Chapter 7: About the Different Medi-Cal Programs

Individuals or families may qualify for healthcare coverage through a variety of Medi-Cal programs. Some of these programs have similar basic eligibility requirements, but each varies in regard to the personal characteristics of recipients or the maximum income and assets allowed under the particular program. Eligibility for Medi-Cal should be approached by using the hierarchy described below to qualify beneficiaries for the program that is most comprehensive or provides coverage with the fewest barriers. A list of aid codes for each of these categories is available in Part 1 of most of the Medi-Cal provider manuals. If a beneficiary is not eligible at all for Medi-Cal, there may be other publicly-funded programs for which she does qualify. These additional programs are discussed in Chapter 17.

If an individual is found to be no longer eligible for her current Medi-Cal program, a county must assess her eligibility for other categories of Medi-Cal before terminating her Medi-Cal coverage. The SB 87 process for assessing a beneficiary’s eligibility for another Medi-Cal program is described at the end of this chapter.

Automatic Eligibility through Cash Related Programs

Those individuals or families who receive any dollar amount of CalWORKs, SSI/SSP, Foster Care or Adoption Assistance, IHSS, Cuban-Haitian Entrant and Refugee Cash Assistance benefits automatically receive full Medi-Cal benefits as well. No separate application for Medi-Cal is required in addition to the application for these benefits.

CalWORKs California Work Opportunity and Responsibility to Kids (CalWORKs) is California’s cash assistance program to low-income families with children. California established the CalWORKs program to conform the state's welfare system to the federal requirements of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). PRWORA eliminated the Aid to Families with Dependent Children (AFDC) entitlement program and replaced it with the Temporary Assistance to Needy Families (TANF) program.

---

1 To get started on finding the appropriate Medi-Cal program for an individual or a family, a helpful resource is the set of Medi-Cal Eligibility Flowcharts on the Health Consumer Alliance Web site at: [http://healthconsumer.org/cs041/Medi-CalFlowChart.pdf](http://healthconsumer.org/cs041/Medi-CalFlowChart.pdf).

2 The hierarchy of Medi-Cal programs and the order in which applications should be reviewed for programs may be found in ACWDL 01-18 (Mar. 16, 2001), modified by ACWDL 06-41 (Dec. 29, 2006).

3 The Medi-Cal provider manuals are available online at: [www.dhcs.ca.gov/ProvGovPart/Pages/BulletinsManuals.aspx](http://www.dhcs.ca.gov/ProvGovPart/Pages/BulletinsManuals.aspx). In most of these manuals, under Part 1—Medi-Cal Program and Eligibility, a chapter entitled “Aid Codes Master List” is available and generally kept up-to-date.


5 42 U.S.C. § 1396a(a)(10)(A)(i)(II); 42 C.F.R. § 435.120.


7 Cal Code Regs. tit. 22, § 50145(a).


Families receiving CalWORKs are automatically eligible for Medi-Cal under Medi-Cal's cash-based 1931(b) program described in section two of this chapter. Families eligible for but not receiving CalWORKs are also eligible for Medi-Cal under the “1931(b) only” category. Most families will remain eligible for a category of Medi-Cal after they leave CalWORKs through transitional Medi-Cal or another category described below.

For more information on CalWORKs, visit www.dss.cahwnet.gov/CDSSWEB/PG85.htm or contact the county welfare department.

In Home Supportive Services (IHSS) In Home Supportive Services helps to pay for in home services so that an individual can remain at home instead of being placed in a nursing home or board and care facility. Eligible individuals must be over 65 years of age, or disabled or blind. Individuals receive Medi-Cal benefits automatically if they receive IHSS. IHSS services are tailored to the individual's needs and may include domestic services, personal care services, accompaniment to services, protective supervision, heavy cleaning, and other services.

For more information on IHSS visit www.cdss.ca.gov/agedblinddisabled/PG1296.htm, contact the local IHSS office located at the county welfare department or read the publications available through Protection & Advocacy’s Web site at www.pai-ca.org/issues/inhome_pubs.html.

Foster Care and Adoption Assistance Children who receive foster care checks are automatically entitled to Medi-Cal. A beneficiary may receive cash benefits through a variety of federal and state foster care programs including federal Foster Care, Adoption Assistance Payments, SSI, CalWORKs, and the Kinship Guardianship Assistance Payments (Kin-GAP). Some children in Foster Care and the Adoption Assistance Program receive cash-related Medi-Cal while some receive their Medi-Cal coverage through the Medically Indigent program. Even if a child does not request actual adoption assistance payments, she may still receive Medi-Cal.

Since the county foster care agency is responsible for ensuring that the health care needs of children under its supervision are met, a child in foster care should be granted expedited Medi-Cal eligibility upon removal from her home so she can quickly access any needed health care. In other words, the county should process the Medi-Cal application for a foster child much faster than the 45 days required under state and federal law. In addition, if a child was already on Medi-Cal when s/he was removed from the home, but does not have access to his/her Medi-Cal card, the county must issue immediate proof of Medi-Cal eligibility at the request of the child's authorized representative, usually her foster care worker or foster care parent.

Immigrant children in foster care should also get full scope Medi-Cal. Children who are either qualified immigrants or permanently residing under color of law (PRUCOL) are eligible for

---

12 Section 1931(b) is codified at 42 U.S.C. § 1396u-1(b). Under this section, many families that would have been eligible for cash assistance under AFDC, but are not eligible under TANF, nevertheless remain eligible for Medicaid coverage.
13 42 C.F.R. § 435.145.
14 42 U.S.C. §§ 672 (Foster Care), 673 (Adoption Assistance) 1396a(a)(10)(A)(i)(I), (II); Cal. Welf. & Inst. Code §§ 11366 (Kin-GAP), 11380.4 (Kin-GAP Plus); Cal. Code Regs. tit. 22, §§ 50145(a), 50227.
16 ACWDL # 01-41 (July 25, 2001); Medi-Cal Eligibility Procedures Manual 4J-1.
17 See the immigrants and health care brochure at www.healthconsumer.org.
full scope Medi-Cal if they meet all eligibility requirements.\textsuperscript{18} Undocumented children are eligible for restricted Medi-Cal benefits. However, undocumented children may be able to receive other necessary medical services from the county or through a county children’s health initiative (CHI), if available in the particular county.

**Former Foster Care Children (FFCC)** A child in Foster Care on her 18\textsuperscript{th} birthday retains eligibility for full-scope, no share of cost Medi-Cal benefits until age 21, as long as she maintains her California residency.\textsuperscript{19} There are no income or asset requirements but citizenship or satisfactory immigration status is required.

When the child is no longer eligible for Medi-Cal based on foster care status, the adolescent will be transferred to the FFCC program, without a new application, based on the foster care case files. All income and assets are waived even if the child returns to his/her parents’ home. California has elected to cover as many children as possible under this program including those on probation.\textsuperscript{20} The only exceptions are undocumented children, children who are incarcerated or in a facility classified as an institution for mental disease or IMD, and children in the Kin-Guardian Assistance Program.\textsuperscript{21} Under federal law an annual redetermination is required. However, because income and assets are waived, the redetermination need only include a status/address update and verification of desire to continue eligibility.\textsuperscript{22}

**Refugee Medical Assistance (RMA)/ Refugee Cash Assistance (RCA)** Individuals qualified as refugees by U.S. Citizenship and Immigration Services (USCIS) include people with refugee status as well as asylees, conditional entrants, Amerasian refugees, citizen children of refugees, Cuban/Haitian entrants, and victims of severe forms of human trafficking. Some needy refugees/asylees meet the eligibility requirements for CalWORKs or SSI and receive cash benefits under either of these programs, as well as Medi-Cal coverage.\textsuperscript{23} Most will not qualify for the CalWORKs or SSI programs, but if they meet the income and resource eligibility standards of these programs, they may receive special Refugee Cash Assistance (RCA) or entrant Cash Assistance (ECA for Cubans and Haitians) and Refugee Medical Assistance (RMA) during their first eight months in the U.S.\textsuperscript{24} The refugee program is fully funded by the federal government. Refugees who qualify for RCA, ECA, or RMA are automatically eligible for Medi-Cal.\textsuperscript{25} RMA can assist individuals who are not eligible for assistance under other programs including single individuals without a disability and couples without children because there is no linkage requirement.\textsuperscript{20} Individuals can apply for these programs at the local welfare office.

\textsuperscript{18} Cal. Code Regs. tit. 22, § 50301(b)(4).
\textsuperscript{20} ACWDL # 00-61 (Nov. 22, 2000), p.3.
\textsuperscript{21} ACWDL # 00-41 (Aug. 14, 2000), 00-61 (Nov. 22, 2000).
\textsuperscript{22} ACWDL # 00-61 (Nov. 22, 2000). Some health advocates are currently working to enable these beneficiaries to retain Medi-Cal eligibility under this program without annual redeterminations.
\textsuperscript{25} Cal Code Regs. tit. 22, § 50257(a).
\textsuperscript{26} Medi-Cal Eligibility Procedures Manual, 24B-3.
**Supplemental Security Income (SSI)** SSI is monthly cash assistance for people who are elderly, blind, or have a disability and who have little to no income for the basic needs of food, clothing, and housing. Those who receive Supplemental Security Income checks automatically receive Medi-Cal benefits. Aid codes 10, 20, and 60 are used to denote these beneficiaries. SSI beneficiaries are entitled to up to three months of retroactive coverage, like other Medi-Cal beneficiaries.

Persons receiving the state administered State Supplementary Payment Program (SSP) receive Medi-Cal automatically as well. SSP is a state program that supplements SSI payments to Medi-Cal beneficiaries. While SSI generally has an automatic cost of living adjustment (COLA), the amount of SSP does not increase automatically each year, but requires legislative action.

In 1996, as a part of the PRWORA, Congress narrowed the definition of eligibility for SSI Children. However the following year, Congress grandfathered in Medicaid eligibility for any child who was receiving SSI on August 22, 1996, and thereafter became ineligible because of the changed definition of disability. Children remain eligible for Medi-Cal if they would have been eligible for SSI but for the change in the definition of disability.

SSI is administered through the Social Security Administration and more information, including a brief online screening tool, can be found at [www.socialsecurity.gov/ssi/index.htm](http://www.socialsecurity.gov/ssi/index.htm) or by phone at 1-800-772-1213. A list of local Social Security Offices can also be found on the Social Security Web site.

**Section 1931(b) Medi-Cal**

Section 1931(b) Medi-Cal covers almost one-third of the Medi-Cal beneficiaries in California. It provides no cost Medi-Cal for CalWORKs beneficiaries as well as those families who do not receive CalWORKs but who would meet the income and resource standards for AFDC as it existed prior to “welfare reform.” Section 1931(b) also covers children who receive Title IV-E foster care maintenance payments or are eligible for adoption assistance, whether they receive payment or not. There is no time limit on receiving 1931(b). Children can receive it until they turn 21.

