



# The Basic Rules of Medicaid Eligibility

Know who can qualify for nursing home coverage





# The Basic Rules of Medicaid Eligibility

Know who can qualify for nursing home coverage

Copyright 2019 ElderLaw Answers

The information in this guide should not be considered legal advice. While we strive to provide as detailed, reliable and understandable legal information as possible in our Elder Law Guides, they cannot substitute for an attorney applying the law and years of experience to a particular client situation. We urge readers to use the Guides as background material and to consult with one of our members before taking action.

Lacking access to alternatives like long-term care insurance or Medicare, most people pay out of their own pockets for long-term care until they become eligible for Medicaid.

---

Since few people have long-term care insurance or can afford to pay the high cost of nursing home care out-of-pocket, most people eventually qualify for Medicaid. By default, it has become the primary source of funding for nursing home care and the long-term care insurance of the middle class.

Congress does not want you to move into a nursing home on Monday, give all your money away on Tuesday, and qualify for Medicaid on Wednesday.

Although their names are confusingly alike, Medicaid and Medicare are quite different programs. Medicare is an “entitlement” program, meaning that everyone who reaches

age 65 and is entitled to receive Social Security benefits also receives Medicare. Medicaid, on the other hand, is a form of welfare – or at least that’s how it began. To be eligible for Medicaid, you must become “impoverished” under the program’s guidelines. Also, unlike Medicare, which is totally federal, Medicaid is a joint federal-state program. Each state operates its own Medicaid system, but this system must conform to federal guidelines in order for the state to receive federal money, which pays for about half the state’s Medicaid costs. (The state picks up the rest of the tab.)

This complicates matters, since the Medicaid eligibility rules are somewhat different from state to state, and they keep changing. (The states also sometimes have their own names for the program, such as “Medi-Cal” in California and “MassHealth” in Massachusetts.) Both the federal government and most state governments seem to

be continually tinkering with the eligibility requirements and restrictions. This most recently occurred with the passage of the Deficit Reduction Act of 2005 (the “DRA”), which was enacted on February 8, 2006, and significantly changed the rules governing the treatment of asset transfers and homes of nursing home residents. The implementation of these differs from state to state. To be certain of your rights in your particular state, consult an elder law attorney. He or she can guide you through the complicated rules of the different programs and help you plan ahead. It is also worth noting that, spurred by incentives from the federal government, state programs are spreading that are aimed at keeping Medicaid long-term care recipients in the community and out of nursing homes for as long as possible.

---

## Qualifying for Medicaid

While two-thirds of nursing home residents are covered by Medicaid, at root it is a health care program for the poor. The definition of “poor” has become quite complex in the area of nursing home coverage. In order to be eligible for Medicaid benefits, a nursing home resident may have no more than \$2,000 (in most states) in “countable” assets. The spouse of the nursing home resident – called the “community spouse” – is limited to one half of the couple’s joint assets up to \$126,420 (in 2019) in countable assets. (In some states the community spouse may keep all of the couple’s assets up to \$126,420, not just half up to that amount.) This figure, called the community spouse resource allowance (CSRA), changes each year to reflect inflation. In addition, the community spouse may keep the first \$25,284 (in 2019), even if that is more than half of the couple’s assets. This figure is higher in some states, up to the full \$126,420 as mentioned above.

All assets are counted against these limits unless the property falls within the short list of “noncountable” assets. These include:

1. Personal possessions, such as clothing, furniture, and jewelry.

2. One motor vehicle of any value as long as it is used for transportation.
3. The applicant's principal residence, provided it is in the same state in which the individual is applying for coverage. In most states, the home has not been considered a countable asset for Medicaid eligibility purposes as long as the nursing home resident intended to return home. Under the DRA such houses may be deemed non-countable only to the extent their equity is less than \$585,000, with the states having the option of raising this limit to \$878,000 (figures rise with inflation). In all states and under the DRA, the house may be kept with no equity limit if the Medicaid applicant's spouse or another dependent relative lives there. *(continued on next page)*

## Case Study: Alice & George

After her husband, George, moved to a nursing home, Alice came with her daughter, Joyce, to consult with an elder law attorney. Alice had been caring for George for years at home as his Alzheimer's disease progressed. Eventually, she had to be hospitalized for minor surgery, and Joyce and her two siblings were able to convince Alice that it was time for George to move to a nursing home.

