



Medi-Cal: Transitional and Presumptive Benefits

Sometimes customers are placed on Medi-Cal by an organization or agency that is not Social Services. Generally, these programs are a temporary measure to ensure access to immediate coverage while the regular Medi-Cal application process is completed. Some programs provide transitional coverage so that a customer has continued access to care while the Medi-Cal case moves from one agency to another.

“Accelerated Enrollment” for Children

Covered California

Children in families who apply for CoveredCA.com are given temporary Medi-Cal if the information submitted to and verified by CoveredCA.com indicates the child(ren) is eligible. Coverage continues until a final eligibility determination is made by Social Services regarding Medi-Cal coverage.

What does the customer need to do?

The customer waits until they get the results from the CoveredCA.com application submitted to the county. Social Services may ask for more information or, if a final determination is made, will send a notice of action with details.

Children’s Presumptive Eligibility (CPE)

Formerly known as Child Health and Disability Prevention (CHDP), Children’s Presumptive Eligibility (CPE) is administered through Qualified Providers. Customers are enrolled by the QP reporting the birth of certain newborns within a specified timeframe. CPE is not a program, but a means to pre-enroll non-Medi-Cal children into temporary coverage while the family applies for continuing coverage.

What does the customer need to do?

The customer needs to complete the Medi-Cal application process. Coverage will end if this isn’t done. The Qualified Provider gives Medi-Cal applications at the time of enrollment; these should be completed and sent in. The customer can also call the Eureka Call Center to complete the entire application process over the phone or find out about other options.

Deemed Eligible

Babies born to mothers on Medi-Cal at the time of birth are “deemed” eligible for Medi-Cal. Providers have the ability to do an “accelerated enrollment” for a newborn to grant immediate Medi-Cal coverage.

What does the customer need to do?

The customer needs to report the baby’s birth to Social Services within ten days, just like with other household changes. While the newborn may have temporary eligibility through the provider, Social Services needs to add the newborn to the Medi-Cal case. When the customer contacts Social Services, the newborn’s name, date of birth and gender may be all that is needed.

Presumptive Eligibility

Pregnancy

The Presumptive Eligibility (PE) program is for individuals who believe they are pregnant and do not have health insurance or Medi-Cal. Many local medical providers are allowed to grant immediate, temporary Medi-Cal coverage to pregnant patients based on income while the customer submits a Medi-Cal application. Unlike almost all other coverage, PE coverage cannot be seen in statewide Medi-Cal systems by Social Services staff.

What does the customer need to do?

The customer needs to complete the Medi-Cal application process. The provider gives the customer a form to give to the county to start the application; some providers send it directly to the county. The customer can also call the Eureka Call Center to complete the entire application by phone or to find out about other options.

Hospital

Hospitals can enroll patients who are getting services or being admitted. These temporary benefits last from the time the application is submitted until the end of the following month. If a customer files a regular Medi-Cal application prior to the last day of the following month in which Hospital Presumptive Eligibility (HPE) was determined, it will continue until a final eligibility determination is made regarding Medi-Cal coverage.

What does the customer need to do?

The customer needs to complete the Medi-Cal application process. The Hospital gives the customer the Insurance Affordability Program Application to start the process. The customer submits this to Social Services or they call the Eureka Call Center to complete the entire application by phone or to find out about other options.

Other Transitional and Temporary Medi-Cal

SSI/SSP Discontinued

A person who receives Social Security Income (SSI) with the State Supplemental Payment (SSP) through the Social Security Administration automatically receives Medi-Cal. When SSI/SSP is stopped for any reason, Medi-Cal coverage continues while Social Services reviews for “regular” Medi-Cal eligibility.

What does a customer need to do?

The customer will be contacted by Social Services, either to inform them of the results of the Medi-Cal determination or to get more information. Coverage remains uninterrupted. If the customer does not hear from Social Services within two months of the SSI/SSP discontinuance, they should call the Eureka Call Center to check the status.

Breast & Cervical Cancer Treatment Program (BCCTP)

BCCTP is coordinated between the provider’s office and the state without county Social Services involvement. Sometimes, due to changing circumstances, the BCCTP eligibility case is referred by the state to the county to review for full ongoing “regular” Medi-Cal.

What does the customer need to do?

The customer doesn't need to do anything unless they are contacted by either the State Department of Health Care Services or Social Services. If they are contacted, they should reply to that letter or phone call. A customer shouldn't ignore contact from Social Services because they are enrolled in BCCTP; there may be times they need to take steps to maintain coverage.