DEPARTMENT OF HEALTH SERVICES
744 P STREET
AMENTO, CA 95814

November 14, 1988

TO: All County Welfare Directors
All County Administrative Officers

Letter No.: 88-88

SUBJECT: CONSECUTIVE TRANSFERS WITHOUT ADEQUATE CONSIDERATION RESULTING IN PERIODS OF INELIGIBILITY

The purpose of this letter is to inform you of how to treat consecutive transfers of property where adequate consideration was not received, i.e., how to treat a transfer for less than adequate consideration which occurs before a prior period of ineligibility has expired.

Title 22, CCR, Section 50411(c) states that, "the period of ineligibility shall begin the first of the month following the date the transfer which resulted in ineligibility occurred." This being the case, you may have overlapping periods of ineligibility.

Section 50411(b)(2) instructs you to "determine the portion of the net value of the property transferred which, if included in the property reserve at the time of transfer, would not have caused such reserve to exceed the property limit that was applicable at that time". Since the applicant/beneficiary may maintain a property reserve in each month of eligibility, it is appropriate to include the property transferred in the available property reserve for the month in which each transfer occurred.

To determine the net uncompensated value for each property transfer, a county would count only that amount of transferred property which exceeded the property limit for that month. This could result in no period of ineligibility for that particular transfer if the total amount transferred would not have caused the property reserve to be in excess. For instance, assume the property reserve was $2,000. If the nonexempt property in the month in which the transfer occurred totaled only $500, a property transfer of $1200 in the month would not have caused the property reserve to be in excess ($500 + $1200 = $1700). Therefore, there would be no period of ineligibility.

Section 50411(b)(5) goes on to say that you may further reduce the period of ineligibility "by deducting the actual cost to the applicant or beneficiary of the following:

(A) Medical expenses.

(B) Out of home care costs in excess of the maintenance needs.

(C) Major home repairs necessary to put the home into livable condition".

These "actual costs" may be paid for or simply incurred as a legal debt by the applicant/beneficiary. Once a county has deducted the actual (monthly) costs of expenses for one period of ineligibility, the expenses have been accounted for and no more actual costs remain to deduct against a different period of ineligibility. Section 14019.3(d) of the Welfare and Institutions Code (see attached) prohibits reimbursement of amounts paid or obligated by the applicant/beneficiary to meet his/her share of cost or to establish eligibility. Once the deductions for actual costs are used to reduce one period of ineligibility, they are also being used to establish eligibility. Thus, allowing the same expense to be used again on a subsequent transfer would be double counting and amount to providing a reimbursement (on paper) of amounts used to establish eligibility. Since this is prohibited, actual costs may not be applied a second time to a second period of ineligibility.

Please note that the monthly maintenance need is used to calculate a period of ineligibility and that period begins the first of the month following the transfer. The use of the maintenance need in this case is not tied to monthly income or the share of cost determination. It simply marks the passage of the period of ineligibility much like minutes mark the passage of an hour.

EXAMPLE

NOTE: For purposes of this example assume the property limit for one person is $2,000.

A private pay person in a nursing home applies for Medi-Cal in October. The person indicates that he/she transferred $15,000 in the previous January; $16,000 in the previous March; and $14,000 in the preceeding month of September. In January the person had no other property.

Transfer 1) ($15,000) First, determine the net uncompensated value by subtracting the amount of the transferred property that would have been included in the property reserve. In January the person had no other property; therefore, subtract the entire $2,000 in the property limit from the amount transferred. This means $13,000 ($15,000 - 2,000) is the net uncompensated value.

Secondly, determine the period of ineligibility by dividing by the appropriate maintenance need (MN) level. In this case the MN would be $35 for a long term care (LTC) individual. The first period of ineligibility would be 371 full months ($13,000 / $35).

Finally, the applicant incurs actual medical expenses at the private pay rate of $2,500 per month. This reduces the period of ineligibility to six months as follows:

JAN	FEB	MAR	APR	MAY	JUN	JUL
Transfer	13,000	10,465	7,930	5,395	2,860	325
Occurred	- 35	- 35	- 35	- 35	- 35	- 35
Here	-2,500	-2,500	-2,500	-2,500	-2,500	290
	10,465	7,930	5,395	2,860	325	-2,500
						-2,210

NOTE: Only $290 of actual expenses from July were necessary to reduce the first period of ineligibility to zero. The remaining $2,210 may be applied to the second transfer.

