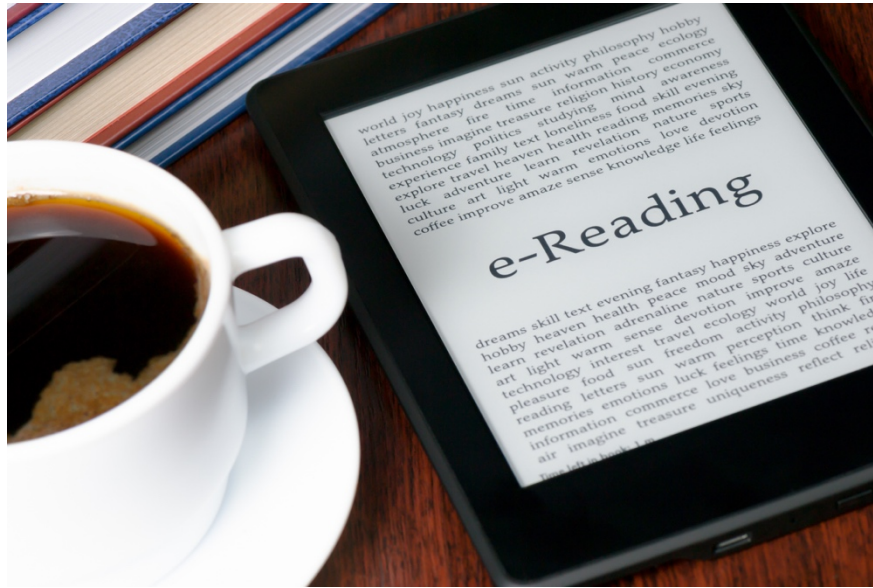


QUALIFYING FOR ALABAMA MEDICAID FOR LONG TERM CARE

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Why is it important to understand Medicaid? Because if long-term care is in your future, or the future of someone you care for, Medicaid will, most likely, be the program that pays for most of that care.

Medicaid is the primary single insurer for long-term care in Alabama. According to Medicaid, the average cost of nursing home care in Alabama in 2018 was about \$6200 per month, and the cost far exceeded that amount in urban areas of the state. It is not unusual to see care over \$7000 per month. At that rate a person will privately pay over \$84,000 per year or more for nursing home care. Not many people can afford an extended stay in a nursing home at private pay rates.

According to The Genworth 2018 Cost of Care Study, the median cost of long-term care services in Alabama was as follows:

Adult Day Care \$9,100 per year/\$758 per month (if available)

Assisted Living \$39,252 per year/\$3271 per month

Homemaker Services \$38,896 per year/\$3241 per month

Home-Health Aide \$38,896 per year/\$3241 per month

Nursing Home (semi-private room) \$75,347 per year/\$6279 per month

Nursing Home (private room) \$79,935 per year/\$6661 per month

People privately pay (with or without long term care insurance) for most home care and all of assisted living. Medicaid pays for limited home care services through a program called home and community based Medicaid Waiver services (HCBS), and Medicaid pays for a majority of care for nursing home residents in Alabama.

Medicare covers only a limited amount of nursing home care and only if a person meets specific requirements. Medicare will pay for the first 20 days of care provided the patient has a three day prior hospitalization and is admitted to a nursing home within 30 days and requires skilled care. While the Medicare literature will indicate that Medicare pays for up to 100 days of nursing home care, the truth is that if the patient continues to have skilled care ordered by the doctor, on day 21 a co-payment of \$170.50 per day begins. That means that in a month even with Medicare paying, the patient will pay over \$5000 per month in co-payments. Under the best of circumstances Medicare will pay for only 20 full days of care and another 80 days if, and only if, skilled care continues to be ordered, and will pay for only about 1 /3 of the cost of care while the patient pays \$170.50 per day. After 100 days Medicare pays nothing.

For many years Medicare, skilled nursing facilities, and visiting nurse associations applied the so-called “improvement” standard to determine whether residents were entitled to Medicare coverage for the care. The standard, which is not in Medicare law, only permitted coverage if the skilled treatment was deemed to contribute to improving the patient’s condition, which can be difficult to achieve for many ill seniors.

Three years ago in the case of *Jimmo v. Sebelius* the Centers for Medicare & Medicaid Services (CMS) agreed to a settlement in which it acknowledged that there’s no legal basis to the “improvement” standard and that both inpatient skilled nursing care and outpatient home care and therapy may be covered under Medicare as long as the treatment helps the patient maintain her current status or simply delays or slows her decline. In other words, as long as the patient benefits from the skilled care, which can include nursing care

or physical, occupational, or speech therapy, then the patient is entitled to Medicare coverage.

