

Share of Cost Medi-Cal

Introduction

Contrary to common misperception, most of the 7 million Californians covered under Medi-Cal do not qualify for cash assistance (also known as “welfare”) through CalWORKs or SSI. Many qualify in other ways, such as through programs for working families with incomes below the poverty level, or programs targeting children, pregnant women, seniors, and people with disabilities. In addition to these programs, share of cost Medi-Cal provides benefits for individuals and families with incomes too high to qualify for cash assistance, but too low to cover their health care costs.

To receive share of cost Medi-Cal, beneficiaries must contribute to their health care expenses by paying a share of the cost of the services they receive each month. Once they meet the full share amount, they are “certified” and Medi-Cal will cover all other costs for that month.

Beneficiaries with share of cost Medi-Cal account for a disproportionate amount of program expenditures. While beneficiaries who met their share of cost obligations comprised just over 1 percent of all Medi-Cal beneficiaries in October 2007, they accounted for about 15 percent of total fee-for-service expenditures, or an estimated \$2.2 billion for fiscal year 2006–07.¹

As California lawmakers consider budget actions that may have an impact on Medi-Cal, understanding the share of cost option and the people it serves is essential. This issue brief provides an overview of share of cost Medi-Cal, including an analysis of Medi-Cal data and a

description of current policy issues which may affect the program.²

Overview of Share of Cost Medi-Cal

Under share of cost Medi-Cal, beneficiaries must incur a predetermined amount of health care expenses each month (their “share of cost”) before Medi-Cal begins to offer assistance for that month. When the share of cost has been met, Medi-Cal will pay for any additional covered expenses for the month. Share of cost requirements apply only during months in which Medi-Cal’s assistance with health care expenses is needed. Beneficiaries pay their share of cost directly to the providers of health care services, not to the state.

Share of cost requirements are not the same as cost-sharing or co-pay requirements. Cost-sharing requires a recipient to pay a set amount or percentage of each health care service received, while “share of cost” requires recipients to take full responsibility for health care expenses up to a predetermined amount.

Share of cost Medi-Cal is typically used by beneficiaries in one of three ways:

1. **Catastrophic coverage.** Medical expenses for a major health event such as an injury or accident.
2. **Long term care coverage.** Support for nursing home care or in-home supportive services.
3. **Coverage for costly chronic conditions.** Health care services for an illness that is costly and/or chronic enough to generate high monthly medical expenses.

Eligibility for Share of Cost

As of October 2007, the overwhelming majority (96 percent) of share of cost recipients were eligible through the medically needy program.³ California’s medically needy program is comprised of aged, blind, and disabled people, low-income families with incomes too high to qualify either for cash assistance (i.e., SSI or CalWORKs) or other income-based Medi-Cal programs, and who also meet other program requirements, such as SSI disability standards or “deprivation” requirements for children, parents, or caretakers.⁴ Although most beneficiaries eligible for the medically needy program have a share of cost obligation, some may qualify without one.⁵

The other 4 percent of share of cost recipients in October 2007 were eligible for Medi-Cal through other programs, including the medically indigent program. This program provides coverage to people who fail to meet one of the categorical requirements for the medically needy program, and includes adults and children.⁶ For example, adults in long term care may also qualify for the medically indigent program if they do not meet disability standard or immigration status requirements for the medically needy program. Beneficiaries are often placed in this program during the disability evaluation and determination process and then retroactively enrolled in another program. Beneficiaries eligible for the medically indigent program may or may not have a share of cost obligation depending on their income.⁷

Calculating Share of Cost

A beneficiary’s share of cost amount is equal to the difference between the individual’s net nonexempt income and the applicable state-determined “maintenance need level.”

Net nonexempt income

– Maintenance need level

Share of cost

Net income is based on “gross income” less allowable deductions for certain expenses and specific types of exempt income.⁸ Under federal law, certain payments are exempt and must not be counted when determining eligibility for Medicaid. Deductions may include payments for other forms of medical insurance and income for household members not applying for coverage.⁹

