

## SHD Paraphrased Regulations - Medi-Cal

### 440 Program Eligibility

#### 440-1

Persons who receive SSI/SSP are eligible to Medi-Cal. Their eligibility for SSI/SSP is determined by the Social Security Administration. (§50179.7)

#### 440-2

Categories of eligibility for the Medi-Cal Program include recipients of AFDC, SSI/SSP and persons who would otherwise qualify for these programs except for the fact that their income or resources exceed the limitations of those programs. (§50201) Persons "linked" to the AFDC Program are children and caretaker relatives of such children when a basis of deprivation exists. (§50205) Persons "linked" to the SSI/SSP are persons who are blind, elderly, or disabled. (§§50219, 50221, and 50223) Other Medi-Cal Programs include the Medically Indigent (MI) Program, miscellaneous special programs, and Medi-Cal Special Treatment Programs. Eligibility under the Medically Indigent Program is limited to children under 21, adults in a nursing facility, and women with a confirmed pregnancy. (§50251) Miscellaneous programs include those for refugees and repatriates, and for qualified disabled and working individuals. (§§50255-50257) Special Treatment Programs are for dialysis and parenteral hyperalimentation patients. (§50264)

#### 440-2A

"Linked" means meeting the SSI/SSP requirements of age, blindness or disability or the AFDC [now CalWORKs] requirements of deprivation of parental support or care. (§50055)

#### 440-3

A person or family applying and approved for AFDC or SSI/SSP or IHSS shall not be required to submit a separate application for Medi-Cal. Medi-Cal eligibility is established automatically. (§50145)

#### 440-3A ADDED 2/04

Under the QR/PB system, a new member is added to the assistance unit as of the first of the month following the reported change or at the beginning of a quarter, depending on circumstances. However, for Medi-Cal eligibility purposes based on linkage to cash aid, the new assistance unit member may establish eligibility the month he/she joined the assistance unit.

If the person moving into the home was timely reported on the QR 7 or was timely and voluntarily reported mid-quarter, cash linked Medi-Cal is effective the month the individual moved into the home. If the recipient did not timely report the new member, cash linked Medi-Cal is effective the month the county received the report of the new assistance unit member.

There is an exception to this beginning date of aid rule. If the assistance unit does not report the birth of a newborn timely, cash linked Medi-Cal for the newborn would begin in the month following the child's birth after eligibility has been established and all verification has been provided. (All-County Letter No. 03-18, April 29, 2003, pp.51-52)

#### 440-3B ADDED 2/04

For both CalWORKs and food stamps, if the person moving into the home has income that once considered would result in the assistance unit/household being financially ineligible for aid, the county shall not take any action to change the assistance unit/household's benefits in the current quarter. The new person would not be entitled to receive Medi-Cal. (All-County Letter No. 03-18, April 29, 2003, pp.54-55)

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#### 440-4

A person or family who has been receiving Medi-Cal under any program other than SSI/SSP and whose eligibility is discontinued shall be evaluated by the county department to determine if Medi-Cal eligibility exists under any other program. (§50183(a))

It had been CDHS' position that when the county has determined there is no basis for continuing Medi-Cal eligibility and the beneficiary alleges disability, he/she should be advised of his/her right to apply as a disabled person. But these persons were not entitled to Medi-Cal either at zero SOC or with an SOC, pending the disability determination. (Medi-Cal Eligibility Procedures Manual §4-0-3) Since the passage of Senate Bill No. 87, aid pending is initiated, and the county must explore all avenues of eligibility before it discontinues non-disability related Medi-Cal. (Welfare & Institutions Code §§14005.31, .32, and .37, effective July 1, 2001; All-County Welfare Directors Letter No. 02-59, December 23, 2002)

#### 440-5

The beginning date of eligibility for persons applying only for Medi-Cal, whose eligibility has not yet been determined, shall be the first day of the month of application if all eligibility requirements of the appropriate Medi-Cal Program are met, or the first day of the month subsequent to the month of application during which the eligibility requirements of the appropriate Medi-Cal Program are met. (§50193(c), replacing §50701(c), effective September 19, 2000)

#### 440-6

A person may choose to have his/her application processed under any program for which he/she is eligible even if such program is not the most advantageous. (§50153(c))

#### 440-7

Linkage to AFDC exists if a child is living with a relative and deprived of parental support or care. Deprivation may be due to a deceased parent, the physical or mental incapacity of a parent, an absent parent or an unemployed parent. Generally, all family members living in the home shall be considered in determining whether linkage to AFDC exists. (§50205)

#### 440-8

When parents may establish linkage to the AFDC-MN program through either absence or unemployment (or through personal incapacity, or death of the other parent) the parents may choose the basis of deprivation. (Medi-Cal Eligibility Procedures Manual §5C-14, Subsection 3e.)

#### 441-1

"Continued absence" exists when a parent is absent from the home and both of the following conditions exist: (1) the nature of the absence results in a termination or interruption of the parent's functioning as a provider of maintenance, physical care, or guidance for the child, regardless of the reason for absence or length of the absence; and (2) the known or indefinite duration of the absence precludes counting on the parent for the present support or care of the children. (§50213(c)(1))

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#### 441-2

When a child stays alternately with each parent, the child shall be included in the MFBU of the parent with whom the child stays the majority of time unless the other parent can establish that he/she has major responsibility for care and control of the child. (§50374)

#### 442-1

AFDC-linked incapacity deprivation exists if the physical or mental impairment is expected to last at least 30 days and substantially reduces or eliminates the parent's ability to support or care for the child; or prevents the parent from working, or limits the amount the parent is paid, or the parent is blind or disabled, per §50223, or the parent works less than full time in a therapeutic or rehabilitative job or a sheltered workshop. (§50211)

#### 443-1A

As of March 1, 2000, when the primary wage earner (PWE) is working fewer than 100 hours in a month, or 100 hours or more in a month, but the family earned income is at or below 100% of the Federal Poverty Level (FPL) for the appropriate MFBU, then deprivation based on unemployed parent exists. (Assembly Bill 1107, Ch. 146, Stats. 1999 effective January 1, 2000; Medi-Cal Eligibility Procedures Manual (MEPM) §5C-13, Example 17)

In determining whether the earned income exceeds 100% of the FPL, count the nonexempt earned income of all parents, spouses and children under 21 who are required to be in the MFBU, regardless of whether these individuals are eligible for §1931(b) benefits, the MN or MI programs, or the Percent programs. *Sneede* rules do not apply for purposes of determining whether the earnings test has been met.

The earned income of a family member is not counted only when the earnings are from an excluded child, or from a family member who is not in the MFBU because the person is receiving Public Assistance (PA) or other PA.

(MEPM §5C-13, 14)

#### 443-2

Deprivation of parental support or care based on Unemployment (U) is set forth in §50215. Per §50215, U-deprivation exists if a parent (who is the primary wage earner (PWE)) is not working, or working fewer than 100 hours per month, or is employed on an intermittent basis more than 100 hours per month on a temporary basis.

Despite the language in §50215, U-deprivation can exist even if neither parent has worked, although in that case the county, in consultation with the parents, shall decide which parent is designated as the PWE. Even if the PWE refuses to apply for and accept Unemployment Insurance Benefits (UIB), U-deprivation can exist, but there is still a requirement that an individual must apply for unconditionally available income to be eligible for Medi-Cal. If the U-parent participates in a strike; deliberately limits self-employment hours; quits a job or employment training; does not actively seek work; or refuses a bona fide offer of employment or employment related training: U-deprivation can still exist. U-deprivation can also exist, as of March 1, 2000 when the family's earned income is at or below 100% of the Federal Poverty Level for the MFBU. (All-County Welfare Directors Letter (ACWDL) No. 97-37, October 3, 1997; Medi-Cal Eligibility Procedures Manual §5C-11, 12, 13, and 14)

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#### 443-3

The principal wage earner (PWE) is the parent who earned the greater amount of income in the 24-month period immediately preceding:

- (a) The month of application, reapplication, or restoration; or
- (b) The date of a redetermination that the family's circumstances have changed so as to meet the requirements for unemployment deprivation. (§50215(c))

When both parents have earned an identical amount of income (including zero income) in the 24-month period preceding evaluation for unemployment deprivation, the county in consultation with the parents shall determine the PWE. (Medical Eligibility Procedures Manual §5C-11)

#### 444-1

Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) established zero share-of-cost Medi-Cal coverage for low-income families who meet the provisions of the July 16, 1996 AFDC plan requirements for income, resources and deprivation (subject to modification at State option). There is an exception in that deprivation due to unemployment can be established as long as the applicant principal wage earner (PWE) works fewer than 100 hours per month (as explained in All-County Welfare Directors Letters (ACWDLs) Nos. 97-17 and 97-37). (ACWDL No. 98-43, September 30, 1998; Social Security Act, §1931(b)) Effective March 1, 2000, the PWE may be considered unemployed even if he/she works over 100 hours, as long as the family's net nonexempt earned income is at or below the FPL. (ACWDL No. 00-04, January 14, 2000, implementing Assembly Bill No. 1107)

Effective May 1, 2001, only the net nonexempt earned income of the parents, or the parent and the parent's spouse, is counted. (Medi-Cal Eligibility Procedures Manual §5S-3(D.)1, as revised effective September 28, 2001)

#### 444-1A

Persons applying separately for the §1931(b)-Only program must first meet residency, age, deprivation and family requirements. After these non-financial requirements have been met, persons must meet the income and property financial requirements. (All-County Welfare Directors Letter (ACWDL) No. 98-43, September 30, 1998; Medi-Cal Eligibility Procedures Manual §5S-2(D.))

