January 2018

MEDICAID INFORMATION FOR LONG-TERM CARE

- Vehicles
- Income & Savings
- Burial Expenses
- The Homeplace
- Real Property
- Level of Care

INTRODUCTION

There are often many questions about eligibility for Medicaid. This document attempts to clarify and simplify some of those areas. It is not to be taken as legal advice and it is not information that can be easily applied outside of the State of Georgia, since state implementation of the Federal Law may be different in each state. It is also not meant to be viewed as an Estate or Medicaid Planning tool but an educational guide to clarify some of the questions one might want to ask an attorney, an estate planning specialist or a Medicaid specialist with your county DFCS office or your nearest Aging & Disability Resource Connection.

The eligibility numbers in this document will change on at least an annual basis, usually effective Jan. 1. Therefore, it is absolutely necessary that persons using this document check the last revision date to make sure they have the latest edition.

For additional copies of this document, contact the Georgia Department of Human Services Division of Aging Services at 1-866-552-4464. For information about this document, contact your nearest Aging & Disability Resource Connection at www.georgiaadrc.com, the State Legal Services Developer at the Division of Aging Services, the Georgia Senior Legal Hotline at (404) 657-9915 or 1-888-257-9519 or the County DFCS office at 1-877-423-4746.

FREQUENTLY ASKED QUESTIONS

Several questions are normally asked as people begin to think about long-term care and Medicaid. Generally, those questions include:

What other options are there to nursing homes?

What does it take to become financially eligible for Medicaid?

How much money and property can I have and still be eligible for Medicaid?

Can I give away my money and property or some of it and still be eligible for Medicaid?

Do I have to spend all of my money before I can become eligible for Medicaid?

What will my spouse live on if I have to go into a nursing home on Medicaid?

Who will pay for my burial if all of my money has to go to the nursing home?

I promised to help send my grandchild to college; do the Medicaid rules prevent me from doing that?

This publication will answer some of these questions, others will be addressed briefly. You will have to seek counsel for answers for your particular situation and fact pattern. Remember, this document is for educational purposes only and not for estate or Medicaid planning or for legal advice.

Will this publication tell me all about Medicaid?

No. There are a number of different types or classes of Medicaid. This publication will only discuss a few classes that will pay for nursing home care for which one might become eligible. Because the same rules apply, this information can also be applied to those who seek to become eligible for Medicaid for certain home and community based programs such as the Community Care Services Program.

Is this the same as Medicare?

No. Medicaid should not be confused with Medicare. Medicare is the health insurance program funded and operated completely by the Federal Government. One is eligible for Medicare when they turn 65 years old, or they have been disabled for 24 consecutive months or because they have a particular kind of kidney disease. Medicare is applied for at the Social Security Administration and is one of the taxes you pay through your employer as you work throughout your career. Medicare operates under the same rules in every state.

What do you mean by classes of Medicaid?

Medicaid, a federal and state funded program administered at the state level by the Georgia Department of Community Health, has several different categories of Medicaid that offer coverage for different reasons. There is Medicaid for children, pregnant women, the blind, the disabled, the aged and others who meet certain eligibility requirements. Each Medicaid program or class has its own set of rules and requirements. Programs offered in one state may not necessarily be offered in another state and if they are, they may operate under different rules.

How do I find out about options/alternatives to nursing homes?

Georgia's Aging & Disability Resource Connection provides information and assistance, awareness, and access to seniors, people with disabilities, family members, caregivers and professionals who may be seeking help for aging parents, loved ones with developmental disabilities or other disabilities and want community options or need assistance navigating the maze of services. If you are seeking such options or alternatives, contact your nearest Aging & Disability Resource Connection through an Area Agency on Aging by calling 1-866-552-4464 or going to their website at **www.georgiaadrc.com**

What "classes" of Medicaid provide Nursing Home coverage?

