067.5 (stating “department shall encourage counties to outstation additional Medi-Cal eligibility workers in nontraditional sites, such as schools, private hospitals, clinics, mental health centers, sites providing services under California Supplemental Food Program for Women, Infants, and Children sites, and community-based organizations …[and] shall require counties [to] redirect a portion of existing funding for Medi-Cal eligibility administration for this purpose.”
8 42 U.S.C. § 1320b-7; 42 C.F.R. § 435.910; Dep’t. Health and Human Servs. & Dep’t. Agric. Policy Guidance Regarding Inquiries into Citizenship, Immigration Status, & SSNs in State Apps. for Medicaid, SCHIP, Temporary Assistance to Needy Families & Food Stamp Benefits (Sept., 20, 2000) (clarifying that only Medicaid applicants are required to provide SSNs and immigration status as a condition of non-emergency Medicaid and instructing states to amend the Medicaid and joint assistance applications accordingly). Note that the DHCS is not allowed to condition the provision of emergency Medi-Cal services on the possession of the SSNs. See Cal. Welf. & Inst. Code §§ 14011.2.
9 A child applying for Medi-Cal should not be disqualified because of a parent’s inability to supply her own SSN. See Lewis v. Grinker, 794 F. Supp. 1193 (E.D.N.Y. 1987), aff’d 965 F.2d 1206 (2d. Cir. 1992) (additional citations omitted).
The date of application is the date the completed application form is received by the county welfare department. If the beneficiary is eligible, her Medi-Cal eligibility begins the first of the month in which she applies.

Individuals who are determined to be disabled and eligible for Supplemental Security Income (SSI) automatically qualify for Medicaid benefits. These individuals do not complete a separate Medi-Cal application; rather, the Social Security Administration, which makes the SSI determination, also determines Medi-Cal eligibility.

**Reasonable Promptness**

The federal Medicaid Act requires that eligibility determinations be made with “reasonable promptness.” Implementing federal regulations clarify that state agencies must make Medicaid eligibility decisions on non-disability applications within 45 days and Medicaid eligibility decisions requiring disability determinations within 90 days.

**Income/Property Deeming**

In the Medi-Cal program, the only income and property that can be deemed, or counted, for purposes of determining an applicant’s eligibility are her own income and property and that of her parents, her spouse or another individual financially and legally responsible for her. This means that income and property of grandparents or caretaker relatives, boyfriends, girlfriends or domestic partners, and children cannot be considered in determining whether an applicant is eligible for Medi-Cal. Note that these rules may differ significantly from the deeming rules of other public benefit programs.

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12 42 U.S.C. § 1396a(a)(10)(A)(ii); 42 C.F.R. § 435.120. This provision applies to both individuals and couples who are receiving SSI.
13 42 C.F.R. §§ 435.909(b)(1), (2) and (3). States such as California which contract with the Social Security Administration to make Medicaid eligibility determinations are called “1634 states” after the section of the SSA that authorizes this process. See Cal. Code Regs. tit. 22, § 50167; Cal. DHCS, ACWDL No. 84-10 (Mar. 28, 1984).
15 42 C.F.R. § 435.911; Cal. Code Regs. tit. 22, § 50177. Note that in situations where an individual’s application for SSI disability is pending, a decision regarding an applicant’s Medicaid eligibility based on disability must still be made within a 90 day period. See 42 C.F.R. §§ 435.541(c)(2), (c)(4); CMS, State Medicaid Manual § 3270. In 1634 states, once the Social Security Administration has made a disability determination, the state Medicaid agency is bound by it for one year. See 42 C.F.R. § 435.541(c)(4); CMS, State Medicaid Manual §§ 3270-3277.
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Due Process Rights, including Entitlement to Medi-Cal Benefits

Medi-Cal applicants have rights to notice and an administrative fair hearing when their eligibility applications are denied or are not acted upon with reasonable promptness. If an individual's application for Medi-Cal benefits is denied, she must be granted a reasonable amount of time to request the fair hearing, not to exceed 90 days from the date that the denial notice is mailed. Individuals can file for a fair hearing in California by calling the State Hearings Division of the Department of Social Services (DSS) at 1-800-952-5253 or by faxing or mailing a written request to that office or to the county welfare department. If the beneficiary has a notice of action showing that her application was denied, she can simply fill out the back of the notice and send that form to the welfare department or to the State Hearings Division at the address on the form. The hearing will be heard by an administrative law judge from the State Hearings Division of the DHCS. For more information about Medi-Cal fair hearings and due process rights, see Chapter 19 of this Manual.

