STATE AND FEDERAL MEDICAID LAWS UPDATE

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A. Social Security Act: Title XIX

Medicaid was created by Title XIX of the Social Security Act in 1965 to provide health care for individuals with low income and resources. The Medicaid program in California is known as Medi-Cal. It is jointly funded by state and federal funds, and is administered by the California State Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS). Locally, Medi-Cal eligibility is determined by the county social services offices.

Federal law creates the basic Medicaid rules, although the states are empowered to create stricter guidelines. The federal Medicaid statutes and regulations are found at 42 U.S.C. §§1396-1396v, and 42 CFR §§420, 430.0-456.657. In addition, CMS created the State Medicaid Manual, and issues periodic Transmittal Letters that contain updates for further guidance.

The California statutes and regulations governing Medi-Cal are found at Welfare & Institutions Code §§ 14000-14685, and 22 CCR §§ 50000-50966. The DHCS promulgated the Medi-Cal Eligibility Procedures Manual for use by county social services workers, and also issues updates in the form of All County Welfare Directors Letters (ACWDL) to update the Medi-Cal rules.

Changes in the federal law continue to shape Medi-Cal rules. For example, California created draft regulations to implement the Medicare Catastrophic Coverage Act of 1988 (42 USC §§ 1396-1397)(MCCA) in ACWDL 90-1 and 90-03. This provision significantly affected a married individual's ability to qualify for Medi-Cal for Long Term Care (LTC) and created the asset cap known as the Community Spouse Resource Allowance (CSRA), which in 2011 is $109,560. In addition, some provisions of the Omnibus Budget Reconciliation Act of 1993 (42 USC § 1396p)(OBRA 93) have been adopted which affect estate recovery and the treatment of trusts. California did not implement the provisions regarding transfers of assets under OBRA 93. It is anticipated that federal law will have the most drastic effect upon the current Medi-Cal rules when the DHCS implements the regulations pursuant to the Deficit Reduction Act of 2005.

Medi-Cal benefits may be classified into basic two categories: Community-based Medi-Cal, and Medi-Cal for Long Term Care. Community-based Medi-Cal provides medical coverage for disabled or aged individuals who are living somewhere other than a Skilled Nursing Facility. The medical coverage provided may be the individual's sole medical coverage, or may be a supplement to Medicare or private insurance, may include some health services available with In Home Support Services, or under a waiver, and includes mental health coverage. Medi-Cal for Long Term Care provides coverage for individuals who are in a Skilled Nursing Facility (SNF). The Deficit Reduction Act will primarily impact Medi-Cal for LTC, whereas the 2010 Health Care Reform will have a greater effect upon Community Medi-Cal.

B. Deficit Reduction Act of 2005

On February 8, 2006 the President signed the Deficit Reduction Act of 2005 (Pub. L 109-171, §6011(c), 120 Stat.4 (DRA). Although California enacted legislation under the Welfare & Institutions Code to effectuate the DRA, such rules will not be enforced until the DHCS develops a procedures for its implementation. Such regulations were created in 2008, however the regulations have not been effectuated and it is uncertain when they will be finalized.

The new rules under DRA will affect the following:

1. Asset Transfers with Extended Lookback Period/ Gifting

Under the current rules, an applicant for Medi-Cal for LTC may make gift transfers in order to meet the resource limitation to qualify for benefits. An applicant may have no more than $2000 in non-exempt, available assets. If married, the applicant's spouse may have $109,560. Gift transfers to the applicant's spouse, who is not in a SNF (Community Spouse) are not penalized. The current rules also permit an applicant to make gift transfers to persons other than the Community Spouse to reduce countable assets in order to qualify. Furthermore, any gift transfer that is below the Average Private Pay Rate (APPR) for nursing home care ($6,840 in 2011), will not result in any periods of disqualification. For gifts that exceed the APPR, the disqualification period is calculated by dividing the value of the gift by the APPR, and rounding down. The result is the number of months that the applicant cannot receive benefits. The penalty period runs from the month of transfer. Current rules permit stacked gifting of multiple gifts, wherein the penalty periods run concurrently. Furthermore, the period of ineligibility shall not exceed 30 months. The Lookback Period for all gift transfers is 30 months. All gift transfers that occur within the 30 months prior to application for benefits must be reported to Medi-Cal.