---

28 Technically, eligibility begins the month after the person applies for or is found eligible for Medicaid. HCFA Letter to State Medicaid Directors, May 2, 1997. However, this does not really affect SSI beneficiaries in California because these beneficiaries are still eligible as medically needy.
33 42 U.S.C. § 1396u-1(b). This category of coverage was created by Congress under Section 1931(b) of the Social Security Act, hence the name of the program.
34 The Federal Medicaid Act previously provided that AFDC beneficiaries automatically receive Medicaid benefits. 42 U.S.C. Sect 1396a(a)(10)(A)(i)(I). When Congress repealed the AFDC program and enacted the TANF program, TANF contained no similar automatic entitlement to Medicaid. Section 1931(b) was an attempt to preserve Medicaid eligibility for former AFDC beneficiaries. As noted earlier in this chapter, under CalWORKs, California’s TANF program, beneficiaries automatically receive Medi-Cal coverage under 1931(b) Medi-Cal.
35 The 60 month lifetime limit for adults on CalWORKs does not apply to Medi-Cal eligibility. If an adult loses eligibility for CalWORKs because she reaches this limit, she does not automatically lose her Medi-Cal, and she may continue to receive Medi-Cal. ACWDL #98-43 (Sept. 30, 1998), p. 2; Medi-Cal Eligibility Procedures Manual, 5S-
Chapter 7: About the Different Medi-Cal Programs

18 or until age 19 if they are enrolled in school. If family members lack a satisfactory immigration status, they may still be included in this program, but they would have only limited scope coverage.

To determine eligibility for 1931(b), linkage must be established, the family must meet the deprivation test and the family income and resources must fall below the program’s limits. Families must meet certain income and property rules to be eligible for 1931 Medi-Cal.

Advocacy Tip

Advocates should always check first to see if families and children are eligible for Section 1931(b) Medi-Cal and, if so, ensure that they are enrolled in this program. The advantage of section 1931(b) is that it provides for parental coverage, no share of cost, and transitional Medi-Cal if the family’s income goes up, in addition to more generous income deductions.

Section 1931(b) Income Eligibility for “Applicants” vs. “Recipients”

There is one set of income rules for “applicants” and a more generous set of rules for “recipients.” A recipient is defined as a person or family member who either received 1931(b) Medi-Cal or CalWORKs during the previous month or was eligible for CalWORKs or 1931(b) during one of the four months prior to the application for Medi-Cal. This means that a family whose income goes up and down can qualify as a recipient if their countable income dipped low enough in one of the preceding four months before applying for Medi-Cal to meet the 1931(b) income limits. Applicants include anyone who does not meet the definition of a recipient. This distinction is important since recipients can use more generous deductions to their income, and thus may have a higher income than applicants and still be eligible for 1931(b) Medi-Cal.

In determining income, various exemptions apply to both recipients and applicants. Exempt income includes:

- Public assistance payments (CalWORKs, CalWORKs diversion payments, foster care payments, general relief, SSI)
- Employment earnings of a child under 14 or under 19 if the child is a full-time student or a part-time student who is not employed full time
- College grants or scholarships
- Earned income tax credits
- Job Training Partnership Act (JTPA) payments

1. If she become ineligible for 1931(b) Medi-Cal, she must be assessed for Medi-Cal eligibility under another program, e.g. as a person with a disability.

36 ACWDL # 98-43 (Sept. 30, 1998). Most of the eligibility criteria initially promulgated in ACWDLs for the 1931(b) program has been consolidated in a more comprehensible form in Medi-Cal Eligibility Procedures Manual, Article 5S. A thorough explanation of MFBU determinations for the Section 1931(b) program may be found in the Medi-Cal Eligibility Procedures Manual, Article 8G.
37 ACWDL # 99-37 (July 16, 1999).
38 ACWDL # 99-37 (July 16, 1999).
• Payments from the California Franchise Tax Board (Renter’s Credit payments)
• Social service payments received under Title XX of the Social Security Act for child care, training and rehabilitation, and other services.

In addition to exempting certain income, 1931(b) also allows for income deductions. The deductions vary depending on whether the person qualifies as an “applicant” or as a “recipient” as defined above. For applicants, monthly deductions include:40

• $90 of earned income per working person
• Dependent care costs with a maximum of $200 per month per child under 2 years and $175 per month if the child is older than two
• Court-ordered child support or alimony paid by the applicant
• $50 in child support or alimony received by the applicant
• Educational expenses (including tuition, books, fees, supplies, travel and child care)
• Self-employed business expenses
• $240 for combined family disability-based income.

If the applicant family’s income, excluding exempt income and after these deductions, is at or below 100% FPL the family is eligible.41

Recipients benefit from the same deductions as applicants. DHCS refers to this test as “Alternative B.” If the family’s income is at or below 100% FPL they are eligible for 1931(b) Medi-Cal.42 If the family is still ineligible, they can use additional deductions to the family income. These additional deductions include:43

• All of the deductions above, except for the $90 earned income deduction
• Any unused portion of the $240 disability-based income deduction is applied to the combined earnings of the two highest earners44
• $120 deduction for each additional earner (if family of 3 or more)45
• And/or half of the remaining earned income.46

The remaining income after these deductions, which DHCS refers to as “Alternative A,” must be below the 1931(b) income limits set forth in the chart below.

40 See the Section 1931(b) budget worksheet at Medi-Cal Eligibility Procedures Manual 5S-14.
41 ACWDL # 00-04 (Jan. 14, 2000), p. 15.
44 “Disability based income” consists of Social Security Administration disability insurance payments and private disability benefits. Temporary Workers Compensation and State Disability Insurance Payments (SDI) are treated as earned income. ACWDL # 98-43 (Sept. 30, 1998), Attach. 1, p 2.
Countable family income must fall below the following limits. Recipients can use Alternative A or B. Alternative A works more favorably for recipients with more earned income. Alternative B works more favorably with unearned income. **Applicants may only use Alternative B.**

<table>
<thead>
<tr>
<th>Persons</th>
<th>Recipient Alternative A—CalWORKs MBSAC</th>
<th>Applicant Alternative B -- 100% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$398/mo $4,776/yr</td>
<td>$867/mo $10,400/yr</td>
</tr>
<tr>
<td>2</td>
<td>653 7,836</td>
<td>1,167 14,000</td>
</tr>
<tr>
<td>3</td>
<td>808 9,696</td>
<td>1,467 17,600</td>
</tr>
<tr>
<td>4</td>
<td>961 11,532</td>
<td>1,767 21,200</td>
</tr>
<tr>
<td>5</td>
<td>1,094 13,128</td>
<td>2,067 24,800</td>
</tr>
<tr>
<td>6</td>
<td>1,229 14,748</td>
<td>2,367 28,400</td>
</tr>
</tbody>
</table>

**Section 1931(b) Resource Limits**

In addition to income, eligible beneficiaries must also have resources below the property limit. Property limits vary with family size. For a family of one or two persons, the property limit is $3,000. For each additional person, add $150 in additional allowable property resources. Certain property is exempt including a home, clothing, and the first $4650 value of a car. When determining the value of a car, only the fair market value minus any encumbrances is counted. Cars used for self-employment, as a home, or to transport disabled family members are completely exempt. Lump sums are counted as property under the 1931(b) program.

---

47 ACWDL # 00-04 (Jan. 14, 2000), p. 17.
48 The amounts under Alternative B increase in April of each year. For the most up-to-date income limits, see the Health Consumer Alliance fact sheet, “Section 1931(b) Medi-Cal for Children, Parents & Caretaker Relatives” at, http://healthconsumer.org/cs0151931b.pdf.
49 Based on FPL figures effective 4/1/08-3/31/09. ACWDL 08-05 (Feb. 14, 2008).
51 Id.
52 ACWDL # 99-03 (Jan. 20, 1999). Note that ACWDL # 98-43 offers information about property in the 1931(b) program; however, ACWDL # 99-02 (Jan. 12, 1999) p. 8 expressly notes that the property rules in attachment 2 to that earlier ACWDL should be disregarded.
53 ACWDL # 99-03 (Jan. 20, 1999).
54 ACWDL # 99-03 (Jan. 20, 1999).
55 ACWDL # 99-20 (May 7, 1999), pp.11-12.
If the child or family is still not eligible and one of the children has her own income or there is income attributable to a stepparent, review the Sneede/Gamma rules in Chapter 5 to determine whether applying those rules may allow for income eligibility.

**Deprivation and the 100-Hour Rule**

In addition to meeting the income and property rules for 1931(b), a family in the 1931(b) program must include a child who is considered “deprived.” This means that at least one of the child’s parents is absent, deceased or disabled, or that the principal wage earner is unemployed or underemployed. The number of hours the principle wage earner can work and still be considered unemployed or underemployed depends on whether the family is an applicant or a recipient as defined above.

For applicants in families in which the deprivation is based on an unemployed or underemployed parent or caretaker, the primary wage earner (PWE) may work no more than 100 hours in a month, or if the PWE works 100 hours or more, the family’s countable earned income after deductions must be at or below 100% of FPL. The primary wage earner for those categorized as recipients may work any number of hours a month as long as the family remains income eligible.

**Children’s Programs**

If children are not eligible for 1931(b), see above, they may be eligible under one of a number of other Medi-Cal categories including the percent programs.

**Percent Programs** The percent programs provide Medi-Cal coverage for pregnant women and children up to age 18; however, the income level for the program depends on the child’s age. Income eligibility for each age range has a maximum limit which is based on a percentage of the federal poverty level, hence the collective name of the programs. The percent programs are sometimes referred to the Asset Waiver or Income Disregard program depending on the group that is covered. For all of the percent programs, children must be citizens or have satisfactory immigration status to receive full coverage. Children without satisfactory immigration status receive only emergency medical treatment and, in the 100% program, pregnancy-related services.

**200% Program** The 200% program is the most generous of the percent programs and provides full-scope Medi-Cal for pregnant woman and infants up to age 1 who have family income below 200% FPL.

---

60 Cal. Code Regs. tit. 22, §§ 50262.5(c)(1), 50262.6(c)(1).
If, at age 1, the child is an inpatient for continuous care that began before the child’s first birthday and the family income is at or above 200% FPL, the child can retain coverage through the end of the inpatient stay. Upon discharge the child should be evaluated for eligibility under another Medi-Cal category, including the 133% program.

For information on determining eligibility for the pregnant woman, see the following section on pregnancy-related programs.

133% Program The 133% program provides Medi-Cal coverage for children from age 1 through age 5 if the family income is at or below 133% of the Federal Poverty Level.

100% Program The 100% program provides Medi-Cal coverage for children age 6 through 18 if the family income is at or below 100% FPL.

