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THE BASIC RULES OF NURSING HOME MEDICAID ELIGIBILITY IN ARKANSAS - 2009

THE BASIC MEDICAID RULES

For all practical purposes, in the United States the only “insurance” plan for long-term institutional care is Medicaid. Medicare only pays for approximately 2 percent of skilled nursing care in the United States. Private insurance pays for even less. The result is that most people pay out of their own pockets for long-term care until they become eligible for Medicaid.

Major Areas

Eligibility for Medicaid services is based on three main requirements:

- Monthly income of no more than \$2,022.00; and
- Total countable assets of no more than \$2,000.00
- No existing penalty for giving away assets

THE ASSET RULES

The basic rule of nursing home Medicaid eligibility is that an applicant, whether single or married, may have no more than \$2,000 in “countable” assets in his or her name. (\$3,000 for the Elder Choices program.) “Countable” assets generally include all belongings except for:

- (1) personal possessions, such as clothing, furniture, and jewelry,
- (2) one motor vehicle;
- (3) the applicant’s principal residence (if it is in Arkansas); and
- (4) assets that are considered inaccessible for one reason or another.

The Home

The home will not be considered a countable asset and, therefore, will not be counted against the asset limits for Medicaid eligibility purposes as long as the nursing home resident intends to return home or his or her spouse or other dependent relatives live there. It does not matter if it does not appear likely that the nursing home resident will ever be able to return home; the intent to return home by itself preserves the property’s character as the person’s principal place of residence and thus as a noncountable resource. As a result, for all practical purposes nursing home residents do not have to sell their homes in order to qualify for Medicaid.

THE TRANSFER PENALTY

The other major rule of Medicaid eligibility is the penalty for transferring assets. If an applicant (or his or her spouse) transfers assets, he or she will be ineligible for Medicaid for a period of time beginning on the date of application for Medicaid benefits. The actual number of months of ineligibility is determined by dividing the amount transferred by \$4215.00. For instance, if an applicant made gifts totaling \$60,000, he or she would be ineligible for Medicaid for 14.2 months ($\$60,000 \div \$4215.00 = 14.2$ months). Another way to look at this is that for every \$4215.00 transferred, an applicant will be ineligible for nursing home Medicaid benefits for one month.

There is a trap for the unwary in the way the rules are written. The DHS may only consider transfers made during the 60-month period preceding an application for Medicaid, the “look back” period. Thus if a person transfers \$300,000 to his children and applies for Medicaid 59 months after signing

the deed, he will be ineligible for 71.1 months ($\$300,000 \div \$4215 = 71.1$) following the transfer. If, instead, he waits 61 months to apply for Medicaid, the DHS may not take the transfer into account.

Exceptions to the Transfer Penalty

Transferring assets to certain recipients will not trigger a period of Medicaid ineligibility. These exempt recipients include:

- (1) A spouse (or anyone else for the spouse's benefit);
- (2) A blind or disabled child;
- (3) A trust for the benefit of a blind or disabled child; or
- (4) A trust for the benefit of a disabled individual under age 65 (even for the benefit of the applicant under certain circumstances).

Special rules apply with respect to the transfer of a home.

Recently enacted legislation provides a very important escape hatch concerning the transfer penalty. A transfer can be cured by the return of the transferred asset in its entirety. Returning even one dollar less than the original gift will provide no cure.

ESTATE RECOVERY

The state has the right to recover whatever benefits it paid for the care of the Medicaid recipient from his or her probate estate. Given the rules for Medicaid eligibility, the only property of substantial value that a Medicaid recipient is likely to own at death is his or her home. Under current law, the state may make a claim against the decedent's home only if it is in his or her probate estate. Property that is jointly owned, in a life estate, or in a trust is not included in the probate estate and thus escapes estate recovery. Congress has given the states the right to seek estate recovery against such non-probate property.

SPOUSAL PROTECTIONS

Assets

Medicaid law provides for special protections for the spouse of a nursing home resident, known in the law as the "community" spouse. Under the general rule, the spouse of a married applicant, who is otherwise eligible, is permitted to keep one-half of the couple's combined assets (as of the date of institutionalization) up to \$109,560.00. In addition, there is a minimum resource allowance for the community spouse of \$21,912.00.

So, for example, if a couple owns \$90,000 in countable assets on the date the applicant enters the hospital, he or she will be eligible for Medicaid once their assets have been reduced to a combined figure of \$47,000 - \$2,000 for the applicant and \$45,000 (one-half of \$90,000) for the at-home spouse. If the couple owned \$200,000 in assets, the spouse in need of care would not become eligible until their savings were reduced to \$111,560.00 (\$2,000 for the nursing home spouse plus a maximum of \$109,560.00 for the community spouse).

Income

In all circumstances, the income of the community spouse will continue undisturbed; he or she will not have to use his or her income to support the nursing home spouse receiving Medicaid benefits. In some cases, the community spouse is also entitled to share in all or a portion of the monthly income of the nursing home spouse. The DHS determines an income floor for the community spouse, known as the minimum monthly maintenance needs allowance, or MMMNA, which, under a complicated formula, is calculated for each community spouse based on his or her housing costs. (Where the community spouse can show hardship, the DHS may award a larger MMMNA, but only after an appeal to fair hearing.) The MMMNA may range from a low of \$1750.00 to a high of \$2739.00 a month. If the community spouse's own income falls below his or her MMMNA, the shortfall can be made up from the nursing home spouse's income.