

Chapter 5: Setting up Medi-Cal Family Budget Units, Spending Down, and Share of Cost

Setting up MFBU (Medi-Cal Family Budget Unit Determination)

In order to determine financial eligibility for an individual or a family, you must know which individuals to include in the Medi-Cal Family Budget Unit (MFBU).¹ The rules for determining MFBU are different if the family has a family member in long term care or in board and care.² The rules discussed below apply only to families without individuals in long-term care. For more information on MFBU for individuals in long term care, please see Chapter 21.

Generally, all family members living in the home, other than those specified below, are included in the MFBU.³ These individuals and their income are counted in the MFBU regardless of whether they are eligible for or want to receive Medi-Cal. A parent's MFBU includes children between 18 and 21 who are claimed as dependents for tax purposes.⁴ A pregnant woman is treated as two people when determining the size of an MFBU.⁵ Individuals who are receiving a type of public assistance or "other public assistance recipients" different from other family members may be in a separate MFBU.⁶ This includes individuals or families receiving SSI, CalWORKs, or refugee assistance.⁷

A family is eligible for Medi-Cal if the family is eligible for CalWORKs or if the family can be "linked" to CalWORKs. Linkage to CalWORKs means that the family could receive the cash benefits of the program, but may have chosen not to apply for the cash benefits. To determine linkage to CalWORKs, however, all family members living in the home are considered including those on public assistance, except for excluded children.⁸

Advocacy Tip ► Note that family members receiving public assistance are treated differently when determining what the MFBU is (where they are not included) and determining linkage for AFDC (i.e. CalWORKs) (where they are included).

¹ Cal. Code Regs. tit 22, § 50371(a). Advocates trying to figure out MFBU may find the discussion in Article 8 of the Medi-Cal Eligibility Procedures Manual to be of assistance.

² Cal. Code Regs. tit. 22, § 50373(a).

³ Cal. Code Regs. tit. 22, § 50373(a)(2).

⁴ Cal. Code Regs. tit. 22, §§ 50351(c), 50373(a)(4). Also see the table in the Medi-Cal Eligibility Procedures Manual at Article 8C.

⁵ Cal. Code Regs. tit. 22, § 50030(b); State Medicaid Manual § 3311.1B (June 1990, Transmittal 45).

⁶ "Other public assistance" refers to some groups of people who lost AFDC or SSI in the 1970s and 1980s due to changes in the way their eligibility was determined and IHSS beneficiaries under regulations that have not been updated since the IHSS waiver was instituted. This manual will not discuss this category of eligibility since it is rarely relevant. The only exception is the Four Month Continuing program for families to continue eligibility due to increased hours of employment or increased earnings. Individuals with increased hours or earnings still must be included in the MFBU. Cal. Code Regs. tit. 22, § 50373(a)(1).

⁷ Cal. Code Regs. tit. 22, § 50078.

⁸ Cal. Code Regs. tit. 22, §§ 50373(a)(3), 50381. A family may voluntarily ask that a child be excluded from the MFBU and Medi-Cal eligibility, except prior to the child's birth or during the child's first two months.

Ineligible Members of the Family

Ineligible members of an MFBU are included in the MFBU for the purposes of determining eligibility based on property and share of cost and have their health care costs used to meet the share of cost, but they are not issued a Medi-Cal card.⁹ Persons who are ineligible for Medi-Cal for any of the following reasons are ineligible members of the MFBU:¹⁰

- Refusing to apply for a Social Security Number, unless the family member is an immigrant without satisfactory immigration status who is applying only for restricted Medi-Cal benefits.¹¹
- Refusing to apply for Medicare.
- Refusing to apply for and accept unconditionally available income.¹²
- Inability to meet the basic eligibility criteria for any of the Medi-Cal programs.
- Parents who reside outside the state and who claim their children residing in the state as dependents in order to receive a tax credit or deduction.
- Refusal by a parent or caretaker relative, without good cause, to cooperate in establishing paternity for a child under eighteen years of age born out of wedlock for whom Medi-Cal is requested.¹³
- A child ineligible for Medi-Cal for any of the above reasons who has separate income or property may be treated as an ineligible member of the MFBU or be excluded. This choice is the option of the person who has legal responsibility for the child.¹⁴
- Persons who are eligible for four month continuing eligibility or Transitional Medi-Cal.¹⁵

Minors who are parents and still living with their own parents are not in the MFBU that includes their children except when they wish to receive minor consent services. Minor parents who wish to receive Medi-Cal, other than minor consent services, are put in an MFBU with their own parents.¹⁶

Family Members Excluded From the MFBU

Any child, other than a fetus or an infant during the first two months of life, may be excluded from the MFBU.¹⁷ This choice is an option for the person who has legal responsibility for the child. A stepparent, not including the parent of separate children, must be excluded from the MFBU.¹⁸ Except for the minor consent programs, the excluded individuals may not apply separately

⁹Cal. Code Regs. tit. 22, § 50379(g). Share of cost is explained later in this chapter.