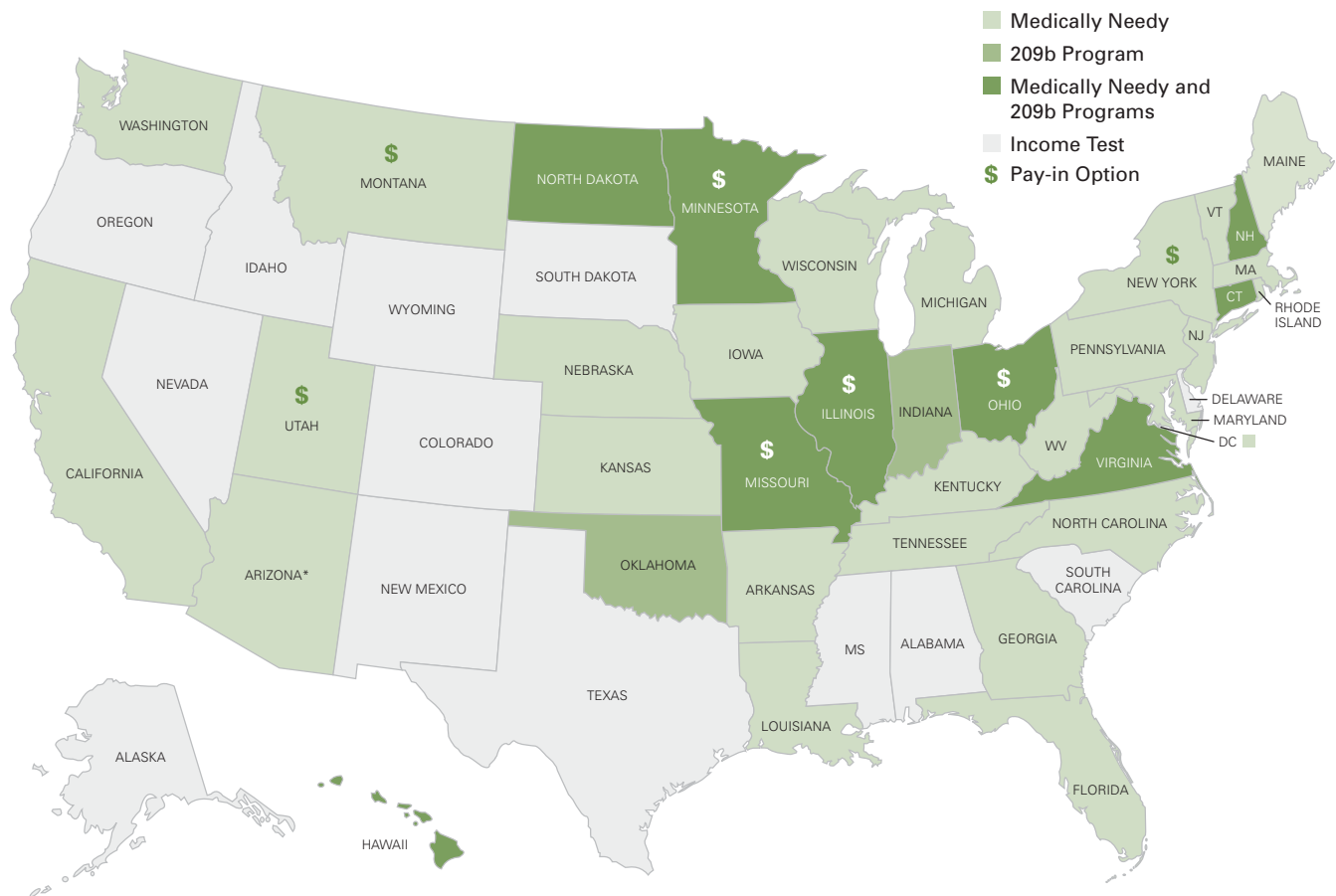
Determining “gross income” can be complicated and depends on the type of income, expenses, and family situation. It includes both earned and unearned income:

- **Earned income** is generally defined as income earned by the beneficiary, including gross income from employment.
- **Unearned income** includes income from sources such as Social Security retirement, survivors or disability benefits, pensions, interest from bank accounts, State Disability Insurance, temporary workers compensation, and unemployment insurance.

The maintenance need level is a fixed amount for living expenses, set by state and federal law, which increases based on family size (see Table 1 on page 4).¹⁰ The more a beneficiary’s net nonexempt income exceeds the maintenance need level, the higher the share of cost amount. There are limits on property and other assets, but there are no maximum income limits for share of cost Medi-Cal. As income increases, so does the share of cost obligation.

For residents of long term care facilities, the maintenance need level is called a “personal needs allowance.” The personal needs allowance is \$50 for residents who receive SSI/SSP and \$35 for those who do not qualify for SSI/SSP. All income above the personal needs allowance must be paid to the nursing facility as the resident’s share of cost.

Spend Down Programs, by State, 2009



*Arizona's program is comparable to a medically needy program.

As of December 2007, 33 states and the District of Columbia had medically needy programs.¹¹ These programs are optional under federal Medicaid law. In general, these are "spend-down" programs that allow individuals with high medical expenses and incomes too high to qualify for other Medicaid programs to deduct those medical expenses from their income. Medically needy income levels vary by state, as do the eligible spend-down periods. California is one of six states that have not updated their medically needy income level since 1989.¹²

Seven states offer a "pay-in" option as part of their medically needy spend-down programs which allows certain beneficiaries to qualify for Medicaid by paying the state an amount equal to the difference between their income and the state's income limit.

