CHAPTER SIX

Medi-Cal

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INTRODUCTION

This overview of the Medi-Cal program addresses issues relevant to older adults and persons with disabilities. At the end of this chapter is a listing of other sources of information about Medi-Cal, including information about consumer informational fliers and Medi-Cal mental health services.

Also listed at the end of this chapter are the sources of the law governing Medi-Cal, as well as websites with access to Medi-Cal regulations and the All-County Letters issued by the State Department of Health Care Services to the counties.

What Is Medi-Cal?

Medi-Cal is California's Medicaid program. In short, Medi-Cal = Medicaid. Medi-Cal provides health care coverage for low-income families and aged, blind or persons with disabilities. Medi-Cal is the main source of health coverage for more than 13 million Californians, or approximately 30 percent of all Californians. More than 2 million persons qualify for Medi-Cal on the basis of age or disability including blindness. Of these, about 54,000 are in Medi-Cal-funded, facility-based long-term care. In January 2014, the Medi-Cal program was expanded under the Affordable Care Act to cover individuals ages 19 to 64. Approximately 3.8 million individuals have been newly enrolled in Medi-Cal under the Affordable Care Act. See page 8 for more information about expansion Medi-Cal.

Medi-Cal is administered through the California Department of Health Care Services (DHCS), and is overseen by the federal Centers for Medicare and Medicaid Services (CMS). California's Department of Managed Health Care (DMHC) also provides oversight of Medi-Cal when Medi-Cal benefits are delivered through managed care plans.

As a condition of California being reimbursed by the federal government for half or more the costs of the program, California has to follow federal Medicaid rules. However, California has substantial leeway as to how it will operate the program, who will be covered, and what services will be offered and has an approved state Medicaid plan that sets forth these details. In order to deviate from this plan, state officials must seek a waiver, also known as a "Medicaid waiver." California's DHCS currently has several waivers from CMS, including for example the Assisted Living Waiver.

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Medi-Cal vs. Medicare

"Medi-Cal" and "Medicare" sound alike and, as a result, each program often is confused for the other. Each requires that an adult beneficiary be either at least 65 years old or disabled, but there are at least two fundamental distinctions between Medi-Cal and Medicare:

- Medi-Cal eligibility is based on financial need, but Medicare eligibility is based on the work history of the person or the person's spouse.
- Because Medi-Cal is designed for persons in financial need, Medi-Cal provides for on-going long-term care, either in a nursing home or (to a more limited extent) at home. Medicare, by contrast, focuses more on acute or short-term care, and provides more limited coverage for long-term care.

Dual Eligibility (Medicare & Medi-Cal)

Some persons – termed "dual eligibles" or "medi-medis" - qualify for both Medicare and Medi-Cal. More than 1.2 million individuals are on both Medi-Cal and Medicare. For those persons with dual eligibility, Medi-Cal will pay the premiums, deductibles and co-payments required by Medicare. The Medi-Cal program also will cover the cost of certain items that the Medicare program doesn't cover, like long-term stays in a nursing home.

Dual-eligible persons generally have no need for Medicare supplemental insurance ("Medigap" insurance) because Medi-Cal already is covering the gaps. However, purchase of supplemental insurance may sometimes be advantageous if the purchase reduces the person's countable income down to a level that will qualify the person for zero-share-of-cost Medi-Cal. See page 12 of this chapter for more information.

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Coordinated Care Initiative

The Coordinated Care Initiative (CCI) is a new California program that changes the delivery of Medi-Cal, Medicare and long-term services and supports to dual eligibles and Medi-Cal recipients living in seven demonstration counties, including Los Angeles County. The CCI includes three changes:

1. Medi-Cal beneficiaries, including dual eligibles, who do not currently receive their Medi-Cal benefit through managed care have to enroll in a Medi-Cal managed care plan to receive their Medi-Cal benefits.
2. Long-Term Supports and Services (LTSS) are added to the Medi-Cal managed care benefit package, including Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP) and nursing facility care. In-Home Support Services (IHSS) under the CCI was a managed care benefit up until January 2017. IHSS is now a carved out benefit.
3. Dual eligible beneficiaries, those with both Medicare and Medi-Cal, have the option to enroll in a new health plan called Cal MediConnect that is responsible for both their Medicare and Medi-Cal benefits.

Automatic enrollment into Cal MediConnect began in July 2014 and ended in June 2015. While automatic enrollment ended, dual eligibles can voluntarily enroll in the program at any time. Those dual eligibles enrolled in Cal MediConnect will receive their Medicare, Medi-Cal (including LTSS) and additional benefits including vision, transportation, and care coordination through a Cal MediConnect plan. Care1st, CareMore, Health Net, L.A. Care, and Molina act as Cal MediConnect plans in L.A. County.

Cal Mediconnect enrollment is voluntary, but all Medi-Cal beneficiaries including dual eligibles, with few exceptions, must be enrolled in a Medi-Cal plan to receive their Medi-Cal benefits.

Justice in Aging has published an “Advocates’ Guide” to the CCI that describes the CCI in detail. It is posted on *www.justiceinaging.org/wp-content/uploads/2016/10/CCI-Advocates-Guide_V5.pdf*

Resources:

www.calduals.org

dualsdemoadvocacy.org/california

MEDI-CAL ELIGIBILITY

Generally

Limited Resources

Eligibility is based on the amount of resources that a person possesses. A person's income determines whether she will be required to pay a monthly share of cost prior to receiving any coverage and, if so, how much.

An unmarried person is eligible for Medi-Cal benefits if she is aged or disabled (as discussed above), and has less than $2,000 in available countable resources. Availability of resources is discussed on page 6-15; a home is generally not considered an available resource. For a couple, the resource limit is increased (but not much) to $3,000.

Exception: those who are newly eligible for Medi-Cal under the Affordable Care Act will not have a resource test. See page 6-8 for more information about expansion Medi-Cal.

Citizenship and Residency

In order to qualify for Medi-Cal, a person generally must be a resident of the United States, or a noncitizen who is lawfully residing here. Emergency Medi-Cal services are available even to those persons whose immigration status does not allow Medi-Cal coverage otherwise. For a summary of eligiblity for federal programs for immigrants, see *http://www.nilc.org/wp-content/uploads/2015/11/med-services-for-imms-in-states.pdf*

Also, the person must reside in California. No particular duration of time is required; the key is whether the person intends to remain in the state, and eligibility is possible even if the person has just moved into the state. A California nursing home resident automatically is considered to have an intent to remain in the state.

REMEMBER:

Resources Determine Eligibility: an individual is ineligible if countable resources exceed the applicable limit.

Income Determines Share of Cost: an individual with a higher income may be eligible, but need to pay a "share of cost" of medical expenses each month before obtaining any Medi-Cal coverage. This is somewhat like a monthly deductible (see "Medically Needy" section).

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Age or Disability

For the purposes of this guide, Medi-Cal eligibility depends on the person being aged (at least 65 years old) or disabled. A person is considered disabled if she is determined to be unable to work for at least one year, due to a physical, mental, or emotional limitation. Eligibility is established after the Medi-Cal program makes this determination, even if the person at that point has been disabled for only a few weeks or even (theoretically) a few days.