Alice and her daughter provided the attorney with the following financial information: Alice and her husband owned their home, which had a fair market value of approximately \$300,000 and an outstanding home equity loan of \$15,000. They had \$150,000 in savings and investments. George received \$1,200 a month in Social Security benefits and an additional pension of \$400. Alice received \$900 a month from Social Security. The nursing home charged \$6,000 a month.

The attorney advised Alice and her daughter that in their state Alice could keep half of the couple's combined savings – \$75,000 – and George could keep \$2,000, for a combined total of \$77,000. They would have to spend down \$73,000 before Medicaid would begin to pick up the tab for George's nursing home care. He advised them that any spending is allowed – even encouraging Alice to take a much-needed vacation – but that giving away assets would be penalized by one month of ineligibility for every \$5,000 transferred.

*(continued on page 6)*

After much discussion (and overcoming Alice's aversion to spending large sums), Alice, Joyce and the attorney came up with the following plan to spend down \$73,000:

\$15,000	Pay off home equity loan
+6,000	One month of nursing home care
+27,000	Purchase an immediate annuity for Alice's benefit
+10,000	Trading in Alice's car for a new one
+ 5,000	Painting Alice and George's house
+10,000	Prepaying George and Alice's funerals
\$73,000	

With this plan, Alice was able to preserve the bulk of the couple's savings by spending it in ways that kept its value for her.

4. Prepaid funeral plans (many states limit the value), up to \$1,500 set aside in a specified burial account, and a small amount of life insurance.
5. Assets that are considered "inaccessible" for one reason or another.
6. Business property that produces income essential for self support.

To find a qualified elder law attorney, go to [elderlawanswers.com](http://elderlawanswers.com).

## Medicaid's treatment of income

The basic Medicaid rule for nursing home residents is that they must pay all of their income, minus certain deductions, to the nursing home. Medicaid pays nursing home costs that exceed the resident's income. But in some states, known as "income cap" states, eligibility for Medicaid benefits is barred if the nursing home resident's income exceeds \$2,313 a month (for 2019), unless the excess above this amount is paid into a "(d)(4)(B)" or "Miller" trust. If you live in an income cap state and require more information on such trusts, consult an elder law specialist in your state.

For Medicaid applicants who are married, the income of the community spouse is not counted in determining the Medicaid applicant's eligibility. Only income in the applicant's name is counted. Thus, even if the community spouse is still working and earning, say, \$5,000 a month, she will not have to contribute to the cost of caring for her spouse in a nursing home if he is covered by Medicaid. In some states, however, if the community spouse's income exceeds certain levels, he or she does have to make a monetary contribution towards the cost of the institutionalized spouse's care. The community spouse's income is not considered in determining eligibility, but there is a subsequent contribution requirement.

What if most of the couple's income is in the name of the institutionalized spouse, and the community spouse's income is not enough to live on? In such cases, the community spouse is entitled to some or all of the monthly income of the institutionalized spouse. How much the community spouse is entitled to depends on what the Medicaid agency determines to be a minimum income level for the community spouse. This figure, known as the minimum monthly maintenance needs allowance or MMMNA, is calculated for each community spouse according to a complicated formula based on his or her housing costs. The MMMNA may range from a low of \$2,057.50 to a high of \$3,160.50 a month, and even higher in Alaska and Hawaii (for 2019; the first figure rises July 1, 2019). If the community spouse's own income falls below his or her MMMNA, the shortfall is made up from the nursing home spouse's income (but see a possible alternative under Increased Resource Allowance below).

## Medicaid's Asset Transfer Rules

The transfer penalty now starts not when you transfer assets but when you would qualify for Medicaid if not for the transfer.

Why not qualify for Medicaid coverage of nursing home care by simply transferring assets out of your name? Because Congress does not want

you to move into a nursing home on Monday, give all your money to

your children (or whomever) on Tuesday, and qualify for Medicaid on Wednesday. So it has imposed restrictions on the ability of people to transfer assets before applying for Medicaid coverage without receiving fair value in return. These restrictions, already severe, were made even harsher by enactment of the DRA.