Under the new DRA rules, the gifting rules will be severely limited. First, the penalty periods will begin from the later of the date of transfer or the date of the application. Second, penalty periods for gift transfers will no longer run concurrently. Most importantly, there will be a 60 month Lookback Period for gift transfers. There will, however be a hardship provision, and the new rules will not be applied retroactively. See Welfare & Institutions Code §14015.

2. Income First Rule

In *Blumer v. Wisconsin Dept. Of Health & Family Services* (2001) 121 S. Ct. 2547, the Supreme Court ruled that the states could choose whether to be an "income-first" or "resource -first" state. California chose to be an income-first state.

Under the current rules, the Medi-Cal beneficiary must pay all of his income minus a $35 maintenance need and any health insurance premiums to the SNF as share of cost. The Community Spouse is allowed to keep a minimum monthly maintenance needs allowance (MMMNA) of $2,739 from the couple's income. The Community Spouse may keep a portion of the Medi-Cal beneficiary's income in order to meet the MMMNA. In addition, aside from the $2000 asset cap for the Medi-Cal applicant, the Community Spouse may keep $109,560, known as the Community

Spouse Resource Allowance (CSRA), in order for the applicant to qualify for LTC benefits.

The current spousal impoverishment rules also allow a community spouse apply for a fair hearing or petition for a court order to retain the couple's income in an amount over $2,739, or keep assets in excess of the CSRA to generate income. An income-first state requires allocation of the MMMNA before the CSRA may be increased. A resource-first state allows increase of the CSRA before allocation of the MMMNA.

The new DRA rules create the income first rule, if the MMMNA and the CSRA are insufficient to support the Community Spouse, Medi-Cal must allow the Community Spouse to retain the couple's income in an amount over $2,739, before the Community Spouse may apply for a fair hearing to keep assets in excess of the CSRA. The rules do not affect the Community Spouse's ability to petition the court to keep assets in excess of the CSRA. See 42 USC §1396r-5(D)(5), (f)(3); ACWDL 06-12.

3. Annuities

Under current rules, annuities are considered an unavailable asset for the purposes of Medi-Cal eligibility in certain cases. The annuity must be annuitized, wherein the annuity provides for regular, actuarially sound, periodic repayment in equal amounts. In addition, work related annuities are considered unavailable. Annuities that do not pay out within the time frame set forth by actuarial tables are treated as gift transfers to the remainder beneficiary. Income derived therefrom is considered income for purposes of calculating the share of cost that must be paid to the skilled nursing facility. Deferred annuities, however, that do not provides for regular, actuarially sound, periodic repayment in equal amounts are treated as a countable asset for purposes of eligibility. Annuities purchased on or after September 1, 2004 are subject to estate recovery by the State of California.

Under the new DRA rules, the purchase of a deferred annuity or an annuity with a balloon payment will be treated as a gift transfer. Some annuities, however will remain exempt, such as work related annuities, and annuitized annuities purchased with the community spouse's CSRA. In addition, Annuities must name the State of California as the remainder beneficiary. See Welfare & Institutions Code §§14002, 14006.41, 14009.6, & 14009.7.

4. Primary Residence

Currently, the home of a Medi-Cal beneficiary is considered an exempt asset for purposes of eligibility, so long as the beneficiary states an intent to return home.

Under the new DRA rules, a person will be ineligible for benefits if the value home equity exceeds $750,000.00. The value is based on the assessed value minus encumbrances. This provision does not apply to beneficiaries who were eligible for benefits before January 1, 2006. There is an exception to this rule if the beneficiary's spouse, minor, blind or disabled child is living in the home or if denial of benefits would result in hardship. Furthermore, there will be a hardship waiver for beneficiaries who were eligible for benefits before January 1, 2006. See Welfare & Institutions Code §14006.15.

5. Promissory Notes, Loans, and Mortgages

Presently, promissory notes, loans and mortgages owned by the Medi-Cal applicant are deemed a countable asset for eligibility purposes. Income derived therefrom is considered income for purposes of calculating the share of cost that must be paid to the skilled nursing facility. A Medi-Cal applicant may use their resources to purchase such an instrument, however, the rules regarding valuation of the asset and inclusion of the repayment as share of cost are not applied consistently by Medi-Cal caseworkers.