More precisely, as shown by a comparison with Chapters 1 and 2, the Medi-Cal disability standard is the same as that used under the Social Security disability programs. A person automatically meets the disability standard if she:

- is receiving Social Security benefits based on disability,
- is receiving Medicare benefits, or
- had received Social Security disability, SSI, or Medicare benefits within the last 12 months and termination or suspension of those benefits was based on something other than no longer being disabled.

For purposes of one Medi-Cal program, the 250% working disabled program, "disabled" also applies to a person 65 and older who qualified for Social Security or Medi-Cal benefits on the basis of disability in the month preceding the month she turned 65.

After meeting the above, an individual can be eligible for Medi-Cal in a number of different ways. The most common possibilities are the following: automatic eligibility (e.g., on a linked program such as SSI), as a "Pickle person," under the Aged & Disabled Federal Poverty Level Program, as a "Medically Needy" person, or under the 250% working disabled program. Each of these is discussed in the following pages.

Kin Caregivers: *A kin caregiver (e.g., someone who is a caretaker relative of a child) who does not qualify for Medi-Cal based on the his/her own status might qualify for Medi-Cal as a caretaker relative of a child who is receiving cash aid. See also Chapter 10.*

Automatic (Categorical Eligibility): SSI

Some persons are automatically eligible for Medi-Cal based on eligibility for other public benefits programs. These persons are termed "categorically eligible" for Medi-Cal. Medi-Cal does not concern itself with these persons' income or resources because those issues have been addressed by another program.

Automatic eligibility is granted if a person receives payments from Supplemental Security Income/State Supplementary Payment (SSI/SSP).

This is the basis for automatic eligibility that is most applicable to older Californians and Californians with disabilities. Other grounds for automatic eligibility apply to families and children, and are not discussed in this guide.

Note: There is no automatic eligibility for CAPI recipients.

Advocacy Tip: Ask if your client has ever been eligible for SSI and Social Security. If so, see the resource available at http://www.healthlaw.org/issues/medicaid/eligibility-and-enrollment/2016Pickle#.WR5eYRPyvfY

Eligibility as a "Pickle Person"

If a person formerly received both SSI and Social Security benefits, but a Social Security cost-of-living increase now makes her ineligible for SSI, she nonetheless will be eligible now for Medi-Cal coverage as if she were still SSI-eligible. The key is whether she would have been eligible for SSI "but for" the Social Security cost-of-living increase. It is not required that the SSI termination be caused by the increase.

The term "Pickle" or "Pickle amendment" comes from the name of J. J. Pickle, a congressman from Texas who was responsible for the Pickle amendment maintaining Medicaid eligibility.

Example: Jane received both Social Security retirement benefits and a small amount of SSI benefits. After receiving an inheritance of $60,000, she became ineligible for SSI because she had gone over the $2,000 resource limit. Six years later, her resources had been spent to below $2,000 but, because of Social Security cost-of-living increases, she was not eligible for SSI. If her Social Security benefits had remained the same for those six years, she would have been SSI-eligible. Jane is a Pickle Person and eligible for Medi-Cal with no share of cost deductible.

Aged & Disabled Federal Poverty Level Program (A&D FPL)

A senior or a person with a disability is eligible for Medi-Cal with no share of cost deductible if her countable income is not more than 100% of the federal poverty level plus $230. In 2017, that means that a person whose countable income is not more than $1,235 qualifies for no-share-of-cost Medi-Cal.

For couples, this program provides Medi-Cal with no share of cost whose countable income does not exceed the federal poverty level plus $310, or the SSI/SSP payment rate for a couple, whichever is greater. In 2017, the income limit for this program is $1,664 per couple.

In determining the countable income, all the SSI rules apply relating to countable income (see p.6-12), PLUS the applicant may deduct any out-of-pocket health plan premium costs. Thus, where countable income is above the no-share-of-cost level, it is recommended that health insurance be purchased in order to bring the income down and avoid paying a huge share of cost deductible under the medically needy Medi-Cal program (discussed on p.6-8). One option is dental insurance because the costs usually are reasonable and there are benefits in having the coverage. Medigap insurance may also make sense in some circumstances (see Chapter 4 for discussion of Medigap insurance).

If a couple is above the income ceiling, one option is for the spouse who needs Medi-Cal the most to apply for the no-share-of-cost program. In 2017, one member of a couple whose income is not more than $1,835 would qualify for no-share-of-cost Medi-Cal under the A&D FPL program. ($1,235 + 600 = $1,835) As explained below, the other member of the couple would have a share of cost of $901 in the medically needy program. ($1,835 - $934 = $901).

For persons with countable income above the no-share-of-cost ceiling, the only option is the medically needy Medi-Cal program.

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"Medically Needy" Program for Seniors and Persons with Disabilities Who Don't Have Enough Money to Pay for Needed Health Care

Under the medically needy program, a person with income above the no-share-of-cost ceiling pays a monthly share of cost equal to the amount of countable income above $600; for a couple, the share of cost is the couple's income exceeding $934. These income limits ($600 for a person, $934 for a couple) have not been updated since July 1989.

The formula is as follows:

> Countable income (see p. 6-10) - income limit ($600/$934) = Medi-Cal Share of Cost (SOC)

For more details on Share of Cost see page 6-13.

Medi-Cal 250% Working Disabled Program

This program allows individuals with disabilities, including those aged 60-64, to purchase Medi-Cal as long as countable income is less than 250% of federal poverty level. Private or public pension or disability benefits are not counted toward income; regular Medi-Cal resource limits apply. For more information see: *http://wclp.org/wp-content/uploads/2016/06/Western_Center_2016_Health_Care_Eligibility_Guide_Full_rev.1.pdf#page=96*

Expansion Medi-Cal

Starting in January 2014, more people qualified for Medi-Cal as part of the Affordable Care Act (ACA), a.k.a. Obamacare.

Low-income Californians who previously weren't eligible now are able to get expanded Medi-Cal, including childless adults younger than age 65 who are not disabled. Anyone with an income at or below 138% of the federal poverty line will qualify. There is no limit on the amount of cash or other resources a person can have. Income is measured differently for expanded Medi-Cal: it is based on "Modified Adjusted Gross Income" (MAGI) as reported on federal tax returns.

The benefits package for expanded Medi-Cal is the same as that of regular Medi-Cal, including the availability of long-term services and supports like IHSS.

Anyone who is 65 or over or who has Medicare will not be eligible for expanded Medi-Cal. Also, anyone who qualifies for Medi-Cal under the existing program rules will not be eligible for expansion Medi-Cal. This means that the expansion of Medi-Cal for the most part will not change the options for current dually eligible or Medi-Cal only seniors and people with disabilities.

This guide does not address Covered California, the new health insurance exchange, or tax credits or subsidies that will be available to help people purchase insurance. For more information about these new programs, go to *www.coveredca.com*.

CALCULATING COUNTABLE RESOURCES AND INCOME

Countable Resources

As described in preceding paragraphs, the Medi-Cal program (except for expansion Medi-Cal) covers only persons or couples with limited resources. Resources include money, bank accounts, real estate, investments, insurance policies, and other items.

The Medi-Cal program, however, considers many resources unavailable or exempt, and will not count those resources against the applicable resource limit. For example, the value of a house used as a residence is considered exempt. An exemption for six months is granted for the proceeds from the sale of a house to be used to purchase another house, or to be used to move to the new house or repair and furnish it.

