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

prepared by Alan Wasserman, current as of May 2022

The following questions are answered in this article:

Question 1: What is Medicaid?

Answer: Medicaid is a government program that pays for a broad range of health care, including hospitalization, physician care, medications, and long-term care. Long-term care may be provided in a nursing home, in an assisted living facility, in a certified family home, or in a private residence in the community. Medicaid 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.

The current website with links to an application is:
https://healthandwelfare.idaho.gov/medical/medicaid/tabid/123/default.aspx

There are four requirements that must be met for Medicaid to pay for an individual's long-term care:

1. The individual must need long-term care;
2. The individual's income must be within Medicaid's long-term care income limit;
3. The individual's (and spouse's, if married) countable assets must be within Medicaid's resource limit; and
4. Even if these three requirements are met, still an individual may be unable to qualify for Medicaid's payment for long-term care if there has been any gifting of assets, by the individual (or spouse, if married), at anytime starting five years prior to an application.

Each of these four requirements is described below.

(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 of application if all the eligibility requirements were met during those months. In many cases, Medicaid can also indirectly pay for any unpaid medical bills incurred during the three months prior to eligibility.)

Question 2: What is considered long-term care?

Answer: For Medicaid purposes, long-term care does not mean skilled care, but rather can simply be custodial care and help with activities of daily living, such as bathing, dressing, toileting, meal preparation, eating, and supervision to ensure safety. Nor is it limited to residents of nursing homes. Medicaid also pays for long-term care provided in an assisted living facility, a certified family home, or one's own private residence.

Whether a person needs long-term care (meets the required "level of care") is determined by the Idaho Department of Health and Welfare. When an applicant resides in a private residence, the Department of Health and Welfare will schedule an in-home assessment by one of its nurses, who will administer a "Uniform Assessment Instrument." The Uniform Assessment Instrument (UAI) is a series of questions aimed at identifying a person's unmet needs for assistance with activities of daily living. An accurate assessment of these needs requires accurate, factual answers to numerous questions. If there is any concern that an applicant will, in response to questioning, minimize his or her limitations, then it is important that a third party with knowledge of those limitations be present during the assessment, to "set the record straight."

For applicants residing in an assisted living facility or certified family home, the Department of Health and Welfare will determine whether the required level of care is met by either relying on the facility's notes or sending a nurse to perform the UAI. And when an applicant is residing in a nursing home, the Department of Health and Welfare will rely on the nursing home's notes as to the applicant's need for long-term care.

Question 3: What is the income limit for long-term care Medicaid?

Answer: In counting an applicant's **income**, the Medicaid program looks at gross monthly income before any deductions. Typical sources of income are Social Security, veteran benefits, pensions, and wages. Aid and Attendance benefits paid by the Veterans Administration, however, are not counted as income.

An applicant's gross countable monthly income must be less than $2,543 (for 2022; it typically increases every January). If income received in the applicant's name is more than the Medicaid long-term care limit one may still qualify using one of two methods.

First, if married and the applicant and spouse's combined incomes are less than double the $2,543 (that is, less than $5,086), then the applicant is considered to be within the Medicaid income limit using what is called the "community property method."

Second, if not married or if the applicant and spouse's combined incomes exceed $5,086, still an applicant may meet the income test by diverting a portion of his or her 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.

Takeaway message regarding income: No one has "too much" income to qualify for Medicaid to pay for long-term care; a "Miller" trust can always be resorted to for those whose income exceeds the Medicaid income limit.

Question 4: What is the resource limit for long-term care Medicaid and how are resources counted?

Answer: The Medicaid **resource** limit for a person seeking payment for long-term care is $2,000. Resources are assets owned as of the beginning of a month. They are counted at their equity value (fair market value minus liens, mortgages, or other encumbrances)

and are valued as of the first moment of each month, before, for example, any of the month's income arrives in a bank account.

Typical resources include real estate, vehicles, bank accounts, cash surrender value of life insurance, investments, and cash. Some resources, however, are "excluded" and so are not counted toward the $2,000 resource limit. Excluded resources are described in answer to question 5, below.