In 11 states, Medicaid eligibility rules for people with disabilities and the elderly can be more restrictive than the federal SSI program. In these "209(b) states," named for the enabling section of federal law, people with disabilities and the elderly must be given the opportunity to spend down to the state's income standard for mandatory eligibility, whether or not the state permits spend-down through a medically needy program. In 209(b) states that also have medically needy programs, individuals who meet the SSI financial requirements (such as by receiving SSI or a state supplement) must only spend down to the 209(b) income standard. Those who do not meet the SSI financial requirements must spend down to the state's maintenance need level. Seven states have medically needy and 209(b) programs and four states have only 209(b) programs.

States that are not 209(b) states and do not have medically needy programs are known as "income test states." In these states, a person who has income above the state's income standard is not eligible for Medicaid. Most of these states, however, have adopted the "300 percent rule" (also called the "special income level" option) which allows a state to set its income standard for nursing home coverage at up to 300 percent of the SSI benefit (\$2,022 per month for an individual in 2010). Federal law also requires these states to allow people with excess income to qualify for Medicaid by putting that income in a trust, known as a "Miller Trust." The trust must be set up to pay the long term care expenses for the Medicaid beneficiary, but must also allow the state to recover the funds after the beneficiary's death.

Source: Kaiser Family Foundation (www.statehealthfacts.org) and Connecticut Office of Legislative Research, Medicaid Spend Down (www.cga.ct.gov).

Table 1. Medi-Cal Monthly Maintenance Need Level

| NUMBER OF PEOPLE IN MEDI-CAL FAMILY BUDGET UNIT* | MONTHLY MAINTENANCE NEED LEVEL |
|---|--------------------------------------|
| 1 | \$600 |
| 2 (one adult, one child) | \$750 |
| 2 (adults) | \$934 |
| 3 | \$934 |
| 4 | \$1,100 |
| 5 | \$1,259 |
| 6 | \$1,417 |
| 7 | \$1,550 |
| 8 | \$1,692 |
| 9 | \$1,825 |
| 10 | \$1,959 |
| Each additional person | \$14 |

*Includes factors such as pregnant individuals in the household.

Source: California Department of Health Care Services, www.dhcs.ca.gov.

Meeting the Share of Cost Amount

Health care expenses incurred by a beneficiary (or dependent family members) with share of cost Medi-Cal will be counted towards meeting their share of cost amount, even if they are unpaid. Qualifying expenses include those otherwise covered under Medi-Cal; co-payments for services and drugs; and any medical equipment, supplies, and prescription and over-the-counter drugs not covered by Medi-Cal but prescribed as medically necessary by a physician. Unpaid medical bills can be used to meet share of cost amounts for future months.

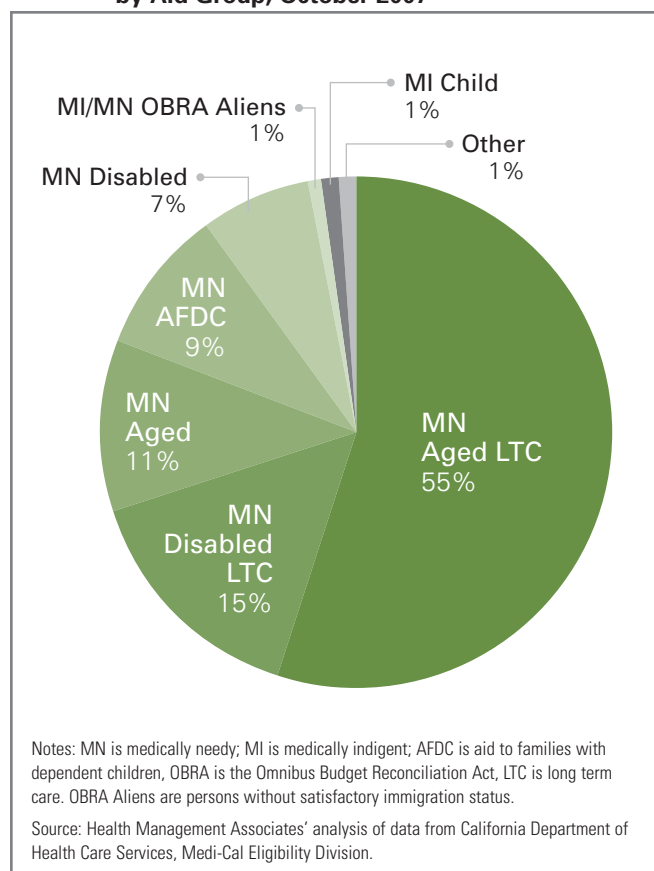
Beneficiaries are not eligible to receive Medi-Cal benefits until their monthly share of cost amount is met and recorded in the Medi-Cal Eligibility Data System (MEDS). Medi-Cal providers access MEDS to review eligibility and determine whether a beneficiary has a share of cost and enter incurred expenses until the share of cost is met each month. If a beneficiary receives services, medication, or medical supplies from a provider who is

not enrolled in the Medi-Cal program, the beneficiary must take a detailed receipt for the services received to a county eligibility worker. Beneficiaries can get retroactive coverage, given other criteria are met, for services received in any of the three months prior to their application if their share of cost is met for those months as well.