¹⁰Cal. Code Regs. tit. 22, § 50379(a).

¹¹Cal. Code Regs. tit. 22, §§ 50302(c), 50379(a)(1).

¹²42 C.F.R. § 436.608, Cal. Code Regs. tit. 22 § 50379(a)(3).

¹³Cal. Code Regs. tit. 22, § 50379(a)(7). See Cal. Code Regs. tit. 22 § 50771.5 for what constitutes “good cause” for not complying with this requirement.

¹⁴Cal. Code Regs. tit. 22, § 50379(b).

¹⁵Cal. Code Regs. tit. 22, § 50379(c).

¹⁶Cal. Code Regs. tit. 22 § 50379(d).

¹⁷Cal. Code Regs. tit. 22, § 50381(a). The Medi-Cal regulations sometimes refer to a fetus as an “unborn” or an “unborn child.”

¹⁸Cal. Code Regs. tit. 22, § 50381(b).

for Medi-Cal.¹⁹ These individuals are not included in the MFBU for the purposes of determining eligibility and share of cost.²⁰ Their health care costs may not be used to meet the MFBU's share of cost.²¹ Excluded children are not considered in determining the program for which the persons included in the MFBU are eligible.²² For example, if a parent decides that a child will be excluded and there are no other children in the MFBU, the family could not qualify for a Medi-Cal program for families with children.

Determining an MFBU for a Child Who Stays Alternately with Each Parent

Special provisions apply to determine the appropriate MFBU when a child splits her time between the homes of two parents. These provisions apply if a child stays alternately for periods of one month or less with each of his parents, and the parents are separated or divorced. This child should be included in the MFBU with whom the child stays for the majority of time unless the other parent can establish that they have the majority of responsibility or care and control of the child.²³ In determining which parent has major responsibility for the child, factors that should be considered include looking at which parent:

- Decides where the child attends school
- Deals with the school on educational decisions and problems
- Controls participation in extracurricular and recreational activities
- Arranges medical and dental care services
- Claims the child as a tax dependent
- Purchases and maintains the child's clothing.²⁴

If each parent spends equal time with the child, then the MFBU depends on which parent applies for Medi-Cal for the child.²⁵

If a child spends equal amounts of time with both parents and both parents apply for Medi-Cal on their behalf, then the child is included in the MFBU of the parent designated as the primary parent by court order, designated as the primary parent by agreement, the parent who is eligible for Medi-Cal, or the party who first applied for Medi-Cal on behalf of the child.²⁶

Once a child is determined to be in one MFBU, she will remain in that MFBU while staying with the other parent for periods of time less than one month. If the child stays with the other parent for longer than one month, then she must be included in that parent's MFBU.²⁷

¹⁹ Cal. Code Regs. tit. 22, §§ 50381(a)(1), (b)(1).

²⁰ Cal. Code Regs. tit. 22, §§ 50381(a)(2), (b)(2).

²¹ Cal. Code Regs. tit. 22, §§ 50381(a)(4), (b)(3).

²² Cal. Code Regs. tit. 22, § 50381(a)(3).

²³ Cal. Code Regs. tit. 22, § 50374 (a)(1).

²⁴ Cal. Code Regs. tit. 22, § 50374(c).

²⁵ Cal. Code Regs. tit. 22, § 50374(a)(3).

²⁶ Cal. Code Regs. tit. 22, § 50374(b).

²⁷ Cal. Code Regs. tit. 22, § 50374(d).

