

MEDICAID IS A “NEEDS BASED” PROGRAM

UNDERSTAND THAT A FOUR PART TEST IS THE KEY TO ELIGIBILITY

For explanation purposes, we like to explain to clients and their families that there is a four-part test for Medicaid eligibility. This may help you to remember and to understand each piece of the eligibility puzzle.

Part 1. Medical Need

This part of the test is met by any individual who is 65 or older who is in need of health related care services. This is done by completing a CARE (Client Assessment and Referral Evaluation) either immediately prior to or soon after nursing facility admission.

Beginning in 1995, it has been necessary for every individual entering a Nursing Facility that is a Medicaid Qualified Facility to complete a CARE assessment. CARE stands for Client Assessment, Referral and Evaluation. In Kansas, there are eleven Area Agencies on Aging that act as the single port of entry into the Kansas long-term care system. A Level I assessment is a pre-admission and complies with the federal requirement for Pre-Admission Screening and Resident Review (PASRR). A Level II assessment pertains to mental health and is not discussed further in this document.

According to the CARE Annual Report for 2005 published by the Kansas Department on Aging, from July 1, 2004 through June 30, 2005, a total of 12,990 persons were given Level I Assessments. 11% of these individuals were under the age of 65 and 40% were over age 85. 62% of these assessments were completed in hospitals. 3% of all Kansas over the age of 65 received an assessment. These CARE (Level I) assessments measure the individual's functional ability to complete Activities of Daily Living (ADL's) and Instrumental Activities of Daily Living (IADL's). Over 80% of those assessed needed assistance with all of the activities of daily living, with the exception of eating, however, 53% needed assistance in this activity. Over 88% of those assessed needed assistance with all of the IADL's with the exception of telephone use, however 61% needed assistance with the telephone.

Activities of Daily Living are considered to be the following: (ADL's) Bathing, dressing, walking, transfer, toileting, and eating.

Instrumental Activities of Daily Living are considered to be the following: (IADL's) Shopping, laundry/housekeeping, meal preparation, transportation, management of medications, money management, and telephone use.

Certainly, most individuals would rather remain in their own homes if possible. Further, the state and insurers have recognized that the cost of providing some

assistance to the individual which allows him or her to remain at home is often less expensive than the cost of full time nursing facility care. The Senior Care Act as adopted in Kansas in 1992, in part, was intended to provide in home assistance to low and moderate income individuals based upon a sliding scale for payment based upon income. The types of services and assistance, if provided, which might allow a person to remain in his or her own home rather than enter a nursing facility are recognized as: bathing, dressing, personal hygiene and toileting assistance, homemaker services such as monitoring and administering medication and respite care. Sometimes these are referred to as Activities of Daily Living. For more information on this, please contact your Area Agency on Aging or SRS.

What we are discussing here is eligibility for assistance when an individual needs assistance that can only be provided, cost effectively, in a nursing home. The CARE Assessment results in a determination of the need for care and the level of that care, in particular by determining what assistance is needed with what are deemed to be essential Activities of Daily living (ADLs). For the most part, to be eligible, an individual must:

- require a treatment plan involving the administration of services which require skills of licensed technical or professional personnel that are provided directly or under the supervision of such personnel and are prescribed by the physician;
- have a physical impairment or combination of physical and mental impairments;
- require professional nursing supervision (medication, hygiene and dietary assistance);
- lack the ability to care for self or communicate needs to others; and
- require medical care and treatment in a nursing facility to minimize physical health regression and deterioration.

Although the “Need” test is a necessary part of the test, it is performed by medical professionals, typically Doctors and Registered Nurses.

Part 2. The Income Test

a. For a single individual (not married)

Some states have specific income levels, over which a person will not be eligible for assistance even if that level of income will not pay the cost of Nursing Home care. In Kansas, however, an individual who is 65 or older, and who has a medical assistance need as defined above, qualifies under the income test as follows:

The individual may retain \$60 as a monthly personal needs allowance and the balance of the individual’s income, if any is applied towards the cost of the nursing home. Medicaid, through SRS, pays the rest. In essence, if the cost of monthly care exceeds the amount of monthly

income the amount of income the individual has which is over and above the personal needs allowance, then this part of the test has been met. (In the event that an unmarried individual has dependents, there is some ability to divert income for the support and shelter of the dependents.)

