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Appendices
Chapter 1:

Introduction To The Medi-Cal Program

Medi-Cal is a state and federally funded program that pays for medically necessary treatment services, medicines and devices for low-income persons, including persons with disabilities. As a condition of receiving federal Medicaid funds for its

1 The federal purpose definition at Section 1901 of the Social Security Act, 42 U.S.C. § 1396: . . . enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care. . .

The State purpose is set out at Welf. & Inst. Code § 14000:

. . . To afford to qualifying individuals health care and related remedial or preventive services, including related social services which are necessary for those receiving health care under this chapter.

The intent of the Legislature is to provide, to the extent practicable, through the provisions of this chapter, for health care for those aged and other persons, including family persons who lack sufficient annual income to meet the costs of health care, and whose other assets are so limited that their application toward the costs of such care would jeopardize the person or family's future minimum self-maintenance and security. It is intended that whenever possible and feasible:

(a) The means employed shall allow, to the extent practicable, eligible persons to secure health care in the same manner employed by the public generally, and without discrimination or segregation based purely on their economic disability. The means employed shall include an emphasis on efforts to arrange and encourage access to health care through enrollment in organized, managed care plans of the type available to the general public. . . .

2 "Medi-Cal" is the name California gives its Medicaid program. "Medicaid" is the term the federal government and most other states use.
Medi-Cal program, California must follow federal Medicaid requirements. Medi-Cal or Medicaid is an extremely complicated program. Do not be surprised if you have to read a section several times before you understand it.

Federal oversight of California's Medi-Cal program is by the Center for Medicare and Medicaid Services (CMS) formerly known as Health Care Financing Administration (HCFA). CMS is a part of the U.S. Department of Health and Human Services with headquarters offices in Baltimore, Maryland and Washington D.C. and a regional office in San Francisco. CMS approves California's state Medicaid plan and any amendments, waiver applications (both for managed care and for home and community based services).

There is a federal Medicaid requirement that there be a single state agency with responsibility for implementing the Medi-Cal program. The California Department of Health Services (DHS) is that agency. DHS delegates some of its responsibility and authority: to County welfare departments which function as agents for the state (eligibility and share of cost determinations); to other state departments such as the State Department of Mental Health (Medi-Cal mental health services), the State Department of Developmental Services (targeted case management and home and community based waiver services), State Department of Drug and Alcohol (Medi-Cal


Even the Supreme Court agrees: "The Social Security Act [including Medicaid] is among the most intricate ever drafted by Congress. Its Byzantine construction ... makes the [Medicaid] Act 'almost unintelligible to the uninitiated.'" Schweiker v. Gray Panthers, 453 U.S. 34, 43, 101 S.Ct. 2633, 2640 (1981), quoting Friedman v. Berger, 547 F.2d 724, 727 n.7 (2d Cir. 1976). State and federal Medicaid statutes have been found to be the equivalent of "the Serbonian bog" referenced in John Milton's Paradise Lost, Book II, line 592 (1667) ("A gulf profound as that Serbonian bog ... [w]here armies whole have been sunk.") in Cherry by Cherry v. Magnant, 832 F.Supp. 1271, 1273 fn 4 (S.D. Ind. 1993). Friedman v. Berger, 409 F.Supp. 1225, 1225-26 (S.D. N.Y. 1976) called it an "aggravated assault on the English language, resistant to attempts to understand it.." Roloff v. Sullivan, 975 F.2d 333, 340 n.12 (7th Cir. 1992) called it "labyrinthine."

methadone and substance abuse programs), State Department of Aging (Multi-Service Senior Programs waiver); to managed care organizations including county operated health systems. As the single state Medicaid agency, however, DHS retains responsibility for compliance with federal Medicaid requirements. Medi-Cal recipients always have the right to look to DHS to enforce their rights under state and federal law even if there is another entity with delegated responsibility.

People who receive Supplemental Security Income (SSI) and In-Home Supportive Services (IHSS) automatically receive Medi-Cal. Children and families who receive CalWORKS or who meet the old requirements for the AFDC program are also eligible for Medi-Cal. Children and pregnant women may receive Medi-Cal under one of the Federal Poverty Level (FPL) programs if their family income is below a certain level. Still others receive Medi-Cal under the Medically Needy and Medically Indigent Child Medi-Cal programs, though often there is a monthly share of cost. "Share of cost" is the amount you must pay or obligate yourself to pay in a month before Medi-Cal takes over.

1. Where to find the law

Under the hierarchy of authority, a federal statute or regulation wins over a conflicting state statute or regulation; a state statute wins over a conflicting state regulation or policy.

(a) Federal statutes and regulations

The federal Medicaid Act is part of the Social Security Act and is commonly known as Title XIX of the Social Security Act. The codified version of Title XIX is found at 42 U.S.C. §§ 1396 through 1397v. You will also often see uncoded references to sections of Title XIX -- for instance, references to Section 1931 which is codified as 42 U.S.C. § 1396u-1. Appendix A1 cross references provisions expressed as sections of the Social Security Act with the codified sections. For instance, with the Appendix A1 chart you will see that a reference to Section 1915(g) about targeted case management is in the codes as 42 U.S.C. § 1396n(g).

Statutes outside the Medicaid Act also affect eligibility for Medi-Cal. Included as part of Appendix A1 is a copy of 42 U.S.C. § 1396v which
lists the other statutes.

Often legislation includes provisions which are not codified but which are referenced as the section of the Act in which they were enacted. These provisions will usually be included under the “notes” section where you find the legislative history of a particular section of the Social Security Act. Probably the most well known of such provisions is the “Pickle Amendment”\(^6\) which is Section 503 of Pub.L. 94-566 (1976) and which is “codified” as a note following 42 U.S.C. § 1396a.

The Medicaid regulations are found in Title 42 of the Code of Federal Regulations (“CFR”), part 430 through 456.

(b) State statutes, regulations, and all county welfare director letters

The Statutes governing the Medi-Cal program are found in Welfare & Institutions Code §§ 14000 through 14685. The statutes governing Medi-Cal Mental Health services include Welf. & Inst. Code §§ 5775-5780 in addition to Welf. & Inst. Code §§ 14680-14685. The statutes governing the Medi-Cal drug treatment program are found at Health & Safety Code §§ 11758.41 through 11758.47. The California Partnership for Long-Term Care is covered at Welf. & Inst. Code §§ 22001 through 22013. In addition, consumer protections under the Knox-Keene Act, Health & Safety Code §§ 1340 et seq., may be relevant where managed care is delivered through a health benefit plan subject to the Knox-Keene Act or where the managed care organization is either required to be qualified under or subject to the consumer protections in the Knox-Keene Act.

The Medi-Cal regulations are in title 22 of the California Code of Federal Regulations (Cal. Code Regs., tit. 22):

Chapter 1, definitions, Cal. Code Regs., tit. 22 §§ 5000 et seq.;

\(^6\) See Chapter 2, § 2, concerning “Pickles.” Footnote 54 sets out the text of the Pickle Amendment.
Chapter 1: Introduction to the Medi-Cal Program

Chapter 2, eligibility, application, share of cost, overpayments, estate recoveries, Cal. Code Regs. tit. 22 §§ 50011 et seq.;
Chapter 3, health care benefits, scope, participation standards, rates, payments, Cal. Code Regs., tit. 22 §§ 51001 et seq.;
Chapter 4, prepaid health plans, Cal. Code Regs., tit. 22 §§ 53000 et seq.;
Chapter 4.5, geographic managed care, Cal. Code Regs., tit. 22 § 53900 et seq.;
Chapter 5, adult day care, Cal. Code Regs., tit. 22 §§ 54001 et seq.;
Chapter 6, primary case management plans, Cal. Code Regs., tit. 22 §§ 56000 et seq.
Chapter 8, California Partnership for Long-Term Care, Cal. Code Regs., tit. 22 §§ 5800 et seq.

In addition, and incorporated into the Medi-Cal regulations, is the MEDI-CAL MANUAL OF CRITERIA. That manual includes, for instance, the admission criteria for nursing facilities, etc. That manual also incorporates the Denti-Cal criteria. Unfortunately, the printed version of the manual available from the state is always out of date.

The regulations implementing the Medi-Cal Mental Health Managed Care program are found at Cal. Code Regs., tit. 22 §§ 1700-1799 (in-patient psychiatric services) and Cal. Code Regs., tit. 22 §§ 1810.100-1850.505 (outpatient services). The latter regulations were adopted as emergency regulations with the final regulations not yet issued.

The regulations implementing the Medi-Cal Drug Treatment Program are found at 9 CCR §§ 9000-9444.

7 Cal. Code Regs. tit. 22 § 51003(e).

8 The regulations at Cal. Code Regs. tit. 22 § 51003(e) indicate that the latest version is April 1998. [Due to a major expansion in this manual, the 1st regulations package will be published for oral/written input in January 1999. To receive this packet, contact either Terri Stackpole (916) 657-0573 or Nancy Hutchison (916) 657-1624.]
In addition to regulations, the Department of Health Services (DHS) operates the Medi-Cal program through DHS All-County Welfare Directors Letters which are abbreviated through this manual as “DHS ACWDL.” See www.dhs.cahwnet.gov/ mcs/ mcpcd/ meb/ ads/
Sometimes the All-County Welfare Director Letters explain how to implement statutes and regulations. Other times they substitute for finally adopted regulations.9

(c) Other sources of state and federal guidelines

The Department of Health Services issues a two-volume MedCal Eligibility Procedures Manual with regular updates for county welfare departments processing Medi-Cal applications, re-evaluations, and share of cost determinations. DHS also issues a Pickle Eligibility Manual.

Now online at www.medi-cal.ca.gov/ click on “publication” DHS issues a series of Provider Manuals for medical services, pharmacy, dental, long-term care, acute care. The general information sections are more or less the same in the manuals we have seen, and contain specific information about the service subject matter.

HCFA’s State Medicaid Manual provides guidelines for states in implementing their Medicaid program. The Manual is available on HCFA’s webpage at www.hcfa.gov/ pubforms/ proqman.htm (Pub 45) and on CD ROM.10 Large portions of the State Medicaid Manual are published in the Commerce Clearing House (CCH) Medicare and Medicaid Guide which is available in both paper and on CD ROM. The CCH Medicare and Medicaid Guide includes all the federal Medicaid

9 See, e.g., DHS ACWDL No. 91-28 (3/22/91), CCH Medi-Cal Guide New Dev. ¶ 7261. See also Welf. & Inst. Code § 14005.30(d), amended as part of the Health Trailer bill, AB 2780.

10 The State Medicaid Manual is updated monthly. You can buy a subscription or a $20 disk every now and then. [Order from CCH, Inc. P.O. Box 4307, Carol Stream, Illinois 60197-4307 or call 1-800-449-6439.]
statutes and regulations, program explanations, proposed regulations, cases including unpublished cases and other developments.

CCH also published until April 1998 the CCH MEDI-CAL GUIDE which included state statutes and regulations, program descriptions, many DHS All-County Welfare Director Letters, proposed regulations, portions of the MANUAL OF CRITERIA, cases and settlements, etc. We continue to cite to the CCH MEDI-CAL GUIDE.

(d) Useful materials about managed care including mental health managed care.

Again, you will find the CCH MEDICARE AND MEDICAID GUIDE a thorough resource of statutes, regulations and case law, program explanations, guidelines, and new developments for managed care and mental health managed care. Medi-Cal Managed Care Directives and Department of Mental Health (DMH) Information Notices contain specific information about particular aspects of the programs. The Rehab. Option Manual and the Medi-Cal Mental Health Managed Care Manual will be useful for general information and explanations.

2. Useful Webpages

The following webpages provide both general and specific information regarding particular programs, including statutes, regulations, new developments, advisory opinions, etc:

www.lsnc.net (federal and CA law)

(federal regulations and statutes, advisory opinions, hearings, rulings, new developments, statistics; Medicaid, Medicare, CHIP, managed care programs)
www.hcfa.gov/pubform/progman.htm (manuals including sections of the State Medicaid Manual)

www.hcfa.gov/medicaid/smdhmpg.htm (letters to State Medicaid Directors)

www.hcfa.gov/medicaid/Stateplan/toc.asp?=CA (Copy of the State Plan as of October 2000)

www.ssa.gov
(Social Security Act - with text of all titles available, general information, new developments and related links)

www.healthlaw.org (the National Health Law - federal legal resources and publications)

www.healthlaw.org/california.html#State
(CA general information; links for consumers, government agencies, public and private health related organizations and advocacy groups)

www.wclp.org (Western Center on Law & Poverty - click on “Health” page for Medi-Cal information)

www.ca.gov (CA statutes/codes, bills, regulations; all CA agency and department information with links, including DSS, DHS, DMH and DDS)

www.leginfo.ca.gov (CA agencies reports, legislative information, statutes and bills)

http://HealthyFamilies.ca.gov (general information and new developments)

www.medi-cal.ca.gov
(CA publications, news information and developments, provider information)

www.calregs.com (CA regulations)

www.healthconsumer.org
Health Consumer Alliance (advocate and consumer fact sheets and information on Medi-Cal and other health programs)

www.medi-cal.org
Medi-Cal Policy Institute (research reports on Medi-Cal)

www.dhs.ca.gov/mcs/mcmcd/FC_MC/Default.htm - California Foster Care Managed Care Resource Guide - lists county-by-county local contacts such as the CHDP office, regional center, juvenile probations, health plans, etc. Also a general state guide.
www.dhs.ca.gov/mcs/mcpd/MEB/ACLs/ACWDLs.htm - DHS All-County Welfare directors Letters.


www.dss.cahwnet.gov/shd/default.htm - State Hearings Division - information about hearings, contact information, Notes from the Training Bureau, links to DSS regulations (the MPP’s) and DSS All-County Letters

www.dss.cahwnet.gov/getinfo/acl.html - DSS All-County Letters including letters concerning the IHSS and Medi-Cal Personal Care Services programs.

www.dss.cahwnet.gov/getinfo/acin.html - DSS All-County Information Notices.

www.dss.cahwnet.gov/ord/CDSSManual_240.htm - Manual of Policies and Procedures, the MPP, including the hearing regulations - i.e., Division 19 (confidentiality), 22 (state hearings), and 30 (IHSS program).

www.dmhca.gov or www.hmohelp.ca.gov - Department of Managed Health Care.

www.cimh.org - California Institute for Mental Health. Click on “Cathie Wright Center” and “publications” for information on children’s system of care, therapeutic behavior services, supplemental mental health services for Healthy Family children.
Chapter 2:
About the different Medi-Cal Programs

To qualify for Medi-Cal, you must meet the eligibility rules of one of the Medi-Cal programs. If you do not fit the requirements for one of the Medi-Cal programs or qualify for California Children's Services (CCS)\(^{12}\), Healthy Families Program or Medicare, then—with limited exceptions\(^{12}\)—the only public health care coverage is that

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\(^{11}\) Health & Safety Code §§ 123800 et seq. See also PAI's service rights manual, CALIFORNIA CHILDREN’S SERVICES (CCS).

\(^{12}\) The limited exceptions include:

(a) Treatment services through county administered Child Health and Disability Prevention (CHDP) programs—Health & Safety Code §§ 124025 et seq. and regulations at 17 CCR § 6800 et seq.—for low-income children who are not eligible for Medi-Cal and whose treatment needs were identified in a CHDP screen. You can apply for these benefits where you apply for Medi-Cal.

(b) The program that pays for HIV medication for persons who do not qualify for Medi-Cal. Program participants with adjusted gross incomes of $50,000 a year or less (or if income higher, be someone who is expected to have medication costs of 20% or more of their adjusted gross income) contribute an amount equal to twice their state income tax liability. Health & Safety Code §§ 120950 et seq. For more information contact the Professional Management Development Corporation at toll free 1(888) 575-2327 for information on this program or contact the County health department in your area.

(c) The Genetically Handicapped Persons Program (GHPP)—Health & Safety Code §§ 125125 et seq.—which covers persons with such disabilities as cystic fibrosis, hemophilia, sickle cell disease, Huntington's disease, Friedreich's Ataxia, Joseph's disease, Von Hippel-Landau syndrome and metabolic disorders such as Wilson's disease, disorders of lactate and pyruvate metabolism, etc. Children (under age 21) with qualifying conditions receive services through CCS. CCS financial eligibility and contribution rules apply here as well including a $40,000 adjusted gross income cap.

(d) California Major Risk Medical Insurance Program—"MRMIP" or "Mr. MIP"—an assigned risk type of program for persons who cannot get adequate health benefit coverage elsewhere. You are not eligible if you have not exhausted COBRA benefits. Assigned risk slots are limited, so there is a waiting list for Mr. MIP. For more information contact MRMIP, 744 P. Street, Room 1077,
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Sacramento CA 95814, (916) 324-4695 or the Managed Risk Board (MRMIB) medical insurance board webpage: www.mrmib.ca.gov., which includes an application form and rate information.

(e) Preventive services (through regional centers for developmentally disabled) for Californians who are uninsured or underinsured and at risk of giving birth to an infant with a developmental disability are available through the regional centers for developmentally disabled persons. The services include genetic counseling and amniocentesis. Welf. & Inst. Code § 4644. Cal. Code Regs., tit. 17 § 54010(a).

(f) End-Stage Renal Disease (ESRD) is a special Medicare program for workers and their dependents including children who need dialysis and/or a kidney transplant. You apply for this benefit at your local Social Security office. A worker may be fully insured for purposes of this program but not fully insured for purposes of qualifying for Social Security Disability Benefits. If you qualify, you are eligible for the full scope of Medicare part A and B services with an obligation to pay all Part A and B premiums, deductibles and co-insurance. 42 U.S.C. § 426-1, 42 C.F.R. §§ 406.13 (eligibility), 405.2100-2184 (provider conditions of participation). See CCH Medicare and Medicaid Guide ¶ 1150.

(g) AIM -- Access for Infants and Mothers -- a subsidized health benefit program for pregnant women and their children through age two for families with income between 200% and 300% of the federal poverty level. Administered by MRMIB, address above. To apply contact Healthcare Alternatives, P.O. Box 15248, Los Angeles CA 90015, (213) 742-0476, or 1-800-433-2611. For more information, including the application form visit the MRMIB webpage: www.mrmib.ca.gov.

(h) Persons who meet the admission criteria for a nursing facility and who are ineligible for Medi-Cal or are eligible with a share of cost because of income deemed (attributed) to them from a child's parent or from a spouse Medi-Cal benefits may qualify for full scope Medi-Cal without a share of cost under the Model Nursing Facility Waiver. See Chapter 16.

(i) Free and low-cost prescription drugs program operated by 85 drug manufactures contact the institute fulfillment center at www.institute-dc.org/prescrip.org or send $5 to Institute Fulfillment Center, Prescription Drug Booklet, PD-370, P.O. Box 462, Elmira NY 14902-0462.

(j) Reduced Cost Prescriptions for Medicare recipients. Medicare recipients may receive prescription drugs at the Medi-Cal price plus 15 cents through pharmacies that accept Medi-Cal. You ask for Medi-Cal medication prices before your prescription is filled. If a problem, call the California Department of Health during business hours at (916) 657-4302. For more information, see www.governor.ca.gov/briefing/camedicare.html.

13 See the separate materials about County Ability to Pay Programs including county drug and alcohol treatment programs and county Short-Doyle mental health programs. See NHeLP's “California...
Appendix A2 includes a chart listing all the Medi-Cal Aid Codes. The Chart also can be downloaded in a Microsoft Word file at: http://files.medi-cal.ca.gov/ pubsdoco/ publications/ masters-mtp/ part1/ aidcodes_z01.doc.

The significant changes in the Medi-Cal programs are related to the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Pub. L. 104-193. PRWORA eliminated the AFDC program and replaced it with TANF -- Temporary Aid to Needy Families -- called “CalWORKS” in California. However, children and family members will qualify under the special AFDC post-welfare reform Medi-Cal whether or not they were former AFDC recipients.

PRWORA also narrowed the definition of disability for children so that children are subject to a disability test which is more difficult than the test for adults. However, the following year Congress, through enactment of the 1997 Balanced Budget Act (BBA), Pub.L. 105-33 (August 5, 1997), protected children who lost SSI as a result of the change in definition by giving them a grandfathered right to Medi-Cal.

1. **Medi-Cal programs linked or related to benefit programs**

   (a) **People who receive SSI or In-Home Supportive Services (IHSS)**

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You receive Medi-Cal benefits automatically if you receive SSI\textsuperscript{14} or IHSS\textsuperscript{15} benefits. Your SSI or IHSS "categorically links" you to the Medi-Cal program. You automatically receive Medi-Cal when you are found eligible for SSI or IHSS. You are considered categorically needy.

\textsuperscript{14} Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) amended 42 U.S.C. § 1382(c)(1) to provide that benefits will not begin until the first of the month after the date of application or the first of the month after the SSI applicant is found to meet the SSI eligibility requirements. That change will have no impact in California because the one-month gap is coverable under the Medically Needy program. HCFA Letter to State Medicaid Directors (May 2, 1997, Judith Moore), www.hcfa.gov/medicaid/wrdl52b.htm.

\textsuperscript{15} In-Home Supportive Services under Welf. & Inst. Code §§ 12300 \textit{et seq}. is part of Chapter 3 (State Supplementary Program -- SSP -- for Aged, Blind and Disabled), under Part 3 (Aid and Medical Assistance), under Division 9 (Public Social Services) of the Welf. & Inst. Code. IHSS is state administered SSP. Persons receiving the state administered SSP receive Medi-Cal as optional categorically needy.

In April of 1999, many people who qualified for IHSS with a share of cost were transferred to the medically needy program. Welf. & Inst. Code § 14132.95(p); DHS ACWDL No. 99-13 (3/29/99). However, their share of cost will continue to be measured by the applicable SSI rate rather than the lower medically needy Maintenance Need Income Level (MNIL) through continued provision of services under the IHSS program in an amount equal to the difference between the MNIL and the applicable SSI grant level. Welf. & Inst. Code § 12305.1.
(b) **Section 1931 Medi-Cal: No cost Medi-Cal for low-income families including CalWORKs recipients**

See the WCL&P’s *CalWORKS Manual (Spring 2000)* Chapter VIII on Medi-Cal

http://www.wclp.org/advocates/library/calworks/index.html

When Congress enacted the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Pub. L. 104-193, it decoupled Medicaid from TANF (Temporary Assistance to Needy Families) the successor to AFDC. Congress mandated that persons who would qualify for benefits under the rules of the federally approved AFDC state plan in effect on July 16, 1996, are entitled to Medicaid benefits. The mandate is included in Section 1931 of the Social Security Act -- hence the name of the program.

Through the flexibility authorized under Section 1931, California has elected to cover most families under 100% of the federal poverty level (in 2002 $1252 for a family of three). Section 1931 also covers families that receive CalWORKs benefits - the name of California’s TANF program.

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16 This section regarding Section 1931(b) Medi-Cal eligibility is based on Chapter VIII of the *Western Center on Law and Poverty’s CalWORKS Manual* (Spring 2000), available at http://www.wclp.org/advocates/library/calworks/index.html.

17 The Federal Medicaid Act provided that Medicaid categorically and automatically linked to the receipt of AFDC benefits. 42 U.S.C. § 1396a(a)(10)(A)(i)(I). When the AFDC program was “replaced” with TANF there was no provision entitling a TANF recipient to receive services under the Medicaid as there had been with AFDC recipients. TANF [CalWORKS] recipients will now receive Medi-Cal services through Section 1931 Medi-Cal.

18 Codified at 42 U.S.C. § 1396u-1.

19 “A state ... may use income and resource methodologies that are less restrictive than the methodologies used under the [AFDC] state plan under such part as of July 16, 1996.” 42 U.S.C. § 1396u-1(b)(2)(C); Welf. & Inst. Code § 14005.30(a)(2).
Children who receive Title IV-E foster care maintenance payments or who have Title IV-E adoption assistance agreements, whether they receive payments or not, are also Section 1931 Medi-Cal eligible. Once on the Section 1931 program, families can earn even more money and remain eligible for free Section 1931 benefits.  

(i) **Interim “Bridge” Medi-Cal for § 1931**

The State was supposed to implement the mandatory provisions of § 1931 when it implemented the CalWORKS replacement for AFDC on January 1, 1998. However, the new § 1931 program was not implemented until the beginning of 1999. In the meantime, because of its delay, DHS agreed to continue the Medi-Cal benefits of anyone terminated from CalWORKS after January 1998. These cases were called “backlog” cases. Once § 1931 was implemented, the counties reviewed all the “backlog” cases to see if they indeed qualified for § 1931 or other programs and terminated them if they did not.

Because of new legislation, effective July 1, 2001, most families should remain eligible for § 1931 benefits when they leave CalWORKS.

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20 Welf. & Inst. Code § 14005.30(a)(1): “To the extent federal financial participation is available, the department shall . . . extend health care services under this chapter to all recipients of aid under Chapter 2 (commencing with Section 11200).” Welf. & Inst. Code §§ 11200 through 11526.5.


22 See DHS e-mail to counties dated 12/31/97; cf. DHS ACL No. 98-24 (5-29-98).

23 See DHS ACLs 98-43 and 99-18.

24 See SB87 (Statutes of 2000)(to be codified as Welf & Inst. Code §§ 14005.31 and following).
(ii) **Income, resource and & deprivation rules**

Families must meet certain income and property rules to be eligible for 1931 Medi-Cal.\(^{25}\) There is one set of income rules for “applicants” and a more generous set of rules for “recipients.”

**What is a recipient?** A recipient is someone who received CalWORKS benefits or Section 1931 Medi-Cal during the previous month (whether through the “bridge” program described above or otherwise) or were eligible to receive CalWORKs or § 1931 (under §1931 applicant rules described below) during one of the four months prior to their application for Medi-Cal.\(^{26}\)

Families whose income goes up and down can also be “recipients.” For example, if a family’s countable income dipped low enough in one of the last 4 months before applying that it would have met the 1931 applicant income limits, then the family should be treated as a recipient family.\(^{27}\)

**What is an applicant?** An applicant is anyone who is not a recipient.

It is very important to determine if a family or person is an “applicant” or a “recipient” because it is much easier for recipients to qualify for 1931.

**What are the property rules?** Property limits vary with family size. For a family of one (1) or two (2) persons, the property limit

\(^{25}\) DHS, ACL 98-43 (9/30/98).


\(^{27}\) DHS ACL 99-37 (7/16/99).
Chapter 2: About the different Medi-Cal Programs

is $3,000.  For each extra person above 2 persons, add $150. Certain property does not count, like a home, clothing, certain other items and the first $4,650 value of a car. Only the fair market value minus any encumbrances counts when valuing a car. Certain cars (for example, cars used to transport disabled family members) do not count at all.

What are the income rules? As of March 1, 2000, applicant families and individuals with countable net income that is at or below 100% of poverty can qualify. Applicant families can take certain deductions from their income before being compared to the 100% poverty income limit, such as $90 per working person, dependent care costs, court-ordered child or spousal support paid to the applicant and the first $50 of child or spousal support received by the applicant. Recipients can either use the same income rules that apply to

28 DHS ACLs 99-03, 99-02, Attach. 2.1, 99-02E, 98-43, Attach. 2 and Attach. 2.1. See also Welf. & Inst. Code § 14005.30(b)).

29 Id.

30 DHS ACL 98-43, p. 5 and Attach. 2. See also DHS ACL 99-02, Attach. 2.1., pp. 1-18. See also DHS ACL 01-62 (11/7/2001) which excludes any vehicle regardless of usage if the equity value is less than $1500.


32 DHS ACL 98-43, Attach. 2, pp. 6-7.

33 Welf. & Inst. Code § 14005.30(c); DHS, ACL 99-54; DHS, ACL 00-04 (1/14/00).

34 DHS, ACL 00-04 (1/14/00), p. 16. These income deductions include 1) $90 per working person (22 CCR § 50553.1); 2) the first $50 of court-ordered child or spousal support received (22 CCR § 50554.5); 3) all court-ordered child or spousal support paid (22 CCR § 50554); 4) educational expenses for college or similar training courses (22 CCR § 50547); 5) certain dependent care costs (22 CCR § 50553.5); 6) certain self-employed business expenses; 7) income of persons excluded from the budget unit; and 8) income counted by public assistance programs to reduce a grant (22 CCR § 50555.1).
applicants or choose to receive more generous earned income deductions. If a recipient uses more generous income deductions, then his or her income will be compared to 1931 income limits which are lower than the 100% poverty level limit. (See Fact Sheet on 1931(b) Medi-Cal at www.healthconsumer.org/Medi-cal.html).

The **100-Hour Rule**. The rules limiting the principal wage earner in two-parent families to less than 100 hours a month of work does not apply to families who are treated as **recipients**. The rule also does not apply to families who are **applicants** if their countable earned income is below 100% of the federal poverty level.

(iii) **Diversion CalWORKs people**

Persons receiving “lump sum” diversion services in lieu of

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35 A recipient under this second option can deduct the same applicant deductions (except the $90 working expense) plus up to $240 per month of disability-based income. DHS, ACL 99-41(8/24/99); DHS, ACL 99-02 (1-12-99); DHS ACL 98-43 (9/30/98), Attach. 1, pp 2 and 8-10. “Disability-based income” consists of Social Security Administration (SSA) disability insurance payments and private disability benefits. DHS treats Temporary Workers Compensation (TWC) and State Disability Insurance Payments (SDI) as earned income. DHS ACL No. 98-43, Attach. 1, p 2. Any unused portion of the $240 disability-based income deduction can be deducted from the combined earned income of the two highest wage earners and an additional $120 from the wages of any other wage earners in the household. DHS ACL, No. 98-43, Attach. 1 pp. 8.9. Finally, the family can deduct 50% of any remaining earned income. DHS ACL 98-43, Attach. 1.

36 DHS ACL No. 00-04 (1/14/00) , p. 2; DHS ACL 98-43 (9/30/98), p.3.

37 DHS ACL No. 01-52 (9/20/2001); DHS ACL No. 00-04 (1/14/00) , p. 2. The earned income of children in the budget unit does not count. DHSACL No. 01-52, Medi-Cal Eligibility Procedures Manual at 5c-13, 5g-3.

CalWORKS cash assistance should arguably automatically be found eligible for Medi-Cal. ³⁹ At a minimum, the counties must determine whether a family is Medi-Cal eligible if the family chooses to receive a diversion payment instead of a monthly case grant without forcing the family to reapply for Medi-Cal. ⁴⁰ The time period for such eligibility will be the value of the assistance divided by what would be the family's maximum aid payment (MAP) to equal the number of months. ⁴¹ At the end of that time period they would be able to continue § 1931 Medi-Cal under the more liberal income and resource rules applicable to recipients versus applicants. Remember, the county must automatically redetermine a family's Medi-Cal eligibility before it terminates benefits. ⁴²

(c) Section 1619(b): People who get no SSI cash assistance because of earned Income

SSI includes regular SSI as well as SSI under the 1619 programs ⁴³ for persons who work even though still disabled. Even though your income is too high to qualify for SSI cash assistance, you are still an SSI beneficiary and eligible for Medi-Cal categorically linked to your SSI status. ⁴⁴ (See PAI's SOCIAL SECURITY MANUAL.)

³⁹ Welf. & Inst. Code § 11266.5(i).

⁴⁰ MPP §81-215.332.

⁴¹ MPP § 81.215.41.

⁴² See Chapter 9.

⁴³ 42 U.S.C. § 1382h(a) and (b).

⁴⁴ Here is an example: Amelia receives both Title II Social Security Disability and SSI: $560 Title II less $20 any-income disregard = $540 SSI countable income. Grant level for an individual in an independent living situation in 2001 is $712 less $540 = $172 SSI grant level. Amelia gets a job earning $500 a month which means that her SSI countable earned income is $217.50: $500 less $625
(d) **Refugee assistance**

Persons are eligible for Medi-Cal if they receive Cuban or Indo-Chinese refugee assistance or other assistance for refugee new entrants. Those eligible for refugee benefits and services also include “Victim of a Severe Form of Trafficking” - sexually exploited persons under age 18 and persons of all ages exploited for their labor or services.

(e) **Categorically Needy: Ineligible for SSI or for the former AFDC for reasons that do not apply to Medi-Cal**

Persons may be eligible to receive Medi-Cal as categorically needy if they are ineligible for SSI or CalWORKS for reasons that do not apply to the earned income disregard = $435 less 50% or $217.50. Her combined earned and unearned income is too high for Amelia to qualify for any SSI cash assistance. However, provided Amelia continues to need Medi-Cal, Amelia continues to be an SSI beneficiary under the 1619(b) program, 42 U.S.C. § 1382h(b). Amelia would lose her 1619(b) status if she no longer needed any Medi-Cal, if she medically improved so that she no longer was under a disability, or if her average income went above the 1619(b) threshold amount. The threshold is determined by adding together the individual SSI earned income break even point (the amount of earnings which would reduce the SSI grant to zero namely two times the grant level plus $85) plus the average cost of Medi-Cal for SSI beneficiaries. The current threshold is $24,583 annual income. SSA Transmittal No. 16 (2-98). See, generally, DHS ACWDL No. 97-27 (6/20/97), CCH MEDI-CAL GUIDE, New Dev. ¶ 7855. People can have individually set thresholds that are higher. See PAI'S SOCIAL SECURITY MANUAL which is posted on PAI's webpage, www.pai-ca.org.

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45 Refugee Resettlement Programs are available to assist new entrants during their first eight months with cash assistance and/or employment assistance. The programs -- and linked Medi-Cal per Cal. Code Regs., tit. 22 § 50257 -- are wholly funded by the U.S. Office of Refugee Resettlement pursuant to the Refugee Act of 1980, 8 U.S.C. §§ 1521. The regulations are at 45 C.F.R. Part 400. See also DHS MEDI-CAL ELIGIBILITY PROCEDURES MANUAL at § 24. The cash assistance program assists persons who are not eligible for assistance under other programs -- primarily single individuals and couples without children. You apply through local welfare departments.

Medi-Cal program. For instance, both SSI and CalWORKS count a stepparent's income and resources to determine a child's eligibility. A FDC used to deem a child's income to his siblings and parents. Medi-Cal counts only the income of a parent or a spouse.47

(f) **Children Who Are No Longer Eligible for SSI because of the Change in Definition of Disability**

Congress in the 1996 PRWORA narrowed the definition of eligibility for SSI children.48 As part of the PRWORA changes in the 1997 Balanced Budget Act,49 Congress conferred mandatory grandfathered Medicaid eligibility for any child receiving SSI on August 22, 1996, and thereafter ineligible because of the changed definition of disability.50 California is

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The important DHS ACWDLs implementing Sneede and Gamma are those which issued after the improvements resulting from Gamma: DHS ACWDL Nos. 96-29 (6/21/96) (good explanation & forms), 97-33 (8/5/97) (explanation & examples), 97-36 (9/19/97) (forms including applying Sneede for purposes of determining eligibility under the Federal Poverty Level Programs), 97-62 (12/10/97) (forms), CCH MEDI-CAL GUIDE New Dev. ¶¶ 7769, 7863, 7867, 7895.


50 Balanced Budget Act § 4913(a) amending 42 U.S.C. § 1396a(10)(A)(i)(II). The reference in that section to “being paid” would appear to exclude those children whose SSI eligibility was in suspense because of income fluctuations. BBA § 4913(b) also excludes persons with applications pending on August 22, 1996, and who were found eligible for benefits for the time period prior to PRWORA but not under the new definition.
automatically continuing benefits for such children and is sending them notices to that effect. This new Medi-Cal category under Aid Code 6P is called “PRWORA No longer Disabled Children.” Children affected by the new definition may also be eligible under other aid categories. Responsibility for continued eligibility determinations under this category will become the responsibility of the counties once procedures are in place. Children will be eligible if they would be eligible for any SSI but for the change in the definition of eligibility.

2. The Different Pickle Programs: Medi-Cal for people who receive Title II Social Security Benefits now and used to Receive SSI

(a) True “Pickles”: People who used to be eligible for SSI and would be now but for intervening COLA increases in Social Security (Title II) Benefits

“Pickle,” the term used both for people who qualify under the program and for the program itself, comes from the name of Texas Congressman J.J. Pickle. He sponsored the 1977 legislation to enable people who were no longer eligible for SSI and categorically linked Medicaid because of cost of living increases in their Title II Social Security cost of living

51 DHS ACWDL No. 97-40 (10/14/97), CCH Medi-Cal Guide New Dev. ¶ 7871.

52 DHS ACL 01-55 (10/04/2001). Many of the children who were terminated from SSI because of the change in disability definition had their Medi-Cal continued while the termination was on appeal. Exhaustion or abandonment of the appeal process will generate termination notices by the state under the Ramos procedures. Page 2. The termination notice will include a new application packet to be returned to the County Ramos coordinator. The children will be eligible so long as they meet the SSI/SSP income and resources limits. Page 3.

53 Aid Code 6R for children who are appealing a termination under the new rules but who are not receiving interim SSI assistance or the Section 1931 programs, the poverty level programs, and AFDC-linked Medically Needy Medi-Cal. For children appealing SSI termination under the PRWORA rules, Medi-Cal will continue past the ALJ hearing level to the Appeals Council. Children also may qualify under one of the federal poverty level programs.
allowances to be eligible for Medicaid as if they were still receiving SSI. Lynch v. Rank established that the Pickle protections extended beyond persons whose receipt of a Title II COLA precipitated termination of SSI to also include others who are not eligible now because of an intervening COLA.

A person may be eligible for categorically needy Medi-Cal with no share of cost under the "Pickle" program if:

- You received SSI (Title XVI) in addition to Social Security benefits at any time after April 1977;
- You are not now eligible to receive SSI because the intervening cost-of-living allowance (COLA) increases in your Social Security benefits were greater than the increases in your SSI, so that your Social Security benefit is now too high for you to qualify for SSI; and
- You meet other SSI eligibility requirements except for income from your Social Security COLA increases.

The Pickle Amendment is Section 503 of Pub.L. 94-566, and is not codified but found in the notes following 42 U.S.C. § 1396a; 42 C.F.R. § 435.135. Because clients always want to know just what the Pickle Amendment says, here is an abridged version:

[Under Title XIX ... medical assistance ... shall be provided to any individual .... if for such month such individual would be (or could become) eligible for benefits under such title XVI except for amounts of income received by such individual ... which are attributable to increases in the level of monthly insurance benefits payable under title II of such act which have occurred pursuant to [cost of living provisions]. . . .

Lynch v. Rank 747 F.2d 528 (9th Cir. 1984), as modified by 763 F.2d 1098 (9th Cir. 1985).

Earned income should not disqualify you as a "Pickle" unless it was substantial because, without the intervening Title II cost-of-living allowance (COLA) increases, you would qualify for continued SSI beneficiary status and Medi-Cal under Social Security's 1619(b) program. [42 U.S.C. § 1382h.] DHS does not agree based on its understanding of HCFA's position. Ask Marilyn Holle (PAI) for briefing on this issue.
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Note: To qualify as a Pickle you do not have to show that you lost SSI because of a Social Security COLA. Under Lynch v. Rank you qualify if you meet the “but for” test: But for theCOLA increases you would be eligible now for SSI.

To see whether you are eligible now for "Pickle" Medi-Cal, go back to the last time you were eligible for and received both SSI and Title II. Usually you lose SSI in January when you have a cost of living increase in your Title II. In most cases you compare your Title II grant level from the time you last received and were eligible for both SSI and Title II Social Security with the current SSI grant level. You “red circle” that old Title II grant level. You are a "Pickle" if you would now be eligible for SSI if you were receiving today the same Title II Social Security benefits as you were receiving before when you qualified for both SSI and Title II. The Title II grant level from the last time you qualified, or could have qualified, for both SSI and Title II continues indefinitely as your “red circled” "Pickle" measure.

The Pickle Amendment protects not only the person receiving the Title II benefits but also the SSI spouse or SSI child to whom the income is deemed. If the spouse or child would be eligible for SSI but for Title II

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57 Sometimes SSI recipients will receive SSI for a month or so after their eligibility for SSI stops. When these additional months extend into the next year, counties often err by saying first, there was no intervening cost of living increase after SSI stopped, and second, you use the next year’s Social Security amount to determine Pickle eligibility. In fact, the SSI recipient was last eligible for and received SSI the prior year and that year’s Social Security benefits should be used to measure whether the former SSI recipient qualifies for Pickle benefits.

58 If you do not know the amount of the Title II benefits the person received when he qualified for both SSI and Title II benefits, you can get back to that amount by using the Gordon Bonnyman reduction factors chart set out annually in a spring issue of CLEARINGHOUSE REVIEW. Bonnyman, “Medicaid Eligibility in a Time Warp,” 22 Clearinghouse Review 120 (June 1988).

59 42 C.F.R. § 435.135(b); Lynch v. Dawson, 820 F.2d 1014 (9th Cir. 1987).
cost of living increase is income that is deemed to them from a spouse or parent, the child or parent would qualify for Medi-Cal as a Pickle.

(b) **Medi-Cal DACs or Pickle DACs (Disabled Adult Child beneficiary of Social Security Benefits based on the Earnings Record of a Parent)**

You may be eligible to receive Medi-Cal with no share of cost under a special program ("Medi-Cal DACs" or "pseudo-Pickle DACs") for people who receive Social Security Disabled Adult Child (DAC)\(^6^0\) benefits if:

- You received SSI in July 1987 or later;
- You initially qualified for Title II DAC benefits, or an increase in DAC benefits, on or after June 1, 1987 (see PAI’s service rights manual on SOCIAL SECURITY);
- You would be eligible for SSI now but for (a) the Title II DAC benefits you first started receiving in July 1987 or later, or (b) the increases in your Title II DAC benefits received in July 1987 or later.\(^6^1\)

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\(^{60}\) 42 U.S.C. § 402(d) and 20 C.F.R. § 404.350. See, e.g., *Smolen v. Chater*, 80 F.3d 1273 (9th Cir. 1996). There are three criteria for qualifying for DAC benefits:

1. You must have been disabled since before age 22. 42 U.S.C. § 402(d)(1)(B), 42 CFR § 404.350(a)(5). Most courts say that you do not qualify if you have had any substantial work (i.e., performed substantial gainful activity). *Anderson v. Heckler*, 726 F.2d 455 (8th Cir. 1984).

2. Your insured worker parent must be receiving Social Security benefits (SSDI or retirement) or be deceased. “Parent” is defined to include whomever raised you -- like a grandparent upon whom you were dependent for care and support. 42 U.S.C. § 416(e) defining child of a worker.


The amount of the DAC beneficiary's benefits is 50% of the wage earner's benefits divided by the number of dependent claimants. If the wage earner is deceased, the amount of the benefits is 75% of what the wage earner would receive. 42 U.S.C. § 402(d)(2).

\(^{61}\) 42 U.S.C. § 1383c(c). Although the proper test is the “but for” test under the language of § 1383c(c) making *Lynch v. Rank* applicable, DHS takes the position that to qualify for DAC Medi-Cal you must have lost SSI benefits because of initially qualifying for or qualifying for an increase in DAC benefits, rather than being someone who would be currently eligible for SSI but for qualifying for
If you received Title II DAC before July 1987 and you want to see if you qualify as a "DAC Pickle" or "Medicaid DAC," compare your Title II grant level in 1987 with the current SSI grant level. If you would qualify for SSI now if your Title II Social Security DAC benefits were at the same level as they were in 1987, then you qualify for no-share-of-cost Medi-Cal as a "pseudo-Pickle DAC" or "Medi-Cal DAC." You would also qualify for no-share-of-cost Medi-Cal if you did not begin to receive Title II DAC benefits until July 1987 or later.

Increases in DAC benefits may be for reasons other than COLAS: Wage earner dies which increases the DAC benefit amount by 50%; a reduction in the number of dependents drawing against the wage earner's account.

In addition to qualifying for no-share-of-cost Medi-Cal as a DAC Pickle, you would also qualify for no-share-of-cost Medi-Cal as a true Pickle.

Whether determining your eligibility for no-share-of-cost Medi-Cal as a true "Pickle" or as a "DAC Pickle," count your Title II benefits before any deduction for Medicare premiums.

Counties are periodically sent lists of DAC recipients whose SSI/SSP has or is being terminated. Counties "must contact each DAC individual on DAC benefits or an increase in DAC benefits. See Chapter 6.1, DHS Pickle Manual and DHS ACWDL No. 91-47 (5/9/91), CCH Medi-Cal Guide New Dev. ¶ 7271. The ACWDL says that to be eligible as a Medicaid DAC or DAC Pickle, the DAC beneficiary must "have been discontinued from SSI/SSP as a result of either having begun receiving [DAC] or receiving an increase in the amount of his/her [DAC] benefits." Consider this example:

John began receiving DAC benefits after July of 1987. He goes into a nursing facility and as a result, his SSI is terminated. Under DHS' analysis, John would be assessed a share of cost. Under the "but for" test John would be a DAC pickle. Paraphrasing the language in § 1383c(c)(2), John ceases to be eligible for SSI because of becoming entitled to DAC benefits in July of 1987 or thereafter. But for initially qualifying for DAC benefits, John would be eligible for SSI while he is in the nursing facility.

Increases in DAC benefits may be for reasons other than COLAS: Wage earner dies which increases the DAC benefit amount by 50%; a reduction in the number of dependents drawing against the wage earner's account.

In addition to qualifying for no-share-of-cost Medi-Cal as a DAC Pickle, you would also qualify for no-share-of-cost Medi-Cal as a true Pickle.

For more information on "pseudo-Pickle DACs," see DHS ACWDL No. 91-47 (5/9/91), CCH Medi-Cal Guide New Dev. ¶ 7271.
the list to determine if assistance is needed in completing the forms required for the application process.”

(c) **Disabled and early retirement widows/widowers who were eligible for SSI immediately prior to receiving widow/widower benefits**

Widows and Widowers who qualify for Social Security benefits under 42 U.S.C. § 402(e) and (f) will be eligible for Medi-Cal

-- so long as they are ineligible for Medicare Part A, and

-- received SSI benefits in the month before the month in which widow/widower benefits began, and

-- are ineligible for SSI because of the widow/widowers benefits but would be eligible in the absence of such benefits.

3. **Medically Needy (MN) and Medically Indigent (MI) Programs**

You are eligible to receive Medically Needy (MN) Medi-Cal if you would be eligible to receive SSI -- or AFDC as it existed on July 16, 1996, -- but your income is too

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64 DHS ACWDL No. 91-47 (5/9/91), CCH Medi-Cal Guide New Dev. ¶ 7271. Counties were sent a list in 1995 of some 330 persons who receive DAC benefits now but used to receive SSI/SSP benefits in the past. The list came from HCFA. Counties were required to re-evaluate their eligibility for DAC Medicaid benefits in any month where they were not eligible for zero share of cost Medi-Cal. DHS ACWDL No. 95-14 (3/6/95).

65 The eligibility regulations for early/disabled widows and widowers are at 20 CFR § 404.335. The eligibility rules are tricky: you must have been married for 9 months unless death was by accident or you have a child in common who is under age 18; you qualify at age 50 and older if you become disabled within seven years of the insured's death, or you qualify at age 60 and older without the need to establish disability. Medicare benefits come with disabled widow/widower benefits after the two-year waiting period on top of the 5-month initial waiting period; for early retirement benefits you wait until age 65 to be eligible for Medicare. There are limitations on remarriage.

high. For example, you may receive a Social Security Disability Income (SSDI) check each month which is more than the SSI grant level plus $20. The Medically Indigent programs cover children up to age 21 who do not meet one of the AFDC requirements, children who receive adoption assistance or are court dependents, pregnant women (if they do not qualify under the Federal Poverty Level Program), and adults in long-term care who do not qualify on other grounds. Qualifying as medically needy or medically indigent may involve “share of cost.” See Chapter 5 on determining share of cost for the Medically Needy and Medically Indigent Programs.

Before looking at the Medically Needy or Medically Indigent programs where there may be a share of cost, your eligibility worker will (or should) first check to see if the family qualifies under the Section 1931 program, second check to see if the family qualifies under Transitional Medi-Cal, and third, to see if any family members qualify under one of the zero-share-of-cost FPL programs including the new FPL program for aged and disabled (which includes children). There will be no share of cost for members of the family who qualify under the FPL programs. However, the family member independently qualifying under one of the zero share of cost programs will be included in the Medi-Cal Family Budget Unit for purposes of determining Share of Cost, if any, under the medically needy or medically indigent programs. For instance, if one member of the family qualified for Medi-Cal under the Aged & Disabled Federal Poverty Level Program (A&D FPL), the rest of the family could qualify for Medi-Cal under the Aged-Blind-Disabled Medically Needy program using that program’s more favorable treatment of earned income. The person qualifying under the A&D FPL program would be included as an ineligible member of the budget unit.

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66 See work sheets at www.healthconsumer.org showing how you determine share of cost for the MN and MI Medi-Cal programs.

68 Per Craig Yagi, DHS, 9/19/2001 e-mail to Protection & Advocacy, Inc.
Practice Tips: If the parent is prevented from working because of the child’s intensive care needs, the child may be eligible for In-Home Supportive Services with the parent as provider. In that case there would be a share of cost determined by the amount the income deemed to the child exceeds the SSI grant level. The child would be eligible for Medi-Cal even if there is only $1 in IHSS benefits.

Alternatively, if the child’s disability would qualify the child for nursing facility care, the child may be eligible for care under a Model Waiver where parental income and resources are not counted. See Chapter 16.

(a) **AFDC-linked Medically Needy Medi-Cal**

Generally, families who do not qualify for Section 1931 benefits (because, for example, their income is too high) may qualify for AFDC-linked MN Medi-Cal. Families with countable incomes above a certain limit, called the medically needy Maintenance Need Income Level (MNIL), must pay a sliding-scale monthly deductible, called a “share of cost” before the AFDC-MN program will cover their monthly medical expenses.

Families must have a “deprived” child. “Deprivation” means that either (a) one parent is absent or “incapacitated” or (b) both parents are in the home but underemployed or unemployed. The AFDC-MN “incapacity” standard is easier to meet than the SSI disability standard. If you have children and you are disabled, but you are waiting for SSA to approve your SSI or SSDI application, you may qualify for CalWORKS benefits and/or AFDC-linked Medi-Cal or § 1931 Medi-Cal. Parents or caretaker

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69 This section is based upon WCLP’s CalWORKS Manual, Chap. VIII.H.

70 WIC § 14005.7; 22 CCR §§ 50090, 50203, 50651-50660.

71 The parental deprivation requirements are set out in 22 CCR §§ 50205, 50209, 50211, 50213, and 50215. They include a deceased, absent, incapacitated, unemployed, or underemployed parent. Children must be living with a parent or relative to be eligible. To be under or unemployed means that the principal wage earner of an applicant or recipient family with two able-bodied parents must work less than 100 hours in a given month in order to be eligible for AFDC-MN. Cal. Code Regs., Tit. 22 §50205. This “100 hour rule” is waived, however, for all families with earned income at or below 100% of the federal poverty level. Welf. & Inst. Code §14008.85(a)(2).
relatives may also qualify for CalWORKS and/or MN or § 1931 Medi-Cal.

A single parent may qualify for AFDC-linked MN Medi-Cal. Both parents in a two-parent family may qualify if one is unable to work because of a health or disability problem or, in certain circumstances, if one of them is underemployed or unemployed. A single parent with a child who receives SSI may qualify for MN Medi-Cal. Children over age 18 and under age 21—and in certain circumstances the parent—may qualify for AFDC-linked MN Medi-Cal. Even if their parents don't qualify for MN Medi-Cal, children may qualify for Medi-Cal under the Medically Indigent program or under one of the Federal Poverty Level Programs. A parent with a child on SSI may also qualify for AFDC-MN Medi-Cal because the caretaker parent would have been eligible for AFDC.

(b) SSI linked ABD (aged-blind-disabled) Medically Needy Medi-Cal

Adults and children are eligible for disability-linked or ABD (for "aged, blind, disabled") MN Medi-Cal if they meet SSI disability standards and resources limitations, but their income is too high to qualify for an SSI

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72 Cal Code Regs., Tit. 22 §§ 50373, 50209(b), 50211(c), 50213(g), 50215(d).