Stepparents

A stepparent is someone who is married to the parent of children who are not his own.²⁸ Therefore, stepparent rules cannot apply to a domestic partner or similar person living in the household. If this person adopts a child who is not his own, the stepparent rules discussed in this section also do not apply because this person is now the parent of the child.²⁹

Family members in a family which includes a stepparent will be in the same “stepparent unit” unless only the separate children of one parent (and not that parent) wish to receive Medi-Cal.³⁰ If the applicant requests that only the separate children of one parent receive Medi-Cal, the county must explain to the applicant the right to make this choice and the effects of excluding the stepparent on the family’s eligibility.³¹ When this occurs, the parent of the separate children still will be considered an ineligible member of the MFBU containing those separate children.³² The members of the stepparent unit, other than the parent of the separate children are to be excluded from the separate children’s MFBU.³³

Specials Rules for MFBUs: *Sneede/ Gamma*³⁴

In determining the eligibility of family members, only income and resources of a spouse of an individual or that of a parent may be considered available for determining a person’s eligibility.³⁵ Two court decisions, *Sneede* and *Gamma*, confirm whose income can be counted or “deemed” to another family member and when a portion of the family’s income called “the personal needs allowance” should be deducted. These cases and following rules, allow some families to become eligible for no cost 1931(b) or Medically Needy Medi-Cal when they would not have been if income or resources of certain family members were deemed to other family members.

Sneede is a court decision about when and how the County may count other certain family members’ income or resources when determining an individual’s or a family’s Medi-Cal eligibility.³⁶ The process of counting someone else’s income or resources toward an individual’s Medi-Cal eligibility is called “*deeming*.” *Sneede* rules only allow the county to deem or count a parent’s income to his or her own child and a spouse’s income to his/her spouse. No one else’s income may be counted, unless a county knows a person is actually giving the beneficiary money.

Gamma is a court decision that requires a county to first allocate or subtract an amount for personal living expenses to a parent or spouse before it deems income or resources from that parent or spouse to other family members for whom they are legally responsible.³⁷ This is called the

²⁸ Cal. Code Regs. tit. 22, § 50094.

²⁹ Cal. Code Regs. tit. 22, § 50068.

³⁰ Cal. Code Regs. tit. 22, § 50375(a).

³¹ Cal. Code Regs. tit. 22, § 50375(b).

³² Cal. Code Regs. tit. 22, § 50375(d)(1).

³³ Cal. Code Regs. tit. 22, § 50375(d)(2).

³⁴ Information from this section came from “Sneede/ Gamma and Section 1931b” Issue Brief found at <http://healthconsumer.org/cs030SneedeGamma.pdf>.

³⁵ 42 C.F.R. 436.602(a)(1).

³⁶ *Sneede v. Kizer*, 728 F. Supp. 607 (N.D. Cal. 1990).

³⁷ *Gamma v. Belshe*, Case No. C94-0852, Reprinted in Medicare & Medicaid Guide (CCH), 40,003.

“personal needs allowance” and must be subtracted from the income of the parent or spouse before any “deeming” to others. The personal needs allowance recognizes that some of the parent’s or spouse’s income must be retained by that person to pay for her own living expenses.

Sneede/Gamma rules only apply if the countable income or resources of the family is too high to allow them to be eligible for free Medi-Cal **and**:

- One of the children has his/her own income or resources, or
- An unmarried parent or a stepparent lives in the home, or
- A caretaker relative cares for the child seeking Medi-Cal.

Example: Mary, James and Billy (Mary’s child from a previous relationship) live together. James and Mary are married. James works part-time, and Mary works only a few hours per month. They apply for Medi-Cal for the whole family. The welfare office lumps the family’s combined income together. The family’s combined income falls below 100% of the federal poverty level for a family of three. Since they are eligible for free §1931(b) Medi-Cal, *Sneede/Gamma* rules do not need to be applied.

To apply the *Sneede/Gamma* Rules, follow these steps in the Health Consumer Alliance brochure, *Sneede/Gamma and Section 1931(b)*.³⁸ However, remember to check to make sure that the individual is not already eligible without applying these rules. There is no need to complete these steps if the entire MFBU qualifies for no share of cost Medi-Cal.

1931(b) and Medically Needy *Sneede v. Kizer* Personal Needs Allowance and Prorated Income Limits³⁹

After apportioning income and taking the deductions via the *Sneede/Gamma* rules, each parent or spouse is entitled to a personal needs allowance. If a budget unit contains only children who are living with one or both parents (not stepparents), then income must be prorated as well. The amounts to deduct and when to deduct them are explained in the Health Consumer Alliance brochure, Section 1931(b) and Medically Needy *Sneede v. Kizer* Personal Needs Allowance and Prorated Income Limits.⁴⁰

Low-income People with Higher Income or More Assets

When an applicant is slightly over either the income or the resource limits for one Medi-Cal program, there may be options for her to spend down her income or assets and become eligible for Medi-Cal.⁴¹

³⁸ <http://healthconsumer.org/cs030SneedeGamma.pdf>.

³⁹ Information from this section came from the “Section 1931(b) and Medically Needy *Sneede v. Kizer* Personal Needs Allowance and Prorated Income Limits” Issue Brief available at <http://healthconsumer.org/cs031Sneedeproratedchart.pdf>.

