

Overview of Medi-Cal for Long Term Care

A. Medi-Cal vs. Medicare

1. Medicare

Medicare is a federal insurance program paid out of Social Security deductions. All persons over 65 or older who have made Social Security contributions are entitled to the benefits, as well as persons under 65 with disabilities who have been eligible for Social Security disability benefits for at least two years, and persons of any age with end-stage renal disease.

Medicare has several parts including Hospital Insurance (Part A) and Medical Insurance (Part B). Those persons eligible for Social Security or Railroad Retirement benefits as workers, dependents or survivors, are eligible for Part A, Hospital Insurance, when they turn 65. If a person has not worked long enough to be covered for benefits, s/he may enroll in Part A and pay a monthly premium. If Medicare Hospital Insurance is purchased, that person must also enroll in Part B, Medical Insurance.

Participants in the Medicare program are liable for co-payments and deductibles as well as for monthly payments for Part B coverage. Medicare is not based on financial need. Anyone who meets the age, disability and/or coverage requirements is eligible.

Medicare does not pay for all medical expenses, and usually must be supplemented with private insurance (“medigap”) or consumers can enroll in an HMO plan that contracts with Medicare. After 3 days of prior hospitalization, Medicare will pay up to 100% for the first 20 days of skilled nursing care. For the 21-100 days, the patient will pay a co-payment. The premiums and copayments are increased every year. There will be no Medicare coverage for nursing home care beyond 100 days in any single benefit period.

It should be noted that Medicare only pays for “skilled nursing care,” does not pay for “custodial care” and the average stay in a nursing home under Medicare is usually less than 24 days. Thus, few can look to Medicare to pay for any substantial nursing home costs.

2. Medi-Cal

Medi-Cal is a combined federal and California State program designed to help pay for medical care for public assistance recipients and other low-income persons. Although Medi-Cal recipients may receive Medicare, the Medi-Cal program is not related to the Medicare program. Medi-Cal is a need-based program and is funded jointly with state and federal Medicaid funds.

B. Medi-Cal Eligibility

SSI and other categorically-related recipients are automatically eligible. Others, whose income would make them ineligible for public benefits, may also qualify as “medically needy” if their income and resources are within the Medi-Cal limits (current resource limit is \$2,000 for a single individual). This includes:

- Low-income persons who are 65 or over, blind or disabled may qualify for the Aged and Disabled Federal Poverty Level Program
- Low-income persons with dependent children
- Children under 21
- Pregnant women
- Medically indigent adults in skilled nursing or intermediate care or those who qualify for Medi-Cal funded home and community based waiver programs.

C. Share of Cost

The State sets a “maintenance need standard”. Since January 1, 1990 the maintenance need standard for a single elderly/disabled person in the community has been \$600 monthly; the Long Term Care maintenance need level (i.e., personal needs allowance when someone is in a nursing home) remains at \$35 monthly for each person.

Individuals whose net monthly income is higher than the state payment rate may qualify for the program if they pay or agree to pay a portion of their income on monthly medical costs. This is called the share of cost. Individuals eligible with a share of cost must pay or take responsibility for a portion of their medical bills each month before they receive coverage. Medi-Cal then pays the remainder, provided the Medi-Cal program covers the services. This works much like an insurance deductible. The amount of the share of cost is equal to the difference between the “maintenance need standard” and the individual’s net non-exempt monthly income.

Important: All Medi-Cal beneficiaries who have a Medi-Cal share-of-cost of more than \$500 will no longer have their Medicare Part B premium covered by Medi-Cal, it will automatically be deducted from the beneficiary’s Social Security check. This does not apply to Medi-Cal eligible nursing home residents, as their Part B premium will continue to be covered by Medi-Cal.

Example #1 Community Based Medi-Cal

Seth is an aged (65) person who lives alone at home and receives \$1,300/ month in pension and Social Security benefits. His resources meet the standard set by the state, i.e., \$2,000 or less in liquid assets, but his income is too high.