Unfortunately, despite the *Jimmo* settlement, the word hasn't gotten out entirely to the hospitals, visiting nursing associations, skilled nursing facilities, and insurance intermediaries that actually apply the rules. Subsequently most residents will have very limited Medicare coverage for nursing home care, and, even if Jimmo is honored, most patients cannot afford the copayments, resulting in a need for Medicaid coverage.

As you can see, qualifying for Medicaid to pay for nursing home care quickly becomes an important concern for those who will need nursing home care on a long-term basis.

Throughout this information you will see that a single person's eligibility is established differently from that of a married person. To define who is married, Medicaid looks to state law. Estrangement, separation or, for that matter, the unknown whereabouts of the spouse does not render the applicant unmarried. Marriage can be a traditional ceremonial marriage or a valid common law marriage. Keep in mind that beginning January 1, 2017, common law marriage was abolished in the Alabama, but marriages established under common law prior to that date are recognized in the state and will render the Medicaid applicant as married for eligibility purposes.

Another marriage issue important to understand is the fact that Alabama Medicaid does not consider the terms of a prenuptial or ante-nuptial agreement when determining eligibility. If the spouse refuses to provide information about resources or provide any support to a spouse in long-term care, the applicant spouse must appeal based on undue hardship and prove efforts he or she has made to obtain spousal participation.

MEDICAID HOME AND COMMUNITY BASED SERVICES

Home and Community Based Medicaid Waiver Services (HCBS) provide services at home to persons with very low income and resources. Application for these services is made through the local area agency on aging. Your local AAA can be located by 1-800-AGE-LINE (1-800-243-5463).

As a threshold issue, the applicant must be sick enough to need nursing home care to qualify for HCBS to keep him or her at home. Also, in all fairness, the rules can be provided, but, in reality, there are a limited number of slots for HCBS, and only the sickest and most economically needy are approved for these services.

Generally speaking a person can have income up to \$2313 and qualify for HCBS, but his or her countable resources cannot exceed \$2000.

For married persons the spouse not receiving HCBS is allowed to protect some assets that do not have to be spent down.

If the applicant is married, \$25,284 up to \$126,420 can be set aside for the spouse. After the protected spousal amount is established, any countable resources over that protected amount except \$2000 will have to be spent down by the applicant.

When an application is taken for HCBS and services denied due to excess resources, it is important to request a spousal assessment (Agency Form 230) so a reassessment can be later made after spend down has been completed and the applicant may then qualify. The spend down amount plus any additional resources accumulated during the spend down must be spent on the applicant spouse before eligibility can be established.

The HCBS community spouse (the spouse not applying for the service) can protect some resources pursuant to the Spousal Impoverishment Rules. In a nutshell, after determining what resources can be excluded (such as the home) the community spouse is allowed to keep the first

\$25,284. If joint assets exceed \$50,000, the community spouse can keep one-half up to a limit of \$126,420.

Example 1: A couple has \$30,000 worth of countable resources. The spouse not receiving the service can protect \$25,284. The remaining \$4716, except for \$2000, will have to be spent by the applicant spouse, for a total spend down of \$2716 required before eligibility can be established.

Example 2: A couple has \$60,000 worth of countable resources. The spouse not receiving the service can protect $\frac{1}{2}$ of that amount for a total of \$30,000. The remaining \$30,000, except for \$2000, will have to be spent down by the applicant spouse, for a total spend down of \$28,000 required before eligibility can be established.

Example 3: A couple has \$300,000 worth of countable resources. The spouse not receiving the service can protect the \$126,420. The remaining \$173,580, except for \$2000, will have to be spent by the applicant spouse, for a total spend down of \$171,580 required before eligibility can be established.

In any of these scenarios the institutionalized spouse may spend down the amount required on home care services, items he/she needs for care at home, to pay legitimate debts belonging solely to him/her, maintenance on property in proportion to his/her ownership interest, the purchase of a burial contract, etc. After the required spend down is complete, a new assessment can establish eligibility.