⁴⁰ <http://healthconsumer.org/cs031Sneedeproratedchart.pdf>.

⁴¹ Note that there is no real upper limit to a person’s income to qualify for the medically needy program. Thus, it can work for a person or family who may have few resources but a high income. A beneficiary potentially may have a share of cost in the thousands of dollars. Clearly, Medi-Cal for these rare individuals should not be the

If her income is too high for some Medi-Cal programs, she may be eligible for a Medically Needy program with a “share of cost.” Under the federal Medicaid program, this is usually referred to as the beneficiary’s “spenddown.” She may also be eligible for the Aged & Disabled Program which ignores a portion of her income or for the 250% Working Disabled Program. Another possibility may be one of the waiver programs described in Chapter 8.

If she has too many resources for one of the Medi-Cal programs, she may be able to spend down some of those resources as described in the “Reducing Excess Property” section of Chapter 4. She also may qualify for the 250% Working Disabled Program which does not count some assets that would count in other Medi-Cal programs.

How Share of Cost is Determined and How it Works

In the Medi-Cal medically needy programs, a beneficiary’s monthly “spend down” is called a “share of cost.” The share of cost is the dollar amount of medical expenses that an individual must incur in a calendar month before Medi-Cal will begin to pay for her medical expenses in that month.⁴²

The share of cost bears similarities to an insurance deductible that is monthly: It must be satisfied before the insurance begins to pay for expenses. If a person has no medical expenses for the month, there is nothing to pay to the insurance company—so it is not like an insurance premium which must be paid in order to receive coverage. However, share of cost is also significantly different than an insurance deductible: With a deductible, the insurance is fully in place and the insurance company generally subtracts out the amount of the deductible when it pays for a medical service costing more than the deductible. In comparison, with a share of cost, until the share of cost is incurred or “met” for a month, it is as if the person has no Medi-Cal coverage at all.⁴³ Any payment or billing arrangements for satisfying the share of cost are left for the patient and the healthcare provider to negotiate.⁴⁴

Advocacy Tip ► The law does not require a person to pay a provider first for the costs of the services used to satisfy a share of cost. These costs need only be *incurred*. The provider may bill the beneficiary for the services, may require upfront payment, or even never really try to collect the money from the patient. Any payment arrangements for these costs are between the healthcare provider and the beneficiary.

Medi-Cal Programs That Have a Share of Cost

Share of cost only applies to the Medically Needy and Medically Indigent programs. Advocates should always check to see if the beneficiary qualifies for no share of cost Medi-Cal first. There are fees based on income and resources in the dialysis and hyperalimentation Medi-Cal

primary source of medical insurance due to the high share of cost that must be met before Medi-Cal will begin to cover expenses.

⁴² Cal. Welf. & Inst. Code § 14054.

⁴³ Cal. Welf. & Inst. Code § 14054, Cal. Code Regs. tit. 22, § 50090.

⁴⁴ See Allied Health Provider Manual, Medi-Cal Program & Eligibility, p. 2.

programs and premiums based on income in the 250% Working Disabled program but these are different from a share of cost. In the other Medi-Cal programs, however, beneficiaries are either eligible or they are not—a beneficiary cannot “spend down” excess income in the same way in order to become eligible.

A beneficiary may have a share of cost in the medically needy programs if her countable income, her family income minus allowable deductions, is more than the medically needy income level for the size of her family.

Determining the Share of Cost Amount

Determine Countable Income

The first step in determining a person’s share of cost is to determine the amount of countable income by deducting allowable deductions from the person’s or family’s gross income.⁴⁵ The medically needy programs are required to follow the aid program to which they are most closely linked.⁴⁶ The ABD Medically Needy program for beneficiaries who are elderly, blind, or have a disability follows SSI rules with respect to allowable deductions when determining countable income.⁴⁷ The AFDC-linked Medically Needy and Medically Indigent programs for beneficiaries that are generally families with children follow the former AFDC rules, in terms of allowable deductions and how income is counted.⁴⁸ Notably, both Medically Needy programs allow deductions for any out-of-pocket expenses for health benefit plan premiums.⁴⁹ This includes premiums or contributions deducted from a beneficiary’s pay by the employer. The allowable deductions and exemptions are explained more fully in Chapter 3.

