ACTEC Law Journal

Volume 41 | Number 2 Article 4

9-1-2015

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I. Introduction and Overview: Medicaid Nursing Home and Medicaid Waiver Programs

Medicaid is a means-tested state and federally funded medical assistance program for certain people, including the elderly and disabled.[1] California has the nation's largest Medicaid program measured by num-

[1] Medicaid is a creature of federal law. *See* 42 U.S.C. § 1396 (2012). Medicaid is implemented on a state-by-state basis. In California, Medi-Cal (California's version of Medicaid) is administered by the California Department of Health Care Services (DHCS). The website for DHCS is http://www.dhcs.ca.gov/ and contains updated information on eligibility.

ber of enrollees.[2] Unlike Medicare,[3] Medicaid helps pay for long-term care. Government expenditures for long-term care in California reached $11.8 billion in 2010,[4] and continue to trend upward.[5] Obviously, long-term care costs are a significant burden to federal and state governments alike,[6] and they actively restrict access to Medicaid's support for such care through a system that penalizes gratuitous transfers and seeks to recover outlays from recipients' estates. As we will describe, the complex rules governing Medicaid-supported long term care make Medicaid planning an arcane skill, practiced by experts.

As we will explain, Medicaid planning in California is especially complicated compared to other state programs. Even more intriguing is the fact that Medicaid planning in California offers many more opportunities than in other states. We believe that hundreds of millions of Medicaid dollars are expended for long-term care in California that would not be so expended in nearly any other state. Where Medicaid is concerned, California is truly the Wild West. We hasten to add that we think California's approach to Medicaid is often more humane and compassionate than in other states.[7]

Long-term disability, such as may arise from a stroke or dementia, can have a devastating effect on the sufferer's finances. Nursing home costs for a semi-private room typically approach $100,000 annually. The costs of residence in a memory care unit are even higher. Since these costs are not covered by Medicare, a period of extended disability often leads to impoverishment.[8] This impoverishment not only brings hard-

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[2] Calif. Healthcare Found,, *California Healthcare Almanac, Medi-Cal Facts and Figures: A Program Transforms* 4 (2013), http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MediCalFactsAndFigures2013.pdf [hereinafter *Healthcare Almanac*].

[3] Medicare provides nearly universal acute care for those 65 and older, but not custodial care. *See* RALPH C. BRASHIER, MASTERING ELDER LAW, 285, 292-293 (2010). Chapter 8 of this book contains further information on Medicare.

[4] The Scan Found., *Who Pays for Long-Term Care in California? (Updated)* (2013), http://www.thescanfoundation.org/sites/default/files/who_pays_for_ltc_ca_jan_2013_fs.pdf. In addition to federal dollars, California spends nearly a quarter of its general funds on health care. *Healthcare Almanac*, *supra* note 2, at 8. Even so, California obtains over half of its Medi-Cal budget from the federal government. *Id.* at 9.

[5] *Healthcare Almanac*, *supra* note 2, at 62.

[6] In California, a third of the Medicaid expenditures on services are for long-term care. *Id.* at 34.

[7] The major exception here is Medi-Cal recovery, which is aggressive compared to other states; however, pending 2016 legislation, if passed, would reduce recovery by DHCS in certain circumstances. *See infra* Part VII.

[8] *See* John A. Miller, *Voluntary Impoverishment to Obtain Government Benefits,* 13 CORNELL J.L. & PUB. POL'Y 81, 88 (2003). Long-term care insurance is available to those healthy enough to qualify and wealthy enough to pay. However, its widespread use seems unlikely. *Id.* at 90 n.67.

ship to the disabled person, it can also damage the finances of his or her spouse, and destroy the chance of inheritance by loved ones. Practitioners can minimize these harsh impacts through proper planning: there are dozens of ways to go broke and some of them are much better than others. This is the art of Medicaid planning.

In this article, we explain both the federal and state structure of Medicaid and illustrate planning opportunities for disabled seniors and their families in California.[9] Every state Medicaid program is unique, but in its current form, California's program, "Medi-Cal," is substantially different from the others. These differences create challenges for practitioners, and also afford practitioners significant planning opportunities unavailable elsewhere. Practitioners should note, using California techniques in other states could lead to disastrous results. We will delineate the major differences between Medi-Cal and Medicaid in most other states along the way. We also examine the ways in which California law is likely to change over the coming years. Thus, this article serves two purposes: first to explain current law and planning practices in California on a comparative basis and, second, to educate about the important changes that are on the horizon.

We note at the outset that there is an extraordinarily valuable resource for California attorneys called *California Elder Law Resources, Benefits, and Planning: An Advocate's Guide*. This two-volume treatise is published by an organization known as the Continuing Education of the Bar (CEB), a self-supporting enterprise overseen by the University of California in cooperation with the State Bar of California. The authors of this CEB treatise are drawn from among the leading elder law attorneys in the state. We make liberal use of this treatise in our analysis. A second valuable resource for attorneys and for the general public that we also use when appropriate is the website of California Advocates for Nursing Home Reform, known as CANHR. CANHR, which is based in San Francisco, engages in litigation, sponsors legislation and serves as a clearing house for information about all aspects of health care for seniors.

A. Medicaid Planning and the Medicaid Program

"Medicaid planning may be defined as the process of effectively accessing government resources to pay for long term health care of a disabled person in the manner that is least financially disruptive to the

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[9] For an excellent broad treatment of disability planning, see Ralph J. Moore, Jr. & Ron M. Landsman, *Planning for Disability,* TAX MANAGEMENT PORTFOLIO 816 (2000) [hereinafter Moore & Landsman]. *See also* COMMERCE CLEARING HOUSE, MEDICARE AND MEDICAID GUIDE (2016); JOHN J. REGAN, REBECCA MORGAN & DAVID M. ENGLISH, TAX, ESTATE & FINANCIAL PLANNING FOR THE ELDERLY (2015).

wellbeing of the person's spouse and family."[10] Over the past 30 years, Congress has altered the architecture of Medicaid to tighten up the system several times, including in the Medicare Catastrophic Coverage Act of 1988 (MCCA,)[11] the Omnibus Budget Reconciliation Act of 1993 (OBRA)[12] and, most importantly, the Deficit Reduction Act of 2005 (DRA).[13] These federal revisions were mostly followed by the states. As we will describe in more detail later, California has lagged behind in this process. The Congressional effort to restrict Medicaid access for long-term care was most recently embodied by the DRA.[14] This legislation significantly changed the rules governing Medicaid long-term care coverage. California law departs from the federal framework in several vital areas covered by the DRA. Compliance with the DRA in California is on the drawing board, but there is no firm implementation date. This means that California elder law attorneys must take care to stay current with state law, and prepare to alter planning techniques once new regulations are implemented.[15]

At the federal level, Medicaid is administered by the Center for Medicaid and Medicare Services (CMS), which is part of the Department of Health and Human Services (HHS).[16] For institutionalized and other disabled persons, states are generally prohibited from using eligibility criteria more restrictive than those used by the Supplementary Security Income program (SSI).[17] Because of this, guidance on various

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10 Sean R. Bleck, Barbara Isenhour & John A. Miller, *Preserving Wealth and Inheritance Through Medicaid Planning for Long-Term Care* 17 MICH. ST. J. MED. & L. 153, 155 (2013).

11 Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, 102 Stat. 683 (1988).

12 Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, 107 Stat. 312 (1993).

13 Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006). It was signed into law in February 2006.

14 The DRA changed rules governing eligibility for long-term care coverage. *See infra* Part II. As of May 2016, California has not implemented most of the DRA. *DRA Update as of March 2015*, CANHR, http://www.canhr.org/medcal/medcal_DRAImplementation.htm (last visited May 3, 2016).

15 In some cases, California attorneys must keep unimplemented portions of the DRA in mind due to the potentially retrospective nature of federal rules. *See* CALIFORNIA ELDER LAW RESOURCES, BENEFITS, AND PLANNING: AN ADVOCATE'S GUIDE (CAL CEB) § 10.4 (2014) [hereinafter CEB TREATISE]. As discussed *infra*, in Part II.D, California has initiated the process of adopting the DRA but only on a prospective basis. Thus, concerns about retroactivity are difficult to assess.

16 42 C.F.R. § 430.0 (2016). CMS instructions and guidelines are maintained in the "State Medicaid Manual." *The State Medicaid Manual*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html (last visited May 3, 2016).

17 42 U.S.C. § 1396a(a)(10)(C) (2012); CEB TREATISE, *supra* note 15, § 9.5(B).

Medicaid issues can be found in the federal SSI statute,[18] the federal SSI regulations,[19] and in the federal SSI policy manual entitled *The Program Operations Manual System* (POMS).[20] However, despite this "general prohibition" on more restrictive criteria imposed on states, California rules are less restrictive than SSI in some places, and more restrictive in others. As a result, reliance on SSI guidelines is less useful when confronted with Medi-Cal specific questions.[21]

Medi-Cal (California's version of Medicaid) is administered by the California Department of Health Care Services (DHCS).[22] One of the Department's chief mechanisms for administering Medi-Cal is through letters addressed to "All County Welfare Directors." These ACWD letters are available on the Department's website.[23] Medicaid planners rely on these letters in devising their plans to help clients qualify for Medi-Cal assistance. We also rely on them in our analysis.

The basic federal structure of Medicaid employs means testing as a screening principle. For most applicants this means they must *spend down* countable resources before they can qualify. The applicant's home is usually exempt from spend down. Spend down by gifting is partially blocked by *look-back rules* for certain *asset transfers*. Gratui-

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18 42 U.S.C. §§ 1381-1383.

19 *See* 20 C.F.R. § 416.101 (2016).

20 *See Program Operations Manual System (POMS) Home*, SOC. SEC. ADMIN., https://secure.ssa.gov/apps10/poms.nsf/aboutpoms (last visited May 3, 2016).

21 CEB TREATISE, *supra* note 15, § 10.3(C)(1).

22 CAL. DEP'T OF HEALTH CARE SERVS., http://www.dhcs.ca.gov/Pages/default.aspx (last visited May 3, 2016). California's Health Resources and Services Administration (HRSA) maintains a State Plan, describing services and rules. *See California State Plan*, CAL. DEP'T OF HEALTH CARE SERVS., http://www.dhcs.ca.gov/formsandpubs/laws/Pages/SPdocs.aspx (last visited May 3, 2016). California is currently implementing a pilot program that integrates Medicare and Medicaid services. In 2014, California began a 3-year pilot project, the Coordinated Care Initiative (CCI), which integrates delivery of medical, behavioral, and long-term care services, and streamlines services for individuals eligible for both Medicare and Medicaid. *See* Cal. Dep't of Health Care Servs., *Coordinated Care Initiative for Medi-Cal Beneficiaries: Fact Sheet*, http://www.dhcs.ca.gov/provgovpart/Documents/Duals/TBL/CCI_Fact_Sheet.pdf. Currently, CCI is available in locations constituting over half of the state population, with expansion planned. *See* Cal. Dep't of Health Care Servs., *CCI Enrollment Timeline by County and Population*, http://www.calduals.org/wp-content/uploads/2014/11/CCI-enrollment-by-County-11.20.14.pdf (revised Nov. 20, 2014). CCI created "Cal MediConnect," which enables dual eligible individuals to receive coordinated medical, dental, vision, behavioral health, and some home and community-based services through a single, organized delivery system. CEB TREATISE, *supra* note 15, § 6.14. CCI integrates long-term services and support into Medi-Cal and requires most beneficiaries to join a Medi-Cal managed care plan to receive benefits. *See id*.

23 *All County Welfare Director's Letters and Medi-Cal Eligibility Division Information Letters*, Cal. Dep't of Health Care Servs., http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/ACWDLbyyear.aspx (last visited May 3, 2016).

tous asset transfers within the *look-back period* trigger a *penalty period* during which Medicaid coverage is denied. The length of the penalty period increases with the value of the property transferred. In addition Medicaid aggregates the property of married couples for spend down purposes while allowing the non-applying spouse to keep a specified minimum of resources. Finally, federal Medicaid law requires the states to engage in *estate recovery* to recover Medicaid funds expended for an older person's care from that person's estate. As we will explain, Medi-Cal deviates from the federal template in all of these areas to varying degrees.

B. The Application Process

When an application is submitted,[24] the County Social Services Office first determines whether the applicant meets financial eligibility criteria, and second, whether the applicant needs long-term care.[25] The need for daily custodial health care services requires two or more functional impairments involving "ambulation, bathing, dressing, self-feeding, toileting, transferring, medication management, or hygiene."[26] If the applicant is "medically needy," but does not fit the income eligibility requirements for Medicaid, so long as the applicant meets the asset limits, he or she can seek full scope Medi-Cal services through the Aged, Blind, and Disabled Program.[27] Where an applicant does not qualify for

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[24] Applications for Medicaid can be requested and submitted online, by mail, phone, or in person. *Steps to Medi-Cal*, CAL. DEP'T OF HEALTH CARE SERVS., http://www.dhcs.ca.gov/individuals/Pages/How.aspx (last visited May 3, 2016). Medicaid long-term care applications are processed through the local County Social Services Offices of DHCS. *Id.* In the County of San Francisco, California, to apply for Medi-Cal services in person, visit the San Francisco Human Services Agency at 1440 Harrison St., San Francisco, CA, 94120. Applications may also be sent to that address.

[25] Cal. Dep't of Health Care Servs.,, *2014 Before You Buy: A Description of the California Partnership for Long-Term Care* 1, 6, 8 (2014), http://www.rureadyca.org/sites/default/files/uploads/byb2014.pdf; CEB TREATISE, *supra* note 15, § 10.18(B).

[26] CAL. WELF. & INST. CODE § 14525.1(a)(2) (West 2016).

