

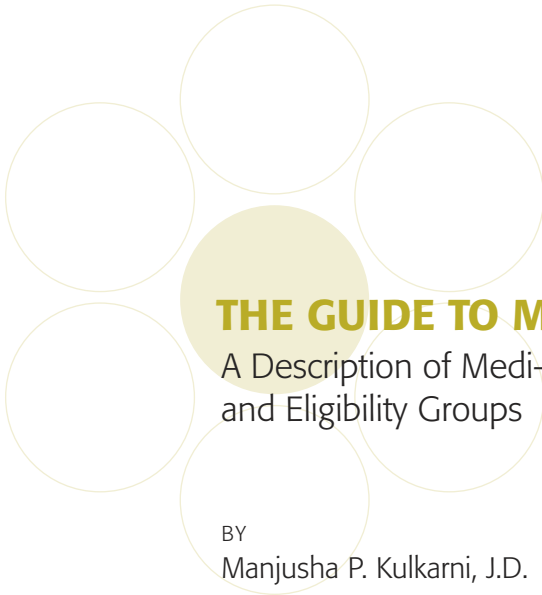


CALIFORNIA  
HEALTHCARE  
FOUNDATION



# THE GUIDE TO MEDI-CAL PROGRAMS

THIRD EDITION, 2006



# **THE GUIDE TO MEDI-CAL PROGRAMS**

A Description of Medi-Cal Programs, Aid Codes,  
and Eligibility Groups

BY  
Manjusha P. Kulkarni, J.D.

FOR  
California HealthCare Foundation

THIRD EDITION, 2006

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## **ABOUT THE AUTHOR**

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Provides important information critical to understanding the Medi-Cal program. This section offers information on:

- ▶ Medi-Cal eligibility;
- ▶ Immigration;
- ▶ Disability;
- ▶ Financial requirements;
- ▶ Application process and redetermination procedures; and
- ▶ Coverage and benefits.

MEDI-CAL PROGRAM DESCRIPTIONS are organized into nine broad categories. Within each category, individual programs are described, aid codes are listed, and the number of beneficiaries is shown to give a sense of the program's relative size and scope. The average monthly number of beneficiaries found in each program description, unless otherwise noted, is from the California Department of Health Services (CDHS) Medical Care Statistics Section.

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## INTRODUCTION

We frequently are asked, “Who qualifies for Medi-Cal?”

*The Guide to Medi-Cal Programs* attempts to answer this question in the form of a quick, easy-to-use reference tool to help people understand basic Medi-Cal eligibility categories and distinctions between coverage groups.

The information in *The Guide* is derived from the over 800-page state Medi-Cal Eligibility Procedures Manual, the California Code of Regulations (Title 22), the Aid Codes Master Chart, and various county manuals. Grasping the intricacies of Medi-Cal eligibility is a challenge, especially for those not involved in the daily task of enrolling people in the program. Medi-Cal is a maze of aid codes, eligibility categories, and services. There are more than 170 aid codes and hundreds of state and county Medi-Cal-related forms. In addition, the differing yet overlapping nature of eligibility categories and the changes in federal and state laws that govern Medi-Cal make eligibility a difficult issue to learn and follow.

*The Guide* is intended to provide a better understanding of this complex program; however, it is important to note that this is NOT an eligibility manual. *The Guide* provides an overview of eligibility categories and a brief description of the population characteristics of each category, but it does not describe the eligibility determination process or the rules that govern the process.

This is the third edition of *The Guide to Medi-Cal Programs*. As with the first edition published in January 2000, individuals and institutions likely to find *The Guide* useful include elected state and local officials and their staff, staff from county social services offices, the California Department of Health Services (CDHS) and other areas of state and local government, those working in health plans, and consumer advocacy groups with an interest in Medi-Cal.

### Important Distinction

*The Guide* is intended to provide a better understanding of this complex program; however, it is important to note that this is NOT an eligibility manual.

### **MEDI-CAL IS A “PATCHWORK” OF PROGRAMS AND SERVICES**

Medi-Cal was established in 1965 as a health benefit to people receiving welfare. Over the past 41 years, additional Medi-Cal eligibility categories have been created both to respond to the health care needs of the growing number of uninsured individuals and to address health coverage issues for disabled and elderly people. Additional coverage categories address the health care needs of select groups of individuals such as those with tuberculosis, breast cancer, or cervical cancer. Each new category results in additional regulations and guidelines. For this reason, Medi-Cal frequently has been referred to as a “patchwork” of programs.

### **THE RULES FOR MEDI-CAL ELIGIBILITY ARE “BORROWED” FROM OTHER PROGRAMS**

Because Medi-Cal’s eligibility rules historically have been linked to welfare, some argue that Medi-Cal has never had its own eligibility guidelines, but rather has borrowed from and responded to eligibility criteria for the nation’s welfare program. To some extent, this is true. For example, after Aid to Families with Dependent Children (AFDC) was replaced by Temporary Assistance to Needy Families (TANF) in 1996, some of the old eligibility rules that existed under AFDC continued to be used to determine a person’s Medi-Cal eligibility. At the same time, new rules were added to the Medi-Cal eligibility determination process. This phenomenon of “holding on to the old” while “adding in the new” has resulted in a long and complex list of eligibility criteria.

### **CALCULATIONS AND DEFINITIONS MAKE THE ELIGIBILITY PROCESS COMPLEX**

A person’s eligibility for various Medi-Cal programs often depends upon answers to questions regarding income, property, and household composition — terms which can be difficult to define. To get a sense of what is involved in determining a person’s eligibility, consider the

definition of “income.” Income is a thing of value received in a given month. At first glance, what is regarded as income may seem fairly straightforward: wages, interest, alimony, and cash assistance, for example. There are, however, many layers of detail regarding income that are required to determine a person’s eligibility. Is the income earned, such as wages, or unearned, such as interest or alimony? Is the income exempt, such as student educational loans, and therefore, not included in Medi-Cal eligibility calculations? Is the income from a parent or child? Is the earner disabled? Is the income received monthly, quarterly, or annually? Is the income counted as that of only the person receiving it or is it partially or fully allocated, or “deemed,” to a spouse or child? Because of the way the programs are structured, these questions must be answered to determine what income is counted for Medi-Cal eligibility purposes.

Similarly, the definition of “property” is not as straightforward as it might seem. Property or a resource is a thing of value obtained in a prior month. Like income, there are items whose value is counted for Medi-Cal eligibility purposes and items that are exempt from the Medi-Cal eligibility calculation. Rules for valuing property are discussed further on page 11.

### **MEDI-CAL GOVERNANCE = FEDERAL AGENCY + STATE AGENCY + 58 COUNTIES**

Congress created the Medicaid program in 1965 through Title XIX of the federal Social Security Act as a partnership between the federal government and state governments. States then created their own individual Medicaid programs within federal guidelines. California’s Medicaid program, called Medi-Cal, was established through the California Welfare and Institutions Code, starting at Section 14000, and Title 22 of the California Code of Regulations.

#### **Definition of Income**

Income includes, but is not limited to, the following:

- Wages;
- Interest from savings or other accounts;
- Dividends from stocks;
- Cash assistance (e.g., CalWORKs or SSI);
- Child support or alimony;
- Education loans or grants; and
- Gifts.

#### **Definition of Property**

Property includes, but is not limited to, items of value such as:

- Houses;
- Cars;
- Personal belongings, including clothes and jewelry;
- Savings, CDs, or other bank accounts;
- IRA or 401(k) accounts;
- Life insurance policies or annuities; and
- Burial plots.



Although California administers Medi-Cal, the federal government continues to establish new requirements and to monitor issues such as the delivery and quality of services, funding, and eligibility standards. Medicaid is overseen at the federal level by the Centers for Medicare and Medicaid Services (CMS) and at the state level by the California Department of Health Services (CDHS).

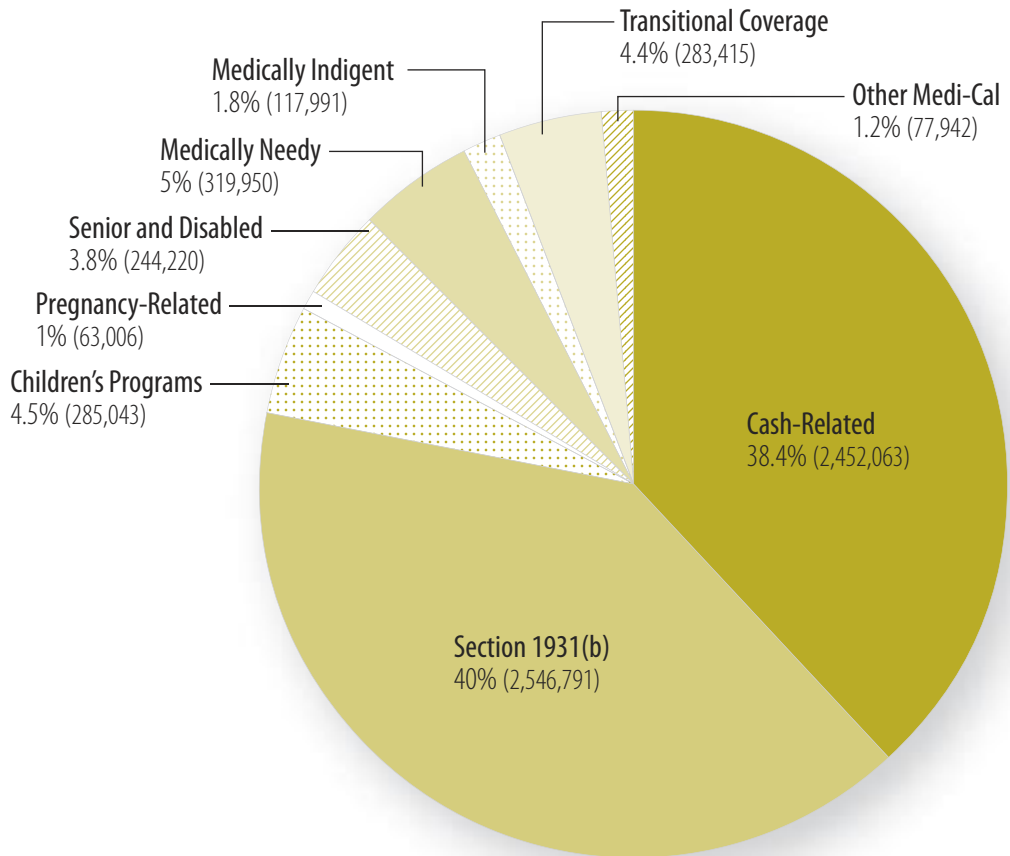
In California, each of the 58 counties plays an important role in administering and implementing Medi-Cal. Each county is responsible for interpreting and implementing state guidance on Medi-Cal eligibility policies and procedures. Many counties have developed their own procedures manuals, eligibility worker trainings, forms, and administrative systems for administering Medi-Cal.

#### **HOW IS MEDI-CAL FUNDED?**

Generally speaking, for every dollar the state spends on Medi-Cal, the state receives a dollar of federal matching funds. (For example, for a service that costs \$200, the state pays \$100 and the federal government pays \$100). The federal government pays a higher proportion of the cost of some types of Medi-Cal expenditures such as investments in information systems, case management services by a licensed health care professional, and family planning.

Some Medi-Cal programs are fully federally funded, such as the Refugee Medical Assistance program (see Tab 1). Other programs and services receive no federal contribution, such as nursing home and prenatal care services for people without satisfactory immigration status.

Overall, federal funds account for 53 percent of the Medi-Cal budget. The balance is funded by California's General Fund (37 percent) and other state and local funds (10 percent).



Source: All enrollment data contained herein are from the CDHS Medical Care Statistics Section and, unless otherwise noted, represent an average of the number of Medi-Cal beneficiaries during the period May 2005 through April 2006.

## ORIENTATION TO BASIC PROGRAM ELIGIBILITY

To understand the eligibility categories outlined in *The Guide*, it is important to grasp the many criteria and concepts that make up the Medi-Cal program.

### WHO IS ELIGIBLE FOR MEDI-CAL?

In general, Medi-Cal beneficiaries have low income and limited resources to pay for the cost of their health care. Applicants must fit into one of several possible categories:

- ▶ Individuals who are aged, blind, or disabled according to Social Security rules.
- ▶ Families with children as long as deprivation exists (CalWORKs-linked).
- ▶ Children or pregnant women without regard to deprivation or property.
- ▶ Individuals with specific health care needs. This category is limited to people in need of:
  - ▶ Dialysis;
  - ▶ Tuberculosis services;
  - ▶ Total parenteral (intravenous) nutrition services;
  - ▶ Breast and cervical cancer treatment;
  - ▶ Certain services for minors; or
  - ▶ Nursing home care.

#### Supplemental Security

**Income (SSI)** is a cash grant of monthly payments designed to increase the monthly income of low-income elderly, blind, and disabled individuals to a minimum amount deemed necessary to live.

Being “linked” means meeting basic criteria of the CalWORKs or SSI programs. For CalWORKs, this means meeting the requirement of deprivation. For SSI, this means satisfying the requirements of being aged, blind, or disabled.

## WHO IS NOT ELIGIBLE FOR MEDI-CAL? WHERE CAN THEY TURN?

Low income or medical need alone is not enough to qualify a person for Medi-Cal. People between the ages of 21 and 65, without children, who are not pregnant, blind, or disabled and who do not fall into one of the above categories generally will not qualify for Medi-Cal.

Individuals who do not qualify for Medi-Cal but need medical care and cannot afford to pay might qualify for county indigent health care services at a county medical facility or county-contracted facility.

All counties have programs—administered and funded by the state and counties—that provide limited free or low-cost services to some groups of individuals who do not qualify for Medi-Cal. These typically are referred to as either the County Medical Services Program or the Medically Indigent Adult Program (see Tab 10).

## DO IMMIGRANTS QUALIFY FOR MEDI-CAL?

A complex lexicon is used to identify a person’s immigration status. In California, CDHS uses “satisfactory immigration status” to refer to immigrants who may be eligible for the full range of Medi-Cal services. Citizens, lawful permanent residents, and certain other immigrants such as those referred to as “Permanent Residence Under Color of Law” (PRUCOL) may receive the full range of Medi-Cal-covered services, provided they meet other eligibility requirements. (Note: PRUCOL is no longer a federally recognized designation for immigrants.)

Undocumented immigrants and certain other immigrants without satisfactory immigration status who meet all other Medi-Cal program requirements may qualify for limited Medi-Cal coverage for Restricted Medi-Cal, which includes emergency services, pregnancy-related services, kidney dialysis, and some nursing home care. (See the OBRA section under Tab 9 for information on coverage for immigrants.)

### **Deficit Reduction Act**

The recently enacted Deficit Reduction Act significantly changes verification of citizenship for purposes of determining Medicaid eligibility. Now, many applicants must provide documentation to prove their status as U.S. citizens. At the time of publication, CMS and CDHS were in the process of finalizing procedures to implement the new law.

## Qualified Aliens

Examples of qualified aliens include:

- Legal permanent residents or green card holders;
- Asylees;
- Refugees;
- Cuban or Haitian entrants; and
- Battered immigrant women and their children under the Violence Against Women Act (VAWA).

## WILL RECEIPT OF MEDI-CAL BENEFITS AFFECT AN IMMIGRANT'S STATUS?

Federal Medicaid law distinguishes between “qualified aliens” and “not qualified aliens.” (An alien is defined as “a person who is not a citizen or national of the United States.”) Congress determines which categories of qualified aliens will be considered eligible for full-scope Medicaid with federal matching funds. There are categories of aliens who entered the country legally but are not considered “qualified aliens” for federal Medicaid purposes.

Although states can elect to provide benefits to any group of immigrants, those not approved to receive federal matching funds will be state-funded only. California provides state-only Medi-Cal to several groups of immigrants through the Restricted Medi-Cal program and several other specialty programs for immigrants who are not qualified aliens.

Depending on immigration status, the Department of Homeland Security can refuse an individual's entry or re-entry into the United States, or stop someone from becoming a permanent U.S. resident, if it believes that the individual is likely to become a “public charge.” The term “public charge” is used by the U.S. Citizenship and Immigration Services (USCIS), an office within the Department of Homeland Security that took over some functions of the Immigration and Naturalization Service, to describe immigrants who are or will be dependent on public benefits. According to the USCIS:

- ▶ **Immigrants without a “green card”** will not be considered a public charge for using health care benefits, including Medi-Cal and Healthy Families, prenatal care, or other free or low-cost medical care at clinics, health centers, or other settings (other than long-term care in a nursing home or similar institution).
- ▶ **Legal permanent residents** cannot lose their “green card” status if they, their children, or other family members use health care benefits,

including Medi-Cal, Healthy Families, prenatal care, or other free or low-cost medical care at clinics, health centers, or other settings (other than long-term care in a nursing home or similar institution).