\$ 1,300	gross unearned income
<u>-20</u>	any income deduction
1,280	net non-exempt income
<u>-600</u>	Maintenance Need Level for 1 single person
\$ 680	Seth’s share of cost

Note: If Seth’s net non exempt income were \$1,235 or less, he would be eligible for Medi-Cal at no share of cost under the Aged and Disabled Program (visit: http://canhr.org/factsheets/medi-cal_fs/PDFs/FS_Community-Based-Medi-Cal-Programs.pdf).

Example #2: Medi-Cal In a Nursing Home

Seth enters a skilled nursing facility. His income is still \$1,300/month.

\$ 1,300	Gross unearned income
<u>-35</u>	Maintenance Need for Long Term Care person
\$ 1,265	Seth’s share of cost to be paid each month to the nursing home or for medical costs not covered by Medi-Cal.

* The remaining \$35 is Seth’s Personal Needs Allowance.

Other Deductions from the Share of Cost:

In addition to the “any income deduction” and the monthly maintenance needs allowance, any monthly medical premiums can also be deducted before the share of cost is determined such as the your Medicare Part B premium. Other deductions can also be made, depending on the circumstances.

For example, under a legal settlement, *Hunt v. Kizer*, recipients may use old, unpaid medical bills for which the beneficiary is still legally responsible to reduce the monthly Medi-Cal share of cost. Some original documentation showing the billing statement is an outstanding balance should be provided to the County eligibility worker. The Share of Cost will be adjusted to reflect the cost of the outstanding balance, which could, for example, mean no share of cost until the old, unpaid bills are paid off. This is not automatic and should be discussed with the eligibility worker upon application for Medi-Cal.

Under the Johnson v. Rank settlement, recipients may use their share of cost to pay for medically necessary supplies, equipment or services not covered under the Medi-Cal program. A current physician's prescription is necessary and must be put in the recipient's record at the facility. This prescription must be a part of the physician's plan of care. After a copy of the prescription and the bill is presented to the facility, the facility will deduct the cost from that month's share of cost and bill the resident for the remaining share of cost.

D. What Does Medi-Cal Cover?

Medi-Cal pays for health care services which meet the definition of "medically necessary." Services include: some prescriptions (although the Medicare Part D program now covers most prescriptions), physician visits, adult day health service, some dental care, ambulance services, some home health, X-ray and laboratory costs, orthopedic devices, eyeglasses, hearing aids, some medical equipment, etc.

All covered services, or the remaining costs over the share of cost of nursing home care, will be covered if the individual meets income/resource requirements. Some services such as home health care, durable medical equipment, and some drugs require prior authorization.

Nursing home care is covered if there is prior authorization from the physician/health care provider. Residents are admitted on a doctor's order and their stay must be "medically necessary". Residents are allowed to keep \$35 of their income as a personal needs allowance. Residents with no income may apply for the Supplemental Security Income/State Supplemental Program (SSI/ SSP), and, if eligible, they will receive a payment of \$50 as a personal needs allowance.

If the individual qualifies for Medi-Cal, s/he does not need private "medigap" or HMO insurance to pay for costs, though if such insurance is carried, the premiums are deducted from income when computing the share of cost, and therefore costs the beneficiary nothing. **If the HMO coverage includes drug benefits, maintaining the HMO coverage may become more important, as the beneficiary will continue to receive drug benefits from the HMO, which may be more comprehensive than the Medicare Part D coverage.**

E. Resource Limitations (Property/Assets)

To qualify for Medi-Cal the recipient must demonstrate that s/he has limited resources available. Since January 1, 1989, the property limit for one person has been set at \$2,000.

Medi-Cal classifies property as "exempt" and "non-exempt." Exempt property is not counted in determining eligibility; non-exempt property is counted. If the applicant has more than \$2,000 in non-exempt property, he/she will not be eligible, unless the property is spent down for adequate consideration before the end of the application month.

