# Chapter 3: Non-MAGI Medi-Cal

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# 3. Non-MAGI Medi-Cal

With the passage of the Affordable Care Act and the requirement that the Modified Adjusted Gross Income (MAGI) methodology be used for the Medi-Cal expansion adult population, parents and caretaker relatives, pregnant women, and children, the programs left in Medi-Cal that continue to use the myriad of pre-ACA rules are commonly referred to as simply "non-MAGI Medi-Cal." The non-MAGI Medi-Cal programs generally serve low-income individuals who are seniors or have disabilities; children and families who are linked to Medi-Cal through other public benefit programs or are in special circumstances such as foster care; individuals in need of specific treatment such as kidney dialysis or breast or cervical cancer; and some refugees. Unlike MAGI Medi-Cal or Covered California, there is no uniform set of eligibility rules for the various non-MAGI Medi-Cal programs.

## A. Non-MAGI Household and Income

In general, most non-MAGI programs have their own guidelines regarding income and which household members to count in determining income. The non-MAGI Medi-Cal programs that do not have specific income or household rules are those programs where enrollees are "categorically-linked" to Medi-Cal by virtue of their enrollment in another public assistance program. Individuals receiving Supplemental Security Income/State Supplementary Payments (SSI/SSP or SSI), CalWORKs, financial assistance for foster care, adoption assistance, or KinGAP do not need to go through another income determination process to receive Medi-Cal; they are automatically eligible. Foster youth are also automatically eligible for Medi-Cal, and under the Affordable Care Act, former foster youth are categorically eligible for Medi-Cal up to age 26 and therefore are also considered to be non-MAGI Medi-Cal.

The other non-MAGI Medi-Cal programs that are not categorically-linked to Medi-Cal require an income determination. There are separate rules for individuals who are considered eligible for SSI but do not receive the cash payment and individuals who are considered to be "medically needy" or "medically indigent." These programs generally serve individuals over age 65 and persons with disabilities and have income and resource/assets limits that are different than the MAGI income rules. For eligibility based on disability, the programs often require a disability determination as well.

Finally, certain non-MAGI programs have no income rules at all, such as Minor Consent or Continuing Eligibility for Children.

In short, when it comes to non-MAGI Medi-Cal, advocates must look at each program separately for its income and household rules, if any.[1] The following chapter divides the non-MAGI programs into the following:

- Full-scope Medi-Cal coverage for seniors and individuals with disabilities;
- Full-scope Medi-Cal for children and families;
- Limited scope Medi-Cal for children;
- Medi-Cal special treatment programs;
- Medicare Savings Programs (MSPs); and
- Refugee Medical Assistance (RMA).

## B. Full-Scope Non-MAGI Medi-Cal for Seniors and Individuals with Disabilities

### 1. Categorically Linked Medi-Cal Based on Disability

#### a. Automatic Medi-Cal for Individuals Receiving Supplemental Security Income (SSI-linked Medi-Cal)

An individual already receiving SSI/SSP or SSI is *categorically linked* to Medi-Cal, *i.e.,* the individual gets Medi-Cal automatically and does not need to apply or qualify

1. In addition to the non-MAGI Medi-Cal program eligibility rules summarized in this chapter, advocates should also be aware that beneficiaries or their spouses who receive long-term care services (LTC) may be subject to different rules. Because this manual focuses on eligibility rules as opposed to the benefits covered by the insurance affordability programs, the rules regarding LTC services are not covered here. For more information on LTC, see California Advocates for Nursing Home Reform's (CANHR's) website at http://www.canhr.org/ under the "Medi-Cal for Long Term Care" tab, which provides an overview of Medi-Cal for long-term care beneficiaries.

separately for Medi-Cal coverage.[2] There are no separate eligibility rules for this Medi-Cal program – the only eligibility determination that is made is for SSI. A Medi-Cal card will be automatically sent in the mail after the SSI benefits begin.[3]

### b. SSI 1619(b) Medi-Cal for Individuals who Lost SSI Because of Earnings from Work

The 1619(b) program provides for the continuation of Medi-Cal eligibility for people who lose SSI cash benefits because of earnings from work.[4] Unlike other Medi-Cal programs, the state Department of Health Care Services does not administer this program; the federal Social Security Administration does. The Social Security Administration determines eligibility for 1619(b) status for people who received SSI in the month before they became ineligible for an SSI cash payment because of earnings from work. People who qualify for 1619(b) status are considered to be SSI recipients even though they do not qualify for an SSI cash payment, which is why their categorically-linked Medi-Cal continues.

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2. 42 U.S.C. § 1396a(a)(10)(A)(i)(II); 42 C.F.R. § 435.120; 22 CCR §§ 50145(a), 50227(a)(2); aid codes 10 (SSI-Aged), 20 (SSI- Blind) and 60 (SSI-Disabled). Note that before payment for In-Home Supportive Services, or IHSS, was shifted to the Medi-Cal program in 2011, IHSS recipients were also treated as categorically-eligible for Medi-Cal. Categorical eligibility for IHSS recipients has ended; an individual must be otherwise eligible for Medi-Cal in order to qualify for IHSS services.
3. While SSI benefits begin on the first of the month after application for SSI, Medi-Cal benefits for SSI-linked beneficiaries are retroactive to the first of the month of application for SSI. SSI-linked Medi-Cal beneficiaries are also eligible for three months of retroactive Medi-Cal from the month of the SSI application, in the same way that non-SSI linked Medi-Cal applicants are eligible for three months of retroactive eligibility. Beneficiaries with outstanding medical bills from these retro periods may submit those bills for reimbursement.
4. 42 U.S.C. § 1382h(b); 20 C.F.R. §§ 416.266-269. Social Security Administration website has information on the 1619(b) program at https://www.socialsecurity.gov/disabilityresearch/wi/1619b.htm. Medi-Cal enrollees who receive 1619(b)-linked Medi-Cal are in the same aid codes as individuals who receive SSI – aid codes 10, 20 and 60. Because the Social Security Administration determines 1619(b) eligibility and effectively treats individuals in 1619(b) as still receiving SSI, the SSA does not inform the state that SSI has stopped. Therefore, you may encounter consumers who no longer receive SSI but are still properly in the SSI aid codes.

**To qualify for the 1619(b) program, an individual must:**

- Have been eligible for an SSI cash payment in the month before earned income caused the SSI cash payment to end;
- Meet the requirements for receiving an SSI cash payment except for earnings;
- Still meet all other SSI eligibility requirements, including disability requirements, countable unearned income requirements, *i.e.*, countable unearned income less than the SSI/SSP benefit payment rate, and countable resource requirements, *i.e.*, countable resources less than $2,000 for an individual or $3,000 for a married couple;
- Need Medi-Cal in order to work; and
- Have gross earned income that is insufficient to replace SSI, Medi-Cal, and any publicly funded attendant care; this is known as the "threshold amount." The threshold amount is the measure the Social Security Administration uses to decide whether an individual's earnings are high enough to replace their SSI and Medi-Cal benefits. The threshold amount is the sum of:
  - The amount of earnings that would cause the SSI cash payments to stop; plus
  - The average annual per capita Medi-Cal expenditure.

In 2016, the threshold amount in California is $37,184; for beneficiaries who are blind it is $38,504.[5] This means that if an individual who formerly received SSI cash payments expects gross earnings in 2016 to be less than $37,184 (or $38,504 if the individual is blind), the Medi-Cal categorical linkage to SSI will continue. No new application is required.

If gross earnings are higher than the threshold amount, the individual may still be eligible for 1619(b) if the Social Security Administration can determine an individualized threshold amount. An individual may qualify to have an individualized threshold amount determination if the individual has any of the following:

- Work expenses related to a disability;

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5. The Social Security Administration publishes a POMS (Program Operations Manual System) every year with each state's per capita Medicaid expenditure and the amount of earnings that would cause the SSI cash payments to stop. The 2016 POMS is POM SI 02302.200, available at: https://secure.ssa.gov/poms.nsf/lnx/0502302200.

- A plan to achieve self-support;
- Publicly funded attendant or personal care (such as IHSS); or
- Medical expenses above the state per capita amount.

Proof of these expenses has to be provided to the Social Security Administration for 1619(b) status to continue.

**Individuals no longer eligible for SSI**

If the Social Security Administration (SSA) determines that an individual is no longer eligible for SSI or 1619(b) status, SSA sends notice of this determination to the state. The state then notifies the county so that the county can redetermine eligibility for Medi-Cal under other programs. The county must continue to provide full-scope Medi-Cal with no Share of Cost until the county determines whether the individual may remain eligible for Medi-Cal on another basis.[6] There are specific procedures that the state and counties must follow to ensure that these individuals do not lose their Medi-Cal when they lose their SSI and to address beneficiaries' ongoing Medi-Cal eligibility.[7]

**2. Severely-Impaired Working Individual (SIWI) Program**

The Severely-Impaired Working Individual (SIWI) provides zero Share of Cost Medi-Cal to working SSI beneficiaries even if their earnings are too high to receive an SSI cash payment. SIWI operates in the same way as the Section 1619(b) program, but is administered by the Department of Health Care Services and the counties rather than by the Social Security Administration, and is available to individuals who are no longer eligible for SSI or the 1619(b) program.[8]

**There are four requirements to be eligible for the SIWI Medi-Cal program.** An individual must:

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6. Welf. & Inst. Code § 14005.37; *Craig v. Bonta,* S.F. Superior Ct., No. CFF 02 500688.
7. *See, e.g.,* ACWDLs 07-24 (Nov. 9, 2007), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c07-24.pdf; 03-53 (Nov. 14, 2003), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c03-52.pdf; 02-54 (Nov. 8, 2002), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c02-54.pdf.
8. ACWDL 97-27 (Jun. 20, 1997) http://www.dhas.ca.gov/services/medi-cal/eligibility/documents/97-27.php; aid code 8G.

- Depend on Medi-Cal to continue working;
- Meet all non-disability requirements for regular SSI/SSP benefits, except for earnings;
- Not have sufficient earnings to replace SSI, Medi-Cal or a publicly-funded personal or attendant care that would be lost due to the individuals's earnings; and
- Have received SSI or Section 1619(b) Medi-Cal in the month immediately preceding the first month of eligibility for the SIWI program. Individuals who meet Section 1619(b) criteria and do not want to have their eligibility determined by the Social Security Administration may also be eligible for the SIWI program when they lose their SSI. For example, an individual who wants to receive Medi-Cal under a Home and Community-Based Services (HCBS) waiver may be eligible for the SIWI program and would need to have their eligibility determined through the Department of Health Care Services, not the Social Security Administration.

**3. Pickle Program**

The Pickle Program[9] provides full-scope, no cost Medi-Cal to individuals who once received SSI but are currently not eligible for a monthly SSI cash payment because of Cost of Living Adjustment (COLA) increases in their Title II Social Security benefits. Title II Social Security benefits include retirement benefits, disability benefits, and survivors' benefits.

**Advocacy Tip:** If an individual is receiving Social Security Disabled Adult Child (DAC) benefits, follow the DAC Medi-Cal procedures described in the following section instead of the Pickle procedures. Eligibility for DAC Medi-Cal should always be evaluated before considering eligibility for Pickle Medi-Cal. This is because DAC Medi-Cal provides all of the protections of the Pickle Medi-Cal program and additional protections, as well.

9. The Pickle Program is named after its congressional sponsor, J.J. Pickle (D-Texas) and was enacted in 1977.

**An individual is eligible for no-cost Medi-Cal under the Pickle Program if the individual**:

- Received SSI and Social Security in the same month (in any month since 1977); and
- Was discontinued from SSI for any reason; and
- Is not currently eligible to receive SSI because of a Social Security benefits COLA, *i.e.*, Social Security benefit level is now too high to qualify him/her for SSI; and
- Meets other SSI eligibility requirements, except for income due to Social Security COLAs.[10]

**Note:** To qualify for the Pickle Program, a beneficiary does not have to show that they actually lost their SSI due to a Social Security COLA. Under *Lynch v. Rank*, individuals qualify by showing that "but for" the COLA increase, they would currently be eligible for SSI.

**"Pickle measure."**

To see if an individual is eligible for the Pickle Program, first determine the Social Security grant level from the last time the individual received *both* SSI and Title II Social Security.[11] Compare that with the current Social Security grant level. The individual is Pickle eligible if they would now be eligible for SSI if they were receiving the *same* Title II Social Security benefits today as the individual received when they last qualified for both SSI and Title II. The Title II grant level from the last time the individual qualified (or could have) for both SSI and Title II continue indefinitely as the

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10. 42 C.F.R. § 435.135; *Lynch v Rank,* 747 F.2d 528 (9th Cir. 1984), as modified by 763 F.2d 1098 (9th Cir. 1985); *see also* ACWDL 83-74 (Nov. 15, 1983) (if one spouse qualifies as Pickle eligible, do not count the Pickle-eligible individual's income or include the individual as an ineligible member of the household.) Aid codes 16 (aged), 26 (blind), and 66 (disabled).
11. An individual who is Pickle-eligible loses SSI in January when the COLA goes into effect. The state publishes updated "Pickle measure" calculation charts and instructions as All County Welfare Directors Letters each year, usually shortly before the beginning of the year. These instructions are typically titled something along the lines of "January 2015 Social Security Title II and Title XVI Cost of Living Adjustments and Related Issues." *See, e.g.,* ACWDL 15-08 (Feb. 29, 2015). The state was a few months' late with the 2015 letter.

individual's *"Pickle measure."*[12]

**Pickle and Deeming**

The "Pickle measure" also applies to Title II Social Security benefits deemed to a Pickle-eligible Medi-Cal beneficiary from an ineligible spouse to a spouse living in the same household, or from an ineligible parent to a minor child living in the same household. This means that the amount of Title II Social Security COLAs is not deemed.[13] This prevents a Medi-Cal beneficiary, who is otherwise Pickle eligible because of their own Social Security COLAs, from losing Medi-Cal because of someone else's Social Security COLAs. This is necessary to give the beneficiary the no Share of Cost Medi-Cal that they would have received if there had been no Social Security cost of living increases at all since they last received SSI.

**Getting and Keeping "Pickle" Medi-Cal**

Any individuals described above who qualify should be able to get Medi-Cal, either as a continuing benefit when they lose SSI or as new applicants for the Pickle Program. The county must redetermine an individual's eligibility under this program when they lose SSI. An individual should remain eligible as long as they meet all SSI eligibility rules except the income rule. As discussed above, the county is obligated to redetermine Medi-Cal eligibility in any case where an individual loses SSI.

**4. Disabled Adult Child (DAC) Medi-Cal**

This program provides full-scope, no cost Medi-Cal to qualifying adults who receive "Social Security Disabled Adult Child (DAC) benefits."[14] An adult is entitled to receive Title II Disabled Adult Child benefits if that adult is unmarried; has a disability that began before the age of 22; and was dependent on his or her parent at the time of application, the time of the parent's death, or at the time the parent's own period of disability began.[15] The standard for determining disability is the same as for the

12. Clearinghouse Review publishes an annual Pickle update by Gordon Bonnyman of the Tennessee Justice Center, which includes step-by-step instructions to screen an individual for Pickle eligibility. *See* "Screening for Medicaid Eligibility under the Pickle Amendment," posted at Sargent Shriver National Center on Poverty Law, http://www.povertylaw.org/clearinghouse/pickle.
13. 42 C.F.R. § 435.135(b); *Lynch v. Dawson*, 820 F.2d 1014 (9th Cir. 1987).
14. 42 U.S.C. § 402(d); 20 C.F.R. § 404.350; *Smolen v. Chater*, 80 F.3d 1283 (9th Cir. 1996).
15. 42 U.S.C. § 402(d)(1)(B); 42 C.F.R. § 404.350(a)(4).