In other words, use of public health benefit programs and services other than long-term care services generally will not be considered a “public charge” issue.

### **DEFINING “DISABILITY” FOR MEDI-CAL**

To be disabled and, therefore, potentially eligible for Medi-Cal based on disability, a person must meet the Social Security Administration’s definition of disability. People who are terminally ill or who have a health condition expected to last at least a year that prevents them from doing work for which they are suited may be considered disabled.

Applicants claiming disability other than blindness under either the Aged/Disabled or Medically Needy Programs must meet the Social Security Administration’s criterion of being unable to engage in “substantial gainful activity” (SGA). Individuals are disqualified from Medi-Cal based upon disability if their work is considered SGA. However, work regarded as SGA does not disqualify an individual from enrollment in the 250% Working Disabled Program (see Tab 5). However, a person in the 250% Working Disabled Program must still meet the Social Security Administration’s definition of disabled even though he or she is allowed to work.

### **MEDI-CAL ELIGIBILITY AND THE FEDERAL POVERTY LEVEL (FPL)**

In general, to be eligible for Medi-Cal, the applicant cannot have income and resources higher than the applicable limits for her family size. Limits vary among programs, but everyone receiving Medi-Cal must be “poor.” Medi-Cal is, therefore, considered a “means-tested” program.

#### **Income Calculation**

When income fluctuates from month to month or seasonally, income is counted annually, not monthly. Without this rule, a farmworker who would exceed the income limits for Medi-Cal coverage in the summer months but meet the income requirements in the winter months would not be eligible for Medi-Cal.

When most people talk about Medi-Cal, they are referring to free Medi-Cal or “no-share-of-cost” Medi-Cal. Individuals who exceed income limits in particular Medi-Cal programs still may be eligible for Medi-Cal, but the services may not be free; these beneficiaries are required to pay a share of the cost of their health services. (See the definition of “share of cost” in the Glossary. Because most people on Medi-Cal do not have to pay a share of cost, information in *The Guide* refers to free (“no-share-of-cost”) Medi-Cal, unless otherwise stated.)

Poverty statistics often focus on a family’s annual income. However, it is monthly income that is important for determining Medi-Cal eligibility. Eligibility for other need-based programs (CalWORKs, the Food Stamp Program, SSI, and CAPI) is also determined monthly.

Federal poverty guidelines are used as a yardstick for defining income eligibility standards for many federal and state programs. Eligibility for food stamps, free and reduced-cost school lunches, help with Medicare premiums, and many, but not all, Medi-Cal programs are tied to the Federal Poverty Level (FPL).

**2006 FEDERAL POVERTY LEVELS (FPL) AS MONTHLY INCOME, BY FAMILY SIZE**

Family Size	100% FPL	133% FPL	200% FPL	250% FPL
1	\$817	\$1,087	\$1,634	\$2,042
2	\$1,100	\$1,463	\$2,200	\$2,750
3	\$1,384	\$1,840	\$2,767	\$3,459
4	\$1,667	\$2,217	\$3,334	\$4,167
5	\$1,950	\$2,594	\$3,900	\$4,875
6	\$2,234	\$2,971	\$4,467	\$5,584

Source: 71 Fed. Reg. 3848 (January 24, 2006). Effective April 1, 2006 through March 31, 2007.

Note: The Federal Poverty Level is updated every year in January or February and is available on the Web site for the U.S. Department of Health and Human Services at <http://aspe.hhs.gov/poverty/06poverty.shtml>.

**Cash Assistance Program for Immigrants (CAPI)** is a California cash assistance program for elderly, blind, and disabled immigrants who are ineligible for SSI.

## DO A PERSON'S PROPERTY OR RESOURCES COUNT IN DETERMINING MEDI-CAL ELIGIBILITY?

A person's property (the things he or she owns, such as a car, home, and bank account) is counted in determining eligibility for Medi-Cal programs except for a few special programs with no assets test (for some children and pregnant women — see list below).

Many rules and exceptions apply when determining how a family's property is counted. For all Medi-Cal programs, the home in which the family lives is not counted toward the property limit. Vehicles are counted differently in each Medi-Cal program. In some Medi-Cal programs, one car is exempt regardless of the value, but in others, the equity value and fair market value are considered for each car in the household. The limits for other property vary by program. Property limits for most Medi-Cal programs start at \$2,000 for one person and increase with family size.

Only a few programs do not count property at all:

- ▶ Children's Percent Programs (see Tab 3);
- ▶ Income Disregard Program (also called the 200% Program or the Federal Poverty Level Program for Infants and Pregnant Women) — (see Tabs 3 and 4);
- ▶ Minor Consent Services (see Tab 3);
- ▶ Safe Arms for Newborns; and
- ▶ Programs for adoption assistance and former foster care children.

The 250% Working Disabled Program is unique in exempting IRAs and 401(k) accounts from property limits (see Tab 5). The special programs for tuberculosis, renal dialysis, and total parenteral nutrition (TPN) have their own special rules for counting property.

### Reporting Status Changes

Medi-Cal beneficiaries are required to report all changes in their own circumstances that might affect their eligibility for Medi-Cal, such as changes in their income or the number of people in their household, to their caseworker within 10 days of the change. They can report the change orally or in writing. Anytime a change is reported, a caseworker re-examines the case and recalculates the beneficiary's Medi-Cal eligibility to make sure he or she still qualifies. Some beneficiaries who are parents are required to submit forms every six months for eligibility redetermination, even if there have been no changes.



### WHAT IS ESTATE RECOVERY?

After a Medi-Cal beneficiary dies, the cost of Medi-Cal services provided to a beneficiary who was over age 55 when he or she received Medi-Cal services or was institutionalized may be recovered from the beneficiary's estate. However, the state will not place a lien on a family home as long as there is a living spouse or a dependent child living in the home. Hardship waivers are considered. Benefits from the Medicare Savings Plans (see Tab 5) are not considered by the estate recovery program.

### MEDI-CAL APPLICATION PROCESS AND REDETERMINATION PROCEDURES

Medicaid eligibility in California is determined by county eligibility workers for most Medi-Cal programs. (The state establishes eligibility criteria within federal guidelines, which the counties then implement.) Because the final eligibility determination rests with counties instead of the state, there are some variations in the eligibility determination process. A county has 45 days to determine a person's eligibility—or 90 days if there is a need to determine whether a person meets disability criteria—although some individuals, including children, pregnant women, or those with breast or cervical cancer, can enroll in Medi-Cal faster through a variety of expedited application options.

A person can obtain Medi-Cal in a variety of ways:

- ▶ **Automatic Enrollment**—For those receiving SSI or CalWORKs, receipt of Medi-Cal is automatic. No separate Medi-Cal application is required.
- ▶ **Deemed Eligibility for Infants**—A baby born to a mother on Medi-Cal is automatically eligible for Medi-Cal for its first year as long as the baby continues to live with the mother in California. Even if this condition is not met, the baby is likely to remain eligible for 12 months under Continuing Eligibility for Children (CEC). (See "II. Continuing Coverage for Children" under Tab 8.)

- ▶ **Mail-In Application for Medi-Cal Only**—Applicants may obtain a Medi-Cal-only application called the MC 210, complete it themselves, and mail it to the county welfare department.
- ▶ **Joint Medi-Cal/Healthy Families Program Mail-In Application**—Pregnant women and children may apply for the Healthy Families Program and for limited categories of Medi-Cal programs using a special shortened mail-in form, which they can complete on their own or with the assistance of a person trained to help them complete the forms. These children may be eligible for Accelerated Enrollment. They can also apply using the limited Health-e-App, a fully automated Web-based application ([www.dhs.ca.gov/health-e-app/](http://www.dhs.ca.gov/health-e-app/)).
- ▶ **Face to Face/In Person**—Individuals may apply in person with a county eligibility worker at the county Medi-Cal office, or at a hospital or clinic where an eligibility worker is sometimes outstationed. A face-to-face interview is not required for Medi-Cal, and the person is allowed to drop off the application without one.
- ▶ **Presumptive Eligibility (PE)**—Federal Medicaid law permits states to identify specific entities to grant immediate temporary Medicaid coverage to certain groups of beneficiaries. The presumptive eligibility programs in California provide immediate, short-term Medi-Cal coverage while the applicant completes the application process for Medi-Cal. One of the PE programs is limited to ambulatory prenatal care for pregnant women. If a pregnant woman applies for regular Medi-Cal, PE is provided until a determination is made on her regular Medi-Cal application.
- ▶ **Accelerated Enrollment (AE)**—Under the federal authority of presumptive eligibility, two groups of beneficiaries receive temporary Medi-Cal services through the Accelerated Enrollment program:
  - ▶ Children who submit the joint Medi-Cal/Healthy Families Program mail-in application and appear to qualify for free Medi-Cal can

get AE. The Single Point of Entry (SPE) (see Glossary), which conducts the screening, assigns AE to these children before forwarding the application to the appropriate county for a determination of eligibility.

- ▶ Women who appear to meet the requirements of the federal Breast and Cervical Cancer Treatment Program (BCCTP) can get AE for temporary, full-scope Medi-Cal coverage while the state's eligibility specialist makes a final determination of eligibility.
- ▶ **CHDP Gateway Enrollment** — Children may immediately pre-enroll in Medi-Cal or the Healthy Families Program through their Child Health and Disability Prevention (CHDP) Program provider for up to two months until a full Medi-Cal application is processed. This pre-enrollment coverage is temporary and provides time for families to submit the regular joint application in order to have an eligibility determination made for Medi-Cal and/or the Healthy Families Program. If the family submits a regular application during the temporary two-month period, this pre-enrollment coverage lasts until the regular eligibility determination is made.
- ▶ **Express Lane Eligibility** — Families receiving food stamps can give their consent that their Food Stamp Program application information be used to determine their eligibility for Medi-Cal and the Healthy Families Program. Express Lane Eligibility also allows schools to release information collected on the National School Lunch Program application to immediately pre-enroll a child eligible for the free meals program until a Medi-Cal determination is completed by the county.
- ▶ **Ex Parte Redetermination** — Senate Bill 87 (a state law passed in 2000) requires a Medi-Cal beneficiary's eligibility for all Medi-Cal programs to be evaluated before benefits can be terminated. Beneficiaries who are found eligible for other programs are automatically transferred to the program most advantageous to the beneficiary.

- **Transitional/Continuing Eligibility Programs**—Most beneficiaries who lose eligibility for cash assistance or Section 1931(b) Medi-Cal can retain their Medi-Cal benefits through one of the transitional programs. Additionally, children who lose free Medi-Cal and would be otherwise assigned a share of cost may remain eligible for no-share-of-cost Medi-Cal for up to 12 months after the last annual redetermination or application date under the Continuing Eligibility for Children Program. (See “II. Continuing Coverage for Children” under Tab 8.)

### **HOW DO ELIGIBILITY WORKERS DETERMINE WHO QUALIFIES FOR WHICH PROGRAM?**

In evaluating eligibility, eligibility workers consider the Medi-Cal programs in a specific order depending on the type of application received and the characteristics of the individuals applying.

The basic rule for determining a person’s eligibility for Medi-Cal is to evaluate the individual and, when possible, the entire family, for the coverage category that provides the most comprehensive coverage without requiring the family to pay a share of the cost of the services.

### **WHAT ARE AID CODES?**

After the county eligibility worker has determined that an applicant qualifies for Medi-Cal, he or she assigns a code or codes—usually a combination of letters and/or numbers—to the applicant’s file as part of the process of opening the Medi-Cal case. These codes, which are for administrative use and invisible to the beneficiary, allow CDHS to track the criteria by which each person qualified for Medi-Cal. For example, a person receiving coverage through the Medically Needy Program would have a different aid code depending on whether he or she is aged, is blind, is part of a family with dependent children, or has a disability.

Health care providers have access to aid codes and use them to determine which services a beneficiary can receive under Medi-Cal.

Aid codes also differentiate between cases that receive federal matching funds and those that are state-funded only. Finally, aid codes distinguish the reporting requirements with which an individual has to comply and whether the individual is in a Medi-Cal category that is time-limited. Aid codes are not federally required but were developed by California to facilitate administration of Medi-Cal and certain other public benefits.

More than 170 aid codes are used by eligibility workers to certify people for public benefits. People may have more than one aid code if they are eligible for more than one program. Further, each Medi-Cal program generally has several aid codes within it. In most cases, a Medi-Cal beneficiary will be found eligible and assigned an aid code for the program with the most comprehensive coverage. (A list of aid codes is located on page 81 of this guide.)

### **CAN THE MEDI-CAL PROGRAM BE SIMPLIFIED?**

Policy discussions about Medi-Cal often reflect a desire to simplify the program. Steps toward simplification begin with an understanding of the current Medi-Cal program. *The Guide* describes the Medi-Cal program as it exists at the time of publication, but every year the Medi-Cal landscape changes with the implementation of new legislation and procedures. Aid codes are added and removed, new forms are introduced and old ones are phased out, and new eligibility criteria are implemented.

Although not directly addressing the underlying complexities of the Medi-Cal program, during the past several years, California has initiated a number of measures designed to make the Medi-Cal program more user-friendly. Examples include the use of the simplified mail-in applications for Medi-Cal coverage for children and the elimination of the requirements that applicants and current Medi-Cal beneficiaries meet face-to-face with eligibility workers during the application and annual redetermination process.

## WHAT BENEFITS ARE COVERED BY MEDI-CAL?

Different Medi-Cal programs offer different benefits. For people who receive full-scope coverage, Medi-Cal covers a broad range of federally mandated services that include:

- ▶ Inpatient and outpatient hospital services;
- ▶ Nursing facility care for people 21 and older;
- ▶ Physician services;
- ▶ Services received at rural and federally qualified health clinic services;
- ▶ Home health care for nursing home-eligible individuals;
- ▶ Laboratory and x-ray services;
- ▶ Pediatric and family nurse practitioner and nurse/midwife services;
- ▶ Early and periodic screening, diagnosis, and treatment for those under age 21; and
- ▶ Family planning services and pregnancy-related services.

All states have the option to provide up to 34 services in addition to those mandated by federal law, and to receive federal matching funds for their provision. These are known as “optional services.” However, once a state elects to offer these services, they are no longer “optional,” and the state must provide them to all qualified Medicaid beneficiaries. California covers most optional services, including:

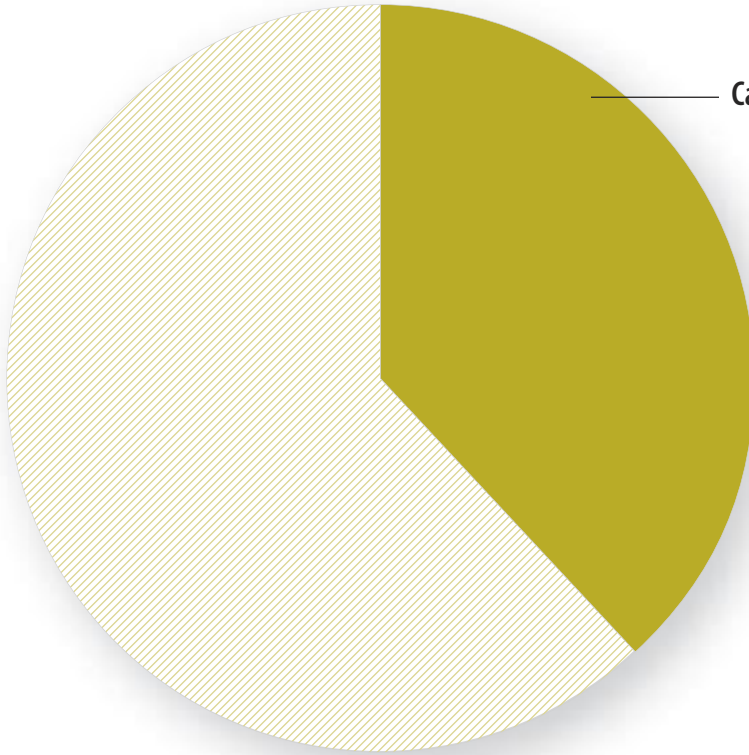
- ▶ Prescription drugs;
- ▶ Dental services, including dentures;
- ▶ Medical supplies;
- ▶ Durable medical equipment;
- ▶ Drug and alcohol treatment services;
- ▶ Medical transportation;

- ▶ Optometrist services; and
- ▶ Prosthetic and orthotic services.

Those who qualify for limited benefits, including those enrolled in the Tuberculosis Program or the Dialysis Program, do not receive a full range of Medi-Cal services, but services only for their qualifying condition. Similarly, individuals without satisfactory immigration status qualify for emergency services, pregnancy services, kidney dialysis, and nursing home care only.







**Cash-Related Programs**

account for 38.4%  
(2,452,063) of  
Medi-Cal recipients

## CASH-RELATED PROGRAMS

Individuals who receive cash aid through certain federal government programs are automatically entitled to Medi-Cal. These federally funded cash programs include CalWORKs, Supplemental Security Income (SSI), Foster Care Assistance, Adoption Assistance, and Entrant or Refugee Cash Assistance. Recipients of these benefits automatically receive full-scope Medi-Cal without having to apply separately for it.

