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The Cost of Care

New Hampshire Medicaid Rules
for Long-Term Nursing Home Care

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Updated: July 2011

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The benefits of knowing the rules *now*...

When a loved one faces the prospect of entering a nursing home, family members invariably will have many questions and concerns. There are social service agencies and programs in the community which can assist a family in locating home health care, adult day care or other social services, any of which could delay or eliminate the need for nursing home placement.

If, however, nursing home placement becomes a reality, one of the major concerns families face is the high cost of nursing home care – the average cost of nursing home care now exceeds \$8,400/month in New Hampshire.

Unfortunately, it is when nursing home care is necessary that many people fully explore Medicaid options for the first time. It is of great benefit to you, and your family, to understand the rules long before facing this situation personally, or with a family member. Planning ahead can make a big difference.

This pamphlet focuses on how a person can qualify for Medicaid coverage without leaving a community spouse (also referred to as the “at-home spouse”), or other loved ones, destitute. The following is just an overview, and, depending upon your individual circumstances and the date of this update (see cover), other options may be available. Please let us know if you have any additional questions or concerns after your review of this summary.

What is Medicaid?

The Medicaid program is a jointly administered federal and state medical assistance program that pays the cost of nursing home care for financially eligible individuals. The New Hampshire Department of Health and Human Services (DHHS) administers the Medicaid program, and a person must apply for benefits at one of the DHHS district offices. Medicaid rules are complicated and constantly changing, and it is highly recommended that you regularly consult with a knowledgeable attorney about your particular circumstances.

What are Medicaid eligibility requirements?

For a person to be financially eligible for Medicaid, he/she must be both **income eligible** and **resource eligible** at the time of application for benefits.

“**Income**” is money that comes into a household on a regular basis – Social Security Retirement, pension payments, annuity distributions, quarterly interest, etc.

“**Resources**” or “assets” are more akin to savings and include money in a checking or savings account, stocks and bonds, real estate, tangible property, etc.

Money is only income during the month in which it is received; if that money is not spent, it is considered a resource the following month.

What is “resource” eligibility?

An applicant may only have no more than \$2,500 in “countable” resources to be eligible for Medicaid. As discussed, examples of countable resources are stocks, bonds, bank accounts and IRAs. The cash value, or surrender value, of life insurance policies might also be included.

If money is held in a joint account, all the funds are presumed accessible to the Medicaid applicant, and therefore generally countable towards the applicant’s resource limit. A joint owner can protect an interest in the account by either proving his or her regular contributions to the account, or by proving that the account was established as a joint account prior to November 1, 1995. In such a case, the applicant will be deemed to own only a proportional share of the account.

Some exceptions...

Not all resources are countable. For instance, **a person’s home and personal property are not counted towards the \$2,500 resource limit.** Examples of other non-countable resources include one automobile, furniture and irrevocable funeral trusts.

Property that has been placed in an irrevocable trust of any sort will not be counted towards the resource limit since the assets belong to the trust, not the applicant or the applicant’s spouse. However, please refer to the section below relating to transfers of assets, since transferring property into an irrevocable trust *may* disqualify someone from Medicaid.

If the Medicaid applicant is single...

If an applicant is single, the resource eligibility rule is simple: the applicant will be eligible for Medicaid once he/she has only \$2,500 or less worth of countable resources remaining. For instance, if a single man had \$10,000 in countable resources at the time of institutionalization, he will not be eligible for Medicaid until he has spent \$7,500.

If the Medicaid applicant is married...

If an applicant is married, however, the rules are considerably more complicated, as explained below.

The importance of requesting a “resource assessment” early...

If a person is married, all countable resources owned by **either the applicant or the applicant’s spouse, or both**, are taken into consideration during what is known as the “resource assessment.” The resource assessment is intended to take an accurate picture of the couple’s finances at the specific point in time when one spouse is institutionalized.

A resource assessment is *not* a Medicaid application. However, it is a required *first step* in the whole Medicaid application process and must be done through a DHHS district office. This is the *only* method by which the Medicaid applicant and the applicant's spouse can learn the State's official determination of the value of the couple's countable resources.