The Medi-Cal program also considers unavailable the value of household goods, a necessary automobile, term life insurance, burial plots, rings and/or jewelry, and irrevocable burial plans. The cash surrender value of a whole life insurance policy is considered unavailable only if its face value is no more than $1,500. Similarly considered unavailable is a revocable burial plan of not more than $1,500.

Property or equipment used in a business is considered exempt, including a bank account used in connection with the business. Rental property does not qualify as business property. However, if a person lives in a unit and rents out other units in the same building, the whole property is exempt under the home exemption.

Work-related pensions and retirement accounts (IRAs, for example) automatically are considered unavailable if owned in the name of the beneficiary's spouse, or if the beneficiary qualifies for Medi-Cal under the 250% working disabled program. Otherwise, if such pensions and retirement accounts are owned in the beneficiary's name, they are considered unavailable only if payment actually cannot be made from the pension or retirement account at the present time, or if periodic payments of principal and interest are being made to the beneficiary from the pension or account. If periodic payments are being made, the payments are considered income and accordingly are considered in the calculation of the beneficiary's countable income.

An annuity may be considered unavailable under certain circumstances. On the other hand, resources held in trust for a beneficiary generally will be considered available to her. A detailed discussion of these issues is beyond the scope of this manual; contact a knowledgeable attorney for advice.

Is the Home Counted As Resource When A Person Is Living Elsewhere?

In general, the fact that a person currently is not living in her home should not cause the home to be counted as a resource by the Medi-Cal program. The key in this situation – which generally occurs when the person is living in a nursing home – is that the person declare her intent to return to the home.

> *TIP: It should never be necessary to sell a home in order to establish eligibility.*

In other words, a nursing home resident does not have to sell her home in order to qualify for Medi-Cal. Under virtually all circumstances, the resident's home is considered an unavailable resource and is not counted against the Medi-Cal resource limitations.

Specifically, a home is an unavailable resource simply if the resident intends to return to her home. The Medi-Cal application asks the resident if she intends to return to her home; if that question is answered "yes," the Medi-Cal program will not count the value of the home against the resource limitation, even if the resident medically has no realistic chance of returning to his or her home.

The relevant question on the Medi-Cal application could be paraphrased as follows: "If the resident were completely healthy, would the resident live in her home?" If the answer to this paraphrased question is "yes," the answer on the Medi-Cal application also should be "yes." And even if the question originally were answered "no," the Medi-Cal program has specified that the answer can be changed to "yes" at any time.

In addition, the home is considered an unavailable resource if the resident's spouse or dependent relative lives in the home. Also, the home is an unavailable resource if the resident's child, brother, or sister (1) lives in the home, and (2) began living in the home at least one year before the resident entered the nursing home.

Regardless of the preceding discussion, nursing home residents and their families often are told to sell the resident's home to pay for nursing home care. This is particularly bad advice: such a sale converts an unavailable resource (the home) into an available resource (cash), which will likely make the resident ineligible for Medi-Cal for an extended time period.

It should be noted that an intent to return to a home does not exempt a home from a Medi-Cal estate claim, following the resident's death. For obvious reasons, an intent to return home matters only when a Medi-Cal beneficiary is alive. Following the beneficiary's death, the Medi-Cal program may attempt to obtain repayment from a home's value, before the home is passed on to the heirs of the deceased Medi-Cal beneficiary.

Medi-Cal estate claims are discussed in more detail later in this chapter.

> *Note: Federal law changed in February 2006 to require states to set caps on home equity for eligibility for nursing home care and for home and community based waiver services. California has not yet implemented these caps. When implementation does take place, the cap will be set at $750,000, the highest cap federally allowed.*

Joint Accounts

The entire contents of a joint account are presumed to be available to the applicant, unless she clearly can trace all or part of the joint account to income or transfers of the other person listed on the account.

Countable Income

There are two categories of income: unearned income (for example, Social Security retirement benefits) and earned income (for example, wages from a job). Since older Medi-Cal beneficiaries are likely retired or disabled, unearned income is more common than earned income.

Almost all unearned income is counted. A mere $20 can be disregarded.

In order to encourage employment, the Medi-Cal rules treat earned income more generously. A Medi-Cal beneficiary can disregard $65 plus one-half of the remainder when determining countable income.

Income received from a reverse mortgage is exempt. However, the income remaining as of the first of the next month is counted against the resource allowance.

See Chapter 2 for further discussion of the income counting rules.

Q. How much is countable of a monthly income of $1,265?

A. It depends on whether the income is unearned or earned.

If the income is unearned, $1,245 is countable. ($1,265 - $20 = $1,245) If the income is earned, $600 is countable. ($1,265 - $65 = $1,200; $1,200 ÷2 = $600)

If $600 of the income is unearned, and the remaining $665 is earned, then $880 is countable. ($600 - $20 = $580; $665 - $65 = $600; $600 ÷2 = $300; $580 + $300 = $880)

Medically Needy: Share of Cost

Generally

As discussed above, Medi-Cal with no share-of-cost is provided to persons who are automatically eligible, who are eligible as Pickle Persons, or who are eligible under the no-share-of-cost program. For the purposes of this guide, other beneficiaries are eligible under the "medically needy" program, and are required to pay—or incur an obligation to pay—a monthly share of cost deductible.

The share of cost is the difference between the person's countable income and the state's maintenance allowance. As mentioned previously, the allowance is $600 for a person and $934 for a married couple.

Note the drastic consequences of missing even slightly the no-share-of-cost territory. If a person has a countable monthly income of $1,225, she automatically receives Medi-Cal with no share of cost under the A&D FPL program. If, however, her income increases by just $20, to $1,245, her monthly share of cost is $645.

As discussed above, purchasing health insurance (maybe dental insurance) can be a wise move if the insurance premium reduces the person's countable income enough to qualify for the no-share-of-cost program.

Remember, individuals who make IHSS payments to providers can count those payments toward their Share of Cost. See Chapter 7.

Q. Mr. X has $1,500 in resources. His only income is a monthly pension of $1,260. Is he eligible for Medi-Cal? Does he have a share of cost?

A. Mr. X is eligible because he has less than $2,000 in resources. His countable income is $1,240 ($1,260 - $20). His countable income is over the Aged & Disabled Federal Poverty Level ceiling of $1,235. His monthly share of cost under the Medically Needy program is $640 ($1,240 - $600 = $640).

Incurring Debt Is Enough For Share of Cost

A share of cost can be met by paying or incurring a debt for health care. It is not necessary that the health care provider be paid at that time, but only that the obligation be incurred.

Bunching Health Care Expenses In Same Month

To the extent possible, a Medi-Cal beneficiary with a relatively significant share of cost should try to bunch her health care expenses in the same month.

Example:

Assume that a beneficiary has a monthly share of cost of $400. Her payment of $200 each month for therapy will never meet the deductible by itself. If, on the other hand, she were to pay $800 for four months of therapy at once, she would meet the deductible, and Medi-Cal at that time would pay $400 for one-half of the therapy - two months' worth.

Share of Cost May Be Met By Payment For Healthcare That Would Not Be Covered By Medi-Cal

For purposes of meeting a share of cost, it is irrelevant whether the health care would be covered by Medi-Cal.

Unmarried nursing home residents in particular can take advantage of this rule. There is no reason for a nursing home resident to try to economize on health care, because by itself the nursing home expense more than meets the resident's share of cost.