- ▶ **CalWORKs**—California Work Opportunity and Responsibility to Kids (CalWORKs) is California’s cash aid, welfare-to-work program for families. Families receiving CalWORKs checks are automatically eligible for Medi-Cal under Medi-Cal’s “Cash-Based Section 1931(b)” Program. Families eligible for but not receiving cash aid from CalWORKs are also eligible for Medi-Cal under the “Section 1931(b)-Only” Medi-Cal category (see Tab 2). (See sidebar for background information on CalWORKs.)

Full-Scope Coverage Aid Codes: 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3P, 3R, 3U, 3W, 30, 32, 33, 35

Average Monthly Number of Beneficiaries: 1,133,711

- ▶ **Supplemental Security Income (SSI) and Supplementary State Payment (SSP)**—SSI/SSP is a cash payment designed to increase the monthly income of the elderly, the blind, and the disabled to a minimum amount deemed necessary to live. The application for SSI/SSP is also an application for Medi-Cal. Those who receive SSI/SSP checks automatically receive Medi-Cal. (See sidebar for more information on SSI/SSP)

Full-Scope Coverage Aid Codes: 10, 20, 60

Average Monthly Number of Beneficiaries: 1,238,886

- ▶ **Foster Care and Adoption Assistance**—Children who are in foster care and receive foster care checks are automatically eligible to receive Medi-Cal through the cash-related program. Some children in the Foster Care Program, the Kinship Guardian Assistance Payment Program (KinGAP), and the Adoption Assistance Program receive

### The Birth of CalWORKs

California established the CalWORKs program in 1997 to conform the state’s welfare system to the federal requirements of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). PRWORA eliminated the Aid to Families with Dependent Children (AFDC) program and replaced it with the Temporary Assistance to Needy Families (TANF) program. CalWORKs is California’s TANF program.

### SSI/SSP

The federal government sets a minimum amount for SSI payments, and each state may choose to supplement this amount based on the cost of living within its borders. This state payment is referred to as the State Supplementary Payment, or SSP. Unlike SSI, SSP is raised at the discretion of the state government and is not automatically increased each year to adjust for inflation. California provides a relatively high supplement to the SSI amount, which generally raises the SSI recipient’s income above the poverty level. A California recipient of SSI/SSP receives state and federal payments in one SSI/SSP check.

cash-related Medi-Cal, while others receive their Medi-Cal coverage through Medi-Cal's Medically Indigent Program (see Tab 7).

Full-Scope Coverage Aid Codes: 4F, 4G, 40, 42

Average Monthly Number of Beneficiaries: 77,592

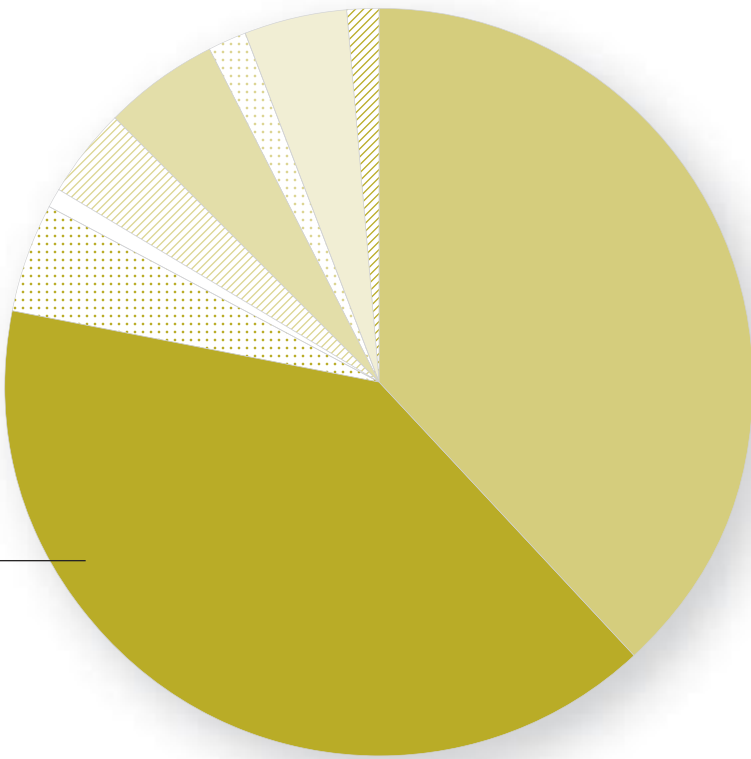
- ▶ **Refugee Medical Assistance (RMA)/Refugee Cash Assistance (RCA)** — Some immigrants fleeing persecution from their homelands are classified as refugees by the U.S. Citizenship and Immigration Services (USCIS, formerly part of the Immigration and Naturalization Service). Entrants and asylees may receive RMA and RCA. It is not necessary to receive RCA in order to receive RMA.

Needy refugees who meet the eligibility requirements for CalWORKs or the Supplemental Security Income (SSI) program receive benefits under these programs as well as Medi-Cal coverage and are not enrolled in RMA or RCA at all. Others who do not qualify for the CalWORKs or SSI programs, but who meet the income and property eligibility standards of these programs, may receive special Refugee Cash Assistance (RCA), Entrant Cash Assistance (ECA — for Cubans and Haitians), or Refugee Medical Assistance (RMA) through the refugee program during their first eight months in the United States. The refugee programs are fully funded by the federal government.

Full-Scope Coverage Aid Codes: 0A, 01, 02, 08

Average Monthly Number of Beneficiaries: 1,874





**Section 1931(b)-Only  
Medi-Cal for Families Program**  
(non-cash related) accounts for 40%  
(2,546,791) of Medi-Cal recipients

## SECTION 1931(B) MEDI-CAL FOR FAMILIES

This category of coverage was created by Congress under Section 1931(b) of the Social Security Act to ensure that needy families with children have access to Medi-Cal. Combining Food Stamps, AFDC, and CalWORKs eligibility criteria, it was created to ensure that families eligible for Medi-Cal under the old AFDC program would continue to be eligible for Medi-Cal after the implementation of CalWORKs. States were also given the option to use “less restrictive” financial requirements to expand coverage to more families, which California did. The Section 1931(b) Program consists of:

- ▶ **Cash-Based Section 1931(b)**—This is the Medi-Cal program for families receiving CalWORKs checks. (See “CalWORKs” under Tab 1.)
- ▶ **Section 1931(b)-Only**—This program provides health coverage for families that do not receive cash aid through CalWORKs but would have been eligible for Medi-Cal through AFDC if AFDC were still in effect. This Medi-Cal-only option also covers families that decide not to enroll in CalWORKs even though they may be eligible for cash assistance.

Eligibility workers try to place families under the Section 1931(b) Program if at all possible because it provides access to all family members, unlike the Percent Programs for children (see Tab 3) and the programs for seniors and the disabled (see Tab 5). Once families are enrolled in the Section 1931(b) Program, they can take additional deductions to remain in the program and are offered Transitional Medi-Cal Coverage if the family’s income becomes too high to qualify for the Section 1931(b) Program due to increased earnings (see Tab 8).

(See the sidebar for information on who qualifies for support.)

### Who’s in the Section 1931(b) Program

In March 2000, the Section 1931(b) Program began covering families with net incomes up to 100 percent of the Federal Poverty Level. A family’s property is also counted in determining eligibility.

The bulk of people on Medi-Cal (parents and children) are primarily in the Section 1931(b) Program. Although they make up 75 percent of beneficiaries, they account for only 33 percent of total Medi-Cal expenditures. Because these beneficiaries are relatively healthy, they use less expensive health care services than other populations.

Source: LAO Cal Facts Health Section, 2004

**Deprivation** of a parent’s support exists when a parent:

- Is absent from the home;
- Is incapacitated (unable to work or care for children);
- Is disabled;
- Is deceased;
- Is employed less than 100 hours per month; or
- Has net earnings at or below 100 percent of the Federal Poverty Level.

Persons who are citizens or have satisfactory immigration status receive a full scope of benefits; persons without satisfactory immigration status who otherwise qualify for the program receive emergency services only.

Full-Scope Coverage Aid Code: 3N

Limited-Scope Coverage Aid Code: 3V (for those without satisfactory immigration status)

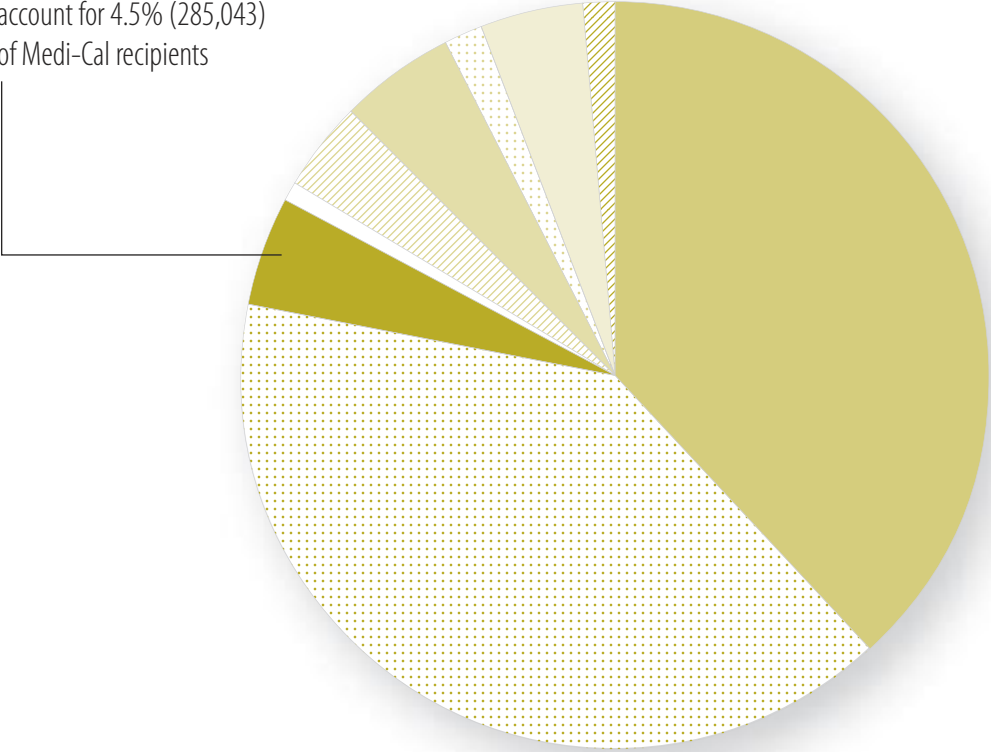
Average Monthly Number of Beneficiaries: 2,546,791





**Children's Programs**

account for 4.5% (285,043)  
of Medi-Cal recipients



## CHILDREN'S PROGRAMS

Children may qualify for Medi-Cal under one of the Percent Programs or other children's programs described in this section. They also may qualify under one or more programs described elsewhere in this guide, such as Section 1931(b) (see Tab 2) or programs for the disabled (see Tab 5).

### PERCENT PROGRAMS

There are three Medi-Cal programs exclusively for children in which eligibility is based solely on family income—specifically, at what percentage of the Federal Poverty Level the family income falls after taking all applicable income deductions and exemptions—and not the family's property. Children enrolled in one of these three coverage groups are likely to have at least one working parent. Often the parent's employer offers no medical insurance or offers insurance covering only the employee and not dependents.

These programs have different family income limits for different age children. Although the limits are advantageous to young children, they can be confusing to Medi-Cal beneficiaries and difficult to administer if families have children of different ages.

- **Income Disregard Program (200% Program)**—Also called the Federal Poverty Level Program for Infants and Pregnant Women, the 200% Program provides full-scope Medi-Cal coverage for infants up to age 1 whose countable family income is at or below 200 percent of the Federal Poverty Level. Infants born to a mother on Medi-Cal are automatically eligible for Medi-Cal for their first year (“deemed eligibility”). Children who are citizens or have satisfactory immigration status receive the full scope of benefits; children without satisfactory immigration status receive emergency services only.

Full-Scope Coverage Aid Code: 47

Limited-Scope Coverage Aid Code: 69 (for those without satisfactory immigration status)

Average Monthly Number of Beneficiaries: 60,838

### No Property Limits or Deprivation Requirements

Both the Income Disregard Program (also called the 200% Program or the Federal Poverty Level Program for Infants and Pregnant Women) and the Percent Programs were designed to make Medi-Cal coverage easier to obtain for children and pregnant women. These programs waive the deprivation requirement (see *Glossary*) and property limit and instead only verify that applicants' incomes fall beneath the monthly income limits. This makes the programs easier to apply for and easier to administer.

### Coverage for Immigrant Children

Although children without satisfactory immigration status receive only emergency coverage, their parents can feel better knowing that in the event of an emergency, their children will be covered for health care services.

Routine checkups and preventive care, however, are covered by Medi-Cal only if the child is a citizen or has satisfactory immigration status. Children without satisfactory immigration status may obtain these checkups through the California Health and Disability Prevention (CHDP) Program. Children with certain severe disabilities may also qualify for treatment services through the California Children's Services (CCS) Program.

*(See Tab 10 for more information about CHDP and CCS.)*

- ▶ **133% Program**—The 133% Program provides Medi-Cal coverage for all children from age 1 until their 6th birthdays whose countable family income is at or below 133 percent of the Federal Poverty Level. Children who are citizens or have satisfactory immigration status receive the full scope of benefits. Children without satisfactory immigration status receive emergency services only.

Full-Scope Coverage Aid Codes: 72, 8P

Limited-Scope Coverage Aid Codes: 74, 8N (for those without satisfactory immigration status)

Average Monthly Number of Beneficiaries: 100,110

- ▶ **100% Program**—The 100% Program provides Medi-Cal coverage for all children age 6 until their 19th birthdays whose countable family income is at or below 100 percent of the Federal Poverty Level. Children with satisfactory immigration status receive the full scope of benefits; children without satisfactory immigration status receive emergency services only.

Full-Scope Coverage Aid Codes: 7A, 8R

Limited-Scope Coverage Aid Codes: 7C, 8T (for those without satisfactory immigration status)

Average Monthly Number of Beneficiaries: 81,307

## OTHER CHILDREN'S PROGRAMS

▶ **Minor Consent Program** — This program offers several specific services to some minors under age 21 who are unmarried and living with a parent or guardian or are claimed as a dependent on a parent's tax return. A minor's eligibility for services is determined on the basis of the minor's income and resources. These cases, which usually receive priority handling, do not take into account parental income or property and, as stipulated by state law, do not require parental notification or consent. Depending on the minor's age, the Minor Consent Program provides:

- ▶ Substance abuse treatment;
- ▶ Mental health services;
- ▶ Family planning, abortion, and pregnancy/prenatal services;
- ▶ Sexually transmitted disease treatment; and
- ▶ Sexual assault treatment.

Minors eligible for the Minor Consent Program must recertify their need for services each month with the county.

Limited-Scope Coverage Aid Codes: 7M, 7N, 7P, 7R (limited to services above only)

Average Monthly Number of Beneficiaries: 9,613

▶ **Accelerated Enrollment** — This program allows children to be immediately enrolled in Medi-Cal while their eligibility for ongoing Medi-Cal is determined. Children must do the following to be eligible for Accelerated Enrollment:

- ▶ Complete a joint Medi-Cal/Healthy Families application;
- ▶ Apply through the Single Point of Entry (see Glossary); and
- ▶ Appear eligible for no-share-of-cost Medi-Cal (see Glossary).

Accelerated enrollment continues until the county determines that the child is eligible for Medi-Cal or until the end of the month in which the child is found ineligible.

Full-Scope Coverage Aid Code: 8E

Average Monthly Number of Beneficiaries: 32,869

- ▶ **National School Lunch Program Express Enrollment** — This program allows children eligible for free meals in participating school lunch programs to be automatically evaluated for Medi-Cal eligibility when parental consent is given. As of July 1, 2003, parents of children in school districts participating in this program are able to allow information in the school lunch program application to be forwarded to the county for a Medi-Cal determination. These children receive full-scope Medi-Cal with no share of cost (see Glossary) until an eligibility determination is made.

