Assisting Medi-Cal Eligible Consumers FAQ
Certified Enrollers

Confused about the Medi-Cal enrollment process? Review frequently asked questions and glossary terms to understand the basics and learn how to seek help for difficult scenarios.

Table of Contents

FREQUENTLY ASKED QUESTIONS (FAQ) 2

- How do I help consumers that are determined pending eligible, conditionally eligible or eligible for Medi-Cal at initial application? 2
- What happens when a current Covered California consumer becomes newly Medi-Cal eligible? 3
- Can I obtain information about or make changes to a consumer's Medi-Cal application or case? 3
- What if a consumer requests two or more Authorized Representatives? 3
- What if a Medi-Cal eligible consumer is having trouble accessing services? 3
- How do I make changes or updates to Medi-Cal or Mixed Household cases? 4
- How do I help consumers Renew their Medi-Cal coverage? 4
- What is Soft Pause and how do I identify when an application is in Soft Pause? 5
- How do I complete Covered California plan selection on a Mixed Household if the case is being reviewed by the county? 6
- What about the phrases "release my application from the county" or "remove soft pause?" 6
- How do I assist a consumer transitioning from Medi-Cal to Covered California? 6
- How can the consumer contact their county social services office? 6

GLOSSARY 7

- SAWS 7
- Mixed Household 7
- Medi-Cal Managed Care Plan 7

We Want Your Input

Covered California's Outreach and Sales team would like your input to update this document in the near future with questions that are not addressed in this FAQ. After reviewing this FAQ, please submit any further questions to OutreachandSales@covered.ca.gov.

FREQUENTLY ASKED QUESTIONS (FAQ)

How do I help consumers that are determined pending eligible, conditionally eligible or eligible for Medi-Cal at initial application?

For consumers determined pending eligible, conditionally eligible, or eligible for Medi-Cal please allow for five business days before contacting the county.

Eligible Determination:

Consumers with an ***eligible*** determination status will be automatically enrolled in Med-Cal. Inform consumers determined ***eligible*** for Medi-Cal that they can expect to receive a Welcome to Medi-Cal packet within 10 days that may include a Benefits Identification Card (BIC), sometimes referred to as a “Medi-Cal” or “BIC” Card. Consumers can also immediately access services as soon as they are determined ***eligible***.

Conditionally Eligible Determination:

Consumers with a ***conditionally eligible*** determination will be enrolled in Medi-Cal. Inform consumers determined ***conditionally eligible*** for Medi-Cal that they can expect to receive a notice from their local county social services office requesting additional information. Consumers may contact their local county social services office to expedite a Medi-Cal application.

Conditionally eligible is usually due to discrepancies with the reported citizenship or immigration status, or the social security number provided or not provided. If the consumer fails to provide the necessary information they may be completely denied and in some instances moved to a restricted scope Medi-Cal program.

Pending Eligible Determination:

A ***pending eligible*** determination indicates potential discrepancies (such as income limits, current incarceration, or deceased) that may delay coverage. Consumers with a ***pending eligible*** determination will not be enrolled in Medi-Cal, but will be contacted by the local county social services office to resolve the eligibility result.

Once the consumer provides the required information, the county will determine the correct eligibility. If the consumer fails to provide information, they will be denied Medi-Cal coverage.

What happens when a current Covered California consumer becomes newly Medi-Cal eligible?

Consumers will be placed in pending eligible status for Medi-Cal and will be placed in a **Carry Forward Status (CFS)** while their case is being reviewed by a county eligibility worker. The CFS will maintain their Covered California plan selection and any APTC eligibility during this review period. Consumers should continue to pay their premiums to ensure there is no gap in coverage. Covered California will send a notice of CFS to the consumer and the consumer will need to keep a look out for letters from the county, as the county may need additional information to complete the determination. Once the consumer's final eligibility determination has been made by the county, the county eligibility worker will lift the CFS and either Medi-Cal eligibility will begin or the APTC eligibility will be updated.

Can I obtain information about or make changes to a consumer's Medi-Cal application or case?

Yes, Agents and CECs may obtain information about a consumer's Medi-Cal case or help consumers make updates to their case information online and with the local county social services office. If changes are reported online, Agents and CECs should assure that the same changes are reported directly with the local county office. However, the Agent or CEC must be designated as an Authorized Representative (AR) directly with the local county social services office.

To become an AR for Medi-Cal cases, the a complete an AR form such as the (MC 306) and submit it to the local county social services office. The consumer must provide their consent to the county office. The AR appointment is effective until the applicant/beneficiary cancels or modifies the AR appointment.