Transfer 2) ($16,000) This transfer occurred in March. Assume the applicant has $500 in savings in March. The net uncompensated value is $14,500 ($16,000 - $1,500 remaining in property limit). The second period of ineligibility is 414 full months ($14,500 / $35). The period is reduced by actual medical expenses ($2,500 private pay rate paid or incurred) as follows. Note that the $2,500 private pay rate expenses for April - June cannot be used since they were applied to the first transfer. The $2,210 in actual expenses remaining from transfer 1 in July can now be applied to transfer 2 starting in July.

MAR	APR	MAY	JUN	JUL	
Transfer	14,500	14,465	14,430	14,395	
Occurred	- 35	- 35	- 35	- 35	
Here	14,465	14,430	14,395	-2,210	actual expenses not applied to transfer 1

AUG	SEP	OCT	NOV	DEC
12,150	9,615	7,080	4,545	2,010
- 35	- 35	- 35	- 35	- 35
-2,500	-2,500	-2,500	-2,500	1,975
9,615	7,080	4,545	2,010	-2,500
				-525

NOTE: Since only $1,975 of December actual medical expenses were required to reduce this second period of ineligibility to zero, the remaining $525 may be applied to the third transfer.

Transfer 3) ($14,000) This transfer occurred in September. Assume the person had no other property in September so that the net uncompensated value is $12,000 ($14,000-$2,000 in the property reserve). The third period of ineligibility is 342 full months ($12,000 / $35). The period is reduced by actual expenses as follows.

Note that since the private pay rate expenses for October and November were previously used to reduce the period of ineligibility for the second transfer, they cannot be used again. The $525 in actual expenses remaining from transfer 2 in December can now be applied to transfer 3 starting in December.

SEP	OCT	NOV	DEC		JAN
Transfer	12,000	11,965	11,930		11,370
Occurred	- 35	- 35	- 35		- 35
Here	11,965	11,930	- 525	actual expenses	-2,500
			11,370	not applied to transfer 1 or 2	8,835

FEB	MAR	APR	MAY
8,835	6,300	3,765	1,230
- 35	- 35	- 35	- 35
-2,500	-2,500	-2,500	1,195
6,300	3,765	1,230	-2,500
			0

NOTE: Only $1,195 of actual expenses were required to bring this last period of ineligibility to zero. If otherwise eligible, the applicant would be issued a Medi-Cal card for the month of May.

If you have any questions, please call Sharyl Shanen-Raya of my staff at (916) 324-4956.

Sincerely,

Original signed by

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosures

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: October 31, 1989

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d as such and shall be made available to has determined the person's eligibility ine-reproduced copies of the beneficiary le from the original unaltered Medi-Cal ample, on the premises of the provider

ary to provide information and evidence non-Medi-Cal health coverage, to that d by those providers prior to rendering

dering Medi-Cal reimbursable services make a good faith effort to verify the by matching the name and signature on California driver's license, or California s, or another type of picture identifica- the provider verifies the beneficiary's ribed above, the state will deem good faith effort of reasonable es and renders services to a presenting ment for those services may later be

ty welfare departments may provide icies and their designated agents as

, 1981. Amended by Stats.1985, c. 425,

14018.4, added by Stats.1977, c. 377, p. 1363,

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nsed primary care clinic, or long-term d Safety Code for care rendered to an of eligibility label does not accompany nentation of eligibility.

, upon the request of a hospital, ed in Section 1326 of the Health retary, replacement Medi-Cal proof of

anges or additions by amendment

eligibility labels or other appropriate documentation of eligibility to the requester, if all of the following conditions are met:

(1) The hospital, licensed primary care clinic, or long-term health care facility as defined in Section 1326 of the Health and Safety Code attempted to obtain a label from the beneficiary at the time the service was provided.

(2) The hospital, licensed primary care clinic, or long-term health care facility as defined in Section 1326 of the Health and Safety Code made a subsequent attempt to obtain a label or other appropriate documentation from the beneficiary.

(c) Notwithstanding subdivision (a), the director shall require that the replacement proof of eligibility label or other appropriate documentation of eligibility provided pursuant to subdivision (b) accompany the bill of the hospital, the licensed primary care clinic, or the long-term health care facility as defined in Section 1326 of the Health and Safety Code.