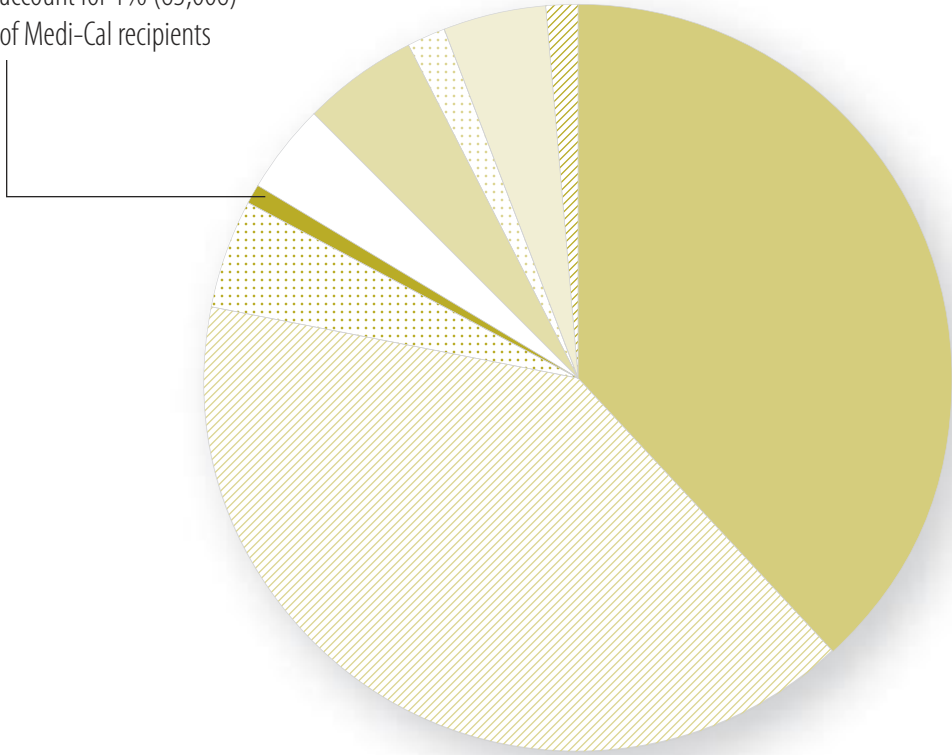
Full-Scope Coverage Aid Code: 7T

Average Monthly Number of Beneficiaries: 306



### Pregnancy-Related Programs

account for 1% (63,006)  
of Medi-Cal recipients



## PREGNANCY-RELATED PROGRAMS

Under Medi-Cal, pregnancy-related services are provided—regardless of a woman’s immigration status—to encourage early and appropriate utilization of prenatal care services. The scope of care for these programs is limited to pregnancy-related services, which are determined on a case-by-case basis by a woman’s doctor and usually are considered to be any services that contribute to a healthy birth outcome.

In addition to the Federal Poverty Level Program for Infants and Pregnant Women, discussed just below, a pregnant woman may be covered through another Medi-Cal program found in this guide or through the Access to Infants and Mothers (AIM) Program (described under Tab 10). Also, many pregnant women receiving free pregnancy care through the Federal Poverty Level Program for Infants and Pregnant Women receive Medi-Cal for their medical needs unrelated to the pregnancy through the Medically Needy Program (MN) (see Tab 6) or the Medically Indigent Program (MI) (see Tab 7), possibly with a share of cost (see Glossary).

► **Income Disregard Program (200% Program)**—Also called the Federal Poverty Level Program for Infants and Pregnant Women, this Medi-Cal program waives Medi-Cal’s property limits for pregnant women. The program provides pregnancy-related services, family planning services, and postpartum care for 60 days following birth or the end of pregnancy for pregnant women whose family income is at or below 200 percent of the Federal Poverty Level. Full-scope or emergency full-scope coverage may also be available to these women under another program such as MN or MI, with or without a share of cost. Women with incomes between 200 and 300 percent of the Federal Poverty Level may be eligible for the Access for Infants and Mothers (AIM) Program (see Tab 10).

Limited-Scope Coverage Aid Codes: 44, 48 (pregnancy, family planning, and postpartum services only)

Average Monthly Number of Beneficiaries: 61,579

Medi-Cal pays for 229,884 births per year—or more than 43 percent of all births in California.

Source: Kaiser Family Foundation, State Health Facts Online 2004

### Income Disregard Program

The Income Disregard Program is so named because some income is not counted (that is, is “disregarded”) when determining a woman’s eligibility for this program.



- ▶ **Postpartum Program**—Most women are covered for postpartum services under their regular Medi-Cal program. For women who received Medi-Cal through the Medically Indigent Program with a share of cost when they were pregnant, this program offers coverage with no share of cost for at least 60 days after the pregnancy ends; that is, from the day the pregnancy ends until the last day of the month in which the 60th day occurs. For example, if a woman gives birth anytime in January, her postpartum coverage will end March 31.

Limited-Scope Coverage Aid Code: 76 (postpartum services only)

Average Monthly Number of Beneficiaries: 1,427

- ▶ **Presumptive Eligibility Program**—The Presumptive Eligibility Program enables a provider to “presume” a pregnant woman is eligible for Medi-Cal based on her answers to a few income and residency questions. To encourage early prenatal care, a woman can be presumptively enrolled at her doctor’s office or clinic with the agreement that she will later apply for regular Medi-Cal through the county office. If a county Medi-Cal eligibility worker later verifies that the woman is indeed both pregnant and eligible, she is removed from the Presumptive Eligibility Program and placed in one of the other Medi-Cal programs for pregnant women. Otherwise, her application for Medi-Cal is denied. Whether or not her Medi-Cal application is approved, the provider is still reimbursed for the services provided during her presumptive eligibility time period, and the state receives federal matching funds. This program covers all walk-in prenatal care services except for delivery, family planning, and optional abortion procedures.

Limited-Scope Coverage Aid Codes: 7F, 7G (limited to pregnancy verification and ambulatory prenatal care)

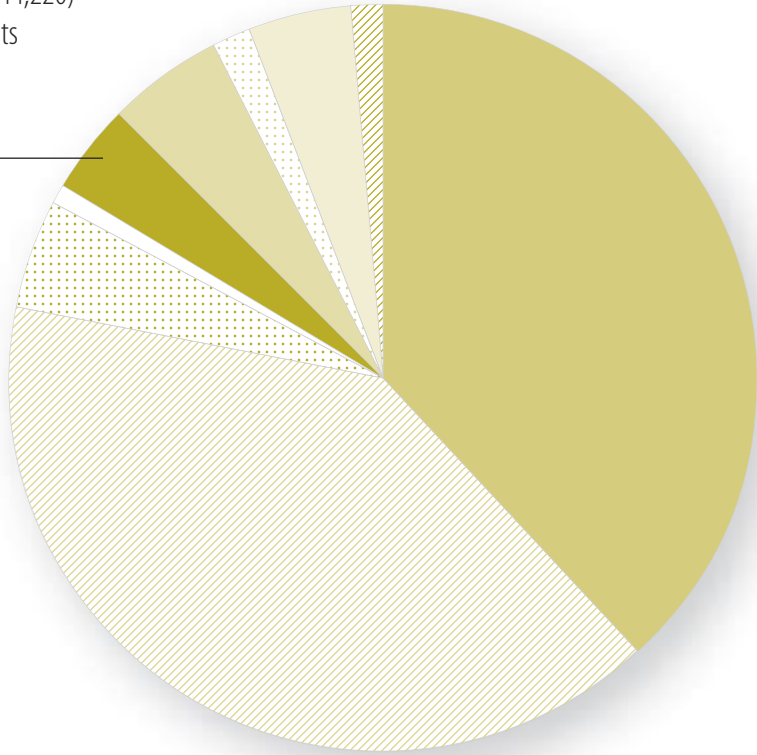
Average Monthly Number of Beneficiaries: Not available.

### **Payer of Last Resort**

Many women receiving coverage through the pregnancy programs are working but have limited or no health insurance. For those with other health insurance, Medi-Cal serves as “the payer of last resort” and will pay for services only after the insurance provider has paid.



**Senior and Disabled Programs**  
account for 3.8% (244,220)  
of Medi-Cal recipients



## SENIOR AND DISABLED PROGRAMS

Seniors and people with disabilities may qualify for Medi-Cal under one of the programs described in this section. They also may be eligible for Medi-Cal under many of the programs described elsewhere in this guide, such as through a link with SSI (see Tab 1).

- ▶ **Aged/Disabled Federal Poverty Level Program** — This Federal Poverty Level program, implemented in 2001, provides “no-share-of-cost” Medi-Cal to many seniors and persons with disabilities who otherwise would pay a share of cost (see Glossary) under the Medi-Cal Medically Needy Program (see Tab 6). Children, like adults, may qualify under this program if they meet the income guidelines and the Social Security Administration’s disability standard. Persons who are citizens or have satisfactory immigration status receive the full scope of benefits; persons without satisfactory immigration status receive emergency services only.

Full-Scope Coverage Aid Codes: 1H, 6H,

Limited-Scope Aid Codes: 1U, 6U (for those without satisfactory immigration status)

Average Monthly Number of Beneficiaries: 160,462

- ▶ **Long-Term Care Program (LTC)** — The Long-Term Care Program provides assistance and care for the elderly, the disabled, and persons with chronic disabilities. Coverage is provided for care in medical or nursing facilities and in their homes through personal care services, case management services, and home and community-based services. Long-term care is not an individual Medi-Cal program but rather a set of services provided under different aid codes (aid codes differ depending on the location of the services and the length of the nursing home stay, if there is one).

The majority of long-term care aid beneficiaries in medical facilities qualify for Medi-Cal under either the Medically Needy Program (see Tab 6) or the Medically Indigent Program (see Tab 7). Most long-term care

Of Medi-Cal expenditures, 61 percent go toward payment of acute care services, 32.6 percent pay for long-term care services, and 6.4 percent fund disproportionate share hospitals.

Source: Kaiser State Health Facts Online 2006

Medi-Cal pays for approximately 67 percent of all nursing home care in California.

Source: Kaiser State Health Facts Online, 2006

beneficiaries who reside at home or in the community are eligible for Medi-Cal through SSI (see Tab 1) or the Aged/Disabled Federal Poverty Level Program. Some people already enrolled in Medi-Cal will move into a long-term care medical facility and then change to an LTC aid code. Individuals who receive Medi-Cal-covered long-term care services include SSI recipients.

The eligibility criteria used for institutionalized individuals are different from those used for other Medi-Cal beneficiaries. For example, where one member of a married couple is in a nursing home, the married couple is permitted to use a higher property limit to ensure that the spouse of a nursing home resident who receives Medi-Cal will have enough resources to continue living independently.

Persons who are citizens or have satisfactory immigration status receive a full scope of benefits; persons without satisfactory immigration status who otherwise qualify for the program receive emergency services only.

Full-Scope Coverage Aid Codes: 13, 23, 63 (for persons in a medical facility)

Limited-Scope Coverage Aid Codes: 53, 55 (for those without satisfactory immigration status)

Average Monthly Number of Beneficiaries: 64,959

- ▶ **250% Working Disabled Program** — This Medi-Cal program is for working disabled individuals who:
  - ▶ Have countable income of less than 250 percent of the Federal Poverty Level;
  - ▶ Meet the Social Security Administration's definition of disability; and
  - ▶ Have less than \$2,000 worth of personal property, excluding retirement plans or accounts approved by the Internal Revenue Service.

Those who meet these criteria are eligible to buy into the Medi-Cal program by paying monthly premium payments on a sliding scale, based on the amount of their earned income (minus exemptions, such as their disability income). Persons must be U.S. citizens or have satisfactory immigration status. Unlike any other Medi-Cal program, persons applying for this program can deduct all of their disability-based income to fall under the income limits for this program.

Full-Scope Coverage Aid Code: 6G

Average Monthly Number of Beneficiaries: 1,835

- ▶ **In-Home Supportive Services (IHSS) Program** — Three programs now provide in-home services: Personal Care Services Program (PCSP), IHSS Independence Plus Waiver, and IHSS Residual Program. All three programs enable individuals to remain safely in their own homes by providing personal care services, removing the need for expensive, long-term care facilities. There is no longer automatic Medi-Cal eligibility based upon receipt of IHSS.
  - ▶ **Personal Care Services Program** — To qualify for PCSP, an individual must be eligible for full scope, federally funded Medi-Cal benefits. Services include ancillary services and protective supervision not provided by a spouse or parent.
  - ▶ **IHSS Independence Plus Waiver** — To qualify for IHSS Independence Plus Waiver services, an individual must be eligible for full-scope, federally funded Medi-Cal. Additionally, the individual must qualify for in-home services through a needs assessment, which is completed by an IHSS social worker. Services include personal care; protective supervision; domestic and related services; accompaniment to medical appointments; teaching and demonstration provided by a spouse or parent of a minor child; restaurant meal allowance; and advance payment for in-home care services.

- ▶ **IHSS Residual Program**— Those who are not eligible for services under PCSP or the IHSS Independence Plus waiver may receive IHSS services through the IHSS Residual Program. This state/county-funded program helps pay for domestic services, such as cleaning, meal preparation, laundry services, and shopping services, for aged, blind, or disabled individuals.

Full-Scope Coverage Aid Codes: 2L, 2M, 2N (former aid codes 18, 28, 68 are being phased out)

Average Monthly Number of Beneficiaries: Not available.

### **MEDICARE SAVINGS PROGRAMS**

Medicare Savings Programs are available only to Medicare beneficiaries and are intended to allow low-income Medicare beneficiaries to offset some out-of-pocket expenses not covered by Medicare. They provide varying levels of help in paying Medicare premiums and deductibles. Although applications for this program are administered by the county Medi-Cal offices, these programs do not provide Medi-Cal benefits and are not subject to the Medi-Cal Estate Recovery Program (see Glossary). Medicare Savings Programs include:

- ▶ **Qualified Medicare Beneficiary (QMB) Program**— The Qualified Medicare Beneficiary Program functions like a free Medicare supplemental policy. This program covers annual deductibles for hospital insurance (Medicare Part A) and medical insurance (Medicare Part B) and 20 percent of each doctor visit that Medicare does not cover. It also pays Medicare Part A and B premiums. QMB, however, does not pay Medicare Part D premiums for prescription drug coverage. Rather, QMB beneficiaries are among thousands of individuals who receive a low-income subsidy to pay Part D premiums for benchmark prescription drug plans. Applicants with countable monthly incomes up to 100 percent of the Federal Poverty Level can qualify for QMB. Coverage is limited to services for which Medicare pays a portion. However, a QMB beneficiary may also qualify for

a Medi-Cal program that would cover the full scope of Medi-Cal services.

Aid Code: 80

Average Monthly Number of Beneficiaries: 5,764

- ▶ **Specified Low-Income Medicare Beneficiary (SLMB) Program** — This program pays Medicare Part B premiums only, for applicants with countable monthly incomes up to 120 percent of the Federal Poverty Level. SLMB beneficiaries can also receive full-scope Medi-Cal benefits if they qualify under another Medi-Cal eligibility category.

Aid Code: 8C

Average Monthly Number of Beneficiaries: Not available.

- ▶ **Qualifying Individual 1 (QI-1) Program** — The QI-1 Program pays Medicare Part B premiums only for applicants with countable monthly incomes between 120 and 135 percent of the Federal Poverty Level. The QI-1 Program will expire September 30, 2007, unless Congress votes to extend it. QI-1 beneficiaries are not eligible to receive full-scope Medi-Cal benefits.

Aid Code: 8D

Average Monthly Number of Beneficiaries: Not available.

- ▶ **Qualified Disabled Working Individual (QDWI) Program** — This program covers Medicare Part A premiums for working people who have lost entitlement to free Part A benefits due to substantial gainful activity (SGA), as defined by the Social Security Administration. To qualify, individuals must have countable income under 200 percent of the Federal Poverty Level and countable resources of not more than \$4,000 (\$6,000 for a couple).

Aid Code: 8A

Average Monthly Number of Beneficiaries: Not available.



## MEDICAID HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER PROGRAMS

A federal Medicaid HCBS waiver allows the state to disregard portions of the Social Security Act and target additional services to specific groups of individuals defined by disability or geographic area who otherwise may require Medi-Cal-funded institutional care. Without the waiver of federal Medicaid rules, the state could not provide extra services to a targeted group defined by their qualifying for Medi-Cal-funded long-term care, could not limit services to specific geographic areas of the state, and could not waive deeming of income and resources from a parent to child or from spouse to spouse. (This feature is called “institutional deeming.”)

Medicaid waivers also allow the state to provide Medicaid coverage to individuals who may not be eligible under regular Medicaid rules.

There are no special aid codes for Medi-Cal recipients who qualify for waiver services. However, special aid codes are assigned to individuals who qualify for Medi-Cal through the institutional deeming and spousal impoverishment feature of some of the waivers: 6V, 6W, 6X, 6Y, IX, and IY.

The table on page 35, “California Medicaid Home and Community-Based Services Waiver Programs,” outlines the eight California HCBS waiver programs.