Application Procedures

No Face to Face/In Person Interview Requirement

Prior to 2000, state law required an applicant to have a face-to-face interview as part of the application process. An applicant no longer needs to be interviewed in person, but she may submit her application by mail instead. While she may not be required to go to the welfare office to apply, an applicant may still choose to do so. Additionally, applicants can obtain assistance in completing their application at the county welfare office. The county welfare department processes most of the mail-in applications.

Mail In Application

The DHCS instructs most Medi-Cal applicants to complete an MC 210 form, the primary mail in application. Revised in April 2006, the MC 210 is available in English, Spanish, Vietnamese, Khmer, Hmong, Armenian, Chinese, Korean, Russian, Farsi, and Lao. Individuals receiving Medi-Cal benefits under mandatory managed care enrollment aid codes can, but are not

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18 U.S. Const. amend. XIV, § 1; 42 U.S.C § 1396a(a)(3); 42 C.F.R. §§ 431.200-250, 431.206(c); Cal. Code Regs. tit. 22, § 50953. See also 42 C.F.R. §§ 435.911-435.920 (determination and redetermination of Medicaid eligibility); CMS, State Medicaid Manual § 2900 et seq.
19 42 C.F.R. § 431.221(d); CMS, State Medicaid Manual § 2901.3; Cal. Welf. & Inst. Code § 10951. Note the 90-day limit does not apply if the beneficiary receives no written notice or the NOA is inadequate. See Morales v. McMahon, 223 Cal. App. 3d 184 (1990).
23 Cal. Code Regs. tit. 22, §§ 50004(c), 50101(a), 50153(b).
25 Cal. DHCS, ACWDL No. 01-68 (Dec. 17, 2001).
required to, attend presentations offered by the DHCS’ vendor, Health Care Options, to explain how managed care works and how to choose a health plan. Whether or not a Medi-Cal applicant attends the information session, Health Care Options will mail her an enrollment packet containing enrollment and health plan information for her review along with her health plan selection of choice.

**Joint Medi-Cal/ Healthy Families Program Mail In Application**

As an alternative to completing the MC 210, children and pregnant women may submit the four-page joint Medi-Cal/Healthy Families program mail-in application. Recently revised, this shortened application allows families to apply for both Medi-Cal and Healthy Families and to have their children enrolled in the program for which they are eligible. This screening process takes place at the Single Point of Entry (SPE), a Sacramento area-based service currently run by private administrative vendor Maximus and overseen by the DHCS with assistance from the Managed Risk Medical Insurance Board (MRMIB). While SPE conducts an initial screening for Medi-Cal and Healthy Families, it is important to remember that in terms of Medi-Cal eligibility, SPE only screens for the Percent of Poverty programs offered to children. It does not screen for Section 1931b or disability-based programs. As a majority of children qualify for Medi-Cal through CalWORKs and Section 1931b, the Single Point of Entry process is not utilized by thousands of California children. This becomes problematic because only children who qualify for free Medi-Cal and whose joint application is sent to SPE are eligible for Accelerated Enrollment, or temporary Medi-Cal benefits, for children who are awaiting a final Medi-Cal determination. Children who apply for Medi-Cal in person or by mailing the MC 210 to the county welfare office typically do not receive Accelerated Enrollment for children. Additionally, the SPE performs a screening function, not an eligibility determination. The actual Medi-Cal eligibility determination does not occur until the application is forwarded to the county and a county eligibility worker makes the Medi-Cal eligibility determination.