For years there was a problem with HCBS cases where property had been given away within five years of application because there was no defined way for the penalty to run. For nursing home Medicaid cases the penalty for giving away property clearly begins to run at a given time. That way a person can determine when he or she will be eligible after the penalty runs. That was not the case for HCBS cases. This meant that if property had been given away by the applicant within five years of application, there was no way to qualify for services until the applicant could reapply

when the transfer was outside five years. That changed in April 2018 when the Center for Medicare and Medicaid Services issued a letter to state Medicaid directors explaining how to calculate when the penalty would run in HCBS cases. That directive (SMD# 18-004) indicated that the HCBS program should go ahead and take the application; determine if the applicant meets the financial and non-financial requirements for eligibility and the level-of-care criteria for the program; develop a person-centered service plan for the applicant; and identify an available waiver slot for the individual's placement. When all of those steps are taken, the penalty will begin to run, and after the penalty ran out, the applicant would qualify for services.

Despite this complicated but hopeful directive, The Alabama Medicaid Administrative Code states that a transfer penalty imposed on an **applicant** for HCBS will cause ineligibility until the applicant is institutionalized or until all money or property is returned in full. A transfer by a **recipient** of HCBS is treated in a different manner. The transfer will cause ineligibility, but the transfer penalty period runs as follows:

“The penalty period for waiver recipients will start to run the month following the month of the transfer and will run continuously until it expires.”

To calculate the penalty the amount transferred is divided by \$6200 (for 2019) to determine the number of months of ineligibility.

The application form used for HCBS is the same as the application for institutional Medicaid found below.

For HCBS waiver cases that use the institutional income limit, the cash surrender value of life insurance is excluded if the total of all policies owned by the individual does not exceed \$5,000.

NURSING HOME ELIGIBILITY STANDARDS

Nursing Home Medicaid is provided in a facility certified to accept Medicaid as a payment source.

In order to qualify for Medicaid to pay for long-term care a person has to be medically sick enough and have income and resources low enough.

Generally speaking an application for a single person is different from an application for a married person because of what is called the spousal impoverishment rules. These are rules enacted in 1988 to make sure that spouses remaining outside the nursing home have the minimum support needed to continue to live independently after the resident spouse enters long-term care. As such, we will look at those differences below.

The spouse going into long-term care is the applicant, and the spouse remaining at home is the community spouse.

THE APPLICATION FORM

A fillable application Form 204/205 can be found online at:

https://medicaid.alabama.gov/documents/9.0_Resources/9.4_Forms_Library/9.4.1_Applicant-Recipient_Forms/9.4.1_Form_204-205_EnD_App_9-15-14_Fillable.pdf

You can fill and print the form, but all of the documentation needed to verify contents will have to be accumulated and attached. The application is filed in the district office covering the applicant's county. Those offices can be located here:

[https://medicaid.alabama.gov/content/10.0 Contact/10.1 Medicaid Contacts/10.1.1 Medicaid Locations.aspx](https://medicaid.alabama.gov/content/10.0%20Contact/10.1%20Medicaid%20Contacts/10.1.1%20Medicaid%20Locations.aspx)

The resident can sign the application if well enough to comprehend, but usually someone with power of attorney/guardianship or conservatorship or a relative completes the application. Due to the complex nature of the application, someone familiar with the applicant's business will need to gather all the information and documentation to complete the application.

An appointment of representative form can be located at

[https://medicaid.alabama.gov/documents/9.0 Resources/9.4 Forms Library/9.4.1 Applicant-Recipient Forms/9.4.1 Form 202 Appoint Representative 9-12-14.pdf](https://medicaid.alabama.gov/documents/9.0%20Resources/9.4%20Forms%20Library/9.4.1%20Applicant-Recipient%20Forms/9.4.1%20Form%20202%20Appoint%20Representative%209-12-14.pdf)

Documentation must be provided to support all matters claimed in the application. This would include proof of gross monthly income for the applicant and spouse; deeds associated with property owned or transferred; proof of insurance; copies of Social Security, Medicare and health insurance cards; trusts; bank accounts; prepaid burial policies; powers of attorney or letters of conservatorship; etc. With each blank completed on the application, think about what paper can prove that this answer is accurate and provide it.

Copies of all bank or other financial account statements must be provided, and copies of cancelled checks, possibly for the previous five years, may be required. If checks were written to cash, or to family members to make purchases, then receipts may be required to document that expenditures were for the applicant and money not transferred as gifts.

Proof of all money or property transferred to others without compensation (gifts) for five years is required.

In order to qualify for Medicaid the applicant must establish medical and financial eligibility. In other words, the applicant must be sick enough as well as financially needy enough.