[27] *See* CEB TREATISE, *supra* note 15, § 9.5(D); CAL. WELF. & INST. CODE § 14051; *Aged and Disabled Federal Poverty Level Program*, CANHR, http://www.canhr.org/factsheets/medi-cal_fs/html/fs_ADFPLP.htm (last visited May 3, 2016) [hereinafter *CAHNR Poverty Level Program*]. Although share of cost is usually required, the program makes Medi-Cal coverage available at no share of cost if the applicant's countable income is within the financial eligibility requirements and the applicant is receiving care at home or in a residential care facility. CEB TREATISE, *supra* note 15, § 9.5(D); *CAHNR Poverty Level Program*, *supra* note 27. As of April 2015, an aged or disabled individual with countable income at or below $1,211, and couples with income at or below $ 1,638 could qualify without paying share of cost. Cal. Advocates for Nursing Home Reform, *If You Think You Need a Nursing Home. . . A Consumer's Guide to Financial Considerations and Medi-Cal Eligibility* 10 (2015), http://www.canhr.org/publications/PDFs/MEB_English.pdf [hereinafter CANHR *Consumer's Guide*].

the Aged, Blind, and Disabled Program, financial eligibility involves meeting resource (asset) and income tests.[28]

Regulations require the county department to approve or deny an application within 45 days of filing.[29] Medi-Cal coverage can be retroactive for up to 3 months prior to the month of application, provided all eligibility criteria was met in each prior month, the applicant received health services, and the applicant was not previously denied for the month in question unless due to county error or circumstances beyond the applicant's control.[30]

When an application has been acted upon, the local county social services office will send the applicant a notification called a "Notice of Action."[31] This notice will advise the applicant that he or she has been approved for Medi-Cal benefits, or provide reasoning for denial or discontinuation, and instructions on requesting a hearing, and designates the applicant's share of cost, if any.[32]

C. Nursing Home Benefits[33]

For persons eligible for nursing home coverage, Medi-Cal requires that all income, after the special allocations described below, be paid to the nursing home, called the "share of cost."[34] Medicaid pays the nursing home the difference between the recipient's share of cost and the Medicaid reimbursement rate for the facility.[35] Under *Hunt v. Kizer*, Medi-Cal will deduct old medical bills from the share of cost.[36]

The Medicaid reimbursement rate is based on the facility's costs to provide care and the level of need of the residents and varies with each facility - but is always less than the private pay rate.[37] The 2016 state-

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28 Within DHCS, the Medi-Cal Eligibility and Enrollment Division governs eligibility procedures. *Medi-Cal Eligibility Division*, CAL. DEP'T OF HEALTH CARE SERVS., http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Medi-Cal%20Eligibility%20Division.aspx (last visited May 3, 2016).

29 CAL. CODE REGS. tit. 22, § 50177(a)(1) (2016). Where eligibility depends on establishing disability or blindness, the county department must approve or deny the application within 90 days of filing. *Id*.

30 *Id*. § 50197(a)(1)-(3); CEB TREATISE, *supra* note 15, § 9.6B.

31 CAL. CODE REGS. tit. 22, § 50179(a).

32 *Id*. § 50179(c)(1)-(2).

33 *Id*. § 51335; CAL. WELF. & INST. CODE § 14091.21 (West 2016).

34 CAL. CODE REGS. tit. 22, § 50090; *Overview of Medi-Cal for Long Term Care*, CANHR, http://www.canhr.org/factsheets/medi-cal_fs/html/fs_medcal_overview.htm (last visited May 3, 2016) [hereinafter CANHR *Overview*].

35 42 C.F.R. § 447.253(b)(1)(iii) (2016); *See also* CANHR *Overview*, *supra* note 34, at 6.

36 ACWD Letter No. 89-87 (Oct. 2, 1989); CEB TREATISE, *supra* note 15, § 11.99(C); *See also* CANHR *Overview*, *supra* note 34.

37 *See* 42 C.F.R. § 447.253.

wide average monthly pay rate for nursing facility services in California is $8,189.[38] When a person qualifies for nursing home coverage, Medi-Cal also provides coverage for most medical expenses, such as prescriptions and physician bills.[39]

D. Medicaid Waiver Programs in California

California has a variety of Medi-Cal program waivers designed to help persons avoid institutionalization.[40] These programs are not all comprehensive, unfortunately, and are most effective when supplemented with other assistance, typically family support. They cover long-term care delivered at home, and community-based alternatives such as adult family homes, and assisted living facilities.[41] Individuals eligible for SSI may receive assistance to live in a Residential Care Facility for the Elderly (RCFE). Some programs include In-Home Supportive Services (IHSS),[42] and Medi-Cal Home and Community Based Waivers.[43] California has other programs covering narrow portions of the aging population.[44] Many are restricted based on location and type of disability, however.[45]

Remarkably, for beneficiaries receiving Medi-Cal from home, there are currently no transfer penalties; in California transfer restrictions

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38 The statewide average monthly pay rate is generally referred to as the "average private pay rate" (APPR). ACWD Letter No. 16-11 (Apr. 25, 2016), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2016/ACWDL16-11.pdf.

39 *See What are the Medi-Cal Benefits?*, CAL. DEP'T OF HEALTH CARE SERVS., http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-Cal_EHB_Benefits.aspx (last visited May 3, 2016).

40 *See List of Medi-Cal Waivers,* CAL. DEP'T OF HEALTH CARE SERVS., http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalWaiversList.aspx (last visited May 3, 2016) [hereinafter DHCS *Waivers*]; *see also Long-Term Care Alternatives (Home and Community-Based Service Options),* CAL. DEP'T OF HEALTH CARE SERVS., http://www.dhcs.ca.gov/services/ltc/Pages/default.aspx. (last visited May 3, 2016) [hereinafter DHCS *Alternatives*].

41 *See* Cal. Dep't of Health Care Servs., *Medi-Cal Provides a Comprehensive Set of Health Benefits That May Be Accessed as Medically Necessary*, http://www.dhcs.ca.gov/services/medi-cal/Documents/Benefits_Chart.pdf.

42 See CAL. WELF. & INST. CODE § 12309.1(A) (West 2016), for requirements for IHSS. Changes to IHSS are likely in the next several years. *See* CEB TREATISE, *supra* note 15, § 6.1.

43 Including Multipurpose Senior Services Program, and Community-Based Adult Services, among others. *See* CEB TREATISE, *supra* note 15, § 6.2. Under the Assisted Living Waiver, some individuals can receive Medi-Cal assistance to live in residential care facilities or public housing. *See id.* § 6.1A.

44 Including California Program of All-Inclusive Care for the Elderly, AIDS Medi-Cal Waiver Program, and Senior Care Action Network. *See* DHCS *Alternatives*, *supra* note 40.

45 *See* DHCS *Alternatives*, *supra* note 40; *see also* DHCS *Waivers*, *supra* note 40.

only apply to applicants and beneficiaries in or going in to nursing homes.[46] In other states transfer restrictions may apply to both home care and institutional care.

II. Challenges for Practitioners Who Do Medi-Cal Planning

Before plunging deeper into the mechanics of Medi-Cal we think it is wise to explain more about the complex relationship between Medi-Cal and federal Medicaid law. As we have indicated already, California's Medi-Cal program is unusual in that it has implemented the federal framework unevenly and slowly over the last several decades. Because the federal framework has evolved, particularly with the implementation of OBRA 1993, the DRA, and now with the Patient Protection and Affordable Care Act (ACA),[47] California's program includes a patchwork of current and outdated state and federal legislation.[48] To add further to this confusion, Medi-Cal law is set out by various state authorities that appear to contradict each other as well as federal law. These different authorities fall within an ambiguous hierarchy. Moreover, it is not always clear which regulations are current and which are vestiges of those effectively repealed in practice but not yet formally updated.[49]

Interestingly, the state's uneven implementation presents both challenges and opportunities for elder law attorneys and applicants alike. California practitioners are uniquely situated to use planning techniques not available in other jurisdictions to help clients and their families avoid the impoverishment described above. However, since the regulatory framework is convoluted and proposed changes seem always on the horizon, California practitioners must be careful to regularly keep ahead of implementation, and make sure consequences of future implementation are consistent with current planning techniques.[50] This is especially difficult since complete DRA implementation by DHCS, when it does occur, will drastically alter many techniques available in California, rendering them not only useless, but in some cases harmful to clients.[51] In

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46 *See* ACWD Letter No. 90-01 (Jan. 5, 1990) (referencing the draft of Cal. Code Regs. tit. 22, § 50490.1); *See also* Cal. Code Regs. tit. 22, § 50418 (2016) *and* CEB Treatise, *supra* note 15, §§ 11.27C, 11.21 (2014).

47 The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), modified Medicaid in important ways that are not directly intended to impact long-term care. *See* Scott Solkoff, *Report on the Patient Protection and Affordable Care Act: Its Impact on the Special Needs and Elder Law Practice,* 11 NAELA J. 1, at 25 (2015).

48 *See* CEB Treatise, *supra* note 15, § 10.3(C)(1).

49 *See id.* § 10.2(B).

50 *See id.* § 10.4 (2).

51 *See id.* § 10.3.

what follows we set out some vital differences and explanations with specific words of caution, where appropriate.

A. Summary Chart of Federal Medicaid Legislation

Name of Act	Medicare Catastrophic Coverage Act (MCCA)	Omnibus Budget Reconciliation Act (OBRA) 1993	Deficit Reduction Act (DRA)
Year Enacted	1988	1993	2006
Current Status Under Federal Law	Most Medicare provisions repealed in 1989 while Medicaid provisions revised by OBRA '93	Many Medicaid provisions replaced by the DRA in 2006	Current
Current Status Under Medi-Cal	Adopted and some Medicaid provisions remain in effect	Partially adopted, with some provisions still in effect	Adopted, but most provisions not in effect pending full implementation

B. MCCA Implementation Notwithstanding Federal Repeal

The short-lived federal Medicare expansion program, known as the Medicare Catastrophic Coverage Act (MCCA), dates back to the Reagan administration. The Act passed in 1988 and was designed to address catastrophic acute care, and not long-term care.[52] Most of the Medicare provisions of MCCA were quickly repealed by the Medicare Catastrophic Coverage Repeal Act of 1989, after significant public backlash.[53] The public outcry over the MCCA was a combined result of the program's mandatory cost-sharing, widespread public misunderstanding of related tax increases, and the failure of the MCCA to address long-term care coverage.[54] Medicaid provisions of the MCCA were not repealed in 1989 but many were replaced by OBRA 1993, and later, by the DRA, as illustrated in the chart above. But California still applies a number of the MCCA provisions.

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[52] *See* David Carter, *An Autopsy of the Medicare Catastrophic Coverage Act of 1988*, 18 N. KY. L. REV. 41, 41 (1990).

[53] *See id.* at 42.

[54] *See id.*

Compared to the asset transfer rules now imposed by the DRA, the MCCA rules do not appear restrictive. However, at the time, the MCCA significantly tightened Medicaid transfer of asset rules.[55] In particular, the MCCA imposed a 30-month look-back period for transfer penalty purposes, which is still followed in California even though federal law now imposes a 60-month look-back period.[56] Also, under the MCCA (as well as OBRA 1993), where an applicant transfers a nonexempt asset, the period of ineligibility begins in the month when the gift was made instead of when the applicant applies and is deemed eligible, as is now required by the DRA.[57] Although the MCCA was amended in 1989 to include transfers by spouses, DHCS implemented the MCCA before that amendment was introduced; and, as a result, many gift transfers in California by an applicant's spouse do not impede eligibility, even when such assets originally belonged to the applicant.[58] Thus, gifting under the California version of the MCCA is lenient compared to the current federal framework in terms of eligibility.[59] Also under the MCCA, only transfers of nonexempt resources are counted when determining eligibility. However, California has imposed regulations on some transfers of notes, liens, life estates, and annuities.[60] Even under those regulations, it is possible to transfer income without effecting long-term care eligibility if the income is divested less than a month after receipt.[61] Whether personal injury awards, inheritances, and insurance benefits count as "income" or "resources" is debated.[62] Outside DHCS, these rules are unlikely to apply. Also, in certain situations, a judge could technically ignore the MCCA draft regulations and instead apply OBRA 1993 provisions.[63]

C. Uneven OBRA 1993 Implementation

OBRA revised Medicaid's long term care provisions in several key areas. It extended the look-back period to 36 months for non-trust gratuitous transfers and to 60 months for transfers into trust,[64] made disclaimer a form of transfer subject to the transfer of asset rules,[65] and

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55 *See* CEB TREATISE, *supra* note 15, § 10.26.
56 *Id*. § 10.28.
57 *Id*. § 10.47.
58 *Id*. § 10.29; *see also* CAL. WELF. & INST. CODE § 14015(a) (West 2016).
59 CEB TREATISE, *supra* note 15, § 10.36.
60 *See id.* § 10.30.
61 *Id.*
62 *Id.*
63 *Id.*
64 42 U.S.C. § 1396p (2012).
65 *Id*. § 1396p(h)(1).

made transfers of exempt property subject to those rules as well.[66] It also revised spousal impoverishment rules,[67] and enacted estate recovery provisions.[68]

California's formal adoption of rules implementing OBRA 1993 was slow and uneven.[69] The OBRA 1993 estate recovery changes and trust rules were implemented in California, but the accompanying federal changes to transfer of asset rules were not.[70] In particular, California did not adopt the 36 month look-back period established by OBRA. Nor did California adopt OBRA's increased restrictions on gifts of exempt property. Further, DHCS draft regulations from 1990 based on the 1988 MCCA are still in effect for planning purposes despite the fact that these rules are based on repealed federal law, and despite the fact that they are technically expired.[71] In addition, California law still relies on spousal impoverishment protections from the MCCA.[72]

Both the MCCA and OBRA calculated the start date of the penalty period based on the month when the nonexempt transfer was made.[73] California still determines the start of the penalty consistent with this approach even though the DRA took a tougher line.[74]

D. Uneven DRA Implementation

The DRA extended the look-back period to 60 months and calculates the start of the penalty period for transfers within the look-back period based on when the applicant applied and was found otherwise eligible.[75] As we will discuss, the start date for the penalty period has crucial planning consequences. The DRA also tightened the rules concerning annuities and strengthened the application of what is known as the income first rule.[76] In addition the DRA placed a cap on the amount of home equity that could be deemed exempt from spend down in certain circumstances.[77]

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66 *Id*. § 1396p.

67 *Id*. § 1396p(a)(2).

68 *Id*. § 1396p(b)(1).

69 CEB TREATISE, *supra* note 15, § 10.3.

70 *Id.*

71 *Id.* § 10.27; *see* ACWD Letter No. 90-01 (Jan, 5, 1990).

72 CEB TREATISE, *supra* note 15, § 10.71.

73 42 U.S.C. § 1396p(c)(1)(D) (2012).

74 CEB TREATISE, *supra* note 15, § 10.47.

75 *Id.*

76 *Id.*

77 *Id.*

Currently, California is not enforcing most of the DRA even though California began enacting legislation to implement it in 2008.[78] This legislation, Senate Bill 483, included a provision making the changes unenforceable until DHCS completes its entire formal adoption procedure.[79] Some provisions that may conflict with the federal framework explicitly permit the State Director of Health Services to adopt "emergency regulations."[80] It is not clear when full implementation will occur.[81] Although this could occur in the 2015-2016 legislative session, sources indicate that it could take much longer given the rate of past implementation and DHCS's implementation of the ACA, which is expected to occur through 2020.[82] California sources also indicate federal regulations will be implemented "only to the extent federal financial participation is available."[83] When all of the DRA does go into effect, it will only apply prospectively.[84] As we will discuss, once this occurs, it will likely result in a greater use of annuities, other insurance products, personal service contracts, and divorce as planning tools.[85]

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78 S.B. 483, 2008 Leg., Gen. Sess. (Ca. 2008). Exceptions: "income first" rule, restricting the expansion of Community Spouse Resource Allowances (CSRA), and "Proof of Citizenship" requirement. Reform of hardship waivers for estate recovery under the DRA may pass in this session. California Advocates for Nursing Home Reform (CANHR) notes the CSRA increases do "not impact 3100 petition court-ordered increases in CSRA or spousal allocation," which will still be honored. Cal. Advocates for Nursing Home Reform, *DRA Implementation in California as of 2/08* (2015), http://www.canhr.org/medcal/PDFs/DRA-Californiaside-by-side200802.pdf.