### Case Study: Alice & George (continued)

After Alice and George (see first Case Study) spent down so that George qualified for Medicaid coverage of his nursing home care, the state Medicaid agency calculated Alice's MMMNA to be \$2,200 a month, based on her housing expenses and the utility costs in the state. Since her own monthly income was only \$900 from Social Security, she had a shortfall of \$1,300 a month. George was permitted to pay this amount from his own income over to Alice each month rather than pay all of his income to the nursing home. His "patient pay amount," the amount he had to pay the nursing home each month, was determined to be \$240, calculated as follows:

	<b>\$1,600</b>	<b>George's total monthly income</b>
	<b>– \$1,300</b>	<b>Income allowance to Alice</b>
	<b>– 60</b>	<b>Personal needs allowance (cash George could keep)</b>
<b>\$</b>	<b>240</b>	<b>Patient pay amount</b>

The restrictions impose a penalty for asset transfers — a period of time during which the person transferring the assets (and his or her spouse) will be ineligible for Medicaid. The period of ineligibility is determined by dividing the amount transferred by what the state Medicaid agency determines to be the average private pay cost of a nursing home in your state. For example, if you live in a state where the average monthly cost of care has been determined to be \$5,000, and you give away property worth \$100,000, you will be ineligible for benefits for 20 months ( $\$100,000 \div \$5,000 = 20$ ).

However, for transfers made prior to enactment of the DRA on February 8, 2006, state Medicaid officials would look only at transfers



made within the 36 months prior to the Medicaid application (or 60 months if the transfer was made to or from certain kinds of trusts). But for transfers made after passage of the DRA the so-called “lookback” period for all transfers is 60 months.

**Innocent gifts to grandchildren could result in extended periods without Medicaid long-term care coverage.**

The second and more significant major change in the treatment of transfers made by the DRA has to do with when the penalty period created by the transfer begins.

Under the prior law, the 20-month penalty period created by a transfer of \$100,000 in the example above would begin either on the first day of the month during which the transfer occurred, or on the first day of the following month, depending on the state. Under the DRA, the 20-month period will not begin until (1) the transferor has moved to a nursing home, (2) has spent down to the asset limit for Medicaid eligibility, (3) has applied for Medicaid coverage, and (4) has been approved for coverage but for the transfer.

For instance, if an individual in our example transfers \$100,000 on April 1, 2018, moves to a nursing home on April 1, 2019, and spends down to Medicaid eligibility on April 1, 2020, that is when the 20-month penalty period will begin, and it will not end until December 1, 2021. The implementation of this change has differed from state to state. In other words, the penalty period does not begin until the nursing home resident is out of funds, meaning she cannot afford to pay the nursing home. If the applicant is already in a nursing home, the facility itself would likely have to foot the bill for the resident’s care.

Transfers should be made carefully, with an understanding of all the consequences. Innocent gifts to grandchildren could, years later, result in extended periods without any long-term care coverage of any kind. People who make transfers must be careful not to apply for Medicaid before the five-year lookback period elapses without first consulting with an elder law attorney. This is because the penalty could ultimately extend even longer than five years, depending on the amount transferred. Also, bear in mind that if you give money to your

children, it belongs to them and you should not rely on them to hold the money for your benefit. However well-intentioned they may be, your children could lose the funds due to bankruptcy, divorce or lawsuit. Any of these occurrences would jeopardize the savings you spent a lifetime accumulating. Do not give away your savings unless you are ready for these risks. In addition, transfers can affect grandchildren's eligibility for financial aid and have bad tax consequences for children receiving the funds. Moreover, the transfer of appreciated property to your children during your life can mean that your children will not get a step-up in basis in the property by inheriting it from you at your death.



Here's how that works: Say you purchased stock for \$10 a share 30 years ago and today it's worth \$100 a share. The \$10 purchase price is your basis. If you sell the stock today, you will have a capital gain of \$90 a share, the difference between the basis and the selling price, on which you will have to pay taxes. If you give the stock to your children, they will have the same basis as you and have to pay the same taxes if they sell it. On the other hand, if

they inherit the stock at your death, under current tax law the stock's basis gets "stepped up" to the value on your date of death. If that is \$100 and your children sell the stock for \$100, then there's no gain and no tax.

In any case, as a rule, never transfer assets for Medicaid planning unless you keep enough funds in your name to (1) pay for any care needs you may have during the resulting period of ineligibility for Medicaid; and (2) feel comfortable in doing it and have sufficient resources to maintain your present lifestyle.

Remember: You do not have to save your estate for your children. The bumper sticker that reads "I'm spending my children's inheritance" is a perfectly appropriate approach to estate and Medicaid planning.



## Case Study: Emily & Ira

Siblings Emily and Ira go to visit an elder law attorney. They are quite concerned about their father, Frank, and their brother, Samuel. Samuel, now 54 years old, has an intellectual disability and has lived with his parents his whole life. Since his mother's death seven years ago, Samuel has been living only with his father. Frank is 85 years old and recently had a stroke. He is receiving care in a rehabilitation facility, but it is unlikely that he will be able to return home. He certainly will not be able to care for Samuel any longer. Since his father's stroke, Samuel has been staying alternately with Emily and Ira. Samuel's presence, along with tending to Frank, has greatly disrupted Emily and Ira's family and work lives. This fill-in arrangement is not working for anyone. But Emily and Ira do care a great deal about Samuel, showing his picture to the attorney, and explaining how his presence in the house had been at least as much a comfort for their parents as it was a burden.