73 Cal Code Regs., Tit 22 § 50030(a), child a person under age 21, except those who are treated as an adult under § 50014(b) (18-21 not living in the home of parent or caretaker relative, not claimed as tax dependent, and not receiving out-of-home care from public agency); § 50014(c) (14-18 not living in the home of a parent or caretaker relative and who does not have a parent, caretaker relative or legal guardian handling affairs). AFDC cash benefits under the old program ended for both parent and child when: (a) the child turns 18 (if she will not graduate before her 19th birthday) or (b) the child graduates from high school (if she graduates before her 19th birthday).

74 Cal. Code Regs., Tit. 22 §§50205(a), 50030, 50014.

75 See Section (4) below.

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For children that usually means that the child is disqualified because of income deemed to the child from the parents. For adults that usually means disability or retirement income (veterans benefits, Social Security benefits, pension) and/or income deemed to the person with a disability by an ineligible spouse.

(c) Medically indigent children who do not meet the Medically Needy SSI or AFDC linkage requirements

Children under age 21 are eligible for Medically Indigent (MI) Medi-Cal even if they do not receive public assistance (SSI or CalWORKS), and even if they would not be eligible for MN Medi-Cal because they do not meet SSI disability standards, AFDC dependency requirements, or other AFDC requirements. For instance, to qualify for AFDC-MN, the child must be living with a parent or other categories of relatives. Therefore, a child living with someone else could get MI Medi-Cal. Similarly, if an AFDC-MN family loses Medi-Cal because the principal wage earner works more than 100 hours a month (and the earned income is more than 100% of the FPL), the children could continue to qualify for Medi-Cal through MI program. If the child’s countable income is above the maintenance need income level, the child may have a share of cost.

77 Cal. Code Regs., tit. 22 § 50251(a)(1), (6), (b).

78 See memo on Social Security Rules for Deeming Income from Parents to a Disabled Child to Determine Whether a Child is Eligible for SSI. To download this memo, go to www.pai-ca.org. Click on “PAI Publications.” Then click on “4. Government Benefits.”

79 But not “Aid & Attendance” which is exempt income. See Chapter 4.

80 See Chapter 16 on Home and Community Based Waivers for persons who would otherwise require care in a nursing facility or intermediate care facility. Under the Model Nursing Facility Waiver income from the ineligible spouse is not deemed to the spouse with the disability.
(d) Adoption assistance and dependency court children

Children may also qualify for MI Medi-Cal if they are eligible for assistance under Aid for Adoption of Children,\(^{81}\) or they are court dependents, or they are otherwise under the jurisdiction of the county.\(^{82}\) This latter category includes children in foster home placement, juvenile probation cases placed in foster care or who are otherwise in out-of-home placement supported by public funds. Children who qualify under these two categories do not need to meet the property, income, citizenship, residence, or institutional status requirements that otherwise apply to Medi-Cal applicants and beneficiaries.\(^{83}\)

(e) “Safe Arms” for newborns

A newborn voluntarily surrendered to an emergency room pursuant to Health & Safety Code §1255.7 will be immediately covered by Medi-Cal through to the end of the following month.\(^{84}\) The purpose is to provide Medi-Cal coverage for health screening assessments and care until the child is returned to a responsible relative/caretaker or is established in the foster care system.

(f) Medically indigent pregnant women or persons in long-term care

Adults are covered under the MI Medi-Cal program if they are in Medi-Cal-funded long-term care (a nursing home or intermediate care facility)

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\(^{78}\) Cal. Code Regs., tit. 22 § 50251(a)(4). Note that there are two aid codes for Adoption Assistance linked Medi-Cal: One where there is federal financial participation (Aid Code 03) and one which is state only (Aid Code 04). The latter are special needs children who did not meet the AFDC eligibility requirements prior to adoption.

\(^{82}\) Cal. Code Regs., tit. 22 § 50251(a)(3).

\(^{83}\) Cal. Code Regs., tit. 22 § 50251(d).

\(^{84}\) Welf. & Inst. Code 14005.24; DHS ACL 01-58 (10/30/2001)
or they are pregnant. 85

(i) Medically indigent in long-term care

For persons in long-term care, you look at this category if there is no other Medi-Cal category in which the person would fit. 86

For instance, the person may need nursing facility care but is not expected to be incapacitated a year or more which is one of the requirements for qualifying for ABD Medically Needy Medi-Cal. 87 Or the person may meet the ABD Medically Needy disability requirements but not have a satisfactory immigration status. 88 The benefits are limited. You receive the full scope of Medi-Cal benefits while you are in long-term care -- including retroactive benefits. 89 However, if you are admitted to acute care, you are

85 Cal.Code Regs., tit. 22 § 50251(b).

86 Welf. & Inst. Code §§ 14005.4, 14052. California did away with the Medically Indigent Adult program in 1983 via 1992 legislation pursuant to AB 799 and SB 2012 which shifted responsibility for indigent medical assistance to the counties. An exception via an uncodified provision was the state's retention of responsibility for persons in long-term care including persons without a Satisfactory Immigration Status. Hence this residual state-only program. See DHS MEDI-CAL ELIGIBILITY PROCEDURES MANUAL at § 19-C.

87 This aid code 53 program covers persons with a satisfactory immigration status including, for the moment, persons qualifying on the basis of PRUCOL (Persons Residing Under Color of Law).

88 This aid code 55 covers non-PRUCOL immigrants without a satisfactory immigration status. See the report of the latest round in Crespin v. Belshé, Alameda Superior Court, Case No. 636715-6, reported in the May 2000 WCL&P's Health &Welfare Task Force Mailing. Judge Hodge denied the State's motion to amend the injunction in light of SB 708.

89 DHS MEDI-CAL ELIGIBILITY PROCEDURES MANUAL at § 19-C.
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(i) Medically indigent pregnant women

For persons who qualify on the basis of pregnancy, this program covers persons whose income is too high for the 200% federal poverty level program. Families with income between 200 and 300% of the federal poverty level may qualify for services through AIM -- Access for Infants and Mothers administered by the Managed Risk Medical Insurance Board (MRMIB). 91

4. Federal Poverty Level (FPL) Programs with a zero share of cost for children and pregnant women

There are three Federal Poverty Level (FPL) programs with a zero share of cost for children or pregnant women. In determining the size of the family, a pregnant woman counts as two persons. 92 If one family member qualifies under an FPL program, this does not make the whole family eligible. However, other family members may be eligible for other MN Medi-Cal programs based on AFDC or SSI linkage, even though they may have a share of cost. The FPL family member is ineligible for any Medi-Cal at all. 90

90 Id. Medi-Cal coverage of long-term care is a carve out of the transfer of medically indigent care to the counties. When California ended its state medically indigent program and transferred responsibility for medical care to the counties, the state retained responsibility for those in long term care.

91 Ins. Code §§ 12695 et seq. There is an enrollment fee of $50. Women are covered 60 days postpartum. Children born under the program are covered from birth to age two. The scope of services include those required to be provided by federally qualified HMOs under 42 CFR § 417.101. Ins. Code § 12698.30. See also note 12, supra. For more information, visit the MRMIB webpage at www.mrmib.ca.gov. AIM applicants whose income after allowable deductions are at 200% or below the FPL will be processed as applicants for pregnancy related services discussed under Section 4.(a) below. See DHS ACWDL Nos. 00-24 (4-13-00) and 00-40 (8-9-00).

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included in the Medically Needy budget unit for purposes of determining the Maintenance Need Income Level (MNIL) that is deducted from countable income.

In 1998 the FPL programs were improved in two ways: First, resources are no longer considered, only income. Second, children from age 6 up to age 19 are eligible when the family income after allowable deductions is 100% of the federal poverty level or less.

To determine whether the monthly family income is at or below the applicable FPL income level, Medi-Cal adds together unearned income plus gross earned income. If you have earned income, Medi-Cal deducts child care expenses and a $90 work allowance. You cannot "spend down" to qualify for the zero-share-of-cost FPL programs even if you are only a couple of dollars over the Federal Poverty Level. However, any income you put in a "cafeteria plan" through work to cover child care costs or medical expenses is not counted as income under any FPL program. If you are a little above the FPL you can bring your income down by putting income in a cafeteria plan. See Section 2 in Chapter 4.

Remember: Children who are not eligible for free Medi-Cal under the FPL or other Medi-Cal programs may be eligible for Healthy Families if their countable income is under 250% of the FPL. And children who would otherwise lose their no share of cost Medi-Cal would be eligible for 12 months from the last determination. See Chapter 9.

89 Welf. & Inst. Code § 14148.75 (Effective 3/1/98). Before this legislation resources were waived only for pregnant women and infants. See also DHS ACWDL Nos. 98-06 (1/13/98) and 98-16 (4/9/98), CCH MEDI-CAL GUIDE New Dev. ¶ 7905.

94 Welf. & Inst. Code § 14005.23. Before the changes the Federal Poverty Level program, only children from age 6 to those born after September 30, 1983, qualified for the 100% of the FPL program.

95 Gross earned income means your wages and salary before any deductions. It does not mean your take-home pay. If you are self-employed, your gross earned income is your adjusted gross income—that is, your gross receipts less IRS allowable deductions. Everything else, including unemployment insurance and social security benefits, is unearned income.

96 Child care allowance—up to $200 a month for a child under age two, $175 for a child aged two or older.
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(a) Pregnant women and infants below age one with income after deductions of not more than 200% of the Federal Poverty Level

Under the 200% of FPL program, low-income pregnant women qualify for all pregnancy-related care during and after pregnancy (for 60 days after the end of the pregnancy, and to the end of the calendar month in which the 60th day falls). As discussed in Chapter 3, pregnant women are entitled to presumptive eligibility so that there is no delay in receiving services. You do not have to pay a share of cost if your family income after allowable deductions does not exceed 200% of the FPL for your family size (in 2002, $3,017 per month for a family of four). If family income is more than 200% of the FPL but not more than 300% of the FPL, the low-income pregnant woman may qualify for benefits under AIM - “Access for Infants and Mothers.” See footnote 91 on AIM in Section 3-(e)(ii) above.

97 Welf. & Inst. Code § 14148(f).

98 “Pregnancy Related Services” means services required to assure the health of the pregnant woman and the fetus.” DHS “Medical Services Provider Manual” at 100-31-2. That definition would cover almost any treatment need. A pregnant woman qualifying for restricted pregnancy related Medi-Cal also may qualify, for instance, for AFDC-linked Medically Needy Medi-Cal with a share of cost to cover such things as glasses. Even if the pregnant woman would qualify for full scope Medi-Cal without a share of cost under another program, a pregnant woman may also wish to qualify under this program as well in order to get immediate services, through the presumptive eligibility procedures.

99 Welf. & Inst. Code §§ 14148.7, 14148(e). The woman seeking presumptive coverage for only pregnancy related Medi-Cal services need only declare on the application form that her pregnancy has been “medically verified.” Women only seeking full scope coverage based on pregnancy will be presumptively eligible and given 60 days to document that verification through verification of the doctor or doctor’s office or clinic. If the documentation is not provided, the woman will receive a notice of action changing the coverage from full scope to pregnancy related coverage. Medi-Cal Eligibility Manual § 4T-1.

100 See Medi-Cal and Healthy Families Income Levels chart which can be found at http://www.healthconsumer.org.
The 200% of FPL zero-share-of-cost program also covers infants under one year of age for medically necessary care.101

(b) Children one year old but not yet age six with income after deductions of not more than 133% of the Federal Poverty Level

The 133% of FPL program covers children who are at least one year old, but who have not yet reached their sixth birthday. For the child to qualify for Medi-Cal, family income after allowable deductions may not exceed 133% of the FPL for the family size (in 2002, $2,007 per month for a family of four).

(c) Children age six but not yet age 19 with income after deductions of not more than 100% of the Federal Poverty Level

The 100% of FPL covers children at least six years of age and not yet age 19. For a child to qualify under this program the family income after allowable deductions may not exceed 100% of the FPL for the family size (in 2002, $1,509 per month for a family of four).

(d) Undocumented children and pregnant women under the Federal Poverty Level Programs

Undocumented children and pregnant women may qualify for Medi-Cal without a share of cost under one of the FPL programs, but they will receive only "restricted" benefits to cover emergency and pregnancy-related care.

101 Cal. Code Regs. tit. 22 § 50262. If the infant is in the hospital when he turns one, he continues to qualify under the 200% infant program until discharged. Cal. Code Regs., tit. 22 § 50262(b)(2). Upon discharge he would be evaluated for eligibility under the 133% FPL and other programs. The same rule applies to children who are receiving inpatient services when they reach age 6. Cal. Code Regs. tit. 22 § 50262.5(b).
5. Federal Poverty Level (FPL) programs for aged and disabled with zero share of cost

There are two Federal Poverty Level (FPL) programs that cover persons with disabilities. One of these also covers aged persons who are 65 and older. In both programs, countable income is determined using SSI rules. If one family member qualifies under an FPL program, this does not make the whole family eligible. However, other family members may qualify under one of the FPL programs for pregnant women and children or they may qualify for Medically Needy Medi-Cal. The FPL family members are included in the Medically Needy budget unit for purposes of determining the Medi-Cal Maintenance Need Income Level (MNIL) that is deducted from countable income.

(a) Aged and Disabled FPL program (A&D FPL)

Beginning January 1, 2001, persons who are 65 and older or who are disabled including children will qualify for Medi-Cal with no share of cost if their countable income before any Medicare deductions is not more than 100% of the applicable federal poverty level plus $230 for an individual or $310 for an eligible couple.102 The federal poverty level in the year 2002 is $739 for an individual and $995 for a couple. The federal poverty level (FPL) for each year comes out in March and goes into effect April 1. For persons who receive Social Security benefits, the January cost of living increase is disregarded (last year’s income levels are used) until the new FPL amounts go into effect in April.

Eligibility for an individual is determined by first determining countable income to be deemed to the applicant or Medi-Cal beneficiary from the ineligible spouse (or parent if a minor) using SSI, rules except that the

102 Welf. & Inst. Code §14005.40, DHS ACWDL 00-57, 00-68, 01-18. Aid Codes are 1H aged, 6H disabled, 1U restricted aged, 6U restricted disabled.
income of a stepparent is not counted when determining the eligibility of a minor who is not his/her child. Second, you deduct from the countable income the Maintenance Need Income Level allowance for the family excluding the family member applying for Medi-Cal under the A&D FPL program. Third, you add in the income of the A&D FPL applicant, if any. Fourth, you deduct the out-of-pocket cost health benefit plan premiums for any member of the family. The balance is the applicant’s countable income. The applicant is eligible if the countable income is not more than 100% of the FPL plus $230.¹⁰³

(b) **250% Working Disabled Program**

This program began April 1, 2000, and covers persons with earned income whose countable income using SSI rules¹⁰⁴ is at or below 250% of

¹⁰³ Example: Nondisabled spouse earns $1800 a month and spouse with a disability receives a $600 monthly pension. Nondisabled spouse’s countable income is $857.50: $1800 less $20 any-income deduction and less $65 earned income deduction = $1715 less 50% additional earned income deduction = $857.50. $857.50 less $600 MNIL for one = $257.50 deemed to disabled spouse. The countable income of the spouse with a disability is $257.50 plus $600 or $857.50. The spouse with a disability is eligible because the countable income is not more than 100% of the federal poverty level ($739 in 2002) plus $230.

Example: Family with two parents and three children including child with a disability. Parents’ earned income is $4085 a month; child has no income. Family’s countable income is $2000 - $4085 less $20 any-income deduction and $65 earned income deduction = $4000 less 50% additional earned income deduction = $2000. $2000 less $1100 MNIL for four (the family size minus the child with the disability) = $900 income attributed to the child. The child qualifies because the income attributed to him is less than 100% of the FPL plus $230. We do not know yet whether Medi-Cal will follow the SSI rule of giving the child to whom income is deemed his or her own $20 any-income deduction.

¹⁰⁴ The SSI earned income deductions include a $65 earned income deduction, deductions for Impairment related work expenses IRWEs, and, after deducting $65 and any IRWEs, 50% of the balance is deducted as a further work incentive deduction. IRWEs include any out-of-pocket expenditure related to your disability and necessary for you to work like maintenance of your specialized van, special clothing, attendant care services to get ready for work, while you work and when you return home, transportation costs including mileage, etc. IRWEs include out-of-pocket medical expenses necessary for you to work even if you would also need the service or equipment or
the federal poverty level (FPL). This program includes persons 65 and older if they are disabled. In determining the amount of countable income, no disability based income is counted. Income not counted includes Social Security benefits based on disability, veterans benefits, private disability pensions, State Disability Insurance. The amount of countable income determines the amount of premiums. If the countable income is $600 or less, the monthly premium is $20. Premiums increase based on income, up to $250 for an individual and $375 for a couple.

The property rules follow SSI property rules with one exception: individual retirement accounts (IRA) or other retirement plans (like KEOGH or 401(k) plans) do not count even if you have access. Under SSI property rules, individual retirement accounts or other retirement plans count if in the name of the SSI recipient but do not count if they are in the name of a spouse or, if the SSI recipient is a child, the parents.

supplies if you were not working. The SSI regulations on determining countable earned income are found at 20 CFR §§ 416.1110-416.1112, and at 416.976 for IRWEs. See Cal. Code Regs, tit. 22 § 50045.1 defining IRWEs.

105 Welf. & Inst. Code § 14007.9 based on the authority in 42 U.S.C. § 1396a(a)(10)(A)(ii)(XIII). See, also, DHS ACWDLs 00-16, and 00-51, 01-14, 01-26 and 01-46. In 2002 250% of the FPL is $1846 a month for an individual and $2488 a month for an eligible couple. Would be applicants have reported difficulty in applying for benefits under this program. We recommend that if there is any difficulty in the application process, that the would be applicant contact the county 250% Working Disabled Liaison listed as an attachment to DHS ACL 01-14 (3/02/2001).

106 For instance, Mary receives $1000 a month in SSDI benefits. She works 8 days a month and grosses $600. She pays a neighbor $10 a day to drive her to work. She cannot use a bus because of her panic attacks. Her SSDI does not count. Only $217.50 of her earned income counts: $600 minus $20 any-income deduction and minus $65 earned income deduction = $515. $515 less IRWE of $80 (8 x $10) = $435 x 50% earned income deduction = $217.50.

107 20 C.F.R. § 416.1202.
6. **Transitional Medi-Cal for persons previously covered under the Section 1931 Medi-Cal Program**

**L. See the WCL&P’s Updated Chapter VIII of the CalWORKs Manual available at www.wclp.org**

Transitional Medi-Cal is no-cost Medi-Cal for persons who lose eligibility for free Section 1931 Medi-Cal or CalWORKs because of work.\(^{108}\)

(a) **Losing Section 1931 due to an increase in earned income**

If the caretaker relative or principal wage earner’s earned income, increased hours or loss of earning disregards makes the family ineligible for Section 1931 Medi-Cal or CalWORKs,\(^{109}\) the family may be eligible for up to two years of transitional Medi-Cal.\(^{110}\) The family is eligible for the first six-month period regardless of income if the family was eligible for Section 1931 Medi-Cal or CalWORKs for at least three out of the prior six months prior to the month of termination. The only reason a family could lose Medi-Cal coverage during this initial six-month period is there is no longer a child living in the home. For the second six-month period and the following 12-month period, the family is eligible if the family income, after allowable deductions for child care, is at or below 185% of the FPL. In 2002, that is $2,791 for a family of four.\(^{111}\)

\(^{108}\) 42 U.S.C. §§1396a(e)(1)(B), 396r-6 and 1396r-1(c)(2); Welf. & Inst. Code §§ 14005.8 and 14005.81; DHS ACL 90-66, p. 4.

\(^{109}\) The termination from CalWORKS and/or Section 1931 Medi-Cal because of a failure to report will trigger a notice about the continued right to Medi-Cal under the TMC program. See DHS ACWDL No. 98-24 (5/29/98).

\(^{110}\) Welf. & Inst. Code §§ 14005.8 and 14005.81.

\(^{111}\) Welf. & Inst. Code § 14005.8. See DHS MEDI-CAL ELIGIBILITY PROCEDURES MANUAL at § 5B.
(b) Losing Section 1931 due to receipt of child/spousal support

If the family loses AFDC because of an increase in child or spousal support collected, the family is eligible for four months of free transitional Medi-Cal without regard to family income.\(^\text{112}\)

(c) Losing Section 1931 due to marriage or family reunification

At the time PRWORA went into effect, California was operating under a waiver which provided 12 months of transitional Medi-Cal for families where the parent or caretaker reunited with an absent spouse or married and as a consequence became ineligible for AFDC -- now Section 1931 -- because of increased income or the elimination of "deprivation."\(^\text{113}\) To the extent "deprivation" is less of a factor under Section 1931 and CalWORKs and to the extent the increased income is due to earned income, many families would probably qualify under the earned income TMC program.

7. Program for Former Foster Care Children (FFCC)

Effective October 1, 2000, California elected to cover adolescents who were in foster care under the responsibility of the state when they turned 18.\(^\text{114}\) When an adolescent is no longer eligible for Medi-Cal based on foster care status, the adolescent will be transferred to the FFCC program without a new application based on a review of the foster care case files. All income and assets tests are waived even if the child returns to her parents’ home. Children and youth will be eligible for this program until


\(^{113}\) Welf. & Inst. Code § 14005.85.

\(^{114}\) Welf. & Inst. Code 14005.28. The option was made available under Sections 121(a) & (c) of the Foster Care Independence Act of 1999, Pub. L. 106-169, now codified at 42 U.S.C. § 1396a(a)(10)(A)(XVII), 1396d(w).
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their 21st birthday.\textsuperscript{115}

California has elected to cover as many children as possible under this program including those on probation.\textsuperscript{116} Therefore adolescents will qualify if they had an open file indicating they were receiving some services even if there were no Title IV-E foster care money involved. The only exceptions are undocumented adolescents,\textsuperscript{117} adolescents who are incarcerated or in a facility classified as an institution for mental disease or IMD.\textsuperscript{118} Children in the Kin-Guardian Assistance Program (Kin-Gap) are not eligible.

Under federal law an annual redetermination is required. However, because income and assets tests are waived, the redetermination need only include “a status/address update and verification of desire to continue eligibility.”\textsuperscript{119}

8. Minor consent program

Under certain circumstances a minor (a person under age 21) may be eligible for limited benefits—"minor consent services"—without regard to family income. The minor may apply for minor consent services without parental contact.\textsuperscript{120} Minor consent services include services related to sexual assault, family planning, and pregnancy. If the minor is age 12 or older, services include those related to substance abuse and

\textsuperscript{115} DHS ACWDL Nos. 00-41, 00-61 (8-14-00, 11-22-00)

\textsuperscript{116} DHS ACWDL No. 00-61 (11-22-00)

\textsuperscript{117} Foster care aid code 58 children will be individually evaluated upon leaving foster care.

\textsuperscript{118} See Chapter 10 for an explanation of why persons who reside in public institutions including those who are incarcerated or who reside in mental health treatment facilities are ineligible for Medi-Cal.

\textsuperscript{119} DHS ACWDL No. 00-61 (11-22-00) at attachment page 3.

\textsuperscript{120} Welf. & Inst. Code § 14010; Cal. Code Regs. tit. 22 § 50147.1(a).
sexually transmitted diseases. They also include out-patient mental health care if the 
minor is over age 12 and can participate in treatment services where: (a) the minor 
needs those services to prevent harm to herself or others, or (b) there is alleged incest 
or other child abuse.¹²¹ Minor consent services do not include in-patient mental health 
services.¹²²

How the minor applies depends on whether he or she is asking for mental 
health services or other services. For mental health services, the minor goes to the 
welfare department with a letter from a health care professional indicating that she 
needs minor consent services because: (a) she is at risk of causing physical or mental 
harm to herself or others, or (b) she is the alleged victim of incest or child abuse.¹²³ The 
letter from the health care professional should estimate the length of time the minor 
will need services because that determines how long the minor's consent services card 
will be valid. If the minor needs only other services, she does not need to submit a 
letter as part of the application process. The application process involves completing 
the form "Request for Eligibility for Limited Services."¹²⁴

While other Medi-Cal beneficiaries receive a plastic card, Medi-Cal beneficiaries 
eligible for only minor consent services receive a paper card. Like those who have a 
plastic card, holders of the minor consent services card will have to be verified to 
determine eligibility. The card contains a code reference to the categories of minor 
consent services authorized.¹²⁵

¹¹¹ Cal. Code Regs., tit. 22 § 50063.5.

¹²² DHS ACWDL No. 94-63 (8/8/94), CCH Medi-Cal Guide New Dev. ¶ 7582.

¹²³ Cal. Code Regs., 22 § 50147.1(c).

¹²⁴ Cal. Code Regs., tit. 22 § 50147.1(b); DHS ACWDL No. 94-63 (8/8/94).

¹²⁵ See DHS ACWDL No. 97-29 (6/23/97), CCH Medi-Cal Guide New Dev. ¶ 7857: 7R 
(for under 12 family planning and sexual assault), 7M (12 and over STD, drug and alcohol, family 
planning, sexual assault but no mental health services under this code), 7P (same as 7M but includes 
outpatient mental health treatment and counseling), 7N (pregnant minors of any age).
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9. Medi-Cal's special programs

(a) Breast and Cervical Cancer Treatment Programs (BCCTP)

Beginning January 2, 2002, uninsured women with a confirmed diagnosis of breast or cervical cancer will be eligible for full scope Medi-Cal during treatment if family income is at or below 200% of the FPL. You can obtain full scope Medi-Cal benefits if you have satisfactory immigration status, are under age 65 and have no other credible health coverage. These benefits continue so long as you are receiving treatment for cancer.

To enroll in the program you must apply through one of three gateway providers: Breast Cancer Early Detection Program (BCEDP), Family Planning Access Care and Treatment (PACT), or Breast and Cervical Cancer Control Program. Your application will be processed electronically. To find such providers, call 1-800-511-2300.

Women (and men) with insurance whose premiums, deductibles and copayments exceed $750 a year are eligible for payment of these costs for up to 18 months for breast-cancer related services and up to 24 months for cervical-cancer related services. Undocumented persons and others without satisfactory immigration status can also obtain cancer-related services under this program.

(b) Tuberculosis program for persons with active TB (contagious) and infected with TB (noncontagious)

California in 1994 opted to cover tuberculosis treatment for persons who do not qualify for Medi-Cal on another basis without a share of cost and whose income and resources do not exceed the maximum amount for

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126 Welf. & Inst. Code § 14007.71; 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(XVIII), 1396a(aa). A single woman would be eligible for this program if her income is at or below $1477 a month in 2002. See, also Medi-Cal Provider Update dated January 2002, explaining the six new aid codes for the full-scope (0M, 0N, 0P) and state only (OR, 0T, 0U) programs
disabled persons under Medi-Cal. Most applications will be through clinics treating Tuberculosis. Financial eligibility requirements follow SSI rules with these exceptions: Married couples are treated as single persons with only the income in the applicant's name counted. Only resources in the name of the applicant plus one half of the community property is counted toward the allowable resources of $2,000.

(c) Special treatment programs: Kidney Dialysis and Hyperalimentation/TPN Program

Medi-Cal also has special programs for persons who need kidney dialysis or parenteral hyperalimentation (TPN/total parenteral nutrition) but who otherwise do not qualify for Medi-Cal. Under both programs you have no copayment obligation if your annual nonexempt annual worth is less than $5,000 -- namely the combination of your nonexempt resources and gross income. Both programs require payment of an amount equal to 2% of your nonexempt annual worth or 1% of your nonexempt annual worth if you are working. The dialysis program requires that you meet the MN linkage requirements except for income

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128 That includes all the earned income disregards and for children, the deeming rules. See the Parent-to-Child SSI Deeming memo. To download this memo, go to www.pai-ca.org. Click on “PAI Publications.” Then click on “4. Government Benefits.”

129 See DHS MEDI-CAL ELIGIBILITY PROCEDURES MANUAL at § 5N; DHS ACL 02-01 (01/03/2002).

130 Welf. & Inst. Code §§ 14140 through 14144.5; Cal. Code Regs. tit. 22 §§ 50801-50831. See DHS MEDI-CAL ELIGIBILITY PROCEDURES MANUAL at §§ 17D (dialysis) and 17E (TPN). The dialysis program is available to California residents without a satisfactory immigration status. See footnotes to Section 3-(e)(i) infra on the Crespin case.

131 What are exempt resources are set out at Welf. & Inst. Code § 14140(a)(1), (2); Cal. Code Regs. tit. 22 § 50825.
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and resources; the parenteral hyperalimentation program does not.

(d) Disabled Substantial Gainful Activity (SGA) workers

This state funded program covers persons who are working even though still disabled and, as a result of working, are ineligible for SSI\(^{132}\) benefits including benefits under the SSI's 1619 program. \(^{133}\) Disabled SGA workers may qualify for Medi-Cal and the In-Home Supportive Services (IHSS) program but may have a share-of-cost. \(^{134}\) These provisions enacted in 1979 preceded Social Security's 1619 program and in fact served as an impetus for the federal program. This program probably has been rendered obsolete by the 250% working disabled program.

(e) Mystery Multiple Sclerosis Program

Welfare & Institutions Code § 14005.75, which was enacted in 1985, appears to provides restricted scope Medi-Cal for persons who began receiving multiple sclerosis treatment services through Medi-Cal and who are otherwise eligible for Medi-Cal under the State Only Medically Indigent program\(^{135}\) or under the Medically Needy program\(^{136}\) but for excess income and resources. The benefits are restricted in the way that pregnancy benefits are restricted in that they are limited to services related to the MS diagnosis. The restricted benefits terminate when third party coverage is obtained (i.e., Medicare kicks in) or in two years, which

\(^{132}\) PAI believes Welf. & Inst. Code § 14005.3 also covers persons who lost Title II Social Security benefits because of work.

\(^{133}\) 42 U.S.C. § 1382h.


\(^{135}\) Welf. & Inst. Code 14005.4.

\(^{136}\) Welf. & Inst. Code § 14005.7.
ever comes first. This program appears intended to cover persons receiving Title II disability but not yet Medicare. There are no instructions or regulations or Medi-Cal code for this program.

10. Medicare-Related programs

There are five Medi-Cal programs listed below for persons who qualify for Medicare and who have limited resources and limited income. Eligibility is defined in terms of a percentage of the Federal Poverty Level. All of the programs follow SSI rules, not necessarily Medi-Cal medically needy rules in determining countable income. All of the programs allow resources of up to $4,000 for an individual and up to $6,000 for a couple versus the SSI and Medically Needy resource allowance of $2,000 and $3,000 for individuals and couples. The resources allowed follow SSI rules in terms of what is exempt.

The Qualified Medicare Beneficiary program is the only one of the Medicare related programs which cover the cost of copayments and deductibles in addition to

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137 DHS ACWDL No. 97-47 (11-17-97), CCH Medi-Cal Guide New Dev. ¶ 7874.

138 See the chart comparing the income requirements of the QMB, QWDI, SLMB, Q-1 and Q-2 programs at DHS ACWDL No. 01-19 (3-21-2001). Because the federal poverty levels for the year do not go into effect until April 1 of each year, Title II cost of living increases for the year are not counted until April for purposes of determining eligibility under one of the Medicare related programs.

139 Where following SSI versus Medically Needy rules make a significant difference is where there is a spouse from whom income is deemed -- particularly when there are children in the family. Ask Social Security for a copy of the RED BOOK ON WORK INCENTIVES for an explanation of how income, particularly earned income is counted.

140 Under Medicare Part A in 2002 there is a $812 hospital deductible per benefit period, $203 per day for the 61st through 90th hospital days, $406 per day for hospital reserve days (when you go over the 90th day in the hospital as allowed under a single “spell of illness”), $101.50 per day for the 21st to the 100th day in a nursing facility. www.medicare.gov/basics/amounts2002.asp. DHS ACL 01-60 (12/10/2001). Under Medicare Part B there is a $100 deductible plus an obligation to pay 20% of the Medicare determined reasonable cost (Medicare pays 80% of the reasonable cost after the $100 deductible). 42 U.S.C. § 1395(a)(b). For most outpatient mental health services,
Part A and Part B premiums. The other programs cover only the cost of the Part A and/or Part B premiums and in the case of Qualified Individual-2 only provides for a once-a-year reimbursement for a small part of the Part B premium.

You may qualify for the QMB and SLMB programs in addition to qualifying for another Medi-Cal program. You are eligible for the QWDI and Qualified Individuals programs only if you are otherwise not eligible for Medi-Cal.

(a) "Qualified Medicare Beneficiary" (or QMB or "Quimby") program.

Persons are eligible if their income is below 100% of the federal poverty -

except for medication management, however, the copay is 50%. 42 U.S.C. § 1395e(c); 42 C.F.R. § 410.155(d). As discussed below, the state Medi-Cal program is no longer required to pay the full amount of the copayments and deductible. The State is responsible for the difference between what Medicare pays and what the Medi-Cal program would pay if it were the only entity paying.

141 Part A covers inpatient hospital services including drugs and biologicals (i.e. blood clotting factors, gamma globulin) supplies, appliances and equipment, tests and laboratory work; nursing facility care following hospitalization; home health care following hospitalization up to 100 visits a year (home health services not following hospitalization or involving more than 100 visits a year are covered under Part B) including speech therapy, physical and occupational therapy, medical supplies and durable medical equipment; hospice care. See CCH MEDICARE AND MEDICAID GUIDE ¶¶ 1205 through 1510. Part A is available without cost to persons who qualify for Medicare. 42 U.S.C. § 426. However, Part A Medicare is available on a voluntary buy-in basis for persons who are ineligible for Medicare because of where they worked or because they never worked. 42 U.S.C. § 1395I-2. The cost of the Part A premium in 2001 is $300 a month. www.medicare.org/basics/amounts2001.asp.


143 42 U.S.C. §§ 1396a(a)(10)(E)(i), 1396d(p).
level or $739 plus $20 or $759 for an individual in 2002. Medi-Cal will pay Part A premiums (for the few who have to pay) and Part B premiums. Medi-Cal will also cover the copay and deductibles the same way it covers the copay and deductibles for dual eligibles (persons who receive both Medicare and Medi-Cal) -- namely, by paying the difference, if any, between what Medicare pays and the amount Medi-Cal would pay if it were the sole payor.\textsuperscript{144} Qualifying as a QMB does not entitle an individual to Medi-Cal benefits, such as prescription drugs, not also covered under Medicare.

A person may qualify for this program as well as another Medi-Cal program such as ABD MN Medi-Cal with a share of cost. However, most individuals who would qualify as a QMB would also qualify under the A&D FPL program. This program may also assist low income individuals with resources that are above SSI limits.

(b) "Qualified Disabled Working Individual" (or QDWI) program.\textsuperscript{145}

If you lost Social Security and regular Medicare because of work but—

- You are still disabled, and
- You are still eligible for Medicare under a work incentive program,\textsuperscript{146} and
- You are under age 65, and

\textsuperscript{144} Prior to the Balanced Budget Act in 1997, states were required to pay the full Medicare deductibles and copays (except the outpatient mental health 50% copays). See, e.g., Pennsylvania Medical Society v. Regan & Snider, 29 F.3d 886 (3d Cir. 1994), and New York City Health and Hospitals Corporation v. Perales, 954 F.2d 854 (2d Cir. 1992). This meant it was easier for QMBs to find health care providers than it was for other Medi-Cal Beneficiaries. However, section 4714(a)(2) of the Balanced Budget Act, Pub.L. 105-100, amended 42 U.S.C. § 1396a(n)(3) and 1396d(p)(3) to eliminate the mandatory differential treatment of QMBs.

\textsuperscript{145} 42 U.S.C. §§ 1396a(a)(10)(E)(ii), 1396d(s); Welf. & Inst. Code 14005.11.

\textsuperscript{146} 42 U.S.C. § 426(b); Public Law 100-203 (OBRA 87), § 9010(f); 42 C.F.R. §§ 406.12(e), 406.20(c), 407(a)(1).
• You are not eligible for any other Medi-Cal program, and
• You have resources within the level provided for QMBs, and
• You have countable earned income under 200% of the FPL—

Medi-Cal will pay the Part A premiums. This program assists persons who used to receive Title II disability benefits, went off cash benefits following a trial work period and performing "substantial gainful activity" or SGA and are no longer eligible for Medicare Part A at no cost because they have exhausted their Extended Period of Eligibility. QWDI does not cover required deductibles or coinsurance. You would qualify for this program if you were an individual and your countable income were below $1,432 a month in 2001 -- which would be $2949 a month gross earned income assuming there were no Impairment Related Work Expense deductions.147

(c) "Specified Low Income Medicare Beneficiaries" (or SLMB) program.148

If you receive Medicare, and your income is below 120% of the FPL, Medi-Cal will pay your Part B premiums but that is all. You would be covered under this program as an individual if your countable income were below $886 a month in 2002.149 This program only makes sense for those few people whose resources are too high to qualify for the new A&D FPL program or the 250% working disabled program.150

147 See DHS MEDI-CAL ELIGIBILITY PROCEDURES MANUAL at § 51.


149 DHS ACWDL No. 00-18 (3-21-00)

150 See the questions and answers about who should apply for SLMB in DHS ACWDL No. 93-27 (4-20-93), CCH MEDI-CAL GUIDE New Dev. § 7478. See also DHS ACWDL Nos. 92-61 (10/23/92) and 93-06 (2/9/93); CCH MEDI-CAL GUIDE New Dev. ¶¶ 7417, 7443.
(d) "Qualified Individual" programs -- or QI Programs

The 1997 Balanced Budget Act authorized these two programs\(^{151}\) for persons who otherwise were not eligible for Medi-Cal\(^{152}\) and provided a five-year block grant to states to cover the costs of the programs.\(^{153}\) While coverage under the other Medicare related programs are an entitlement, coverage under these two programs is on a first-come basis until the allocated pot of money runs out.\(^{154}\)

(i) Qualified Individual-1 program -- or QI-1s

This program pays the Part B premium of persons who are between 120% and 135% of the federal poverty level. You would be covered under this program as an individual if your countable income were below $998 a month in 2002.

(ii) Qualified Individual-2 program -- or QI-2s

This program provides for payment of a portion of the Part B premium -- namely $3.91 a month in 2002 -- for persons whose countable income is between 135% and 175% ($1292 in 2002) which represents an amount equal to the savings in the Part A program from shifting all of home health care to Part B Medicare. California

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\(^{151}\) Section 4732 of the Balanced Budget Act amending 42 U.S.C. §§ 1396a(a)(10)(E)(iv) and 1396d(b).


\(^{149}\) 42 U.S.C. § 1396u-3.

\(^{154}\) 42 U.S.C. § 1396u-3(e).
has a procedure for a once-a-year reimbursement for eligible individuals.\textsuperscript{155}

\textsuperscript{155} DHS ACWDL No. 01-66 (12-10-01).
Persons who apply for Medi-Cal at any time during a month and who are found eligible, will start receiving Medi-Cal benefits as of the first month of application.  

1. How do I apply for Medi-Cal?

(a) When your application for other public assistance is an application for Medi-Cal

Your application for SSI or In-Home Supportive Services (IHSS) is an application for Medi-Cal benefits as well. That used to be the case also with AFDC before the implementation of Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Pub.L. 104-193. Your application for SSI will result in Medi-Cal if it is approved, but it is a good idea to make a separate application with the county welfare department for Medi-Cal based on disability under either the Medically Needy program for aged, blind and disabled (MN ABD) or under the Aged and Disabled Federal Poverty Level program (A&D FPL).

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159 Although Medi-Cal is no longer linked to AFDC's successor program -- TANF (Temporary Aid to Needy Families) or CalWORKS in California – the applications are processed together.
(b) **Applying for Medi-Cal based on disability instead of or in addition to SSI or Social Security Disability**

Your separate Medi-Cal application will be approved faster because the county\(^{160}\) must give you a decision on your Medi-Cal application within 90 days, while Social Security has no time limit for deciding whether you qualify for SSI. We know from experience that you are more likely to be found disabled when you are applying for ABD Medically Needy Medi-Cal or the A&D Federal Poverty Level Program than when you apply for SSI even though the same disability standard is used. If Medi-Cal approves you first, and Social Security later denies your SSI, your Medi-Cal coverage will continue as long as you continue to appeal the SSI denial and meet all the time deadlines.\(^{161}\) More than half of the initial SSI denials which are appealed are reversed on appeal.

A denial of Social Security Disability benefits on disability grounds technically should not, but probably will, affect a subsequent application for ABD MN Medi-Cal. See Question 2 below.

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\(^{160}\) Although your notice of action will come from the county, the disability determination will be made by the same state government program that makes disability determinations for the Social Security Administration: The Disability & Adult Program Division (D&APD) within the State Department of Social Services. However, the disability determinations for ABD Medically Needy Medi-Cal and the Aged & Disabled FPL program are made by separate units within the D&APD. To get the name and telephone number of the analyst handling a particular ABD Medically Needy or A&D FPL application, call these numbers with the applicant's name and Social Security Numbers: In the South, call Master Files at (213) 480-6400; in the North, call Master Files at (510) 286-3706.

The County, however, will make the determination relating to income and resource eligibility.

\(^{161}\) HCFA STATE MEDICAID MANUAL § 3272.2. For a longer explanation, See Parks, "The Relationship Between Medicaid and Social Security Administration Disability Determinations: An Introduction for Advocates" in CLEARINGHOUSE REVIEW, April 1992, at 1556.
(c) When you apply for Medi-Cal through the mail or through your county welfare office

A change in the law effective July 1, 2000, provides for applications by mail. Adults and families can now apply for Medi-Cal using a four page application. Applications can be requested from the local county welfare office and mailed back. As of January 2, 2002, mail-in applications are available in 11 languages.

People retain the option of going into the county welfare office to apply for Medi-Cal and the option of going into the county welfare office in person with the completed application packet or for help in completing the packet. The Medi-Cal applications that are processed through the county welfare departments include the following:

- Section 1931 Medi-Cal that goes with CalWORKs, or
- Medi-Cal categorically linked to a refugee cash assistance program, or
- Zero-share-of-cost Medi-Cal federal poverty level (FPL) programs for low-income pregnant women, infants, children, and aged or disabled persons, or
- Medically Needy Medi-Cal linked to SSI (ABD MN Medi-Cal) or to AFDC standards, or

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162 CA. Welf. & Inst. Code § 14011.15 (Face-to-face interviews could not be required unless for good cause, a suspicion of fraud, or in order to complete the application process); DHS ACWDL 00-31 (05/08/00), 00-31E (06/23/00), 01-06, 01-68 (12/17/01).

163 A copy of the application and instructions to counties can be found at Medi-Cal Eligibility Procedures Manual at 4S.

164 When you apply for CalWORKs or “Diversion” CalWORKs, the eligibility worker will assist you in applying for Section 1931 as well. But more people other than CalWORKs participants are also eligible for Section 1931 Medi-Cal.
• Medically Indigent Child Medi-Cal, or
• 250% Working Disabled Program, or
• Special programs for kidney dialysis or parenteral hyperalimentation, or
• Medicare-linked special programs, or
• Minor consent services programs, or
• Medi-Cal payment of Medicare HMO Premiums for plans that include prescription drugs

(d) Medi-Cal Healthy Families Joint Application

In addition, children and pregnant women can use the joint Medi-Cal/Healthy Families mail-in application.\(^{165}\) The application is mailed to a single point of entry which processes the application. As of now, pregnant women will be processed only for Medi-Cal eligibility. Parents can ask that their children be considered for either Medi-Cal or Healthy Families or both. However, children who are eligible for free, zero share-of-cost Medi-Cal are not eligible for Healthy Families. The single point of entry will first determine if a child is eligible for free Medi-Cal. If so, the application is forwarded to the county welfare office only if the parent has checked off the Medi-Cal box on the application. If the parent has not asked that the application also be used for Medi-Cal eligibility, then the child would have to apply separately for Medi-Cal. On the other hand, children who are eligible for Healthy Families, might also be eligible for Medi-Cal with a share-of-cost. The Medi-Cal coverage may be important for children who need services that Healthy Families does not cover, even if the family has to pay a share-of-cost. Therefore, it is important for parents to ask that the application be used for both programs. Families can request a Medi-Cal/Healthy Families joint application by calling 1-888-747-1222. Additional information for families (including on getting

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help to fill out the application) can be found at http://www.healthyfamilies.ca.gov/.

**Note:** When you are applying by mail or in person for one of the disability linked Medi-Cal programs where there will need to be a disability determination by the Medi-Cal program (see next section), make certain you ask for the disability packet to fill out. These are the forms that need to be completed to be sent to the Department of Social Services’ Disability & Adult Programs Division (D&APD).

(e) **When you apply for Medi-Cal as part of your Food Stamp application or recertification.**

When families apply for food stamps or at the time of the annual recertification, families will be asked for permission to use the information in the food stamp file to determine the Medi-Cal or Healthy Families eligibility of family members who are not receiving these health benefits.

(f) **When there needs to be a disability determination through the Medi-Cal program**

If there has been a disability determination within the last 12 months, or you have received benefits including Medicare or Medi-Cal based on disability within the last 12 months and there has been no intervening determination that you are not disabled or no longer disabled, then you

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166 MC 223, statement of facts concerning disability and work history. If there is a question you cannot answer, do not leave blank but include an explanation.

MC 220, authorization for release of medical information. Complete one for each treating source. You can photocopy blank forms if you did not get enough.

can qualify for Medi-Cal based on disability without a new determination.\textsuperscript{168} Examples of situations where a new disability determination is not required include:

- termination of Social Security Disability benefits based on substantial gainful activity but continued eligibility for Medicare benefits (which indicates Social Security considers you to be medically disabled);

- suspension of SSI because of increased income or resources;

- provisional reinstatement of Social Security or SSI disability benefits under the Ticket to Work and Work Incentives Improvement Act;\textsuperscript{169}

- termination of SSI, IHSS or Social Security disability benefits within the past 12 months for reasons other than a determination that you are no longer disabled.

\textbf{(g) Applying for Medi-Cal through a School Lunch Program application - “Express Lane Eligibility”}

Beginning July 2, 2002, school districts may opt to participate in a program where families may consent to have the information in the School Lunch Program application also used to establish their children’s eligibility for Medi-Cal.\textsuperscript{170} Children under age 6 are deemed to meet the income requirements for no-share-of-cost Medi-Cal. Children age 6 and over will be individually

\begin{footnotesize}
\begin{enumerate}
\item Cal.Code Regs., tit. 22 § 50167(a)(1)(B).
\item Section 112 of Pub. Law 106-170 provides that a former recipient of Social Security or SSI based on disability who lost eligibility and benefits based on work or earnings can be reinstated to benefits without a new application within the 60 months following their entitlement to benefits. 42 U.S.C. § 423(i) and 1383(p). The person with a disability will receive up to six months of provisional benefits while Social Security reviews continuing eligibility under the medical improvement standard rather than the more stringent standards applied to new applicant. If Social Security decides you have medically improved, you can appeal the determination although provisional Social Security or SSI benefits will not continue. Your Medi-Cal will continue during the whole appeal process.
\end{enumerate}
\end{footnotesize}
evaluated. If a child is determined to be financially ineligible for Medi-Cal, the parent will receive a notice and a Healthy Families application.

(h) **Applying for Medi-Cal in a hospital or nursing facility**

If you are in a nursing facility, the nursing facility will help you apply for Medi-Cal. Many hospitals have outstationed Medi-Cal eligibility workers who process Medi-Cal applications.

(i) **Applying through your provider for coverage under the tuberculosis program and for presumptive eligibility based on pregnancy or a breast or cervical cancer diagnosis.**

Applications for the Medi-Cal Tuberculosis Treatment program can be made and processed through clinics and physicians providing TB care though they also can be made through county welfare offices. A special application form is used which includes physician verification of TB.

Applications for presumptive eligibility based on pregnancy can be made through qualified perinatal providers. Similarly applications for presumptive or accelerated eligibility can be made through clinics and providers with the Breast Cancer Early Detection Program (BCEDP), Family Planning Access Care and Treatment (PACT),

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171 The county is unable to determine a child’s financial eligibility by the information on the School Lunch Program application, the county will contact the family for more information about household composition, allowable deductions. Welf. & Inst. Code § 14005.41(c)(1)(B). The families of children found eligible may be asked for additional information - presumably a Social Security Number or other documents to establish a Satisfactory Immigration. If the additional information is not provided, the child will be enrolled in Medi-Cal under the emergency program. Welf. & Inst. Code § 14005.41(c)(2).

172 **MEDI-CAL ELIGIBILITY PROCEDURES MANUAL (MEPM) § 5N-B.**

173 **MC274-TB**, set out at the end of MEPM §5N.

174 **MEPM § 5M-1.**
and the Breast and Cervical Cancer Control Program (BCCCP). To find such providers, call 1-800-511-2300. For more information about the presumptive or accelerated eligibility programs based on pregnancy or breast or cervical cancer, call 1-800-824-0088 to speak with an eligibility worker.

(j) Applying for retroactive Medi-Cal at your county welfare office

You also go to your county welfare office to apply for:

(i) Retroactive benefits for up to three months before the month in which you applied for SSI or IHSS, or for CalWORKs (assuming you applied for Section 1931 Medi-Cal at the same time).\(^\text{175}\)

(ii) Retroactive benefits for up to three months before the month you applied directly for Medi-Cal.\(^\text{176}\)

2. Any reason why I should apply for Medi-Cal before I apply for SSI? For Social Security Disability?

If it is more important for you to receive Medi-Cal quickly because of an immediate or chronic health need, apply first for ABD Medically Needy Medi-Cal or the A&D FPL program. You have a right to a decision within 90 days but the time limit is often exceeded.\(^\text{177}\) If you apply for both Social Security Disability benefits or SSI at the same time, the state will not develop the Medi-Cal case but rather will wait for the SSI determination to be made. If the SSI application is denied, the state will automatically


\(^{176}\) Id.

\(^{177}\) The Disability & Adult Programs Division -- the unit in the Department of Social Services that makes the disability determinations for both Social Security and the Medically Needy and disability FPL programs -- is supposed to contact you before the 85\(^{\text{th}}\) day with an explanation if the processing time will go beyond 90 days. Radcliffe v. Kizer, San Francisco Superior Ct. 910-804 (Stip. Judg. 4-23-93). DHS ACWDL 93-50 (7-23-93). There are separate units doing the disability determination for Social Security and doing the disability determination for the state Medi-Cal programs.
deny the Medi-Cal application because at that point the state is prohibited from making a disability determination. 178

(a) When you apply for both SSI and Medi-Cal

The preclusive effect of the Social Security decision only applies if SSA has made an SSI disability determination within the 90-day time limit in §435.911(a)(1). SSA never makes its disability determination within the 90-day period so there should be no preclusive effect of the adverse SSA determination. Nonetheless, your Medi-Cal will be automatically denied even though the decision on your SSI application was made well beyond the 90-day period. 179

(b) When you apply for SSI after you qualify for ABD Medically Needy Medi-Cal

If you apply first for Medi-Cal and are found eligible on the basis of disability, and you later apply for SSI and are denied, your Medi-Cal will continue as long as you timely appeal the SSI denial. The Medi-Cal will continue past the Social Security ALJ level to the Appeals Council. 180

You should be able to apply for Social Security disability and Medi-Cal on the basis of disability at the same time because a denial of disability benefits on disability grounds does not preclude one from making a

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178 42 C.F.R. § 435.541(a)(2).

179 42 C.F.R. §435.541(c)(2) similarly provides that the State Medicaid agency must make a disability determination if SSA does not make a disability determination within 90 days.

180 Disabled Rights Union v. Kizer, 744 F.Supp. 221, 226 (C.D. Cal. 1990) (“The Secretary [of Health & Human Services] now takes the position that under the new regulations a Medicaid recipient who timely appeals an initial determination of nondisability by SSA may continue to receive benefits pending final administrative resolution of the appeal”). See, also, DHS ACWDL Nos. 87-21 and 87-54 (9-10-87), set out at Section 140.15 of the CCH Medi-Cal Guide.
42 C.F.R. § 435.541(c)(1) provides that the state agency must make a separate determination of disability for Medi-Cal eligibility when the individual applies as a non-cash recipient and has not applied for SSI. 