79 CAL. WELF. & INST. CODE § 14005(d) (West 2016); CEB TREATISE, *supra* note 15, §§ 10.4, 11.4.

80 *See* CAL. WELF. & INST. CODE § 14006.1(a).

81 The permissiveness of this expanded timeline for implementation, though debatable, depends on the provision. Some provisions were statutorily required by federal law to become effective on or soon after February 2006, but California did not enact legislation to implement all provisions within that time. CMS sent a guidance to State Medicaid directors in July 2006 discussing effective dates for compliance. Some have strict deadlines, and others appear to have permissive deadlines. It is unlikely the federal government anticipated California would take this much time for implementation for either type of provision.

82 CEB TREATISE, *supra* note 15, § 9.1; *see generally* Solkoff, *supra* note 47, at 25-26 (discussing Medicaid expansion under the ACA and what portions of the cost of Medicaid expansion will be borne by the federal government and the states).

83 CAL. WELF. & INST. CODE §§ 14001.11(d), 14006.15(e) (except with regard to Long-Term Care Insurance for which general state funds are available if federal funds are not); CEB TREATISE, *supra* note 15, § 10.20(C); CAL. WELF. & INST. CODE § 14006.15(d).

84 DRA rules for disqualification for substantial home equity will be prospective, but some provisions of the home equity rule apply differently depending on whether the applicant was eligible before the DRA was passed. *See* CAL. WELF. & INST. CODE §§ 14005(e), 14006.15.

85 CEB TREATISE, *supra* note 15, § 11.4.

The upshot of all this is that California has gone its own way. Most importantly, it uses a 30 month look-back period, starts the look-back period on the date of gift, and disregards gifts of exempt property even though federal law runs counter to these practices.[86]

E. Warning Regarding Ambiguity Among California Authorities

As described, portions of Medi-Cal law in effect as of the time of this writing represent the state's implementation of several bodies of federal legislation: the MCCA, OBRA 1993, the DRA, and soon, the ACA. Again, large portions of that federal legislation are no longer current under federal law and CMS regulations. As a result, California law appears to conflict with itself in many areas, and some issues do not have a clear leading authority on which practitioners and clients can rely. In particular, secondary sources warn, practitioners cannot rely on either the obsolete official published transfer regulations (22 California Code of Regulations sections 50406-50410) *or* the "apparently mandatory" OBRA 1993 or DRA transfer rules that replaced the MCCA in federal and state statutes.[87] Until DHCS issues DRA compliant transfer regulations, practitioners must rely on draft MCCA transfer regulations issued in 1990[88] because these rules are those that are currently in use and enforced by county eligibility workers.[89] California law supports the authority of such letters.[90] Yet, experts warn, due to the holding in *CANHR v. Bonta*, instructions and guidance from ACWDL, MEDIL, and opinion letters are subject to attack as "illegal underground regulations" if not yet formally promulgated under the Administrative Procedures Act.[91] There is no clear resolution to this troubling contradiction.

Considering these challenges, it is difficult to say whether a consistent leading authority exists for Medi-Cal practitioners. This may help explain why we often turn to the CEB treatise in the analysis that follows.

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86 *Id.*

87 CEB TREATISE, *supra* note 15, § 10.27.

88 ACWD Letter No. 90-01 (Jan. 5, 1990) (referencing drafts to CAL. CODE REGS. tit. 22, §§ 50408.5-50411.5).

89 *Id*.

90 CAL. WELF. & INST. CODE § 14001.11(c) (West 2016).

91 Cal. Advocates for Nursing Home Reform v. Bonta, 130 Cal. Rptr. 2d 823 (Ct. App. 2003); CEB TREATISE, *supra* note 15, § 9.4.

III. Income and Resource Eligibility Rules for Single Persons

A. Income[92]

Effective January 2014, as a result of the Affordable Care Act (ACA), income eligibility for Medi-Cal is determined, counted and valued in accordance with the Social Security Act.[93] The ACA is being phased in through 2020, and Medi-Cal eligibility is expanding.[94] "Covered California" is California's version of the ACA's health insurance exchange. Because Covered California is not a Medi-Cal program, benefits received through Covered California are not subject to Medi-Cal recovery. Individuals whose income is too low for Covered California will now be enrolled in the Medi-Cal Expansion Program, which provides medical care through a managed care plan.[95]

Currently, California applicants must show their income is insufficient to pay for all of the applicant's care; and since nursing homes in California cost $9,000 or more per month, this burden is often easily met.[96] For applicants living at home, California has a fixed maintenance need standard, which in 2015 is $600 monthly for single applicants.[97] In a nursing home, a single individual's income must be less than the private pay rate in the facility plus the applicant's regular monthly medical expenses.[98] If an applicant's income is above the California need standard, a monthly "share of cost" is required.[99]

Rent from the home is income to the recipient,[100] which must be included when determining the applicant's share of cost.[101] However, certain expenses such as interest (but not principal) on encumbrance payments, taxes and assessments, insurance, utilities, and maintenance

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92 Cal. Welf. & Inst. Code § 14005.64-65; *see* Cal. Code Regs. tit. 22, § 50501 (2016).

93 42 U.S.C. § 1396a(a)(A)(i)(viii) (2012); *see* Cal. Welf. & Inst. Code § 14005.64.

94 CEB Treatise, *supra* note 15, § 9.1.

95 *Medi-Cal Expansion: Covering More Californians*, Cal. Dep't of Health Care Servs., http://www.dhcs.ca.gov/Pages/Medi-CalExpansionInformation.aspx (last visited May 3, 2016). For more on Medi-Cal and the ACA see *Affordable Care Act Resources,* CANHR, http://www.canhr.org/aca/Affordable_Care_Act_Resources.html (last visited May 3, 2016).

96 CEB Treatise, *supra* note 15, § 11.96.

97 CANHR *Consumer's Guide*, *supra* note 27. Note, this differs from the income standards established by the Federal Aged and Disabled program.

98 CEB Treatise, *supra* note 15, § 11.96.

99 *See* CANHR *Consumer's Guide*, *supra* note 27.

100 Cal. Code Regs. tit. 22, § 50453.7(c) (2016).

101 *See id*. § 50508.

expenses for the home can be deducted in calculating countable income from rent.[102]

A Medi-Cal recipient in Long-Term Care may keep up to $208.33 of income for up to 6 months to pay for home maintenance if a physician certifies the recipient will likely return home in that period.[103]

B. Resources[104]

Under the ACA, Medi-Cal for acute care is available based on income level and there is no asset limit.[105] However, standard Medi-Cal asset limitations apply for nursing home care.[106] Under these rules unmarried recipients cannot have more than $2,000 in non-exempt resources.[107] Exempt resources are defined below.[108] Assets above the limit must be "spent down." As we discuss below, spending down resources is a key element of Medicaid planning, which can be carried out differently depending on whether the institutionalized person is single or married.

Common examples of resources which will make a person ineligible if they exceed $2,000 include vacation property;[109] boats, campers, and trailers;[110] recreational or additional vehicles;[111] stocks, bonds, mutual funds;[112] cash on hand unless it is income received in that month;[113] the net cash surrender value of life insurance policies (except life insurance with a combined face value of $1,500 or less);[114] and amounts held in revocable trusts.[115]

Joint bank accounts are governed by two sets of regulations in California. Under both regulations, Medi-Cal applicants can show joint

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102 *See id*. § 50508(a)(1).

103 *Id*. § 50605(b)-(c); ACWD Letter No. 12-24 (Sept. 10, 2012) (referencing the draft of CAL. CODE REGS. tit. 22 § 50605(b)-(c)).

104 CAL. WELF. & INST. CODE § 14005.64 (West 2016).

105 19 U.S.C. § 1902(e)(14)(C) (2012); 42 C.F.R. § 435.603(g) (2016). In California all counties are supposed to be moving toward managed care plans for all Medi-Cal services—this is not limited to persons under expanded Medi-Cal. There are no asset tests for persons who are covered under expanded Medi-Cal, but recovery regulations apply to all services provided for those recipients who are age 55 or older. CAL. CODE REGS. tit. 22 § 50605(b)-(c).

106 CEB TREATISE, *supra* note 15, § 10.18.

107 CAL. CODE REGS. tit. 22, § 50420 (2016).

108 *See infra* Part III.C.

109 *Id*. §§ 50418(b), 50427.

110 *Id*. § 50463(a).

111 *Id*. § 50461(a)-(b).

112 *Id*. § 50456.

113 *Id*. § 50451.

114 *Id*. § 50475.

115 *Id*. § 50453(b).

funds belong to someone else even if they have right of access to the account by showing that the other joint owner declares the income from the account on his or her income tax return. Or, the applicant can show he or she made a gift of his or her interest when the joint owner was added to the account or when the account was opened. If the applicant makes the necessary showing, the Medi-Cal program requires that his or her name be removed from the account.[116] Resources are valued according to the net market value of the applicant's equity interest in the resource.[117] Any encumbrances on the resource are subtracted from the market value to determine the net market value.[118]

A life estate can also be a non-exempt resource. The value of a life estate is either (1) the entire market value of the property on which the life estate is held if the applicant was the owner of the property prior to selling it, and is retaining a revocable life estate in it;[119] or (2) determined in accordance with the California State Gift Inheritance Tax Formula, or, at the applicant's option, a lesser value established by a qualified appraiser in accordance with section 50441(c)(2) of the California Code of Regulations.[120]

Spend-down to the "property reserve" of $2,000 must be met at some time during the month of application for Medi-Cal benefits in order for an applicant to be eligible.[121] If the applicant's property reserve has been in excess of the property limit from the first day of the month of application through the date of application, the applicant must bring their property reserve within the property limit by the last day of the month of application by any means except for transfer without adequate consideration.[122]

C. Exempt Resources

Some resources are not counted, that is, they are deemed "exempt" resources, when determining whether a single applicant for Medi-Cal coverage has exceeded the $2,000 property reserve limit. As discussed *infra* in Part VIII, exempt resources can present significant Medi-Cal planning opportunities.

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116 For more on joint bank accounts and regulations governing such accounts, see CEB TREATISE, *supra* note 15, § 9.33(d); CAL. CODE REGS. tit. 22, § 50453(B) (2016); CAL. CODE REGS. tit. 22, § 50402.

117 CAL. CODE REGS. tit. 22, § 50415(a).

118 *Id*. § 50415(b).

119 *Id*. § 50442(c)(1).

120 *Id*. § 50442(c)(2).

121 *Id*. §§ 50401(a)(3), 50420(a)-(b).

122 *Id.* § 50420(c).

1. *Homes*[123]

The applicant's home is exempt. Once the DRA is implemented, California rules will impose a limit on the exempt home equity of a Medi-Cal applicant for applications made on or after January 1, 2009.[124] This limit increases annually pursuant to federal law based on the consumer price index. If DRA regulations were implemented in 2015, the home equity limit would be $828,000.[125] This provision is not yet in effect because of the delay in DHCS's implementation of the DRA.[126] Thus, although the home equity cap was made into law in California as of 2009, the cap is not currently in force and it is not clear exactly when it will be.[127] When it is finally applied, California's implementation includes additional provisions effectively "softening" the negative impact of the home equity cap.[128] For instance, the equity interest subject to the cap is either the property tax assessment value minus encumbrances, *or* the appraised value minus encumbrances, *whichever is less*.[129] In practice, the tax assessment value of California real property is often far less than the fair market value, thus this provision makes it less likely for the equity interest subject to the cap to be in excess of the cap.[130]

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123 In addition to the applicant's home, business property is exempt if used in whole or part as a means of self-support so long as it meets business property guidelines, though income will be counted toward the share of cost determination. 42 U.S.C. § 1382b(a)(3) (2012). *See* ACWD Letter No. 91-28 (Mar. 22, 1991); ACWD Letter No. 95-22 (Apr. 3, 1995).

124 CAL. WELF. & INST. CODE § 14006.15(b) (West 2016); *see* S.B. 483, 2008 Leg., Gen. Sess. § 3 (Cal. 2008).

125 *War on Poor Elders: Veterans Affairs and House Committee Looking at Reducing Ability to Access Long Term Care Assistance*, CANHR, http://canhr.org/publications/newsletters/NetNews/Feature_Article/NN_2015Q4.htm (last visited May 3, 2016). *See* CAL. WELF. & INST. CODE § 14006.15(b).

126 CAL. WELF. & INST. CODE § 14006.15(f)-(g); CEB TREATISE, *supra* note 15, § 10.20(A).

127 CAL. WELF. & INST. CODE § 14006.15(f)-(g); CEB TREATISE, *supra* note 15, § 10.20(A).

128 CEB TREATISE, *supra* note 15, § 10.20(B).

129 CAL. WELF. & INST. CODE § 14006.15(a).

130 CEB TREATISE, *supra* note 15, § 10.20(B). In California, where property value seems to always be skyrocketing, avoiding property tax reassessment is a vital consideration for practitioners. Increases in assessed value of real property can negatively impact eligibility. *Id*. § 30.11(6). Increases in assessed property value for tax purposes are limited to 2% annually instead of appraised value, assuming no change in ownership. *See* Peter S. Stern, *Irrevocable Income Only Trusts and California Alternatives*, Am. L. Inst., *Asset Preservation for Elder Law Clients: IIOTs Compared to Other Alternatives*, (CLE materials from Apr. 21, 2015), http://files.ali-cle.org/thumbs/datastorage/skoobesruoc/pdf/TSWB22_chapter_10_thumb.pdf. Most common property transfers for Medi-Cal eligibility are not treated as changes in ownership, such as transfers between spouses and RDPs, and some transfers between parents and children. *See* CAL REV. & TAX CODE § 63.1(d)(1) (West 2016). For an analysis of the flawed character of California property

Even when the DRA is implemented, the home equity limit does not apply if the home is occupied by a spouse, a disabled child, blind child, or child under twenty-one.[131] This limit also does not apply if the applicant was determined to be eligible for medical assistance for home and facility care based on an application filed before January 1, 2006, or if the department determines that ineligibility would result in hardship.[132] In addition, this limit does not apply to the value of home equity owned by the spouse of an applicant unless the spouse is considered part of the Medi-Cal Family Budget Unit (MFBU).[133] A home includes "land or buildings surrounding, contiguous to, or appertaining to the residence."[134] Proceeds from the sale of a home are exempt for six months from the date of receipt if proceeds are intended for purchase of another principal residence.[135] Property which the applicant formerly used as a home is also exempt as the principal residence in certain circumstances.[136]

Even if the applicant is not currently living in the home, the property can be treated as exempt if the applicant states in writing that he or she intends to return to the property to live.[137] A statement of intent to return home does not have to be supported by medical verification and does not require a demonstration that a return is likely.[138] If the applicant has diminished capacity, a legal representative may still indicate a subjective intent to return home on the application.[139] Also, an appli-

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tax law, see John A. Miller, *Rationalizing Injustice: The Supreme Court and the Property Tax*, 22 HOFSTRA L. REV. 79-144 (1993).

