

## Chapter 4

# Medicaid

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### SYNOPSIS

- 4-1. Medicaid
  - 4-2. Long-Term Care
  - 4-3. New Medicaid Regulations Within the Deficit Reduction Act of 2005
  - 4-4. Medicaid Payment for Medicare Premiums, Deductibles, and Co-Payments
  - 4-5. Glossary
  - 4-6. Resources
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The purpose of this chapter is to clarify important information you need to know about Medicaid. It will answer your questions about eligibility requirements and enrollment processes.

### 4-1. Medicaid

Medicaid is a federal-state medical assistance program for low-income recipients of public benefit programs. Medicaid provides more complete coverage than does Medicare, without significant payments from the beneficiaries. Only low-income persons with limited resources who are elderly, blind, disabled, or are low-income families can receive Medicaid.

#### Who Receives Medicaid?

Medicaid was created as an add-on health benefit to two welfare programs: Supplemental Security Income (SSI) and Aid to Families with Dependent Children (AFDC). AFDC was replaced by the Temporary Assistance for Needy Families (TANF) program. Recipients of either SSI or TANF, or those who would qualify for AFDC if it still existed, are eligible for Medicaid, as are Old Age Pension (OAP) recipients who are disabled or more

than 64 years of age. People who would continue to receive those benefits except for earned income or cost of living increases often continue to receive Medicaid. Women with breast or cervical cancer may also qualify if they lack health insurance.

The eligibility rules for elderly or disabled people generally use the SSI income and resource rules. Total resources (bank accounts, property, etc.) may not exceed \$2,000 for an individual, or \$3,000 for a married couple. Some property does not count as a resource, like your residence, your car, some funeral items or plans, wedding jewelry, and life insurance with a cash value of \$1,500 or less. For long-term care (see section 4-2, below), the income cap is three times the SSI payment standard for one, or \$2,022 per month for 2009. For additional income and resource rules for couples, see "Spousal Protection" in section 4-2, below.

There are many additional eligibility rules, including citizenship requirements, special requirements for long-term care, and severe transfer restrictions (see "Estate Planning" in section 4-2, below).

## What Services Are Covered?

In Colorado, Medicaid covers most necessary services, including hospital, nursing home, physician, prescriptions, medical supplies and equipment, skilled home care (nurse or Certified Nursing Assistant required), and assistance with transportation. In addition, non-skilled or personal in-home services are provided by Home and Community Based Services (HCBS) programs for specific groups such as the elderly and people with developmental disabilities, mental illnesses, AIDS, or other chronic disabilities.

While there is a co-payment for some services (\$.50 to \$10 or more in Colorado), Medicaid generally pays the entire charge approved by the Medicaid program. Additionally, most nursing home recipients must pay all but \$50 per month of their income toward their care. Medicaid is the payor of last resort, so other insurance, including Medicare, must pay first.

## How to Apply for Medicaid

Apply for Medicaid at your county Department of Social or Human Services. If you are receiving SSI, bring your SSI award letter. If you are eligible for SSI but are not receiving it, first go to your local Social Security office to apply for SSI. You can apply for OAP and Medicaid at the county Department of Social Services at the same time. Nursing home residents apply in the county in which the nursing home is located.

You will need to be able to verify income, resources, age, and disability, if any. You should bring the following documents with you:

- ▶ Proof of all income, including investment income, if any;
- ▶ Bank statements for all accounts;
- ▶ Copies of title or other proof of ownership of any real estate or other assets;
- ▶ Copies of life and health insurance policies;
- ▶ Proof of age, such as a birth certificate; and
- ▶ Medicare and Social Security cards.

While you may be asked to come back for another appointment with any documentation that is lacking, you have a right to sign the first page of the application when you first come in. This serves as your application date. If you cannot travel to the office, a responsible person can apply on your behalf.

Nursing home residents should tell the nursing home staff that they are applying for Medicaid. The law prohibits a nursing facility from requiring a third-party guarantee of payment.

## **4-2. Long-Term Care**

Nursing home and Home and Community Based Services (HCBS) are available only when there is a medical need for nursing-home level care. HCBS may be available to help a recipient stay in his or her home, but only when the cost to the program is less than the cost of a nursing home. Twenty-four-hour care is not available in the home, since it would cost more than nursing home care. Because of the cost of long-term care, the income limit for eligibility is three times the SSI payment level (approximately \$2,022), but see the “Estate Planning” subsection below for exceptions. There was a recent change to require proof of disability for long-term care.

