

Medi-Cal Questions and Answers



If a Partnership policy covers a patient's stay in a private room in a nursing home until policy benefits are exhausted, and the patient transitions into Medi-Cal, with a Share of Cost (SOC), do they have to spend the SOC for services specifically pertinent to the nursing home?

No, the patient can spend their SOC on a variety of medical services. This SOC obligation does not necessarily need to be paid to the nursing home. For example, if the nursing home patient needs four occupational therapy treatments per week, but Medi-Cal only allows two per week, the additional occupational therapy treatments could be paid through the SOC. In this example, even though Medi-Cal covers occupational therapy, any additional services a person wants above and beyond what Medi-Cal would have covered could be paid as the SOC. Therefore, the SOC services paid by the patient must not be Medi-Cal covered services in order for their costs to count toward the Medi-Cal SOC. In addition, services that would usually be covered by Medi-Cal, such as the use of a health aide, can be paid as the SOC if the service provider is not a Medi-Cal provider.



If a Partnership policy covers a patient's stay in a private room in the nursing home until policy benefits are exhausted, and the patient transitions to Medi-Cal, with a SOC, will the nursing facility transfer them into a semiprivate room?

It is possible that the patient will be transferred to Medi-Cal covered accommodations.



Additionally, if a Partnership policy covers a patient's stay in a private room in the nursing home until policy benefits are exhausted, and the patient transitions into Medi-Cal, with a SOC, and the nursing facility intends to transfer them out of their private room and into a semi-private room, can the patient use their SOC to guarantee their continued stay in a private room?

Yes, as long as the patient's SOC, or some combination of their SOC, their assets and/or any remaining insurance, is high enough to cover the rate for the private room. If the nursing facility charges Medi-Cal for any portion of the facility cost, the patient cannot pay the difference between the Medi-Cal covered accommodation and a private room. The patient may be able to afford to pay the entire cost of the nursing facility charge as their SOC, because they will no longer need to use any of their income to pay for drugs, Medi-Gap (part B) policy co-pays or deductibles, etc. This is because once the patient is on Medi-Cal; the Medi-Cal benefits will cover all these medically necessary services. The patient's income therefore, depending on each individual's circumstances, may be sufficient to pay the facility costs (while meeting their SOC) so they can be sure to remain in a private. If not, the patient may have to move into Medi-Cal covered accommodations.

For example, if the private room cost is \$3,500 and the policyholder has \$3,500 in income, they can use that amount to pay for the private room. Medi-Cal would then be available to cover any other medically necessary item.

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How long does a person have to be living in California before they can be deemed a resident of California for Medi-Cal eligibility purposes?

There is no time period associated with being a California resident. However, a person does have to be physically present in California with the intent to remain in California permanently or indefinitely.



Where can I get more information on Medi-Cal Eligibility?

You can find more information by downloading a copy of "Before You Buy," found on the Partnership's web site. This document, which provides an explanation of asset protection and Medi-Cal Eligibility rules, must be provided to consumers when long-term care presentations are made, in compliance with Partnership regulations. "Before You Buy" is updated annually with new figures on current Medi-Cal resource and income limits.



What property/assets are allowable for Medi-Cal?

The Medi-Cal program determines eligibility for benefits on a "means" tested basis. If a Medi-Cal applicant's property/assets are over the Medi-Cal property limit, the applicant will not be eligible for Medi-Cal unless they lower their property/assets according to the program rules. The Medi-Cal eligibility worker looks at how much an applicant and their family has each month. If their property/assets are below the limit at any time during that month, the applicant will get Medi-Cal, if otherwise eligible. If a person has more than the limit for a whole month, Medi-Cal benefits will be discontinued.

A person's home, furnishings, personal items, and one motor vehicle are not counted. A single person is allowed to keep \$2,000 in property/assets, more if they are married and/or have a family. (If a person has a Partnership policy, however, each dollar the Partnership policy pays out in benefits entitles the insured to keep a dollar of his/her assets should he/she ever need to apply for Medi-Cal Services.)

For example, if a person receives an inheritance that puts their property/asset amount to more than \$2,000, they would be required to spend that amount down to \$2,000 before Medi-Cal would pay for any further care.



Can a facility transfer or discharge a resident out of the facility because of a change in the resident's method of payment from private or long-term care insurance payment to Medi-Cal payment?

Generally, no. The only exception is if the facility is not certified to accept payment from the Medi-Cal program. In that case, the facility would be allowed to transfer or discharge the resident if the resident's stay is no longer covered by long-term care insurance and he/she is unable to continue to pay privately. However, the facility is required to inform residents of this possibility at the time they are admitted to the facility.

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What are the community spousal resource limits for 2002 when qualifying for the Medi-Cal nursing home benefit?