Title II Social Security Disability Insurance (SSDI) program. To qualify as a Medi-Cal Disabled Adult Child an individual must be entitled to receive Title II Disabled Adult Child benefits and must have had and lost SSI because of eligibility for these Title II benefits.

Individuals first receive Social Security DAC payments at the time of the retirement, disability or death of a parent. When this occurs, an individual who is receiving SSI can begin receiving a DAC payment that is higher than the SSI payment rate. This makes the individual ineligible for SSI and for SSI-linked Medi-Cal. The DAC Medi-Cal program maintains the status quo with respect to Medi-Cal by continuing to provide categorical Medi-Cal so long as the individual would be eligible for SSI if the individual were not receiving the DAC Social Security payments. The DAC Medi-Cal program, like the Pickle program, also provides protection from loss of SSI-linked Medi-Cal caused by Social Security COLAs. This second part of the DAC Medi-Cal program is sometimes called the "Pickle DAC" or "pseudo Pickle DAC" program.

**DAC Program Eligibility Requirements**

Individuals who receive "Social Security DAC" benefits can qualify for full-scope, no-cost Medi-Cal if they:

- Received SSI in July 1987 or later;
- Initially qualified for Title II DAC benefits, or qualified for an increase in Title II DAC benefits, on or after June 1, 1987; and
- Would be eligible for SSI now but for either:
  - the current receipt of Title II DAC benefits which they first became eligible for while they were receiving SSI, or
  - the increase in Title II benefits because of COLAs since they last received both Title II benefits and SSI.[16]

16. 42 U.S.C. § 1383c(c); ACWDL 91-47 (May 9, 1991), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c91-47.pdf. The ACWDL states that to be eligible for the DAC or DAC Pickle programs, the DAC beneficiary must have been discontinued from SSI/SSP as a result of either having begun receiving DAC benefits or receiving an increase in DAC benefits.

In order for an individual with Title II DAC benefits to continue to receive Medi-Cal with no Share of Cost, the Social Security Title II income is disregarded when calculating Medi-Cal eligibility.[17] Under federal law, the individual is treated for Medicaid purposes as if they were still an SSI beneficiary.[18]

To determine if an individual who received both Title II Social Security DAC and SSI at some time in the past qualifies for the Medi-Cal DAC Program, compare their Title II grant level in 1987 with the current SSI grant level. If they would qualify for SSI now, *i.e.,* if their Title II DAC benefits were at the same level as when they last qualified for both benefits, then the individual is eligible for no-cost Medi-Cal through the Medi-Cal DAC program.[19] The individual would also qualify for no-cost Medi-Cal if they became eligible for Title II DAC benefits after July 1987.[20]

**Note:** When determining an individual's eligibility for no-cost Pickle or DAC Medi-Cal based on COLA's, you cannot deduct Medicare premiums from the person's Title II benefits. In others words, count the Title II benefits before any Medicare premium deductions are taken.

**Getting and Keeping DAC Medi-Cal**

Any individual described above who qualifies should be able to get Medi-Cal either as a continuing benefit when she loses SSI or, if later, as a new applicant under the Medi-Cal DAC Program. The state periodically sends counties lists of Title II DAC recipients whose SSI/SSP has been or is being terminated.[21] The counties are required to contact the recipients to see if they need assistance in completing the forms required for the application process.[22]

Eligible individuals should remain eligible as long as they meet all the other SSI

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17. ACWDL 07-29 (Nov. 26, 2007), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c07-29.pdf.
18. 42 U.S.C. § 1383c(c).
19. Increases in DAC benefits may occur due to COLA's, a reduction in the number of dependents drawing against the wage earner's amount, or the death of the wage earner.
20. ACWDL 91-47 (May 9, 1991), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c91-47.pdf.
21. *See, e.g.,* ACWDL 95-14 (Mar. 6, 1995), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/95-14.pdf.
22. *Id.*

eligibility rules.

**5. Disabled Widow/Widower Programs**

This program provides full-scope, no-cost Medi-Cal to individuals with disabilities who lost SSI as a result of receiving Title II widow's or widower's benefits or surviving divorced spouse benefits alone or combined with other Title II benefits.[23]

Generally, in order to qualify for this program, an individual must have been married to the deceased for at least nine months. However, the nine-month requirement does not apply in certain circumstances, such as when the spouse's death was an accident; the spouse died while serving on active duty in the armed forces; or the couple has a child in common under age 18.[24] Individuals may qualify for these benefits if they are age 60 or older or if they are 50 or older and have a disability that started no later than seven years after the spouse died (or seven years after the individual was last entitled to benefits).[25] In addition, an individual who remarries may lose their eligibility for these benefits, depending on the circumstances.[26]

Widows/widowers disability benefits convert to early retirement benefits at age 60. However, an individual is eligible for Medicare after the conversion to early retirement benefits at age 60 if the individual meets the Title II SSDI disability criteria. In addition, the individual must meet the SSDI disability criteria in order to qualify for no-cost Medi-Cal under the Disabled Widow program. The individual will generally

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23. 42 U.S.C. § 402(e) and (f); 20 C.F.R § 404.335; 42 C.F.R. § 435.138. Medicare benefits come with the disabled widow/widower benefits after the two-year waiting period, on top of the initial five-month wait period, so long as the individual meets the disability criteria for Title II Social Security disability benefits.
24. 20 C.F.R § 404.335(a). Other situations where the nine-month rule does not apply include: When the couple's marriage was delayed because the now-deceased spouse was in a previous marriage to an individual who was mentally incompetent and institutionalized (20 C.F.R. § 404.335(a)(2)(iv)); when the couple had been previously married to each other and the prior marriage lasted at least nine-months (20 C.F.R. § 404.335(a)(2)(iii)); when in the month before marriage the individual was entitled to any of these benefits or payments: widow's, father's, mother's, wife's husband's parent's or disable child's benefits (20 C.F.R. § 404.335(a)(4)).
25. 20 C.F.R § 404.335(c); ACWDL 93-02 (Jan. 12, 1993), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c93-02.pdf.
26. 20 C.F.R § 404.335(e).

meet the disability criteria because of the requirement that the individual lose SSI because of receipt of widow/widower benefits. This is because SSI that is payable before the age of 65 is always based on disability.

**Widow/Widower with Disabilities Program Requirements**

Persons with disabilities who are widows, widowers and surviving divorced spouses and qualify for Social Security disability or early retirement benefits will be eligible for Medi-Cal if they:

- Are ineligible for Medicare Part A;
- Received SSI in the month prior to the month in which their widow/widower disability benefits or early retirement benefits began; and
- Would be eligible for SSI but for the receipt of the widow/widower benefits.[27]

**Getting and Keeping Widow/Widower with Disabilities Benefits**

Individuals who qualify should continue to get Medi-Cal when they lose SSI, or as new applicants to Medi-Cal. They should remain eligible as long as they meet all the other SSI eligibility rules, and until they become entitled to Medicare Part A. As discussed above, counties are obligated to redetermine Medi-Cal eligibility in any case where an individual loses SSI or Medi-Cal under a particular Medi-Cal program.

### 6. Aged and Disabled Federal Poverty Level (A&D FPL) and Blind Federal Poverty Level (Blind FPL) Programs

The A&D FPL and the Blind FPL Programs provide no-cost, full-scope Medi-Cal to

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27. 42 U.S.C. § 1383c(d). There is also a Disabled Widow/Widower program that provides no-cost Medi-Cal for individuals who received an increase in widow/widowers benefits due to a one-time increase in those benefits in January 1984. That one-time increase was due to the elimination of the additional early retirement reduction factor for individuals under age 60. This program does not apply to anyone who first filed an application for the program after June 30, 1988. *See* 42 U.S.C. § 1383c(b); 42 C.F.R. § 435.137; ACWDLs 93-02 (Jan. 12, 1993), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c93-02.pdf; 88-74 (Sept. 21, 1988), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c88-74.pdf; and 86-54 (Oct. 10, 1986), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c86-54.pdf. Very few people qualified for this program.

low-income individuals who are either over the age of 65, or who have a disability.[28] Children and adults can qualify as disabled if they meet the Social Security Administration's (SSA) disability criteria.[29] Note that an individual who is in long-term care in a nursing facility is not eligible for this program.[30]

**Must be over 65 or have a disability.** An individual must be *either* over the age of 65, or have a disability (including blindness under SSDI disability standards) to be eligible for the A&D FPL program, or blind under the SSI program standards to be eligible for the Blind FPL program.[31]

Individuals are considered *disabled* for the A&D FPL program if either:

- They are receiving Social Security Disability Insurance (SSDI) benefits (including Disable Adult Child and Widow/Widowers benefits), or
- They meet the disability requirements for SSI (including the SSDI definition of blindness) but do not receive SSI because their income exceeds the SSI limits. For adults, disability is defined as having a physical or mental impairment that

28. 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(X) and 1396a(m) (allowing states the option to adopt a program for seniors and individuals with disabilities); Welf. & Inst. Code § 14005.40. The aid codes are 1H for individuals who are aged and 6H for individuals with disabilities; 1U and 6U are aid codes for restricted scope Medi-Cal for individuals who are over age 65 or disabled, respectively. The Blind FPL aid code is 2H.
29. 42 U.S.C. § 1396a(m)(1); 42 U.S.C. § 1382c.
30. ACWDL 00-57 (Nov. 14, 2000), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/00-57.pdf.
31. The Blind FPL program was enacted because the federal American Recovery and Investment Act (ARRA) prohibited states from cutting back certain categories of Medicaid eligibility. The July 1, 2009 reduction in SSI benefit payment rates would have resulted in one of these Medi-Cal cutbacks because individuals who lost SSI because of the reduction would have lost automatic zero Share of Cost Medi-Cal as well. The Blind FPL program was enacted in order to give zero Share of Cost Medi-Cal to people who are blind who lost Medi-Cal because of the SSI reduction.

prevents the individual from working;[32] the impairment must be expected to last at least 12 months or to result in death. For children, they must meet the SSI eligibility rules for children,[33] which assess whether the child has a physical or mental impairment that results in marked and severe functional limitations.[34]

Individuals who are blind who are receiving Title II benefits automatically meet the disability definition of the A&D FPL program.[35] Individuals who are not receiving Title II benefits will meet the disability definition for this program only if they meet the Title II definition of blindness, which is narrower than the SSI definition of blindness. Therefore, they must be referred to the Disability Determination Service Division-State Programs (DDSD-SP) to be evaluated for disability before benefits under the A&D FPL Program can be granted. DDSD-SP will evaluate for disability and will determine whether the individual meets the Title II definition of blindness.

Individuals who are blind who lost SSI due to benefit reductions in 2009, or who are new applicants for Medi-Cal and allege blindness, will be evaluated for the Blind FPL program using the SSI definition of blindness. If the new applicant is determined to meet the Title II definition of blindness, or becomes eligible for SSDI benefits, the individual will be transferred into the A&D FPL program.[36]

**Income Limits.** To be eligible for the A&D FPL or the Blind FPL Medi-Cal programs, an applicant's countable income cannot exceed a level set by the state that is based on the Federal Poverty Level. The countable monthly income limit for an individual

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32. In order to have a disablity under SSDI disability standards, the individual must be unable to engage in "Substantial Gainful Activity" or "SGA" which means the individual cannot do work activity which involves significant physical or mental effort that is performed (or generally performed) for pay or profit. ACWDL 00-68 (Dec. 29, 2000), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/00-68.pdf. The Disability Determination Service Division-State Programs, a division of the California Department of Social Services, is responsible for making disability determinations for Medi-Cal. *See* ACWDL 11-11 (Feb. 25, 2011), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c11-11.pdf.
33. Welf. & Inst. Code § 14005.40(c)(1).
34. 42 U.S.C. § 1382c(a)(3)(C)(i).
35. ACWDL 00-68.
36. ACWDL 09-28 (June 17, 2009), at p. 3, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c09-28.pdf.

adult or child is based upon the Federal Poverty Level (100% FPL), plus $230.[37] The countable income limits for a married couple who are both applying for Medi-Cal, *i.e.,* the couple either both have disabilities or are over age 65, both are blind, or one is disabled or over 65 and the other is blind, is based upon 100% FPL, plus $310, *or* the SSI/SSP level, whichever is higher.[38] In addition, for purposes of calculating countable income for those individuals who receive Social Security (Title II), their annual cost of living adjustment (COLA) shall be disregarded from January through March, *i.e.*, until the new FPL limits go into effect in April.[39]

In 2015, under the A&D FPL program the monthly income limit for an individual was $1,211 and $1,638 for a couple.[40] For the Blind FPL program, the income limit was $1,211 for an individual; $1,666 for a couple where one individual is blind and the other is aged or disabled; and $1,751 for a couple where both individuals are blind.[41]

**Countable Income.** The income of the applicant, the applicant's spouse living in the same household, and the parents when the applicant is a minor child living in the same household, is counted in determining the applicant's "countable" income.[42] Note that under SSI rules, certain free assistance an individual gets from others like

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37. Welf. & Inst. Code § 14005.40(c)(1). The Federal Poverty Level (FPL) is announced each February and is effective the following April 1st for one year.
38. *Id*. The SSI/SSP cash benefit levels change each year on January 1st. The SSI rate is based upon the Federal Benefit Rate (FBR) set by the Social Security Administration (SSA) and a State-only Supplemental Payment (SSP) is added to the FBR to get California's SSI/SSP benefit amount. *See, e.g.,* ACWDL 15-08 (Feb. 9 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-08.pdf. Note that the SSI couple rate for people who are aged or disabled is less than the A&D FPL level for a couple, so the A&D FPL level is applied. However, the SSI couple rate if one or both members of the couple are blind is greater than the A&D FPL level for a couple. Therefore, for the Blind FPL program, the SSI couple rates are used instead of the A&D FPL couple rates. There are two rates, one for a couple if both members are blind, and a lower rate for a couple if one member is blind and the other is over 65 or has a different disability. ACWDL 15-24 (July 15, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-24.pdf.
39. Welf. & Inst. Code § 14005.40(f).
40. ACWDL 15-12 (Feb. 27, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-12.pdf.
41. ACWDL 15-24.
42. ACWDL 01-18 (Mar. 16, 2001), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c01-18.pdf.

rent or food – called "in-kind support" – counts as income.[43] However, under these Medi-Cal programs, in-kind support and maintenance is determined using Medi-Cal rules.[44] This means that an item is not counted as income unless the entire item of need is provided to the Medi-Cal beneficiary.[45] For example, if a non-applicant spouse gets support to cover some but not all of a monthly utility bill, then the amount of that assistance is not considered in-kind support; it would only qualify as in-kind support if the entire utility bill were covered.

**No spend-down.** Individuals whose countable income (after exclusions and deductions, see below) is above the A&D FPL or the Blind FPL income limits cannot "spend down" their income to become eligible. Instead, those individuals will have to be considered under the Aged, Blind & Disabled – Medically Needy (ABD-MN) Share of Cost program, where they will be required to pay a Share of Cost before Medi-Cal will cover services. Because the income limit for A&D FPL is significantly higher than the limit for the ABD-MN program, an applicant who has countable income even one dollar over the A&D FPL income limit will only be able to qualify under the ABD-MN program and will owe a Share of Cost of hundreds of dollars, rather than receiving free Medi-Cal.[46] For a discussion of the ABD-MN Share of Cost Medi-Cal Program and Share of Cost, *see* section B.8 below.