Changes in income should always be reported to the county so that a share of cost will be appropriately increased or decreased in the following month.⁵⁰

Medically Needy Maintenance Need Income Level Allowance

Once the countable income is determined, you then deduct the Medically Needy Maintenance Need Income Level (MNIL) from the countable income.⁵¹ The MNILs have remained unchanged since 1989 and remain: \$600 for 1 person, \$750 for 2 people, \$934 for a couple or 3 people, \$1100 for 4 and \$1259 for 5 people.⁵² Additional amounts are added on as the family size

⁴⁵ Cal. Code Regs. tit. 22, § 50653(a)(1).

⁴⁶ 42 U.S.C. § 1396a(a)(17)(B); 402 C.F.R. § 435.601(b). *See e.g. Tinoco v. Belshe*, Case no. C-94-0947 (N.D. Cal. Nov. 8, 1995), CCH MEDI-CAL GUIDE New Dev. 7760.

⁴⁷ 42 C.F.R. § 435.831(b)(2).

⁴⁸ 42 C.F.R. § 435.831(b)(1). The exception is that unlike the former AFDC program, Medi-Cal only counts the income of the spouse or the parent and does not deem income from a stepparent, from one sibling to another or from a child to a parent. 42 U.S.C. § 1396a(17)(D).

⁴⁹ 42 C.F.R. § 435.831(d)(e)(1), Cal. Code Regs. tit. 22, §§ 50555, 50555.2.

⁵⁰ Cal. Code Regs. tit. 22, §§ 50653.3, 50653.5.

⁵¹ Welf. & Inst. Code § 14005.12, Cal. Code Regs. tit. 22, §§ 50603

⁵² MNIL or MNL levels are shown in the Health Consumer Alliance chart at:

<http://healthconsumer.org/cs012FPLchart.pdf>.

increases. The amount by which the countable income exceeds the MNIL represents the person's share of cost:

$$\text{Countable Income} - \text{MNIL} = \text{Share of cost}$$

Sneede/Gamma Rules

Under federal Medicaid law, income can be deemed only from a parent to a child or from a spouse to another spouse.⁵³ In determining the Medi-Cal eligibility of one child, you can count some of the income of a parent but you cannot count the income of a brother or sister. Instead, you use the Sneede and Gamma rules discussed at the beginning of this chapter.⁵⁴

Family Budget Unit

Medi-Cal Family Budget Units are discussed at the beginning of this chapter and are obviously important in determining whether a family or individual has a share of cost and how high that share of cost is. In terms of whose income is counted, the Medi-Cal applicant or recipient and the income of that person's spouse, or if under 18, the income of that person's parent if living in the same house are all included in determining the income. Income and resources belonging to persons other than the spouse or natural/adoptive parents are not counted when determining Medi-Cal eligibility or share of cost for anyone applying to receive Medi-Cal benefits.⁵⁵

Advocacy Tip ► The portion of income of a Medically Needy or Medically Indigent person or a person responsible for the MFBU which is counted in determining the eligibility of a spouse, parent or child as a public assistance recipient shall be deducted. In other words, if the Medically Needy/Indigent person's income was used for determining a family member's eligibility for a public assistance program, that same income should not be counted again toward determining the Medically Needy/Indigent person's eligibility. Public assistance includes SSI. Second, remember that a child living in the same home as his or her parents even if they have their own children living there as well are still in the same MFBU as their parents. Cal. Code Regs. tit.22, § 50555.1(a); Cal. Code Regs. tit.22, § 50068; ACWDL # 95-07 (Jan. 25, 1995).

Meeting the Share of Cost

Individuals can meet their share of cost by paying for medical goods and services, by incurring medical expenses even if those bills have not yet been paid, or by presenting old medical bills that the person or the family is obligated to pay.⁵⁶ These expenses may be medical expenses of the individual, a family member, or financially responsible relative that are not subject to payment by

⁵³ 42 U.S.C. § 1396a(a)(17)(D), 42 C.F.R. 436.602(a)(1).

⁵⁴ 728 F. Supp. 607 (N.D. Jan. 5 1990).

⁵⁵ ACWDL # 96-31 (Jun. 10, 1996).

