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**Medicaid Eligibility
for
Long Term Care in Colorado**

INTRODUCTION

For all practical purposes, in the United States the only "insurance" plan for long-term institutional care is Medicaid. Medicare only pays for approximately 7 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. Although *Medicare* is an entitlement program, *Medicaid* is a form of welfare -- or at least that is how it began. So to be eligible, you must become "impoverished" under the program's guidelines.

Despite the costs, paying privately for nursing home care may be advantageous. By paying privately, an individual is more likely to gain entrance to a better quality facility. The obvious disadvantage is the expense; in Colorado, state nursing home fees average \$5,991 a month and Denver Metro fees, \$6,572 per month. These are official Colorado figures. In fact, the costs could be as much as 10% more. Without proper planning, nursing home residents can lose the bulk of their savings.

For most individuals, the object of long-term care planning is to protect savings while also qualifying for nursing home Medicaid benefits. This can be done within the following rules of Medicaid eligibility.

In Colorado, the Department of Health Care Policy and Financing administers Medicaid through local Departments of Human Services. The State publishes regulations in the Colorado Code of Regulations which it modifies frequently to carry out federal and state changes to the law. However, to qualify for federal reimbursement, the state program must comply with applicable federal statutes and regulations. So the following explanation includes references to both state and federal law.

This newsletter reviews the significant highlights of Medicaid in Colorado. Of course, it is simplified and some lesser known aspects are not reviewed. The discussion which follows incorporates the portions of The Deficit Reduction Act of 2005 (DRA) that affect Colorado Medicaid. The new rules concerning how penalties are assessed for gifts, the increase of the look-back period to five years and impacts on annuity planning are discussed.

If the reader is contemplating taking actions that could result in Medicaid impacts, then the reader should consult with an elder law attorney.

THE MEDICAID PROFILE

I call the basic criteria set by the Colorado regulations for a person to qualify for Medicaid, the Medicaid Profile. The applicant must meet the following criteria for him or her to qualify for Medicaid.

- ✓ **Care:** He or she needs a nursing home level of care or supervision
- ✓ **Income.** In Denver, the maximum gross income allowed is \$6,572 per month in 2009.
- ✓ **Resources:** An applicant and his or her spouse may have unlimited exempt assets and counted assets not exceeding \$111,560 for 2009: \$109,560 for the community spouse and \$2,000 for the applicant. A single applicant is limited to no more than \$2,000 in counted assets.
- ✓ **Facility:** He or she must be at a facility that participates in Medicaid.
- ✓ **Bed:** The facility must be able to give him or her a "bed", that is, a bed for which the State will supplement the applicant's income to pay the facility.
- ✓ **Gifts or Transfers Without Fair Consideration:** No prior qualifying gifts or transfers without fair consideration since February 8, 2006. If the applicant or spouse made gifts, then Medicaid payments are delayed during a calculated ineligibility period.

THE ASSET RULES

The basic rule of nursing home Medicaid eligibility is that an applicant may have no more than \$2,000 in "counted" assets in his or her name. In addition, for couples, the "at home" spouse is entitled to an allowance from counted assets of \$109,560 in 2009. Counted assets generally include all assets *except* the following:

- (1) the principal residence in Colorado, if the equity in it does not exceed \$500,000 for a single applicant, and is not counted, for instance, if spouse lives in the home,¹
- (2) one automobile, whatever its value,
- (3) household and personal possessions, such as clothing, furniture, jewelry, etc., but not personal effects acquired for investment, for example, coin collections, gems, jewelry without family significance, etc.,
- (4) a qualifying burial plan or burial trust,
- (5) the cash value of a whole life insurance policy, or policies, owned by either spouse *if* the *face* amount of the policy, or total policies, is \$1,500.00 or less, and
- (6) certain other assets that apply in special situations.

If the nursing home resident applies for Medicaid and signs an official form that he or she intends to return to his home, then the applicant's home will not be considered a countable asset. The home is not countable even if it does not appear likely that the nursing home resident can return home. Therefore, the home will not be counted against the asset limits for Medicaid eligibility.