**CALIFORNIA MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAMS**

<b>Program Name</b>	<b>Persons Eligible</b>	<b>Services</b>	<b>Referred By</b>
<p><b>Acquired Immune Deficiency Syndrome (AIDS) Waiver</b></p>	<p>Persons on Medi-Cal with an HIV or AIDS diagnosis who are certifiable for placement in a nursing facility or acute care hospital, but choose to live at home. This includes those who have a health condition made difficult to manage because of the HIV diagnosis.</p>	<p>Wide range of community-based services including, but not limited to, case management, homemaker services, attendant care, transportation, meals, skilled nursing care, and medical equipment.</p>	<p>Department of Health Services, Office of AIDS</p>
<p><b>Assisted Living Waiver Pilot Project (ALWPP)</b></p> <p>The ALWPP is a three-year pilot project.</p>	<p>Persons on Medi-Cal who are 21 years of age or older, who meet the Nursing Facility (A or B) Level of Care, and who live in Sacramento, San Joaquin, or Los Angeles County.</p>	<p>Participants will reside in either a Residential Care Facility for the Elderly (RCFE) or in a Public Subsidized Housing (PSH) Unit. Waiver services are: Assisted Living Services, Care Coordination, Nursing Facility Transition Care Coordination, Translation and Interpretation Services, Consumer Education, Environmental Accessibility Adaptations, and Community Transition Services. Participants who reside in RCFEs will receive services from the RCFE. Participants who reside in PSHs will receive services from a Medi-Cal licensed Home Health Agency. Care coordination is provided by Care Coordination Agencies that contract with CDHS.</p>	<p>Department of Health Services, Medi-Cal Operations Division Monitoring and Oversight Section</p>
<p><b>DDS Home and Community Based Services (HCBS) Waiver</b></p> <p>Aid Codes:* 6V (no share of cost) 6W (share of cost)</p> <p>*For those who qualify for full-scope Medi-Cal through the institutional deeming or spousal impoverishment rules under the waiver.</p>	<p>Developmentally disabled persons under the Regional Center definition who would otherwise require care in one of the categories of intermediate care facility for persons with developmental disabilities (ICF/DD). Institutional deeming and spousal impoverishment rules are applied.</p>	<p>Wide range of community-based services, including home health, physical and occupational therapy, and transportation.</p>	<p>Department of Developmental Services Regional Centers</p>

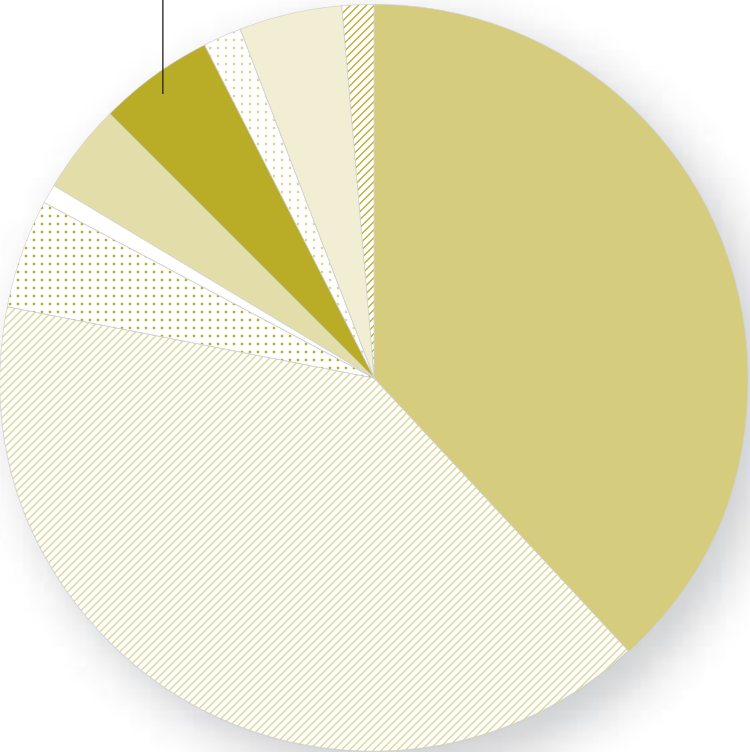
CALIFORNIA MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAMS, CONTINUED

Program Name	Persons Eligible	Services	Referred By
<p><b>HCBS Nursing Facility/Acute Hospital (NF/AH) Waiver</b></p> <p>Medi-Cal In-Home Operations administers three waivers: 1) Nursing Facility Level A and B (NF A/B); 2) Nursing Facility Subacute (NFA); and 3) In-Home Medical Care (IHMC). These three waivers will be combined into a single waiver starting January 1, 2007.</p> <p>Aid Codes:* 6X (no share of cost) 6Y (share of cost)</p> <p>*For those who qualify for full scope Medi-Cal under the institutional deeming or spousal impoverishment rules under the NF A/B and NFA waivers.</p>	<p>Physically disabled individuals, including children, who would otherwise require acute hospital or nursing facility care but wish to remain in the community. Institutional deeming and spousal impoverishment rules are applied (see Glossary).</p>	<p>Home health care, including nursing, case management, respite care, utility coverage, and minor home modifications.</p>	<p>Department of Health Services In-Home Operations (IHO) Section</p>
<p><b>In-Home Medical Care Services (IHMC) Waiver</b></p>	<p>Individuals requiring acute hospital care for 90 consecutive days or greater but who wish to receive care at home.</p>	<p>Home health care, including nursing, case management, respite care, utility coverage, home aide assistance, and minor home modifications.</p>	<p>Department of Health Services In-Home Operations (IHO) Section</p>
<p><b>Multipurpose Senior Services Program (MSSP) Waiver</b></p> <p>Aid Codes:* IX (share of cost) IY (no share of cost)</p> <p>*For those who qualify for full-scope Medi-Cal through spousal impoverishment rules.</p>	<p>Persons on Medi-Cal who are 65 years of age or older, who live in the counties and zip codes covered by the waiver, and who are certifiable for placement in a nursing facility but choose to live at home. Spousal impoverishment rules are applied.</p>	<p>Wide range of community-based services including, but not limited to: case management, personal care, money management, homemaker services, housing assistance, meals, transportation, and respite care.</p>	<p>Department of Aging</p>
<p><b>Nursing Facility Level A and B (NF A/B) Waiver</b></p>	<p>Physically disabled individuals, including children, who would otherwise require intermediate (NF-A) or skilled nursing (NF-B) care for 365 consecutive days or greater but wish to remain in the community.</p>	<p>Home health care, including nursing, case management, respite care, utility coverage, home aide assistance, personal care services, and minor home modifications.</p>	<p>Department of Health Services In-Home Operations (IHO) Section</p>
<p><b>Nursing Facility Subacute (NF SA) Waiver</b></p>	<p>Physically disabled adults who would otherwise require subacute nursing facility care for 180 consecutive days or greater but wish to remain in the community.</p>	<p>Home health care, including nursing, case management, respite care, utility coverage, home aide assistance, personal care services, and minor home modifications.</p>	<p>Department of Health Services In-Home Operations (IHO) Section</p>



**Medically Needy Program**

accounts for 5% (319,950) of Medi-Cal recipients



## MEDICALLY NEEDED PROGRAM

States are not required to offer medically needy (MN) coverage, but if a state chooses to have a Medically Needy Program, it must be designed within certain parameters set by the federal government. Individuals in the Medically Needy Program do not receive cash assistance from another government program (for example, SSI or CalWORKs), usually because their income is too high to qualify for cash aid.

However, to be eligible for Medically Needy Medi-Cal, individuals must meet the SSI requirements of age, blindness, or disability, or the former AFDC requirements of deprivation. When determining countable income, the income allowed to be disregarded depends on whether the Medically Needy Medi-Cal is linked to the former AFDC program or the SSI program, because the income disregards follow the related cash assistance program's rules. To be eligible for the Medically Needy Program, individuals must be one of the following:

- ▶ 65 or older;
- ▶ Disabled;
- ▶ Blind;
- ▶ Parents or children who meet deprivation requirements (see Glossary); or
- ▶ Caretaker relatives.

Pregnant women may also be eligible for the Medically Needy Program, but they are more likely to be eligible for Medi-Cal's 200% Program (see Tab 4) or for the Access for Infants and Mothers Program (AIM) (see Tab 10), which provides coverage to women with incomes between 200 and 300 percent of the Federal Poverty Level.

## Share of Cost

The amount of health care expenses a recipient must incur before Medi-Cal begins to pay for goods and services is referred to as “share of cost.” Whether or not a recipient has a share of cost, and how much it is, are determined by an eligibility worker based on monthly family income. An individual’s share of cost is the amount of his or her countable income above the Maintenance Need Level (MNL). Special rules apply to persons who qualify for the Medi-Cal Personal Care Services Program or IHSS Independence Plus Waiver services with a share of cost (*see Tab 5*).

A beneficiary does not actually have to pay the share of cost but can satisfy it by incurring expenses in other ways:

- Plan several non-urgent medical or dental appointments in one month.
- Ask the doctor to prescribe two to three months of prescriptions in one month.
- Use receipts for over-the-counter medicine and other items not covered.
- Use unpaid medical bills from past months.

Those who receive Medically Needy Medi-Cal may be eligible with or without a “share of cost.”

- ▶ **Without a share of cost** — Beneficiaries of Medically Needy Medi-Cal with no share of cost receive medical goods and services upon presentation of their Medi-Cal card, as do other beneficiaries.
- ▶ **With a share of cost** — Beneficiaries with a share of cost must first incur the amount of the monthly share of cost for medical expenses before Medi-Cal will pay for any medical goods or services.

Full-Scope Coverage Aid Codes: 14, 17, 24, 27, 34, 37, 64, 65 (state-funded only), 67

(Additional Medically Needy aid codes are listed under other sections, including Section 1931(b), SB 87, and OBRA.)

Average Monthly Number of Beneficiaries: 319,950

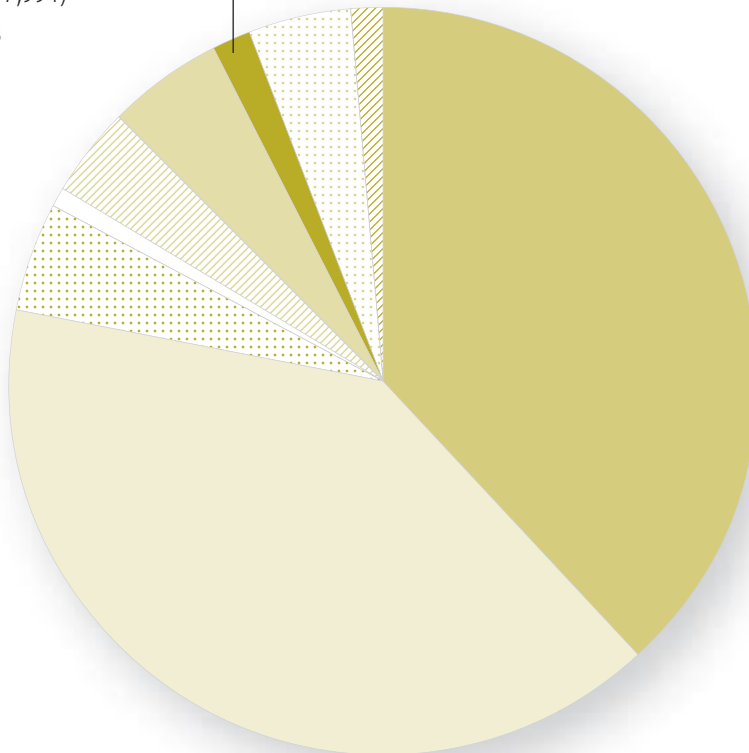
Wherever possible, a Medi-Cal beneficiary should be placed in a program with no share of cost. These programs are described under **Tabs 1 to 5 and 8 to 9**. (See the sidebar for more information on share of cost.)





**Medically Indigent Program**

accounts for 1.8% (117,991)  
of Medi-Cal recipients



## MEDICALLY INDIGENT PROGRAM

The Medically Indigent (MI) Program offers Medi-Cal coverage to several very different groups of people. The financial eligibility criteria are the same as those for the Medically Needy Program (see Tab 6), but individuals can qualify for the Medically Indigent Program even if they don't have dependent children and are not over 65, disabled, or blind. Individuals covered by Medi-Cal's Medically Indigent Program may or may not have a share of cost (see Glossary), depending on family income.

Generally, people who receive care through Medi-Cal's Medically Indigent Program are:

- ▶ Pregnant women and persons under age 21 who do not meet the deprivation requirements of the Medically Needy Program;
- ▶ Some children receiving Foster Care Assistance;
- ▶ Some children who are eligible for Aid for Adoption of Children;
- ▶ Abandoned babies;
- ▶ People who reside in nursing facilities, who are between the ages of 21 and 65, who are there for short-term care, and who are not disabled (state-funded only); or
- ▶ Individuals without satisfactory immigration status who are in need of nursing home care (state-funded only).

Although the federal government does not require states to offer Medically Indigent (MI) programs, California has opted to establish an MI program within Medi-Cal. The state receives federal funding for children and pregnant women in the MI Program, but care for other adults is state-funded only.

The Medically Indigent Program can be confusing because there is a statewide Medi-Cal Medically Indigent (MI) Program as well as county Medically Indigent Adult (MIA) programs (see Tab 10). The county MIA programs are not part of Medi-Cal.

Full-Scope Coverage Aid Codes: 03, 04, 2A, 4A, 4K, 4S, 5K, 81, 82, 83, 86, 87

Average Monthly Number of Beneficiaries: 117,991

Wherever possible, a beneficiary should be placed in an aid code for a program with no share of cost (see Glossary), as described under Tabs 1 to 5 and 8 to 9.

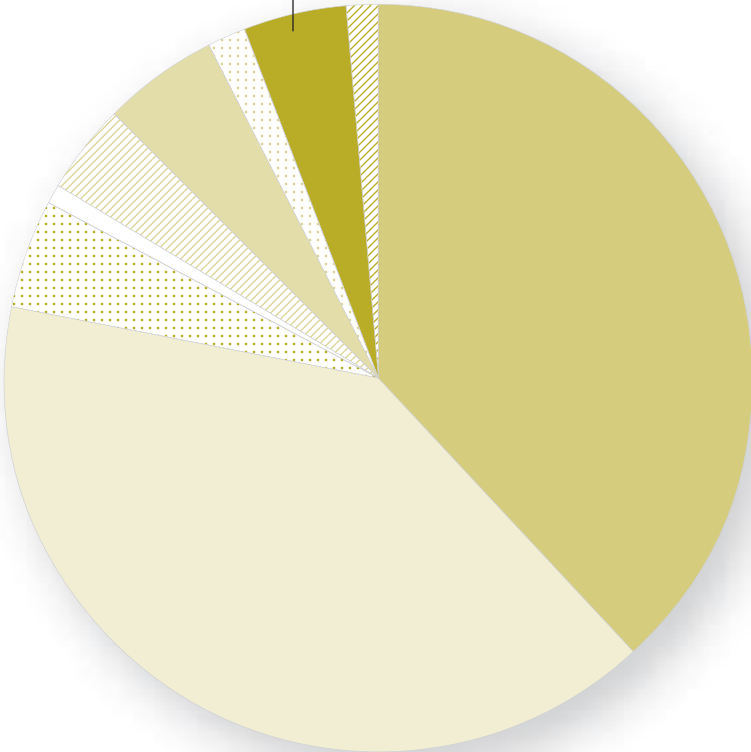
### **Medically Indigent Example**

An example of a Medi-Cal Medically Indigent recipient is a single, 30-year-old man without children who is injured in a motorcycle accident on the way home from work. He needs three months of rehabilitation in a nursing facility but is not expected to be permanently disabled. If he meets financial criteria — which are the same as those for the Medically Needy Program — he can receive coverage through the Medically Indigent Program. He is not in the MN program because he does not meet the definition of disabled (i.e., unable to work for 12 months or more) and does not have children at home.



**Transitional/Continuing Medi-Cal Coverage**

accounts for 4.4% (283,415) of Medi-Cal recipients



## TRANSITIONAL/CONTINUING MEDI-CAL COVERAGE

When individuals become ineligible for one Medi-Cal program, they often can qualify to receive Medi-Cal under another program discussed in this guide or through transitional/continuing Medi-Cal coverage discussed just below. Transitional/continuing coverage can be divided into three main categories:

- ▶ Transitional coverage for people who have lost cash assistance (CalWORKs, SSI, or Foster Care Assistance) or Section 1931(b) Medi-Cal;
- ▶ Continuing coverage for children; and
- ▶ Procedural safeguards that ensure continuing coverage.

### I. TRANSITIONAL COVERAGE FOR PEOPLE WHO HAVE LOST CASH ASSISTANCE

People who have lost cash assistance (CalWORKs, SSI, or Foster Care Assistance) may be eligible for Medi-Cal.

#### PEOPLE TRANSITIONING OFF CALWORKS

People leave CalWORKs for many reasons. For example, they may have started working or may have married. Or they may have reached a time limit in CalWORKs after which they no longer qualify. Caseworkers recalculate eligibility for people who stop receiving cash assistance. As discussed below, most of these individuals can continue to receive Medi-Cal for a specified period of time provided that they remain in the state and have given their caseworker the required information.