The following property is generally exempt and, therefore, not counted in determining eligibility:

- **The Home:** totally excluded, if it is the principal residence. Includes mobile home, houseboat, or an entire multi-unit dwelling as long as any portion serves as the principal residence of the applicant, and buildings surrounding, contiguous to, or appertaining to the residence. The property remains exempt if a person in a nursing home or the person's representative expresses an intent to return home on the Medi-Cal Application and Statement of Facts, or if an "exempt" individual resides in the home, such as a spouse, a minor, blind or disabled child (of any age) or a sibling or son or daughter who has lived in the home continuously for at least one year before the applicant entered a nursing home. Note that when the home is exempt, it can be transferred without penalty and without affecting the Medi-Cal eligibility.
- **Other Real Property:** can be exempt if the net market value of the property (assessed value or fair market value, whichever is less – minus any encumbrances such as mortgages, loans, etc.) is \$6,000 or less and the beneficiary is "utilizing" the property, i.e., receiving yearly income of at least 6% of the net market value. Property used as a business can also be exempt if it meets the standards under the program, i.e., it is actually used as a business, reported to the IRS as such, etc. – see below for details on other real property and business property.

- **Household Goods and Personal Effects:** totally exempt.
- **Jewelry:** for a single person, wedding, engagement rings and heirlooms are totally exempt and other items of jewelry with a total net market value of \$100 or less are exempt; for spouses, when one spouse is in a nursing home, there is no limit on exempt jewelry for determining institutionalized spouse's eligibility.
- **Cars/motor Vehicles:** one vehicle used for transportation is totally exempt.
- **Whole Life Insurance:** policies with a total face value of \$1,500 or less. If the total face value of the policy or policies exceeds \$1,500, then the cash surrender value of the policies is counted toward the \$2,000 cash reserve. If the cash surrender value exceeds the \$2,000 cash reserve, the applicant will not be eligible unless, he/she reduces the value of the policy.
- Term Life Insurance: totally excluded.
- **Burial Plots:** totally excluded.
- **Prepaid irrevocable burial plan of any amount and \$1,500 in designated burial funds:** There is no limit on the amount of the irrevocable burial fund, but the \$1,500 in designated funds must be kept separate from all other accounts and designated as a burial account. Accumulated interest on burial funds is also exempt.
- IRAs and work-related pensions:
 - In applicant's/beneficiary's name: The balance of the IRA or the pension is considered unavailable if applicant/beneficiary is receiving periodic payments of interest and principal.
 - In spouse's name: The balance of the IRA or Pension fund is totally exempt from consideration and is not included in the community spouse resource allowance (CSRA).
- Non work-related annuities:
 - Annuities purchased prior to 8/11/93: Balance is considered unavailable if applicant/ beneficiary is receiving periodic payments (of any amount) of interest and principal.
 - Annuities purchased between 8/11/93 and 3/1/96: Annuities purchased between 8/11/93 (the date the federal law changed) and 3/1/96 (the date California law changed) that cannot be restructured to meet the new requirements will continue to be treated under the old rules (see above). Written verification from the company or agent who issued or sold the annuity must be obtained stating that the annuity cannot be restructured.
 - Annuities purchased on or after 3/1/96 by the applicant or the applicant's spouse: the individual and/or spouse must take steps to receive periodic payments of interest and principal; payments must be scheduled to exhaust the balance of the annuity at or before the end of the annuitant's life expectancy. Annuities structured to exceed the life expectancy will result in denial or termination of benefits due to transfer of non-exempt assets.
 - Note: Annuities purchased by the applicant/beneficiary on or after 9/1/04 will be subject to Medi-Cal recovery when the beneficiary dies.
 - **Cash reserve:** Applicant/beneficiary may retain up to \$2,000 in liquid assets, e.g., savings, checking, excess cash surrender value of life insurance.
- **Community Spouse Resource Allowance (CSRA):** Community (at home) spouse may retain up to \$120,900 in liquid assets, not including the home and other exempt assets, such as IRAs and retirement funds.
- Any assets above the property reserve limit of \$2,000 or \$120,900 in the case of a community spouse, or any asset that is not exempt will be counted by Medi-Cal in determining eligibility.

F. The Home

The home of a Medi-Cal beneficiary continues to be exempt from consideration as a resource under a wide variety of circumstances. These are spelled out in detail in W&I Code §14006(b). Under these provisions, a home will continue to be considered an exempt principal residence if:

1. During any absence, including nursing home stays, the individual intends to return to the home and states so in writing. If the beneficiary is incapacitated, a family member or someone acting on his/her behalf may so state this intent.
2. The individual's spouse, child under the age of 21, or dependent relative continues to reside in the home.
3. The residence is inhabited by the recipient's sibling, who has an equity interest in the home, or by a son or daughter who has resided there continuously for at least one year prior to the date the recipient entered the nursing home.
4. There are legal obstacles preventing the sale and the applicant/beneficiary provides evidence of attempts to overcome such obstacles.
5. The home is a multiple dwelling unit, one unit of which is occupied by the applicant.

