

Questions and Answers about Medicaid for Those Receiving Long-Term Care in Idaho

Question 1: What is Medicaid?

Answer: Medicaid is a government program that pays for medical services, including long-term care in a nursing home, in an assisted living facility, or in a private residence in the community. It is administered by the Idaho Department of Health and Welfare, and an application for Medicaid may be submitted to any Department of Health and Welfare office.

To receive Medicaid payment for long-term care, you must meet the financial eligibility requirements described below. Also, regardless of what setting you reside in, you must need the type (or level) of care provided in a nursing home.

In addition to paying for care starting with the month of application, Medicaid can pay for up to three months of nursing home care before the month you apply if you were in a nursing home and can show you met the eligibility requirements during those months.

Question 2: What are Medicaid's basic financial eligibility requirements for long-term care?

Answer: To get Medicaid to help pay the cost of long-term care, your **income** and your **resources** must be within limits set by law.

In counting your income for a month, the Medicaid program looks at what you received that month. Income typically includes such things as Social Security, VA benefits, and wages.

In counting your resources for a month, Medicaid looks at what you have on the first day of the month that you already had in the previous month. Resources typically include such things as real estate, vehicles, bank accounts, and stocks.

Income

Your gross countable monthly income must be less than \$2,022 (for 2009).

If your income is more than the Medicaid long-term care level you may still qualify under one of two methods. First, if you are married and your income combined with your spouse's income is less than double the \$2,022 level (that is, less than \$4,044), then your income is considered to be within the Medicaid income limit using what is called the "community property method."

Second, if you are not married or if you and your spouse's combined incomes exceed \$4,022, then you may divert a portion of your income into a special type of trust called a "Miller" trust. A "Miller" trust must be in place no later than the month Medicaid coverage is desired.

Once you are determined eligible for long-term care Medicaid, you will be allowed to keep a portion of your income, depending on your living arrangement. You will be allowed to keep the first \$40 per month of your income for your personal needs if you are residing in a nursing home. You will be allowed to keep the first \$90 per month of your income for your personal needs if you are residing in an assisted living facility. You will be allowed to keep the first \$674 per month of your income for your personal needs if you are residing in a private residence other than your own and are not being charged any rent. And you will be allowed to keep the first \$1,011 per month of your income for your personal needs if you are residing in your own home, regardless of whether you pay rent or a mortgage, or in a private residence other than your own and you are being charged rent.

The rest of your income will be used as follows:

1. an amount for your spouse if you have one, as explained in answer to question 3, below;
2. an amount for any dependent family members living with your spouse;
3. for a single person or an institutionalized couple only, an amount (not more than \$212) for the maintenance of a home for up to six months after entering a nursing home or assisted living facility, but only if a physician has certified that the person or a member of the couple is likely to return to the home within the six month period. (Even without any physician's certification, if there is rental income from a home to which a Medicaid recipient or spouse intends to return, that income may be used for payment of home maintenance, taxes, and insurance, and only the amount of rental income left over will be treated as additional income to you.);
4. an amount to pay health insurance premiums;
5. an amount to pay medical bills for services not covered by Medicaid (usually services provided before you became eligible for Medicaid), if the bills are still owed and not covered by any insurance; and
6. an amount to cover certain miscellaneous items, such as guardianship or trustee fees.

Any remaining income must be paid to the nursing home, assisted living facility, or home health agency for your care. The part of your care you pay for is called your "patient liability" or "contribution." Medicaid covers the rest.

Resources

The limit for resources (assets, property, savings) that a single person may have is \$2,000. Certain "exempt" resources are not counted in determining whether you fall within this limit. Exempt resources are described in answer to question 5, below.

When a married person applies for Medicaid for long-term home care, his or her spouse is allowed to have substantially more resources. The rules relating to resources for married applicants and their spouses are explained in answer to question 4. Rules about giving away your property are described in answer to question 6.

Question 3: What income can I keep if my spouse goes into a nursing home?

Answer: If your spouse begins receiving long-term care, and you remain at home (or live elsewhere, but do not receive long-term care), Medicaid allows you to keep the greater of:

- all income paid in your name, no matter how much; or
- all income paid in your name plus as much of your spouse's income as is necessary to bring your income up to \$1,750 per month. And, if your housing costs (rent or mortgage, maintenance fee for a condominium or cooperative, property taxes, homeowner's insurance, and utilities) exceed \$525 per month, the \$1,750 level can be increased up to \$2,739 by the amount of this excess. (In calculating housing costs, your actual costs for rent, mortgage, maintenance fee, taxes, and insurance are used. For utilities, a standard figure of \$400 per month is used.)