Also, as discussed below, an unmarried nursing home resident generally has a relatively large share of costs, since a resident's income allocation is only $35.

In California, a Medi-Cal office may recognize this procedure for nursing home residents as the *Johnson v. Rank* procedure. Under the *Johnson v. Rank* procedures, the item or service to be covered under share of cost needs to be in your plan of care.

Example:

A nursing home resident has a share of cost of $800. Ordinarily, she pays the $800 to the nursing home, and the Medi-Cal program pays the remainder of the nursing home charges. But the resident instead can meet her share of cost by paying the $800 for specialized therapy ordered by her doctor. The Medi-Cal program then will pay the entirety of the nursing home charges.

Share of Cost May Be Satisfied By Payment for Past-Due Health Care Expenses

Paying a past-due health care bill is one example of a way to spend the share of cost amount on an expense that would not be covered by Medi-Cal. The past-due bill must have been incurred during a period of time prior to the month in which the beneficiary became Medi-Cal eligible.

This share-of-cost strategy can be very useful in the not uncommon situation where a Medi-Cal beneficiary is saddled with a health care bill that she otherwise would never be able to pay. A Medi-Cal office will know this strategy as the *Hunt v. Kizer* procedure.

The Tardy Medi-Cal Application

It's an unfortunately common situation. An elderly person, usually residing in a nursing home, has had her resources spent down to the brink of Medi-Cal eligibility. If just a bit more of the resources were to be spent-on the nursing home bill, for example-a Medi-Cal application could be approved without a problem.

But of course, in the sad story that you hear in your office, the resources were not spent below the Medi-Cal eligibility level, and a Medi-Cal application was not filed on a timely basis. Instead, the son or daughter handling the finances simply quit paying the nursing facility bills and other health care expenses, hoping that some benevolent cosmic force would initiate Medi-Cal eligibility. Although the son or daughter eventually filed the Medi-Cal application, it was denied summarily by the Medicaid program, because the applicant's resource level was still too high.

When Medi-Cal finally is approved, after the passage of many months, the elderly person has Medi-Cal coverage for future health care expenses, but she has no way to pay the thousands of dollars of health care expenses that were incurred during the time that the son or daughter was stumbling through the Medi-Cal process.

The problem can be moderated somewhat by the availability of three-month retroactive coverage although, of course, retroactivity is only useful if the applicant was eligible during the three months prior to the filing of the application.

The best remedy for this problem is applying the past-due bill towards the person's monthly share-of-cost obligation, for those persons who have enough income to be assessed such a monthly deductible. Assume, for example, that a nursing home resident owes $5,000 for past-due nursing home expenses, and has a monthly share-of-cost of $500. If the $500 is designated towards the past-due balance (rather than towards current-month expenses), the Medi-Cal program will pay the entirety of the current month's health care expenses. After ten months, the past-due balance will be paid off, and the resident can resume designating the $500 towards current-month expenses.

FINANCIAL ELIGIBILITY RULES FOR NURSING HOME RESIDENTS

Eligibility for Unmarried Nursing Home Residents

Eligibility for an unmarried nursing home resident is determined the same way it is determined for a single person living in the community. The relevant question is: Are available resources $2,000 or less? If the answer is yes, the applicant is eligible.

As discussed above, the home is not counted if an unmarried nursing home resident states her intent to return to the home.

Q. Alfredo is a resident in a nursing home. He is single. The nursing home charges $5,000 each month. Alfredo has savings of $1,500 and a monthly income of $700. Is he eligible for Medi-Cal? How much does he pay the nursing home each month? How much will he have to pay monthly if the nursing home is not certified for Medi-Cal?

A. Alfredo is eligible and will pay a monthly share of cost of $665. ($700 - $35 = $665) If the nursing home is not certified, Medi-Cal will not pay, and he will be liable for the entire $5,000 each month.

Share of Cost for Unmarried Nursing Home Residents

The income disregards for unearned and earned income do not apply, and the monthly income allocation is only $35. This miniscule amount is based on the Medi-Cal program's assumptions that a resident's basic needs – room and board, plus necessary health care – all are furnished by the nursing home.

SSI Payment When Resident Has No Other Income

In rare instances, a resident will have no income. The SSI/SSP program will provide an income of $50 per month (assuming that the resident's resources are no more than $2,000), and the resident automatically will be eligible for Medi-Cal. If, however, an SSI recipient is expected to be in the nursing home for no more than 90 days and needs the full monthly SSI benefits in order to maintain a home, full SSI benefits will be continued on a temporary basis even if the resident's stay ends up exceeding 90 days.

Maintaining The Home While In Nursing Home

Obviously, $35 per month is not enough to allow a nursing home resident to keep up with monthly rent or mortgage payments. To address this situation (although not very well), the Medi-Cal program allows a resident to keep an additional income allocation for home-related expenses if a doctor certifies that the resident will need nursing home care for no more than six months.

Unfortunately, this allocation is only $209 per month which, although better than nothing, probably is not enough to allow a resident to keep up with rent or mortgage obligations.

If a resident expects to be in a nursing home for no more than 90 days, she should consider remaining on regular community Medi-Cal, by refusing to apply for long-term care Medi-Cal. This may allow her to retain more income. See above.

TIP- If the resident's home is rented, the rental income can be applied towards mortgage payments and other house expenses. Overall the resident will not profit - because any initial profit will increase the resident's share of cost - but at least the resident can use the rental income to pay expenses.

Eligibility for Married Nursing Home Residents

As described in the preceding paragraphs, the Medi-Cal program generally does NOT pay for care until a nursing home resident has virtually spent all of his or her available resources. As a result, in past years a spouse of a nursing home resident had been forced to spend virtually all of the couple's resources for nursing home care.

In response to this situation, federal and state governments decided that the Medi-Cal program should allow a spouse of a nursing home resident to retain additional resources and income (assuming the spouse does not also live in a nursing home).

Consequently, a couple comprised of a nursing home resident and an "at-home" spouse is eligible for Medi-Cal payment of the nursing home charges if the couple does not have over $120,900 in available resources (for 2017).

Within 90 days after Medi-Cal eligibility of a married resident is established, the couple must allocate their resources between themselves so that no more than $2,000 in available resources is held in the resident's name. Once this allocation is complete, the resident will remain eligible for Medi-Cal as long as his or her available resources do not exceed $2,000, regardless of the amount of his or her spouse's resources.

Q. What if the resident's spouse receives a $150,000 bequest while her husband is in the nursing home?

A. The bequest will not affect her husband's Medi-Cal eligibility, assuming that eligibility was established before the bequest was received.

Share of Cost for Married Nursing Home Residents

From the couple's joint income, the at-home spouse is allowed to keep an individual monthly income of at least his or her individual monthly income or $3,023 (for 2017), whichever is greater. Of the couple's remaining income, $35 is given to the resident as a personal allowance and the remainder is applied to nursing home charges and to certain current and past medical bills. The Medi-Cal program then will pay the remainder of the nursing home charges.

Q. Marcus lives in a nursing home; his wife Evelyn lives in an apartment. The nursing home charges $4,000 per month. Marcus and Evelyn jointly have $80,000 in savings. Marcus receives $1,100 monthly from Social Security; Evelyn receives an $900 monthly pension. Is Marcus eligible for Medi-Cal? How much will he have to pay the nursing home each month?