Share of Cost Beneficiaries

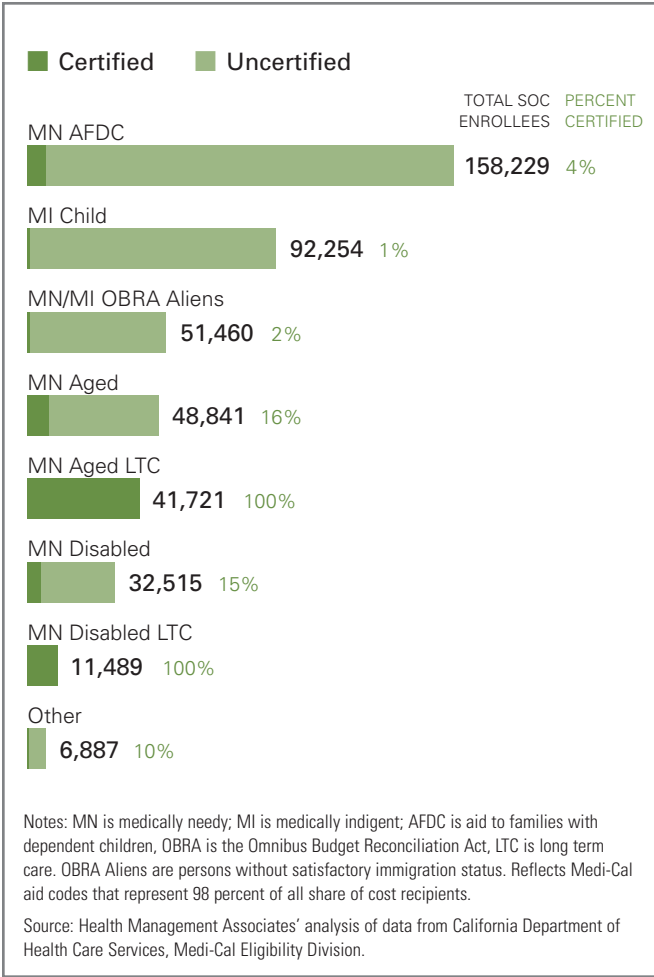
In October 2007, 75,594 Medi-Cal beneficiaries qualified for share of cost Medi-Cal and were receiving health care benefits. Of these, 70 percent were eligible through the medically needy program for the elderly and people with disabilities in nursing facilities or other long term care facilities (Figure 1). Other medically needy programs accounted for an additional 26 percent of share of cost recipients. Most certified recipients received benefits in the Medi-Cal fee-for-service delivery system rather than in a Medi-Cal managed care delivery system.

Figure 1. Certified Share of Cost Beneficiaries, by Aid Group, October 2007



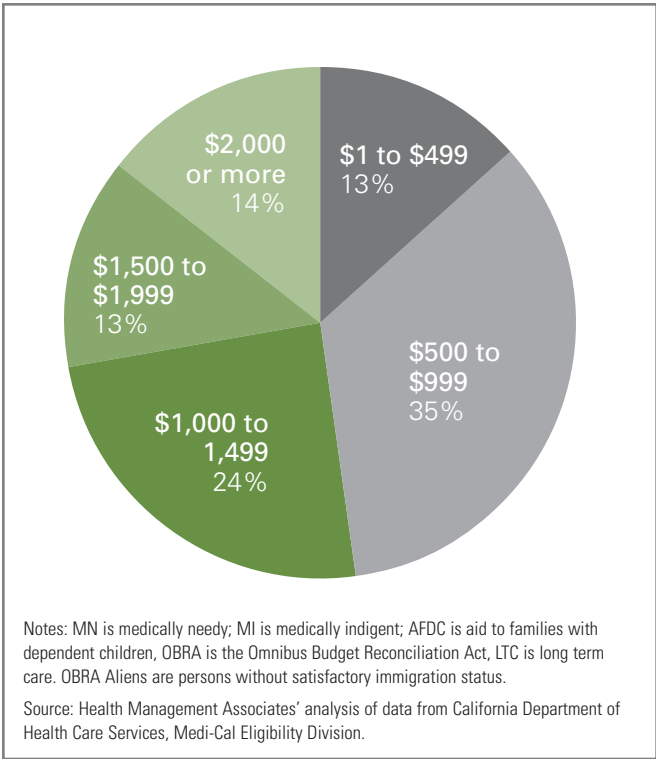
In addition to these certified recipients, there were many more beneficiaries enrolled in share of cost Medi-Cal who did not incur expenses equal to share of cost obligations in October 2007, and therefore did not receive benefits that month. Overall, only one in six beneficiaries enrolled in share of cost Medi-Cal actually met their share of cost obligation in October 2007 and therefore were certified as eligible to receive Medi-Cal benefits. The likelihood of meeting share of cost obligations varies by aid code (Figure 2). Due to the very high cost of nursing home care, nearly all beneficiaries requiring long term care incurred expenses sufficient to meet their monthly share of cost amount.