131 CAL. WELF. & INST. CODE § 14006.15(c)(1) (West 2016).

132 *Id*. § 14006.15(c)(2)-(3).

133 CAL. CODE REGS. tit. 22, § 50377(a) (2016); CAL. CODE REGS. tit. 22, § 50403(a). A spouse will be considered part of the applicant's MFBU if: "(1) both spouses are aged, blind or disabled; (2) one or both spouses is in LTC or board and care;" and "(3) both spouses apply for and are eligible for Medi-Cal." CAL. CODE REGS. tit. 22, § 50377(c)(1)-(3).

134 CAL. CODE REGS. tit. 22, § 50425(a).

135 *Id*. § 50425(a).

136 CAL. CODE REGS. tit. 22, § 50425(c) (where income of the family was considered in determining eligibility; applicant is absent but a child under 21 or dependent relative is living on the property; sibling or child age 21 or over has lived there continuously for one year or more immediately preceding the date of institutionalization and continues to live there; property can't be sold, proof of attempts to sell are provided; and, applicant doesn't live on the property and doesn't intend to return; property can't be converted into cash and is not exempt, and effort to sell was made).

137 *Id*. § 50425(c)(3).

138 *Id*.

139 ACWD Letter No. 95-48 (Aug. 24, 1995) (referencing the draft of CAL. CODE REGS. tit. 22, § 14006); CEB TREATISE, *supra* note 15, § 10.21(3).

cant may amend an application to convey a subjective intent to return home at any time.[140]

As explained in the discussion of Medi-Cal estate recovery below, Medi-Cal will usually have an estate claim against the Medi-Cal recipient's interest in an exempt home at the time of death of the Medi-Cal recipient for an amount equal to the cost of medical care provided.[141]

2. *Vehicles, Household Furnishings, Personal Effects, and Burial Expenses*

One motor or other vehicle is exempt, regardless of value, if used for the recipient's transportation.[142] Recreational and commercial vehicles are not exempt unless there are no other vehicles for the applicant's transportation.[143]

Livestock and poultry retained primarily for personal use are exempt.[144] Musical instruments are exempt.[145] In addition, home furnishings,[146] clothing,[147] wedding and engagement rings, and heirlooms are exempt.[148] Other items of jewelry with a net market value of $100 or less are exempt.[149]

Any burial plot, vault, or crypt is exempt, regardless of value.[150]

3. *Life and Long-Term Care Insurance, Tax Credits, and Related Benefits*

Life Insurance is exempt if the combined face value of all policies is $1,500 or less.[151]

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140 CEB TREATISE, *supra* note 15, § 10.21(3); *see* CAL. CODE REGS. tit. 22, §§ 50425(c)(7), 50428 (2016); *see also* ACWD Letter No. 95-48 (referencing the draft of CAL. CODE REGS. tit. 22, § 14006). For a discussion of how the applicant's subjective intent to return home can be used to help avoid estate recovery during the applicant's lifetime, see *infra* Part VII.

141 CAL. CODE REGS. tit. 22, § 50428. Pending legislation would drastically change Medi-Cal recovery. *See infra* Part VII.

142 CAL. CODE REGS. tit. 22, § 50461(a)(1).

143 *Id*. § 50461(a)(1).

144 *Id.* § 50473.

145 *Id*. § 50473.

146 *Id*. § 50465.

147 *Id*. § 50467(a).

148 *Id*. § 50467(b)(1)-(2).

149 *Id*. § 50467(b)(3).

150 *Id*. §§ 50476, 50477(a), 50479.

151 *Id*. § 50475. The net cash surrender value shall be included in the property reserve if the face value is greater than $1,500.

The insured amount under a certified Long-Term Care Insurance Policy is exempt after the policy coverage has been exhausted.[152] Even though it is not a countable asset, long-term care insurance may have an indirect impact on Medi-Cal eligibility because payments represent a source of funds used for long-term care. If these funds are sufficient to cover long-term care, spend down may be avoidable; if these funds are not sufficient to cover long-term care, their existence may still reduce the need to spend down other assets for eligibility.[153] This is generally good news for applicants because it means that countable assets can be preserved for longer, which may give the applicant additional time to shelter those other assets through transfer.[154]

The Earned Income Tax Credit (EITC) payment or an advance payment thereof made by an employer shall be exempt in the month following the month of receipt,[155] as well as reasonable amounts saved from a child's exempt earnings for future education or for other future identifiable needs are exempt as property.[156] Payments from the California Franchise Tax Board, including Renters Credits, Senior Citizens Homeowners and Renters Property Assistance, and Senior Citizens Tax Postponement are exempt.[157]

Relocation assistance benefits are exempt if they are not spent and are kept identifiable.[158] Retroactive SSI and Title II benefits are exempt for six months after the month of receipt.[159] Disaster and emergency assistance payments made by local, state, or federal government agencies, or disaster assistance organizations are exempt, regardless of value or date of payment.[160]

4. *Sales Contracts*

Property purchased under a signed sales contract by the applicant or beneficiary is included in the property reserve; however, property sold by the applicant or beneficiary in a signed sales contract is exempt.[161] Interest payments received count as unearned income, while

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152 *Id*. § 50453.7. If one purchases a $100,000 Long-Term Care Partnership policy where the policy pays $100,000 for actual long-term care expenses for the policy-holder, $100,000 in otherwise non-exempt assets will be deemed exempt.

153 CEB TREATISE, *supra* note 15, § 13.70(1).

154 *Id.* § 13.70(1). For further information regarding long-term care partnerships that coordinate with Med-Cal, please see *id.* § 13.77.

155 CAL. CODE REGS. tit. 22, § 50449 (2016).

156 *Id.* § 50453.5.

157 *Id.* § 50454.5.

158 *Id.* § 50448.5(b).

159 *Id.* § 50455.

160 *Id.* § 50481. Interest on those payments is also exempt.

161 *Id.* § 50405(a)-(b).

principal payments are considered property.[162] Property purchased or sold under a verbal or unsigned contract is counted as belonging to the seller until the sale is complete.[163]

5. *Annuities*

In the context of Medicaid planning, annuities have been used by some applicants to circumvent spend down without lengthening the penalty period. Because it was perceived as an area of potential abuse, the DRA established certain limitations on the use of annuities.[164] Many DRA annuity rules are not currently in effect in California, but will be in the future, though the exact timeframe is debatable.[165] Once these rules are in effect, they will drastically change treatment of annuities in regard to recovery and eligibility.

According to the California rules implementing this portion of the DRA, the DRA must apply to annuities purchased or significantly changed after February 7, 2006.[166] Thus, although the DRA does not apply retroactively, and even though DHCS has not formally adopted the DRA, those annuities may fall under DRA requirements.[167] For single persons in California, annuities are currently of limited value for Medi-Cal planning.[168] This is partly due to California's hefty tax on nonqualified annuities.[169] The residual value of annuities purchased on or after September 1, 2004 can be recovered by the state.[170]

Under California law, whether an annuity purchased for the benefit of either spouse counts as a fair market value transfer for purposes of eligibility depends on its terms and date. If an annuity purchased on or after August 11, 1993 is "actuarially sound," then DHCS will consider it "fair market value" and not count it against the applicant for eligibility.[171] If the annuity is not "actuarially sound," determined by using CMS life expectancy tables, income from the annuity, including interest and principal, it is countable income to the recipient when received – and generally must be participated toward cost of care.[172] If an annuity

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162 *Id.* § 50405(b).
163 *Id.* § 50405(c).
164 *See supra* Part II.D.
165 *See supra* Part II.D.
166 CEB TREATISE, *supra* note 15, §§ 11.35, 11.37(A).
167 *Id.* §§ 11.35, 11.37(A).
168 *Id.* § 11.32(a).
169 CAL. REV. & TAX. CODE § 12202 (2016); CEB TREATISE, *supra* note 15, § 11.38.
170 CAL. CODE REGS. tit. 22 § 50961(h) (2016).
171 *See* CEB TREATISE, *supra* note 15, § 11.38.
172 "Any annuity purchased before August 11, 1993 is unavailable for eligibility purposes so long as the beneficiary is receiving periodic payments of interest and principal." CAL. CODE REGS. tit. 22, § 50489.5(g); CEB TREATISE, *supra* note 15, § 11.34. "Annuities

is purchased with a payout period longer than the life expectancy of the annuitant, DHCS will deem the purchase, in part, an uncompensated transfer subject to penalties.[173] The cash surrender value of deferred annuities is considered "available" for eligibility.[174]

Annuities that have no cash surrender value, and are not assignable for value during life, are not considered resources if, in the case of an annuity for a single person, the state is named as the contingent beneficiary of the annuity.[175] In California, the individual can "prohibit" the state from acquiring a remainder interest through a writing, in which case the annuity is treated as a transfer for less than fair market value, subject to eligibility requirements.[176] Since all annuity income paid to a single Medicaid recipient must be paid toward the cost of care, and the state must often be named as contingent beneficiary of the annuity, converting resources into an annuity will usually not make economic sense for single persons as a method to establish eligibility.

IRA and work-related pension payments are not required to meet Medi-Cal annuity requirements, and the balance is considered unavailable so long as the beneficiary received periodic payments of both interest and principal.[177]

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purchased between August 11, 1993 and March 1, 1996 must meet the new regulations, which may be waived for hardship." CANHR *Consumer's Guide*, *supra* note 27; CEB TREATISE, *supra* note 15, § 9.31; ACWD Letter No. 90-01(Jan. 5, 1990) (referencing the draft of CAL. CODE REGS. tit. 22, § 50402(e)).

173 The notion is that one is gifting a remainder interest for one's heirs. As we will discuss *infra* in Part VIII.L, an annuity benefitting a spouse continues to have some planning utility. CAL. CODE REGS. tit. 22, § 50489.5(g)(C). The amount of uncompensated transfer in California is the value of all payments that will be paid under the contract during the period in excess of life expectancy of either the beneficiary or spouse. CAL. CODE REGS. tit. 22, § 50489.5(g)(A).

174 CEB TREATISE, *supra* note 15, § 11.34.

175 *See* Bleck et al., *supra* note 10, at 155 ("The DRA requires the state to be named contingent beneficiary for annuities for a community spouse if the community spouse dies during the annuity term."); *see also* Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006). However, this has not yet been implemented in California. Currently, in California, the remainder interest of annuities acquired on or after September 1, 2004 are subject to recovery. For annuities purchased later, the term for the spouse can be no less than five years, or the spouse's life expectancy, *whichever is less*. *See also* CAL. CODE REGS. tit. 22, §§ 50960.12(a); 50961(h); CAL. WELF. & INST. CODE § 14009.6(a) (West 2016).

176 CAL. WELF. & INST. CODE § 14009.6(d). In addition, the state is limited from becoming a remainder beneficiary in certain circumstances. *Id*. § 14009.7.

177 *See* ACWD Letter No. 90-01 (referencing the draft of CAL. CODE REGS. tit. 22, § 50402 (e)(2)).

IV. Income and Resource Eligibility for Married Couples

A. Overview of Couple Eligibility Rules[178]

Medicaid has a number of rules that are designed to protect the income and assets of one spouse, often called the "community spouse," when the other spouse goes into a nursing home or begins to receive Medi-Cal benefits. These rules are designed to avoid the "impoverishment" of the community spouse.[179] By middle-class standards, they are not generous.

The federal Medicaid statute expressly preempts state community property law for purposes of determining the ownership of income and assets.[180] "Medicaid determines ownership according to the name in which income is received or the title of an asset."[181] However, in California, under the MCCA rules still in effect, transfers by the community spouse of the community spouse's separate property do not disqualify the institutionalized spouse.[182]

If both spouses are in a long-term care or residential care facility and neither have previously applied for Medi-Cal, the couple may agree to divide their community property, and each applicant's separate property plus one-half of the community property must be valued at $2,000 or less.[183]

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178 The rights and responsibilities of RDPs are recognized for state-only Medi-Cal programs. CEB Treatise, *supra* note 15, § 9.5G; *see* ACWD Letter No. 12-36 (Dec. 10, 2012). In addition under CMS guidelines, "where a state recognizes a civil union or domestic partnership as a marriage, that marital status is recognized under the Medicaid and CHIP programs, consistent with this guidance." Dep't of Health & Hum. Servs., Ctr. for Medicaid & CHIP Servs., SMDL No. 14-005, United States v. Windsor *and Non-MAGI Populations* (May 30, 2014), https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-005.pdf; *see also* Peter S Stern, *Long-Term Care Medi-Cal on the Cusp of the Deficit Reduction Act and the Affordable Care Act*, 20 Cal. Tr. & Est. Q., 21, 25, 30 n.60 (2014).

179 Stern, *supra* note 178, at 25.

180 42 U.S.C. § 1396r-5(a)(1) (2012).

181 *See* Bleck et al., *supra* note 10, at 166.

182 ACWD Letter No. 90-01 (Jan. 5, 1990) (referencing the draft of Cal. Code Regs. tit. 22, § 50411.5(a)(3)); CEB Treatise, *supra* note 15, § 10.58.

183 Cal. Dep't of Health Care Servs., *Notice Regarding Standards for Medi-Cal Eligibility* 7077 (2015), http://www.dhcs.ca.gov/formsandpubs/forms/Forms/MCED/DHCS_Forms/DHCS_7077_ENG_0115.pdf; Cal. Dep't of Health Care Servs., *Medi-Cal General Property Limitations, MC Information Notice 007* (2014), http://www.dhcs.ca.gov/formsandpubs/forms/Forms/MC%20Information%20Notices/MC007ENG(0414).pdf [hereinafter *Medi-Cal General Property Limitations*].

B. Income Eligibility[184]

Under the MCCA, income is only considered available to the institutionalized spouse for eligibility determination where that spouse's name is written on the check or other instrument representing income.[185] This is colloquially known as the "name on check" rule. Where both names are listed, one half of the income is attributable to each spouse.[186] If the income is drawn from a trust, it will be considered the income of the spouse "to whom the payments are actually made."[187] Please note that income attribution rules apply regardless of California community property law.[188] For California's current rules on "joint bank accounts," please see *supra* Part III.B.

As with single applicants, most married applicants can easily show their income is insufficient to pay for the average $9,000 or more per month required for nursing home care.[189] For the community spouse, California has a fixed maintenance need standard (called a "Minimum Monthly Maintenance Needs Allowance," or "MMMNA"), which is adjusted annually based on cost of living increases. In 2016 the MMMNA is $2,981 per month.[190]

C. Resource Eligibility[191]

Under federal law, all resources of both spouses are considered in determining eligibility, regardless of state community property distinctions, and Prenuptial and Separate Property Agreements are disregarded;[192] however, in California, these distinctions are important in regard to resource eligibility.[193] Only transfers of resources by the applicant may disqualify the applicant.[194]

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184 42 U.S.C. § 1396r-5(b), (d) (2012); *see also* CAL. WELF. & INST. CODE § 14005.64-.65 (West 2016).

