

The Basic Rules of Nursing Home Medicaid Eligibility

INTRODUCTION

For all practical purposes, in the United States the only “insurance” plan for long-term institutional care is Medicaid. Medicare only pays for approximately seven percent of skilled nursing care in the United States. Private insurance pays for even less. The result is that most people pay out of their own pockets for long-term care until they become eligible for Medicaid. While Medicare is an entitlement program, Medicaid is a form of welfare -- or at least that’s how it began. So to be eligible, you must become “impoverished” under the program’s guidelines.

Despite the costs, there are advantages to paying privately for nursing home care. The foremost is that by paying privately an individual is more likely to gain entrance to a better quality facility. The obvious disadvantage is the expense; in Maryland, nursing home fees average \$6,500 a month. Without proper planning, nursing home residents can lose the bulk of their savings.

For most individuals, the object of long-term care planning is to protect savings (by avoiding paying them to a nursing home) while simultaneously qualifying for nursing home Medicaid benefits. This can be done within the following rules of Medicaid eligibility.

In Maryland, Medicaid is administered by the Department of Social Services (the “DSS”). However, in order to qualify for federal reimbursement, the state program must comply with applicable federal statutes and regulations. So the following explanation includes both state and federal law as applicable.

THE ASSET RULES

The basic rule of nursing home Medicaid eligibility is that an applicant, whether single or married, may have no more than \$2,500 in “countable” assets in his or her name. “Countable” assets generally include all belongings except for (1) personal possessions, such as clothing, furniture, and jewelry, (2) one motor vehicle, (3) the applicant’s principle residence (if it is in Maryland), and (4) assets that are considered inaccessible for one reason or another.

The applicant’s home will not be considered a countable asset and, therefore, will not be counted against the asset limits for Medicaid eligibility purposes as long as the nursing home resident intends to return home or his or her spouse or other dependent relatives live there. It does not matter if it does not appear likely that the nursing home resident will ever be able to return home; the intent to return home by itself preserves the property’s character as the person’s principle place of residence and thus as a noncountable resource. As a result, for all practical purposes, nursing home residents do not have to sell their homes in order to qualify for Medicaid.

THE TRANSFER PENALTY

The other major rule of Medicaid eligibility is the penalty for transferring assets. If an applicant (or his or her spouse) transfers assets, he or she will be ineligible for Medicaid for a period of time beginning on the date you would “otherwise qualify” for Medicaid benefits. The actual number of months of ineligibility is determined by dividing the amount transferred by \$6,800¹. For instance, if an applicant made gifts totaling \$6,800, he or she would be ineligible for Medicaid for 1 month ($\$6,800 \div \$6,800 = 1$). Another way to look at this is that for every \$6,800 transferred, an applicant will be ineligible for nursing home Medicaid benefits for one month.

EXCEPTIONS TO THE TRANSFER PENALTY

Transferring assets to certain recipients will not trigger a period of Medicaid ineligibility. These exempt recipients include:

- (1) a spouse (or anyone else for the spouse’s benefit)
- (2) a blind or disabled child
- (3) a trust for the benefit of a blind or disabled child
- (4) a trust for the benefit of a disabled individual under age 65 (even for the benefit of the applicant under certain circumstances)

Special rules apply with respect to the transfer of a home. In addition to being able to make the transfers without penalty to one’s spouse or blind or disabled child, or into trust for other disabled beneficiaries, the applicant may freely transfer his or her home to:

- (1) a child under age 21
- (2) a sibling who has lived in the home during the year preceding the applicant’s institutionalization and who already holds an equity interest in the home.
- (3) a “caretaker child”, who is defined as a child of the applicant who lived in the house for at least two years prior to the applicant’s institutionalization and who during that period provided such care that the applicant did not need to move to a nursing home.

Recently enacted legislation provides a very important escape hatch concerning the transfer penalty. A transfer can be cured by the return of the transferred asset in its entirety. Returning even one dollar less than the original gift will provide no cure.

¹Before June 1, 2009, the amount used to calculate Medicaid penalties was \$4,300. In other words, for Medicaid applications filed before June 1, 2009, the formula for assessing a penalty for gifts made during the lookback period was 1 month penalty for each \$4,300 gifted.

