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MEDICAID ELIGIBILITY FOR LONG TERM CARE SERVICES

Medicaid is a federal/state program based on financial and medical need. The Medicaid program will pay for most medically-necessary services for individuals who qualify. Medicaid pays for 70% of all nursing home care and serves approximately 48,000 individuals in home and community based waiver programs.[1]

The Ohio Department of Medicaid operates the Medicaid program in Ohio. The County Departments of Job and Family Services process Medicaid applications and make initial eligibility decisions.

There are many different categories of individuals who can be eligible for Medicaid. **This presentation only addresses the category of individuals who need Medicaid to pay for nursing facility level of care services**.

The eligibility rules are found in the Medicaid Eligibility Manual, or MEM, which is the Ohio Administrative Code chapter 5160:1-3, and is located online at http://emanuals.odjfs.state.oh.us/emanuals/ohpeligibility/MEM.

[1] Medicaid's "Day of Reckoning" SFY 2006-07 Executive Budget presented by Barbara Coulter Edwards, Ohio Medicaid Director, at the Ohio Aging Advocacy in Action 2005 Conference, March 2, 2005.

An individual must meet three basic rules to be eligible for Medicaid:

1. the individual must be categorically eligible
2. the individual's countable income must be at or below a certain level
3. the individual's countable, available resources must be at or below $1,500

CATEGORICAL ELIGIBILITY

An individual can be eligible for Medicaid to pay for nursing home care only if he or she is a member of one of the following three categories: aged (65 or older), blind, or disabled. If the individual meets the nursing facility level of care, he is presumed to be disabled.

INCOME ELIGIBLITY

In general, for coverage of nursing facility or home and community based services, the individual will be income-eligible for Medicaid if the individual's monthly income is equal to or less than the monthly cost of care. Income is defined at O.A.C. 5160:1-3-03.1 as what can reasonably be expected to be received each month, or periodically, for that individual's support.

Income is earned or unearned. Income includes all amounts received each month by the individual for support/maintenance from sources such as Social Security, pension, income from a trust, IRAs and Annuities from which the individual is receiving a periodic payment, retirement plans, Veterans Benefits, Railroad Retirement, etc. The individual's gross income, minus a $20 disregard for unearned income (Social Security, pension etc.) or a $65 disregard for the first half of earned income and one-half of the remainder, is compared to the Medicaid reimbursement rate for the facility, and if the income is less, the individual will be income-eligible.

Certain types of income are not counted at all - Supplemental Security Income (SSI), General Assistance, VA benefits based on need, Grants, Scholarships, other income designated by law to be disregarded. O.A.C. 5160:1-3-3.11.

If the individual is married and institutionalized, only the income attributed to that individual is considered. In other words, there is no deeming of income between spouses once institutionalization occurs. Similarly, when a child enters a nursing facility or home and community based care, the parent's income will not be deemed to the child beginning the month after institutionalization.

When a married individual receives a joint check with his or her spouse, the income is attributed in accordance with the ownership rights on the check.

In-kind services can constitute income. For example, if the community spouse lives in the household of another and pays no rent, Medicaid will value that arrangement as benefiting the spouse in the amount of $214 in 2015, which is one-third of the $643 Medicaid Need Standard for 2015.

Example of calculating countable income: Mr. Smith has $1,012 in gross Social Security benefits before the Medicare Part B deduction, and $567 in a retirement pension. He enters a nursing facility. His "countable Medicaid income" is $1,579 minus a $20 disregard, or $1,559. The month reimbursement rate for that facility is $6,500. Because his income is less than the reimbursement rate for that facility, he meets the Medicaid income eligibility criteria.

RESOURCES

The Medicaid resource standard for an individual is $1,500. The individual must have a legal interest in the property and the property must be available to the individual for use and disposition for the resource to be countable. "Resources" are everything left after the income is taken out for the month.

