Paying for Long-Term Care: An Overview of Medical Assistance

Prepared by the Elder Law Team at:

MASER | AMUNDSON | BOGGIO | HENDRICKS P.A.

Your rock in a hard place

July 2018

THE NUMBERS REFERENCED IN THIS BOOKLET CHANGE IN JANUARY AND JULY OF EACH YEAR.

WE RECOMMEND YOU MEET WITH AN ELDER LAW ATTORNEY TO DISCUSS THE PARTICULARS OF YOUR SITUATION. RECOMMENDATIONS ARE BASED ON INDIVIDUAL CIRCUMSTANCES. THIS PAMPHLET IS FOR INFORMATIONAL PURPOSES AND IS NOT LEGAL ADVICE.

Table of Contents

Introduction

Families confronting the decisions around caring for an elder loved one are faced with daunting emotional, physical and financial challenges. For many, these concerns are confusing and overwhelmingly difficult. This booklet was prepared to relieve some of the common fears associated with financing the care of a person with a chronic illness or disability.

This publication focuses on Medical Assistance as a payor for long-term care services: who is eligible; how to apply; what happens to the community spouse; and what may happen after death.

Please be aware that this material is presented for informational purposes only and is not intended as legal advice. You should seek the advice of qualified professionals (elder law attorney, financial advisor, tax professional) before implementing any long-term care plan.

Long-term care includes medical and non-medical care. Long-term care services help meet the health and personal needs of people who have a chronic illness or disability. Long-term care services also assist people with activities of daily living such as dressing, grooming, bathing, transferring and using the bathroom.

Long-term care services may be provided at home, in an assisted living facility, residential care home or in a nursing facility.

People frequently ask “Doesn’t Medicare pay for long-term care?” The short answer is NO. ***Medicare*** is health insurance for people over 65, people who are blind or disabled or people with ALS or end stage renal disease. Generally, Medicare does not pay for long-term care expenses. Medicare may pay for long-term care up to 100 days, but only if the long-term care stay was preceded by a three-day hospital stay in which the patient was admitted (not on observation status). The federal ***Medicaid*** program, known as Medical Assistance in Minnesota, is long-term health coverage for those who meet certain criteria.

Long-term care is expensive. Whether you or your family member receives long-term care in the home, in an assisted living or in a nursing facility, the monthly bills can run from a few hundred dollars for a few hours of care to $10,000 or more for around-the-clock care.

Families pay for long-term care services through one or more of the following methods:

- Private assets
- Fixed income & investments
- Long-term care insurance
- Medical Assistance
- Veterans Benefits

This pamphlet will focus on the Medical Assistance program.

Medical Assistance Overview

Medical Assistance (MA) is Minnesota's Medicaid program. Medicaid was established under Title XIX of the Social Security Act in 1965 to help provide medical coverage to qualified needy persons. MA is governed by both federal and state law and is funded by both the state and federal governments. The Minnesota Department of Human Services oversees the program statewide. Each Minnesota County administers the program for its residents. The federal Centers for Medicare and Medicaid Services oversee the Medicaid program nationally.

In order to qualify for MA, a person must meet specific criteria. The rules governing qualification for MA are complex and change frequently.

Medical Assistance for Long-Term Care vs. Waivered Programs

Medical Assistance for Long-Term Care provides payment for long-term care services in nursing facilities for qualifying individuals.

Home and community-based waiver programs provide a range of services to individuals who reside in the community (i.e. in their own home, in assisted living, or in a group home) and who without the waivered services may need to be institutionalized. The purpose of the Waivered Programs is to promote community living and independence with services and supports individualized to meet the needs of each recipient.

The Elderly Waiver Program (EW) is designed to help individuals who are 65 years of age or older, who live in the community, and who require the level of care provided in a nursing facility. In addition to EW, Minnesota has implemented other waiver programs to provide services to a range of ages, disabilities and conditions.

Medical Assistance
Eligibility Criteria

The three basic criteria for MA eligibility are as follows:

- You must be a Minnesota resident;
- You must meet a categorical basis of eligibility, i.e. be over age 65, blind or disabled; and
- You must meet financial eligibility requirements.

In order to be eligible for the Elderly Waiver Program, the following additional criteria must also be met:

- Have a MNChoices Assessment with a county social worker or nurse;
- Be determined to require a nursing facility level of care;
- Be able to remain safely in the community rather than a nursing facility;
- Choose to remain in the community; and
- Be able to receive services in the community at a cost that is less than a nursing facility.

Asset Rules

A MA applicant is allowed $3,000 or less in available assets. If both individuals of a married couple apply for MA, they are each allowed $3,000 or less in available assets. Spousal impoverishment rules (discussed below) apply to a married applicant with a community spouse.