Just because the home is exempt for eligibility purposes, does not mean that the home is immune from an estate claim after the beneficiary dies. (See CANHR's consumer booklet on Medi-Cal Recovery, http://www.canhr.org/publications/PDFs/Medi-Cal_Recovery.pdf, for more information on the Medi-Cal Recovery Program).

Intent to Return

The principal residence is exempt based upon a person's subjective intent to return, even though he/she may never have the ability to return to that residence. If the applicant is unable to complete the application, his/her representative may indicate that intent. The eligibility worker may not restrict, in any way, the individual or his/her representative in the process of indicating that intent. As long as the applicant or beneficiary declares an intention to return home on the Medi-Cal application (by checking the "yes" box), the house will be treated as a principal residence, exempt from being counted as a resource by Medi-Cal. The Medi-Cal application and/or supplemental forms may use the language "hope" or "expect" to return home, rather than "intend."

Unless the applicant is requesting an income deduction to maintain the home for the return within six months pursuant to Title 22, Section 50605, the county may not require any verification of the individual's ability to actually return home. If the applicant or his/her representative incorrectly states that there is no intent to return and later makes a correction, the county must accept that correction (See ACWDL Nos. 95-48 and 00-11).

Intent to return home will also keep the home exempt if the community spouse dies first, but only for the life of the institutionalized spouse. Applicants/beneficiaries may want to transfer the home entirely to the community spouse in order to avoid an estate claim after the surviving spouse dies. In addition, if the community spouse dies first, the home will likely end up in the probate estate of the institutionalized spouse and be swallowed up in estate recovery claims.

G. Other Real Property/Business Property

Real property other than the principal residence can be exempt if the net market value of the property (minus encumbrances) is \$6,000 or less and if the beneficiary is "utilizing" the property, i.e., receiving yearly income of at least 6% of the net market value. The net market value is the assessed value (which is often lower) or the appraised value, minus encumbrances, whichever is less.

Utilization Requirements

Other real property must meet utilization requirements in order to be exempt. This means that the property must generate at least 6% a year of the net market value. If the property does not generate income, then the full net market value of the property will be counted (22 CCR § 50416(b)(j)).

Good Cause

If the applicant has made bona fide efforts to meet the utilization requirements but is unable to do so, the utilization period can be extended indefinitely and the applicant can be eligible. For example, if the applicant has made bona fide efforts to sell the property, but is unable to do so, the property won't be included in the countable resources. Note that the regulations include specific criteria for what constitutes "good cause" and "bona fide" efforts to sell (§§50416, 50417).

Market Value

The market value of property is very important, since it is used to determine the net market value. The market value of real property in California is one of the following, whichever is less: (22 CCR §50412)

- the assessed value determined under the most recent property tax assessment or
- the appraised value by a qualified real estate appraiser The market value of real property outside of California is one of the following, whichever is less:
- the value established by the assessment method used where the property is located or
- the appraised value by qualified real estate appraiser.

Business Property

Property used in whole or in part as a business or as a means of self-support is exempt. Rental real property, however, will not be exempt unless the property is clearly held as a business. If the applicant can demonstrate with tax returns or other evidence that the property is clearly a “business,” not just investment property, it can be exempt (22 CCR §50485(d), ACWDL 91-28).

Income from Real Property

If a Medi-Cal beneficiary is renting real property, including the principal residence, the “net” income from the property is used in determining what will be counted toward the share of cost. Certain expenses are deducted from the gross rental income to determine the net income. These include taxes and assessments, interest payments (not principal), insurance, utilities and upkeep and repairs.

Upkeep and repairs are the greater of either: the actual amount expended for upkeep and repairs during the month or 15% of the gross monthly rental, plus \$4.17 per month. (22 CCR §50508). Note that other calculations are used for income from rental of rooms, rental of unit(s) in a multiple dwelling unit or other dwellings on the property (22 CCR §50508).