Figure 2. Share of Cost Beneficiaries, by Aid Group and Status, October 2007



A beneficiary's share of cost, the monthly amount of medical expenses they must incur before they are eligible to receive benefits, can range from less than \$50 to more than \$2,000 per month. In October 2007, more than half of share of cost Medi-Cal beneficiaries had a share amount of \$1,000 or more (Figure 3). Among this group, approximately one in ten met their share of cost. However, among those with a share of cost below \$1,000, almost one in four met their obligation.

Figure 3. Share of Cost Beneficiaries, by Share of Cost Amount, October 2007



Between October 2005 and October 2007, the number of share of cost Medi-Cal beneficiaries increased approximately 11 percent and those who met their monthly share of cost increased 5 percent.

Share of Cost Expenditures

In fiscal year (FY) 2006–07, the estimated weighted average per person expenditure for certified share of cost Medi-Cal beneficiaries was approximately \$34,000, nearly eight times the average expenditures for Medi-Cal beneficiaries overall.¹³

While certified share of cost beneficiaries comprised just over one percent of all Medi-Cal beneficiaries in October 2007, the total fee-for-service expenditures for this group is estimated at \$2.2 billion for FY 2006–07, or about 15 percent of fee-for-service expenditures overall.¹⁴ Limitations in Medi-Cal administrative data make it difficult to conduct detailed analysis of expenditures for this group.

Looking Ahead

As policymakers, program officials, and the public consider the future of health care programs and costs in California, there are several issues related to share of cost Medi-Cal that warrant attention.

Impact of State Budget Proposals

Governor Schwarzenegger issued several proposals in his state budget for FY 2010–11 that, if enacted, may increase participation in share of cost Medi-Cal. Two proposals—the elimination of the Adult Day Health Care benefit and a significant reduction in funding for the In-Home Supportive Services (IHSS) program—may increase demand for residential long term care as many served by these community-based programs would require care in a skilled nursing facility. Consequently, many of these beneficiaries might be expected to shift to Medi-Cal medically needy and medically indigent long term care programs with a share of cost, as they would spend down their income and assets to qualify for full Medi-Cal long term care coverage.

The number of individuals who qualify for and become certified for share of cost Medi-Cal is also likely to increase if the legislature adopts the governor's proposals

to cap Medi-Cal spending on medical supplies, medical equipment, and prescription drugs; eliminate coverage for over-the counter drugs; and implement new copayments for hospital visits. In addition, if copayments are increased for families with a child enrolled in Healthy Families, more parents may meet their own share of cost.

Impact of National Health Reform

Federal health care reform, enacted in March 2010, is likely to extend Medi-Cal coverage to more than 2 million Californians in 2014 and make subsidized coverage available to other low-income residents through new state insurance exchanges. Both of these coverage expansions can be expected to reduce demand on share of cost Medi-Cal for people seeking coverage for catastrophic or costly chronic conditions. The health care reform law, however, did not significantly change Medicaid eligibility standards for long term care services. Thus, nursing home residents and recipients of in-home supportive services, who make up the vast majority of people in California meeting their share of cost amount, are likely to continue to rely on share of cost Medi-Cal to help finance these vital services.

Misaligned Medicare and Medi-Cal Income Eligibility

In 2008, the state stopped paying the Medicare Part B premium for many dual-eligible beneficiaries enrolled in Medicare and share of cost Medi-Cal. The policy change affected about 57,000 seniors and persons with disabilities who pay a monthly share of cost of at least \$501.¹⁵ For some beneficiaries, this has resulted in their nonexempt income to swing under and over the income limit for share of cost Medi-Cal. For example, when a beneficiary with a \$510 share of cost amount pays his or her own Part B premium, the amount of the premium (like any other health insurance premium) is deducted from the beneficiary's nonexempt income, which reduces the share of cost amount below \$500 and restores eligibility for the Medicare Part B premium reimbursement.

Outdated Maintenance Need Level

Current federal law does not permit states to set the maintenance need level above 133 ⅓ percent of eligibility levels for the former Aid to Families with Dependent Children (AFDC) program, which have remained unchanged since federal welfare reform was enacted in 1996.¹⁶ States may adjust their maintenance need levels annually for inflation; however, California has not applied a cost of living adjustment since 1989. Consequently, a sizeable and growing gap has emerged between the maintenance need level and the federal poverty level, which is adjusted annually for inflation. If California's maintenance need level were also adjusted annually for inflation, it would be 73 percent higher in 2010. States also have the option to adopt more generous income exemptions with approval of a state plan amendment, which would effectively serve to increase the maintenance need level.

