



MEDICAID AND LONG TERM CARE

For all practical purposes, in the United States the only “insurance” plan for long-term institutional care 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—or at least that’s how it began. 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 the desired facility. The obvious disadvantage is the expense; in Georgia, nursing home fees can be \$8,000.00 a month or even more. 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. Please keep in mind that every Medicaid case is unique. This article could not possibly address all of the rules and regulations of Medicaid eligibility. Accordingly, in seeking to obtain Medicaid eligibility individual legal counsel should be sought.

In Georgia, Medicaid is administered by the Georgia Department of Community Health (“DCH”). However, in order to qualify for federal reimbursement, the state program must comply with applicable federal statutes and regulations. The following explanation includes both Georgia and federal law as applicable.

THE ASSET RULES

The 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. If the applicant is married, a spouse living in the community can have an additional \$123,600 (2018 figure) 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; (4) a burial resource allowance of up to \$10,000; and (5) certain retirement accounts and/or annuities.

The Home

A home with an equity value of less than \$572,000 (2018 figure) will not be considered a countable asset for a single applicant and, therefore, will not be counted against the asset limits for Medicaid eligibility purposes as long as the nursing home resident intends to return home or his or her spouse or another dependent relative lives there. The \$572,000 equity limitation does not apply if an applicant is married. 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.

THE TRANSFER PENALTY

Another major rule of Medicaid eligibility is the penalty for transferring assets. If an applicant (or his or her spouse) transfers assets, he or she will be ineligible for Medicaid for a period of time beginning on the date of the transfer. The actual number of months of ineligibility is determined by dividing the amount transferred by the average monthly cost of a nursing home in Georgia – currently \$6,175.00. For instance, if an applicant made gifts totaling \$50,000, he or she would be ineligible for Medicaid for 8.1 months ($\$50,000 \div \$6,175 = 8.097$).

The period of ineligibility does not begin when a transfer is made. Rather, it begins when the applicant is “otherwise eligible” for Medicaid benefits. This means that the clock does not start ticking on the transfer until the applicant has spent down to the resource eligibility level and has entered into a nursing home.

Technically, there is no cap on the period of ineligibility. So, for instance, the period of ineligibility for the transfer of property worth \$432,250 is 70 months ($\$432,250 \div \$6,175 = 70$). However, Georgia may only consider transfers made during the 60-month period preceding an application for Medicaid (the “look-back” period). Effectively, then, there is now a 60-month cap on periods of ineligibility resulting from transfers. However, the full 70 month penalty can apply if a Medicaid application were mistakenly filed during the 60 months following the transfer.

Exceptions to the Transfer Penalty

Transferring assets to certain recipients will not trigger a period of Medicaid ineligibility. These exempt recipients include a spouse and a special needs trust for the benefit of a disabled individual under age 65.

Special rules apply with respect to the transfer of a home. In addition to being able to make the transfer without penalty to one's spouse or into a trust for other disabled beneficiaries, the applicant may freely transfer his or her home to a blind or disabled child; a child under age 21; 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 a “caregiver child,” who is 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.

The law provides a very important escape hatch for those who find they must qualify for Medicaid during a period of ineligibility. A transfer can be cured by the return of the transferred asset, either partially or in its entirety.

ESTATE RECOVERY

The State of Georgia has the right to recover whatever benefits that were paid for the care of a Medicaid recipient from the recipient's estate following his or her death. Georgia has adopted what has come to be known as "expanded" estate recovery. This means that the state is allowed to pursue not only the assets of a Medicaid recipient that are part of his probate estate, but also assets passing by life estate, beneficiary designation and joint tenancy. Estates valued at under \$25,000 at the time of death are exempt from estate recovery.

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 \$50-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 that continues to live at home.

Qualified Income Trust

If a Medicaid applicant has gross monthly income in excess of \$2,250 per month, he must establish a Qualified Income ("Miller") Trust in order to be eligible to receive nursing home Medicaid benefits. Each month, a portion of the Medicaid recipient's income is transferred into the Miller Trust, thereby allowing the individual to be income-eligible for Medicaid benefits.

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 married applicant is permitted to keep an additional \$123,600 (2018 figure) in countable resources in his name.

Income

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 nursing home 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. The community spouse is entitled to have income equal to the amount established as that year's minimum monthly maintenance needs allowance, or MMMNA. For 2018, this figure is \$3,090 in income per month. For instance, if the spouse in the nursing home has income in the amount of \$2,500 per month and the community spouse has income of \$1,000 per month, the spouse in the nursing home will be allowed to divert \$2,090.00 per month to the community spouse to bring her income up to the MMMNA.

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 more verifications regarding such issues as the amount of assets and dates of transfers are required. If the applicant does not comply with these requests and deadlines on a timely basis, the application will be denied. In addition, after Medicaid eligibility is achieved, it must be re-determined every year.