Families may obtain help with the joint application from a Certified Application Assistant (CAA), who works at an Enrollment Entity (EE). CAAs’ assistance is provided free of charge. For each uninsured child a CAA successfully enrolls in Healthy Families or Medi-Cal, the EE receives $50. The EE receives another $50 if a CAA provides assistance with a child’s Annual Eligibility Review (AER). If a family is enrolling a child and also undergoing an AER for another child in a given year, the maximum reimbursement an EE can receive for providing assistance to that family is $100 per year. CAAs can help families complete a paper application or a fully automated Web-based application called Health-e-App. Each time a CAA successfully enrolls an uninsured child via Health-e-App, the EE receives $60. Most CAAs are staff members of

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26 Cal. DHCS, ACWDL No. 01-06 (Jan. 18, 2001).
33 Id.
34 See www.healthyfamilies.ca.gov/English/caa/caa_reimbursement.htm.
community-based organizations and other non-profit agencies.\textsuperscript{37} The MRMIB provides a list of CAAs on the Healthy Families website as well as a zip code search function to help families find the nearest CAA.\textsuperscript{38}

**Presumptive Eligibility**

Under federal Medicaid law, California provides temporary Medi-Cal coverage to pregnant women while their Medi-Cal applications are being processed.\textsuperscript{39} Pregnant women who have completed a shortened application and are found to be presumptively eligible for Medi-Cal receive ambulatory prenatal services.\textsuperscript{40} For pregnant women found to be eligible for regular Medi-Cal, their presumptive eligibility period ends when the positive Medi-Cal determination is made.\textsuperscript{41} For those women found to be ineligible for regular Medi-Cal, their presumptive eligibility period ends the last day of the month in which the negative Medi-Cal determination is made.\textsuperscript{42} See Chapter 7 for more information about presumptive eligibility for pregnant women.

**Accelerated Enrollment**

Children who appear to qualify for full-scope, no share of cost Medi-Cal and whose joint application is sent to Single Point of Entry are eligible for Accelerated Enrollment.\textsuperscript{43} Accelerated Enrollment for children offers temporary, free Medi-Cal benefits after the child’s application has been screened by Single Point of Entry and is awaiting a final Medi-Cal determination by the county welfare department.\textsuperscript{44} Women who appear to qualify for the federal Breast and Cervical Cancer Treatment Program (BCCTP) can also obtain Accelerated Enrollment.\textsuperscript{45} Under Accelerated Enrollment, they receive temporary, full-scope Medi-Cal coverage while the state’s eligibility specialist makes a final eligibility determination.\textsuperscript{46} See Chapter 7 for a more complete discussion of this program.

**Automatic Enrollment**

As discussed above, individuals receiving CalWORKs and SSI are automatically enrolled in Medi-Cal.\textsuperscript{47} No separate Medi-Cal application is required.

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\textsuperscript{37} Id. § 2699.6629(b).
\textsuperscript{38} See [www.healthyfamilies.ca.gov/English/joining.html](http://www.healthyfamilies.ca.gov/English/joining.html).
\textsuperscript{39} Cal. DHCS, ACWDL No. 93-78 (Oct. 27, 1993).
\textsuperscript{40} 42 U.S.C. § 1396r-1. Note that presumptive eligibility does not cover labor and delivery services, in-patient care, or dental services, which are provided to those with restricted scope benefits and full-scope Medi-Cal.
\textsuperscript{42} Id. § 11(5)(c).
\textsuperscript{43} Cal. DHCS, ACWDL No. 02-36 (June 19, 2002).
\textsuperscript{44} Id.
\textsuperscript{45} 42 U.S.C. § 1396r-1b; Cal. DHCS, ACWDL Nos. 02-12 (Mar. 4, 2002), 06-09 (Feb. 24, 2006), 06-25 (Aug. 2, 2006).
\textsuperscript{46} Id.
Deemed Eligibility for Infants

Babies born in California to mothers enrolled in Medi-Cal are automatically eligible for Medi-Cal for their first year of life as long as they continue to live in California with their mothers.\(^{48}\) Infants who do not fulfill this condition may still be eligible under Continuing Eligibility for Children, discussed below.\(^{49}\)

CHDP Gateway Enrollment

Through their Child Health and Disability Prevention (CHDP) program providers, children receiving CHDP services may pre-enroll in Medi-Cal or Healthy Families while they await an eligibility determination for those programs.\(^{50}\) The temporary services are provided for two months, or until the child is determined eligible for Medi-Cal or Healthy Families, whichever comes later.\(^{51}\)

