

PRESERVING ASSETS FOR THE FAMILY IN THE MEDICAID QUALIFICATION PROCESS

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INTRODUCTION

Skilled nursing facilities in the Western New York region cost approximately \$12,000.00 to \$15,000.00 a month. The method for obtaining payment for these expenses may vary based on several factors. Often a patient goes into a hospital for acute care before being discharged to a “rehab” facility. If that occurs, it is likely that Medicare will pay in full for the first twenty (20) days of that nursing home care, as long as the patient continues to be classified as “rehabilitative” in nature. (Generally interpreted as meaning the patient intends to return home eventually and it is considered to be medically possible to safely care for the individual at home following rehabilitation.) Medicare may also pay for the next eighty (80) days with a \$164.50 per day co-pay, if the patient continues in a “rehab” placement. Bear in mind that Medicare is an “insurance” program, with sometimes hefty co-pays and deductibles.

Generally, Medicare coverage begins the day a patient is moved out of “Acute Care” and is then re-categorized as being on “Alternate Level of Care” (ALC) or “rehab” status. Western New York area hospitals have different policies as to when they consider a person to be on “ALC” status. The Medicare co-pay must be paid for by the client or possibly from other third party private health insurance coverage (such as a “Medigap” policy) if available.

MEDICAID COVERED SERVICES

Medicaid provides payment for institutional and community based medical care for persons who meet the state eligibility requirements and receive services from a participating provider or facility. Medicaid will pay for medical and nursing home costs not covered by Medicare and/or other medical insurance, such as Blue Cross & Blue Shield, if the client qualifies. Medicaid is a payer of last resort and will only provide coverage when all other payment sources have been exhausted. Payments received from other sources must first be applied to the nursing home bill and Medicaid will then make up the difference, but only up to the Medicaid determined reimbursement rate for skilled nursing facilities. The facility is not allowed to seek additional amounts from the patient on a private pay basis, even though the private pay rates exceed the Medicaid reimbursement rate.

MEDICAID PLANNING

Basic Eligibility Guidelines/Income and Resource Limitations

Medicaid allows an "institutionalized person" (meaning anyone confined to a nursing home or other facility) to retain \$16,800.00 in assets (the "resource allowance"), plus an additional \$1,500.00 in cash, liquid assets, or the cash surrender value of a life insurance policy which is specifically designated for burial purposes, while still qualifying for Medicaid benefits. The "resource allowance" includes bank accounts, jointly-held assets, cash values on life insurance policies, etc. The applicant may also establish a funeral home account of an unlimited amount set aside in an "Irrevocable Trust" to pay for funeral expenses for themselves or their spouse. These accounts have to be set up according to Medicaid rules. Most licensed funeral homes in New York State have the necessary forms required to set up this type of account.

In addition to the resource allowance for a single individual, there is a separate income allowance of \$50.00 per month, which the institutionalized individual is allowed to retain from their total monthly income for payment of personal needs while in the nursing facility. Also, if the institutionalized individual has Medicare and/or private medical insurance coverage in addition to Medicaid, they are allowed to pay the premiums for these policies from their monthly income.

Community Spouse Resource Allowance

In the case of a married couple, all resources held by either spouse will be considered as available to the institutionalized spouse for purposes of determining Medicaid eligibility. However, in the event the Medicaid applicant is married and his/her spouse continues to live in the community, the spouse will be allowed to retain a Community Spouse Resource Allowance (“CSRA”), currently equal to a minimum of \$74,820.00 or one-half of the couple’s total resources if greater than this, (up to a maximum of \$137,400.00), in addition to one automobile, the primary residence (as long as the equity in the residence does not exceed \$955,000.00), the household contents, and any prepaid burial accounts.

Net Available Monthly Income (“NAMI”) Contributions

In addition, the community spouse may keep up to \$3,435.00 per month in income, even if the income is received in the name of the institutionalized spouse. (This community spouse income allowance is also referred to as the “Minimum Monthly Maintenance Needs Allowance” or “MMMNA”.) The “institutionalized spouse” is also permitted to keep \$50.00 per month from their own income. The remaining income of both spouses is classified by DSS as the “net available monthly income” (“NAMI”) and must be used to pay for the nursing home costs. However, in those instances where the income received by the community spouse alone exceeds the Minimum Monthly Maintenance Needs Allowance, the community spouse will only be requested to contribute

25% of the excess towards the monthly cost of the nursing home. An allowance from the NAMI contribution is also available to cover the cost of private health insurance, long term care insurance, and Medicare premiums.