Determining Eligibility under the Percent Programs

When determining whether the family is income eligible advocates should first look for any applicable deductions. If the family has earned income, they may deduct:

- $90 in earned income per working person
- Child care costs (which are subtracted from earned income with a maximum of $200 per child under 2 years or $175 if the child is older or disabled)
- Court-ordered child or spousal support paid by the beneficiary
- $50 in child support or alimony received by the beneficiary
- Certain student loans
- Education expenses
- Income allocation for any child excluded from the MFBU
- Income used to determine Public Assistance for another family member
- Self employed business expenses (choice of 40% of income or the actual expenses).

The health insurance premiums or deductions that apply solely to persons who are aged, blind or disabled cannot be deducted from earned income.

Property for the percent programs is irrelevant, only income matters. Therefore, applicants for this program do not have to provide any information about assets.

This program provides coverage with no share of cost. Pregnant women and children covered in the percent programs, or other Medi-Cal categories, may not be charged deductibles,

---

63 Cal. Code Regs. tit. 22, §§ 50262.5(a)(2), 50262.6(a)(2).
65 Cal. Code Regs. tit. 22, §§ 50262.5(a)(2), 50262.6(a)(2).
coinsurance, or co-payments. It is also important to note that when determining the family size, a pregnant woman counts as two persons.

Advocacy Tip ► A family cannot “spend down” to qualify a pregnant woman or the children for the zero share of cost percent programs, even if they are only a couple of dollars over the applicable Federal Poverty Level. However, any income a parent or caretaker relative puts in a “cafeteria plan” through the workplace to cover child care costs or medical expenses is not counted as income under the percent programs.

If one person in the family qualifies under a percent program, this does not make the whole family eligible. However, other family members may be eligible for other Medi-Cal programs, including both free programs and those which include a share of cost. The family member enrolled in a percent program will be included in the Medically Needy budget unit for purposes of determining the Maintenance Need Income Level (MNIL) that is deducted from countable income. Also, children who are not eligible for free (i.e. no share of cost) Medi-Cal under 1931(b) or the percent programs may be eligible for Healthy Families if the family’s countable income is below 250% FPL. Healthy Families is described briefly in Chapter 17. Children with disabilities may qualify for disability linked Medi-Cal which is described later in this chapter.

Other Medi-Cal Programs for Children

Deemed Eligibility Infants born to a mother on Medi-Cal are automatically eligible for Medi-Cal for their first year. This is called “deemed eligibility.” Medi-Cal eligibility for newborns continues without regard to changes in family income or resources until the infant’s first birthday, as long as the infant continues to live with the mother. Deemed eligibility applies where the mother is in a Medi-Cal program with no share of cost or in a share of cost program and she met the share of cost in the month of birth.

Continuous Coverage for Children (CEC) In 2001, Medi-Cal established the CEC program so that children under age 19 living in California could continue to keep their no share of cost Medi-Cal until their next scheduled annual redetermination. CEC coverage continues for twelve months beginning with the month of eligibility. This is true even if a family’s income increases or there is a change in household composition that would otherwise make the child ineligible for Medi-Cal. CEC applies to children losing cash-based eligibility—including foster care, but it does not apply to children in the minor consent program. If deemed eligibility for an infant ends, CEC may continue

67 Cal. Code Regs. tit. 22, §§ 50262.5(c)(2), 50262.6(c)(2).
68 42 U.S.C. §§ 1396a(a)(2)(A), (a)(2)(B); 42 C.F.R §§ 447.53(b)(1), (b)(2). Note that proposed new federal regulations seek to allow states to impose cost sharing on beneficiaries where this was not previously possible. See e.g. 73 Fed. Reg. 9727-9740 (Feb. 20, 2008).
69 Cal. Code Regs. tit. 22, § 50030(b); State Medicaid Manual § 3311.1B (June 1990, Transmittal 45).
70 Cal. Code Regs. tit. 22, § 50262.3(b); ACWDL # 03-49 (Oct. 6, 2003).
71 ACWDL # 03-49 (Oct. 6, 2003).
to run. A county may move the child into another aid code or keep the child in the aid code he/she is already in during the twelve month period as long as the new aid code does not offer lesser coverage.

**Bridging Program** Children who no longer qualify for no share of cost (SOC) Medi-Cal but who appear to be eligible for the Healthy Families Program remain enrolled in Medi-Cal for an additional month to give the family time to complete the Healthy Families application process. Families with children that would only be eligible for Medi-Cal with a SOC must be offered the bridge to Healthy Families. The county must then forward the annual redetermination form, the SOC calculation worksheet, or the notice of action to the Healthy Families program for processing. Families can thereby avoid having to complete a separate application for the Healthy Families program.

A similar bridging program called the Healthy Families to Medi-Cal Presumptive Eligibility program (PE) offers families with children an additional period of Healthy Families coverage while an application for Medi-Cal is under consideration. Children who lose Healthy Families coverage at the Annual Eligibility Review (AER) because of a decrease in income will have their AER form sent to the appropriate county for an eligibility determination. Coverage under the HF to Medi-Cal PE program continues until a final Medi-Cal eligibility determination is made.

**Minor Consent Services** This program offers limited services to youth under 21 years of age who are unmarried and living with a parent or guardian or are claimed as a dependent. A minor’s eligibility for services is determined on the basis of the minor’s income and resources. These cases do not take into account parental income or assets and, as stipulated by state law, do not require parental consent or notification. If the child is already on Medi-Cal and receiving services through a managed care plan, she will be referred to her managed care plan for these services.

Minor consent services provide services for:
- Sexual assault
- Drug or alcohol abuse for children 12 years of age or older
- Pregnancy
- Family planning
- Sexually transmitted diseases for children 12 or older
- Mental health outpatient care for children 12 or older who are mature enough to participate intelligently and for whom the care is needed to prevent the child from seriously harming herself or others, or because the child is the alleged victim of sexual abuse or incest.

---

75 ACWDL # 03-49 (Oct. 6, 2003), p. 4.
76 Cal. Ins. Code §12693.98; ACWDL # 07-03 (Feb. 2, 2007), 07-09 (May 14, 2007). Note that this program is administered by MRMIB, not DHCS. Cal. Ins. Code § 12693.98(a)(2).
77 ACWDL # 07-03 (Feb. 2, 2007).
78 ACWDL # 07-03 (Feb. 2, 2007).
79 ACWDL # 07-15 (July 3, 2007).
84 Cal. Code Regs. tit. 22, § 50063.5; ACWDL # 94-63 (Aug. 8, 1994).
To apply, the minor must complete a “request for Eligibility for Limited Resources” in person at the county Medi-Cal office or at an outstation site.\(^{85}\) If the minor is requesting outpatient mental health services, she will have to bring a letter from a mental health professional saying she meets the criteria listed above.\(^{86}\) The child’s parents are not to be contacted regarding the child’s application nor informed that the application occurred.\(^{87}\) However, there is a requirement to involve the child’s parent(s) or guardian(s) for mental health outpatient services unless the mental health professional believes that their involvement would be inappropriate.\(^{88}\)

While other Medi-Cal beneficiaries receive a plastic card, Medi-Cal beneficiaries eligible only for minor consent services receive a paper card which will need to be verified by providers. The card, which is good for one year, contains a code reference to the authorized categories of minor consent services.\(^{89}\)

**Accelerated Enrollment** Children who complete the joint Medi-Cal/Healthy Families application, apply through the Single Point of Entry (SPE) and appear eligible for Medi-Cal receive immediate, accelerated enrollment. Accelerated enrollment begins on the first day of the month that the SPE receives the application and continues until the child is determined eligible for Medi-Cal or the end of the month in which the child is found ineligible.\(^{90}\)

**National School Lunch Program Express Enrollment** As of July 1, 2003, school districts participating in the National School Lunch Program, with a parent’s consent, can voluntarily agree to have information on the school lunch program application forwarded to the county for a Medi-Cal determination. These children receive full-scope Medi-Cal with no share of cost until a final determination is made.\(^{91}\)

**Pregnancy Related Programs**

To enable women to receive prenatal care promptly, California counties are expected to expedite the application process for pregnant women applying for Medi-Cal. This is based upon the principle that pregnant women have immediate need for health care.\(^{92}\) To qualify for Medi-Cal, a woman may need to obtain written verification of the pregnancy, or, under certain circumstances, she may self-declare her pregnancy.\(^{93}\)

---

\(^{85}\) Cal. Code Regs. tit. 22, § 50147.1(b); ACWDL # 94-63 (Aug. 8, 1994). Outstation sites are places such as clinics and hospitals, other than welfare offices, where a person may apply for Medi-Cal.

\(^{86}\) Cal. Code Regs. tit. 22, § 50147.1(c); ACWDL # 94-63 (Aug. 8, 1994).

\(^{87}\) See Cal. Fam. Code §§ 6920-6929 for a minor’s capacity to consent to these confidential services.

\(^{88}\) ACWDL # 94-63 (Aug. 8, 1994).

\(^{89}\) ACWDL # 97-29 (Jun. 23, 1997); Medi-Cal Eligibility Procedures Manual, 4V-3, 4V-5.

\(^{90}\) ACWDL # 02-36 (Jun. 19, 2002).

\(^{91}\) Cal. Welf. & Inst. Code § 14005.41; ACWDL # 03-07 (Jul. 8, 2003), 03-35 (Jul. 2, 2003). Some undocumented or PRUCOL women may receive pregnancy-related care under aid codes 58 or 5F which are termed “OBRA aliens.” ACWDL # 98-12 (Mar. 3, 1998).

\(^{92}\) Cal. Welf. & Inst. Code § 14148(e).

Presumptive Eligibility (PE) Program

The presumptive eligibility program enables a provider to “presume” a pregnant woman is eligible for Medi-Cal based on her answers to a few income and residency questions. To encourage early prenatal care, a woman can be presumptively enrolled into Medi-Cal through a qualified provider or clinic with the agreement that she will later complete an application for Medi-Cal. Medi-Cal will start immediately if the pregnancy is confirmed and the family income is not higher than 200% of FPL (counting the pregnant woman as two people.)

The beneficiary must then start the formal Medi-Cal application process by the end of the month following the month the temporary presumptive benefits started. If she applies for Medi-Cal or CalWORKs during the PE coverage period, then her PE coverage continues for another 60 days. If the county determines that she is eligible for Medi-Cal, she is removed from the presumptive eligibility program and placed in one of the other Medi-Cal programs. If her application for Medi-Cal is denied, her PE coverage ends at the end of the month in which she is found ineligible for Medi-Cal. If the PE recipient has good cause for not applying or following through on her Medi-Cal application, her provider should contact the PE Support Unit at 1-800-824-0088. It is important that beneficiaries follow through with the formal application process because women can only be determined presumptively eligible for Medi-Cal once for each pregnancy.