A. Marcus is eligible because the couple's joint resources ($80,000) are less than the resource maximum of $120,900. He will not have to pay the nursing home anything: the couple jointly is entitled to retain up to $3,058 ($3,023 + $35 = $3,058), and their monthly income is only $2,000. ($1,100 + $900 = $2,000)

Q. What will the share of cost be if Evelyn's monthly income increases to $2,500 per month?

A. Evelyn will keep her $2,500 income, and can obtain an allocation of $523 from her husband to reach the at-home spouse income allocation of $3,023. Marcus can retain his income allocation of $35, and he will pay a share of cost of $542 monthly. ($1,100 - $523 - $35 = $542)

Q. What will the share of cost be if Evelyn's monthly income increases to $3,500 per month?

A. Evelyn is allowed to keep her entire income. The income allocation of $3,023 does not limit her income; it just limits the amount of income that she can be allocated from her husband's income. Marcus is allowed to retain his $35 income allocation, and he must pay a share of cost of $1,065 ($1,100 - $35 = $1,065).

Increased Resource Allocation for Generating Adequate Income

Under certain circumstances, an at-home spouse can obtain an order from a court or an administrative law judge which will allow the at-home spouse to retain additional resources. An order may be granted if the at-home spouse needs the resources in order to generate an adequate income. Specifically, an order can allow the couple to retain more than $120,900 in available resources, if the income which could be generated by the retained resources would not cause the total monthly income available to the at-home spouse to exceed $3,023.

This can be an extremely important provision for the frugal clients who have low incomes but have managed to save significant amounts of money.

Increased Income Allocation for Emergency Situations

A court or administrative law judge may increase the spouse's income allocation above $3,023 if the extra income is necessary "due to exceptional circumstances resulting in significant financial duress." Courts and administrative law judges rarely grant such orders, unfortunately.

EXAMPLE

Assume that Marcus & Evelyn have savings of $200,000, Marcus (the nursing home resident) receives a monthly Social Security payment of $700, and Evelyn receives a monthly pension of $300.

At first glance, Marcus appears to be ineligible for Medi-Cal, because the couple's joint savings of $200,000 far exceed the resource limit of $120,900. However, because the couple's joint income, including interest income, is less than the couple's total income allowance of $3,058, the couple will be allowed to retain all of their savings.

Assume a 6% simple interest rate on the couple's savings. The couple's savings account produces $12,000 in interest each year, or $1,000 monthly. Thus, the couple's monthly income totals $2,000: Marcus' $700 payment plus Evelyn's $300 pension plus the $1,000 interest.

Because the couple's total monthly income of $2,000 is less than the $3,058 total income allowance for the couple ($3,023 for Evelyn, and $35 for Marcus), the couple can obtain an order which will increase their resource allowance to a total of $200,000.

Giving Away Resources to Become Medi-Cal Eligible

Older persons often give away resources to children and grandchildren. Sometimes these gifts have nothing to do with Medi- Cal eligibility – the older person just wants to have the pleasure of giving the gift during her lifetime, rather than having the gift be made after her death, through operation of a will or trust.

On the other hand, sometimes these gifts are made with Medi- Cal eligibility in mind. An older person who is in a nursing home, or expects to enter a nursing home in the near future, gives away resources in order to create or accelerate Medi-Cal eligibility.

For understandable reasons, the Medi-Cal program doesn't want nursing home residents to give their resources away and immediately apply for Medi-Cal. As explained below, the Medi-Cal program assesses a period of ineligibility based on the size of a gift.

In general, a resident's giving away of resources causes the resident to be ineligible for Medi-Cal reimbursement from the month of the give-away for the amount of time those resources could have paid for nursing home care. (For this calculation, the Medi-Cal program assumes nursing home costs of approximately $8,515 monthly.) Any transfer of resources for which the resident received adequate compensation is considered a sale, not a give-away, and does not result in Medi-Cal ineligibility.

This general rule has multiple exceptions. For example, a give-away of resources to a resident's spouse or disabled child will not create Medi-Cal ineligibility. Transfer of any resource considered unavailable by the Medi-Cal program also will not create ineligibility. In addition, the Medi-Cal program will not penalize a resident for a give-away which occurred more than two and a half years before the month of the Medi-Cal application.

The most important fact is that the period of ineligibility starts in the month in which the give-away was made, even if the Medi-Cal application was not filed until much later.

As shown by the Q and A's below, a period of ineligibility can be essentially irrelevant, if it expires before the resident is otherwise eligible for Medi-Cal.

The relevant law is complicated—even more complicated than this short answer suggests. No one should make an eligibility-accelerating give-away without first consulting with a knowledgeable attorney.

Federal law changed in February 2006, and these changes will be adopted by California within the next year or two. Under the changes, a period of ineligibility will almost always be relevant, because ineligibility will start in the month in which the resident otherwise would have been eligible for Medi-Cal. Also under the changes, the Medi-Cal program will look back five years rather than two and a half. The new rules will not apply to transfers made before the rule change.

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Q. Priscilla lives in a nursing home. She has $1,400 in savings, and a monthly income of $1,500. In June 2015, she gave $63,000 as a cash gift to her daughter. Is she eligible for Medi-Cal today? When could she successfully apply for Medi-Cal?

A. Priscilla is eligible today. The money given away ($63,000) would have been enough to pay for seven months of nursing home care. The seven-month penalty period began in June 2015, and ended at the end of January 2016.

Q. Frank also lives in a nursing home. In June 2015 he gave $684,000 to his daughter. When could he successfully apply for Medi-Cal? What would happen if he applied for Medi-Cal today?

A. Frank should not file an application until December 2017. The Medi-Cal program so far will only look back two and a half years, so if an application is filed in December 2017, the look-back will not include June 2015, the month in which the gift was made.

If Frank were to apply today, he would be penalized 80 months (over six years), starting from June 2015. Frank would not be eligible for Medi-Cal coverage of nursing home care until 2021.

Share of Cost if Beneficiary Lives in Residential Care Facility for the Elderly

A resident's payment to a Residential Care Facility for the Elderly (RCFE) is taken into account in the calculation of the Medi-Cal monthly "share of cost."

As discussed above, health care services are provided with no share of cost if a single Medi-Cal beneficiary has a countable monthly income of no more than $1,235 for 2017. RCFE residents with a countable monthly income of more than $1,235 generally will have a Medi-Cal share of cost. If, however, the resident pays a monthly facility fee, the share of cost will be the difference between the countable monthly income and the facility's monthly fee.

Medi-Cal is now covering care (but not room and board) in RCFEs in several California counties. This includes services for several hundred Medi-Cal recipients in Los Angeles County who otherwise would require care in a nursing facility. The services are being provided under a home and community based services waiver called the Assisted Living Waiver Pilot Project. For contact information for Los Angeles and for the other counties (Riverside, Sacramento, San Bernadino, San Joaquin) see *http://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx*.

EXAMPLE

An RCFE resident has a countable monthly income of $1,300. In general, she will have a monthly Medi-Cal share of cost of $700 ($1,300 - $600 = $700). If, however, the facility costs $1,000 monthly, the resident's share of cost would be reduced to $300 ($1,300 - $1000 = $300).

