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Medicaid Benefits

Both the federal and state governments fund Medicaid — the medical services assistance program for low-income individuals. In Missouri, the Family Support Division (FSD) administers this assistance program called Vendor Medicaid, which pays indefinitely (unlike Medicare) for the care of qualified individuals who reside in skilled nursing facilities. In general, Vendor Medicaid pays the difference between the person's income and the total bill each month.

An individual must meet the following criteria to qualify for Vendor Medicaid:

- Reside in a licensed skilled nursing facility in a Medicaid-certified bed
- Meet the medical disability standard of federal and state law [either blind, declared incompetent, or needing assistance with at least two (2) ADL's]
- Not have countable assets worth more than $3,000 (as of 7/1/19 will increase to $4,000)

Finding a Medicaid-Certified Bed

A state-licensed long-term care skilled nursing facility may apply to the state government to have some or all of its beds certified for Medicaid. If the skilled nursing facility does not want all its beds Medicaid-certified, it must designate the number of beds it wants approved. Federal law requires Medicaid-certified beds to be adjacent to one another within a long-term care setting. For example, a long-term care community cannot scatter 10 Medicaid-certified beds throughout its location.

Initially, the state will inspect the long-term care rooms with Medicaid-certified beds to ensure those beds meet federal standards. Keep in mind that the standard of care at long-term care settings with Medicaid-certified beds is the same whether an individual is in a private-pay or a Medicaid-certified bed.
Long-term care communities also can add or subtract from their number of Medicaid-certified beds at any time by applying to the state.

Meeting the Medicaid Disability Standard

In general, individuals who are medically certified as needing assistance with two (2) Activities of Daily Living will qualify for Vendor Medicaid. Some conditions, such as one who suffers dementia which is deemed to result in cognitive impairment, automatically qualify. Remember, individuals who live in Independent Living Facilities or in Assisted Living Facilities are not entitled to receive state sponsored Vendor Medicaid even though they may need assistance with two (2) Activities of Daily Living - only a resident in a Skilled Nursing Facility may apply for Vendor Medicaid.

There is a form of Medicaid that is available **only** to those who are in an Assisted Living Facility (ALF). This form is called Supplemental Nursing Care (SNC). If an individual

meets the requirement to be accepted into an ALF, it is presumed that they require assistance with at least 2 ADL's. Unlike Vendor Medicaid (skilled nursing facility), the SNC for Medicaid does not have a look back period. Thus, it is possible to move all the assets [except for $999 per person] out of the person's name and immediately apply for the benefit. Depending upon the amount deducted for Medicare Parts A & B from his or her social security check, the total monthly benefit could be approximately $445 - $460 per month. In addition, all prescription drugs are provided by the SNC program simply by presenting the Medicaid card at the individual's pharmacy (sometimes, a small co-pay is required).

Determining Countable Assets

Assets that count as available resources to pay for long-term care include cash, stocks, bonds, real property (other than a primary residence), IRAs, 401k plans and any cash surrender value of insurance policies. The rule of thumb is that an asset is "countable" if the individual applying for Vendor Medicaid can access the asset and convert it to cash within twenty (20) days.

Assets that do not count as available resources generally include a primary residence, two automobiles and personal property (such as clothing, furniture and costume jewelry). Individuals who own a life insurance policy can exclude $1,500 of the cash surrender value from available resources, if they do not have an irrevocable pre-paid funeral plan. Irrevocable pre-paid funeral plans are exempt, but if you have such a plan, then any cash value in an insurance contract will be considered as non-exempt.

A primary residence is generally not required to be sold. If it is owned by an applicant who is single, it will not be considered "available" at the time of the application, but it will be subject to a Medicaid recovery lien upon the Medicaid recipient's death. An exception is a TEFRA (Tax Equity and Fiscal Responsibility Act) lien which can be applied upon approval prior to that individual's death. If the applicant is married, there are ways to keep a primary residence "safe" from such a recovery lien while a spouse is still alive, but individuals in this situation should seek guidance from a qualified elder law attorney. Getting qualified help is vitally important when a residence is involved.

Transferring Assets to Children and Family

Under state and federal law, individuals who transfer any assets such as cash, investments and real estate, to someone other than a spouse will incur a penalty if the transfer occurred within the five years before applying for Medicaid. Keep in mind that any transfers of assets that occurred five (5) years or more before the application for Medicaid is filed will <u>not</u> be considered. This is a great example as to how asset protection planning well in advance can make a huge difference for a family.

The penalty period for transfers begins at the time an individual applies, is in a Medicaid bed and is determined to otherwise be eligible for Medicaid from an income and medical standpoint. The Missouri Family Support Division calculates this penalty by dividing the amount transferred by the average monthly cost to occupy a semi-private room in a

skilled nursing facility.

