THE BASIC RULES OF NURSING HOME MEDICAID ELIGIBILITY

For all practical purposes, in the United States the only "insurance" plan for long-term nursing home care for many seniors is Medicaid. Medicare only pays for approximately 7 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. 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 Massachusetts, nursing home fees can be as high as $9,000 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 Massachusetts, Medicaid is administered by the MassHealth Agency.

On February 8, 2006, President Bush signed the Deficit Reduction Act of 2005, which significantly changed the federal Medicaid laws. The three most important changes concern: 1) the transfer of assets to qualify for Medicaid; 2) Medicaid annuities; and 3) Medicaid's treatment of the primary residence. These changes, as well as the current Massachusetts law regarding Medicaid, are summarized below.

<u>The Asset Rules</u>

The first basic rule of nursing home Medicaid eligibility is that an applicant, whether single or married, may have no more than $2,000 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 principal residence (if it is in Massachusetts and it has equity less than $750,000), and (4) assets that are considered inaccessible for one reason or another.

The Home

Prior to February, 2006, Medicaid did not count the value of an applicant's home in determining eligibility. This meant that an individual did not need to sell his or her home, regardless of value, in order to qualify for Medicaid. Under the new rules, however, a home with equity over $750,000 is now counted in determining Medicaid eligibility. However, even under

the new rules, a home continues to be noncountable regardless of value if a spouse, disabled or blind child, or child under the age of 21 lives there.

Homes with equity valued under $750,000 are not considered a countable asset as long as the nursing home resident intends to return home or his or her spouse or another dependent relative lives 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 principal 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 if the home has equity worth less than $750,000.

The Transfer Penalty

Medicaid penalizes applicants who transfer assets by imposing one month of ineligibility for nursing-home benefits for every $7,680 (as of 2007) given away. However, by changing two important aspects of the Medicaid rules, Congress has imposed much stricter penalties than ever before.

Under the old rules, Medicaid would review three years (or in the case of trusts five years) of financial statements in order to identify any disqualifying transfers. This is known as the “look-back period.” The new law extends the look-back period to five years for all transfers.

More significantly, however, the new law also changes the date on which the penalty period begins. Under the old rules, the penalty period started when the transfer was made. The new law shifts the start-date of the penalty period to the date when the person requires a nursing home level of care and his or her funds have run out. The new law will not apply to transfers made prior to February 8, 2006.

The easiest way to explain the current transfer rules is by way of an example. Let’s assume Mrs. Smith transfers $20,000 to her grandson on March 15, 2006. On April 15, 2007, Mrs. Smith suffers a stroke and is admitted to a skilled nursing facility. Assume she spends down her assets below $2,000 as of August 2007. Under the old transfer rules, the March 15, 2006 transfer would have made Mrs. Smith ineligible for Medicaid benefits for almost three months, starting March 1, 2006, and ending at the end of May 2006. Thus under the old rules Mrs. Smith would have been eligible in August 2007. Under the new rules, however, the transfer penalty would not start until August 1, 2007 and would end in November.

There is no cap on the period of ineligibility. So, for instance, the period of ineligibility for the transfer of property worth $500,000 is 65 months ($500,000 ÷ $7,680 = 65.1). However, the DMA may only consider transfers made during the 60-month period preceding an application for Medicaid, the "look-back" period. Effectively, then, there is a 60-month cap on periods of ineligibility resulting from transfers. People who make large transfers have to be careful not to apply for Medicaid before the applicable “look-back” period passes.

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; (2) a blind or disabled child; (3) a trust for the benefit of a blind or disabled child; and (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, and 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; or (3) a "caretaker child", 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.

A transfer can be cured by the return of the transferred asset either partially or in its entirety.

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 $72.80-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 who 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.

The spouse of a Medicaid applicant is entitled to keep a portion of the couple’s assets. The community spouse is entitled to keep a minimum of $20,328 and a maximum of $101,640 (2007 figures). This calculation is not affected whether the assets are jointly held by the couple or they are all in the name of the nursing home spouse. For example, if a couple owns $75,000 in countable assets on the date the applicant enters a hospital, the community spouse will be entitled to a resource allowance of $75,000. If they have $250,000, the community spouse can keep a maximum of $101,640.

Income

Although the amount of assets a couple can keep is strictly limited, MassHealth treats income differently. In all circumstances, the income of the community spouse will continue undisturbed; he or she will not have to use his or her income to support the 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. MassHealth determines an income floor for the community spouse, known as the minimum monthly maintenance needs allowance, or MMMNA, which is calculated under a complicated formula, for each community spouse, based on his or her housing costs. Where the community spouse can show hardship, MassHealth may award a larger MMMNA, but only after an appeal to fair hearing. The MMMNA may range from a low of $1,712 to a high of $2,541 (2007 figures) a month. If the community spouse's own income falls below his or her MMMNA, the shortfall is made up from the nursing home spouse's income.

Annuities

One means of protecting assets for the community spouse is through the purchase of an annuity. The purchase of an annuity transforms excess assets that would otherwise make the nursing home spouse ineligible for Medicaid into a noncountable stream of income for the community spouse. The annuity must be irrevocable and have a term certain -- a guaranteed number of years of payment -- that is shorter than the life expectancy of the healthy spouse. In addition, the money paid back by the annuity over the life expectancy of the annuitant must be equal to or greater than the amount initially paid for the annuity. The annuity should not be purchased until the spouse enters a nursing home.

Congress has also changed the annuity regulations. The old Medicaid rules allowed the spouse to name anyone he or she wanted to receive the remaining annuity payments if the spouse died during the annuity term. Under the new rules, Medicaid requires that annuities name the Commonwealth of Massachusetts as the beneficiary. Although the revised statute is somewhat ambiguous, when a community spouse purchases the annuity it appears that the Commonwealth can only seek reimbursement from the annuity for benefits provided to the community spouse.

Increased Resource Appeal for the Community Spouse

Where a couple’s combined income is less than the MMMNA, the community spouse can petition MassHealth for an increase in the standard resource allowance so that the additional funds can be invested in order to generate income to make up the shortfall. Given current low rates of return, this permits the low income community spouse to retain a substantial level of savings above $101,640, while maintaining eligibility for the nursing home spouse.

Estate Recovery

The state has the right to recover whatever benefits it has paid for the care of a Medicaid recipient from his or her probate estate. Property that passes outside of probate, such as jointly owned real estate, or property in a life estate, or in a trust, escapes estate recovery. In addition, Medicaid must defer its claim if there is a surviving spouse. Medicaid cannot recover against the

estate until after the spouse's death.

Massachusetts does not seek recovery against the estates of those decedents who owned long-term care insurance when they entered the nursing home, provided that the policy was an individual policy approved by the Division of Insurance. This exemption from estate recovery applies only if the applicant for Medicaid checks the correct box on his or her application. In addition, this exception may no longer apply under the new federal changes. If the applicant owns long-term care insurance, consult with our office before filing a Medicaid application.

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 MassHealth 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, MassHealth will deny the application. In addition, after Medicaid eligibility is achieved, it may be re-determined every year. Although simple Medicaid applications do not require an attorney's involvement, it makes sense to work with a qualified elder law attorney in more complicated situations. Examples of situations that may delay or impede eligibility without proper legal advice include: a spouse residing in the community, or if there are any issues relating to transfers, trusts or real estate other than the primary residence.

The Medicaid rules are presently in a state of flux. Therefore, it is more important than ever for you to keep in regular contact with our office so we can advise you as the rules change.