b. For a married individual

Income is allocated between both spouses as follows:
For eligibility purposes, the husband's income is his, the wife's income is hers, and joint income is divided and allocated one half to each. However, for eligibility purposes all income is reported. The amount of income and how it affects eligibility for the spouse who needs assistance is the same as for a single person. The spouse needing assistance (the institutionalized spouse) is allowed \$60 per month as a personal needs allowance. The remainder of that spouse's income is applied as follows:

After that initial \$60 for personal needs, the balance goes to the spouse who does not need assistance (community spouse), from a minimum of \$1,750.00 up to a monthly maximum amount of \$2,610.00 in circumstances in which the cost of housing warrants a greater amount under the guidelines and regulations. If there is any remaining income over and above this amount allowed to the community spouse, it is applied towards the cost of care. If the cost of care is greater than the excess income, Medicaid through SRS pays the rest.

Part 3. The Resource Test

a. For a single individual

The value of all available non-exempt resources must be determined. In order to be eligible for Medicaid, the individual must have available non-exempt resources of \$2,000 or less. What are "exempt" resources, or in other words, what doesn't have to be counted as an available resource?

- The home the person lives in or intends to return to and its contents (furniture and household goods);
- One car, as long as it is used at least four times a year to get medical treatment or prescriptions;
- Clothing;
- Cash surrender value of life insurance policies up to a maximum amount of \$1,500;
- Designated accounts for burial up to a maximum of \$1,500;
- Burial spaces;
- Irrevocable burial contracts or life insurance policies designated for funeral expenses up to \$7,500 plus accrued interest;

- Property, both real and personal used in the individual's trade or business;
- Income producing property which is valued at \$6,000 or less and which produces income at the rate of 6% or greater.

Without other planning, all available non-exempt resources must be spent down to the \$2,000 threshold in order for the individual to become eligible for Medicaid under the resource portion of the eligibility test.

b. Eligibility for a married individual

The resource portion of the eligibility test for a married person is slightly more complicated. In this situation the way the system works is to follow a devised plan that will allow the spouse who needs assistance (institutionalized spouse) to become impoverished (meaning that he or she has available non-exempt resources of \$2,000 or less) while, at the same time, not causing the community spouse to likewise become impoverished.

To start with, when determining the Medicaid eligibility of the spouse who needs assistance, the value of all available non-exempt resources of both spouses are added together as if they are in a common pot. It doesn't matter whether or not the property is owned individually or in both names. Clients and their families need to understand that available resources that are in the name of the spouse who doesn't need assistance (community spouse) are taken into consideration. (An exception is that Qualified Retirement Plan benefits-401k's and IRA's of the community spouse do not have to be counted.)

DIVISION OF RESOURCES

(This is a process that is done when one spouse needs to become eligible for assistance and one spouse will remain in the home or community.)

Many individuals have a great misconception when it comes to understanding a division of resources between spouses. It is not uncommon to have clients who believe it is as simple as dividing the available non-exempt resources 50/50, between the two spouses. Most clients and their families have heard about a "division of resources," but don't understand the rules imposed by the "system." The eligibility rules work as follows:

If the couple has a very limited amount of available resources, after determining what one-half of those resources would be, if that amount is less than \$20,880, then the community spouse is allowed all of the available non-exempt resources up to a maximum of \$20,880. The remainder, if any, is allocated to the institutionalized spouse and must be spent down to the \$2,000 eligibility threshold.

If half of the available resources are greater than \$20,880, but no greater than \$104,400, then the available resources are divided 50/50. Again, the institutionalized spouse must spend down to the \$2,000 threshold with the resources that are allocated to him or her through this process. However, in the event that one half of the available non-exempt resources would be greater than \$104,400, then all resources over and above the \$104,400 allocated to the community spouse would be allocated to the institutionalized spouse and subject to the spend-down requirements.

A couple can increase the resources allocated to the community spouse by making use of the administrative hearing process. SRS can be asked to assess the income and resources of the couple for eligibility purposes. If dissatisfied with the resources allocation, either spouse can ask for a hearing at which the resource allocation can be raised so that enough income can be generated to bring the community spouse's income up to the maximum of \$2,610.00 per month.

In the event that both spouses need assistance, eligibility is determined for each on an individual basis.

Part 4. Fourth Part of eligibility test-Gifts and Transfers for less than full consideration. (This is sometimes referred to as the "transfer test.")

THIS IS WHERE THE MOST DRASTIC CHANGES REGARDING ELIGIBILITY HAVE BEEN MADE!