Medicaid excludes the value of:

1. The home and the land associated with it, occupied by:
    - the individual,

- the individual's spouse,
- dependent (under 21), blind, or disabled child,

  or
- a sibling with a verified equity interest in the home who has lived in the home for the past year,

If none of the above applies, then the value of the home is exempt as a resource for the first 13 months after Medicaid eligibility; after the first 13 months, the home must be listed for sale at the auditor's value. The individual must make a bona fide effort to sell the home, and it must be listed at a value not to exceed 90% of the auditor's value. Provided the individual is making a bona fide effort to sell the home, the home remains an exempt resource. O.A.C. 5160:1-3-05.13.

2. Life insurance with a face value equal to or less than $1,500; if face value is over $1,500, then all of the cash value is counted. O.A.C. 5160:1-3-05.12.
3. Irrevocable burial contracts for individual or spouse, and burial space for individual, spouse, family members. O.A.C. 5160:1-3-05.6 and 5160:1-3-05.7.
4. One motor vehicle, regardless of value, if used for medical transportation or employment, if handicapped equipped, or if there is a community spouse; otherwise, one motor vehicle up to trade-in blue book value of $4,500, regardless of liens. O.A.C. 5160:1-3-05.11.
5. Income producing property used to meet basic living needs. Equity is excluded up to $6,000, only if income produced exceeds 6% of equity. O.A.C. 5160:1-3-05.19.
6. Property that produces goods or services to provide for basic living needs, up to a maximum of $6,000 in equity. O.A.C. 5160:1-3-05.19.
7. Receipt of certain lump sums, such as retroactive benefits, Social Security/SSI, for the first six months after receipt. O.A.C. 5160:1-3-05.8.

8. Household goods and personal effects. O.A.C. 5160:1-3-05.10.
9. Any resource which is not otherwise available for use by the individual: does the individual have the legal right and ability to use and dispose of the property? If the property cannot be sold, it should not be available. Examples: life estates with no value, property held in ownership with another when the co-owner refuses to liquidate the property. O.A.C. 5160:1-3-05.17.

Resource Calculation where there is no Community Spouse: Add all countable available resources and compare to the resource standard of $1,500. If under standard, meets the resource test.

Community Spouse Resource Allowance (CSRA): Add countable available resources based on the value as of the first continuous date of institutionalization (30 days or more) – the "snapshot" date, then apply the total to the following formula:

Community Spouse receives a RESOURCE ALLOWANCE of:

THE **GREATER** OF:

$23,844 (2015),

OR

one-half of remaining countable available resources

not to exceed $119,220 (2015).

OR

greater amount needed by Community Spouse established at fair hearing, to generate income for the Monthly Income Allowance, see O.A.C. 5101:6-7-02.

Institutionalized spouse receives a "resource allowance" of $1,500, and is resource-eligible when total countable resources are at or below amount allocated per above formula. Example: Couple has $100,000 in countable resources on date of institutionalization. Community spouse is allocated $50,000; institutionalized spouse is allocated $1,500. Countable resources must be reduced to at or below $51,500 for the institutionalized spouse to be eligible for Medicaid payment for his or her care.

42 U.S.C. 1396r-5(c)&(e); O.A.C. 5160:1-3-06.3.

TRANSFER OF ASSETS

Medicaid Transfer of Asset rules are complicated. A Medicaid application filed during a Medicaid transfer of asset penalty period can have a profound and possibly disastrous affect on the individual's ability to obtain Medicaid.

The Medicaid transfer of assets rules can be found at 42 U.S.C. 1396p(c) & (e), R.C. § 5111.011, and O.A.C. 5160:1-3-07.

Restricted period of coverage - types of medical services to which the Medicaid transfer of asset rules apply:

The Medicaid transfer penalty rules currently apply only to nursing facility services or services provided through a home and community based waiver (such as PASSPORT and the Home Care Waiver program). The individual under a Medicaid transfer penalty remains potentially eligible for Medicaid to pay for all other medical services, such as pharmaceutical drugs and home health benefits. The Medicaid penalty is a "restricted period of coverage."