**Income Exclusions or Deductions**

There are numerous income exclusions and deductions available under A&D FPL and Blind FPL programs that may lower an individual's countable income.[47] These programs follow medically needy rules regarding income exclusions and deductions.[48] This means that an individual gets all of the SSI exclusions and

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43. 20 C.F.R. §§ 416.1102, 416.1103(a)(3)-(5), (b)(2); 22 CCR §§ 50509 and 50511. Note that the definition of in-kind income is different in the "deemed SSI" programs, which use SSI methodologies for determining income in all respects. For example, clothing does not count as in-kind income under the SSI program or the Medi-Cal "deemed SSI" programs.
44. 22 CCR § 50509.
45. 22 CCR § 50509(b).
46. This unfair result is sometimes referred to as the A&D FPL "cliff," meaning the individual who is only slightly above the A&D FPL limit (and therefore ineligible for A&D FPL Medi-Cal) pays a high penalty (a high SOC in the ABD-MN program) that is much more than the number of dollars s/he is above the A&D FPL income limit.
47. 20 C.F.R. §§ 416.1112, 416.1124. Note that applicants cannot deduct In-Home Supportive Services (IHSS) expenses.
48. 42 U.S.C. § 1396a(m).

deductions and any additional Medi-Cal exclusions and deductions applicable to the program. The following monthly income exclusions and deductions are available, among others:

- Unearned income:[49] $20 is excluded per month.
- Earned income:[50]
  - $65 is excluded per month plus one-half (1/2) of the remainder of gross monthly earned income (*e.g., $565 gross monthly wages results in $250 in countable monthly income; 565 – 65 = 500; 500÷ 2 = 250*). **Note**: Married couples can only use the 65 + ½ deduction once.
  - Any unused portion of the $20 unearned income deduction above (*i.e.,* if less than $20 of unearned income is excluded, whatever amount up to $20 is left is the unused portion).
  - Income-related work expenses (IRWEs).[51]
- The cost of any health insurance premiums.[52]
- A $315 Personal Care Services (PCS) deduction for individuals residing in board of care homes[53]

49. 20 C.F.R. § 416.1121 (unearned income defined).
50. 20 C.F.R. § 416.1110 (earned income defined).
51. These are out-of-pocket work expenses that an individual needs to become or remain employed, *e.g.,* maintenance on a specialized van; attendant care services to get ready for work; transportation costs; medical devices; work related equipment. 20 C.F.R. § 416.976 and 22 CCR § 50045.1.
52. 22 CCR § 50555.2.
53. Welf. & Inst, Code § 14005.40 (g)(1)(C) and (2); ACWDL 01-18, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c01-18.pdf. (the PCS deduction is an income disregard that applies to a resident of a licensed community care facility (in lieu of the board and care deduction) when the PCS deduction is greater than the board and care deduction).

**Advocacy Tip:** Help your clients avoid a Share of Cost of hundreds of dollars in the ABD-MN program by aggressively using these exclusions and deductions so that they qualify for no-cost A&D FPL. A helpful tip is for your client to buy a Medi-Gap or other private health insurance product, including dental or vision insurance. Clients can deduct the cost of that policy or product and that may help them get under the strict income limit in the A&D FPL and Blind FPL programs. If your client purchases private health insurance with coverage that duplicates Medi-Cal coverage, the private health coverage would be billed first and then Medi–Cal would pay for the services it covers after the private health carrier pays or denies a claim.

**Deduction for Non-Applicant Household Members.** If there are other family members living in the home who are not applying for benefits, deduct a Maintenance Need Allowance, also known as the Maintenance Need Income Limit or MNIL, from the household's countable income for each non-applicant. Non-applicant children, however, are included in the ineligible spouse's MNIL.[54]

**Maintenance Income Need Level (MNIL)**

| Family Size | MNIL | Family Size | MNIL |
|---|---|---|---|
| 1 | $600 | 6 | $1,417 |
| 2 (1 adult + 1 child) | $750 | 7 | $1,550 |
| 2 Adults | $934 | 8 | $1,692 |
| 3 | $934 | 9 | $1,825 |
| 4 | $1,100 | 10 | $1,959 |
| 5 | $1,259 | | |

54. *Id.*

**Advocacy Tip:** Don't forget to deduct the MNIL from the countable household income for anyone living in the household who is not applying for the A&D FPL or Blind FPL programs.

Example: A woman who is disabled lives with her husband and three children. The husband earns $4005 per month and there is no other family income. Countable income is $1960 ($4005 – $20 – $65 = $3920; 3920 ÷ 2 = $1960). Then deduct the MNIL for four ($1100) family members who are not eligible and the resulting income of $860 is below the income limit.

**Resource Limits.** The maximum value of non-exempt property a beneficiary can have to be eligible for A&D FPL or Blind FPL Medi-Cal is $2000 for an individual and $3000 for a married couple.[55]

**Exempt resources.** Certain property an individual has does not count against the resource limits.[56] Some of those exemptions are:

- The individual's primary residence;
- Clothing, household goods and other personal items;
- One car;
- Certain items necessary for self-employment (*e.g.*, building, inventory or bank account) or that are used on the job (*e.g.,* tools or a second car).

### a. Special Rules for A&D FPL and Blind FPL Programs

**Individuals No Longer Eligible for SSI.** If beneficiaries are determined by the Social Security Administration to no longer meet SSI eligibility standards due to excess

55. 20 C.F.R. § 416.1205.
56. 20 C.F.R. §§ 416.1210 (effective 3/9/05) for a list of excluded resources; 20 CFR §§ 416.1216, 416.1218.

income or other non-disability related reasons, the counties must redetermine their eligibility under the A&D and Blind FPL programs and all other Medi-Cal programs, pursuant to a court order in the case of *Craig v. Bonta*.[57] The state and counties must follow specific procedures to ensure that these people do not lose their Medi-Cal when they lose their SSI and to address each beneficiary's ongoing Medi-Cal eligibility.[58] The counties should first determine whether the individual is eligible for Disabled Adult Child or Disabled Widow(er)s Medi-Cal, then Pickle Medi-Cal, then A&D FPL Medi-Cal, then Blind FPL Medi-Cal, in that order.

**Individuals who Allege a Disability.** If a child or adult who is determined to be no longer eligible for a specific Medi-Cal program states they have a disability, the county must review their eligibility for this and other Medi-Cal programs based upon disability. All the beneficiary has to do is allege a disability, either in writing or orally, and Medi-Cal coverage must continue until the disability evaluation is complete and final.[59] Counties should provide these individuals with any paperwork necessary to consider their eligibility based upon disability and send the application to the Disability Determination Service Division-State Programs (DDSD-SP), the state agency responsible for determining disability for Medi-Cal purposes.

### 7. 250% Working Disabled Program (250% WDP)[60]

The 250% Working Disabled Program (250% WDP) provides full-scope Medi-Cal to individuals who:

- Have countable income below 250% FPL;

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57. *Craig v. Bonta,* S.F. Superior Ct. No. CFF 02 500688 (2003); s*ee also, e.g.,* ACWDLs 07-24 (Nov. 9, 2007). http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c07-24.pdf; 03-53 (Nov. 14, 2003), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c03-52.pdf; 02-54 (Nov. 8, 2002),http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c02-54.pdf.
58. *Id.*
59. ACWDL 01-36 (June 19, 2001), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c01-36.pdf.
60. Federal law gives states the option of providing Medicaid benefits to individuals with family income below 250% FPL who would be entitled to SSI but for the fact that their income is too high to qualify for SSI. 42 U.S.C. § 1396a(a)(10)(A)(ii)(XIII). California has exercised its option to establish Medicaid benefits for the working persons with disabilities. Welf. & Inst. Code § 14007.9(a)(1).

- Meet the Social Security definition of "disabled;"
- Have countable resources below the limits allowed under SSI ($2,000 for an individual and $3,000 for a married couple);[61]
- Are U.S. citizens or have satisfactory immigration status; and
- Are working.

Individuals who qualify can obtain full-scope Medi-Cal benefits by paying monthly premiums under a schedule based upon their countable (non-exempt) income.[62]

**Advocacy Tip:** If an individual has a disability and is working, then consider eligibility under the 250% Working Disabled Program before considering the ABD-MN Share of Cost Program because the monthly premiums will likely be less than the Share of Cost obligation under the ABD-MN program. Also, the Social Security Administration's requirement that an individual be unable to participate in "Substantial Gainful Activity" (SGA) to qualify for SSDI benefits does not apply to this program.[63]

Another benefit of the 250% WDP is it allows enrollees to retain their earned income so they may accrue resources and not lose their eligibility. See the description of this unique benefit of the program in the "Exempting Retained Earned Income" later in this section.

**Working Individuals**

An individual must be working to qualify for this program. Applicants are considered working if they have *any* monthly earnings from work – there is no minimum amount of hours or pay. Work may also include earned in-kind income, if the earned in-kind

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61. The 250% WDP is a "deemed SSI eligible" program. 42 U.S.C. § 1396a(a)(10)(A)(ii)(XIII). Therefore, SSI methodologies for determining income and resources apply, and SSI income and resource exclusions apply with additional exclusions provided under state Medi-Cal law.
62. Welf. & Inst. Code § 14007.9(c), (d)(a)(1) (which exercises a federal Medicaid option under 42 U.S.C. §§1396r-1a and 1396a(a)(10)(A)(ii)(XIII)). ACWDL 00-16, (Mar. 16, 2000), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c00-16.pdf. Aid code: 6G (full-scope). There is no restricted scope 250% Working Disabled Program for undocumented immigrants.
63. Welf. & Inst. Code § 14007.9(a)(2)(1)(B).

is the only earnings.[64] An applicant must provide proof of employment and proof of earnings.[65]

Once enrolled in the 250% Working Disable Program, an individual can be temporarily unemployed and still remain on the program. For more information regarding periods of unemployment, see "Rules for Maintaining Eligibility" below.

**Individuals Who are Disabled**

An individual must meet the Social Security definition of disability, without regard to the "substantial gainful activity" component of the federal definition, in order to qualify for this program.[66] This means an individual must have a medically determinable physical or mental impairment that has lasted or is expected to last for at least one year which would qualify that individual to receive SSI or SSDI.[67]

**Income Limits**

To qualify for Medi-Cal under the 250% WDP, an unmarried individual's *countable* income (income minus allowable exclusions) must be below the 250% of the federal poverty level for a household of one.[68] If an individual is married and their spouse's income is deemed to them (or both spouses are applying), then countable income must be below 250% FPL for a household of two.[69] In addition, an individual must have countable income below the SSI/SSP benefit payment rate after excluding earnings from countable income.

**Income Exclusions**

The SSI income exclusions apply, with one important exception: ***all*** disability-based income is deducted.[70] This means that disability-based income – such as workers' compensation, SDI, or other Social Security benefits, and state and private disability

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64. ACWDL 00-51 (Sept. 27, 2000) at p. 6, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/00-51.pdf.
65. ACWDL 00-51, at p. 3. Proof of employment includes but is not limited to pay stubs, written verification of employment from an employer, contracts, or 1099 IRS forms.
66. Welf. & Inst. Code § 14007.9(a)(2)(1)(B).
67. 42 U.S.C. § 1382c(a)(3).
68. Welf. & Inst. Code § 14007.9(a)(1)(A).
69. *Id.*
70. 42 C.F.R. § 435.831(b)(2); Welf. & Inst. Code § 14007.9(b)(1). See section B.6 for the SSI income deductions and exclusions.

income – is not counted in determining an individual's eligibility for the 250% WDP. An individual's Title II Social Security Disability Insurance that converts to Social Security Retirement when that individual reaches retirement age is also not counted.[71]

**Income Deeming**

Only count the income of the applicant (except for disability income) and the spouse, if the applicant is married. If the applicant is a child, count the parent's income.

**In-Kind Support and Maintenance:** Special rules count the value of food, clothing, or shelter given to the individual (or paid for) by another.[72] Shelter includes room, rent, gas, electricity, water, sewer, and garbage collection services.[73]

**Advocacy Tip:** Counties must first determine eligibility for MAGI Medi-Cal for each family member, including for working persons with disabilities before looking at the 250% Working Disabled Program. Family members who are eligible for the 250% WDP are their own households, even if they are a child. They are treated as an "other public assistance" exception, i.e., the individual and his or her income are not included in the family's household when determining other family members' eligibility for Medi-Cal. However, a 250% WDP-eligible married couple is grouped together in the same household.

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71. Welf. & Inst. Code § 14007.9(b)(5); ACWDL 11-38 (Nov. 9. 2011), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c11-38.pdf. The exemption of disability income that converts to retirement income is limited to Social Security disability benefits and is not applicable to other public or private retirement entities, such as when an individual receives disability from the California Public Retirement System but then qualifies for Social Security income based on retirement.
72. ACWDL 00-51 at p. 4; *see also* ACWDL 00-16 (Mar. 16, 2000), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c00-16.pdf.
73. *Medi-Cal Eligibility Procedures Manual*, 5R-6.

**Resource Limit**

The 250% Working Disabled Program has the same resource limits as the SSI program.[74] This means that the maximum value of non-exempt property an individual can have is $2,000 for an individual and $3,000 for a married couple.[75]

**Special Property Deduction:** Individual retirement accounts (IRAs) or other retirement plans (e.g. Keogh's or 401(k) plans) *do not count* as property even if the individual has access to them.[76]

**Exempt Property:** Because the 250% Working Disabled Program follows SSI's rules for excluding resources as well as Medi-Cal rules providing additional exclusions, property that is considered exempt under SSI is also considered exempt under 250% WDP.[77] Some of those exemptions are:

- The individual's primary residence;
- Clothing and personal items;
- One car; and
- Certain items necessary for self-employment (*e.g.*, building, inventory or bank account) or that are used on the job (*e.g.,* tools, or a second car).

**Exempting Retained Earned Income:** Money that is earned from working while enrolled in the 250% WDP can be exempted from the program's resource limits of $2000 for an individual and $3000 for a couple.[78] This money is exempt so long as the money is put into a separately identifiable account from the enrollee's checking and savings account that are counted as resources under the Medi-Cal program.[79] There is no limit on the amount of earned income an individual can keep in the separately identifiable account.[80] ***This means that an individual enrolled in the 250% WDP is able to build assets without jeopardizing eligibility.*** An individual who loses 250% WDP eligibility but continues to receive Medi-Cal in a program

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74. Welf. & Inst. Code § 14007.9(a)(3).
75. 20 C.F.R. § 416.1205(c).
76. Welf. & Inst. Code § 14007.9(b)(2).
77. *See* 20 C.F.R. § 416.1210 for a list of excluded resources.
78. Welf. & Inst. Code § 14007.9(b)(4); ACWDL 11-38.
79. *Id.*
80. ACWDL 11-38, p. 3.

that requires age, blindness or disability as the basis for eligibility will keep these additional property exclusions.[81]

**Premium Costs**

All eligible individuals for the 250% Working Disabled Program must pay premiums based upon their countable income.[82] There is a minimum premium of $20 per individual per month and a maximum premium of $250 per individual per month.[83] The following chart outlines the various premiums based upon countable income.[84]

**250% Working Disabled Program Premiums**

| Countable Monthly Income | Monthly Premium: Individual | Monthly Premium: Married Couple |
|---|---|---|
| $1 - $600 | $20 | $30 |
| $601 - $700 | $25 | $40 |
| $701 - $900 | $50 | $75 |
| $901 - $1100 | $75 | $100 |
| $1101 - $1300 | $100 | $150 |
| $1301 - $1500 | $125 | $200 |
| $1501 - $1700 | $150 | $225 |
| $1701 - $1900 | $175 | $275 |
| $1901 - $2100 | $200 | $300 |
| $2100 – up to 250% FPL for 2 | $250 | $375 |

Premium payments are due by the 10th of each month. 250% WDP enrollees may pay their premiums via electronic fund transfer (EFT) for free to the Department of Health Care Services at www.paycalifornia.com, or by mailing payment to DHCS.[85]

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81. Weif & Inst. Code § 14007.9(c); ACWDL 11-38.
82. Welf. & Inst. Code § 14007.9(d).
83. Welf. & Inst. Code § 14007.9(d)(f)(1).
84. ACWDL 00-16, Enclosure 3 at p. 10; *Medi-Cal Eligibility Procedures Manual*, 5R-5.
85. Welf. & Inst. Code § 14007.9(g). For more information on how enrollees may pay their premiums, see Medi-Cal form MC 0384 (Rev. 12/12).