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3. If I need to apply for both SSI and Medi-Cal now because I need the cash assistance, what can I do?

If you applied for SSI and Medi-Cal at the same time, you need to let the DAPD know that you are insisting that they immediately develop your Medi-Cal case and that you will insist that a decision be made within the statutory 90 day time period. Check on your case constantly and ask the analyst how far along she is in gathering evidence and what you can do to help. You can help by reminding your doctors to answer the DAPD’s letters.

If your Medi-Cal application is denied on the basis of an SSI denial made more than 90 days after your Medi-Cal application, you can appeal. The grounds for the appeal of the Medi-Cal denial is that the SSI denial was made more than 90 days after your Medi-Cal application and therefore you are entitled to an independent evaluation of your disability. The state is required to make a disability determination with reference to the Medi-Cal application.\(^{182}\)

4. Is there any way I can receive retroactive benefits if I believe I may have been eligible for Medi-Cal before my application month?

In most cases you may receive retroactive Medi-Cal benefits. Medi-Cal will pay retroactive benefits for the three months immediately preceding the month you applied\(^{183}\) or reapply if Medi-Cal determines that you would have been eligible during those months if you had applied. You must submit the application for retroactive benefits separately, and you must apply within one year of each month for

\(^{182}\) 42 C.F.R. § 435.541(c)(2).

\(^{183}\) Cal.Code Regs., tit. 22 §§ 50148, 50197. Remember, your application for SSI is also an application for Medi-Cal so that the month of application for SSI is also your application month for Medi-Cal. If you are denied SSI, take your denial letter to the county welfare department to apply directly for Medi-Cal. If you do this within 30 days of the date on the SSI, your Medi-Cal application date is the date you first applied for SSI. Cal.Code Regs., tit. 22 § 50181.
which you request retroactive coverage. For retroactive coverage, or months you have medical bills, you must have been eligible for Medi-Cal in the month(s) for which you are requesting coverage.

5. I receive SSI. Is there anything I need to do in order to get Medi-Cal?

No. If you receive SSI, you automatically receive Medi-Cal as of the first of the month after the month in which you applied or after the month you were first found eligible for benefits. You may also be eligible for Medi-Cal for up to three months prior to the month you applied for SSI benefits. However, to get benefits for the three prior months you must apply for retroactive benefits at your county welfare office. You must apply within one year of the months you want covered retroactively as explained in Section 4 above.

If you need to use your Medi-Cal card before you receive it, you may take your SSI award letter to your county welfare office to have your Medi-Cal card specially issued. You can do this even before you receive an SSI check.

6. How long does it take for Medi-Cal to process an application?

If the Disability & Adult Programs Division (D&APD) does not need to make a disability determination as part of your application process, the county has 45 days

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184 If you are appealing an SSI denial, to protect your right to retroactive benefits for any of the three months before you applied for SSI, you probably need to apply for retroactive Medi-Cal before you finish your SSI appeal. Your application for retroactive benefits will be held in abeyance pending the SSI determination. If your SSI application is approved, your case file will be sent to the DAPD for a disability determination for the retroactive period. DHS ACWDL 01-59 (11-2-2001), p. 3.

185 The case does not have to be sent to the D&APD for a disability determination if: (a) you were receiving SSI or Title II Social Security disability benefits or IHSS or Medi-Cal based on disability within the last 12 months and you stopped receiving those benefits for any reason other than a determination that you were no longer blind or disabled, or (b) you have not been receiving title II Social Security benefits for more than a year but you are receiving Medicare which indicates Social Security considers you still to be medically disabled. DHS MEDI-CAL ELIGIBILITY PROCEDURES
to process your application.\textsuperscript{186} However, Medi-Cal may extend the time for processing your application if you have good cause for needing additional time to submit requested documents.\textsuperscript{187}

If you are asking for ABD Medi-Cal because you are blind or disabled, or you are applying for A&D FPL program because you are disabled, the application may take 90 days if there is no current disability determination.\textsuperscript{188} The application process involves (a) a determination at the county level that you meet the eligibility requirements except for disability or blindness and (b) a determination at the state level—the D&APD—that you meet the SSI standards for blindness or disability. The D&APD also has a contract with the Social Security Administration to make determinations about whether SSI applicants meet disability and blindness standards. However, benefits can begin before the D&APD determination if you meet the presumptive eligibility criteria discussed in the following question.

\section*{7. Is there any way I can start receiving disability linked (ABD) Medi-Cal before the D&APD decides whether or not I meet the SSI disability standard?}

Yes, if you meet the presumptive eligibility requirements in the Medi-Cal regulations.\textsuperscript{189} The presumptive eligibility criteria for Medi-Cal are the same as those for SSI at 20 C.F.R. § 416.934. If you meet the presumptive eligibility criteria, and you

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\textsuperscript{186} Cal. Code Regs. tit. 22 § 50177(a)(1).


\textsuperscript{188} Cal. Code Regs. tit. 22 § 50177(b)(2), § 50175.

\textsuperscript{189} Cal. Code Regs. 22 § 50167(a)(1)(C). Cancer which is expected to be terminal despite treatment; paraplegia or hemiplegia; severe mental retardation with an I.Q. less than 50; absence of more than one limb or amputation of a leg at the hip; total blindness or deafness; hemiplegia due to a stroke more than three months ago; cerebral palsy, muscular dystrophy or muscle atrophy with marked difficulty in walking requiring the use of two crutches or a walker or a wheelchair; diabetes with the amputation of one foot; Down's Syndrome with an I.Q. of 59 or below; end stage renal disease requiring chronic dialysis or transplant; or AIDS.
meet the other eligibility criteria, your case will be processed within 45 days.

Even though you qualify for presumptive benefits, the paperwork will be sent to D&APD for a disability determination. Sometimes the D&APD will identify someone who is entitled to presumptive benefits and will direct the county to process the case on that basis while the D&APD makes the formal determination. The presumptive eligibility means you do not have to wait until the D&APD makes a final decision before your Medi-Cal can start. If after you start receiving presumptive Medi-Cal you are told you are not eligible, you can appeal and continue receiving Medi-Cal during your appeal. See Chapter 17.

8. Is there any way I can get an expedited disability determination from D&APD?

If you have an urgent need for treatment for a life threatening medical condition and that treatment is not available through a county facility, the D&APD will process the case as an “urgent case PD request.” The request needs to be identified by the county in item 10 of MC 221, the cover form used by the county to send the disability package to the D&APD. The request needs to be supported by a detailed medical report with substantiating documents.¹⁹⁰

In other cases you can help expedite the decision by insuring the analyst assigned to your case has all the reports and information needed.¹⁹¹ The medical evidence must show not only that you meet the SSI disability standard, but also that you have or will meet the SSI disability standard for 12 months or more.¹⁹²

¹⁹⁰ See Section 22C-3.3-3.5, DHS MEDI-CAL ELIGIBILITY PROCEDURES MANUAL The package including the completed MC 223 and MC220 forms will be faxed and mailed to the D&APD.

¹⁹¹ See footnote [160] about how to find out the name, telephone and fax number of the DAPD analyst assigned to your case.

¹⁹² For more information about how you can show that you meet the SSI disability standard, look at Protection & Advocacy’s Social Security Manual on its website www.pai-ca.org. Also see www.bamsl.org/barjour/sum20/Steitz.htm (explains the disability standard); www.clsphila.org/abc1.htm (Community Legal Services of Philadelphia, information on establishing disability for children), www.angelfire.com/on2/camhpra/20.html (includes explanation of disability standard in explanation of
Chapter 3: Applying for Medi-Cal Benefits and Retroactive Benefits

9. I'm pregnant. Is there a way to qualify for Medi-Cal right away?

Yes. You may qualify as presumptively eligible for pregnancy services through qualified providers of prenatal services—called Comprehensive Perinatal Services Program (CPSP) providers. Your Medi-Cal covered pregnancy related services may start immediately if your pregnancy is confirmed and you report that your family income is not above 200% of the FPL counting you as two persons. You will fill out a one-page form to establish your presumptive eligibility in coverage. If you are a mother-to-be, and you are alone, you qualify if your countable income is not more than $1,990 a month in 2002. However, you must start the application process formally by the end of the month following the month your temporary presumptive benefits started. You do that by applying for AFDC or Medi-Cal through the county welfare department or through the on-site eligibility worker in the clinic. It is important to follow through on the formal application process because you get only one presumptive eligibility per pregnancy.

To find a participating perinatal provider in your area, or to get more

Social Security/SSI program), www.law.mercer.edu/legalcommunity/gaghe/hchch8.pdf (SSI disability standard for Georgia’s Medically Needy Medicaid program). Social Security’s listing of publications explaining disability can be found at www.ssa.gov/englist.html. To see how an ALJ from the State Hearings Division would look at your medical evidence if you went to a hearing, look at www.dss.ahw.net/shd/docs/prdocs/ParaRegs-Disability-Medical-Evidence.HTML.

193 Earned income deductions for purposes of determining countable income are $90 work allowance deduction and childcare of up to $200 a month for a child under 2 and $175 for a child 2 and older. Cal. Code Regs., tit. 22 §§ 50262(a)(3), 50262.5(a)(2), 50553.5

194 See DHS ACWDL Nos. 98-19 (5-21-98), 98-42 (10-2-98) implementing Welf. & Inst. Code § 14011.1 providing for simplified application forms for pregnant women and children under the FPL programs and not requiring a face-to-face interview.

195 See DHS ACWDL No. 93-78 (10/27/93), CCH MEDI-CAL GUIDE New Dev. ¶ 7506, and Section 5-M of the MEDI-CAL ELIGIBILITY PROCEDURES MANUAL.
information about programs to help pregnant women, call 1-800-BABY-999 or 1-800-222-9999 from a touch-tone phone.

10. I’ve been diagnosed with breast/cervical cancer. Is there a way to get treatment right away? Do I have to show I meet the SSI disability standard?

There is a way to qualify for Medi-Cal right away if your family income is not more than 200% of the FPL - or $1477 a month for an individual in 2002. See Section 1-i above. You qualify for full-scope Medi-Cal under the Breast and Cervical Cancer Treatment Program (BCCTP) based on diagnosis. You do not have to show that you meet the SSI disability standard.

11. I am covered by Medi-Cal and due to give birth in a month or two. How does my new baby get covered?

If you are covered by Medi-Cal when your child is born, you are covered by Medi-Cal for the first two months. The hospital where you give birth will provide you with a form that you will sign and they will send in to Medi-Cal, so there will be no gaps in your baby’s Medi-Cal coverage.196 If you are covered by Medi-Cal when your baby is born and your baby lives with you, your baby is covered by Medi-Cal without a separate application until she is one year old.197

12. How does Medi-Cal decide whether you are eligible or not?

In determining who is eligible for Medi-Cal the county department first identifies the category of programs - i.e., children and families versus aged, blind or disabled. Sometimes applicants can be evaluated under both categories such as a child or a parent with a disability. The county looks first at programs where people can qualify without a share of cost before looking at programs with a share of cost or a

196 DHS ACWDL No. 98-32 (8/11/98)

If considering the children and family category, the county first will look at the 1931 program. If the family or individual is ineligible for 1931 or transitional Medi-Cal, the county will then look at the federal poverty level programs for children and pregnant women. Finally, the county will look at the AFDC linked medically needy program.

If considering the aged, blind and disabled category, the county looks first at the new Aged & Disabled Federal Poverty Level program. If disabled and there is any earned income, the county then looks at the 250% Working Disabled program. The county also were look at he specialty programs tuberculosis, breast and cervical cancer, dialysis, hyper-alimentation. Then ABD Medically Needy share-of-cost Medi-Cal program is looked at last because that program usually involved a share-of-cost.

13. My SSI application has finally been approved. How do I get Medi-Cal to cover my back medical expenses?

Take the letter from Social Security into your county welfare department and ask to speak with a Medi-Cal eligibility worker. The County can give you two things: One, a temporary card to use until your plastic beneficiary identification card (bic) comes in the mail. Two, numbered Letter of Authorization forms to take to those who gave you health care so that they can bill Medi-Cal. The county may give you additional forms to take back to the Social Security office to verify the date of application.

You may be able to apply for retroactive Medi-Cal for up to three months before

See DHS’ Medi-Cal Eligibility Procedures Manual § 14E about issuing the MC-180 forms to take to providers and Cal.Code Regs., tit. 22 § 50746. The current version of the MC-180 form can be found in the attachment to DHS ACWDL No. 00-58 which is a draft of Section 12C to the DHS Medi-Cal Eligibility Procedures Manual, the section covering retroactive changes in the amount of a share of cost.
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199 the month of application if the retroactive months are within the past 12 months.

14. What if I paid for my medical expenses and pharmacy bills while waiting for Medi-Cal to process my case. How do I get my money back?

See the answer to the prior question. It is Medi-Cal’s position that you take the MC-180 Letter of Authorization to the provider who will give you back the money you paid when payment is received from Medi-Cal. Medi-Cal’s position is based on provisions in state and federal law which says a provider must accept Medi-Cal as payment in full. State law also requires the provider to submit a claim to the Medi-Cal program for services which the Medi-Cal recipient paid for before the application was approved. Billing Medi-Cal and reimbursing the Medi-Cal beneficiary appears to be a condition of participation in the Medi-Cal program. Medi-Cal does nothing to enforce a provider’s obligation to bill and reimburse. Because the Medi-Cal payment is usually less than what the Medi-Cal recipient paid, providers at times are unwilling to bill Medi-Cal particularly where the provider does not participate in Medi-Cal and getting paid by Medi-Cal also means applying to be a provider. The state Medi-Cal program takes the position that Medi-Cal recipients cannot be reimbursed for out-of-pocket expenses even when the provider refuses to bill Medi-Cal. We contend Medi-Cal’s position conflicts with the federal Medicaid Act when the Medi-Cal recipient is not able to be reimbursed by the provider.


200 Welf. & Inst. Code § 14019.3 and specifically subsections (a) and (e). See, also, 42 C.F.R. § 447.15.

201 Welf. & Inst. Code § 14019.3(b).

202 Welf. & Inst. Code § 14019.3(b).

203 The Medi-Cal position was upheld in Schwarzmer v. Belshé, San Francisco Superior Court No. 987697 (2000). That decision is on appeal. For more information on that case, contact Mike Keys, Bay Area Legal Aid, (510) 663-4755.

204 Case law and other authorities support direct reimbursement for out-of-pocket expenses incurred during the application process, where there has been an erroneous denial or termination, and
If a provider is unwilling to bill Medi-Cal and therefore you cannot get reimbursed from the provider, we recommend that you request a fair hearing. Your fair hearing should ask for relief in the alternative: that the Medi-Cal program either reimburse you for your out-of-pocket expenses or the Medi-Cal program force the provider to bill and reimburse you. See Chapter 17. To minimize problems in getting reimbursed for medical care expenditures by you or someone on your behalf, make certain you use providers who participate in Medi-Cal and that you tell the provider (such as though a note to go into your file) that your Medi-Cal application is pending.

Chapter 4:

Income, Resources

and Medi-Cal Eligibility

This chapter covers what income and resources count and what income and resources don’t count; when income is earned income or unearned income and what difference that may make; how you “spend down” excess resources to qualify for Medi-Cal. Every Medi-Cal program (except the Former Foster Care Child - FFCC - program covering adolescents leaving foster care until age 21)\(^{205}\) considers income for purposes of determining eligibility. Except for the federal poverty level programs for women and children and the FFCC program, every Medi-Cal program considers resources.

1. **What is income?**

   Income consists of things of value you receive in a month.\(^ {206} \)

\(^{205}\) See Chapter 2, section 7.

\(^{206}\) Cal. Code Regs. tit. 22 § 50501. Sometimes what you receive in a month is not income: insurance reimbursement, proceeds from the sale of an exempt asset. Proceeds from the sale of an exempt asset also do not count as either income or resources in the month of receipt. However, whatever is left over at the beginning of the next month counts against your resource allowance. For instance, if you sell your car for $3,000 in January, that money does not count as a resource or income in January. What you have left over in February would count against your resource allocation.
“in-kind” benefits but only if the “in-kind” income is in the form of food, clothing, housing (including utilities but not telephone).  

What you have left over as of the first of the next month becomes a “resource.”

2. Does Medi-Cal count my take home pay or gross income before deductions?

Medi-Cal counts your gross earned income before any deductions, not your take-home pay. However, if part of your salary is put in a cafeteria plan to pay medical expenses and/or childcare, the part put into the cafeteria plan is exempt income. If you are self-employed, your gross earned income would be in effect your adjusted gross income -- that is, what you would pay taxes on. Similarly, unearned income is counted after IRS allowable deductions in securing that income.

3. Exempt income: Is there any income that does not count?

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207 Cal. Code Regs. tit. 22 § 50509 (defining in-kind income), § 50511 (explaining how in-kind income is valued). In our experience Medi-Cal eligibility workers, unlike workers in Social Security offices, do not seek out in-kind income issues.

208 Earned income only includes income on which you pay Social Security/FICA taxes. 20 C.F.R. §§ 416.1110(a), 404.429(c). Earned income consists of wages, self-employment, and book royalties. If you participate in a cafeteria plan at work to pay for child care or unreimbursed medical expenses, your gross income is calculated after the cafeteria plan deductions. Income sheltered in a cafeteria plan is exempt from both social security (FICA) taxes and income taxes. POMS § SI 00820.100-C.1. Contributions to a tax deferred retirement account, however, are not exempt from Social Security/FICA and therefore are counted as income. Unearned income on the other hand, includes everything else, interest from bank accounts, gifts, social security or Veteran benefits.

209 See, e.g., Cal. Code Regs. tit. 22 §§ 5050(a)(1), (8), 50505. These rules follow SSI rules which define countable earned income from self-employment as gross receipts less IRS allowable deductions to determine adjustable gross income. 20 CFR § 416.1110(b).

Yes. Exempt income includes social services and public assistance, foster care, public housing assistance, volunteer and job training programs and assistance, public educational loans, work study and grants, renters assistance, property tax relief and earned income tax, among others.

4. Is there any difference between earned and unearned income in how it is counted?

Yes, there is a lot of difference. You are always better off with earned income versus unearned income. Earned income gets more deductions than unearned income. This means that your total income will more likely fall below the maximum income levels for eligibility under the 1931 and FPL programs or there will be a lower share of cost under the Medically Needy programs.

5. Are the earned income deductions the same in all the Medi-Cal Programs?

No. You are usually better off under the ABD (Aged-Blind-Disabled) Medically Needy program, the A&D FPL (Aged & Disabled Federal Poverty Level) program, or

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211 Cal. Code Regs. tit. 22 §§ 50525 (public assistance), 50527 (social services), 50528 (other assistance based on need including payments from regional centers for persons with developmental disabilities, probation departments, etc.), 50529 (Section 8 and other housing assistance).

212 Cal. Code Regs. tit. 22 § 50531.

213 Cal. Code Regs. tit. 22 § 50529 (Section 8, other federal HUD housing assistance), § 50535 (relocation assistance)

214 Cal. Code Regs. tit. 22 § 50530 (Department of Rehabilitation training grants), §§ 50538, 50540, 50541 (VISTA and other volunteer programs), § 50539 (JTPA).


216 Cal. Code Regs. tit. 22 §§ 50523.5 (renters and senior home taxpayer relief), 505365.5 (disaster and emergency assistance).
the Section 1931(b) “recipient” program than you are under the other programs. The ABD Medically Needy program, the Aged & Disabled Federal Poverty Level (A&D FPL) program, and the 250% Working Disabled program follow SSI rules to deduct from earned income a $65 earned income deduction and 50% of the balance.217 The AFDC-linked Medically Needy and Medically Indigent programs follow AFDC rules. So do the Federal Poverty Level programs for pregnant women and children.218 These programs only allow $90 a month earned income deduction but they do allow for deduction of child care costs from earned income.

The Section 1931(b) program allows a $240 earned income monthly deduction if you are considered a “recipient.”219 A recipient is a person or family who has been determined eligible for 1931(b) program or the CalWORKs program in at least one of the 4 months before their application for Medi-Cal.220 Under 1931(b), disability-based

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217 42 U.S.C. §§ 1396a(a)(17), 42 C.F.R. § 435.831(b)(2). Thus, if the worker is a person with a disability, the worker should also be able to follow SSI rules and deduct Impairment Related Work Expenses or Blind Work Expenses as can SSI recipients who work and have a disability or are blind. 20 C.F.R. §§ 416.976, 416.1112(a)(6), (8).


219 Section 1931(b) “recipients” are treated more favorably than applicants. To be considered a Section 1931(b) recipient, you or your family in any given month must have either:

1) received 1931(b) during the previous month, whether through interim coverage (“special factors”) or otherwise, OR

2) qualified for 1931(b) coverage during one of the four months preceding the application of Medi-Cal even if you did not actually receive 1931(b). An applicant is anyone who is not treated as a recipient. See DHS ACWDL No. 98-43 (9/30/98). Given a choice between Medi-Cal through 1931(b) or AFDC-MN, generally you should chose 1931(b) as a recipient if you qualify because of the following 1931(b) advantages: you can work 100 hours or more without losing eligibility; parents in a two-parent household where the earnings do not exceed 100% of the FPL qualify for Medi-Cal where they may not under AFDC-MN; earned income receives greater and more deductions; one person can own property worth up to $3000 (as opposed to $2000); and if you lose coverage under 1931(b), coverage should automatically continue under Transitional Medi-Cal (TMC) for up to 24 months. See Chapter 2 for more information on TMC and DHS ACWDL Nos. 99-41 (8-24-99), 99-54 (10-14-99), 99-56 (11-11-99), 00-04 (1-11-00).

220 See DHS ACWDL Nos. 98-43 (9/30/98), 00-34 (5/8/00).
income receives special treatment by allowing the same $240 deduction that earned income allows -- but the $240 deduction is only allowed once. After that, as a continuing Section 1931(b) recipient, only half of your earned income is counted. However, if you are considered a Section 1931(b) “applicant,” the AFDC rules generally apply so you will only receive a $90 earned income deduction. For both the 1931(b) recipients and applicants, child care costs are also deducted from earned income.

6. Are the unearned income deductions the same in all the Medi-Cal programs?

No. The AFDC-linked Medically Needy and Medically Indigent and 1931(b) programs as well as the Federal Poverty Level programs for pregnant women and children follow AFDC rules. You can deduct court ordered child support or alimony payments from either earned or unearned income. You also deduct $50 monthly from any child support or alimony income received.

Under the ABD Medically Needy program and the A&D and Working Disabled 250% Federal Poverty Level programs, only two thirds of the child support received by the child with the disability is counted. There is no offset for receipt of alimony payments. You cannot deduct court-ordered child or spousal support.

The medically needy programs take into consideration health benefit plan premiums when determining share of cost.

7. Is unemployment insurance earned or unearned Income? What about State Disability Insurance (SDI)? What About Temporary Workers Compensation payments?

Temporary Workers Compensation (TWC) Payments or temporary disability indemnity payments are treated as earned income under the AFDC-linked Medically Needy program and the A&D and Working Disabled 250% Federal Poverty Level programs, only two thirds of the child support received by the child with the disability is counted. There is no offset for receipt of alimony payments. You cannot deduct court-ordered child or spousal support.

The medically needy programs take into consideration health benefit plan premiums when determining share of cost.


222 Cervantez v. Sullivan, 963 F.2d 229 (9th Cir. 1990) (upheld SSA’s position that income garnished for child support is counted when determining eligibility for or amount of SSI benefits).
Needy and Medically Indigent and 1931(b) programs. Under the ABD Medically Needy program, the A&D FPL program and the Medicare Related programs, TWC is treated as unearned income.

Under the Working Disabled 250% FPL program, TWC is exempt income and not counted at all.224

State Disability Insurance (SDI) is also treated as earned income under the AFDC-linked Medically Needy and Medically Indigent and 1931(b) programs.225 But under the ABD Medically Needy program, A&D FPL program, and Medicare Related programs, SDI is unearned income.

SDI is exempt income under the Working Disabled 250% FPL program.226

Unemployment Insurance is treated as unearned income in all the programs.

8. Resources: What counts as a resource? How much can I have and still be eligible for Medi-Cal?

Resources include cash or any other property you could convert to cash for your maintenance and support. It does not include money or other things of value you got this month -- only what you have left over from last month and earlier. Only income that is available is considered.227 On the Department of Health Services’ website you

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223 Sawyer v. Shalala & Belshé, DHS ACWDL No. 96-32 (6/10/96); DHS ACWDL No. 98-43 (9/30/98).

224 DHS ACWDL No. 00-16 (3-16-2000), Enclosure 3 (“Draft Procedures”), § VI-B-2-(ii).

225 Tinoco v. Belshé, DHS ACWDL No. 96-31 (6/10/96); DHS ACWDL No. 98-43 (9/30/98).

212 DHS ACWDL No. 00-16 (3-16-2000), Enclosure 3 (“Draft Procedures”), § VI-B-2-(ii).

can find an excellent summary of the Medi-Cal property rules.\textsuperscript{228}

Some resources don't count at all because they are exempt. See the questions and answers below.

Resources don't matter if you are applying for the zero share of cost Federal Poverty Level programs for children below age 19 and pregnant women. Resources don't matter if you are receiving Medi-Cal as a Former Foster Care Child (FFCC). See Chapter 2. Resources do matter for other programs. If you are a single person, the resource allowance is $2,000 ($3000 under the 1931(b) program). If your family consists of two people, the resource allowance is $3,000. After that, for the medically needy programs and the Section 1931(b) program, you add $150 for each additional person up to $4,200 for ten people.

9. **Exempt resources: What resources don't count?**

The DHS form “Medi-Cal General Property Limitations” also identifies exempt resources.\textsuperscript{229}

The following resources are exempt (i.e. they do not count):
- The home you live in;
- Proceeds from the sale of a home used to purchase another home (for six months);\textsuperscript{230}
- Other income-producing real property or a trust deed from sale of your property not exceeding $6,000 in assessed value (not the same as face

\textsuperscript{228} MC007 (10-00), “Medi-Cal General Property Limitations,” available in PDF at www.dhs.ca.gov/publications/forms/Medi-Cal/Info.htm

\textsuperscript{229} See footnote above.

\textsuperscript{230} Cal. Code of Regs., tit. 22 § 50426. The funds can be used to cover the cost of moving, furnishings and repairs and alterations in addition to the actual purchase. When the sale includes taking back a note, the Medi-Cal program should follow the rules in 20 C.F.R. § 416.1212(d)(2) which say that the note and proceeds received from the note are also exempt to the extent they are reinvested into the new residence.
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To qualify for the exemption under the Section 1931(b) program the vehicle must be used for getting to work or while at work (including while temporarily unemployed), transporting a person with a disability in the household, transporting the household’s primary source of water or fuel. Otherwise exempt if worth less than $4650 or if more than that, the equity value is $1500 or less. DHS ACL 01-62 (11/7/01).

In other programs, a second vehicle would be exempt as a resource necessary for self-support if you use the vehicle while at work. This is consistent with the SSI exemptions enacted by the Section 8014 of the 1989 Omnibus Budget Reconciliation Act (Pub.L. 101-239) codified at 42 U.S.C. § 1382b(a)(3). DHS ACWDL No. 91-28 (3/22/91), CCH M E D I - C A L G U I D E New Dev. ¶ 7126, proposed regulation 22 CCR § 50485(b). The All-County Letter directs “county welfare departments to implement the provisions contained in the attached set of draft regulations.” In a subsequent All-County Letter, DHS ACWDL No. 95-22 (4/3/95), CCH M E D I - C A L G U I D E New Dev. ¶ 7648, DHS appears to have interpreted the OBRA 1989 provision to exempt only resources necessary for self-employment thereby ignoring the express language of 42 U.S.C. § 1382b(a)(3) exempting resources needed by an individual as an employee.

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231 See above endnote and DHS ACWDL No. 91-28 (3/22/91), CCH M E D I - C A L G U I D E New Dev. ¶ 7261. The exemption includes real property [proposed Cal. Code Regs. tit. 22 § 50485(d)], inventory [proposed Cal. Code Regs. tit. 22 § 50485(a)(1)], and the cash in a business operating account [proposed Cal. Code Regs. tit. 22 § 50485(c)].

• Burial funds\textsuperscript{234}, trusts, or contracts with a value of $1,500 or less excluding interest accrued while on Medi-Cal; burial plot or space or that part of a contract you are still making payments on that covers burial space; all of a paid-up contract for burial expenses that includes a burial spot;\textsuperscript{235}

• Retirement accounts (IRA, Keogh, tax-sheltered annuity) that belong to your spouse or parent (but the cash-in value of any retirement accounts that belong to you when you apply for or receive Medi-Cal where you are not currently receiving payments of principal and interest may count against your resource limitation - except under the Working Disabled 250\% FPL program\textsuperscript{236});

• Retirement accounts where you are currently receiving payments of principal and interest and under certain conditions annuities.\textsuperscript{237} Otherwise the retirement account is not exempt except under the Working Disabled 250\% of FPL program.

• Recreational items except boats,\textsuperscript{238} trailers and campers (unless it is your principal residence);

• Adaptive equipment needed because of a disability;\textsuperscript{239}

• A child's savings from his or her own earnings;

• Resources equal to payments received under a long-term care policy

\textsuperscript{234} The burial fund may be a separate bank account you have designated for that purpose. You may not commingle it with other funds. For instance, you cannot say that $1,500 of a $3,000 bank account is a burial fund, but you can move $1,500 of that account into a separate account for burial expenses.

\textsuperscript{235} See ACWDL No. 92-58 (10/2/92), CCH Medi-Cal Guide New Dev. ¶ 7415.

\textsuperscript{236} Welf. & Inst. Code § 14007.9(b)(2).


\textsuperscript{238} But the boat would be exempt if used for self-support.

\textsuperscript{239} DHS ACWDL No. 97-39 (10/13/97).
Resources are not counted in any of the Federal Poverty Level Programs for pregnant women or children.

10. What happens when I am over the resource limit when I apply? How can I get eligible?

(a) Spending down your resources in the month of application

If your resources are greater than the Medi-Cal limits when you first submit your Medi-Cal application, you have until the end of the month to reduce them to resource limits. If you do, and you are otherwise eligible, you will get Medi-Cal for the whole month. When you submit your application, an eligibility worker must tell you about your right to reduce your resources to qualify in the month of application. If no one explains this rule to you in person (either because your interview is delayed to the next month or because the worker forgets) then the county may not apply the resource limits to you. 241

When you spend down your resources in the month you apply, you may reduce your property without any inquiry about whether you made a transfer without "adequate consideration" -- unless you are in a long-term care facility when you apply or go into such a facility in the 30

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240 A Medi-Cal applicant or recipient may have additional exemptions in an amount equal to any payments made for long-term care services under a certified long-term care insurance policy. The exemptions also apply to Medi-Cal liens for institutional long-term care and for Medi-Cal services provided to those aged 65 or older. See Welf. & Inst. Code §§ 22000 et seq. (California Partnership for Long-Term Care); Cal. Code Regs. tit. 22 §§ 50453.7 and 58000 et seq., and www.dhs.ca.gov/cpltc/

241 DHS ACWDL No. 85-58 (8/25/85); DHS ACWDL No. 91-78 (9/17/91); DHS Fair Hearing Decision No. 90305183.
months following your qualifying for Medi-Cal.\textsuperscript{242}

(b) Spending down your resources retroactively on medical expenses under \textit{Principe v. Belshé}\textsuperscript{243}

If you do not manage to spend down your excess resources in the month of application, there is a way you can qualify for the month of application by paying off medical bills. Under \textit{Principe v. Belshé}, you can spend down excess property retroactively on qualified medical expenses to establish eligibility for Medi-Cal, beginning with the month of application. \textit{Principe} will allow this only when payment of the medical expenses occurs \textit{in a later month}, and proof of the payment is provided to the county. Qualified medical expenses include bills that are incurred for either 1) you or spouse, 2) any member of the individuals’ Medi-Cal Family Budget Unit (MFBU), or 3) your children who are not members of the MFBU but who are living with you. \textit{Principe}, however, cannot be used in order to establish eligibility for Medi-Cal for any of the three months before the month of application.\textsuperscript{244}

The same payment for medical expenses cannot be used under \textit{Principe v. Belshé} and to meet the share of cost under \textit{Hunt v. Kizer}.\textsuperscript{245} Essentially, payment on qualified medical expenses can be used either to spenddown excess property retroactively or be used as your share of cost. See Chapter 5 for information on share of cost and \textit{Hunt v. Kizer}.

11. Disabled spouse: Can my disabled spouse receive Medi-Cal if our family income is too high to qualify for SSI?

\textsuperscript{242} 42 U.S.C. §§ 1396p(c), (e); HCFA, State Medicaid Manual § 3250

\textsuperscript{243} DHS ACWDL No. 97-41 (10/24/97).

\textsuperscript{244} DHS ACWDL No. 97-41 (10-24-97) at page 7.

\textsuperscript{245} No. Civ. 89-836 (E.D. Cal. 1989), CCH \textsc{Medi-Cal Guide} New Dev. ¶ 7139, implemented by ACWDL No. 90-11 (1/19/90).
Yes. Your disabled spouse may qualify under the A&D FPL program or under the ABD MN Medi-Cal program or - if she has earned income - under the Working Disabled 250% FPL program.

If your disabled spouse is in a Medi-Cal-funded medical facility, but would not be eligible for Medi-Cal at home because of family income or resources, your spouse may qualify for Medi-Cal under special rules that apply when one spouse is in a nursing facility. See Chapter 11. If your disabled spouse would medically qualify for admission to a nursing facility or would qualify for Medi-Cal in a nursing facility, she may be eligible for Medi-Cal under the Model Nursing Facility Waiver program. See Chapter 16.

If your disabled spouse receives Title II Social Security benefits and Medicare, but is ineligible for Medi-Cal programs that may provide some help: the Qualified Medicare Beneficiary or QMB program and the Specified Low Income Medicare Beneficiary or SLMB program. See Chapter 2. Under both programs individuals may have resources t to exceed $4,000 for an individual and $6,000 for a couple (versus $2,000 and $3,000 respectively under Medi-Cal). Under QMB which covers persons with income of no more than 100% of the Federal Poverty Level, Medi-Cal will pay the Part A premium (for those few who have to pay), the Part B premium and the copayment for Medicare covered services. Under SLMB which covers persons up to 120% of the FPL, Medi-Cal will pay for the Part B premium.

12. My daughter receives SSI and Medi-Cal. What about Medi-Cal coverage for my other two children? What about her father and me?

Medi-Cal cannot count again income that Social Security has already counted to determine the amount of your daughter's SSI check.²⁴⁶ That means your children

²⁴⁶ Cal. Code Regs. tit. 22 § 50555.1. However, despite this regulation, Medi-Cal eligibility workers often count the income that Social Security also counts. Telling the Medi-Cal eligibility workers about this regulation should prevent them from counting the income again.
would qualify for Medi-Cal with no share of cost. However, there may be a share of cost if you are your daughter's IHSS provider. Social Security does not count IHSS wages received by a parent or spouse when determining the financial eligibility of the child or other spouse receiving the IHSS services.

You and your daughter's father would not be eligible for Medi-Cal unless one of you is unable to work for health reasons or is the primary wage earner and is underemployed or unemployed - or is earning less than the federal poverty level program under the Section 1931(b) program.

13. Pension plan: I have a pension plan through work. How will that affect my daughter's eligibility for Medi-Cal? How will that affect my eligibility for Medi-Cal?

Your pension plan -- or Individual Retirement Account or KEOGH -- does not count in determining your daughter's eligibility for Medi-Cal (though if she qualifies for one of the Federal Poverty Level programs for infants and children, resources would not matter).

If you are applying for Medi-Cal, the first question is whether the pension fund is available to you. The second question is whether you are receiving payments of principal and interest. It is considered available to you if you could take all the money out now, even if getting the money means a penalty. If it is not available, it is not a resource. If it is available but you are receiving payments of principal and interest,

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247 See the worksheets for calculating medically needy eligibility and share of cost at www.healthconsumer.org.

248 See page 4 of “Medi-Cal General Property Limitations,” MC007 (10-00), available in PDF format at http://www.dhs.ca.gov/publications/forms/pdf/mc007inf.pdf. Under “IRAs, KEOGHs, and other work-related pension plans,” MC007 follows the SSI rule at 20 CFR § 416.1202 to say this:

These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal and payments of principal and interest are being received, the balance is considered unavailable and is not counted.

the retirement plan does not count as a resource. However, if you are a person with a disability with earned income, your own retirement account would be an exempt resource under the Working Disabled 250% FPL program.

14. **Business:** I have an auto repair shop and own the building it is in. Will the business keep me from qualifying for Medi-Cal?

   No! The business including the building, land, equipment, and the business' operating bank account are all exempt under Medi-Cal as they are exempt under the SSI program.

15. **Trust account:** What happens if I have a trust account? Does that count as a resource?

   Depends. Medi-Cal's rules about trusts are different from the rules SSI and AFDC programs use. Under SSI and the former AFDC program, if you are the beneficiary of a trust, but the trustee does not have to make payments to you or on your behalf, then the trust generally is not "available" to you and does not count as an asset. Medi-Cal works in reverse. Most of the time, if a trust is revocable, or if the trust terms do not prohibit the trustee from making payment to you or on your behalf,

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250 Med-Cal Information Notice MC-007 (10-00) on general property limitation.

251 Welf. & Inst. Code § 14007.9(b)(2).

252 *See* DHS ACWDL 91-28 (3/22/91), CCH Medi-Cal Guide New Dev. ¶ 7261, which included draft regulations (22 CCR §§ 50473 and 50485). The All-County Letter directed counties to exempt resources related to self-support when making eligibility determinations. The directive was pursuant to changes made by section 8014 of OBRA 1989, Pub.L. 101-239, codified at 42 U.S.C. § 1382b(a)(3). The subsequent DHS ACWDL No. 95-22 (4/3/95), however, says that “self-support” means only “self-employment.” That conflicts with Section 1382b(a)(3) which says the self-support exemption extends to the “property . . . used . . . by such individual as an employee.”

the trust is considered "available" for Medi-Cal purposes. There are some important exceptions.

First, if you actually receive SSI, you should get Medi-Cal no matter what Medi-Cal might think about the trust.

Second, if you are disabled, under age 65, and your trust meets certain conditions—it was established by a parent, grandparent, legal guardian, or court, and the state has a claim against the assets remaining in the trust when you die—then the special Medi-Cal rules do not apply.

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254 DHS ACWDL No. 93-07 (2/10/93) (proposed regulations, effective 5/1/93); 42 U.S.C. § 1396p(d) (3).

Third, the special Medi-Cal rules do not apply to your trust if you are disabled, no matter what your age, if (a) the trust is run by a nonprofit association, (b) the association pools the accounts of various beneficiaries, (c) the accounts were established by a parent, grandparent, legal guardian, or court, and (d) the state has a claim against assets that are not retained by the trust when you die.\textsuperscript{256}

Fourth, if it would be an “undue hardship” for Medi-Cal to disqualify you because of problems with your trust, you should receive Medi-Cal.\textsuperscript{257}

Fifth, even if your trust does disqualify you from Medi-Cal, other people in the family—who are not your spouse or children—should get Medi-Cal if they are otherwise eligible.

\textbf{Note:} If your trust is countable for Medi-Cal, and the trustee makes it irrevocable so it will not count any more, that change might lead to a penalty disqualifying you from Medi-Cal-financed nursing home care. 42 U.S.C. §§ 1396p(d)(3)(B)(ii) and 1396p(c); 22 CCR § 50409.

This is a very complicated area of the law. Congress passed a law in 1993 that made it even more complicated. People with problems in this area should be referred to attorneys specializing in elder law or in estates and trusts for persons on federal or state benefits.\textsuperscript{258} Existing trusts including special needs trust should be regularly reviewed because of both changes in the law and changes in how the law is interpreted.

\textsuperscript{256} 42 U.S.C. § 1396p(d)(4)(C); DHS ACWDL No. 94-01(1/5/94).

\textsuperscript{257} 42 U.S.C. § 1396p(d)(5).

\textsuperscript{258} Referrals can be obtained from the California Advocates for Nursing Home Reform (CANHR), (800) 474-1116 for consumers, (415) 474-5171 general, www.canhr.org.
Chapter 5:
How Share of Cost is Determined, How Share of Cost Works

Share of Cost only applies to the Medically Needy and Medically Indigent programs. Always check to see whether someone would qualify for a program where there is no share of cost: Programs under Section 1931(b) or one of the federal poverty level programs for children/families or for seniors and persons with disabilities.

1. What is a share of cost?

A share of cost is the monthly amount Medi-Cal requires you to pay each month, or requires you to agree to pay in the future, for medical goods and services before Medi-Cal begins to pay. You may meet your share of cost by paying for, or by agreeing to pay for, medical goods and services. You may meet your share of cost by paying an old bill, or by presenting an old bill you are obligated to pay. You can meet your share of cost by paying for or agreeing to pay for services and equipment Medi-Cal would not cover if Medi-Cal were paying.\footnote{259} For instance, you may meet your share of cost by paying for medically necessary occupational therapy which Medi-Cal would not cover under its two-visits-a-month service limitation.

You may use a bill only once—either as an incurred obligation or as an obligation you paid. However, if the bill is more than your share of cost, you may carry over the excess into other months. For instance, you may pay part of what you

owe in one month, and more of what you owe in the next month.\footnote{260}

2. \textbf{What Medi-Cal programs have a share of cost?}

The Medically Needy and Medically Indigent programs are the only ones where there is a share of cost.\footnote{261} You may have a share of cost in the medically needy programs if your countable income (that is your income less allowable deductions) is more than the medically needy income level applicable to your family size. You also may have a share of cost in the medically indigent programs -- see Chapter 2. At Appendix A2 and the DHS website, www.dhs.ca.gov, is a chart with all the Medi-Cal codes for each of the Medi-Cal programs. That chart also indicates which Medi-Cal programs have a share of cost. You find out which code is assigned to you by having a provider put your plastic Beneficiary Identification Card (BIC) through the point of service (POS) machine. The Medi-Cal two-digit code is at the top of the screen in the middle and is just to the right of the two-digit county code.

In many of the Medi-Cal programs, however, you are either eligible or you are not. For instance, to qualify for the Federal Poverty Level Programs, your income must be at or below the income cutoff points, depending on family size. You cannot “spend down” on medical expenses to qualify.

3. \textbf{Determining the share of cost amount?}

The first step in determining share of cost is determining the amount of countable income by deducting allowable deductions from gross income.\footnote{262} The medically needy programs are required to follow the aid program to which they are

\footnote{260} See DHS ACWDL No. 90-11 (1/19/90), CCH \textit{Medi-Cal Guide} New Dev. ¶ 7139. See, also, DHS CWDL Nos. 93-63A, 93-74.

\footnote{261} There are also fees based on income and resources in the dialysis and hyperalimentation Medi-Cal programs; there are premiums based on income in the Working Disabled 250\% FPL program -- see Chapter 2.

\footnote{262} Not all money you get is counted as income. In addition, earned income put into a cafeteria plan is not counted as income at all. See Chapter 4, Section 2.
Chapter 5: How Share of Cost is Determined, How Share of Cost Works

The ABD (aged-blind-disabled) Medically Needy program follows SSI rules with respect to allowable deductions when determining countable income. The AFDC-linked Medically Needy and medically indigent programs follow the former AFDC rules, in terms of allowable deductions and how income is counted. In addition, both Medically Needy programs allow deductions for any out-of-pocket expenses for health benefit plan premiums. That includes premiums or contributions deducted from your paycheck by the employer.

Share of Cost calculations for Medically Indigent children follow AFDC Medically Needy rules for determining countable income.

After the countable income is determined, you then deduct the Medically Needy Maintenance Need Income Levels (MNILs) or allowance from the countable income. The amount by which your countable income exceeds the MNIL based on the number of people in the family is the share of cost. Below is an example of someone who gets Social Security Disability benefits. For more examples including those which involve earned income, child care or dependent care costs, child support payments or income, see the worksheets for calculating medically needy eligibility and share of cost at www.healthconsumer.org.

Example: Joe lives alone and receives $1000 in Social Security Disability benefits. He needs Medi-Cal. This is how his Medi-Cal share of cost would be determined:

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263 42 U.S.C. § 1396a(a)(17)(B); 402 CFR § 435.601(b). See, e.g., Tinoco v. Belshé, Case No. C-94-0947 (N.D.Cal. Nov. 8, 1995), CCH MEDI-CAL GUIDE New Dev. ¶ 7760 (because California’s AFDC program treated State Disability Insurance or SDI as earned income, the AFDC-linked medically needy program was required to do so as well.)

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

265 42 C.F.R. § 435.831(d)(e)(1).

266 Welf. & Inst. Code § 14005.12. The MNILs have been unchanged since 1989: $600 for 1, $750 for two, $934 for couple or 3, $1100 for 4, $1259 for 5.
### Chapter 5: How Share of Cost is Determined, How Share of Cost Works

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Amount</th>
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<tr>
<td>1</td>
<td>Unearned income</td>
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<tr>
<td>2</td>
<td>Less any-income deduction</td>
<td>($20.00)</td>
</tr>
<tr>
<td>3</td>
<td>Countable unearned income</td>
<td>$980.00</td>
</tr>
<tr>
<td>4</td>
<td>Earned income</td>
<td>$0.00</td>
</tr>
<tr>
<td>5</td>
<td>Unused balance of $20 any-income deduction</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Less $65 work incentive deduction</td>
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</tr>
<tr>
<td></td>
<td><strong>Subtotal</strong></td>
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</tr>
<tr>
<td>7</td>
<td>Less 50% for additional work incentive deduction</td>
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</tr>
<tr>
<td>8</td>
<td>Countable earned income</td>
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<tr>
<td>9</td>
<td>Total earned and unearned income</td>
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<tr>
<td>10</td>
<td>Health benefit plan payment deduction*</td>
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</tr>
<tr>
<td>11</td>
<td>Less allowance for family of One</td>
<td>($600.00)</td>
</tr>
<tr>
<td>12</td>
<td>Total monthly share of cost</td>
<td>$280.00</td>
</tr>
</tbody>
</table>

* Although technically the total Title II income should be counted before any Medicare deduction and with the cost of Medicare deducted as a health benefit plan deduction, practically Medi-Cal counts the Title II income after the Medicare deduction.

**Note:** If the income level at Step 9 were $946 or less using 2001 federal poverty level amounts and before any Medicare deductions, Joe would qualify for Medi-Cal with zero share of cost under the A&D FPL program. See Chapter 2.

4. I am eligible for medically needy Medi-Cal with a monthly share of cost. How does that work?
With limited exceptions, all Medi-Cal beneficiaries will have a plastic identification card—called a Beneficiary Identification Card (BIC). The monthly paper cards with stickers and proof of eligibility are gone. As a share-of-cost Medi-Cal beneficiary, you will be able to use the card as payment in full after you meet your monthly share-of-cost obligations.

Most Medi-Cal providers have Point of Service (POS) devices or computer systems to verify your status. The POS devices are similar to those used for credit cards in that they both send and receive information. Providers use the POS device or computers to send information back to Medi-Cal.

You may meet your share-of-cost obligation by paying or agreeing to pay the Medi-Cal provider for services received this month. The provider will enter share-of-cost information through a procedure known as “transaction clearance.” Once share of cost has been met, the Medi-Cal host computer will tell that provider and other providers that you have met your share of cost. The host computer will give the provider an Eligibility Verification Confirmation (EVC) number. However, if you are meeting your share of cost by:

- An unpaid bill for services received this month from a non-Medi-Cal provider, or
- A paid bill for services received this month from a non-Medi-Cal provider,

[267] Newly eligible Medi-Cal beneficiaries with an immediate need for Medi-Cal services will receive a temporary paper 30-day card while waiting for their plastic card. Minors who qualify for minor consent service will not get a plastic BIC but will receive a paper identification card good for a year but requiring activation month by month. See DHS ACWDL No. 94-28 (3/14/94), CCH MEDI-CAL GUIDE New Dev. ¶ 7544.

[268] For those few providers that do not have the swipe machines, verification and share of cost information will be handled by telephone. Medi-Cal Eligibility Procedures Manual §12H-4.

[269] Medi-Cal Medical Service Provider Manual at 100-28-1.

[270] Medi-Cal Medical Services Provider Manual at 100-28-1.
• An unpaid bill for services you received before this month, or
• A payment on a bill for services you received before this month

then you need to take the bills and evidence of payment, if any, to the county welfare department. See the following question and answer. The welfare department will check the bills and enter your share-of-cost information into the computers. When the payment or bill involves a non-Medi-Cal provider, some counties use the old MC-177 Share-of-Cost forms and procedures where the non-Medi-Cal provider signs off on the MC-177 form. 271

5. Meeting share of cost by using an unpaid old bill or by paying down an old bill.

You may meet your share of cost with an old bill you are obligated to pay or with a payment on an old bill. You cannot use a bill twice to meet a share of cost. However, if the bill you owe is more than your share of cost, you may pay an amount equal to your share of cost—or count that part of the obligation which equals your share of cost—and carry the balance over to subsequent months. When you use an old bill, you need to take the bill with you to the county welfare office. An old bill has to meet certain requirements. It must:

• Be an original bill (or a copy with the provider's initials or signature);
• Have a billing or rebilling date within the last 90 days;
• Include the provider's name and address;
• Include the provider's Medi-Cal ID, taxpayer ID, or license number;
• Include the name of the person who received the service; and
• Include the type and date of service.

The old bill you use can be from before you qualified for Medi-Cal. The old bill can come from a collection agency. You will have problems if you put the charge on a credit card because Medi-Cal assumes that any payments you made were for the medical bill.

271 See Medi-Cal Eligibility Procedure Manual at §12.
If everything else fails, there is a way to validate an old bill by a sworn statement.\textsuperscript{272}

6. Share of cost rules for nursing facility residents

Under the settlement in an old case -- Johnson v. Rank\textsuperscript{273} -- a nursing facility resident may meet his share of cost through expenditures for "medically necessary medical or remedial care, supplies or equipment not paid for by the Medi-Cal program which are consistent with the plan of care ordered by the physician"\textsuperscript{274} before any payment to the nursing facility. To establish that the medical or remedial care, services or equipment is consistent with the plan of care, the chart or plan of care itself must contain an order from the Medi-Cal recipient's physician. Something written on a sheet from a prescription pad is enough.

The procedure laid out in All-County Welfare Directors Letter No. 89-54 gives the nursing facility responsibility for seeing that bills and payments are counted against the share of cost. The resident or resident's family member gives the bills/ receipts to the nursing facility along with the physician's order if not already in the file. If these are given to the nursing facility before or at the time the nursing facility share of cost is paid, the amount of the share of cost will be reduced by the amount of the bills. If presented subsequently, the bills will reduce the share of cost the following month.\textsuperscript{275}

\textsuperscript{272} DHS ACWDL No. 90-80 (8/20/90), CCH MEDI-CAL GUIDE New Dev. ¶ 7232.

\textsuperscript{273} No. 84-5979-SC, Consent Decree 11/22/85, modified effective 10/1/89, E.D. Cal., CCH MEDICARE AND MEDICAID GUIDE New Dev. ¶ 35,026.

\textsuperscript{274} DHS ACWDL No. 89-54 (July 24, 1989), CCH MEDI-CAL GUIDE New Dev. ¶ 7108; 42 C.F.R. 435.832(c)(4)(ii).

\textsuperscript{275} DHS ACWDL No. 89-54 no longer is valid on how long you had to get credit on an old paid bill. The ACWDL says you only have two months after the month of the bill to submit for credit against the share of cost. That can no longer be valid under the revised preliminary injunction in Hunt v. Kizer which was implemented by DHS ACWDL No. 90-11 (1/19/90): “requiring that the Department of Health Services (DHS) no longer impose any time limitations on medical expenses which Medi-Cal applicants or beneficiaries may use to meet their share of cost.” CCH MEDI-CAL GUIDE
New Dev. ¶ 7139.
7. Using bills from other family members

(a) Ineligible family members and responsible relatives

The medical expenses of ineligible family members and responsible relatives count. For instance, if the child is covered as Medically Needy but the parents are not, the parents’ medical bills will count to reduce the child’s share of cost. Family budget units will receive Share of Cost Summary Letters which list the responsible relatives and ineligible persons whose bills count against a share of cost.

