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A Medicaid Long-Term Care Eligibility Primer: Basic Eligibility Rules

A Medicaid Long-Term Care Eligibility Primer: Basic Eligibility Rules

By Journal Staff

Determining Medicaid eligibility for elders who need nursing home care is central to the practice of elder law. The purposes of various Medicaid rules, which vary from state to state, can seem incomprehensible—even for those who provide excellent Medicaid planning services.

Medicaid,[1] referred to as "medical assistance" or MA in some states and "MediCal" in California, is operated by the states under federal guidelines and financed by both state and federal funds. It pays for health care for low-income persons who are aged, blind, or disabled as well as poor workers in welfare-to-work programs and their dependents. Medicaid is the only nationwide program that provides or causes states to support long-term care benefits. Coverage is limited to those persons who are unable to pay for their own care, and further restrictions are imposed by the states.

Medicaid rules are frequently confusing and contradictory. In part, this is true because the program was not so much planned as it was perpetuated by the 1965 legislative enactment that made permanent federal grants for health care for the poor. At that time, more than half of the elderly were considered to be poor; on the other hand, nursing home care was less costly and less likely to continue for years because life expectancy was lower. Since that time, the states and federal government have worked, sometimes at cross-purposes, to provide needed care while keeping costs in check. The resulting rules, therefore, can serve conflicting goals. While this is a nightmare for the purist and policy wonk, it is a gift to lawyers seeking to meet their clients' needs.

The most important Medicaid benefit for clients of the private bar is extended nursing home care, an expenditure that represents nearly half the Medicaid budget nationwide. The broader picture of Medicaid purposes, eligibility, and benefits is essential for the practitioner, however, for two principal reasons:

- First, the basic purposes and guidelines of federal financial assistance for the poor are the context for interpreting eligibility for Medicaid reimbursement for nursing home costs.
- Second, Medicaid home care is of growing importance, as very impaired people remain at home.

Eligibility Generally

Medicaid is intended to provide health services for persons whose incomes are too low to purchase either health insurance (including Medicare) or health care. For eligible persons, Medicaid pays the health care provider directly and the health care provider must accept the fee as payment in full. Basic Medicaid eligibility, therefore, is linked to eligibility for federally supported, need-based income assistance programs.

Because the states set their

Substantially similar discussion appeared in the COUNSELING OLDER CLIENTS, by *Alison Barnes, Lawrence A. Frolik* and *Robert Whitman,* American Law Institute-American Bar Association (1997). Medicaid eligibility also will be discussed in COUNSELING OLDER CLIENTS, by *Alison Barnes, A. Frank Johns* and *Nathalie Martin,* forthcoming in 2003.

own Medicaid income eligibility standards within the federal guidelines, some persons receiving income benefits are not eligible for basic medical assistance. An individual who qualifies for Supplemental Security Income (SSI) may be ineligible for Medicaid in these five states: Hawaii, Illinois, Indiana, North Carolina, and Utah.

SSI Eligibility and Categorically Needy Eligibility

Supplemental Security Income (SSI) is the federally authorized program of minimum income for the very poor who are aged, blind, or disabled. In 2002, the federal poverty level is $8,860 for an individual, while SSI pays $545 for an individual and $817 for a couple in most states (notable exceptions being New York, Alaska, and Hawaii); and restrict assets to $2,000 for an individual and $3,000 for a couple, excluding certain property, such as a home where the individual resides. Individuals who meet the income and asset guidelines of their states are termed "categorically needy."

In order to qualify for SSI on the basis of age, an individual need only provide proof of date of birth. A formal birth certificate is not essential. SSI eligibility automatically provides Medicaid eligibility in many states. In six states, the application for SSI and Medicaid are combined into one. A number of other states use separate applications, although the eligibility criteria are the same.

Some states, including Section 209(b) states and states utilizing more recent Section 1902(r)(2) of the Medicaid Statute; can apply more restrictive criteria for Medicaid eligibility than for SSI. (See section immediately below.)

Medically Needy and Spend-Down Defined

States may provide Medicaid to individuals who do not meet the income requirements of their programs. These individuals, termed "medically needy", incur medical expenses that effectively reduce their incomes to the standard for categorically needy eligibility. Deducting incurred medical costs to calculate eligibility is called "spend down" or spending down income.

Thirty-five states have medically needy programs in 2002. According to the Center for Medicare and Medicaid Services (CMS), thirteen states use a spend-down target that is higher than the SSI benefit, fourteen have a target medically needy level below SSI, and seven have a target that is less than half of the SSI amount.