An individual may be disenrolled from the program for failure to pay the required premiums for two consecutive months.[86]

**Rules for Maintaining Eligibility**

As long as a low-income adult or child meets the disability criteria, is working, meets the income and resource limits, and pays the monthly premium, they should remain eligible for the program.

Beneficiaries in the 250% Working Disabled Program may experience periods of unemployment and still retain their eligibility. Breaks in employment are limited to 26 weeks total during an annual eligibility time period, and an enrollee must continue to pay premiums during those times to retain their eligibility (although counties are not responsible for enforcing the collection of premium payments during the period of unemployment).[87]

As is the case with other Medi-Cal programs, if an individual loses eligibility for 250% WDP then the county must always undertake a review to determine whether the individual is eligible for Medi-Cal on any other basis.[88]

**Advocacy Tip:** If an individual who is receiving SSI loses their eligibility due to increased earnings, make sure the county has redetermined the individual's eligibility for Medi-Cal both under the A&D FPL Program and the 250% WDP.

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86. ACWDL 00-16, p. 3.
87. Welf. & Inst. Code § 14007.9(a)(2); ACWDL 11-38 (Nov. 9, 2011), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c11-38.pdf.
88. ACWDL 00-51, p. 5. If beneficiaries lose eligibility for the 250% WDP and they have retirement accounts such as IRAs or 401k accounts, those accounts will continue to be exempt as resources, meaning they will not be considered countable resources, if the beneficiaries are found to be otherwise eligible for other Medi-Cal programs that require age, blindness or disability as the basis for eligibility. Welf. & Inst. Code § 14007.9(c); ACWDL 11-38 at p.4.

### 8. Aged, Blind and Disabled – Medically Needy (ABD-MN): Free and Share of Cost

Individuals who are over age 65 or disabled can receive Medi-Cal under the Aged, Blind and Disabled Medically Needy (ABD-MN) program[89] if the individual:

- Does not want to receive SSI;[90]
- Is not eligible for SSI because the individual does not meet an SSI eligibility condition that does not apply to the Medi-Cal program;[91] or
- Has an application pending for SSI.[92]

Individuals who qualify as ABD-MN usually do not get free Medi-Cal, but rather have to pay a "Share of Cost" (SOC).[93] This means that they must "spend down" their income to a specific Medi-Cal eligibility level each month that they use Medi-Cal in order for their Medi-Cal coverage to take effect. Share of Cost is explained later in this section.

The county must refer individuals who may be eligible for SSI, and who agree to apply for that program, to the Social Security Administration for a determination of SSI/SSP eligibility.[94] Pending the SSI/SSP determination, the county department shall determine eligibility under any other program for which the individual may be eligible.[95] This includes the ABD-MN program.

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89. 42 U.S.C. § 1396a(a)(10)(C); 42 C.F.R. §§ 435.300 *et seq.,* 435.800 *et seq*. and 436.800 *et seq*.; Welf. & Inst. Code §§ 14005.7(c), 14005.9 and 14051; 22 CCR §§ 50203; 50401 *et seq*.; 50501 *et seq*.; 50549 *et seq*.; 50555.1. Note: For rules regarding the deeming of income from parents to a disabled child to determine if the child is eligible for SSI, go to http://www.disabilityrightsca.org/pubs/PublicationsSocialSecurity.htm.
90. 22 CCR § 50203. This is an "optional categorically needy" program under federal law. 42 C.F.R. § 435.210.
91. *Id*. This is a "mandatory categorically needy" program under federal law. 42 C.F.R. § 435.122.
92. *Id*.
93. ABD-MN aid codes with no Share of Cost: 14 (Aged), 24 (Blind), 64 (disabled); C1 (restricted, aged), C3 (restricted, blind), C7 (restricted, disabled). ABD-MN aid codes with Share of Cost: 17 (aged), 27 (blind), 67 (disabled); C2 (restricted, aged), C4 (restricted, blind), C8 (restricted, disabled).
94. 22 CCR § 50153(b)(3).
95. 22 CCR § 50153(b)(3)(b).

**Advocacy Tip:** If someone loses SSI, or is ineligible for SSI for some reason other than general, categorical or financial eligibility, check the Medi-Cal regulations, Medi-Cal Eligibility Procedures Manual, and ACWDLs to see if that eligibility condition under SSI exists in the Medi-Cal program. If it does not, the individual may receive Medi-Cal under this program. For example, so called "fugitive felons" are ineligible for SSI benefits under some circumstances, but remain eligible for Medi-Cal. Therefore, if the county has terminated Medi-Cal or refuses to take a Medi-Cal application because the individual is ineligible for SSI, insist on the application being processed; it may turn out that the individual was determined ineligible for SSI due to a requirement that does not exist under Medi-Cal, and therefore the individual could be entitled to Medi-Cal after all.

**Income**

To qualify for Medi-Cal under the ABD-MN Program without a SOC, a household's *countable income* (income minus allowable deductions) must be below the Maintenance Needs Income Level (MNIL) for the household's size. See the MNIL chart later in this section. If the household's income limit is above the MNIL, the beneficiary will have a Share of Cost.

**Income Exemptions**

Certain income does not count in determining ABN-MN eligibility. The ABD-MN program follows the SSI income exemption rules.[96] Exempt income includes, among others:

- Public Assistance, including social services, foster care payments and public housing assistance;[97]

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96. 42 C.F.R. §§ 435.811(c) and 435.831(b)(2); 22 CCR §§ 50521 through 50544. 20 C.F.R. §§ 416.1102 and 416.1103 set out the SSI income counting rules. *See also* the discussion above for the A&D FPL Program, which also follows the SSI rules.
97. 22 CCR §§ 50525 (public assistance), 50527 (social services), 50531 (foster care), 50529 (Section 8 or federal HUD housing assistance), 50535 (relocation assistance).

- Voluntary job training programs and assistance;[98]
- Public education loans, work study payments grants and educational expenses;[99]
- Property tax refunds or rebates and earned income tax credits;[100]
- Renters assistance;[101]
- One-third of child-support received for a child with disabilities;[102] and
- Wages placed in a cafeteria plan to pay medical expenses or child care.[103]

**Income Deductions**

Not all non-exempt income is considered when determining an individual's income for purposes of the ABD-MN program. Instead, individuals are allowed to take certain deductions that reduce the amount of countable income. The ABD-MN program also follows the SSI income exclusion rules and more generous Medi-Cal rules.[104] The following monthly exclusions are available:

- $20 from either earned or unearned income – this is called the $20 "any income" deduction;[105]
- Earned income deductions;
- Any unused portion of the $20 "any income" deduction;[106] (described above)
- $65, plus one-half of the remainder of gross earned income;[107]
    - Impairment-Related Work Expenses (IRWE's) for people who are disabled under the SSI standard (the IRWE deduction is taken after subtracting one-half of the remainder, as described above).

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98. 22 CCR §§ 50530 (Dept. of Rehab training grant), 50538 -41 (other programs).
99. 22 CCR §§ 50533 and 50546.
100. 22 CCR §§ 50523 and 50543.5.
101. 22 CCR §§ 50523.5 (assistance from the California Franchise Tax Board), 50535 (relocation funds). *See also* 50454.5(a)(1) (renters credit among the type of assistance that may be provided by the California Franchise Tax Board).
102. 22 CCR § 50549.1
103. 20 C.F.R. § 404.1053.
104. 42 C.F.R. §§ 435.811 and 435.831(b)(2); 20 C.F.R. §§ 416.1102, 416.1103; 22 CCR §§ 50519 and 50545-50555.2; *see also* the discussion above for the A&D FPL Program, which also follows the SSI rules.
105. 22 CCR § 50549.2.
106. 22 CCR § 50551.2.
107. 22 CCR § 50551.3. Note that Temporary Workers Compensation, State Disability Income (SDI) and Unemployment Insurance (UI) are treated as unearned income. 22 CCR § 50507.

    - The Blind Work Expense (BWE) deduction, which is a deduction for all work expenses available to those who are blind under the SSI standards (the BWE deduction is taken before subtraction of the one-half the remainder, as described above).
- Health benefit/insurance premiums;[108]
- MNIL: The family's monthly maintenance need income level (see MNIL chart later in this section).

**Income Deeming: *Sneede/Gamma* Rules**

"Income deeming" refers to the rules on whether to count the income of others to determine an individual's non-MAGI Medi-Cal eligibility. There are two important court cases regarding Medi-Cal deeming. The first is *Sneede*, in which the court addressed when and how another individual's income can count in determining an individual's Medi-Cal eligibility.[109]

When there are income earners in the home who are children or who are adults other than an applicant's parent or spouse, their income must not count in determining the applicant's income eligibility.[110] The reason is that the legal obligation to support runs only between spouses, and between parents and their children, and not, for example, between siblings or between stepchildren and stepparent.[111] For example, if a child applicant's 10-year-old brother earns money from a paper route, that money is not available to the applicant and should not be counted against the applicant. Likewise, if an applicant's stepmom is in the home and she works, her earnings are not considered available for the support of the applicant. In contrast, in the case where the applicant is married the spouse's income will be considered if the spouse is in the same household. Similarly, in the case of a child applicant, the parent's income is counted if the parent is in the same

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108. 42 C.F.R. § 435.831(e)(1); 22 CCR § 50555.2.
109. *Sneede v. Kizer,* 728 F.Supp. 607 (N.D. Cal. 1990).
110. 42 U.S.C. § 1396a(a)(17)(D); 42 C.F.R. § 435.602(a)(1).
111. The Affordable Care Act's adoption of MAGI methodology did not change the income deeming rules regarding stepparents and stepchildren in the non-MAGI programs. Therefore, in the MAGI Medi-Cal programs a stepparent's income is deemed to a stepchild, while in the non-MAGI programs a stepparent's income would not be deemed to the stepchild under the *Sneede* rule.

household with the child.[112]

However, even if another individual's income can be deemed to the applicant, not all of that income is considered available to the applicant. The *Gamma* court held that a parent or spouse can first deduct a "personal need allowance" from her income for her own living expenses before income is deemed to family members for whom she is legally responsible.[113]

When to use ***Sneede*** and ***Gamma*** Rules

*Sneede/Gamma* procedures are only applicable if the combined income of the family makes the family ineligible for free Medi-Cal **and** one of the following is true:

- One of the children has their own income or;
- A stepparent or an unmarried parent lives in the home; or
- A caretaker relative cares for the child seeking Medi-Cal.

Therefore, an adult applicant would only count her income and the income of her spouse, if they are in the same household. And if the applicant is a child, the income of the parent would be counted to the child if the parent lives with the child.

If a child has her own income, special prorated income limits apply and *Sneede* procedures must be applied to the Medically Needy eligibility determination, where the child is kept in a separate mini-budget unit (called a MBU).[114] In addition, if more than one individual in the family is aged, blind or disabled, the income deductions (discussed above) are subtracted from the combined nonexempt income of all aged, blind and disabled medically needy individuals in the household and the spouse or parents of these individuals. Finally, if income from a family member is deemed to be available to one family member applicant, it cannot be counted again in determining

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112. In these cases, these individuals would be considered part of the same Medi-Cal Family Budget Unit (MFBU). *See* 22 CCR §§ 50351, 50371, 50373, 50557.
113. *Gamma v. Belshe*, No. C94-0852 (N.D.Cal 1995) *reprinted at Medicare & Medicaid Guide* (CCH), ¶ 40,003.
114. 22 CCR §§ 50381(a), 50558(a), (b).

another family member's eligibility.[115]

**Resource Limits**

The ABD-MN program follows the SSI resource rules, but also has more generous limits and exclusions.[116] In order to qualify for ABD-MN, the family's property must be below certain property limits (see chart below).[117] In addition, applicants who are over the property/resource limit at the time they submit their application have until the end of the month to reduce their property to the resource limits.[118] This is called the "spend down" of resources. If an applicant successfully spends down to the resource limit before the end of the month of application, they will be eligible for Medi-Cal for that entire month.[119]

**Aged, Blind and Disabled-Medically Needy: Property Limits**

| Family Size | Property Limits |
|---|---|
| 1 | $2,000 |
| 2 | $3,000 |
| 3 | $3,150 |
| 4 | $3,300 |
| Per Add'l Individual | Add $150 |

115. 22 CCR §§ 50555.1, 50557(b). For more guidance on how to apply the *Sneede/Gamma* rules, see the Health Consumer Alliance's fact sheets on income deeming, which can be found at http://healthconsumer.org/publications.htm. Note these fact sheets are pre-Affordable Care Act when the *Sneede/Gamma* rules were used by more families. Now, MAGI Medi-Cal allows access to free care for more family members at higher incomes than the ABD-MN Medi-Cal Program. Those who are not MAGI Medi-Cal eligible may find more generous benefits through a Covered California plan with financial assistance than a Medi-Cal Share of Cost program in many circumstances. Nonetheless, if an individual finds the cost-sharing in Covered California to be too expensive for their particular health care needs (or is over age 65), it is worth checking if the *Sneede/Gamma* rules work to their benefit.
116. 42 C.F.R. § 435.840(b). See 22 CCR §§ 50418 and 50425 – 50489 for the types of property that are considered exempt and not included in determining eligibility.
117. 22 CCR § 50420(a).
118. 22 CCR § 50420(c)(1).
119. *Id.*

**Resource Exemptions**

Some property does not count as a resource for this program. Exempt property includes, but is not limited to:[120]

- Primary residence (home);[121]
- One car (plus a second car if it is used for work to produce income – not just to get to and from work);[122]
- Household items and personal effects (including furniture, appliances, clothing and some jewelry);[123]
- Equipment and property necessary for self-support while at work or in own business;[124] and
- Retirement accounts (IRA's, programs through work) of parents who are ineligible family members, *i.e.*, not eligible for or electing Medi-Cal.[125]

**Medi-Cal "Share of Cost"**

As previously mentioned, individuals who qualify as ABD-MN usually do not get free Medi-Cal, but rather have what is known as a Share of Cost (SOC). Share of Cost is a sliding-scale monthly payment based on the income above the Medi-Cal income level for free care for the medically needy, known as the Maintenance Needs Income Level (MNIL).[126] If an applicant's income is below the Maintenance Need Income Level for her family size, she qualifies for free ABD-MN, meaning she has no Share of Cost. Medi-Cal Share of Cost programs do not count as *minimum essential coverage* for purposes of the individual mandate of the Affordable Care Act. Currently, there is an exemption for individuals in Medi-Cal Share of Cost programs to avoid the tax penalty imposed on individuals without minimum essential coverage. Nonetheless,

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120. *See* 20 C.F.R. §§ 416.1210, 416.1212, 416.1216, and 416.1218; 22 CCR §§ 50418 and 50425 – 50489.
121. 20 C.F.R. § 416.1212; 22 CCR § 50425.
122. 20 C.F.R. §§ 416.1218, 416.1220.
123. 20 C.F.R. § 416.1216; 22 CCR §§ 50465, 50467.
124. 20 C.F.R. § 416.1220.
125. ACWDL 02-51 (October 18, 2002), at p. 2, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c02-51.pdf.
126. The MNILs are fixed amounts according to family size that have not been changed in California since 1989. *See, e.g.,* ACWDL 92-49 (July 23, 1992), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c92-49.pdf.

persons under age 65 should check whether a Covered California plan with financial assistance would better serve their needs.