And, as described in answer to question 6, below, when a married person applies for Medicaid to pay for long-term care, additional assets that would otherwise be countable are also excluded so as to be available for the benefit of the spouse.

Rules about giving away assets are described in answer to question 10, below.

Question 5: What assets are not counted toward the $2,000 resource limit when determining Medicaid eligibility?

Answer: Unless specifically excluded, all assets owned by a Medicaid applicant (and spouse, if married) are counted. Assets excluded from the $2,000 resource limit include one's home, household goods and personal effects, a vehicle (two vehicles, if married), the cash surrender 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, otherwise countable assets that cannot be sold within 20 working days are temporarily excluded while efforts are being made to sell them.

- One's home

  A person's home (which can be a house and all surrounding land, a condominium, or a mobile home) is an excluded resource. As long as the person's spouse or minor or disabled child lives in the home, its value is not counted.

  Importantly, however, a person is ineligible to receive long-term care Medicaid services if there is more than $750,000 equity in the person's home, unless a spouse or a minor or disabled child is living in the home.

If a person resides in a nursing home, assisted living facility, or certified family home and has no spouse or minor or disabled child living in the home, still the home will be excluded if the person intends to return to it (and there is no more than $750,000 equity in the home). This intent to return home exclusion applies if the person (or someone on the person's behalf) simply expresses to the Department of Health and Welfare an intent to return, even if it seems unlikely the person will ever be able to return home. As currently interpreted by the Department of Health and Welfare, however, this exclusion of a person's home based on intent to return does not apply to homes located outside of Idaho. In such cases, the only basis for excluding the out-of-state home is to place it up for sale, and as long as it remains for sale its value is not counted.

Homes held in a trust are not excluded from the resource limit. To enjoy the exclusion, the home must be transferred back into the name of the Medicaid applicant and/or spouse.

The proceeds from the sale of an excluded home are also excluded if, within three months of when they are received, they are used to purchase a new home. And for a married individual already approved for Medicaid, a home's sale proceeds are simply excluded in favor of the spouse.

- 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 excluded, because it cannot be sold, then payments received will be treated as income. The Department of Health and Welfare gives itself the discretion whether to exclude a contract and count the contract's payments as income or to count the contract as a resource, in which case only the interest portion of each payment is counted as income.

- Vehicles

For unmarried individuals, one vehicle is excluded, regardless of it value. For married couples, two vehicles are excluded.

- Life insurance

The cash surrender value of life insurance is excluded 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 policies totals more than $1,500, the entire cash surrender value (the amount the insurance company will pay if the policy is canceled) of those policies is counted as a resource. Life insurance with no cash surrender value does not count as a resource; such policies have no effect on Medicaid eligibility.

- Burial funds and burial spaces

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 excluded life insurance, then the face value of the excluded life insurance will count as part of the individual's burial fund. So, for example, if a Medicaid recipient has excluded life insurance with a face value of $1,000, then only $500 more may be excluded in an account for burial expenses.

An irrevocable trust for burial expenses or a prepaid burial plan is excluded as long as it does not exceed reasonably anticipated burial expenses. The value of such a trust or plan, however, will count against the exclusion for burial funds or life insurance. In effect, one may either prepay for funeral arrangements or set aside $1,500 in a burial fund account, but not both.

Burial spaces for a Medicaid recipient and for immediate family members are excluded regardless of value.

- Household goods and personal effects

Household furniture and other household goods, including clothing, jewelry, and personal care items are excluded.

- Retirement accounts (IRA's, 401(k)'s) from which the required minimum distribution is withdrawn are excluded (the distribution is counted as income). And for married individuals, retirement accounts in the name of the spouse are excluded.

Question 6: What additional assets are excluded to protect the spouse of a married Medicaid applicant?

Answer: In addition to the assets excluded as described in answer to question 5, above, when a Medicaid applicant is married a **community spouse resource allowance** also does not count toward the $2,000 resource limit. This allowance comprises the couple's

choice of assets that otherwise would be counted, such as bank accounts, investments, non-home real estate, the cash surrender value of life insurance, or extra vehicles.