In some situations, (where the community spouse's retained income is less than \$3,435.00) it may be argued that the community spouse needs additional resources in order to generate the additional income required to meet the Minimum Monthly Maintenance Needs Allowance. This may require that the community spouse sign a statement refusing to contribute his or her excess resources towards the institutionalized spouse's care and a Medicaid fair hearing.

The Deficit Reduction Act of 2006 ("DRA")

New Medicaid regulations were implemented on February 8, 2006. The new legislation significantly changed the old Medicaid rules established under the Omnibus Budget Reconciliation Act ("OBRA") of 1993. Among the many changes included in the 2006 act were an increase in the look-back period for Medicaid applications from 36 months to 60 months and entirely different provisions regarding the timing of the imposition of the penalty period for uncompensated transfers of assets (gifts) made in the 60 months prior to a Medicaid application for long-term care. Under the 2006 revisions, penalty periods do not commence until (1) the applicant is in a skilled nursing facility and (2) has met the applicable financial eligibility requirements for the Medicaid Long Term Care program.

The "Look Back" Period

The DRA increased the look-back period for transfers made on or after February 8, 2006, from 36 to 60 months. The significance of the increased look-back period is minimal in most cases, however, since when an applicant utilizes crisis-planning techniques as outlined hereinbelow, the imposition of the penalty period is the more relevant calculation. The look-back period is only significant in those limited cases where an uncompensated transfer of assets was made before the look-back period commenced.

Regional Penalty Rates

In the event that any resources are transferred by the Medicaid applicant to another person, (other than his or her spouse), during the look back period, a "penalty period" is assessed during which the applicant must privately pay the costs of the nursing home. The penalty period is determined by dividing the amount of the total transferred resources by the current Average Regional Rate for nursing home care in the applicant's geographical area. In Western New York, this figure is currently \$11,884.00 per month. This means that if an applicant (or his or her spouse) gives away resources at any time during the 60-month look back period immediately preceding an application for Medicaid assistance, Medicaid will attempt to determine how many months of nursing home care the applicant could have paid for (at the Medicaid rate, not the private pay rate) if they had not given away the resources. Then, for that number of months, DSS will impose a "penalty period" during which they will not pay for nursing home care, but will pay for all other covered medical expenses, such as hospitalizations, emergency room visits, physician services, durable medical equipment costs, ambulance and medically necessary transportation services and prescription drugs.

Calculation of Penalty Periods and Spend-Down Requirements

Under the DRA, the penalty period does not START to run until you have exhausted all your resources (spent down to the applicable Medicaid resource allowance level) and then have applied for and been found otherwise eligible for Medicaid long term care coverage. For example, if you were a single individual who gifted \$50,000.00 within the last 5 years and had now spent down your remaining assets to the current Medicaid resource allowance of \$16,800.00 and had no other resources available with which to privately pay for your nursing home care, you would NOW face a period of 4.52 months with NO available Medicaid coverage as a result of the \$50,000.00 gift.

Transfers Exempt from the Penalty Period

The following transfers are exempt from the transfer penalty rules:

1. Assets that were transferred to an applicant's spouse, or to another for the sole benefit of the applicant's spouse.
2. Assets that were transferred outright to the applicant's blind or disabled child or to a trust established solely for the benefit of such child.
3. Assets that were transferred for fair market value or for other valuable consideration.
4. Assets that were transferred exclusively for a purpose other than to qualify for medical assistance (Medicaid).
5. Assets that were transferred for less than fair market value that were subsequently ALL returned to the applicant or spouse.

Penalty-Free Transfers to Disabled Children

It is important to note that transfers made to an applicant's blind or disabled child will not result in any penalty period. For most purposes, the use of a Supplemental Needs Trust is advised in order not to jeopardize the eligibility of the blind or disabled child from government benefits that he or she may be receiving or may be entitled to at some point in the future. Recent Medicaid decisions have indicated that the remainder of such a trust must be the estate of the disabled or blind child rather than a third party in order to prevent any transfer to such a trust as being construed as a transfer to an individual other than the disabled child.