### **Program of All Inclusive Care for the Elderly (PACE)**

Another option available to frail elders is known as the Program of All Inclusive Care for the Elderly (PACE). This program provides comprehensive health care and supportive services for people 65 years and older. In Colorado, the PACE contract is currently managed by Total Long-Term Care (TLC) and is only available in the Denver metropolitan area and Colorado Springs. For more information, contact Total Long-Term Care at (303) 869-4739, or inquire about this program through your local county Department of Social Services.

### **Estate Planning**

Even with the higher income cap, many people who have income too high to qualify for Medicaid long-term care are still unable to pay for nursing home care (since nursing homes charge more than \$2,022 per month). In those cases, a trust — sometimes known as an “income trust” or “Miller trust” — may set aside enough income to make an individual eligible. Other forms of estate planning may preserve some assets. However, transfers to create eligibility can result in severe penalties, particularly if made within three years before applying for Medicaid (or five years, if the transfer took place on or after February 8, 2006, or if the transfer involved a trust). Because of the possible penalties, any financial planning should be done by an attorney with Medicaid expertise.

## **Spousal Protection**

The “Spousal Protection rule” allows a spouse who remains at home to avoid poverty by keeping between \$1,750 and \$2,739 of the couple’s monthly income, while the institutionalized spouse receives Medicaid. The community spouse generally may also keep his or her IRAs, pensions, other exempt property as described above under general Medicaid eligibility rules, and up to \$109,560 in non-exempt resources. The spousal protection rules are indexed to the Consumer Price Index and change yearly.

## **Estate Recovery**

Under a program known as the Colorado Estate Recovery Program, the state can recover Medicaid expenditures from the recipient’s estate after he or she dies. The estate recovery program applies to people who were 55 years of age or older when they received such assistance, as well as to all institutionalized individuals. The program permits the state to file a claim against an individual Medicaid recipient’s estate, including a lien on the home. After the person dies, the state can enforce the lien and recover the expenses paid by Medicaid from the proceeds of the sale of the property. No action is taken against the property while the Medicaid recipient is still living.

The home may be protected from recovery if a surviving spouse or dependent child is still living there. There are other exceptions to recovery. It is important to consult with an attorney knowledgeable about Medicaid eligibility concerning these provisions, since they are complex and subject to change.

### **4-3. New Medicaid Regulations Within the Deficit Reduction Act of 2005**

On February 8, 2006, President Bush signed the Deficit Reduction Act (DRA) of 2005. This legislation contained several changes to the Medicaid regulations that will affect elderly individuals who apply for the program. Here are the major parts of the new rules.

#### **Increases the Look-Back Period**

Now, all transfers made on or after February 8, 2006, whether to individuals or to trusts, will be subject to a five-year look-back period rather than the prior three-year look-back period. This will make the application process more difficult and could result in more applicants being denied for lack of documentation, given that they will need to produce five years’ worth of records instead of three years.

#### **Postpones the Penalty Period Start Date**

Under the old rules, if you made a transfer within the three years prior to a Medicaid application, you would incur a penalty period based on the amount of the gift. The penalty period would begin on the month that you made the transfer. The new law shifts the start of the period of ineligibility for a transfer of assets from the first day of the month of the transfer to the later of that date or “the date on which the individual is eligible

for medical assistance under the State plan and would otherwise be receiving institutional level care.” So, what does this mean? First, the penalty period does not begin until the individual moves to the nursing home or requires a level of care that is equal to nursing home care. Second, the penalty period does not begin until the person would be eligible for Medicaid, meaning until they have spent down to \$2,000 (or a different asset limit in some states).

An example should help explain how this will work. Let’s assume that a senior transfers \$60,000 to her son on July 1, 2006, but keeps \$100,000 in her name. Let’s further assume that our senior falls and breaks her hip on July 1, 2007, and subsequently moves to a nursing home. The senior spends down her savings over the following year, leaving her eligible for Medicaid on July 1, 2008, but for the transfer penalty. Under the new law, because the penalty does not start until she is at a nursing home level of care and is down to the \$2,000 asset limit (minus the normal exemptions such as the residence, a vehicle, personal property items, and a burial plot or plan), she would not be eligible until April 30, 2009. Unless the son can give back the \$60,000 transfer, there will be no funds to pay for care unless a family member helps or the senior appeals and receives a waiver of the ineligibility period.