The Transfer of Asset rules:

Federal and Ohio law set forth three transfer of asset Medicaid rules - the general rule, which applies to all types of assets other than the home, and the more specific rules which apply to transfers of the home and transfers to a trust.

General transfer of asset Medicaid rule:

A resource transfer is considered to be improper if the individual transfers his legal interest in a countable resource for less than fair market value for the purpose of qualifying for Medicaid, a greater amount of Medicaid, or to avoid the use of the resource.

Four elements to an improper transfer:

1. The transfer of a legal interest:

   An exchange of ownership, such as taking one's name off of an asset, giving an asset away to another person or entity, the reduction of an ownership interest in property, including acts done by a spouse, agent, or attorney-in-fact. Adding a name to an asset as a joint tenant is not a transfer of a resource, but adding a tenant-in-common is a transfer of a resource because it is a reduction of ownership.

2. In a countable resource:

   Except for transfers of the home, the asset being transferred must be "countable" for Medicaid purposes for the transfer to be considered improper. In other words, the transfer of an exempt resource is by definition not improper, with the exception of the transfer of a home (see below).

3. For less than fair market value:

   The individual must receive less than the fair value of the asset being transferred to be considered to be improper. Example: a car worth $25,000 and sold for $15,000 will be found to have been transferred for less than fair market value in the amount of $10,000.

4. For the purpose of qualifying for Medicaid, a greater amount of Medicaid, or to avoid the use of a resource:

   A transfer of an asset is not improper if made for reasons not associated with obtaining Medicaid or remaining eligible for Medicaid.

If the transfer falls within the above definition, then a presumption arises that the transfer was done to qualify for Medicaid. This presumption may be rebutted with clear, convincing and credible evidence that the transfer was solely for other reasons, such as transfers made (1) as part of an established gifting pattern or (2) with the intent and belief that fair value was being received in exchange for the transferred asset, and (3) transfers made prior to the need for medical services, when the individual is in good health.

Certain transfers are permitted:

1. Transfers between spouses or to another for the sole benefit of the spouse.
2. The transfer of any asset to a disabled child. "Disabled child" means child over the age of eighteen who is unable to engage in any substantial gainful activity because of a physical and/or mental impairment that has lasted, or can be expected to last, at least twelve months, or result in death.
3. Transfers for fair value.
4. Transfers of an exempt resource other than the home.
5. Transfers into a special needs trust or a Medicaid pooled trust.
6. Transfers made exclusively for a reason other than qualifying for Medicaid.

Ohio's home transfer Medicaid rule:

Transfers of an otherwise exempt home are considered improper if made for less than fair market value during the 60- months prior to Medicaid application, or any time after, unless the home was transferred to one of the following individuals:

1. The individual's spouse, provided the spouse does not subsequently transfer the home to a third party.

2. The individual's child under the age of 21.
3. The individual's child over the age of 21 who is blind or permanently disabled (meets the disability criteria for Social Security benefits).
4. The individual's child over the age of 21, who was living in the home for the two year period before the individual is placed into the nursing facility, and who, during this two year period, provided care to the individual that prevented the individual from entering the facility. This "Adult Caretaker Child" exception to the home transfer rule requires that the child provide evidence of the parent's level of care – the parent must have needed care at the intermediate or skilled level for the entire two year period, as certified by the parent's physician, using Medicaid Form 3697.
5. The individual's sibling who has lived in the home for the year before the individual enters the nursing facility and who has an equity interest in the home.

When transfers are examined: the "Look-back" period:

When an individual applies for Medicaid, Medicaid examines transfers made by the individual, his or her spouse, or any individual acting on the individual/spouse's behalf, during the sixty-month period before the application and institutionalization, (or if not institutionalized, the date of application). This is called the "look back" period. Transfers made during this time period are presumed to have been done to qualify for Medicaid or to protect future eligibility. If this presumption is not rebutted by clear, convincing and credible evidence, then Medicaid imposes a penalty, called a "restricted period of eligibility."