Nursing Home Medicaid and Supplemental Security Income Medicaid are the classes of Medicaid that will be dealt with in this document. To keep from making this document extremely long and very confusing, it is best that the requirements for just these classes be addressed here. Another class will not be covered in detail here, except to mention that it was formerly known as the Adult Medically Needy Spenddown Program for Nursing Facility Care for those with income over the maximum amount, which allowed beneficiaries to spenddown the excess amount to the required levels to become eligible for long-term facility care. See Page 7 for Important Information on that type of Adult Medically Needy.

What about the transfer of money and property, will that be discussed here too?

Yes. Since transferring money and property can have a direct impact on whether or not someone is eligible for Medicaid for long-term care, that issue will be addressed in this document.

What does it take to become eligible for the Medicaid that pays for Nursing Home care?

First, for an individual to be eligible for Medicaid, it is necessary to know that person is financially eligible for Medicaid either through Supplemental Security Income or Nursing Home Medicaid. The rules are different for each one and they are addressed later in this document.

Second, there is a required level of care. In order for Medicaid to pay for a person's stay in a nursing home and the care they receive, a person must first meet the required "Level of Care". This means that the state has established certain medical requirements that one through his/her doctor must prove have been met in order to be deemed eligible. Next, the person must already be a resident in a nursing home that is certified to accept Medicaid as payment and must have been there for at least 30 days.

What is the level of care that must be met in order to be eligible for Medicaid to pay for your nursing home stay?

The person must have a physical and/or mental impairment, which requires continued nursing care, monitoring and supervision, under the direction of a licensed doctor. The person must be unable to provide this nursing care to him/herself.

Simply put, the person must meet at least one requirement from column A and one requirement from either column B or C:

A. Medical Status Monitoring / management of a medical condition(s) directed by a licensed physical **[required]**	**B. Mental Status**	**C. Functional Status**
Nutritional management	Memory deficiencies but more than just forgetfulness	Limited / extensive staff help moving around
Skin care maintenance, treatment needed	Trouble making decisions	Assistance needed with feeding and setting up meals
Catheter care	Behavior problems	Direct assistance needed to help maintain continence
Physical, speech or other therapy needed less than five times a week	Undetermined cognitive problems	Communication deficiencies
Specialized nursing services needed to restore person to previous state of health		Personal hygiene, dressing requires direct assistance **[must be accompanied by one of the above]**
Vital signs need to be monitored		
Help needed managing medications		

[NOTE: These categories are being simply and generally stated. More detail on them must be obtained from the administering agency for an actual determination of eligibility.]

What are the rules for Medicaid eligibility under Supplemental Security Income?

Supplemental Security Income is a federal entitlement program available from the Social Security Administration for persons who are 65 years old, blind or otherwise disabled and meet a certain income requirement. In Georgia, Supplemental Security Income entitles a beneficiary to a monthly check and Medicaid eligibility.

When an individual or a couple is in a nursing home or a long-term care situation, these are the general income and resource rules that must be met in order to be eligible for Supplemental Security Income Medicaid to pay for that long-term care:

2018 Maximum Income Limit:	$750 per month for an individual
	$1,125 per month for a couple
	(Income is money that comes into the household during the month)
Maximum Resource Limit:	$2,000 per month for an individual
	$3,000 per month for a couple
	(Think of resources as property of value that is owned for more than 1 month, such as houses, land, cars, cash in checking accounts, savings accounts, IRAs, CDs)

What are the rules for Medicaid eligibility under Nursing Home Medicaid?

2018 Maximum Income Limit:	$2,250 per month for an individual
Maximum Resource Limit:	$2,000 per month for an individual
	$3,000 per month for a couple

If my loved one's income is over the eligibility amount, is it still possible to become eligible for Nursing Home Medicaid?

In order for those persons whose income exceeds the Maximum Income Limit to become eligible for Medicaid for long-term care, they can create a Qualified Income Trust, commonly known as a "Miller Trust" for the excess income. For more information about a "Miller Trust" or to obtain assistance with creating a "Miller Trust", call the Georgia Senior Legal Hotline at 1-888-257-9519 or your local Area Agency on Aging at 1-866-552-4464 for the number of your Elderly Legal Assistance Program provider or contact a private attorney.