- ▶ **Transitional Medi-Cal (TMC) Coverage**— If individuals stop receiving CalWORKs cash assistance or Section 1931(b)-Only Medi-Cal due to increased earnings, they may qualify for TMC for up to 12 months. The first six months is available regardless of income and the countable income limit for the second six months is 185 percent FPL. The coverage is federally and state-funded.

**Transitional Medi-Cal (TMC)** for adults helps those leaving CalWORKs achieve self-sufficiency. Adults and children can qualify for TMC if they have been receiving Section 1931(b) Medi-Cal even if they have not received CalWORKs. It is hoped that providing health coverage will help keep people from cycling back onto welfare when faced with medical problems for themselves or their children.

(An additional 12 months of coverage was eliminated in 2003.)  
Children under 19 years of age may qualify for the Healthy Families Program or another Medi-Cal program after TMC is exhausted.

Persons who are citizens or have satisfactory immigration status receive a full scope of benefits; persons without satisfactory immigration status who otherwise qualify for the program receive emergency services only.

Full-Scope Coverage Aid Codes: 39, 59

Limited-Scope Aid Codes: 3T, 5T (for those without satisfactory immigration status)

Average Monthly Number of Beneficiaries: 115,207

- **Four-Month Continuing Medi-Cal**—If beneficiaries stop receiving CalWORKs cash assistance or Section 1931(b)-Only Medi-Cal due to the increased receipt of child support or alimony, they may qualify for four months of continuing Medi-Cal.

Persons who are citizens or have satisfactory immigration status receive a full scope of benefits; persons without satisfactory immigration status who otherwise qualify for the program receive emergency services only.

Full-Scope Coverage Aid Code: 54

Limited-Scope Aid Code: 5W (for those without satisfactory immigration status)

Average Monthly Number of Beneficiaries: 852

#### PEOPLE TRANSITIONING OFF SSI/ SSP

Although “inability to work” and not having substantial gainful activity (SGA) are criteria for SSI disability benefits when you apply, there are programs to encourage SSI recipients to work while maintaining their disability status for Medi-Cal benefits. Elderly as well as disabled people losing their Supplemental Security Income (SSI) and State Supplementary Payment (SSP) cash benefits may be eligible to continue their Medi-Cal coverage under a number of programs.

- ▶ **Section 1619(b) Program** — Section 1619(b) of the Social Security Act encourages severely disabled persons to seek and maintain employment by providing continuing Medi-Cal benefits to certain individuals who lose eligibility for SSI/SSP due to their earnings. People under the Section 1619(b) Program are SSI recipients for purposes of Medi-Cal. To qualify for the Section 1619(b) Program, individuals must need Medi-Cal in order to continue working.
- ▶ **Severely Impaired Working Individuals (SIWI) Program** — The SIWI Program allows certain beneficiaries to retain Medi-Cal benefits despite losing SSI/SSP due to marriage or a spouse’s increased earnings or property. This happens because spousal deeming requirements, which mandate counting a spouse’s income for eligibility purposes, are waived. To qualify for Medi-Cal under this program, individuals must need Medi-Cal in order to continue working.

Full-Scope Coverage Aid Code: 8G (SIWI only)

Average Monthly Number of Beneficiaries: 0

- ▶ **“Pickle” Program (or Title II Disregard Program)** — People who received both SSI and Social Security Title II benefits, but who are not currently eligible for an SSI/SSP payment due to an intervening cost-of-living adjustment (COLA) to their Social Security Title II benefits are put in the curiously named “Pickle” Program where they can continue to receive “no-share-of-cost” Medi-Cal.

The number of new “Pickles” created each year is related to the amount of the Social Security COLA and whether or not California has raised its State Supplementary Payment (SSP). This is an excellent example of how rules for non-Medi-Cal programs directly affect Medi-Cal eligibility.

### **Pickle Eligibility**

The Pickle eligibility category is the result of the 1976 “Pickle Amendment” and a 1983 lawsuit, *Lynch v. Rank*. Jake Pickle was a member of the U. S. House of Representatives from Texas.

In California, the state “Pickle Handbook” instructs workers on how to determine Pickle eligibility. The technical term for this group of Medi-Cal beneficiaries is “Title II Disregard.”



People are screened for “Pickle” eligibility each time they apply for Medi-Cal and for three years after their SSI/SSP has been terminated. In addition, each year the Social Security Administration sends to the state a list of individuals who have stopped receiving SSI. The state then forwards this list to the counties, where caseworkers determine whether the individuals on the list qualify for Medi-Cal as “Pickles.”

Full-Scope Coverage Aid Codes: 16, 26, 66

Average Monthly Number of Beneficiaries: 18,576

- ▶ **Craig v. Bonta**— Under this court case, aged, blind, or disabled individuals who are terminated from SSI/SSP for any reason other than death or incarceration must remain on full-scope Medi-Cal with no share of cost (see Glossary) until a determination of their eligibility for another Medi-Cal program is made. A new application is never required for these beneficiaries.

Full-Scope Coverage Aid Codes: 1E, 2E, 6E

Average Monthly Number of Beneficiaries: 19,296

- ▶ **Disabled Adult Children (DAC) Program**— Individuals who qualify for this program are people over age 18 who either:
  - ▶ Were born with some kind of disabling condition; or
  - ▶ Became disabled before age 22 and whose SSI/SSP benefits were discontinued because of Retirement Survivor Disability Insurance (RSDI) benefits (either the receipt of or entitlement to RSDI benefits or an increase in the RSDI benefits that are currently received).

Individuals qualifying as disabled adult children can receive Social Security Title II benefits from a parent’s work history, which can entitle them to substantially more money than they could claim on their own work history or more money than they could receive from SSI. To allow these individuals to continue their “no-share-of-cost”

Medi-Cal coverage, this Social Security Title II income is disregarded when calculating Medi-Cal eligibility.

Full-Scope Coverage Aid Codes: 6A, 6C

Average Monthly Number of Beneficiaries: 3,138

- ▶ **Disabled Widow/ers (DW) Program**—Certain disabled widow/ers and surviving divorced spouses who are not eligible for Medicare and who lose SSI eligibility when they begin claiming retirement benefits as widow/ers may keep full-scope Medi-Cal under this program.

Full-Scope Coverage Aid Code: 36

Average Monthly Number of Beneficiaries: 83

- ▶ **Former Foster Care Children (FFCC) Program**—Children in Foster Care Assistance under the responsibility of the state on their 18th birthday retain eligibility for full-scope, “no-share-of-cost” Medi-Cal benefits until age 21 under this program as long as they maintain California residency. There are no property or income limits, but citizenship or satisfactory immigration status is required.

Full-Scope Coverage Aid Code: 4M

Average Monthly Number of Beneficiaries: 4,779

## II. CONTINUING COVERAGE FOR CHILDREN

- ▶ **Continuous Eligibility for Children (CEC) Program**—In 2001, Medi-Cal established the CEC Program so that children under age 19 living in California could continue to receive “no-share-of-cost” Medi-Cal for up to 12 months regardless of a change in circumstances, even if the rest of their family is no longer eligible. CEC also applies to children who lose foster care eligibility or those who return home from an out-of-home placement, such as in a medical facility. A county may move the child into a special aid code or keep the child in the same aid code. When a child is moved into CEC, the CEC benefits last until the next scheduled annual redetermination date.

Children who are citizens or have satisfactory immigration status receive a full scope of benefits; children without satisfactory immigration status who otherwise qualify for the program receive emergency services only.

Full-Scope Coverage Aid Code: 7J

Limited-Scope Aid Code: 7K (for those without satisfactory immigration status)

Average Monthly Number of Beneficiaries: 43,755

- ▶ **Bridging Program** — Children who no longer qualify for “no-share-of-cost” Medi-Cal but who appear to be eligible for the Healthy Families Program during their Medi-Cal redeterminations are continued on Medi-Cal for an additional month. If the family consents, the eligibility worker forwards the annual redetermination form to the Healthy Families Program to be processed as an application for that program. For the additional month, children in this program continue with the Medi-Cal coverage that they already have. It is presumed that these children will be enrolled in Healthy Families in the following month. This Bridging Program is jointly funded by the federal and state governments, but the state funding is from the Healthy Families Program and not Medi-Cal.

Full-Scope Coverage Aid Code: 7X

Average Monthly Number of Beneficiaries: Not available.

### III. MEDI-CAL SAFEGUARDS FOR ALL MEDI-CAL BENEFICIARIES

Numerous safeguards are in place to ensure that Medi-Cal coverage is continued when a Medi-Cal beneficiary experiences any change in circumstances. Two important safeguards include Senate Bill 87 and the Medi-Cal appeals process.

- ▶ **Senate Bill 87 (SB 87)** — People no longer eligible for one Medi-Cal program may still be eligible for another program. SB 87 requires that Medi-Cal benefits not be discontinued when a beneficiary becomes

ineligible for Medi-Cal under one program until eligibility for Medi-Cal under all programs has been considered.

In determining a person's eligibility for other programs, the county must first conduct an "ex parte" redetermination (see Glossary). That is, the county may not ask the person for eligibility information that the county can obtain from county or state records. If the county cannot establish eligibility from the ex parte review, it must attempt to reach the beneficiary by phone and then in writing to request only the missing information needed to continue eligibility. In general, Medi-Cal beneficiaries retain their current aid code during this redetermination. If, however, a person is claiming to have a disability that would entitle the person to continue Medi-Cal coverage, the individual may be shifted into one of four aid codes, pending a disability determination.

Full-Scope Coverage Aid Codes: 38,\* 6J, 6R

\*The Edwards holding category, while still used by some counties, is obsolete after the implementation of SB 87, so 38 is added here.

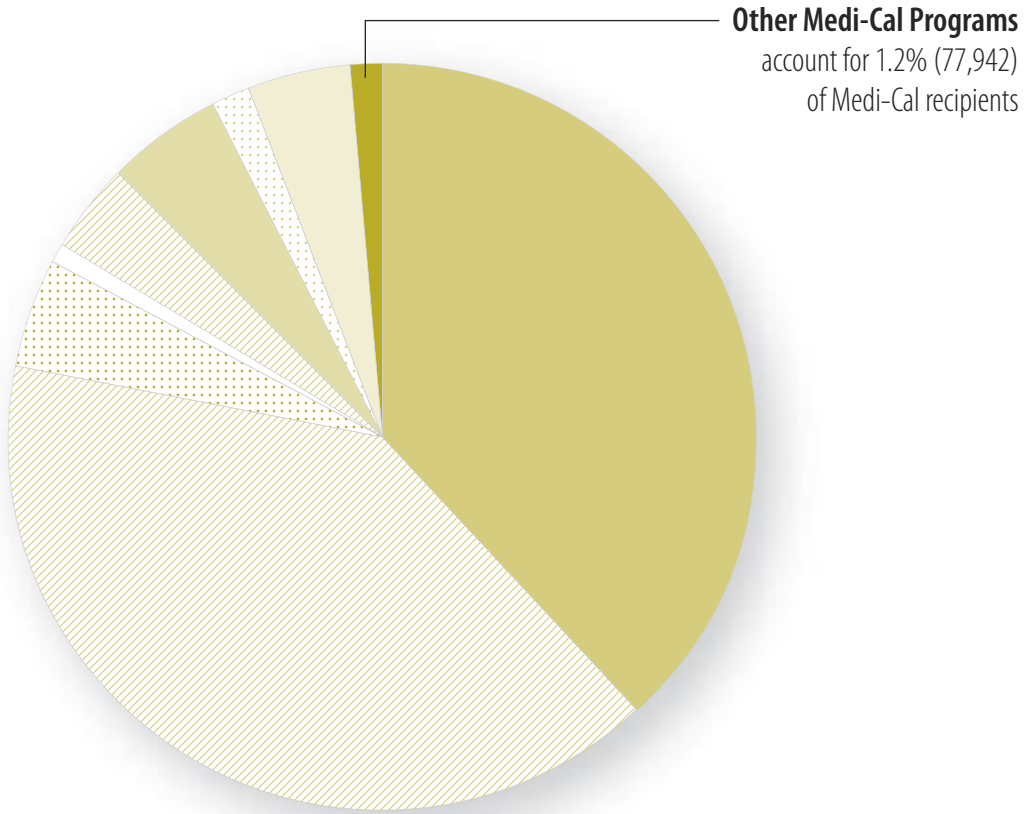
Limited-Scope Aid Codes: 5J, 5R

Average Monthly Number of Beneficiaries: 77,729

- ▶ **Medi-Cal Appeals Process** — Medi-Cal beneficiaries who experience a denial of eligibility or a delay in or termination of services can challenge these actions through a Medi-Cal appeal and an administrative hearing. To make a challenge, individuals can call Medi-Cal, write a letter, or complete the form on the back of the Notice of Action letter. They can participate in an administrative hearing by explaining their case to an administrative law judge and providing related documents. The judge will decide the case after hearing the beneficiary's account and Medi-Cal's explanation. While it is not required, beneficiaries can bring an advocate or attorney to argue their case.

- ▶ **“Aid Paid Pending”** — If a person is terminated from Medi-Cal and has appealed the termination decision prior to the scheduled termination date, he or she may request that coverage continue until the appeal is decided. The period of continued coverage is known as “Aid Paid Pending.”





## OTHER MEDI-CAL PROGRAMS

In addition to the general Medi-Cal program outlined above, several very specialized programs offer limited-scope services to smaller segments of the population.

- ▶ **Breast and Cervical Cancer Treatment Program (BCCTP)**— This program provides treatment services to eligible California residents diagnosed with breast and/or cervical cancer, whose family income does not exceed 200 percent of the Federal Poverty Level. Eligible applicants can be screened and enrolled into BCCTP only by authorized Every Woman Counts or Family PACT providers using a new Internet-based application form sent directly to the California Department of Health Services.

Women who appear to meet the federal eligibility requirements can get presumptive eligibility with temporary, full-scope Medi-Cal coverage while a Medi-Cal determination is made.

Individuals who meet federal BCCTP requirements will receive full scope, “no-share-of-cost” Medi-Cal coverage for the duration of their cancer treatment if they meet all other eligibility requirements. To get this full-scope coverage, an individual must:

- ▶ Be female;
- ▶ Be under 65;
- ▶ Be a citizen or national of the United States or have satisfactory immigration status;
- ▶ Have no creditable health insurance;
- ▶ Have been diagnosed with breast and/or cervical cancer; and
- ▶ Be in need of treatment.

Applicants who do not meet federal standards but who meet state-funded BCCTP standards will receive services limited to cancer



treatment and cancer-related services for a specified time period (18 months for breast cancer and 24 months for cervical cancer). The state-funded BCCTP standards allow an individual to be a male or female of any age who may or may not have unsatisfactory immigration status. The state standards require an individual only to:

- ▶ Have been diagnosed with breast and/or cervical cancer;
- ▶ Be in need of treatment; and
- ▶ Have copayments, deductibles, premiums, or coinsurance of over \$750 annually if they have creditable health coverage.

Women without satisfactory immigration status receive emergency, pregnancy-related, and long-term care services in addition to cancer treatment.

Full-Scope Coverage Aid Codes: OM, ON, OP

Limited-Scope Coverage Aid Codes: OR, OT, OU, OV

Average Monthly Number of Beneficiaries: 9,325

- ▶ **Family Planning, Access, Care, and Treatment (PACT)** — Family PACT is a Medi-Cal program that provides family planning services to men and women with family income at or below 200 percent of the Federal Poverty Level. Family PACT provides a variety of family planning services for people at risk for becoming pregnant or causing a pregnancy. The program covers limited services, including contraception, emergency contraception, pregnancy testing and counseling, preconception counseling, sterilization, testing and treatment for sexually transmitted infections, cancer screening, hepatitis B immunization, and HIV screening. The program is funded under a five-year demonstration project waiver. Individuals may access these services through an approved provider.

Limited-Scope Aid Code: 8H

Average Monthly Number of Beneficiaries: Not available.

- ▶ **Dialysis Program**— This Medi-Cal program covers services related only to kidney dialysis. It is designed for people who do not qualify for disability payments through SSI and, therefore, do not qualify for disability-based Medi-Cal. This program is available to people with higher incomes and resources to prevent their impoverishment due to their medical condition and to facilitate their ability to continue working. Beneficiaries pay on a sliding scale based upon their income and property. This program is state-funded only.

Limited-Scope Aid Code: 71

Average Monthly Number of Beneficiaries: 74

- ▶ **Tuberculosis (TB) Program**— This program provides Medi-Cal coverage for tuberculosis-related outpatient services to individuals with TB. While TB is considered a public health risk, having the disease does not necessarily qualify an individual for disability payment through SSI, and, therefore, many individuals with TB do not qualify for disability-based Medi-Cal. The TB program has fixed income and property limits and is funded by the federal and state governments.