Certain transfers or gifts of property can incur a penalty that will affect eligibility for Medicaid purposes. Does this mean that gifts cannot be made by an individual who may need Medicaid assistance in the future? The answer is no, however, within certain guidelines, a person cannot give away assets "for the purpose of becoming eligible for Medicaid." An outright transfer or gift by the individual or on the individual's behalf within five years of the date of application for eligibility is presumed to have been made for the purpose of becoming eligible for benefits, and this will cause the individual to become ineligible for benefits for a specific period of time depending upon the value of what was transferred. Transfers for full value (sale for adequate consideration) do not affect eligibility.

THE "LOOK BACK' PERIOD

Under previous law, when an individual applied for Medicaid, three years of all financial records of the Medicaid applicant had to be provided to Medicaid. This included all financial transactions and assets owned at any time during the three year period prior to applying for benefits. The look-back period for transfers to trusts was 60 months. That is, all transfers to trusts within the previous 60 months were required to be disclosed. The new law requires all applicants provide five years of financial records regardless of whether it was transferred to a trust or otherwise.

For those individuals who made transfers before the effective date of the new law and expected the look-back to be 36 months, the rules have not changed. The new law “look-back period” is only for transfers after the effective date of the new act.

TRANSFER PENALTY PERIOD

The most comprehensive change under the law is the change in what has come to be known as the transfer penalty. Under the previous law, an individual who gave away assets for no consideration (a gift) was considered an “uncompensated transfer.” Simply put, the individual gave away something for which he or she did not receive a value in return. That would be considered a “value for value” transfer. If a “value for value” transfer is made, if the value received is appropriate and sufficient (fair market value), then there is not uncompensated transfer and no transfer penalty.

The transfer penalty period (for Kansans) is based upon the total uncompensated value divided by the factor of \$4,000.00. NOW, (for transfers made after the effective date of the new act, the penalty period does not begin to run until the Medicaid Applicant is residing in a nursing home and depletes his or her assets to the qualifying level (\$2,000). Assume an individual made an uncompensated transfer of assets of \$40,000 on August 1 of 2007. The individual entered a nursing home on October 1 of 2008 and paid his or her own way until September 1 of 2009 at which time his or her amount of available resources is under \$2,000. If the individual applies for assistance he or she will not be eligible for assistance until the transfer penalty period of ten months runs. Therefore, the individual would not be eligible for assistance under the Medicaid program until July 1, 2010.

(All gifts given during a year are added together) “ROUNDING DOWN” NO LONGER POSSIBLE FOR MULTIPLE GIFTS

Under the old rules, a person could give away \$2,999 in consecutive months and not incur any penalty period, even if this were done for multiple months. Since the old period of ineligibility was figured by dividing the amount or value transferred by \$3,000, no period of ineligibility was possible. The new law requires that all transfers that constitute less than one-month’s penalty over any twelve month period must be aggregated, thereby eliminating the ability to “round down.”

GIFT TAX RULES ARE DIFFERENT FROM MEDICAID ELIGIBILITY RULES

Many people are confused by the Federal Estate and Gift Tax rules and how they impact gifts that can be made by an individual contemplating Medicaid eligibility. Many of our

clients believe that they can make a transfer of up to \$12,000 per person. This is the line Congress has drawn for the purpose of record keeping and tax implications. For gift tax purposes any person can give up to \$12,000 each to any multiple of individuals on a calendar basis and there is no tax consequence to the giver or the recipient. However, this is for gift tax purposes and *has nothing to do with the eligibility rules for Medicaid*. Therefore the controlling rule when contemplating Medicaid eligibility is that if transfers or gifts (when added together) exceed more than \$3,000, eligibility will be affected. What if over a period of months more a total of more than \$12,000 is transferred to one individual? For Gift Tax purposes, this results in a reduction of the lifetime unified credit or exemption against gift taxes-currently \$1,000,000. It does not affect Medicaid eligibility. Sometimes it is necessary to file a gift tax return showing the use of the unified credit or exemption against estate and gift taxes. However, no federal gift tax is ever owed in this situation unless you give away the entire unified credit or exemption of \$1,000,000.

PLANNING NOTE: Certain transfers may cause periods of ineligibility which could have been avoided had the individual been aware of the consequences. For example, a disclaimer of an inheritance or failing to exercise a spousal election for what Kansas law says is available to a surviving spouse can be considered transfers that trigger a period of ineligibility. In many situations, a simple cure is to transfer back to the individual the asset or assets the transfer of which would otherwise cause a period of ineligibility.