Fortunately, they have located a group home that looks like a good setting for Samuel. Unfortunately, it costs \$3,000 a month. Once Medicare coverage ends, Frank's nursing home expense will be \$6,000 a month. Frank's estate, including the value of his house, is approximately \$500,000, so \$9,000 a month would disappear quickly. While Emily and Ira are not seeking an inheritance themselves, they see their parents' estate being depleted over the next several years and their having to support Samuel themselves, or find publicly-funded care that may not be what they want for their brother. They are much relieved when the elder law attorney advises them that Frank can create a trust to hold his estate for the sole benefit of Samuel, allowing Frank to immediately qualify for Medicaid coverage of his nursing home care. With the cost of care suddenly \$3,000 rather than \$9,000 a month, the trust fund will be able to pay for Samuel's care for many years, perhaps indefinitely, and even foot the bill for extras that will enhance his life.

---

## Permitted Transfers

While most transfers are penalized with a period of Medicaid ineligibility, certain transfers are exempt from this sanction. Even after entering a nursing home, you may transfer any asset to the following individuals without having to wait out a period of Medicaid ineligibility:

- Your spouse (but this may not help you become eligible since the same asset limit on both spouses' assets will apply);
  - Your child who is blind or permanently disabled; or
  - Into trust for the sole benefit of anyone under age 65 and permanently disabled.
  - In addition, you may transfer your home to those listed above, as well as to the following individuals:
  - Your child who is under age 21 (rather unusual for nursing home residents);
  - Your child who has lived in your home for at least two years prior to your moving to a nursing home and who provided you with care that allowed you to stay at home during that time (often referred to as the "caretaker" child);
  - A sibling who already has an equity interest in the house and who lived there for at least a year before you moved to a nursing home.
- 

## Is Transferring Assets Against the Law?

You may have heard that transferring assets to achieve Medicaid eligibility is a crime. Is this true? No. But what about a professional advising someone to engage in asset transfers for Medicaid planning? That is a crime, at least in the statute books. However, it has been ruled to be an unconstitutional violation of the First Amendment. Nevertheless, it remains on the books.

As part of a 1996 health care bill, Congress made it a crime to transfer assets for purposes of achieving Medicaid eligibility. Congress repealed the law as part of the 1997 Balanced Budget bill, but replaced it with a statute that made it a crime to advise or counsel someone for a fee regarding transferring assets for purposes of obtaining Medicaid. This meant that although transferring assets was again legal, explaining the law to clients could have been a criminal act.



In 1998, then-Attorney General Janet Reno determined that the law was unconstitutional because it violated the First Amendment protection of free speech, and she told Congress that the Justice Department would not enforce the law. Subsequently, a U.S. District Court judge in New York said that the law could not be enforced for the same reason. See *New York State Bar Association v. Reno* (N.D.N.Y., No. 97-CV-1760, April 7, 1998). Accordingly, the law remains on the books, but it will not likely be enforced. In theory, however, a federal prosecutor in any state other than New York could seek to enforce the law. Another attorney general could see things differently than Janet Reno did.

---

## Trusts

The problem with transferring assets is that you have given them away. You no longer control them, and even a trusted child or other relative may lose them. A safer approach is to put them in an irrevocable trust.

Whether trust assets are counted against Medicaid's resource limits depends on the terms of the trust and who created it. Medicaid considers the principal of revocable trusts (that is, the funds held in the trust) to be assets that are countable in determining Medicaid eligibility. Thus, revocable trusts are of no use in Medicaid planning.

The funds in most irrevocable trusts are counted as available to the applicant for Medicaid if the trust was created by the applicant or his or her spouse. The funds in most trusts created and funded by someone else are not considered available. However, there are some exceptions to these general rules. For instance, Medicaid does not count the principal of an "irrevocable, income-only" trust as a resource, even if created by the Medicaid applicant or his or her spouse, provided the trustee cannot pay principal to or for the benefit of the nursing home resident or his or her spouse. That is, only the income from the trust is payable.

Another exception to the general rules, in the case of a trust created by someone other than the nursing home resident or his or her spouse, is when the trust document obligates the trustee to make distributions of trust property. In such a case, the trust funds will be considered available to the extent of such obligation.