Maintaining the Home for Return of LTC Resident

In addition to the \$35 for personal and incidental needs, a person in long term care can retain an amount of income for upkeep of a home if all of the following conditions are met:

1. The spouse or family of the LTC resident is not living in the home.
2. The home, whether rented or owned by the LTC patient, is actually being maintained for the return of the LTC resident.
3. There is a verified medical statement that the person will return home within six months.

The amount allowed for upkeep of the home depends on the living circumstances of the LTC resident (See 22 CCR §50605(c)).

H. Spending Down/Gifting Assets

Resources must be reduced to the property limit of \$2,000 for at least one day during the month in which a person is establishing eligibility. Giving away non-exempt resources may render a person ineligible for a period of time running from the date of the transfer.

Penalties for transferring or gifting away non-exempt assets only apply if a Medi-Cal beneficiary or applicant enters a nursing home. If an applicant lives at home and gifts away property, there are no transfer penalties. The transfer rules are triggered when a person enters a nursing home and applies for Medi-Cal. The Medi-Cal application will ask if the applicant transferred any assets within the 30 months prior to the date of the application. The transfer rules apply only to non-exempt (countable) assets.

A transfer of non-exempt assets can result in a period of ineligibility which is the lesser of 30 months or the value of the transferred assets divided by the average private pay rate (APPR) at the time of application. The current APPR is \$8,189. (Subject to change April 2017)

Example:

Mr. D transfers \$15,000 to his son in January 2016, and applies for Medi-Cal in February of 2016. Because Mr. D is in a nursing home, a transfer period will be triggered. The amount transferred (\$15,000) is divided by the 2016 APPR (\$8,189), and Mr. D will be subject to a period of ineligibility of 1.9 months. Since California does not count partial months, he will be ineligible for one month, running from the month of transfer (January 2016). Thus, Mr. D will not be eligible for January of 2016, but he will be eligible as of February 1, 2016.

Example:

If Mr. D transfers \$8,500 to his son and \$8,500 to his daughter in January 2016, each transfer is calculated separately. Each amount transferred (\$8,500) is divided by the APPR of \$8,189, and Mr. D will be ineligible for January 2016 only.

Note: Assets in any amount can be transferred at any time to a blind or disabled child of any age. The child's disability must meet the requirements under the Social Security Act, i.e., the child must meet the disability requirements for SSA or SSI disability benefits. Transfers of a home or any asset to a blind or disabled child will not affect the Medi-Cal beneficiary or applicant's eligibility. However, a transfer of liquid assets may impact the benefits of a child who is receiving SSI benefits, in which case an SSI specialist should be consulted.

I. Spousal Impoverishment Laws

California law allows the community spouse to retain a certain amount of otherwise countable resources available to the couple at the time of application. This is called Community Spouse Resource Allowance (CSRA) and it increases every year according to the Consumer Price Index. The current (2017) CSRA is \$120,900. [ACWDL 16-25 (12/22/16):

www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2016/ACWDL16-25.pdf.]

Separate property will be counted in the total resources and subjected to the \$120,900 limit. However, only non-exempt resources are counted in the spouses' combined, countable resources at the time of application for Medi-Cal. Thus, IRA's in the community spouse's name, household goods, personal effects, a car, the house, jewelry, etc. are all totally excluded, regardless of value, and the at home spouse can retain these, as well as the CSRA of \$120,900.

Resources acquired after the spouse is institutionalized and before he/she goes on Medi-Cal are not protected and will be counted at the time of application. However, once the spouse is eligible for Medi-Cal, any resources acquired after eligibility by the community spouse are protected and will not affect the institutionalized spouse's eligibility. For example, if the community spouse inherited \$100,000 after the nursing home spouse was on Medi-Cal, she could keep this without affecting the other spouse's eligibility. Resources held prior to the spouse's institutionalization may be transferred under certain conditions.

Spending Down: A spouse can spend down resources on anything, whether or not it is for his or her own benefit. Mortgage notes on property held in the names of both spouses could be paid in full by the institutionalized spouse without a period of ineligibility for transferring assets for less than fair market value.