(b) Family members in a different program (FPL)

If you pay a medical bill for a child in your family who is on the Federal Poverty Level (FPL) Program, you can count that bill against the share of cost for other members in the Medically Needy Medi-Cal Family Budget Unit (MFBU).

8. Medically Needy Maintenance Need Income Level (MNIL) allowance

The Medically Needy Maintenance Need Income Level (MNIL) allowance -- the amount that is deducted from income to determine share of cost has not been changed since 1989. The MNIL allowances are $600 for an individual, $750 for an individual and child, $934 for a couple or three people, $1100 for four people.

While the MNIL allowances may not be so low in comparison with the former AFDC and the current CalWORKS assistance programs, they are low in comparison to SSI. The low allowances stemmed from CMS requiring a single MNIL standard for

276 42 C.F.R. § 435.831(b); Medi-Cal Medical Services Provider Manual at 100-25

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

278 Compare $600 with the individual grant level in 2001 of $712; compare $934 with the couple grant level in 2001 of $1265. The Center for Medicare and Medicaid Services (CMS) formerly The Health Care Financing Agency or (HCFA) is now the federal agency that oversees the implementation of state Medicaid/Medi-Cal programs. The agency amended 42 C.F.R. § 435.1007 to
both the AFDC linked and the ABD Medically Needy programs. Intervening changes in the law provide various ways by which the MNIL allowances could be increased, but the State has elected not to do so. The current allowances have remained unchanged since 1989.

9. Social Security dependent benefits: I work and have two children. One child receives Social Security dependent benefits because her father is deceased. How does that affect eligibility? How does it affect share of cost?

(a) Sneede and Gamma Rules

Under federal Medicaid law, income can be deemed from a parent to a child or from a spouse to another spouse.\(^{279}\) In determining the Medi-Cal eligibility of one child, you can count some of the income of a parent but you cannot count the income of a brother or sister even though you can do that under the old AFDC program and now under CalWORKs. How you actually do that was the subject of two California cases: Sneede v. Kizer\(^{280}\) and Gamma v. Belshe\(^{281}\) and lots of DHS All-County Letters.\(^{282}\)

\(^{279}\) 42 U.S.C. § 1396a(a)(17)(D).


\(^{281}\) No. C94-0852 THE (N.D. Cal. Nov. 16, 1995), CCH MEDI-CAL GUIDE New Dev. ¶ 7798.

\(^{282}\) The important ones are those which issued after the improvements resulting from Gamma: DHS ACWDL Nos. 96-29 (6/21/96) (good explanation & forms), 97-33 (8/5/97) (explanation & examples), 97-36 (9/19/97) (forms including applying Sneede for purposes of determining eligibility under the Federal Poverty Level Programs), 97-62 (12/10/97) (forms), CCH MEDI-CAL GUIDE New...
(b) Applying *Gamma* rules to your case

Start with your income and reduce it by allowable deductions. See worksheets for calculating medically needy eligibility and share of cost at [www.healthconsumer.org](http://www.healthconsumer.org). Then deduct $600 for your maintenance needs. You divide the balance between your two children.\(^{283}\)

Each child will have as his own countable income the income deemed to him from you. The child with the Social Security dependant’s benefits also will have that income as part of his countable income. Each child’s share of cost will be the difference between his countable income and $375.\(^{284}\)

In one unit would be the child who receives Social Security dependent benefits. Medi-Cal would count the Social Security benefits plus part of the mother’s income. In the other unit would be the mother and the other child. Medi-Cal would count part of the mother’s income. The procedures are explained in DHS ACWDL No. 90-76 (8/31/90), CCH Medi-Cal Guide New Dev. ¶ 7220.

10. My daughter receives SSI and Medi-Cal. What about Medi-Cal coverage for my other two children? What about two parents?

Medi-Cal cannot count again income that Social Security has already counted to

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\(^{283}\) DHS ACWDL No. 97-36 (9/19/97), CCH Medi-Cal Guide ¶ 7867.

\(^{284}\) *Id.* For the child with the Social Security dependent’s benefits, Healthy Families coverage may make more sense depending on the amount of the share of cost.
determine the amount of your daughter's SSI check. That means your children would qualify for Medi-Cal with no share of cost. There may be a share of cost if the children have their own income, or if a parent is your SSI daughter's IHSS provider, since Social Security would not count IHSS received by the parent to provide services to the SSI daughter. The two parents would not be eligible for Medi-Cal unless one parent is unable to work for health reasons or is the primary wage earner and is unemployed or under employed.

11. I am a parent with a 16-year-old married child living in my home. What does this mean in terms of our Medi-Cal Family Budget Unit 287

A child living in the same home as his or her parent is in the same Medi-Cal Family Budget Unit as the parent. 288

12. What if someone such as a relative or regional center pays my medical bill after I am billed? Does that bill still count against my share of cost?

Yes! You meet your share of cost by incurring an obligation to pay no matter who—brother or regional center—pays the bill afterwards. If your brother gives you the money instead of paying the bill directly, you have to count it as income, so you are no farther ahead. If your brother pays the bill directly, that payment does not count as income to you because paying for medical expense directly is not countable in-kind income. 289 If the regional center reimburses you for your Medi-Cal share of cost, rather

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285 Cal. Code Regs. tit. 22 § 50555.1(a): that portion of the income of an MN or MI person or a person responsible for the MFBU which is counted in determining the eligibility of a spouse, parent or child as a PA [public assistance] or other PA recipient shall be deducted. Public assistance includes SSI/SSP. Cal. Code Regs., Tit.22 §50068.

286 20 CFR § 416.1161(b)(16).

287 DHS ACWDL No. 98-19 (May 21, 1998)

288 DHS ACWDL No. 95-07 (1/25/95).

289 20 C.F.R. § 416.1103 (a)(1)
than paying the amount you owe directly to the provider, it does not count as income additionally because it is state-funded assistance based on need.  

13. If I don’t need Medi-Cal in one month, does that have any effect on my share of cost the next month?

No. The only thing that counts is whether your medical obligations equal your monthly share of cost for the current month.


(a) Make sure you are not a Pickle

If you used to receive SSI, but do not receive SSI now because of the amount of your Title II Social Security benefits, double check that you are not eligible for Medi-Cal with no share of cost as a "Pickle." See Chapter 2.

(b) Standard $315 deduction for personal care services received from the Board & Care facility available from April 2000 as a result of Pettit v. Bontá.

The Sacramento Superior Court in Pettit v. Bontá ruled that when Medi-Cal determines share of cost for persons in Board & Care residential facilities, the Medi-Cal program must recognize that part of what the resident pays to the facility should be counted as an incurred medical expense for personal care services. As people are being redetermined

Cal. Code Regs. tit. 22 § 50509 specifies what in-kind income counts: in-kind housing, utilities, food or clothing. In-kind income for medical expenses is not included in the list. Cf Cal. Code Regs. tit. 22 § 50528(b)(2).

Sacramento Superior Court No. 99CS01150, judgment entered 3-24-00.

DHS ACWDL 00-56 (11/15/00).
under the new rules, their share of cost if any will be determined retroactively back through April of 2000. If when the new rules are applied there is still a share of cost though, a lower share of cost, the Medi-Cal beneficiary may opt to have future SOC amounts reduced to offset the too high share of cost paid before. If it is determined that there should have been no share of cost or the Medi-Cal beneficiary opts to recover retroactively for the excess share of cost, the county will provide information about recouping out-of-pocket medical expenses from the provider.  

This is how the new system will work:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
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<tr>
<td>Social Security Disability Benefits</td>
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<td>Less $20 any income deduction</td>
<td>(20)</td>
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<tr>
<td>Less Personal Care deduction</td>
<td>(315)</td>
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<td></td>
<td>$ 865</td>
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<td>Less MNIL for one</td>
<td>(600)</td>
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<tr>
<td>Share of Cost</td>
<td>$ 265</td>
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</table>

(c) **Alternative option to adjust your MNIL by the amount you pay the board & care above $600**

State law\(^{294}\) authorizes you to add to the Maintenance Need Income Level

\(^{293}\) See Section 12C, DHS MEDI-CAL ELIGIBILITY PROCEDURES MANUAL which is attached to DHS ACWDL 00-56 (11/15/00). The attorneys representing Pettit anticipate affected persons will have problems getting retroactive benefits and are considering seeking relief so that they can be reimbursed directly rather than only if the provider agrees to bill Medi-Cal. Advocates with affected clients should contact Herb Semmel, NSCLC, at (213) 639-0930 or hsemmel@nsclc.org - or Marilyn Holle at (213) 427-8757 x3011 or marilyn@pai-ca.org

\(^{294}\) Welf. & Inst. Code § 14005.7(e): "In determining the income of a medically needy person residing in a licensed community care facility, income shall be determined, defined, counted and valued, in accordance with Title XIX of the federal Social Security Act, any amount paid to the facility for residential care and support that exceeds the amount needed for maintenance shall be deemed
(MNIL) the amount you pay to the board-and-care facility which is above the MNIL level. The only time using the alternative method would make sense is if the amount you pay to the facility is more than $915 - the amount of the MNIL plus the personal care allowance.

15. To meet my share of cost, am I limited to what the Medi-Cal program covers?

No! You may count against your share of cost services and things your doctor orders that are medically necessary but which Medi-Cal does not cover. For instance, you can use your share of cost to cover: (a) doctor-ordered over-the-counter drugs and supplies; (b) additional occupational therapy services beyond the two a month Medi-Cal covers; and (c) physical therapy services Medi-Cal does not cover. Federal law says that you deduct payments for medical services not covered by Medi-Cal before you deduct for services which would be covered by Medi-Cal.\(^\text{295}\)

16. May I count over-the-counter medications and supplies against my share of cost?

Yes, provided the over-the-counter medications and supplies are medically necessary. Ask your physician to write out on a prescription pad the supplies and medications you need. Purchase the supplies and medication from the pharmacist window, show the pharmacist the doctor’s note, and ask the pharmacist to put your card into the machine and enter information about what you spend against your share-of-cost obligation.

17. Expenses from non-Medi-Cal providers: How can I count expenses such as taxis and case management against my Medi-Cal share of cost when the

unavailable for the purposes of this chapter.”

\(^{295}\) 42 C.F.R. § 435.811(e)
provider is not a Medi-Cal provider?

Since case management is a recognized Medi-Cal service, there should not be a problem in meeting your share of cost with case management services. If the case manager is not a Medi-Cal provider, see prior question about how you get credit for the cost to you of case management. While we believe taxi transportation to the doctor is something you can charge against your share-of-cost obligation when you cannot use buses and there is no alternative transportation, the Medi-Cal program does not agree. Medi-Cal is, however, reviewing its policy. We believe the food and veterinary costs for a service animal also would be covered but a fair hearing may be required to establish coverage.

18. County denial: What if the county says I cannot count a particular cost against my share of cost?

First, ask for a notice of action that shows (a) the reason Medi-Cal will not allow the cost and (b) the authority (like a regulation or statute) for not allowing the cost. Second, ask for a fair hearing to challenge the denial. See Chapter 17. If the county will not give you a notice of action, you have two claims in your appeal: (a) refusal to provide a notice of action, and (b) disallowance of a medically necessary medical or remedial service or item.

19. Whose income gets counted in determining share of cost?

Most supported living or independent living agencies that provide services to developmentally disabled regional center clients would qualify as a provider of case management services if the services were delivered or supervised by a Licensed Clinical Social Worker (LCSW) or other health care professional. Most of these agencies are, in fact, Medi-Cal providers indirectly through providing services to regional center clients under the DDS HCB Waiver program. See Chapter 16.

Call Protection & Advocacy for technical assistance in requesting Medi-Cal to count such expenses against your share of cost and for technical assistance in your Medi-Cal fair hearing if that is necessary.
You count the income of the Medi-Cal applicant or recipient and the income of that person’s spouse, or if under 18 years, the income of that person’s parent if living in the same home. Income and resources belonging to persons other than spouse or natural/adoptive parent are not counted when determining Medi-Cal eligibility and SOC for anyone applying to receive Medi-Cal benefits.\(^{298}\)

20. **I used to get my Medi-Cal by paying a share of cost for my IHSS. Now my IHSS has been transferred to Medi-Cal. What does this mean for me?**

Many people who paid a share of cost for In-Home Supportive Services were transferred April 1, 1999, to Medi-Cal because Medi-Cal personal care services became available to persons who qualify for Medi-Cal as medically needy.\(^{299}\) Services for the following persons were not transferred to Medi-Cal: Persons whose services are provided solely by a spouse or, if the IHSS recipient is a child, a parent;\(^{300}\) persons who receive advance pay.\(^{301}\) While protective supervision continues to be a benefit covered

\(^{298}\) DHS, ACWDL No. 96-31 (June 10, 1996)


\(^{300}\) IHSS Ch. 939 A.B. No. 1773 W & I §12300(d) Social Services Healthcare personal care service, Ch. 7 A.B. No. 5 (1993) Amends and Appeals § 14132.95 - 14132.95(f) family member means parent of a minor child or a spouse. Where some of the services are provided by a spouse or parent of a minor, there will be no share of cost if one of the providers is someone other than the spouse or parent of a minor.

\(^{301}\) Federal Medicaid law requires that payments be made after services are delivered. See 42 U.S.C. § 1396d(a), 42 C.F.R. § 447.20(b). However, counties which have Public Authorities as authorized in Welf. & Inst. Code § 12301.4 could provide advance payment and then bill as a provider for the services delivered after the fact. Alternatively, the Department of Social Services as a provider might be able to bill for the services delivered after the fact.
only by the residual IHSS program, if other services are covered by the Medi-Cal personal care services program, the share of cost will be treated as a Medi-Cal share of cost.\footnote{302}

Share-of-cost persons whose attendant care services were transferred to the Medi-Cal program are not penalized in that they continue to pay a share of cost measured by the difference between their countable income and the applicable SSI grant level rather than the lower Medically Needy Income Level.\footnote{303} The transfer to Medi-Cal, however, allows the state to reduce its cost by being able to draw down the federal Medicaid match.

Although the Medi-Cal personal care services received by persons who are transferred from the IHSS program to the Medi-Cal personal care services program will be treated like any other Medi-Cal services in that they operate as a lien for persons who are 55 years of age or older, there are other offsetting advantages in being transferred to Medi-Cal. As recognized by DHS,\footnote{304} people will be able to deduct any health benefit premiums to reduce share of cost. In addition, people will not be

\footnote{302} If you receive other services and the protective supervision is provided by someone other than the parent of a minor or spouse, then the other services will be transferred to the Medi-Cal Medically Needy program. If you receive protective supervision as well as Medi-Cal personal care services and qualify for Medi-Cal with no share of cost under the A&D FPL program, you will not have a share of cost under the residual IHSS program. DHS ACWDL No. 10-01, January 24, 2001.

The Department of Health Services originally included protective supervision in the menu of services covered under the Medi-Cal program. Section 7 of Chap. 939, statutes of 1992 (AB 1773). However, because IHSS protective supervision is limited under the regulations to persons who need those services because of a mental impairment, and because federal regulations [42 CFR § 440.230(c)(1)] bar discrimination on the basis of diagnosis, DHS sponsored legislation which removed protective supervision from the menu of personal care services set out at Welf. & Inst. Code § 14132.95(d). Section 2 of Chap. 7, statutes of 1993 (AB 5).

\footnote{303} Persons who need attendant care but who have a share of cost continue to receive IHSS in an amount equal to the difference between the MNIL and the applicable SSI grant level. Welf. & Inst. Code 12305.1.

\footnote{304} DHS ACWDL No. 99-13 (March 29, 1999).
Chapter 5: How Share of Cost is Determined, How Share of Cost Works

limited to using the share of cost to pay for authorized attendant care as they were under the IHSS program. They will be able to use their share of cost for other expenses as well as personal care services beyond those authorized or covered under Welf. & Inst. Code § 14132.95.305

305 One example would be to cover the time the attendant needs to be with you between the hours authorized for specific tasks. See PAI’s memo on personal care services and share of cost on its website - www.pai-ca.org - under publications and then under IHSS.
Chapter 6: Medi-Cal Services and Benefits

This chapter discusses what benefits you can get with your Medi-Cal card. The same scope of benefits is available to Medi-Cal recipients whether those benefits come through fee-for-service or through managed care. The only exceptions are specialty mental health services under the rehabilitation option, which the State says are only available through county Mental Health Plans. Managed care organizations, however, may require prior approvals where they are not required in fee-for-service Medi-Cal. For instance, in fee-for-service Medi-Cal, you do not need a prior authorization to see a doctor; in managed care you usually need prior authorization to see a specialist. The managed care organization may require prior approval for medications that do not need prior authorization under fee-for-service Medi-Cal.

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306 Under “fee-for-service” you take your Beneficiary Identification Card -- your plastic BIC - to whatever doctor or other provider that will accept you as a Medi-Cal patient.

307 Specialty mental health services include case management services and “rehabilitative services which include remedial services directed at restoration to the highest possible functional level for persons with psychiatric disabilities and maximum reduction of symptoms of mental illness.” Welf. & Inst. Code § 14021.4(a)(4).

308 Welf. & Inst. Code § 14021.4(a)(2)-(3), (b), (f), (g) added rehab option services to county Medi-Cal Short-Doyle programs, which were incorporated into the Mental Health Medi-Cal managed care plans. PAI contends that persons who are not eligible for services based on diagnosis through Medi-Cal Mental Health Plans - persons with traumatic brain injury for instance - but who nonetheless need the type of rehabilitation option services available through the Mental Health Plans are entitled to receive such services through fee-for-service Medi-Cal. For more information about Medi-Cal Mental Health Plan services, see PAI’s separate Medi-Cal Mental Health Manual.
As discussed below, you are eligible for an expanded scope of benefits if you are under age 21 or in a nursing facility. Persons who are not eligible for full-scope Medi-Cal because of their immigration status are eligible for a restricted scope of “emergency” benefits. See issue brief on “Immigration and Health Care at www.healthconsumer.org.

1. What sorts of things does Medi-Cal cover?

Medi-Cal pays for such things as:

- Doctor visits
- Adult day health care
- Personal care (IHSS Attendant Care) services

309 But psychiatric visits are available only through local Mental Health Plans. Psychiatric visits are no longer available through fee-for-service Medi-Cal.

310 Personal care services under Medi-Cal pursuant to Welf. & Inst. Code § 14132.95 and In-Home Supportive Services (IHSS) pursuant to Welf. & Inst. Code §§ 12300 et seq. are treated as a uniform program. The rules are the same whether IHSS services are through Medi-Cal or through the regular IHSS program under DSS. Currently, the following persons qualify for services only through the IHSS portion of the program: persons whose providers are a spouse or the parent of a minor (because of federal Medicaid limitations on who can be a provider), persons who receive advance pay to pay their providers directly (because of federal Medicaid requirements requiring payment only after services are delivered), and persons who receive only domestic or related services (house cleaning including kitchen dishes, changing bed linens, meal preparation, laundry, food shopping and laundry) and no personal care services because of the federal Medicaid requirement of some personal care services as a condition of federal Medicaid coverage of such related services.

Effective April of 1999, many of the share of cost IHSS recipients under Welf. & Inst. Code §§ 12300 et seq. were transferred to Medi-Cal without any penalty. See §§ 25 and 27 of Chapter 329, Statutes of 1998 (the Social Services Trailer Bill), adding Welf. & Inst. Code § 12305.1 and
• Emergency services (the provider must call Medi-Cal or the managed care organization promptly to get emergency authorization);
• Transportation** to doctor visits and to other medically necessary Medi-Cal-covered services;**
• Testing for diagnostic purposes;
• Screenings for children under age 21 including lead screenings;\(^{311}\)
• Investigation of Home Environment to identify source of lead contamination in the environment of a child;\(^{312}\)
• Surgical procedures**
• Prescriptions if they are on the contract list and, as of October 1, 1994, six or fewer prescriptions a month (but Medi-Cal may pay for more than six prescriptions a month or for medications not on the Medi-Cal list if you get prior authorization through the pharmacist or your own doctor);\(^{313}\)

amending Welf. & Inst. Code § 14132.95. By no penalty we mean that persons who qualify for personal care services with a share of cost will continue to pay a share of cost measured by the difference between their countable income and the applicable SSI grant level rather than the lower Medically Needy Income Level. Welf. & Inst. Code § 12305.1. See Chapter 5.


\(^{312}\) Cal. Code Reg., tit. 22 §§ 51340.1(d), 51242(i), 51232.2(b). Prior authorization is not needed if the criteria in Section 51340.1(d) are met. With respect to lead contamination identified, Medi-Cal does not cover the cost of any abatement services. Abatement funding would have to come from other sources.

\(^{313}\) Welf. & Inst. Code § 14133.22(a). The limit does not apply if you are in a nursing facility, and does not apply to family planning drugs. Welf. & Inst. Code § 14133.22(b), (c). It is possible the limit does not apply to drugs required because of cancer or an organ transplant.
• Incontinence supplies for Medi-Cal recipients age 5 and older;\textsuperscript{314}
• Hospitalization;**
• Medical supplies;
• Durable medical equipment (for example, wheelchairs, prostheses, braces) including “equipment needed to assist a disabled beneficiary in caring for a child”\textsuperscript{315};**
• Occupational and physical therapy;
• Outpatient drug abuse services under the California State Department of Alcohol and Drug Programs, when provided as part of a county mental health program;
• Services including transportation services provided through a school to accommodate to a child’s disability or to implement a special education program or through county mental health to implement a special education program.\textsuperscript{316}

\textsuperscript{314} Cal. Code Regs., tit. 22 § 59998(b). If the child is a regional center client, voucher reimbursement would be available to children 3 and over - and to children under 3 when there is “financial need and when doing so will enable the child to remain in the family home.” Cal. Code Regs., tit. 17 § 54355(g)(2)(B).

\textsuperscript{315} Welf. & Inst. Code § 14132(m). Coverage of equipment needed because of the disability limitations of a child caretaker was added by Chap. 453, stats 2000 (AB 2152). See the finding supporting the coverage of such equipment in the notes following Welf. & Inst. Code § 14132.

\textsuperscript{316} Contrary to the usual Medicaid rule that Medi-Cal is the payor of last resort, the federal Medicaid Act provides that Medi-Cal coverable services required to implement a special education program are to be funded by Medi-Cal. 42 U.S.C. § 1396b(c). See also 42 U.S.C. § 1412(a)(12)(A)(i):

“the financial responsibility of each public agency described in subparagraph (B) including the State Medicaid agency and other public insurers of children with disabilities, shall precede the financial responsibility of the local educational agency (or the State agency responsible for developing the child’s IEP).”
Chapter 6: Medi-Cal Services and Benefits

Pursuant to 42 U.S.C. § 1396b(c), DHS issued emergency regulations [Regulation Packet R-6-93E, December 13, 1993, CCH MEDI-CAL GUIDE New Dev. ¶ 7526] designed to draw down federal Medicaid funds to match state and local school funds used to provide a variety of services to Medi-Cal beneficiaries—mental health evaluations and services, including counseling services; assessments in the areas of hearing, vision, development, psychosocial status; health education; physical and occupational therapy; speech pathology and audiological services; nursing and school health aide services; medical transportation. Cal. Code Regs. tit. 22 § 51360. The regulations do not cover equipment such as communication devices.

317 See Chapter 10. The HCFA State Medicaid Manual at Section 4390 describes the criteria used to determine whether a facility is classified as an Institution for Mental Disease (IMD): Whether identified, licensed, or JCAH accredited as a psychiatric facility; facility specializes in providing psychiatric or psychological treatment; the facility is under the jurisdiction of the State Department of Mental Health or its patients primarily come from state mental facilities; whether there are locked wards; the residents' average age is significantly lower than the average age of a typical nursing facility; more than 50% of the residents have mental diseases which require inpatient treatment according to the patients' medical records or a professional review team report a preponderance of mental illness in the diagnoses of facility residents. See also 42 C.F.R. § 435.1008.

**The provider must get Medi-Cal approval before providing the services.

The California Legislature has also authorized various services for persons with mental illness such as "rehabilitative services which include remedial services directed at restoration to the highest possible functional level for persons with psychiatric disabilities and maximum reduction of symptoms of mental illness."

Under the EPSDT program, children are not limited to the Medi-Cal services available to adults, but may, based on medical necessity, be entitled to an expanded scope of benefits. EPSDT stands for "Early and Periodic Screening, Diagnosis, and

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• Dental services and for children, dental sealants;**
• Stay in a nursing facility (excluding facilities classified as "Institutions for Mental Disease" for persons under age 65) or intermediate care facility for persons who are developmentally disabled (ICF/DD);**
• Other services not generally available to adult Medi-Cal recipients may be made available to targeted groups under a home and community based waiver.** See Chapter 16.

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The California Legislature has also authorized various services for persons with mental illness such as "rehabilitative services which include remedial services directed at restoration to the highest possible functional level for persons with psychiatric disabilities and maximum reduction of symptoms of mental illness."

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Treatment," a federal requirement imposed on the state Medi-Cal program. See Chapter 7.

2. **Does Medi-Cal cover case management?**

   Medi-Cal covers most case management services provided to Medi-Cal beneficiaries with developmental disabilities through regional centers and through other programs administered by the California State Department of Developmental Services (DDS). Case management is also a part of the services provided through CCS-approved special care centers. Case management may also be provided through county departments and through community based organizations under contract with counties. Counties may elect to provide case management services to certain high risk groups. State and federal law defines case management as "services which assist clients to gain access to needed medical, social, educational, and other services."

   The language in 42 U.S.C. § 1396n(g)(1) exempts case management from the general federal Medicaid rules about statewideness and comparability. That means the state may limit case management to specific geographic areas and may target particular groups without making the service available to other Medi-Cal beneficiaries who have a comparable need for such services.

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318 Welf. & Inst. Code § 14132.48(a), (b).


320 Welf. & Inst. Code § 14132.44(b) says that counties may elect to provide, directly or through contracts with other agencies, case management to any or all of the following groups: high-risk children, youth, and families; pregnant, postpartum, and parenting women; persons with HIV infection; homeless persons; substance abusers; persons who use multiple service providers; persons with catastrophic or chronic illnesses; elderly persons at risk of institutionalization. Counties electing to do so spend county money as the state match to draw down the federal financial participation.

3. Getting prior authorization for a medical service

(a) Fee for Service

The provider will submit a treatment authorization request (TAR) form with documentation of your need for the requested services, medicine, or device. In most cases the provider will submit the TAR by fax. However, the provider also may mail the TAR or may telephone in the request and, if approved, follow up with a written confirmation. The documentation must explain why you need the service to protect life, to prevent significant illness or disability, or to alleviate severe pain. The provider must submit complete medical justification with the TAR form because that is the only thing the Medi-Cal analyst reviews except in the case of medical transportation. Medi-Cal will return the TAR form to the provider with its approval or denial and the reason for the denial. Medi-Cal must send you a notice when a TAR is denied with (a) an explanation of why the authorization was denied and (b) information about your appeal rights.

(b) Managed Care

See Chapter 7 about how to get prior authorization from Medi-Cal for children's EPSDT services when: (a) the service requested is beyond that available for adults, or (b) the service and the reason it is needed meet the common sense EPSDT medical necessity definition but not the draconian Medi-Cal medical necessity definition.

Welf. & Inst. Code §§ 14133.3, 14133.37, 14133.6, 14133.65, 14133.9, 14136.1, 14136.3, 14136.4; Cal. Code Regs. tit. 22 § 51003.

Welf. & Inst. §§ 14059.5, 14133.3(a). If the Medi-Cal beneficiary is under the age 21, the EPSDT medical necessity definition may apply. See Chapter 7.

Welf & Inst. Code § 14133.6 (“In acting upon prior authorization requests for non-emergency medical transportation services, the department shall consider all relevant information in its possession regarding the beneficiary for whom the services are requested.”)

The managed care plan itself authorizes services. The managed care plan can set the rules about prior authorization and the procedures. Usually requests come from the primary care physician. The requests may go to the plan itself or more commonly to the medical director of the group with which the primary physician is associated. If the plan is subject to the Knox-Keene Act, Health & Safety Code §§ 1340 et seq., then the consumer protections that are generally available to managed care are available to Medi-Cal recipients as well.

4. How long does Medi-Cal have to approve or deny a TAR?

(a) Services and Equipment other than Pharmacy

The California Legislature said that the Medi-Cal program is to act on a TAR in a timely manner. A timely manner is an average of five working days following receipt of the TAR. If the Medi-Cal program does not act on a TAR within 30 days of receiving it, the TAR is approved by operation of law. The Medi-Cal program may approve, deny, modify, or ask for additional information. If you submit additional information, the Medi-Cal program processes the TAR as a new TAR in terms of timeliness. Sometimes the Medi-Cal program “defers” a TAR and sends it back to the

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327 County Mental Health Plans and some County Operated Health Systems have been exempted from becoming qualified under the Knox-Keene Act so that the protections generally available to consumers in private and public managed care are not available to persons receiving services from County Mental Health Plans (MHPs) and most County Operated Health Systems (COHS). Welf. & Inst. Code § 1487.5 (COHS), § 5777(f) (MHPs). However, federal law authorizing the COHS in Solano/Napa, Santa Cruz and Orange Counties required that they be qualified under the state Knox-Keene Act. Section 9517(c)(3) of Pub.L. 99-272, the Medicare and Medicaid Budget Reconciliation Amendments of 1985, codified as a note under 42 U.S.C. § 1396b.

328 The Knox-Keene Act is administered by the Department of Managed Health Care. For information about consumer protections including complaint and independent medical review procedures, visit the Department’s website at www.hmohelp.ca.gov.

329 Welf. & Inst. Code § 14133.9(d).

provider for more information. If Medi-Cal does not defer the TAR within 30 days of receipt, the TAR is deemed approved.\footnote{331} 

(b) Prescription drugs

Prior authorization is needed for prescription drugs that exceed the six-a-month limit.\footnote{332} Prior authorization is also needed for prescription drugs that are not on the formulary. The usual procedure is for the pharmacist to fax in the TAR together with any medical justification. A response is required within 24 hours of Medi-Cal’s receipt of the TAR.\footnote{333} The pharmacist also may provide 72 hours worth of prescription drugs pending a response on the TAR.\footnote{334} 

5. What does Medi-Cal consider to be "medically necessary"?

State law defines medically necessary as those services, medicines, supplies and devices necessary to protect your life, to prevent a significant illness or disability, or to alleviate severe pain.\footnote{335} What constitutes a severe disability is informed by Welf. & Inst. Code § 14059 which says Medi-Cal is to address conditions that “interfere with capacity for normal activity.” Medically necessary services include rehabilitation and

\begin{enumerate}
\item \footnote{331} Id. See DHS Fair Hearing Decision No. 9422445.
\item \footnote{332} Welf. & Inst. Code § 14133.22(a). There are procedures for getting prior authorization for up to six prescription drugs that otherwise would not require prior authorization. See Section 400-12 of the Pharmacy Provider Manual, http://files.medi-cal.ca.gov/pubsdoco/Pubs_Home.asp. That way if there was an emergency need for a drug which is on the contract list, there would be no need for a prior authorization because you had already used up your allowed six drugs.
\item \footnote{333} Welf. & Inst. Code § 14133.37(a), 42 U.S.C. § 1396r-9(d)(5)(A). Although the state and federal statute require response within 24 hours of receipt, the compromise practice is that Medi-Cal will respond by 5 p.m. of the business day following the business day of receipt and if there is no response, the TAR will be deemed approved. Thus, a TAR faxed in on Sunday will be deemed received on Monday and if not acted on by 5 p.m. on Tuesday, will be deemed approved.
\item \footnote{334} Welf. & Inst. Code § 14133.37(b); 42 U.S.C. § 1396r-8(d)(5)(B).
\item \footnote{335} Welf. & Inst. Code §§ 14059.5, 14133.3.
\end{enumerate}
other services needed to attain or retain the capability for normal activity, independence, or self care.

Medi-Cal will not pay for treatment, medicines, or devices that are considered "experimental." Medi-Cal will cover, with prior authorization, services that are investigational, provided they meet regulatory criteria. For certain low incidence or "orphan" disabilities, what may appear to be "experimental" or "investigational" is not, in fact, because health care professionals who treat that particular disability generally accept the treatment or procedure.

In some cases, however, a different medical necessity standard is applied:

(a)  **Children:** The restrictive Medi-Cal definition of "medical necessity" does not apply to treatment of children's health needs identified by a Child Health and Disability (CHDP) program screening or evaluation, or by a treating physician during an "inter-periodic screen." The applicable definition is the federal definition: diagnostic or treatment services which are medically necessary "to correct or ameliorate defects and physical and mental illness and conditions discovered" during a regular (periodic) or

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336  Cal. Code Regs. tit. 22 § 51303(g).

337  Cal. Code Regs. tit. 22 § 51303(h). Regulation criteria include demonstrating that conventional therapy will not adequately treat the condition, nor prevent progressive disability or premature death; that the provider has a record of safety and success; and that there is a reasonable expectation that the investigational service will significantly prolong life or will maintain or restore a range of physical and social function.

However, if you otherwise qualify for inpatient care, treatment involving "investigational new drugs, clinical trials or other ancillary or investigational services . . . shall not in itself be construed to be part of a research study protocol, and shall not constitute grounds for denial on that basis." [Welf. & Inst. Code § 14137.8.]

For persons with AIDS, ARC, or who are HIV positive, Medi-Cal covers medications classified by the Food and Drug Administration or DHS as an Investigational New Drug. [Welf. & Inst. Code § 14137.6.]

338  "Inter-periodic screen" means any visit to the doctor not included in the EPSDT screening schedule. Cal. Code Regs. tit. 22 § 51184(a).
inter-periodic screen.  

(b) "Medi-Medis": If you are eligible for both Medicare and Medi-Cal, you may use the Medicare standards of medical necessity for services covered by both Medicare and Medi-Cal. The Medicare program defines "medically necessary" in a more common-sense fashion than does Medi-Cal. For example, Medi-Cal will pay for cataract surgery for loss of vision in one eye only if both eyes are affected; Medicare will pay for cataract surgery to restore sight even if only one eye is affected. Under Medicare you get two good eyes; under Medi-Cal you get only one good eye.

(c) Persons in Nursing Facilities: Federal law provides that individuals who are in nursing facilities are entitled to receive "the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accord with the comprehensive assessment and plan of care." Compare this standard to California's "medically necessary" standard for Medi-Cal. State Medi-Cal regulations provide that occupational, physical, speech and psychological therapy services are not covered in the daily rate for SNFs. In settling Valdivia v.

339 Cal. Code Regs., tit. 22 §§ 51184(b), 51340(e)(3).


341 Nursing facilities include what used to be called skilled nursing facilities (SNF) and intermediate care facilities (ICF). However, federal regulations [42 C.F.R. § 483.5] provide that the various intermediate care facilities for the developmentally disabled (ICF/DD, ICF/DD-H, and ICF/DD-N) are not "nursing facilities" even when the ICF/DD facilities otherwise meet the criteria of nursing facilities under federal Medicaid law. [42 U.S.C. § 1396r(a).] As a consequence, residents of ICF/DD facilities which otherwise meet the definition of "nursing facility" are denied the benefit of the protections and care standards afforded residents of other nursing facilities through the Nursing Home Reform Laws.

342 42 C.F.R. § 483.25.
Kizer, a case addressing California's failure to comply with the federal Nursing Home Reform Laws, the Medi-Cal program acknowledged its obligation to authorize services beyond the two-visit-a-month limitation—such as more frequent physical therapy or psychologist sessions—when you need more frequent therapy to meet the standard in 42 C.F.R. § 483.25. 343

(d) **Dual Eligible (CCS & Medi-Cal) Children:** Children who are covered by both Medi-Cal and CCS should have the TARs for services related to their physically handicapping condition reviewed by CCS for prior authorization. The CCS medical necessity standard traditionally has been consistent with the EPSDT standard. CCS also covers reimbursement for transportation and living expenses for both the child and the caregiver if medical visits involve overnight travel. CCS case manages such children with respect to services needed for the eligible condition. CCS uses a common sense medical necessity standard consistent with its purpose of minimizing the long-term disabling effects of an eligible condition.

(e) **Preventative and Rehabilitation Services for Mentally Ill:** Effective July 1, 1993, a range of preventative and rehabilitative services became part of the Short-Doyle Medi-Cal program administered through county departments of mental health and then became a part of the services provided by local mental health plans. Those optional services contain their own definition of medical necessity: the "highest possible functional level" and "maximum reduction of symptoms of mental illness." 344

(f) **Prescription Drugs:** The federal Medicaid regulation at 42 C.F.R. § 440.120(a) defines "prescribed drugs" as "simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance..."

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343 Class Action Stipulation and Order filed April 13, 1993, "Duties and Responsibilities," ¶ 2-f, set out in full at CCH MEDI-CAL GUIDE New Dev. ¶ 7516.

6. I cannot find a doctor or other service provider who will accept Medi-Cal. What can I do?

If you cannot find a doctor or other provider who will accept Medi-Cal, the state Medi-Cal field offices (the offices that review prior authorization requests) have an obligation to provide you with the names of doctors or providers in your area who will accept Medi-Cal. You should contact Medi-Cal field offices directly for this information. Look in the phone book under State of California, Department of Health Services. If you cannot find the number in your phone book, call (916) 445-4171.

If you need help finding a dentist who will accept Medi-Cal, call (800) 322-6384.

7. Limits on number of treatments

The Medi-Cal program provides that you can have no more than two of the following treatment or assessment services each month: psychology, 345 physical therapy, occupational therapy, speech pathology, audiology, podiatry, chiropractic, acupuncture, prayer or spiritual healing services. 346 Medi-Cal requires prior authorization for most podiatry services and for all physical therapy services. 347 Medi-Cal can cover more than two physical therapy treatments in a month if you have prior authorization for “treatment immediately necessary to prevent or reduce anticipated

345 Psychologist and psychiatrist services with limited exceptions are now available through Medi-Cal managed care provided through local Mental Health Plans (MHPs) - see Chapter 15. The exceptions include Medicare-Medi-Cal claims, services delivered through a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Indian Health Center (IHC). For more information about what fee-for-service psychologist services are excluded from specialty mental health services through MHPs, look at the Allied Health Services provider manual at http://files.medi-cal.ca.gov/pubsdoco/Pubs_Home.asp and search for both psychologist and “specialty mental health.” Compare the procedure and diagnosis codes under both.


hospitalization or to continue necessary plan of treatment after discharge from a hospital", and the treatment will result in significant improvement within a short time period. 348 Since you are receiving two or more physical therapy services this calendar month, you are not eligible for any of the other listed services, regardless of the medical necessity for such services.

However, if you are a child (under age 21) and your need for additional services is identified through a CHDP screen (periodic screen) or through an encounter with a licensed health care professional (inter-periodic screen), you are not subject to monthly visit limitations if your additional visits meet the EPSDT medical necessity standard.349

If you are in a nursing facility and you need additional treatment services in order to "attain or maintain the highest practicable physical, mental and psychosocial well-being, in accord with the comprehensive assessment and plan of care"350, the two-visit-a-month limitation does not apply.

8. Medications not on the Medi-Cal list

If the medication you need is not on the Medi-Cal list, that just means there has to be prior authorization to get it. Your pharmacy or doctor needs to submit a TAR to Medi-Cal. A letter or report from the doctor who wrote the prescription should go with the TAR, and should explain the following:351

- Why none of drugs or items on the formulary which are for treating your

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348 Cal. Code Regs. tit. 22 § 51309(d).
349 Cal. Code Regs. tit. 22 § 51340(g).
350 42 C.F.R. § 483.25
351 If you are under age 21 and cannot meet the adult medical necessity standard, you may be able to get authorization for the needed medication if you meet the EPSDT requirements discussed in the next section.
health problem meet your needs. If other drugs were tried, explain what led the doctor to conclude you should be receiving the medication prescribed.

- Why you need the particular drug or item to protect your life, to prevent significant illness or disability, or to alleviate severe pain, and the risk or consequences if you do not get the prescribed drug. \(^{352}\)

If the medication is on the Medi-Cal contract list, but you need the medication in a form other than that listed, the justification sent in with the TAR should explain why you need the medication in the requested form. You do not have to justify the medication itself since it is on the Medi-Cal contract list.

Your pharmacist can phone in or fax the request for authorization with the justification letter. Your doctor also can fax the TAR to Medi-Cal. Medi-Cal must provide "a response by telephone or other means of telecommunication within 24 hours of the receipt of an authorization request." \(^{353}\)

If you need your medicine right away and the pharmacist will not give you the medication on an emergency basis, you may pay for a few days' worth of your medicine. The pharmacist will reimburse you when Medi-Cal approves the TAR. If it is an emergency, the pharmacist can give you 72 hours' worth of medication. \(^{354}\)

If Medi-Cal denies the TAR, you have a right to a notice telling you why and a fair hearing to challenge the denial. See Chapter 17.

9. **Prescription Limits**

For a prescription above the six month limit, you do not have to provide the

\(^{352}\) PAI believes, though Medi-Cal disagrees, the correct standard is that set out in the federal Medicaid regulation at 42 C.F.R. § 440.120(a).

\(^{353}\) Welf. & Inst. Code § 14133.37(a).

\(^{354}\) Welf. & Inst. Code § 14133.37(b).
justification that you would if the medication were not on the formulary. The TAR must include the diagnoses relevant to the medication. This is important because someone who needs more than six prescriptions a month may have multiple diagnoses. If the physician or pharmacist does not write down the diagnoses for which the medication is prescribed, the TAR may be denied. In addition, if more than one medication is used to address a health problem, it is important that the TAR include an explanation like the following: "Patient is controlled (stabilized) on a multi-drug therapy consisting of [name the drugs] and his health [stability] would be jeopardized without the mix of prescribed medications." Otherwise, the Medi-Cal consultant reviewing the TAR may disallow it if he sees that Medi-Cal had paid for other medications for the particular health problem.

10. **Pharmacy Policies and Refusal to Submit TARs**

A pharmacist might tell Medi-Cal recipients that the pharmacy does not submit TARs (Treatment Authorization Requests) to Medi-Cal for prescriptions above the six limit or for medications that are not on the formulary.

In such a case, write down the name of the pharmacy of the pharmacist. Ask someone in your doctor's office to call the pharmacy. The pharmacy is most likely to cooperate if it is in the same building as your doctor, or if your doctor's other patients go to that pharmacy. If the doctor cannot help you with the pharmacy, ask her to recommend another pharmacy.

If the pharmacy is part of a chain—that is, there are other pharmacies with the same name—the policy of not submitting TARs may not be the company policy. You can call the chain's headquarters and ask to speak with someone about a pharmacy problem.

In addition, your doctor can submit the TAR directly to Medi-Cal by faxing the TAR form with the medical justification to the pharmacy reviewers.

11. **Can Medi-Cal make the pharmacist submit TARs?**
Medi-Cal says no. Submitting TARs when necessary is not a condition of doing business under the Medi-Cal program.

12. What if the pharmacist says that, since Medi-Cal does not cover a particular medication, I will have to pay for it if I need it?

That statement may constitute fraud where Medi-Cal will pay for the drug if approved following the submission of a TAR which establishes medical necessity.\textsuperscript{355} The fraud is in suggesting that there is no way Medi-Cal would cover the medication, so the only way to get the medication is to pay for it. There would be no fraud if the pharmacist simply said she would not submit the TAR.

\textsuperscript{355} You may report Medi-Cal fraud to the two offices processing prescription TARs for forwarding to the appropriate person: Inyo County, Kern County, San Luis Obispo County south—State Medi-Cal Drug unit, Attn. Dr. Craig Mizuno, State Building, Room 9103, 107 South Broadway, Los Angeles CA 90012; Northern California—State Medi-Cal Drug Unit, Attn. Dr. Joyce Rutan, P. O. Box 201007, Stockton CA 95201.
Chapter 7: Medi-Cal Services for Children

Children of course have the same Medi-Cal rights as adults. This chapter covers the extra Medi-Cal service rights children have through EPSDT. The chapter also covers the relationship between California’s Children Services (CCS) and Medi-Cal and between Medi-Cal and AB 3632--namely services through county Mental Health or the school which are a part of the child’s special education and the Individual Education Program (“IEP”).

1. What is EPSDT

Early and Periodic Screening, Diagnosis and Treatment (“EPSDT”) refers to a federal Medicaid obligation imposed on the states as a condition of receiving federal Medicaid money. Eligible children and young people under 21 years of age are

356 42 U.S.C.§ 1396d(a)(4)(B) which lists early and periodic screening, diagnostic and treatment (EPSDT) services as a Medicaid service, 1396a(a)(10)(A) which includes EPSDT among the services a state is required to provide, § 1396d(r) which lists the required EPSDT services, and § 1396a(a)(43) which requires the state to inform families about the availability of EPSDT services and about the need for immunizations and which requires the state to arrange screening services and corrective treatment identified by the screens.

The state EPSDT regulations are found at Cal. Code Reg., tit. 22, § 51184 (definitions),
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entitled to expanded benefits under EPSDT in addition to the Medi-Cal services available to adults. In contrast to the Medi-Cal program’s obligations to adults, Medi-Cal must not only cover needed EPSDT services but are responsible for conducting outreach and screening services and must actually arrange for needed corrective treatment. 358

There are two parts to the EPSDT program—the screening part and the diagnostic and treatment services part.

(a) Screening services

Screening services (which includes any visit with a health care professional 359) include both an initial and periodic screens 360 (like scheduled "well baby" examinations, immunizations) and inter-periodic screens (defined as any encounter with a health professional who identifies a need for follow-up diagnostic services or treatment

357 42 U.S.C. § 1396d(a)(B) (EPSDT services for eligible individuals under age 21).


360 The minimum frequency for periodic screens is set out at Cal. Code Reg., tit. 17, § 6847. The interval and frequency requirements “must meet reasonable standards of medical and dental practice as determined by the State after consultation with recognized medical and organizations involved in child health care and with respect to immunizations. . . .” 42 U.S.C. § 1396d(r)(1)(A).
screens. Screens are “periodic comprehensive child health assessments.” They are regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth, and vision, dental, and hearing services.” Medi-Cal provides periodic screens for Medi-Cal children in accord with the requirements of the Child Health & Disability Prevention (CHDP) Program. Medi-Cal beneficiaries are required to be offered assistance with transportation and scheduling of the assessment appointment. Assistance with referral and scheduling follow-up diagnostic and treatment services and assistance with transportation is also available to Medi-Cal beneficiaries.

The CHDP program also provides screening and limited services to low-income children. In addition, an “inter-periodic screen” may include an encounter with a provider prior to Medicaid eligibility, or a provider that otherwise does not participate in Medi-Cal.

See also 42 U.S.C. § 1396d(r)(1)-(4) which sets out requirements for screening and evaluation. Cal. Code Reg., tit. 17 §§ 6846(b) and 6843.


Health & Safety Code §§ 124025-124110 (CHDP), 120475 (immunizations) and 104395 (expanding the CHDP program to include children with family income up to 200% of poverty using Proposition 99 tobacco tax funds); Cal. Code Reg., tit. 17, §§ 6800 et seq. “EPSDT Screening Services mean: (1) An initial, periodic, or additional health assessment of a Medi-Cal eligible individual under 21 years of age provided in accordance with the requirements of the Child Health and Disability Prevential (CHDP) program as set forth in Title 17, Sections 6800 et seq.” – Cal. Code Reg., tit. 22 § 51184(a).

Cal. Code Reg. tit. 17 § 6844(b)(1); 42 C.F.R. § 441.62.

The CHDP program covers low-income children to age 19 who do not qualify for Medi-Cal because immigration status or because the family income is too high provided the income is not more than 200% of the federal poverty level (FPL). The state CHDP program provides evaluations, assessment, and follow-up care for children over one year old who do not meet the income standards for the Medi-Cal 100% and 133% FPL programs (see Chapter 2), as long as the family income is not more than 200% of FPL. Health & Safety Code §§ 124925-124110 and 104395.

Ordinarily states have the option of not covering certain services in their state plan. Under EPSDT, however, California and other states must cover any optional service—that is, anything California could opt to include in its Medi-Cal program—if the EPSDT medical necessity definition is met in the absence of an alternative cost effective way of addressing the child’s treatment needs. However, the state has broad discretion in determining how to meet a child's diagnostic and treatment needs.

2. What is the EPSDT medical necessity standard?

Children eligible for Medi-Cal are entitled to “necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and

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368 The CHDP program covers low-income children to age 19 who do not qualify for Medi-Cal because immigration status or because the family income is too high provided the income is not more than 200% of the federal poverty level (FPL). The state CHDP program provides evaluations, assessment, and follow-up care for children over one year old who do not meet the income standards for the Medi-Cal 100% and 133% FPL programs (see Chapter 2), as long as the family income is not more than 200% of FPL. Health & Safety Code §§ 124925-124110 and 104395.

369 42 U.S.C. § 1396d(r)(5): EPSDT services include “[s]uch other necessary health care, diagnostic services, treatment, and other measures described in [§ 1396d(a), the section that lists all the Medicaid services a state could opt to provide] to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services, whether or not such services are covered under the State plan;” See also 22 CCR §§ 51184(c) and 51340(e).

370 Of the list of Medicaid services set out at 42 U.S.C. § 1396d(a), 42 U.S.C. § 1396a(a)(10)(A) lists the services which are mandatory and required to be provided by a state. The balance of the services are optional.

371 Cal. Code Regs. tit. 22 § 51340(e)(1)(F)
physical and mental illnesses and conditions discovered \(^{372}\) by the screening services, whether or not such services are covered under the state plan.\(^{373}\)

3. **What kinds of services are outside the scope of regular Medi-Cal services but available under EPSDT?**

(a) **Services beyond the visit limitations imposed by Medi-Cal**

Some of the Medi-Cal services available to adults are subject to visit or treatment limits. Those limits do not apply to children and youth under EPSDT. Although the Medi-Cal program allows only two occupational therapy visits a month for adults, \(^{374}\) that limitation need not apply for children. Although the Medi-Cal program covers only short visits under its home health care benefit, \(^{375}\) shift nursing and other services are available to children because the state could elect to provide shift nursing as part of its home health care benefit or as private duty nursing.

(b) **Services that meet the EPSDT Medical Necessity Standard but not the Adult Standard.**

The restrictive Medi-Cal definition of “medical necessity” applicable to

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\(^{372}\) Under EPSDT, children are entitled to treatment for conditions that existed prior to eligibility for Medicaid. HCFA, Region IV Transmittal Notice (5-1-91); 58 Fed.Reg. 51,288, 51,290-91 (10-1-93), cited at page 6, n. 80, Perkins, AN ADVOCATE’S MEDICAID EPSDT REFERENCE GUIDE (National Health Law Program, 11-93).

\(^{373}\) 42 U.S.C. § 1396d(r)(5); Cal. Code Regs. tit. 22 § 51184(b)

\(^{374}\) Cal. Code Regs. tit. 22 § 51304 (“Program coverage is limited to a maximum of two visits in a calendar month”)

\(^{375}\) Cal. Code Regs. tit. 22 § 51337(b)
Welf. & Inst. Code § 14059.5: “A service is ‘medically necessary’ or a ‘medical necessity’ when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.”

(c) Services which are not available to adults because they are not in the Medi-Cal State Plan.

California has recognized that private duty nursing, environmental lead screening, services from a Licensed Clinical Social Worker (LCSW), Marriage and Family Counselor (MFC), and provided under EPSDT, therapeutic behavior services (TBS) and Licensed Psychiatric Technician (LPT). EPSDT may require that services the state will provide only in an institutional setting must be provided in less restrictive and more natural environments when the treating physician believes a noninstitutional setting is medically necessary under the EPSDT medical necessity standard. The Americans with Disabilities Act also requires that Medi-Cal services be delivered in the community whenever possible.