Whether or not her Medi-Cal application is approved, the provider is still reimbursed for the services provided during a woman’s presumptive eligibility time period, and the state receives federal matching funds. This program covers all ambulatory prenatal care services. It does not cover the costs of delivery, family planning or induced abortion procedures.
Income Disregard and Asset Waiver Program  
(200% Program for Pregnant Women)

Under the 200% FPL program, low-income pregnant women with incomes below 200% qualify for all pregnancy-related care. There is no share of cost for this program and beneficiaries cannot be charged co-payments or deductibles.

Pregnancy-related services are defined as services required to assure the health of the pregnant woman and the fetus. These include office visits, prenatal care, services for complications of pregnancy, lab tests, prescription medicine, anesthesia, labor and delivery, postpartum care and family planning services. This also includes important dental services for pregnant women, including exemption from the $1,800 limit on adult dental services.

Pregnancy-related services are available both for women who are citizens and for non-citizens who cannot prove satisfactory immigration status. For undocumented children and most other Medi-Cal beneficiaries, Medi-Cal coverage includes only emergency services and family planning services. However, restricted coverage for pregnant women also includes medically necessary pregnancy-related services. Coverage applies to care during the pregnancy and through the end of the month in which the sixty days after the end of the pregnancy occurs. As discussed above, pregnant women are entitled to presumptive eligibility so that there is no delay in receiving services.

If the family income is more than 200% but less than 300% FPL the pregnant woman may qualify for benefits under the “Access for Infants and Mothers” program which is described in Chapter 17 of this manual.

As with children enrolled in the 200% program, resources are not considered in determining eligibility, only income. Therefore, the value of cars, amounts in bank accounts, or other assets of the applicant are irrelevant to eligibility. For family size, the pregnant woman counts as two persons.

To determine countable income, add together unearned income plus gross earned income. Gross earned income is wages and salary before any deductions. For earned income, deductions include:

- $90 in earned income per working person
- Up to $200 a month in child care expenses for children up to 2 or $175 a month for children over two or disabled, court ordered child support or spousal support paid by the beneficiary

\[\text{103} \quad \text{42 U.S.C. §§ 1396a(a)(10)(A)(ii)(IV), (VI), 1396a(l)(1)(A); Cal. Welf. & Inst. Code § 14148(f); Medi-Cal Eligibility Procedures Manual, Article 5F. For a summary of the program and eligibility, see the Health Consumer Alliance issue brief at http://healthconsumer.org/cs027POP.pdf.}\]
\[\text{104} \quad \text{42 U.S.C. § 1396o(a)(2)(B); 42 C.F.R § 447.53(b)(2).}\]
\[\text{105} \quad \text{Medi-Cal Medical Services Provider Manual at 100-31-2.}\]
\[\text{106} \quad \text{Calif. Medi-Cal Dental Program Provider Manual at Section 4, pp. 4-3-4-5.}\]
\[\text{107} \quad \text{Cal. Welf. & Inst. Code § 14007.7.}\]
\[\text{108} \quad \text{42 U.S.C. § 1396a(e)(5); Cal. Welf. & Inst. Code § 14005.18.}\]
\[\text{109} \quad \text{Cal. Welf. & Inst. Code §§ 14148.7, 14148(e).}\]
\[\text{110} \quad \text{Cal. Code Regs. tit. 22, § 50030(b); State Medicaid Manual § 3311.1B (June 1990, Transmittal 45).}\]
\[\text{111} \quad \text{See Chapter 3 for the full list of income exemptions and deductions.}\]
• $50 in child support or alimony received by the beneficiary
• Certain student loans
• Educational expenses
• An income allocation for any child excluded from the MFBU\textsuperscript{112}
• Income used to determine public assistance for another family member
• Self-employed business expenses.

If a pregnant minor is not eligible for Medi-Cal without a share of cost under the normal income rules, all income and resources from the pregnant minor’s parent(s) should be disregarded when determining eligibility for the 200% program, even if the minor is living at home or is between the ages of 18 and 21 and is claimed by the parent as a tax dependent.\textsuperscript{113}

**Postpartum Programs**

Most women are covered for post-partum services under their regular Medi-Cal program. For women who received Medically Indigent Medi-Cal with a share of cost when they were pregnant, the 200% program offers coverage for at least 60 days after the pregnancy ends, meaning from the day the pregnancy ends until the last day of the month in which the 60\textsuperscript{th} day occurs.\textsuperscript{114}

**Programs for Seniors and People with Disabilities**

There are two Federal Poverty Level programs that cover persons with disabilities at low or no cost, the Aged & Disabled FPL program and the 250% Working Disabled program. Other programs including the Medically Needy program and the Medically Indigent program also provide much needed care to seniors and persons with disabilities. These programs are described in depth below.

**Aged and Disabled FPL Program (A&D FPL)**

Implemented in 2001, the A&D FPL program provides Medi-Cal with no share of cost to a person or a couple who is 65 or older or who is disabled (including minors).\textsuperscript{115} To qualify for the program the person must be elderly or able to show that she meets the Social Security definition of disability. Therefore, if she is a child, she must be able to show that she meets the child disability rules, or if she is an adult, that she cannot engage in any substantial gainful activity because of any medically determinable physical or mental impairment which can be expected to result in death or last at least twelve straight months.\textsuperscript{116} A person has met the definition of disability if she is receiving Social Security Disability Income (SSDI) or other Social Security Disability benefits. For a couple to

\textsuperscript{112} Cal. Code Regs. tit. 22, § 50558b; ACWDL # 04-25 (June 25, 2004); Medi-Cal Eligibility Procedures Manual 5K-21.

\textsuperscript{113} ACWDL 03-34 (Jun. 19, 2003).

\textsuperscript{114} 42 U.S.C. § 1396a(e)(5); Cal. Welf. & Inst. Code § 14005.18. Also see Medi-Cal Eligibility Procedures Manual, Article 5G for more information on this part of pregnancy-related care.


\textsuperscript{116} The more complete definition of “disability” for an adult can be found at 42 U.S.C. § 1382c(a)(3)(A), (B). The disability definition for a child may be found at 42 U.S.C. §1382c(a)(3)(C).
be eligible, both need to be either elderly and/or have a disability. In a single household, one individual may qualify for this program, while a spouse qualifies for the 250% Working Disabled program. If SGA is an issue, then the beneficiary should look for eligibility under the 250% Working Disabled program for which SGA is not relevant. Substantial Gainful Activity (SGA) is evaluated by the state when determining eligibility for this program.

Income levels after April 1, 2008 require that a person’s countable income be below $1097 for an individual or $1524 for a married couple. These income limits are based on the federal poverty level plus a $230 disregard for a disabled or aged individual or $310 for a couple. The countable income for couples cannot be lower than the SSI/SSP payment level for an individual or a disabled couple, which means that the income limit for couples in this program is frequently higher than 100% of the FPL plus the $310 disregard. Also, annual Social Security (Title II) cost of living adjustments (COLAs) which generally take effect with January are disregarded until the annual FPL increase goes into effect, which is usually in April. For children, the eligibility determination must include income which may be deemed from a parent.

To determine eligibility, Medi-Cal calculates the household’s total countable earned and unearned income. Medically needy income deductions apply except that the income of a stepparent is not counted. Deductions include:

- $20 from unearned income
- Health insurance premiums.

From earned income the following deductions apply:

- $65, any unused portion of the $20 deduction described above
- any impairment-related work expenses which are out-of-pocket expenses needed to become or remain employed (for example a specialized van, special clothing, attendant care services, transportation costs, medical devices, work related equipment, residential modification, etc.)
- plus half of any remaining earned income.

In addition, an applicant living in a board and care home may use the $315 personal care services deduction. A person cannot deduct IHSS expenses; however, IHSS caregiver wages paid

---

117 ACWDL # 01-18 (Mar. 16, 2001), 02-38 (June 28, 2002).
118 ACWDL # 00-68 (Dec. 29, 2000).
119 ACWDL # 02-38 (June 28, 2002). If SGA is an issue, then the beneficiary should look for eligibility under the 250% Working Disabled program for which SGA is not relevant.
120 Welf. & Inst. Code § 14005.40(c)(1); ACWDL # 00-57 (Nov. 14, 2000), 07-27 (Nov. 19, 2007). Note that the federal poverty level increases annual, usually reported in late January and applied to Medi-Cal programs in April. The income disregard amounts, however, are set by the statute and have not changed.
121 Welf. & Inst. Code § 14005.40(c)(1); ACWDL # 07-27 (Nov. 19, 2007).
123 See Chapter 3 for income deductions. The deductions available to a person in the ABD-MN program apply to beneficiaries of the A&D FPL Program. See ACWDL # 00-57 (Nov. 14, 2000), 02-38 (June 28, 2002). For examples of how income eligibility is determined, see the Health Consumer Alliance issue brief on this program, at http://healthconsumer.org/cs029AgedDisabled.pdf.
124 Cal. Code Regs. tit. 22, § 50555.2; ACWDL # 00-57 (Nov. 14, 2000).
to a spouse or a parent are exempt income. Also, it is important to note that married couples can only use the $20 and $65 and ½ deductions once.

If there are other family members who are not applying for this program, then some of the household income must be allocated to those family members. Once the household’s countable income has been calculated, deduct the maintenance need allowance (MNA) based on the number of family members in the household other than the person applying for the A&D FPL program. The maintenance need allowances are:

- 1 person, $600
- 2 persons, $750
- 2 adults, $934
- 3 persons, $934
- 4 persons, $1100
- 5 persons, $1259
- 6 persons, $1417
- 7 persons, $1550
- 8 persons, $1692.

If the resulting net income is below the applicable income limit for the A&D FPL program, then the person is eligible.

This program also has property limits. Exempt property includes a home, clothing, one car and certain other things, such as items necessary for self-employment or things that are used for the person’s job. Individual development accounts are also exempt. A & D FPL allows a maximum value for non-exempt property of $2000 for an individual or $3000 for a couple.

Ineligible beneficiaries may not spend down monthly income (as someone who is medically needy with a share of cost may) to become eligible. However, if a person is not income eligible for the A&D FPL program, she should be eligible under the Medically Needy program which likely will require a monthly share of cost. An undocumented person will qualify for only restricted services including emergency care and pregnancy related services. People in long-term care are not eligible for this program. Remember, a person should first try to qualify for Medi-Cal under 1931(b) or as a “Pickle” (described below) before obtaining eligibility for this category.