MEDI-CAL PROGRAM SEEKING REPAYMENT FOLLOWING DEATH OF MEDI-CAL BENEFICIARY

Medi-Cal Estate Claims

After a resident's death, the Medi-Cal program can take money from a resident's estate to repay the Medi-Cal program for benefits paid on behalf of the resident. However, the Medi-Cal claim is limited to the amount of Medi-Cal payments made on behalf of the Medi-Cal beneficiary, or the value of the beneficiary's estate, whichever is less.

Also, the Medi-Cal program cannot make a claim against the resident's estate if the resident is survived by a spouse, a minor child, or a child who is disabled under the standards of the Social Security Administration. In addition, under the provisions of the California Partnership for Long-Term Care, the Medi-Cal program cannot make a claim against a certain amount of a resident's estate if an insurance policy certified by the Medi-Cal program paid at least that amount to a nursing home on the resident's behalf. Furthermore, the Medi-Cal program must waive an estate claim if the resident's heirs show that enforcement of the claim would cause them to suffer a substantial hardship.

The law pertaining to Medi-Cal estate claims is complicated, and changes frequently. Specific questions should be directed to a knowledgeable attorney. Resource: New Medi-Cal Recovery Laws: *http://www.canhr.org/publications/PDFs/Medi-Cal_Recovery.pdf*

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APPLICATIONS

Applying

If a person has automatic eligibility, no application is necessary. Otherwise, an application must be submitted. Applications are processed in the local office of the Department of Public Social Services (DPSS). Applications can also be made through Covered California.

In the case of older persons, applications generally are submitted directly to the local DPSS office. Nursing home residents may receive substantial assistance from the facility's social worker. Also – although this service is generally more used by younger Medi-Cal beneficiaries – an application may be submitted at a hospital or clinic, if a county DPSS eligibility worker is stationed there.

The application for SSI/SSP is also an application for Medi-Cal. So, if SSI is denied because of a too-high income, and the applicant then takes the denial letter to Medi-Cal within 30 days of the date of the denial, the date of application for Medi-Cal will be the SSI application date.

Retroactive Eligibility

Eligibility for Medi-Cal can be made retroactive for up to three months preceding the month in which the application is filed. Of course, the applicant must have been financially eligible for each month in which retroactive eligibility is requested.

Submitting Information

The applicant will be required to document her age, resources, and income. If the applicant is under age 65 and is not receiving Social Security benefits based on disability, she will be evaluated to determine if she meets the Social Security definition of disability. Because of changes in federal law, applicants - and current recipients - may be required to provide documents that show that the applicant or recipient is a citizen or is a legal resident. Documentation will not be required for those who receive Social Security or SSI benefits.

TIP- *To the extent possible, an applicant should make things easy for the Medi-Cal program. Make copies of all relevant financial records, and organize those copies for easy review. Prepare a cover page or pages that summarize all of the financial information. Pull together medical records showing that the applicant meets the Social Security definition of disability. For example, the process might be expedited by a letter from the treating physician, explaining why the applicant meets a particular Social Security disability listing.*

If a family member or friend of the applicant is willing to help in getting medical evidence, include a letter release, signed by the applicant, indicating that the friend or family member will help in getting any missing information.

Processing of Application

An applicant should receive an approval or denial of the application within 45 days of submitting the application. If, however, a disability determination needs to be made, the application processing period is extended to a total of up to 90 days.

Notice of Action

The Medi-Cal program's decision is mailed in a Notice of Action, which must describe the action taken and the reasons for that action. The Notice of Action will describe how a decision can be appealed.

Usually an appeal is made with the Notice of Action form itself, by writing in the reason for appeal in the space provided, and mailing the Notice of Action to the address listed. An applicant or advocate should make a copy of the Notice of Action before mailing it back.

MEDI-CAL SERVICES

Medi-Cal Managed Care

Over the last decade, California has been moving most populations eligible for Medi-Cal benefits from fee-for-service into managed care. Today, approximately 10.7 million Medi-Cal beneficiaries residing in 30 counties receive their medical services through health plans mirroring traditional health maintenance organizations (HMOs). The movement of Medi-Cal only beneficiaries into managed care began in 2011. Los Angeles County uses a two-plan model where there is one Local Initiative plan (LA Care) and one commercial plan (HealthNet).

Under Medi-Cal managed care, a beneficiary is enrolled in a plan to receive her Medi-Cal benefits. Beneficiaries can also choose to enroll in a partner plan. LA Care partners with Anthem Blue Cross, Care1st, and Kaiser. Health Net partners with Molina. The plan is paid a single rate from the State to deliver a beneficiary's health care services. Plans contract with providers including, for example, doctors, specialists, hospitals, and pharmacies to develop a "network." Individuals enrolled in a managed care plan will be assigned a primary care physician who is responsible for referring the beneficiary to other care providers. Unlike fee-for-service where a provider obtains approval through the Treatment Authorization Request (TAR) process, under managed care the plan must approve services.

Dual eligible enrolled in a Medi-Cal plan primarily use Medi-Cal managed care providers only for their long-term services and supports and services not covered by Medicare (e.g. transportation and supplies). This is because their medical care is generally covered by Medicare. The Medi-Cal plan is also responsible for paying an co-insurance payable after Medicare has paid.

Fee-For-Service Prior Approval

Though rare, some individuals do still access their Medi-Cal through fee-for-service. Fee-for-service Medi-Cal requires prior approval for some services and medications. No prior approval is needed for emergency care, most physician services, or for up to six per month of medications on Medi-Cal's formulary (list of medications).

To obtain prior approval, health care providers submit a Treatment Authorization Request (TAR). If a TAR is denied, the Medi-Cal program should send a Notice of Action to the health care provider and the beneficiary, with an explanation of the denial and information about appeal rights.

Except for medical transportation TARs, the Medi-Cal program will look only at the documents submitted by the provider in support of the TAR. Many TARs are denied because the medical justification is notcomplete. Before a beneficiary appeals adenied TAR, she should look at the packet submitted to Medi-Cal to see if there was enough information to show that the item was really needed, and that the Medi-Cal medical necessity definition had been met.The Medi-Cal program covers services, medicines, supplies and devices necessary to protect life, prevent significant illness or disabilit, or alleviate severe pain. The standard is much more limited than a commonsense definition of necessity.

Physician documentation can be essential. For instance, for medications not on the Medi-Cal formulary, the beneficiary's physician should write a letter explaining why medications on the formulary are inadequate, and what could happen if the beneficiary did not receive the medication. The pharmacist then can fax the physician's letter together with the TAR form for review by the Medi-Cal program.

Medication TARs that are not acted on by the close of the next business day are automatically approved. Other TARs are automatically approved if they are not acted on within 30 days of the date of receipt by the Medi-Cal program.

Appeals of Denied TARs

The reality is that TAR denials often are not sent to beneficiaries. The Medi-Cal program often — and wrongly — treats TAR-related matters as private correspondence between Medi-Cal and the provider.

Don't be shy in requesting copies of documents (including TARs and TAR denials) from the health care provider. Also, of course, don't be shy in filing appeals of denied TARs. If you were not sent a denial notice, an appeal probably will be timely even if more than 90 days after the denial.