The 300% Rule and Section 209(b) States

Not all states allow all Medicaid applicants with excess income to spend down. States that had programs for the poor in place in 1972 when §209(b)[2] was enacted can use an alternative income standard for Medicaid eligibility under federal criteria. The 209(b) states include Connecticut, Hawaii, Illinois, Indiana, Minnesota, Nebraska, New Hampshire, North Dakota, Ohio, Oklahoma, Utah, and Virginia. Other states can also use the 209(b) alternative eligibility standard if they opted to do so in their state plans. They include Alabama, Alaska, Arkansas, Arizona, Arizona, Colorado, Delaware, Florida, Idaho, Iowa, Louisiana, Mississippi, Nevada, New Mexico, Oklahoma, Oregon, South Carolina, South Dakota, Texas, and Wyoming. *Caveat:* States may apply spend down to some applicants, and use the alternative rules for others.

The alternative standard is the "300 percent eligibility rule" that allows individuals to qualify for Medicaid assistance only if their income does not exceed a flat maximum rate regardless of medical costs.[3] The states are known as "income cap" states. Under federal law, a state may limit Medicaid medically needy eligibility to individuals whose income does not exceed an amount equal to three times (300%) of the maximum SSI benefit amount for one person. In 2002, the income cap figure was $1,635 (adjusted annually for inflation).

This method creates a "gap group" of retired persons whose pension and social security benefits exceed the income cap but are less than the cost of nursing home care. In order to obtain care, many had to improvise by paying for home services and relying on family or charity, or move to a non-income cap state. Some sought court-ordered trusts to receive their income, upon condition that the trustee distribute less than the maximum income level for Medicaid eligibility.[4] However, a growing number of states by statute treated such trusts as though they were created by the applicant and denied eligibility anyway. Congress responded to the prob-

lem by creating the Miller trust. (This will be covered in a future Medicare/Medicaid column on Planning for Medicaid Eligibility.) States may also extend eligibility under certain income disregards recognized by the federal government to help gap group members. (See § 1902(r)(2), below.)

Section 1902(r)(2) Eligibility

In 2001, CMS enacted final regulation § 1902(r)(2) in order to allow states to use less restrictive income determination methods when identifying individuals qualified for Medicaid assistance. The regulation allows states the option of defining certain eligibility groups in order to target particular populations without affecting the program's eligibility for federal financial participation. The purpose is to allow states to create more effective long-term care networks for aged and disabled people. A particular target group of 1902(r)(2) is ineligible elders in 209(b) income cap states.

Essentially, the state is allowed to not count some of the applicant's income, rather than requiring that it be spent down. The eligible groups can include nursing home residents and recipients of home and community-based care, but cannot target home and community-based care alone. (The extensive list of groups is available at http://www.cms.gov/medicaid.)

Section 1902(r)(2) also allows states to disregard certain resources of an individual who receives benefits under a long-term care insurance policy. However, this disregard includes a requirement that the state seek to recover assets upon the recipient's death though the assets are outside of the probate estate.

Interaction of Medicaid Eligibility for Elders With Welfare-to-Work

In 1996, the federal government ended traditional welfare programs, including Aid for Dependent Children (commonly called AFDC), and replaced it with work-related payments. Medical assistance is provided to individuals who participate in the welfare-to-work programs according to the eligibility guidelines of each state.

This change does not affect aged and disabled persons generally, because any person who receives payment from the Social Security System (including retirement benefits or SSI) is ineligible to participate in a welfare-to-work program.

Medicaid Benefits

The package of Medicaid benefits is broader than Medicare services, because Medicaid eligible individuals are considered unable to pay for any services, such as dentistry and eye care, which are not covered by Medicare. To the extent states are able, it is beneficial to them to meet the needs of citizens through Medicaid, because of federal financial participation.[5]

Some Benefits Must Be Provided by the State

Federal regulation mandates that certain services be provided for the "categorically needy" population (those who meet low-income and asset requirements), including inpatient and outpatient hospital services.[6] The state must also provide an array of services, including medical equipment, health screening, lab, X-ray, and dental surgery.[7]

Some Benefits Are Provided at the State's Option

States can choose to offer certain optional services in their Medicaid programs.[8] Services include dentistry, alternative medicine, home health care, private duty nursing, physical therapy, prescription drugs, dentures, prosthetic devices, eyeglasses, and others.

Generally, states may provide two types of long-term care using Medicaid funds: nursing home care and home and community-based care. Not all states elect to do so, and many restrict eligibility. Some states have begun to pay for assisted living using Medicaid funds.