Due to the significant differences in the Medi-Cal income eligibility thresholds and the state's maintenance need level, beneficiaries no longer eligible for traditional Medi-Cal due to an increase in monthly income may face significant share of cost amounts, often much more than the income rise. This phenomenon, known as the “share of cost cliff,” primarily affects low-income seniors and people with disabilities. It can cause major service disruptions and interruptions in coverage for beneficiaries who cannot meet their share of cost amount.

For example, in 2010, an aged or disabled individual with a net nonexempt income of \$1,133 per month does not have a share of cost if she is enrolled in the Aged and Disabled Federal Poverty Level program. However, if this individual has an income increase of only one dollar per month, she will no longer qualify for the Aged and Disabled Federal Poverty Level program and must pay \$534 each month as her share of cost amount based on eligibility at the medically needy income levels. This share of cost amount would represent 47 percent of her monthly income.¹⁷

Program Complexity

Calculating and tracking share of cost amounts can be complicated and confusing for beneficiaries. An accurate share of cost calculation requires both the beneficiary and county eligibility worker to account for the beneficiary's income and exemptions. Beneficiaries may not understand which expenses qualify to meet their share of cost or know when their share of cost has been met. Eligibility workers play a critical role in educating beneficiaries about share of cost Medi-Cal.

Another essential role is played by providers, who bear a large administrative responsibility to track, enter, and adjust payments for share of cost beneficiaries. Providers often must review and revise payments if an individual's share of cost amount changes or if services are deemed retroactively covered. Some states provide a pay-in option to reduce administrative complexity and prevent confusion on the part of beneficiaries and providers, by allowing beneficiaries to pay their share of cost in advance to the state Medicaid program rather than track, record, and report medical costs as they are incurred.

Conclusion

Share of cost Medi-Cal provides an essential pathway to health care coverage for thousands of California residents with significant medical or long term care expenses, but with incomes too high to qualify for traditional Medi-Cal. The recent economic downturn has increased reliance on this and other Medi-Cal coverage options for persons losing their private sector coverage, and current state budget proposals may further increase demand for share of cost Medi-Cal in the near term.

With the passage of national health care reform, new coverage options are on the horizon for millions of low-income Californians through the expansion of Medicaid and the availability of subsidized insurance plans issued through state insurance exchanges. These actions should reduce demand for share of cost Medi-Cal beginning in 2014, particularly among Californians with

low and modest incomes who see a decrease in their out-of-pocket medical expenses. However, share of cost Medi-Cal will continue to be an important source of coverage for many seniors and people with disabilities receiving long term care in nursing homes and in their communities.

ABOUT THE AUTHORS

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ACKNOWLEDGEMENTS

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ABOUT THE FOUNDATION

The California HealthCare Foundation works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at www.chcf.org.

Appendix A: How the Maintenance Need Level Works¹⁸

When determining eligibility for Medi-Cal with share of cost, the maintenance need level is deducted from the net nonexempt income. The share of cost amount is equal to the net nonexempt income minus the maintenance need level.¹⁹

EXAMPLE 1: Bob and Mary are applying for Medi-Cal. They are married with no children. Both are over 65 years old and neither has a job. Their only income is Bob’s Title II Social Security benefit of \$1,537 per month and they pay \$193 for a Medicare Supplemental Insurance Policy. Their net nonexempt monthly income is below the \$1,525 eligibility threshold for a couple under the Aged and Disabled Federal Poverty Level program. Consequently, Bob and Mary are eligible for Medi-Cal with no share of cost.

| | | |
|---|----------------|--|
| | \$1,537 | Monthly income |
| – | <u>20</u> | Allowable deduction from unearned income |
| | \$1,517 | |
| – | <u>193</u> | Medicare Part B premiums |
| | \$1,324 | Net nonexempt income |
| – | <u>\$1,525</u> | <i>Income limit for couple under the Aged and Disabled Federal Poverty Level program</i> |
| | \$0 | No share of cost |

However, if Bob’s Social Security benefit were higher, e.g. \$1,739 per month, then the couple’s net nonexempt income would be \$1,526, exceeding the income limits for couples under the Aged and Disabled Federal Poverty Level program. Consequently, their share of cost would \$592, the difference between their net nonexempt income and the maintenance need level for couples.

| | | |
|---|------------|--|
| | \$1,739 | Increased monthly income |
| – | <u>20</u> | Allowable deduction from unearned income |
| | \$1,719 | |
| – | <u>193</u> | Medicare Part B premiums |
| | \$1,526 | Net nonexempt income |
| – | <u>934</u> | <i>Maintenance need level for two adults</i> |
| | \$592 | Share of cost |