THE ESTATE RECOVERY UNIT (ERU):

The State of Kansas, through the Estate Recovery Unit of the Department of SRS has the right and ability to recover for benefits paid from the property or estate of the individual who became eligible and received the benefits.

Estate recovery is a Medicaid collection program that allows the government to recover funds that were paid out as Medicaid benefits. The collection is taken from property the Medicaid recipient owned prior to death. The federal basis for the Estate Recovery Program is found at 42 U.S.C. 1396p (Section 1917 of the Social Security Act). Generally, within certain restrictions, the states are allowed to conduct recoveries through liens imposed on the homes of Medicaid recipients while they are alive or through actions taken against property owned at death or both. The claim can only be established for Medicaid costs on recipients who, prior to their death, were 55 years of age or older, or who were an inpatient in a long term care facility regardless of age. The claim will not be established if the recipient has a surviving spouse or surviving children who are under the age of 21, or who are blind or permanently disabled. Within these general federal guidelines, each state is allowed to fashion its own recovery program.

Kansas implemented Estate Recovery in 1992 with an effective date of July 1, 1992. The Kansas Department of Social and Rehabilitation Services (SRS) can recover from pay-on-death accounts owned by a Medicaid recipient upon their death. See K.S.A. 9-1215, 9-1216, 17-2263, 17-2264, 17-5828, and 17-5829. SRS can assert claims, within certain

limitations, on a recipient's decedent estate, a recipient's spouse's estate, a recipient's conservatorship estate or on property transferred away by a recipient while on assistance. See K.S.A. 39-709(g)(2).

Since the initial passage of the Estate Recovery Program in Kansas in 1992, certain statutory provisions have augmented the program. In 1993, funds in personal needs accounts held by nursing homes were made available for recovery. See K.A.R. 30-10-11(h). In 1997, SRS's ability to file a claim against guardianship or conservatorship assets was clarified by amendments to K.S.A. 59-3026. SRS has also been granted the authority to file claims against real estate subject to transfer-on-death deeds (K.S.A. 59-3501) and recover excess funds in irrevocable pre-arranged funeral plans owned by the Medicaid recipient (K.S.A. 16-301 et seq).

During the five-year period from 2001 to 2005, the Kansas SRS Estate Recovery Unit collected over \$26 million. Since Medicaid is jointly funded by federal and state money, the collections are split between the federal and state governments. Based upon Kansas' financial participation in Medicaid, approximately 40% or \$10.4 million has been retained by Kansas over the past five years.

FIRST CLASS CLAIM

When made in the context of probate, the Medicaid claim is a first class claim against the decedent's estate. The claim is junior to reasonable funeral expenses, but is higher than all other creditors' claims. For Medicaid received on or prior to June 30, 2004, the Estate Recovery Unit (ERU) can make a claim only against property owned solely by the Medicaid recipient. However, for any Medicaid payments provided after June 30, 2004, the ERU may establish a claim on any property *interest* owned by the deceased recipient. This includes all real and personal property in which the decedent had any legal title or interest immediately before or at the time of death. Therefore, claims can be made against assets conveyed through joint tenancy, tenancy-in-common, survivorship, transfer-on-death deed, pay-on death contract, life estate, trust, annuity, life insurance policy or similar arrangement. The claim is limited to the deceased recipient's interest in the property.

MEDICAID LIENS

In situations where a Medicaid recipient has received inpatient care from a nursing home or other medical institution and is not reasonably expected to return home, the Estate Recovery Unit may impose a lien on the recipient's real property. The lien is only imposed if the person received funded care in a Medicaid approved facility for at least 6 months and payments are being made directly to the nursing facility. Prior to initiating the lien process, the ERU shall obtain a written statement from the individual's attending physician attesting to the expectation of the individual's return home.

If the individual is not reasonably expected to return home, the Estate Recovery Unit will send a notice to the individual or their representative of ERU's intention to impose a lien on the recipient's real property. The notice will advise the recipient of his or her right to request an administrative hearing.

To impose a lien, the Estate Recovery Unit will file a written lien with the Register of Deeds in the county where the property is located. A lien may not be imposed on the home of the recipient, or later enforced upon the death of the recipient, if any of the following individuals reside in the home:

- Spouse of the recipient;
- Recipient's child who is under 21 years of age, blind, or permanently disabled or who has provided care to the recipient, allowing him or her to remain in the home and defer entry into a nursing facility for at least 2 years;
- Recipient's sibling who has an equity interest in the home and who has continuously resided in the home for at least 1 year immediately prior to the recipient's admission into a long term care facility.

