Medicaid General Requirements

Medicaid's **general eligibility** requirements for long-term care stipulate that an individual must be 65 or older, or permanently disabled or blind. He or she must also be a U.S. citizen (or hold qualified immigrant status) and be a resident of the state in which application for Medicaid is made.

Medicaid Functional Requirements

Medicaid applicants must undergo a **functional assessment** and, as a result, be determined to need long-term care. The assessment, performed by a medical specialist, is also used to determine where the care should be delivered: in a skilled nursing facility or in the home or community. The functional assessment is generally based on whether an individual needs assistance with ADLs. Meeting Medicaid's functional eligibility requirements for home and community-based services may or may not be the same as the requirements for skilled nursing home care, depending on the state. In 2007, federal law changed to allow states to impose less stringent functional requirements for those who are able to receive care outside a nursing home.

Medicaid Financial Requirements

The individual must have **asset** and **income levels** that are at or below certain thresholds. These levels are determined by the state in accordance with federal guidelines. Medicaid's financial requirements are explained in more detail later in this chapter.

Medicaid Benefits

Medicaid does not pay benefits directly to beneficiaries. Instead, it makes payment to the providers furnishing services. The individual states establish eligibility standards, determine which benefits to cover, and establish provider payment rates.

All state Medicaid programs must cover the following basic services:

- inpatient and outpatient hospital services

- laboratory and X-ray services
- skilled nursing services
- home health services
- physician and certified nurse practitioner visits
- family planning
- periodic health check-ups
- diagnosis and treatment for children

Medicaid may also pay for things such as prescription drugs, clinic visits, prosthetic devices, hearing aids, some dental care, eye exams and glasses, transportation to and from treatment, and services not covered by Medicare.

All states provide long-term care services for people who are Medicaid-eligible and qualify for institutional care. Though the federal Medicare program does not cover the costs of assisted living facilities, Medicaid may pay for some level of the care component of assisted living. In 2007, states were granted the authority to pay for assisted living under Medicaid state plan amendments. Even so, benefits are limited.

Even when Medicaid does pay for long-term care, the conditions are not always the most favorable. Assisted living facilities, which allow residents some privacy and independence, often do not accept Medicaid patients, nor do all nursing homes. Most nursing facilities do accept Medicaid but limit the number of Medicaid beds they make available. Applicants can face long waits for the facility they prefer. Many times, they must settle for a facility far away from home and inconvenient for family. The placement process differs from state to state, but in some states, patients must take the first bed that becomes available no matter where in the state it is located. The available facility may not be as satisfactory as the patient’s and family’s first choice in terms of cleanliness, staffing, or quality standards.

Home and Community-Based Waivers

At one time, it was common for state Medicaid programs to require that long-term care be delivered only in nursing homes or skilled nursing facilities. Today, virtually all allow for covered care to be received in the home or in a community-based setting as well, under what is known as a waiver program. A **waiver program** enables a state to provide a variety of home and community-based services as alternatives to institutionalization for qualifying individuals or targeted groups. In this way, Medicaid waiver programs provide individualized support that helps people live in their homes or in community settings instead of institutional settings. Waiver programs essentially permit states to "waive" some of Medicaid's provisions and allow individuals to seek and receive Medicaid-covered care and services through means other than nursing homes.

Potential services that may be delivered under a waiver program include day services, respite care, home modifications, personal emergency response systems, nonmedical transportation, and other services that keep beneficiaries at home and out of institutions for as long as possible. Waivers can also be used to provide Medicaid services for waiver participants that are not offered to other adult Medicaid beneficiaries, such as case management and personal assistance services.

Today the proliferation of community-based programs has captured a significant portion of the Medicaid funding that at one time went entirely to nursing home care.

Medicaid's Financial Requirements

To be eligible for Medicaid to pay for long-term care requires that a recipient have a low income and very few assets. In most states, LTC Medicaid recipients are limited to no more than $2,000 or $3,000 in assets. For many who need long-term care and who do not have any means other than Medicaid to cover the cost, this means that they will first have to "**spend down**" their assets to a level that qualifies them for benefits. Consequently, most private resources must be exhausted before Medicaid will pay for long-term care, essentially a process of self-impoverishment.

Unfortunately, those who must spend down their assets to qualify for Medicaid-paid long-term care lose not only their financial security but their independence and freedom of choice as well. Furthermore, once a person has been forced to deplete resources to qualify for LTC, he or she is so impoverished that returning to a pre-Medicaid financial position will never be an option.

Medicaid Treatment of Assets

Individual states establish their own eligibility rules and determine the level of assets that may be retained to receive long-term care under Medicaid. To this end, assets are deemed countable or noncountable. **Countable assets** are those whose values are counted in determining eligibility;**noncountable assets** are not considered.