The amount of the community spouse resource allowance is arrived at by first adding up all countable assets of the couple as of the first day of long-term care. It does not matter, at the time of applying for Medicaid, which spouse owns what assets or whether an asset is community or separate property. Unless explicitly excluded, all assets of the couple as of the day the applicant's long-term care started are counted as part of this resource assessment or "snapshot" of their countable assets.

Total countable assets are then divided in half, and the result is the community spouse resource allowance. There is, however, an upper limit to this allowance, such that regardless of the total amount of countable assets, the maximum spousal allowance is $137,400 (for 2022). All countable assets in excess of the allowance are counted toward the $2,000 Medicaid resource limit. Similarly, there is a minimum community spouse resource allowance of $27,480 (for 2022).

If a couple's total countable assets at the time of application exceed their community spouse resource allowance plus $2,000, the application will be denied. Medicaid will not provide coverage until their countable assets are reduced to that level. Very importantly, however, the spouse not applying for Medicaid (the "community spouse") may keep more than one-half of the couple's countable assets (even if this is more than the $137,400 maximum) if the combined incomes of both spouses are not enough for the community spouse to meet living expenses. The level of income considered to be needed by the community spouse to meet living expenses is explained in answer to question 8, below.

To take advantage of this rule providing the community spouse with a higher or "upwardly revised" community spouse resource allowance, the couple must apply before spending down their assets. The couple in such a case can expect their Medicaid application to be denied (on the basis they still have "excess" resources). The couple must then file an appeal of the denial to the Department of Health and Welfare's Hearing Officer.

Regardless of whether a couple must spend their countable assets down to half of their snapshot total plus $2,000 or to some higher level, they may do so by paying debts, buying excluded assets, and otherwise purchasing goods or services of value to either spouse. The couple need not simply expend its excess assets paying for the long-term care of the ill spouse. The only limitation is that they may not give away their assets, as explained in answer to question 10, below.

After a couple has spent down to their community spouse resource allowance (or, based

on low combined incomes, spent down to their upwardly revised community spouse resource allowance) and Medicaid is approved, the rules for treating assets become more relaxed. Ongoing Medicaid eligibility of a married individual will not be affected by increases in the resources of the community spouse. In other words, once a married person establishes eligibility for long-term care Medicaid, the spouse's resources may increase above the one-half limit that applied at the time of application. Such increases will not affect the eligibility of the spouse on Medicaid. Even assets acquired by the long-term care spouse after eligibility is established, such as by inheritance, will not affect ongoing Medicaid eligibility if the assets are transferred to the community spouse before the end of the month they are acquired.

Examples:

1. A couple with a $200,000 home, two cars, and $80,000 in the bank when the ill spouse starts receiving long-term care will be able to establish Medicaid eligibility for the ill spouse once they spend down their bank account to $42,000 by the beginning of a month. Their home and two cars are excluded and $40,000, half of the $80,000 snapshot, represents the community spouse resource allowance, so they will be within the $2,000 limit once their bank account balance is no more than $42,000.

After eligibility is established, if the couple sells the house and places all the sale proceeds in the name of the community spouse, Medicaid will remain in place without interruption, even though the community spouse will then have $240,000 in the bank.

2. In stark contrast is the scenario where this couple sold their $200,000 home before long-term care started. In that case, their snapshot total of countable assets would be $280,000 as of the beginning of long-term care, and the community spouse resource allowance would be half of the $280,000 or $140,000, but then reduced to $137,400 (the current maximum community spouse allowance). Medicaid will not be available, then, until the couple spends down to $137,400 plus $2,000, or to $139,400, leaving the community spouse with about $101,000 less than the $240,000 in example 1 had they waited to sell their home.