#### 444-1B

For §1931(b) purposes, an applicant is a person or family which has submitted an application for Medi-Cal and who was not on the §1931(b) program, separately or as a CalWORKs recipient, in any of the four months previous to the application month. (ACWDL No. 98-43, Attachment 1, p. 1, September 30, 1998)

#### 444-1C

It is important to determine eligibility under the §1931(b) because:

1. Families that are discontinued from CalWORKs or §1931(b) due to excess earnings from employment or increased child/spousal support are eligible for either the Transitional Medi-Cal (TMC) or the Four-Month Continuing programs. Medically Needy (MN) persons are not.

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2. Recipients may work over 100 hours and remain eligible if the family income is below the limit.
3. There are no time limits. Families not eligible for CalWORKs because the time limit on their CalWORKs eligibility has expired may qualify for the §1931(b) program.
4. Families may choose to separately apply for the §1931(b) program because they do not wish to be CalWORKs recipients, or because they are not eligible for CalWORKs.
5. A family may not be eligible for CalWORKs but may be eligible for the §1931(b) program due to certain less restrictive AFDC rules no longer applicable to CalWORKs (e.g., deductions for child care costs), but which continue to apply to the § 1931(b) program.

(Medi-Cal Eligibility Procedures Manual §5S-1(B.1))

#### 444-1D

Counties were instructed by All-County Welfare Directors Letters (ACWDLs) No. 98-43 and 99-18 to implement the §1931(b) program. CDHS required all counties to correct any case in which a family was denied eligibility or placed in an SOC code without completing a §1931(b) review. Each county must certify it has done so by May 1, 2001. (ACWDL No. 01-29, April 23, 2001)

#### 444-1E

Persons eligible for §1931(b) may choose to be aided under certain other mandatory programs (e.g., the Pickle program, or a special limited benefits program such as QMB) but they may not choose to be aided under the MN program, because that is an optional federal category. (Medi-Cal Eligibility Procedures Manual §8G-4)

#### 444-2

For eligibility to exist under §1931(b), there must be a child (including an unborn) under 18 years of age; except that a child from 18 to 19 may be eligible if he/she is enrolled as a full-time student (as defined by the school) in high school, or if he/she has not completed high school, in a vocational or technical training program which cannot result in a college degree, and the student can reasonably be expected to complete either of these programs before reaching age 19. (All-County Welfare Directors Letter (ACWDL) No. 98-43, p.3, September 30, 1998; Medi-Cal Eligibility Procedures Manual (MEPM) §5S-3(D.3))

The child must be deprived of parental support or care, and the child must be eligible for zero SOC Medi-Cal in either the Public Assistance §1931(b), MN, MI, CE, Continuing Eligibility for Children, Bridging or Percent program, in order for the parent(s) to be eligible for §1931(b) benefits. (MEPM §§5S-4 as revised effective September 28, 2001, §8G-2, as revised effective March 14, 2001)

#### 444-2A

The following example from the Medi-Cal Eligibility Procedures Manual (MEPM) shows how a parent, with a zero SOC under §1931(b) but initially ineligible for §1931(b) benefits because her only child has an SOC

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under §1931(b), can qualify for §1931(b) benefits:

Example 6: (Sneede Case - Child with Income is only Eligible for Percent Program)

A single mother and her nine month-old child with income apply for Medi-Cal. The mother has net nonexempt income of \$889 and the child has net nonexempt income of \$620. The county determines §1931(b) and then applies Sneede because the family is over the §1931(b) limit.

Section 1931(b) MFBU		Sneede MBU No. 1		Sneede MBU No. 2	
Mother	\$889	Mother	\$696	Child	\$620 + \$193 from Mother
Child	620	Total	696	Total	\$813
Total	1,509	Limit	696		\$469
Limit (2)	938				

The mother is potentially eligible for §1931(b) because she has a zero SOC. She keeps her parental needs amount of \$696 and allocates the remainder to her child; however, the child is above the prorated Sneede 100% limit. The county then evaluates the child for the MN program. Since the child has an SOC, he or she is evaluated for the 200 Percent program. There are no health premiums to add back.

MN		200 Percent Program	
Child	\$620	Mother's Income	\$889
Total	620	Child's Income	620
Limit	600	Total	1,509
		Limit (2)	1,875

Child is eligible for the 200 Percent program. Mom is eligible for §1931(b) because she has a child who is eligible for Medi-Cal with no SOC. The child may be eligible as a recipient the following month if Mom has earned income using Alternative B.

(MEPM §8G-9, Example 6)

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#### 444-3

Deprivation under §1931(b) is the same as in the Medically Needy (MN) program for absence and incapacity. Under the unemployed (U) parent program, the requirement that the primary wage earner (PWE) work fewer than 100 hours in a month applied only to applicant §1931(b) families prior to March 1, 2000. The 100-hour limitation does not apply to: (1) Families who are beneficiaries with unemployment as a basis of deprivation, or who should have been beneficiaries under that program during the phase-in, look back period to January 1, 1998; or (2) Applicants after March 1, 2000, whose family's total net nonexempt earned income is not more than the FPL. The parents' earnings, or the earnings of the parent and spouse, are the only earnings counted as of May 1, 2001. (All-County Welfare Directors Letter (ACWDL) No. 98-43, pp. 3-4, September 30, 1998; W&IC §14005.30; Medi-Cal Eligibility Procedures Manual §5S-3; as revised effective September 28, 2001)

#### 444-4

The MFBU, including unborns, is the basic unit of persons considered in determining an individual's or family's SOC for §1931(b) purposes. If the MFBU has too much property or income to qualify for §1931(b) benefits, then the county must follow a *Sneede/Gamma* type analysis (modified as to allowable deductions and the parental needs amount) to determine if there can be §1931(b) eligibility for any member(s) of any of the Mini-Budget Units (MBUs). (All-County Welfare Directors Letter (ACWDL) No. 98-43, pp. 5 and 7, September 30, 1998)

#### 444-4A

Persons who are not eligible for CalWORKs such as those who are CalWORKs sanctioned, fleeing felons, and persons who have reached their CalWORKs time limits are eligible for §1931(b) without a separate determination, are eligible for §1931(b) without a separate determination, if other family members remain eligible for CalWORKs; while aliens who are not eligible for CalWORKs because they do not have satisfactory immigration status are eligible for restricted §1931(b) benefits. The only exceptions to this are the non-needy caretaker relatives whose income are resources were not considered by CalWORKs and those persons who do not meet the AFDC/CalWORKs definitions of a child (e.g., over 18 and not enrolled in school and expected to graduate before age 19.) (Medi-Cal Eligibility Procedures Manual §8G-2, modifying §5S-4)

#### 444-4B

A pregnant woman who has no other eligible children but the unborn (who when born would be deprived) may not be aided under the §1931(b) program until her last trimester, i.e., the last four months of pregnancy. If the father of the unborn is living in the home, he may not be aided under this program until the baby is born and the baby is deprived. The father can be aided under the Medically Needy (MN) program because he has linkage. The father's income is counted in the §1931(b) MFBU of the pregnant woman and the unborn even though he is an ineligible member of that MFBU until the child is born. The unmarried father may opt out of the MFBU if he provides information, when required, to establish deprivation for the unborn. The unborn may be counted in the maintenance need prior to the last trimester if there are other deprived children even if the unborn is not deprived of parental care. If the parents are not married and the pregnant woman is ineligible for §1931(b) due to excess income or property, *Sneede* rules apply. Continuous eligibility rules apply to both the pregnant woman and the infant up to age one. (Medi-Cal Eligibility Procedures Manual §5S-3(D.2) as revised effective September 28, 2001, and 8G-2)