Express Lane Eligibility

Through Express Lane Eligibility, families who receive food stamps can permit information from their Food Stamp Program application to be used to determine their eligibility for Medi-Cal and Healthy Families.\(^{52}\) Additionally, Express Lane Eligibility allows schools to release information from a child’s National School Lunch Program application in order to pre-enroll a child receiving free meals into Medi-Cal until a final determination is made by the county welfare department.\(^{53}\)

Ex-Parte Redetermination

Under Senate Bill 87 (SB 87), a Medi-Cal beneficiary’s eligibility for all Medi-Cal programs must be evaluated before the individual’s benefits can be terminated.\(^{54}\) If the beneficiary is found eligible for another Medi-Cal program, she should be automatically transferred by an eligibility worker into that program. This process should always occur without the need for a beneficiary to submit a new application.\(^{55}\) If, however, continued Medi-Cal eligibility cannot be established by \textit{ex parte} review, then the county must attempt to contact the beneficiary by telephone.\(^{56}\) If the county is unsuccessful reaching the beneficiary by telephone, the county should then send a MC 355 form to the beneficiary.\(^{57}\) MC 355 highlights the information that is needed in order to complete the eligibility determination.\(^{58}\)

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\(^{48}\) Cal. Code. Regs. tit. 22, § 50262.3; Cal. DHCS, ACWDL No. 03-49 (Oct. 6, 2003).

\(^{49}\) Id.

\(^{50}\) Cal. Welf. & Inst. Code § 14011.7; Cal. Health & Safety Code § 124033(b).

\(^{51}\) Id. See also Cal. DHCS, ACWDL No. 05-02 (Feb. 17, 2005).

\(^{52}\) Cal. DHCS, ACWDL No. 01-10 (Feb. 13, 2001).


\(^{55}\) Cal. DHCS, ACWDL No. 07-24 Reminder to Counties to Follow Procedures Set Forth in Senate Bill 87 (SB 87) and \textit{Craig v. Bonta} (Nov. 9, 2007).

\(^{56}\) Id.

\(^{57}\) Id.

\(^{58}\) Id.
Retroactive Benefits

When applying for Medi-Cal benefits, applicants may request retroactive Medi-Cal coverage for medical services received during any of the three calendar months immediately preceding the month of application if they would have qualified for the program during the month(s) in question. Individuals seeking retroactive benefits must complete a supplemental form that accompanies a MC 210. An applicant may request the retroactive coverage at the time of application or within one year of the month for which the retroactive coverage is sought.

Conlan Reimbursement

Following California court decisions in *Conlan v. Bonta* and *Conlan v. Shewry*, the DHCS was ordered to implement a beneficiary reimbursement process that enables a Medi-Cal beneficiary to obtain direct reimbursement of expenses paid out-of-pocket for Medi-Cal covered services which she received during specific periods of eligibility. These periods include 1) the retroactive eligibility period (up to three months prior to the month of application to the Medi-Cal program); 2) the evaluation period (from the time of the application to the Medi-Cal program until eligibility is established); and 3) the post-approval period (the time period after eligibility is established but before the applicant has been notified). An individual must demonstrate or provide the following to obtain reimbursement under *Conlan*:

- She paid for a medical or dental service or someone paid it on her behalf;
- She received a medical or dental service from a Medi-Cal enrolled provider (unless the service was received during the three months prior to applying for Medi-Cal);
- For services that were provided and would have required Medi-Cal prior authorization, the medical or dental provider completed documentation indicating medical necessity for the service;
- She was Medi-Cal eligible to receive the medical or dental service that was provided;
- The medical or dental service was a benefit under the Medi-Cal program;
- The service was provided on or after June 27, 1997; and;
- After the beneficiary received her Medi-Cal BIC card, she contacted the provider and showed the provider her card, but was not given her money back.

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60 See id.
62 Cal. DHCS, ACWDL No. 07-01 Medi-Cal Mass Mailing Letter to All Medi-Cal Head-of-Household and Former Medi-Cal Beneficiaries Since June 27, 1997 (Jan. 12, 2007).
63 Id.
64 Id.