3. Even worse for the couple would be the sale of the home after long-term care started, but before applying for Medicaid. In that case, they would have the same $80,000 snapshot total as of the beginning of long-term care as in example 1 (they still owned the house when long-term care started, so only the $80,000 in the bank would be counted for the couple's snapshot), so they would still have to spend down to half plus $2,000 of their snapshot, or to $42,000. As a result, the $80,000 in the bank and the $200,000 proceeds from the sale of their home would all have to be spent down to $42,000 before Medicaid could start, leaving the community spouse with $200,000 less than had they waited to sell until after Medicaid started.

Takeaway message for resources: the timing of the sale of excluded assets, such as one's home, can make a big difference in how many assets are protected for the community spouse.

Question 7: How much do I have to pay for my long-term care when I'm on Medicaid?

Answer: Once determined eligible for long-term care Medicaid, an individual will continue to receive his or her income as usual, but will be allowed to keep only a portion of it, depending on the living arrangement. While living in a nursing home, the first $40 per month of income may be kept for personal needs. While in an assisted living facility or certified family home, the first $116 per month of income may be kept for personal needs and another $725 to pay for room and board. If residing in a private residence other than one's own and not being charged any rent, the first $841 per month of income may be kept for personal needs. And if residing in one's own home, regardless of whether rent or a mortgage is paid, or in a private residence other than one's own and rent is being charged, then the first $1,514 per month of income may be kept for personal needs.

Any remaining income after these allowances for the individual will be used as follows:

1. An amount for a spouse's living expenses, as explained in answer to question 8, below;

2. An amount for any dependent family members living in one's home;

3. If not married, an amount (not more that $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 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 intends to return, that income may be used for payment of a mortgage, home maintenance, taxes, utilities, and insurance, and only the amount of rental income left over will be treated as additional income to the Medicaid recipient.);

4. An amount to pay health insurance premiums (Medicaid will pay a person's Medicare premiums, but a person may maintain a Medicare supplement and continue paying for it out of monthly income);

5. An amount to pay ongoing medical bills for services not covered by Medicaid and an amount to pay for medical services provided during the three months before

becoming eligible for Medicaid, if the bills are still owed and were not covered by any insurance; and

6. An amount to cover certain miscellaneous items, such as guardianship or trustee fees, withheld income taxes, and garnished child support.

Any remaining income, if any, must be paid to the nursing home, assisted living facility, certified family home, or home health agency for the care it provides. This is called one's "share of cost." Medicaid then pays the balance of the cost of care. (For in-home personal care services, Medicaid also pays for the first 16 hours per week of care, so a share of cost, if any, is not incurred unless more than 16 hours per week of care is used.)

Question 8: What income will be available for my spouse's needs?

Answer: As long as one's spouse is not also receiving long-term care, Medicaid's rules provide for the following:

1. The community spouse keeps all income received in their name, no matter how much;

2. If the community spouse's income is less $2,177.50 per month, then enough of the Medicaid spouse's income as is necessary may be kept by the community spouse to bring his or her income up to that amount.

3. If the community spouse's housing costs (rent or mortgage, maintenance fees for a condominium or cooperative, property taxes, homeowner's insurance, and utilities) exceed $653.25 per month, the $2,177.50 level can be increased, up to a maximum of $3,435.00, by the amount of this excess. (In calculating housing costs, actual costs for rent, mortgage, maintenance fee, taxes, and insurance are used; for utilities, a standard allowance of $361 per month is used.)

Examples:

1. - Medicaid spouse in nursing home receives monthly income of $900
   - community spouse receives monthly income of $2,400
   - community spouse's housing costs (mortgage or rent, utilities, property taxes, and homeowner's insurance) do not exceed $653.25

The community spouse keeps all $2,400, but keeps none of the Medicaid spouse's $900,

because the $2,400 is sufficient to meet community spouse's living expenses of $2,177.50. After the allowances and deductions described in answer to question 7, above, are made, whatever is left of the $900 must be paid to the nursing home toward the Medicaid spouse's share of cost.

2. - Medicaid spouse receives monthly income of $2,400
   - community spouse receives monthly income of $900
   - again, community spouse's housing costs (mortgage or rent, utilities, property taxes, and homeowner's insurance) do not exceed $653.25

The community spouse keeps all $900 plus $1,277.50 of the Medicaid spouse's income, to bring the community spouse's disposable income up to $2,177.50 ($900 + $1,277.50 = $2,177.50).