185 ACWD Letter No. 90-03 (Jan. 8, 1990) (referencing the draft of CAL. CODE REGS. tit. 22, § 50512); CEB TREATISE, *supra* note 15, § 10.80(b).

186 CEB TREATISE, *supra* note 15, § 10.80(b); *see* ACWD Letter No. 90-03 (referencing the draft of CAL. CODE REGS. tit. 22, § 50512).

187 CEB TREATISE, *supra* note 15, § 10.80(b); *see* 42 U.S.C. § 1396r-5(b) (2012).

188 CEB TREATISE, *supra* note 15, § 10.80(b); 42 U.S.C. § 1396r-5(b)(2).

189 CEB TREATISE, *supra* note 15, § 11.96.

190 *See* CANHR *Consumer's Guide*, *supra* note 27, at 13.

191 *See* 42 U.S.C. § 1396r-5(c), (f); *see also* CAL. CODE REGS. tit. 22, §§ 50419-50420 (2016). California uses the term "property" where federal sources use "resources." CEB TREATISE, *supra* note 15, § 9.14.

192 John A. Miller, *Medicaid Spend Down, Estate Recovery and Divorce: Doctrine, Planning and Policy*, 23 ELDER L.J. 41, 52 (2015).

193 *See infra* note 292 and accompanying text; *see also* CEB TREATISE, *supra* note 15, § 12.33.

194 CEB TREATISE, *supra* note 15, § 10.58(a).

Because the resources test for Medicaid eligibility lumps all of the assets of a married couple together, some assets owned solely by the non-disabled spouse may have to be spent down in order for the disabled spouse to qualify.[195] When the applying spouse enters a nursing home, the community spouse is permitted to retain some non-exempt resources (called the "Community Spouse Resource Allowance," or CSRA), which increases every year according to the Consumer Price Index.[196] All of the couple's combined non-exempt assets in excess of that amount must be spent down before Medicaid eligibility is obtained for the institutionalized spouse.[197] Once the resource limit is reached, the institutionalized spouse must transfer his or her interest in the CSRA to the community spouse.[198] After the date of Medi-Cal application, the couple has 90 days to separate spousal assets.[199]

The same resource rules and exemptions described above for single persons apply to couples, with the following additions:

1. IRA and work-related pensions in the community spouse's name are exempt; however, income received by the community spouse is considered when determining the community spouse's allocation from the institutionalized spouse, if any.[200]
2. Resources acquired by the institutionalized spouse after the spouse becomes institutionalized will be counted against the applicant for eligibility purposes; however, resources acquired by the community spouse after the institutionalized spouse is determined eligible will not affect the eligibility of the institutionalized spouse.[201]
3. The CSRA can be increased if either spouse files for a Fair Hearing, where income of both spouses is insufficient to meet the MMMNA; to increase the MMMNA in cases of financial distress; or, by court order.[202]
4. The home (regardless of value) is exempt if the community spouse resides in the home; a child under age 21 or "de-

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195 42 U.S.C. § 1396r-5(c)(2) (2012).

196 CANHR *Consumer's Guide*, *supra* note 27, at 11. The 2016 CSRA is $119,220. The institutional spouse is entitled to another $2,000 in a separate account. *Id.*

197 *Id.*

198 *Id.* at 13.

199 *See Medi-Cal General Property Limitations*, *supra* note 183.

200 ACWD Letter No. 90-01 (Jan. 5, 1990) (referencing the draft of CAL. CODE REGS. tit. 22, § 50458).

201 CANHR *Consumer's Guide*, *supra* note 27, at 12.

202 202 *Id.* at 14; *see* CEB TREATISE, *supra* note 15, § 11.107.

> pendent relative" living the home will also result in an exemption.[203]

If the home is sold before the beneficiary applies for Medi-Cal, the proceeds will factor into the eligibility determination, even where the home was solely in the name of the community spouse. However, the institutionalized spouse is permitted to transfer his or her interest in the home to the community spouse before or after entering a nursing home, which will allow the community spouse to sell the home, with the added benefit of preventing a recovery claim on the home should the community spouse decide to remain.[204]

V. Transfer of Asset Rules[205]

A. How Transfers of Assets May Affect Eligibility[206]

Medicaid's transfer of asset rules *delay* eligibility for nursing home coverage for a period of time. This is called the transfer penalty.[207] The purpose of the penalty is to deter transferors from voluntarily impoverishing themselves in order to qualify for Medicaid coverage for their long-term care costs. The typical example of such a transfer is a large gift of cash or property to the transferor's child. As discussed *infra* in Part VIII, the transfer of asset rules do not foreclose all planning opportunities. It is ironic that more planning opportunities remain for persons of substantial means than for those persons of lesser means. This is an irony quite familiar to those who do tax planning.

A transfer may result in penalty if the following conditions are met:

1. The transfer is for less than fair market value.
2. The transfer is to someone other than a spouse or disabled child.
3. The transfer is for the purpose of qualifying for Medicaid.
4. The transfer is made during the "look-back" period.[208]

California's uneven implementation of changes in federal law leads to several planning opportunities not found elsewhere, addressed below.[209]

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203 CANHR *Consumer's Guide*, *supra* note 27, at 15.

204 *Id.* at 16. This assumes the home does not pass to the institutional spouse upon the death of the community spouse.

205 Cal. Code Regs. tit. 22, § 50411 (2016).

206 *See* 42 U.S.C. § 1396p(c) (2012); *see also* Cal. Code Regs. tit. 22, § 50411; Cal. Welf. & Inst. Code § 14015(a)-(g) (West 2016).

207 Cal. Code Regs. tit. 22, § 50411(a).

208 *Id.*

209 See *infra* Part VIII for a discussion of which unique Medicaid planning techniques are available in California.

B. The Look-Back Period

Only transfers within a certain period of time before application is made, called the "look-back period," are subject to a transfer penalty.[210] Under the DRA, the look-back period is 60 months.[211] As of this writing, in California, the look-back period remains 30 months.[212] Additionally, California rules define the start date for the penalty period as beginning the month the transfer was made,[213] whereas the DRA rules define the penalty period as beginning once the applicant applies and is found "otherwise eligible."[214] Due to these differences, California's program is more favorable to applicants who wish to transfer nonexempt resources without waiting out the entire look-back period, as well as applicants who do wait out the look-back period, since it is only half the length of the time required by the DRA. Transfers not within the look-back period have no effect on Medicaid eligibility.[215]

C. Calculating the Transfer Penalty

If a disqualifying transfer is made in California, the period of ineligibility is then calculated based on the methodology below.

1. *Calculation Methodology*

The period of ineligibility is the number of months resulting when the net fair market value of the asset in question is divided by the monthly average private nursing facility cost.[216] For 2016, the monthly

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210 CAL. CODE REGS. tit. 22, § 50411. Under CAL. CODE REGS. tit. 22, § 50408(b), the state presumes property transferred by the applicant two or more years before the date of initial application was not to establish eligibility or reduce share of cost, and is not considered in determining eligibility. However, under Draft Regulation 50408.5(b) set out in ACWD Letter No. 90-01, the look-back period is now 30 months. *See* ACWD Letter No. 90-01 (Jan. 5, 1990) (referencing the draft of CAL. CODE REGS. tit. 22, § 50408.5).

211 Although OBRA 1993 called for a 36-month look-back, the 36-month look-back period will never be implemented in California since when California changes it will move to the 60-month look-back period established in the DRA. CEB TREATISE, *supra* note 15, § 10.26.

212 ACWD Letter No. 90-01 (referencing the draft of CAL. CODE REGS. tit. 22, § 50408.5(b)).

213 CAL. CODE REGS. tit. 22, § 50411(c) (2016); *see* ACWD Letter No. 90-01 (referencing the draft of CAL. CODE REGS. tit. 22, § 50411.3(a)).

214 CEB TREATISE, *supra* note 15, § 10.47 (citing 42 U.S.C. § 1396p(c)(1)(D)(ii)).

215 CAL. WELF. & INST. CODE § 14015(c) (West 2016). Thus, if a person gives away $1 million six years before applying for Medicaid, that gift will not be considered in determining eligibility.

216 CAL. CODE REGS. tit. 22, § 50411(b)(4) (2016); *see* Cal. Dep't of Health Care Servs., *Medi-Cal Questions and Answers* 3, http://www.dhcs.ca.gov/services/ltc/Documents/Medi_CalQandA.pdf [hereinafter *Medi-Cal Questions and Answers*].

average private nursing facility cost in California is $8,189.[217] The period of ineligibility may be reduced based on certain costs to the beneficiary.[218] The period of ineligibility may be stated as a formula.

$$\text{Period of Ineligibilty} = \frac{\text{FMV of Gift}}{\text{Av. Monthly N.H Cost}}$$

It should be noted that under California law the maximum penalty period is 30 months.[219]

2. *The Period of Ineligibility BEGINS with the Month of Transfer*

Based on the MCCA, California's current rules provide that the period of ineligibility begins in the month when the resources were transferred regardless of whether the person was eligible at the time he or she entered the nursing home or became eligible for Medi-Cal after the date of institutionalization.[220] Then, under MCAA and OBRA 1993, DHCS divides the disqualifying amount transferred by the statewide average private pay rate (APPR) rounded down to the next full number, and uses this figure to determine the period of ineligibility.[221] This means that a Medicaid applicant has to be determined eligible in all respects except for the imposition of the transfer penalty.[222] As we will discuss later,[223] the DRA takes a different approach to initiating the ineligibility period.

D. Transfers Which Cause No Penalty

There are a number of transfers that are express exceptions to the Medicaid asset transfer rules and do not cause the imposition of a pe-

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217 ACWD Letter No. 16-11 (Apr. 25, 2016), http://www.dhcs.ca.gov/services/medical/eligibility/Documents/ACWDL2016/ACWDL16-11.pdf.

218 CAL. CODE REGS. tit. 22, § 50411(b)(5)(A)-(C).

219 ACWD Letter No. 90-01 (Jan. 5, 1990) (referencing the draft of CAL. CODE REGS. tit. 22, § 50411.3(b)(1)).

220 CEB TREATISE, *supra* note 15, § 10.34.

221 CEB TREATISE, *supra* note 15, § 10.34; *see also* ACWD Letter No. 90-01.

222 Non-exempt resources must be reduced to $2,000 or less by the first of the month when the application is made, and applicants must be deemed in need of long-term care on the same day. *See* CANHR *Consumer's Guide*, *supra* note 27, at 4. If already on Medicaid, the transfer penalty will begin on the first day of the month of the transfer, and an application is not required to start the ineligibility period. This could arise if a Medicaid beneficiary disclaims or gives away a subsequent inheritance. CEB TREATISE, *supra* note 15, § 10.34.

223 *See infra* Part VIII.B.1.

riod of ineligibility.[224] Note that the following exceptions, currently active as of April 2015, differ significantly from those available in other states because the version of the MCCA rules attached to ACWD Letter No. 90-01 (Jan. 5, 1990) are still technically in effect in California:[225]

> 1. Gifts not in the "look-back period," that is, gifts made more than 30 months before applying.[226] The reader is reminded that the federal look-back period is 60 months.
>
> 2. Transfers of the principal residence while it enjoys exempt status to anyone.[227] Under current federal law there are four distinct but limited exemptions from the transfer rules for homes. These are (1) transfer of the home to the spouse; (2) transfer to a child of the applicant who has lived in the home and provided care to the applicant (which was necessary for the applicant to remain independent) for the two year period immediately prior to institutionalization or Medicaid eligibility; (3) transfer of the home to a sibling of the applicant who has an equity interest in the home and who has lived in the home for one year immediately prior to institutionalization or Medi-Cal eligibility; and (4) transfer to a child of the applicant under the age of 21.[228] The clear implication of these exemptions is that other gratuitous transfers of the home within the lookback period are subject to transfer penalties, at least as far as federal law is concerned.[229] Apparently DHCS takes the position that these Federal exemptions apply in California to homes that otherwise would be non-exempt.[230]
>
> 3. Transfers of the home where foreclosure or repossession is imminent, so long as there is no evidence of collusion.[231]
>
> 4. Transfers to a spouse or transfers into an annuity for the benefit of a spouse.[232]
>
> 5. Transfers to a blind, totally, or permanently disabled child or to a trust for the sole benefit of a disabled child where the

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224 Some of these exceptions present planning opportunities. *See infra* Part VIII. For now we simply describe the exceptions.

225 CEB TREATISE, *supra* note 15, § 10.34.

226 *See Medi-Cal Questions and Answers*, *supra* note 216, at 3.

227 CEB TREATISE, *supra* note 15, § 10.55(a) (citing ACWD Letter No. 02-60 (Dec. 23, 2002)).

228 42 U.S.C. § 1396p(c)(2)(A)(i)-(iv) (2012).

229 *Cf.* THOMAS D. BEGLEY, JR. & JO-ANNE HERINA JEFFREYS, REPRESENTING THE ELDERLY CLIENT 7.06[I][1] (Aspen 2015).

230 CEB TREATISE, *supra* note 15, § 10.56(b).

231 CAL. WELF. & INST. CODE § 14015(b)(4) (West 2016).

232 *See* CEB TREATISE, *supra* note 15, §§ 10.58(a), 10.60, 10.61. With respect to spousal annuities see *infra* Part VIII.L

trust is funded by the disabled applicant's own assets.[233] Any remaining funds in the trust upon the death of the beneficiary or the beneficiary's spouse must be received by the state.[234]

6. Transfers to a trust for the sole benefit of a disabled person under 65 years of age where the trust is funded by the disabled applicant's assets.[235] Any remaining funds in the trust upon the death of the beneficiary or the beneficiary's spouse must be received by the state.[236]

7. Transfers in exchange for fair market value consideration.[237]

8. Gifts that have been returned to the applicant.[238]

9. Transfers of exempt resources other than the home or sales contracts.[239]

10. Transfer of assets that are exempt due to the purchase of a Long-Term Care Partnership Insurance Policy.[240]

11. Transfers not made for the purpose of qualifying for Medicaid long-term care coverage.[241]

E. Waiver of Penalty

DHCS must waive the application of the transfer penalty where it will create undue hardship.[242]

VI. Post-Eligibility Treatment of Income and Resources

A. Allocation of Institutionalized Person's Income

Generally, a person in a nursing facility who has been determined eligible for Medicaid must pay virtually all income to the facility for the

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233 *Id.* §§ 10.60, 10.62(b).