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#### 444-4C

A stepparent may be aided as an "essential person" in the §1931(b) program regardless of whether he/she has deprived children or non-deprived mutual children of his or her own. His or her linkage may be based only on the fact he/she is a spouse of a parent who has a separate child deprived by an absent parent. (The MN program only allows a stepparent to be linked if he/she is a spouse of a parent who has a separate child who is deprived because of that parent's incapacity.) Regardless of whether or not the stepparent wishes to be aided under §1931(b) he/she is included in the budget unit as an eligible or ineligible person depending on his/her choice. The exception would be when only the separate children of the spouse wish to be aided. He/she would not be in the budget unit; however, the spouse would deem some of the income to the other spouse and any mutual children. (Medi-Cal Eligibility Procedures Manual §5S-4(D.)5)

#### 444-4D

The CalWORKs program allows an otherwise eligible adult parent, his/her minor child, and a caretaker to all be aided when they reside in the same home. The parent is still financially responsible even if the caretaker has care and control. These rules also apply to the §1931(b) program. (Medi-Cal Eligibility Procedures Manual (MEPM) §§5S-4(D.6) and 8D-3)

#### 444-4E

All persons in the family who are living in the home are evaluated for §1931(b) in the same MFBU, whether or not they have linkage, except if the person is receiving a cash grant, such as SSI/SSP, CalWORKs, In Home Supportive Services.

"Persons who are considered to be receiving Public Assistance (PA) or other PA are not in the MFBU except for those receiving Four Months Continuing and Transitional Medi-Cal benefits (see 50373 California Code of Regulations."

(Medi-Cal Eligibility Procedures Manual (MEPM) §8G-2, first bullet)

#### 444-4F

The following persons, while ineligible for CalWORKs, are eligible for §1931(b) Medi-Cal:

- (1) Persons deleted from the CalWORKs AU because of a Welfare-to-Work (WTW) sanction.
- (2) AUs discontinued from CalWORKs for failure to provide a monthly or annual income report.

(All-County Welfare Directors Letter No. 02-59, December 23, 2002, Answers B-3 and B-7)

#### 444-5

A family's countable income must be less than the §1931(b) income limit for that size family to be income eligible for that program.

Federal and state law require that income eligibility for a family or individual can be established under §1931(b) for those who meet either the criteria of the CalWORKs program or the former AFDC program, as it existed on July 16, 1996. When CalWORKs rules have changed or are dissimilar to a corresponding AFDC rule, the §1931(b) program adopts the more liberal of the

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corresponding rules. (All-County Welfare Directors Letter (ACWDL) No. 98-43, p.4, September 30, 1998; Medi-Cal Eligibility Procedures Manual §5S-5)

444-5A

The following procedure is used to determine the net nonexempt income of an applicant, or applicant family, and whether the applicant MBFU is income eligible for zero SOC under §1931(b) of the Social Security Act.

- (1) Determine gross unearned income (i.e., any income which is not earned income) of all members of the MFBU.
- (2) Determine nonexempt unearned income by subtracting unearned income exemptions from gross unearned income.
- (3) Determine remaining nonexempt unearned income by subtracting applicable unearned income deductions (e.g., educational expenses, property expenses from property income when the property income is considered unearned, or \$50 deduction for family support received) from the amount in (2). Effective November 1, 2002, deduct \$240 from Disability-Based Income, i.e., Disability Insurance from the Social Security Administration and private disability benefits.
- (4) Determine the adjusted gross earned income by subtracting applicable deductions (e.g., business expenses from self-employment income, property expenses from property income, and JTPA payments to a child) from gross earned income.
- (5) Determine nonexempt earned income by subtracting applicable earned income exemptions from adjusted gross earned income. Temporary Workers compensation and State Disability Insurance are treated as earned income because of the *Tinoco* and *Sawyer* lawsuits.
- (6) Deduct \$90 from the nonexempt earned income of each MFBU member with earnings.
- (7) Subtract qualifying dependent care expenses from the remaining nonexempt earned income.
- (8) Add the MFBU's remaining nonexempt unearned income (from Step 3) to the remaining net nonexempt earned income (in Step 7). Subtract qualifying child or spousal support payments. Round down to the next nearer dollar. The result is the MFBU's net nonexempt income.
- (9) Compare the MFBU's net nonexempt income (Step 8) with the §1931(b) income limit amount for the size of the MFBU. The MFBU is eligible for §1931(b) benefits if net nonexempt income is less than the appropriate limit.
- (10) If net nonexempt income equals or exceeds the income limit amount, and if one or more children in the MFBU receives income, or the parents are unmarried, determine eligibility for the Mini-Budget Units (MBUs) by following *Sneedel/Gamma* rules, as modified for §1931(b) evaluation. If any of the MBUs are still ineligible for §1931(b) benefits, evaluate eligibility for children under the Medi-Cal percentage programs, and for the MFBU and all MBUs under the medically needy program.

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(All-County Welfare Directors letter (ACWDL) No. 98-43, Attachment 1, pp. 4-5, September 30, 1998 and ACWDL No. 02-44, August 27, 2002)

444-5B

The following procedure is used to determine the net nonexempt income of a recipient, or recipient family, and whether the recipient MFBU is eligible for zero SOC under §1931(b) of the Social Security Act.

- (1) Determine gross unearned income, which excludes disability-based unearned income.
- (2) Determine nonexempt unearned income by subtracting unearned income exemptions from gross unearned income.
- (3) Determine remaining nonexempt unearned income by subtracting applicable unearned income deductions (e.g., educational expenses, property expenses from property income when the property income is considered unearned, or \$50 deduction for family support received) from the amount in (2).
- (4) & (5) Determine net nonexempt disability-based unearned income by subtracting exemptions from gross disability-based income, and then by subtracting \$240.
- (6) Determine the adjusted gross earned income by subtracting applicable deductions (e.g., business expenses from self-employment income, property expenses from property income and JTPA payments to a child) from gross earned income.
- (7) Determine nonexempt earned income by subtracting applicable earned income exemptions from adjusted gross earned income.
- (8) Subtract \$240 from nonexempt earned income if there has been no deduction made from disability-based unearned income; otherwise subtract any portion of the \$240 that has not already been subtracted as a deduction from disability-based unearned income.
- (9) Subtract one-half (50%) of the remaining nonexempt earned income, as determined in Step (8).
- (10) Subtract the dependent care deduction, if any, from nonexempt earned income, as determined in Step (9). Net nonexempt earned income has been established.
- (11) Determine total net nonexempt income by adding:
  - (a) Remaining nonexempt unearned income from Step (3).
  - (b) Remaining net nonexempt disability-based unearned income from Steps (4) and (5).
  - (c) Net nonexempt earned income from Step (10).

Then subtract any qualifying spousal or child support payments from this total. Total net nonexempt income has been determined.

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(12) Compare the MFBU's net nonexempt income (Step 11) with the §1931(b) income limit amount for the size of the MFBU, which is the AFCD Minimum Basic Standard of Adequate Care (MBSAC) as of July 1, 1999. The MFBU is eligible for §1931(b) benefits if net nonexempt income is less than the appropriate limit.

(13) If net nonexempt income equals or exceeds the income limit amount, the FPL for the unit, and if one or more children in the MFBU receives income, or the parents are unmarried, determine eligibility for the Mini-Budget Units (MBUs) by following *Sneed/Gamma* rules, as modified for §1931(b) evaluation. Then, follow the income eligibility rules for applicant §1931(b) units, both for MFBU and MBUs. If any MFBU or any of the MBUs are still ineligible for §1931(b) benefits, evaluate eligibility for children under the Medi-Cal percentage programs, and for the MFBU and all MBUs under the medically needy program.