---

125 ACWDL # 01-18 (Mar. 16, 2001).
128 ACWDL # 04-24 (Jun. 25, 2004).
129 ACWDL # 00-57 (Nov. 14, 2000).
250% Working Disabled Program

This program provides full-scope Medi-Cal to working disabled individuals with countable income below 250% of FPL. Eligible persons must pay a premium based upon their income. A beneficiary must be eligible to receive SSI/SSP if earnings were disregarded; thus, an immigrant who is not eligible for SSI would not be eligible for this program at all. Persons must be U.S. Citizens or have satisfactory immigration status to qualify. Those with satisfactory immigration status include qualified aliens and those permanently residing under color of law (PRUCOL) only if they were lawfully residing in the U.S. and receiving SSI on August 22, 1996.

To qualify as disabled for the 250% Working Disabled program, an applicant must show that she meets the Social Security definition of disability. This can be done by showing that she: receives Social Security disability benefits; no longer receives Social Security disability benefits because she is working, but retains Medicare coverage because of continued disability; currently receives Medi-Cal or In-Home Support Services (IHSS) based on disability; or received Medi-Cal, IHSS, SSI or Social Security within the last 12 months and during that time was not determined to be no longer disabled. In addition, the applicant can qualify as disabled if she is determined by the Disability and Adult Programs Division (DAPD) of the Department of Social Services to meet Social Security’s definition of disability without taking into consideration earnings. Substantial Gainful Activity (SGA) is not a consideration in determining eligibility in this program.

In order for a disabled person to qualify for Medi-Cal under this program she must be working. Generally, this will be proved by paystubs or written verification from an employer. Working is defined as having any monthly earnings from work. This can also include earned in-kind income.

An applicant is income eligible if her countable monthly income after deductions is below 250% FPL. Generally, the SSI income counting rules apply with certain exceptions. However, ALL disability-based income is excluded and does not count toward countable income. This includes worker’s compensation, Social Security Disability Income, Veterans’ Benefits and state and private disability income. There is also a $20 deduction from earned or unearned income. Additional deductions apply to earned income. These include $65 from earnings plus any unused portion of the $20 deduction; any impairment related work expenses which are out-of-pocket expenses that the applicant needs to become or remain employed, and half of any remaining earned

---

131 ACWDL # 00-16 (Mar. 16, 2000), p. 2-4; Medi-Cal Eligibility Procedures Manual, 5R-1.
132 ACWDL # 00-16 (Mar. 16, 2000), p. 3-4, ACWDL # 00-51 (Sept. 27, 2000), p. 8-9.
133 ACWDL # 00-51 (Sept. 27, 2000), p. 6.
134 ACWDL # 00-16 (Mar. 16, 2000), p. 2; Medi-Cal Eligibility Procedures Manual, 5R-1.
135 HCFA, Dear State Medicaid Director Letter, March 9, 1998. This letter clarifies that states should use net income and apply SSI income disregards when determining eligibility under this program.
136 ACWDL # 00-16 (Mar. 16, 2000), p. 2; Medi-Cal Eligibility Procedures Manual, 5R-1.
income. In kind support and maintenance in this program is counted in a manner similar to SSI rules and differently than under other Medi-Cal programs.\textsuperscript{138}

Property limits also apply. For adults, only the property of the applicant and her spouse counts. Single adults cannot have more than $2,000 in countable property and married couples cannot have more than $3,000 in countable property. For children, only the applicant’s property and some of their parents’ property counts. The child (someone who is unmarried and not the head of the family, and either under age 18 or under 22 and a student attending school or a vocational training program) cannot have more than $2000. Exempt property for all applicants include the applicant’s home, clothing, one car, and certain other things necessary for self-employment or used on the job. There is a special property deduction for individual retirement accounts (IRA) or other retirement plans, including 401k plans, even if the applicant has access to the account.\textsuperscript{139}

All eligible persons must pay a monthly premium based upon countable income to receive Medi-Cal. The paid premium amount appears in MEDS in the same way as when a share of cost is met. For this reason, sometimes eligibility workers confuse the premium that is due with a share of cost that is owed. This program has no share of cost, so the amount due in MEDS for a person in this program is always the premium amount.\textsuperscript{140} The premiums are listed below:

<table>
<thead>
<tr>
<th>Countable Income</th>
<th>Premium for One Person</th>
<th>Premium for a Couple</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1-600</td>
<td>$20</td>
<td>$30</td>
</tr>
<tr>
<td>$601-700</td>
<td>$25</td>
<td>$40</td>
</tr>
<tr>
<td>$701-900</td>
<td>$50</td>
<td>$75</td>
</tr>
<tr>
<td>$901-1100</td>
<td>$75</td>
<td>$100</td>
</tr>
<tr>
<td>$1101-1300</td>
<td>$100</td>
<td>$150</td>
</tr>
<tr>
<td>$1301-1500</td>
<td>$125</td>
<td>$200</td>
</tr>
<tr>
<td>$1501-1700</td>
<td>$150</td>
<td>$225</td>
</tr>
<tr>
<td>$1701-1900</td>
<td>$175</td>
<td>$275</td>
</tr>
<tr>
<td>$1901-2100</td>
<td>$200</td>
<td>$300</td>
</tr>
<tr>
<td>$2101- up to 250% of FPL</td>
<td>$250</td>
<td>$375</td>
</tr>
</tbody>
</table>

\textsuperscript{138} Medi-Cal Eligibility Procedures Manual 5R-6-5R-7.
\textsuperscript{139} 20 C.F.R. § 416.1202; ACWDL # 00-16 (Mar. 16, 2000), p. 2; Medi-Cal Eligibility Procedures Manual, 5R-1.
\textsuperscript{140} ACWDL # 01-46 (Aug. 20, 2001).
A beneficiary may be terminated with notice if she fails to pay premiums for two consecutive months.\textsuperscript{141} Note that payments are sent to the state, and if payments are not made, the state, not the county terminates the person’s eligibility. However, the county must redetermine her eligibility for all other Medi-Cal categories prior to termination, as with any other Medi-Cal termination.

A beneficiary may request and receive retroactive Medi-Cal coverage for the three months prior to application, just as in other Medi-Cal programs. She will need to pay the premiums for any retroactive months if she wants those months covered.\textsuperscript{142}

Beneficiaries in the 250\% Working Disabled program are entitled to Medicare Part B buy-in like other Medi-Cal beneficiaries.\textsuperscript{143}

Some counties have attempted to deny eligibility for this program merely because the beneficiary turned 65. This is incorrect. The program does not contain an upper age limit.\textsuperscript{144} However, a beneficiary still may lose eligibility at age 65 for one of two possible reasons. A beneficiary receiving SSDI (exempt under this program) will be switched to Social Security Retirement benefits (not exempt) at age 65. Therefore, the beneficiary may lose income eligibility. Additionally, a person must be SSI eligible, except for earnings, under this program. If the beneficiary’s new Social Security Retirement benefits are higher than the current SSI maximum benefit for a similar beneficiary in her living circumstances, she would not be eligible for this program.

**Other Medi-Cal Programs for Seniors and People with Disabilities**

Seniors and people with disabilities may qualify for In Home Supportive Services (IHSS) or Medi-Cal Home and Community-Based Waiver Programs. These programs and eligibility for them are described in Chapter 8.

**Medically Needy**

States are not required to offer Medically Needy (MN) coverage, but if a state chooses to have a Medically Needy program it must be designed within certain parameters set by the federal government. Since the Medicaid Act was passed in the 1960’s, amendments to the Act which provide states with options for covering people in programs other than the Medically Needy program—and thus avoiding a share of cost—have proliferated. California has adopted many of the federal options, thus reducing the number of people in the state’s Medically Needy program as well as reducing a financial barrier to healthcare. For example, pregnant women may be eligible for a Medically Needy program, but they are also likely to be eligible for Medi-Cal’s 200\% program at no cost or for AIM which provides coverage for pregnant women with incomes between 200\% and 300\% with modest premiums.

\textsuperscript{141} Medi-Cal Eligibility Procedures Manual 5R-8-5R-9.
\textsuperscript{142} Medi-Cal Eligibility Procedures Manual 5R-9.
\textsuperscript{143} ACWDL # 00-51 (Sept. 27, 2000), p. 3.
\textsuperscript{144} See e.g. Q&A # 26 of ACWDL # 00-51 (Sept. 27, 2000), p. 8. Note also that DHCS worksheets and instructions for the worksheets for this program say to include the applicant’s Social Security retirement income.
The Medically Needy coverage is generally for people who do not receive cash assistance that would give them automatic Medi-Cal coverage (e.g. SSI and CalWORKs) because they have other earned or unearned income which makes their overall income too high to qualify for cash assistance. The Medically Needy program serves the same categorical groups as does full Medi-Cal. To be eligible for the Medically Needy program, individuals must be 65 years of age or older, disabled, blind, or be a parent or caretaker relative or children who meet the deprivation requirements. Those who have Medically Needy Medi-Cal may be eligible with or without a share of cost. A share of cost is the amount of health care expenses a beneficiary must incur before Medi-Cal begins to cover the beneficiary’s medical expenses in that month. Whether or not a recipient has a share of cost, and how much it is, is determined based on monthly family income. This term is further defined and an explanation of how to meet a share of cost is found in Chapter 5.

Before looking at the Medically Needy or the following Medically Indigent programs where there may be a share of cost, first check to see if the family or individual qualifies for one or more of the programs discussed earlier in this chapter, which could provide coverage without a share of cost for children.

**Medically Needy for the Aged, Blind and Disabled**

To qualify as aged, a person must be 65 years of age or older. To qualify as a person who is blind or with a disability, the applicant must be an adult or a child who meets the Social Security blindness or disability definition. The person usually meets the resource limits for Medi-Cal programs for aged, blind or disabled beneficiaries, but she has income that is too high for those other programs. Income in the Medically Needy program may be deemed from a parent (but not from a stepparent) if the applicant is a child who lives with her parent. Income may also be deemed from a spouse.

An applicant qualifies for no share of cost (SOC) or “free” Medi-Cal if her countable family income, which is income minus allowable deductions, is at or below the Medically Needy Levels listed below. In calculating income, only count the income of the person applying, the spouse if in the same household, or a parent if in the same household as a child applicant under the age of 18. Certain income is exempt, certain deductions are taken from income and special income rules apply in certain instances. These eligibility rules and how to meet a share of cost are described in Chapter 5.