Consequence of an improper transfer:

Transfers of assets that are determined to be improper result in a penalty. Medicaid will not pay for the following medical services during the period of restricted coverage:

Nursing facility services

Home and Community Based Services (such as PASSPORT, the Home Care Waiver, Individual Options Waiver, the Residential Facility Services Waiver, the Assisted Living Waiver)

The penalty period.

The length of time during which the penalty applies, is determined by the following formula:

> the amount of the transferred asset is divided by the average private pay rate of a nursing facility in Ohio, currently $6,327, to determine the number of months that Medicaid will not pay for the above listed services.

The penalty begins the month the applicant is "otherwise eligible" and carries forward until the number of months is satisfied or until some or all of the asset have been reconveyed.

There is no cap on the length of the penalty period.

Example:

> Joan gives $100,000 cash to her niece on January 1, 2015. The next day, Joan goes into a nursing facility and applies for Medicaid. Medicaid looks back 60 months from January 2, 2015, the date Joan both enters the facility and applies for Medicaid. The January 1, 2015 gift is reviewed. Joan is unable to rebut the presumption that the transfer was done so Joan could get Medicaid to pay for her care, and a penalty is applied. The penalty begins the month that Joan lived in a nursing home and applied for Medicaid and but for the gift is eligible for Medicaid. Therefore, the penalty will begin, January 2015, and goes forward for 15.8 months:. $100,000 ÷ $6,327 = 15.8 months.

Multiple transfers incur multiple periods of ineligibility.

Undue hardship:

When an asset has been transferred and the individual is unable to rebut the presumption that the transfer is improper, Medicaid must determine whether the individual will suffer undue hardship if Medicaid benefits are denied.

> An undue hardship is said to exist if the individual's attempts to make the resources available by consulting with legal counsel and it has been determined that the resources no longer exist, are unavailable or that the costs in attempting to retrieve the resources are prohibitive.

Incompetent individuals with no agent or guardian are referred to the county prosecutor or Medicaid's in-house legal staff to attempt to make the resource available.

Spending Down Resources to Eligibility for a Married Couple:

Mr. Smith enters the facility January 1, 2015. Mrs. Smith lives at home. The countable Medicaid assets total $160,000. The assets must be reduced to $81,500 before Medicaid can pay for Mr. Smith's care, the spend down can be as follows:

$160,000.	Mrs. Smith's Resource Allowance (1/2 of $160,000) plus Mr. Smith's
-81,500.	Resource Amount of $1,500
78,500.	
-20,000.	2 funerals
58,500.	
-25,000.	new car
33,500.	
-9,000.	home repairs
24,500.	
-24,500.	care – 3 months
0.	

TRUSTS

Medicaid treats trusts differently depending on the grantor, beneficiary, reason for the trust, and how the trust is funded. A brief description of the Medicaid trust rules follows; however, this outline is not intended to address this particular aspect of the Medicaid rules in great detail. The reader is cautioned to research further before drafting a "Medicaid-friendly" trust.

Third Party Trusts: Trusts created after August 10, 1993 are available if established by the applicant or spouse, for his or her benefit, or established by a court, administrative body, or other entity or person for individual's behalf, regardless of the purpose for the trust, if the trustee has the ability to invade the principal through an ascertainable standard (health, maintenance, and support) for the benefit of the Medicaid recipient. These types of trusts are considered available to the extent of any income paid to the individual, and to the amount of the principal which the trustee has discretion to distribute. Placing assets into trusts may also be considered to be a transfer of a resource, subject to the period of restricted coverage. Any income paid to third parties is considered a transfer and will be subject to a period of restricted coverage. O.A.C. 5160:1-3-05.2(C)(2) and (4).

Trusts created for certain individuals are exempt, for supplemental services/special needs, see R.C. § 1339.51 and R.C. § 5111.151.