For more information on the role of a Medi-Cal Authorized Representative, see Welfare & Institutions Code section 14014.5. An individual can be assigned as an Authorized Representative as long as the customer would like to keep them as an AR on the case.

What if a consumer requests two or more Authorized Representatives?

Consumers can have multiple ARs at the same time. A new AR can be added to the Medi-Cal case by going through the same process outlined in the question above.

What if a Medi-Cal eligible consumer is having trouble accessing services?

The Department of Health Care Services has an Ombudsman office which is a person in a government agency to whom people can go to make complaints or explain problems with the programs or policies of the agency.

- Assist members with navigating through the Medi-Cal Managed Care System
- Help members find information in order to access appropriate mental health services
- Address concerns or grievances about services

- Conducts impartial investigations of member complaints about managed care health plans
- Helps members with urgent enrollment and disenrollment problems
- Offer information and referrals

Website: http://www.dhcs.ca.gov/services/Pages/Ombudsman.aspx

Medi-Cal Managed Care
Phone: 1-888-452-8609
Email:MMCDOmbudsmanOffice@dhcs.ca.gov

Mental Health
Phone: 1-800-896-4042
Email: MHOmbudsman@dhcs.ca.gov

How do I make changes or updates to Medi-Cal or Mixed Household cases?

Generally, the county social services office is responsible for Medi-Cal and mixed household case management.

It's important to note that Covered California Service Center Representatives cannot make changes to cases with individuals that are Medi-Cal eligible, including Mixed Households. Certified Agents and CECs are able to make changes to Covered California accounts. However, to follow up with the county eligibility worker, Agents and CECs must be an Authorized Representative for the consumer with the county. *Any changes made online to Covered California accounts should be reported directly to the local county social services office.*

How do I help consumers Renew their Medi-Cal coverage?

Medi-Cal coverage is renewed annually. There is no specific renewal season, this means that Medi-Cal can renew cases all year long. Medi-Cal will attempt to electronically verify a consumer's information prior to sending a packet or forms. If all information is verified electronically, the consumer will not get a renewal packet. If additional verification is needed once the electronic verification is made, the consumer will receive a form or packet from the county about their renewal. It is important that the consumer provides the Information requested by the date indicated on the notice.

A Notice of Action (NOA) will be sent to the consumer once a final eligibility determination has been made. If a consumer experiences an issue during the renewal process, please contact the county, Covered California Certified Enrollment Counselor Help Desk at 855-324-3147, EnrollmentAssistanceSupport@covered.ca.gov or Ombudsman at (888) 452-8609 depending on the need.

If the consumer gets a form or packet from the county about their renewal, it is important that they provide the information requested by the date indicated in the notice. Agents and Certified Enrollment Counselors (CECs) should be aware that prior to sending a form or packet requesting information, the county will attempt to verify information electronically. If the electronic verification is successful, the consumer will not be asked to provide any additional information, so **not all consumers will get a renewal packet**. However, they will receive a Notice of Action (NOA) from the county with the final eligibility determination.

While consumers, Agents, and CECs are able to report changes through the Covered California account, they should follow-up directly with their county eligibility worker to verify that the changes reported in the online application were processed. If the consumer is having trouble reporting changes, it's important that they contact the county directly and let them know of these changes. If the Agent or CEC is an Authorized Representative with the county, they should contact the local county social services office.

What is Soft Pause and how do I identify when an application is in Soft Pause?

When there is a report of change in a MAGI Medi-Cal eligible household that changes a member of the household's eligibility from Medi-Cal to Covered California, a consumer's case may be placed in Soft Pause. Department of Health Care Services regulations require this review to protect certain consumers who have been identified as Medi-Cal eligible, and when changes are reported that affect the consumer's eligibility.

Soft Pause is applied to households with:

- Children
- Pregnant women
- Parents/Caretaker relatives
- Individuals aged 65 and older
- Individuals that are blind or disabled

Soft Pause is intended to review eligibility for Non-MAGI Medi-Cal programs.

When a case is in Soft Pause, the consumer's eligibility in CalHEERS will continue to reflect Medi-Cal eligible despite changes made in CalHEERS. The Agent or CEC assisting the consumer, nor the consumer, will not be able to complete Covered California plan selection until the review is complete and the Covered California plan selection functionality is enabled by the County Eligibility Worker. The consumer, or their Medi-Cal Authorized Representative can contact the county and request the completion of eligibility updates and Soft Pause review.

If an Agent or CEC would like to confirm a consumer in Soft Pause, contact Covered California Certified Enrollment Counselor Help Desk 855-324-3147 or EnrollmentAssistanceSupport@covered.ca.gov.