Medicaid Program Rules and Waiver For State Flexibility

Under federal guidelines, each service must be provided in the amount, duration, and scope sufficient to achieve the objectives of the Medicaid program. Some state-imposed arbitrary limits (for example, five office visits per month or ten hospital days per year) have been found acceptable, while others (for example, three office visits per month) have been rejected when challenged in the courts.[9]

Traditionally, the state's Medicaid plan must allow recipients free choice among participating health care providers. States can, however, offer HMO-type of care or offer some optional services from a single provider if the federal Health

Care Financing Administration (HCFA) approves a waiver of the "freedom of choice" provision or the state includes this option in its plan under more recently drafted general guidelines.

Medically Needy Eligibility

People with high medical bills may qualify for Medicaid assistance, even though their incomes and assets exceed the eligibility limits. Such persons are termed "medically needy,"[10] as opposed to basic "categorically needy" eligibility.[11]

Some states provide medically needy eligibility to some people, but not to institutionalized elderly people. A growing number of federal waivers and rule revisions allow these states to support Medicaid nursing home care for the indigent aged without creating an entitlement for all such individuals in the state. While this seems unfair to those excluded, states are provided this flexibility to protect them from the need to undertake a very large obligation all at once. It is to be hoped that those states conscientiously seek to treat all their elder citizens equitably.

Generally, an elderly individual can qualify as medically needy by meeting the requirements for categorically needy status except the income limits. The individual can deduct incurred medical expenses from excess income to reach a recalculated net income figure that is below the eligibility level for that state. The process of deducting medical expenses from excess income or resources is called "spending down." The bills deducted in the spend-down process do not need to be paid. The state may allow spend-down on a monthly basis (that is, medical expenses incurred in a given month are deducted from monthly income to reach the maximum eligible monthly income) or over a longer period, up to six months.[12]

An individual can qualify as medically needy because of high medical bills while living in the community. Generally, income must be spent down to the level of SSI eligibility, though some states allow elderly applicants to keep more of their income while living in the community with costly health care needs.

Once in the nursing home, a single person must spend all income on the cost of care except for a monthly "personal needs allowance" (PNA). Under federal guidelines, the PNA must be at least $30. Most states allow $40 or $45 per month, and some states allow more.

Application and Eligibility

Thirty-two states use the same application for income assistance and medical assistance in 2002. In a number of states, a separate application is required but eligibility is substantially the same.

A Medicaid application may be filed either by the proposed recipient or the health care institution caring for the proposed recipient. Benefits may be retroactive, covering services delivered (that is, by the delivery date, not the date of billing) from the first day of the third month prior to the month of application.[13]

Applications generally are processed in the county welfare office. They consist of state forms with multiple pages documenting the applicant's income and resources and other possible coverage of medical expenses, since Medicaid requires that all other sources of coverage be exhausted.

Eligibility Determination Process

Calculating eligibility for an elderly medically needy person is a complicated process, subject to interpretation and revision. A conference with the worker determining eligibility and his or her supervisors can be very helpful in reaching a positive outcome. However, the attorney must examine the client's records carefully and understand the assets and transactions revealed there.

If, for example, the client presents account statements for the preceding year, state Medicaid officials will inquire about the purpose of withdrawals and deposits. For instance, a withdrawal of $20,000 that the client asserts was used for the purchase of an automobile will require confirmation of the car's purchase price and ownership by the client. If the car cost less and the balance was a gift, or the care is titled in another's name, the balance might be a prohibited transfer of assets. If the car is titled in the name of someone other than the client or spouse, it was a prohibited transfer. Deposits that do not reflect income from known sources will be subject to inquiry because they suggest the existence of undeclared assets.

Many times, verifications of income, assets, or liabilities cannot be obtained within the time frame set by the state for processing the application. The application will be denied on the date set for receipt of all verifications if some are absent. However, the applicant has thirty days from the date of the denial to supply the verifications and have the original application processed. The date of the application is important if the applicant is seeking benefits for the full period of retroactivity because the new application will generally cause the loss of two months' worth of benefits.

What Is Available Income?

Detailed rules defining the income available to an applicant are found in the laws and regulations governing poverty income benefits, including SSI. A number of specific exclusions are also detailed in federal law and regulations.[14]

The first step to eligibility determination is adding up the individual's income, which is defined to include anything received, in cash or in kind, that can be used to meet needs for food, clothing, or shelter.[15] The value of medical care and social services is not included in income, and financial assistance in the form of food stamps, housing assistance, and educational funds are not income.[16] Compensation for an expenditure also is generally excluded, so funds such as proceeds from the sale of an asset and tax refunds are not income. (They are, of course, included in resources.)

