Probate Code

4264. An attorney-in-fact under a power of attorney may perform any of the following acts on behalf of the principal or with the property of the principal only if the power of attorney expressly grants that authority to the attorney-in-fact:

(a) Create, modify, revoke, or terminate a trust, in whole or in part. If a power of attorney under this division empowers the attorney-in-fact to modify or revoke a trust created by the principal, the trust may be modified or revoked by the attorney-in-fact only as provided in the trust instrument.

(b) Fund with the principal's property a trust not created by the principal or a person authorized to create a trust on behalf of the principal.

(c) Make or revoke a gift of the principal's property in trust or otherwise.

(d) Exercise the right to reject, disclaim, release, or consent to a reduction in, or modification of, a share in, or payment from, an estate, trust, or other fund on behalf of the principal. This subdivision does not limit the attorney-in-fact's authority to disclaim a detrimental transfer to the principal with the approval of the court.

(e) Create or change survivorship interests in the principal's property or in property in which the principal may have an interest.

(f) Designate or change the designation of beneficiaries to receive any property, benefit, or contract right on the principal's death.

(g) Make a loan to the attorney-in-fact.

(1)

Probate Code

15401. (a) A trust that is revocable by the settlor or any other person may be revoked in whole or in part by any of the following methods:

(1) By compliance with any method of revocation provided in the trust instrument.

(2) By a writing, other than a will, signed by the settlor or any other person holding the power of revocation and delivered to the trustee during the lifetime of the settlor or the person holding the power of revocation. If the trust instrument explicitly makes the method of revocation provided in the trust instrument the exclusive method of revocation, the trust may not be revoked pursuant to this paragraph.

(b) (1) Unless otherwise provided in the instrument, if a trust is created by more than one settlor, each settlor may revoke the trust as to the portion of the trust contributed by that settlor, except as provided in Section 761 of the Family Code.

(2) Notwithstanding paragraph (1), a settlor may grant to another person, including, but not limited to, his or her spouse, a power to revoke all or part of that portion of the trust contributed by that settlor, regardless of whether that portion was separate property or community property of that settlor, and regardless of whether that power to revoke is exercisable during the lifetime of that settlor or continues after the death of that settlor, or both.

(c) A trust may not be modified or revoked by an attorney in fact under a power of attorney unless it is expressly permitted by the trust instrument.

(d) This section shall not limit the authority to modify or terminate a trust pursuant to Section 15403 or 15404 in an appropriate case.

(e) The manner of revocation of a trust revocable by the settlor or any other person that was created by an instrument executed before July 1, 1987, is governed by prior law and not by this section.

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Skilled nursing facility (SNF) situations

Medicare covers skilled nursing facility (SNF) care. There are some situations that may impact your coverage and costs.

Observation services

Your doctor may order observation services to help decide whether you need to be admitted to the hospital as an inpatient or can be discharged. During the time you're getting observation services in the hospital, you're considered an outpatient—you can't count this time towards the 3-day inpatient hospital stay needed for Medicare to cover your SNF stay. Find out if you're an inpatient or an outpatient.

Readmission to a hospital

If you're in a SNF, there may be situations where you need to be readmitted to the hospital. If this happens, there's no guarantee that a bed will be available for you at the same SNF if you need more skilled care after your hospital stay. Ask the SNF if it will hold a bed for you if you must go back to the hospital. Also, ask if there's a cost to hold the bed for you.

Meeting the 3-day inpatient hospital stay requirement

Here are some examples of common hospital situations that show if you've met the 3-day inpatient hospital stay requirement:

> **Situation 1:** You came to the Emergency Department (ED) and were formally admitted to the hospital with a doctor's order as an inpatient for 3 days. You were discharged on the 4th day.
> **Is my SNF stay covered?** Yes. You met the 3-day inpatient hospital stay requirement for a covered SNF stay.

> **Situation 2:** You came to the ED and spent one day getting observation services. Then, you were formally admitted to the hospital as an inpatient for 2 more days.
> **Is my SNF stay covered?** No. Even though you spent 3 days in the hospital, you were considered an outpatient while getting ED and observation services. These days don't count toward the 3-day inpatient hospital stay requirement.

Refusing care

If you refuse your daily skilled care or therapy, you may lose your Medicare SNF coverage. If your condition won't allow you to get skilled care (like if you get the flu), you may be able to continue to get Medicare coverage temporarily.

Stopping care or leaving

If you stop getting skilled care in the SNF, or leave the SNF altogether, your SNF coverage may be affected depending on how long your break in SNF care lasts.

If your break in skilled care lasts more than **30 days**, you need a new 3-day hospital stay to qualify for

additional SNF care. The new hospital stay doesn't need to be for the same condition that you were treated for during your previous stay.

If your break in skilled care lasts for at least **60 days** in a row, this ends your current benefit period and renews your SNF benefits. This means that the maximum coverage available would be up to 100 days of SNF benefits.