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Services Provided

As appropriate for a safety-net health care program, the Medi-Cal program covers a range of services. These services include the following:

- Doctor visits;
- Hospital inpatient and outpatient care;
- Nursing home care;
- Medications (although Medicare Part D covers medications for many Medi-Cal beneficiaries);
- Home health care;
- Personal care services (IHSS);
- Hospice care;
- Physical therapy;
- Hearing aids (see page 6-34);
- Ambulance services; and
- Medical transportation to and from medical appointments;
- Durable medical equipment, including wheelchairs, suctioning machines, shower chairs, oxygen, ostomy supplies, etc. (see page 6-34);
- Specialty mental health services including psychiatric services through local Mental Health Plans;
- Drug and alcohol treatment programs; and
- Dental benefits as of May 2014
- Non-Medical Transportation: starting in July 2017, health plans will be responsible for providing transportation to medical services by any mode (e.g. car, bus, train, etc.)

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Getting Services For Persons Eligible for Medi-Cal and Medicare

For services covered by both Medi-Cal and Medicare, the Medi-Cal program defers to the Medicare program's more common sense definition of medical necessity. Usually billings are sent electronically to Medicare and then are sent electronically to Medi-Cal. When a dual eligible is enrolled in a Medi-Cal plan (as is the case now for almost all dual eligibles residing in Los Angeles County), Medicare providers will submit the bill to Medicare and then separately submit the claim to the dual eligible's Medi-Cal plan. Medi-Cal will supplement the 80% of reasonable cost that Medicare pays (see Chapter 4) up to the amount that Medi-Cal would pay were it the sole payor. That usually is zero, given that Medi-Cal reimbursement rates generally are low.

The one area where different rules apply is with respect to durable medical equipment, especially custom or power wheelchairs. In the area of wheelchairs there is incompatibility between Medi-Cal and Medicare because of Medicare's "homebound" rule for home health care (see Chapter 4). Under Medicare, a beneficiary receives the wheelchair that she needs to get around the house. Under Medi-Cal, she receives a wheelchair that allows her also to travel in the community.

If a dually-eligible person needs a power wheelchair or wheelchair with any kind of custom feature, she should get a good assessment from an outpatient rehabilitation facility like Rancho Los Amigos or Northridge Hospital. Their outpatient programs know how to put together a report explaining what she needs and why. These outpatient programs also will be able to help her find a provider who will accept someone with both Medicare and Medi-Cal.

The person's physician can prescribe the equipment recommended by the outpatient program. The person then brings to the durable medical equipment provider the following documents: the physician's letter, the assessment report, and any other medical records – such as a hospital discharge summary – describing disability-related limitations. The provider submits a Treatment Authorization Request (TAR) to the Medi-Cal program or a prior authorization to the Medi-Cal plan.

If the authorization is approved, the provider delivers the equipment and then submits billing to the Medicare plan. The Medicare program pays 80% of what it says is the reasonable cost (see Chapter 4), and then sends the claim to the Medi-Cal program, which pays the other 20%. Then the provider bills the Medi-Cal program separately for the difference between what Medi-Cal would pay were it the sole payor, and what the provider received jointly from Medi-Cal and Medicare in the crossover electronic billing system. This procedure is known as the Charpentier procedure.

Of course, the most common overlap between Medi-Cal and Medicare involves the payment for medications by Medicare Part D. This topic is covered in detail in Chapter 5.

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Medical Need for Nursing Home Care

In contrast to the Medicare program, the Medi-Cal program does not have restrictive medical requirements for the coverage of nursing home care. It is only required that the resident require nursing home care; it is irrelevant whether the nursing home care is considered skilled care or custodial care.

Medi-Cal Will Pay for Care in a Residential Care Facility for the Elderly

In Los Angeles County and selected other counties

Medi-Cal, under a pilot-program waiver, will be paying for several hundred slots in Los Angeles County RCFEs. Also, both the Medicare and Medi-Cal programs can pay for certain health care services provided in a Residential Care Facility for the Elderly by licensed health care professionals. Generally these services are provided through an outside agency - a home health agency or, in the case of a terminally-ill resident, a hospice agency. For more information, see *www.dhcs.ca.gov/services/ltc/pages/AssistedLivingWaiver.aspx.*

Community Based Adult Services (CBAS)

Community Based Adult Services (CBAS), formerly known as Adult Day Health Care (ADHC), can be provided to Medi-Cal beneficiaries who have intensive health careneeds. Center-based services provided can include medical and nursing services; physical, occupational and speech therapy; psychiatric and psychological services; social services; recreational and social activities; hot meals; nutritional counseling; laundry; bathing; and transportation to and from the center.

Provision of CBAS under Medi-Cal requires a doctor's authorization and subsequent approval by the Medi-Cal program/plan. Participants must meet the criteria for Nursing Facility-A Level of care, or have certain mental or cognitive impairments, as well as CBAS eligibility and medical necessity criteria. For more information about the new CBAS program, see *www.dhcs.ca.gov/services/medi-cal/Pages/ADHC/ADHC.aspx.*

In addition, starting in October 2012, CBAS participants who are in counties where Medi-Cal managed care is available must enroll in the Medi-Cal managed care plan in order to get CBAS. They can continue to see their Medicare doctor for Medicare services.

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Transportation

The Medi-Cal program provides emergency transportation as well as transportation to and from routine medical appointments. Payment for non-emergency transportation only is possible for beneficiaries who are physically or mentally unable to use other forms of private or public transportation.

Prior authorization is not required for emergency transportation to the nearest qualified facility. On the other hand, prior authorization is generally required for non-emergency medical transportation.

Starting in July 2017, the Medi-Cal program will pay for Non-Medical Transportation (NMT) to medical services. This will include transportation or reimbursement for transportation by car, bus, train, etc

Multipurpose Senior Service Waiver Program (MSSP)

The MSSP waiver provides social and health care management for seniors who are certifiable for placement in a nursing home, but who wish to remain in the community. A MSSP client must be 65 years of age or older, live within a MSSP site's service area, and have health care needs that would qualify her for nursing home admission.

The word "waiver" refers to a waiver of the federal Medicaid law that generally requires that all Medicaid services be available equally across a state. MSSP services are limited; each MSSP site has only a certain number of waiver slots.

The MSSP waiver includes an "institutional deeming" feature. That means that for the member of the couple who is a senior and who would qualify for nursing facility care, eligibility for Medi-Cal will be made as if he or she were living in a nursing facility. The MSSP waiver is a means by which the spouse who would otherwise qualify for Medi-Cal funded nursing facility care may qualify for Medi-Cal while living at home, sometimes with no share of cost.

MSSP waiver services can include:

- Intensive medical case management, including nursing and psychosocial assessments;
- Attendant care and homemaker services;
- Transportation;

- Nutritional supplements and home delivered meals;
- Counseling;
- Durable medical equipment and supplies;
- Adult day care;
- Housing assistance (i.e., replacement of stove or refrigerator) and modifications;
- Money management and assistance with bill paying;
- Protective supervision; and
- Respite care (care in facility, to provide respite to regular caregivers).

Note: This program is going to be added to the benefits offered through Medi-Cal managed care under the Coordinated Care Initiative. At least initially, MSSP should not change as a Medi-Cal managed care benefit.

Other Waiver Programs

Persons with disabilities and seniors also may be eligible for services under the combined nursing facility and acute care waiver administered by In-Home Operations through the Department of Health Care Services.

Like the MSSP waiver, this waiver includes an "institutional deeming" feature that applies the same financial eligibility rules that would apply if a married person were receiving care in a nursing home.

The services available under this waiver include home nursing, utility payments, home modifications for accessibility, and case management. In addition, the waiver includes supplemental waiver personal care services that can be combined with personal care services authorized by IHSS.