**Family Maintenance Income Need Level (MNIL)**

| Family Size | MNIL | Family Size | MNIL |
|---|---|---|---|
| 1 | $600 | 6 | $1,417 |
| 2 (1 adult + 1 child) | $750 | 7 | $1,550 |
| 2 Adults | $934 | 8 | $1,692 |
| 3 | $934 | 9 | $1,825 |
| 4 | $1,100 | 10 | $1,959 |
| 5 | $1,259 | | |

Each month, individuals who are above their MNIL must "spend down" their income by paying for medical expenses on their own until they meet their SOC for that month. After meeting the SOC for the month, Medi-Cal will pay for the remainder of the covered services in that month. SOC is a dollar-for-dollar amount; if the beneficiary is $70 over the MNIL, the SOC is $70. If the beneficiary is over $71, the SOC is $71. Medi-Cal with a SOC is not to be confused with a monthly premium; unlike a premium, SOC is not owed in months the beneficiary does not seek services.

**Advocacy Tip:** Always first look to see if the individual or family qualifies for a free Medi-Cal program, such one of the MAGI Medi-Cal programs. Income standards in these programs are more generous and there is no Share of Cost for the beneficiary. If the individual is disabled and working, then look at eligibility under the 250% Working Disabled Program, which typically has a smaller premium than the Share of Cost owed under the ABD-MN program. Finally, in many instances, a Covered California plan with financial assistance would be cheaper than enrollment in the ABD-MN program, depending on the Share of Cost and whether certain services provided only through Medi-Cal were needed.

**Determining Share of Cost**

If an applicant's countable family income exceeds the Maintenance Need Income Level, the applicant will have a Share of Cost. As discussed above, the family's *countable income* is determined by subtracting any allowable exempt income and deductions from total income. The amount by which the *countable income* exceeds the Maintenance Need Income Level, based upon the number of people in the family, is the Share of Cost.[127]

**Example:** If a family of 4 has a monthly countable income of $2,000 and a Maintenance Need Income Level of $1,100, the family must incur a $900 Share of Cost ($2,000 - $1,100 = $900) before Medi-Cal will cover their medical care in any month they seek care from Medi-Cal coverage.

Beneficiaries can meet their Share of Cost obligation amount by either paying for, or agreeing to pay for costs incurred for medical goods and services (even services or supplies Medi-Cal would not cover).[128]

**Continued Eligibility for ABD- MN Benefits**

As long as an individual is age 65 or older or meets the disability criteria, and also meets the income and resource limits, they should remain eligible for the program. The individual's Share of Cost may also fluctuate depending on family size, income, or deductions, so it is important for the individual to report any change right away to the county eligibility worker.

### C. Full-Scope Non-MAGI Medi-Cal for Children and Families

Most children and families are now found eligible for Medi-Cal under MAGI rules. However, there are still some programs that do not use the MAGI methodology to determine a child or parent's eligibility for Medi-Cal – largely because these programs are not reliant on income determinations at all, but rather connection to another program. The following non-MAGI programs provide full-scope no-cost Medi-Cal for children or families.

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127. 22 CCR § 50653.
128. 42 C.F.R. § 435.831(i)(1)(ii); 22 CCR § 50655; *see also Johnson v Rank*, 110 F.R.D. 99 (N.D. Cal 1986).

### 1. Automatic Eligibility Due to Receipt of Government Benefits

Just as for individuals receiving SSI, families receiving welfare cash assistance and children receiving assistance because they no longer live with their biological parents are linked to Medi-Cal by their eligibility for those programs. Children and families who receive the following types of state or federal government benefits are categorically-linked to Medi-Cal and are automatically eligible for full-scope Medi-Cal:

- **Federal foster care benefits:**[129] These benefits are also called *Youakim* if the child is placed with a relative.
- **Adoption Assistance Payments (AAP):**[130] Federal benefits for children with "special needs."
- **CalWORKs:**[131] State welfare cash assistance.
- **State foster care benefits:** For children who do not meet the eligibility requirements of federal foster care.[132] For example, children do not have to be removed from their home by a court order to be eligible for state foster

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129. 42 U.S.C. §§ 672; 1396a(a)(10)(A)(i)(I); 42 C.F.R. § 435.115(e)(2). Generally, a child's eligibility for federal funding under Title IV-E of the Social Security Act which covers federal foster care benefits is based on whether the child was eligible for Aid to Families with Dependent Children (AFDC) while living with a parent in the month prior to the Dependency Court petition being filed or the signing of a Voluntary Placement Agreement. 42 U.S.C. § 672(a)(1)(B), (a)(3)(A). Under the holding of *Rosales v. Thompson,* 321 F.3d 835 (9th Cir. 2003), a child can still meet this requirement if that child lived with a relative at any time during the six months prior to the petition being filed in Dependency Court or the Voluntary Placement Agreement being signed. "Youakim" is the term used if the child is federally eligible for federal foster care funding and living with a relative; it comes from the case *Youakim v. Miller,* 425 U.S. 231 (1976). It is the relative's version of federal foster care funding. These children receive Medi-Cal in Aid Codes 42, 46, and 49 (for non-minor dependents aged 18 up to 21). ACWDL 12-03 (Jan. 10, 2012).
130. The Adoption Assistance Program is a cash grant program to facilitate the adoption of children who are hard to place who would require permanent foster care placement without this assistance. 42 U.S.C. §§ 673(a)(1)(B), 1396a(a)(10)(A)(i)(I), 42 C.F.R. § 435.115(e)(1). These children receive Medi-Cal in Aid Codes 03, 04, 06, 07, and 4A. 42 U.S.C. §§ 673(a)(1)(B), 1396a(a)(10)(A)(i)(I), 42 CFR § 435.115(e)(1) and ACWDLs 12-03 (Jan. 10. 2012); 08-30E (Feb. 25, 2009), and 00-22 (Apr. 10, 2000).
131. Welf. & Inst. Code § 14005.30(a)(2); 22 CCR §§ 50525, 50528. The CalWORKs-linked aid codes are 30, 31, 32, 33, 35, 3A, 3C, 3D, 3E, 3F, 3G, 3H, 3L, 3M, 3P, 3U, 3W, and K1.
132. Welf. & Inst. Code § 11401; 22 CCR § 50531. These children receive Medi-Cal in Aid Code40, 43, 45, 4C, 4H, 4L, 4K, 4N, 4P, 4R, and 5K (for non-minor dependents aged 18 up to 21).

care benefits.[133]

- **Kin-GAP:** State cash assistance to certain children under 18 who were dependents in the foster care system and who are now living with relatives who have obtained a guardianship.[134] Kin-GAP children receive cash benefits at an amount identical to the basic federal foster care rate.[135]

### 2. Children in Foster Care

Most children who have been abandoned by their parents or removed from their parents' custody are eligible for free Medi-Cal regardless of their immigration status, with very limited exceptions (although immigration status can affect the scope of Medi-Cal benefits). The process by which a child becomes eligible, however, can be affected by how the child came to live outside the parents' home. If a child was removed from the parents' custody by a court order due to allegations of abuse, neglect, or abandonment, the child does not have to separately apply for Medi-Cal. For children in the foster care system, the county must either apply for them or help them apply.

Once eligible, there is no reason that a child in foster care should lose his or her Medi-Cal eligibility while in foster care, other than death.

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133. *Id.* at (c) or (d).
134. Welf. & Inst. Code §§ 11363-11366; ACWDL 00-22 (Apr. 10, 2000), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c00-22.pdf. These children receive Medi-Cal in Aid Codes 4F, 4G, 4S, 4T, and 4W.
135. Welf. & Inst. Code § 11364; DSS ACL 99-97, p.2 (Nov. 4, 1999).

**Immigrant Children in Foster Care:** Immigrant children who are in foster care are subject to the same rules and requirement as immigrant children who are not in foster care. Until Health for All Kids (SB 75) is implemented in 2016 and all otherwise eligible children are granted full-scope Medi-Cal regardless of immigration status, advocates should keep the following rules in mind:[136] Children who are either qualified immigrants or permanently residing under color of law (PRUCOL) immigrants are eligible for full-scope Medi-Cal if they meet all eligibility requirements. Children who do not have immigration documentation are eligible for restricted Medi-Cal if they meet all eligibility requirements. Counties and attorneys can help undocumented children in foster care apply for "Special Immigrant Juvenile Status."[137] Children who have applied for Special Immigrant Juvenile Status are considered PRUCOL immigrants because they have permission to remain in the United States. Once granted Special Immigrant Juvenile Status, they will receive a green card. For a more detailed discussion of immigration status and its effect on Medi-Cal eligibility, see Chapter 1.

**Special Rule Regarding Children in Foster Care and Managed Care Plans**

Children in foster care are not required to enroll in a Medi-Cal managed care plan, and are not included in a mandatory managed care enrollment category unless they reside in a county with a County Operated Health System, where enrollment in managed care is mandatory and fee-for-service providers difficult to find.[138] For children outside a County Operated Health System county, the Department of Children and Family Services may enroll a foster care child in managed care if the agency, in consultation with the child's caregiver, determines that such enrollment

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136. See Chapter 1, Section A.2 for an explanation of the new Health for All Kids program which will allow undocumented children access to the same Medi-Cal programs as other children.
137. 8 U.S.C. § 1101(a)(27)(J); 8 C.F.R. § 204.11. *See also* State Plan Amendment 13-0026MM (effective January 1, 2014).
138. Welf. & Inst. Code § 14093.09; *see also* ACWDLs 00-13, p.2 (Mar. 22, 2000), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c00-13.pdf and ACWDL 97-02 (Jan. 13, 1997), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/97-02.pdf. COHS counties are Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura and Yolo.

is in the best interest of the child.[139] However, specialty mental health services are provided entirely by a managed care system. The child must have those services arranged and authorized through the County Mental Health Plan in their county of origin, even if those services are provided in the placement county.[140]

**3. Former Foster Youth Under Age 18 and Not Living with their Parents**

All other children who used to be in foster care but no longer live with their parents are still likely to be Medi-Cal eligible because only the child's income counts toward that child's eligibility.[141] Public assistance cash grants that the child receives, such as CalWORKs and SSI,[142] do not count as income for Medi-Cal eligibility purposes.

**4. Former Foster Youth 18 and Older**

Before the Affordable Care Act, children who aged out of foster care on their 18th birthdays were entitled to Medi-Cal under the Former Foster Care Children's (FFCC) Program until they turned 21.[143] The Affordable Care Act extends Medicaid eligibility to former foster youth to age 26.[144]

As of January 1, 2014, youth who were in foster care on their 18th birthday and received Medi-Cal while in foster care are eligible for Medi-Cal up to age 26.[145] Former foster youth are eligible for Medi-Cal regardless of their income, resources,

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139. Welf. & Inst. Code § 14093.09(a).
140. Welf. & Inst. Code §§ 5777.7, 11376, and 11380.9; Department of Mental Health Info. Notice 09-06 (May 4, 2009).
141. *Sneede v. Kizer*, 728 F. Supp. 607 (N.D. Cal. 1990); *Medi-Cal Eligibility Procedures Manual*, Article 8F.
142. 22 CCR §§ 50525, 50528.
143. *See* ACWDLs 00-61 (Nov. 22, 2000), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/00-61.pdf and 00-41 (Aug. 14, 2000), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/00-41.pdf for information on Medi-Cal eligibility for former foster youth prior to the Affordable Care Act.
144. 42 U.S.C. § 1396a(a)(10)(A)(i)(IX); Proposed 42 C.F.R. § 435.150.
145. 42 U.S.C. § 1396a(a)(10)(A)(i)(IX); Welf. & Inst. Code § 14005.28(a); ACWDL 14-41 (Feb. 5, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-41.pdf; MEDIL 14-05 (Jan. 17, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-05.pdf; MEDIL 13-07 (Jun. 28, 2013), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL%20I13-06.pdf.

other insurance, and living arrangements (unless they are institutionalized or incarcerated). Even if they have significant resources, income, insurance from work, or live at home, they are still eligible for this program.[146] Former foster children qualify for full-scope Medi-Cal until age 26 regardless of their immigration status.[147] This extended coverage to age 26 is also available to former foster youth who turned 18 in foster care in another state and have subsequently moved to California.[148] However, if the former foster youth was not receiving Medi-Cal (or Medicaid in her state of origin) while in foster care, that individual can only receive Medi-Cal under the FFCC Program up to age 21.[149]

Individuals in foster care on their 18th birthday are to be automatically enrolled in Medi-Cal under the FFCC Program, Aid Code 4M, without any interruption in coverage, without requiring a new application, and without having to provide additional information.[150] Former foster youth who did not get automatically enrolled in Medi-Cal should go to their local county office and get enrolled using the simplified, one-page application for former foster youth.[151] For more information regarding former foster youth getting Medi-Cal, see Chapter 5 section A.2.i.

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146. *See, e.g.,* ACWDL 14-41, at Qs. 6 and 7.
147. ACWDL 15-29 (Sept. 16, 2015) at p.3, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-29.pdf (instructing counties that in the rare case when a former foster youth exits foster care without immigration status for federal Medicaid eligibility, the former foster youth should submit a Statement of Citizenship, Alienage and Immigration Status (MC 13 form) and upon receipt of the individual's attestation counties are to enroll the individual in full-scope Medi-Cal Aid Code 4M).
148. *Id.* ACWDL 14-41, at Q. 4.
149. 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVII); proposed 42 C.F.R. § 435.226; ACWDL 14-41 (describing the population of former foster care youth who did not receive Medicaid in foster care as the "optional coverage group" and the former foster youth who were in foster care at age 18 and received Medicaid as the "mandatory coverage group").
150. Welf. & Inst. Code § 14005.28(a)(1); ACIN I-31-15 (July 22, 2015); ACWDL 14-41; MEDIL I 14-05; MEDIL 13-07. Individuals who were previously enrolled in aid codes 40, 42, 43, 45, 46, 49, 4C,4H, 4L, 4N, or 5K are all eligible under the ACA FFCC extension with aid code 4M up to the age of 26. MEDIL 14-05.
151. As of January 2014, the California Healthcare Enrollment, Eligibility and Retention System (CalHEERS) was not programmed to disregard income determinations for former foster youth. MEDIL 14-05. A system fix was scheduled to go live September 2015 to ensure that former foster youth who apply online through Covered California or otherwise have their information run through CalHEERS will receive correct eligibility determinations. And as of March 2016, former foster youth will be allowed to skip unnecessary questions such as about income and taxes on the online application.