If the home is titled in the name of a trust, a corporation, partnership, etc., then the home will be counted. Title to the home may be conveyed to the applicant or the applicant's spouse solely or them both jointly. Then, the home will no longer be counted.

¹ or a dependent child under age 21 or blind or disabled child lives in the home.

THE TRANSFER PENALTY FOR GIFTS

Except as explained below, Medicaid regulations create a penalty for transferring assets. Children of the applicant are the most common recipients of counted gifts. An applicant will be ineligible for Medicaid for a period based on a formula which depends on the amount of the gift or “transfer without fair consideration” by the applicant or the applicant's spouse. Dividing the amount transferred by \$5,991² determines the actual number of months of ineligibility. For instance, if an applicant made a gift of \$17,973 before the application, then the ineligibility period is three months³.

Gifts or “transfers without fair consideration” may be taken into account by the Department for five years following the gift. After five years has expired, the gift would not be counted. This rule started on February 8, 2006.

The Regulations do allow a gift to be ignored if the gift was not for the purpose of qualifying for Medicaid. The only case that I have seen so far that has successfully avoided the penalty was one in which the applicant was healthy and had funds for his care at the time of the gift. Later he had a severe stroke and very expensive care. Only on appeal was this section upheld to avoid the effects of the gift.⁴

The gifting rules have created a “Medicaid Trap for the Unwary”. The ineligibility period for a gift is *deferred until the person applies for Medicaid*. This creates a “ticking time bomb” for individuals who are not familiar with the rules. The person who applies meets the Medicaid Profile. Although the applicant would qualify for Medicaid except for making a gift, *Medicaid will not pay the facility until the ineligibility period is over!* For example, if the person made a gift of \$17,973 on or after February 8, 2006, then, upon application, the Department would deny him or her Medicaid payments for the three months after the application. Medicaid would not pay for the applicant's care until the first day of the fourth month after the person applied!

Nursing homes are wary of taking patients who apply for Medicaid. The facilities are worried that they will admit a patient who has made a gift after the enactment date, but the patient or the patient's representative does not know it. The facility may not discharge a patient who is “Medicaid pending”. During that time, the facility receives only the patient's income, less the personal needs allowance, for payment each month. Once the Department denies the application, the nursing home may evict the applicant from the nursing home for nonpayment.

While the patient who made a gift may apply for Medicaid alleging undue hardship as defined by the regulations, hardship is difficult to prove and is rarely approved by the Department of Human Services. An appeal from the denial by the Department may have to be taken without any guarantee of success.

² This amount is increased annually.

³ $\$17,973 / 5,991 = 3$

⁴ There are several criteria in the Regulations that must be met that I have not listed.

A very important “escape hatch” is available concerning the transfer penalty. Returning a transferred asset to the applicant for Medicaid can “cure” the penalty for a transfer. After that, the transfer is treated as if they had never made it.

EXCEPTIONS TO THE TRANSFER PENALTY

Transferring assets to certain recipients will not trigger a period of Medicaid ineligibility. Medicaid authorities recognize the following exempt recipients:

- (1) a spouse⁵
- (2) a blind or disabled child
- (3) the trustee of a trust for the benefit of a blind or disabled child
- (4) the trustee of a trust for the benefit of a disabled individual under age 65

Special rules apply with respect to the transfer of a home. Besides being able to make the transfers without a penalty to the persons named above, the applicant may freely transfer his or her home to:

- (1) a child under age 21
- (2) a sibling who has lived in the home during the year preceding the applicant's institutionalization, and who already holds an equity interest in the home
- (3) a "caretaker child"⁶

TREATMENT OF INCOME

Unlike assets, a couple's income is not pooled for the Medicaid application. Each spouse's income is treated separately: “his is his” and “hers is hers.” Income from joint investments is split equally between the spouses. An applicant in the Denver Metro Area may have no more than \$6,572⁷ per month in income to qualify for Medicaid. If the applicant's income is more than \$2,022 per month but less than the maximum⁸, however, then Colorado law permits a statutory trust to be used to achieve Medicaid eligibility. In this way, an applicant can avoid the dilemma of having both more income than the maximum permitted by Medicaid rules, but not having enough money to pay privately for nursing home care.