234 Cal. Code Regs. tit. 22, § 50489.9(a)(3)(C) (2016).

235 CEB Treatise, *supra* note 15, §§ 10.60, 10.62(b).

236 Cal. Code Regs. tit. 22, § 50489.9(a)(3)(C).

237 Cal. Welf. & Inst. Code § 14015(a) (West 2016).

238 42 U.S.C. § 1396(p)(c)(2)(C)(iii) (2012). Partially returned gifts will result in a prorated reduction of the penalty period. *See* CEB Treatise, *supra* note 15, § 10.62(b).

239 Cal. Code Regs. tit. 22, §§ 50428, 50453.7(c), 50461(a)(1), 50465, 50467(a)-(b), 50473, 50508, 50508(a)(1), 50605(b)-(c).

240 Cal. Code Regs. tit. 22, § 50453.7 (2016). Such policies may affect eligibility. CEB Treatise, *supra* note 15, § 13.70.

241 For transfers made 2 or more years before an initial application, it is assumed the transfer is not for the purpose of qualifying. Cal. Welf. & Inst. Code § 14015 (West 2016); CEB Treatise, *supra* note 15, § 10.63(d). *But see* ACWD Letter No. 90-01 (Jan. 5, 1990) (applying the 30 month rule).

242 CEB Treatise, *supra* note 15, § 10.64; ACWD Letter No. 90-01 (referencing the drafts of Cal. Code Regs. tit. 22, §§ 50096.5, 50411.5(a)(5)).

cost of care. However, income may be allocated for various other purposes. The most common allocations are as follows:

1. The monthly Personal Needs Allowance of a recipient in a nursing home, which for most residents is $35.00 in 2016.[243]

2. For the applicant's spouse the MMMNA,[244] which is adjusted annually based on cost of living. In 2016, the MMMNA is $2,981 per month.[245] The community spouse can keep all checks paid in his or her name, regardless of amount and regardless of whether the income is community income.[246] If the income in the name of the community spouse is less than $2,981, the community spouse can keep enough of the nursing home spouse's income to bring the community spouse's income up to $2,981.[247] Note, this amount is not a cap on how much the community spouse can keep since the community spouse can always keep all income paid in his or her name.[248] The community spouse has the right to request a hearing if she or he disagrees with DHCS's determination of the spousal allowance or participation amount.[249]

3. An allowance for the benefit of a disabled relative other than the beneficiary's spouse or child in certain circumstances.[250]

4. Amounts for prior incurred medical expenses for which the recipient is liable — even if incurred when the recipient was ineligible.[251]

5. Health care premiums for the nursing home resident and any person in the resident's family, including Medicare premiums, and premiums for long-term care insurance or supplemental "Medigap" policies.[252]

6. Income may be kept for home upkeep provided certain circumstances are met, the dollar amount to be determined annually based on a number of factors.[253]

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243 CAL. CODE REGS. tit. 22, § 50605(a)(1).

244 *See* CANHR *Consumer's Guide, supra* note 27, at 13.

245 *See id.*; 42 U.S.C. § 1396r-5(d) (2012).

246 *See supra* Part IV.B (discussing the "name on check" rule). *See also* Dep't of Health & Hum. Servs., *Spouses of Medicaid Long-term Care Recipients* 5 (2005), https://aspe.hhs.gov/sites/default/files/pdf/74086/spouses.pdf.

247 *See* Cal. Advocates for Nursing Home Reform, *Year 2016 Rate and Cost of Living Adjustments* (2016), http://www.canhr.org/medcal/PDFs/RateCOLA2016.pdf.

248 *See supra* Part IV.B.

249 42 U.S.C. § 1396r-5(e).

250 CAL. CODE REGS. tit. 22, § 50605(d)-(e) (2016).

251 *See* CANHR *Overview, supra* note 34.

252 CAL. CODE REGS. tit. 22, § 50555.2.

253 *Id.* § 50605(b)-(c) (enumerating the factors for keeping income, and the dollar amounts permitted).

B. Post-Eligibility Treatment of Resources[254]

Resources exempt when determining eligibility are exempt after eligibility is established. For couples, Medi-Cal allows the community spouse to accumulate non-exempt resources after the institutionalized spouse becomes eligible without affecting his or her eligibility;[255] however, clients should be warned that any resources accumulated by the community spouse after the institutionalized spouse is institutionalized but before he or she is deemed eligible are counted against the institutionalized spouse and can result in a penalty.[256]

VII. Medicaid Estate Recovery[257]

A. Basic Rule

DHCS may recover from the estate of a Medicaid recipient when Medicaid benefits were paid on behalf of the decedent after he or she turned 55.[258] In many states this right of recovery arises at death against any property in which the Medicaid recipient had an interest at the moment preceding death, but California does not appear to follow this rule.[259] Thus, although technically a state might seek recovery against a life estate,[260] DHCS rarely seeks recovery of a decedent's interest in a

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254 *See* Bleck et al., *supra* note 10, at 188-96 (discussing details on how other state programs treat resources after the applicant establishes eligibility).

255 *See* CANHR *Consumer's Guide, supra* note 27, at 12.

256 *See id.*

257 42 U.S.C. § 1396p(a) (2012); Cal Welf. & Inst. Code § 14009.5 (West 2016). Please note possible major upcoming changes regarding Medi-Cal recovery. Pending legislation, entitled S.B. 33, 2015 Leg., Reg. Sess. (Cal. 2015), would amend Cal Welf. & Inst. Code § 14009.5, limiting recovery to what is required under federal law. S.B. 33 would also require DHCS to waive recovery claims against homesteads "of modest value," based on FMV of 50% or less of the county average. *Medi-Cal Recovery Bill Now a 2-Year Bill!*, CANHR, http://www.canhr.org/legislation/2015/leg_updateSB33.html (last visited May 3, 2016).

258 Cal Welf. & Inst. Code § 14009.5; Cal Prob. Code §§ 215, 9202, 19202 (West 2016); Cal. Code Regs. tit. 22, §§ 50961-50966 (2016). Where an applicant was permanently institutionalized before age 55, the distinction may not apply. CEB Treatise, *supra* note 15, § 12.34(4)(a).

259 CEB Treatise, *supra* note 15, §§ 12.2(B), 12.17(3), 12.26(f); *cf.* Begley & Jeffreys, *supra* note 229, § 9.04[B]. The Estate Recovery Section of DHCS pursues the enforcement of the Department's recovery rights. DHCS is required to be notified as a creditor in virtually all probate and non-probate proceedings. In California, the "Notice of Death" can be submitted online through the DHCS site. *See Estate Recovery (ER) Program*, Cal. Dep't of Health Care Servs., http://www.dhcs.ca.gov/services/Pages/TPLRD_ER_cont.aspx (last visited May 3, 2016). Alternatively, notice may be mailed to: Department of Healthcare Services, Estate Recovery Section, MS 4720, P.O. Box 997425, Sacramento, CA 95899-7425.

260 Cal. Code Regs. tit. 22, § 50960.12 (2016).

life estate.[261] DHCS cannot recover at all against property interests that the decedent irrevocably transferred prior to his or her death; however, it will seek recovery where the transfer is subject to revocation.[262] Compared to Medicaid programs in other states, this provides an additional planning technique for California clients.

B. Specific Estate Recovery Rules

1. Usually, Medicaid's right to file an estate claim only arises at the death of the Medicaid recipient. However, though this is rarely done in practice in California since it is easily avoidable,[263] the state can file a lien against the property of a Medicaid recipient who is in a nursing home if the applicant states he or she does not intend to return home.[264] Even after the lien is filed, it will be removed if the applicant later states an intention to return home, even if actual return is unlikely.[265] The state will also remove the lien if any of the following relatives of the beneficiary are living in the home: a surviving spouse, dependent relative, co-owner, blind or disabled child, child under 21, or a sibling with equity interest lawfully residing in the home who has been living in the home for at least one year since the date the beneficiary was institutionalized.[266] A home transferred gratuitously to avoid estate recovery must be exempt at the time of transfer in order to avoid triggering ineligibility.[267]

2. California's recovery program is aggressive in that mandatory recovery is extended to successors for mandatory claims, which is optional but not required under federal law.[268] The burden of this policy can be minimized with use of Medi-Cal exceptions and limitations.[269] Under federal law, estate recovery against the estate of an applicant's spouse is permitted but not mandatory.[270]

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261 CAL. CODE REGS. tit. 22, § 50691; CEB TREATISE, *supra* note 15, §§ 12.26(f), 12.28(1)-(2), 12.45(5).

262 CAL. CODE REGS. tit. 22, § 50961(j).

263 CEB TREATISE, *supra* note 15,§ 12.9(1).

264 CAL. CODE REGS. tit. 22, §§ 50425(c)(7), 50428; CEB TREATISE, *supra* note 15, § 12.9(1).

265 CEB TREATISE, *supra* note 15, § 12.9(1); *see* ACWD Letter No. 02-35 (June 18, 2002). This can be remedied simply by correcting the application. CEB TREATISE, *supra* note 15, § 12.10(2) (practice tip).

266 CEB TREATISE, *supra* note 15, § 12.9(1); *see* ACWD Letter No. 02-35.

267 ACWD Letter No. 02-35.

268 CAL WELF. & INST. CODE § 14009.5 (West 2016).

269 CEB TREATISE, *supra* note 15,§ 10.21.

270 *Id.* § 12.16(2) (citing a letter from CMS to DHCS). Please note possible major upcoming changes regarding Medi-Cal recovery. *See supra* text accompanying note 257.

3. There is some ambiguity within the State of California regarding which services entitle DHCS to seek recovery. Under one state regulation, DHCS is permitted to recover for "healthcare services" *only*;[271] however, under another state law, the department may recover for "all payments made by the Medi-Cal program on behalf of the decedent," including payments made to managed care plans, and excluding personal care services provided by IHSS as well as costs for certain types of premiums.[272]

4. A "Voluntary Post Death Lien" is a new type of lien in California, although there is "apparently little federal authority" to support it.[273] Voluntary post death liens appear to offer an additional "last resort" planning opportunity in California, assuming alignment with federal regulations. This arises when a hardship hearing and appeal has already failed. It requires the successor to be living on the property and unwilling to sell, that the successor is unable to pay DHCS's full claim (specifically, that the successor's income be below the federal poverty level),[274] and a loan application and denial.[275] Notably, DHCS determines the fulfillment of these requirements totally separately from its determination of hardship waiver requirements, regardless of overlapping criteria. If such a lien is placed on the property, DHCS requires monthly payments by the successor until the lien amount, plus interest, is paid in full.[276] The interest will accrue at an annual rate of 7% and is fully due upon either the death of the successor, sale, refinance, transfer, change of title, escrow, or by default of the successor's monthly payments.[277]

5. The state only recovers for Medicaid benefits paid for recipients age 55 or older, except where the recipient was also a nursing home resident.[278]

6. As noted above, DHCS cannot recover at all against property interests that the decedent irrevocably transferred prior to his or her

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271 CAL WELF. & INST. CODE § 14009.5.

272 CAL. CODE REGS. tit. 22, § 50961(c) (2016).

273 CEB TREATISE, *supra* note 15, § 12.11(3); CAL. CODE REGS. tit. 22, §§ 50960.36, 50965.

274 CAL. CODE REGS. tit. 22, § 50965(d).

275 *Id.* § 50965(a).

276 CEB TREATISE, *supra* note 15, § 12.12(a).

277 *Id.* If a successor conveys property before DHCS receives all payment, he or she must give notice to the director within 30 days and alert the new owner of the lien obligation. CAL. CODE REGS. tit. 22, § 50965(f). It is not yet clear how DHCS plans to enforce this obligation. CEB TREATISE, *supra* note 15, § 12.14(c). Although a "listing lien" is defined by statute, there is currently little DHCS authority to support it. *See* CAL WELF. & INST. CODE § 14006(b)(5) (West 2016).

278 CAL. WELF. & INST. CODE § 14009.5(b)(1).

death.[279] As such, DHCS does not seek recovery of a decedent's interest in a life estate where the remainder was irrevocably transferred even though federal law would permit doing so.[280] However, DHCS will seek recovery against the entire asset where there is a retained life estate and the remainder transfer was revocable.[281] Clearly, this argues against the use of revocable trusts for asset transfers.

7. In its definition of "estate" subject to recovery, DHCS now expressly includes living trusts, joint tenancies, tenancies in common, and life estates passing to another person (when revocable), limited in the same manner described *infra*.[282] Life estate interests can be valued "at the time of death" not taking into account the fact of death, but California appears not to do this.[283] Joint tenancy interests may be recovered by DHCS, but are limited to the extent of the decedent's interest.[284] Life insurance owned by the Medicaid recipient is not considered part of the recipient's estate unless the recipient's estate is named as the beneficiary or the policy "reverts to the estate."[285]

8. In California, Medicaid estate recovery is limited to the amount equal to healthcare services received *or* the value of the property received by any recipient from the decedent by distribution or survival, *whichever is less*.[286] Similarly, DHCS is limited to recovering either all payments made by Medi-Cal on behalf of the decedent, *or* the decedent's equity interest in the property at the time of death, *whichever is*

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279 CAL. CODE REGS. tit. 22, § 50961(j) (2016).

280 CEB TREATISE, *supra* note 15, §§ 12.26(f), 12.27(1). *See supra* Part III.B.

281 CAL. CODE REGS. tit. 22, § 50961(i); CEB TREATISE, *supra* note 15, § 12.28(2).

282 *Medi-Cal Recovery Frequently Asked Questions* (*FAQ)*, CANHR, http://www.canhr.org/factsheets/medi-cal_fs/html/fs_medcal_recovery_FAQ.htm (last visited May 3, 2016) [hereinafter *Medi-Cal FAQ*]. For individuals who died before October 1, 1993, however, "estate" is defined according to the common law. CAL. CODE REGS. tit. 22, § 50960.12(b); Cal. Advocates for Nursing Home Reform v. Bonta, 130 Cal. Rptr. 2d 823, 831 (Ct. App. 2003). See *infra* Part VIII for a variety of Medicaid planning techniques.

283 CAL. CODE REGS. tit. 22, § 50960.12(a); CEB TREATISE, *supra* note 15, § 12.26(f). In some states retention of a life estate is sufficient to cause the entire asset to be subject to estate recovery (even when the remainder was given away outside of the look-back period). *See, e.g.*, Idaho Dep't of Health & Welfare v. McCormick, 283 P.3d 785, 791-93 (Idaho 2012). For discussion, see John A. Miller & Aaron Roepke, *Medicaid Planning in Idaho*, 52 IDAHO L. REV. (forthcoming 2016).

284 CAL. CODE REGS. tit. 22, §§ 50960.12(a). It is not clear whether this applies to policies taking the form of an annuity or proceeds of such policies. CEB TREATISE, *supra* note 15, § 12.32(h).

285 *See* CAL. WELF. & INST. CODE § 14009.5(a) (West 2016).