⁵⁶ Cal. Welf. & Inst. Code § 14054. The easiest to read explanation of how to apply old and current medical bills toward a share of cost can be found in Article 10R of the Medi-Cal Eligibility Procedures Manual.

a third party.⁵⁷ Once the share of cost is met for the month, the beneficiary is certified for Medi-Cal as of the first day of that month.⁵⁸

The medical goods and services that a person pays for to meet their share of cost do not have to be services that are covered under Medi-Cal.⁵⁹ The services may also be services that Medi-Cal could cover, but were provided by a non-Medi-Cal provider.⁶⁰ However, the bill may not be for services that are subject to payment by the Medi-Cal program.⁶¹

The services only need to be things that the doctor has ordered as medically necessary. Federal law states that payments for medical services not covered by Medi-Cal should be deducted before those services which are covered by Medi-Cal.⁶² For example, a beneficiary could pay for medically necessary occupational therapy which Medi-Cal would not cover under its two visits per month service limitation.⁶³ This bill should be deducted first from the share of cost leaving other bills that can then be covered by Medi-Cal. This also applies for over the counter medications and supplies that are medically necessary.⁶⁴ The beneficiary will need to ask her doctor to write out a prescription for the services and supplies that are needed. The supplies should then be purchased at the pharmacy window and the pharmacist should be given the BIC card and asked to enter the information in the point of service (POS) system. Alternatively, if the beneficiary wants to apply an unpaid bill to a future month's share of cost, she should hold onto the provider's bill for the medical services and not apply the cost of the service to this month's share of cost.

A beneficiary may meet her share of cost by using an old bill that she is still obligated to pay or she can use a bill from the current month that she may have paid but not previously applied to her share of cost. Old bills from previous months can only be applied to a share of cost to the extent that they are still unpaid.⁶⁵ An old bill can be from services obtained before the individual was enrolled in Medi-Cal, but except in certain circumstances, the bill cannot be more than four years old.⁶⁶ It can also be from a collection agency, rather than directly from the provider.⁶⁷ These bills must be taken to the county eligibility worker. A Medi-Cal provider cannot apply them to the beneficiary's share of cost.⁶⁸ The bill must be the original, have a billing or rebilling date within the last 90 days, include the provider's name and address, include the provider's Medi-Cal ID, taxpayer ID or license number, include the name of the person who received the service and include the type and date of service.⁶⁹ Please note that beneficiaries may have difficulty if they charge the services on

⁵⁷ 42 C.F.R. § 435.831(d).

⁵⁸ Medi-Cal Eligibility Procedures Manual, Article 10R-17.

⁵⁹ 42 C.F.R. § 435.831(e)(2). Med-Manual, 100-28 (share of cost). See *Johnson v. Rank*, F.R.D. 99 (N.D. Cal 1986), Medi-Cal Eligibility Procedures Manual, Article 10R-8.

⁶⁰ Medi-Cal Eligibility Procedures Manual, Article 10R-8.

⁶¹ Medi-Cal Eligibility Procedures Manual, Article 10R-5.

⁶² 42 C.F.R. § 435.831(h)(1).

⁶³ 42 C.F.R. § 435.831(e)(3).

⁶⁴ If the item or service requires a prescription, Medi-Cal will presume that it's a bona fide medical expense. If it does not normally require a prescription, this presumption does not apply. Medi-Cal Eligibility Procedures Manual, Article 10R-4.

⁶⁵ Medi-Cal Eligibility Procedures Manual, Article 10R-1.

⁶⁶ Medi-Cal Eligibility Procedures Manual, Article 10R-8-R-9.

⁶⁷ Question 4, ACWDL # 90-80 (Aug. 20, 1990).

⁶⁸ Medi-Cal Eligibility Procedures Manual, Article 10R-15.

⁶⁹ An original bill is one prepared by the provider. It may not be the first billing for the service. ACWDL # 90-45 (May 16, 1990). A photocopy may be acceptable if it a provider stamp, signature, or other documentation attest to

a credit card because Medi-Cal assumes that any payments made to the credit card company were for the medical bill.⁷⁰ However, if everything else fails, it is possible to validate an old bill by a sworn statement.⁷¹ A beneficiary may use old bills to satisfy a share of cost in a previous month if the bill is for services provided in a month previous to the month in which she wants to meet the share of cost.⁷² If a beneficiary is trying to get payment for medical services more than a year previous and she had a share of cost at that time, she may need to get a provider to complete a special form MC 180-2 to show that the share of cost was satisfied.⁷³

Beneficiaries can also apply any co-payments that they had to pay for outpatient services, emergency room visits, or prescription drugs toward their share of cost. However, if the beneficiary has paid these expenses, they may only be applied to satisfy the share of cost in the same month in which the services or medical items were received.⁷⁴ *Paid* bills can only be used to satisfy the share of cost in the month in which the expenses were incurred, even if this means applying the expense to a share of cost in a previous month.⁷⁵

Generally, a beneficiary may not apply a bill to a future month's share of cost.⁷⁶ However, counties have the discretion to accept old medical bills for application toward a share of cost one month in advance.⁷⁷