Countable Assets

As a general rule, applicants for Medicaid-paid LTC may retain only about $2,000 to $3,000 in countable assets. Countable assets, also called **nonexempt assets**, include:

- cash
- checking and savings accounts
- certificates of deposit and money market accounts
- stocks, mutual funds, bonds, and other investment holdings
- IRAs and other retirement investments
- nonresident property

Generally, all money and property that can be valued and turned into cash are considered countable assets, unless it is specifically exempt. If the value of total countable assets exceeds the Medicaid eligibility limit, the applicant must then spend down these assets to the state-prescribed limit before qualifying. Certain allowances are made for married couples that enable the **at-home**(**community) spouse** to retain some countable assets and, therefore, remain living at home. (This is explained in the section “Avoiding Spousal Impoverishment” later in this chapter.)

Noncountable Assets

Certain assets are not considered in the Medicaid eligibility determination. These are termed noncountable (or “exempt”) assets and include the following:

- **primary residence**—A primary residence is not countable as long as the home’s equity is less than $500,000 (or up to $750,000 at the state’s option).[9] The exempt value is unlimited if a spouse, a child under the age of 21, or a blind or permanently disabled child is living in the home.
- **automobile**—One automobile of any value is exempt if one spouse is institutionalized. One auto of any value is exempt if the spouse needs the auto for employment or if the vehicle has been modified to be handicapped accessible.
- **household belongings**—Household belongings, including furniture, appliances, and similar items, are not countable.
- **personal possessions**—Personal possessions such as jewelry, clothing, and similar items are not countable.
- **business property essential to self-support**—A business property is exempt if it produces income sufficient to justify possession of the business assets (equipment and supplies, inventory, cash on hand).
- **burial contracts**—Burial contracts are exempt, though limits on the amount of the exemption may be imposed. The value of the burial contract must be reduced by the cash value of any life insurance policies.
- **burial plot**—This exemption is for the applicant and his or her immediate family. It includes the purchase or prepayment of a gravesite, the opening and closing of a gravesite, a cremation urn, a casket, an outer burial container, and a headstone or marker.
- **cash surrender value of life insurance**—The cash value of any life insurance owned is exempt as long as the value of all such policies does not exceed a certain amount. For this purpose, some states define “value” as cash value; other states define “value” as face value. Regardless, the value limit is typically very low, such as $1,500 or $3,000.

Medicaid Treatment of Income

States assess a Medicaid applicant's income level as well as the sources of his or her income. Like assets, income is deemed either countable or not countable. Most states define countable income as income from:

- salaries and wages
- pensions
- Social Security
- veterans' benefits
- interest earnings and dividends

Noncountable income includes:

- Temporary Aid to Needy Families (TANF) payments
- supplemental security income (SSI)
- food stamps
- Low Income Home Energy Assistance Program (LIHEAP) benefits
- foster care payments
- certain housing subsidies

Some states impose a cap on the amount of income one can earn and still qualify for Medicaid long-term care assistance; other states do not have an income limit. However, once individuals are deemed eligible for Medicaid long-term care, they will be required to contribute a substantial portion of their income to the cost of care. This amount varies from state to state; it also varies depending on whether the individual is in a nursing facility or is receiving care at home or in the community and whether a spouse is living in the home.

Generally speaking, those who receive care in a nursing facility must contribute virtually all of their income toward the cost of their care; Medicaid picks up the remainder. (The income of an institutionalized person's spouse is not affected and does not have to be directed to paying for the institutionalized spouse's care.) An institutionalized beneficiary is permitted to retain only a nominal amount of monthly income, such as $30 or $50. Medicaid recipients who receive care in

their homes or through a waiver program are generally allowed to retain a higher level of income than those in a nursing facility.

All states provide that greater income amounts may be retained if the Medicaid recipient is married and his or her spouse remains in the community.

Transferring Assets

In years past, given the Medicaid eligibility rules, applicants were tempted to simply transfer their assets to family members to meet eligibility criteria. Not surprisingly, the law now imposes certain requirements to curb this practice.

If an asset is improperly transferred, a state can consider the asset countable. States can “look back” for 60 months, called the **look-back period**, to find improper transfers of assets. If a transfer of assets for less than fair market value is found to have been made during the look-back period, the state will withhold payment for nursing facility care and other long-term care services for a specific period. This period is called the **penalty period**.

The penalty period begins when the individual enters a nursing home and otherwise meets Medicaid’s eligibility requirements. The length of the penalty period is based on two factors:

- the market value of the property transferred
- the average monthly rate for nursing facility care in the applicant’s area

The value of the transferred property is divided by the average monthly nursing facility rate in the applicant’s area. The result is the penalty period: the number of months that Medicaid will not pay for care.

For example, suppose Gene transferred his $30,000 investment holdings to his son, Jake, on March 1, 2016. On August 1 of that year, Gene enters a nursing home and applies for Medicaid. The state will look back 60 months from the date Gene entered the nursing home and applied for Medicaid and bring into its asset assessment all transfers Gene made during this time—from July 31, 2011, through August 1, 2016. The $30,000 transfer to his son will be included in Gene’s asset assessment. If the average monthly rate for nursing facility care in

Gene's area is $6,000, Medicaid payments for Gene's care will be withheld for five months ($30,000 ÷ $6,000). The effect is that Gene will have to pay out of pocket toward the cost of his care an amount equal to the value of the asset he transferred.