MEDICAL ELIGIBILITY

To be medically eligible for Medicaid to pay for long-term care a doctor must certify that nursing care is required on a daily basis, in a nursing facility on an inpatient basis and under the supervision of a RN and under the general direction of a physician. The Alabama Administrative Code lists specific services that a resident might require, two of which are needed for an initial admission. These services include administration of a potent and dangerous injectable medication and solutions on a daily basis or administration of routine oral medications, eye drops or ointment; restorative nursing procedures such as gait training, bowel and bladder training; nasopharyngeal aspiration requirement for maintenance of a clear airway; maintenance of tracheostomy, gastrostomy, colostomy, ileostomy and other tubes; feeding tubes; pressure ulcers or other widespread skin disorders; observation of unstable medical conditions; use of oxygen on a regular or continuing basis; application of dressing involving prescription medications; comatose condition; assistance with at least one defined activity of daily living (transfer, mobility, eating, toileting, expressive and receptive communication, orientation, medication administration).

Medicaid residents who are discharged to a hospital and have had no break in institutional care since discharge from a nursing home and residents re-admitted in less than 30 days after being discharge into the community must meet only one of the service requirements. Also persons admitted to a nursing facility as a private pay resident in spend down status with no break in institutional care for more than 30 days who become financially eligible for Medicaid only need one of the service requirements to be medically eligible for Medicaid to pay for nursing home services.

Financial eligibility consists of income and resource eligibility.

In order to establish eligibility for any particular month, the applicant must meet the income and resource limits on the first day of that particular month. It can be confusing when someone is eligible for Medicaid, and their income arrives and pushes their bank account over \$2000. This is all right so long as the bills are paid, and the balance falls back down to \$2000 or less by the first of the next money.

INCOME ELIGIBILITY

The income limit in 2019 to qualify for institutional Medicaid, whether the applicant is married or single, is \$2313 (gross income). If the applicant is married, the income of the community spouse is reported, but it is not counted for eligibility purposes. So the community spouse keeps all of his or her income while there are very specific limitations on what the applicant can do with his or her income.

If the applicant's income exceeds \$2313, a Medicaid Qualifying Income Trust (MQIT) can resolve the problem of excess income. The MQIT is an irrevocable trust which is established and a bank account opened in the name of the trust. The applicant's income is routed for direct deposit into that bank account. If established and funded properly, the applicant can have any amount of income over \$2313 without it being a bar to establishing eligibility for Medicaid.

Next we will look at how the applicant's income is used when placed in a MQIT. For now just understand that this will solve the problem of the applicant's income being over the income limit of \$2313.

PERSONAL LIABILITY AND SPOUSAL MMMNA

When eligibility is established (the person is medically eligible, the resources are low enough and the income is low enough or a MQIT has been established) Medicaid figures a budget to determine the amount of income the nursing home resident must pay directly to the nursing home. After that amount is paid, Medicaid picks up the difference in that personal liability and the nursing home Medicaid rate for room and board.

To calculate the personal liability the resident is allowed to keep:

- The personal needs allowance of \$30 per month (also an additional \$90 if the resident is eligible for Veteran's Benefits that are dropped to \$90 after eligibility is established);
- The spousal minimum monthly maintenance needs allowance (known as the MMMNA, this is enough money to bring the income of the community spouse up to \$2058 in 2019);
- Family maintenance needs allowance (a similar allowance for minor or dependent adult child, a dependent parent or a dependent sibling of either spouse);
- Costs of necessary medical or remedial care not covered by a third party (e.g. Medicare Part B premium).

Example of how to calculate the MMMNA:

An applicant has \$2800 income and qualifies for Medicaid with a MQIT. The community spouse has \$1200 income making her eligible for \$858 in MMMNA ($2058 - 1200 = 858$). The applicant's personal liability budget will allow him to route that much to his spouse monthly.

These allowances are made to the extent the resident's income can cover them. It is entirely possible for the patient to exhaust his or her income before paying any personal liability to the nursing home.

It is important to recognize that when a Medicaid application is pending the applicant should pay all of his or her income to the nursing home except the amounts listed above. If that is not done there will be an unpaid balance at the nursing home, and there will be no way to pay that balance if a person's Social Security or other income has already been spent without paying the personal liability. After eligibility is

established Medicaid will publish the exact personal liability to use.

A MQIT packet to establish an income trust is Form 262 and can be located here:

https://medicaid.alabama.gov/documents/9.0_Resources/9.4_Forms_Library/9.4.1_Applicant-Recipient_Forms/9.4.1_Form_262_QIT_Packet.pdf

MQIT ISSUES

While a MQIT will qualify a person for Institutional Medicaid when he or she has income over the income limit, this type of trust cannot be used to qualify such a person with excess income for Medicaid to cover HCBS.