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376 Welf. & Inst. Code § 14059.5: “A service is ‘medically necessary’ or a ‘medical necessity’ when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.” See Chapter 6, section 5.


379 An example is the services of a licensed psychiatric technician which has traditionally only been available in an institutional setting but may be necessary to enable a Medi-Cal beneficiary under the age of 21 to live in the community. See Medi-Cal Fair Hearing Decision 98104224, adopted by the Director of Health Services 9-4-98, which found that the claimant needed the skills and expertise of a Licensed Psychiatric Technician to provide needed EPSDT services in the home.


381 See Olmstead v. L.C., 527 U.S. 581, 119 S.Ct. 2176, 144 L.Ed.2d 540 (1999). Also see the letters from HCFA to State Medicaid Directors explaining how Olmstead imposes a community integration obligation on the administration of state Medicaid programs such as California’s...
Medi-Cal program. Go to www.hcfa.gov/medicaid/smdhmpg.htm (main menu for State Medicaid Director Letters) and select ADA/Olmstead all related letters.
4. How do I get EPSDT diagnostic or treatment services?

It depends on whether you are in managed care or in fee-for-service Medi-Cal.

(a) Fee-for-service

The criteria for qualifying for EPSDT supplemental services are set out in the regulations at 22 CCR § 51340(d). The Treatment Authorization Request (TAR) submitted by a provider must state that it is submitted under EPSDT. The medical justification supporting the TAR must address the following:

- Principal diagnosis and significant associated diagnoses.
- Prognosis.
- Date of onset of the illness or condition, and etiology if known.
- Clinical significance or functional impairment caused by the illness or condition.
- Specific types of services to be rendered by each discipline with physician's prescription where applicable.
- The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals.
- The extent to which health care services have been previously provided to address the illness or condition, and results demonstrated by prior care.
- Any other documentation necessary to justify the medical necessity of the requested service.

If the provider submitting the TAR is not a type of provider recognized under the adult program, then as part of submitting a TAR the provider also submits a request to be qualified as an EPSDT supplemental service provider in accord with Cal. Code Reg., tit. 22, § 51242. If you do not have a provider, see the question below about case management services.
We recommend that any TAR documentation include a cover letter with headings that track what the state EPSDT regulations require to meet the medical necessity standard. The cover can reference attached existing documents which address the particular criterion.

(b) Managed care

First, you should find out whether the Child Health & Disability Prevention (CHDP) program is inside or outside the managed care plan -- that is, whether you can go outside the plan to secure EPSDT/ CHDP screening and assessment services. You should be able to find out this information from your county CHDP program by calling (916) 654-0499 for the number of your county CHDP program. If outside the managed care plan, one option is to request a CHDP screening to determine what services will assist you. The CHDP recommendation about what is needed to correct a mental, physical or medical condition would support your request for such services from the managed care plan. If CHDP is in your Medi-Cal Managed Care plan, then expressly request CHDP screening and diagnostic services.

Second, if the services you need relate to a CCS eligible condition, then the next question is whether CCS eligible conditions are treated inside the managed care plan or outside through CCS. Except for children covered by the County Operated Health Systems in Napa/Solano and Santa Barbara Counties, all children with CCS eligible conditions who are enrolled in managed care receive services related to their eligible condition through CCS. These services are “carved out” of managed care. You would look to CCS for Medi-Cal EPSDT services related to the child’s eligible condition.

(c) **County mental health plans**

All Medi-Cal children and youth up to age 21 are automatically enrolled in California’s mental health managed care “carve out” program administered through local mental health plans. They are entitled to special protections regarding outreach, identification, case management and access to services.\(^{384}\)

To start a request for Medi-Cal mental health services or for an assessment, call the county access hotline for a referral to a participating provider.\(^{385}\) Children with intensive mental health needs may be eligible for day treatment, psychotherapy, individual and family counseling as often as required, including services in the home when necessary, crisis intervention and stabilization, residential placement, drug and alcohol treatment, and any other services which is regarded as medically necessary by a licensed mental health practitioner. Under the federal EPSDT law, a county MHP cannot deny services because existing services and programs are not appropriate or the existing service provider will not agree to serve the child; the county mental health plan must provide needed services, even if these must be individually developed for the particular child.

Children may obtain Medi-Cal mental health services from a county clinic, a private organization provider under contract with the county or from a psychiatrist, psychologist, a Licensed Clinical Social Worker (LCSW) or Marriage and Family Therapist (MFT) who participates in the

\(^{384}\) For the CMS (formerly known as HCFA) requirements for serving children with special health care needs in managed care, see State Medicaid Director Letter #01-012, January 19, 2001, www.hcfa.gov/medicaid/smd11901.pdf.

\(^{385}\) For the access number for your county’s Medi-Cal Mental Health Plan, go to the website of the California Department of Mental Health (DMH): www.dmh.ahwnet.gov/countyservices.htm. Click on “county mental health directors” for a county-by-county listing of local numbers and the crisis/access number in the lower left hand corner of the county box. (DHS has delegated to DMH oversight responsibility for the delivery of mental health services to Medi-Cal beneficiaries.)
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county’s managed care network. A listing of the county’s mental health providers can be obtained by calling the county Access line or other county offices.\textsuperscript{386}

If your child has an “AB 3632” county mental health case manager, ask the case manager to assist you in getting needed assessments and Medi-Cal services from the local MHP. Follow-up your request with a note such as a thank-you note confirming your request. See also Section 11 below.

5. Child mental health services in the community or home setting.

Under EPSDT children and young people covered by Medi-Cal have access to mental health diagnostic and treatment services. Children up to age 21 with mental health needs have a right to individualized mental health services through Medi-Cal in California before being placed out-of-home. If the child is at risk of being placed in a group home rate classification level 13 and 14 or above, recent state law will require close cooperation between county mental health agencies and children’s services staff to see if there are alternatives to out-of-home group home placement. SB 933 (Welf. and Inst. Code § 5867.5) requires an interagency mental health assessment when children are placed in group homes, rate classification level 13 and 14 or above.

Under the class certification order and preliminary injunction in \textit{Emily Q. v. Bontá},\textsuperscript{387} a case pending in federal court, some children may be eligible to receive one-on-one therapeutic behavior services to enable them to move to a less restrictive

\textsuperscript{386} See preceding footnote about how you contact your county’s mental health department for the listing of providers and services.

\textsuperscript{387} Case No. CV-98-4181-AHM (C.D. Calif.), Class certification and preliminary injunction order May 5, 1999; Permanent Injunction motion pending. DMH all-county letters 99-03 (7-23-99) and 99-04 (9-9-99) implementing the preliminary injunction concerning therapeutic behavior services can be found at \url{www.dmh.cahwnet.gov/county_letters.htm}. DMH Information notices 99-09 (6-2-99) and 00-03 (6-23-00) can be found at \url{www.dmh.cahwnet.gov/county_notices.htm}. 
Class members include children: (1) who have had an acute psychiatric admission in the past 24 months, (2) who are in a group home rate classification level 12 or above (3) who are in a locked mental health treatment facility or (4) who are at risk of being placed in a group home rate classification level 12 or above or in a locked mental health treatment facility.

The SB 163 Wraparound Services Pilot might be another option. The target children are (a) those in the dependency or juvenile court system who would be placed in a group home rate classification level 12 or above, (b) those who are classified in the Special Education System as Seriously Emotionally disturbed or (SED) and who would be placed out of home pursuant to AB 3632/ Government Code 7572.5, or those who are or would be placed in a rate classification level of 12 or higher. There is no financial eligibility requirements or barriers for participating in the SB 163 pilot. To find out if there is a pilot in your county and for contact information, call (916) 445-2890.

The purpose of the pilot is to keep eligible children in or return them to permanent family settings. The pilot allows counties the flexible use of State foster care funds to provide eligible children with family-based service alternatives to group home care using Wraparound as the service alternative. Wraparound is a family-centered, strength-based, and needs-driven planning process for creating individualized services and supports for children and their families.

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388 For a handout on therapeutic behavior services, visit the Protection & Advocacy website at www.pai-ca.org and click on “publications” and then “mental health.”


390 Cal Code Reg., tit5, § 3030(i); The term “emotionally disturbed” or ED is used in federal law though state and federal criteria are the same. 34 C.F.R. § 300.7(c)(4).

6. **How do I know if the services I need can be covered under EPSDT?**

    Services available under EPSDT may include any services that the state could include in its state plan. If a particular service is being provided under Medi-Cal or Medicaid in another county or another state, they are services which can be covered under EPSDT for your child.\(^{392}\)

7. **My child is eligible for both California Childrens Services (CCS) and Medically Needy (MN) Medi-Cal or the Aged & Disabled Federal Poverty Level Program. How does CCS and Medi-Cal work together?**

    If your child qualified under the A&D FPL program (see Chapter 2), you would also financially qualify for services through CCS.

    Under MN Medi-Cal you would have a monthly share of cost before Medi-Cal begins to pay. See Chapter 5. Under CCS you would have an annual share of cost for treatment services for eligible physically disabling conditions.

    However, there is no CCS cost, and therefore no share of cost, for diagnostic services, for occupational or physical therapy, or for other services provided through a CCS Medical Treatment Unit (MTU) attached to a special school. After you establish initial Medi-Cal eligibility through your county welfare office, CCS will handle case management for treatment of CCS eligible conditions. This means that CCS, not Medi-Cal, will review prior authorization requests for anything related to the CCS-eligible condition and provided under CCS.

    If you are enrolled in managed care, services related to the CCS eligible condition are carved out of managed care - that is, CCS authorizes and case manages them.

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\(^{392}\) If a service your child needs is being provided in another county through Medi-Cal, but not in your child's county, the state may be violating his rights under Federal Medicaid state-wideness and comparability requirements. 42 U.S.C. § 1396a(a)(1), 1396a(a)(10)(B); *Sobky v. Smoley*, 855 F. Supp. 1123, 1140 (E.D. Cal. 1994)
those services. The only exceptions are children who are covered by the County Operated Health Systems in Santa Barbara and Napa/Solano counties.\textsuperscript{393}

There are unanswered questions about coordinating benefits and rights when a child is covered by both Medi-Cal and CCS: How do CCS and Medi-Cal coordinate their fair hearing procedures? Are Medi-Cal's EPSDT TAR procedures followed when requesting a service that CCS is case managing? If CCS fails to act on an authorization request within 30 days, is the request automatically approved?\textsuperscript{394} How do CCS and Medi-Cal coordinate CCS's payment obligations and Medi-Cal's share-of-cost obligations?

Families with earned income and whose child meets the SSI disability standard to qualify for ABD MN Medi-Cal but whose income is too high to qualify for the Aged & Disabled Federal Poverty Level (A&D FPL) program, should evaluate whether they may be better off establishing their CCS financial eligibility through Medi-Cal rather than independently through CCS. This is because: (a) Medi-Cal will cover all health care needs, not just those related to the qualifying handicapping condition; (b) under Medi-Cal you can use unpaid bills\textsuperscript{395} from other months to meet your share of cost in a month you need services; (c) your child can qualify for CCS case management even if the family income is too high to qualify for CCS directly; (d) other eligible members of the family budget unit may also qualify for Medi-Cal;\textsuperscript{396} and (e) you can deduct insurance premiums in figuring your share of cost under Medi-Cal as well as the out-of-pocket medical expenses of other members of the family including ineligible

\textsuperscript{393} Welf. & Inst. Code § 14094.3(a). However, in counties where CCS is not carved out, the managed care plan must follow and maintain CCS standards, use CCS paneled providers, and follow treatment plans approved by CCS. Welf. & Inst. Code 14094.1(a).


\textsuperscript{395} See Chapter 5

\textsuperscript{396} In a family of 5 with two parents and three children including the child with disabilities, the other children would also qualify for Medi-Cal. The parents would also if one were disabled under AFDC standards, one were unemployed, or if there was only one parent in the household. See Chapter 2.
parents—something you cannot do under CCS. Another option is qualifying the child for Healthy Families. A Healthy Families' enrollee receives services through CCS for a CCS eligible condition without additional costs.

8. I am 14 years old and I think I may be pregnant. Is there a way I can find out without telling my parents?

Yes, through Medi-Cal's Minor Consent Services program. See Chapter 2.

9. Are there any circumstances when a child may receive mental health services without involving his parents?

Yes. A child age 12 or older may qualify for Medi-Cal-funded mental health services without involving his parents, and without regard to family income, if a health care professional writes to the county welfare department saying the child needs mental health services because of a risk of harm to himself or others, or because he is an alleged victim of abuse.

10. How can I figure out what Medi-Cal services and programs would help my daughter's behavioral problems? How can she get those services?

One starting point is through Medi-Cal-funded case management services.

(a) Case management through the regional center

If your daughter is a client of a regional center, Medi-Cal covers the case

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397 See Chapter 5.

398 For information on Healthy Families benefits, visit www.mrmib.ca.gov.

399 See Section 8 in Chapter 2 about minor consent services.
management services she receives through the regional center.\footnote{400} Ask the regional center to amend her regional center Individual Program Plan (IPP) to include expressly the help you need to coordinate and access the services she needs. Your daughter has a right to these services under both the Lanterman Act and the Medi-Cal program. \footnote{401} If the regional center denies case management services, you have a right to challenge that through the fair hearing process.\footnote{402}

(b) **Case management through the county mental health plan**

Medi-Cal is paying for the services your child as a Medi-Cal recipient is receiving through the county MHP. If your child is a Medi-Cal recipient, then mental health services provided pursuant to AB 3632/882 are also paid for by Medi-Cal.\footnote{403} We believe the county is therefore obligated to inform the child and the family about the range of EPSDT supplemental services available to assist particularly as an alternative to residential

\footnote{400} Welf. & Inst. Code § 14132.48(a), and (b). Medi-Cal covers most case management services provided to Medi-Cal beneficiaries with developmental disabilities through regional centers and through other programs administered by the California State Department of Developmental Services. The regional center is the generic agency for providing case management services to Medi-Cal consumers.

\footnote{401} For more information about your daughter's rights to regional center services, visit PAI's website at www.pai-ca.org to download or print the manual “RIGHTS UNDER THE LANTERMAN ACT.” Or order by calling (800) 776-5746.

\footnote{402} Welf. & Inst. Code §§ 4710-4714 governing regional center fair hearings. We believe the changes in the procedures for fair hearings involving issues under the Medi-Cal Home and Community based waiver also applies to disputes over Medi-Cal funded case management services. In cases involving Medi-Cal rights, the proposed fair hearing decision is reviewed by the director of DHS in accordance with Federal Single State Agency Requirements. 42 C.F.R. § 431.10.

\footnote{403} 42 U.S.C. § 1396b(c); “Mental Health Services for Special Education Pupils: A Report to the State Dept. of Mental Health and the California Dept. of Education,” at 44 (March 1997).
Chapter 7: Medi-Cal Services for Children

The obligations under Medi-Cal to children include an informing obligation -- namely, an obligation to advise Medi-Cal children and their families about the kinds of mental health services available to them through EPSDT. Congress, when enacting the Medicaid EPSDT provisions, directed that states take “aggressive action” to inform the families of recipients about EPSDT. 135 Cong.Rec. S13234 (Dec. 12, 1989). Federal regulations and the State Medicaid Manual require that families be informed of the specific services covered by EPSDT and where and how to obtain those services. 42 CFR § 441.56(a)(1984); HCFA, State Medicaid Manual, § 5121.C (Apr. 1990)

If your daughter is currently receiving services from a county mental health program as part of her special education Individualized Education Plan (IEP), affirmatively ask for case management services under Medi-Cal. Follow up any oral request with a written request for case management assistance. If the request is denied without your being referred to someone else in the County MHP, we believe you have a right to a notice telling you why your daughter was denied case management services. You also have a right to a Medi-Cal fair hearing to challenge the denial of case management services whether or not you received a notice.

11. What is the relationship between AB 3632/special education mental health services and Medi-Cal?

Federal and state special education laws require that the state, through local school districts, provide various supportive services—called “related services.” These services enable children who qualify for special education to benefit from their educational programs. “Related services” include occupational and physical therapy, and the range of outpatient services provided by county mental health agencies. Under the Individuals with Disabilities Education Act (IDEA), children with disabilities who qualify for special education are entitled to a free, appropriate, public education.

404 The obligations under Medi-Cal to children include an informing obligation -- namely, an obligation to advise Medi-Cal children and their families about the kinds of mental health services available to them through EPSDT. Congress, when enacting the Medicaid EPSDT provisions, directed that states take “aggressive action” to inform the families of recipients about EPSDT. 135 Cong.Rec. S13234 (Dec. 12, 1989). Federal regulations and the State Medicaid Manual require that families be informed of the specific services covered by EPSDT and where and how to obtain those services. 42 CFR § 441.56(a)(1984); HCFA, State Medicaid Manual, § 5121.C (Apr. 1990)

405 Cal. Code Regs., tit. 2 § 60020(i).

education (FAPE).\textsuperscript{407} An Individualized Education Plan (IEP)\textsuperscript{408} involving the family, school personnel, and others knowledgeable about the needs of the child determines the programs and services a special education student needs. Assembly Bill 3632, codified at Government Code §§ 7570 through 7588, enacted a way to share responsibility for delivering related services identified in the IEP. Government Code § 7576 says that county mental health programs are responsible for delivering mental health services (beyond counseling and guidance and other less intensive psychological services) when identified as necessary in the IEP. County mental health programs determine which mental health services are to be included in the IEP.\textsuperscript{409}

If a child qualifies for special education on a diagnosis of "Severely Emotionally Disturbed" (SED), and county mental health determines that 24-hour residential placement is necessary to enable the child to benefit from his special education program, county mental health also has responsibility for case managing and arranging such placement.\textsuperscript{410} However, before determining if a residential placement is necessary, state regulations require consideration of “less restrictive alternatives, such as providing a behavioral specialist and full-time behavioral aide in the classroom, home and other community environments. . . .”\textsuperscript{411}

\textsuperscript{407} 20 U.S.C. §1412(a)(5)(b)

\textsuperscript{408} Title 20 U.S.C. § 1401(8); 34 C.F.R.§ 300.4

\textsuperscript{409} The AB 3632 process can be very slow since the county may take 50 days or more to complete its assessment. Federal law, however, requires that Medi-Cal services be provided with “reasonable promptness.” Although waiting lists are permitted, routine appointments should be available within 7 days.

\textsuperscript{410} For more information, go to the PAI website at www.pai-ca.org and then click on publications and next “special education.” Look for Chapter 9, \textit{Information on Inter-Agency Responsibility for Related Services (AB 3632/882) of the SPECIAL EDUCATION RIGHTS AND RESPONSIBILITIES MANUAL.}

\textsuperscript{411} Cal. Code Regs., tit 2, § 60100(c). This regulation refutes any argument that a school is only obligated to provide a one-on-one behavior aide during school hours. An advocate may want to consider requesting a functional analysis assessment and behavior intervention plan through special education [ Ed. Code § 56521 and Cal. Code Regs., tit. 5, §§ 3001(f), 3052] and at the same time request TBS (therapeutic behavioral services) through the mental health plan.
Special education students whose IEPs say they need related services may have those services covered by Medi-Cal—through the school district or through county mental health/mental health plans.  This is an exception to the general rule that Medi-Cal is the payor of last resort or, that Medi-Cal does not pay for services another entity—like the school district—is required to provide. The IDEA was amended in 1997 to provide that the financial responsibility of any public agency, other than an education agency, which is involved in the provision of special education or related services, including the state Medicaid agency, shall precede the financial responsibility of local education agencies.

A child with mental health treatment needs is not limited to what is defined as necessary in his IEP. The Medi-Cal recipient child is entitled to receive medically necessary mental health services through the county mental health plan.

12. What is a Katie Beckett waiver? How can my child qualify for one?

The Katie Beckett waiver is part of the federal Medicaid Act. It is totally separate from that part of the Medicaid Act relating to home and community based waivers. The Katie Beckett waiver is something the state can opt to include in its state plan in the same way it can add an optional service. The type of approvals required for a home and community based waiver are not required for a Katie Beckett waiver. Under the Katie Beckett waiver, a state may elect to waive the parental income

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412 42 USC § 13d6b(c). If the state elected to do so, the Medi-Cal program could cover the treatment portions of services provided by residential treatment centers. Except for those placed in a nursing facility or an Intermediate Care Facility for the developmentally disabled, federal Medicaid law bars using Medicaid funds for room and board.


414 42 U.S.C. § 1396a(e)(3).

415 42 U.S.C. §§ 1396n(c)-(e). Congress added the Katie Beckett waiver provision to the federal Medicaid Act because of the Act's unfairness to a little girl named Katie Beckett. Before the waiver, Katie's needs were not covered at home because of family income and resources, but those same medical needs were covered in a medical care facility without regard to family income and resources.
and resources for all children who would qualify for Medi-Cal-funded long-term care in a nursing facility, intermediated care facility for the developmentally disabled or hospital. To "qualify" under this provision means that the child would medically qualify for long-term care and that Medi-Cal would cover the child's long-term care. The Katie Beckett waiver would enable a child to receive up to the amount the Medi-Cal program would spend if the child were in an appropriate medical facility. California does not have a Katie Beckett waiver.  

Although California has not opted for the Katie Beckett waiver, it has achieved similar results of waiving parental income and resources through the Model Nursing Facility waiver and the Developmentally Disabled Waiver pursuant to 42 U.S.C. §1396n(c). See Chapter 16.

416Although the Legislature twice passed bills authorizing California to opt for the Katie Beckett waiver, the governor vetoed both bills. AB 249 (1987) and AB 2862 (1996).
Chapter 8:
Immigrants and Health Care

This Chapter has been deleted as out of date. On Immigrants and Health Care issues, refer to the Western Center on Law and Poverty’s publication and the Health Consumer Alliance website at www.healthconsumer.org (Issue Brief on “Immigration and Health Care”).
Chapter 9:
Extended Medi-Cal Services for Children and for Others Who Lose SSI or Become Ineligible for Medi-Cal

The basic rule is that before Medi-Cal eligibility can be terminated under one program, the county and state agency must evaluate the case to see if the person would be eligible under any other program. To facilitate the redetermination process, persons determined to no longer eligible under one program continue to receive Medi-Cal for at least another month. Eligibility for Medi-Cal “shall not be terminated... until the county makes a specific determination based on facts clearly demonstrating that the beneficiary is no longer eligible for Medi-Cal under any basis and due process rights guaranteed under this division have been met.”

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417 42 U.S.C. § 1396a(a)(19). See 42 C.F.R. §§ 435.916(c)(1) (state agency to redetermine eligibility when it receives information about changes in a recipient’s circumstances that may affect his/her eligibility), 435.930(b) (state agency to continue Medi-Cal until recipient is found to be ineligible). See also DHS ACWDL No. 97-57 (12/8/97) which makes clear the rule applies to all programs and explains:

Redetermination should be initiated by an examination of the file to see if there is any indication that another basis for eligibility might exist. If there is not enough information in the file to make a determination, additional information can be requested from the recipient. If the recipient fails to provide the requested information within a reasonable time, benefits can then be terminated without completing the redetermination.

Several court cases are controlling on these issues for all Medi-Cal recipients. When one basis for eligibility disappears, the Department of Health Services must make a prompt determination of eligibility on other possible bases before the termination of benefits.

418 Welf. & Inst. Code § 14005.37(d), added by SB 87, Ch. 1088, Statutes of 2000. Other provisions in this section include the requirement that the county “make every reasonable effort to gather information available to the county that is relevant to the beneficiary’s Medi-Cal eligibility prior to contacting the beneficiary,” [14005.37(e)]; the requirement that if the information is not available to the
Beginning October 1, 2000, children who are under the responsibility of the foster care system (including those who are not receiving title IV-E funds) when they turn 18 will be automatically transferred to a new program called the “Former Foster Care Child” program or FFCC program when they leave the foster care system. No separate application is required. See Chapter 2, Section 7.

1. **Continuous Eligibility for Children (CEC)**

Beginning January 1, 2001, children under the age of 19 (i.e., have not yet reached their 19th birthday) who qualify for no-share-of-cost Medi-Cal (including Medi-Cal categorically linked to SSI or IHSS) are entitled to a period of continuous eligibility for zero-share-of-cost Medi-Cal for either 12 months or until the next annual redetermination date, whichever comes earlier.\(^{419}\) This is despite any intervening change in circumstances which would otherwise change children from zero share of cost to having a share of cost or would otherwise render them ineligible for Medi-Cal.\(^{420}\) The Continuing Eligibility for Children protections or CEC also applies when a county, then the county will contact the beneficiary by phone [14005.37(f)]; the requirement that a mail contact include a clear and simple cover letter with a telephone contact and a form on which is highlighted the information needed; the requirement that if the beneficiary submits information requested within 30 days of the termination of Medi-Cal, the county shall treat the receipt as timely and if the beneficiary is eligible, the termination will be rescinded. Welf. & Inst. Code § 14005.37(k). See the Western Center on Law & Poverty’s November 2001 SB 87 Guide, available from the website www.wclp.org or at www.healthconsumer.org.


\(^{420}\) DHS ACWDL 01-01 gives as one example a child whose parent’s income increases so that he/she is no longer eligible for one of the FPL programs but would be eligible for Medically Needy Medi-Cal with a share of cost. The child would be given a no-share-of-cost medically needy aid code. In another example, the family’s resources are not counted under the applicable FPL program but with an increase in family income the child is no longer eligible under the FPL program and the excess resources make the child ineligible under the Medically Needy program. The child’s zero-share-of-cost Medi-Cal would continue.
child loses Medi-Cal because of becoming ineligible for SSI.\textsuperscript{421} It does not apply to minor consent services.\textsuperscript{422} Eligibility for no-share-of-cost transitional Medi-Cal does not start a new period of eligibility.\textsuperscript{423} The 12-month CEC period would start with the redetermination that was prior to the start of Transitional Medi-Cal.

A CEC period may start prior to the date of application if found eligible for no-share-of-cost retroactive Medi-Cal. If the applicant applied in January and was eligible in January with a share of cost and also applied for December and was found eligible for December with no share of cost, The CEC period would start in December and run through the following November.\textsuperscript{424}

CEC is also available to assist children in foster care transition back to the home. Foster care review of Medi-Cal eligibility is scheduled to take place every 6 months. The 12-month CEC would run from the last foster care review.\textsuperscript{425}

Infants through to age one whose mothers at birth were eligible for and receiving Medi-Cal and who are living with their mothers are eligible for continuous Medi-Cal coverage without the need for a separate application.\textsuperscript{426}

\textsuperscript{421} DHS ACWDL 02-14 (3/8/2002), question 48. The state is working on procedures to apply CEC automatically to children whose SSI eligibility terminates or is suspended.

\textsuperscript{422} DHS ACWDL 02-14 (3/8/2002), question 32.

\textsuperscript{423} Transitional Medi-Cal is itself a form of continuing eligibility. See Questions 49 through 51 about Transitional Medi-Cal and CEC in DHS ACWDL 02-14. See Chapter 2 about Transitional Medi-Cal.

\textsuperscript{424} DHS ACWDL 02-14, Questions 45-47.

\textsuperscript{425} DHS ACWDL 02-14, Questions 23 through 27.

2. Losing SSI

(a) Losing SSI because of an increase in income and/or resources

If your (or your child’s) SSI stops because your income increased or because of excess resources, you will first receive a notice of action from the Social Security Administration. Information about your SSI stopping is posted in the State Data Exchange (SDX) which triggers a Medi-Cal termination notice with an application form.

Under federal law, the settlement in the Ramos v. Myers case, and a new state law

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427 When your SSI is stopped because of excess income or resources, your SSI is not terminated, only suspended. If your income or resources are reduced within the following 12 months after your termination, your SSI will be automatically reinstated upon request. If you are not reinstated then your SSI will be terminated after 12 months so that to requalify for SSI you would have to reapply. See 20 C.F.R. §§ 416.1323 (suspension due to excess income), 416.1324 (suspension due to excess resources), 416.1335 (termination after 12 continuous months of suspension).

If your SSI stops because of your own earned income, then you should still be an SSI recipient under the 1619(b) program, 42 U.S.C. § 1382h(b). You will continue to receive Medi-Cal even though your income is too high for cash assistance. See PAI’s Social Security manual. If your own earned income puts you above the general and individually determined 1619(b) threshold and your earned income stays above the cap for more than 12 months so that your suspension turns into a termination, under the 1999 work incentive improvement legislation, you may be reinstated to 1619(b) if your income drops within 60 months of your last receipt of title XVI benefits including 1619(b) benefits. (Incentives to work and work Incentives Improvement Act), 42 U.S.C. § 1383(p)(1)(C)(i). You will receive up to 6 months of provisional benefits while Social Security reviews your case. 42 U.S.C. § 1383(p)(7). Eligibility for reinstatement will be determined under the medical improvement standard. 42 U.S.C. § 1383(p)(3) referencing § 1382c(a)(4).

428 If you think Social Security made a mistake in stopping your SSI or your child’s SSI, then you should appeal the suspension by asking for a reconsideration. If you do so within 15 days of the date on the notice (or within 10 days of receiving the notice) and you ask for continuation of benefits on the separate benefits continuation form, your SSI will continue until the reconsideration decision. To have an in-person meeting to make the reconsideration decision, ask for a reconsideration by informal conference. If you cannot go to the office, your informal conference can be by phone.
that went into effect in 2001,\textsuperscript{429} when you lose your SSI, Medi-Cal cannot cut off your benefits until the county has determined whether or not you qualify for Medi-Cal on another basis.\textsuperscript{430} You will receive at least one month of Medi-Cal after your last SSI month.\textsuperscript{431} The state Medi-Cal program will send you: (a) a notice that your SSI-linked Medi-Cal is terminated and (b) a new Medi-Cal application form so that the county eligibility workers can determine whether you qualify for Medi-Cal under another program. If your SSI stopped because of excess income, you will receive an interim share of cost pending the processing of your new Medi-Cal application form.\textsuperscript{432}

It is very important that you fill out and return the application to the county by the date indicated—usually the 20th of the month. It is important that you do this even if you are also appealing the termination. We recommend that you send in the application by return receipt requested so that you have proof of when the county received your application. Because the county often makes mistakes in how it processes the new application,\textsuperscript{433} we also recommend that you appeal your first termination—to make

\textsuperscript{429} The new state law is Welf. & Inst. Code § 14005.37.

\textsuperscript{430} Instructions to counties for this program are in the DHS MEDI-CAL ELIGIBILITY PROCEDURES MANUAL § 5E - Ramos v. Myers Procedures (7/15/87).

\textsuperscript{431} Section I-B in DHS MEDI-CAL ELIGIBILITY PROCEDURES MANUAL at Section 5E-1; Cal. Code Regs., tit. 22 §§ 50179.5, 50183. Under Welf. & Inst. Code § 14005.37, you cannot have your Medi-Cal terminated until the county affirmatively determines you are not eligible under another basis - which could take more than one month.

\textsuperscript{432} The State Data Exchange (SDX) includes information about the amount of income triggering the SSI suspension. Section I-D at 5E-1 of the DHS MEDI-CAL ELIGIBILITY PROCEDURES MANUAL.

\textsuperscript{433} For instance, when the county gets the new application, it should input information into the state computer so that Medi-Cal will continue until a decision is made on the new application. In fact, counties often do not input a continuation direction upon receipt of the new application. As a consequence, Medi-Cal will be terminated as of the first of the next month even if no determination has been made on the new application. For an explanation of how the county is supposed to handle the new application under the Ramos v. Myers’ procedures, See Section III at pages 5E-3 through 5E-5,
sure that your Medi-Cal continues while the county processes your new Medi-Cal application.

If you do not return the new MN Medi-Cal application, or if the county decides you don't qualify, you will receive a second notice of action from the county terminating your extended Medi-Cal benefits under Ramos. If you appeal this county termination notice before the end of the month, your Medi-Cal will continue as "aid paid pending" until your fair hearing. If you forgot to send your new Medi-Cal application in on time, appealing this second termination notice should give you time to straighten out the problem while still receiving Medi-Cal.

(b) Losing SSI when Congress narrowed the definition of disability for children

New, more restrictive SSI disability standards for children were included in the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). However, in the 1997 Balanced Budget Act, Congress mandated that these children's Medicaid benefits must continue automatically as long as the child would be eligible for SSI but for the change in the definition of disability under the 1996 federal law. This special entitlement continues even if there are breaks in coverage. This protection is in addition to the continuation of Medi-Cal benefits during the appeal of a termination of SSI benefits on the ground that the child does not meet the new disability standard.

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(c) Losing SSI when going into a nursing home

If you lose SSI because you enter a nursing home, Medi-Cal will continue with no share of cost, but the county must contact you within 30 days and help you complete a Medi-Cal application. Although you do not have to send a Medi-Cal application to the county, and the county is supposed to make sure that your Medi-Cal continues without interruption, it is still a good idea to appeal the first termination notice—in case the county makes a mistake.

(d) Losing SSI and/or Social Security disability benefits because no longer disabled

If Social Security says you are no longer disabled and therefore no longer eligible for SSI, SSDI, DAC, or Widow/ Widower disability benefits and you timely appeal, then your Medi-Cal will continue through the appeal process even if you did not appeal in time for your disability benefits to continue during the appeal process. As soon as Medi-Cal gets information from the State Data Exchange indicating your benefits are being terminated because you are no longer disabled, Medi-Cal will send a

436 If you enter a nursing facility temporarily in that you do not expect to stay there more than 90 days or three months and you have a home to go back to so that you need your full SSI check to maintain your home and you submit to Social Security by the 90th day of being in a medical facility something from your doctor that says you are not likely to be in the institution for more than 90 full consecutive days, you will continue to get your full SSI check. 20 C.F.R. §416.212(b), 42 U.S.C. §1382(e)(1)(G). If you are in a hospital before you go into a nursing facility, you add together the time in the hospital and the nursing facility.

437 Section III-B at pages 5E-4 and 5E-5, DHS MEDI-CAL ELIGIBILITY PROCEDURES MANUAL; Cal. Code Regs. tit. 22 § 50147.

438 The first step in an appeal of a termination is a request for reconsideration and the second step is a request for a hearing before an administrative law judge (ALJ). For more information about the appeal process, see the Social Security Manual posted on PAI’s webpage - www.pai-ca.org - or visit the Social Security webpage at www.ssa.gov/ and click on “frequently asked questions.” Then chose “benefits,” followed by “hearings and appeals.”
notice advising you that your Medi-Cal will continue if you appeal.\footnote{See DHS ACWDL 99-27 (5-28-99).}

If you appeal the determination that you are no longer disabled by filing a request for reconsideration within 15 days of the date on the notice (or 10 days from receipt) or have good cause for filing later, your SSI or Social Security disability benefits can also continue until there is an ALJ decision. At the same time you appeal the Social Security determination, you must also file a benefit continuation form with Social Security in order for your benefits to continue.\footnote{You must also timely appeal by filing a request for a hearing if you receive an adverse request for reconsideration. “Timely” in the Social Security system means within ten days of receipt or within 15 days of the date on the notice or envelope. If you do not file your reconsideration request in time for your benefits to continue following the initial termination, your benefits can resume if you appeal the reconsideration denial within 15 days of the date on the notice. Conversely, if you do not timely appeal the reconsideration denial, your benefits will stop. You will need to fill out a separate benefits continuation form when you request a reconsideration or hearing before the ALJ. See DHS ACWDL Nos. 97-28 and 97-56, CCH MEDI-CAL GUIDE NEW DEV.}

To avoid any interruption in your Medi-Cal benefits, you should appeal separately your Medi-Cal termination notice. When the county appeals worker calls, tell her that you are appealing your SSI termination so your Medi-Cal should continue. If the county worker agrees, sign a conditional withdrawal of your hearing request based on the County Worker’s agreement that your Medi-Cal will continue. This applies to people who got Medi-Cal linked to SSI as well as to people who received too much income to qualify for SSI and who qualified for Medi-Cal as Medically Needy. To get continued Medi-Cal you must timely appeal your Social Security and/or SSI termination at each step - reconsideration, hearing, and appeals council.\footnote{See DHS ACWDL Nos. 97-28 and 97-56, CCH MEDI-CAL GUIDE NEW DEV.}

3. **Losing CalWORKs or other Medi-Cal Eligibility Links**

Just as with SSI, when you lose your CalWORKs benefits because the county...
Chapter 9: Extended Medi-Cal Services

sends you are no longer eligible, the state must continue Medi-Cal benefits with no share of cost. Under the Edwards v. Myers judgment, Medi-Cal must continue until the county decides whether you continue to qualify under the Section 1931 Medi-Cal program or whether you qualify on another basis—such as transitional Medi-Cal for people who used to qualify for Section 1931 Medi-Cal, the MN Medi-Cal program (if your income or resources have increased) or one of the FPL programs (if you no longer meet the AFDC-linkage requirements but you still have a low income).

New state laws that went into effect July 1, 2001, gives greater protection to persons transitioning off of CalWORKS or when circumstances change that can otherwise affect Medi-Cal eligibility. When this occurs, the county cannot automatically terminate eligibility. The county must “redetermine” eligibility before cutting benefits. In doing so, the county must follow three specific steps to try to support a finding of eligibility: 1) a thorough exparte review, making every reasonable effort to gather information about eligibility before contacting the person; 2) phone contact, if necessary, and 3) sending a special form requesting only necessary information not otherwise available to the county. The county must give 20 days for the person to return the form with the necessary information. Only after following these steps, can the county send a notice of action notifying the person that eligibility will be terminated. The person has the opportunity to appeal the decision, and ask for “aid paid pending” the outcome of a state fair hearing.

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442 See section (1b) in Chapter 2. If you qualify for CalWORKS, you also qualify for Section 1931 Medi-Cal but you also can qualify for Medi-Cal independently of CalWORKS.


444 See Welf. & Inst. Code §§ 14005.31, 14005.32, 14005.34.

(a) **Transitional Medi-Cal**

Families losing CalWORKS or 1931(b) eligibility because of earnings are eligible for up to 24 months of free, no share of cost Medi-Cal. In order to be eligible, families must have been receiving either CalWORKS or 1931(b) during at least three of the last six months before losing such benefits. During the first six months of this transitional Medi-Cal (TMC), families qualify regardless of income. During the second six months, families must remain employed, unless there is good cause. Also after the first six months, the families' gross average income (minus child care costs) may not exceed 185% of the federal poverty level. There are no property limits for the TMC program.

Families losing CalWORKS or 1931(b) due to an increase in child or spousal support also are eligible for four months of TMC. To qualify, families must have been receiving CalWORKS or 1931(b) at least three of the last six months prior to losing such benefits. There are no income or property limits for four-month TMC.

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446 Ca. Welf. & Inst. Code §§ 14005.8-14005.81; Medi-Cal Eligibility Procedures Manual at 5B-3 *et. seq.* Families losing AFDC-MN coverage because of incurred earnings also qualify for TMC if during at least three of the last six months preceding loss of AFDC-MN, the family would have qualified for 13931(b).

447 Children under age 19 lose TMC Medi-Cal after one year because they should receive Medi-Cal under the Federal Poverty Level program for children or receive Healthy Families. Medi-Cal Eligibility Procedures Manual at 5B-5. Families also are required to submit quarterly status reports during the first year of TMC. A federal waiver request to eliminate reporting during the first year was denied by the federal agency. However, families do not have to submit quarterly status reports during the second year. Id. at 5B-3; Cal. Welf. & Inst. Code § 14005.81.

Chapter 9: Extended Medi-Cal Services

Note: Families losing CalWORKS should first be evaluated for § 1931(b) eligibility since there are no time limits.

(b) Medi-Cal/Healthy Families Bridge Program

Children who are no longer eligible for free, no share of cost Medi-Cal can be eligible for one additional month of Medi-Cal to allow the child to apply for the Healthy Families program. In order to be eligible for the Bridge program, children must:

C be one year of age or older, but not yet age 19; and
C be otherwise eligible for Healthy Families (e.g., a citizen or qualified alien without other health coverage whose family net income is at or below 250% of the federal poverty level) and
C irrespective of property, have a share of cost in the month following the last zero, share of cost month.

449 Ca. Insurance Code § 12693.98. Section 16.5, Chpt. 171, Stat. 2001 amends this section to require two months of coverage. However, DHS has taken the position that the extension from one month to two will not apply until the Healthy Families parent expansion has been approved by the Centers for Medicare and Medicaid Services. DHS ACWDL No. 01-57 (10/15/2001). Final approval is imminent. This benefit also will be available to parents of children in Healthy Families or Medi-Cal once the parent expansion has been implemented. Also pursuant to the waiver is a two-month bridge for children and parents losing Healthy Families to apply for Medi-Cal. Cal. Insurance Code § 12693.981(e).

450 DHS ACWDL Nos. 99-06 (02/01/1999), 01-57 (10/15/2001). In other words, a child may have a zero share of cost in January by being eligible for Medi-Cal under a federal poverty level program, AFDC-Medically Needy, Blind or Disabled- Medically Needy, Medically Indigent, CalWORKS, § 1931(b), the Income Disregard Program for Infants, SSI, or Transitional Medi-Cal. In February, the county redetermines eligibility following the steps described in section 3 above and finds that there is no eligibility under a zero share of cost program. ACWDL No. 99-06. With one year continuous eligibility for most children, this redetermination will not need to occur until the annual
Families should receive notices of action indicating termination of zero share of cost eligibility, eligibility for share of cost Medi-Cal, and eligibility for the Bridge program. Families can appeal their termination from zero share of cost Medi-Cal if they believe that they still should be eligible or appeal the amount of their share of cost if they believe that the amount is incorrect and too high. In addition, counties may send families a Healthy Families application packet. If not, families can call 1-800-888-5305 to request a packet.

4. **What if I was receiving Medi-Cal because I am disabled but I was subsequently Denied SSI?**

If you are receiving Medi-Cal on the basis of disability (ABD Medically Needy Medi-Cal or A&D FPL program) and then are denied SSI because Social Security says you are not disabled, your disability linked Medi-Cal will continue if you appeal your SSI denial within 65 days of the date on the notice (or have good cause for filing late) for each level of review. If you timely appeal, your Medi-Cal benefits will continue until you receive an unfavorable decision from the Social Security Appeals Council.\(^{451}\)

5. **How does Medi-Cal know what my SSI Disability Benefits are?**

When SSI is terminated or suspended, the information is posted on the State Data Exchange (SDX). If you are denied because of excess income then the data will include information about what amount is in excess of the income limit.

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\(^{451}\) HCFA State Medicaid Manual § 3272.2. DHS 1. CL 01-59 (11/2/2001). Even if you don’t timely appeal or lose at the Appeals Council, your benefits just might continue because our experience is that the state is not enforcing the punitive aspects of the Disabled Rights Union judgment.
6. I applied for SSI and was initially found to be presumptively disabled so I received SSI and Medi-Cal. Social Security then decided I was not disabled and stopped my SSI. I am appealing through Social Security. What happens to my Medi-Cal.

You are entitled to continue receiving Medi-Cal through your Social Security appeal process through to the appeals council. Persons who appeal the Social Security determination that they are no longer disabled, should specifically ask for continuing Medi-Cal. The state computer system has recently been updated so that the counties can see that the SSI applicant had been granted presumptive disability but that the application was denied. The state computer system also can tell whether there is an appeal pending. The County will contact the state who will reinstate your Medi-Cal.

7. Four years ago my SSDI stopped because of work. I am not working now and I reapplied for SSDI. Social Security reinstated my SSDI while processing my application. Will I qualify for Medi-Cal?

Yes. You were reinstated because of provisions in the new Ticket to Work and Work Incentives Improvement Act which say that if your title II Social Security disability benefits stopped before because of work within the past 60 months, you can be reinstated to provisional benefits for six months while Social Security processes your new application. For purposes of the Medi-Cal program, your provisional reinstatement will satisfy the disability criteria for the medically needy program or the Aged & Disabled FPL program. If Social Security decides you are not eligible for Social Security disability benefits and terminates your provisional benefits, you will be eligible for continued Medi-Cal benefits as long as your Social Security appeal is pending.

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452 DHS ACWDL No. 01-59 (11/2/2001)


454 42 U.S.C. §423(i).
Chapter 10:
Eligibility And Where You Live: Institutions for Mental Disease (IMD) and Public Institutions

1. Institution for Mental Disease (IMD)

“IMD” is a federal Medicaid Act term. Federal Medicaid reimbursement is not available for care and services for any persons who otherwise would be a Medi-Cal recipient if under age 65 and “a patient in an institution for mental diseases.” Regulations define IMD as “a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services.” Except for psychiatric hospitals or units, most IMDs in California are locked nursing facilities. Care for residents under 65 is funded not by Medi-Cal but through County Mental Health.


456 42 C.F.R. § 435.1009. CMS (formerly know as HCFA) guidelines indicate that indices of an IMD include: (a) being under the jurisdiction of the state mental health agency, (b) accredited as a psychiatric facility, (c) specializing in providing psychiatric or psychological services to residents, (d) more than 50% of the residents require specialized services related to mental illness. HCFA STATE MEDICAID MANUAL § 4390.C, reproduced in CCH MEDICARE AND MEDICAID GUIDE ¶ 14.601.25. “Mental Disease” does not include dementia (like Alzheimer’s or mental retardation). HCFA, STATE MEDICAID MANUAL § 4390.D.
Chapter 10: Eligibility and Where you Live

2. Inmate of a public institution and qualifying for Medi-Cal

Federal Medicaid reimbursement is not available for care and services for any persons who otherwise would be a Medi-Cal recipient if under age 65 and “an inmate of a public institution (except as a patient in a medical institution).”\(^{457}\) A public institution is defined in federal Medicaid regulations as one which “is the responsibility of a governmental unit or over which a governmental unit exercises control.”\(^{458}\)

- The term “public institution” as used in the federal Medicaid Act does not include a “medical institution”—staffed and capable of handling medical and nursing needs.\(^{459}\)
- The term “public institution” as used in the federal Medicaid Act does not include a publicly-operated community residence of 16 or fewer beds. However, that public institution exception does not apply to residences adjacent to larger institutions or facilities licensed as nursing facilities or ICFs.\(^{460}\)
- A person is not considered an “inmate of a public institution” if “[h]e is in a public educational or vocational training institution for purposes of securing educational or vocational training.”\(^{461}\)


\(^{458}\) 42 C.F.R. § 435.1009.

\(^{459}\) This is different from SSI’s public institution rule. For SSI a “public institution” includes medical facilities.

\(^{460}\) Definition of “Public institution” in 42 C.F.R. § 435.1009 excludes “a publicly operated community residence.” The definition of a “publicly operated community residence” in 42 C.F.R. § 435.1009 “residential facilities located on the grounds of, or immediately adjacent to, any large institution or multiple purpose complex.”

\(^{461}\) Excluded from the definition of “Inmate of a public institution” in 42 C.F.R. § 435.1009 are individuals “in a public educational or vocational training institution for purposes of securing education or vocational training”; or “in a public institution for a temporary period pending other arrangements appropriate to his needs.”
Chapter 10: Eligibility and Where you Live

• A person is not considered an “inmate of a public institution” if “[h]e is in a public institution for a temporary period pending other arrangements appropriate to his needs.”

3. IMD nursing facility

If you live in a Nursing Facility that is classified as an Institution for Mental Disease (IMD). You might be able to get Medi-Cal and/or SSI. This depends on your age and on whether the IMD is public or private. Federal Medicaid law says Medicaid or Medi-Cal does not include:

Care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or . . .

Care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

(a) Ineligible for SSI or Medi-Cal if under 65 and in a public IMD

You would be eligible for Medi-Cal, assuming you met other eligibility rules, if you are 65 years of age or older, regardless of whether the IMD is private or public. Under the SSI program, you are not eligible for SSI if you are "an inmate in a public institution," with several exceptions. One of the SSI "public institution" exceptions is that, if Medi-Cal covers at least 50% of the cost of care, then you are eligible for SSI. But because Medi-Cal can't cover your care because you are in an IMD and you are under

462 Excluded from the definition of “Inmate of a public institution” in 42 C.F.R. § 435.1009. This is why dependency court and foster children held in public facilities such as Los Angeles County’s MacLaren Hall qualify for Medi-Cal.

the age of 65 years, you cannot qualify for SSI under the Medi-Cal coverage exception.

(b) **Ineligible for Medi-Cal but Eligible for SSI if under 65 and in a private IMD**

While being a resident of a public IMD means you don't get SSI, as a resident of a private IMD you would qualify for SSI and, theoretically, to Medi-Cal categorically-linked to your receipt of SSI. Theoretically, Medi-Cal would cover services other than nursing facility services covered under the daily rate -- ancillary services such as physician services, prescriptions, etc. CMS, however, disallowed California federal financial participation for such services and that disallowance was sustained on appeal. Thus while you are in a private IMD, you will receive your full SSI check -- namely the amount of SSI you would receive if you were living on your own in the community -- there will be no Medi-Cal with federal financial participation attached to that SSI.

(c) **Eligible for SSI and Medi-Cal if 65 or older more and in a private IMD**

If you are under age 21 or over age 65, you receive SSI at the $45-a-month nursing facility rate in 2001, but Medi-Cal covers the cost of care in the nursing facility and all ancillary services.

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440 Decision in the Appeal of the California Department of Health Services, Appeals Board of HHS, Docket No. 91-151, Decision No. 1338 (6/15/92), reprinted in CCH Medicare and Medicaid Guide New Dev. ¶ 40,383: "the general IMD exclusion . . . does not distinguish among services, and prohibits Medicaid payment for the ancillary and physician services that California provided to individuals 22-64 in IMDS." At p. 31,575.
4. Services outside hospital

If you are in a state mental hospital, going outside the hospital for services won't work. Medi-Cal will not pay for the services outside of the hospital either. You are ineligible for Medi-Cal because of where you live. Under Medicaid law, you are ineligible because you are either an "inmate in a public institution" or a "patient in an institution for mental disease." There are no grounds for independently qualifying for Medi-Cal through SSI.

441 42 U.S.C. §§ 1905(a)(27)(A) and (B).
Chapter 11:
Medi-Cal and Long-Term Care

For general information on consumer rights in nursing facilities, see the National Senior Citizens Law Center's quarterly “Nursing Home Law Letter” and Nursing Facility Manual as well as other postings under “Nursing Homes” on its webpage. See, also, the California Advocates for Nursing Home Reform’s quarterly publication “The Advocate” available from CANHR’s website. In addition, see Bet Tzedek Legal Services' excellent consumer/advocate publication “Nursing Home Companion.”

1. Intermediate Care Facilities (ICFs) and nursing facilities

Q: What is the difference between an ICF and a nursing facility? Aren't they the same?

A. Some large intermediate care facilities for developmentally disabled (ICF/DD) are indistinguishable from nursing facilities. Small ICF/DD

“Long term care” includes nursing facilities (NF) such as subacute nursing facilities, “level A” nursing facilities (which used to be called intermediate care facilities for the developmentally disabled), and “level B” nursing facilities which used to be called “skilled nursing facilities. The term also includes intermediate care facilities for the developmentally disabled (ICF) and the following subcategories: ICF/DD, ICF/DD-H (habilitative), ICF/DD-N (nursing).

Visit Bet Tzedek's webpage at www.bettzedek.org for an excellent on-line guide to nursing home law and other publications which can be ordered.
facilities—like the ICF/DD-H facilities—are very different. However, federal regulations provide that, even if the facility meets all the criteria to classify it as a nursing facility under the Nursing Home Reform Act,\textsuperscript{446} residents of ICF/DD facilities do not have the protections and benefits available to residents of nursing facilities which are not ICF/DD facilities. Residents of ICF/DD licensed facilities do, however, have service rights and limited protections under the federal regulations governing state licensed ICF/DD facilities.\textsuperscript{447}

### 2. ICF and “Disabled Adult Child” (DAC) benefits

**Q:** I was living in a group home and receiving both SSI and Title II Social Security (DAC) benefits. Then the group home changed to an ICF. I lost my SSI and the county said I had to pay the ICF everything over $35. Is that correct?

**A:** Maybe. If you were receiving any Social Security Title II Disabled Adult Child (DAC) benefits in July of 1987, what the county told you is correct.

