MEMORANDUM ON ELIGIBILITY FOR NURSING HOME MEDICAID

General Requirements

In order to qualify for nursing home Medicaid, an applicant must meet the "medical necessity" requirement, which generally requires a medical disorder or disease requiring attention by registered or licensed vocational nurses on a regular basis. The Director of Nursing in the nursing home or an applicant's medical doctor should be able to assess whether someone meets the medical necessity requirement.

Once it is determined that there is a medical necessity for nursing home care, the applicant must meet two financial tests: the income test and the resources test. The general rule is that in order to qualify for Medicaid nursing home care, an unmarried applicant cannot have more than $2,022.00 in monthly income (for the 2011 calendar year) and no more than $2,000.00 in resources or assets. If both spouses apply, the incomes are combined and the income cap is twice the cap for the individual, $4,044.00. The resource limitations for a married couple, both of whom apply, is $3,000.00. However, the limitations are not as stringent when the applicant is married and his or her spouse is not institutionalized. The non-institutionalized spouse can have unlimited income and resources, including even resources transferred (without penalty) from the spouse on Medicaid.

Income Limitations

For applicants who are married and the applicant's spouse is ineligible, the income cap is the same as for an unmarried applicant, but the income is allocated according to the person to whom the money is payable ("the name on the check" rule), so that if a check is made payable to the noneligible spouse, it is not counted in determining eligibility for the institutionalized spouse. In addition, if an applicant's income exceeds the cap, he or she may still qualify by reducing income through what is known as a "Miller Trust" or a "Qualified Income Trust" by making the applicant's income payable to a trust that meets certain requirements. In order to constitute a "Miller Trust" or a "Qualified Income Trust" the trust must have the following features:

1. The trust is only funded with the income from the individual;

2. The trust is irrevocable;

3. The State will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid by Medicaid on behalf of the individual;

4. The trust must require that the trustee: (a) pay to the beneficiary a monthly personal needs allowance; (b) pay to the spouse of the beneficiary a sum sufficient to provide a minimum monthly maintenance needs allowance; and (c) pay from the funds remaining the cost of medical assistance provided to the beneficiary.

Resource Limitations

In determining whether an individual meets the Medicaid resource requirements, the cash, other liquid assets, or any real or personal property that could be converted to cash which are owned by the individual are counted as of 12:01 a.m. on the first day of each month. There are some assets that are excluded resources and are therefore not considered as resources for purposes of Medicaid eligibility. Some examples of excluded resources are:

For an unmarried applicant:

1. Homestead to which the applicant intends to return, limited to $500,000.00 in equity;

2. Any amount of term life insurance;

3. An automobile of any value;

4. Burial contract or policy to the extent it is worth less than $1,500.00 (or an unlimited amount if it is non-refundable).

For a married applicant with a spouse not living in a nursing home or other medical institution and not on Medicaid:

1. One automobile of unlimited value;

2. Household goods of unlimited value;

3. Burial plots of unlimited value for certain immediate family members;

4. And all of the exemptions that apply to an unmarried person.

If both spouses living in a nursing home and rely on Medicaid:

1. All exemptions that an unmarried person receives;

2. Must have no more than $3,000.00 in "countable" resources.

If both spouses live in a nursing home, but only one relies on Medicaid:

1. The spouse who does not rely on Medicaid can have unlimited income and resources, including even resources transferred (without penalty) from the spouse on Medicaid.

Spousal Impoverishment Rules

The resource limitation for a married couple, with the ineligible spouse not living in an institution, is determined by figuring the couple's "protected resource amount." The protected resource amount is the *greater* of (1) one-half of the couple's countable resources, not to exceed the maximum set by federal law ($109,560.00 for 2011); or (2) the minimum set by federal law ($21,912.00 for 2011). Then within the first year of eligibility, all countable assets in excess of $2,000.00 must be transferred to the community spouse.

In addition, federal law provides for a "minimum monthly maintenance needs allowance" for the community spouse, which is currently $2,739.00 per month. If the community spouse's income is less than that amount, the community spouse is allowed to keep an allowance consisting of enough income of the institutionalized spouse to give the community spouse the full allowance. This rule is not taken into account in determining eligibility; however, once an individual meets the other eligibility requirements, the income will be paid to the spouse first, up to the amount necessary to increase the spouse's income to $2,739.00 per month, before the income is used for payment to the nursing home. If the combined countable incomes of both spouses (after certain deductions) exceed the monthly maintenance needs allowance, the excess income must be paid to the Medicaid program.

Transfer Penalties

Finally, to avoid a person becoming eligible for Medicaid simply by giving all of his or her resources away, there are transfer penalties for transfers for less than fair market value. The basic rule is that a person making a transfer for less than fair market value is ineligible for Medicaid for one day for every $122.50 gifted. This figure represents the average private cost for a day of nursing home care in Texas for 2011.