Income that is not legally owned by the applicant or not available for use by reasonable efforts cannot be counted.[17] In contrast, liquid resources are those that can be converted into cash within twenty business days. By definition, liquid resources include stocks, bonds, mutual fund shares, promissory notes, mortgages, life insurance policies, savings accounts, checking accounts, and certificates of deposit.[18]

Income received by family or household members other than the spouse (or parent) generally cannot be counted.[19] Rather, the individual must have a legal responsibility to support the applicant. While a number of states have old laws that require support for elderly parents, they are not enforced in the Medicaid application process in 2002.

For spouses living together in the community, the income of the non-applicant spouse is considered to be available to the other spouse regardless of whether any money is actually contributed for support.[20] The process of attributing one spouse's income to the other is called "deeming." The result is termed "countable income," which must be below the state's eligibility standard. However, an applicant can present evidence that the spouse's income is in fact withheld, and the spouse refuses to provide support.

Other rules apply when one spouse is institutionalized. (This will be covered in an upcoming Medicare/Medicaid column on spousal impoverishment guidelines.)

Countable Assets

Assets are countable for the purposes of Medicaid eligibility if the applicant is the legal owner[21] and can liquidate the asset to pay for medical care.[22] Assets such as promissory notes or real estate generally can be sold, and the applicant must make reasonable efforts to do so before the asset can be considered unavailable. Individual Retirement Accounts (IRAs) and other retirement benefits are generally considered available, minus any penalty for early withdrawal. However, if a lump sum distribution is not available, the payments are income in the month received and assets thereafter only if unspent. Assets that are the subject of litigation concerning ownership generally are not available. Rental units in a homestead are not considered as resources, although the rents are counted as income in the month received.[23]

The value of the asset for Medicaid purposes is its fair market value (FMV). If applicants renounce assets that would be their legal property, the FMV nevertheless can be counted for Medicaid purposes.[24]

Certain types of property are exempt from the total of resources, including a homestead;[25] household items and personal effects;[26] an automobile valued up to $4,500 (the entire value, provided it is necessary for employment or medical treatment, or because of climate, terrain, or distance; or is specifically modified to accommodate a handicap);[27] a burial plot and a separate burial fund up to $1,500;[28] or life insurance with a face value up to $1,500.[29]

Non-liquid resources that are counted, but are assessed according to their equity value,

generally include loan agreements, certain household goods and automobiles that are not exempt, machinery, buildings, and land. Equity is the amount the asset would bring on the open market in the area where it is located, deducting the amount the owner owes for it.[30]

In addition, property is exempt if it is essential to self-support.[31] Nonbusiness property used to produce goods or services necessary to one's daily activities is also excluded.[32] This typically applies to tools, animals, and croplands.

Appeals

An applicant who is denied Medicaid eligibility can appeal the decision by following a process determined by the state, within federal standards for fair hearings on other important benefits.[33] The initial action is the applicant's request for a fair hearing by the agency that denied the application.[34] The hearing must be held at a reasonable date and time after the request, before an impartial person who was not involved in the initial determination. The procedure is informal, and the rules of evidence do not apply. However, the hearing is generally electronically recorded to provide a record in the event of further appeal. In most states the applicant has the right to another administrative hearing with state-level officials.

If the final decision of the agency is adverse, the applicant has a right to judicial review. A notice of appeal must be filed with the agency within thirty days after the final decision, after which the applicant may file a petition with the courts.

Attorney Fees

In Medicaid cases, unlike Social Security cases, an attorney and client can establish any fee arrangement without review by the federal government. However, the nature of the work implies that finances are (or will be) quite limited. Therefore, a flat fee for a package of related planning services is the most common method of billing.

Caveat: If the bill is submitted to one other than the client, the attorney should be aware of potential breaches of confidentiality in any itemized list of services.

In the federal courts the Equal Access to Justice Act[35] may allow fees, provided the matter goes beyond the administrative process to the courts. Some states also have private attorney general statutes that provide for an attorney fee if the case involves significant matters of public policy.

Note: This discussion of the basics of the Medicaid program is planned as the first in a three-part series. Part Two will include Planning for Medicaid Eligibility for Individuals, and Part Three will cover Spousal Impoverishment Guidelines.