(All-County Welfare Directors Letter (ACWDL) No. 98-43, Attachment 1, pp. 5-7, September 30, 1998)

#### 444-5C

It is the position of the CDHS that income and income exemptions and income deductions are determined under the draft income regulations set forth in Exhibit B of All-County Welfare Directors Letter (ACWDL) No. 98-43, commencing with Draft Regulation §50508, as well as any actual Title 22 regulations and modifications to those actual regulations contained in previous ACWDLs. The medically needy (MN) regulations in §§50501 through 50555 which are superseded, for §1931(b) purposes only, are set forth in draft regulations §§50508, 50509, 50523.5, 50527, 50533, 50539 and 50543, set forth in Exhibit B. New §1931(b) draft regulations, set forth in Exhibit B, are §§50271.1, 50527.5, 50535.2, 50536.1 - .3, and 50538.3 - .4. No regulations have been amended by the CDHS as of December 1, 2002. (ACWDL No. 98-43, Attachment 1, pp. 8-14, and Exhibit B, September 30, 1998)

#### 444-5D

Effective March 1, 2000, applicant MFBU's whose net nonexempt income is at or below 100% of the Federal Poverty Level (FPL) are potentially eligible for §1931(b) benefits. (All-County Welfare Directors Letter No. 00-04, January 14, 2000) This is true even if the principal wage earner (PWE) is working 100 hours or more in the month. (Medi-Cal Eligibility Procedures Manual §8G-1)

#### 444-5E

The following reflects the CDHS position as to the status of income limits in the §1931(b) Medi-Cal program.

"Since March 1, 2000, the Section 1931(b) program has had two income limits: (1) the original Section 1931(b) 'cash-based' income limit, and (2) a new income limit set at the federal poverty level (FPL). The cash-based limit for the Section 1931(b) program is currently used only for purposes of determining eligibility for recipients in circumstances in which the \$240 and one-half deduction was applied. The FPL income limit is currently used for purposes of determining the eligibility of applicants for the Section 1931(b) program, and for purposes of determining the eligibility of Section 1931(b) recipients in circumstances in which the \$240 and one-half income deduction was not applied.

"State law requires that the Section 1931(b) program ensure Medi-Cal coverage of families who could have qualified under the rules of the former Aid to Families with

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Dependent Children program and ensure Medi-Cal coverage of families who do, or could, qualify as recipients of the California Work Opportunity and Responsibility to Kids (CalWORKs) program. Under the Section 1931(b) income limits in place effective March 1, 2000, Section 1931(b) program coverage of these required groups is ensured without any further increases in the Section 1931(b) income limits, notwithstanding the October 2000 increases in the CalWORKs income limits. Therefore, the requirements of state law are met without any further increases in the Section 1931(b) income limits beyond those which were effective March 1, 2000."

(All-County Welfare Directors Letter No. 00-48, September 12, 2000)

#### 444-5F

Beginning with the January 2001 Social Security COLAs, counties are not to apply those COLAs to the §1931(b) program until the Federal Poverty Levels (FPLs) are released and applied, which is generally in April. (All-County Welfare Directors Letter No. 00-53, October 23, 2000)

#### 444-5G

Persons considered "recipients" are income eligible for the §1931(b) program if they meet, either in the MFBU or MBU, one of these two tests: (1) Allow a deduction of \$240 from disability-based unearned income, plus a deduction of any unused portion of the \$240 as well as a one-half deduction from earned income, which if less than the July 1, 1999 Minimum Basic Standard of Adequate Care for the unit, establishes eligibility. (2) Allow a \$240 deduction from Social Security or private disability benefits, plus a \$90 deduction from earned income, which if equal to or less than the Federal Poverty Level (FPL) for the unit establishes eligibility.

Persons considered "applicants" use only Test 2, and that Test is applicable as of November 1, 2002. Prior to November 1, there was no \$240 deduction for applicants.

(Medi-Cal Eligibility Procedures Manual §8G-5)

#### 444-5H ADDED 2/05

Effective July and August 2004 and again beginning December 2004, the income standards for the Section 1931(b) Program income eligibility "Test A" applicable to recipients only increased.

For a family of one person, the income standard is \$398 in July and August and beginning in December 2004. The income standard in September through November 2004 and for all months prior to July 2004 was \$390 for one person.

For a family of two persons, the "Test A" income standard is \$653 in July and August 2004 and beginning in December 2004. The two-person income standard in September through November 2004 was \$639.

Beginning December 2004, income standards for all size families will be applied to all Medi-Cal only recipient cases being evaluated for 1931(b) eligibility.

The other Section 1931(b) income test (Test B) applicable to both applicants and recipients which uses 100% of the Federal Poverty Level as the income limit and which is updated each April is not affected by this change. (All-County Welfare Director's Letter 04-35, November 3, 2004)

## SHD Paraphrased Regulations - Medi-Cal

### 440 Program Eligibility

#### 444-6

In §1931(b) cases, personal property is generally determined, defined, counted and valued in accordance with Food Stamp (FS) rules. However, when the AFDC rules in effect on July 16, 1996 are less restrictive than the FS rules (e.g., in the valuation of automobiles, as set forth in draft regulation §50491(l)), then a combination of the July 16, 1996 AFDC regulations and FS regulations is used so that §1931(b) applicants and recipients are not penalized.

For real property cases, generally the July 16, 1996 AFDC regulations determine the value of countable property.

There are certain court cases, applicable to the Medi-Cal program, which apply to the evaluation of property eligibility, e.g., *Principe v. Belshé*.

In addition to the above, there are certain regulations in Title 22, as amended by previously issued draft regulations, which apply to the §1931(b) program, and others which do not. A chart showing which regulations apply, and which do not, is set forth in All County Welfare Directors Letter (ACWDL) No. 98-43, Attachment 2, p. 6, September 30, 1998 and amended by ACWDL No. 99-02E, Attachment 2.1, May 7, 1999. None of the Title 22 regulations have been amended as of December 1, 2002. (ACWDL No. 98-43, p.5, and Attachment 2)

#### 444-6A

The property limit for one person in the §1931(b) program is \$3000. For all other family sizes, the medically needy resource limits are used. (All-County Welfare Directors Letter (ACWDL) No. 98-43, p.5, September 30, 1998; Medi-Cal Eligibility Procedures Manual §5S-5)

#### 444-6B

Any motor vehicle that has an equity value of \$1500 or less shall be exempt, and is not to be included in the property reserve when determining eligibility for the §1931(b) Medi-Cal program. (All-County Welfare Directors Letter No. 01-62, November 7, 2001, to be effective June 1, 2001)

#### 444-7

Once a family is potentially eligible for §1931(b) benefits because there is a caretaker relative and a child (including an unborn in the last trimester before birth, or children under age 18, or an 18-year-old who can reasonably be expected to graduate from high school, or a trade or technical school, before age 19) the following process shall be followed.

- (1) Provide *Edwards* continuing benefits, as appropriate.
- (2) Determine the Medi-Cal Family Budget Unit (MFBU).
- (3) If the MFBU is §1931(b) eligible because deprivation exists, and non-linking factors are met, the MFBU receives Medi-Cal benefits with a zero SOC.
- (4) If the MFBU is ineligible, determine which if any individuals are eligible for §1931(b) benefits under the modified §1931(b) *Sneede* analysis.
- (5) If there are family members who are ineligible or have an SOC, evaluate for Transitional Medi-Cal (TMC) and for four month continuing eligibility.

## SHD Paraphrased Regulations - Medi-Cal

### 440 Program Eligibility

- (6) If there are still family members who are ineligible or have an SOC, determine eligibility and the SOC for any such member(s) under the MN and/or MI programs.
- (7) If there are any family members who remain ineligible or have an SOC after the MN/MI review, evaluate the children and any pregnant woman under the percent programs. If anyone still has an SOC, determine eligibility under the standard *Sneed* analysis, including percent program evaluation.

(All County Welfare Directors Letter (ACWDL) No. 99-02E, pp. 1-7, and Medi-Cal 1931(b) Charts, May 7, 1999)

#### 444-8B

Exempt personal property for the §1931(b) program includes, but is not limited to:

- (1) Personal items and goods to furnish and equip a home.
- (4) Loans when there is a written agreement signed and dated by the lender and the MFBU member which specifies the obligation of the MFBU member to repay the loan, and a repayment plan which provides for installments of specified amounts that are to continue on a regular basis until the loan is fully repaid.
- (5) The cash surrender value of life insurance policies.
- (6) The cash value of KEOGH plans which involve a contractual relationship with individuals who are not MFBU members, pension plans or pension funds.
- (8) The full value of deeds of trust, promissory notes, mortgages, installment contracts or agreements if interest income is being produced.
- (9) Property essential to the employment of self-employment of an MFBU member.