Additionally, DSS regulations allow the transfer of the applicant's primary residence to a blind or disabled child with no resulting penalty period. The primary residence may also be transferred penalty-free to a spouse, a dependent child under the age of 21, or a sibling of the Medicaid applicant who has an equity interest in the home and who has been residing in the home for a period of at least one year immediately prior to the date the applicant became institutionalized. There is also a penalty free transfer possible to an adult child of the applicant, provided that the adult child has resided in the home for a period of at least two (2) years before the date the applicant became institutionalized and who "provided care" to the applicant.

Special Rules for Annuities and Retirement Accounts

The purchase of an annuity after February 8, 2006 will be treated as an uncompensated transfer of assets for Medicaid eligibility purposes unless the following requirements are met:

1. The Annuity must be irrevocable and non-assignable.
2. The Annuity must be in immediate pay-out status and payable in approximately equal monthly installments, with no balloon payments permitted. Payments from the Annuity will be treated as income for purposes of determining the Net Available Monthly Income (NAMI contribution).
3. The Annuity must be actuarially sound; that is, it must be calculated based on the actual life expectancy of the individual as determined by the Social Security Administration tables.
4. The annuity must name the State as the remainder beneficiary unless there is a community spouse and/or a minor or disabled child, in which case the State must be named as the contingent beneficiary.
5. The Annuity must use the Applicable Federal Rate (as determined by the Internal Revenue Code.)

Retirement Accounts

It is possible under certain circumstances to elect to have a retirement account treated as income rather than as a resource for purposes of determining Medicaid eligibility. For the most part, retirement accounts that are in pay-out status (such as an immediate annuity) and for which the scheduled payments do not exceed the Medicaid applicant's life expectancy (in other words, are actuarially "sound") will be treated as unearned income in the month received and will not be treated as a resource. It is important to note, however, that if the scheduled payments are guaranteed for a "term certain" that exceeds the applicant's life expectancy, then the income stream that is payable for the period exceeding the life expectancy will be treated as a transfer subject to the penalty period rules. For example, if an applicant with a ten (10) year life expectancy elects a retirement account pay-out schedule with a twenty (20) year term certain, then the present value of the ten (10) years worth of payments exceeding the applicant's life expectancy will be treated as an uncompensated transfer. The same rule also applies to the treatment of the spouse's retirement accounts (such as IRAs, 401Ks or 403Bs). As long as the applicant (or spouse) is taking the minimum required distributions after age 70½, or substantially equal annual withdrawals

prior to age 70½, the annual distribution will be treated as income (pro-rated over the twelve (12) month calendar year) and the cash value of the retirement account will not be treated as an available resource. If the applicant or spouse is under the age of 70½ however, the entire value of the account will be applied to the Community Spousal Resource Allowance.

Planning Strategies

Any assets that are given away within five (5) years from the time a client needs to qualify for Medicaid will automatically result in a penalty period, the duration of which is determined by the amount transferred. What is not ascertainable is the date on which this resulting penalty period will commence. Therefore, unless the client has sufficient assets to private pay the cost of a nursing facility for five years or has a long term care policy with sufficient coverage, you must be very careful when recommending asset transfers for the purpose of future Medicaid qualification. Remember that there is no penalty period for transferring assets from the institutionalized spouse to the community spouse. Since Medicaid only imposes a penalty if an applicant gives away assets, (to someone other than a spouse), applicants can spend their money on anything for which they receive a return of fair market value. Thus, a client can pay off any outstanding debts with his or her remaining assets without subjecting themselves to any penalty period for doing so. They can also make improvements to their real property, purchase a new car, new appliances, or go on a vacation without imposing a penalty period. Some individuals may elect to “trade-up” on their personal residence, since New York State has elected to preserve exempt status for the residence as long as the equity does not exceed \$955,000.00. Transfers to irrevocable trusts and the use of the deed transfer with retained life estate also remain viable planning strategies, since New York State has not yet expanded the estate recovery rules to include non-probate assets. Long term care insurance will obviously play a much larger role in Medicaid planning in the future and new provisions allowing for reciprocity between states should make the product even more popular.