Income: California law allows the community spouse to retain a maximum monthly maintenance needs allowance (MMMNA). The current (2017) MMMNA is \$3,023. [ACWDL 16-25 (12/22/16): www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2016/ACWDL16-25.pdf]. This amount is adjusted annually by a cost of living increase.

Under the "name on the instrument rule," the community spouse may retain any income received in his/ her name alone, even if this exceeds the MMMNA. For example, if the community spouse's monthly income (in his or her name alone) is \$5,000, the community spouse may keep it all.

If the community spouse's monthly income is less than the MMMNA of \$3,023, he/she may receive an allocation from the institutionalized spouse's income until he/she reaches the \$3,023 MMMNA; file for a fair hearing to increase the CSRA to generate additional income; and/or obtain a court order to obtain additional

income-generating resources. With current miniscule interest rates, it is relatively easy for a community spouse to retain assets above the CSRA, if his/her income is low.

J. Family Allocation

Federal and state laws allow for a family allocation to be offset from the income of an institutionalized spouse for the support of a dependent “family member” when there is a community spouse at home. Family members include only natural or adopted minors or dependent children, or dependent parents or siblings of the institutionalized or community spouse who are residing with the community spouse. In order for the children to receive the maximum family member allocation, there must be a community spouse. Grandparents who have legal guardianship over grandchildren have been hit hard by this onerous rule, and foster children are not considered “children” or even “family members” for the purposes of long term care Medi-Cal.

The family member base allocation amount, which is used to determine how much income the long term care beneficiary may allocate to family members, is increased annually. The current amount, \$2,003, is effective July 1, 2016 through June 30, 2017. Of course, the allocation is only possible if the institutionalized spouse has sufficient income left over after the spousal allocation to the community spouse.

The family allocation is calculated separately for each family member. Any income is deducted from the maximum allocation, and the remainder is divided by 3 to arrive at the total maximum allocation. If the child or children receive no income, the maximum family allocation amount would be \$667.67 for each child.

Example

\$ 2,003	(maximum family allocation)
<u>-300</u>	(Social Security income received by child)
1,703	divided by 3 = \$567.67 maximum family allocation for each child

(source: MEDIL I 16-08; Form MC 176 W, section IX)

K. Ethical Considerations

Property reduction requirements can usually be easily handled and documented, and it can be tempting for many attorneys to advise clients to reduce excess property on the purchase of exempt assets prior to a nursing home entry. It may be difficult however, to find a nursing home placement for a person who has spent all of his/her resources or who has few resources.

Although “duration of stay” requirements, i.e., requiring private pay for a set period of time, are illegal, nursing homes can and do review potential patients’ finances prior to admission. In most cases, they are unwilling to accept Medi-Cal eligible residents upon admission. The longer a person can pay privately, the more options there are available regarding nursing home placement.

In addition, a private pay patient may receive a higher level of service, e.g., a private room, although relatives of nursing home residents are now permitted to supplement the Medi-Cal rate to pay for non-covered services such as a private room, television or phone services. These factors should be considered when advising clients how to reduce excess resources. Once a patient has been admitted to a Medi-Cal certified facility, s/he cannot be transferred or evicted simply because of a change from private pay to Medi-Cal payment status. Thus, unless a person can pay privately for an indefinite period of time, s/he should be advised to seek out a Medi-Cal certified nursing home.

L. Medi-Cal Recovery

Medi-Cal applicants, beneficiaries and their spouses should always be aware of the Medi-Cal Recovery rules and plan ahead if they want to avoid recovery on their home or other assets. For detailed information on the Medi-Cal Recovery program, see CANHR’s consumer booklet on Medi-Cal Recovery, http://www.canhr.org/publications/PDFs/Medi-Cal_Recovery.pdf.

For more detailed information about Long Term Care Medi-Cal, order a copy of CANHR’s *“If You Think You Need A Nursing Home: A Consumer’s Guide to Financial Considerations and Medi-Cal Eligibility.”* (www.gifttool.com/shop/ShopProductDetails?ID=1325&VER=1&LNG=EN&PID=35502&DID=776)