Allowable Transfers

Certain transfers are permitted. For example, a transfer to a spouse, a transfer to a third party for the benefit of a spouse, a transfer to a child over age 21 living in the home for at least two years before the applicant's institutionalization and who provided care to delay institutionalization, and transfers to disabled children are allowed and will not result in a Medicaid penalty period, even if made during the look-back period.

Avoiding Spousal Impoverishment

Before 1997, requiring applicants for Medicaid LTC benefits to spend themselves into near poverty had the unintended consequence of also impoverishing the community spouse. Today, spouses of nursing facility residents are protected from what is termed **spousal impoverishment**. States are required to permit the community spouse to retain income sufficient for support. This is termed a**monthly maintenance needs allowance (MMNA)**.

The allowable *income* amount that a Medicaid recipient may keep to support a community spouse varies from state to state, but it is generally in the range of 200 to 300 percent of the federal poverty level. If the community spouse's own income is below the allowed MMNA, the shortfall is made up from the nursing home spouse's income.

Any income the community spouse receives in his or her own name may be retained fully by the community spouse. In all circumstances, the income of the community spouse will continue undisturbed. That is, the state cannot require any portion of the community spouse's personal income to be used to cover the cost of care for the institutionalized spouse. In addition, a community spouse is allowed to retain without modification his or her share of income that is payable to the couple jointly.

With respect to *assets*, a community spouse may retain half or more of the couple's combined countable assets, subject to state and federal minimum and maximum limits, without jeopardizing the Medicaid eligibility of the institutionalized spouse. All states must allow the community spouse to keep all countable assets up to a certain minimum ($23,844 in 2016) and up to half of assets above this amount, up to a maximum amount ($119,220 in 2016). A state may impose a limit less than the maximum, but not more. (Minimum and maximum amounts are subject to change every year.) The following simplified example illustrates how the asset rules for spouse's work. It assumes a couple has combined countable assets of $78,000. The state in which the couple resides has set the asset limit for an institutionalized spouse at $2,000, and the community spouse is allowed to retain one-half of the couple's countable assets, up to a maximum of $119,220. This year, the husband enters a nursing home and applies for Medicaid.

Total countable assets:	$78,000
Maximum allowance for nursing home spouse:	– $2,000
Maximum allowance for community spouse (half of assets):	– $39,000
Amount exceeding maximum asset allowance:	$37,000

The maximum allowance for the nursing home spouse ($2,000) plus the maximum allowance for the community spouse ($39,000) results in a total asset allowance for the couple of $41,000. To qualify for Medicaid assistance, this couple must spend down $37,000 of their joint countable assets.

Estate Recovery

Federal laws require states to recover Medicaid-paid expenses for long-term care from the estates of individuals who were institutionalized. This is known as **estate recovery** and occurs after the individual's death. If the decedent, as the Medicaid recipient, was 55 years old or older at the time of death and received Medicaid benefits on or after October 1, 1993, the state must initiate a recovery claim for expenses it paid for nursing facility services and home and community-based services. States also have the option of seeking recovery for

payments for other Medicaid services. Estate recovery cannot be initiated if the Medicaid recipient leaves a surviving spouse or a child under the age of 21 (or a child of any age who is blind or disabled).

Estate Recovery Rules

Assets subject to recovery include both real and personal property. **Real property** includes homes and land. **Personal property** includes vehicles, furniture, bank accounts, and similar assets. The state may claim a portion of personal property owned jointly with another person. Property that was deemed not countable for purposes of qualifying for Medicaid *can* be subject to estate recovery at the Medicaid recipient's death.

Recovery of assets from an estate may be made:

- after the death of an unmarried Medicaid recipient
- after the death of a surviving spouse
- when the Medicaid recipient has no surviving child under age 21
- when the Medicaid recipient has no surviving child of any age who is blind or totally disabled

In cases where estate recovery would create an **undue hardship** for surviving family members, the right to immediate recovery may be waived by the state. The administrator of a Medicaid recipient's estate must apply for a hardship waiver within six months of the decedent's death or within 30 days of receiving notice of a claim against the estate, whichever is later. The request for a hardship waiver must be in writing.

Medicaid and Long-Term Care Insurance

In recognition of the growing need for long-term care and the additional burden that will inevitably fall on hard-pressed state Medicaid programs as the ranks of the elderly continue to expand, the federal government effected a number of far-reaching reforms with the passage of the **Deficit Reduction Act (DRA)** in 2006. Among the many provisions of this act were changes to Medicaid rules that now allow for the expansion of state **long-term care partnership plans**—plans that

link state Medicaid programs with private long-term care insurance policies. Partnership plans are intended to encourage consumers to purchase affordable long-term care insurance policies and thus reduce the burden on state Medicaid programs. Partnership plans and the types of LTC policies that may be used for such plans are the topics of Chapters 5 and 6.