(All County Welfare Directors Letter No. 99-02E, setting forth Draft §50491(m), May 7, 1999)

#### 444-9

The §1931(b) program should have been implemented as follows:

**New Applications:** All new Medi-Cal applications for families and children are to be evaluated for the §1931(b) program beginning no later than January 1, 1999. These cases are to be evaluated for current and future §1931(b) eligibility.

**Ongoing Cases:** Since the §1931(b) provisions went into effect on January 1, 1998, retroactive eligibility for all AFDC-MN, MI children, federal poverty level cases with infants and children and Aid Code 38 (Edwards) with or without a share of cost (SOC) must be evaluated back to January 1, 1998. Eligibility for Transitional Medi-Cal needs to be established.

Counties shall complete their evaluation of Aid Code 38 cases for §1931(b) eligibility by April 30, 1999. Counties shall complete their evaluation of all other cases for §1931(b) within one year, i.e., no later than December 31, 1999.

## SHD Paraphrased Regulations - Medi-Cal

### 440 Program Eligibility

Those MFBU's which had an SOC in a retroactive month but have no SOC for that month after the §1931(b) evaluation are entitled to:

1. Having future SOC amounts adjusted; or
2. Seeking reimbursement from the provider.

Counties should follow procedures outlined in Medi-Cal Procedures Manual §12-C.

(Medi-Cal Eligibility Procedures Manual §5S-2(C.))

444-10

The requirements of the *Sneed* lawsuit apply to the §1931(b) determination.

This means that if a family is determined ineligible for §1931(b) rules because of excess property or failure to meet the MBSAC income test, *Sneed* provisions apply if there is a *Sneed* class member.

Generally, the same *Sneed* methodology used in the regular Medi-Cal program is followed under §1931(b) except for the following:

Income exceptions: Under regular *Sneed*, deductions for the aged, blind, and disabled are applicable. These deductions are not permitted in the §1931(b) *Sneed* determination. Under regular *Sneed*, the SOC is based on the Maintenance Need Income Level (MNIL) (or prorated amount), and a parental needs amount of \$600 is allowed for the parent before the parent allocates to others for whom that parent has responsibility. Under §1931(b) *Sneed*, income eligibility is based on the MBSAC (or its prorated amount) and the parent is allowed a \$389 parental needs deduction as of July 1, 1999 (which relates to the MBSAC for one as specified in the AFDC Title IV-A State Plan in effect on July 16, 1996) before allocating to others. This amount changes based on the CalWORKs income limit.

Note: The \$240 deduction and the "1/2" (of the remainder of the earned income deduction) is not applied to applicants; however, under *Sneed*, each recipient may receive these deductions if applicable, which is similar to regular *Sneed* rules described in §8F of the Medi-Cal Eligibility Procedures Manual (MEPM). As of March 1, 2000, recipients have a choice between having the \$240 and 1/2 deducted and using the current §1931(b) income limit, or having a deduction of \$90 and using an income limit of 100% of the FPL. Applicant income limits will be raised to 100% of the FPL.

(MEPM 5S-6(F.))

444-11

To be eligible for the TMC program the individual must: (1) have been eligible for the CalWORKs program or §1931(b) program in three of the six months preceding the month of discontinuance and (2) have lost CalWORKs or §1931(b) program eligibility due to increased earnings from employment. Persons who have been terminated from CalWORKs must be first evaluated for §1931(b) before placing them into the TMC program. If they are eligible for §1931(b), they remain in that program until their earnings cause them to be ineligible. The family should then be evaluated to see if eligibility exists under TMC. (Medi-Cal Eligibility Procedures Manual §5S-7(G.))

## SHD Paraphrased Regulations - Medi-Cal

### 440 Program Eligibility

#### 445-1 REVISED 6/07

Verification of disability may be made in accordance with procedures established by the Disability Determination Service Division (DDSD) formerly known as Disability and Adult Programs Division (DAPD), and previously known as the Disability Evaluation Division (DED) of the California Department of Social Services. Except in the event of a delay due to circumstances beyond the control of the county, all necessary information shall be submitted to DAPD within 10 days after the county's receipt of the Statement of Facts. (§50167(a)(1)(D); All-County Welfare Directors Letters No. 97-54, December 1, 1997 and 06-28E, November 9, 2006)

#### 445-2

Disability may be verified by a Social Security Administration (SSA) Title II award letter which shows current receipt of benefits and no reexamination date or a reexamination date in the future, or an SSA Title II increase or decrease notice, or a signed statement from the SSA which indicates that the applicant is eligible to Social Security benefits based on disability. (§50167(a)(1)(B))

#### 445-3

Federal law provides that if an applicant does not have a good reason for failing or refusing to take part in a consultative examination, he or she is subject to a determination that no disability exists. Good reasons for failure to appear include illness on the date of the test, inadequate notice of the scheduled examination or test, inadequate information about the physician involved, or the applicant having had death or serious illness occur in the immediate family. (20 CFR §416.918)

#### 445-4

A request for retroactive Medi-Cal may be made in conjunction with, or after, application for public assistance or Medi-Cal. The application must be submitted within one year of the month for which retroactive coverage is requested. (§50148) An application for SSI/SSP benefits is an application for public assistance. (§50078) Example: An individual who is approved for SSI/SSP effective April 1994, and who requests retroactive coverage in February 1995 may be entitled to coverage in February and March 1994, but not in January 1994 because more than one year has elapsed between February 1995 and January 1994. (All-County Welfare Directors Letter No. 95-81, December 8, 1995, Situation 2)

#### 445-5

REVISED 6/07 Counties may grant presumptive disability (PD) when the applicant meets any of the following conditions. State Program (SP)-DAPD granted PDs are not limited to the categories shown below:

No. Impairment Categories.

1. (Obsolete: Reserved)
2. Amputation of a leg at the hip.
3. Allegation of total deafness.
4. Allegation of total blindness.

## SHD Paraphrased Regulations - Medi-Cal

### 440 Program Eligibility

5. Allegation of bed confinement or immobility without a wheelchair, walker, or crutches, due to a long-standing condition--exclude recent accident and recent surgery.
6. Allegation of a stroke (cerebral, vascular accident) more than 3 months in the past and continued marked difficulty in walking or using a hand or arm.
7. Allegation of cerebral palsy, muscular dystrophy or muscle atrophy and marked difficulty in walking (e.g., use of braces), speaking or coordination of the hands or arms.
8. (Obsolete: Reserved)
9. Allegation of Down syndrome.
10. Allegation of severe mental deficiency made by another individual filing on behalf of a client who is at least 7 years of age.

For example, a mother filing for benefits for her child states that the child attends (or attended) a special school, or special classes in school, because of mental deficiency, or is unable to attend any type of school (or if beyond school age, was unable to attend), and requires care and supervision of routine daily activities.

NOTE: "Mental deficiency" means mental retardation. This PD category pertains to individuals whose dependence upon others for meeting personal care needs (e.g., hygiene) and in doing other routine daily activities (e.g., fastening a seat belt) grossly exceeds age-appropriate dependence as a result of mental retardation.

11. A child is younger than one year and the birth certificate or other evidence (e.g., hospital admission summary) shows a weight below 1200 grams (2 pounds 10 ounces) at birth.
12. Human immunodeficiency virus (HIV) infection.
13. A child is younger than one year and available evidence (e.g., the hospital admission summary) shows a gestational age at birth on the table below with the corresponding birth-weight:

Gestation Age (in weeks)	Weight at Birth
37-40	Less than 2000 grams (4 pounds, 6 ounces)
36	1875 grams or less (4 pounds, 2 ounces)
35	1700 grams or less (3 pounds, 12 ounces)
34	1500 grams or less (3 pounds, 5 ounces)
33	At least 1200 grams, but no more than 1325 grams

14. PD will be granted to all terminally ill individuals, whether they receive Hospice Services or not.
15. Allegation of spinal cord injury producing inability to ambulate without the use of a walker or bilateral hand-held assistive devices for more than two weeks, with confirmation of such status from an appropriate medical professional.

## SHD Paraphrased Regulations - Medi-Cal

### 440 Program Eligibility

16. End stage renal disease with ongoing dialysis and the file contains a completed HCFA-2728 form from the applicant's medical provider.