3. - Medicaid spouse receives monthly income of $2,400
   - community spouse receives monthly income of $900
   - community spouse's housing costs (mortgage or rent, utilities, property taxes, and homeowner's insurance) **exceed** $653.25

If the community spouse has housing costs of rent or mortgage and also pays for utilities, then the amount of income the community spouse needs to live on is increased by the amount those housing costs exceed $653.25. With rent or mortgage of, say, $800 per month plus utilities, the community spouse is said to need an additional $507.75 per month ($800 rent + $361 utility allowance - $653.25 = $507.75) beyond the base $2,177.50, for a total of $2,685.25. The community spouse, therefore, keeps all $900 plus $1,785.25 of the Medicaid spouse's income, to bring the community spouse's disposable income up to $2,685.25 ($900 + $1,785.25= $2,685.25).

Under "unusual circumstances," a community spouse may be allowed to keep even more of the Medicaid spouse's income if a hearing officer decides, in an administrative proceeding, that more income is needed to avoid "significant financial hardship for the community spouse."

Question 9: When may my spouse protect more than half of our countable assets?

Answer: Understanding how much income the Medicaid rules say a community spouse needs to meet living expenses is critical to understanding when a couple is entitled to an upwardly revised community spouse resource allowance as described in answer to

question 6, above. This is because the rules provide that the community spouse resource allowance may be increased (the couple may keep more of their countable assets, even more than the current maximum of $137,400) if their combined incomes are insufficient to meet the community spouse's living expenses.

The Medicaid rules do this by first determining whether the community spouse's own income is enough to meet living expenses. The minimum amount of income considered necessary for the community spouse is $2,177.50/month (until its annual adjustment on July 1, 2022). This amount can be higher, as much as $3,435, depending on the community spouse's housing costs.

Next, after making various deductions, how much of the Medicaid spouse's income is available to the community spouse? Then, is the community spouse's own income plus the portion of the Medicaid spouse's income that is available after those deductions less than the amount the community spouse needs for living expenses? If so, then the community spouse may protect enough of the couple's countable assets to generate interest income on those assets to make up for the shortfall.

For 2022, the Medicaid program uses an interest rate 1.26%. With such a low interest rate, it requires significant assets to generate enough interest to make up for even a small shortfall of income. For example, if a couple's combined incomes available to meet the community spouse's living expenses were short by just $100/month, then the community spouse would need $95,238 of assets to generate $100/month. A $200/month shortfall would require double that, or $190,476 of assets. If the couple's countable assets are less than that amount (plus another $2,000 for the Medicaid spouse), then Medicaid is available immediately, without having to spend down any of their assets.

In such cases, the couple is said to qualify for an upwardly revised community spouse resource allowance. That is, the couple need not spend down to one-half of the countable assets they had when long-term care started (when the snapshot was taken). They may instead protect in favor of the community spouse as much of their countable assets as is needed to satisfy this upwardly revised resource allowance before any of their assets are counted toward the $2,000 Medicaid resource limit.

Examples:

1. - Medicaid spouse receives monthly income of $1,600
   - community spouse receives monthly income of $1,000
   - they have no rent or mortgage and, in addition to paying for their utilities, their property taxes and homeowner's insurance total less than $290/month

With Medicaid spouse **in a nursing home** at time of application, the community spouse's

$1,000 income plus the portion of the Medicaid spouse's income available after deductions ($1,600 - $40 nursing home allowance = 1,560) is more than enough to meet the community spouse's living expenses of $2,177.50/month. The couple must, therefore, spend down to half of the snapshot total of their countable assets plus $2,000 (but no less than $29,480 and no more than $139,400.) Community spouse will be able to keep $1,177.50 of Medicaid spouse's income for a total income of $2,177.50 to meet living expenses.