EXAMPLE 2: Tom is single, elderly, and employed.²⁰ He receives \$1,000 Social Security (unearned income) every month, before Medicare premiums are taken out. He also earns \$800 a month from work. Tom is not eligible for the Aged and Disabled Federal Poverty Level program, as his nonexempt monthly income is \$214.50 over the allowable amount of \$1,133. As a result, he will be eligible for Medi-Cal with a share of cost of just over \$747.

| | | |
|---|-----------------|--|
| | \$800.00 | Earned income |
| – | <u>65.00</u> | Allowable deduction from earned income |
| | \$735.00 | |
| × | <u>0.50</u> | Allowable deduction from earned income |
| | \$367.50 | Nonexempt earned income |
| + | \$1,000.00 | Unearned income |
| – | <u>20.00</u> | Allowable deduction from unearned income |
| | \$1,347.50 | Net nonexempt income |
| – | <u>\$600.00</u> | <i>Maintenance need level for individual</i> |
| | \$747.50 | Share of cost |

These forms are intended to provide an understanding of calculating share of cost; however, they appear here as samples only and should not be used for determination of eligibility.

Share of Cost Medi-Cal | 11

SHARE OF COST DETERMINATION – MFBUs WITH LTC PERSON INCLUDED - LTC

| | | | | | | | | | |
|--|-----|--------------------|---------------------|--------------|--|---|--|---|--|
| Case Name | | | | | | County District | | County Use | |
| <input type="checkbox"/> New Application <input type="checkbox"/> Redetermination <input type="checkbox"/> Change <input type="checkbox"/> Retroactive Eligibility <input type="checkbox"/> Correction | | | | | | Effective Eligibility Date for this Budget Mo. _____ Yr. _____ | | | |
| State Number | | | | | Birthdate | | (1) Social Security No. and (2) Health Ins Claim No. or Railroad Retirement No | | Other Coverage |
| Co. | Aid | 7 Digit Serial No. | MFBU | Pers. No. | Name – First, Middle, Last | Mo. | Day | Yr. | Sex |
| | | | | | | | | | (1) _____ (2) _____ |
| | | | | | | | | | (1) _____ (2) _____ |
| | | | | | | | | | (1) _____ (2) _____ |
| | | | | | | | | | (1) _____ (2) _____ |
| | | | | | | | | | (1) _____ (2) _____ |
| | | | | | | | | | (1) _____ (2) _____ |
| | | | | | | | | | (1) _____ (2) _____ |
| I. Income of MFBU members applying as aged, blind, or disabled plus income of spouse or parent (except PA or other PA) | | | | | II. Income of MFBU members not listed in I. (except PA or other PA) | | | | |
| A. NONEXEMPT UNEARNED INCOME | | | | | A. NONEXEMPT UNEARNED INCOME | | | | |
| | | a. ABD-MN | b. Spouse or Parent | | 1. Social Security | | 2. Countable Income from I. 18 | | |
| 1. Social Security | | | | | 2. Net Income From Property | | 3. Total countable eligibility income (add 1 and 2) | | |
| 2. Net Income From Property | | | | | 3. Other - Itemize | | DEDUCTIONS ADDED BACK FOR LTC SOC | | |
| 3. Other - Itemize | | | | | 4. | | 4. ABD income deductions (e.g. any income deduction) | | +\$20 |
| 4. | | | | | 5. Total unearned income (add 1 thru 4) | | 5. Other income deductions | | |
| 5. Total (add 1 thru 4) | | | | | 6. Deductions | | 6. Total deductions added back (add 4 and 5) | | |
| 6. Deductions | | | | | 7. Countable unearned inc. (5 minus 6) | | 7. Total countable income (add 3 and 6) | | |
| 7. Remainder (5 minus 6) | | a. | b. | | 8. Deductions | | ALLOCATIONS AND DEDUCTIONS | | |
| 8. Combined unearned income (add 7a and 7b) | | | | | 9. Net earned income (MC 176W, Part IV, Line 11) | | 8. Allocation from LTC/B&C Income (176W, Part III) | | |
| 9. Any income deduction | | - \$20 | | | | 9. Subtotal countable Income (add 7 and 8) | | 9. Allocation to excluded children (176W, Part I) | |
| 10. Countable unearned income (8 minus 9) | | | | | | 10. Child Support/ Alimony Paid. | | 10. Income to determine PA Eligibility | |
| B. NONEXEMPT EARNED INCOME | | | | | B. NONEXEMPT EARNED INCOME | | | | |
| 11. Gross Earned Income | | a. | b. | | 11. Total countable income (9 minus 10) | | 11. Health Insurance | | |
| 12. Deductions | | | | | 14. Combined earned inc. (add 13a and 13b) | | 12. Total allocations/deduction (add 8 through 11) | | |
| 13. Remainder (11 minus 12) | | a. | b. | | 15. \$65 earned inc deduction plus \$ unused \$20 | | 13. Total net nonexempt income (7 minus 12) | | |
| 14. Combined earned inc. (add 13a and 13b) | | | | | 16. Remainder (14 minus 15) | | 14. Total net nonexempt income rounded | | |
| 15. \$65 earned inc deduction plus \$ unused \$20 | | | | | 17. Countable earned inc. (divide 16 by 2) | | 15. Maintenance Need | | |
| 16. Remainder (14 minus 15) | | | | | 18. Total countable inc. (add 10 and 17) | | a. MFBU members not in LTC No. | | |
| 17. Countable earned inc. (divide 16 by 2) | | | | | | | b. MFBU members in LTC | | |
| 18. Total countable inc. (add 10 and 17) | | | | | | | • Personal Needs | | |
| IV. EXEMPT INCOME | | | | | c. Total maintenance need (15a + 15b) | | | | |
| | | | | | 16. Share of cost (14 minus 15) | | | | |
| | | | | | 17. Underpayment adjustment | | | | |
| Eligibility Worker Signature/Computation Date | | | | | Worker Number | | County Use | | 18. Adjusted Share of Cost (17 minus 18) |
| | | | | | | | | | |