286 *Id.*

less.[287] DHCS is also entitled to an annual interest rate of 7% on any unpaid portion until the claim is completely satisfied.[288]

9. In California, retirement accounts naming a predeceased beneficiary are subject to recovery if they default to the probate estate.[289] Thus, practitioners should advise clients to add contingent beneficiaries, and to update their beneficiary designations when and if a beneficiary predeceases.

10. DHCS has implemented regulations allowing for estate recovery against annuities where payments remain after the death of both spouses.[290]

11. Medicaid recovery may be waived for "undue hardship."[291]

VIII. Medicaid Planning Techniques

Based on the foregoing analysis, we shall summarize techniques used throughout the country and describe California-specific variations on those techniques. As the reader will see, several planning opportunities are unique to California.[292] Some of these techniques are quite remarkable in scope. Please recall, for beneficiaries receiving Medi-Cal from home, there are currently no transfer penalties; transfer restrictions *only* apply to applicants and beneficiaries in or going into nursing

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287 Cal. Code Regs. tit. 22, § 50961(a) (2016); CEB Treatise, *supra* note 15, § 12.21(2)(a). There has been debate on California's definition of "equity interest" and "fair market value." CEB Treatise, *supra* note 15, § 12.21(2)(a).

288 Cal. Code Regs. tit. 22, § 50961(l)(1). Interest accumulates as of the notice of claim or date of distribution, whichever comes later.

289 *See Medi-Cal FAQ*, *supra* note 282.

290 Please note, these regulations result from *California Advocates for Nursing Home Reform v. Bonta*, 130 Cal. Rptr. 2d 823, 840 (Ct. App. 2003). *See* Cal. Code Regs. tit. 22, § 50961(h). DHCS can recover personal property upon the beneficiary's death; however, this is rarely done. CEB Treatise, *supra* note 15, § 12.33(i); *see supra* Part III.C.5.

291 Cal. Welf. & Inst. Code § 14009.5(c)(1) (West 2016) (defining "undue hardship" as existing if certain circumstances are met). If a Medicaid recipient is survived by a RDP, the Department "shall recognize an undue hardship and defer recovery as it would in the case where a spouse survived the Medicaid recipient. *Id.*; *see* Cal. Code Regs. tit. 22, § 50963(a). For possible effects of upcoming legislation known as S.B. 33, 2015 Leg., Reg. Sess. (Cal. 2015), see *supra* text accompanying note 257.

292 One of the authors has written previously on the more widely accepted Medicaid planning techniques. Bleck et al., *supra* note 10, at 188-96. Please also note, although federal Medicaid law does not recognize the distinction between community and separate property, in California, transfers by the community spouse of his or her separate property are not disqualifying so long as the community spouse re-transfers separate or community property received from the applicant spouse *after* the applicant is institutionalized. See CEB Treatise, *supra* note 15, § 12.33(i) for more information.

homes.[293] Thus, before California practitioners utilize the techniques described below, it would be prudent to first exhaust all possibilities that would allow the beneficiary to remain at home, including those facilitated by waiver programs administered in the beneficiary's locality.

A. Gifting and Waiting Out the Look-Back Period

1. *Federal Law*

For applicants with substantial assets, it may be advantageous to transfer assets quickly to start the clock running on the look-back period.[294] There is no limit on the amount that can be given away if the gift is not within the look-back period — though applying before the look-back period ends can have disastrous consequences. Of course, under the DRA the look-back period is 60 months so it is challenging for most people to maintain enough funds to cover long-term care during the look-back period. Term limited long-term care insurance can be a significant planning tool in this regard.[295]

Voluntary impoverishment may leave the donor in difficult circumstances even if the look-back period is satisfied.[296] Some planners will recommend that the donees, often the children of the donor, use the donated assets to establish a special needs trust with the parent (the original donor) as life beneficiary and with the children (the SNT grantors) as remaindermen.[297] The parent's assets remain available to enhance his or her quality of life without being subject to either spend down or estate recovery. In addition to waiting out the look-back period, the key to the success of this strategy is that the SNT must be properly drawn to avoid being deemed a countable asset of the Medicaid applicant. When using this technique some lawyers will require the SNT grantors use a different attorney from the attorney who planned

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293 ACWD Letter No. 90-01 (Jan 5, 1990) (referencing the draft of CAL. CODE REGS. tit. 22, § 50490.1); CAL. CODE REGS. tit. 22, § 50418 (2016); CEB TREATISE, *supra* note 15, §§ 11.21(A), 11.27(C).

294 Again, please note that the current look-back period in California is 30 months; however, in most states, under the DRA, the look-back period is 60 months. *See supra* Part V.B.

295 The challenge, of course, is to qualify for long-term care insurance. Typically the insurer will deny coverage to a person who is already approaching incapacity at the time of application.

296 Medicaid benefits simply permit survival and do not guarantee comfort. *See* Miller, *supra* note 8, at 86.

297 Some useful reference sources for special needs trusts include the following: THOMAS D. BEGLEY, JR. & ANGELA E. CANELLOS, SPECIAL NEEDS TRUSTS HANDBOOK (Aspen 2015); KEVIN URBATSCH, ADMINISTERING THE CALIFORNIA SPECIAL NEEDS TRUSTS (2011); STEPHEN ELIAS & KEVIN URBATSCH, SPECIAL NEEDS TRUSTS: PROTECTING YOUR CHILD'S FINANCIAL FUTURE (5th ed. 2013).

the initial gift. This helps establish that the SNT was not simply a quid pro quo for the original gift.

2. *California Law*

In California, the look-back period is only 30 months. Thus, in California the potential applicant does not need to retain as many assets in order to get through the look-back period. This is a huge advantage for those who wish to make transfers prior to the look-back period. Obviously, when California comes into compliance with the DRA, this advantage will go away.

B. Gifting in the Look-Back Period and Waiting Out the Penalty Period

1. *Federal Law*

Some gift strategies work even when the transfer occurs within the look-back period. In such cases, the key is to have assets to pay for long-term care during any period of Medicaid ineligibility arising from a transfer. The DRA limited the utility of this strategy by causing the ineligibility period to begin on the *later of* the date of the gift or the date of application. With one exception noted below, this largely eliminated the planning technique known as *the half loaf strategy* because gifts made during the look-back period now trigger a penalty period that starts upon applying for Medicaid. Since a person applying for Medicaid is already approaching impoverishment, they have few assets except exempt property with which to pay for care during the penalty period. Thus, in a DRA compliant state, the half loaf strategy only works when a Medicaid recipient sells exempt property such as the home and then gives away part of the sale proceeds while retaining some proceeds to cover a transfer penalty.

2. *California Law*

In California the so-called half loaf strategy still works, even for countable assets, because the period of ineligibility starts on the date of the gift. Moreover, we hasten to note that in California a gift of exempt property triggers no penalty period. We will have more to say about this shortly. Just as notable is the ability to make gifts during the penalty period with little or no penalty. This remarkable and aggressive California-specific planning technique is sometimes called "gift stacking."[298] Gift stacking involves the interaction of several rules and practices. These include the following:

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298 Please note, this technique will not be available when the DRA is formally implemented in California. CEB TREATISE, *supra* note 15, § 10.49(4).

a. The start date of the penalty period for a gift of non-exempt property is the beginning of the month in which the gift is made.
b. The penalty period for separate gifts made during the same month each runs concurrently.
c. Structured properly, multiple gifts to the same person are treated as separate gifts for purposes of the first two rules.

Unlike in other states where gifts made during the look-back period result in a cumulated penalty, under the MCCA rules that are still in effect in California, each gift transfer creates its own ineligibility period, and all such terms can run concurrently.[299] Unless the transfers are made to the same person, from the same account, and on the same date, DHCS will not aggregate the ineligibility periods.[300] Used carefully, gift stacking can significantly reduce or even eliminate the transfer penalty period for applicants.[301]

Example 1: "Gift Stacking" to Shorten Ineligibility Period

A single person gives $25,000 each to two other persons on January 15th before applying for Medi-Cal and entering a nursing home on June 15th. Because an uncompensated transfer occurred within the 30-month MCCA look-back period before the applicant applied for Medi-Cal, the applicant was subject to two periods of ineligibility: one arising from each gift of $25,000. Each gift resulted in a 3.28-month period of ineligibility (based on the 2014 APPR), rounded down to the next full number, which would be 3 months each.[302] The two 3-month disqualification periods both run from January 1st to April 1st. Accordingly, the applicant's eligibility for Medi-Cal after admission to the nursing home was unaffected by the transfer.[303]

Example 2: "Gift Stacking" to Eliminate the Ineligibility Period

A single person gives $5,000 by check drawn on the same checking account each day of a 30-day month six months before applying for Medi-Cal. These checks may be written to

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299 *See id.* § 10.36(6); *see also* Cal. Dep't of Health Care Servs., *Period Of Ineligibility For Nursing Facility Level-Of-Care Work Sheet (MC 176 PI)* (2007) http://www.dhcs.ca.gov/formsandpubs/forms/Forms/mc176pi.pdf [hereinafter *Form MC 176*].

300 *See* CEB TREATISE, *supra* note 15, § 10.36(6); *see also Form MC 176*, *supra* note 299.

301 Note, this California technique assumes a 30-month look-back, pursuant to the MCCA.

302 Under the DRA, rounding down to the nearest whole number of months is not permitted; however, California allows rounding down as of the time of this writing. *See* CEB TREATISE, *supra* note 15, § 10.48(3).

303 This example is adapted from the CEB Treatise. *Id.* §§ 10.34, 10.43.

> the same person or to different persons. Thirty checks for $5,000 apiece equal $150,000 in gifts. Because an uncompensated transfer occurred within the 30-month MCCA look-back period before the applicant applied for Medi-Cal, the applicant was subject to thirty periods of ineligibility: one arising from each gift of $5,000. Each gift resulted in less than one month of ineligibility (based on the 2014 APPR), rounded down to the next full number, zero. The 30-month disqualification periods run from the first day of the month in which the transfers were made, and all expired before the end of the month. Accordingly, the applicant's eligibility for Medi-Cal after admission to the nursing home was unaffected by the transfers.[304]
>
> It is difficult to see any policy justification for this planning opportunity since it so plainly circumvents the need-based character of Medicaid. Again, we emphasize that once the DRA is implemented in California, gift stacking will be an artifact of the past. In the meantime, as we have already noted, it represents a remarkable planning opportunity. However, it is worth stating a second time that gifting away assets leaves the donor in a financially vulnerable state. In addition, if gifts are made the timing is also important if the client is planning to enter a nursing home. This is because nursing homes can decline to admit someone who is clearly headed toward Medicaid support.

C. Purchasing Exempt Resources

1. *Federal Law*

Using countable assets to purchase or update exempt resources is a common and very useful Medicaid planning technique.[305] This is called "asset repositioning."[306] For example, the home can be made elder safe,[307] repaired or remodeled, or even sold and a new, more expensive home or condominium purchased. These sorts of enhancements are especially useful if there is a spouse remaining in the home or if the applicant plans to use long-term care in the home.[308] The mortgage can be

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304 *See id.* §§ 10.34, 10.36.

305 See *supra* Part III.C, for a list of the exempt resources.

306 *See* Miller, *supra* note 8, at 94.

307 Many modifications to homes can make life more comfortable and safe for those approaching old age or incapacity such as lowering cabinets, installing grab bars in bathrooms, adding motion sensor lights on stairs, and placing easy-open handles on doors and windows.

308 *See* Thomas D. Begley & Andrew H. Hook, *Medicaid Planning is More Challenging After Recent Reforms*, 33 EST. PLAN. J. 3, 7-8 (2006).

paid down or off. Excess resources can be used to purchase household furnishings, appliances, or even a new car. Note that these exempt resources may be subject to recovery in some states following the deaths of the recipient and spouse. Thus, as we describe in the next sections, asset repositioning usually offers greater advantages for married couples.

2. *California Law*

In California, asset repositioning is a particularly workable strategy to avoid spend down and estate recovery because gratuitous transfers of exempt and unavailable assets do not trigger transfer penalties.[309]

D. Transfer the Home to Certain Children or Siblings

1. *Federal Law*

As noted earlier, federal law creates certain exemptions for transfers of the home. For example, exemptions apply in the case of a transfer to a child who has lived in the home and cared for the applicant for the two-year period immediately prior to institutionalization, or a sibling who has lived in the home for one year and has an equity interest in the home, or a disabled child.[310]

2. *California Law*

At present in California these exemptions have less significance than in other states since, as already noted, California permits penalty-free transfers of exempt property to anyone for any reason. As we discuss below, in California the focus is likely to be on the form of transfer to employ since the structure of the transfer may have important income, estate and property tax consequences. The tax consequences of trusts, for example, are different in California compared to other states.

E. Trust Options

Generally, Medicaid planning techniques can be implemented in various ways, many of which utilize trusts. We have already noted the utility of the third-party special needs trust. Much like other methods of implementation discussed here, Medicaid planning techniques involving trusts in California depart significantly from those used in other states. A thorough comparison of trusts in California to those used in other

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309 ACWD Letter No. 90-01 (Jan. 5, 1990) (referencing the draft of CAL. CODE REGS. tit. 22, § 50490.1); CAL. CODE REGS. tit. 22, § 50418 (2016); CEB TREATISE, *supra* note 15, §§ 11.21(A), 11.27(C).

310 CEB TREATISE, *supra* note 15, § 10.56(b); *see supra* Part V.D. *See also* REGAN ET AL., *supra* note 9, at 31.

states is necessarily outside the scope of this article. Thankfully, several state-specific resources have outlined the practical uses and warnings related to these methods.[311]

1. *Federal Law*[312]

Briefly then, under federal law, irrevocable gratuitous transfers into third-party beneficiary trusts are subject to the same 60-month look-back period and transfer penalty hurdles as outright gifts. Obviously, this represents a significant barrier to their use. If this barrier can be overcome, an obvious asset to focus on is the home. To be effective Medicaid planning tools, trusts must be irrevocable since the assets in a revocable trust are treated as available resources for Medicaid purposes.

2. *California Law*

As suggested above, trusts have limited utility for Medi-Cal eligibility planning due in a large part to the way the state taxes trust income.[313] Trusts are most useful in the context of Medi-Cal when planning to avoid estate recovery, especially when seeking to protect the home.[314] Because exempt and unavailable assets can be transferred to

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311 42 U.S.C. § 1396p(d)(4)(A) (2012); CAL. CODE REGS. tit. 22 50489-50489.9(a)(3)(A) (2016);. CEB TREATISE, *supra* note 15, §§ 9.54-9.61; ELIAS & URBATSCH, *supra* note 297; URBATSCH, *supra* note 297. *See* CONTINUING EDUC. OF THE BAR- CAL., SPECIAL NEEDS TRUSTS: PLANNING, DRAFTING AND ADMINISTRATION (2015); *see also* Stern, *supra* note 130, at 209. For more on special needs trusts, see John J. Campbell, *Preserving Public Benefits in Physical Injury Settlements: Special Needs Trusts and Beyond*, 2 NAELA J. 367, 368-381 (2006); Jeffrey N. Pennell, *Special Needs Trusts: Reflections on Common Boilerplate Provisions*, 6 NAELA J. 89 (2010).