17. Allegation of Amyotrophic Lateral Sclerosis (ALS, Lou Gehrig's Disease)

(Medi-Cal Eligibility Procedures Manual §22C-3.6, revised effective March 9, 2007)

#### 445-5A

State Programs-Disability and Adult Programs Division (DAPD), formerly Disability Evaluation Division (SP-DED) may grant Presumptive Disability (PD) in situations where the available evidence shows a strong likelihood that disability will be established when complete evidence is obtained and a formal determination is made. (Medi-Cal Eligibility Procedures Manual (MEPM) Letter No. 151, September 27, 1995)

PD, whether granted by the county or SP-DED, is granted when the determination is made, and is not allowed for retroactive months. (MEPM, §22C-3.1)

#### 445-6

The Social Security Administration (SSA) makes disability determinations based on social security law. A disability determination by any other governmental or nongovernmental agency is not binding on the SSA. (POMS DI 24515.011)

#### 445-9

The County Welfare Department (CWD) is required to forward a DED (now the DAPD) referral packet to DED no later than ten days after receipt of the Statement of Facts or other statement of disability is received, except in the event of a delay due to circumstances beyond the control of the CWD. (All-County Welfare Directors Letter No. 93-50, July 23, 1993; *Radcliffe v. Cahill*, Stipulation for Entry of Judgment and Order, Case No. 910804, April 23, 1993, San Francisco County Superior Court)

#### 445-10

It is the position of the CDHS that Medi-Cal benefits must continue for any beneficiary (but not for Medi-Cal applicants) who is terminated from Title II and/or SSI/SSP disability benefits due to cessation of disability and who appeals that termination. The continuation of Medi-Cal benefits includes the 65-day period following the Title II and/or SSI notice of planned action, or the latest Title II and/or SSI/SSP appeal decision, if unfavorable, in order to allow the individual to file the next level of appeal (even if an appeal is not filed).

Due to the numerous levels of appeals and extensive backlogs in SSA hearings, beneficiaries could receive Medi-Cal for several years before a final decision is rendered. "A decision becomes 'FINAL' when the beneficiary does not or cannot appeal the termination of Title II or SSI/SSP disability benefits any further. Medi-Cal benefits will continue through the 65-day period following the denial of an appeal in which the next level of appeal can be filed."

(All-County Welfare Directors Letter No. 97-28, June 23, 1997, p. 5)

#### 445-12

Due to a federal interpretation, the process for determining Medi-Cal eligibility of "no longer disabled" former SSI/SSP recipients will not be referred to as an "application process", but a "redetermination". "Similar to the *Edwards* lawsuit for the AFDC cases, Medi-Cal benefits must

## SHD Paraphrased Regulations - Medi-Cal

### 440 Program Eligibility

continue at zero share of cost for persons losing SSI/SSP disability cash benefits due to cessation of disability while eligibility is redetermined under Medi-Cal rules." (All-County Welfare Directors Letter No. 97-28, June 23, 1997, p. 8)

#### 445-13

Former SSI/SSP recipients who receive AFDC/TANF while their SSI appeals are pending do not lose their rights to continued SSI-based benefits at zero SOC after AFDC/TANF benefits terminate. Until a "final" decision is rendered on the SSI appeal, those individuals are eligible for zero SOC Medi-Cal, unless the county determines those individuals are ineligible for Medi-Cal.

Those former disabled SSI/SSP recipients appealing the loss of federal disability benefits are considered public assistance (PA) beneficiaries for Medi-Cal purposes until the SSI appeal is resolved, or those individuals do not appeal their SSI decisions.

(All-County Welfare Directors Letter No. 97-28, June 23, 1997, pp. 5-7)

#### 446-2

Refugees and entrants who are not eligible for AFDC, SSI/SSP, MN or MI child programs may be eligible for Medi-Cal through the Refugee Medical Assistance (RMA) or Entrant Medical Assistance (EMA) Program. (§50257(a))

RMA eligible persons must meet the definition of refugees (Manual of Policies and Procedures (MPP) §§69-203.1, .2) or children of refugees (MPP §§69-301 - 305); meet eligibility requirements contained in Articles 4 - 13 (§§50141 - 50715), except that in-kind services provided by a shelter or resettlement agency are not income; and provide the name of the resettlement agency to the county. (§50257(b)). They must also not have been denied or terminated from RCA for failure or refusal to comply with registration, employment, education or training requirements of MPP §69-208; and they may not be full-time students in an institution of higher education, as defined in MPP §69-206.51 unless such enrollment is part of an employability plan under MPP §§69-206.52 - .54, or of an unaccompanied minor plan under MPP §§69-213.23 or 69-213.62.

RMA eligibility shall be limited to the shorter of: (1) Eight months of U.S. Residency, beginning with the month of entry; or (2) The time period for which the CDHS determines that sufficient federal funds are available under the RRP or the CHEP. (§50257(e))

#### 446-3

Federal regulations require that in determining eligibility for the Refugee Medical Assistance Program, the state must comply with Medicaid regulations. Thus, when refugee eligibility for Refugee Cash Assistance or Entrant Cash Assistance is terminated, there must be a prompt determination of eligibility on other bases, before Medi-Cal benefits are terminated. (All-County Welfare Directors Letter No. 97-57, December 8, 1997; *Edwards v. Kizer* (1985) 167 Cal. App. 3d 1071; Medi-Cal Eligibility Procedures Manual §24B-11)

#### 446-3A

When refugees (including those eligible for Refugee Cash Assistance, Refugee Medical Assistance, and Entrant Cash Assistance) receive time limited Medi-Cal benefits the county must redetermine if the refugee is eligible for Medi-Cal prior to the end of the month of refugee aid. Federal regulations require that Medi-Cal benefits must be continued until the beneficiary's eligibility for ongoing benefits can be determined.

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### 440 Program Eligibility

Prior to July 1, 2001, the CDHS policy was that the county should review the file to determine if there is any other basis for Medi-Cal eligibility. The county should request information from the recipient if there is not enough information to make an eligibility determination. If the recipient fails to provide the requested information within twenty days from the mailing of the request for information, benefits can be terminated. (All-County Welfare Directors Letter (ACWDL) No. 98-36, August 27, 1998; ACWDL No. 99-17, April 14, 1999)

As of July 1, 2001, the CDHS implemented changes to W&IC §§14005.32 and .37. The new rules require the county to make greater efforts to obtain information concerning the eligibility of all persons discontinued from Medi-Cal, and to use an *ex parte* process (i.e., a review without necessarily involving the Medi-Cal beneficiary) when eligibility under one Medi-Cal program ends. (ACWDLs No. 01-36, June 19, 2001 and 01-39, July 13, 2001)

#### 447-4

Aged, blind, or disabled (ABD) persons may be eligible for zero SOC Medi-Cal benefits if they meet all the following conditions:

1. The person receives Title II Social Security, i.e., Retirement, Survivors, and Disability Insurance (RSDI).
2. The person has received, and been entitled to receive, RSDI (formerly OASDI) and SSI/SSP in the same month in any month since April 1977.
3. The person has been discontinued from SSI/SSP for any reason.
4. The person has received an RSDI cost-of-living adjustment (COLA) in any month since SSI/SSP was discontinued.
5. The person would be eligible to receive SSI/SSP benefits if the RSDI COLAs received after SSI/SSP ineligibility are disregarded.

(Pickle Handbook, §15, p. 15-1, implementing *Lynch v. Rank*)

#### 447-4A

In the Pickle eligibility determination, the person must have "received" both RSDI (formerly OASDI) and SSI/SSP in the same month. This requirement has been interpreted as follows:

- (1) If Title XVI (SSI/SSP) and/or Title II (RSDI) benefits are awarded retroactively, Pickle eligibility may be determined from the last date of actual SSI/SSP eligibility and the first date of entitlement to RSDI benefits.
- (2) Those who received SSI/SSP but were later found by the SSA to have been ineligible for those benefits are not potential Pickle eligibles.
- (3) Actual receipt of SSI/SSP is required, but only entitlement to, rather than actual receipt of RSDI is needed to meet Pickle eligibility requirements.

(Pickle Handbook, §2, p. 2-1)

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### 440 Program Eligibility

447-5

Pickle persons must be within the resource limit (\$2,000 for an individual and \$3,000 for a couple) at 12:01 a.m. on the first day of the month for which eligibility is being determined. If a person is not eligible on that moment of the first, he/she is not Pickle eligible for the entire month. (Pickle Handbook, §15, p. 15-12)

447-6 REVISED 12/05

To determine the amount to be disregarded for purposes of determining Pickle eligibility:

1. Determine the current benefit amount of RSDI.
2. Determine when the last SSI/SSP check was received.
3. Multiply the current benefit amount by the multiplier for the time period the last SSI/SSP check was received. For the period \_\_\_\_\_, the multiplier is \_\_\_\_\_.