ESTATE RECOVERY

The state has the right to recover whatever benefits it paid for the care of the Medicaid recipient from his or her probate estate. Given the rules for Medicaid eligibility, the only property of substantial value that a Medicaid recipient is likely to own at death is his or her home. Under current law, the state may make a claim against the decedent's home only if it is in his or her probate estate. Property that is jointly owned, in a life estate, or in a trust is not included in the probate estate and thus escapes estate recovery. Congress has recently given the states the right to seek estate recovery against such nonprobate property; so far, Maryland has not acted on this new provision.

TREATMENT OF INCOME

When a nursing home resident becomes eligible for Medicaid, all of his or her income, less certain deductions, must be paid to the nursing home. The deductions include a \$68-a-month personal needs allowance, a deduction for any uncovered medical costs (including medical insurance premiums), and, in the case of a married applicant, an allowance he or she must pay to the spouse that continues to live at home.

SPOUSAL PROTECTIONS

Assets

Medicaid law provides for special protections for the spouse of a nursing home resident, known in the law as the "community" spouse. Under the general rule, the spouse of a married applicant is permitted to keep one-half of the couple's combined assets (as of the date of institutionalization) up to \$109,560.00, (this figure is as of 1/1/09 and is subject to change yearly). In addition, there is a minimum resource allowance for the community spouse of \$21,912.00 (this figure is as of 1/1/09 and is subject to change yearly).

So, for example, if a couple owns \$43,824.00 in countable assets on the date the applicant enters the hospital, he or she will be eligible for Medicaid once their assets have been reduced to a combined figure of \$24,412.00: \$2,500 for the applicant and \$21,912.00 (one half of \$43,824.00) for the at-home spouse.

The determination of the level of the couple's assets is made as of the date of institutionalization of the nursing home spouse. That date is the day on which he or she enters either a hospital or a long-term care facility in which he or she then stays for at least 30 days. It is advantageous for the couple to try to have as much money as possible in their names on that date up to \$219,120.00 so that the amount the community spouse is allowed to keep will be as high as possible.

Income

In all circumstances, the income of the community spouse will continue undisturbed. The community spouse will not have to use his or her income to support the nursing home spouse receiving Medicaid benefits. In some cases, the community spouse is also entitled to share in all or a portion of the monthly income of the nursing home spouse. The DSS determines an income floor for the community spouse, known as the minimum monthly maintenance needs allowance, or MMMNA, which, under a complicated formula, is calculated for each community spouse based on his or her housing costs. (Where the community spouse can show hardship, the DSS may award a larger MMMNA, but only after an appeal to fair hearing.) The MMMNA may range from a low of \$1,750 to a high of \$2,739 a month, (these figures are as of 7/1/08 and is subject to change yearly). If the community spouse's own income falls below his or her MMMNA, the shortfall can be made up from the nursing home spouse's income.

Increased Resource Allowance

Community spouses whose incomes are less than their MMMNA have an alternative to receiving the shortfall from the nursing home spouse. Instead, they may petition the DSS for an increase in the standard resource allowance so that these additional funds may be invested in order to generate income to make up the shortfall. Given current low rates of return, this often can permit the community spouse to retain substantial level of savings. In some instances, even with the award of the higher resource allowance the community spouse will need to draw on the nursing home spouse's income to some extent. Unfortunately, the DSS may not award an increased resource allowance upon application. The intake worker must award the standard allowance described above and the applicant must appeal the determination to a fair hearing.

The Medicaid Application

Applying for Medicaid is cumbersome and tedious. Every fact asserted in the application must be verified by documentation. The application process can drag on for several months as the DSS demands more and more verifications regarding such issues as the amount of assets and dates of transfers. If the applicant does not comply with these requests and deadlines on a timely basis, DSS will deny the application. In addition, after Medicaid eligibility is achieved, it must be re-determined every twelve (12) months.

As always, if you should have any questions or concerns, please do not hesitate to contact us at inquiries@samlawoffice.com.