Under the new rules, the funds used to purchase promissory notes, loans and mortgages will be considered a gift transfer unless the instrument provides for regular, actuarially sound, periodic repayment in equal amounts. Furthermore, the instrument must not provide that the balance owed is cancelled upon the death of the lender. See Welfare & Institutions Code §14015.

6. Life Estates

Presently life estates owned by Medi-Cal applicant are deemed a countable asset for eligibility purposes. Under the new rules, the funds used to purchase a life estate will be treated as a gift transfer unless the Medi-Cal applicant resides in the home for at least one year from the date of purchase. See Welfare & Institutions Code §14015.

7. Continuing Care Community Fees

A Continuing Care Retirement Community is a facility that offers all levels of care including assisted living and skilled nursing care for its residents. Life Care Contracts are offered by such communities to provide all levels of care as it becomes needed by the community resident. Under Current rules, such a contract is not considered an asset. Under the new rules, the fee paid for such a contract is considered an asset if the fee is refundable, can be used to pay for care, and does not creates an ownership interest in the community itself.

C. The Effect of the 2010 Health Care Reform on Medicaid and Medicare

In March 2010, the Patient Protection and Affordable Care Act of 2010 (PPACA) Pub. L. No. 111-148 (2010); and the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152 (2010) together known as the Affordable Care Act (ACA) became law. The ACA will greatly expand eligibility for Medi-Cal, and will substantially affect Medicare. The group that will be affected the most will be the recipients of “Medi-Medi,” those individuals who receive Medi-Cal and Medicare, also known as “dual eligibles.”

In November 2010, California won federal approval for its Bridge to Reform Section 1115 Waiver program. Under the plan, California will receive $10 billion in federal funds to revamp its technology to process the high volume of new applicants who will be eligible in 2014. $2.9 billion will be allocated for coverage for newly-eligible low income individuals. *See California Bridge to Reform a Section 115 Waiver Fact Sheet, DHCS.*

In California, the number of Medi-Cal enrollments will increase. By 2014, an

additional 1.9 million California residents who are under age 65 will be eligible for Medi-Cal benefits. Under ACA, all individuals with up to 133% of the poverty level will qualify. For example, an individual who earns $14,404 or a family of four that earns $29,327 will qualify for Medi-Cal benefits under the ACA. *Expanding Existing Public Insurance Programs Like Medi-Cal to Cover More Lower Income Californians*.

In addition, the ACA will require Medi-Cal to apply the spousal impoverishment rules to the spouse of a beneficiary Medicaid Home and Community Based Services (HCBS) waiver. *PPACA § 2404.* Currently, under the Medi-Cal rules, the spousal impoverishment rules only apply to the community spouse of a beneficiary of Medi-Cal for long term care who is in a SNF. The ACA requires that beginning in 2014, spouses of HCBS waiver beneficiaries shall enjoy the same spousal impoverishment rules as the community spouse does when his or her spouse is on Medi-Cal for long term care. *Id.*

The ACA also has key features that have an immediate effect on individuals on Medicare. For example, the Act solves the Medicare Part D "Donut Hole" coverage gap for prescription medications. Medicare beneficiaries do not receive coverage after the first $2,830 of spending. The ACA increased the coverage limit by $500, and will provide a 50% discount for brand name drugs while during the phase-in period. The ACA promises to close the gap by 2020. *PPACA § 3301.* In addition, the ACA will provide an annual wellness visit, and eliminate out-of pocket co-pays for preventative care for Medicare beneficiaries including prostate screenings, mammograms, and cholesterol and diabetes screening. *PPACA §§ 4103, 4104.*

Most importantly, there will be greater coordination in the delivery of services to dual eligibles who receive Medicare and Medi-Cal benefits. The ACA created the Federal Coordinated Health Care Office (FCHCO) in cooperation with the Center for Medicare are Medicaid Services to improve the delivery of services to such beneficiaries. *PPACA § 2602(c).* The goal of the FCHCO is to ensure full access to beneficiaries, improve the quality and to create outreach to the community regarding the availability of services. *Id.*