> **Special Needs Trust** - Assets of a disabled individual under 65, established by court, parent, grandparent, guardian, used for supplemental services, provided that upon death of beneficiary the corpus is paid to Medicaid to the extent of Medicaid paid for that individual - 42 U.S.C. 1396p(d)(4)(A), often called "(d)(4)(A) trusts, O.A.C. 5160:1-3-05.2(C)(3)(a).
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> **Qualifying Income Trust** – Income only trust if Medicaid receives an amount equal to the Medicaid that was paid for that individual, and provided no resources are used to establish the trust, 42 U.S.C. 1396p(d)(4)(B) (these trusts are used if the

individual's income exceeds the income eligibility for Medicaid), O.A.C. 5160:1-3-05.2(C)(3)(b), R.C. § 5111.151.

Medicaid Pooled Trust - A trust set up by a non-profit for a disabled individual, in which the assets of all such individuals are pooled, used for supplemental services, and from which the remainder is either paid to Medicaid to the extent of Medicaid payments made for that individual and then to heirs, or to the non-profit upon the individual's death, 42 U.S.C. 1396p(d)(4)(C), O.A.C. 5160:1-3-05.2(C)(3)(c), R.C. § 5111.151.

Supplemental Services Trust - A supplemental services trust established through a third party (usually a parent) for the benefit of an individual eligible to receive services from the state or county boards of developmental disabilities or mental health, not to exceed the maximum allowed by law ($234,000 in 2011, to increase $2,000 each year), provided that upon the death of the beneficiary, at least 50% of the assets in the trust are paid to organizations who benefit individuals with DD or mental illness. The trusts can be intervivos or testamentary. R.C. § 1339.51; O.A.C. 5160:1-3-05.2(C)(3)(d), R.C. § 5111.151.

Trusts Established by Will for the Benefit of a Surviving Spouse – Payments made to a surviving spouse are income. The portion of the trust from which payment can be made is a countable resource. Payments made to third parties are deemed to be improper and are imputed to the surviving spouse. If the spouse elects against the Will, the penalty for an improper transfer will not be imposed. O.A.C. 5160:1-3-05.2(C)(5), R.C. § 5111.151.

ANNUITIES

A planning technique for a married couples is the purchase of an annuity, where the community spouse exchanges spend-down funds for a stream of income, and provided the

annuity complies with the Medicaid annuity rule found at 42 U.S.C. 1396p(c)(1)(F) and (G), the purchase is a proper use of spend-down funds. The annuity needs to be irrevocable, non-assignable, actuarially sound, does not have a balloon payment or deferral, and the State is named as the remainder beneficiary in the first position. O.A.C. 5160:1-3-22.8. Currently, the State of Ohio treats the annuity purchases as an improper transfer, as if the spouse gave the purchase money away without getting anything back.

There are 4 court cases from Ohio which say that the State's practice of imposing an improper transfer violates federal law. *Hughes v. McCarthy*, 734 F.3d 473 (6th Cir. 2013), cert. denied 134 S.Ct. 1765, (March 31, 2014); *Rorick v. Ohio Dept. of Job and Family Svrs.,* 2010-Ohio-5571 (Ohio App. 1st Dist. 2010), juris. declined, 2011-Ohio-1049; *Vieth v. Ohio's Department of Job & Family Services*, 2009-Ohio-3748 (Ohio App. 10th Dist. 2009); *Koenig v. Dungey*, 2014-Ohio-4646 (1st Dist. App.). *Hughes* further found that such treatment gives rise to enforceable rights through 42 U.S.C. 1983. *Hughes* at 473.

A class action on this issue has been filed with the Southern District of Ohio. See *Wagner v. McCarthy*, Civil Action No. 14-648 (S.D. Ohio).

If you use an annuity as a planning tool, be sure to calculate the anticipated Monthly Income Allowance (MIA) before it is purchased. A determination of whether the annuity is the best way to go depends in part on the impact it has on the community spouse's income and the receipt of the MIA.