MC 176 M-LTC (11/07)

ENDNOTES

1. Expenditures are estimated based on the proportion of share of cost beneficiaries who meet their share of cost relative to the total number of beneficiaries in the given aid code, and the proportion of beneficiaries enrolled in fee-for-service versus managed care.
2. Share of cost historical data file for October 2007 provided by the California Department of HealthCare Services.
3. The majority of Medi-Cal aid codes separate beneficiaries with and without a share of cost. A small number of Medi-Cal aid codes include both types of beneficiaries with and without a share of cost (13, 63, and 58). Beneficiaries in these codes were treated as having share of cost in data analysis for this brief.
4. Deprivation requires at least one parent to be absent from the home, deceased, incapacitated, or disabled.
5. For example, a child who is not eligible for Medi-Cal through the Children's Federal Poverty Level or 1931(b) programs because she is 19 years old may be eligible through the Medically Needy program without a share of cost, where a person is not considered an adult until age 21.
6. The Medi-Cal Medically Indigent program is distinct from the county Medically Indigent Adult programs for individuals ineligible for Medi-Cal.
7. Of the remaining beneficiaries, 12 percent are in aid codes designated as medically needy/medically indigent.
8. Exemptions include public assistance, student loans, housing assistance, foster care, and Earned Income Tax Credits.
9. Health Consumer Alliance, *ABD-Medically Needy Medi-Cal for Persons who are Aged, Blind, or have Disabilities*, October 2007 (www.healthconsumer.org) accessed October 31, 2009.
10. Social Security Act, Section 1903(f)(1), California Welfare and Institutions Code 14005.12
11. Kaiser Commission on Medicaid and the Uninsured, *Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities*, February 2010 (www.kff.org).
12. Crowley, Jeff. "Medicaid Medically Needy Programs: An Important Source of Coverage." Kaiser Commission on Medicaid and the Uninsured, January 2003.
13. Average expenditures for all Medi-Cal beneficiaries is based on all beneficiaries regardless of whether they have any Medi-Cal expenditures. Share of cost beneficiaries who meet their share of cost and are certified are more likely to have Medi-Cal expenditures.
14. Expenditures are estimated based on the proportion of share of cost beneficiaries who meet their share of cost relative to the total number of beneficiaries in the given aid code, and the proportion of beneficiaries enrolled in fee-for-service versus managed care.
15. California Department of Health Care Services, Medicare Part B Premium Changes, April 2009 (files.medi-cal.ca.gov) accessed March 10, 2010.
16. Social Security Act, Section 1903(f)(1)
17. Bill Analysis AB 55, (Dymally), as introduced December 4, 2006.
18. Examples are adapted and updated from California Advocates for Nursing Home Reform (CANHR) Aged and Disabled Federal Poverty Level Program (www.canhr.org) accessed May 1, 2009.
19. The term "maintenance need allowance" is often used by eligibility workers in place of "maintenance need level" to denote a family's maintenance need level.
20. Beneficiaries could qualify for no-cost Medi-Cal under the Aged and Disabled Federal Poverty Level program as long as their net nonexempt income does not exceed the maximum income per individual or couple. In addition, the 250 Percent Working Disabled Program is designed to allow the working disabled to exempt disability-based income, such as Title II disability insurance benefits, state disability insurance benefits, and even worker's compensation benefits. The disabled individual may have net nonexempt income up to 250 percent of the federal poverty level.
21. For income from wages, state Medi-Cal eligibility rules allow the beneficiary to deduct the first \$65 of gross earnings, and to count only 50 percent of remaining amount toward nonexempt income.