The following example shows the effect that a transfer of assets can have when an individual needs to apply for Vendor Medicaid:

> Mrs. Jones transferred $61,220 from a savings account to her children July 1, 2013. She now requires long-term care in a skilled nursing facility but has limited income and assets to cover the cost. Mrs. Jones applies for Vendor Medicaid April 15, 2018.
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> While investigating Mrs. Jones' financials for the past five years, her caseworker will note the transfer that occurred July 1, 2013 and divide the dollar amount of the transfer ($61,220) by the average cost for one month of care in a skilled nursing community in the state of Missouri ($6,122 as of April 1, 2018).
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> This calculation results in the number of months that an individual will be ineligible to receive Vendor Medicaid payments. In this example, Mrs. Jones will be ineligible for ten (10) months from the day she applied (April 15, 2018). Therefore, she will become Medicaid-eligible February 16, 2019. Had Mrs. Jones received proper advice, her family would have waited until after July 1, 2018 and the whole $61,220 would have been safe, minus any amount needed to pay for care from April 15 – July 1, 2018.

Because individuals must pay privately during any penalty period until approved for Medicaid, it is often best not to transfer assets without first consulting an attorney who specializes in elder or disability law. There are many techniques available and only an expert in this area, such as an experienced elder law attorney, should be relied upon to guide an applicant and his or her family in these situations.

Exceptions for Transferring Assets

Because Missouri still allows important exceptions to the rules for transferring assets to children and family, individuals should seek the advice of a qualified elder law attorney before applying for Medicaid. One exception for transferring assets applies to an individual's primary residence. Even before approval of Medicaid benefits, an individual can transfer a primary residence to the following:

- A spouse
- A child less than age 21
- A blind or disabled child (who qualifies for payments from Supplemental Security Income or Social Security Disability)
- A child who has lived in the residence with the parent and has taken care of them for at least two years immediately before the parent becomes a long-term care resident and applies for Medicaid (this requires a primary care physician's statement documenting that the parent could not have remained living in the home without the child living there, too.)
- A sibling who has an ownership or "equity interest" in the residence and lives

there at least one year immediately before the individual becomes a long-term care resident and applies for Medicaid (If two siblings have lived with one another for at least a year, the one who owns the primary residence might want to consider selling an interest — even as small as 1% — to the sibling so all of the remaining ownership interest can transfer to the sibling.)

Declaration and Assessment of Assets for Married Couples

Federal and state guidelines allow married couples a "Declaration and Assessment of Assets," which permits the spouse who does not become a long-term care resident (known as the community spouse) to keep all or part of the couple's assets. While the government instituted the assessment of assets process in 1989, contrary to popular belief, it does not allow a spouse who remains at home to keep one-half (1/2) of the assets. The rule states that the spouse who continues to live at home may keep one-half (1/2) but not more than $123,600 of assets. As you will see, it is not really a "division" of assets, but really is a "snapshot" of all the assets the couple has at that time. Again, individuals should consult with an elder law attorney for proper advice.

An individual can request the Family Support Division to assess a married couple's countable assets if one spouse becomes a long-term care resident in a Medicaid-certified bed or has been receiving care in a medical facility for 30 consecutive days. This assessment determines the "spousal share" amount, which is how much money the spouse remaining at home can permanently set aside for his or her use. However, be warned of this: The state of Missouri does not permit the caseworkers at the Family Support Division to explain to an applicant or his or her family the different ways that assets could be saved from being spent to pay for care.

For couples with very little assets, there is a "minimum spousal share" that a spouse who remains at home may keep - for 2018, the minimum spousal share is $24,720. If the couple has countable assets less than that amount, the spouse remaining at home may keep all of it up to the minimum. If the countable assets amount to more than $24,720, the rule is that the Community Spouse may retain half of all countable assets, but not more than $123,600 or no less than $24,720. The Family Support Division caseworker will tell the spouse who becomes the long-term care resident that he or she must spend his or her portion of the assets down to $3,000 before he or she can apply for Medicaid. However, as you will see in the following paragraphs, there are ways to save the amount above the amount that the spouse still living at home can keep.

Once the Family Support Division completes the "assessment of assets" calculation, then a married couple knows the amount that the State of Missouri declares they must spend for a spouse to become eligible for Medicaid. Because a married couple can use the "spend down" amount to pay for anything that benefits either spouse, a married couple can use that money for expenses other than just long-term care, including food, utilities, rent, home repairs, remodeling and replacement of an automobile. However, a qualified elder law attorney may be able to provide advice for other alternatives that could allow the Community Spouse to keep the other half of the assets as well [see the example set out below].

The following explanation illustrates one way that a spouse who remains at home can keep a substantial amount, or sometimes all, of the remaining countable assets:

- The couple has countable assets that exceed $260,000
- The spouse who remains at home keeps the maximum ($123,600)
- The long-term care resident spouse is told to spend that excess $136,400 down to $3,000

According to the Family Support Division Income Maintenance Manual, the couple must spend the remainder, no matter what the amount, but this manual does not specify additional ways, such as the purchase of a qualifying annuity, that will let the spouse who remains at home to keep a substantial portion, or possible all, of the assets that would otherwise be required to be spent for their spouse's care. Again, seek out the advice of an expert in this area.