The resource assessment will inform the couple of the description and value of the resources DHHS contends are *countable*. The resource assessment will also specify the amount of resources the community spouse is allowed to retain, as well as how much money must be "spent down" by the couple before the institutionalized spouse would be eligible for Medicaid.

It is important to review the resource assessment carefully in the event an inadvertent error was made by DHHS. **You can locate** the DHHS office nearest you by visiting the DHHS web site at www.dhhs.state.nh.us. Once at this site, click on the Contact tab and then click on the "District Offices" tab.

Consider a legal consultation. It may be helpful to speak with an attorney with expertise in Medicaid regulations and planning before starting the Medicaid application process.

Spousal resource allowance ...

Medicaid rules expressly protect a *portion* of a couple's resources for the community spouse (i.e. the person living independently in his/her home, in the community). This portion is known as the "spousal resource allowance."

The spousal resource allowance is scheduled to increase every year on January 1st in accordance with the consumer price index. As there was no increase in the consumer price index in 2010, the 2011 figures below are the same as the 2010 figures. The general rule is that the community spouse is permitted to retain one-half of the couple's countable resources; however, there is both a minimum and maximum resource allowance, as illustrated by the chart below:

Spousal Resource Allowance as of January 1, 2011		
Resources valued at, or under, \$43,824	Resources valued between \$43,842 and \$219,120	Resources valued more than \$219,120
\$21,912	One-half	\$109,560

Therefore, the community spouse is permitted to retain **at least** \$21,912, or one-half of the assets up to **a maximum** of \$109,560.

The institutionalized spouse will be able to retain \$2,500 (which is the resource eligibility limit for Medicaid applicants). Under these rules, a couple with \$225,000 (total resources at the time of resource assessment) would be entitled to protect \$112,060, and would be advised to spend \$112,940 before the institutionalized spouse was eligible for Medicaid:

\$109,560 (Spousal resource allowance)
+\$ 2,500 (Institutionalized spouse's resource limit)
\$112,060 (Total protected)
\$225,000 (Countable resources)
- \$112,060 (Total protected)
\$112,940 ("Spend down")

The "spend down" ...

After the resource assessment is complete and the couple has been informed by DHHS as to how much they must spend before the institutionalized spouse can apply for Medicaid, the couple understandably may be concerned about the implications that the required "spend down" will have on the community spouse.

However, Medicaid "spend down" planning *can* take place after the resource assessment, and *should* take place before a formal Medicaid application is made.

Planning your "spend down" ...

First of all, the spend-down amount does not have to be spent solely on nursing home care. The money can be spent on any item or service that provides value to either spouse. For instance, the money can be spent making long-overdue repairs to your home, purchasing a car to replace an existing vehicle, traveling, etc. – as long as the couple is receiving *value* for their money.

There are other planning options, such as purchasing an annuity to benefit the community spouse (an annuity can provide a reliable stream of income for the community spouse). It is important to understand and carefully consider the disqualification rules pertaining to transferring assets prior to making gifts to individuals other than a spouse (see **Beware of "spend down" traps: Know the rules about transfers of property, and related disqualification periods**, on pages 7- 8).

Income eligibility ...

A Medicaid applicant's income must be less than the Medicaid reimbursement rate for the specific nursing facility in which he/she is residing. Only the *applicant's* income is counted. If the applicant is married, the *spouse's* income is ignored when determining income eligibility.

Medicaid reimbursement rates generally exceed \$4,000/month, and they vary from facility to facility.

If an applicant's income is *higher* than the Medicaid reimbursement rate, Medicaid eligibility is only possible if the applicant has expenses that are recognized as permissible deductions, such as court-ordered spousal support payments.

If the Medicaid application is ultimately approved, the community spouse may be entitled to a portion of the institutionalized spouse's income, known as the "spousal income allowance."

"Spousal income allowance" ...

In addition to providing the community spouse with a resource allowance, the Medicaid rules also provide for an income allowance. While the community spouse cannot be forced to use any of his/her own income to help pay for nursing home care once the spouse is on Medicaid, the community spouse *might* be entitled to receive a portion of the institutionalized spouse's income to help pay household expenses.