What if I am already the Trustee of a Qualified Income Trust, what do I do every month?

If you have already been named Trustee of a Qualified Income Trust, it is most important that you manage the deposit of money into and withdrawal of money out of the Qualified Income Trust properly so that the nursing home resident will continue to be eligible to receive Nursing Home Medicaid. If the Trustee fails to properly handle the Qualified Income Trust, this may result in the termination of Medicaid benefits for the resident, as well as an obligation to repay the program for

payments made on the resident's behalf those months that the Qualified Income Trust was improperly managed.

Here are some helpful pointers for handling the proceeds of a Qualified Income Trust to ensure that Medicaid benefits are not jeopardized:

Monthly Qualified Income Trust Process: This process must be repeated each month that the resident remains in the nursing home under Nursing Home Medicaid.

1. The Qualified Income Trust is unlike other trusts that you may have heard about. The Qualified Income Trust is an income trust, meaning money flows into and out of the Qualified Income Trust each month. Handled properly, the Qualified Income Trust will always have a $0 balance at the end of each month. The only exception to this is if the bank requires a minimum balance to hold the account open.

2. Direct deposits of any monies into the Qualified Income Trust are not permitted.

3. Each month, the county DFCS office will advise the nursing home what the resident's Patient Liability is for that month and the nursing home will inform the Trustee. 'Patient Liability' is usually all of the resident's gross income, minus allowable deductions (see below), and minus the $50 Personal Needs Allowance ($90 for Veteran's Benefits), which the resident keeps.

4. The money deposited into the Qualified Income Trust must be taken from the resident's income, not from the Trustee's income or anyone else's income. The resident must be income eligible for Nursing Home Medicaid in the month in which the Qualified Income Trust is funded. This means, that the first month some of the resident's money is deposited into the Qualified Income Trust, that deposit must be an amount sufficient to reduce the resident's gross income below the maximum income limit of $2,250.

5. The Trustee will make three financial transactions each month: 1) deposit a sufficient amount of the resident's income into the Qualified Income Trust to reduce the resident's gross income to below $2,250. (It is recommended that the gross income be reduced to $1,900, so you don't cut it too close.); 2) withdraw all of the money you just deposited into the Qualified Income Trust and pay it to the Nursing Home. This will reduce the balance in the Qualified Income

Trust to $0, (or the minimum the bank requires, if applicable); and, 3) pay the balance of the resident's Patient Liability to the nursing home from the remainder of the resident's personal income for the month.

Deductions allowed from "Gross Income" include:

- State and Federal Income Taxes that are required to be withheld by the paying agency are allowable deductions.
- Medicare premiums for Part B and Part D are allowable deductions from gross income until the second month following the resident's approval for Nursing Home Medicaid.
- Medical expense(s) that are not covered by third parties or by Medicaid are allowable deductions.

Deductions not allowed from "Gross Income" include:

- Deductions within the control of the resident for state and/or federal taxes
- Mortgage payments on the resident's home
- Property insurance on the resident's home

[The response to the question above is included courtesy of a Fact Sheet prepared by Attorney Mary Winklejohn with the Georgia Senior Legal Hotline.]

The resource limits are really low; does that mean that I have to use up every penny that I have saved?

No, not necessarily. Some resources are included when eligibility is being determined, which means that the total value of those resources must fall within the resource limit. Some resources are excluded when eligibility is being determined, which means that although they fit the definition of a resource, there is a special rule which allows you to own or possess that resource and it doesn't count against you when you're trying to become eligible for Medicaid. See the chart on the following page.