The ERU may foreclose on a Medicaid lien by filing an action in the Kansas district court in the county where the property is located. The action may be filed as a civil action or after death as part of a probate proceeding.

PROCEDURE FOR RECOVERY

Upon notification of a recipient's death, the Estate Recovery Unit will assess the situation and make a determination as to whether or not to proceed with the recovery action. The ERU will look to see if any persons remain in the home that would restrict enforcement of the claim. If the claim can be enforced, ERU will evaluate the potential size of the estate and the amount of paid medical assistance claims to determine if it is cost effective to bring a probate action. The action taken could include an agreement with the heirs, making claims against financial accounts, or filing a probate action. Because state law permits family members of a decedent to alter any prearranged funeral or burial agreements at the time of need, they are subject to estate recovery. If a less expensive arrangement results and money is leftover, the excess funds must be turned over to the Estate Recovery Unit if the decedent was a Medicaid recipient or was the spouse of a former recipient.

In addition to excess funeral funds, balances remaining in personal need accounts held at nursing facilities must be turned over to the ERU. Funds remaining in bank, savings and loan, and credit union accounts are also available for recovery. If there is no valid Medicaid claim or estate recovery is not applicable, any remaining funds in these accounts are returned to the family.

VOIDABLE TRANSFERS

Transfers of property by Medicaid recipients subject to estate recovery provisions can be voided by the ERU. By voiding the transfer, ownership is returned to the Medicaid recipient. This applies to any transfer made while receiving Medicaid, including prior transfers if Medicaid was retroactively applied during the period in which the transfer occurred. Any partial or total transfer of property may be considered, including transfers of exempted property. Transfers of real property, which equal or exceed \$5,000 and transfers of personal property of \$500 or more are reachable by ERU.

MEDICAID ELIGIBILITY AND TRUSTS

Kansas Trust Law Changes in the Context of Medicaid Eligibility

Kansas Supreme Court cases of recent years that address Medicaid eligibility and the administration of the Medicaid program by the Kansas State Department of Social and Rehabilitation Services affirm a consensus position that Medicaid, as a “welfare” or “needs-based” program is to be last resort-to be used only when the individual has no other available resources. In furtherance of this position, special provisions have now been made in the law (through changes to K.S.A. Chapter 39) to put the State of Kansas in a position as a “super” creditor or “exception” creditor when it comes trust beneficiaries who have a need to become Medicaid eligible. It would not, however, be appropriate to say that most of these planning issues don’t or won’t remain a concern for Kansas practitioners.

K.S.A. CHAPTER 39 – MENTALLY ILL, INCAPACITATED AND DEPENDENT PERSONS; SOCIAL WELFARE

K.S.A. 39-709. Eligibility requirements of applicants for and recipients of assistance, available resources; failure to comply with reporting and other requirements, penalties; automatic assignment of support rights; “medical assistance estate” defined; lien procedures and enforcement.

39-709 (e) *Requirements for medical assistance for which federal moneys or state moneys or both are expended.*

- (1) Resources from trusts shall be considered when determining the eligibility of a trust beneficiary for medical assistance. Medical assistance is to be secondary to all resources, including trusts that may be available to an applicant or recipient of medical assistance. *If a trust has discretionary language, the trust shall be considered to be an available resource to the extent, using the full extent of discretion, the trustee may make of any of the income or principal available to the applicant or recipient of medical assistance.* Any such discretionary trust shall be considered an available resource unless:

- (a) The trust is funded exclusively from resources of a person who, at the time of the creation of the trust, owed no duty of support to the applicant or recipient; and
- (b) The trust contains specific contemporaneous language that states intent that the trust is supplemental to public assistance and the trust makes reference to Medicaid, medical assistance or title XIX of the social security act.

CONCLUSION

In order to properly assess any situation and plan accordingly, it is necessary to obtain or create a financial statement reflecting all assets, their values and how they are titled. For those items that have beneficiary designations, we need to verify how those beneficiary designations have been made. We also need information on all income sources, earned and unearned. We typically ask for a copy of the last two years income tax returns. It is important that we verify how the home is titled. The more information we have, the better job we will be able to do in planning for the maximum use, benefit and protection of assets in the event of the need to become eligible for Medicaid assistance, which has certainly been limited under the terms of the new law adopted in 2006.

At Tim J. Larson, JD, PA, we provide assistance in understanding Medicaid. If you or someone you know is interested, please have them contact us at 316-729-0100.