### 5. Transitional Medi-Cal (TMC)

Transitional Medi-Cal allows families who are leaving welfare or are no longer eligible for Medi-Cal due to increased earnings to keep their Medi-Cal benefits for up to one year.[152] Transitional Medi-Cal is a critical Medi-Cal eligibility extender for families, but is only available to parents, caretaker relatives, and children who are enrolled in the MAGI Parents and Caretaker Relatives, MAGI Children or CalWORKs-linked programs. This is because Transitional Medi-Cal is available to families who receive Medi-Cal under the provisions of Section 1931(b) of the Medicaid statute, which the Affordable Care Act consolidated into the MAGI Parent/Caretaker Relative and Children's categories, or through CalWORKs.[153]

As soon as a county eligibility worker determines that a family will lose Medi-Cal due to increased income and they are in Parent or Caretaker Relative aid codes, the MAGI Medi-Cal Children's aid codes (not TLICP aid codes), or a CalWORKs aid code, the county must automatically transfer the family into the Transitional Med-Cal program to ensure there is no break in coverage. [154]

**Leaving Welfare or Medi-Cal:** To qualify for Transitional Medi-Cal, a family must be losing CalWORKs or Medi-Cal eligibility as a Parent/Caretaker Relative or the MAGI Medi-Cal Children's aid codes for one of the following reasons:

1. Increased earnings from employment;
2. Loss of earned income disregards; or
3. Increased hours of employment.[155]

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152. 42 U.S.C. §§ 602(a)(37); 1396a(e)(1)(B) and 1396r-6; Welf. & Inst. Code §§ 14005.75, 14005.76, 14005.8-14005.89. TMC was established by Congress and the Reagan Administration in 1988 as a work incentive to allow families leaving welfare to keep Medi-Cal for up to one year even if their earnings go over the welfare income limit. The purpose of TMC was to encourage families leaving welfare to work and remain employed by continuing their Medi-Cal coverage.
153. CMS, Frequently Asked Questions, "Medicaid/CHIP Affordable Care Act Implementation FAQs: Eligibility Policy," at Q.5 (May 22, 2012) (stating that the ACA did not repeal § 1931 and that it continues under the ACA through the MAGI Medi-Cal programs for parents, caretaker relatives, pregnant women, and children).
154. Welf. & Inst. § Code 14005.8(a)(1).
155. Welf. & Inst. Code § 14005.8(a)(1).

A family must have received CalWORKs or Medi-Cal for at least three months of the six months immediately prior to the month in which the family became ineligible.[156]

**Age:** To be eligible a family must have a child living in the home who is under age 18, or under 19 if the child is enrolled in school and expected to graduate before her 19th birthday.[157] There is no age limit for a parent or caretaker relative to receive Transitional Medi-Cal.

**Income**: For the first six months of Transitional Medi-Cal, there is no income limit.[158] After the initial six months, the family can stay on Transitional Medi-Cal if its countable income is below 185% FPL.[159]

**Advocacy Tip:** If a beneficiary does not receive a notice about her right to receive Transitional Medi-Cal, or how to continue to receive it after the initial six months, her Medi-Cal has likely been improperly terminated. The termination should be appealed. And Transitional Medi-Cal cannot be terminated until the county determines whether the family is eligible on another basis.

156. *Id.*
157. *Medi-Cal Eligibility Procedures Manual*, 5B-4.
158. Welf. & Inst. Code § 14005.8(a)(1). Aid codes 39 (full scope TMC, initial 6 months) and 3T (restricted scope TMC for undocumented, initial 6 months).
159. Welf. & Inst. Code § 14005.8(a)(c); *Medi-Cal Eligibility Procedures Manual*, 5B-4. Aid codes 59 (full-scope TMC, second 6 months) and 5T (restricted scope TMC for undocumented, second 6 months).

### 6. Continuous Eligibility for Children

Children who receive free, full-scope Medi-Cal are guaranteed to keep that coverage until their next scheduled Annual Redetermination date[160] or 19th birthday, whichever comes first, even if their families' income goes up or their family experiences other changes that would otherwise make them ineligible or require payment of a Share of Cost (SOC) or premium.[161] Continuous Eligibility for Children is not available to children who are in the Minor Consent program (for a discussion of Minor Consent, see Section D.1 below).[162]

Common examples when CEC would help a child keep free Medi-Cal include:

- Countable household income increases, or
- Household composition changes, *e.g.,* same income covers fewer people.

There are three aid codes for children in CEC: 7J for children who are citizens or have satisfactory immigration status, 7K for undocumented children, and 06 for children losing federal Adoption Assistance Payments prior to their 18th birthday.

Counties' implementation of these aid codes has been inconsistent; a child may be receiving ongoing Medi-Cal through CEC but remain in the previous aid code. Advocates should make sure that children who are inappropriately kept in the previous aid code do not lose Medi-Cal or get a Share of Cost or premium before the next scheduled annual redetermination date.

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160. The annual redetermination date is when the county reevaluates ongoing eligibility for all Medi-Cal recipients. The date is set by the application date and occurs every 12 months. 42 C.F.R. §§ 435.916(b) and 435.930(b); Welf. & Inst. Code § 14012; 22 CCR § 50189. See Chapter 6, Section A.3 for a complete description of the process.
161. 42 U.S.C. § 1396a(e)(12); Welf. & Inst. Code § 14005.25; ACWDL 14-05 (Feb. 20, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-05-w-attach.pdf. Continuous Eligibility for Children is available to children enrolled in the MAGI Medi-Cal Children's program, the Targeted Low-Income Children's Program (TLICP), and for children in the following non-MAGI programs: categorically linked through SSI or CalWORKs; the Pickle program; the federal poverty level program for the disabled (A&D FPL); and the 250% Working Disabled Program. *Id.* at p. 2.
162. ACWDL 01-01 (Jan. 8, 2001), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c01-01.pdf.

**Advocacy Tip:** Infants under the age of one do not need CEC if they were born to Medi-Cal eligible mothers because they are guaranteed coverage until their first birthday under Deemed Eligibility (DE) for Newborns. See Section C.7 below. There should be no practical impact on your clients. The only infants under age one who would need CEC are those who were born to mothers not eligible for Medi-Cal, such as those who become eligible after birth. A child who becomes eligible at two months of age would not have an annual redetermination until the age of 14 months, not on her first birthday.[163]

At the scheduled annual redetermination, the CEC period ends. If a child is found eligible for ongoing full-scope, no-cost Medi-Cal, a new CEC period begins and the child is guaranteed another 12 months of free Medi-Cal until the next scheduled annual redetermination.[164] If the child is found to be ineligible for no-cost Medi-Cal, the child may be eligible for a program that requires payment, such as the Targeted Low-Income Children Program (which requires a premium for some enrollees, depending on their age and income), a Share of Cost program, or a qualified health plan offered through Covered California.[165]

**7. Deemed Eligibility for Newborns**

Infants who are born to mothers who are eligible and receiving Medi-Cal at the time of birth may be enrolled in Medi-Cal without an application.[166] See Chapter 5, Section A.2.b for information on getting onto Medi-Cal through the Deemed Eligibility

163. This is the example provided in ACWDL 01-01, p.5 (Jan. 8, 2001) (ACWDL 01-01 is superseded where it conflicts with ACWDL 14-05, which it does not in this example).
164. ACWDL 14-05.
165. *Id.*
166. 42 U.S.C. § 1396a(e)(4); 22 CCR § 50262.3 also regulates the deemed eligibility program but it reflects an old version of 42 U.S.C. § 1396(e)(4) and is out-of-date. *See* ACWDL 09-17 (Apr. 3, 2009), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c09-17.pdf.

Program. Deemed eligible infants are enrolled in Medi-Cal Aid Code 8U.[167]

**8. Aid for Families with Dependent Children – Medically Needy**

Another medically needy program is the Aid for Families with Dependent Children – Medically Needy (AFDC-MN).[168] This program covers children and some parents and caretaker relatives whose income exceeds the limits of the MAGI Parents and Caretaker Relatives and the MAGI Children's programs, discussed in Chapter 2. As in the Aged, Blind and Disabled – Medically Needy program, beneficiaries in the AFDC-MN program with countable incomes over the Medically Needy Income Level (MNIL) have to pay a Share of Cost. With the advent of MAGI and the elimination of the asset test, the only families who would be in the AFDC-MN program would have a Share of Cost. If an individual's income is so low they qualify for free AFDC-MN, they would qualify for a MAGI program.

Because the Affordable Care Act eliminated the asset test for most Medi-Cal beneficiaries and the income limits for the MAGI Parents/Caretaker Relatives and Children's are higher than the limits these populations were subject to pre-ACA, the number of beneficiaries who would use this program is relatively small.

**Age.** To be eligible for AFDC-MN, children must be under age 21; there is no age limit for parents and caretaker relatives. Parents and caretaker relatives must live with the children for the family to be eligible for this program.[169]

**Income**. With the advent of the Affordable Care Act, no family should be in the AFDC-Medically Needy program without a share of cost. With a Share of Cost, there is no income limit *per se*, as any income over the MNIL is reflected dollar-for-dollar as

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167. Note, Aid Code 8V provides Share of Cost deemed eligibility for infants born to mothers in a Share of Cost program. Hopefully with changes to programs available to pregnant women, including the integration of the former AIM program into the Medi-Cal Access Program for pregnant women and the availability of coverage via Covered California, this aid code will not be needed now that Share of Cost Medi-Cal is not considered minimum essential coverage.
168. Welf. & Inst. Code § 14005.7.
169. ACWDL 14-28 (Jul. 7, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-28.pdf. The pre-ACA eligibility requirement that children be "deprived" was eliminated as of January 1, 2014.

the individual's Share of Cost.

To determine a family's income for AFDC-MN, the applicant's family is divided into a Medi-Cal Family Budget Unit (MFBU) in order to determine the income and resource limit for the family's size. The basic Medi-Cal Family Budget Unit rules are:[170]

- Include everyone living in the home not receiving SSI or CalWORKs, regardless of whether they are eligible for or want to receive Medi-Cal
- Parents and all children (including 18 to 20 year olds and the unborn) make up the basic Medi-Cal Family Budget Unit;
- Stepparents are in the same Medi-Cal Family Budget Unit with the family (unless the only individuals who want Medi-Cal are the separate children of the other parent);
- The Medi-Cal Family Budget Unit must have at least one child who is under 21 or a fetus.[171]

For a list of ineligible and excluded household members from the Medi-Cal Family Budget Unit, *see* 22 CCR §§ 50379 and 50381.

**Special Income Rules.** If a child has her own income, special prorated income limits apply and a *Sneede* Medically Needy counting procedure is used. See the income deeming discussion in Section B.8 above for information regarding *Sneede*. In addition, if more than one individual in the family is aged, blind or disabled, the income deductions (discussed below) are subtracted from the combined nonexempt income of all aged, blind and disabled Medically Needy individuals in the household and the spouse or parents of those individuals. Finally, if income from a family member is used to determine income eligibility for one family member, *e.g.,* "deeming" to a spouse, it cannot be counted again for another family member's eligibility, *e.g.,* a child.[172]

**Income Deductions and Exemptions.** Medically Needy beneficiaries can take any exemptions and deductions allowed in the former AFDC case assistance program,

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170. 22 CCR § 50373.
171. For children who alternate between parents and households, *see* 22 CCR § 50374.
172. 22 CCR § 50555.1

as well as deductions for amounts paid for Medicare and other health insurance payments.[173]

The following monthly income deductions may be taken:

- $90 in earned income, per worker;
- Dependent care costs, which are subtracted from earned income;
  - maximum $200 per child under 2 years;
  - maximum $175 if older child or disabled;
- Court-ordered child or spousal support paid by the beneficiary;
- $50 in child or spousal support received by the beneficiary;
- Education expenses (including tuition, books, fees, supplies, travel, child care); and
- Health insurance premiums.

**Resources.** The property limit is based on family size. It is $2000 for one, $3000 for two, and $150 for each additional Medi-Cal Family Budget Unit member. Exempt resources include a home, one car, clothing, essential property for employment, *i.e.,* tools of the trade, business property, and certain other items.[174]

**9. Medically Indigent**

The Medically Indigent program is a state-only program that provides coverage to children and pregnant women who would otherwise be eligible for Medically Needy or the former Section 1931(b) program (now MAGI Parents and Caretaker Relatives and MAGI Children's), but fail to meet one of the categorical requirements. However, since the implementation of the Affordable Care Act and other health reforms in California, this program has drastically decreased in importance because most of the

173. Welf. & Inst. Code §§ 11200 *et seq*., and 14005.7(d). The income exemptions can be found at 22 CCR §§ 50523, 50523.5, 50454.5, 50525, 50527, 50529, 50535, 50531, 50533, 50544, 50543, 50543.5.
174. ACWDL 99-03 (Jan. 20, 1999), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/99-03.pdf.

categorical requirements no longer exist, such as the "deprivation test,"[175] and more generous income limits are available in other programs. The regulations for these programs have not been updated, but are at 22 California Code of Regulations § 50251.

Given the more generous MAGI rules that apply to these populations, practically speaking, the Medically Indigent programs will only apply to children over 266% FPL or pregnant women over 322% FPL who cannot get into a Covered California plan due to open enrollment limitations or immigration status.[176] Because those income limits are far above the Maintenance Need Income Limits (MNIL) – see the MNIL chart in Section B.8 above – any person who is in the Medically Indigent program will have a very high Share of Cost.

## D. Limited Scope Medi-Cal Programs for Children

### 1. Minor Consent

The Minor Consent Program (also called "Sensitive Services") provides children under age 21 with limited and specific Medi-Cal benefits without regard to family income. Those benefits are: pregnancy related services, family planning, treatment for sexual assault, rape, or sexually transmitted diseases, drug and alcohol abuse treatment, and outpatient mental health services, including counseling.[177] The minor can consent to and receive these services confidentially, *i.e.,* without their parent's consent or knowledge.[178]

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175. Welf. & Inst. Code § 14005.30(b)(2). The deprivation test is an old welfare rule that requires a family to have a "deprived child" in the home to get benefits, which means a child is deprived of parental support in some way. Deprivation of a child was established through the absence, death, incapacity, or the unemployment or underemployment of at least one parent in the child's family. With the ACA and the adoption of the MAGI methodology, California eliminated deprivation as a Medi-Cal eligibility criterion.
176. Aid codes include 82, 83, 86, 87, D1, and C9, though note the codes 83, 87, and D1 with a Share of Cost are the only ones likely to be used, given the expansion of other Medi-Cal programs under health reform.
177. Welf. & Inst. Code § 14010; Fam. Code §§ 6924-6929; 22 CCR §§ 50147.1, 50157(f)(3), 50167(a)(6)(D)(4), 50195(d), 50063.5; ACWDL 97-29 (June 23, 1997); ACWDL 94-63 (Aug. 8, 1994); Aid Codes 7M, 7N, and 7P.
178. *See* Health & Safety Code §§ 1231110 and 1231115(a) (regarding confidentiality of treatment).

All children under age 21 are eligible; however there are specific age limits for some services:

- Only children age 12 and older can consent to outpatient mental health services, services related to sexually transmitted diseases and their prevention, and drug and alcohol abuse treatment.[179]
- Children under age 12 can consent to family planning, treatment for sexual assault or rape, and pregnancy related services.[180]

**Income and resources:** *No* income or resources of a child's parents are counted in determining eligibility for Minor Consent Medi-Cal.