Example:

If \$2,400 is paid in your name and \$600 is paid in your nursing home spouse's name, you can keep \$2,400. If \$600 is paid in your name and \$2,400 is paid in your spouse's name, you can keep your \$600 plus at least \$1,150 of your spouse's income ($\$1,750 - \$600 = \$1,150$). And, if your housing costs are, for example, \$500 per month rent or mortgage and you also pay for your utilities, you can keep an additional \$375 of your spouse's income because the \$1,750 level is increased by the excess of your housing costs over \$525 ($\$500 \text{ rent} + \$400 \text{ utility allowance} - \$525 = \$375$).

A spouse at home may be allowed to keep more of an institutionalized spouse's income if a hearing officer decides, in an administrative proceeding, that "due to unusual conditions" more of the spouse's income is needed to avoid "significant financial hardship for the community spouse."

An additional amount may also be allowed for the care of a dependent family member.

Question 4: What resources can I keep if my spouse goes into a nursing home?

Answer: This question must be answered in two parts. There is one set of rules for what you can have at the time your spouse applies for Medicaid for long-term care and there is an entirely different set of rules for what you can have and keep after your spouse is found eligible for Medicaid for long-term care.

At the time of application for Medicaid for long-term care, the following rules apply:

1. All resources of both spouses will be added together to determine eligibility at the time of application. It does not matter, at the time of applying for Medicaid, which spouse owns what resources or whether a resource is community or separate property.
2. The spouse not receiving long-term care (the "community spouse" or at-home spouse) can keep all resources that are "exempt" under the rules described in answer to question 5, below. There is no limit on the value of a home, a car, household goods, or personal effects that the spouse at home can keep.
3. The spouse at home is also allowed to keep one-half of non-exempt resources that the couple had when long-term care began. This is in addition to the \$2,000 of non-exempt resources that the spouse receiving long-term care may have. The one-half of non-exempt resources that may be kept by the community spouse can not exceed \$109,560 (for 2009). The minimum a spouse may keep is \$21,912, even if that is more than one-half of what the couple had when long-term care began. If the couple's total non-exempt resources exceed one-half plus \$2,000 of what the couple had when long-term care began, Medicaid will not provide coverage until those resources are reduced to that level.
4. The spouse at home may be allowed to keep more than one-half of the couple's non-exempt resources (without being limited by the \$109,560 maximum) if the combined income of both spouses is not enough to give the spouse at home the level of income allowed by the rules explained in answer to question 3 above (\$1,750 to \$2,737). To be allowed to keep more resources, the spouse must obtain a decision from the Department of Health and Welfare's Hearing Officer that more resources are necessary to produce the permitted income level.
5. The couple may reduce excess resources by paying debts, buying exempt assets, and otherwise purchasing goods or services of value to either spouse. The couple need not simply expend its excess resources paying for the long-term care of the ill spouse.

(Although it does not matter which spouse owns the resources at the time of applying for Medicaid, any excess over \$2,000 must be transferred to the spouse not receiving long-term care (the community spouse) within 60 days after a Medicaid application is approved. After that, the

spouse on Medicaid must not have more than \$2,000 worth of non-exempt resources in his or her name at the end of every month.)

The rules explained above apply when a married person is first applying for Medicaid for long-term care. As noted earlier, different rules apply after your spouse is approved for Medicaid for long-term care. After an application is approved, continuing eligibility of the spouse on Medicaid will not be affected by increases in the resources of the spouse at home. In other words, once one spouse establishes eligibility for Medicaid for long-term care, the other spouse's resources may increase above the one-half limit that applied at the time of application. The increase will not affect the on-going Medicaid eligibility of the spouse on Medicaid. Even assets acquired by the long-term care recipient after eligibility is established will not affect on-going Medicaid eligibility if they are transferred to the community spouse before the end of the month they are acquired.

Question 5: What resources are not counted to determine Medicaid eligibility?

Answer: Some resources are considered exempt and are not counted toward the one-half plus \$2,000 resource limit. Exempt resources include your home, household goods and personal effects, a vehicle, the cash value of life insurance policies if their combined face values do not exceed \$1,500, most burial plots and irrevocable prepaid burial plans, and certain other property and items used for self-support. Some of these are described in more detail below.

Also, non-exempt resources that cannot be sold within 20 working days are temporarily disregarded while efforts are being made to sell them.

Exempt Resources

- Home exemption

As long as a Medicaid recipient's spouse or, in some cases, a dependent or disabled relative, continues to live in the home, the home (which can be a house and all surrounding land, a condominium, or a mobile home) is an exempt resource. (A married Medicaid applicant or recipient still may wish to transfer his or her interest in a home to a spouse. Such a transfer may be made in order to make it easier for the spouse to sell or otherwise dispose of the home. On the other hand, such a transfer is not always a good idea. It makes sense to consult with a lawyer familiar with Medicaid and estate planning before making such a transfer.)