### **The Effective Date**

The new transfer rules apply to all transfers occurring on or after the date of enactment of the DRA (February 8, 2006). Transfers made before February 8, 2006, will be judged under the old rule, where the penalty period begins in the month of the transfer.

### **Hardship Waivers**

Each state will institute a process for seeking a hardship waiver where the application of the transfer penalty would result in deprivation of medical care that would endanger the applicant’s health or life, or of “food, clothing, shelter, or other necessities of life.” The process must include notice to applicants, a timely process for ruling on the application, and an appeal process.

The new law also permits the nursing home to apply on behalf of the individual for such a waiver upon receipt of consent from the resident or his or her personal representative. However, the waiver is only for hardship to the resident, not to the facility. If a facility cannot evict a nonpaying resident without providing alternative care and no alternative care exists, there is really no hardship to the resident, only the nursing home.

### **Annuities**

The new rules require that the state be “named the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant.” The provision also provides that the state be the secondary beneficiary where a community spouse or minor or disabled child is the primary beneficiary.

## **The Valuable House Rule**

Under the new law, homes of nursing home residents in which the residents own more than \$500,000 in equity shall be countable unless the nursing home resident's spouse, child under age 21, or blind or disabled child is living in the house. The effective date of this provision was January 1, 2006.

## **Deposits or Buy-Ins at Continuing Care Retirement Communities (CCRCs)**

Any amount required for a deposit in a CCRC, or that is used for a buy-in at CCRCs, will now be counted as an asset. In the past, CCRCs would require, say, a \$50,000 buy-in for residence but would provide for these funds to be held and returned to the person, or their beneficiaries, when the individual moved out or passed away. Under the new rule, these deposits will be seen as countable assets that will need to be recouped and spent down before Medicaid eligibility.

### **4-4. Medicaid Payment for Medicare Premiums, Deductibles, and Co-Payments**

People whose income makes them ineligible for Medicaid may still qualify for one of three Medicaid programs that pay Medicare-related costs.

A Qualified Medicare Beneficiary (QMB) receives payment by Medicaid of all Medicare premiums, deductibles, and co-pays. The QMB resource maximum is \$4,000 for an individual or \$6,000 for a couple. The QMB income maximum is \$887 for one person, and \$1,187 for a couple.

Similarly, a Special Low-Income Medicare Beneficiary (SLMB) receives only payment of Medicare premiums. The SLMB income maximum is higher: \$1,060 for one person or \$1,420 for two. The SLMB resource maximums are the same as for a QMB.

Finally, a similar program called QI-1 can provide assistance with Medicaid premiums with income up to \$1,190 for one person and \$1,595 for two, but any assistance is subject to the availability of state funding. The resource maximum is the same as for a QMB.

Note that some earned income may be excluded for all three of these income caps, and that the income caps change annually as poverty figures are changed.

## 4-5. Glossary

**Estate Recovery.** A method by which the state seeks to recover the costs of medical care provided to Medicaid recipients age 55 or older and to all institutionalized individuals, through imposition of a lien on real property, which is acted upon after the person dies and from assets in the probate estate.

**Home and Community Based Services (HCBS).** Services paid for by Medicaid that are provided in an individual's home or in a Medicaid-certified Alternative Care Facility. HCBS includes personal care, as well as traditional Medicaid (medical) services.

**Medicaid.** A program that pays some health care costs for qualifying individuals with low incomes and assets. It will cover some expenses that Medicare does not (for example, outpatient prescriptions).

**Miller Income Trusts.** If an individual has monthly income in excess of \$2,022 in 2009 but less than the average private pay rate for nursing home care in the geographic region in which he or she resides, that individual may qualify for Medicaid benefits for long-term nursing home care or Home and Community Based Services (HCBS) by means of a trust.

**PACE.** Program of All Inclusive Care for the Elderly that provides comprehensive health care and supportive services for frail individuals over the age of 65. This is Secondary Insurance coverage, which is accessed only after the primary insurance benefits are exhausted.

## 4-6. Resources

For more information about Medicare and Medicaid, call your nearest senior center. See a list of county Departments of Social Services in section 5-7, "Resources."