Many banks do not understand the MQIT, and some just refuse to open an account named for the trust. Some banks will erroneously require the person opening the account to obtain an EIN from the IRS. In some situations when no local bank will open an account named for the MQIT, Medicaid can designate a patient account at the facility to receive and disburse the MQIT funds.

INCOME ISSUES

If the income of both spouses exceeds the income limit, do not be concerned and create a MQIT. Only the income of the applicant exceeding \$2313 results in the need for a MQIT.

When a couple receives joint income (e.g. a rent check) the income is allocated between the husband and wife in proportion to that which each owns the assets producing the income. Otherwise when a check is received that is not related to an underlying investment, the income is attributed to the name on the check.

Even if the applicant's income exceeds the income limit, he or she should consider setting up a MQIT and applying for Medicaid to create the additional income for the community spouse.

Example: A man enters the nursing home with a charge of \$6500 per month. His income is \$7000 per month. His wife remains at home with \$1000 income. He should establish a MQIT so that he can qualify for Medicaid and route \$1558 of his income to his wife to bring her income up to \$2058. If he does not, then each month he will pay his bill for \$6500 leaving only \$500 for his wife to use and bringing her income up to only \$1500.

Medicaid will not permit an applicant to refuse or decline income. Refusal of income or resources is treated as giving that income or asset away. However, the cost-of-living adjustment for the Alabama Teachers or State Employees Retirement Pension Plan is an exception to that rule. A person can refuse the cost-of-living increase if such increase negatively impacts Medicaid eligibility.

RESOURCE ELIGIBILITY

An inventory of all assets owned is compiled when a Medicaid application is being filed.

The resource limit is \$2000. That means that a person can only have \$2000 worth of "countable" assets; recognize that there are some types of property that do not count at all. Excluded resources will be discussed below.

A single person can clearly establish eligibility when resources reach \$2000. It is, however, a little harder to establish financial eligibility in the case of a married person.

In order to determine how much a community spouse gets to preserve for himself or herself, a married person applying for Medicaid must provide an inventory of property/assets the couple jointly and individually owned on the "snapshot" date (defined as when the person entered long-term care, which might be when he or she entered a hospital from which a placement was made to a nursing home). From the resources that existed on the snapshot date, the home is protected for the spouse who will continue to live there (referred to as the community spouse). Besides the home, the community spouse is allowed to keep the first \$25,284. If

joint assets exceed \$50,000, the community spouse can keep one-half up to a limit of \$126,420. This is called the Spousal Impoverishment Protected Resource Amount.

After reserving what can be set aside for the spouse, all remaining funds over \$2000 must be spent down by the applicant.

Example One: A couple has \$20,000 in countable assets. The community spouse keeps it all because it is below \$25,284, and the applicant spouse qualifies for Medicaid.

Example Two: A couple has \$40,000 in countable assets. One-half is \$20,000, but the spouse keeps the first \$25,284. The applicant must spend down the rest except for \$2000 ($\$40,000 - \$25,284 = \$14,716 - \$2000 = \$12,716$) before qualifying for Medicaid.

Example Three: A couple has \$60,000 in countable assets. The community spouse keeps one-half, \$30,000. The applicant must spend down the rest except for \$2000 ($\$60,000 - \$30,000 = \$30,000 - \$2000 = \$28,000$) before qualifying for Medicaid.

Example Four: A couple has \$300,000 in countable assets. One-half is \$150,000, so the cap of \$126,420 applies, and that amount is retained by the community spouse. The applicant spouse must now spend down \$171,580 ($\$300,000 - 126,420 = 173,580 - 2000 = 171,580$) before qualifying for Medicaid.

SPEND DOWN

Spending down excess resources can be done by a number of methods, but some of these methods should be employed prior to placement in long-term care (when the snapshot happens) so that the amount for spend down is lower. This might include payment of debt to leave the spouse in a better financial situation. For instance, paying off the home will convert countable resources into excluded resources and ease the community spouse's monthly expenses.

Another example might be pre-payment of funeral expenses. During spend down the applicant must spend the resources allocated to him or her as well as his or her income (less the personal needs allowance).