Available Assets

Under the MA program guidelines, assets are available to pay for long-term care if the asset has monetary value and is not otherwise excluded or unavailable. These assets include, but are not limited to:

- Cash
- Stock
- Savings Accounts
- Checking Accounts
- Cash surrender value of life insurance policies
- Contracts for Deeds
- Mortgage Deeds
- Certificates of Deposit
- Bonds
- Most Trusts
- Qualified Contributions such as IRAs or 401Ks
- Investments in precious metals, gems, art
- Cash value of Annuities

Excluded (Exempt) Assets

An excluded (exempt) asset is not required to be used to pay for long-term care. Excluded (exempt) assets include:

- *The Homestead*. The homestead is defined as an individual's primary place of residence. For a MA recipient, the homestead is excluded for the longer of the following:
    - The first six months of the MA recipient's residence in a long-term care facility; or
    - For as long as the MA recipient intends to return home and can reasonably be expected to return home, as certified by the MA recipient's physician; or
    - For as long as the homestead remains the residence of the MA recipient's spouse, child under age 21, child of any age who is blind or permanently and totally disabled, sibling with an equity interest in the home who resided in the home at least 1 year immediately before the MA recipient's date of institutionalization, or child or grandchild who provided 2 years of verifiable care and lived in the home for 2 years immediately prior to institutionalization.
- *Household and Personal Goods*
- *One Vehicle (any value)*
- *Properly Structured Prepaid Funerals*
- *Certain Specialized Trusts*

Unavailable Assets

Unavailable assets may at some time convert to available assets, for example when real property sells. Unavailable assets include:

- *Jointly Owned Real Estate with Someone Other Than a Spouse*
- *Assets of an Unprobated Estate*
- *Real Property for Sale*
- *Life Estates*

Asset Allocation to Spouses

The community spouse is allowed to keep up to a maximum of $123,600 in available assets, plus any excluded or unavailable assets. This figure is for the year 2018 and is adjusted annually each January for cost of living. Assets may be transferred to the community spouse at any time to bring the community spouse up to the allowable amount of assets.

Available assets in excess of the maximum amount must be appropriately reduced before either spouse will qualify financially for MA.

Income Rules

The MA recipient is allowed to keep $99 from his/her income per month as a personal needs allowance. This amount is adjusted annually.

The community spouse is entitled to a minimum monthly income allowance of at least $2,058, up to a maximum of $3,090. These numbers are also adjusted annually. The exact amount of the community spouse income allowance is determined by his or her shelter expenses (i.e. rent, mortgage, utilities, insurance, taxes). If the community spouse's own income is less than his or her specifically determined monthly income allowance, then he or she will be allowed to retain a portion of the MA recipient's income.

Important: If the MA recipient's and community spouse's combined income total less than the community spouse's monthly income allowance, then additional income-producing assets may be allocated to the community spouse above the community spouse asset allocation.

Gifting Rules:
i.e. The Difficulty with Being Generous

A MA applicant and spouse must report all gifts and transfers for less than fair market value within a period of 60 months (five years), sometimes called the “lookback period”, prior to the date of MA application. Any gift or transfer for less than fair market value may generate a period of ineligibility for MA benefits (there are just few exceptions to this rule). The ineligibility period does not begin to run until the individual is otherwise eligible for MA and submits an application.

Gifts made 61 months or more prior to the date of application for MA do not have to be reported and will not cause a period of ineligibility for MA.

If gifts or transfers were made within 60 months of application, the ineligibility period is calculated as follows:

<u>Calculation of Ineligibility Period</u>.

Transfer amount ÷ SAPSNF = # of months of ineligibility

The SAPSNF is the Statewide Average Monthly Payment for Skilled Nursing Facility Care. As of the date of publication, this amount is $7,288. This figure changes annually in July.

Examples:

Betty transferred her house to her son in 2015. The house was worth $180,000 at the time of transfer. If Betty applies for MA within 60 months of making this transfer, her period of ineligibility will be 24.70 months, or 2.06 years.

$180,000 ÷ $7,288 = 24.70 months

Let's say, in addition to transferring her house to her son in 2015, Betty also transferred ownership of her life insurance policy with a cash value of $10,000 to her son and transferred a CD worth $15,000. Now Betty's period of ineligibility will be 28.13 months, or 2.34 years.

$180,000 + $10,000 + $15,000 = $205,000
$205,000 ÷ $7,288 = 28.13 months

If Betty applies for MA within 60 months of making these transfers, the 28.13 month period of ineligibility begins to run in the month of application for MA benefits. The period of ineligibility does <u>not</u> begin at the time the gift is made.

Estate Recovery

Upon the death of the MA recipient or if the MA recipient is married at the time of death, upon the death of the surviving spouse, county agencies may make a claim against the estate of the MA recipient or the recipient's spouse for the amount of MA paid during the MA recipient's lifetime.

Claims Against Real Estate

County agencies may file a lien against non-homestead real estate owned by a MA recipient on or after the time benefits are received. County agencies may make a claim against the homestead of the community spouse of a MA recipient after the community spouse dies.

Estate recovery is complex and in more recent years, estate recovery law has become more strict and farther reaching when it comes to the state's ability to recover assets from a MA recipient or surviving spouse's estate.

We recommend that you meet with an elder law attorney if you are handling an estate administration that contains an estate recovery claim for MA benefits.

NOTES:

MASER | AMUNDSON | BOGGIO | HENDRICKS P.A.

Your rock in a hard place

6601 Lyndale Avenue South
Suite 320
Richfield, MN 55423
952-925-4147

www.maserlaw.com

Updated July 2018