With Medicaid spouse **in an assisted living facility** at time of application, $841 is first deducted from Medicaid spouse's income, leaving $759 available to supplement the community spouse's $1,000 income. This $759 plus community spouse's own $1,000 income leaves the community spouse with $1,759 for living expenses, so the community spouse is considered to be $418.50/month short of the $2,177.50 needed. As such, the couple may keep up to $398,571.42 of countable assets for the community spouse and another $2,000 for the Medicaid spouse, for a total of $400,571.42. If the couple's countable assets total less than that, no spend down is required. Community spouse will also keep $759 of Medicaid spouse's income to meet living expenses.

With Medicaid spouse **living at home** at time of application, $1,514 is first deducted from Medicaid spouse's income, leaving $86 available to supplement community spouse's $1,000 income. This $1,086 for the community spouse's living expenses is considered to be $1,091.50/month short of the $2,177.50 needed. As such, the couple may keep up to $1,039,523.80 of countable assets for the community spouse and another $2,000 for the Medicaid spouse, for a total of $1,041,523.80. If countable assets total less than that, no spend down is required. Couple will then also be able to keep all of their income to meet living expenses; any in-home care authorized by Medicaid will be paid in full by Medicaid.

2. - Medicaid spouse receives monthly income of $2,500
   - community spouse receives monthly income of $1,000
   - they pay for their utilities and they have a mortgage and property taxes and homeowner's insurance that total $1,392/month or more
   or
   - they pay for their utilities and their rent is $1,392/month or more

With Medicaid spouse **in a nursing home** at time of application, the couple must spend down to half of snapshot total of countable assets plus $2,000, but no less than $29,480 and no more than $139,400. Community spouse will then keep $2,277.50 of Medicaid spouse's income for a total of $3,277.50 to meet living expenses.

With Medicaid spouse **in an assisted living facility** at time of application, the community spouse is considered to be $618.50/month short, so the couple may keep up to $589,047.61 of countable assets for the community spouse and another $2,000 for the Medicaid spouse, for a total of $591,047.61. If countable assets total less than that, no spend down required. Community spouse will also keep $2,277.50 of Medicaid spouse's income for a total income of $3,277.50 to meet living expenses.

With Medicaid spouse **living at home** at time of application, the community spouse is considered to be $1,291.50/month short, so the couple may keep up to $1,230,000 of countable assets for the community spouse and another $2,000 for the Medicaid spouse, for a total of $1,232,000. If countable assets total less than that, no spend down required. Couple will then also be able to keep all of their income to meet living expenses; any in-home care authorized by Medicaid will be paid in full by Medicaid.

In both examples, if the Medicaid spouse is found eligible while at home and then moves to an assisted living facility or to a nursing home or is found eligible while in an assisted living facility and then moves to a nursing home, Medicaid coverage will remain in place.

Takeaway message number two regarding resources: the timing of a Medicaid application can make a big difference in how many assets may be protected for the community spouse. Applying while still living in one's home, before entering a nursing home or assisted living facility, can often permit Medicaid eligibility without having to spend down any assets.

Takeaway message number three regarding resources: many couples with relatively low combined incomes will not have to spend down any of their assets, but they must apply before spending their assets in order to use the rule allowing for an upwardly revised community spouse resource allowance.

Question 10: May I transfer assets without affecting my Medicaid eligibility for long-term care coverage?

Answer: 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. As a general matter, transfers of assets for less than fair value at anytime starting five years prior to filing a Medicaid application for long-term care will lead to a transfer penalty. (There is no gifting penalty for non-long-term care Medicaid.)

Certain transfers of assets, however, are not penalized:

1. A transfer of assets to a spouse or to a minor or disabled child may be made without penalty. The transfer may be made either before or after an individual qualifies for Medicaid.

Although there is no Medicaid penalty for transferring resources to one's spouse, remember 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.

(Caution: 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 later 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.)

2. There is no penalty if an asset is sold for a fair price. Nor is there any penalty if it can be demonstrated that a transfer was made for reasons exclusively other than to qualify for Medicaid or to avoid Medicaid estate recovery.

3. Exempt resources (described in answer to question 5), other than the home or an exempt land sales contract, may be given away to anyone without penalty.