(d) This section shall remain in effect only until both the Secretary of the Senate and the Chief Clerk of the Assembly have received certification by registered mail from the Director of Health Services, that the automated eligibility verification system required by Section 14042 is operative for all counties and has been demonstrated to be accurate for each county at the 97-percent level as required by Section 14042 and as of that date is repealed.

(Added by Stats.1983, c. 1315, § 3. Amended by Stats.1986, c. 202, § 1; Stats.1987, c. 1161, § 3.)

1981 Legislation.

Former § 14018.4 was repealed by Stats.1981, c. 102, p. 740, § 111, urgency, eff. June 28, 1981.

1984 Legislation

Another § 14018.4, added by Stats.1983, c. 819, § 1, relating to similar subject matter, was repealed by Stats. 1984, c. 193, § 152.

Section 152 of Stats.1984, c. 193, provides in part:

"The repeal made by this section shall not affect the existence or validity of Section 14018.4 of the Welfare and Institutions Code, as added and repealed by Chapter 1315 of the Statutes of 1983."

Library References

Social Security and Public Welfare ⇐241.65.
C.J.S. Social Security and Public Welfare §§ 137, 138.

§ 14018.5. Repealed by Stats.1976, c. 1383, p. 6279, § 1, operative Jan. 1, 1982

§ 14019. Identification card as authorization for payment under conditions prescribed by director; exceptions

Notwithstanding the provisions of Section 14018, except as provided in Sections 14019.1 and 14019.6, a Medi-Cal card shall be authorization for payment for health care services rendered, under conditions prescribed by the director and to the extent required by federal law, during any of the three months immediately prior to the month in which application was made, and for which such person would have otherwise been eligible.

(Amended by Stats.1982, c. 328, p. 1581, § 13, urgency, eff. June 30, 1982.)

1982 Amendment. Added "except as provided in Sections 14019.1 and 14019.6" following "Section 14018".

§ 14019.1. Repealed by Stats.1982, c. 328, p. 1581, § 14, urgency, eff. June 30, 1982; operative Jan. 1, 1983; Stats.1982, c. 1594, p. 6323, § 29, urgency, eff. Sept. 30, 1982, operative Jan. 1, 1983

The repealed section added by Stats.1982, c. 328, p. 1581, § 14, urgency, eff. June 30, 1982, amended by Stats.1982, c. 1594, p. 6323, § 29, urgency, eff. Sept. 30, 1982, providing that adults at least 21 years of age were ineligible for services for any of the three months immediately prior to the month in which application was made, was repealed by its own terms on Jan. 1, 1983.

§ 14019.3. Return of payment for services otherwise covered by Medi-Cal program; submission of claim for Medi-Cal reimbursement

A beneficiary or any person on behalf of the beneficiary who has paid for health care services otherwise covered by the Medi-Cal program received by the beneficiary shall be entitled to a return from the provider of any part of the payment which meets all of the following:

(a) Was rendered during any period prior to the receipt of his or her Medi-Cal card, for which the card authorizes payment under Section 14018 or 14019 * * *.

Asterisks * * * indicate deletions by amendment

(b) Was reimbursed to the provider by the Medi-Cal program, following all audits and appeals to which the provider is entitled * * *;

(c) Is not payable by a third party under contractual or other legal entitlement * * *;

(d) Was not used to satisfy his or her paid or obligated liability for health care services or to establish eligibility.

To the extent permitted by federal law, whether or not a facility actually evicts a beneficiary, a beneficiary who may validly be evicted pursuant to Section 1439.7 of the Health and Safety Code, and who has received and paid for health care services otherwise covered by the Medi-Cal program shall not be entitled to the return from the provider of any part of the payment for which service was rendered during any period prior to the date upon which knowledge is acquired by the licensee of the application of the beneficiary for Medi-Cal or the date of application for Medi-Cal, whichever is later.

Upon presentation of the Medi-Cal card or other proof of eligibility, the provider shall submit a Medi-Cal claim for reimbursement, subject to the rules and regulations of the Medi-Cal program. Payment received from the state in accordance with Medi-Cal fee structures shall constitute payment in full, except that a provider may recover remaining unpaid charges to the extent that any other state or federal medical care programs permit the recovery or to the extent that any other contractual entitlement, including, but not limited to, a private group or indemnification insurance program, is obligated to pay the charges for the care provided the beneficiary. The provider shall return any and all payments made by the beneficiary, or any person on behalf of the beneficiary, other than a third party obligated to pay charges by reason of the beneficiary's other contractual or legal entitlement for Medi-Cal program covered services upon receipt of Medi-Cal payment.