312 For a discussion of Medicaid planning focusing on federal law, see RALPH J. MOORE & RON. M. LANDSMAN, *Planning for Disability*, *in* TAX MANAGEMENT PORTFOLIOS, A-70 to A-78 (2007); Bradley J. Frigon & W. Eric Kuhn, *Which SNT, When and Why?*, 5 NAELA J. 1 (2009). For information related to Medicaid Qualified Trusts in California prior to 1993, see CAL. CODE REGS. tit. 22, § 50489.1. For a discussion of trust rules in states that have fully implemented the DRA, pooled asset trusts, and trusts for the sole benefit of the community spouse outside of California, see Bleck et al., *supra* note 10, at 175-78.

313 CEB TREATISE, *supra* note 15, §§ 9.53, 11.101. Trusts that cannot benefit the applicant may be subject to a 60 month look-back period. For a brief breakdown of the tax differences of trust planning in California compared to other states, see Sonja K. Johnson, *California Income Taxation of Trusts: Pitfalls and Considerations for Settlors, Beneficiaries and Trustees*, ELDER L. BLOG (Aug. 1, 2010, 10:54 PM), http://www.lexisnexis.com/legalnewsroom/estate-elder/b/estate-elder-blog/archive/2010/08/01/california-income-taxation-of-trusts-pitfalls-and-considerations-for-settlors-beneficiaries-and-trustees.aspx (last visited May 3, 2016).

314 See CEB TREATISE, *supra* note 15, §§ 10.62(b), 11.81(d). Because DCHS never fully implemented OBRA 1993, California laws do *not* prevent transfer penalties for trusts established for disabled persons under 65 unless the trust is established with the disabled applicant's own funds. *Lawyers, Trusts, and Money*, CANHR, http://canhr.org/

any person at any time without penalty as described below, trusts may not be the cheapest and most efficient transfer method for many Californians.

F. Transfer Exempt Assets to Other Persons

1. *Federal Law*

While not required, transferring title of exempt resources solely into the name of the community spouse can avoid ineligibility for the institutionalized spouse if the resources are sold, as well as protect the assets from Medicaid estate recovery.[315] For the community spouse, there is a one-time only "snapshot" of community resources at the time of initial eligibility. Unless the institutionalized spouse is deinstitutionalized or becomes ineligible for Medicaid, increases or changes of the form of wealth of the community spouse, and uncompensated transfers by the community spouse, are usually disregarded.[316]

2. *California Law*

As we have already mentioned, in California, applicants can transfer exempt property to *anyone*, and not just to the community spouse, without penalty.[317] Please note, pursuant to the state Family Code, unilateral gifts or transfers of community property for any purpose without the consent of both spouses is prohibited.[318]

The following techniques apply similarly in California and other states.

G. Consuming Excess Resources

Similar to using nonexempt resources for the purchase of exempt property, Medicaid applicants can spend excess resources on themselves. Nothing will be accomplished if other countable resources are purchased, but the excess resources can be spent on long-term care, vacations, entertainment, additional help around the home, or other services. A parent who is approaching disability might move in with a family member and agree to pay market rate rent. In some circumstances, the purchase of a life estate in the home of a child is a viable

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publications/newsletters/NetNews/Feature_Article/NN_2014Q1.htm (last visited May 3, 2016). For more information on SNTs applicable in the context of Medicaid planning, see Bleck et al., *supra* note 10, at 188-196.

315 *See* Michael J. Millonig, *Post-Eligibility Transfers*, 3 NAELA J. 33, 33-34 (2007).

316 *Id.*

317 CAL. WELF. & INST. CODE § 14015(b) (West 2016); ACWD Letter No. 90-01 (Jan. 5, 1990) (referencing the draft of CAL. CODE REGS. tit. 22, § 50411.5(a)(4)(B)).

318 CAL. FAM. CODE § 1100(b) (West 2016).

strategy for the persons approaching incapacity or for the community spouse of an incapacitated person.[319]

Properly drafted and implemented family caregiver agreements may function as an effective spend down strategy that avoids transfer penalties.[320] These quid pro quo arrangements may also reduce some conflicts that families experience when one family member provides more care than others.

H. Transfer Remainder Interest in the Home with Retention of a Life Estate

Another popular planning technique for avoiding Medicaid recovery is to transfer a remainder interest in the home.[321] Since the residence is exempt and can be transferred to anyone under California law,[322] this will not impact eligibility.[323] Although life estates are expressly subject to estate recovery,[324] irrevocably transferred remainder interests and the retained life estate are expressly barred from recovery.[325] As an additional advantage of this tactic, there will be no property tax reassessment until the beneficiary's death; and, if a child of the beneficiary receives the property then there will be no property tax reassessment on the death of the life estate holder.[326] Reasons to avoid this approach include complex family dynamics, expectation of rental income (which will increase share of cost), and future sale of the home.[327]

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319 *See* Begley & Hook, *supra* note 308, at 8-9; REGAN ET AL., *supra* note 9, at 31. However, note that the purchaser has to live in the home for at least a year.

320 *See, e.g.*, Donna S. Harkness, *Life Care Agreements: A Contractual Jekyll and Hyde?*, 5 MARQ. ELDER'S ADVISOR 39, 55-56 (2003); Heather M. Fossen Forrest, Comment, *Loosening the Wrapper on the Sandwich Generation: Private Compensation for Family Caregivers*, 63 LA. L. REV. 381, 383-86 (2003); Begley & Hook, *supra* note 308, at 9. Various tax consequences arise from these arrangements.

321 Stern, *supra* note 130, at 207. For applicability of life estates for avoiding estate recovery outside California, see REGAN ET AL., *supra* note 9, 31-32.

322 Such a transfer will be considered a gift, and the beneficiary will have to file a gift tax return. *See* Stern, *supra* note 130, at 207.

323 *See id.*; CEB TREATISE, *supra* note 15, §§ 11.21(A), 11.27(C), 11.74(3); *see also* ACWD Letter No. 90-01 (Jan. 5, 1990) (referencing the draft of CAL. CODE REGS. tit. 22, § 50490.1); CAL. CODE REGS. tit. 22, § 50418 (2016); CANHR *Consumer's Guide*, *supra* note 27, at 17.

324 CAL. CODE REGS. tit. 22, § 50960.12(a). In some other states, the state will seek to recover against a life estate by valuing it the moment before death. This is true even for third party created life estates. *See* BEGLEY & JEFFREYS, *supra* note 229, § 9.04[B][4].

325 CAL. CODE REGS. tit. 22, § 50961(i).

326 *See* Stern, *supra* note 130, at 207. Conversely, under the DRA, a typical Qualified Personal Residence Trust (QPRT) might well do the job. For a discussion of QPRTs, see John A. Miller & Jeffrey A. Maine, *Wealth Transfer Tax Planning for 2013 and Beyond*, 2013 BYU L. REV. 879, 945-46. (2013).

327 *See* Stern, *supra* note 130, at 207, 210.

In addition to the options described above, there are several options exclusively available to married couples. Where appropriate, the authors will distinguish major differences between California and federal law below.

I. Revise Estate Plans

The community spouse and other family members should consider the option of revising his or her estate plan to address the possibility that he or she may die before the person on Medicaid because an inheritance by the nursing home spouse could cause ineligibility or subject the inherited resources to the Medicaid claim.[328] Other family members or friends who otherwise might leave bequests to a Medicaid recipient should consider revising their estate plans as well. This is an area where a special needs trust can be an important planning tool.

It is important to note that estate plans encompass more than just wills or irrevocable trusts. For example the beneficiary designations on retirement accounts and life insurance are also part of an estate plan. Property passing to the Medicaid recipient or his estate under these instruments will either disqualify him or be subject to estate recovery.

J. Requesting an Excess Resource Allowance[329]

Another option available to married couples is requesting an enlarged resource allowance. If the community spouse has an income below the MMMNA ($2,981 in 2016),[330] and would still have an income below that amount after the institutionalized spouse's income is added, then either spouse can file for a Fair Hearing to increase the MMMNA or the Community Spouse Resource Allowance (CRSA) ($119,220 in 2016).[331] This may be especially useful where the community spouse

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328 *See* Bleck et al., *supra* note 10, at 193-196 (discussing the revision of a community spouse's estate plan in states that have fully implemented the DRA); Miller & Maine, *supra* note 326, at 906, 934 (discussing transfer tax planning using marital deduction and credit shelter trusts).

329 CMS issued guidance applying spousal impoverishment protections to beneficiaries of home and community services. *See* DEP'T OF HEALTH & HUM. SERVS., CTR. FOR MEDICAID & CHIP SERVS., SMDL No. 15-001, *Affordable Care Act's Amendments to the Spousal Impoverishment Statute* (May 7, 2015), http://www.medicaid.gov/federal-policy-guidance/downloads/SMD050715.pdf.

330 *See* CANHR *Consumer's Guide, supra* note 27, at 13. *2015 SSI and Spousal Impoverishment Standards*, MEDICAID, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-ssi-and-spousal-impoverishment-standards.pdf.

331 *Id.*

wishes to keep income-generating resources.[332] In order to enlarge the resource allowance without first allocating income away from the institutional spouse, it is necessary to seek a change in court rather than through an administrative hearing.[333]

K. Divorce, Legal Separation, or Non-Binding Unions

In some states divorce may be a rational Medicaid planning tool.[334] In California, this is less true. Couples with modest resources often find the CSRA is adequate.[335] For couples with greater assets, substantial community property, and where the community spouse has substantial separate property, divorce may have limited utility in California.[336] Some couples may secure the economic benefit of divorce without a divorce through a court petition, or an administrative appeal proceeding seeking to enlarge the CSRA.[337] Still, the current availability of the less drastic techniques described earlier such as gift stacking make divorce less appealing. Once the DRA is implemented in California, divorce may become a more useful planning tool. It appears sensible to conclude that California's current Medicaid program does not encourage marriage dissolution like other state programs that have fully implemented the DRA.[338]

L. Purchase an Annuity for the Community Spouse[339]

1. *Federal Law*

Purchasing annuities for the community spouse is another method that is more likely to be used outside the state of California because of the availability of more efficient methods of transfer in the state. In states that have fully implemented the DRA, excess resources can be used to purchase an immediate annuity for the community spouse that provides for periodic income payments.[340] The DRA established a safe

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[332] *See* CANHR *Consumer's Guide, supra* note 27, at 11; *see also* CEB TREATISE, *supra* note 15, §§ 11.98(B)(1), 11.113(b).

[333] CEB TREATISE, *supra* note 15, §§ 11.98(B)(1), 11.113(b).

[334] For more information on the use of divorce in estate planning generally, see John A. Miller, *Medicaid Spend Down, Estate Recovery, and Divorce: Doctrine, Planning, and Policy*, 23 ELDER L.J. 41 (2015).

[335] CEB TREATISE, *supra* note 15, § 11.90(d).

[336] *Id.* §§ 11.90(d), 11.91(1), 11.92(2).

[337] CAL. PROB. CODE. §§ 3100-3154 (West 2016). Where that fails, requesting an increased CSRA as part of a court order for legal separation may be a useful option for some. CEB TREATISE, *supra* note 15, § 11.90(d).

[338] CAL. PROB. CODE. §§ 3100-3154.

[339] For further information on requirements of annuities in California see *supra* Part III.C.5.

[340] Bleck et al., *supra* note 10, at 193-196.

harbor for such annuities.[341] Among the requirements to meet the safe harbor are the requirements that payout cannot exceed the life expectancy of the community spouse and that the state must be named as a secondary beneficiary.[342]

2. *California Law*

Again, since California law allows for so many other valuable Medicaid planning opportunities, many will choose to forego those offered by annuities because of associated costs and complicated requirements. This is especially true since technically the DRA could be in effect in California when the annuities are distributed, and would have to comply with DRA regulations. In addition to those requirements for single applicants discussed *supra*, the payout term cannot exceed the life expectancy of the Medicaid applicant or spouse.[343] No transfer penalty will be assessed for the purchase of the annuity that fits the state's requirements, and the value of the annuity income stream will not be counted toward the resource limit for Medicaid eligibility.[344] So long as it is structured to qualify under a future DRA exception, purchasing an actuarially sound, level-payment annuity for the applicant's spouse is a tactic that may be used under both current California law as well as under the DRA.[345]

In terms of recovery, along with those requirements for single applicants discussed *supra*,[346] the state is limited from becoming a remainder beneficiary where an annuity is considered all or part of the CSRA, Retirement Annuities, and in certain other enumerated circumstances.[347]

IX. Conclusion

Medi-Cal planning for long-term care is unlike Medicaid planning in any other state. These differences arise from California's halting and erratic implementation of changes in federal Medicaid law over the past

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341 42 U.S.C. § 1396p(e) (2012).

342 *Id.*

343 *See* Cal. Code Regs. tit. 22, § 50489.5(g) (2016); Bleck et al., *supra* note 10, at 194-195 (discussing the effects of purchasing an annuity for the community spouse in states that have fully implemented the DRA). DHCS uses CMS-inspired tables to determine life expectancy, set forth in Section 3258.9 (Revision 64), Part 3 of the Heath Care Financing Administration's State Medicaid Manual. Cal. Code Regs. tit. 22, § 50489.5(g)(B) (2016). DHCS life expectancy tables are often inconsistent with those used by insurance companies. CEB Treatise, *supra* note 15, § 9.32.

344 Cal. Code Regs. tit. 22, § 50489.5(g).

345 CEB Treatise, *supra* note 15, § 11.39(2).

346 *See supra* Part III.C.5.

347 Cal. Welf. & Inst. Code § 14009.7 (West 2016).

quarter of a century. Many of the differences are profound opportunities for applicants and their families. California's unique planning opportunities include the use of waiver programs to remain home and avoid transfer penalties, the shorter look-back period, the favorable start date for the penalty period, the permissibility of gift stacking, and the ability to transfer exempt assets to persons other than the spouse without penalty.

There is a price to be paid for these boons. Medi-Cal is a composition of ill-fitting and incoherent parts. There are enacted laws that are not yet in force. There are rules that are followed though their lawfulness is in doubt. There are rules that are not followed though they remain on the books. There are accepted practices that are not fully delineated by rule or statute. There are rules that seem to contradict other rules.

When this blend of opportunity and incoherence will end is unclear. Right now California is grappling with the implementation of the Affordable Care Act. The state has indicated it will come back to DRA implementation once the ACA provisions are in place. If past is prologue to the future, full implementation of the DRA in California could be years away. On the whole this a great benefit to persons needing long-term care assistance provided they have access to the expert guidance of an elder law attorney. Without that assistance, such persons face a complex system of rules and a very uncertain outcome. In the end, California's Medi-Cal system is a classic example of the principle that knowledge is power. In this article we have attempted to enlarge that circle of knowledge.