However, if you did not receive any Title II DAC benefits in June of 1987, and you first started receiving DAC benefits in July of 1987 or later, then you would qualify for no-share-of-cost Medi-Cal as a “Medi-Cal DAC” or “pseudo-Pickle DAC.” See Chapter 2. Expect a fight and a fair hearing if you did not first qualify for DAC benefits while you were in the facility and receiving SSI. The DHS PICKLE MANUAL erroneously indicates you’re not eligible for Medi-Cal DAC benefits if you are in long-term care.\textsuperscript{448}

\textsuperscript{446} 42 U.S.C. § 1396r(a).

\textsuperscript{447} 42 C.F.R. §§ 485.400 et seq.

\textsuperscript{448} See pages 6.1 and 6.2 attached to DHS ACWDL No. 93-30. The source of the error is that DHS is not applying the “but-for” test. Under the but-for test the resident of a long-term care facility would be eligible for no-share-of-cost Medi-Cal if he initially qualified for DAC benefits in July.
3. ICF and Income deductions

Q: If you are living in an ICF and have a share of cost of everything over $35 since I have been receiving Title II DAC benefits since 1982. Why doesn’t Medi-Cal allow me the earned income deductions I used to get when the facility was a group home instead of an ICF?

A: When you live in an ICF or nursing facility, the federal government requires states to impose different rules for counting income. California could, like 26 other states, amend its state plan to incorporate work incentive deductions as part of the personal needs allowance. California uses the most restrictive rules possible and has not chosen to address the system’s work penalty. The current rules penalize people who live in ICFs and nursing facilities and who also work: (a) by counting their gross income rather than their earned income after mandatory deductions, and (b) by not giving them the work incentive deductions they could get if they received SSI in the facility, or if they

of 1987 or later. See Section 2.(b) including footnotes in Chapter 2.

449 See 42 C.F.R. § 435.725(c) which covers persons in Medi-Cal funded facilities who are classified as “categorically optionally needy,” and 42 CFR § 435.832(c) which covers persons in Medicaid funded facilities who are classified as “Medically Needy.” In California, persons in Medi-Cal funded facilities who are not receiving SSI would be covered by Medi-Cal as “medically needy.” However, many such persons also could be covered as categorically optionally needy because they would be eligible for SSI if they were not in long-term care. The relevant language is in both regulations. When those regulations say “income that was disregarded in determining eligibility must be considered in the process [of determining share of cost],” they are directing states to use gross income and are barring them from granting long-term care residents the earned income deductions afforded Medi-Cal recipients who are not in long-term care.

450 For example, $65 work incentive deduction plus a deduction of 50% of the balance. Cal. Code Regs. tit. 22 § 50551.3.
qualified for ABD Medi-Cal outside a nursing facility or ICF.\textsuperscript{451} The rules also penalize people with unearned income where there are income tax or other mandatory expenses. In both cases and particularly where there is earned income, people in long-term care may end up with a share of cost larger than their income or with their $35 a month for personal and incidental needs seriously reduced.\textsuperscript{452}

4. **Eviction from facility**

**Q:** The facility is evicting me. What are my rights? What can I do?

**A:** Did Medi-Cal deny your doctor's request for continued coverage of your stay? Did Medi-Cal say you are no longer eligible to live in the facility? If so, you have a right to challenge Medi-Cal’s decisions. You have a right to have Medi-Cal continue while you appeal. You have a right to have the hearing at the facility itself because that is your home. See Chapter 17 for more information on the fair hearing process.

If it is the facility which is evicting you, your rights and what you can do depend on whether you live in a nursing facility or in an ICF/DD facility.

\textsuperscript{451} Welf. & Inst. Code § 14005.9(b) (directs that deductions allowed in the community not be allowed while in a medical institution); Welf. & Inst. Code § 14005.12(d) (allowance when in long-term care), (e) (deduction for care of dependents). California could recognize other needs such as work incentive deductions within the scope of personal and incidental needs but has not yet elected to do so.

\textsuperscript{452} See Peura v. Mala, 977 F.2d 484 (9th Cir. 1992). If you are in long-term care and receive SSI (in 2001 SSI/SSP grant level of $45), you receive work incentive deductions and would be eligible for the 1619(b) program if your earned income after allowable deductions is too high for any cash assistance.
Overview of the Medi-Cal System March 2002 revisions

(a) Rights when in a nursing facility and threatened with eviction

If you live in a nursing facility and not an ICF/DD, the federal Nursing Home Reform laws and regulations\(^453\) govern your rights.

(i) Six good cause grounds for discharge or transfer

The nursing facility cannot transfer or discharge you unless there is documented\(^454\) good cause to do so which fits into one of the good cause grounds allowed.\(^455\) There are six good cause grounds for transfer or discharge: (a) when it is necessary for your own welfare and your needs cannot be met where you are; (b) your health has improved sufficiently so that you no longer need the services provided by the facility; (c) when it is necessary for the health and/or safety of other residents; (d) when you haven't paid including any share of cost obligation; (e) the facility is closing, or “ceases to exist.”\(^456\)

(ii) Even if discharge is based on good cause grounds, the nursing facility must comply with notice requirements

In order for the nursing facility to be able to discharge or transfer you, the nursing facility must strictly comply with the notice requirements. All the “t’s” must be crossed and all the “i’s” dotted.

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\(^{454}\) 42 C.F.R. § 483.12(a)(3). If the ground for discharge is medical improvement so that the services are no longer needed, or because of an urgent medical need of the resident, the attending physician must have documented that in the clinical record. \textit{Id.}

\(^{455}\) 42 C.F.R. § 483.12(a)(2).

\(^{456}\) 42 C.F.R. §§ 483.12(a)(2)(i) through vi.
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The notice must be made at least 30 days before any transfer or discharge with some exceptions.\textsuperscript{457} The notice must include all the required information including the reason for the discharge and its effective date, the location to which the resident is being transferred or discharged, and appeal rights.\textsuperscript{458} In addition, the nursing facility is required to take steps to prevent transfer trauma.\textsuperscript{459}

(iii) Discharge or transfer fair hearings

Appeals of evictions are handled by administrative law judges from the Department of Health Services.\textsuperscript{460}

You stay in the facility until the administrative law judge decides your case.\textsuperscript{461} The facility has the burden of establishing that there are good cause grounds to transfer or discharge you and that all the procedural requirements are met. Our experience is that when the good cause and/or procedural requirements are not met, the nursing facility has to start over.\textsuperscript{462}

\textsuperscript{457} 42 C.F.R. § 483.12(a)(5)(i). However, less notice may be required where the health and safety of other residents may be involved or because of the urgent medical need of the resident or the resident has been in the facility less than 30 days. 42 C.F.R. § 483.12(a)(5)(ii).

\textsuperscript{458} 42 C.F.R. § 483.12(a)(6).

\textsuperscript{459} 42 C.F.R. § 483.12(a)(7).

\textsuperscript{460} Fair hearing regulations at 42 C.F.R. §§ 483.200-483.206.

\textsuperscript{461} 42 C.F.R. § 483.204(b) makes the Medi-Cal fair hearing rules apply which includes the requirement of maintaining the services during the pendency of the hearing process.

\textsuperscript{462} In a consolidated case involving the transfer of a group of residents of the Rancho Los Amigos nursing facility when the facility was being closed, the Department of Health Services ALJ
(b) Rights when in an ICF/DD and threatened with eviction

If you live in a facility licensed as an ICF/ DD facility, there are some state and federal protections. Under federal regulations, if the facility wants to transfer or discharge you, the facility must: (a) document the good cause for doing so, (b) provide a reasonable time to effect the transfer, (c) develop a final assessment report, and (d) prepare a post-discharge plan of care.\footnote{463} There is no administrative procedure under state or federal regulations for you to enforce the right not to be discharged or transferred except for good cause. State licensing regulations provide some additional protections from being discharged except for good cause. Facilities must have policies and procedures on transfer, discharge, and what constitutes cause for termination of services.\footnote{464}

found that although there was a good cause ground for transfer, Rancho could not proceed because 30-days notice was not provided, the transfer location was not specified, and obligations regarding orientation for transfer were not met.

In another case where Medi-Cal had denied reauthorization, the discharge notice was withdrawn when the ALJ noted that the treating physician had not indicated in the clinical record that the resident’s condition had changed so that she no longer needed nursing facility services.

In another case the Department of Health Services ruled the nursing facility could not discharge a resident where Medi-Cal had denied authorization because of the failure to identify the location to which the resident would be discharged.

\footnote{463} 42 C.F.R. §§ 483.440(b)(4)(5).

\footnote{464} ICF/DD, Cal. Code Regs. tit. 22 § 76521(c)(3); ICF/DD-H, § 76916(a)(3); ICF/DD-N, § 73917(a)(3). A resident has the right not to be transferred except for his welfare or the welfare of others in the facility or a failure to pay share of cost. ICF/DD, § 76525(a). No client shall be summarily discharged by the licensee unless the client is clearly engaged in behavior that is a threat to property or to the safety of others. ICF/DD-N, § 73925(b)(7); ICF/DD-H, § 76924(b)(7). Alternatively, the admissions contract must indicate the conditions under which the admission agreement may be terminated. ICF/DD, § 76555(b)(7).
Although there are no administrative procedures for enforcing the right not to be discharged or transferred out except for cause, we do not believe the facility can use self-help to evict you. We believe the facility would have to file a lawsuit to evict you, and you could raise your right not to be evicted except for cause in that context.

5. Qualifying for admission to ICF/DD

Q: Our son was head injured at age 19, so he does not qualify for regional center services. Can he qualify for services in an ICF/DD-H?

A: In the opinion of PAI attorneys, yes. The state regulation limiting admission to ICF/DD facilities to people who are also eligible for regional center services conflicts with federal law. That law provides that ICF/DD services are available to persons who meet the Medicaid definition of developmental disability.\(^{466}\)

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\(^{465}\) To qualify for regional center, services you must have been disabled prior to age 18. Welf. & Inst. Code § 4512(a).

\(^{466}\) See Parry v. Crawford, 990 F.Supp. 12650, 1257 (D.Nev. 1998) (Nevada could not limit ICF services to persons with mental retardation and was required to make services available to persons who met the federal definition of persons who are mentally retarded or have a related condition). The CMS (formerly known as HCFA) Medicaid definition of developmentally disabled includes persons with mental retardation and persons with "related conditions." 42 CFR § 435.1009. Note that although the Medicaid definition of developmental disability is not as broad as the federal definition of developmental disability in 42 U.S.C. § 6001(5), the Medicaid definition is broader than the state service definition of developmental disability in Welf. & Inst. Code § 4512(a) in two ways: First, it includes persons who became disabled prior to age 22 rather than prior to age 18. Second, it includes persons whose adaptive deficits are the result of a neurological or other impairment without involving any impairment in cognitive functioning. Comments accompanying the adoption of the CMS regulation say that the "definition encompasses individuals with severe physical impairments associated with disorders such as spina bifida and muscular dystrophy..." and "the related condition may not affect the individual's intellectual ability." 51 CFR 19177, 19178 (5/27/86); 51 C.F.R. 19177, 19180.
6. I live in a nursing facility, not an ICF/DD. What are my service rights?

(a) Pre-Admission screen to see if you are mentally ill or developmentally disabled and if so, whether you could receive the services you need outside a nursing facility

Federal law requires that before someone is admitted to a nursing facility there is to a preliminary screen\(^{467}\) to determine if the person is either mentally ill\(^{468}\) or developmentally disabled.\(^{469}\) If so, there is supposed to be a more involved evaluation to determine whether the person's treatment needs could be met in a setting other than a nursing facility and whether the person needs "specialized services."\(^{470}\) For a person who meets the federal Medicaid definition of developmental disability, that can mean placement in an ICF/DD.

There is never such a screen or fuller evaluation before someone is admitted to a nursing facility. California performs the "preadmission" screen within the first few months following admission to a nursing facility.

\(^{467}\) 42 USC § 1396r(e)(7); 42 C.F.R. § 483.106(a). See, also, the Department of Health & Human Services Office of Inspector General Report "Younger Nursing Facility Residents with Mental Illness: Preadmission Screening and Resident Review Implementation and Oversight," 93i-05-99-00700; 1/01, found at www.hhs.gov/oig/oei/whatsnew.html.

\(^{468}\) Defined at 42 C.F.R. § 483.102(b)(1).

\(^{469}\) Mental retardation and related conditions defined at 42 C.F.R. §§ 435.1009 and 483.102(b)(3).

\(^{470}\) 42 C.F.R. § 483.120.
If the person meets the federal criteria for mental illness or developmental disability and, is determined to need specialized services but also is determined to need nursing facility services, then those services must be provided in the nursing facility.\textsuperscript{471}

(b) Comprehensive assessment and plan of care

The Nursing Home Reform laws require that, when you go into a nursing facility, you must have a comprehensive assessment and a plan of care.\textsuperscript{472} These are very important documents because they define your service rights in the facility. You should review these documents to be sure your assessment is complete and accurate, and your plan of care contains everything you need. The plan of care is: (a) to enable you to recover function to the extent possible and (b) to prevent or minimize loss of function and skills through services to maximize your mental, physical and psychosocial well being.\textsuperscript{473} The plan of care defines your right to services including supplemental services authorized by Medi-Cal through a Treatment Authorization Request or TAR process.\textsuperscript{474}


\textsuperscript{472} 42 U.S.C. § 1396r(b)(3); 42 C.F.R. § 483.20.

\textsuperscript{473} 42 U.S.C. § 1396r(b)(4), 42 C.F.R. § 483.25(a).

\textsuperscript{474} Valdivia v. Kizer, Class Action Stipulation and Order filed April 13, 1993, "Duties and Responsibilities," ¶ 2-f, set out in full at CCH MEDi-CAL GUIDE New Dev. ¶ 7516, and in CCH MEDICARE AND MEDICAID GUIDE New Dev. ¶ 41,959. Valdivia implemented the service rights of nursing facility residents at 42 U.S.C. § 1396r(b)(4).
(c) Maximize mental, physical and psychosocial well being as the medical necessity standard for nursing facility residents

This is the standard that applies when Medi-Cal reviews an authorization for supplemental services beyond what Medi-Cal normally allows (such as speech therapy, psychologist visits and physical therapy), not the Medi-Cal definition of medical necessity at Welf. & Inst. Code §§ 14059.5, 14133.3.

(d) Individual rights and right to be free of chemical or physical restraints when not required for treatment purposes

The facility must respect and enforce your Individual rights—such as the right to visitors, personal autonomy, dignity and privacy. The nursing facility may use physical restraints or psychoactive drugs only when documented for treatment purposes.

7. I live in an ICF/DD, not a nursing facility. What are my service rights?

Under the federal regulations, admission to ICF/DD facilities is limited to persons who are mentally retarded or have a "related condition" and who need "active treatment": (a) to acquire behaviors related to self-determination and as much independence as possible, and (b) to prevent or slow regression or loss of functional status.

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477 Standard set out at 42 U.S.C. § 1396r(b)(4) and at 42 C.F.R. § 483.25(a).
477 42 U.S.C. § 1396d(d) and 42 C.F.R. §§ 440.150, 483.400 through 483.480.
(a) Development of an Individual Program Plan (IPP)

Upon admission, the facility staff must meet with you (and with other agencies and family as appropriate) to develop an IPP. The staff is to perform a comprehensive functional assessment which identifies: (a) problems and strengths, (b) developmental and behavioral management needs, and (c) need for services—without regard to whether such services are actually available. The plan must be detailed and specific, and must designate who is responsible for what.\textsuperscript{478} State licensing regulations impose similar obligations.\textsuperscript{479}

(b) Do not have the benefit of the nursing facility medical necessity standard

The Medi-Cal program has taken the position that, unlike residents of nursing facilities, ICF/DD residents cannot receive authorization for psychological or therapy services beyond two per month. Medi-Cal also uses the medical necessity standard in Welf. & Inst. Code § 14059.5 rather than the federal standard applicable to nursing facility residents. However, PAI attorneys believe that the regular Medi-Cal necessity standards do not apply to services identified in the IPP and services that are active treatment or specialized services.\textsuperscript{480}

Residents who are also regional center clients may be eligible for supplemental services through the regional center when the services they

\textsuperscript{478} 42 C.F.R. § 483.440.


\textsuperscript{480} 42 CFR §§ 483.120(a)(2), 483.440(a)(1), 483.440(c)(d).
need are not available through the facility or Medi-Cal because: (a) the services are not medical or remedial, (b) or because they are not realistically available through the ICF or Medi-Cal, or (c) services needed are outside the scope of “active treatment” and do not meet the stringent medical necessity standard in Welf. & Inst. Code § 14059.5.  

8. **My spouse is going into a nursing facility and we will apply for Medi-Cal. What does that mean in terms of our resources? In terms of our income?**

Federal Medicaid law provides certain protections for the community spouse (the spouse who does not go into a nursing facility). In 2001, the community spouse may retain up to $2,175 a month in income and $87,000 in resources—not counting the home. The institutionalized spouse may retain $35 a month in personal and incidental expenses and $2,000 in resources. The community spouse's monthly income allowance and exempt resources increase each year based on the consumer price index. In addition, the income that may be retained by the community spouse may be increased if there are children or other special needs.

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481 For more information about your rights as a regional center client and under the Lanterman Act, visit our website at [www.pai-ca.org](http://www.pai-ca.org) and click on “publications” and then click on “Lanterman Act” for the PAI Manual “Rights under the Lanterman Act.” You can also order the publication by calling (800) 776-5746.

482 42 U.S.C. §§ 1396r(5)(a)-(h). See STATE MEDICAID MANUAL § 3260 regarding the income and resource eligibility rules where there is an institutionalized and community spouse, reprinted at CCH MEDICARE & MEDICAID GUIDE ¶ 14,311.168.

483 Earned income disregards used to determine countable income under various of the Medi-Cal programs do not apply to the monthly spousal maintenance need allowance. For instance, there are no extra income deductions for earned income.

484 DHS ACWDL No. 00-58 (11/14/2000).
9. Veterans' Aid and Attendance

Q: I am a veteran in a nursing facility who receives a veteran's “Aid & Attendance” allowance and my wife is at home. How is “Aid & Attendance” counted?

A: Where there is a spouse or minor child at home, all of the “Aid and Attendance” is exempt income. If there is no spouse or minor child at home, then the first $90 is exempt with the balance applied toward the cost of nursing facility care.\(^{485}\)

10. Holding space in a nursing facility

Q: I live in a nursing facility but am in a hospital for surgery. What are my rights to go back to the nursing facility?

A: The nursing facility must hold your bed for seven days.\(^{486}\) Medi-Cal will pay the facility for the bed hold for the seven days.\(^{487}\) If you are in the hospital for more than seven days, you lose your bed hold. However, the nursing facility is required to readmit you past the seven days if there is an available bed.\(^{488}\)


\(^{486}\) Cal. Code Regs. tit. 22 § 72520(a) (nursing facility), § 73504(a)(ICF), § 76506(a) (ICF/DD), and § 76909.1(a) (ICF/DD-H).

\(^{487}\) Cal. Code Regs. tit. 22 § 51535.1 applies to all Medi-Cal funded long term care. The amount of payment is the daily rate less an allowance for saved food costs.

\(^{488}\) 42 C.F.R. § 483.12(b)(3); Cal. Code Regs. tit. 22 § 72520(c) (nursing facility), § 73504(c) (ICF), § 76506(c) (ICF/DD), and § 76900.1(c) (ICF/DD-H).
11. Leaves from nursing facility

Q: My sister wants to take me with her to Catalina for a few days. What are my rights if I live in a nursing facility? In an ICF/DD facility?

A: You can go no matter what kind of long-term care facility you live in! Medi-Cal will pay the facility for a limited number of temporary absence days based on type of facility in which you reside -- which for a nursing facility means up to 30 days a year. The day you leave counts as one day of leave but not the day you return. One of the approved reasons for a leave is being with family and friends. Your leave needs to be approved by your doctor and if you already have had 18 days of leave and want more, make sure your doctor incorporates them into your plan of care. Of course, the facility must keep your bed vacant during your approved leave.

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489 Welf. & Inst. Code §§ 14018 (developmentally disabled individuals), 14108.1 (nursing facilities for persons with psychiatric disabilities), 14018.2 (other nursing facilities); Cal. Code Regs. tit. 22 § 51535(a)(1) (73 days for ICF/DD facilities), (a)(2) (30 days for residents of nursing facilities for persons with psychiatric disabilities), and (a)(3) (everyone else, including nursing facilities, 18 days plus an extra 12 days).

490 Cal. Code Regs. tit. 22 § 51535(c)(3). Thus, if you leave Monday and come back Saturday, that would count as five days of leave.

491 Cal. Code Regs. tit. 22 § 51535(b)(1). PAI believes the “approved” grounds are too narrow and therefore inconsistent with residents' rights under the Nursing Home Reform Act and the Americans with Disabilities Act.


493 Cal. Code Regs. tit. 22 § 51535(c)(2).
12. Transferring property can affect eligibility

Q: One year ago I gave my daughter $20,000. I am in a Nursing home because of a stroke that happened after my gift to my daughter. My savings are gone. Medi-Cal says I'm not eligible. Why? What can I do?

A: Transfers of nonexempt property for less than fair market value within 30 months of applying for Medi-Cal to cover long-term care may result in a period of ineligibility. To determine the months of ineligibility, divide the value of the property transferred by the average private pay rate for nursing facilities. The months of ineligibility start back when the transfer was made. In this case, any period of ineligibility would have been exhausted at the time of applying for Medi-Cal so the transfer should have no effect.

Even if you were within a presumed period of ineligibility because of the transfer, you have the right to a fair hearing to establish that the transfer was exclusively for a purpose other than to qualify for Medi-Cal or that it was not your intent to dispose of the resources at less than their market value. You could show that the gift was for a different purpose because the gift was made before the stroke.

494 42 U.S.C. §§ 1396p(c), (e).
495 DHS ACWDL No. 01-15 (3-7-01) gives the 2001 average at $4,163 a month.
496 State Medicaid Manual § 3250.1, reproduced at ¶ 14,311.81 in CCH MEDICARE & MEDICAID GUIDE.
497 Id. at § 3250.3.
13. **Do I have to sell my home if I go into a nursing facility?**

   No! If you are Medically Needy Medi-Cal when you are in a nursing facility and your intent is to return home (even if the intent is unrealistic), your home remains your exempt “principal residence.”

14. **Will Medi-Cal put a lien on my house to pay for my nursing facility care?**

   Maybe. Medi-Cal can put a lien on your house to pay for nursing facility care, or any other long-term care facility if you do not intend to return home. But there are certain restrictions where Medi-Cal cannot put a lien. The most common ones that could apply are the following: 1) you or a beneficiary declares in writing that you or a beneficiary intends to return home to live; 2) a spouse, child under age 21 or a dependent relative, including a disabled child over age 21, lives in the house; 3) a sibling or child over age 21 has lived in the house for at least one year before the time you entered the long-term care facility, and is still currently living there. You should be aware that, under Cal. Code Regs. tit. 22 § 50428(1)(E), you have the right to appeal for a county level review and a state hearing prior to Medi-Cal putting a lien on your house. The procedures on how to appeal must be in the “Notice of Action” sent to you by Medi-Cal.

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498 Welf. & Inst. Code § 14006(b)(2). Additional grounds for maintaining that exemption under Welf. & Inst. Code § 14006(b): (a) your spouse or dependent relative lives there; (b) your child or sibling lives there and has lived there for a year before your going into the nursing facility; or (c) your home is an apartment in a multiple unit dwelling and the other units are producing income for you or your family consistent with its value.

15. I pay a share of cost to the nursing facility. I can’t talk because of my disability. Can I use the share of cost money to buy an Augmentative Communication Device?\textsuperscript{500}

Yes! But there are steps to follow under the Johnson v. Rank procedure discussed in Section 6 of Chapter 5. The first step would be the cost of an assessment and transportation to the assessment. Make certain both the assessment and the transportation are written into your comprehensive care plan. When you get your evaluation and recommendation, that also should be in your file and made part of your care plan. You can use your share of cost each month toward the Augmentative Communication Device until it is paid off.

16. Special order equipment

Q: I can’t get around by myself in the wheelchairs that the nursing facility has. It is also uncomfortable and painful to sit in them. How can I get the wheelchair I need?

A: Expect a battle to get what you need.\textsuperscript{501} You are going to be caught between Medi-Cal and the Nursing Facility. Medi-Cal regulations provide that Medi-Cal will only authorize custom or special order chairs and that everything else is the responsibility of the nursing facility.\textsuperscript{502} The

\textsuperscript{500} There is a wide range of augmentative communication devices available for people’s varying needs based on the users physical limitations and cognitive ability. Typically such devices have pre-programmed phrases and words to mix and match plus, where appropriate, means of adding words during a communication and sentence-by-sentence recapitulation.

\textsuperscript{501} For help, call Taymour Ravandi at (916) 488-9950 in PAI’s Sacramento Office. Taymour has successfully represented several nursing facility residents in getting the wheelchairs they needed for greater independence. While his job responsibilities have changed, he will be able to link you with the person who can provide technical assistance if he is unable to assist you.

\textsuperscript{502} Cal. Code Regs. tit. 22 § 51321(h)(2): “Canes, crutches, wheelchairs, and walkers may be authorized only when the item must be custom made or modified to meet the unusual medical needs of
nursing facility which may have initially supported a treatment authorization request for the chair, may take a contrary position out of concern that it will be obligated to purchase a wheelchair that costs between $5000 and $15,000.

The issue of who is responsible for what is also relevant if you decide to spend your share of cost to purchase the wheelchair you need. See the discussion of Johnson v. Rank in Chapter 5. If it is concluded that the wheelchair is the responsibility of the nursing facility, you would not be able to use your share of cost to purchase it. However, that problem probably would not arise unless there was an audit and that would be long after you had your wheelchair.

the patient and the need is expected to be permanent. A custom wheelchair, either manual or power, is one which has been uniquely constructed to address a particular patient’s individual medical needs for positioning, support and mobility.” In a prior section, the regulations say: “A patient may be considered to have unusual medical needs when a disease or medical condition is exacerbated by physical characteristics such as height, weight and body build. Physical characteristics, in and of themselves, shall not constitute an unusual medical condition.” Cal. Code Regs., tit 22 § 5132(h)(1).
Chapter 12:
Medi-Cal, Title II Social Security Benefits & Medicare

This Chapter is out of date and has been Deleted Temporarily.
This Chapter has been Deleted Temporarily
1. In addition to my Medi-Cal coverage, Medi-Cal says I also have Other Health Coverage (OHC). What does this mean? How does Medi-Cal deal with OHC?

Other Health Coverage (OHC) is any private health coverage plan or policy which provides or pays for health care services. Some examples of OHC include: Prepaid Health Plans (PHPs), Health Maintenance Organizations (HMOs), employer/employee benefit plans, Medicare-contracted HMOs, Medicare supplemental policies and union welfare trust funds. The following are NOT considered OHC: Medi-Cal managed care, Medicare fee-for-service, automobile insurance and life insurance.

If you have OHC, federal and state law requires that the OHC be “fully utilized” before seeking services or payment through Medi-Cal. In other words, you must first try to get services through your OHC plan. If your plan limits you to certain doctors and other providers, Medi-Cal will not cover services from other providers.\textsuperscript{503} Your doctor or other provider must bill your health plan before billing Medi-Cal. If there is a denial or there is no response in 90 days, your doctor or other provider can bill Medi-Cal with a copy of the denial or the billing.\textsuperscript{504} If your health plan pays the claim, the

\textsuperscript{503} See question 2 for a possible exception.

\textsuperscript{504} Requirements for denial letter at Provider Manual, “Other Health Coverage” page 3 (September 1999). In lieu of the denial document, pharmacists can attach a verification. Id. at page 4 (December 2001). When there is no response, “90-day response delay” is written on the completed and dated insurance claim form submitted with the Medi-Cal billing. Id. at 5 (December 2001).
provider can bill Medi-Cal for the difference between the payment received and what Medi-Cal would pay if it were the sole payor.\footnote{505}

2. My health plan doctor or provider won’t take Medi-Cal for my deductible or copayments. What can I do?

Check with other doctors or providers in your area to find those who participate in Medi-Cal and will accept Medi-Cal. Ask for help from your plan’s member services. If there are doctors or providers who participate in Medi-Cal but who are unwilling to accept Medi-Cal for your deductible and copay, your health plan’s member services department should be able to help you get the cooperation of those doctors and other providers.

If member services is unable to help you and there are no doctors or other providers in your geographic area who will accept Medi-Cal, ask member services for a letter from the plan identifying the categories of providers where there are no plan providers in your geographic area that accept Medi-Cal.\footnote{506} You can use the Plan letter as a denial to go in with the Medi-Cal billing by another provider. Before you do so, we also recommend that you contact Medi-Cal’s Health Insurance Referral Hotline at 1-800-952-5294 weekdays 8 a.m. to 5 p.m. That number is to the part of Medi-Cal that handles problems with OHC. Through that number you also may be able to remove the OHC mandatory billing requirement from your Medi-Cal card - your plastic Beneficiary Identification Card or BIC - when it is swiped. We also recommend that you call EDS’ (the company that contracts with Medi-Cal to pay the Medi-Cal billing) beneficiary information line at (916) 636-1980. You would call to make sure the

\footnote{505}{Provider Manual, “Other Health Coverage” page 2 (December 2001).}

\footnote{506}{See footnote [511] infra about filing a complaint with the Department of Managed Health Care. Not helping you find a plan provider who accepts Medi-Cal or not providing you a letter documenting the lack of providers would violate the plan’s obligations under Health & Safety Code § 1367(d) as explained in footnote [511].}
letter you got from your plan’s member services meets the requirements for a plan “denial” so that you can go to another provider.

3. **My Medi-Cal card shows that I have OHC, so some providers do not want to take my Medi-Cal card. Why not?**

   The reason why providers such as pharmacists and equipment suppliers do not want to serve you is because they must bill the OHC plan first, even though they know the billing is futile and payment will be denied.  

   DHS takes the position that providers are not required to accept all Medi-Cal recipients, even those treated in the past by that provider. Of course, if a provider swipes the BIC or Medi-Card, then the provider is obligated to accept Medi-Cal as payment in full.  

   If the provider, however, does not take your BIC and so does not verify your Medi-Cal eligibility because you have OHC, DHS says that’s O.K.  

   PAI contends that DHS’ position is inconsistent with federal Medicaid law which requires the Medi-Cal program to insure that its providers do not discriminate against you and refuse to deal with you just because you have OHC.  

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507 See DHS MEDI-CAL ELIGIBILITY PROCEDURES MANUAL at § 15A.

508 Welf. & Inst. Code § 14019.4. Provider Manual, “Other Health Coverage”, page 2 (12-01): “Providers are prohibited from billing Medi-Cal recipients, or individuals acting on their behalf, for any amounts other than the Medi-Cal copayment or Share of Cost (SOC). ¶ Therefore, if the recipient’s OHC requires a copayment, coinsurance, deductible, or other cost sharing, the provider is not permitted to bill the recipient.”

509 Provider Manual, “Provider Guidelines” at page 9 (12-00) under “Obligations to Recipients”: “When a provider elects to verify a recipient’s Medi-Cal eligibility, the provider has agreed to accept an individual as a Medi-Cal patient once the information obtained verifies that the individual is eligible to receive Medi-Cal benefits. , , , After receiving verification that a recipient is Medi-Cal eligible, a provider cannot deny services because: The recipient has other health insurance coverage in addition to Medi-Cal.” Emphasis added.

510 42 U.S.C. § 1396a(a)(25)(D) says “a person who furnishes services and is participating under the [state Medicaid] plan may not refuse to furnish services to an individual (who is entitled to
If you believe a provider refuses to take your Medi-Cal card just because you have OHC and need help finding a provider, you should call the DHS Health Insurance Section (HIS) at 1-800-952-5294. If your OHC is a Medi-Cal managed care plan, you should call the plan or call Medi-Cal Managed Care Ombudsman at 1-800-452-8609.

4. The providers won’t take my Medi-Cal card, but my OHC does not cover durable medical equipment or certain medications. What can I do?

As explained in question 2 above, the providers don’t want to take your Medi-Cal card since it means they have to bill the OHC plan first, which is futile because the request for payment will be denied or more likely ignored. You can remove this OHC barrier by getting a letter directly from the OHC plan specifically stating which benefits, such as certain medications or durable medical equipment, are NOT covered under the policy and statutes that they will deny any bill for these items. If your OHC plan benefits have been exhausted for treatment and services, then the letter from the plan needs to state that coverage has been exhausted. The letter needs to include all the relevant OHC plan information, such as your name, address and Social Security Number, and needs to be dated within the prior 12 months or within the term of the current plan coverage. This letter will actually serve as a substitute for billing the OHC. When you give the provider a copy of this letter, the provider will send a copy of the letter to Medi-Cal with the bill without having to bill the OHC plan first. Medi-Cal will then pay the pharmacist and durable medical equipment supplier.

If you continue to have problems and need help with providers, you should call Medi-Cal at 1-800-952-5294. If your OHC is also a Medi-Cal managed care plan, call the Medi-Cal Managed Care Ombudsman at 1-800-452-8609. If your private health benefit plan will not assist you by providing you with the letter you need, file a grievance with

have payment made under the plan for the services the person furnishes) because of a third party’s potential liability for payment for the service;” 42 C.F.R. § 447.20(b) says “a state plan must provide [that] . . . a provider may not refuse to furnish services covered under the plan to an individual who is eligible for medical assistance under the plan on account of a third party’s potential liability for service(s).”
Chapter 14: Medi-Cal and Private Health Benefit Plans

the plan and a complaint with the Department of Managed Health Care if the plan is subject to DMHC’s jurisdiction.511

5. The pharmacists won’t accept Medi-Cal for my co-payment or deductible and says I have to pay it. What do I do?

Pharmacists and other service providers may not bill you for your OHC plan’s co-payment or deductible. They may only bill the recipient for the Medi-Cal co-payment or for the Medi-Cal share of cost, if any. According to Medi-Cal, providers are not required to serve you as a Medi-Cal recipient even if the pharmacist or pharmacy participates in the Medi-Cal program generally. PAI contends that DHS and Medi-Cal’s position is wrong because federal law requires Medi-Cal providers to serve you.512 If you continue to have problems with service providers, you should call 1-800-952-5294, and ask Medi-Cal to intervene with that provider or identify a provider who will work with you.

6. The pharmacist won’t accept Medi-Cal for my co-payment or deductible and says I have to pay it. Can the pharmacist be right?

Yes. Once a provider swipes your card, the provider cannot refuse to provide services to a Medi-Cal recipient who has OHC. However, federal and state law requires that the OHC be “fully utilized” before you seek services or payment through Medi-Cal. Therefore, the provider will refer you to your OHC plan he or she does not participate in your OHC plan’s exclusive provider network. This referral can be

511 See [www.hmohelp.ca.gov](http://www.hmohelp.ca.gov). One basis for the complaint is that the refusal to provide such documentation needed to access services through Medi-Cal that are not available through the plan violate the plan’s obligations under Health & Safety Code § 1367(d) (“furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice”).

512 See quotes from the language in 42 U.S.C. § 1396a(a)(25)(D) and 42 CFR § 447.20(b) in note 510 above.
avoided if you present a copy of the letter from the OHC saying they will NOT provide or cover the payment for services you are requesting. See question 4 above.

It is important to note that if your OHC is for example, an HMO, Medi-Cal will not pay for services that your HMO covers if you decide to seek treatment and services from a provider who is not authorized by the HMO. You will then be liable for payment because your OHC plan was not “fully utilized.” However, if the treatment and services provided are for emergency care, the HMO will likely pay for them until your condition has stabilized. The emergency care provider would then contact the HMO and bill the HMO.

7. **I live outside the OHC service area (my child’s OHC is through an absent parent who lives elsewhere). What can I do to get the provider services I need easier?**

Medi-Cal recipients who have OHC but live outside the service area are assigned a non-restricted OHC code “A.” Therefore, if you have the non-restricted code “A,” the providers may bill Medi-Cal directly for the services without having to bill the OHC first and waiting to receive the payment denial. For example, if your child has OHC from a parent who lives out of state, your child lives outside the OHC service area. Your child’s OHC code should then be “A.” If it isn’t, to have the code changed to “A” you need to contact DHS, HIS at 1-800-952-5294.

8. **My foster child’s BIC says she has Other Health Coverage which is causing a problem in getting care. What can I do?**

The OHC designation can be removed by the county welfare eligibility worker, by the foster care worker, or by a Medi-Cal provider by calling 1-800-952-5294. The caller’s records must show that a needed service is not available through the other health plan by either something in writing from the plan or written notes about a

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513 For more information on OHC regarding an absentee parent, see DHS ACWDL No. 95-26 (4/10/95).
telephone or other oral communication with the health plan. Alternatively, noncoverage can be presumed if the plan does not respond within 15 days to a written request about coverage.\[^{514}\]

Once the OHC designation has been removed, the child will have access to all Medi-Cal services without having to bill the OHC first.

9. **My work hours were cut and now I have to pay for my OHC. Is there any way Medi-Cal can help?**

Maybe. First, any health benefit plan or OHC payment you make is offset against income to reduce or eliminate your share of cost. It is also a deduction when determining eligibility under the Aged & Disabled Federal Poverty Level (A&D FPL) program. However, the income offset for payments for these plans are not available in the FPL programs for pregnant women and children.

Second, in certain circumstances Medi-Cal will pay for you continuing OHC under its Health Insurance Premium Payment (HIPP) program if you or your child have expensive care needs.\[^{515}\] The Medi-Cal program will pay your health insurance premiums for you if your share of cost is $200 per month or less, and the average

\[^{514}\] DHS ACWDL 01-61 (11-6-2001), page 1: “The request may be made if written documentation or documentation of oral communication from the other health insurer confirms that the specific provider, service, frequency or location is not covered by the OHC. If, within 15 days of a written or oral request made by a duly authorized party for confirmation of non-coverage, the other health coverage carrier does not provide a written response or an oral response that can be documented, DHS will grant the request to remove the OHC notation. ¶ All documentation of confirmation of non-coverage should be retained in the foster care child’s file as it may be subject to future review by DHS.” Page 2: “Once the OHC indicator has been removed, all eligible physical health, mental health, or other benefits covered under Medi-Cal may be billed directly to Medi-Cal.”

\[^{515}\] Welf. & Inst. Code 14124.91. For more information on HIPP, see DHS ACWDL Nos. 95-26 (4/10/95), 99-70 (12-8-99).
monthly cost of your care is at least twice the amount of the insurance premium.\textsuperscript{516} Your county Medi-Cal worker will help you fill out the Health Insurance Questionnaire (Form DHS 6155). If your county worker is not familiar with the HIPP program, refer the worker to Section 15H in Volume 2 of the \textsc{MEDI-CAL ELIGIBILITY MANUAL}. For more information call 1-866-298-8443.

10. \textbf{I receive Medicare benefits and I'm a Medicare recipient. Does Medi-Cal deal with Medicare recipients differently?}

Yes. Medi-Cal does deal with Medicare recipients benefits a little differently. First, if you have both fee-for-service Medicare and Medigap insurance as your OHC, the provider must bill three different parties: 1) Medicare for the Medicare-covered services, 2) your OHC plan and 3) Medi-Cal last. Second, if your OHC is a Medicare HMO the provider will refer you to your HMO. As discussed in question 4, you can avoid this referral if you get a letter from the OHC specifically saying they will NOT provide or cover payment of the services you are requesting.

11. \textbf{Do I have to use my OHC if I'm asking for minor consent services?}

\textsc{NO!} You do not have to go to the OHC plan if you are asking for minor consent services, because doing so would frustrate your right to confidentiality protections. You will need to follow the same procedures to get minor consent services discussed in Chapter 2.

\textsuperscript{516} DHS ACWDL No. 91-08 (2/5/91); No. 91-03 (1/4/91); DHS \textsc{MEDI-CAL ELIGIBILITY PROCEDURES MANUAL (MEPM)} § 15H; CCH \textsc{MEDI-CAL GUIDE New Dev.} ¶ 7198. There is also a second Employer Group Health Plan (EGHP) program with similar rules. DHS ACWDL No. 93-37 (6/25/93); No. 91-94. See also DHS MEPM §15H-1. Once approved, participation in HIPP and EGHP is mandatory. If you disenroll from your insurance, you may lose your Medi-Cal entirely. DHS ACWDL No. 93-37 (6/25/93).
Chapter 15: Medi-Cal Managed Care

1. Managed care plan providing physical and limited mental health care

   See N H e.LP’s separate materials about M edi-Cal M anaged Care and materials posted on its website: www.healthlaw.org and at www.healthconsumer.org.

   (a) What should I do when Medi-Cal tells me I must sign up for a Managed Care Plan? What questions should I ask? What do I need to know?

   You have a choice. If you have a doctor you want to stay with, call the doctor's office and ask if she belongs to any of the plans on your list. Here is a list of other things to consider to decide which plan will best serve your health needs. You need to know:

   (a) Where do you go to see a doctor? How many buses do you have to take?
   (b) Will the plan help you with transportation to and from the doctor and clinics?
   (c) If you go into a hospital, what hospital would that be? Is the hospital a tertiary level hospital (able to handle complicated problems)? Will the hospital allow your doctor to provide you with sterilization when you deliver your child, if that is what you want?
(d) Does the plan include a range of specialists, including pulmonologists, etc., and pediatric specialists if you have a child, rehabilitation specialists, etc?

If Medi-Cal or the HMO makes promises to you, ask them to put the promises in writing.

If your child is covered by CCS, talk to a nurse case manager at the CCS main office for your county and ask them which place they are used to working with. Also talk to the liaison nurse in the clinic your child attends. It is important that there be good coordination between your health plan and CCS. The CCS case manager nurse or the clinic nurse may be able to help you make a decision about which plan.

(b) Will I be able to continue seeing my own doctor if I sign up for managed care?

You will be able to continue seeing your doctor only if your doctor is signed up with one of the plans. Ask your doctor. If your doctor is not available through any of the plans available to you and you are required to sign up with a plan, ask these two additional questions: (1) Are you eligible for an exemption from managed care so that you can stay with your doctor? (2) Does your doctor have any recommendations about the managed care doctor you should request.\(^{517}\)

(c) If I'm required to sign up with a managed care plan, Is there any way I can avoid signing up, any way to get an exemption?

\(^{517}\) In the giant enrollment packet you receive when you make your choices will be the list of providers for each plan.
You may if you are an American Indian. Otherwise if you have a complex medical condition you may be able to get an exemption to remain with your doctor and in fee-for-service Medi-Cal if your doctor is not part of any participating plan. You must be in the middle of treatment for a complex condition in order to get an exemption. This exemption may not be available to you if you are in a county organized health system (COHS) plan or in a plan in San Diego or Sacramento.

(d) What can I do if I disagree with the managed care plan?

There are three things you can do:

First, you can file a complaint or grievance with the managed care plan itself. Within seven days of completing your enrollment, you should receive a booklet explaining your rights under the plan, including what to do in an emergency, how to make an appointment, and how to file a grievance or complaint with the plan. Follow the procedures in the booklet. Be sure to make notes about every phone conversation and keep copies of any letters you write. We recommend that you keep your notes in a notebook along with any papers you receive from Medi-Cal, the plan, or your doctor.

Second, you can file a request for a Medi-Cal fair hearing. See Chapter 17. You do not have to go through the managed care plan's internal grievance procedure first. You may pursue both procedures at the same time. You are in a stronger position to request a fair hearing when your treating physician requests authorization for something and it is denied than when your own doctor will not make a referral. Examples of the kinds of things that might lead you to request a fair hearing include:

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519 Cal. Code Regs., tit. 22 § 53887(b)-(e).
(a) Your doctor requested a referral to a specialist but the plan would not approve the request. You asked your doctor to refer you to a specialist and she would not do so.

- Your doctor said she could not write a prescription for a particular drug because it was not among those on the plan list or “formulary”.
- You asked for a second opinion and could not get it.

You should never file a grievance instead of asking for a fair hearing. You can lose important rights. Always file for a fair hearing. You can always withdraw if you get what you need.

Third, if the plan is covered by the Knox-Keene Act, Health & Safety Code §§ 1340 et seq., you can file a complaint with the Department of Managed Health Care.\textsuperscript{520}

(e) I talked to my doctor about a referral for some short term mental health counseling. My managed care plan says I have to go to the County Mental Health Plan. Is that right?

Probably not. The County Mental Health Plan provides services only for adults with chronic and severe mental health treatment needs.

To get the services you need, you may have to go through the process of being referred to County Mental Health to get a denial. Because your doctor already indicated you needed some counseling, you would be in a better position to get the counseling services from your own managed care organization after the denial.

\textsuperscript{520} Visit the agency’s website at \url{www.hmohelp.ca.gov} to find out if your plan is regulated by the department and to file a complaint.
Do I have any extra rights if my Medi-Cal managed care organization is also a health benefit service plan under the Knox Keene Act?

Yes! If your managed care organization is a Knox-Keene Act plan, you have the same consumer protections as other enrollees with private insurance — unless the legislation specifically says Medi-Cal enrollees do not get the rights given to other enrollees. Most health benefit plans are covered by the Knox-Keene Act. The Knox-Keene Act is administered by the Department of Managed Health Care. You may file a complaint with the Department of Managed Health Care by calling their 800 number -- F 1 888-HMO-2219 [TDD 1-877-688-9891] -- or by completing and mailing the complaint form on the agency’s webpage: www.hmohelp.ca.gov. However, the Department of Managed Health Care usually will not process through a grievance until you have provided the plan 30 days to address the problem unless there is an emergency.

Do I have Extra Rights Because I am in a Managed Care Plan?

Yes. You have extra rights if your Managed Care plan is licensed by the state under the Knox-Keene law. Most plans are licensed by the state, except for the County Organized Health Systems. Cal Optima in Orange County is licensed. See the issue brief, Knox-Keene Protections Quick Reference: Health & Safety Code at http://www.healthconsumer.org/managedcare.html and also the California Patient’s Guide, http://www.calpatientguide.org for more information about your rights under the Knox-Keene law. For more information about how to enforce these rights, see hmohelp.ca.gov.

521 Health & Safety Code §§ 1340 et seq.

522 “Enrollees” and “subscribers” are the names used by health benefit plans for persons who are entitled to get services from the health benefit plan. For general information about your rights as a member of a managed care plan, see “The California Patient’s Guide,” prepared by the Taxpayer & Consumer Rights Foundation and the Department of Consumer Affairs: www.calpatientguide.org
(h) **How can I find out if my Medi-Cal managed care plan is covered by the Knox-Keene Act?**

You can go to the website at [www.dmhc.ca.gov](http://www.dmhc.ca.gov) or call 1-888-HMO-2219.

(i) **I am in a County Operated Health System. Do the Knox-Keene Act protections apply to me?**

No, unless the services are provided by a health benefit plan which contracts with the County Operated Health System (COHS) — the way that Orange County’s CalOptima COHS contracts with Knox-Keene Act plans. Orange County’s Cal Optima is qualified as a Knox-Keene plan. Some COHS may seek qualification as a Knox-Keene plan in order to serve Healthy Family children. Although federal law authorizing the COHS in Orange, Solano/Napa and Santa Cruz Counties require that the county operated health system be one that “meets the requirements for health maintenance organizations under the Knox-Keene Act,” state law exempts these three COHS from qualifying under the Knox-Keene Act.

(j) **Speciality care centers**

**Q:** I have Sickle Cell Anemia and would like to go to a specialty care center where I can see a team of doctors with special expertise on Sickle Cell. My managed care plan said I could not go because the specialty care center was not in the network. What can I do?

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A: What you can do depends on whether or not your managed care plan is covered by the Knox-Keene Act. If the plan is covered, you can file a grievance which talks about your rights under Medi-Cal and your rights under Knox-Keene.524

(i) Under Knox-Keene you would argue

(a) that not having the specialty care center as part of the network and not authorizing you to go out of the network so that you can get services through a treatment team and a specialty care center is not consistent with good professional practice. You would then argue that this violates your rights under Health & Safety Code § 1367(d) which requires the plan to “furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.”

(b) that by not including a sickle cell specialty care center in the network and not having a procedure for approving services outside the network, the plan does not “have the organizational and administrative capacity to provide services to subscribers and enrollees” within the meaning of Health & Safety Code § 1367(g).

524 You also may file a Medi-Cal fair hearing request at the same time. If you elect to delay filing a Medi-Cal fair hearing request, remember that filing a grievance does not toll the time period for requesting a Medi-Cal fair hearing.

After you have given the grievance procedure 30 days to fix the problem, you can file a complaint with the Department of Managed Health Care.
(c) that because sickle cell is “a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling,” and because there is no in-plan provider able to deliver the needed services and care coordination, the plan is obligated to contract with a center outside the network in accord with Health & Safety Code § 1374.16(b), (d), (e).

(d) that the decision not to approve a referral to the sickle cell specialty care center was based on the cost and administrative hassles in doing so and was not a decision unhindered by fiscal and administrative considerations and thus was in violation of Health & Safety Code § 1367(g).

(ii) Under Medi-Cal you would argue

(a) that you are entitled to the same scope of benefits under managed care Medi-Cal as you are under fee-for-service Medi-Cal. 525

(b) that coordinated care through a specialty care center is reasonable and necessary to protect life, to prevent significant illness or significant disability, and/or to alleviate severe pain. 526 The scope of “prevent significant illness or significant disability” includes barriers which “interfere with capacity for normal activity including

525 42 U.S.C. § 1396n(b)(4).

526 Welf. & Inst. Code § 14059.5.
(iii) If Only Medi-Cal rights and no Knox-Keene Act rights

If the Knox-Keene Act does not apply, then your options are the plan’s grievance procedures and a Medi-Cal Fair hearing.

(k) I’ve been having some symptoms that worry me but my doctor seems to think the symptoms don’t mean anything. What can I do to get the doctor to take me seriously?

Try this: First write on the top of a piece of paper: “From [your name]. Please put this in my file.” Write this about one inch or so down so that there will be room for the holes that will be punched when it goes into the file. If you have access to a two-hole punch, prepunch your paper.

Second, write on the next line: Things to talk to the doctor about.

Third, write down the problems that concern you. Be specific. For instance, if pain is one of the problems, explain when the pain starts or gets worse (time of day, what you are doing when the pain gets worse). Don’t be shy even if the problem is embarrassing -- such as problems relating to going to the bathroom. If you have trouble writing down the problems, get someone to help you.

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527 Welf. & Inst. Code § 14059. 42 U.S.C. § 1396 identifies as a purpose of the federal Medicaid program “rehabilitation and other services to help . . . attain or retain capability for independence or self-care. . . .”
When you tell the receptionist you are there, give the sheet of paper to the receptionist.

If you are having a problem getting an appointment, fill out the sheet and mail it to the doctor or drop it off at the doctor's office.

2. Speciality mental health through county mental health plans

See Protection & Advocacy’s Manual on Medi-Cal Mental Health Plans, Report on California's waiver program, and other materials on Medi-Cal Mental Health Services on its website: www.pai-ca.org click on “publications” and then on “mental health.”

Medi-Cal Mental Health Services are provided through county based Mental Health Plans (MHP). To start the process of getting services, you call the MHP’s access number (which is also the MHP crisis number). The number for each county (along with addresses and other information) can be found at www.dmh. Cahwnet.gov/pdf/cmhda.pdf. Los Angeles County’s access number, for instance, is 1-800-854-7771.

(a) Consolidation of Medi-Cal mental health services

Through a series of statutory and regulatory changes occurring from 1995 to 1998, Medi-Cal funded mental health services which were provided through fee-for-service Medi-Cal\textsuperscript{528} and through County Medi-Cal Short-

\textsuperscript{528} Primarily acute psychiatric hospital care, outpatient psychiatrist and psychologist visits.
In 1972 Welf. & Inst. Code § 14021 was amended to add Short-Doyle community mental health services to the scope of benefits under the Medi-Cal program. The result was the development of the Short-Doyle/Medi-Cal (SD/MC) program in addition to the Fee-For-Service Medi-Cal (FFS/MC) program for mental health services. The SD/MC program provided cost-based reimbursement for a broad range of mental health services and a limited range of services for treatment of substance abuse. These mental health services are provided by the county directly or through providers which contract with the county. The FFS/MC program provided reimbursement for a comprehensive range of health services and a limited range of mental health services. Services are reimbursed on a fee-for-service basis, or within managed care contracts. These mental health FFS/MC services were provided primarily by private hospitals and private practitioners.

