

NEW YORK MEDICAID GUIDE

2009

1. What is Medicaid?

Medicaid provides payment for institutional and community-based care for eligible persons who are treated by participating institutions and practitioners. Medicaid covers nursing home care and all other medical care including home care, acute hospital care, physicians and pharmacy.

2. When is a person over age 65 eligible to receive Medicaid?

Medicaid is a means-tested, needs-based program with limitations on income and resources. Anyone who meets the income and resource limitations is eligible to receive Medicaid.

3. Availability of income/resources (assets): What are current asset and income levels that allow Medicaid eligibility?

INCOME: Income is broadly interpreted, and includes earned and unearned income and most government benefits.

The current monthly income limit for a family of one seeking community based Medicaid (i.e., care in the home) is **\$745**. For a family of two, the limit is **\$1,087**.

The current monthly income limit for a spouse of an applicant seeking coverage for nursing home care is **\$2,739**.

RESOURCES: The resource or asset limit for a family of one seeking community based Medicaid (i.e., care in the home) is **\$13,800** plus **\$1,500** in a separate burial account. For a family of two, it is **\$19,200**.

The spouse of an applicant seeking coverage for nursing home care is allowed between **\$74,820** and **\$109,560** in resources, plus **\$1,500** in a burial account.

Income and resource levels are subject to yearly adjustments.

4. What resources are not counted when determining Medicaid eligibility?

Exempt from inclusion in the Medicaid eligibility resource limit are your family residence (without regard to value); irrevocable pre-paid burial expenses; personal and household property; one automobile; and any life insurance policies with a face value of less than **\$1,500**.

The family residence must be the primary residence of the applicant, and/or his or her spouse or minor or disabled child. It may be a one, two, or three family house, and also includes any attached property. In order to qualify as the family residence (referred to by Medicaid as “homestead”), the home must be necessary and appropriate to the applicant. Therefore, if an individual with no spouse and/or no minor disabled child enters a nursing home and is not medically expected to return home, he or she would no longer have an exempt homestead due to the fact that the home would no longer be “necessary or appropriate” for that individual. It would then be treated as an available resource for Medicaid eligibility purposes.

5. How can an individual whose income exceeds the Medicaid limit still qualify for Medicaid?

As discussed above, the income limits are **\$745** for a family of one, and **\$2,739** for a community spouse of the Medicaid applicant. If the individual has otherwise met Medicaid eligibility requirements, that individual would have to contribute any income over these amounts toward the cost of the care of the institutionalized individual on a monthly basis.

6. What are Department of Social Services’ (DSS) requirements to determine Medicaid eligibility for long-term care?

In order to qualify for Medicaid in New York State, the following must apply:

- (a) The applicant must be a resident of New York State;
- (b) The applicant must meet the current monthly income limit subject to the contribution discussed above;

(c) The applicant must meet the resource limits discussed above.

7. What is “spending down”?

If the value of the applicant’s resources is over the allowed amount, that individual would be expected to use his or her assets to pay for his or her long-term care, or “spend down” for care until his or her resources were depleted to the resource exemption amount applicable to that person. In other words, the individual is spending down his or her assets to meet the eligibility resource requirement.

8. What are DSS transfer of asset rules?

Any asset transferred *for the purpose of qualifying for Medicaid* is considered an impermissible transfer of assets for which a penalty is imposed. Any transfer of assets for which the transferor does not receive “fair market value” is considered a transfer for the purpose of qualifying for Medicaid unless it can be proven that the transfer was made for another purpose.

Any transfer or sale of an asset for which the applicant receives the fair market value, no penalty period will be imposed.

For transfers mad exclusively for *some purpose other than qualifying for Medicaid*, no penalty period will be imposed. An example of this type of transfer would be to repay an outstanding debt, or as a gift for a specific purpose, or a gift as part of a long-established pattern of gift-giving.

A period of ineligibility (“penalty period”) will be imposed for any transfers of assets which do not meet the above criteria. A period of ineligibility for Medicaid institutional services will result form these transfers. Medicaid will calculate the period of ineligibility by the following statutory formula: the dollar value of the transfer divided by the average monthly cost for one month of nursing home care equals the number of months of ineligibility for Medicaid institutional services.

For example, if Mr. Smith gives **\$74,180** to his son as a gift, Medicaid will calculate the period of ineligibility by dividing the gift amount by the average monthly cost of nursing home care (**\$7,418**) to equal the number of months of penalty: $\$74,180/\$7,418 = 10$

months.

The average monthly cost of care for our region is currently **\$7,418**.

The look-back period is 36 months (60 months for trusts) until February 1, 2009 at which time resource documentation for the past 37 months (60 months for trusts) will be required. The look-back will increase by one-month increments until February 2011 at which time the full 60-month look-back period will be in place for all transfers of assets. For transfers made on or after February 8, 2006, the penalty period starts on the first day of the month after which assets have been transferred for less than fair market value, or the first day of the month the institutionalized individual is receiving nursing facility services for which Medicaid would be available, which is later.

Any transfer of assets between spouses incurs no penalty period. However, any transfer by either spouse to a third party will create period of ineligibility for the institutionalized spouse, subject to the transfer rules stated above.

9. Can I give my home to my son/daughter so the nursing home won't take it?

The transfer of a personal residence will result in a period of ineligibility unless the personal residence is transferred to one of the following individuals:

- A spouse of the individual;
- A child of the individual who is under 21 or certified blind or permanently and totally disabled;
- The sibling of an individual who has an *equity* interest in the home, and was residing in the home for at least one year immediately before the date of institutionalization; or
- An adult, non-disabled son or daughter who is residing in the home for at least two years immediately before the date of institutionalization, and who was *providing care* to the individual which permitted him or her to reside at home.

An "*equity interest*" is defined as having an ownership interest in the property as evidenced by being named on the deed, having paid monthly mortgage payments or having made capital improvements. "*Providing care*" is defined as making arrangements or actively participating in the arrangement for care, either directly or indirectly, full time or part time.

10. Can I sell my home to my son/daughter for less than its full value and still get Medicaid?

Any transfer for less than full value is subject to imposition of a period of ineligibility calculated on the difference between what full market value of the asset was and the amount which the individual received for the asset.

11. Will Medicaid pay for home care?

Medicaid home care services include:

- Part-time or intermittent nursing;
- Home health aide services;
- Physical, speech, and occupational services;
- Personal care services;
- Care provided through the long-term health care program (“nursing without walls”)

To obtain these services, one must have a written order for a plan of treatment by his or her physician, and must pass a “nursing assessment” and a “social assessment”, which will assess the individual’s need for and appropriateness of the care. The plan of treatment must be approved by the provider prior to commencement of the home care services.

Most importantly, the average net monthly cost of the proposed care is then compared against the average monthly cost in a residential facility to determine if the plan of care is cost effective. If the average monthly cost of the home care exceeds 90% of the cost of institutionalization, the home care will be denied in favor of placement in a facility, subject to certain exemptions, which are stringent.

12. How do Medicaid rules differ for a single person and a married person whose spouse is still living in the community?

A single individual applying for nursing home coverage is allowed to keep \$13,800 in resources and \$50 in monthly income and be eligible for Medicaid. A married person in the community is allowed to keep a maximum of \$109,560 in resources and \$2,739 in

income monthly. The residence of a single individual who will not return home will become an “available” resource for Medicaid qualifying purposes; an institutionalized married person who will never return home retains the exemption on his or her personal residence as long as the community spouse lives there.