(Pickle Handbook, §15, p. 15-8; All-County Welfare Directors Letter (ACWDL) No. 05-35, November 2, 2005)

447-7

For purposes of determining Pickle eligibility, the amount of any income received is established on a monthly basis. Income may not be averaged, approximated, or allocated over a period of time. The only exception to this is that self-employment income is to be averaged. (Pickle Handbook, §15, p. 15-14)

447-8 ADDED 12/05

Effective January 1, 2006 through March 31, 2006, the SSI/SSP payment standard for one aged or disabled person living independently is \$812. The SSI/SSP payment standard for a couple living independently is \$1437.

Effective April 1, 2006 through December 31, 2006 the SSI/SSP payment standard for one aged or disabled person living independently is \$836. The SSI/SSP payment standard for a couple living independently is \$1472.

(All-County Welfare Directors Letter (ACWDL) No. 05-35, November 2, 2005)

447-8A REVISED 12/05

As of January 1, 2005, the SSI/SSP payment standard for \_\_\_\_\_ (aged or disabled) (blind) person(s) is \_\_\_\_\_ (All-County Welfare Director's Letter \_\_\_\_\_)

447-9

Once an individual (either a single person or a couple) is a potential Pickle individual, determine the individual's eligibility as follows:

- (1) Determine the individual's total unearned income, and subtract the \$20 unearned income exclusion.
- (2) Add the gross earned income, and subtract the \$65 and 1/2 earned income exclusion.

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### 440 Program Eligibility

- (3) Subtract the Title II COLA disregard amount (as determined in Pickle Handbook, §15, p. 15-8).
- (4) Compare the amounts determined in Steps 1, 2 and 3 with the current SSI/SSP payment level.

If the net income is equal to or less than the SSI/SSP payment level, the individual is eligible for zero SOC Medi-Cal benefits as a Pickle person.

(Pickle Handbook, §18, pp. 18-4, 18-5)

#### 447-10 REVISED 12/06

A potential Pickle person may have income from In-Kind Support and Maintenance (ISM). That ISM may be in the form of the Value of the One-Third Reduction (VTR) or the Presumed Maximum Value (PMV). (Pickle Handbook, §14, p. 14-1)

The VTR is a flat one-third reduction of the Federal Benefit Rate (FBR). It applies either in full, or not at all. If it applies, no other ISM is counted. The VTR is not rebuttable, i.e., there are no facts which will change the amount of unearned income which is counted to the Pickle person or couple if the VTR applies. In the year 2005, the VTR for an individual is \$193 and for a couple is \$289.66.

In the year 2006, the VTR was \$201 for an individual and \$301.33 for a couple. Those amounts increased to \$207.66 for an individual and \$311.33 for a couple in 2007. (Pickle Handbook, §14, pp. 14-1, 14-11, 14-11a, 14-12. An example of living arrangements in which the VTR applies is when the potential Pickle person lives in the household of another and receives both food and shelter from someone in that household. (Pickle Handbook, §14, p. 14-11) (All-County Welfare Director's Letters 04-37, December 22, 2004 05-35, November 2, 2005 and 06-29, November 1, 2006)

The PMV dollar amounts for individuals and couples are \$20 greater than the VTR for an individual and \$20.33 greater for a couple. (In 2007 the couple amount is also \$20 greater than the VTR amount). The PMV is rebuttable. An example of the PMV is when a potential Pickle person lives in his/her own household (i.e., owns or rents), or lives in noninstitutional care or a group home, and receives ISM from someone outside the household. (Pickle Handbook, §14, p. 14-11)

#### 447-11 ADDED 7/06

Eligibility to zero SOC Medi-Cal benefits was extended to certain disabled widows and widowers through OBRA '87 amendments to the Social Security Act. The amendment allows widow(er)s between the ages of 60 and 64, who lose Social Security benefits as a result of becoming entitled to or receiving an increase in Title II benefits (early widow(er)s benefits), to continue their Medi-Cal eligibility until they become eligible for Part A of Medicare. Eligibility under this provision was effective July 1, 1988.

Individuals are deemed to be SSI/SSP recipients for purposes of Medi-Cal under this provision if they meet the following conditions:

- Are between the ages of 60 and 64

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### 440 Program Eligibility

- Are eligible for and receiving early widow(er)s benefits under Section 202 (e) or Section 202 (f), or under any other provision of Section 202 if they are also eligible under subsection (e) or (f) of the Act;
- Are not entitled to Medicare Part A (hospital insurance); and
- Are ineligible for SSI/SSP benefits under Section 1616 (a) of the Act because of receipt of Title II benefits under Section 202 of the Act.

These individuals are deemed to be SSI/SSP recipients for Medi-Cal purposes as long as they would continue to be eligible for SSI or SSP in the absence of the widow(er)s benefits described above.

Anytime the county is evaluating an individual with Title II income, the county shall determine whether disabled widows benefits are being received. If so, the county must determine whether the individual would meet the Disabled Widow (DW) program criteria. In certain instances, an individual who would be ineligible for Pickle benefits after the January COLA might still be eligible for Pickle benefits as a disabled widow because under the DW program, initial DW entitlement as well as COLAs may be disregarded in the determination.

(Pickle Handbook, §5, p. 5-1 through 5-4)

447-12 ADDED 9/08

When both members of a couple pass the screening test, their income and disregard amounts must be combined for the needs test. If both members of the couple pass the screening test but are ineligible after completing the needs test for a couple, **the needs test must be completed for each individual using only his/her income and disregard.** (Pickle Handbook §15, p. 15-9, emphasis added)

447-14

Since November 1986, there has been potential Pickle eligibility for Disabled Adult Children (DAC).

To be eligible for zero SOC under this program, the person must meet, the following requirements.

- (1) Be 18 years of age or older.
- (2) Have received SSI/SSP on the basis of blindness or disability which began before the person reached 22 years of age.
- (3) Currently receive RSDI (formerly OASDI) as a result of this blindness or disability.
- (4) Have been discontinued from SSI/SSP because: (a) the person became entitled to Social Security (SS) child's benefits on or after July 1, 1987 based on a disability (including blindness) which began before age 22; or (b) the childhood disability benefits were increased.

In determining financial Pickle eligibility, none of the Social Security childhood benefits, or increases, shall be counted as income.

(Pickle Handbook, §6, p. 6-1)

## SHD Paraphrased Regulations - Medi-Cal

### 440 Program Eligibility

448-1

Recipients of In-Home Supportive Services (IHSS) are eligible to Medi-Cal provided that any net nonexempt income in excess of the SSI/SSP benefit level shall be applied to the cost of IHSS. (Manual of Policies and Procedures (MPP) §30-755.31) A person is eligible to Medi-Cal under the IHSS category if the person is receiving IHSS and the person is paying all of his or her net nonexempt income in excess of the SSI/SSP payment level toward the cost of IHSS. (§50245)

448-2

The Social Security Act encourages severely disabled persons to seek and maintain employment. These severely impaired working individuals, whose earnings from substantial gainful activity are too high to retain financial eligibility for SSI/SSP continue to remain eligible for Medicaid as deemed SSI recipients as long as their income without consideration of earnings does not exceed the SSI/SSP payment level. They are referred to as "1619(b)" recipients, because eligibility is established under Title XVI, §1619(b) of the Social Security Act.

The CDHS has issued instructions for determining eligibility for such individuals. There are four basic requirements. These individuals must:

1. Depend on Medicaid to continue working.
2. Meet all nondisability requirements for SSI/SSP benefits except for earnings.
3. Have insufficient earnings to replace SSI cash benefits, Medicaid, publicly-funded personal or attendant care which would be lost due to the individual's earnings.

AND

4. Have received SSI, or have been eligible as a 1619(b) person, in the month before the Medi-Cal Only determination/eligibility is initially established.

(All-County Welfare Directors Letter No. 97-27, June 20, 1997)

448-4

The medically indigent (MI) program includes persons under age 21 who:

1. Cannot meet the eligibility requirements as (Public Assistance (PA) or other PA recipients, as Medically Needy (MN) persons, or MN family members.
2. Are not an MN family member because of the exclusion of a child from the MFBU.
3. Are children who are not living with a parent or relative and for whom a public assistance agency is assuming financial responsibility in whole or in part.
4. Are children receiving assistance under Aid for Adoption of Children (now the Adoption Assistance Program).
5. Are children who are not eligible as AFDC (now CalWORKs) MN persons because they are not living with a relative.