(Amended by Stats.1985, c. 10, § 18, urgency, eff. March 6, 1985; Stats.1985, c. 11, § 18, urgency, eff. March 6, 1985; Stats.1985, c. 776, § 1.)

1985 Legislation

Section 6 of Stats.1985, c. 776, provided:

"The State Department of Health Services shall seek any federal waivers necessary to implement the provisions of this act. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained or for which waivers are not required shall be implemented notwithstanding any inability to obtain federal waivers for the other provisions. No provision of this act shall be implemented unless matching funds from Title XIX of the federal Social Security Act are available." [Federal waiver request denied Mar. 13, 1986 per Dept. of Health Services letter of May 8, 1986.]

Effect of amendment of section by two or more acts at the same session of the legislature, see Government Code § 9605.

Notes of Decisions

1. In general

Where physician submitted a Medi-Cal claim for reimbursement for services rendered medicare patient, physician bound himself to Medi-Cal law's prohibition against "balance billing," and was required to pursue his right to reimbursement through the program; therefore, agreement by patient's mother to pay for physician's services pursuant to an independent agreement was not enforceable, and physician's nonacceptance of medicare assignments, his office's policy of requiring prepayment in full, and his billing Medi-Cal as a favor or courtesy were irrelevant. Serafini v. Blake (Super.1985) 213 Cal.Rptr. 207, 167 C.A.3d Supp. 11.

Physician who provided medical services to Medi-Cal beneficiary and received payment in amount authorized by Medi-Cal fee schedule, which was less than amount of bill reflecting usual and customary fee for such services, was not entitled to recover difference from settlement in third-party action, even though settlement included payment in full for medical services necessitated by third party's negligence. Palumbo v. Myers (App. 3 Dist. 1983) 197 Cal.Rptr. 214, 149 C.A.3d 1020.

§ 14019.4. Proof of eligibility; prohibition against provider seeking reimbursement or payment for covered services; receipt; exemption

(a) Any provider of health care services who obtains a label or copy from the Medi-Cal card or other proof of eligibility pursuant to this chapter shall not seek reimbursement nor attempt to obtain payment for the cost of such covered health care services from the eligible applicant or recipient, or any person other than the department, a third party payer who provides a contractual or legal entitlement to health care services.

(b) Whenever a service or set of services rendered to a Medi-Cal beneficiary results in the submission of a claim in excess of five hundred dollars ($500), and the beneficiary has given the provider proof of eligibility to receive such service or services, the provider shall issue the beneficiary a receipt to document that appropriate proof of eligibility has been provided. The form and content of such receipts shall be determined by the provider but shall be sufficient to comply with the intent of this subdivision. Skilled nursing facilities and intermediate care facilities are exempt from the requirements of this subdivision.

(Amended by Stats.1985, c. 776, § 2.)

1985 Legislation

Necessity of federal waivers and implementatic 1985, c. 776, see note under § 14019.3.

Notes of Decisions

1. In general

Individuals to whom health care services are p which Medi-Cal pays medicare part B premiums | California's buy-in agreement with secretary of human services received health care services u plan even though health care provider was rein medicare for 80 percent of "reasonable costs services. Samuel v. California Dept. of Healt

§ 14019.6. Spenddown of excess prop

Notwithstanding any other provisior property limit, may establish eligibility f which application was made, by spendd

(Added by Stats.1982, c. 328, § 15, urge

§ 14021. Mental health services

Notwithstanding any other provision c health services:

(a) Mental health services provided b

(b) Mental health services provided i community mental health center organiz of 1963. No amount shall be paid for federally funded community mental hea government under the Community Ment Short-Doyle community mental health se unless the Short-Doyle community ment health center participates in a county m

(c) Outpatient drug abuse services un Drug Programs provided by a county certified under this chapter which has ar abuse services.

(d) Inpatient hospital services in an ins that the institution for mental diseases i federal Social Security Act and regulati

Notwithstanding Section 14157, no mor for the purposes of this section unles purposes of this section.

The amendment of this subdivision ena constitute a change in, but is declarator

(Amended by Stats.1984, c. 1327, § 93,

1984 Legislation

Effect of amendment of section by two or more a same session of the legislature, see Governm § 9605.

§ 14021.3. Amendment of state plan management services as funds

The department shall amend the stat Section 1915(g) of Title 19 of the Social