



## GENERAL MEDICAID INFORMATION CURRENT AS OF JANUARY 1<sup>st</sup>, 2022

### Eligibility

**Caution:** These guidelines are illustrative and may vary with your individual circumstances.

For individual Medicaid recipients who are blind, certified disabled, or 65 years of age or older, who receive Medicare and are living at home, Medicaid allows \$934.00 in monthly income. \$20.00 in monthly income is disregarded, making an effective allowance of \$954.00. Any income exceeding this amount will be paid either toward the recipient's own health care costs or to Medicaid. The individual is allowed \$16,800 in resources.

For married couples living at home, if both spouses receive Medicare, are blind, certified disabled, or 65 or older, and both need Medicaid, the allowances are \$1,367.00 in combined monthly income, with the \$20.00 disregard making an effective allowance of \$1,387.00, and \$24,600.00 in combined resources.

Included in resources are stocks, bonds, savings, CDs, IRAs, real property (**except for one's home in most cases**), and certain life insurance policies. If an insurance policy's face value is \$1,500.00 or less, Medicaid counts the face value toward the burial fund. If a policy's face value is over \$1,500.00, Medicaid counts its cash value toward the resource limit. Term life insurance policies do not count as resources because they do not have a cash value.

Pre-need funeral and burial accounts purchased for the Medicaid recipient, spouse, and/or immediate family members may be exempt in whole or in part from Medicaid's consideration. To be exempted, the moneys must usually be placed in an *irrevocable trust* account with a funeral director. Any remainder left in the account after the beneficiary's funeral and burial would go to the Department of Social Services. As long as these criteria are met, there is no apparent limit on the amount in the account and only a few limits on items that may be purchased. A separate burial account of up to \$1,500.00 may be kept by recipients and/or spouses in **some** situations, and is

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not counted as an asset by Medicaid. In most cases, one automobile is exempt; that is, its value is not counted as an asset toward the resource allowance.

If one spouse is a Medicaid recipient who needs long-term care in a skilled nursing facility or non-acute hospital care while awaiting nursing home placement, married couples are allowed more resources and income. The enhanced allowances also obtain in certain long-term home health care situations. If the community spouse is not a Medicaid recipient, he or she is allowed to keep combined income of up to \$3,435.00 per month. If the Medicaid recipient is permanently absent from the home, he or she retains a personal expenditure allowance of \$50.00 per month in most cases. Medicaid allows a community spouse to hold on to at least \$74,820.00 in non-exempt resources and the institutionalized spouse an additional \$16,800.00. The resource limits for the community spouse may be increased in **some** cases. It may also be possible for the community spouse to retain more income and resources despite these limits in **some** cases.

### **Transfers of Assets**

Upon application for Medicaid coverage of long-term care, **any resources** held by the applicant or spouse at any time during the period 60 months prior to the application, known as the “look-back period,” **must be accounted for in order for the applicant to become eligible for Medicaid**. Receipts for large purchases must be saved, and should be available if requested by Medicaid. **Any transfer of an asset for less than fair market value (gift), made within the look-back period, will be presumed to have been made for the purpose of qualifying for Medicaid and will likely result in a period of ineligibility for Medicaid coverage of long-term care.**

Medicaid calculates an ineligibility period for Medicaid coverage of long-term care by dividing the fair market value of the gift by the average cost of one month’s nursing home coverage. The result (quotient) represents the number of months the Medicaid applicant/recipient will be ineligible for Medicaid coverage of long-term care. The penalty period would not begin running until the person is receiving the long-term care services and would otherwise, except for the gift(s), qualify for Medicaid.

In New York’s Western Region, Medicaid estimates the average cost of one month’s nursing home care to be \$11,884.00 in 2022. Medicaid uses this figure to determine the length of an ineligibility period for Medicaid coverage of long term care. For example, if a single applicant gave away \$118,840.00 in February 2020, and applied for Medicaid in January 2022, he or she would have restricted Medicaid coverage for exactly 10 months. This 10-month period of coverage ineligibility would not begin to

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run until the person was actually receiving long-term care services and had, in the case of this single individual, \$16,800.00 or less in assets.

***NEW: Two and a half year “look-back” for long-term care services in the community beginning October 1, 2020.***

Beginning October 1, 2020, the new Medicaid rules will require a full review of an individual’s finances, going back two and a half years (30 months), if that person is seeking Medicaid coverage of long-term care services in the community.

This two-and-a-half-year look-back will likely work in the same way that the five-year look-back for Medicaid nursing home coverage does. Thus, beginning on October 1, 2020, if an individual is looking to enroll in a Medicaid run long-term care services program such as the Consumer Directed Personal Assistance Program (CDPAP), that person first must provide two and a half years of financial records (i.e. bank statements, retirement plan statements, etc.) to the Local Department of Social Services (LDSS). The LDSS is the entity that processes Medicaid applications and will review all the provided documents in order to determine eligibility.

*How will this look-back affect eligibility?*

If the LDSS determines there were transfers made for less than fair market value, commonly referred to as an “uncompensated transfer,” then a penalty period is imposed. The applicant must then privately pay for services for the length of the penalty period BEFORE Medicaid will begin to cover the services.

It is not clear, based on the language of the final bill, whether individuals already receiving Medicaid coverage of long-term care services in the community will also be subject to the look-back. There are concerns that if this were the case, then when Medicaid enrollees are due to recertify, a look-back could result in them having a penalty period imposed on them and potentially losing services. However, the current hope is that individuals who are already enrolled in Medicaid long-term care services will be grandfathered into the program and eligibility will continue regardless of past financial transfers.

*What is a transfer for less than fair market value?*

Generally, the LDSS will want further clarification as to where or how certain large transfers were spent. For example, if an individual transfers property during the look-back period, then the LDSS will inquire as to how the proceeds from the transfer were

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spent. This is because there is a presumption in the law that large transfers made during the look-back period were done for the purpose of qualifying for Medicaid. There are a few exceptions to this presumption, but it can often prove difficult to overcome. If an exception cannot be met nor a valid explanation can be provided as to why the funds were transferred during the look-back period, then the LDSS will impose a transfer penalty upon the person seeking Medicaid coverage.

*How does the LDSS determine the penalty?*

Currently, it appears that the formula used when calculating a transfer penalty for long-term services in the community will be the same as that used when calculating transfer penalties for nursing home Medicaid applicants.

There are several people and entities to whom assets may be transferred for less than fair market value without penalty. These include: a spouse, another for the sole benefit of the spouse, a blind or disabled minor or adult child or a trust established for the sole benefit of that child, and a trust established for the sole benefit of an applicant who is under age 65 at the time of the transfer.

There are also a number of people to whom a **homestead** may be transferred without penalty. These people include:

1. A spouse.
2. A minor child (under 21) of the Medicaid applicant/recipient (A/R).
3. A child of the Medicaid A/R who is certified blind or certified permanently and totally disabled; the child can be of any age.
4. An adult child of the Medicaid A/R who has lived with the Medicaid A/R, in the home of the A/R and provided care, for at least two years immediately prior to institutionalization.
5. A sibling of the Medicaid A/R who has an equity interest in the home of the Medicaid A/R, and has lived with Medicaid A/R in the home of the A/R, for at least one year immediately prior to institutionalization.

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With proper Medicaid advice, it is still possible in a limited way to use such exempt transfers as a financial planning tool. Please see a private attorney specializing in Medicaid law for more advice in this area **before** engaging in any estate planning.

This is general Medicaid information. Since every case is different, we advise potential clients to call about specific circumstances: 716-853-3087.

**This information is subject to change at any time.**

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