Skilled nursing facility (SNF) care

Medicare Part A (Hospital Insurance) covers skilled nursing care

in certain conditions for a limited time (on a short-term basis) if all of these conditions are met:

You have Part A and have days left in your benefit period to use.

You have a qualifying hospital stay .

Note

- During the COVID-19 pandemic, some people may be able to get renewed SNF coverage without first having to start a new benefit period.
- If you're not able to be in your home during the COVID-19 pandemic or are otherwise affected by the pandemic, you can get SNF care without a qualifying hospital stay.

Your doctor has decided that you need daily skilled care. It must be given by, or under the supervision of, skilled nursing or therapy staff.

You get these skilled services in a SNF that's certified by Medicare.

You need these skilled services for a medical condition that's either:

- A hospital-related medical condition treated during your qualifying 3-day inpatient hospital stay, even if it wasn't the reason you were admitted to the hospital.
- A condition that started while you were getting care in the SNF for a hospital-related medical condition (for example, if you develop an infection that requires IV antibiotics while you're getting SNF care)

.

Your costs in Original Medicare

You pay:

Days 1–20: $0 for each benefit period .

Days 21–100: $185.50 coinsurance per day of each benefit period.

Days 101 and beyond: All costs.

Note

Your doctor or other health care provider may recommend you get services more often than Medicare covers. Or, they may recommend services that Medicare doesn't cover. If this happens, you may have to pay some or all of the costs. Ask questions so you understand why your doctor is recommending certain services and whether Medicare will pay for them.

What it is

Welfare and Institutions Code

14124.7. (a) No long-term health care facility participating as a provider under the Medi-Cal program shall seek to evict out of the facility or, effective January 1, 2002, transfer within the facility, any resident as a result of the resident changing his or her manner of purchasing the services from private payment or Medicare to Medi-Cal, except that a facility may transfer a resident from a private room to a semiprivate room if the resident changes to Medi-Cal payment status. This section also applies to residents who have made a timely and good faith application for Medi-Cal benefits and for whom an eligibility determination has not yet been made.

(b) This section does not apply to any resident of a skilled nursing facility or intermediate care facility, receiving respite care services, as defined in Section 1418.1 of the Health and Safety Code, unless it is already being provided through a Medicaid waiver program pursuant to Section 1396n of Title 42 of the United States Code, or is already allowed as a covered service by the Medi-Cal program.

(c) Nothing in this section shall limit a facility's ability to transfer a resident within a facility, as provided by law, because of a change in a resident's health care needs or if the bed retention would result in there being no available Medicare-designated beds within a facility.

(d) This section shall be implemented only to the extent it does not conflict with federal law.

State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

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December 9, 2020

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY WELFARE ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS

Letter No.: 20-27

SUBJECT: 2021 Medicare Catastrophic Coverage Act Spousal Impoverishment Caps

The purpose of this letter is to inform counties of an increase to the maximum income and property caps under the Medicare Catastrophic Coverage Act.

Effective January 1, 2021, the community spouse resource allowance is $130,380.00 and the maximum spousal income allocation/minimum monthly maintenance needs allowance is $3,260.00 per month.

DHCS will inform counties when these amounts are updated on the following forms, via a Medi-Cal Eligibility Division Information Letter:

- Medi-Cal General Property Limitations (MC 007)
- Notice Regarding Standards for Medi-Cal Eligibility (DHCS 7077), and
- Notice Regarding Standards for Medi-Cal Eligibiliy and Recovery (DHCS 7102).

If you have any questions regarding this ACWDL, please contact Teresa Jones by email at Teresa.Jones@dhcs.ca.gov or by phone at (916) 345-8151.

Original Signed By

Linda Ngyuen, Chief
Policy Development Branch
Medi-Cal Eligibility Division

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

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DATE: April 24, 2020

TO: ALL COUNTY WELFARE DIRECTORS Letter No.: 20-11
ALL COUNTY WELFARE ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS
ALL COUNTY MEDS LIAISONS

SUBJECT: 2020 Statewide Average Private Pay Rate for Nursing Facility Services

This letter announces that the 2020 statewide Average Private Pay Rate for nursing facility services is $10,298. Use this when calculating the period of ineligibility for transfers of nonexempt property for less than fair market value whenever the date of application, or the date of institutionalization, (the more recent of the two) occurs in 2020, and a disqualifying transfer has occurred. Do not update existing periods of ineligibility on an annual basis. Counties must not use this figure to recalculate periods of ineligibility where the dates of application and institutionalization occurred prior to January 1, 2020.

If you have any questions regarding property, please contact Teresa Jones at (916) 345-8151 or by e-mail at Teresa.Jones@dhcs.ca.gov.

Original Signed By,

Linda Nguyen, Chief
Policy Development Branch
Medi-Cal Eligibility Division

(7)

State of California—Health and Human Services Agency

Department of Health Care Services

PERIOD OF INELIGIBILITY FOR NURSING FACILITY LEVEL-OF-CARE WORK SHEET

For use only when transfers made by an institutional individual occurred on or after January 1, 1990.