If you go into a nursing home or assisted living facility and have no spouse or other dependent or disabled relative living in your home, the home will still be exempt if you intend to return to it. The exemption applies if you state (or someone on your behalf

states) your intention to the Department of Health and Welfare, even if it seems unlikely that you will be able to return home.

The proceeds from the sale of an exempt home are also exempt if, within three months of when they are received, they are used to purchase a new home.

- Land sales contracts

The seller's interest in a real estate sales contract typically is given a value by the Medicaid program equal to the contract's outstanding balance. A lower value may be shown by obtaining quotes from parties who buy such contracts. If such a contract is treated as exempt, because it can not be sold, then payments received will be treated as income.

- Vehicle exemption

One vehicle is exempt no matter how much it is worth.

- Life insurance exemption

The cash surrender value of life insurance may be claimed as exempt if the total face value (the original amount payable at death as stated on the policy's "face") of all policies owned by the individual is not more than \$1,500. For couples, each spouse has this \$1,500 face value limit. If the face value of an individual's life insurance is more than \$1,500, the entire cash surrender value (the amount the insurance company will pay if the policy is canceled) is counted as a non-exempt resource. (This means it will count as part of the one-half plus \$2,000 allowed for a couple's resources or as part of the \$2,000 allowed for an unmarried individual.) Life insurance with no cash surrender value does not count as a resource; it has no effect on Medicaid eligibility.

- Burial funds and burial spaces exemption

A burial fund of \$1,500 for an individual (and an additional \$1,500 for a spouse) may be claimed as exempt if it is set aside in a separate account to cover burial or cremation expenses. If an individual has life insurance that is claimed as exempt, then the face value of the exempt life insurance will count as part of the individual's burial fund. So, for example, if a Medicaid recipient has exempt life insurance with a face value of \$1,000, then only \$500 more may be exempted in an account for burial expenses.

An irrevocable trust for burial expenses or a pre-paid burial plan may be claimed as exempt as long as it does not exceed reasonably anticipated burial expenses. The value of such a trust or plan, however, will count against the exemption for burial funds or life insurance.

Burial spaces for a Medicaid recipient and for immediate family members are exempt no matter how much they are worth.

- Household goods and personal effects exemption

The first \$2,000 of household furniture and other household goods, including clothing, jewelry, and personal care items are exempt for an unmarried person. These items are totally exempt for a married person, regardless of value. And, as a practical matter, the \$2,000 limit for unmarried persons is not applied, as the Department of Health and Welfare does not inventory or otherwise scrutinize such items.

Question 6: May I transfer resources without affecting Medicaid eligibility for long-term care coverage?

Answer: The rules concerning transfers of assets changed on February 8, 2006, so that different rules apply to transfers made before February 8, 2006 as compared to transfers made on or after February 8, 2006. A transfer is any sale, gift, or other relinquishment of ownership of an asset that does not bring fair value (or adequate consideration) to the party making the transfer.

Transfers to a spouse have the following rules:

- There is no Medicaid penalty for transferring resources to your spouse. Remember, however, that the resources of both spouses are added together in determining initial Medicaid eligibility. See answer to question 4, above. So, if a couple has more resources than are permitted at the time of application, a transfer from one spouse to the other will not change that condition.
- A transfer to a spouse or disabled child may be made without penalty either before or after an individual qualifies for Medicaid.

Transfers to someone other than a spouse or disabled child have the following rules:

- There is no penalty if you sell your resources for a fair price.
 - (a) Exempt resources (described in answer to question 5), other than the home or an exempt land sales contract, may be given to anyone without penalty.
 - (b) A home may be transferred without penalty to:
 - A **spouse**
 - A **child** who either: (a) has lived in the home and cared for the parent for two years immediately before the date the parent starts long-term care, thereby postponing the need to start long-term care; or (b) is under 21 or blind or

- permanently and totally disabled (the disability criteria for this purpose are the same as those used for Social Security and SSI disability determinations)
- A **brother or sister** who has an equity interest in the home and has lived there at least one year immediately before the date of their sibling's start of long-term care.

The person making the transfer does not need to live in the home at the time of the transfer to one of the people listed above.

- There may be a penalty if you transfer **non-exempt** resources or transfer a home (except to one of the people listed above) for less than fair market value within 36 months of applying for Medicaid (if the transfer was made before February 8, 2006) or within 60 months of applying for Medicaid (if the transfer was made on or after February 8, 2006). Such transfers may result in a period of ineligibility for Medicaid. (Transfers involving trusts are subject to different and more complicated rules, and are not discussed in this brochure.) Under a state law unique to Idaho, such transfers also may be set aside by the Department of Health and Welfare.