Another way to accomplish spend down without incurring a transfer penalty is to establish a special needs trust. Instead of spending all of the excess resources on the cost of nursing home care, the required spend-down funds can be placed into a pooled special needs trust, such as The Alabama Family Trust, and the elderly person can begin receiving Medicaid benefits if otherwise eligible. Money in the trust can be used to provide things such as diapers, pajamas, clothes, a private room, or sitters in the nursing home. Meanwhile, Medicaid begins paying for the monthly room and board at the facility. See more information concerning this trust at

<https://janneallaw.com/2019/09/18/save-your-money-with-a-medicaid-spend-down-special-needs-trust/>.

There are different types of special needs trusts, but the type permitted in Alabama for disabled persons over 65 are pooled trusts that require that money left in the trust at the death of the nursing home resident be used first to reimburse Medicaid for the cost of care for which the agency paid.

RESOURCES

Resources include cash, mortgages, cash surrender value of life insurance when the face value exceeds \$5000, stocks and bonds, mutual funds, promissory notes, real estate, checking and savings, certificates of deposit, etc. In other words, resources are just about everything the applicant and/or his or her spouse has accumulated during life.

EXCLUDED PROPERTY

All property counts unless it is specifically excluded. Some excluded resources include the following:

- Household goods and personal effects
- One automobile
- Insurance, cash or prepaid burial contracts up to \$5000 in value (this value further excludes the value of the space items such as the plot, marker, casket, vault, opening and closing the grave [see more information below])
- The home for the community spouse as long as he or she lives there (no lien can be taken)
- The home if a dependent relative other than a child under 21, blind or disabled lives there (a lien may be taken)
- The home if a dependent child who is under 21, blind or disabled lives there (no lien may be taken **and the property may be transferred without penalty**)
- The home if a sibling with an equity interest lives there and was lawfully residing in the home for at least one year immediately prior to the applicant being admitted to the medical institution (no lien may be taken **and property may be transferred without penalty**)
- The home if the applicant has a reasonable intent to return home (a lien may be taken but dissolves if the patient actually does return home)
- Real property where a joint owner lives for whom sale of the property would cause a loss of housing (a lien may be taken)
- Up to \$6000 equity value in income producing property (remaining equity is a countable resource)
- Life estates
- Real property the applicant is making a bona fide effort to sell (a lien will be taken)
- Property held in a special needs trust meeting highly specific federal legal requirements;
- Term life insurance with no cash surrender value;
- \$5000 titled for burial or designated in a Statement of Claimant or Other Person form
- Prepaid burial funds worth \$5000 (in calculating the amount invested, do not count the space items such as plot, marker, casket, vault, opening and closing the grave which are completely excluded as a resource);
- Cash surrender value life and burial Insurance policies that have a combined face value of \$5000 or less (the face value is a countable resource but may be excluded when designed for burial)

- Cash surrender value life and burial insurance policies that have a combined face value exceeding \$5000 where up to \$5000 is designated for burial (the amount not designated for burial is treated as a countable resource)
- Proceeds paid by a long-term care Partnership Policy (for each dollar of benefits paid one dollar of assets is not counted toward the eligibility limit). For more about what qualifies as a Partnership Policy see

<https://www.aldoi.gov/Consumers/LongTermPartnership.aspx>

It is important to recognize that all exclusion categories have highly specific requirements to qualify for the exclusion. It is wise to obtain legal advice before transferring property to be sure that no penalty will occur as a result.

VALUING RESOURCES

Joint Bank Accounts: When a bank account is jointly titled, Medicaid will count the full amount as property of the applicant unless a joint owner, such as a child, can track his or her contributions to the account.

Real Property: Real property is valued by Medicaid as the value of the tax assessor's appraised value, less any indebtedness on property. If the property cannot be sold for an amount equal to that value, the property value can either be reassessed by the county or, if the appraised value is over one year old, a commercial appraisal can be used to establish value.

Annuities: If the annuity can be sold, revoked, surrendered or cashed in, it is a countable resource.

Promissory notes and mortgages: If it can be sold, a promissory note or mortgage is a resource. If it cannot be sold, proceeds from the instrument are income. Statements from financial institutions may be required concerning the value of the instrument.

Mineral and timber rights: If a person owns a life estate, he normally does not own mineral and timber rights unless the deed or will by which the life estate was acquired specifically states that the life tenant is entitled to the mineral and timber rights. For ownership more than a life estate, Medicaid will assign a value to mineral rights equal to the income from those rights for the past four years. Timber rights will generally require a private appraisal.