Only transfers within the "lookback period" are subject to penalty. After the Deficit Reduction Act of 2005 was signed by President Bush on February 8, 2006, the length of time for the lookback period increased from three to five years. If you made a transfer for less than fair market value on or after February 8, 2006, the lookback period is five years (or 60 months) and the ineligibility period begins from the date of the transfer, provided that no Medicaid application is filed for at least 60 months after the calendar month of the gift. For transfers or gifts made before February 8, 2006, the penalty period is three years (or 36 months) for uncompensated gifts and five years (or 60 months) for transfers to certain trusts and begins on the first day of the month of the transfer. The new five-year lookback period for all transfers after February 8, 2006 has been gradually implemented and will not take full effect until February 8, 2011. However, transfers to irrevocable trusts are still subject to the five-year look back period.

For example, if $20,000.00 is gifted, there will be a 163 day penalty period. If the transfer was made on or after February 8, 2006, the penalty period will not begin until the transferor is living in a Medicaid-approved nursing home facility, satisfies all of the Medicaid requirements and income restrictions, and has filed an application for Medicaid assistance. If the transfer was made before February 8, 2006, the penalty period began on the first day of the month the gift was made.

There are certain transfers that are exempted from the transfer penalty rules. Some examples are: transfers of a home to a spouse or a relative meeting certain requirements (i.e., a minor or disabled child); transfers to the individual's spouse or to another for the sole benefit of the spouse; transfers to a trust established solely for the individual's disabled child under age 21; any transfers to a trust established solely for the benefit of an individual under 65 who is disabled; transfers of income to a Miller Trust; transfers in which the individual intended to dispose of the property at fair market value (even if the actual consideration turned out to be less); and any transfers made exclusively for a purpose other than to qualify for Medicaid. If transfers are made for any of these purposes, the penalty period will be avoided.

In addition, effective January 1, 1997, it is a crime to knowingly and willfully dispose of assets in order for an individual to become eligible for Medicaid, if disposing of the assets results in the imposition of a period of ineligibility. The penalty is a maximum fine of $10,000 and/or imprisonment for one year. Because this is a relatively new statute, it is unclear exactly how strictly it will be enforced, but it is certainly an issue that must be considered carefully before making any transfers.

In summary, the rules for becoming eligible for Medicaid nursing home care are quite complex and sometimes confusing. This memorandum is intended to help you understand the basic rules of eligibility, but it is of course not an exhaustive reference on the subject. In addition, since these rules have their basis in federal law, they are always subject to change by Congress.

Medicaid Estate Recovery

On March 1, 2005, Texas implemented the Medicaid Estate Recovery Program (MERP) in compliance with Federal Medicaid laws. The Texas Department of Aging and Disability Services manages the program. The program is designed to return monies paid to Texas Medicaid beneficiaries during their lifetime to the state Medicaid program.

Under the MERP, the state may file a claim against the estate of a deceased Medicaid recipient, age 55 or older, who applied for certain long-term care services on or after March 1, 2005. Claims include the cost of services, hospital care, and prescription drugs supported by Medicaid under certain approved programs.

However, there are exceptions to filing these MERP claims. The Medicaid Estate Recovery Program claims will only be filed when it is cost-effective. Claims that are considered not cost-effective are those where:

1. The value of the estate is $10,000.00 or less;

2. The recoverable amount of Medicaid costs is $3,000.00 or less; or

3. The cost of selling the property would be equal to or greater than the property's value.

In addition, a claim will not be filed should one or more of the following conditions exist:

1. There is a surviving spouse;

2. There is a surviving child or children under 21 years of age;

3. There is a surviving child or children of any age who are blind or permanently and totally disabled under Social Security requirements; or

4. There is an unmarried adult child residing continuously in the Medicaid recipient's homestead for at least one year before the time of the Medicaid recipient's death; or

5. If there will be an undue hardship and the recovery will not be effective.

As stated above, if the transfer penalty would cause an undue hardship, the claim will not be filed. The law provides that an undue hardship exists when enforcing the penalty period for asset transfers would deprive the Medicaid applicant of (1) medical care necessary to maintain the applicant's health or life, or (2) food, clothing, shelter, or necessities of life. An undue hardship waiver may be filed when:

1. The estate property:

   A. Has been the site of a family business, farm or ranch for at least 12 months prior to the death of the Medicaid recipient;

   B. Is the primary income producing asset of the heirs;

   C. Produces at least 50% of their livelihood; and

   D. Recovery by the state would affect the property and result in heirs losing their primary source of income.

2. The estate's beneficiaries would be eligible for public or medical assistance if a recovery claim is collected;

3. Allowing one or more heirs to receive the estate enables them to discontinue eligibility for public or medical assistance;

4. The Medicaid recipient received medical assistance as the result of being a crime victim; or

5. Other compelling reasons exist.

A hardship waiver specific to the homestead may be filed when:

1. One or more of the heirs have gross family income below 300% of the federal poverty level.

If an applicant asserts an undue hardship, state Medicaid agencies must approve or deny the application within a reasonable time and must inform the applicant that he or she has the right to appeal the decision and provide a process by which this can be done. In addition, the applicant must be told that application of the penalty period can be halted if undue hardship exists. With the resident's consent, nursing homes may now pursue hardship waivers on the resident's behalf.

Remember, these rules are subject to change. The information regarding the Medicaid Estate Recovery Program was provided by the Department of Aging and Disability Services on June 6, 2008.