For a minor to be eligible for the Minor Consent Medi-Cal Program, the child must be considered to be living in the home of a parent. A child need not be physically living in the home with their parent(s). If they are temporarily living with a relative or friend, they may be eligible if their parents are legally and financially responsible for the minor.[181] If the child is not considered to be living in the home of a parent, the county must process the child's application and determine eligibility as if the child were an adult if the child appears to be competent, in which case the child may be entitled to full-scope Medi-Cal.[182]

**2. Income Disregard Program for Pregnant Girls under Age 21 Program**

This program provides pregnancy-related Medi-Cal without a Share of Cost to pregnant young women and teens who live with their parent/s and who would not otherwise qualify for Medi-Cal because they are over-income due to their parents'

179. 22 CCR § 50063.5; Fam. Code § 6924 (mental health care can be provided to children age 12 and older "who are mature enough to participate intelligently and which is needed to protect the child from harming themselves or others because the children are the alleged victims of incest or child abuse."); Fam. Code § 6926 also include STD prevention services; ACWDL 12-03 (Jan. 10, 2012).
180. 22 CCR § 50063.5.
181. Medi-Cal Eligibility Procedural Manual, 4V-2.
182. 22 CCR § 50147.1(e).

income.[183] To qualify, the pregnant applicant must be under 21 years old; unmarried; live with a parent/s and be claimed as a dependent by the parent/s; and not file her own taxes.[184]

### 3. The Child Health and Disability Prevention (CHDP) Program

CHDP is a program that provides free initial, periodic and inter-periodic (called "periodicity schedule") medical health screens and limited medical treatment to children.[185] Children who are not otherwise eligible for Medi-Cal can qualify for the program up until the middle of first grade or if they are under 19 years old and their family income is at or below 266% of FPL.[186] CHDP services include preventative health screens such as physical and dental exams, "well baby" and "well child" exams, vision and hearing tests, immunizations, nutrition screening, lead screening and referrals for further diagnosis and treatment, if necessary. CHDP health providers often provide the health exams required for enrollment in school. To get CHDP services, an individual must see a doctor, clinic or other health care provider who is in the CHDP program. To find a medical provider in the CHDP program, an individual should call the local CHDP phone number in their county.[187]

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183. State Plan Amendment #13-029 (approved Jan. 14, 2014, effective Dec. 31, 2013). Aid codes 44 (restricted, citizens and immigrant with satisfactory immigration status) and 48 (restricted, undocumented). This Income Disregard program stems from the pre-Affordable Care Act Medi-Cal programs known as the Federal Poverty Level (FPL) Percentage Programs for Pregnant Women and Children, which had no asset test. Welf. & Inst. Code §§ 14148, 14148.75. With the advent of the ACA and the MAGI methodology, the majority of beneficiaries in the FPL Percentage Programs moved to the MAGI Parent/Caretaker Relative, Pregnant Women, and Children's programs, except for some young women who were ineligible for those programs due to parental income. As a result of efforts by advocates, the state created this Income Disregard Program for Unmarried Pregnant Women under Age 21 to ensure those young women and girls have access to services.
184. *Id.* at Attachment 2.2-A, Supplement 1.
185. Health & Safety Code §§ 124025-124110.
186. CHDP Provider Manual, Eligibility at p. 1 (Dec. 2014). With the advent of the ACA, the upper income eligibility limit for CHDP was raised from 200% FPL to 266% FPL. At the time of publication of this guide, the state regulation on CHDP, 17 CCR § 6830(b), still has 200% FPL as the limit but has been superceded by DHCS guidance.
187. To find the phone number for the local CHDP program go to www.dhcs.ca.gov/services/chdp/Pages/CountyOffices.aspx.

**Advocacy Tip:** CHDP and CHDP Gateway (See Chapter 5, Section A.2.e) are different programs with different scope of services. Children who qualify for the CHDP Gateway get the full scope of services covered by Medi-Cal. This includes doctor's visits, hospital services, medications, dental care, mental health care, vision care (eye glasses), x-rays, lab tests, and specialty care, among other services.

## E. Medi-Cal Special Treatment Programs

### 1. Breast and Cervical Cancer Treatment Programs

California has two Breast & Cervical Cancer Treatment Programs (BCCTPs) for low-income individuals with incomes under 200% of the Federal Poverty Level who have been diagnosed with breast or cervical cancer.[188] One is a federal Medicaid optional program that provides women with immediate, full-scope, no-cost Medi-Cal, which is commonly referred to as Federal BCCTP.[189] The other is a state-only funded program, commonly referred to as State BCCTP, which provides time-limited, cancer-related Medi-Cal services to low-income uninsured or underinsured individuals.[190]

**Age, Gender and Immigration Status**: An individual's age, gender, and immigration status, as well as whether the individual has other health coverage, determine whether the individual qualifies for the federal program with full-scope Medi-Cal benefits or the state-funded program with a time-limited cancer treatment-only benefit. For a more detailed discussion of immigration issues, see Chapter 1, Section A.

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188. *See generally* ACWDL 06-09 (Feb. 24, 2006), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c06-09.pdf (providing an overview of California's implementation of BCCTP).
189. Welf. & Inst. Code § 14007.71 (exercising a federal Medicaid option under 42 U.S.C. §1396a(a)(10)(A)(ii)(XVIII)). Aid Codes: 0M, 0N, and 0P. Aid Code 0W is for women who no longer meet federal eligibility requirements and who will continue to receive transitional full-scope Medi-Cal services until the county completes an eligibility determination for other Medi-Cal programs.
190. Health & Safety Code §§ 104160, et seq. (creating a State-funded only BCCTP program for individuals who are determined ineligible for the federal BCCTP). Aid codes: 0R, 0T, 0U, and 0V (limited in scope and duration).

- ***Federal BCCTP*:** Only women under age 65 who are citizens[191] or qualified immigrants (including PRUCOL) with no other health coverage may qualify for full-scope, no cost Medi-Cal under the federal BCCTP.[192]
- ***State BCCTP:*** Women of any age with breast or cervical cancer and men of any age with breast cancer who are citizens, qualified immigrants, or are without satisfactory immigration status, may be eligible for the time limited, cancer-treatment only Medi-Cal, even if they have other health coverage.[193]

**Income:** Both the Federal and the State BCCTPs require an individual's monthly income to be at or below 200% of the Federal Poverty Level for the family size.[194]

**Property or Resource Limits:** Property or asset limits do not apply to either the Federal or State BCCTP. If all eligibility requirements are met, an individual is eligible for BCCTP no matter how much property the individual has.

**Other Health Coverage:** The Federal and State BCCTPs have different requirements concerning the availability of other health coverage.

- ***Federal BCCTP:*** In order for a woman to be eligible, she must have no other *creditable health coverage*.[195] Health insurance coverage counts as creditable coverage even if the deductibles, co-pays or coinsurance costs are high. But, if the other health coverage does not include coverage for treatment of breast or cervical cancer, then it is not considered creditable

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191. Consumers who declare they are United States citizens or nationals and are applying for or receiving benefits through Federal BCCTP need to satisfy federal Deficit Reduction Act of 2005 (DRA) documentation requirements. *See* ACWDL 08-25 (Aug. 1, 2008), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c08-25.pdf (describing the procedure for processing evidence of citizenship for BCCTP under the DRA).
192. The federal statute authorizing the optional BCCTP limits coverage to women under age 65 without "creditable coverage." 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVIII), (aa).
193. ACWDL 06-09 at p.2.
194. Welf. & Inst. Code § 14007.71(a) (requiring an individual under the federal program to meet the requirements of Health & Safety Code § 104162(c), which imposes the income limitation); Health & Safety Code § 104162(c), (d).
195. 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVIII), (aa)(4).

health coverage and the woman can be eligible for the federal program.[196]

- ***State BCCTP:*** People can be eligible for the program if they are either uninsured or underinsured. "Underinsured" means either:
  1. The individual has health insurance that covers breast or cervical cancer treatment, but the sum of the individual's insurance deductible, premiums, and expected co-payments in the initial 12-month period that breast or cervical cancer treatment services are needed exceeds $750; *or*
  2. The individual has Share of Cost or restricted scope Medi-Cal.[197]

**2. Tuberculosis Program**

The Tuberculosis Program provides outpatient medical services related to the diagnosis and treatment of a TB infection for individuals who have either active TB (contagious) or are infected with TB (non-contagious) and who do not qualify for Medi-Cal on another basis without a Share of Cost.[198]

**TB infected:** In order to qualify for the Tuberculosis program, an individual must be infected with TB, meaning that a physician must indicate a positive diagnosis or suspect there is a TB infection.[199]

**Income and resources:** Before the Affordable Care Act, eligibility for the TB Program was based on the income and resources limits applied to individuals with disabilities under Medi-Cal and generally followed SSI rules.[200] But as of January 1, 2014, the

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196. Section 2701 of the Public Health Service Act contained the definition of "creditable coverage." *See* 42 U.S.C. § 300gg(c)(1) (2006). The Affordable Care Act eliminated the statutory definition of the term but nevertheless followed the definition of "creditable coverage" as it existed prior to the passage of the law. *See* Affordable Care Act § 1101.
197. Health & Safety Code § 104161(g); ACWDL 06-09 at p.2; *see also* Health & Safety Code § 104162.1 (where the individual is underinsured, the State will only pay for the individual's breast and/or cervical cancer treatment co-payments, premiums and deductibles or for treatment services not otherwise covered by the other health insurance).
198. Welf. & Inst. Code § 14005.20 (which exercises a federal Medicaid option available under §13603 of OBRA, amending 42 U.S.C. § 1396a(a)(10)(A)(ii)(XII)); 22 CCR §§ 51187 and 51187.1; *Medi-Cal Eligibility Procedures Manual*, 5N-2; Aid Code 7H.
199. 42 U.S.C. §1396a(z)(1)(A); 22 CCR § 51187(b).
200. Welf. & Inst. Code § 14005.20(b)(1).

TB program moved to the MAGI methodology to determine the income limit and resources applied to individuals with disability under Medi-Cal.[201]

An individual remains eligible for this program as long as the TB infection and the need for treatment continue.

**3. Kidney Dialysis and Parenteral Hyperalimentation and Related Services**

Medi-Cal's Special Treatment Programs provide kidney dialysis or parenteral hyperalimentation (also called Total Parenteral Nutrition or "TPN") services to individuals who need them but do not otherwise qualify for Medi-Cal or would receive the services with a Share of Cost.[202] Unlike other Medi-Cal programs, this Special Treatment Program looks at an individual's annual net worth to determine financial eligibility. Eligible individuals with non-exempt net worth under $5,000 receive dialysis and TPN services at no cost, while those with non-exempt net worth at or above $5,000 are obligated to pay a percentage of the treatment costs for services not covered by other insurance or other government programs.[203]

- **Kidney Dialysis:** This special treatment program provides kidney dialysis, including full-care, self-care or home-care dialysis and related services. Treatment includes hospital and physician services related to the treatment of renal failure, related lab tests, medical supplies, and drugs.[204] Unlike most programs, the kidney dialysis program is available to undocumented immigrants pursuant to a court order.[205] For a more detailed discussion of immigration status issues, see Chapter 1, Section A.
- **Hyperalimentation/TPN Program:** TPN provides total nutrient replacement

201. Welf. & Inst. Code § 14005.20(b)(2).
202. Welf. & Inst. Code §§ 14140 to 14144.5; 22 CCR §§ 50264; 50801 to 50831; *Medi-Cal Eligibility Procedures Manual*, Article 17. Medi-Cal maintains two varieties of Special Treatment Programs. The first is known as "Special Treatment Programs-Only," which is for individuals who would otherwise be Medi-Cal eligible as Medically Needy except they are over the property limit. The second variety is the "Special Treatment Programs-Supplement," which is for individuals in need of dialysis or TPN services who have Medi-Cal with a Share of Cost through the Medically Needy program.
203. Welf. & Inst. Code §§ 14142, 14142.5.
204. *Medi-Cal Eligibility Procedures Manual*, 17A-1.
205. *Crespin v. Kizer,* 226 Cal. App. 3d 498 (1990). Aid Code 55 covers non-PRUCOL immigrants without satisfactory immigration status.

through a catheter positioned in the chest for individuals who, for whatever reason, are unable to eat and digest food.[206]

**Eligibility Requirements**

**Individuals in need of special treatment:** To qualify, an individual must need either dialysis or TPN and must not otherwise qualify for Medi-Cal.[207] Individuals who need dialysis and are under age 65 are not eligible for Medi-Cal's dialysis treatment if they are eligible for Medicare dialysis coverage (this limitation does not apply to an individual in need of TPN).[208]

**Income/Resources:** Income and resources are assessed as an individual's annual non-exempt net worth. Annual net worth is the combination of non-exempt property/resources and gross income.[209] Consumers with an annual non-exempt net worth less than $5,000 are eligible for dialysis and related services or TPN and related services at no-cost.[210] Individuals with an annual non-exempt net worth of $5,000 or more can still qualify for the program if they agree to pay a Share of Cost, although they cannot do so if their non-exempt net worth exceeds $250,000.[211]

The following resources are exempt and therefore not taken into account when determining net worth:

- One motor vehicle used for transportation of a family member;
- The first $40,000 of market value of the applicant's home;
- The first $1,000 paid for life insurance placed in burial trust;
- Wedding/engagement rings, heirlooms, clothing, household furnishings and equipment; and
- Equipment, supplies and material needed for employment, for self-support, or for an approved plan of rehabilitation or self-care necessary for employment

206. *Medi-Cal Eligibility Procedures Manual*, 17A-1.
207. 22 CCR § 50817(b)(1), (2).
208. 22 CCR § 50817(b)(3).
209. Welf. & Inst. Code §§ 14140(a), 14142, 14142.5; 22 CCR § 50825.
210. Welf. & Inst. Code §§ 14142(a), 14142.5(a).
211. Welf. & Inst. Code §§ 14142(b), 14142.5(b).

(e.g. a wheelchair lift van).[212]

**Beneficiaries' Cost-sharing Obligation:** If a beneficiary's annual nonexempt net worth is over $5,000 but under $250,000, then the beneficiary is responsible for cost sharing in the amount of 2% of annual nonexempt net worth.[213]

**Whose resources count:** *For adults:* The resources of the applicant and the applicant's spouse count in determining net worth. *For children:* The child's parents' income counts if the child is under age 21, unmarried, and living with his/her parents.[214]

**Ongoing Eligibility for Medi-Cal Special Treatment Programs:** Eligibility for these programs will only exist as long as the particular treatment is needed, or in the case of dialysis, until Medicare eligibility is established. However, before terminating benefits, the county must redetermine eligibility for other Medi-Cal programs.[215]

### F. Medicare Savings Programs (MSPs)

The Medicare Savings Programs (MSPs) are special categories of Medi-Cal eligibility for individuals who are Medicare eligible and have limited income and resources. This benefit is limited to paying the Medicare premiums and in some cases the Medicare deductibles, coinsurance and copayments of those who qualify. In other words, the state pays these individuals' Medicare out-of-pocket costs but is not obligated to provide additional Medi-Cal benefits unless the individual qualifies for Medi-Cal on another basis.

An individual does not have to qualify for any other Medi-Cal program to be eligible for an MSP. For example, an individual may have countable resources that are higher

212. 22 CCR § 50825(c).
213. Welf. & Inst. Code §§ 14142(b), 14142.5(b); 22 CCR § 50827(d)(2).
214. 22 CCR § 50825(b).
215. Welf. & Inst. Code § 14005.37.

than other non-MAGI Medi-Cal programs allow (for example, $2,000 for an individual) but countable resources that are less than the MSP allows. See below for the applicable MSP resource limit. If the individual meets all MSP eligibility requirements, the individual will be eligible for MSP even though the individual is not eligible for Medi-Cal under any other Medi-Cal category.

The MSP programs are very important for people who have Medi-Cal with a Share of Cost because the Medically Needy Medi-Cal program no longer pays the Medicare Part B premium for this group. The MSP program will pay the Medicare Part B premium instead. Medi-Cal payment of the Medicare Part B premium is called "buy-in" and is currently available only for people who receive full-scope Medi-Cal with no Share of Cost.

**Advocacy tip:** If you are aware of an individual with a Share of Cost for Medi-Cal, explore with the individual the possibility of applying for an MSP. This will save them the cost of the Medicare Part B premium, which is usually deducted from the individual's Social Security check. It's usually best not to dis-enroll from Medicare Part B because there may be a penalty at the time of reenrollment in the form of a higher Part B premium.