If a parent or child in the family qualifies for Medi-Cal under the A & D FPL program, other family members may qualify for ABD-MN (or AFDC-MN). For determining the maintenance need level to subtract from the income of the other family members, the family member covered under

---

146 For general information about this program see the Health Consumer Alliance issue brief, “ABD Medically Needy Medi-Cal for Aged, Blind or Have Disabilities,” at: http://healthconsumer.org/cs044ABD-MN.pdf.
149 Note that Medically Needy Levels are also often referred to as Medically Needy Income Levels or MNLs or MNILs. These terms refer to the same thing.
the A & D FPL program would be included.\footnote{ACWDL # 00-57 (Nov. 14, 2000).} As with all categories of Medi-Cal, a person who is in the Medically Needy program should not be terminated from Medi-Cal until the county checks to see if she can qualify for another category of Medi-Cal eligibility.\footnote{Cal. Welf. & Inst. Code §§ 14005.31-14005.32.}
AFDC Medically Needy for Children, Parents, and Caretaker Relatives

This program covers children and youth under age 21 and some parents and caretaker relatives. Generally, children in families who do not qualify for 1931(b) Medi-Cal because the family income is too high may qualify for one of the percent programs and the parent(s) or caretaker relative may qualify for the AFDC linked Medically Needy Medi-Cal. Qualifying for this program relies on many of the rules for eligibility in the former AFDC program which pre-existed CalWORKs.

In order to qualify, a family must have a “deprived” child. Deprivation means that either one parent is absent or incapacitated or both parents are in the home but underemployed or unemployed. Under- or unemployed means that the principal wage earner of an applicant or recipient family with two able-bodied parents doesn’t work or works less than 100 hours in a given month in order to be eligible for AFDC-MN. The primary wage earner is the parent who, in the 24 months prior to the month of application or redetermination earned the most income. This 100 hour rule is waived, however, for all families with earned income at or below 100% of the federal poverty level. A child’s earned income is exempt when determining whether the principal wage earner is unemployed under the 100 hour rule. If a family is found to have a “deprived” child, Medi-Cal can potentially cover the child, deprived siblings, the unemployed parent and the other parent.

Children who do not meet the deprivation or other non-financial requirements of the AFDC-MN program are labeled as Medically Indigent (MI), but are otherwise treated as if they were AFDC-MN. Such children include 20 year olds and most 19 year olds (particularly those who are not enrolled in school, and thus are no longer eligible for 1931(b).) More information is provided on the Medically Indigent Program in the next section.

A beneficiary qualifies for the AFDC-MN program with no share of cost if her countable income is at or below the Maintenance Need Level (MNL) for a household of the size of her household. For more information on how to count the family income, see Chapter 3. To better understand how share of cost is calculated and a beneficiary may meet her share of cost, please see Chapter 5.

If a family is terminated from AFDC-MN because a parent works more than 100 hours a month, check to see if they could have been eligible for Medi-Cal through 1931(b). Recipients of 1931(b) can work more than 100 hours a month even with family income over 100% FPL. Also, if a family’s earnings would qualify the family for AFDC-MN with a share of cost, see if they qualify

---

155 Cal. Code Regs. tit. 22, § 50215(c).
159 See the discussion of the 1931(b) program earlier in this Chapter.
for 1931(b). Recipients of 1931(b) have much more generous earned income deductions, giving families free Medi-Cal at higher gross income levels. In addition, unlike 1931(b) families, families losing no share of cost AFDC-MN because of increased countable earnings do not qualify for Transitional Medi-Cal (TMC), which continues full Medi-Cal coverage for up to twelve months after losing 1931(b). Remember that if a family was receiving AFDC-MN Medi-Cal but was eligible for 1931(b), they should be treated as a 1931(b) recipient and are therefore entitled to the more generous income rules at redetermination.

**Medically Indigent**

The Medically Indigent program generally applies to pregnant women and children under 21 who do not meet the Medically Needy deprivation requirements. These include:

- Some children receiving foster care or who are eligible for Aid for Adoption of children
- Abandoned babies
- People between the ages of 21 and 65 in nursing homes who are there for short term care and are not disabled (under the Social Security definition) or individuals without satisfactory immigration status who are in need of long-term nursing home care.

The Medi-Cal Medically Indigent (MI) Program is sometimes confused with the Medically Indigent Adult (MIA) Programs found in a number of California counties. However, these county programs are not a part of the Medi-Cal program. The MIA programs are county healthcare programs to cover indigent adults who are not eligible for Medi-Cal programs, particularly childless, able-bodied adults.

A child may qualify for MI Medi-Cal if she is eligible for assistance under Aid for Adoption of Children. A child who is not living with a parent or relative, but is a financial responsibility of a public agency may receive MI Medi-Cal. This latter category includes some children in foster home placement, juvenile probation cases placed in foster care, or who are otherwise in out-of-home placements supported by public funds. Children who qualify under these two categories do not need to meet the property, income, citizenship, residence or institutional status requirements that otherwise apply to MI Medi-Cal beneficiaries.

The Medically Indigent Medi-Cal program applies to newborns voluntarily surrendered to a safe-surrender site through the safe arms program. Those infants are immediately covered by

---

160 Cal. Code Regs. tit. 22, § 50251. The MI categories of coverage largely represent groups of individuals not covered in the federal-state Medicaid program. Thus, California covers these individuals with state-only money. Note that the MI program existed before the Healthy Families program. For many children eligible under the MI program, Healthy Families may be another option.


164 Cal. Code Regs. tit. 22, § 50251(c).

Medi-Cal through the end of the following month.\textsuperscript{167} The purpose is to provide Medi-Cal coverage for health screening assessments and care until the child is reclaimed by the parent or other person who surrendered the child or until the child is established in the foster care system.

Non-elderly adults are only covered by the MI Medi-Cal program if they are in a skilled nursing facility or intermediate care or if they are pregnant and do not qualify for one of the other Medi-Cal categories.\textsuperscript{168} This category is used for a very few people requiring skilled nursing or intermediate care when there is no other category that fits. This may be because the person lacks satisfactory immigration status or is not expected to be incapacitated for a year or more and thus does not meet the definition of “disability.”\textsuperscript{169} The benefits for this program are limited. An individual enrolled in this program receives full scope Medi-Cal while in skilled nursing care or intermediate care, including retroactive coverage; however, her Medi-Cal does not cover acute care.\textsuperscript{170}

Coverage for the Medi-Cal MI program may or may not have a share of cost. The MI program pre-dates many of the Medi-Cal program expansions to cover beneficiaries in programs without a share of cost. Whenever possible, a beneficiary should be placed in a newer program with no share of cost.

**Transitional/ Continuing Medi-Cal Coverage**

When individuals become ineligible for one Medi-Cal program, they often qualify for Medi-Cal under another program already discussed in this chapter or under transitional or continuing Medi-Cal coverage.

**Transitional Coverage for People who Lose Cash Assistance**

**Transitional Medi-Cal (TMC)** TMC is no cost Medi-Cal for families who lose eligibility for free Section 1931(b) Medi-Cal or CalWORKs because the family has increased countable earnings.\textsuperscript{171} If the caretaker relative or principal wage earner’s earned income, increased hours or loss of earnings disregards makes the family ineligible for Section 1931(b) Medi-Cal, the family may be eligible for up to twelve months of transitional Medi-Cal.\textsuperscript{172} The family is eligible for the first six month period regardless of income if the family was eligible for Section 1931(b) Medi-Cal or CalWORKs for at least three out of the prior six months before termination.\textsuperscript{173} To be eligible the family must have a child under age 18 (or under age 19 if the child is enrolled in school and expected to graduate before her 19th birthday) living in the home.\textsuperscript{174} Medi-Cal coverage should continue with no interruption

---


\textsuperscript{169} Cal. Welf. & Inst. Code §§ 14005.4, 14007.65, 14052.

\textsuperscript{170} Medi-Cal Eligibility Procedures Manual, Article 19C.

\textsuperscript{171} 42 U.S.C. §§ 1396a(e)(1), 1396r-6; Cal. Welf. & Inst. Code § 14005.8; ACWDL # 90-32 (Mar. 30, 1990), 90-66 (June 28, 1990). Medi-Cal Eligibility Procedures Manual, Article 5B-3 through 5B-13 contains an analysis based on the statutes and the ACWDLs on the Transitional Medi-Cal Program (TMC).

\textsuperscript{172} Cal. Welf. & Inst. Code § 14005.8; Medi-Cal Eligibility Procedures Manual 5B-3.

\textsuperscript{173} Medi-Cal Eligibility Procedures Manual 5B-4.

\textsuperscript{174} Medi-Cal Eligibility Procedures Manual 5B-4. Note that it appears arguable whether this age limit should apply. This section of the manual is based on regulations that were never finalized. Current Medi-Cal regulations define a child as a person under age 21. Cal. Code Regs. tit. 22, § 50030. An ACWDL [# 90-66 (Jun. 28, 1990)] indicates
between the 1931(b) coverage and the TMC coverage. For the first six months, the family qualifies for TMC regardless of income.\textsuperscript{175} For the second six-month period, the family is eligible if the gross income, after allowable deductions for child care, is at or below 185\% of FPL.\textsuperscript{176}

To help families leaving cash aid for work obtain coverage under TMC, the county is required to provide individuals with simple and clear written information on TMC at the time Medi-Cal eligibility is granted and every six months.\textsuperscript{177} The notices must include the availability of TMC, how to ensure automatic coverage and the family’s responsibilities under TMC if aid is terminated for any reason; a form that the family can fill out and return to the county to start TMC coverage; the reporting requirements while the family is receiving TMC; whether TMC will be approved for the second six month period and if not, the reason(s) why; appeal rights and how to reapply for Medi-Cal.\textsuperscript{178}

If a family’s income decreases, the family may return to 1931(b) coverage. If family income continues to exceed 1931(b) limits after TMC is exhausted, children may qualify for another Medi-Cal category or Healthy Families. Parents and caretaker relatives should be reviewed for eligibility for Medi-Cal under another category such as a disability-related category.

If some family members lack a satisfactory immigration status, they may still be included in this program, but they would have only limited scope coverage.