Payments received by the applicant from a reverse mortgage or long term care insurance are *not* counted as income. Likewise, VA payments for “aid and attendance” are also not counted.

When a nursing home resident becomes eligible for Medicaid, the recipient must pay all of his or her income, less certain deductions, to the nursing home. The deductions include a monthly personal needs allowance of \$50 or \$90 (if a Veteran) and, for a married applicant, an allowance paid to the spouse who does not receive Medicaid benefits.

⁵ Or anyone else for the spouse's benefit.

⁶The regulations define a caretaker child of the applicant as one who lived in the house for at least two years before the applicant's institutionalization and who, during that period, provided such care that the applicant did not need to move to a nursing home. There are other requirements. See an elder law attorney if you think that you or a child may be a caretaker child.

⁷ For 2009. This amount is increased annually and varies by region.

⁸ The “Gap” or “Utah Gap”

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 rule for Colorado, the spouse of a married applicant is permitted to keep up to \$109,560⁹ of the couple's combined counted assets at the time of the Medicaid application.

So, for example, if a couple owns \$161,560 in *countable assets*, the spouse in need of care would not become eligible until their savings are reduced by \$50,000 to \$111,560: \$2,000 for the nursing home spouse plus a maximum of \$109,560 for the community spouse.

The determination of the level of the couple's assets is made as of the date of the application for Medicaid.

Income

In all circumstances, the income of the community spouse will continue undisturbed. The community spouse will *not have to use his or her income to support the nursing home spouse* who is receiving Medicaid benefits. Sometimes, the community spouse is also entitled to share in all or part of the monthly income of the nursing home spouse; this is called the monthly income allowance. The community spouse may receive income from their spouse to raise their income to a calculated maximum. This maximum takes into account the community spouse's income and certain expenses. The total can range from a low of \$1,750.00 to a high of \$2,739.00¹⁰ a month. If the community spouse's own income exceeds this maximum, then he or she would not share in their spouse's income.

Increasing the Community Spouse's Financial Security: The Medicaid Annuity

If the income from the nursing home spouse is not enough to raise the total income of the community spouse to the minimum level (MMMNA), then the community spouse can purchase a *qualifying*¹¹ irrevocable single premium immediate commercial annuity sufficient to raise the income of the community spouse to the minimum: the MMMNA. I call these "spousal support annuities" because they increase the long-run support for the community spouse. Such an *annuity is not counted as a resource*, but the income from it is counted instead. If it is actuarially sound, then no transfer without fair consideration would occur by purchasing the annuity. If the income from the annuity raises the income of the community spouse above the MMMNA, however, then a gift may result in a period of ineligibility for Medicaid for both spouses.¹²

⁹ For 2009. This amount is increased annually.

¹⁰ For 2009. This amount is increased annually.

¹¹ These annuities must have certain restrictions as part of the contract that only apply to Medicaid situations.

¹² Beware: the regulations in this area are complex and the annuities are *irrevocable*.

RULES FOR ANNUITIES

Beneficiary Designations for Medicaid Annuities

While the community spouse must name the Department of Health Care Policy and Financing as the primary beneficiary of the annuity, the Department may only receive payments if the community spouse has later qualified for Medicaid and a bill has accumulated for the funds spent by the State. Otherwise, the community spouse can name the couple's children or anyone else as the beneficiary of the annuity should he or she die before all the payments have been made. For example, a wife, age 75, could purchase an actuarially sound Medicaid single premium immediate annuity that would pay out for up to twelve years. The beneficiaries of her annuity could receive the remaining monthly payments should she die before the annuity has paid the twelve years or 144 months of payments in full. She does not have to name her husband, who is on Medicaid, as the beneficiary.

If a single applicant is the owner and annuitant of a policy in his or her name, then the applicant must name the Department of Health Care Policy and Financing as the primary beneficiary of the annuity to the extent of any unsatisfied claim for estate recovery. For the applicant who has a spouse or a disabled or minor child, the applicant may name either of them as the primary beneficiary at the applicant's death. The applicant must name the Department of Health Care Policy and Financing as secondary beneficiary.