The consolidation of mental health services took place in two stages: The first stage of consolidation was called “Medi-Cal Psychiatric Inpatient Hospital Services Consolidation” and became effective March 1995. The second stage is called “Medi-Cal Specialty Mental Health Services Consolidation” and became effective September 1997. Most of the county MHPs were on line by January of 1998 with the last county, San Diego, coming on line in July of 1998.

(i) CMS approved waiver to implement consolidation

The consolidation was pursuant to a waiver and an amended waiver approved by the Health Care Financing Administration (HCFA) under 42 U.S.C. § 1396n(b). CMS agreed to “waive” the 

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530 See the authorizing legislation at Welf. & Inst. Code §§ 5775-5780 and 14680-14685. Most County Mental Health Plans are operated by county mental health, the entity that administered the predecessor Short-Doyle Mental Health Medi-Cal.

531 The term “consolidation” was coined because it refers to the joinder, or consolidation, of two Medi-Cal service delivery systems, namely, the Fee-For-Service Medi-Cal program and the Short-Doyle Medi-Cal programs.
recipients’ federal right under the Medicaid statute to freedom of choice. Although consolidation means that Medi-Cal recipients are limited to the county Mental Health Plan as the source of all mental health treatment services, Medi-Cal recipients retain their freedom to choose among the providers under the plan. Consolidation of Medi-Cal mental health services means the MHPs are responsible for the delivery and authorization of services. The Department of Health Services has delegated oversight and implementation responsibility to the Department of Mental Health (DMH). However, DHS remains responsible to CMS for local MHP compliance with federal Medicaid requirements, since it is the single state agency responsible to CMS for the overall administration of the state Medicaid plan.

(ii) Emergency regulations

DMH adopted emergency regulations governing the provision of specialty mental health services by Medi-Cal Mental Health Plans (MHPs) effective November 1, 1997.\textsuperscript{532} Since the emergency regulations are effective only for 180 days,\textsuperscript{533} they were readopted the end of June, 1998, and have been repeatedly readopted since then.

(b) Who’s eligible to receive services from county mental health plans?

County MHP services are for a “target population” of adults who have chronic and severe psychiatric disabilities. They also target children under age 21 who need mental health treatment services.

\textsuperscript{532} Cal. Code Regs. tit. 9, §§ 1810.100 \textit{et seq.}

\textsuperscript{533} Welf. & Inst. Code § 5775(e)(2).
County mental health plans are responsible for providing all specialty mental health Medi-Cal services to Medi-Cal eligible individuals (a) who have an included diagnosis and (b) who meet the eligibility and medical necessity criteria in state regulations. A list of the included and excluded diagnoses and a summary of the eligibility standard is in Appendix A 15. An example of an excluded diagnosis is mental retardation. An example of an included diagnosis is an anxiety disorder. If you have both an included diagnosis and an excluded diagnosis, you must still get services from the county MHP for the included diagnosis. See Question “(g)” below. Services for the excluded diagnosis, such as mental retardation, are provided through fee-for-service or a managed care plan serving the other health needs.

Persons who are eligible for services from the county MHP cannot get services from Fee-for-Service psychologists or psychiatrists. However, the psychiatrist or psychologist who was providing treatment in fee-for-service Medi-Cal may have joined the county MHP.

(c) Are the rules the same for adults and children in terms of who's eligible and what services they can get?

No. The eligibility criteria and scope of services are better for children. Children includes people below age 21. See Chapter 7 about Medi-Cal services for children.

(d) What kind of services are available through county mental health plans?

Services that used to be available through fee-for-service -- psychiatrist and psychologist visits and psychiatric inpatient hospital services -- are available through Mental Health Plans. Also available are the case management and rehabilitative services. These are services which
traditionally were available through County Medi-Cal Mental Health Short-Doyle programs which were the predecessor to the County MHPs. Also on the list are psychiatric nursing facilities, but these services are covered under Medi-Cal only for persons age 65 or older. The list of services and a description of the categories of rehabilitative services are included in Appendix A15.

Children are eligible for an expanded scope of mental health treatment services under EPSDT including services to support them in their homes and other community alternatives to large group homes or institutional placement. They are not subject to the limited menu of services available to adults 21 and older. They are entitled to receive any mental health service they need using a commonsense medical necessity standard which California could elect to include in its Medi-Cal program. See Chapter 7.

Rehabilitation option services were added to the Short-Doyle program in 1993 and are now a part of the services available under the Mental Health plan. Rehab option services provide greater flexibility than other categories of services because of where and how they can be delivered and the type of services “directed at restoration to the highest possible functional level for persons with psychiatric disabilities and maximum reduction of symptoms of mental illness.”


535 Welf. & Inst. Code 14021.4(a)(4). The federal description of the rehab option says this: other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. 42 U.S.C. § 1396d(a)(13), emphasis added.
(e) **What are the eligibility and medical necessity criteria for receiving mental health services under a mental health plan?**

Threshold issues for access to services through the MHP are (a) eligibility for MHP services and (b) the definition of medical necessity under the MHP. Although eligibility criteria and medical necessity criteria should be separate issues, the state managed care regulations merge these two issues together. The eligibility criteria for receiving services under the mental health plan are incorporated into the medical necessity criteria at Cal. Code Regs. tit. 9 § 1830.205. It is important that advocates distinguish between these two types of criteria contained in regulation § 1830.205. The eligibility criteria are at subsections (b)(1), (b)(2)(A) and (B), and (b)(3)(C). The medical necessity criteria are at subsections (b)(3).

(i) **Three-Part test for determining eligibility and medical necessity**

The three-part test tracks the three subsections of Cal. Code Regs. tit. 22 § 1830.205. The client must meet both the eligibility criteria and the medical necessity criteria for receiving a covered mental health plan service. The three factors to analyze include: (1) Does the client have a listed Axis I DSM IV diagnosis?; (2) Does the client meet at least one of the impairment-related criteria?; and (3) Does the client meet all of the three intervention-related criteria?

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There are five axes considered in an assessment. Each axis “refers to a different domain of information which may help the clinician plan treatment and predict outcome.” DSM-IV, p. 25. The different axes are identified as follows: I, clinical disorders and other conditions that may be a focus of clinical attention; II, personality disorders, mental retardation; III, general medical conditions; IV, psycho social and environmental problems, V, global assessment of functioning. *Id.* “Axis I is for reporting all the various disorders or conditions in the [DSM-IV] Classification except for the Personality Disorder and Mental Retardation (which are reported on Axis II).” *Id.*
(a) The first question is whether the person has an included diagnosis

Most Axis I DSM IV diagnoses are included. See Appendix A15.

(b) The second question is whether the psychiatric disability is severe enough

The severity criteria are in subsection (b)(2) of the regulation. The regulations at Cal. Code Regs. tit. 9 § 1830.205(b)(2) say the person:

Must have at least one of the following impairments as a result of the mental disorder(s) listed in subdivision (1) above:

(A) A significant impairment in an important area of life functioning.

(B) A probability of significant deterioration in an important area of life functioning.

(c) The third question is whether the medical necessity definition for MHP services is met.

This is known as “intervention criteria” and are set out in subsection (b)(3). The regulations at Cal. Code Regs. tit. 9 § 1830.205(b)(3) say the person:

Must meet each of the intervention criteria listed below:
(A) The focus of the proposed intervention is to address the [eligible condition].

(B) The expectation is that the proposed intervention will:

1. Significantly diminish the impairment, or
2. Prevent significant deterioration in an important area of life functioning.

(ii) What can I do if the county MHP says I can’t get services?

First, in most cases you will not get a written notice when you are denied services. You do not need a notice, however, in order to request a Medi-Cal fair hearing or file a grievance. See Chapter 17 about Medi-Cal fair hearings. Ask the person who said no to give you a notice or something which explains why the service was denied. Ask for information or help to request a Medi-Cal Fair Hearing and/or file a grievance.

Second, is the denial, termination, or reduction consistent with broader standards of medical necessity in state and federal law which the MHP may be ignoring? Under the hierarchy of authority, a federal statute or regulation wins over a conflicting state statute or regulation; a state statute wins over a conflicting state regulation or policy.

The following medical necessity standards apply to the delivery of services under a Medi-Cal Mental Health Plan:

@ the general medical necessity definition for the entire Medi-Cal program, Welf. & Inst. Code § 14059.5;
@ the federal medical necessity definition for Rehabilitative Option Services, 42 C.F.R. § 440.130(b);
Chapter 15: Medi-Cal Managed Care

@ the state medical necessity definition for Rehabilitative Option Services; Welf. & Inst. Code § 14201(e)(1);
@ the Rehabilitation Option Manual criteria for medical necessity.

Third, there is a State Ombudsman who can help you with problems you are having with your county mental health plan: 1-800-896-4042 [TTY 1-800-896-2512].

(f) If I think I need services through a County Mental Health Plan, how do I start?

You start by calling the 800 access number for your county. If you are told on the phone that you are not eligible, ask for that in writing. You have the right to a Medi-Cal fair hearing if you are told you are not eligible for services through the County MHP — and a right to a hearing if you are not given a notice! See Chapter 17.

What is supposed to happen next is referral for assessment to determine whether you are eligible and what services would help you.

(g) Will I be able to see a psychiatrist without going through the mental health plan if the mental health plan says I do not have an eligible diagnosis?

Yes, but it's tricky. A fee-for-service psychiatrist's billing will be bumped out only if the billing enters one of the specialty mental health billing codes\textsuperscript{537} and one of the specialty mental health procedures codes.\textsuperscript{538}

\textsuperscript{537} Medi-Cal Provider Medical Services Manual at 200-52-2 (2/98), Table 2, diagnoses codes covered by specialty mental health.

\textsuperscript{538} Medi-Cal Provider Medical Services Manual at 200-52-1 (11/97), Table 1, Specialty Mental Health HCPCS/Medi-Cal procedure codes. “HCPCS” is the acronym for CMS (formerly know as HCFA) Common Procedures Code System. The Medi-Cal program has its own parallel
(h) I receive Medicare and Medi-Cal. Am I required to go through the county mental health plan to see a psychiatrist or psychologist?

No. Dual eligibles can continue in fee-for-service Medi-Cal for services covered by Medicare and Medi-Cal. 539

(i) If I am eligible for services under a County Mental Health Plan, are there any circumstances when I can receive psychiatrist and psychologist services through fee for service?

Yes, through certain clinics: Federally Qualified Health Centers, Rural health Centers and Indian Health Center Services. 540

(j) I have a psychiatric disability. I am on the street and need help finding a place to live. Can the county MHP help me?

Maybe. You may qualify for Medi-Cal case management services through the county mental health program. Case management services could help you find a place to live or help you maintain the stability of coding because sometimes Medi-Cal will have multiple codes for a single HCPC number. Included in the specialty mental health covered codes is 90862, the code for medication management including prescription and medication review. Id. at 200-100-3 (2/97).

539 Medicare/Medi-Cal cross over claims are excluded from Medi-Cal Mental Health Managed Care. Medi-Cal Providers Medical Services Manual at 200-52-4 (11/97).

540 Medi-Cal Medical Services Provider Manual at 200-52-4 (11/97).
your current living situation. A county mental health to assign you a case manager. If county mental health says no, and you do not like that answer, you have the right to request a Medi-Cal fair hearing to challenge the denial.

(k) I am on Medi-Cal and Being Released from a 72-hour, Welfare & Institutions Code § 5150 Hold. What right do I have to be linked up with follow-up services through the county mental health plan?

You have a right to be "referred for further care and treatment on a voluntary basis ..." [Welf. & Inst. Code § 5152(b), emphasis added.] Further care and treatment would be would be through a county mental health plan. "Referral" is defined in Welf. & Inst. Code § 5008(d). It includes the requirement that it be effective—even if that means

541 Case Management through County Mental Health Plans is an amalgam of targeted case management under 42 U.S.C. § 1396n(g) and rehab option services. Targeted case management services (or “brokerage” services as called by County Mental Health Plans) is defined as “services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.” 42 U.S.C. § 1396n(g)(2). The rehab option portion of the services includes assistance with daily living, crisis intervention, evaluation and re-evaluation. “Short-Doyle/Medi-Cal Manual for the Rehabilitation Option and Targeted Case Management,” at 2-15 (6/93), issued by Systems of care, California Department of Mental Health, last revised 7/1/95.

542 "Referral" is referral of persons by each agency or facility providing . . . evaluation services to other agencies or individuals. The purpose of referral shall be to provide continuity of care, and may include, but need not be limited to, informing the person of available services, making appointments on the person's behalf, discussing the person's problem with the agency or individual to which the person has been referred, appraising the outcome of referrals, and arranging for personal escort and transportation when necessary. Referral shall be considered complete when the agency or individual to whom the person has been referred accepts responsibility for providing the necessary services. All persons shall be advised of available pre-care services which prevent initial recourse to hospital treatment or aftercare services which support adjustment to community living following hospital treatment. These services may be provided through county welfare departments, State Department of Mental Health, Short-Doyle programs, or other local agencies."
personally escorting or transporting you. "Referral" is not complete until the agency to which you are referred accepts responsibility for providing necessary services. These obligations are consistent with the facility's discharge planning responsibilities.
Chapter 16: 
Medi-Cal Home and Community Based Waiver Programs

Through home and community based waivers a State, with federal approval, may make an array of home and community based services available to targeted groups of persons who otherwise would require Medi-Cal funded long-term care in a nursing facility (including subacute facility), intermediate care facility, or a hospital. In addition to including as “medical assistance” services that are not available in the state plan, the waiver waives certain other federal requirements. For instance, federal Medicaid law requires that if the state makes a service available to one group of persons, the state is generally required to make that same service available to all.

543 Approval is by the Health Care Financing Administration -- “CMS” — which is a part of the U.S. Department of Health & Human Services (DHHS) and is the entity that administers the state implementation of Medicaid.

544 Section 1915(c)(1) of the Social Security Act, 42 U.S.C. § 1396n(c)(1) provides in part:

The Secretary [of Health & Human Services] may by waiver provide that a State plan approved under this title may include as “medical assistance” under such plan payment for part or all of the cost of home or community based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan.
similarly situated persons. Through a home and community based waiver, the federal Medicaid Act permits waiver of compliance with the comparability requirement and the statewideness requirement in order to target an expanded scope of services to persons who otherwise would require long-term care.

In addition to waiving comparability and statewideness, federal law also authorizes the state to elect to treat the waiver participant as if he or she were in a Medi-Cal funded long-term care facility for purposes of financial eligibility. This is called “institutional deeming versus “community deeming.” The waivers with an institutional deeming component are “model” waivers. Under a model waiver the income and resources of a parent of a child under age 18 are not counted, or not “deemed” to the child, for purposes of determining a child’s eligibility under the waiver just as they would not be deemed or counted under either SSI or Medi-Cal if the waiver participant were in a Medi-Cal funded long-term care facility.

Medi-Cal beneficiaries who would qualify for Medi-Cal funded out-of-home care (for example SNF or in one of the ICF/DD programs) at a minimum are entitled to home health care as medically necessary as long as the total cost of Medi-Cal services while at home would not cost more than the cost of the Medi-Cal funded out-of-home alternative.

Section 1915(c) of the Social Security Act, 42 U.S.C. § 1396n(c)(3), provides in pertinent part: A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) [1396(a)(1)] (relating to statewideness), section 1902(a)(10)(B) [1396a(a)(10)(B)] (relating to comparability), and section 1902(a)(10)(C)(i)(III) [1396a(a)(10)(C)(i)(III)] (relating to income and resource rules applicable in the community).

Section 1915(c)(3) of the Social Security Act, 42 U.S.C. § 1396n(c)(3).
Under a model waiver the income and resources of the spouse of the waiver applicant are not counted to determine the waiver applicant’s eligibility for Medi-Cal and share of cost. If you qualify for a model waiver, you are eligible for full-scope Medi-Cal.

For general information about home and community based waivers, visit the National Health Law Program’s website at www.healthlaw.org and click on “medicaid” and then go to the March and May 2000 fact sheets on waivers. For more information about California’s waivers and how people qualified under a model waiver apply for full-scope Medi-Cal, see DHS All-County Welfare Directors Letters Nos. 96-60 (October 31, 1996) and 97-27 (June 20, 1997) and Section 19D from the Medi-Cal Eligibility Procedures Manual.

1. Types of home and community waivers in California

Q: What home and community based waivers are available in California to enable persons who would otherwise require care in a medical facility to live at home or in a community placement?

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548 When a child is in a nursing facility or other Medi-Cal funded long-term care, neither SSI nor Medi-Cal count the income or resources of the parent. The income and resources of a parent is counted only when the child and the parent are living in the same household. SSI rule: 20 C.F.R. §§ 416.1160(d) (ineligible parent means someone who lives with child), 416.1160(a)(2) (deeming income from ineligible parent to child), 416.1202(b) (deeming of resources from ineligible parent to child). Medi-Cal rule: Cal. Code Regs. tit. 22 § 50351(b)(4) (“Relative’s responsibility shall be parent for child living in the parent’s home”).

549 See Chapter 11 and the discussion of spousal impoverishment protections when one spouse is in the community and the other in a nursing facility. While under spousal impoverishment rules the income of the community spouse is capped, that is not the case under a model waiver. Under spousal impoverishment rules the income of the spouse in the community may include the income of the spouse in the nursing facility up to the community spouse cap. That is not true under a model waiver where the waiver spouse is treated as being in his or her own budget unit so that income of the waiver spouse is counted using medically needy rules to determine share of cost, if any.
A: There are six CMS approved Home and Community Based waivers in California.

(a) **Nursing facility waiver for Medi-Cal recipients who would otherwise require care in a nursing facility including a subacute facility**

This is the waiver program for people who are already eligible for Medi-Cal. The Medi-Cal program limits the amount of home health care to short visits and occasionally additional home health aide assistance. While PAI believes Medi-Cal’s limitations violate federal Medicaid law for persons who would otherwise require care in a nursing facility, such persons are able to get shift nursing through the waiver. The waiver also provides help with utility bills associated with equipment use, home health aides, therapy (occupational, physical, speech), alterations for accessibility, and family training. Beginning in 2000, personal care services to supplement those available under the state plan are also available under the waiver.

To start the application process call Medi-Cal In-Home Operations and request referrals to home health agencies.

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550 42 U.S.C. § 1396a(a)(D),

551 See Welf. & Inst. Code 14132.97. See, also, PAI’s June 2000 memo on personal care services under the waiver: www.pai-ca.org and then click on “publications” and then on Health.

552 Home health agency rates had been unchanged for over a decade and then were increased with no requirement that any part of the increase be passed onto the nurses in the form of wages. It is difficult to find home health agencies willing to work with Medi-Cal under current agency rates: $29.41 an hour for Licensed Vocational Nurse (LVN), $18.90 for home health aides, $40.57 an hour for registered nurses, and $45.43 an hour for a supervising R.N. These are the EPSDT nursing rates which have been used in the waiver program. Cal. Code Regs., tit. 22 § 51532.1(b).

The Medi-Cal regulations for waiver rates authorize rate setting on an individual case-by-case basis. Cal. Code Regs. tit. 22 § 51524(a). If you are unable to find a home health agency which will accept you as a Nursing Facility waiver client because they are unable to staff the case at current rates, ask the agency to submit a nursing facility Treatment Authorization Request (TAR) at the rates.
The home health agency will put together a Treatment Authorization Request (TAR) and submit it to In-Home Operations. The timelines applicable to TARs generally are also applicable to waiver TARs.

(b) **Model nursing facility waiver:**

**Q:** “Model” nursing facility waiver for people who would otherwise require care in a nursing facility and are eligible for Medi-Cal with a share of cost based on a parent’s or spouse’s income or ineligible for Medi-Cal because of a parent’s or spouse’s or parent’s resources.

**A:** The Model Nursing Facility Waiver is the same as the regular Nursing Facility Waiver except for the following: (1) Once you have been found to medically qualify for the waiver, you are referred to the county for processing for full scope Medi-Cal. (2) For children, once qualified under the model waiver, receive most of their nursing services through the regular Medi-Cal program and EPSDT. See Chapter 7 on Children.
(c) Developmentally disabled:

Q: Departmental of Developmental Services (DDS) Waiver for persons who would qualify for services in an intermediate care facility for the developmentally disabled.

A: This waiver covers developmentally disabled clients of regional centers -- and probably a few others who do not meet the state definition of developmental disability for purposes of regional center eligibility.\(^{553}\) The waiver includes a wide range of services to support persons in the community. Applications are through regional centers for developmentally disabled. This waiver also includes the option for institutional deeming so that children and adults may qualify without regard to the income and resources of their parents or spouses.

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\(^{553}\) The waiver covers persons who would otherwise be eligible for placement in an ICF for persons who are mentally retarded or developmentally disabled. Federal, not state standards apply to who qualifies for such ICFs. *Parry v. Crawford*, 990 F.Supp. 12650 (D.Nev. 1998); 42 CFR § 435.1009 (definition of condition related to mental retardation). The federal definition of related conditions includes persons disabled prior to age 22. The state definition of developmental disabilities (mental retardation and related conditions) requires that the condition originate before age 18. Welf. & Inst. Code § 4512(a).
(d) **In-Home Medical Care (IHMC) Waiver** for persons who otherwise would require care at least 90 days a year in an acute hospital

This is a waiver which expired in 1990 and is annually extended through CMS (formerly known as HCFA). Very few people are added to this waiver. This waiver does cover people who lack community supports and receive services in New Start congregate health facilities with 4 to 6 persons.

(e) **DHS Acquired Immune Deficiency Syndrome (AIDS) Waiver**

Individuals with HIV/ AIDS related conditions who need nursing facility level of care are eligible as are certain children under age 13 with category A, B, or C HIV CDC classification. This waiver covers specific geographic areas. The waiver does not operate statewide as does the nursing facility waiver.

Additional criteria include Medi-Cal financial eligibility and, meeting the Social Security disability standard.

The HIV/ AIDS waiver can provide skilled homemaker and nursing services, transportation, specialized medical equipment and attendant care. Other services include psycho-social counseling, Medi-Cal supplement for Infants and Children in foster care, nutritional supplements, home delivered meals and nutritional counseling.

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554 Waiver services are available to individuals in the following counties: Alameda, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Humboldt, Lake, Lassen, Los Angeles, Madera, Marin, Mariposa, Mendocino, Modoc, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity Ventura, Yuba, and Yolo.

555 AIDS Waiver p. 11
HIV/AIDS Waiver enrollees’ are typically referred by government and community agencies, family members, friends or self-referral. Each applicant must go through a screening process. The screening process begins when the case manager receives the referral. Once the case manager determines the client is eligible for waiver services an attending physician certifies the client’s level of care needs.\(^556\)

(f) Department of Aging Multipurpose Senior Service Program (MSSP) Waiver for frail elderly

Individuals age 65 or older who meet nursing facility admission criteria are eligible if they are receiving Medi-Cal under an eligible aid code.\(^557\) The applicant must live in the MSSP catchment area.\(^558\) The MSSP waiver provides case management. MSSP’s other services include (1) attendant care in the home including protective supervision (2) home repairs (3) transportation and accompaniment, (4) money management (5) respite (6) meal services and (7) housing assistance.

The application process can be handled by phone, in the medical facility the applicant hopes to leave, or by a visit to the home.

2. My husband is in a nursing home. Will the waiver help him to come home?

Yes. However, you do not have to be in a nursing home to qualify for any of the waivers except the In-Home Medical Care (IHMC) waiver.

\(^{556}\) AIDS Waiver p. 50

\(^{557}\) MSSP Waiver p. § 3–4. Qualifying Medi-Cal aid codes are: 10, 14, 16, 18, 20, 24, 26, 28, 60, 64, 66, and 68. For general information about the MSSP waiver visit www.aging.state.ca.us/internet/programes/mssp.htm

\(^{558}\) For information about MSSP waiver catchment areas in your county and how you apply, call your county Area Agency on Aging. For a listing of the 35 current catchment sites, visit www.aging.state.ca.us/internet/programes/msspcont.htm
3. I am married, work and am disabled enough to qualify for a nursing facility. Will the waiver help me?

Under certain circumstance individuals who met the definition of Qualified Severely Impaired Working Individual may lose SSI eligibility including eligibility under 1619(b) because of a spouse’s earnings or resources. For working individuals under the model waiver, the nursing facility waiver authorizes deductions equal to the deduction allowed under SSI for earned income, including any amounts below the 1619(b) general or individual threshold. The requirements for a qualified severely disabled person include the following:

(1) the individual must depend on Medicaid to continue working;

(2) Meet all non-disability requirements for regular SSI/SSP benefits except for earnings;

(3) Not have sufficient earnings to replace SSI cash benefits, Medicaid, publicly-funded personal or attendant care that would be lost due to the person earnings and;

(4) Have received SSI or was eligible for 1619(b) in the month before the Medi-Cal Only determination/eligibility is initially established.560

4. Counting income under nursing facility model waiver

Q: Under the Nursing Facility Model Waiver, which doesn’t count? Is it the Income of the Spouse or Parent? How is My own Income Counted?

A: Your income is treated individually as yours and is counted in your own budget unit of one person. Your spouse’s income or your parents’ income is not counted. If you have earned income, you are treated under the rules described in Question 3 above. If you have unearned income and not earned income, you follow the medically needy rules for a one-

559 42 U.S.C. § 1382h. See Chapter 2 for an abbreviated discussion of the 1619(b) program.

560 ACWDL No. 97-27 (June 20, 1997).
The reviewed waiver may be covering persons who would qualify for the A & D FPL program if the monies of their spouse or parent were not counted.

5. I receive $1100 a month in Social Security Benefits. Will a waiver help me?

No. It only waives deeming -- that is, income or resources that otherwise would be attributed to you from a spouse or parent to determine your Medi-Cal eligibility. It does not waive your own income.

6. It is hard to get in and out of my house because I use a wheelchair and there are steps. Can I get a ramp built through the Waiver

Yes. You can get a ramp built through the Nursing Facility waiver, the DDS waiver, the IHMC waiver and the MSSP waiver.

7. When I am on a Waiver, how does it affect my other Medi-Cal benefits?

First, you look to the regular Medi-Cal program to see if your needs can be met. You then look to the waiver programs to see if it can fill in your service gaps. When children qualify for the model nursing facility waiver, they look first to the regular Medi-Cal program which includes the full scope of EPSDT benefits.

8. What if I have a disagreement about my waiver. What are my rights?

Since waivers are a Medi-Cal service, your regular Medi-Cal fair hearing rights are available to you. Those rights include “aid paid pending” if the waiver seeks to reduce or terminate your services.

561 The reviewed waiver may be covering persons who would qualify for the A & D FPL program if the monies of their spouse or parent were not counted.

562 If you need attendant care, your share of cost will be the difference between your countable income (see Chapter 5) and the SSI grant level versus the lower Medically Needy Maintenance Need Income Level.
However, you should distinguish between problems with the providers (like the home health agency under a nursing facility waiver or the supported living agency under the DDS waiver administered by the regional center) and problems with the entity that approves services under the waiver. If there is a problem with the provider, ask for help from the agency that administers the waiver - such as In-Home Operations with respect to services under either of the nursing facility waivers.

9. **PACE: Programs for All Inclusive Care of the Elderly**

PACE provides services like those in a Waiver for persons aged 55 or older who have both Medicare and Medi-Cal and who would qualify for nursing facility care. Under PACE the duration and scope limitations applicable to the regular Medi-Cal program do not apply.

There are three demonstration PACE programs in California in San Francisco, Alameda and Sacramento Counties. Congress in the 1997 Balanced Budget Act converted PACE to a regular program under Medicare and, at the State’s option, Medicaid. The Medicaid Act defines the scope of benefits and beneficiary cost as follows:

(a) all items and services covered under title XVIII [Medicare] (for individuals enrolled under section 1894 and all items and services covered under this title, but without any limitation or condition as to amount duration, or scope and without application of deductibles, copayments, coinsurance, or other cost-sharing that would otherwise apply under such title, or this title, respectively; and

(b) all additional items and services specified in regulations, also based on those required under the PACE protocol; it determines how the scope of services beyond the Medi-Cal regulations and will be used as the basis in developing PACE regulations.

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564 See, e.g., San Francisco: On Lok Senior Health Services. See attachment to DHS ACWDL No. 97-18, CCH Medi-Cal Guide New Dev. ¶ 7846.

565 42 U.S.C. §§ 1396u-4, 1395eee(a),
Spousal Impoverishment rules also apply to the PACE program. This means that even though a spouse is not institutionalized, the PACE spouse is considered to be in his/her separate Medical Family Budget Unit and permitted to transfer resources and income under the spousal impoverishment rule to his or her community spouse. See Chapter 11.

The fee-for-service typical duration and scope limitations do not apply to the PACE program. For example, typical Medi-Cal beneficiaries are entitled to two occupational therapy sessions a month. However, PACE allows you to increase your occupational therapy sessions if necessary.
Chapter XIV in Western Center on Law & Poverty's CALWORKSMANUAL (3d Ed, Spring 2000) provides a good overview of the fair hearing process. You also should visit the website of the State Hearings Division, the unit within the Department of Social Services: www.dss.cahealth.gov/shd/default.htm. In addition to a description of the fair hearing process, the website includes the State fair hearing regulations, the Bench Book used by Administrative Law Judges (ALJ) as their guide and for language articulating the standards to be used, the paraphrased regulations, and Notes from the Training Bureau.

1. What If I disagree with Medi-Cal?

You have the right to challenge anything Medi-Cal does—or does not do—which you believe to be wrong and which hurts you. You challenge Medi-Cal by requesting a fair hearing. You do not need a notice of action from the county or state in order to request a fair hearing. You have 90 days in which to ask for a fair hearing.

2. What if I disagree with my Medi-Cal managed care plan?

You have the right to challenge what the managed care plan does—or does not do—to the same extent you can challenge what Medi-Cal does if you are outside a managed care plan and in the fee-for-service system. The fair hearing procedure is the same if your doctor requested or recommended something the medical group or managed care plan would not approve—such as a denial of approval for a medication not on the “formulary.” In such a case the managed care plan is really acting as the Medi-Cal field office.

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566 Visit Western Center’s website at www.welp.org for manual and to order your own copy of the manual.
There are complications, however, when you and your primary care physician do not agree so there never is a request for approval from the doctor’s group in which your doctor practices and/or from the managed care plan itself. PAI believes you have a right to notice and a Medi-Cal Fair Hearing if your physician’s denial is based not on medical judgment but based on the physician’s understanding of what Medi-Cal or the plan covers or does not cover. Medi-Cal says no right to a notice, but you can go to a fair hearing.

3. What if I Disagree With a County Mental Health Plan?

You have the right to challenge what county mental health plan does or does not do just as you would be able to challenge through a Medi-Cal fair hearing whatever any managed care plan did nor did not do. You also have the right to challenge what a program that contracts with a county mental health plan does or does not do. Some of the things you may wish to challenge include:

- Termination from a program before you are ready;
- Putting you on a waiting list for a program you think you need now;
- Disagreement about your treatment plan or refusal to develop a treatment plan;
- Denying you a service or an evaluation you believe you need;
- Refusal to provide a case manager, or disagreement about what sorts of things the case manager should help you with.

4. My Medi-Cal managed care plan has a grievance procedure. How does the grievance procedure work with the Medi-Cal fair hearing procedure?

You have the right to pursue either the grievance or the Medi-Cal fair hearing or both at the same time. Pursuing both at the same time may help you solve your problem. Sometimes the fact that there is a fair hearing pending will help you solve the problem in the grievance. Even if a grievance is not able to fix the problem, you will be better prepared for the hearing because you will understand the managed care plan’s position.

Remember that if you decide to pursue the grievance first, that does not stop the 90 days time period you have for asking for a fair hearing. The Medi-Cal fair hearing clock keeps ticking while you go through the grievance procedure. Therefore, it is
important to ask for a hearing, even if you withdraw your request once your problem is fixed.

5. **What if my managed care plan doctor and I disagree? What about a Medi-Cal fair hearing?**

   In Fee-For-Service Medi-Cal, you and the provider or doctor are usually on the same side. That is not necessarily the case in managed care. First, clarify whether your disagreement is about whether something is medically necessary or appropriate or about whether the plan or Medi-Cal will cover something.

   If the dispute is about whether something is medically necessary, ask about a second opinion. Most plans will authorize a second opinion from someone who is within the plan.

   If the dispute is about whether something is covered by Medi-Cal or the plan, ask for a fair hearing and file a grievance with your plan.

6. **Medi-Cal Denied coverage for the services my doctor ordered. What can I do?**

   Medi-Cal often refuses to pay for services and equipment by denying a treatment authorization request (TAR), even when your doctor prescribes the services. Medi-Cal will claim that the services are not medically necessary, or are not covered under the state Medi-Cal plan. You can file a fair hearing request to challenge that, and to change Medi-Cal's "no" to "yes." The Department of Health Services and the Administrative Law Judges call hearings about denied services and equipment "scope" hearings.

   **(a) Notice and 10-days for aid paid pending**

   When Medi-Cal denies services or denies a TAR, it must send a "notice of action" to you and to your provider explaining the reason for the denial and the regulation on which it is based, and telling you how to appeal. Medi-Cal must also send you a notice when it modifies a TAR, or "defers" it by delaying approval until your doctor submits additional

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information. If you are receiving ongoing services and Medi-Cal decides to terminate or reduce those services, it must send you and your provider a notice at least ten days in advance. If you appeal during this ten-day period or before the services are reduced or terminated, Medi-Cal must continue services until your hearing. This is known as “aid paid pending.” See Question and Answer 12 for more information about when services and eligibility for services will continue while you are appealing.

(b) 90-day time period for appealing

You have 90 days from the date of your notice of action to appeal the decision. If you do not appeal within 90 days but decide to do so later, make a new request for the service and then appeal the second denial.

(c) Deciding whether enough information went in with the Treatment Authorization Request (TAR) or whether a new TAR should be submitted.

In deciding whether to appeal, review the request or TAR that the provider sent to Medi-Cal. Medi-Cal only looks at the TAR itself and the supporting documents which were sent in with the TAR when Medi-Cal decides whether or not to approve the TAR. The only exception is when the TAR involves transportation. If the TAR package did not include a letter from your treating doctor explaining in detail why you need the service, or other documents about why the service is medically necessary, it might be faster to start over again by filing a new request with adequate


570 Welf. & Inst. Code § 10951. However, if you didn’t receive notice, or the notice didn’t explain why Medi-Cal denied your request and cite a regulation, then the 90-day limit does not apply. *Morales v. McMahon*, 223 Cal.App.3d 184 (1990).

571 Welf. & Inst Code § 14133.6 (says Medi-Cal is required to look at whole file)
letters and documentation to support your need for the service. If the TAR is resubmitted, make certain the documentation addresses the applicable medical necessity standard. See Chapter 6.

If there was good documentation about why you need the requested service or item, request a fair hearing right away.

7. **What if it is the Managed Care Plan or the Doctors Group that won’t authorize what my doctor ordered?**

   You have the same appeal rights as explained under Question 6 above. However, if the plan is subject to the Knox-Keene Act, you also may be able to file a complaint with the Department of Managed health Care.572 See Chapter 15. You may have additional rights if the services were denied because they are “investigational” or “experimental” and you have a life threatening or seriously debilitating condition. Under those circumstances you may be able to get an expedited independent review. You may be entitled to an expedited independent external review of the denial.573

8. **How do I ask for a fair hearing? How long do I have to file?**

   You file for a fair hearing by filling out and mailing the reverse side of the Medi-Cal notice-of-action form you want to challenge. Or you can call (800) 743-8525. Or you can fax (916-229-4110) and/ or mail a letter to:

   Office of the Chief Administrative Law Judge
   State Hearings Division
   Department of Social Services
   744 P Street, Mail Stop 37-19
   Sacramento CA 95814
   Re: Medi-Cal Fair Hearing
   Your Name
   Your state Medi-Cal number or your Social Security number

572 Visit DMHC’s website at www.hmohelp.ca.gov.

573 Health & Safety Code § 1370.4.
Your address and phone

Your letter should include a general statement about why you are asking for a hearing. For example

- The county is taking too long to process my Medi-Cal application. I submitted my application on x date. It is now y date.
- I believe I am eligible for Medi-Cal.
- Medi-Cal denied the request for an electric wheelchair even though I can no longer get around on my own in my manual wheelchair.
- I am in a nursing facility and need physical therapy so that I can get around with a walker instead of getting around only with a wheelchair.

You have 90 days from the date of the Medi-Cal action you are challenging to ask for a fair hearing.

9. Who hears my case? How soon will I get a hearing? How soon will I get a decision?

Medi-Cal hearings -- like other state benefits hearings -- are heard by administrative law judges (ALJs) from the State Hearings Division of the Department of Health Services: www.dss.ca.gov/health/shd/default.htm.

(a) Fair hearing process

Although testimony is given under oath and although there is a tape recorder so that there will be a record of the hearing, the Medi-Cal hearing procedure is designed to be fair to unrepresented lay persons. For instance, the County or State DHS or the health plan if managed care has to go first. ALJs have not required the State DHS to follow the rule applied to counties which requires that they have the position statement available to the Medi-Cal recipient two business days before the hearing. 574

574 Welf. & Inst Code § 10952.5. Two days prior to the date of the hearing the opposing party must provide a copy of the position statement.
However, ALJs have found the county rule to apply to county mental health plans.\textsuperscript{575}

(b) **DHS review of proposed fair hearing decisions**

The decision issued by the ALJ in a Medi-Cal hearing is a proposed decision unless the Director of Health Services has delegated her authority to adopt the decision to the Chief ALJ. The Director has not delegated her authority on Medi-Cal scope hearings including EPSDT nor on cases involving managed care. These proposed decisions are reviewed by the Department of Health Services and are either adopted, changed, or set for further hearing.\textsuperscript{576}

(c) **90 days for hearing decision to issue**

Federal Medicaid regulations require fair hearing decisions to issue within 90 days of the fair hearing request.\textsuperscript{577}

10. **What Information and material do I need to get ready for a “Scope” Medi-Cal Fair Hearing when managed care is not involved?**

Start with the Manual of Criteria to see if the service or equipment at issue is covered in the Manual. The Manual of Criteria is in a book separate from the other Medi-Cal regulations but it is a part of the regulations.\textsuperscript{578} It covers many services (for example, hospital care, long-term care) and sets out the criteria the field office will use in deciding whether to authorize services in a particular case.

\textsuperscript{575} The position statement therefore also would need to be available two days before the hearing where the Medi-Cal fair hearing is against a county operated health system plan, a GMC plan, or a two-plan county plan.

\textsuperscript{576} Welf & Inst. Code § 10959.

\textsuperscript{577} MPP § 22-009.1, 42 CFR 431.244(f)

\textsuperscript{578} Cal. Code Regs. tit. 22 § 51003(e).
(a) **Subregulatory Materials -- field instruction notices, policy memos, provider manual**

Medi-Cal Field Offices also follow Field Instruction Notices (FINs) and Policy Statements. FINs and Policy Memos are important because they may explain how the Medi-Cal program defines medical necessity when they approve or deny devices or services of the type you requested. Because of a law suit, DHS is in the process of converting its FINs and Policy Memos into regulations - primarily for inclusion on the *Manual of Criteria*.

The FINs and Policy Statement are not regulations but guidelines. They are not binding on you or on the Administrative Law Judge who will hear your case. However, if you can show how to fit within the Medi-Cal guidelines, Medi-Cal should not be able to deny coverage for the service or device requested. They should be stopped from doing so.

To get a copy of any relevant guidelines, we recommend you send a public records act request with a copy of your fair hearing request. In our experience, DHS will simply send you a copy of the requested guidelines or advise you there are none. You will also get relevant sections from the Provider Manual.
(b) Using a California Public Records Act Request.

Sample California Public Records Act Request

via facsimile (916) 657-1156 and mail

Diana Bontá, R.N., D.P.H.
Department of Health Services
P.O. Box 942732
Sacramento CA 94234-7320

Attn: Office of Legal Services

Re: Public Records Act Request --
Documents related to [explain what service or equipment is at issue -- i.e., "guidelines or standards for evaluating TARs for electric wheelchairs."]

Dear Ms. Belshé:

[Your agency], pursuant to the California Public Records Act [Government Code §§ 6250 et seq.], hereby requests to inspect [§ 6253(a)] and copy [§ 6256] the following records:

Any Field Instruction Notice (FIN), policy memo, provider manual provision, Manual of Criteria provision or any other document setting out or explaining any guideline or standard or directions [relate to the subject matter of the TAR at issue -- i.e., "or otherwise relating to the coverage of electric wheelchairs under the Medi-Cal program."]

As you know, the CPRA requires you to respond to the request within 10 days. Government Code § 6256. This Public Records Act request is pursuant to our representation of [client’s name], Medi-Cal No. xxx, with respect to his pending Medi-Cal fair hearing [State Hearing No. if you have it] concerning the denial of TAR No. xxx for [subject matter of TAR]. We request that you send us a copy of the requested documents without charge because they are requested in connection with the pending Medi-Cal fair hearing.

Sincerely,

Endorsement: Copy of the Fair Hearing Request.

cc: State Hearings Division, DSS, 744 "P" Street M.S. 37-19, Sacramento CA 95814, via mail & fax (916) 653-8690.
(c) **Looking at the file in the Medi-Cal Field Office**

Call the telephone number on the TAR denial form and make arrangements to look in the file. We have found very interesting notes and materials in the file which are never included with the position statement filed with DHS' position statement. There has been field office consolidation in the sense that a single field office may handle a category of TARs for the state. The file may need to be shipped to your local field office.

(d) **Copies of other hearing decisions**

It is useful to get other fair hearing decisions approving services similar to those you have requested. Although the hearing judge does not have to follow other hearing decisions, she or he may find them persuasive because all the Medi-Cal scope hearings are subject to DHS review and adoption or alternation. You can find decisions by looking at the "Digest of Hearing Decisions."[^579] And you can get Medi-Cal scope fair hearing decisions from Western Center on Law and Poverty[^580].

(e) **Subpoena Duces Tecum**

If you do not get a response from the Department of Health Services to your Public Records Act request, contact your local hearing office and ask

[^579]: Available on the State Hearings Division’s website in October of 2001.

[^580]: These are copies of decision that have been reported in Welfare Task Force mailings over the years. Often the advocate's position statement also is available.
for the presiding judge to request the documents. Be prepared to do a short memo (or fill out the form the hearing office faxes you) about why you need a subpoena. You can also call the 800 number on the hearing request acknowledgment and ask them to explain what you have to do to get a subpoena duces tecum (pronounced sah-PEE-na due-ses TEE-kum) issued. You have responsibility for serving the subpoena.

(f) **Beefing up the medical justification**

Review the medical justification that went in with the TAR. Doctors sometimes write in shorthand for other health professionals. You may need to work with the doctor and/or nurse to amplify what was submitted with the TAR documentation. At the fair hearing, DHS usually objects to the augmentation; your position is that what is being submitted is nothing new -- that the augmented information merely expresses what another health care professional with comparable expertise would understand from the original submission.

(g) **Arranging for expert testimony via phone**

Although it is unlikely you would be able to get the doctor or other health care professional to appear in person, you may be able to arrange to have your experts testify by phone. We recommend that you send a fax memo to the presiding judge where your case will be heard with a copy to the DHS representative. Assuming your witness will be available by phone

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582 DSS MPP 22-052. But the witness will be paid by the State Hearings Division. MPP 22-052.1.

583 To find out who the DHS representative will be, phone the local Medi-Cal field office who will give you the name and fax number of the representative.
on the day the hearing is scheduled, also advise if there needs to be any adjustment in the scheduling of the hearing for that day.\footnote{584}

11. What happens if the county says I am no longer eligible for Medi-Cal?

See Chapter 9. If the state or county says you are no longer eligible for Medi-Cal, the county must review your case to see whether you are eligible for Medi-Cal on another basis. If you think the County is wrong when it says you are no longer eligible under your current program, request a fair hearing. Although there are procedures for continuing Medi-Cal while the county redetermines your eligibility on another basis, our experience is that people's Medi-Cal will often end before there is a redetermination. Therefore we recommend that you request a fair hearing even if you agree you are no longer eligible under your current program but believe you would be eligible under another program.

12. What actions can I challenge in a fair hearing?

In a fair hearing, you can challenge Medi-Cal's actions in any or all of the following areas:

- Refusal to process, or delay in processing, your Medi-Cal application;
- Determination that you are not eligible for Medi-Cal, or that you are no longer eligible for Medi-Cal;
- The amount of your monthly share of cost;
- Denial of a prior authorization request or TAR (be sure to check the packet that was sent into Medi-Cal to see if, instead of appealing, you want to

\footnote{584} If your witness will not be available on the day of the hearing, you probably do not want a continuance with the case going back into the scheduling hopper where you have no control over when the rescheduled hearing will be set. The better route is to talk to the presiding judge, advise your witness is not available, and work out an understanding that you will appear for purposes of rescheduling the hearing at a time convenient to the ALJ and your witness.
resubmit it with more complete documentation) or a managed care or county mental health denial of authorization for a service or referral;

- Termination of a service such as medical transportation to receive dialysis, nursing or home- and community-based waiver services, long-term care (nursing facility or ICF);

- Refusal to reauthorize a service such as physical therapy when the treatment goals of the original authorization have not been met.

13. **What happens to my Medi-Cal benefits while I am appealing?**

If you request a fair hearing within 10 days of the date of the notice which says you are no longer eligible for Medi-Cal, or before your Medi-Cal eligibility ends, your Medi-Cal benefits will continue until the Administrative Law Judge issues a hearing decision.\(^{585}\) Similarly, if you receive a notice terminating kidney dialysis, chemotherapy or radiation treatments, transportation, in-home medical care services, or a stay in an SNF or ICF, your benefits will continue until the hearing decision if you request a fair hearing within 10 days of the notice date or before the benefits end.\(^{586}\)

**(a) Aid paid pending when a service not reauthorized**

In certain circumstances, Medi-Cal services can continue pending a hearing decision when Medi-Cal refuses to reauthorize the services. Some non-acute hospital services can continue pending a hearing decision (or pending completion of the request reauthorization if earlier) provided that: (a) the reauthorization TAR is received by the Medi-Cal field office before (or within 10 days after) expiration of a prior authorization; and (b) your request for hearing is submitted within 10 days of mailing the denial

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\(^{585}\) MPP §22-002, MPP§22-001(h)(1), MPP §22-072.7; 42 CFR 431.231(a) and (c)

\(^{586}\) Cal. Code Regs., tit. 22 § 51014.2(a).
notice to you, or before the expiration of the prior TAR, whichever is later. The following services are included:

- Long-term care (nursing facilities including subacute, ICF);
- Chronic hemodialysis (including all related services such as transportation);
- In-home medical care services (and all related services);
- Skilled Nursing Facility Waiver services (and all related services);
- Model Community-Based Waiver services (and all related services);
- All other non-acute services when your treating doctor substantiates through what he sent in with the TAR or what is written on the TAR cover that services should continue because the treatment goal on the original TAR has not been met.

(b) Aid paid pending when continued acute care not authorized

If Medi-Cal denies your request to reauthorize acute care, and you had been approved for at least five days, and your treating doctor determines that you cannot be discharged from the hospital because you still need care in an acute facility, Medi-Cal funding at the acute care rate can continue pending a hearing. Medi-Cal will have the notice of denial delivered to you personally by the first working day following the denial—unless your treating doctor says the notice should be delivered by other means for health reasons. Medi-Cal coverage of the acute care will continue pending the hearing if you request a fair hearing within 10 days of the notice denying reauthorization.

14. Important Phone Numbers for the State Hearings Division the unit in the Department of Social Services that conducts the fair hearings

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587 Cal. Code Regs., tit. 22 § 51014.2(a), § 51003(c)(1)

588 Cal. Code Regs. tit. 22 §§ 51014.1, 51014.2
Medi-Cal appeals are heard by Administrative Law Judges from the State Hearings Division, California Department of Social Services, 744 P Street, Sacramento CA 95814

Toll-free Appeal Line: (800) 743-8525
Fax: (916) 229-4110
Office of Chief ALJ: (916) 657-3550

Los Angeles Regional Office: (213) 897-3983
fax: (213) 897-3204

San Francisco Regional Office: (415) 557-0526
fax: (415) 557-1166

San Diego Regional Office: (760) 735-5070

Sacramento Regional Office: (916) 229-4187
APPENDIX FOR CHAPTER 1

Please contact NHeLP at 310-204-6010 for a copy
A2

APPENDIX

FOR CHAPTER 2
The following aid codes identify the types of services for which different Medi-Cal/CMSP/CCS/GHPP recipients are eligible.