How do I complete Covered California plan selection on a Mixed Household if the case is being reviewed by the county?

Consumers or their Medi-Cal Authorized Representatives must contact the County Eligibility Worker and request the completion of eligibility updates and Soft Pause review to allow plan selection functionality to be restored for Covered CA eligible individuals on the case.

What about the phrases "release my application from the county" or "remove soft pause?"

Previously, the phrases "release my application" or "remove soft pause" were used to request completion of county updates. However, these are inaccurate, and should not be used. The term "soft pause" is a technical phrase, and refers to a multi-step process of evaluating eligibility for Non-MAGI Medi-Cal. A Covered California plan cannot be selected for the individuals in Soft Pause until the Soft Pause review is completed.

The best way to request action from the county is to ask for eligibility updates to be completed. If a consumer is certain that they do not want to be evaluated for Non-MAGI Medi-Cal, they can communicate that request to the County Eligibility Worker.

How do I assist a consumer transitioning from Medi-Cal to Covered California?

The county will send a Notice of Action (NOA) no less than 10 days before the last day of Medi-Cal coverage. In addition, Covered California will send a notice (NOD01) indicating they qualify for Covered California and need to select a plan by the end of the month and pay the premium by the due date in order for coverage to begin. If the consumer has not yet selected an APTC plan and paid their premium, it is important that they do so as soon as possible in order to avoid a gap in coverage.

Loss of Medi-Cal is considered the same as loss of Minimum of Essential Coverage (MEC). Agents and CECs can use this loss of coverage as a Qualifying Life Event (QLE) for the Special Enrollment Period (SEP).

How can the consumer contact their county social services office?

Click here for a contact list of county office phone numbers and addresses.

GLOSSARY

SAWS

"SAWS" is the Statewide Automated Welfare System that is used by the counties to determine Medi-Cal program eligibility in California. This system supports the eligibility and benefit determination, enrollment, and case maintenance functions at the county level for the state's major health and human services programs, including Medi-Cal.

The Covered California enrollment system, also known as CalHEERS, works in conjunction with SAWS to transmit enrollment and eligibility information. When a consumer is determined eligible for Medi-Cal in CalHEERS, the determination is sent to the county and stored in SAWS. The county will use this information to complete Medi-Cal enrollment in SAWS. Conversely, when a consumer is determined eligible for Covered California by the county, the eligibility information is transmitted to CalHEERS.

The counties are organized into consortia's which use specific software systems for their SAWS. These are known as:

- *C-IV*
- *Cal-WIN*
- *LEADER Replacement System (LRS)*

Mixed Household

Mixed households have at least one member eligible for a Covered California Health Plan with Premium Assistance (Advanced Premium Tax Credit or APTC) and at least one member eligible for Medi-Cal (MAGI and/or non-MAGI). For more information about Modified Adjusted Gross Income (MAGI) Medi-Cal and non-MAGI Medi-Cal refer to the Medi-Cal Advance Study Course in Learning Management System (LMS).

Medi-Cal Managed Care Plan

A Medi-Cal Managed Care Plan contracts with specific doctors, clinics, specialists, pharmacies, and hospitals. These providers make up the health plan's "network." Some eligible consumers may be automatically enrolled into a Medi-Cal Managed Care Plan if they reside in a County Organized Health System (COHS.) A COHS is a local agency created by a county board of supervisors to contract with the Medi-Cal program.

Consumers in a COHS county will select a health care provider that participates in the COHS Medi-Cal Managed Care Plan.

COHS Counties:

Orange	Santa Cruz	Monterey
San Mateo	Solano	Napa
Yolo	Santa Barbara	Del Norte
Lake	Humboldt	Lassen
Marin	Mendocino	Merced
Modoc	San Luis Obispo	Shasta
Siskiyou	Sonoma	Trinity
Ventura		

Medi-Cal beneficiaries who reside in non-COHS counties will receive a Medi-Cal Managed Care enrollment packet from Health Care Options (the company that works for the Medi-Cal Program to help consumers choose or change health plans). The enrollment packet will allow consumers to choose a Medi-Cal Managed Care Plan and select their providers.

Information about the plans available in each county can be found at: http://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx. For questions about enrollment into Medi-Cal Managed Care plans, please contact Health Care Options at (800) 430-4263.

For questions about Medi-Cal eligibility, contact the local county social services office, and for questions about Medi-Cal Managed Care Plan expedited enrollments, contact the Medi-Cal Managed Care Office of the Ombudsman at (888) 452-8609.