STEP 1. Minimum Monthly Maintenance Needs Allowance. The starting point in figuring out whether a community spouse is entitled to an income allowance is the "**minimum monthly maintenance needs allowance**," which currently is **\$1,838.75** (as of July 1, 2011). If the community spouse's income is less than \$1,838.75, she/he automatically is entitled to receive a portion of the institutionalized spouse's income in order to bring income up to that figure.

STEP 2. Shelter Costs. The next step in determining the income allowance for a community spouse is analyzing the community spouse's "shelter costs." Shelter costs are those costs associated with maintaining the home (such as home insurance, mortgage payments, property taxes, utility costs, etc.).

STEP 3. Calculating Allowance. If the community spouse spends over **\$552 (as of July 1, 2011)** on shelter costs each month (this figure is known as the "excess shelter deduction"), the income allowance should be increased *over* the \$1,838.75 level, dollar for dollar, to a **maximum of \$2,739** (this figure is known as the "**maximum monthly maintenance needs allowance**"). As with the spousal resource allowance, the maximum monthly maintenance needs allowance is scheduled to increase every January in accordance with the consumer price index, but the 2011 figure is identical to those in 2010.

The minimum monthly maintenance needs allowance is \$1,838.75 (as of July 1, 2011) (rounded up by the Department of Health and Human Services to \$1,839) and is scheduled to increase every year on July 1st with the consumer price index.

Mr. and Mrs. Reynolds: An example

Mr. Reynolds enters a nursing home. His total monthly income includes a pension of \$1,500, and social security retirement payments of \$1,000 (total \$2,500). Mrs. Reynolds has a social security monthly income of \$500, and a small pension of \$150.

Mr. and Mrs. Reynolds own a home. However, between real estate taxes, a mortgage, utility costs and homeowners' insurance, Mrs. Reynolds has monthly shelter costs totaling \$1,046.

Mrs. Reynolds' income allowance would be calculated as follows:

\$1,839 (Minimum monthly maintenance standard)
- 650 (Mrs. Reynolds' individual income)
\$1,189 (Minimum spousal income allowance)

\$1,046 (Mrs. Reynolds' shelter costs)
- 552 (Excess shelter deduction)
\$ 494 (Excess shelter costs)

\$ 1,189 (Minimum spousal income allowance)
+ 494 (Excess shelter costs)
\$ 1,683 (Spousal income allowance from husband's income)

\$1,683 (Spousal income allowance from husband's income)
+ 650 (Mrs. Reynolds' own income)
\$2,333 (Mrs. Reynolds' total monthly maintenance allowance)

Your right to a hearing ...

If the monthly maintenance allowance is not adequate to meet the community spouse's expenses, the community spouse may be able to obtain an increase through a fair hearing. You may also appeal *any* Medicaid eligibility decision if you believe an error has been made.

If the community spouse is awarded a support order from a court to cover living expenses, the state will honor it, even if it brings the community spouse's income *above* the maximum maintenance allowance of \$2,739.

Beware "spend down" traps: Know the rules concerning transfers of property and related disqualification periods.

Some people facing the need for a nursing level of care believe that they must impoverish themselves to become eligible for Medicaid. While this may not be far from the truth, it is essential that you understand the rules concerning the transfer of property, and how these rules could impact Medicaid eligibility.

Both federal and state governments have enacted laws that could disqualify you from Medicaid eligibility if property/assets are deliberately given away in order to reduce resources.

On February 8, 2006, the Deficit Reduction Act of 2005 (the "DRA") was signed into law, resulting in significant changes to the Medicaid gifting and disqualification rules.

In order to determine the disqualification period applicable to a gift (defined as a "transfer of property for less than market value"), five factors must be considered:

- 1) The applicable "look-back" period;
- 2) The date of the gift;
- 3) The value of the gift;
- 4) The applicable "disqualification" period; and
- 5) The average monthly cost of nursing home care (currently **\$8,421.17** in New Hampshire).