Trusts: Other than a special needs trust, a trust is a resource to the extent that the applicant (or spouse) has the legal right to compel distributions from the trust, is entitled to distributions payable directly to him or her from the trust, has the right to direct the use of the funds or has the right to revoke the trust. If a Medicaid Applicant and/or spouse establish a revocable (living) trust, where the Medicaid Applicant and/or spouse have unrestricted access to the corpus of the trust, then the corpus is a countable resource to the Applicant. Note that generally proceeds in an irrevocable trust created outside five years that allows the donor to be paid only income from the trust will not be considered resources for Medicaid purposes.

Stocks and bonds: Stocks and bonds count as resources. Government bonds can be valued at www.savingsbonds.gov/.

Retirement accounts: Even if liquidating causes tax liability, retirement accounts count as resources to the extent that funds can be accessed.

Mobile Home: When a mobile home is located on the applicant's land, its value is considered part of the real property, but if the mobile home is located on the land of someone other than the applicant, it is valued as personal property. No matter where it is located, if the mobile home is the home of the applicant, it is subject to the same exclusions as the principal residence discussed above, but Medicaid will not take a lien on the mobile home. Failing any way to exclude the mobile home, Medicaid counts the equity value in the property as a resource.

Burial Funds: Money invested in burial arrangements are considered a resource. Medicaid will allow a recipient and his or her spouse to each have \$5000 set aside for burial and exclude those funds from countable resources at the time of application. That is a simple enough rule, but calculating how the burial exclusion works, is a little more difficult. Different options include the following

- Some people plan to use term life insurance for burial, and this is fine. Term insurance has no cash surrender value, so it is completely excluded as a resource for Medicaid purposes.
- Some people have pre-paid burial/cremation contracts. Prepaid burial funds worth \$5000 are fine (in calculating the amount invested, do not count the space items that include the plot, marker, casket, vault, opening and closing the grave because these line items are completely excluded as a resource);
- The \$5000 burial exclusion can be established by titling a financial account for burial or by designating funds in a Statement of Claimant or Other Person form as part of the Medicaid application.
- When life and burial Insurance policies (that do have a cash value) are used as the burial exclusion, and the combined *face* values are \$5000 or less, the face value is a countable resource and may be excluded when designed for burial;
- When life and burial insurance policies (that do have a cash value) are used as the burial exclusion, and the combined *face* values exceeds \$5000, the combined cash surrender value is a countable resource and up to \$5000 worth may be excluded when designated for burial (amount not designated for burial is a countable resource);

GIFTING AND TRANSFER PENALTIES

Medicaid looks back at all financial transactions that occurred five years prior to application. If assets were given away during that five year period Medicaid will deny coverage at the rate of one month for every \$6200 transferred. This is why early financial planning for long-term care is so critical. There are multiple strategies to reduce countable assets, but some of those strategies, including irrevocable income only trusts or a life estate deed require a five year leeway before long-term care will be needed.

Example: A second home valued at \$175,000 is transferred to a child in January 2017. The parent applies for Medicaid in July 2019. A penalty of 28.22 months ($175,000 \div 6200$) would be imposed. That penalty would not begin to run until the parent is in the nursing home and has used all his resources and, but for the transfer, would be eligible for Medicaid. That means someone will have to privately paying for care for over two years during the time the penalty runs.

Giftting is not just giving away property. It is any transfer of an asset for less than the value assigned by Medicaid. An example might be selling a home for less than the tax assessor's appraised value. Often people trying to sell property will reduce the price to unload the property, and this is fine unless the owner is, or may become, a Medicaid applicant within five years. A better plan is to have the property reassessed or to obtain a commercial appraisal if the appraised value is over one year old. A house sold for \$35,000 when the tax assessors appraised value is \$52,000 will be a \$14,000 uncompensated transfer and result in a 2.26 month penalty.

When transfers have been made within five years, it is important to use caution in making the Medicaid application since the application may be filed too soon, causing a penalty to be assessed.

Example: A person gives away \$250,000 on January 28, 2015. He is admitted to a nursing home in September 2019,

and the facility pressures the family to make application for Medicaid. The application is filed in October 2019. A 40.32 month penalty is triggered based on the gift made within five years ($\$250,000 \div \$6,200 = 40.32$). The applicant will not be eligible for Medicaid until 2023. Had the application been made in February 2020 he would have been awarded Medicaid with no penalty because he would have been outside the five year look back.

A transfer penalty can be assessed when a family member is paid for caregiving services without a caregiver contract being put in place.