## SHD Paraphrased Regulations - Medi-Cal

### 440 Program Eligibility

6. Are persons who are under 21 years of age who can qualify as MN blind or disabled persons but choose to apply as MI persons.

(§50251(a))

448-5

The Breast and Cervical Cancer Treatment Program (BCCTP) was authorized by Assembly Bill No. 430, Ch. 171, Stats. 2001, to be effective January 1, 2002. The CDHS was given the authority to implement the BCCTP, at first by All-County Welfare Directors Letters (ACWDLs) and then by issuing regulations. (W&IC §14007.71(d))

The statutory authority provides for, e.g., screening, clinical exams, and treatment. There are different coverages for women and men, for federal and state eligible persons, and for different age groups. Some persons will receive full scope Medi-Cal coverage for their cancer treatment (e.g., federally eligible women with no health insurance who are under age 65) while others (e.g., those meeting only State standards) will receive cancer treatment services only for a limited time period.

(See W&IC §14007.71; Health and Safety Code §§104160-104163)

448-5A ADDED 7/06

Assembly Bill 430 (Chapter 171, statutes of 2001) provides the state with authority to implement the federal Breast and Cervical Cancer Treatment Program (BCCTP). Effective January 1, 2002, California provides full-scope, \$0 share of cost Medi-Cal to women under age 65 who are citizens or lawful immigrants and who are screened through the Centers for Disease Control and Prevention (CDC) National Breast and Cervical Cancer Early Detection program providers and are found to be in need of treatment for breast and/or cervical cancer, including some precancerous conditions.

In California the authorized screening providers are Every Woman Counts (EWC) or Family Planning, Access, Care and Treatment (FPACT) program.

Eligibility for federal BCCTP continues as long as the woman is in need of treatment and meets all federal BCCTP eligibility requirements.

(ACWDL 06-09, February 24, 2006)

448-5B ADDED 7/06

Assembly Bill 430 established a state-funded BCCTP program. This program covers breast and/or cervical cancer patients who have been determined ineligible for the federal BCCTP program such as women 65 and over, women under 65 without satisfactory immigration status or men of any age or immigration status.

The state-funded BCCTP covers breast and/or cervical cancer treatment and related services only. It is limited to up to 18 months for breast cancer and up to 24 months for cervical cancer. The state-funded component of BCCTP is not a Medi-Cal program.

(ACWDL 06-09, February 24, 2006)

## SHD Paraphrased Regulations - Medi-Cal

### 440 Program Eligibility

448-5C ADDED 7/06

If an individual contacts the county to apply for BCCTP, or an individual applying for Medi-Cal at the county appears to be eligible for BCCTP, that individual should be referred to the BCCTP toll-free line, (800) 824-0088. (ACWDL 06-09, February 24, 2006)

448-5D ADDED 12/06

The California Department of Health Services has the statutory authority to complete eligibility determinations for BCCTP applicants under BCCTP rules. When a BCCTP beneficiary no longer meets the federal BCCTP requirements and is scheduled to be discontinued from her BCCTP Medi-Cal eligibility, an eligibility review under SB 87 for eligibility under other Medi-Cal programs must be completed before her BCCTP Medi-Cal benefits can be discontinued.

The BCCTP does not have statutory authority to make determinations of eligibility for any other Medi-Cal program. Therefore, when BCCTP determines that a woman is no longer eligible for Medi-Cal under the federal BCCTP rules, the BCCTP staff will discontinue her from BCCTP Medi-Cal and place her in an interim Medi-Cal aid code pending the county completion of redetermination, as required by Welfare and Institutions (W&I) Code, Section 14005.37.

A woman becomes ineligible for federal BCCTP Medi-Cal benefits under any of the following circumstances:

1. She has turned 65 years of age.
2. She has obtained creditable insurance coverage, as determined by BCCTP.

Only those cases where the woman is determined by BCCTP staff to no longer meet the federal BCCTP eligibility criteria will be referred to the counties. There are certain reasons for discontinuance from BCCTP Medi-Cal that do not require a redetermination by the county. As indicated in Sections 14005.37 and 14005.39, these exceptions are:

- Death
- Moved out of state
- Voluntary withdrawal from the Medi-Cal program
- Failure to cooperate or fraud

### **BCCTP and County Coordination**

When the BCCTP beneficiary is determined no longer eligible for federal BCCTP

Medi-Cal, BCCTP staff will send a Notice of Action (NOA) to inform her of this, as well as the reason for the discontinuance. The NOA will advise the BCCTP beneficiary that she will continue to receive full-scope, no-cost Medi-Cal or restricted Medi-Cal on an interim basis until the county makes a determination of her eligibility for any other Medi-Cal program. The beneficiary will continue to receive full-scope, no-cost Medi-Cal benefits or restricted benefits until the county social services agency completes a redetermination of her eligibility under other Medi-Cal programs.

(ACWDL 06-25, August 2, 2006)

## SHD Paraphrased Regulations - Medi-Cal

### 440 Program Eligibility

#### 449-1

Persons whose SSI/SSP eligibility has been discontinued may apply for Medi-Cal at the County Welfare Department. A new application is required. The CDHS is also to notify the county of the referral. (§50183 and §50183.5)

#### 449-2

When an individual is discontinued from SSI/SSP, CDHS is required to do the following:

- A. Issue a Notice of Action to all such persons and inform them of the actions they must take to have Medi-Cal-only eligibility determined.
- B. Mail an application for Medi-Cal only, and a short-form version of the Medi-Cal Statement of Facts, to persons discontinued due to excess resources or excess income.
- C. Extend for one month past discontinuance no-cost Medi-Cal eligibility, including issuing Medi-Cal cards, for SSI/SSP individuals discontinued as the result of excess resources, while the county determines Medi-Cal-only eligibility based on current information from the client.
- D. For those persons discontinued due to "excess income," determine an initial share of cost (SOC) using income information supplied on the State Data Exchange (SDX), and issue an MC 177 to client for the month following discontinuance. Client is also sent an application for Medi-Cal only and a short-form version of the Medi-Cal Statement of Facts.
- E. Identify persons discontinued due to residing in a long-term care (LTC) facility and prepare a listing for counties to be used to identify and contact those persons and assist them with applying for Medi-Cal.
- F. Afford a state hearing to persons who appeal the loss of their SSI/SSP-based Medi-Cal, if such a hearing is requested timely in accordance with the California Department of Social Services (CDSS) regulations.
- G. Grant aid paid pending to persons who appeal loss of their SSI/SSP-based Medi-Cal in a timely fashion in accordance with CDSS regulations.

(Medi-Cal Eligibility Procedures Manual §5E implementing *Ramos v. Myers* (1981), Judgment by Consent No. C80-0332 WHO, U.S. District Court (N.D. Cal.))

#### 449-3

Effective June 30, 2002, when SSI cash benefits are terminated, and the discontinuance is not due to the death or incarceration of the beneficiary, the beneficiary shall continue to receive full-scope, zero SOC Medi-Cal benefits until the county redetermines eligibility. Counties shall not terminate or make eligibility determinations ... until instructions are issued in a separate letter. (All-County Welfare Directors Letter (ACWDL) No. 02-45, implementing *Craig v. Bontá*, Temporary Restraining Order, San Francisco county Superior Court, Case No. CPF-02-500688, June 24, 2002)

The *Craig* order applies to individuals who lost SSI benefits due to entry into long-term care (LTC). Beneficiaries are eligible for zero SOC Medi-Cal benefits until counties receive further

## SHD Paraphrased Regulations - Medi-Cal

### 440 Program Eligibility

instructions from the CDHS. (Those instructions were issued in ACWDL No. 03-24.) In fact, all the *Ramos* instructions set forth in Medi-Cal Procedures Manual §5E are obsolete, and must not be implemented. (ACWDL No. 02-54, November 8, 2002)

#### 449-3A

Beneficiaries of the *Craig v. Bontá* lawsuit must be given the same procedural safeguards as are accorded to all other persons who have been discontinued from zero SOC Medi-Cal. Those procedures, outlined in All-County Welfare Directors Letter (ACWDL) No. 02-59, include ex parte review, direct contact, and written request for information prior to discontinuing benefits or assessing an SOC. (ACWDL No. 03-24, May 6, 2003)

#### 449-3B ADDED 12/04

The old *Ramos* business rules that allowed only one month of eligibility have been replaced to allow ongoing eligibility until the county completes the redetermination of Medi-Cal (ACWDL 04-31, question and answer 12, October 22, 2004)