The 2002 community spouse resource allowances are \$89,280 in assets and \$2,232 in monthly income. For a married couple with one spouse in a nursing home and the other spouse at home, the spouse at home may keep up to \$89,280 in resources (property and other assets) while the spouse in a nursing home may keep \$2,000. The spouse at home may keep all of the income received in his or her name, regardless of the amount. If the amount is below \$2,232 per month, the spouse in the nursing home may allocate income to bring the at-home spouse's income up to the \$2,232 per month limit. The spouse in the nursing home is permitted to keep \$35 a month for personal needs. (For 2001, the amounts were \$87,000 in assets and \$2,175 in income).



How long before applying for Medi-Cal can a person transfer assets?

The Medi-Cal "Look-Back" period in California is 30 months. "Transfer" means an outright gift or a "sale" made at less than "fair market value." If a disqualifying transfer of property is made, Medi-Cal will calculate the period of ineligibility for nursing facility level of care. It will be the number of months resulting when the "net fair market value" of the transferred asset, which would have resulted in excess property at the time of the transfer, is divided by the monthly average private nursing facility cost. In 2002, the average cost used to calculate the period length is \$4,322 per month. In 2001, this amount was \$4,163.



Can a nursing home resident give away their income, or does it need to be spent on medically necessary care? Let us say a person is in a nursing home and wants to give their grandchild \$50 for their birthday. Can they do that?

There is currently no transfer of income penalty in California. However, a nursing home resident's income must be used to meet their SOC, or Medi-Cal will pay for NO services during that month. The nursing home resident is allowed only \$35 for personal needs. It is fine if he/she wants to give their \$35 away, but then there will be nothing for personal needs unless the individual wants to dip into their \$2,000 property reserve. Funds from their \$2,000 property reserve may also be given away without penalty. When funds are used from the \$2,000 property reserve, the reserve can be increased the following month to the \$2,000 limit.

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If a person applies for Medi-Cal, can they have a principal residence in another state (outside of California) and still qualify for Medi-Cal?

Yes, but the person has to distinguish between "principal residence" and "primary residence". In other words, they can have a principal residence anywhere, as long as they eventually return to it to live. In order to qualify for Medi-Cal, a person must show that they are presently living in California with the intention to remain permanently, or for an indefinite period. A person could be living in a California nursing home with the intention to remain indefinitely, but still have the intention to eventually return to their principal residence out-of-state.



If a Medi-Cal applicant's spouse transfers assets, will that result in any period of ineligibility for nursing home care?

Generally, California will not impose any period of ineligibility for nursing home care on the applicant if his or her spouse previously transferred assets. The exception is if the asset/resource transferred originally belonged to the applicant. In that case, a disqualification period will be imposed if the spouse received the assets from the applicant before the applicant went into the nursing home and then transferred them to a third party. This is because the Medi-Cal rules differ for a "community spouse" and an "individual spouse". If the spouses wait until one of them goes into the nursing home, the spouse will be a "community spouse". Then a transfer of property from the spouse in the nursing home to the community spouse that is then transferred to a third party, does not trigger any period of ineligibility.



What if the above transfer was to a family member, such as an adult child?

The transfer by the applicant's spouse must be a real gift transfer. If the adult child, for example, is only holding the assets, it probably really is a trust. In that case, the transfer could either cause a period of ineligibility or simply result in the assets continuing to be counted as available to the applicant.

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How much does a person have to pay for services while on Medi-Cal?

The county looks at the applicant's income after he or she establishes eligibility for Medi-Cal by spending down assets to no more than \$89,280 for a couple with one spouse institutionalized or \$2,000 for a single individual. The county looks at the income the individual receives in his or her own name and divides in half the income received in the name of both spouses. Of the income that counts as the income of the applicant, all (less \$35) of the applicant's income is considered his or her "share of cost" for Medi-Cal. This works like a regular health insurance deductible. The applicant pays or obligates him or herself to pay that much each month on medical expenses before Medi-Cal pays the remainder of Medi-Cal covered services.

For example, a single individual in a skilled nursing facility has an income of \$1,000 per month. This person is allowed to retain \$35 per month for personal needs. The remainder (\$965) of the countable income goes toward his or her share of cost each month. Medi-Cal pays the remainder of the expenses for the month up to the Medi-Cal reimbursement rate that is negotiated with the facility. The law precludes the facility from "balance billing" or charging the individual or family for any more than the share of cost.

In the case of an institutionalized spouse with a well spouse in the community, the institutionalized spouse is allowed to allocate some of his/her income to the community spouse as long as the community spouse's income is below a certain level. For the year 2002, that amount is \$2,232. If the community spouse's income is over that amount, the community spouse retains all of his/her income.