The length of the period of ineligibility depends on the value of the resource given away. There is no maximum length for a period of ineligibility. If you make a gift that could cause a period of ineligibility, do not apply for Medicaid before consulting with an attorney or other person who understands Medicaid's rules. Doing so could cause you to go without Medicaid eligibility much longer than necessary.

The process of calculating periods of ineligibility is complicated and varies depending on whether the transfer occurred before February 8, 2006 or on or after that date. After reading the following explanation, if you are left with questions about the effects of gifts or other transfers you have made, you should talk with a lawyer who is knowledgeable about Medicaid before applying.

For transfers made before February 8, 2006, as noted above, the penalty rules apply if the transfer was made within 36 months of applying for Medicaid. In such cases, calculate the penalty as follows: take gifts one month at a time; look at the earliest month during the 36 month look-back period before the Medicaid application in which any gifts were made and add all that month's gifts together; then calculate the period of ineligibility based on that month's total gifts by dividing the total by \$6,145 (for applications filed in 2009). The number of months of ineligibility is the result of this division, rounded down to the nearest whole number (unless there was a subsequent month in which other gifts were made that falls within the first gifting month's ineligibility period without rounding down, in which case the answer is rounded up to the nearest whole number). The penalty period begins to run in the month the transfers were made, unless there is already another period of ineligibility in progress. If there is, then the new penalty period begins when all earlier periods are through. This calculation is repeated for each month within the look-back period in which transfer without adequate consideration were made.

These rules will cease to be of any applicability for all applications filed starting February 8, 2009, as all such applications will be more than 36 months after February 8, 2006. Starting then, the transfer penalty rules will apply only to gifts made (1) within 60 months of applying; or (2) on or after February 8, 2006, whichever is later. For transfers made on or after February 8, 2006, calculate the penalty length the same as above (except that it is rounded off to the nearest day, not month). More significantly, the penalty's starting date is different. Instead of starting when the transfer occurred, the penalty starts in the later of: (1) the month after the month of the transfer; or (2) the month in which the person applies and is found to be otherwise eligible for Medicaid.

Example:

If you made a gift of \$25,000 in March 2006, the penalty would last for four months and two days (\$25,000 divided by \$6,145 equals 4.07 months or four months and two days). It would start to run in April 2006 (the month after the month of transfer) or in the month you file an application and are found to be in all other respects eligible, whichever is later. So if you apply in May 2009, which is within 60 months of March 2006, and at that time are within the Medicaid income and resource limits, then the penalty would start on May 1, 2009 and its last day would be September 2, 2009. If you are in a nursing home, Medicaid would start paying for the nursing home's charges on September 3, 2009. From May 1 until then you would have what is called restricted eligibility, which means Medicaid would pay only for other forms of medical care, such as doctors and hospitals. If, however, you are at home or in an assisted living facility, you would be totally ineligible for Medicaid until September 3.

Idaho has chosen to apply these rules in an even more restrictive manner. It interprets the Medicaid law to say that if you are subject to a transfer penalty and reside at home or in an assisted living facility, then the penalty does not start to run until you are in a nursing home, even if while living at home or in an assisted living facility you are in all other respects eligible for long-term care Medicaid. If you find yourself being subjected to this overly restrictive application of the transfer penalty rules you should seek the assistance of an attorney to challenge it.

- No matter when a transfer is made, there is no period of ineligibility if it can be demonstrated that the transfer was made for reasons exclusively other than to qualify for Medicaid. Also, the Department of Health and Welfare may waive a period of ineligibility if it finds that denial of benefits will cause undue hardship.
- Generally, before you apply for Medicaid for long-term care, the same restrictions apply to transfers by either you or your spouse. This means that if either you or your spouse gives away resources the gift may result in a period of ineligibility for you. Once you are receiving Medicaid, however, subsequent gifts made by your spouse will not affect your continuing eligibility.

Question 7: Will the state of Idaho have lien or claim against my estate?

Answer: The state of Idaho seeks to recover from a Medicaid recipient's estate an amount equal to what Medicaid paid for the recipient's care after the recipient turned 55 of age. Recovery will be delayed if, at the time of death, a Medicaid recipient has a surviving spouse or a surviving child who is under 21 or blind or disabled.

Although federal law says the state of Idaho's claim only applies to property in which the Medicaid recipient has a legal interest at death, the state of Idaho nonetheless pursues its claim against property in the estate of a spouse as well (unless the spouse's estate can show a particular asset was the spouse's separate property from before the marriage or was acquired during the marriage by gift or inheritance).