The look-back period. At the time of applying for Medicaid, the applicant must reveal any gifts made within the prior 60 months (5 years) - this is commonly known as the Medicaid "look-back period." Any gifts made *more than* 60 months prior to the date of application *do not* have to be revealed.

The value of the gift. The value of the gift, in conjunction with the average cost of nursing home care, will determine the time period (measured in months) of "disqualification" from receiving Medicaid benefits. For example, a \$50,528.00 gift would disqualify an applicant for 6 months: $\$50,528.00 / \$8,421.17 = 6$

When does the "disqualification period" begin to run?

The disqualification will not begin to run until the individual applies for Medicaid and was "otherwise eligible" to receive Medicaid benefits.

For example, if a \$50,528.00 gift was made 24 months before a Medicaid application is filed, the applicant would be denied Medicaid benefits, and would be advised that he or she would not be eligible for Medicaid benefits until a 6-month disqualification period had passed.

Important note: Not all transfers of assets are subject to these rules. For instance, a transfer of an asset from one spouse to another is *never* subject to these rules. Furthermore, there are special rules relating to the transfer of a home. You may need the services of an attorney experienced in Medicaid regulations if you wish to plan well for Medicaid eligibility.

Your home ...

If you are married. As noted earlier, if you are married your home is not a countable resource for Medicaid eligibility purposes. For married couples, the home is always protected for the community spouse. The community spouse will *not* be required to sell the home, and a lien will *not* be placed on the home. **Note:** Under the DRA, only \$506,000 of equity in the primary residence will be exempt unless a spouse, minor or disabled child is lawfully residing in the residence. **Also note:** If a house is titled in the name of a revocable trust, the New Hampshire DHHS will require the house be removed from the trust and titled in the name of an individual owner(s) in order to take advantage of this exemption.

If you are single. A single person, however, *could* be required to sell his/her home within six months of receiving Medicaid *if* there are no other owners of the home, and *if* certain qualifying individuals (disabled adult child and/or minor/dependent child) are not living in the home.

If the home is owned jointly with any other second or third party, there can be no forced sale of the home.

Other important factors regarding home ownership and Medicaid eligibility ...

In addition to protecting the community spouse and other co-owners of real estate, there are additional individuals who receive protection.

For instance, if a disabled adult child or minor/dependent child lives in the home, the home *cannot* be sold and a lien *cannot* be placed on it. In fact, the home could be transferred (that is, "gifted" to them) to a disabled adult child or minor/dependent child without jeopardizing Medicaid eligibility.

Similarly, if an adult child who is *not* disabled lives in the home and has been providing care to the Medicaid applicant for at least two years, enabling the Medicaid applicant to remain at home rather than in a nursing home, the same protections apply.

Protections also apply to siblings of an applicant who have an equity interest in the home and had been residing in the home for at least one year prior to the applicant's nursing home admission.

Your estate: The limitations of government recovery/reimbursement ...

When a Medicaid recipient dies, the state government has an obligation to recover the Medicaid funds (both federal and state) that have been paid towards nursing home care. However, there are very specific *limits* on the state's right in seeking recovery of these monies, and to require reimbursement.

1. Recovery/reimbursement can never take place during the lifetime of the Medicaid recipient's spouse.
2. Recovery/reimbursement is only permitted against the estate of the Medicaid recipient, and not against the estate of the Medicaid recipient's spouse.
3. There are restrictions on the state's right to place a lien against a home, particularly if a spouse, or other protected individual (such as a dependent or disabled child, see above) is living there.

In 2005, the State of New Hampshire expanded Medicaid recovery to encompass "life estates" and joint tenancies in real estate, as well as any asset held by the Medicaid recipient in joint name regardless of when the joint ownership or life estate was established. Under this law, the State has the authority to seek recovery from the other joint owners for the amount of Medicaid paid on behalf of the deceased Medicaid recipient, up to the value of the Medicaid recipient's ownership interest in the asset immediately prior to death. Recovery *shall not* apply to property interests established prior to July 1, 2005, or to non-recipients who paid fair market value for an ownership interest at the time the property was acquired. See RSA Ch. 167:14-a, VI.

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