---

## Testamentary Trusts

Testamentary trusts are trusts created under a will. The Medicaid rules provide a special “safe harbor” for testamentary trusts created by a deceased spouse for the benefit of a surviving spouse. Unlike a trust created during life for a spouse, the assets of these trusts are treated as available to the Medicaid applicant only to the extent that the trustee has an obligation to pay for the applicant’s support. If payments are solely at the trustee’s discretion, they are considered unavailable to the Medicaid applicant. While totally illogical, if one spouse creates a trust during his life for his spouse, the funds will be considered available should the wife apply for Medicaid benefits. On the other hand, should the first spouse create the same trust with the same funds, but through his will, the funds will be considered unavailable.

Therefore, these trusts can allow a healthy spouse living in the community (a “community spouse”) to leave funds for their surviving institutionalized husband or wife that can be used to pay for services that are not covered by Medicaid. These may include extra therapy, special equipment, evaluation by medical specialists or others, legal fees, visits by family members, or transfers to another nursing home if that becomes necessary.

---

## Safe Harbor Trusts

The Medicaid rules provide for three “safe harbor” trusts that are exceptions to the general trust rules. The first, referred to as a “(d)(4)

(A)” or “pay-back” trust, must be created by a parent, grandparent, guardian or court for the benefit of a disabled individual under age 65. It may be funded with the disabled individual’s own funds, and the trust property will not be considered available in determining the disabled individual’s eligibility for Medicaid benefits as long as the trust provides that at the beneficiary’s death the state will be reimbursed out of any remaining trust funds for Medicaid benefits paid on behalf of the beneficiary during his or her life.

The second safe harbor trust, often referred to as a “(d)(4)(B)”, “Miller” or “Income” trust, permits nursing home residents in states with an “income cap” to shelter excess income and still qualify for Medicaid benefits.

The third safe harbor, often referred to as a “(d)(4)(C)” or “pooled” trust, is similar to a (d)(4)(A) trust. The differences are as follows: (1) The trust must be administered by a not-for-profit corporation for the benefit of more than one beneficiary, though it can set up separate accounts for each beneficiary; (2) The disabled individual himself or herself may fund the trust, as well as his or her parent, grandparent or guardian, or a court; (3) An alternative to reimbursing the state for Medicaid expenditures made on the beneficiary’s behalf upon his or her death is to have the funds remain in the trust for the benefit of its other beneficiaries.

## Estate Recovery

The rules described above limit who may receive Medicaid coverage of nursing home care. But they are not the whole story. Once someone receives Medicaid benefits, whether for nursing home care or for any other health care cost after the age of 55, the state will seek reimbursement from his or her estate after death. However, no recovery can take place until the death of the recipient’s spouse, or as long as there is a child of the deceased who is under 21 or who is blind or disabled. (How this deferral of estate recovery works in practice depends on the state in question.)

In most cases, Medicaid beneficiaries do not have any estate to speak of; otherwise they would not have been eligible for Medicaid in the first place. However, in many states, Medicaid beneficiaries can keep their homes. They also could inherit money unexpectedly (or through poor planning) or be the beneficiary of a personal injury claim, leading them to have money at the end of their life despite being impoverished before then.

In those cases, whether the state will successfully recover against the Medicaid beneficiary's estate depends on how the property is held and on the particular state's laws. All states seek recovery against the probate estate of the deceased Medicaid beneficiary. Some also seek recovery against non-probate property in which the deceased had an interest, such as jointly-held real estate, life insurance and trust property (see our separate Guide on The Probate Process for a discussion of the difference between the probate and non-probate estate). With proper planning, most individuals can avoid recovery against their estates.

Medicaid liens are often confused with estate recovery. While estate recovery only occurs at death, typically if the Medicaid beneficiary is permitted to keep his or her home the state will place a lien on it to be paid back if the house is sold while the beneficiary is alive. Exceptions to the lien exist, substantially paralleling the exceptions to the transfer penalty for giving away the home. Thus, no lien may be applied if a spouse, disabled or minor child, or caretaker child is living there. People often confuse these exceptions as protecting the house from estate recovery as well. They do not. To assume they will can be a costly error. While there is a deferral of estate recovery during the life of a surviving spouse or until a minor child reaches age 21, as described above, this only delays the estate recovery. States, however, are supposed to waive estate recovery in the case of "hardship," which they are free to define.

---

To find a qualified elder law attorney, go to [elderlawanswers.com](http://elderlawanswers.com).