APPEALS

From the date listed on a Notice of Action, an applicant or beneficiary generally has 90 days in which to appeal. The applicant or beneficiary should follow the directions on the Notice of Action.

If a Notice of Action is not available, an appeal request should be mailed to Office of the Chief Administrative Law Judge, State Hearings Division, Department of Social Services, 744 "P" Street, Mail Station 9-17-37-95814, Sacramento California 95814. The applicant or beneficiary should indicate that she is asking for a Medi-Cal fair hearing, and should list her name and Social Security number. Alternatively, an appeal request can be made by calling (800) 952-5253, or faxing an appeal request to (916) 651-5210 or (916) 651-2789. It is recommended that a faxed request also be mailed. You can also mail a copy to your county office.

***Tip**: When making an appeal by phone (the fastest way to preserve aid paid pending) call: (800) 952-5253, then*

1. *press 1 for English when prompted*
2. *then press 1 for state fair hearing*
3. *then press 1 for hearing info*
4. *then press 3 and hold for a live person (8-12, 1-5 on weekdays except holidays).*

Continuation of Benefits While Appeal Is Pending (Aid Paid Pending)

If an appeal is requested promptly, existing benefits will continue at least until the hearing decision is issued. To obtain continuing benefits, the appeal generally must be made within ten days of the issuance of the Notice of Action or before the effective date of the termination or change in benefits.

Appeal Hearings

Appeals are somewhat informal, and are conducted by a hearing officer employed by the state. Although Medi-Cal beneficiaries can represent themselves, representation by an attorney is advised.

Appeal in Managed Care

If a Medi-Cal managed care plan denies, reduces, or terminates services, like under fee-for-service a beneficiary has appeal rights. A beneficiary can file both an internal appeal with the health plan and request a state fair hearing (the same process as in FFS Medi-Cal). Generally, advocates recommend filing both an internal appeal and a request for a fair hearing at the same time, and then withdrawing or postponing the fair hearing if the plan favorably resolves the internal appeal. The appeal may result in more information from the plan about the issue as well as quicker

resolution of the dispute, while the request for a state fair hearing maximizes the beneficiary's due process rights. However, a request for a state fair hearing can preclude the right to an Independent Medical Review (described in the following paragraphs).

Whether a beneficiary files an internal plan appeal or requests a state fair hearing, if that request is made within 10 days of a notice of action reducing or terminating ongoing services, the plan must provide aid paid pending. In any case, a request for a fair hearing must be made within 90 days of the notice of action unless there is a good reason that the deadline was missed (e.g., the notice was not received).

To file an internal plan appeal, the beneficiary should follow the managed care plan's appeal process. If the plan's initial response does not favorably resolve the issue, the beneficiary then may file the appeal with the Department of Managed Health Care (DMHC) for an external review of the decision.

There are two options at the external review stage: either requesting an Independent Medical Review (IMR) by an external medical expert if the denial involves a medical judgement, or filing a complaint with DMHC for all other issues. The IMR is available if the beneficiary has already used the internal plan appeal process and was denied, or received no answer within 30 days. An IMR can be requested in cases where the plan finds that the service is not medically necessary; the plan refuses to pay for out-of-network emergency or urgent care; or the plan says that the treatment requested is experimental or investigational. An IMR must be requested within six months of the plan's written response to an appeal. A beneficiary cannot get an IMR if she has already requested a state fair hearing decision. However, a beneficiary can ask for a state fair hearing after an IMR if she does not receive a favorable decision, as long as the request for a fair hearing is still within 90 days of the original decision denying, reducing, or terminating services.

BILLING THE BENEFICIARY

Medi-Cal Must Be Accepted As Payment In Full

A provider can accept Medi-Cal payments only after being certified. A certified provider must accept Medi-Cal as payment in full. A beneficiary can be asked to pay only the monthly share of cost (if any) and some nominal co-payments for medications.

Prohibition Against Balance Billing: Pursuant to state and federal law, providers cannot bill Medi-Cal beneficiaries, including dual eligibles, for medically covered services. If your client has received a bill, the bill should be disputed. For sample letters and resources on balance billing, Justice in Aging has a toolkit for advocates available at http://www.justiceinaging.org/our-work/healthcare/dual-eligibles-california-and-federal/balance-billing/

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SUPPLEMENTAL MATERIALS

Medi-Cal Legal Resources

California Statutes

General - Welfare & Institutions Code §§ 14000- 14685

Mental Health Services – Welfare & Institutions Code §§ 5775- 5780, 14680- 14685.

Drug Treatment Programs – Health & Safety Code §§11758.14- 11758.47.

Website for statutes: *www.leginfo.ca.gov/calaw.html*

California Regulations

General – California Code of Regulations, Title 22, §§ 5000- 5660

Mental Health – California Code of Regulations, Title 9, §§ 1700- 1850.505

Drug Treatment Programs – California Code of Regulations, Title 9, §§ 9000- 9444

Website for regulations: *www.oal.ca.gov*

California Department of Health Care Services publications

All-County Letters – *http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/ACWDLMasterIndex.aspx*

Provider Manuals and Bulletins – *http://www.medi-cal.ca.gov/publications.asp*

Statistics – *http://www.dhcs.ca.gov/dataandstats/statistics/Pages/RASD_Default.aspx*

Federal Information from the Centers for Medicare and Medicaid Services (CMS)

CMS letters to State Officials About Medicaid – *https://www.cms.gov/SMDL/*

California's state Medicaid plan and state Medicaid plan amendments – *http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/california.html*

Other information about the Medi-Cal program

www.healthconsumer.org – This is the website for the Health Consumer Alliance, including the Los Angeles County HCA office with Neighborhood Legal Services. Useful information includes a Medi-Cal Manual plus information about Medi-Cal for consumers, including information about different Medi-Cal programs. The Medi-Cal consumer information is in multiple languages. The manual (2008) can be found at: *http://healthconsumer.org/publications.htm#manuals.*

www.disabilityrightsca.org – Disability Rights California has a good handout on the new Mandatory Enrollment of Seniors and Persons with Disabilities in Managed Care: *http://www.disabilityrightsca.org/pubs/549501.pdf*. DRC also has extensive resources on mental health issues: *http://www.disabilityrightsca.org/pubs/PublicationsMentalHealth.htm*

www.healthlaw.org – The National Health Law Program's website includes general information about Medicaid along with information unique to California.

www.canhr.org/medcal/index.html – California Advocates for Nursing Home Reform offers an overview of Medi-Cal for long-term care.

www.chcf.org/publications/ – Medi-Cal publications start with #170 on this website of the California HealthCare Foundation. The main website links to statistical information about the Medi-Cal program.

www.disabilitybenefits101.org – This website includes information about benefits for persons with disabilities who are attempting to work.

www.justiceinsging.org – This is the website of Justice in Aging. Relevant publications include *The Baby Boomer's Guide to Nursing Home Care*, and *20 Common Nursing Home Problems—and How to Resolve Them*, and a recent issue brief "Medicaid Block Grants: Attacking the Safety Net for Low-Income Older Adults." Justice in Aging also has extensive resources on the Coordinated Care Initiative.

www.wclp.org – The Western Center on Law & Poverty. Click onto the Health page.

www.calduals.org- This website includes materials and resources regarding the Coordinated Care Initiative