<table>
<thead>
<tr>
<th>Code</th>
<th>Benefits</th>
<th>SOC</th>
<th>Program/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0A</td>
<td>Full</td>
<td>No</td>
<td>Refugee Cash Assistance (FF). Includes unaccompanied children. Covers all eligible refugees during their first eight months in the United States. Unaccompanied children are not subject to the eighth-month limitation provision. This population is the same as aid code 01, except that they are exempt from grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.</td>
</tr>
<tr>
<td>01</td>
<td>Full</td>
<td>No</td>
<td>Refugee Cash Assistance (FFP). Includes unaccompanied children. Covers all eligible refugees during their first eight months in the United States. Unaccompanied children are not subject to the eighth-month limitation provision.</td>
</tr>
<tr>
<td>02</td>
<td>Full</td>
<td>Y/N</td>
<td>Refugee Medical Assistance/Entrant Medical Assistance (FFP). Covers refugees and entrants who need Medi-Cal and who do not qualify for or want cash assistance.</td>
</tr>
<tr>
<td>03</td>
<td>Full</td>
<td>No</td>
<td>Adoption Assistance Program (AAP) (FFP). A cash grant program to facilitate the adoption of hard-to-place children who would require permanent foster care placement without such assistance.</td>
</tr>
<tr>
<td>04</td>
<td>Full</td>
<td>No</td>
<td>Adoption Assistance Program/Aid for Adoption of Children (AAP/AAC) (non-FFP). Covers cash grant children receiving Medi-Cal by virtue of eligibility to AAP/AAC benefits.</td>
</tr>
<tr>
<td>07</td>
<td>Restricted to emergency services</td>
<td>No</td>
<td>Asset Waiver Program. Infant – Undocumented/Nonimmigrant Alien (but otherwise eligible). Provides emergency services only for infants up to age 1 year and continues beyond 1 year when inpatient status, which began before 1st birthday, continues and family income is between 185 percent and 200 percent of the Federal poverty level (State-only program).</td>
</tr>
<tr>
<td>08</td>
<td>Full</td>
<td>No</td>
<td>Entrant Cash Assistance (ECA) (FFP). Provides ECA benefits to Cuban/Haitian entrants, including unaccompanied children who are eligible, during their first eight months in the United States. (For entrants, the month begins with their date of parole.) Unaccompanied children are not subject to the eighth-month limitation provision.</td>
</tr>
<tr>
<td>1H</td>
<td>Full</td>
<td>No</td>
<td>Federal Poverty Level – Aged (FPL-Aged) Provides full scope (no Share of Cost) Medi-Cal to qualified aged individuals/couples.</td>
</tr>
<tr>
<td>1U</td>
<td>Restricted to pregnancy and emergency services</td>
<td>No</td>
<td>Restricted Federal Poverty Level – Aged (Restricted FPL-Aged) Provides emergency and pregnancy-related benefits (no Share of Cost) to qualified aged individuals/couples who do not have satisfactory immigration status.</td>
</tr>
<tr>
<td>10</td>
<td>Full</td>
<td>No</td>
<td>SSI/SSP Aid to the Aged (FFP). A cash assistance program administered by the SSA which pays a cash grant to needy persons 65 years of age or older.</td>
</tr>
<tr>
<td>Code</td>
<td>Benefits</td>
<td>SOC</td>
<td>Program/Description</td>
</tr>
<tr>
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</tr>
<tr>
<td>13</td>
<td>Full</td>
<td>Y/N</td>
<td>Aid to the Aged – LTC (FFP). Covers persons 65 years of age or older who are medically needy and in LTC status.</td>
</tr>
<tr>
<td>14</td>
<td>Full</td>
<td>No</td>
<td>Aid to the Aged – Medically Needy (FFP). Covers persons 65 years of age or older who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only.</td>
</tr>
<tr>
<td>16</td>
<td>Full</td>
<td>No</td>
<td>Aid to the Aged – Pickle Eligibles (FFP). Covers persons 65 years of age or older who were eligible for and receiving SSI/SSP and Title II benefits concurrently in any month since April 1977 and were subsequently discontinued from SSI/SSP but would be eligible to receive SSI/SSP if their Title II cost-of-living increases were disregarded. These persons are eligible for Medi-Cal benefits as public assistance recipients in accordance with the provisions in the Lynch v. Rank lawsuit.</td>
</tr>
<tr>
<td>17</td>
<td>Full</td>
<td>Yes</td>
<td>Aid to the Aged – Medically Needy, SOC (FFP). Covers persons 65 years of age or older who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC required.</td>
</tr>
<tr>
<td>18</td>
<td>Full</td>
<td>No</td>
<td>Aid to the Aged – IHSS (FFP). Covers aged IHSS cash recipients, 65 years of age or older, who are not eligible for SSI/SSP cash benefits.</td>
</tr>
<tr>
<td>20</td>
<td>Full</td>
<td>No</td>
<td>SSI/SSP Aid to the Blind (FFP). A cash assistance program, administered by the SSA, which pays a cash grant to needy blind persons of any age.</td>
</tr>
<tr>
<td>23</td>
<td>Full</td>
<td>Y/N</td>
<td>Aid to the Blind – LTC Status (FFP). Covers persons who meet the federal criteria for blindness, are medically needy, and are in LTC status.</td>
</tr>
<tr>
<td>24</td>
<td>Full</td>
<td>No</td>
<td>Aid to the Blind – Medically Needy (FFP). Covers persons who meet the federal criteria for blindness who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only.</td>
</tr>
<tr>
<td>26</td>
<td>Full</td>
<td>No</td>
<td>Aid to the Blind – Pickle Eligibles (FFP). Covers persons who meet the federal criteria for blindness and are covered by the provisions of the Lynch v. Rank lawsuit. (See aid code 16 for definition of Pickle eligibles.)</td>
</tr>
<tr>
<td>27</td>
<td>Full</td>
<td>Yes</td>
<td>Aid to the Blind – Medically Needy, SOC (FFP). Covers persons who meet the federal criteria for blindness who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC is required of the beneficiaries.</td>
</tr>
<tr>
<td>28</td>
<td>Full</td>
<td>No</td>
<td>Aid to Blind – IHSS (FFP). Covers persons who meet the federal definition of blindness and are eligible for IHSS. (See aid code 18 for definition of eligibility for IHSS.)</td>
</tr>
<tr>
<td>Code</td>
<td>Benefits</td>
<td>SOC</td>
<td>Program/Description</td>
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</tr>
<tr>
<td>3A</td>
<td>Full</td>
<td>No</td>
<td>California Alternative Assistance Program – Aid to Families with Dependent Children, Family Group (CAAP-AFDC [FG]) (FFP). Individuals who have declined a federal cash grant and instead will receive child care assistance and Medi-Cal.</td>
</tr>
<tr>
<td>3C</td>
<td>Full</td>
<td>No</td>
<td>California Alternative Assistance Program – Aid to Families with Dependent Children, Unemployed Parent Group (CAAP-AFDC [U]) (FFP). Individuals who have declined a federal cash grant and instead will receive child care assistance and Medi-Cal.</td>
</tr>
<tr>
<td>3E</td>
<td>Full</td>
<td>No</td>
<td>CalWORKS LEGAL IMMIGRANT – FAMILY GROUP (FFP). Provides aid to families in which a child is deprived because of the absence, incapacity or death of either parent.</td>
</tr>
<tr>
<td>3G</td>
<td>Full</td>
<td>No</td>
<td>AFDC-FG (State only) (non-FFP cash grant FFP for Medi-Cal eligibles). Provides aid to families in which a child is deprived because of the absence, incapacity or death of either parent, who does not meet all federal requirements, but State rules require the individual(s) be aided. This population is the same as aid code 32, except that they are exempt from the AFDC grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.</td>
</tr>
<tr>
<td>3H</td>
<td>Full</td>
<td>No</td>
<td>AFDC-FU (State only) (non-FFP cash grant FFP for Medi-Cal eligibles). Provides aid to pregnant women (before their last trimester) who meet the federal definition of an unemployed parent but are not eligible because there are no other children in the home. This population is the same as aid code 33, except that they are exempt from the AFDC grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.</td>
</tr>
<tr>
<td>3L</td>
<td>Full</td>
<td>No</td>
<td>CalWORKS LEGAL IMMIGRANT – FAMILY GROUP (FFP). Provides aid to families in which a child is deprived because of the absence, incapacity or death of either parent.</td>
</tr>
<tr>
<td>3M</td>
<td>Full</td>
<td>No</td>
<td>CalWORKS LEGAL IMMIGRANT – UNEMPLOYED (FFP). Provides aid to families in which a child is deprived because of the unemployment of a parent living in the home.</td>
</tr>
<tr>
<td>3N</td>
<td>Full</td>
<td>No</td>
<td>AFDC – Mandatory Coverage Group Section 1931(b) (FFP). Section 1931 requires Medi-Cal be provided to low-income families who meet the requirements of the Aid to Families with Dependent Children (AFDC) State Plan in effect July 16, 1996.</td>
</tr>
<tr>
<td>3P</td>
<td>Full</td>
<td>No</td>
<td>AFDC Unemployed Parent (FFP cash) – Aid to Families in which a child is deprived because of the unemployment of a parent living in the home and the unemployed parent meets all federal AFDC eligibility requirements. This population is the same as aid code 35, except that they are exempt from the AFDC grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.</td>
</tr>
<tr>
<td>Code</td>
<td>Benefits</td>
<td>SOC</td>
<td>Program/Description</td>
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</tr>
<tr>
<td>3R</td>
<td>Full</td>
<td>No</td>
<td>Aid to Families with Dependent Children (AFDC) -- Family Group (FFP) in which the child(ren) is deprived because of the absence, incapacity or death of either parent. This population is the same as aid code 30, except that they are exempt from the AFDC grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.</td>
</tr>
<tr>
<td>3T</td>
<td>Restricted to pregnancy and emergency services</td>
<td>No</td>
<td>Initial Transitional Medi-Cal (TMC) (FFP). Provides six months of emergency and pregnancy-related initial TMC benefits (no SOC) for aliens who do not have satisfactory immigration status (SIS) and have been discontinued from Section 1931(b) due to increased earnings from employment.</td>
</tr>
<tr>
<td>3U</td>
<td>Full</td>
<td>No</td>
<td>CalWORKS LEGAL IMMIGRANT – UNEMPLOYED (FFP). Provides aid to families in which a child is deprived because of the unemployment of a parent living in the home.</td>
</tr>
<tr>
<td>3V</td>
<td>Restricted to pregnancy and emergency services</td>
<td>No</td>
<td>Section 1931(b) (FFP). Provides emergency and pregnancy-related benefits (no SOC) for aliens without SIS who meet the income, resources and deprivation requirements of the AFDC State Plan in effect July 16, 1996.</td>
</tr>
<tr>
<td>30</td>
<td>Full</td>
<td>No</td>
<td>AFDC-FG (FFP). Provides aid to families with dependent children in a family group in which the child(ren) is deprived because of the absence, incapacity or death of either parent.</td>
</tr>
<tr>
<td>32</td>
<td>Full</td>
<td>No</td>
<td>AFDC-FG (State only) (non-FFP cash grant FFP for Medi-Cal eligibles). Provides aid to families in which a child is deprived because of the absence, incapacity, or death of either parent, who does not meet all federal requirements, but State rules require the individual(s) be aided.</td>
</tr>
<tr>
<td>33</td>
<td>Full</td>
<td>No</td>
<td>AFDC – Unemployed Parent (State-only program) (non-FFP cash grant FFP for Medi-Cal eligibles). Provides aid to pregnant women (before their last trimester) who meet the federal definition of an unemployed parent but are not eligible because there are no other children in the home.</td>
</tr>
<tr>
<td>34</td>
<td>Full</td>
<td>No</td>
<td>AFDC-MN (FFP). Covers families with deprivation of parental care or support who do not wish or are not eligible for a cash grant but are eligible for Medi-Cal only.</td>
</tr>
<tr>
<td>35</td>
<td>Full</td>
<td>No</td>
<td>AFDC-U (FFP cash). Provides aid to families in which a child is deprived because of unemployment of a parent living in the home, and the unemployed parent meets all federal AFDC eligibility requirements.</td>
</tr>
<tr>
<td>Code</td>
<td>Benefits</td>
<td>SOC</td>
<td>Program/Description</td>
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</tr>
<tr>
<td>36</td>
<td>Full</td>
<td>No</td>
<td>Aid to Disabled Widow/ers (FFP). Covers persons who began receiving Title II SSA before age 60 who were eligible for and receiving SSI/SSP and Title II benefits concurrently and were subsequently discontinued from SSI/SSP but would be eligible to receive SSI/SSP if their Title II disabled widow/ers reduction factor and subsequent COLAs were disregarded.</td>
</tr>
<tr>
<td>37</td>
<td>Full</td>
<td>Yes</td>
<td>AFDC-MN (FFP). Covers families with deprivation of parental care or support who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC required of the beneficiaries.</td>
</tr>
<tr>
<td>38</td>
<td>Full</td>
<td>No</td>
<td>Continuing Medi-Cal Eligibility (FFP). Edwards v. Kizer court order provides for uninterrupted, no SOC Medi-Cal benefits for families discontinued from AFDC until the family's eligibility or ineligibility for Medi-Cal only has been determined and an appropriate Notice of Action sent.</td>
</tr>
<tr>
<td>39</td>
<td>Full</td>
<td>No</td>
<td>Initial Transitional Medi-Cal (TMC) – Six Months Continuing Eligibility (FFP). Provides coverage to certain client's subsequent to AFDC cash grant discontinuance due to increased earnings, increased hours of employment or loss of the $30 and 1/3 disregard.</td>
</tr>
<tr>
<td>4A</td>
<td>Full</td>
<td>No</td>
<td>Adoption Assistance Program (AAP). Program for AAP children for whom there is a state-only AAP agreement between any state other than California and adoptive parent(s).</td>
</tr>
<tr>
<td>4C</td>
<td>Full</td>
<td>No</td>
<td>AFDC-FC Voluntarily Placed (Fed) (FFP). Provides financial assistance for those children who are in need of substitute parenting and who have been voluntarily placed in foster care.</td>
</tr>
<tr>
<td>4F</td>
<td>Full</td>
<td>No</td>
<td>Kinship Guardianship Assistance Payment (Kin-GAP). Federal program for children in relative placement receiving cash assistance.</td>
</tr>
<tr>
<td>4G</td>
<td>Full</td>
<td>No</td>
<td>Kin-GAP. State-only program for children in relative placement receiving cash assistance.</td>
</tr>
<tr>
<td>4K</td>
<td>Full</td>
<td>No</td>
<td>Emergency Assistance (EA) Program (FFP). Covers juvenile probation cases placed in foster care.</td>
</tr>
<tr>
<td>4M</td>
<td>Full</td>
<td>No</td>
<td>Former Foster Care Children (FFCC) 18 through 20 years of age. Provides full-scope Medi-Cal benefits to former foster care children who were receiving benefits on their 18th birthday in aid codes 40, 42, 45, 4C and 5K and who are under 21 years of age.</td>
</tr>
<tr>
<td>40</td>
<td>Full</td>
<td>No</td>
<td>AFDC-FC/Non-Fed (State FC). Provides financial assistance for those children who are in need of substitute parenting and who have been placed in foster care.</td>
</tr>
<tr>
<td>42</td>
<td>Full</td>
<td>No</td>
<td>AFDC-FC/Fed (FFP). Provides financial assistance for those children who are in need of substitute parenting and who have been placed in foster care.</td>
</tr>
<tr>
<td>44</td>
<td>Restricted to pregnancy-related services</td>
<td>No</td>
<td>Income Disregard Program. Pregnant (FFP) United States Citizen/Permanent Resident Alien/PRUCOL Alien. Provides family planning, pregnancy-related and postpartum services for any age female if family income is at or below 200 percent of the federal poverty level.</td>
</tr>
<tr>
<td>45</td>
<td>Full</td>
<td>No</td>
<td>Children Supported by Public Funds (FFP). Children whose needs are met in whole or in part by public funds other than AFDC-FC.</td>
</tr>
<tr>
<td>Code</td>
<td>Benefits</td>
<td>SOC</td>
<td>Program/Description</td>
</tr>
<tr>
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</tr>
<tr>
<td>47</td>
<td>Full</td>
<td>No</td>
<td>Income Disregard Program (FFP). Infant – United States Citizen, Permanent Resident Alien/PRUCOL Alien. Provides full Medi-Cal benefits to infants up to 1 year old and continues beyond 1 year when inpatient status, which began before 1st birthday, continues and family income is at or below 200 percent of the federal poverty level.</td>
</tr>
<tr>
<td>48</td>
<td>Restricted to pregnancy-related services</td>
<td>No</td>
<td>Income Disregard Program. Pregnant – Undocumented/Nonimmigrant Alien (but otherwise eligible). Provides family planning, pregnancy-related and postpartum services for any age female if family income is at or below 200 percent of the federal poverty level. Routine prenatal care is non-FFP. Labor, delivery and emergency prenatal care are FFP.</td>
</tr>
<tr>
<td>49</td>
<td>Restricted to pregnancy-related services</td>
<td>No</td>
<td>Income Disregard Program. Pregnancy – Amnesty Alien. Provides family planning, pregnancy-related and postpartum services to any age female with income at or below 200 percent of the federal poverty level.</td>
</tr>
<tr>
<td>5F</td>
<td>Restricted to pregnancy and emergency services</td>
<td>Y/N</td>
<td>OBRA Aliens. Covers non-immigrant and undocumented aliens who do not have proof of permanent resident alien, PRUCOL or amnesty alien status, but who are otherwise eligible for Medi-Cal.</td>
</tr>
<tr>
<td>5K</td>
<td>Full</td>
<td>No</td>
<td>Emergency Assistance (EA) Program (FFP). Covers child welfare cases placed in EA foster care.</td>
</tr>
<tr>
<td>5T</td>
<td>Restricted to pregnancy and emergency services</td>
<td>No</td>
<td>Continuing TMC (FFP). Provides an additional six months of continuing emergency and pregnancy-related TMC benefits (no SOC) to qualifying aid code 3T recipients.</td>
</tr>
<tr>
<td>5W</td>
<td>Restricted to pregnancy and emergency services</td>
<td>No</td>
<td>Four Month Continuing (FFP). Provides four months of emergency and pregnancy-related benefits (no SOC) for aliens without SIS who are no longer eligible for Section 1931(b) due to the collection or increased collection of child/spousal support.</td>
</tr>
<tr>
<td>5X</td>
<td>Full</td>
<td>No</td>
<td>Second Year Transitional Medi-Cal (TMC). Provides a second year of full-scope (no SOC) TMC benefits for citizens and qualified aliens age 19 and older who have received six months of additional full-scope TMC benefits under aid code 59 and who continue to meet the requirements of additional TMC. (State-only program.)</td>
</tr>
<tr>
<td>5Y</td>
<td>Restricted to pregnancy and emergency services</td>
<td>No</td>
<td>Second Year TMC (state only). Provides a second year of continuing emergency and pregnancy related TMC benefits (no SOC) to qualifying aid code 5T recipients 19 years of age or older.</td>
</tr>
<tr>
<td>Code</td>
<td>Benefits</td>
<td>SOC</td>
<td>Program/Description</td>
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</tr>
<tr>
<td>50</td>
<td>Restricted to CMSP emergency services only</td>
<td>Y/N</td>
<td>CMSP. MI – Restricted. Covers persons who have undetermined immigration status.</td>
</tr>
<tr>
<td>53</td>
<td>Restricted to LTC services only</td>
<td>Y/N</td>
<td>Medically Indigent – LTC (Non-FFP). Covers persons age 21 or older and under 65 years of age who are residing in a Skilled Nursing or Intermediate Care Facility (SNF or ICF) and meet all other eligibility requirements of medically indigent, with or without SOC.</td>
</tr>
<tr>
<td>54</td>
<td>Full</td>
<td>No</td>
<td>Four-Month Continuing Eligibility (FFP). Covers persons discontinued from AFDC due to the increased collection of child/spousal support payments but eligible for Medi-Cal only.</td>
</tr>
<tr>
<td>55</td>
<td>Restricted to pregnancy and emergency services</td>
<td>No</td>
<td>Aid to Undocumented Aliens in LTC Not PRUCOL. Covers undocumented aliens in LTC not Permanently Residing Under Color Of Law (PRUCOL). LTC services: State-only funds; emergency and pregnancy-related services: State and federal funds. Recipients will remain in this aid code even if they leave LTC.</td>
</tr>
<tr>
<td>58</td>
<td>Restricted to pregnancy and emergency services</td>
<td>Y/N</td>
<td>OBRA Aliens. Covers nonimmigrant and undocumented aliens who do not have proof of permanent resident alien, PRUCOL or amnesty alien status, but who are otherwise eligible for Medi-Cal.</td>
</tr>
<tr>
<td>59</td>
<td>Full</td>
<td>No</td>
<td>Additional TMC – Additional Six Months Continuing Eligibility (FFP). Covers persons discontinued from AFDC due to the expiration of the $30 plus 1/3 disregard, increased earnings or hours of employment, but eligible for Medi-Cal only, may receive this extension of TMC.</td>
</tr>
<tr>
<td>6A</td>
<td>Full</td>
<td>No</td>
<td>Disabled Adult Child(ren) (DAC)/Blindness (FFP).</td>
</tr>
<tr>
<td>6C</td>
<td>Full</td>
<td>No</td>
<td>Disabled Adult Child(ren) (DAC)/Disabled (FFP).</td>
</tr>
<tr>
<td>6G</td>
<td>Full</td>
<td>No</td>
<td>250 Percent Program Working Disabled. Provides full-scope Medi-Cal benefits to working disabled recipients who meet the requirements of the 250 Percent Program.</td>
</tr>
<tr>
<td>6H</td>
<td>Full</td>
<td>No</td>
<td><strong>Federal Poverty Level – Disabled (FPL-Disabled)</strong> Provides full scope of benefits (no Share of Cost) Medi-Cal to qualified disabled individuals/couples.</td>
</tr>
<tr>
<td>6N</td>
<td>Full</td>
<td>No</td>
<td>Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)/No Longer Disabled Recipients (FFP). Former SSI disabled recipients (adults and children not in aid code 6R) who are appealing their cessation of SSI disability.</td>
</tr>
<tr>
<td>Code</td>
<td>Benefits</td>
<td>SOC</td>
<td>Program/Description</td>
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</tr>
<tr>
<td>6P</td>
<td>Full</td>
<td>No</td>
<td>PRWORA/No Longer Disabled Children (FFP). Covers children under age 18 who lost SSI cash benefits on or after July 1, 1997, due to PRWORA of 1996, which provides a stricter definition of disability for children.</td>
</tr>
<tr>
<td>6R</td>
<td>Full</td>
<td>No</td>
<td>No longer Disabled Children (FFP). Covers former SSI disabled children under age 18 who lost SSI cash benefits due to cessation of disability and who are appealing their cessation of SSI disability.</td>
</tr>
<tr>
<td>6U</td>
<td>Restricted to pregnancy and emergency services</td>
<td>No</td>
<td>Restricted Federal Poverty Level – Disabled (Restricted FPL-Disabled) Provides emergency and pregnancy-related benefits (no share of cost) to qualified disabled individuals/couples who do not have satisfactory immigration status.</td>
</tr>
<tr>
<td>6V</td>
<td>Full</td>
<td>No</td>
<td>Aid to the Disabled – DDS Waiver (FFP). Covers persons who qualify for the Department of Developmental Services (DDS) Regional Waiver.</td>
</tr>
<tr>
<td>6W</td>
<td>Full</td>
<td>Yes</td>
<td>Aid to the Disabled – DDS Waiver (FFP). Covers persons who qualify for the Department of Developmental Services (DDS) Regional Waiver.</td>
</tr>
<tr>
<td>6X</td>
<td>Full</td>
<td>No</td>
<td>Aid to the Disabled – Model Waiver (FFP). Covers persons who qualify for the Model Waiver.</td>
</tr>
<tr>
<td>6Y</td>
<td>Full</td>
<td>Yes</td>
<td>Aid to the Disabled – Model Waiver (FFP). Covers persons who qualify for the Model Waiver.</td>
</tr>
<tr>
<td>60</td>
<td>Full</td>
<td>No</td>
<td>SSI/SSP Aid to the Disabled (FFP). A cash assistance program administered by the SSA that pays a cash grant to needy persons who meet the federal definition of disability.</td>
</tr>
<tr>
<td>63</td>
<td>Full</td>
<td>Y/N</td>
<td>Aid to the Disabled – LTC Status (FFP). Covers persons who meet the federal definition of disability who are medically needy and in LTC status.</td>
</tr>
<tr>
<td>64</td>
<td>Full</td>
<td>No</td>
<td>Aid to the Disabled – Medically Needy (FFP). Covers persons who meet the federal definition of disability and do not wish or are not eligible for cash grant, but are eligible for Medi-Cal only.</td>
</tr>
<tr>
<td>65</td>
<td>Full</td>
<td>Y/N</td>
<td>Aid to the Disabled Substantial Gainful Activity/Aged, Blind, Disabled – Medically Needy IHSS (non-FFP). Covers persons who (a) were once determined to be disabled in accordance with the provisions of the SSI/SSP program and were eligible for SSI/SSP but became ineligible because of engagement in substantial gainful activity as defined in Title XVI regulations. They must also continue to suffer from the physical or mental impairment that was the basis of the disability determination or (b) are aged, blind or disabled medically needy and have the costs of IHSS deducted from their monthly income.</td>
</tr>
<tr>
<td>66</td>
<td>Full</td>
<td>No</td>
<td>Aid to the Disabled Pickle Eligibles (FFP). Covers persons who meet the federal definition of disability and are covered by the provisions of the Lynch v. Rank lawsuit. No age limit for this aid code.</td>
</tr>
<tr>
<td>67</td>
<td>Full</td>
<td>Yes</td>
<td>Aid to the Disabled – Medically Needy, SOC (FFP). (See aid code 64 for definition of Disabled – MN.) SOC is required of the beneficiaries.</td>
</tr>
<tr>
<td>68</td>
<td>Full</td>
<td>No</td>
<td>Aid to the Disabled IHSS (FFP). Covers persons who meet the federal definition of disability and are eligible for IHSS. (See aid codes 18 and 65 for definition of eligibility for IHSS.)</td>
</tr>
<tr>
<td>Code</td>
<td>Benefits</td>
<td>SOC</td>
<td>Program/Description</td>
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</tr>
<tr>
<td>69</td>
<td>Restricted to emergency services</td>
<td>No</td>
<td>Income Disregard Program. Infant (FFP) – Undocumented/Nonimmigrant Alien (but otherwise eligible). Provides emergency services only for infants under 1 year of age and beyond 1 year when inpatient status, which began before 1st birthday, continues and family income is at or below 200 percent of the federal poverty level.</td>
</tr>
<tr>
<td>7A</td>
<td>Full</td>
<td>No</td>
<td>100 Percent Program. Child (FFP) – United States Citizen, Lawful Permanent Resident/PRUCOL/(IRCA Amnesty Alien [ABD or Under 18]). Provides full benefits to otherwise eligible children, ages 6 to 19 and beyond 19 when inpatient status began before the 19th birthday and family income is at or below 100 percent of the federal poverty level.</td>
</tr>
<tr>
<td>7C</td>
<td>Restricted to pregnancy and emergency services</td>
<td>No</td>
<td>100 Percent Program. Child – Undocumented/Nonimmigrant Status/[IRCA Amnesty Alien (Not ABD or Under 18)]. Covers emergency and pregnancy-related services to otherwise eligible children, ages 6 to 19 and beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the federal poverty level.</td>
</tr>
<tr>
<td>7F</td>
<td>Valid for pregnancy verification office visit</td>
<td>No</td>
<td>Presumptive Eligibility (PE) – Pregnancy Verification (FFP). This option allows the Qualified Provider to make a determination of PE for outpatient prenatal care services based on preliminary income information. 7F is valid for pregnancy test, initial visit, and services associated with the initial visit. Persons placed in 7F have pregnancy test results that are negative.</td>
</tr>
<tr>
<td>7G</td>
<td>Valid only for ambulatory prenatal care services</td>
<td>No</td>
<td>Presumptive Eligibility (PE) – Ambulatory Prenatal Care Services (FFP). This option allows the Qualified Provider to make a determination of PE for outpatient prenatal care services based on preliminary income information. 7G is valid for Ambulatory Prenatal Care Services. Persons placed in 7G have pregnancy test results that are positive.</td>
</tr>
<tr>
<td>7H</td>
<td>Valid only for TB-related outpatient services</td>
<td>No</td>
<td>Medi-Cal Tuberculosis (TB) Program. Covers individuals who are TB-infected for TB-related outpatient services only.</td>
</tr>
<tr>
<td>7J</td>
<td>Full</td>
<td>No</td>
<td>Continuous Eligibility for Children (CEC) program. Provides full-scope benefits to children up to 19 years of age who would otherwise lose their no Share of Cost Medi-Cal.</td>
</tr>
<tr>
<td>7K</td>
<td>Restricted to pregnancy and emergency services</td>
<td>No</td>
<td>Continuous Eligibility for Children (CEC) program. Provides emergency and pregnancy-related benefits (no Share of Cost) to children up to 19 years of age who would otherwise lose their no Share of Cost Medi-Cal.</td>
</tr>
<tr>
<td>7M</td>
<td>Valid for Minor Consent services</td>
<td>Y/N</td>
<td>Minor Consent Program (Non-FFP). Covers minors aged 12 and under 21. Limited to services related to Sexually Transmitted Diseases, sexual assault, drug and alcohol abuse, and family planning.</td>
</tr>
<tr>
<td>Code</td>
<td>Benefits</td>
<td>SOC</td>
<td>Program/Description</td>
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</tr>
<tr>
<td>7N</td>
<td>Valid for Minor Consent services</td>
<td>No</td>
<td>Minor Consent Program (FFP). Covers pregnant female minors under age 21. Limited to services related to pregnancy and family planning.</td>
</tr>
<tr>
<td>7P</td>
<td>Valid for Minor Consent services</td>
<td>Y/N</td>
<td>Minor Consent Program (Non-FFP). Covers minors age 12 and under 21. Limited to services related to Sexually Transmitted Diseases, sexual assault, drug and alcohol abuse, family planning, and outpatient mental health treatment.</td>
</tr>
<tr>
<td>7R</td>
<td>Valid for Minor Consent services</td>
<td>Y/N</td>
<td>Minor Consent Program (FFP). Covers minors under age 12. Limited to services related to family planning and sexual assault.</td>
</tr>
<tr>
<td>7X</td>
<td>Full</td>
<td>No</td>
<td>One-Month Healthy Families (HF) Bridge (FFP). Provides one additional calendar month of health care benefits with no Share of Cost, through the same health care delivery system, to Medi-Cal-eligible children meeting the criteria of the HF Bridging Program.</td>
</tr>
<tr>
<td>70</td>
<td>Restricted to pregnancy-related services</td>
<td>No</td>
<td>Asset Waiver Program (Pregnant). United States Citizen, Permanent Resident Alien/PRUCOL Alien or Undocumented/Nonimmigrant Alien (but otherwise eligible). Provides family planning, pregnancy-related, and postpartum services under the State-only funded expansion of the Medi-Cal program for a pregnant woman having income between 185 percent and 200 percent of the federal poverty level (State-Only Program).</td>
</tr>
<tr>
<td>71</td>
<td>Restricted to dialysis and supplemental dialysis-related services</td>
<td>Y/N</td>
<td>Medi-Cal Dialysis Only Program/Medi-Cal Dialysis Supplement Program (DP/DSP) (Non-FFP). Covers persons of any age who are eligible only for dialysis and related services.</td>
</tr>
<tr>
<td>72</td>
<td>Full</td>
<td>No</td>
<td>133 Percent Program. Child – United States Citizen, Permanent Resident Alien/PRUCOL Alien (FFP). Provides full Medi-Cal benefits to children ages 1 up to 6 and beyond 6 years when inpatient status, which began before 6th birthday, continues and family income is at or below 133 percent of the federal poverty level.</td>
</tr>
<tr>
<td>73</td>
<td>Restricted to parenteral hyperalimentation-related expenses</td>
<td>Y/N</td>
<td>Medi-Cal TPN Only Program/Medi-Cal TPN Supplement Program (Non-FFP). Covers persons of any age who are eligible for parenteral hyperalimentation and related services and persons of any age who are eligible under the Medically Needy or Medically Indigent Programs.</td>
</tr>
<tr>
<td>Code</td>
<td>Benefits</td>
<td>SOC</td>
<td>Program/Description</td>
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</tr>
<tr>
<td>74</td>
<td>Restricted to emergency services</td>
<td>No</td>
<td>133 Percent Program (OBRA). Child Undocumented/Nonimmigrant Alien (but otherwise eligible) (FFP). Provides emergency services only for children ages 1 up to 6 and beyond 6 years when inpatient status, which began before 6th birthday, continues and family income is at or below 133 percent of the federal poverty level.</td>
</tr>
<tr>
<td>75</td>
<td>Restricted to pregnancy-related services</td>
<td>No</td>
<td>Asset Waiver Program (Pregnant). Provides family planning, pregnancy-related, and postpartum services for amnesty aliens under the State-only funded expansion of the Medi-Cal program for a pregnant woman having income between 185 percent and 200 percent of the federal poverty level (State-Only Program).</td>
</tr>
<tr>
<td>76</td>
<td>Restricted to 60-day postpartum services</td>
<td>No</td>
<td>60-Day Postpartum Program (FFP). Provides Medi-Cal at no SOC to women who, while pregnant, were eligible for, applied for, and received Medi-Cal benefits. They may continue to be eligible for all postpartum services and family planning. This coverage begins on the last day of pregnancy and ends the last day of the month in which the 60th day occurs.</td>
</tr>
<tr>
<td>79</td>
<td>Full</td>
<td>No</td>
<td>Asset Waiver Program (Infant). Provides full Medi-Cal benefits to infants up to 1 year, and beyond 1 year when inpatient status, which began before 1st birthday, continues and family income is between 185 percent and 200 percent of the federal poverty level (State-Only Program).</td>
</tr>
<tr>
<td>8F</td>
<td>CMSP services only (companion aid code)</td>
<td>Y/N</td>
<td>CMSP Companion Aid Code. Covers persons eligible for certain benefits under the Medi-Cal program and other benefits under CMSP. 8F is used in conjunction with Medi-Cal aid codes 52, 53 and 57 to facilitate the payment of claims for covered benefits. 8F will appear as a special aid code and will entitle the eligible client to full-scope CMSP coverage for those services not covered by Medi-Cal.</td>
</tr>
<tr>
<td>8G</td>
<td>Full</td>
<td>No</td>
<td>Qualified Severely Impaired Working Individual Program Aid Code. Allows recipients of the Qualified Severely Impaired Working Individual Program to continue their Medi-Cal eligibility.</td>
</tr>
<tr>
<td>8H</td>
<td>Family PACT (SOFP services only)</td>
<td>N/A</td>
<td>Family PACT (also known as SOFP – State-Only Family Planning). Comprehensive family planning services for low income residents of California with no other source of health care coverage.</td>
</tr>
<tr>
<td>8N</td>
<td>Restricted to emergency services</td>
<td>No</td>
<td>133 Percent Program (OBRA). Child Undocumented/Nonimmigrant Alien (but otherwise eligible except for excess property) (FFP). Provides emergency services only for children ages 1 up to 6 and beyond 6 years when inpatient status, which began before 6th birthday, continues, and family income is at or below 133 percent of the federal poverty level.</td>
</tr>
<tr>
<td>Code</td>
<td>Benefits</td>
<td>SOC</td>
<td>Program/Description</td>
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</tr>
<tr>
<td>8P</td>
<td>Full</td>
<td>No</td>
<td>133 Percent Program. Child – United States Citizen (with excess property), Permanent Resident Alien/PRUCOL Alien (FFP). Provides full-scope Medi-Cal benefits to children ages 1 up to 6 and beyond 6 years when inpatient status, which began before 6th birthday, continues, and family income is at or below 133 percent of the federal poverty level.</td>
</tr>
<tr>
<td>8R</td>
<td>Full</td>
<td>No</td>
<td>100 Percent Program. Child (FFP) – United States Citizen (with excess property), Lawful Permanent Resident/PRUCOL/(IRCA Amnesty Alien [ABD or Under 18]). Provides full-scope benefits to otherwise eligible children, ages 6 to 19 and beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the federal poverty level.</td>
</tr>
<tr>
<td>8T</td>
<td>Restricted to pregnancy and emergency services</td>
<td>No</td>
<td>100 Percent Program. Child – Undocumented/Nonimmigrant Status/(IRCA Amnesty Alien [with excess property]). Covers emergency and pregnancy-related services only to otherwise eligible children ages 6 to 19 and beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the federal poverty level.</td>
</tr>
<tr>
<td>80</td>
<td>Restricted to Medicare expenses</td>
<td>No</td>
<td>Qualified Medicare Beneficiary (QMB). Provides payment of Medicare Part A premium and Part A and B coinsurance and deductibles for eligible low income aged, blind, or disabled individuals.</td>
</tr>
<tr>
<td>81</td>
<td>Full</td>
<td>Y/N</td>
<td>MI – Adults Aid Paid Pending (Non-FFP). Aid Paid Pending for persons over 21 but under 65, with or without SOC.</td>
</tr>
<tr>
<td>82</td>
<td>Full</td>
<td>No</td>
<td>MI – Person (FFP). Covers medically indigent persons under 21 who meet the eligibility requirements of medical indigence. Covers persons until the age of 22 who were in an institution for mental disease before age 21. Persons may continue to be eligible under aid code 82 until age 22 if they have filed for a State hearing.</td>
</tr>
<tr>
<td>83</td>
<td>Full</td>
<td>Yes</td>
<td>MI – Person SOC (FFP). Covers medically indigent persons under 21 who meet the eligibility requirements of medically indigent.</td>
</tr>
<tr>
<td>84</td>
<td>CMSP services only (no Medi-Cal)</td>
<td>No</td>
<td>CMSP, MI – A (Non-FFP). Covers medically indigent adults aged 21 and over but under 65 years who meet the eligibility requirements of medically indigent.</td>
</tr>
<tr>
<td>85</td>
<td>CMSP services only (no Medi-Cal)</td>
<td>Yes</td>
<td>CMSP, MI – A (Non-FFP). Covers medically indigent adults aged 21 and over but under 65 years, who meet the eligibility requirements of medically indigent.</td>
</tr>
<tr>
<td>Code</td>
<td>Benefits</td>
<td>SOC</td>
<td>Program/Description</td>
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</tr>
<tr>
<td>86</td>
<td>Full</td>
<td>No</td>
<td>MI – Confirmed Pregnancy (FFP). Covers persons aged 21 years or older, with confirmed pregnancy, who meet the eligibility requirements of medically indigent.</td>
</tr>
<tr>
<td>87</td>
<td>Full</td>
<td>Yes</td>
<td>MI – Confirmed Pregnancy (FFP). Covers persons aged 21 or older, with confirmed pregnancy, who meet the eligibility requirements of medically indigent but are not eligible for 185 percent/200 percent or the MN programs.</td>
</tr>
<tr>
<td>88</td>
<td>CMSP services only (no Medi-Cal)</td>
<td>No</td>
<td>CMSP, MI – A/Disability Pending (Non-FFP). Covers medically indigent adults aged 21 and over but under 65 years who meet the eligibility requirements of medically indigent and have a pending Medi-Cal disability application.</td>
</tr>
<tr>
<td>89</td>
<td>CMSP services only (no Medi-Cal)</td>
<td>Yes</td>
<td>CMSP, MI – A/Disability Pending (Non-FFP). Covers medically indigent adults aged 21 and over but under 65 years who meet the eligibility requirements of medically indigent and have a pending Medi-Cal disability application.</td>
</tr>
<tr>
<td>9A</td>
<td>BCEDP only</td>
<td>No</td>
<td>The Breast Cancer Early Detection Program (BCEDP) recipient identifier. BCEDP offers benefits to uninsured and underinsured women, 40 years and older, whose household income is at or below 200 percent of the federal poverty level. BCEDP offers reimbursement for screening, diagnostic and case management services. Please note: BCEDP and Medi-Cal are separate programs, but BCEDP is using the Medi-Cal billing process (with few exceptions).</td>
</tr>
<tr>
<td>9H</td>
<td>HF services only (no Medi-Cal)</td>
<td>No</td>
<td>The Healthy Families (HF) Program provides a comprehensive health insurance plan for uninsured children from 1 to 19 years of age whose family's income is at or below 200 percent of the federal poverty level. HF covers medical, dental and vision services to enrolled children.</td>
</tr>
<tr>
<td>Code</td>
<td>Benefits</td>
<td>SOC</td>
<td>Program/Description</td>
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</tr>
<tr>
<td>9J</td>
<td>GHPP</td>
<td>No</td>
<td>GHPP-eligible. Eligible for GHPP benefits and case management.</td>
</tr>
<tr>
<td>9K</td>
<td>CCS</td>
<td>No</td>
<td>CCS-eligible. Eligible for all CCS benefits (i.e., diagnosis, treatment, therapy and case management).</td>
</tr>
<tr>
<td>9M</td>
<td>CCS Medical Therapy Program only</td>
<td>No</td>
<td>Eligible for CCS Medical Therapy Program services only.</td>
</tr>
<tr>
<td>9N</td>
<td>CCS Case Management</td>
<td>No</td>
<td>Medi-Cal recipient with CCS-eligible medical condition. Eligible for CCS case management of Medi-Cal benefits.</td>
</tr>
<tr>
<td>9R</td>
<td>CCS</td>
<td>No</td>
<td>CCS-eligible Healthy Families Child. A child in this program is enrolled in a Healthy Families plan and is eligible for all CCS benefits (i.e., diagnosis, treatment, therapy and case management).</td>
</tr>
</tbody>
</table>

**Special Indicators:** These indicators, which appear in the aid code portion of the county ID number, help Medi-Cal identify the following:

**IE – Ineligible:** A person who is ineligible for Medi-Cal benefits in the case. An IE person may only use medical expenses to meet the SOC for other family members associated within the same case. Upon certification of the SOC, the IE individual is not eligible for Medi-Cal benefits in this case. An IE person may be eligible for Medi-Cal benefits in another case where the person is not identified as IE.

**RR – Responsible Relative:** An RR is allowed to use medical expenses to meet the SOC for other family members for whom he/she is responsible. Upon certification of the SOC, an RR individual is not eligible for Medi-Cal benefits in this Medi-Cal Budget Unit (MBU). The individual may be eligible for Medi-Cal benefits in another MBU where the person is not identified as RR.
List of Specialty Mental Health Services
Covered by County Mental Health Plans
(Cal. Code of Regs., tit. 9, § 1810.247)

1. Rehabilitation Services
   a. Mental Health Services (including non-brokerage case management)
   b. Medication Support Services
   c. Day Treatment Intensive
   d. Day Rehabilitation
   e. Crisis Intervention
   f. Crisis Stabilization - Emergency Room
   g. Crisis Stabilization - Urgent Care
   h. Adult Residential Treatment Services (16 beds or less)
   i. Crisis Residential Treatment Services (16 beds or less)
   j. Psychiatric Health Facility (16 beds or less)
2. Psychiatric Inpatient Hospital Services
3. Targeted Case Management/Brokerage
4. Psychiatry
5. Psychology
6. EPSDT (Children's Services) Supplemental Mental Health Services
7. Psychiatric Nursing Facility Services
8. Psychiatric Inpatient Hospital Services

Definition of Various Rehabilitative Services (from Cal. Code of Regs., tit. 9), as compared to the DMH Short Doyle Medi-Cal Manual for the Rehabilitation Option (7/1/94) at 4-3.

1. ADULT RESIDENTIAL TREATMENT - Rehabilitation services provided in a non-institutional residential setting where Individuals are supported in their efforts to restore, maintain and apply interpersonal and independent living skills, and community support systems. Programs shall provide a therapeutic community including a range of activities and services for Individuals who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. This is a structured package program with services available day and night, seven days a week.

2. ASSESSMENT - Assessment is a clinical analysis of the history and current status of the Individual's mental, emotional, or behavioral disorder. Relevant cultural issues and history may be included where appropriate. Assessment may include diagnosis and the use of testing procedures.

3. CASE MANAGEMENT/BROKERAGE - Case Management/Brokerage services are activities provided by program staff to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other needed community services for eligible Individuals.
4. COLLATERAL - Contact with one or more significant support persons in the life of the Individual which may include consultation and training to assist in better utilization of services and understanding mental illness. Collateral services include, but are not limited to, helping significant support persons to understand and accept the Individual's condition and involving them in service planning and implementation of service plan(s). Family counseling or therapy which is provided on behalf of the Individual is considered collateral.

5. CRISIS INTERVENTION - Crisis Intervention is a quick emergency response service enabling the Individual to cope with a crisis, while maintaining his/her status as a functioning community member to the greatest extent possible. Crisis is an unplanned event that results in the Individual's need for immediate service intervention. Crisis Intervention services are limited to stabilization of the presenting emergency. This service does not include Crisis Stabilization which is provided in a 24-hour health care facility or hospital outpatient program.

6. CRISIS RESIDENTIAL - Therapeutic and/or rehabilitation services provided in a 24-hour residential treatment program as an alternative to hospitalization for Individuals experiencing an acute psychiatric episode or crisis, and who do not present medical complications requiring nursing care. Individuals are supported in their efforts to restore, maintain and apply interpersonal and independent living skills, and access community support systems. Interventions, which focus on symptom reduction, shall also be available. This is a structured, packaged program with services available day and night, seven days a week.

7. CRISIS STABILIZATION - This is an immediate face-to-face response lasting less than 24 hours, to or on behalf of an Individual exhibiting acute psychiatric symptoms, provided in a 24 hour health facility as allowable under the facility licensure. Services must be provided in a distinct and separate part of the facility, and shall be available 24 hours per day. The goal is to avoid the need for Inpatient Services by alleviating problems which, if not treated, present an imminent threat to the Individual or other's safety or substantially increase the risk of the Individual becoming gravely disabled.

8. DAY REHABILITATION - Day Rehabilitation provides evaluation, rehabilitation and therapy to maintain or restore personal independence and functioning consistent with requirements for learning and development. This is an organized and structured program, which provides services to a distinct group of Individuals. Day Rehabilitation is a packaged program with service available at least three hours and less than 24 hours each day the program is open.

9. DAY TREATMENT INTENSIVE - Day Treatment Intensive service provides an organized and structured multi-disciplinary treatment program as an alternative to hospitalization, to avoid placement in a more restrictive setting, or maintain the Individual in a community setting. These services are provided to a distinct group of Individuals and occur in a therapeutic, organized and structured setting. Day Treatment Intensive is a packaged program with service available at least three hours and less than 24 hours each day the program is open.

10. GROUP SERVICES - Services provided to two or more individuals who are treated at the same time and which focuses on the mental health needs of the individuals in a group setting.

11. HOSPITAL INPATIENT - (See Inpatient Hospital Services)
12. INPATIENT HOSPITAL SERVICES - Inpatient Hospital Services are ordinarily furnished in a general acute hospital for the care and treatment of an acute episode of illness under the direction of a physician. They are provided in an institution that:
   a. Is maintained primarily for the care and treatment of individuals with disorders other than tuberculosis and mental diseases;
   b. Is licensed or formally approved as a hospital by an officially designated authority for State standard setting;
   c. Meets the requirements for participation in Medicare; and,
   d. Has in effect a DMH approved UR plan applicable to all Medi-Cal eligible individuals.

13. INPATIENT PSYCHIATRIC HOSPITAL SERVICES - Inpatient Psychiatric Hospital Services are furnished under the direction of a physician providing diagnosis, treatment, and/or care to Short-Doyle/Medi-Cal eligible individuals, age 17 or younger, and 65 and older with mental disorders in an acute psychiatric hospital. These services are billed as Inpatient Hospital services.

14. MEDICATION SUPPORT SERVICES - Medication support services include prescribing, administering, dispensing, and monitoring of psychiatric medication(s) and biological necessary to alleviate the symptoms of mental illness, which are provided by a staff person within the scope of practice of his/her profession.

15. MENTAL HEALTH SERVICES - Mental Health Services are interventions designed to provide the maximum reduction of mental disability and restoration or maintenance of functioning consistent with the requirements for learning, development, independent living and enhanced self-sufficiency. Services shall be directed toward achieving the Individual’s goal/desired results/personal milestones.

16. OUTPATIENT HOSPITAL SERVICES - Outpatient Hospital Services can be certified as case management and/or rehabilitative service providers and must be provided by an institution that:
   a. Is licensed or formally approved as a hospital by an officially designated authority for State Standards setting;
   b. Meets the requirements for participation in Medicare; and
   c. Provides basic mental health services.

17. REHABILITATION - This service activity may include any or all of the following: assistance in restoring or maintaining an Individual’s or group of Individuals’ a) functional skills, b) daily living skills, c) social skills, d) grooming and personal hygiene skills, e) meal preparation skills, f) medication compliance, and g) support resources; Individual and family counseling; training in leisure activities integral to achieving the Individual’s goals/desired results/personal milestones.

(a) The following mental necessity criteria determine Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under this subchapter, except as specially provided.
(b) The beneficiary must meet criteria outlined in (1), (2), and (3) below to be eligible for services:

(1) The applicant must:

Be diagnosed by the MHP with one of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Education, published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders, except Autistic Disorders
(B) Disruptive Behavior and Attention Deficit Disorders
(C) Feeding and Eating Disorders of Infancy and Early Childhood
(D) Elimination Disorders
(E) Other Disorders of Infancy, Childhood or Adolescence
(F) Schizophrenia and other Psychotic Disorders
(G) Mood Disorders
(H) Anxiety Disorders
(I) Somatoform Disorders
(J) Factitious Disorders
(K) Dissociative Disorders
(L) Paraphilias
(M) Gender Identity Disorder
(N) Eating Disorders
(O) Impulse Control Disorders Not Elsewhere Classified
(P) Adjustment Disorders
(Q) Personality Disorders, excluding Antisocial Personality Disorder
(R) Medication-Induced Movement Disorders related to other included diagnoses.

9 CCR § 1830.205(b)(1).

(2) Must have at least one of the following impairments as a result of the mental disorder(s) listed in subdivision (1) above:

(A) A significant impairment in an important area of life functioning.
(B) A probability of significant deterioration in an important area of life functioning.
(C) Excerpt as provided in § 1830.210, a probability a child will not progress developmentally as individually appropriate. For the purpose of this section, a child is a person under the age of 21 years.

(3) Must meet each of the intervention criteria listed below:
(A) The focus of the proposed intervention is to address the condition identified in (2) above.

(B) The expectation is that the proposed intervention will:
1. Significantly diminish the impairment, or
2. Prevent significant deterioration in an important area of life functioning, or
3. Except as provided in § 1830.210, allow the child to progress developmentally as individually appropriate.

(C) The condition would not be responsive to physical health care based treatment.

(c) When the requirements of this section are met, beneficiaries shall receive specialty mental health services for a diagnosis included in subsection (b)(1) even if a diagnosis that is not included in subsection (b)(1) is also present.


(a) For beneficiaries under 21 years of age who do not meet the medical necessity requirements of § 1830.205(b)(2) and (3), medical necessity criteria for specialty mental health services covered by this subchapter shall be met when all of the following exist:

(1) The beneficiary meets the diagnostic criteria in § 1830.205(b)(1),
(2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and
(3) The requirements of Title 22, § 51340(e)(3) are met; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under § 1830.205 or under Title 22, § 51340(e)(3) and the requirements of Title 22, § 51340(f) are met.

(b) The MHP shall not approve a request for an EPSDT Supplemental Specialty Mental Health Service under this section if the MHP determines that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service covered by this subchapter.

(c) The MHP shall not approve a request for specialty mental health services under this section in home and community based settings if the MHP determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the beneficiary’s otherwise inappropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner.

**Covered Diagnoses ("Included Diagnoses")**

- Pervasive Developmental Disorders, except Autistic Disorders
- Disruptive Behavior and Attention Deficit Disorders
- Feeding and Eating Disorders of Infancy and Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood or Adolescence
- Schizophrenia and other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorder
- Eating Disorders
- Impulse Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders related to other included diagnoses.

**Excluded Diagnoses:**

- Mental Retardation
- Learning Disorders
- Motor Skills Disorder
- Communication Disorders
- Autistic Disorders, Other Pervasive Developmental Disorders are included.
- Tic Disorders
- Delirium, Dementia, and Amnestic and Other Cognitive Disorders.
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorders*
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorder

Other conditions that may be a focus of clinical attention, except medication induced movement disorders which are included.

*A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present.*
MEDI-CAL PSYCHOTROPIC MEDICATION LIST*
June 1998

Chlorpromazine HCL  √ Promazine HCL  √ Triflupromazine HCL
Fluphanazine Decanoate  Fluphanazine Enanthate  Fluphanazine HCL
Perphenazine  Trifluoperazine HCL
Mesoridazine Besylate  √ Pimozide  Thioridazine HCL
√ Phenazine Sulfate  Chlorprothixene  √ Isocarboxazid
Haloperidol Lactate  Haloperidol  Haloperidol Deconoate
√ Loxapine Succinate  Molindone HCL  √ Loxapine HCL
Thiothixene  Lithium Carbonate  Thiothixene HCL
Amantadine HCL  Trihexphenidyl HCL  Lithium Citrate
√ Biperiden HCL  √ Biperiden Lactate  Procyclidine HCL
√ Clozapine  Risperidone  Benztropine Mesylate
√ Tranylcypromine Sulfate  Zyprexa  Olanzapine
Seroquel

Note: The check mark ( √ ) noted above indicates that these drugs require a TAR (Treatment Authorization Request.)

*These medications have been excluded from the responsibility of the pre-paid health plan.
REQUEST FOR MEDI-CAL FAIR HEARING
COUNTY SPECIALTY MENTAL HEALTH SERVICES

To: Chief ALJ, Administrative Adjudications Division (AAD)
California Department of Social Services (CDSS)
744 "P" Street, Sacramento CA 95814
Phone: (916) 657-3550

(You can mail this in or fax it to (916)-229-4110. You can also call in a hearing request to 1-800-743-8525, but the line is often busy.)

Re: Medi-Cal Fair Hearing—Specialty Mental Health Medi-Cal Services
Respondent: Local Mental health Plan, County of ________________________

Recipient’s Name:________________________________________
Medi-Cal No.: ______________ Telephone:_______________________
Social Security No.: __________ Date of Birth:_____________________
Address:___________________________________________________

Filed by (Name & Relationship):______________________________
Address & Phone (if different from above):_______________________
Reason for Requesting Hearing:
I was told that I wasn’t eligible for specialty mental health services but I really am.
I was told that I could not see the doctor/provider I want to see.
I was told that I couldn’t get the following service that I need:_______

Other reasons:________________________________________________
___________________________________________________________
___________________________________________________________

Interpreter needed? _______ Language?________________________
Home hearing needed? _____ Other accommodations needed?________
Date: ______________ Signature:_______________________________

cc: Director, County Mental Health
County Patient Rights Office