The Advantages of Individual Retirement Annuities

Individual Retirement Annuities also are not counted. These permit a person to purchase a qualifying irrevocable single premium immediate annuity from funds in an IRA, 401K, Roth IRA, and other qualified retirement plans. These annuities must comply with Section 408 of the Internal Revenue Code. The rules stated above for cash annuities regarding the income as it impacts the MMMNA do not apply to these retirement annuities. No gift can result from their purchase. Upon purchase, the IRA is no longer counted as an asset. Without this treatment, normally an IRA would be counted at 80% of its stated value.

Using the Medicaid Annuity to Support the Applicant During an Ineligibility Period

Families often come to me for crisis Medicaid planning when their spouse or parent needs expensive long term care and the applicant or the spouse has made gifts that the recipients cannot give back. The Medicaid annuity can be used to provide monthly income to add to the applicant's income during an ineligibility period. Between the two sources of income, the applicant can pay the nursing home in full each month. For instance, the individual files the application and then the Department denies Medicaid for five months. During those months, the applicant is responsible for paying the nursing home which costs \$6,500 per month. The applicant has \$1,500 of monthly income. The annuity can pay the applicant \$5,000 per month for five months: \$25,000. After the five months are over, the annuity is paid in full. The applicant then applies again for Medicaid and is eligible. I call this annuity an "applicant support annuity" instead of a "spousal support annuity".

ESTATE RECOVERY

Lien

While a Medicaid recipient is in a qualified facility, the State may file a lien on the recipient's home in limited circumstances. Only if a doctor determines that there is no reasonable likelihood that the recipient will return to the home and after the Department gives notice to the recipient, may the State assert its lien. If the community spouse or certain other persons reside in the home, however, then the State may not file its lien.

Recovery from the Decedent's Estate

Colorado 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, Colorado may make a claim against the decedent's home only if it is in his or her probate estate. The State may not recover, however, if a spouse survives the deceased Medicaid recipient or if there is a child of the recipient who is under age 21, or a blind or disabled dependent of the recipient. Also, the State may not recover its medical expenditures from the sale of the home if a qualifying sibling or child meets certain criteria. For instance, no recovery may be made if a surviving child is a "caretaker child". In the State's discretion, the State may waive, compromise or settle its claims for "good cause."

A probate estate does not include property that is jointly owned, held as a life estate or in a trust, or held in an annuity, etc. and thus these assets escape estate recovery. Congress has given the states the right to seek estate recovery against such nonprobate property. So far, Colorado has not passed laws or regulations to allow such recovery.

The Medicaid Application

Applying for Medicaid is cumbersome and tedious. Every fact asserted in the application must be verified by documentation. The application process can drag on for several months as the local Department of Human Services demands verification regarding such issues as the amount of assets and dates of transfers. If the applicant does not comply with these requests and deadlines promptly, Human Services will deny the application. We often see the children of parents who are applicants for Medicaid struggle to obtain financial information since their parents kept poor records and were secretive regarding their assets. If they do not provide the documents to the Department promptly, then the Department could dismiss the application for "lack of cooperation."

Changes in the Law and Use of Information

Medicaid laws and regulations change frequently. The values showed for levels of benefits and for other calculations increase once a year. Some change in the middle of the year and others at the beginning of the year. The values used in this discussion are accurate through the revision date indicated. Please check these figures with an attorney or Medicaid eligibility technician when applying for Medicaid.

This article is not intended as legal advice but is intended for educational use. The reader should not rely on the information contained in it to make decisions concerning Medicaid. Instead, the reader should consult with a qualified elder law attorney who specializes in Medicaid before taking action concerning a Medicaid matter.

About the Author

The National Elder Law Foundation has certified Mr. Mitchell as an Elder Law Attorney. Colorado, however, does not certify specialists in any field. Mr. Mitchell is past co-chair of the Colorado Bar Association's Elder Law Committee and has been a member of the National Academy of Elder Law Attorneys, Inc. since 1991. He has lectured to attorneys on Medicaid topics. Since 1980, Mr. Mitchell has practiced in the fields of guardianship, probate and estate planning as well.