Case name: _____

Case number: _____

Eligibility Worker number: _____

Date: _____

REMINDER:

- Do not calculate a period of ineligibility if the month of transfer was more than 30 months from the date for which nursing facility level-of-care under Medi-Cal is being requested.
- Do not add transfers together unless they are transfers made on the same day, from the same account, to the same person.
- The period of INELIGIBILITY can be reduced whenever the institutionalized individual receives additional compensation for the property transferred.
- The period of INELIGIBILITY terminates if the property is transferred back to the institutionalized individual.
- Payments from state-certified long-term care policies are to be deducted from the total net nonexempt property.

A. WAS THE PROPERTY TRANSFERRED EXEMPT OR EXCEPTED FROM INCLUSION IN THE PROPERTY RESERVE AT THE TIME OF TRANSFER? ☐ YES ☐ NO

*If YES, **STOP. No period of ineligibility exists.** If **NO**, continue to B.*

B. DETERMINE THE UNCOMPENSATED VALUE OF THE PROPERTY TRANSFERRED.

1. Net market value of nonexempt property transferred. _____
2. Amount of compensation received in excess of encumbrances and closing costs. _____
3. Uncompensated value (line 1 minus line 2). _____

C. WAS THE UNCOMPENSATED VALUE OF THE PROPERTY TRANSFERRED LESS THAN THE AVERAGE PRIVATE PAY RATE (APPR)? ☐ YES ☐ NO

1. Uncompensated value (B.3.) _____
2. APPR as of the date of application or the date of institutionalization, whichever is most recent. _____
3. Total (line 1 minus line 2) _____

*If YES, **STOP. No period of ineligibility exists.** If **NO**, continue to D.*

D. IS THERE A POTENTIAL PERIOD OF INELIGIBILITY? (Skip D and continue to E if individual was a Medi-Cal Long-Term Care beneficiary at time of the transfer.) ☐ YES ☐ NO

1. Uncompensated value (B.3.) divided by APPR (round down to the nearest whole number) _____
2. Number of months including month of transfer up to and excluding the month of application or retroactive month, if applicable. _____
3. Total (line 1 minus line 2) _____

*If D.3. is equal to or less than zero, check **NO** and **STOP. No period of ineligibility exists.***
*If D.3. is greater than zero, check **YES** and continue to E.*

E. WAS THE INSTITUTIONALIZED INDIVIDUAL WITHIN THE PROPERTY LIMITS AT THE TIME OF TRANSFER? ☐ YES ☐ NO

1. Amount of other net nonexempt property available to the institutionalized individual at the time of transfer. Note: If an applicant is an institutionalized spouse with a community spouse, include the net nonexempt property available to the community spouse. _____
2. Uncompensated value of property transferred (line B.3.) _____
3. Total net nonexempt property (add lines 1 and 2) _____
4. Enter $2,000. (If the applicant is an institutionalized spouse with a community spouse, include the Community Spouse Resource Allowance (CSRA) in effect at the time of application in addition to the $2,000.) _____
5. Uncompensated value which would have resulted in excess property, transferred to establish eligibility (line 3 minus line 4). If greater than amount in line 2, enter amount in line 2. _____

*If amount is $0 or less, check **YES. STOP. No period of ineligibility exists.***
*If amount is greater than zero, check **NO**—continue to Section F*

F. PERIOD OF INELIGIBILITY FOR NURSING FACILITY LEVEL-OF-CARE.

1. Uncompensated value of transferred property that would have resulted in excess property (line E.5.) ..... _____
2. APPR ..... _____
3. Number of months in the period (line 1 divided by line 2, round down to nearest whole number) ..... _____

If less than one, ***STOP. No period of ineligibility exists.***

4. **Applicants:** Number of months including month of transfer and up to and excluding month of application and retroactive month (line D.2.) ..... **Beneficiaries:** Number of months including month of transfer up to and excluding current month _____
5. Months of ineligibility remaining (line 3 minus line 4) ..... _____
6. If the number of months remaining in line 5 is greater than zero, the PERIOD OF INELIGIBILITY WILL EXPIRE ON _____
   (Begin with the month of application, retroactive month, or current month if the person is a beneficiary.)

G. BENEFICIARIES ONLY: DID THE PERSON RECEIVE MEDI-CAL FOR NURSING FACILITY LEVEL-OF-CARE IN A MONTH THROUGHOUT WHICH A PERIOD OF INELIGIBILITY SHOULD HAVE EXISTED? ..... ☐ YES ☐ NO

If YES, there is an overpayment for nursing facility level-of-care only. A referral is required.

NOTE: ***Prior to sending a Notice of Action*** imposing a period of ineligibility for nursing facility level-of-care:

- Evaluate for undue hardship.
- If undue hardship DOES NOT exist, forward case information to DHCS Medi-Cal Eligibility Division Property Analyst for review.