The Medicaid Administrative Code states:

“If a case has sitter service issues, the applicant must be able to document all the following information to avoid a transfer penalty:

- 1) If there is a written personal service agreement, the type, frequency, and duration of the services being provided must be described as well as the amount of consideration to be paid for the services. If the case has no personal care agreement in place and the applicant is claiming payments were made for sitter services, the applicant/sponsor must explain on the Agency Statement of Claimant form the type, frequency, and duration of services provided as well as the manner of payment and the amount of payments made to the sitter(s).

- 2) Documentation must establish that the applicant needed the assistance of sitter services. Such documentation can be provided by the applicant/sponsor explaining on the Agency Statement of Claimant form why the applicant needed the sitter services, or a statement from the applicant's doctor regarding the health condition of the applicant can be provided. However, a doctor's statement is not a

requirement. Also, the level of assistance needed does not have to meet the nursing facility level of care.

3) Sitter services must be received by the applicant at or after the time of payment for the services. "At the time of service" includes payments made within a reasonable or generally accepted time frame after receipt of the services. For example, payments made on a weekly or monthly basis immediately after receipt of the services meet this requirement. Otherwise, sitter services received prior to the payment for such services are considered past consideration and a transfer unless there is a valid personal service agreement in place prior to the services being rendered. Therefore, past consideration will only be allowed in a case that has a personal service agreement in place prior to the services being rendered that meets all the requirements for a valid personal service agreement. If the case has no personal service agreement and past consideration has been received in exchange for the sitter services, then a penalty shall be imposed.

4) The amount of consideration received cannot exceed the fair market value for the rendered service. The rates for these services must be reasonable and shown to be comparable to the usual and customary rates in the local area. The applicant is responsible for establishing that rates are reasonable.

5) Documentation must establish that sitter services were actually provided. Examples of documentation are time sheets and attendance logs, statements from the sponsor and sitter(s) (preferably on the Agency Statement of Claimant form), and copies of checks and any other documentation showing that sitter services were provided. You should always require a statement from the sponsor and the sitter(s) stating that the sitter actually provided the care and explaining the circumstances surrounding the care. If the applicant/sponsor cannot obtain a statement from a sitter(s) then a reasonable explanation must be given

as to why the statement could not be obtained. Examples of a reasonable explanation are that the sitter has moved and cannot be located, the sitter is deceased, or that the sitter refuses to provide the statement. If any of these reasons are given, then the applicant/sponsor must provide another statement on the Agency Statement of Claimant form explaining the reason the sitter(s) statement could not be obtained.

6) If a family member was reimbursed for sitter services to the applicant while the applicant was residing in a nursing facility or hospital then a transfer for Medicaid eligibility purposes is presumed and a penalty shall be imposed. If a non-family member was reimbursed for sitter services to the applicant while the applicant was residing in a nursing facility or hospital and sufficient documentation has been furnished establishing that the services were actually needed and provided, and that the services were provided for fair market value, then no transfer penalty shall be imposed.

PERMISSIBLE TRANSFERS

Permissible transfers are those allowed by law resulting in no penalty being imposed. As previously listed with excluded resources, while some property can be excluded and a lien taken, some property can actually be transferred without creating a penalty. This would include:

- Home when a child under 21, blind or disabled lives there
- Home when a sibling with an equity interest was residing there for at least one year prior to the institutionalization
- Home when a son or daughter of such claimant who was residing in the applicant's home for a period of at least two years immediately before the date of applicant's admission to the medical institution or nursing facility, and who provided care to such claimant which permitted the applicant to reside at home rather than in an institution or facility

- Transfers of money into a Special Needs Trust. For more information see <https://janneallaw.com/2019/09/18/save-your-money-with-a-medicaid-spend-down-special-needs-trust/>.

ESTATE RECOVERY

Federal law requires Medicaid to recoup funds paid for care from the probate estates of recipients at death. Those include:

Benefits that were not paid correctly to a person of any age (resulting in what is known as an overpayment); benefits paid after age 55 for nursing home Medicaid; benefits paid after age 55 for home and community based Medicaid Waiver services; benefits paid for hospital and drugs for persons who received those benefits in connection with nursing home or waiver Medicaid after the age of 55; expenditures for SSI eligible persons who qualify for Medicaid in the community; expenditures for a person of any age who permanently resides in a nursing facility, intermediate care facility for the intellectually disabled or other medical institution.

It is important to know that funds paid by a Long Term Care Partnership Policy are exempt from Medicaid Estate Recovery.

More about Medicaid Estate Recovery can be read in the following ebook at this author's web site:

https://janneallaw.files.wordpress.com/2019/09/alabama-medicaid-estate-recovery_08-19.pdf