Beneficiaries cannot use the same unpaid amount of a bill twice to meet their share of cost.⁷⁸ Nor can a beneficiary use interest charged on an unpaid bill toward the share of cost.⁷⁹ However, if the bill is large enough to cover more than one month of the share of cost, the extra amount can be applied to the share of cost in the succeeding months.⁸⁰

Advocacy Tip ► If a beneficiary does not expect to have monthly health care expenses that will exceed her share of cost and thus make her Medi-Cal eligible for the month, she may be smart to avoid using her Medi-Cal card for the month and saving unpaid bills to apply to the share of cost in a later month. This can save the beneficiary money in a later month when she expects to have higher health care expenses.

its accuracy. Questions 1 & 2, ACWDL 90-80 (Aug. 20, 1990), Medi-Cal Eligibility Procedures Manual, Article 10R-6.

⁷⁰ See Question 3, ACWDL # 90-80 (Aug. 20, 1990) and Medi-Cal Eligibility Procedures Manual, Article 10R-9-R-10 for using medical expenses charged to a credit card.

⁷¹ Question 2, ACWDL # 90-45 (May 16, 1990), Question 5, ACWDL # 90-80 (Aug. 20, 1990), CCH Medi-CAL GUIDE NEW Dev. 7232, Medi-Cal Eligibility Procedures Manual, Article 10R-12.

⁷² Medi-Cal Eligibility Procedures Manual, Article 10R-5.

⁷³ ACWDL # 01-14 (Oct. 31, 2001), Medi-Cal Eligibility Procedures Manual, Article 10R-5.

⁷⁴ Medi-Cal Eligibility Procedures Manual, Article 10R-2.

⁷⁵ Medi-Cal Eligibility Procedures Manual, Article 10R-2.

⁷⁶ Medi-Cal Eligibility Procedures Manual, Article 10R-7.

⁷⁷ Medi-Cal Eligibility Procedures Manual, Article 10R-7.

⁷⁸ Question 5, ACWDL # 90-45 (May 16, 1990), Question 3, ACWDL # 90-80 (Aug. 20, 1990).

⁷⁹ Question 6, ACWDL # 90-45 (May 16, 1990), Medi-Cal Eligibility Procedures Manual, Article 10R-10.

⁸⁰ ACWDL # 90-11 (Jan. 19, 1990), CCH Medi-Cal GUIDE New Dev. 7139. See also ACWDL # 93-63A (Aug. 27, 1993), ACWDL # 93-74 (Oct. 15, 1993), Medi-Cal Eligibility Procedures Manual, Article 10R-7-R-8.

Third Party Payment of Medical Expenses

It is not uncommon for a regional center or a relative to pay a portion of a person's medical expenses. Some of these bills paid by a third person can be used to meet a beneficiary's share of cost since a share of cost can be met by "incurring" the bill. The logistics of how this is done are important so that the payment does not count as income or in-kind income for the client. In-kind income includes in-kind housing, utilities, food, or clothing.⁸¹

For example, if a beneficiary's brother gives her money instead of paying the bill directly, she must report it and count it as income, so his payment has left her no further ahead. If, on the other hand, the brother pays the medical bill directly, that payment does not count as income to the beneficiary and it can be used to meet her share of cost.⁸² The client should submit the bill to the county to meet her share of cost prior to having the brother pay the healthcare provider for the services. If a regional center reimburses the client for their Medi-Cal share of cost, rather than paying the money directly to the provider it does not count as income because it is state-funded assistance based on need.⁸³

Slightly different rules apply to individuals who are eligible for both Medi-Cal and Medicare (called dual eligibles). Those individuals receive their prescription drugs through Medicare Part D. They may be able to use their co-payments for medications toward their share of cost, but they cannot use the amount paid by the Medicare Part D plan for their prescription drugs toward the share of cost for the month. In addition, for those individuals who are dual eligibles, payments made by the AIDS Drug Assistance Program (ADAP) can no longer be used to satisfy the share of cost. However, ADAP payments may still satisfy the share of cost of individuals who have Medi-Cal, but not Medicare.

Non-Medical Bills: Care Management Bills, Transportation, etc.

Case management is a recognized Medi-Cal service and expenses from that service should be allowed to meet a share of cost. If the case manager is not a Medi-Cal provider, the bill can still be submitted to meet the share of cost. Transportation to and from the doctor's office can also be a Medi-Cal covered service, and thus there is a valid argument that it be used toward a person's share of cost. Getting a county to recognize these expenses as applicable to a person's share of cost may require a fair hearing.