Here is an example of a couple with one spouse in a nursing facility and one spouse in the community:

Institutionalized Spouse	\$1500 Social Security
	<u>\$400 Pension</u>
	\$1900 Total
Spouse	\$600 Social Security

In this case, the institutionalized spouse is allowed to allocate \$1,632 each month to his or her spouse ($\$2,232 - \$600 = \$1,632$). The remainder, in excess of the \$35 the institutionalized spouse is allowed to retain for personal needs, goes toward the share of cost each month. Medi-Cal pays the remainder of his or her medical expenses ($\$1,900 - \$1,632 \text{ spousal allocation} = \$268 - \$35 = \$233 \text{ share of cost}$).



What percentage of nursing homes is Medi-Cal approved? Medicare approved?

Nearly 88% of the 1,400 nursing homes in California accept Medi-Cal:

- Title 18 only (Medicare): 8.3%
- Title 18/19 (Medicare/Medi-Cal): 80.4%
- Title 19 only (Medi-Cal): 7.3%
- No Participation 4.0%

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How are retirement annuities treated for Medi-Cal eligibility?

Annuities are not considered exempt unless they are IRAs, KEOGHS, or work-related pension funds held in the name of a person who does not want Medi-Cal for him- or herself. If payments are being received, however, those payments are considered income. The cash surrender value of IRAs, KEOGHS and work-related pension funds held in the name of an individual who does not want Medi-Cal is counted until the individual takes steps to receive either the cash lump sum or periodic payments of principal and interest. The periodic payments are considered income and the balance is considered unavailable.



Are the assets identified in a pre-nuptial agreement disregarded for the purpose of eligibility when an individual applies for Medi-Cal? What about estate recovery?

With a prenuptial agreement, the county considers the living situation of the individual at the time of application in order to determine Medi-Cal eligibility. Let us take a look at three living situations:

Example #1: Both spouses are at home. All non-exempt property over \$3,000 (including assets identified in a pre-nuptial agreement) is counted in determining Medi-Cal eligibility.

Example #2: Both spouses are in board & care or only one spouse is in board & care and one remains at home or both spouses are in long-term care. The property of the non-applicant spouse that is established as separate property in the pre-nuptial agreement (as long as it remains separate) is disregarded for purposes of establishing eligibility. Half of the community property is also disregarded.

Example #3: One spouse is at home or in a board & care facility. The other is in a medical institution or nursing facility and expected to remain for 30 days. All non-exempt property (including assets identified in pre-nuptial agreements) counts in determining eligibility. The couple is allowed to keep \$89,280 (for 2002) in assets or the amount identified by court order or fair hearing, whichever is greater.

For purposes of estate recovery, in all of these examples the state can only make a claim against assets that pass from the deceased Medi-Cal beneficiary to his or her spouse (i.e., the community property interest in the assets) upon death. Any assets that pass to the surviving spouse before the death of the Medi-Cal beneficiary are not recoverable.



Are assets my spouse inherits disregarded for eligibility purposes when I apply for Medi-Cal? For the purpose of estate recovery?

In the case of an inheritance, the assets disregarded for determining eligibility are the same as those in a pre-nuptial agreement. The estate recovery program can only file claims against the assets that pass from deceased Medi-Cal beneficiaries to their surviving spouses upon death. Any assets that pass to the surviving spouse before the death of the Medi-Cal beneficiary are not recoverable.

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Are assets from a prior marriage exempt for eligibility purposes? What about estate recovery?

The term "exempt" applies to a "type" or "classification" of property given exempt status by statute or regulation. Assets from a prior marriage are not a type of property that is exempt. Property from a prior marriage may be considered separate property if it has not been combined with the property of the current spouse. If the property is separate property, it may or may not be counted, as in the living situations described above. Estate recovery can file a claim against any asset (e.g., the community property interest) that passes from the deceased person to the surviving spouse upon his or her death. Estate recovery only takes place, however, when the surviving spouse dies.



The institutionalized spouse has \$200,000 of assets protected through a Partnership policy. The spouse at home gives \$200,000 to a child on January 1, 1999, and applies for Medi-Cal on February 28, 2000. Is there a penalty under the rules for transfer of property?

In this example, assuming the couple has no other countable property (all they have is \$200,000 in assets) at the time of the transfer, the transfer of the protected assets is considered a transfer of exempt property. Therefore, there is no period of ineligibility for nursing facility level of care. This above exemption only applies during the lifetime of the institutionalized spouse for eligibility purposes. After the institutionalized spouse dies, this exemption no longer applies. For estate recovery purposes, however, the \$200,000 of asset protection continues even after the death of the protected spouse.



Is there such a thing as a “Medi-Cal friendly annuity”?