4. A home may be transferred without penalty to:

- An adult child who 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

- A child under age 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 still be living in the home at the time of the transfer to one of the people listed above. Furthermore, these exceptions apply only to transfers made during the lifetime of the individual; they do not apply to transfers at death, such as by Will.

If a transfer of assets does not fit within an exception to the transfer rule, then a transfer penalty is applied. The transfer penalty bars Medicaid payment for long-term care (but not for other covered services, such as hospital care, doctor's care, and medications) for a period of time depending on the value of the assets given away. Under a state law unique to Idaho, such transfers also may be set aside in a court proceeding brought by the Department of Health and Welfare.

In 2022, for every $9,481 gifted away, there is a one month penalty. The transfer penalty period is calculated by dividing the value of all transferred assets by $9,481, which is the average monthly charge for nursing home care. The result is then rounded down to the nearest day. There is no maximum length for the penalty period.

Caution: If you make a gift that could cause a period of ineligibility, then do not apply for Medicaid before consulting with an attorney or other person who understands Medicaid's rules. Doing so can cause you to go without Medicaid eligibility much longer than necessary.

A transfer penalty period starts to run (1) the month in which the person applies and is found to be otherwise eligible for Medicaid; or (2) if already receiving Medicaid, then the month after the month of the transfer.

Example:

If a gift of $30,000 was made anytime starting five years before applying for Medicaid coverage for long-term care, then the penalty will be three months and 17 days ($30,000 divided by $9,481 equals 3.16 months, or three months and 4 days). And the penalty period would start to run with the month of application if the applicant is found to be in all other respects eligible (or the month after the transfer if the transfer was made at a time when the individual was already receiving long-term care Medicaid). During the penalty period the individual will have "restricted eligibility," which means Medicaid will be in place, but will pay for only non-long-term care medical expenses. The Department of Health and Welfare may waive the penalty altogether if it finds that denial of benefits will cause undue hardship. Such hardship waivers must be requested within just 10 days from the issuance of a notice imposing a penalty period.

When an application is filed for Medicaid for long-term care, the same restrictions apply to transfers by either the individual applying or the individual's spouse. Once a married person is receiving long-term care Medicaid, however, subsequent gifts made by the person's spouse will not effect the individual's continuing eligibility. (The spouse will face a transfer penalty of their own if the spouse applies for long-term care Medicaid within five years of the transfer, and the Department of Health and Welfare may also seek to set aside such transfers, but Medicaid for the spouse already eligible will not be interrupted.)

Takeaway message regarding gifting: the timing of an application for long-term care Medicaid can lead to a drastically different period of ineligibility for the payment of long-term care. If a gift that will cause a lengthy penalty period was made, say, four years and 10 months prior to applying, the penalty will extend for the full length of the

penalty period. By waiting just two months to apply, so that the gift will have been more than five years ago, there will be no penalty.

Question 11: Will the state of Idaho have a lien or claim against my estate?

Answer: Yes, the state of Idaho seeks to recover from a Medicaid recipient's estate (property owned at death) for all Medicaid benefits paid on behalf of the recipient while age 55 and older. The state does so by filing a lien against the recipient's estate. (In very limited circumstances, the state may impose a lien during the recipient's lifetime.)

Medicaid estate recovery must be delayed, however, for as long as a Medicaid recipient is survived by a spouse or a child who is under age 21 or blind or disabled. Thus, a surviving spouse will be free, for example, to sell the couple's home and retain all the sale proceeds. Medicaid may not seek to collect its claim until after the death of a surviving spouse and then only if there are no surviving children under age 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. If, however, the spouse's estate can show a particular asset was never community property, that it was the spouse's separate property from before the marriage or was acquired during the marriage by gift or inheritance, then Medicaid's estate recovery claim will not extend to any such assets (unless the spouse also received Medicaid).

Takeaway message regarding estate recovery: the state of Idaho may not try to collect on its estate recovery claim until after the death of the Medicaid recipient. And even then it may not do so as long as there is a surviving spouse or a surviving child who is blind, disabled, or under age 21.