Limited-Scope Aid Code: 7H

Average Monthly Number of Beneficiaries: 1,031

- ▶ **Total Parenteral Nutrition (TPN) Program**— This program covers services related to TPN, which involves intravenous feedings. Some people with TPN work and do not qualify for disability-based Medi-Cal, but still cannot afford TPN services on their incomes. Instead of having a fixed income or property limit, individuals in the TPN program pay on a sliding scale according to their countable income and property. This program is state-funded only.

Limited-Scope Aid Code: 73

Average Monthly Number of Beneficiaries: 2

- **Omnibus Budget Reconciliation Act (OBRA) Program**—Although it is commonly called such, OBRA is not really a Medi-Cal “program” but rather a category of aid for people without satisfactory immigration status (SIS) who are eligible for *emergency care, pregnancy-related care, and nursing home care only*. Emergency services are funded jointly by the state and federal governments; pregnancy-related services and nursing home care are state-funded only.

The Section 1931(b) Program, Transitional Medi-Cal, Four-Month Continuing Medi-Cal, the Medically Needy Program, the Income Disregard Program, and the Percent Programs all include people who lack satisfactory immigration status (SIS). Unlike other beneficiaries in these categories, these individuals receive restricted benefits only.

Limited-Scope Coverage Aid Codes: 5F, 58

(Note: There are other aid codes for individuals who lack SIS: 0U, 1U, 3T, 3V, 48, 5T, 5W, 5S, 6U, 69, 7C, 7K, 74, 8N, 8T. The numbers of beneficiaries for these codes are captured in other programs.)

Average Monthly Number of Beneficiaries: 66,527

### Coverage for Immigrants

The federal government will pay for Medicaid services for people without satisfactory immigration status if the services are for an emergency medical condition (this includes emergency labor and delivery, but does not include organ transplant procedures). For most people without satisfactory immigration status, California also provides coverage for pregnancy-related services, family planning services, kidney dialysis, and nursing home services, using state-only funds.





## NON-MEDI-CAL PROGRAMS

Individuals who do not qualify for Medi-Cal because they do not meet the financial and other eligibility criteria or do not possess satisfactory immigration status may be able to qualify for one of the non-Medi-Cal programs discussed below. Some of these programs provide a full scope of benefits, while others offer limited benefits based upon an individual's medical condition or health care needs.

- ▶ **Access for Infants and Mothers (AIM) Program**— The AIM Program, administered by the state of California, provides health coverage to pregnant women and their newborns/infants with family incomes between 200 and 300 percent of Federal Poverty Level. Services include prenatal visits, hospital delivery, and postpartum care for 60 days. Children born to AIM mothers are now enrolled in the Healthy Families Program (see description on page 55) upon birth.
- ▶ **California Children's Services (CCS) Program**— The CCS Program, administered by the state and counties, provides funding for medical care for eligible children whose families have low incomes or high medical expenses and who have serious medical problems, including:
  - ▶ Acute injury and illness;
  - ▶ Genetic diseases;
  - ▶ Chronic conditions;
  - ▶ Physical disabilities;
  - ▶ Congenital defects; or
  - ▶ Major injuries due to violence or accidents.

CCS covers medical services related to the eligible condition, including physician services, hospital care, laboratory work, x-rays, rehabilitation services, pharmaceuticals, equipment, and case management. CCS also provides case management for Medi-Cal-enrolled children under

the age of 21 for services related to their eligible condition and covers Healthy Families-enrolled children for services related to their eligible condition. Every county has a CCS office that can be reached by calling the county health department.

Aid Codes: 9K, 9M, 9N, 9R (Note: CCS is not a Medi-Cal program.)

- ▶ **Child Health and Disability Prevention (CHDP) Program**— The CHDP Program, administered by the state and counties, provides preventive health screening examinations to children with family incomes of less than 200 percent of Federal Poverty Level. States are required to provide these services to Medi-Cal beneficiaries under age 21 under a federal program called the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program. Additionally, through CHDP, California provides screening services to income-qualifying children who do not have satisfactory immigration status. Screenings include a physical examination, immunizations, and laboratory tests, such as a lead blood test.

Aid Codes: 8U, 8V, 8W, 8X, 8Y (Note: CHDP is not a Medi-Cal program.)

- ▶ **CHDP Gateway Enrollment**— CHDP became a gateway to Medi-Cal and the Healthy Families Program in July 2003, which means that children may be immediately pre-enrolled in Medi-Cal or the Healthy Families Program through their CHDP provider after they file an automated application. CHDP Gateway Enrollment provides up to two months of eligibility while the family completes an application for continued coverage under one of the programs.
- ▶ **County Medical Services Program (CMSP)**— CMSP is a county medical assistance program that serves individuals who are unable to pay for their health services but are not eligible for Medi-Cal. Thirty-four small, rural counties participate in the CMSP to satisfy their obligations to provide health care to the indigent. Counties contract with CMSP as part of the state requirement to serve the same

population as the county Medically Indigent Adult Program (discussed on page 56). The Office of County Health Services administers the program in conjunction with county officials. The CMSP is funded by state and county funds.

Aid Codes: 50, 84, 85, 88, 89, 8F

CMSP clients receive medical benefits including those covered by the Medi-Cal program, with the exception of pregnancy-related services, long-term care, and services provided by chiropractors, acupuncturists, and psychologists. The CMSP provides coverage to persons with countable monthly incomes under 200 percent of the Federal Poverty Level, although some have to pay a share of cost.

- ▶ **Genetically Handicapped Persons Program (GHPP)** — GHPP provides health coverage for both adults and children not eligible for CCS (see page 53) who have specific genetic diseases, including:
  - ▶ Cystic fibrosis;
  - ▶ Hemophilia;
  - ▶ Sickle cell disease;
  - ▶ Certain neurological diseases; and
  - ▶ Certain metabolic diseases.

Families with income over 200 percent of the Federal Poverty Level pay fees based on a sliding scale. The program is administered statewide through the GHPP office in Sacramento.

Aid Code: 9J

- ▶ **Healthy Families Program (HFP)** — The Healthy Families Program is California’s State Children’s Health Insurance Program (SCHIP). The Healthy Families Program provides health coverage to children in families with incomes up to 250 percent of the Federal Poverty Level who do not qualify for free Medi-Cal and do not have private health



insurance. Former Access for Infants and Mothers (AIM) babies are now enrolled in the Healthy Families Program at birth. Covered services are provided by managed care plans and participation in the HFP requires payment of a monthly premium. Services are similar to those in the benefits package for California state employees. The program does not consider a family's property in determining eligibility and does not have a deprivation test. HFP is administered at the state level by the Managed Risk Medical Insurance Board (MRMIB).

Aid Codes: 0C, 9H

- ▶ **Major Risk Medical Insurance Program (MRMIP)** — This state program provides 36 continuous months of health insurance for Californians unable to obtain coverage in the individual health insurance market, usually due to a pre-existing condition. The premium cost is shared between MRMIP and the participant. After 36 months, beneficiaries are disenrolled from the program and are given the opportunity to enroll into guaranteed coverage that health plans are required to offer in the individual insurance market. Coverage is similar to benefits offered by MRMIP, but the cost of premiums is 10 percent higher. The MRMIP program is administered at the state level by the Managed Risk Medical Insurance Board (MRMIB).
- ▶ **Medically Indigent Adult (MIA) Program** — MIA is a county medical assistance program in the larger California counties. MIA is similar to CMSP (discussed on page 54) because it serves people who are unable to pay for their medical care, but are ineligible for Medi-Cal. MIA programs are funded and administered by the county. Some of the larger counties with MIA programs refer to their programs as the County Medical Services Program even though they do not participate in the CMSP.

► **Medicare**—Medicare is a federal health insurance program that pays for health care services for U.S. residents who are age 65 or older or who are permanently disabled. It is funded from a government trust fund into which eligible persons paid during their working years. Inpatient services are generally covered through Part A, Medicare’s hospital insurance, and outpatient services are provided through Part B, its medical insurance. Individuals who paid into the trust fund do not have to pay a premium for Part A, but they do have to pay a Part B premium. In January 2006, a prescription drug program called Medicare Part D began providing prescription drugs to Medicare beneficiaries for a limited cost. Medicare beneficiaries can obtain their medications through prescription drug plans that participate in Medicare Part D. Because Medicare is not a means-tested program, there are no income or resource criteria for the program. The program is administered through local offices of the Social Security Administration.







## **GLOSSARY**

### **100-HOUR RULE**

The 100-hour rule is used to measure deprivation and to determine a child's Medi-Cal eligibility for the Section 1931(b) and Medically Needy Programs. Even if other deprivation criteria do not exist (that is, a parent is not absent, deceased, disabled, or incapacitated) and a family's net income is over 100 percent of the Federal Poverty Level, the family may be still be eligible for Medi-Cal as long as the principal wage earner of the family is working less than 100 hours per month.

### **AID CODES**

Aid codes identify the criteria by which each person qualifies for Medi-Cal and the type of services he or she receives, and makes clear whether the services are funded by the state or federal government or both. An aid code is a combination of two numbers or a letter and a number and is attached to a Medi-Cal beneficiary's identification numbers. Current aid codes can be found at: [http://files.Medi-Cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/aidcodes\\_z01c00.doc](http://files.Medi-Cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/aidcodes_z01c00.doc) and also on page 81 of this guide.

### **AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)**

AFDC was the welfare entitlement program in effect prior to the 1996 welfare reform legislation. AFDC is still important because the Medically Needy Program has retained eligibility rules based on AFDC and the Section 1931(b) Program has retained some (but not all) AFDC rules. CalWORKs is the new California welfare program for families with minor children at home.

### **ASSISTANCE UNIT**

An assistance unit is a group of people receiving benefits together. For Medi-Cal, this is usually a family unit or subset of a family unit, often called a Medi-Cal Family Budget Unit, or MFBU. For cash aid, Medi-Cal, and the Food Stamp Program, assistance units may be determined differently. For CalWORKs and Medi-Cal, the assistance unit consists of people with a legal responsibility for one another—parents, children, and spouses.

Determining who is in an assistance unit can be quite complicated and has a significant impact on whether or not a person qualifies for Medi-Cal.

### **CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS (CALWORKS)**

CalWORKs is California's welfare-to-work program, established by the state Welfare-to-Work Act of 1997. The program, which replaced AFDC, makes welfare a temporary source of cash assistance by placing a five-year lifetime limit on receipt of benefits for adults (not for children) and by mandating work requirements.

### **CASH ASSISTANCE PROGRAM FOR IMMIGRANTS (CAPI)**

CAPI is a program funded solely by the state that provides monthly cash benefits to children and adults with disabilities under the SSI program or seniors aged 65 or older who are ineligible for SSI/SSP benefits because of their immigration status. CAPI follows SSI financial and nonfinancial rules, except those rules requiring satisfactory immigration status. Although Medi-Cal is not linked to receipt of CAPI, persons receiving CAPI are eligible for one of the Medi-Cal programs for seniors and persons with disabilities.

### **CATEGORICALLY NEEDY**

Beneficiaries are described as "categorically needy" if they qualify for Medi-Cal under one of the eligibility categories defined by federal Medicaid law. Categorically needy beneficiaries qualify by meeting financial requirements and possessing necessary personal characteristics.

### **CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)**

formerly known as the Health Care Financing Administration, or HCFA

A federal agency within the U.S. Department of Health and Human Services, CMS administers the Medicare and Medicaid programs. It also runs the State Children's Health Insurance Program (SCHIP).

### **CRAIG V. BONTA**

*Craig v. Bonta* was a 2002 court case that determined that the provisions of Senate Bill 87 (SB 87) also apply to beneficiaries who lose SSI eligibility.

SB 87 requires that an SSI beneficiary’s eligibility for all Medi-Cal programs be evaluated before Medi-Cal benefits are terminated.

### **DEEMING**

Deeming occurs when the state considers income or property as automatically available to a Medi-Cal applicant. Generally, only a spouse or parent’s income is deemed available to the individual applying for Medi-Cal benefits. Special deeming rules apply when a child or spouse is seeking Medi-Cal coverage of institutional or long-term care services.

### **DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS)**

DDS is one of several departments comprising California’s Health and Human Services Agency (CHHS). DDS provides services for over 177,000 children and adults with developmental disabilities and 21,000 infants who have a developmental delay or who are at risk of becoming developmentally disabled. Services are offered through state-operated developmental centers and contracts with 21 nonprofit agencies called regional centers. [www.dds.ca.gov](http://www.dds.ca.gov)

### **DEPARTMENT OF HEALTH SERVICES (CDHS)**

CDHS is one of several departments under California’s Health and Human Services Agency (CHHS). The Medical Care Services section of CDHS directly operates Medi-Cal (California’s Medicaid program), including the program’s eligibility, scope of benefits, reimbursement, and other related components. Currently, approximately 6.5 million Californians receive Medi-Cal benefits and services. [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)

### **DEPRIVATION**

“Deprivation” is a circumstance that must exist in a family for members to be eligible for CalWORKs or AFDC-related Medi-Cal programs. The deprivation requirement exists in addition to income and property limits. Deprivation occurs when one of the following is true:

- ▶ A parent is absent from the home;
- ▶ A parent is incapacitated (unable to work or care for children);
- ▶ A parent is disabled;
- ▶ A parent is deceased;



- ▶ A parent is employed less than 100 hours per month; or
- ▶ A parent has net earnings at or below 100 percent of the Federal Poverty Level.

### **DISABILITY**

For Medi-Cal purposes, a disabled person is an individual who has met certain criteria set by the Social Security Administration. The disability criteria are different for children and adults. Disabled individuals must have severe physical and/or mental problem(s), which—for adults—will last at least 12 months and keep them from working during those 12 months, or are expected to result in death.

### **DUAL ELIGIBLE**

Elderly and/or disabled persons who qualify for benefits under both the Medicaid and Medicare programs are referred to as “dual eligibles.” Payments for services for these individuals are first made by Medicare; Medicaid serves as a secondary payment source. Dual eligibles are sometimes referred to as “Medi/Medis.”

### **EDWARDS V. KIZER**

*Edwards v. Kizer* was a 1985 court case that assured continuing Medi-Cal coverage for most families leaving CalWORKs. These families received Medi-Cal coverage for one to two months until their eligibility for another Medi-Cal program was determined. In 2000, the Edwards process was made obsolete by SB 87, which requires that a beneficiary’s eligibility for all Medi-Cal programs be evaluated before benefits are terminated.

### **EMERGENCY SERVICES**

Federal Medicaid law defines an emergency condition as one with acute symptoms of sufficient severity that, without immediate medical attention, could put the patient’s life in jeopardy, result in serious impairment to bodily functions, or result in serious dysfunction of any bodily organ or part. The definition includes emergency labor and delivery and treatment for severe pain.

## **ESTATE RECOVERY**

The cost of Medi-Cal services provided to a beneficiary who is over age 55 or has been institutionalized may be recovered from the beneficiary's estate after the beneficiary dies. However, a Medi-Cal lien will not be placed on the home as long as there is a living spouse or dependent child, including an adult disabled child living in the family home. Hardship waivers are considered.

## **EX PARTE REDETERMINATION**

Under the “ex parte” process, when a change in circumstances affecting Medi-Cal eligibility occurs, the county is required to first attempt to determine Medi-Cal eligibility without the involvement of the beneficiary by checking information from recently opened case records and other available sources to verify information that is unlikely to change (for example, applicant's birth date) or that is already on file with another program (for example, through the Food Stamp Program or TANF records, or wage and payment information), available through the State Data Exchange (a Social Security website that provides information about current and former Social Security and SSI recipients). Medi-Cal reduced its documentation requirements to comply with California's SB 87 (discussed on page 66) and with a “Dear State Medicaid Directors” April 7, 2000, letter sent from the Centers for Medicare and Medicaid Services (CMS), to avoid “unnecessary and repetitive requests” for information.

## **FEDERAL POVERTY LEVEL (FPL)**

The Federal Poverty Guidelines, often referred to as the Federal Poverty Level, are issued each year in January or February in the Federal Register by the U.S. Department of Health and Human Services. The guidelines, a simplified version of poverty thresholds developed by the U.S. Census Bureau for statistical purposes, are used to determine financial eligibility for certain federal and state programs, including many, but not all, of the Medi-Cal programs. The most current federal poverty guidelines are available at: <http://aspe.dhhs.gov/poverty/06poverty.shtml>.

### **HEALTH INSURANCE PAYMENT PROGRAM (HIPP)**

HIPP is a program within Medi-Cal that pays private health coverage premiums for Medi-Cal beneficiaries when it is cost-effective to do so. To enroll in the state's HIPP program, a Medi-Cal beneficiary must have a high-cost medical condition, have a share of cost no greater than \$200, and have either a current private health coverage policy or access to health coverage through an employer or a COBRA program.