Using Bills from Other Family Members

Bills used to meet a person's share of cost may include medical bills from other family members and financially responsible relatives, even if those individuals are not eligible for Medi-Cal.⁸⁴ For example, if a child is covered under Medi-Cal as Medically Needy with a share of cost, the

⁸¹ Cal. Code Regs. tit. 22, § 5059.

⁸² 20 C.F.R. § 416.1103(a)(1). The money that the brother pays directly to the provider is unavailable income. Cal. Code Regs. tit. 22, §§ 50513, 50515.

⁸³ Cal. Code Regs. tit. 22, § 50528(b).

⁸⁴ 42 C.F.R. § 435.831(d); Medi-Cal Medical Services Provider Manual at 100-25.

parents' or a caretaker relative's medical bills will count to reduce the child's share of cost. Family budget units should receive share of cost summary letters which list the responsible relatives and ineligible persons whose bills count toward the share of cost.⁸⁵ Also, if the family pays a medical bill for a child who is on the Federal Poverty Level Program, you can count that bill against the share of cost for other members in the Medically Needy Medi-Cal Family Budget Unit.

Share of Cost Rules for Nursing Facility Residents

Different rules apply for individuals who are in long term care facilities. If a member of the MFBU is in a long-term care facility, the share of cost is determined by first looking at the countable income.⁸⁶ To the countable income, the deductions that are normally taken from nonexempt income are added back into the income.⁸⁷ Then apply the deductions available to all medically needy and medically indigent MFBU's.⁸⁸ This net nonexempt income amount is then rounded off to the nearest dollar amount.⁸⁹ The share of cost will be the difference between this amount and the maintenance need amount, usually \$35—if the individual will be in the facility for the entire month, for a person in long-term care.⁹⁰

A Medi-Cal beneficiary in long-term care can obtain a physician's prescription or order for a non-medical or remedial drug or service and have the cost of that item applied to her share of cost.⁹¹ People in a licensed board and care facility may apply incurred personal care services to their share of cost.⁹² For additional information on this topic, please see Chapter 21.

Practically, How a Share of Cost Works

With limited exceptions of some newly eligible beneficiaries, Medi-Cal beneficiaries receive a plastic Beneficiary Identification Card (BIC). Those who have a share of cost can use this card as payment only after they have met their share of cost obligations. Most Medi-Cal providers will have Point of Service (POS) devices or computer systems to verify the status or status can be verified via telephone.

When a healthcare provider swipes the card through the POS device, the provider will see a message indicating whether the beneficiary has an outstanding share of cost for that month. If the beneficiary is meeting her share of cost by paying or agreeing to pay the Medi-Cal provider for the services she is about to receive, the provider can enter this information and receive a confirmation that the share of cost has been met or partially satisfied. However, if the beneficiary wishes to meet her share of cost by using paid or unpaid bills from a healthcare provider, then she must take these bills to her eligibility worker at the county welfare office where the worker can manually clear the share of cost in the MEDS system. Healthcare providers cannot clear a share of cost for old bills or services in previous months.

⁸⁵ Medi-Cal Medical Services Provider Manual at 100-28-11, 100-25-9.

⁸⁶ Cal. Code Regs. tit. 22, § 50653(a)(2)(A).

⁸⁷ Cal. Code Regs. tit. 22, §§ 50653(a)(2)(B), 50547-50554.

⁸⁸ Cal. Code Regs. tit. 22, §§ 50653(a)(2)(C), 50555.1-50555.4.

⁸⁹ Cal. Code Regs. tit. 22, § 50653(a)(2)(D).

⁹⁰ Cal. Code Regs. tit. 22, §§ 50653(a)(2)(F), 50605.

⁹¹ *Johnson v. Rank*, ACWDL # 89-54 (July 24, 1989).

⁹² *Pettit v. Bontá*, ACWDL # 00-56 (Nov. 15, 2000).

Incorrect Share of Cost or Refusal to Apply Certain Bills to Share of Cost

A Medi-Cal beneficiary should receive an eligibility notice which states the amount of her share of cost. She should also receive a notice anytime the amount of her share of cost is changed. If either of these amounts is incorrect, she has the right to request a fair hearing.

If the county refuses to apply a particular bill to a beneficiary's share of cost the beneficiary should ask for a notice of action that includes the reason Medi-Cal will not allow the cost and the authority for not allowing it. The beneficiary should then ask for a fair hearing to challenge the denial. If the county refuses to provide a notice of action, the beneficiary can still file an appeal based on the county's refusal to provide a notice of action and disallowance of a medically necessary service or item.

For more information on notices and appeals, see Chapter 19.