Purchasing Annuities to Benefit a Spouse

If a Medicaid Qualifying Annuity is purchased with the money that the family is told it must spend, then all of that "excess" money may be kept for the benefit of the spouse who remains out in the community (the "Community Spouse"). To make this annuity qualify under Federal law, the annuity requires the Community Spouse to name the institutionalized spouse as the primary beneficiary should the community spouse die before the annuity has made all payments. The State of Missouri is the secondary beneficiary at the death of both spouses if the annuity has not paid out in full. In other words, if there is enough money left, the State of Missouri may get all of its money back. Next, the family members will receive any money remaining after the State of Missouri has been paid back. But, remember, federal law permits the spouse who remains at home, the Community Spouse, to be the designated "immediate payee" during the annuity period, allowing the Community Spouse to keep the payments. If the Community Spouse lives beyond the term of the annuity, the Community Spouse keeps all the payments and the annuity terminates. If both spouses pass before the annuity has paid out in full, the state may recover its costs from any residual amount remaining to be paid out after the long-term care resident dies. Any annuity must meet federal guidelines for actuarial soundness, which means it must pay the full amount invested by the time the annuity is set to terminate.

How Much of a Couple's Income Can a Spouse Keep?

Generally, the resident's monthly income (i.e. monthly benefits in his or her name) will go directly to the skilled nursing facility to pay for long-term care costs, and the spouse who remains at home will keep his or her own income. However, there is a provision that permits designation of some or all of the long-term care resident's income to the spouse or dependents who remain at home if their income is less than a certain limit — the Minimum Monthly Maintenance Needs Allowance (MMMNA). The amount of this designated income can vary depending on the situation and falls within limits set by law

(amounts may change annually). For 2018, a spouse who remains at home with no dependents may receive an allotment to increase their monthly income to a minimum of $2,030 or a maximum of $3,090 per month. Most spouses who remain at home receive the minimum unless their housing costs are unusually high.

Waiting for Medicaid Approval

Final approval of a Medicaid application usually takes one to three months if there are no complications. If an annuity must be reviewed, that time period could be four to six months. During that period, the single resident must turn over his or her income to the long-term care provider, except for $50 for personal use in addition to the amount of any medical insurance premiums that he or she must pay. For a married applicant, the Community Spouse may keep the amount that has been calculated that he or she may keep each month, plus the $50 from the income of the institutionalized spouse for his or her personal needs. Medicaid allows a long-term care community to require a deposit or full payment as a condition of admission while a resident is waiting for approval. However, the long-term care provider must refund any money paid for Medicaid-covered care during this waiting time, except for any surplus amount that the Family Support Division determines.

What Medicaid Does Not Cover

Medicaid benefits do not pay for the expenses of a personal telephone, cable television and some hair salon services.

What Happens to Personal Funds When a Medicaid Recipient Dies

State law requires a long-term care community to report the amount of any remaining funds within 60 days of a resident's death. The state then has 60 days to notify the long-term care provider of how much it intends to collect. The executor of the resident's estate may claim any remaining funds. An exception is if individuals need the money for funeral expenses; then the long-term care community can send it immediately to the funeral director.

What Happens to a House Still in the Name of the Medicaid Recipient When a Medicaid Recipient Dies

Federal and state laws require each state agency that administers Medicaid to file a lien on any real property (including a house) that a Medicaid recipient still owns when he or she dies. The State of Missouri may place a TEFRA lien on property owned by any individual approved to receive Vendor Medicaid benefits after they move into a long-term care community and it is determined there is no reasonable expectation for that person to return home.

If individuals own real property, they may receive a Notice of Intent to File Medicaid

TEFRA Lien from the DSS Division of Medical Services. The state cannot file a lien on an individual's house, however, if one or more of the following persons legally reside there:

- Spouse
- Disabled adult child or child less than age 21
- Sibling who has lived there for at least one year before the individual began living in a long-term care community and has equity interest in the property.
- An adult child who has lived in the residence with the Recipient of Medicaid Services for 2 or more years provided the person's treating physician states that if the adult child had not been living with the Recipient during that 2-year period, the Recipient could not have stayed at home.

If an individual receiving Medicaid does return home from a long-term care community following a discharge, the state will remove any filed property lien. Again, before filing to receive Medicaid benefits, seek advice from an elder law attorney for individuals who own any property, investments or cash.

When to Apply for Medicaid

Complete the application as soon as an individual begins residing in a Medicaid-certified bed whether this is following an arrival from the hospital, a home or a move from a private-pay bed and it appears that all asset criteria is met. You may apply in person *at the state Family Support Division office in the county where the long-term community is located*. However, if you have ownership of a house, cash and investments and life insurance with cash value, it is strongly suggested that you contact a qualified elder law attorney to guide you through the process.

When applying for Medicaid, requesting a Declaration and Assessment of Assets or both, individuals should bring the following with them:

- Proof of marriage
- Proof of age (i.e., a birth certificate, driver's license, passport, etc.)
- Social Security cards for both applicant and spouse
- Deeds to all real property (including the house in which the applicant lives)
- Bank account statements or books
- Stock certificates
- Certificates of deposits
- Bonds (including U.S. savings bonds)
- Life insurance policies
- Prepaid burial contracts
- Annuity contracts or statements
- Proof of income (i.e., award letters for Social Security, VA benefits, pensions, etc.)