### **LINK/LINKED**

For most Medi-Cal programs, a person must be “linked” to SSI or CalWORKs. This means they meet the SSI requirement of age, blindness, or disability or the CalWORKs requirements of deprivation of parental support or care.

### **MANAGED RISK MEDICAL INSURANCE BOARD (MRMIB)**

MRMIB is a state entity governed by a board of five appointed members. MRMIB administers three programs, each of which provides some form of health care coverage to specific populations. These programs are the Access for Infants and Mothers Program (AIM), the Healthy Families Program, and the Major Risk Medical Insurance Program (MRMIP). [www.mrmib.ca.gov](http://www.mrmib.ca.gov)

### **MEDICALLY NEEDY**

Beneficiaries are described as “medically needy” if they fit into Medi-Cal eligibility categories but their income or property exceeds the categorically needy levels.

### **MEDI-CAL FAMILY BENEFIT UNIT (MFBU)**

An MFBU includes all family members living in the home who are not receiving cash aid. If a family member is ineligible for assistance but still legally responsible for those in the MFBU, he or she will be included in the MFBU.

### **MINI BUDGET UNIT (MBU)**

An MBU is a sub-unit of an MFBU. The MBU is used to determine eligibility by *Sneede v. Kizer* requirements (discussed on page 67).

### PERMANENT RESIDENCE UNDER COLOR OF LAW (PRUCOL)

Lawful permanent residents who meet all other eligibility requirements are eligible for the full range of Medi-Cal covered services. Certain other immigrants, who are not lawful permanent residents, are also eligible for the full range of Medi-Cal-covered services, provided they meet Medi-Cal eligibility requirements and PRUCOL criteria. There are eleven PRUCOL categories, which include:

- ▶ Persons who were paroled into the U.S. for less than one year;
- ▶ Persons who were granted indefinite voluntary departure;
- ▶ Persons who were granted a stay of deportation;
- ▶ Certain battered immigrants; or
- ▶ Immigrants who live in the U.S. with the knowledge of the U.S. Citizenship and Immigration Services (USCIS) and whom the USCIS does not plan on deporting.

### PUBLIC CHARGE

This is a term used by the immigration laws to describe immigrants who have become or will become dependent on public benefits in a way that may affect their ability to adjust their immigration status. Depending on immigration status, the Department of Homeland Security can refuse an individual's entry or re-entry into the United States or stop someone from becoming a permanent U.S. resident if it believes that the individual is likely to become a public charge. However, an immigrant is not automatically inadmissible into the United States because he or she received public benefits in the past. The USCIS publishes *A Quick Guide to 'Public Charge' and Receipt of Public Benefits* stating that an immigrant using public health care benefits (except for long-term care) would not be considered a "public charge." *The Quick Guide* is available at: [http://uscis.gov/graphics/publicaffairs/summaries/Summ\\_CA.pdf](http://uscis.gov/graphics/publicaffairs/summaries/Summ_CA.pdf).

### RAMOS V. MYERS

*Ramos v. Myers* is a 1981 court case in which California DHS was ordered to mail a Medi-Cal application along with an informational notice to certain SSI beneficiaries whose SSI was being discontinued and to extend these individuals' Medi-Cal benefits for an extra month while the county

determined their Medi-Cal eligibility based on current information. This “Ramos” process was made obsolete when *Craig v. Bonta* (2002) required CDHS to redetermine eligibility for beneficiaries losing SSI in accordance with SB 87 (discussed below) before their Medi-Cal benefits could be discontinued.

### **SB 87**

Senate Bill 87 (SB 87), passed in 2000, requires that a Medi-Cal beneficiary’s eligibility for all Medi-Cal programs be evaluated before benefits can be terminated. The law also prohibits requesting information from a beneficiary that has already been provided, is not relevant to the case, or is not likely to change. The “ex parte redetermination” (see page 63) is the first step in the three-step SB 87 redetermination process.

### **SECTION 1619(B)**

One of the biggest concerns SSI beneficiaries have about going to work is the possibility of losing Medicaid coverage. Section 1619(b) of the Social Security Act provides protection for these beneficiaries. Section 1619(b) offers continuing SSI/SSP status and continuing Medicaid benefits (categorically linked to the SSI/SSP status) for disabled or blind SSI beneficiaries who have earnings too high to qualify for an SSI cash payment but need Medicaid benefits to continue to work. To qualify for continuing Medicaid coverage, a person must meet the Medicaid use and income threshold tests.

### **SHARE OF COST (SOC)**

Share of cost refers to the monthly amount of health care expenses a Medically Needy (MN) or Medically Indigent (MI) beneficiary must incur before Medi-Cal begins to offer assistance. Whether a beneficiary has a share of cost, and how much it is, is based on monthly family income. No-share-of-cost Medi-Cal is free Medi-Cal.

### **SINGLE POINT OF ENTRY (SPE)**

Single Point of Entry is the central processing center for all mail-in joint applications for the Healthy Families Program and Medi-Cal for Children.

At SPE, an administrative vendor screens applications for Healthy Families and Medi-Cal eligibility. Applications that are believed to qualify for Medi-Cal are provided accelerated enrollment and then sent to the applicant's county of residence for an eligibility determination. Applications that are believed to qualify for the Healthy Families Program are sent to the Healthy Families Program for an eligibility determination. The administrative vendor at SPE also processes electronic applications and answers telephone calls about Medi-Cal, the Healthy Families Program, application processes, and application status. Children who may qualify for Medi-Cal on the basis of disability should apply through their county rather than through SPE because it does not screen for disability or share-of-cost Medi-Cal.

### **SNEEDE V. KIZER**

*Sneede v. Kizer* was a 1991 case in which the court ruled that if a family does not meet Medi-Cal eligibility as a whole, the family's eligibility may be determined in smaller units (MBUs) if certain circumstances apply. "Sneeding," as it is commonly called, addresses the issue of whose income and resources may be counted to determine eligibility. *Sneede v. Kizer* held that the state can deem an individual's income and resources to be available only for the individual herself, her spouse, or her child. These rules were further updated by a subsequent case, *Gamma v. Belshe*, which requires that before a parent's or spouse's income is deemed available to those for whom the parent or spouse is responsible, the parent or spouse must receive an allocation for his or her own support.

### **SOCIAL SECURITY AGED/SOCIAL SECURITY DISABILITY (SSA/SSD)**

Social Security Aged and Social Security Disability insurance benefits are cash payments issued by the Social Security Administration. These benefits do not automatically entitle someone to Medi-Cal. They do, however, establish the necessary "linkage" factor (see "Link/Linked" on page 64). This means that because the beneficiary is elderly or disabled, he or she may qualify for Medi-Cal if Medi-Cal's income and property limits are met.

### **SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTARY PAYMENT (SSI/SSP)**

SSI is a cash payment designed to increase the monthly income of the elderly and disabled to a minimum amount deemed necessary to live. The federal government sets a minimum amount for SSI payments, and each state may choose to increase this limit based on cost-of-living adjustments. California has chosen this option and pays an additional amount above the federal limit, called the State Supplementary Payment (SSP). Beneficiaries receive both the federal and state payments in one SSI check. SSI beneficiaries in California are categorically eligible for Medi-Cal.

### **TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)**

TANF is the federal welfare program that replaced AFDC. It provides cash aid and job search assistance to poor families. CalWORKs is the name of California's TANF program.







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## AID CODE QUICK REFERENCE

The Aid Code Quick Reference is updated regularly by CDHS and is therefore subject to change. The codes published here reflect the April 4, 2006 update. Current codes can be found at: [http://files.Medi-Cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/aidcodes\\_z01c00.doc](http://files.Medi-Cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/aidcodes_z01c00.doc).

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03 MI Child-AAP (Federal)	27 Blind-MN (SOC)	3U CalWORKs-LI-unemployed
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0N BCCTP-AE	33 CalWORKs-Child only, parent ineligible for TANF	45 MI Child-Foster Care (FC)
0P BCCTP-Federally eligible persons	34 Families-MN (no SOC)	47 200%-Income disregard-Infant
0R BCCTP-High Cost OHC	35 CalWORKs-Two parent (State, cash)	48 200%-Income disregard-Pregnant (no SIS)
0T BCCTP-State only	36 Disabled COBRA Widow/ers	4A MI Child-Out of State AAP Children
0U BCCTP-Undocs	37 Families-MN SOC	4C AFDC FC Voluntarily Placed
0V Post-BCCTP-Undocs (emergency, pregnancy-related, LTC only)	38 Families- <i>Edwards v. Kizer</i> continued eligibility	4F KinGAP Cash Assistance (FFP)
10 Aged-SSI/SSP (Cash)	39 Initial TMC (6 months)	4G KinGAP Cash Assistance (State)
13 Aged-MN-LTC (SOC/no SOC)	3A Safety Net-All Other Families (CW Timed Out, Child only)	4K MI Child-EA Foster Care, Probation (Obsolete)
14 Aged-MN (no SOC)	3C Safety Net-Two Parents (CW Timed Out, Child only)	4M MI Child-Former Foster Care
16 Aged-Pickle eligible	3D CalWORKs Pending	53 MI Adult-LTC
17 Aged-MN (SOC)	3E CalWORKs-LI-AF-Mixed	54 MN (no SOC, 4-month continuing)
18 Aged-IHSS	3G CalWORKs-no parent (State)	55 MI/MN (no SIS, LTC, pregnancy-related, emergency services)
1E <i>Craig v. Bonta</i> -aged	3H CalWORKs-LI-no parent	58 MI/MN (no SIS, pregnancy-related, emergency services)
1H Aged-FPL Program	3L CalWORKs-LI-AF (State)	59 MN (no SOC, continuing TMC, 6 months)
1U Aged-FPL Program (no SIS)	3M CalWORKs-LI-Two parents (State)	5F MI/MN (no SIS, pregnant woman)
1X MN-no SOC (MSSP Waiver-aged)	3N MN-No SOC-1931(b) non CalWORKs	
1Y MN-SOC (MSSP Waiver-aged)	3P CalWORKs-AF-exempt	
20 Blind-SSI/SSP (Cash)		
23 Blind-MN-LTC (SOC/no SOC)		

5J MN (no SOC, SB87 Pending Disability ESO)	6Y HCB Waiver (SOC)	83 MI-Child (SOC)
5K MI Child-EA Foster Care-CWS (State)	71 Dialysis Program/Dialysis Supplement Program	86 MI Adult-Pregnant (no SOC)
5R MN (SOC-SB87 Pending Disability ESO)	72 133% FPL Program Citizen/LI/PRUCOL Child	87 MI Adult-Pregnant (SOC)
5T MN (no SOC, continuing TMC, 6 months, ESO)	73 TPN only/ TPN Supp	8A QDWI
5W MN-no SOC, 4-month continuing, ESO	74 133% FPL Program (no SIS Child)	8C SLMB
60 Disabled-SSI/SSP (Cash)	76 60-day Postpartum	8D QI-1 120 to 135% FPL
63 Disabled-MN-LTC (SOC/no SOC)	7A 100% FPL Program (Citizen/LI/PRUCOL Child)	8E Accelerated Enrollment Child
64 Disabled-MN (no SOC)	7C 100% FPL Program (no SIS Child-ESO, Pregnancy-related)	8G Qualified SIWI (Section 1619b)
65 Disabled-SGA/ABD-MN (IHSS) (SOC/no SOC)	7F PE Pregnancy Verification Only	8H Family PACT
66 Disabled-Pickle eligible	7G PE Ambulatory Prenatal Care	8N 133% FPL Excess Property (no SIS, Child-ESO)
67 Disabled-MN SOC	7H Tuberculosis	8P 133% FPL Excess Property (Citizen/LI/PRUCOL Child)
68 Disabled-IHSS	7J CEC-no SOC	8R 100% FPL Excess Property (Citizen/LI/PRUCOL Child)
69 200% FPL Income Disregard Infant (no SIS-ESO)	7K CEC-no SOC (no SIS-ESO, Pregnancy-related)	8T 100% FPL Excess Property (no SIS, Child-pregnancy + ESO)
6A DAC-Blind	7M MC (age 12 to 21) Sexually Transmitted Disease, Drug/Alcohol Abuse, Family Planning, Assault	8U Deemed Eligible CHDP Gateway (no SOC MC)
6C DAC-Disabled	7N MC (under age 21) Pregnancy-related Services, no SOC	8V Deemed Eligible CHDP Gateway (SOC MC)
6E <i>Craig v. Bonta</i> -Disabled	7P MC (age 12 to 21) Services in 7M+ Outpatient Mental Health Care	8W CHDP Gateway, Pre-enrollment for Medi-Cal
6G 250% FPL Working Disabled	7R MC (under 12) Family Planning, Sexual Assault	8X CHDP Gateway, Pre-enrollment for HFP
6H Disabled-FPL Program	7T National School Lunch Program Express Enrollment	8Y CHDP only (no SIS)
6J MN (no SOC, SB87 Pending Disability)	7X MC-HFP Bridge	9H Healthy Families Child
6N Former SSI no Longer Disabled in SSI Appeals Status	7Y HFP-MC Bridge	9J GHPP Eligible
6P PRWORA no Longer Disabled Child	80 QMB	9K CCS Eligible Child
6R SB87 Pending Disability SOC	81 MI-APP	9M CCS Medical Therapy Program only
6U Disabled-FPL Program (no SOC, no SIS-ESO)	82 MI-Child (no SOC)	9N CCS Case Management of Medi-Cal benefits
6V DDS Waivers (no SOC)		9R CCS Eligible HFP Child
6W DDS Waivers (SOC)		
6X HCB Waiver (no SOC)		

## KEY TO ABBREVIATIONS USED IN MEDI-CAL

A—Adult (ages 21 to 65)	EDD—Employment Development Department	PE—Presumptive Eligibility
AAC—Aid for Adoption of Children	EMA—Entrant Medical Assistance	PRUCOL—Permanent Residence Under Color of Law
AAP—Adoption Assistance Program	ESO—Emergency Services Only	PRWORA—Personal Responsibility and Work Opportunity Reconciliation Act
ABD—Aged, Blind, or Disabled	FC—Foster Care	QDWI—Qualified Disabled Working Individual
ADAM—Automated District Attorney Match	FG—Family Group	QI—Qualifying Individual
AE—Accelerated Enrollment	FPACT—Family Planning, Access, Care, and Treatment	QMB—Qualified Medicare Beneficiary
AF—All Families	FPL—Federal Poverty Level	RAW—Replacement Agricultural Worker
AFDC—Aid to Families with Dependent Children	FPSA—Formerly PRUCOL SSI/SSP Alien	RCA—Refugee Cash Assistance
AIM—Access for Infants and Mothers	FS—Food Stamp Program	RDP—Refugee Demonstration Project
ANEC—Abused, Neglected, or Exploited Children	FTB—Franchise Tax Board	RegDP—Registered Domestic Partners
APP—Aid Paid Pending	GA—General Assistance	RMA—Refugee Medical Assistance
BCCTP—Breast and Cervical Cancer Treatment Program	GHPP—Genetically Handicapped Persons Program	SAW—Special Agricultural Worker
BCEDP—Breast Cancer Early Detection Program	GR—General Relief	SC—Special Circumstances
C—Children under 21	HCBS—Home and Community-Based Services	SED—Seriously Emotionally Disturbed
CAAP—California Alternative Assistance Program	HF or HFP—Healthy Families Program	SGA—Substantial Gainful Activity
CalWORKs—California Work Opportunity and Responsibility to Kids	IEVS—Income & Eligibility Verification System	SIS—Satisfactory Immigration Status
CAPI—Cash Assistance Program for Immigrants	IHO—In Home Operations	SIWI—Severely Impaired Working Individuals
CCS—California Children’s Services	IHSS—In-Home Supportive Services	SLMB—Specified Low-Income Medicare Beneficiary
CEC—Continuous Eligibility for Children	IRCA—Immigration Reform and Control Act	SO—Services Only
CHDP—Child Health and Disability Prevention Program	KinGAP—Kinship Guardian Assistance Payment	SOC—Share of Cost
CMSP—County Medical Services Program	LI—Legal Immigrant	SS—Social Security
CP—Confirmed Pregnancy	LTC—Long-Term Care	SSA—Social Security Administration
DAC—Disabled Adult Children	MC—Minor Consent	SSI/SSP—Supplemental Security Income/State Supplementary Payment
DP—Dialysis-Only Program	MI—Medically Indigent	TANF—Temporary Assistance for Needy Families
DSP—Dialysis Supplement Program	MN—Medically Needy	TMC—Transitional Medi-Cal
EA—Emergency Assistance	MSSP—Multipurpose Senior Services Program	TPN—Total Parenteral Nutrition
EAPC—Expanded Access to Primary Care	NE—New Entrant	UP—Unemployed Parent
ECA—Entrant Cash Assistance	NI—Non-Immigrant	ZP—Zero Payment
	OBRA—Omnibus Budget Reconciliation Act	2P—2 Parent
	PCSP—Personal Care Services Program	



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