**Edwards** A family or person transitioning off CalWORKs cash assistance may be placed in a holding category known as “Edwards” or “Aid code 38” for at least one month while their eligibility for other Medi-Cal coverage is determined.\textsuperscript{179}

**Four Month Continuing Medi-Cal** If a family stops receiving CalWORKs assistance or 1931(b) Medi-Cal due to receipt of child support or alimony, they may qualify for four months of continuing Medi-Cal.\textsuperscript{180} Four Month Continuing Medi-Cal has no share of cost and families qualify regardless of income or assets.\textsuperscript{181} In order to be eligible, families must have been receiving Section 1931(b) Medi-Cal or CalWORKs for three of the six months before losing such benefits, and must have a deprived child.\textsuperscript{182}

\begin{footnotesize}
\begin{itemize}
\item[\textsuperscript{175}]\textsuperscript{175} 42 U.S.C. §§ 1396a(e)(1), 1396r-6; Cal. Welf & Inst. Code § 14005.8(a)(1); Medi-Cal Eligibility Procedures Manual 5B-4.
\item[\textsuperscript{176}]\textsuperscript{176} Medi-Cal Eligibility Procedures Manual 5S-8.
\item[\textsuperscript{177}]\textsuperscript{177} Medi-Cal Eligibility Procedures Manual 5B-8.
\item[\textsuperscript{178}]\textsuperscript{178} 42 U.S.C. § 1396r-6(b)(2), 1396u-1; Cal. Welf. & Inst. Code § 14005.62; Medi-Cal Eligibility Procedures Manual 5B-8.
\item[\textsuperscript{179}]\textsuperscript{179} ACWDL # 90-06 (Jan. 8, 1990), 91-67 (July 30, 1991); Medi-Cal Eligibility Procedures Manual, Article 4O. “Edwards” refers to the \textit{Edwards v. Kizer} lawsuit which mandated this coverage.
\item[\textsuperscript{180}]\textsuperscript{180} 42 U.S.C. § 1396u-1(c)(1); 42 C.F.R. § 435.115(f); Cal. Code Regs. tit. 22, § 50243(c); Medi-Cal Eligibility Procedures Manual 5B. This program was originally due to expire, but was extended indefinitely. ACWDL # 90-33 (Apr. 5, 1990).
\item[\textsuperscript{181}]\textsuperscript{181} Medi-Cal Eligibility Procedures Manual, 5B-1.
\item[\textsuperscript{182}]\textsuperscript{182} Id.
\end{itemize}
\end{footnotesize}
People Transitioning off SSI/ SPP Although inability to work is a criterion for SSI disability, once on SSI, there are programs to encourage SSI beneficiaries to work while maintaining their disability status for Medi-Cal benefits. People who are elderly or have a disability and lose their Supplemental Security Income and State Supplementary Payment (SSP) cash benefits may be eligible to continue their Medi-Cal coverage under a number of programs.

Section 1619b- Severely Impaired Working Individual Section 1619b of the Social Security Act encourages severely disabled persons to seek and maintain employment by providing continuing Medi-Cal benefits to certain beneficiaries who lose eligibility for SSI/SSP due to their earnings. The Severely Impaired Working Individuals (SIWI) program also allows beneficiaries to retain Medi-Cal benefits despite losing SSI/ SSP due to marriage or a spouse’s increased earnings or property by waiving spousal deeming requirements. To qualify for Medi-Cal under this program, an individual must need Medi-Cal in order to continue working. Note that an individual who is eligible for Medi-Cal under this program is considered to be receiving SSI benefits still, even though she does not actually receive a check.

This program is different than the Qualified Disabled Working Individual (QDWI) program described in Chapter 9. That program only pays an individual’s Medicare Part A premiums, while this program provides Medi-Cal coverage.

Pickle This oddly named program is named after the Congressman who sponsored the legislation creating it in 1977. People who qualify for Medi-Cal under the Pickle Amendment are often referred to as “Pickles.” The amendment enables people who are no longer eligible for SSI because of cost of living increases in their Title II Social Security Cost of living allowances to remain eligible for Medicaid as if they were still receiving SSI. Lynch v. Rank established that the Pickle protections extended beyond persons whose receipt of a Title II COLA precipitated termination of SSI to also include others who became ineligible for SSI for other reasons and are not eligible now only because of an intervening COLA. A person may be eligible for categorically needy Medi-Cal with no share of cost under the Pickle program if she meets all of these requirements:

- Received SSI (Title XVI) in addition to Social Security (Title II) benefits at any time after April 1977

---

183 42 U.S.C. §§ 1382h(b), 1396d(q); 42 C.F.R. § 435.120(c); Cal. Welf. & Inst. Code § 14005.3; ACWDL # 97-27 (Jun. 20, 1997). Section 1619 of the Social Security Act corresponds to 42 U.S.C. § 1328h.
184 ACWDL # 97-27 (Jun. 20, 1997).
185 42 U.S.C. §§ 1382h(b)(1)(C), 1396d(q)(2)(C); ACWDL # 97-27 (Jun. 20, 1997).
187 The Pickle Amendment is § 503 of Pub. L. 94-566. It was not codified, but the language may be found in the notes following 42 U.S.C. § 1396a. 42 C.F.R. §435.135; Cal. Code Regs. tit. 22, § 50564. The Pickle Amendment was enforced in California through the Lynch v. Rank lawsuit. See, e.g. ACWDL # 83-53 (July 13, 1983). For general information about the Pickle program, see the Health Consumer Alliance issue brief at: http://healthconsumer.org/cs020Pickle.pdf.
189 Lynch v. Rank, 747 F.2d 528 (9th Cir. 1984), as modified by 763 F.2d 1098 (9th Cir. 1985).
190 See the examples in ACWDL # 83-16 (Feb. 22, 1983); ACWDL # 83-53 (July 13, 1983).
• Is not now eligible to receive SSI because the intervening cost-of-living allowance (COLA) increase in Social Security (Title II) benefits were greater than the increase in SSI, so that her Social Security benefit is too high for her to receive any SSI cash assistance
• Meets other SSI eligibility requirements, except for income due to the COLA increases.\footnote{Cal. Code Regs. tit. 22, § 50564(a).}

Note that earned income should not disqualify a person as a Pickle unless it is substantial because without the intervening Title II COLA increases the person would continue as an SSI beneficiary under the 1619(b) program described above.\footnote{Under 42 U.S.C. 1382h(a)(1), the individual is treated as if she were still receiving SSI in order to qualify under 1619(b).} The Pickle amendment protects not only the person receiving the Title II benefits but also an SSI spouse or SSI child to whom the income is deemed.\footnote{2 C.F.R. § 435.135(b); Lynch v. Dawson, 820 F 2d 1014 (9th Cir. 1987).} If a spouse or child would be eligible for SSI but for a Title II cost of living increase in income that is deemed to her from her spouse or parent, the child or parent would qualify for Medi-Cal as a Pickle.

When screening for Pickle eligibility, the best approach is to follow the steps and income reduction factor table updated annually at the Shriver Center’s Web site.\footnote{Bonnyman, Screening for Medicaid Eligibility under the Pickle Amendment, Tennessee Justice Center, posted at Sargent Shriver National Center on Poverty Law, \url{www.povertylaw.org/advocacy/publications/pickle-screening.html}.}

An individual should be screened for Pickle eligibility each time she applies for Medi-Cal and for three years after her SSI/SSP has been terminated. In addition, each year the Social Security Administration sends to the state a list of individuals who have stopped receiving SSI. The state then forwards the list to the counties, where caseworkers determine whether the people on the list qualify for Medi-Cal as Pickles.

**Craig v. Bonta** Under this court case, an aged, blind or disabled individual terminated from SSI/SSP for any reason other than death or incarceration must remain on full-scope Medi-Cal without a share of cost until the county determines whether she is eligible for another Medi-Cal program.\footnote{Craig v. Bonta, S.F. Superior Ct., No. CFF 02 500688.} Beneficiaries losing SSI/SSP must have their Medi-Cal continued and evaluated under the SB 87 process.\footnote{ACWDL # 07-24 (Nov. 9, 2007).}

**Disabled Adult Children (DAC)** Disabled Adult Children are eligible for no share of cost Medi-Cal under a special program called Medi-Cal DACS.\footnote{ACWDL # 87-49 (Aug. 26, 1987).} This program covers a “disabled adult child” (DAC) who is over 18, was born with or became blind or disabled before age 22, and whose SSI/SSP benefits were discontinued because of her receipt of or entitlement to Retirement Survivor Disability Insurance (RSDI) benefits or an increase in RSDI benefits that she currently receives.\footnote{42 U.S.C. §§ 402(d), 1383c(c); 20 C.F.R. § 404.350. See, Smolen v. Chater, 80 F.3d 1273 (9th Cir. 1996).}

The DAC continues to receive Medi-Cal if she meets all of the following requirements:

• She is now receiving Social Security Survivor benefits
• She received SSI in July 1987 or later

\footnote{\textit{Craigs v. Bonta}, S.F. Superior Ct., No. CFF 02 500688.}
• She initially qualified for Title II DAC benefits, or an increase in DAC benefits, on or after June 1, 1987.
• She would be eligible for SSI now but for either the Title II DAC benefits, or the increase in her Title II DAC benefits.

This coverage applies to a Disabled Adult Child who can claim Social Security Title II (RSDI) benefits based on her parent’s work history. These benefits may entitle her to substantially more money than claiming on her own work history or more than she might receive from SSI. To qualify for DAC benefits a person must have been disabled since before age 22. Most courts say that a beneficiary does not qualify if she has had substantial work experience. Parents of DACs must either be receiving Social Security benefits including SSDI or retirement or be deceased. The definition of parent can include persons like grandparents upon whom the child was dependent for care and support. The individual must also be unmarried to qualify as a DAC.

To allow the DAC individual to continue her no share of cost Medi-Cal coverage, the Social Security Title II income is disregarded when calculating Medi-Cal eligibility. Under federal law, she is treated for Medicaid purposes as if she were still an SSI beneficiary.

As with Pickles, counties are periodically sent lists of DAC recipients whose SSI/SSP has or is being terminated. Counties must contact each DAC individual on the list to determine if they need assistance in completing the forms necessary for the application process. No face to face interview is required for the DAC to transition to this coverage.

**Disabled Widow/ers (DW)** Certain disabled widows and widowers and surviving divorced spouses who qualify for certain Social Security benefits may keep full scope Medi-Cal under this program. To be eligible for the Social Security benefits, the parties must have been married for at least 9 months unless death was by accident or there is a common child under age 18. Individuals qualify for benefits at 50 and older if they became disabled within seven years of the insured’s death, or at age 60 without the need to establish disability. Medicare benefits come with disabled widow/widower benefits after the two-year waiting period or, for early retirement benefits, the person must wait until age 65 to be eligible. In addition, there are limitations to remarriage.

---

199 ACWDL # 93-36 (Jun. 11, 1993).
200 42 U.S.C. §1383c(e).
201 42 U.S.C § 402(d)(1)(B); 42 C.F.R. § 404.350(a)(5).
202 See, e.g., Anderson v. Heckler, 726 F.2d 455 (8th Cir. 1984).
204 42 U.S.C. § 402(d)(1)(B); 20 C.F.R. § 404.350(a)(4)
205 ACWDL # 07-29 (Nov. 26, 2007).
206 42 U.S.C. §1383c(e).
207 ACWDL # 91-47 (May 9, 1991).
208 ACWDL # 96-46 (Aug. 16, 1996).
209 42 U.S.C. §§ 1383c(b), (d), 402(e) and (f); 42 C.F.R. §§ 435.137, 435.138; ACWDL # 86-54 (Oct. 10, 1986), 93-02 (Jan. 12, 1993).
211 42 U.S.C. § 402(e).
To be eligible for Medi-Cal under this program, an individual cannot be eligible for Medicare Part A; must have received SSI benefits in the month before the month in which the widow/widower benefits began; and must be ineligible for SSI because of the widow/widower benefits but would be eligible in the absence of such benefits.213

Other Medi-Cal Programs

Breast and Cervical Treatment Program (BCCTP) The BCCTP program provides treatment services to eligible California residents diagnosed with breast and/or cervical cancer, and whose family income does not exceed 200% FPL.214 Eligible applicants can be screened and enrolled into BCCTP by authorized providers using an Internet-based application form sent directly to the California Department of Health Care Services. Authorized providers are physicians in the Cancer Detection Programs: Every Woman Counts [formerly known as the Breast Cancer Early Detection Program (BCEDP) & Cervical Cancer Program (BCCCP)] or Family PACT. An authorized provider may be located by calling 1-(800)-824-0088.215

The program actually has two parts: A federal part which is a Medicaid program and a state-only part that is not technically a Medicaid program, but still is run by the Medi-Cal program.