There is no such thing as a Medi-Cal-friendly annuity. The balance of an annuity is considered unavailable as long as the owner receives equal monthly payments for a number of years, less than or equal to life expectancy (based upon life expectancy tables designated by Health Care Financing Administration for this purpose). The final payment may be smaller to exhaust the annuity. If payments are not equal and monthly, the cash surrender value is counted. If payments extend beyond life expectancy, a period of ineligibility for nursing facility level of care may result. Some annuities pay very small amounts, with a balloon payment at the end. These annuities, even though set up to exhaust within life expectancy, are not annuitized in accordance with DHS rules. The cash surrender value is counted in determining eligibility. In many cases, these annuities are irrevocable and do not have a cash value and there is nothing to count. Individuals who purchase this type of annuity lose financial control while cashing in their life insurance policies, stocks, bonds, etc. Many times they have to pay heavy capital gains taxes and surrender penalties in the process.

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Does Medi-Cal pay for Residential Care Facilities for the Elderly (RCFE's), also known as Assisted Living or Board and Care?

Currently, Medi-Cal does not pay for board and care in a RCFE, since RCFE care is not considered to be medical care. In addition, RCFE's are not licensed as medical care providers. Medi-Cal does, however, allow an individual to retain income each month, up to the amount of the monthly charge of the facility, as long as the person requires and is receiving custodial care within the facility. If an individual is residing in an RCFE simply because the individual enjoys the luxury of not having to cook, clean and do laundry, Medi-Cal does not allow the individual to retain the additional income. If the individual is residing in the facility, however, because he or she requires assistance and needs custodial care, Medi-Cal allows the individual to retain more of his or her income.

For example, a single individual residing in a RCFE receives \$1,000 a month from Social Security and the RCFE charges \$1,000 per month. This individual would normally only be able to retain \$600 per month because he or she is not residing in a hospital or intermediate or skilled nursing facility. Because he or she requires custodial care in an RCFE, the county allows the individual to retain \$600 per month and considers the remaining \$400 per month "unavailable" (similar to an income deduction) because the facility charge is \$1,000 per month.

This individual, then, has a zero share of cost and Medi-Cal pays all of the individual's medical expenses in that month for Medi-Cal covered services. If, however, the facility charges only \$900 per month, the county will consider only \$300 per month (in addition to the \$600) as "unavailable". In this case, the individual has a share of cost of \$100 per month that he or she pays or obligates him or her to pay on medical expenses before Medi-Cal pays the remainder of Medi-Cal covered services.

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How does the look-back period affect a person's eligibility for Medi-Cal benefits?

In California, any transfer of a non-exempt asset (also called "countable") within 30 months of an individual's application for Medi-Cal for nursing facility level of care may result in a period of ineligibility. This period of ineligibility will only apply to the nursing facility level of care and, if otherwise eligible, the individual would be eligible for all other Medi-Cal covered services. Remember, the look-back period does not apply to those assets that are exempt (also called "not countable"). The most common exempt asset is the individual's principal residence. The period of ineligibility is determined by dividing the average private pay rate (APPR) in California, currently \$4,322, into the value of the transferred non-exempt asset. Let us take a look at the following example:

Ten months prior to Ms. Peabody's (a single individual) application to Medi-Cal to pay for her stay at Sunnyside Nursing Facility, she transferred \$200,000 from her bank account to her son John. She meets all other eligibility requirements for Medi-Cal. Would Ms. Peabody have a period of ineligibility for payment to the nursing facility as determined by her eligibility worker? If so, what would be the period of ineligibility?

Yes, Ms. Peabody would have a period of ineligibility of 21 months. Here is how it is calculated:

The first step taken by the eligibility worker would be to determine the maximum period of ineligibility. This is accomplished by dividing the value of the \$200,000 non-exempt transfer by the APPR for 2002, which is \$4,322. For this example, the calculation results in 46 months. OBRA 93 (Omnibus Budget Reconciliation Act) lifted the ceiling on the maximum period of ineligibility. Remember, however, that the maximum period of ineligibility in California is still 30 months. In this example, the transfer took place 10 months prior to Ms. Peabody's application for Medi-Cal. In determining the actual period of ineligibility, the eligibility worker would start counting beginning with the 10th month and continue through the 30th month. The ineligibility period would thus be 21 months. Medi-Cal would not begin to pay for Ms. Peabody's nursing facility costs until another 21 months had passed.

The period of ineligibility is always the lesser of one of the following:

- 30 months; or
- the number of months obtained by dividing the value of the transfer by the APPR; or
- the difference between 30 months from the date of the transfer and the date of application for Medi-Cal benefits, inclusive. In other states, the look-back period and the period of ineligibility may differ from that used in California.