RETIREMENT AND INCOME SUPPLEMENTING ACCOUNTS (RISA)

O.A.C. 5160:1-3-03.10. A retirement fund such as an IRA and a 401(k) will be considered a resource to the full extent of the legal ability to convert the fund to cash, minus any penalty associated with its surrender. If access to the principal is foreclosed and monthly or periodic income is paid, the income will be considered under the unearned income rules and the principal will not be a countable resource. The applicant must take steps to access all income sources, and must attempt to maximize available income. Consequently, the applicant is required to verify that an attempt has been made to get the community spouse to waive his or her rights under the plan. O.A.C. 5160:1-3-03.10. If the applicant has a disabled child, the applicant can opt for a smaller monthly payment, leaving a portion of the fund for the child.

A RISA is not a resource if the individual must terminate employment for access.

POST ELIGIBILITY TREATMENT OF INCOME AND RESOURCES

Patient Liability: Once an individual is approved for Medicaid, a determination is made of the amount of income that is to be paid to the nursing facility. This is called the "patient liability" and is calculated as follows:

Calculate applicant's gross monthly income
Subtract Personal Needs Allowance of $50
Subtract any amount necessary for remedial medical expenses not covered by Medicaid
Subtract amounts for health insurance and Medicare Part B premium
Subtract amount for Maintenance Needs Allowance, calculated as set forth below
Subtract past unpaid medical expenses not covered by Medicaid
Remainder is the amount owed to nursing facility.

O.A.C. 5160:1-3-24.

Monthly Income Allowance: The Monthly Income Allowance, or MIA, is the amount set aside from nursing facility resident's income to support the community spouse and/or dependent children. The formula to determine the amount for the community spouse is:

> Determine the Minimum Monthly Maintenance Needs Allowance (MMMNA), currently $1,967 (2014),
>
> Add to this the amount that the community spouse's shelter costs (rent/mortgage, property taxes, insurance, and utilities that exceed a standard utility allowance of $498/2015) exceed an Excess Shelter Allowance ($590/2015) - if the community spouse's shelter costs do not exceed the Excess Shelter Allowance, then skip this step;
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> Add any excess amount awarded by court order or state hearing;
>
> Add a Family Allowance equal to one-third of the MMMNA less the gross amount of the family member's income;
>
> Subtract the amount of the community spouse's gross monthly income. The result is the amount of the institutionalized spouse's income that the community spouse may keep each month to meet his or her needs while living in the community.
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> 42 U.S.C. 1396r-5(d); O.A.C. 5160:1-3-24.

Waivers: If the individual is on a home and community based waiver, the individual is also permitted to keep an "individual maintenance need allowance" ($1,430/2014).

ESTATE RECOVERY

Estate Recovery: The Ohio Department of Job and Family Services may recover Medicaid benefits paid from the estate of a permanently institutionalized individual of any age and from the estate of an individual 55 years of age and older who is not permanently institutionalized, only after the surviving spouse has died and the individual has no dependent, disabled, or blind children, and only against the estate of the individual who was on Medicaid. "Estate" includes recovery from non-probate assets. The Department may grant an undue hardship or defer recovery – see O.A.C. 5160:1-2-07.

42 U.S.C. 1396p(b)(1); O.A.C. 5160:1-2-07.

PROCEDURAL PROCESS

Applications: The Medicaid Application is filed with the County Department of Job and Family Services in the county in which the individual lives, or in the county in which the individual is placed in the nursing facility. The Department of Job and Family Services must determine eligibility within 45 days of application, absent extenuating circumstances. An authorized representative may apply for the individual and his or her acts bind the applicant in most situations.

Notices/Hearing Rights: Applicants/recipients must receive written notice of any determination affecting the scope of coverage and benefits. The individual has a right to appeal any determination (except for mass changes) to a state hearing. The appeal must be requested within 90 days of the mailing date of the decision. Further appeal and judicial review is available. If benefits are being terminated, the individual has a right to continue to receive those benefits provided he or she requests a state hearing within 15 days after the termination notice has been mailed.