To be eligible for the federal BCCTP program, a beneficiary must be a woman; under age 65; a citizen or national of the United States or have satisfactory immigration status; have no creditable health insurance; and have a confirmed primary diagnosis of breast and/or cervical cancer.216 It is not enough to have just an initial mammogram or Pap smear, and the biopsy must show dysplasia or an advanced stage of cancer. Having satisfied these requirements, a beneficiary will receive full-scope, no cost Medi-Cal coverage for the duration of her cancer treatment, as long as she continues to meet other eligibility requirements.217

A woman who appears to meet the federal eligibility requirements can get accelerated enrollment with immediate, temporary, full-scope Medi-Cal coverage until a Medi-Cal determination is made. If accelerated eligibility is approved, the state will send her a Beneficiary Identification Card (BIC), usually within 4 days. Until she receives the card, the beneficiary can receive services by using the confirmation document. Accelerated enrollment ends on the date of a Medi-Cal determination or the last day of the following month if the applicant states that she does not want continuing Medi-Cal. If accelerated enrollment is not approved, the applicant must wait for the State Eligibility Specialist to make an eligibility determination.

Applicants who do not meet federal standards, but who have a breast and/or cervical cancer diagnosis and need treatment may be eligible for state-only BCCTP.218 Both men and women of any age qualify for the state-only program, and a beneficiary need not have a satisfactory immigration status to be eligible. An applicant must be a California resident. Unlike the federal program, an

---

213 42 U.S.C. § 1382e(d); ACWDL # 93-02 (Jan. 12, 1993), p. 4.
215 ACWDL # 06-09 (Feb. 24, 2006). The state’s health Web site also has information and links for cancer detection and this insurance program at: www.dhs.ca.gov/cancerdetection/default.htm.
216 42 U.S.C. § 1396a(aa); ACWDL # 06-09 (Feb. 24, 2006).
217 ACWDL # 06-09 (Feb. 24, 2006).
218 ACWDL # 06-09 (Feb. 24, 2006).
applicant can be eligible even with other creditable health insurance if in the initial twelve months of treatment that insurance would leave her with costsharing (i.e. co-payments, coinsurance, deductibles, or premiums) of over $750 annually.219 In this instance, the state will pay these additional costs.220 An individual eligible for this program receives services limited to cancer treatment and cancer-related service for a limited time period. For breast cancer, the time period is 18 months and for cervical cancer the time period is 24 months.221 However, a state-only beneficiary may qualify for a new period of eligibility if she has a new tissue diagnosis of breast or cervical cancer.222

A state-only eligible beneficiary does not receive full-scope Medi-Cal like beneficiaries do for the federal program. The application process for state-only BCCTP is the same as for the federal program; however, there is no accelerated enrollment or presumptive eligibility.

Unlike most other Medi-Cal programs, a state eligibility specialist rather than a county eligibility worker processes eligibility and annual redeterminations under this program.223 A beneficiary who loses eligibility under the BCCTP must be assessed for Medi-Cal eligibility under other Medi-Cal categories of coverage.224

A person who already has full-scope Medi-Cal with no share of cost—which already provides full coverage—is not eligible for this program.225 However, a beneficiary who has full-scope Medi-Cal with a share of cost or limited scope Medi-Cal may be eligible for no share of cost coverage for her breast and/or cervical cancer treatment under the federal BCCTP.226

Safe Arms for Newborns This program covers newborns whose mothers have voluntarily surrendered them. It is discussed under the Medically Indigent program above.

Family PACT Family PACT stands for Family Planning, Access, Care and Treatment.227 It provides a variety of family planning services including all birth control methods, emergency contraception (Plan B), pregnancy testing, counseling and referrals, HIV testing and counseling, some basic infertility treatments, Pap smears, sterilization, testing and treatment for sexually transmitted infections, treatment for female urinary tract infections, cancer screening, hepatitis B vaccination and referral, breast and prostate cancer screening and self-examination instruction, cervical cancer screening, education and counseling about reproductive health immunization. Family PACT does not pay for abortions or pregnancy care or primary care. Individuals should be screened for other categories of Medi-Cal to see if they are eligible for full- or limited-scope Medi-Cal.

---

219 Cal. Health & Safety Code § 104161(g)(1); ACWDL # 06-09 (Feb. 24, 2006).
221 Health & Safety Code § 104161.1; ACWDL # 06-09 (Feb. 24, 2006).
222 ACWDL # 06-09 (Feb. 24, 2006).
223 ACWDL # 06-09 (Feb. 24, 2006).
224 ACWDL # 06-25 (Aug. 2, 2006).
225 ACWDL # 06-09 (Feb. 24, 2006).
226 Health & Safety Code § 104161(g)(2); ACWDL # 06-09 (Feb. 24, 2006).
227 Information about the program may be found on the Family PACT Web site at: www.familypact.org/. A local provider may be found by typing in a zip code on the Web site. Health Consumer Alliance consumer brochures on the program may be found at: http://healthconsumer.org/brochures.htm#familypact.
This Medi-Cal demonstration project waiver program is for both men and women with family income at or below 200% FPL. A beneficiary may not have another source of coverage for family planning services. A beneficiary who has Medi-Cal with a share of cost can use Family PACT if she has not met her share of cost for the month. An applicant must apply for Family PACT through an authorized provider, and she may access services only through approved providers.

**Tuberculosis (TB) Treatment Program** California covers tuberculosis treatment for a person who does not qualify for full scope Medi-Cal on another basis without a share of cost and whose income and resources do not exceed maximum amounts based on those applied to a person or couple with a disability under Medi-Cal. A person must have a diagnosis of TB infection. If a beneficiary qualifies for this program, she is entitled to a limited number of TB treatment-related services. Most applications for this program are done through clinics treating tuberculosis. Financial eligibility requirements follow SSI rules except that married couples are treated as single persons with only the income in the applicant’s name counted, and only the resources in the name of the applicant plus one half of the community property is counted toward the allowable resources of $2,000. The program is available to U.S. citizens and people with satisfactory immigration status.

**Special Treatment Programs:**

**Kidney Dialysis and Hyperalimentation/ TPN program** Medi-Cal has special programs for persons who need kidney dialysis or parenteral hyperalimentation (TPN/ total parenteral nutrition) but who do not otherwise qualify for Medi-Cal. These programs cover only dialysis or TPN for a person who would qualify for Medi-Cal except that her income or property is in excess of limits for no share of cost Medi-Cal. Under both programs there is no co-payment obligation if the beneficiary’s annual net worth is less than $5,000. This includes her combined nonexempt resources and gross income. If her net worth is $5,000 or more, both programs require payment on a sliding scale which is the amount equal to 2% of each $5,000 of her net worth or 1% of her annual net worth if she has coverage under the Medi-Cal Medically Needy or Medically Indigent program.

---

232 Medi-Cal Eligibility Procedures Manual, Article 5N, Cal. Code Regs. tit. 22, § 50268. This program began as an optional federal program and was codified at Cal. Welf. & Inst. Code § 14005.20. However, the state statute was repealed by Stats. 2006, c. 128 (A.B. 1744), § 2.
235 Medi-Cal Eligibility Procedures Manual, 5N-3-5N-6. Note that the program has a special Tuberculosis Income Standard which changes annually and is usually published through ACWDLs. See, e.g. ACWDL # 07-31 (Dec. 3, 2007).
237 TPN provides total nutrient replacement through a catheter positioned in the chest for persons who, for whatever reason, are unable to eat and digest food. Medi-Cal Eligibility Procedures Manual, 17A-1.
239 Cal. Welf. & Inst. Code § 14142, Cal. Code of Regs. tit. 22, § 50264. Medi-Cal refers to the “Medi-Cal Special Treatment Programs-Only” for people who are not otherwise eligible for Medi-Cal, but may receive coverage under this program only for these services. The “Medi-Cal Special Treatment Program-Supplement” offers the same limited coverage, but for people who have Medi-Cal through either the Medically Needy or Medically Indigent program.
Chapter 7: About the Different Medi-Cal Programs

Medicare-Related Programs

There are several programs for people who have Medicare and who have limited resources and limited income, commonly referred to as QMB (“Quimby”), SLMB (“Slimby”), QDWI, and QI. These are referred to as the “Medicare Savings Programs.” These programs do not, by themselves, provide Medi-Cal coverage. Rather, Medi-Cal pays part or all of the beneficiary’s Medicare cost sharing so that the low-income beneficiary may have more complete coverage under Medicare. Except for the QI beneficiaries, people in these programs may also receive Medi-Cal coverage if they apply and qualify for coverage under one of the Medi-Cal programs. The Medicare Savings Programs are described in detail in Chapter 9.

A Note on SB 87 and ex parte Redeterminations:

When a Medi-Cal beneficiary loses eligibility under one Medi-Cal category, federal and state laws require the state to assess her eligibility for other categories of Medi-Cal before terminating her Medi-Cal coverage. In California, these rules and the process to redetermine eligibility are referred to as “SB 87.” This is often called a “change in circumstances” redetermination and requires that the county do an ex parte review of all available files; a verbal request for missing information needed to make an eligibility determination for another Medi-Cal program; and a written request for missing information to determine if a beneficiary may be eligible for Medi-Cal under a different category.

In addition to these three steps, there are two other important procedural protections to help a beneficiary keep Medi-Cal. First, if she responds to the verbal or written request, the county must accept the response up to 30 days after a date of termination (for non-response) and process it as if it were submitted on time. This is called the “30 day period to cure.” Second, the county may only request information that is necessary to determine eligibility, has not been provided before, and is not subject to change. For example, the county cannot ask for or stop benefits due to non-submission of a birth date or social security number or other information that does not change, or a pay stub or car registration or other information that the consumer has already provided. These two protections plus the three steps described above are collectively referred to as “SB 87 procedures.” SB 87 is also discussed in Chapter 6.

---

239 This is a reference to the legislation that provided for this process in California: S.B. 87, § 7, (Stats. 2000, c. 1088).