Endnotes

1. 42 U.S.C. §1396; 42 C.F.R. §§430-456.
2. Soc. Sec. Act §1902(f) codified at 42 U.S.C. 1396a.
3. 42 U.S.C. §1396b(f)(4)(C).
4. According to Miller v. Ibarra, 746 F. Supp. 19 (D. Colo. 1990), such a trust was not a Medicaid Qualifying Trust (MQT) because Congress intended to prevent only voluntary transfers to qualify for Medicaid.
5. The federal government provides 50% to 80% of the costs of Medicaid approved under the state plan, depending upon the average per capita income in the state. Thus, very poor states receive nearly the maximum, while nine more affluent states split Medicaid costs 50%-50% with the federal government.
6. Mandated services include: laboratory and X-ray services; skilled nursing facility (SNF) care for persons aged 21 and over; home health care for SNF-eligible persons; physician services; rural health clinic services; early and periodic screening, diagnosis, and treatment services for individuals over the age of 21, and obstetric and gynecological services. 42 U.S.C. 1396A(a)(10)(A), 42 C.F.R. §440.210 .
7. 42 U.S.C. §1396d(a)(1)-(25).
8. 42 U.S.C. §1396s(a)(10)(C).
9. *See, e.g.*, Alexander v. Choate, 469 U.S. 287 (1985) (court rejects the argument that a reduction of hospital coverage from 14 days to 10 days unfairly discriminates against the handicapped in violation of §504 of the Rehabilitation Act of 1973).
10. 42 U.S.C. §1396a(10)(A-C).
11. *Id.*
12. On comparability of categorically and medically needy and the method for calculating spend-down, *see* Hogan v. Heckler, 769 F.2d 886 (1st Cir. 1985). Medical bills need not be paid to be considered "incurred." *See* Cohen v.

Quern, 608 F. Supp. 1324 (N.D. Ill. 1984) (on the definition of incurred expenses in a §209(b) state). Beneficiaries are not permitted to refuse any of the income that is their legal property.

13. 42 U.S.C. §1396a(a)(34); 42 C.F.R. §435.914.
14. 42 U.S.C. §1382a(b); 20 C.F.R. §416.1124(c).
15. *See* 42 U.S.C. §1382a(a); 20 C.F.R. §416.1102.
16. 20 C.F.R. §416.1103.
17. 42 U.S.C. §1396a(a)(17). *See, e.g.,* Ceryes v. St. Louis County Welfare Bd., 402 N.W.2d 209 (Minn. App. 1987) (proceeds from a note on property held by a medically needy nursing home resident for sale of property to her son and daughter-in-law were found to be available despite the fact the son had never made payments, because neither the resident nor her representative had made any effort to collect); Gordon v. Commissioner of N.Y. Dep't of Social Servs., 131 A.D. 96, 520 N.Y.S.2d 876 (App. Div. 1987) (proceeds from a lawsuit are not considered available under "chronic care facility" exception to Medicaid rules, even though they have been paid to the nursing home resident).
18. 42 C.F.R. §416.1201(b-c).
19. 42 U.S.C. §1396a(a)(17)(D). States occasionally try to force relative contributions, however. *See, e.g.,* Sneed ex rel. Thompson v. Kizer, 728 F. Supp. 607 (N.D. Ca. 1990) (state ordered to desist deeming income from, for example, children to parents and between unmarried cohabiting persons).
20. 42 U.S.C. §1396a(a)(17)(D).
21. *See* Jackson v. Missouri Dep't of Social Servs., 706 S.W.2d 611 (Mo. Ct. App. 1986).
22. However, states have argued (and may again) that assets cannot be "spent down" like income, and must be spent before the application process begins. *See* Haley v. Commissioner of Pub. Welfare, 394 Mass. 466, 476 N.E.2d 572 (1985). The impact of such a rule is clarified by the 2002 Supreme Court case Wisconsin Dept. of Health and Family Services v. Blumer, 122 S. Ct. 962, in which the initial calculation of assets to be transferred to the community spouse led to liquidation a balance in the assets of the institutionalized spouse that could not generate enough income to provide the community spouse's monthly maintenance needs allowance.
23. 20 C.F.R. §416.1220.
24. *See* In re Scrivani, 116 Misc. 2d 204, 455 N.Y.S.2d 505 (N.Y. Sup. Ct. 1982).
25. 42 U.S.C. §1382b(a)(1); 20 C.F.R. §416.1212.
26. 20 C.F.R. §416.1216.
27. *Id.* §416.1218.
28. *Id.* §416.1231.
29. *Id.* §416.1230.
30. *Id.* §416.1201(c)
31. *Id.* §416.1220-.1224.
32. *Id.* §416.1220.
33. *See* Goldberg v. Kelly, 397 U.S. 254 (1970) (on fair hearings).
34. 42 U.S.C. §1396a(a)(3); 42 C.F.R. §431.200 et seq..
35. 28 U.S.C. §2412.

Elder's Advisor

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