There are currently four MSP categories:

1) Qualified Medicare Beneficiary;
2) Specified Low-Income Medicare Beneficiary;
3) Qualified Individual; and
4) Qualified Disabled and Working Individual.

Each category has slightly different rules but the eligibility for each is based upon income as a percentage of the Federal Poverty Level.[216]

**Immigration status requirements:** Other than United States citizens, only Lawful

216. *See, e.g.,* ACWDL 15-14 (Mar. 11, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-14.pdf. These are updated annually.

Permanent Residents who have resided in the United States continuously for at least five years are eligible to "buy in" to the Medicare program, *i.e.*, secure Medicare without having sufficient work history.[217] This is an exception to the normal Medi-Cal eligibility rules that allow many other immigrants to receive services Medi-Cal is only making payment to Medicare, not administering its own health services program.

**1. Qualified Medicare Beneficiary (QMB or "Quimby") Program**

The QMB Program pays the cost of both the Part A[218] and Part B[219] premiums for Medicare, as well as all Medicare co-payments and deductibles.[220] QMB beneficiaries therefore pay no Part A or Part B premiums, no annual deductible and

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217. 22 CCR §§ 50773(a)(2) and 50775(a).
218. Part A Medicare covers inpatient hospital services, including: drugs, blood, supplies, appliances and equipment, tests and lab work, nursing facility care following hospitalization, home health care following hospitalization (up to 100 visits per year, including speech therapy, physical and occupational therapy, medical supplies and durable medical equipment, and hospice care). Part A is available without cost to individuals who qualify for Medicare. *See* 42 U.S.C. § 426. However, Part A Medicare is available on a voluntary buy-in basis for individuals who are ineligible for Medicare because of where they worked or because they never worked. *See* 42 U.S.C. § 1395i–2. The cost of the Part A premium in 2015 is $407 per month for those individual with less than 30 quarters of Medicare-covered employment. These amounts change each year on January 1. *See* Medicare website: www.medicare.org for more information.
219. Part B Medicare covers outpatient services: doctors' services, outpatient medical and surgical services, and supplies (including mental health services and outpatient clinic services), outpatient hospital services and supplies, durable medical equipment, blood, certain cancer screenings (prostate, mammograms, colonoscopy, etc.), diabetes services, glaucoma testing, Pap tests and Pelvic examinations, vaccinations, and home health care services not covered by Part A. Individuals who qualify for Part A may purchase Part B. Those who do not qualify for Part A can still purchase Part B coverage if they are age 65 or older and are citizens or have satisfactory immigration status and have resided in the US continuously over the past 5 years. *See* 42 U.S.C. § 1395o. The cost of the Part B premium is $104.90 per month in 2015. These numbers change annually on January 1st. *See* the Medicare website (www.medicare.org) for more information.
220. 42 U.S.C. § 1396a(a)(10)(E)(i). For Part A in 2015, there is a $1,260 deductible for hospitalization during the first 60 days and $315 per day coinsurance for days 61-90 and $630 for days 91-150. ACWDL 15-13E (Apr. 15, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-13.pdf . These amounts change annually on January 1st.

no cost sharing. Medi-Cal pays the premium and other cost sharing.[221]

To qualify as a QMB, an individual must:

- Be entitled to Medicare Part A insurance (whether the premium is free or through enrollment and payment of the monthly premium);[222]
- Have ***countable income*** of not more than 100% FPL;[223] and
- Have ***countable resource***s of not more than $7,280 ($10,930 for a married couple) in 2015.[224]

QMB beneficiaries may also be entitled to full-scope Medi-Cal benefits if they qualify under another Medi-Cal eligibility category. Most QMB beneficiaries will qualify under the A&D FPL Program. See Section B.6.

**2. Specified Low-Income Medicare Beneficiaries (SLMB) Program**

The SLMB Program is an MSP that pays Part B premiums for Medicare beneficiaries. SLMB beneficiaries pay no Part B premiums, which is $104.90 for all Medicare beneficiaries in 2015.[225] Also, a SLMB beneficiary may be awarded benefits retroactively for up to three months prior to the month of application if she was eligible during those months.[226]

To qualify as a SLMB, an individual must:

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221. 42 U.S.C. §§ 1396a(a)(10)(E)(i); 1396d(p)(3). QMB's relief from cost sharing is available for all Medicare benefits, regardless of whether those benefits are offered under Medi-Cal. Benefits are available in the first month after eligibility is determined.
222. 42 U.S.C. § 1396d(p)(1)(A).
223. 42 U.S.C. § 1396d(p)(1)(B), (p)(2). Certain income is not counted. All programs follow the SSI rules in determining countable income. *See* Section B.6 for the SSI income rules.
224. 42 U.S.C. § 1396d(p)(1)(C). ACWDL 15-13E. Federal law sets the MSP property limits at three times the SSI property limit, plus an annual percentage increase equal to the increase in the Consumer Price Index. Certain resources are not counted like a home, a car, household possessions, some burial funds and life insurance; *See* earlier discussion in Section B.6. All MSP programs follow the SSI rules in determining countable resources.
225. 42 U.S.C. §§ 1396a(a)(10)(E)(iii); 1396d(p)(3)(A)(i); ACWDL 15-13E.
226. *Medi-Cal Eligibility Procedures Manual*, 5J-1.

- Be eligible for Medicare Part A insurance (whether the premium is free or through enrollment and payment of the monthly premium);
- Have *countable income* between 100% and 120% of the FPL;[227] and
- Have *countable resources* of not more than $7,280 ($10,930 for a married couple).[228]

SLMB beneficiaries can also receive full-scope Medi-Cal benefits if they qualify under another Medi-Cal eligibility category. The SLMB program also aids individuals whose resources are too high to qualify for the A&D FPL Program or the 250% Working Disabled Program, which both provide full-scope Medi-Cal. See Section B.6 and B.7 above.

**3. Qualified Individual (QI) Program**

The QI Program (or QI-1 Program) is a Medicare Savings Program that covers Part B premiums for Medicare beneficiaries.[229] The QI program is similar to the SLMB program; the primary difference is that the QI program applies to beneficiaries with slightly higher incomes than those who qualify for the SLMB program. Beneficiaries may receive benefits for 3 months prior to the month of application if they were eligible during those months.

To qualify as a QI, an individual must:

- Be eligible for Medicare Part B insurance (whether the premium is free or through enrollment and payment of the monthly premium);

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227. 42 U.S.C. § 1396a(a)(10)(E)(iii). Certain income is not counted. All MSP programs follow the SSI rules in determining countable income found in Section B.6 above.
228. 42 U.S.C. §§ 1396a(a)(10)(E)(iii) and 1396d(p)(1)(C); ACWDL 15-13E. Federal law sets the MSP property limits at three times the SSI property limit, plus an annual percentage increase equal to the increase in the Consumer Price Index. Certain resources are not counted like a home, a car, household possessions, some burial funds and life insurance. All MSP programs follow the SSI rules in determining countable resources.
229. 42 U.S.C. §§ 1396a(a)(10)(E)(iv), 1396(p)(3)(A)(ii). QI, also called "QI-1" is an expansion of the SLMB program authorized by Congress in the Balanced Budget Act (BBA) of 1997. QI is not an open entitlement, which means that once the state's annual allotment for QI funds is expended, no other individuals can get the benefit.

- Have *countable income* between 120% and 135% of the FPL;[230] and
- Have *countable resources* of not more than $7,280 ($10,930 for a married couple).[231]

QI beneficiaries are *not* eligible to receive full-scope Medi-Cal benefits. [232] This program is no longer a temporary program, but it is not an entitlement. [233] Total funding for the program is limited. A new application must be filed each year, and applications are accepted on a first-come, first-served basis, with priority given to prior-year recipients.

**4. Qualified Disabled and Working Individual (QDWI) Program**

The QDWI Program pays beneficiaries' Medicare Part A premiums. The QDWI program is available for individuals with disabilities, in a work incentive program, and no longer eligible for Medicare Part A at no cost because they lost Title II and premium-free Medicare benefits when their earned income exceeded the required Substantial Gainful Activity (SGA) limit.[234] They cannot be otherwise eligible for Medi-Cal. The QDWI program pays for Part A premiums ($407 per month in 2015); it does not pay for Part B.

To qualify as a QDWI, an individual must:

- Have a disability;
- Be under age 65;

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230. 42 U.S.C. §§ 1396a(a)(10)(E)(iv) and 1396u–3(b)(3). Certain income is not counted. All MSP programs follow the SSI rules in determining countable income.
231. 42 U.S.C. §§ 1396a(a)(10)(E)(iv), 1396d(p)(1)(C). All MSP programs follow the SSI rules in determining countable resources found in Section B.6 above.
232. 42 U.S.C. § 1396a(a)(10)(E)(iv).
233. PL No. 114-10 § 211 (2005); 42 U.S.C. § 1396u–3(b)(3).
234. The vocational portion of the disability definition requires that the individual be "unable to engage in any substantial gainful activity." *See* 42 U.S.C. § 1382c(a)(3). Generally, when an individual earns over a specified monthly amount, they are considered to be engaging in a SGA (the monthly SGA limit for individuals who are not blind in 2015 is $1090). Authority for the QDWI program can be found in 42 U.S.C. §§ 1396a(a)(10)(E)(ii); 1396d(s); Welf. & Inst. Code § 14005.11; ACWDL 90-48 (June 6, 1990), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c90-48.pdf; *Medi-Cal Eligibility Procedures Manual*, Article 5I.

- Be eligible for Medicare as a working disabled individual (sometimes referred to as a work incentive program);[235]
- No longer be eligible for Medicare Part A at no cost;
- Have ***countable income*** under 200% of the FPL;[236] and
- Have ***countable resources*** of not more than $4,000 ($6,000 for a married couple).[237]

QWDI beneficiaries are *not* eligible to receive full-scope Medi-Cal benefits and cannot be otherwise Medi-Cal eligible.[238]

**Getting On and Keeping MSPs**

Medicare beneficiaries who qualify must apply at the local county welfare department by completing the state application form.[239] People who qualify for the QMB, SLMB and the QDWI programs should remain eligible indefinitely as long they meet the eligibility income and resource requirements.[240] The QI program is not an open entitlement program, which means that once the state's annual allotment for QI funds is used, no other individuals can get the benefit. Individuals who qualify for the QI program will only remain eligible for one year so long as they meet the income and resource requirements; they must reapply for the benefit every year. QI recipients who reapply are given priority over new applicants.

### G. Refugee Medical Assistance

Refugees, asylees, Cuban/Haitian entrants, and Victims of a Severe Form of

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235. Medicare rules addressing when a working individual who is disabled under age 65 may qualify for Medicare despite engaging in "substantial gain activity" are found at 42 U.S.C. § 426(b) and 42 C.F.R. §§ 406.12(e), 406.20(c)(3).
236. 42 U.S.C. § 1396d(s)(2). Certain income is not counted. All MSP programs follow the SSI rules in determining countable income found in Section B.6 above.
237. 42 U.S.C. § 1396d(s)(3) ("resources … do not exceed twice the maximum amount of resources that an individual or a couple may have and obtain benefits for supplemental security income benefits…"). Certain resources are not counted. All MSP programs follow the SSI rules in determining countable resources found in Section B.6 above.
238. 42 U.S.C. § 1396d(s)(4).
239. ACWDLs 08-21 (May 15, 2008), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c08-21.pdf and 01-48 (Aug. 27, 2001), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c01-48.pdf.
240. 42 C.F.R. § 435.930(b).

Trafficking are eligible for eight months of full-scope Medi-Cal under the Refugee Medical Assistance (RMA) program if they do not otherwise qualify for Medi-Cal[241] and have an income under 200% of the Federal Poverty Level (FPL).[242] Because the Medi-Cal expansion made coverage available to Expansion Adults under 138% FPL, effectively the RMA program applies to eligible immigrants between 138% to 200% FPL. Because some refugees with incomes below 138% FPL are also receiving Refugee Cash Assistance and the codes have not yet been de-linked, they are in the related RCA code rather than the M1 code for newly eligible adults.[243] Additionally, eligible immigrants with incomes over 200% FPL are eligible for Refugee Medical Assistance with a Share of Cost,[244] although financial assistance through Covered California is typically a better option for those immigrants.

While RMAs uses MAGI income rules, the income of the refugee's sponsor, in-kind services and shelter provided by a sponsor or resettlement agency, income earned after the date of application, and Refugee Cash Assistance are all excluded income.[245] There is no asset test for this program. Although Refugee Medical Assistance is funded by the federal Office of Refugee Resettlement[246] rather than the Centers for Medicare and Medicaid Services, Refugee Medical Assistance recipients must receive the same level of health services as all other Medicaid recipients.[247]

The eight-month eligibility period begins on the date of entrance for refugees, the date asylum was granted for asylees and Cuban/Haitian entrants, and the date of

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241. 45 C.F.R. § 400.100(a)(1); 22 CCR § 50257(a). A separate regulatory provision requires medical assistance to be provided to Cuban and Haitian entrants to the same extent it is provided to refugees. 45 C.F.R. § 401.12. Asylees and trafficking victims do not have refugee status but are treated as refugees by law and therefore are eligible for the RMA program. ACWDL 14-16 (Apr. 1, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-16.pdf.
242. 45 C.F.R. § 400.101(a)(2); *Medi-Cal Eligibility Procedures Manual*, 24B-3.
243. *See* ACWDL 15-16 (Mar. 20, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-16.pdf and ACWDL 14-16 for information on transitioning Refugee Medical Assistance beneficiaries into the M1 adult expansion aid code or moving to Covered California as necessary at the end of the RMA period.
244. 45 C.F.R. § 400.103. *Medi-Cal Eligibility Procedures Manual*, 24B-3. Share of Cost programs in general are not minimum essential coverage that meet the individual mandate and the high cost sharing makes them unaffordable to most.
245. *Medi-Cal Eligibility Procedures Manual*, 24B-4; ACWDL 15-16, p.2.
246. ORR is part of the Administration for Children and Families.
247. 45 C.F.R. § 400.105.

certification for Victims of a Severe Form of Trafficking.[248] Thus for these individuals, it is important they enroll as soon as possible.

Because Refugee Medical Assistance is governed by the Refugee Resettlement Act rather than the Medicaid Act, there are a few differences. The purpose of the Refugee Resettlement Act is to assist refugees in resettling in the U.S.,[249] and at one time, refugees were eligible for 36 months of health care. Some of the sentiment to ensure that refugees have access to medical care during the length of their resettlement period, regardless of what changes might occur, still exists in the program. Once enrolled in Refugee Medical Assistance, individuals may not be cut off until the end of the eight-month eligibility period, even if their income increases.[250] In addition, those enrolled in both Refugee Medical Assistance and Refugee Cash Assistance cannot be cut off of Refugee Medical Assistance before the end of the eight months just because they lose their cash assistance.[251] Finally, although Refugee Medical Assistance is a federal program, recipients should still have their eligibility for other Medi-Cal programs redetermined before being completely terminated from Medi-Cal or being transferred to Covered California.[252]

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248. ACWDL 14-16, p. 2; *Medi-Cal Eligibility Procedures Manual*, 24B-1.
249. *See* 8 U.S.C. § 1522 and 45 C.F.R. § 400.1(b).
250. 45 C.F.R. § 400.104.
251. *Medi-Cal Eligibility Procedures Manual*, 24B-4.
252. *See* 45 C.F.R. § 400.93(b) and (d); *Medi-Cal Eligibility Procedures Manual*, 24B-11; ACWDL 15-16, p. 3.