MEDICAID RESOURCES CHART	
Resources	**Rules**
Cash; stocks; bonds; money market accounts; certificates of deposit; etc.	Must not exceed the maximum resource limit for SSI Medicaid or Nursing Home Medicaid
Real property (land) • Noninstitutionalized applicant/recipient homeplace is excluded from resources regardless of the value • The homeplace of the institutionalized applicant/recipient is counted as a resource but the equity value is treated as follows: — If the equity value is $572,000 or less, the property is excluded — If the equity value is over $572,000, the applicant/recipient is no longer eligible for Medicaid payment to the nursing home and Institutionalized Hospice agency — If the equity value is over $572,000, the applicant/recipient is no longer eligible for Medicaid for home and community based waivered services. The applicant/recipient's case is denied/closed.	The house you live in and all the land the house is on and any other buildings on that land as long as the applicant/recipient states in writing an intention to return home or if a dependent family member or spouse is still living in the home while the applicant/recipient is absent. Other instances when real property **may be** excluded as a resource include the following: • If the property is a nonbusiness property and is income producing (rental property is excluded as a resource but the rent is treated as income) up to $6,000 of the equity value may be excluded if the property produces at least a 6% annual return on the excluded portion. • If the property is used to produce goods or services for home use or home consumption, only up to $6,000 of equity value is excluded regardless of the rate of return. Everything over $6,000 is a countable resource.
IRAs A countable resource if there is an option to withdraw the fund as a lump sum, even if ineligible for periodic payments.	IRAs from which payments are being made to the Medicaid recipient are excluded as a countable resource as long as they include part of the principal. Some IRAs may be a countable resource or considered as a transfer of assets.
Annuities Under the Deficit Reduction Act changes, annuities are considered in determining eligibility • An irrevocable, nonassignable actuarially sound annuity providing for equal monthly payments is treated as income to the applicant/recipient or spouse.	**Purchased before 2/8/06** — if actuarially sound, are treated as retirement funds. **Purchased on or after 2/8/06** — the applicant/recipients must name the State of Georgia as the remainder beneficiary if there is no spouse, minor or disabled child. If either exists, the State may be named after them.
Burial accounts	$10,000 limit (see following charts)
Household goods / personal property	Regardless of value, they are excluded, as long as they are not held as an investment.

How is a person supposed to pay for burials and funerals if they can't save any money?

There is a way of setting aside some money for burial.

Some resources are treated differently for SSI than they are for Nursing Home Medicaid and it makes it is necessary to provide additional information about them. Those resources include burial contracts, burial accounts, life insurance policies, automobiles and property other than the homeplace.

See the following tables.

TREATMENT OF RESOURCES UNDER SUPPLEMENTAL SECURITY INCOME RULES	
Resource	**Rules**
Automobile	If one of the following is true, then the entire value of one vehicle is excluded regardless of the amount: • The automobile is needed for employment transportation • The automobile is needed for transportation back and forth for medical treatment • The automobile is needed for handicapped accessibility • The automobile is necessary for the particular climate, terrain or for the performance of activities of daily living
Life insurance	Policies with a face value of up to $1,500 are excluded
Burial contracts	Burial contracts or pre-need contracts which one has with a funeral home to take care of burial arrangements of self, spouse or immediate family members are excluded from consideration of eligibility if the following are true: • It has been paid in full • It is itemized • It is owned by the Medicaid recipient and is for the benefit of him/her or the spouse or an immediate family member (spouse; minor/adult natural, adopted or step children and their spouses; parents and their spouses; and siblings and their spouses)
Burial accounts	Recipients are allowed to have up to $1,500 in a burial account. If one does have a burial account, the total face value of the life insurance policies must be subtracted from that amount as well as any nonburial space portions of an irrevocable burial trust or contract.

TREATMENT OF RESOURCES UNDER NURSING HOME MEDICAID

[Only one burial contract and one cemetery contract per person may be excluded from resources]

Resources	Rules
Life insurance Face value must equal the purchase price of the burial contract; Any life insurance policy used to fund a burial contract that itemizes each item purchased will be treated as a burial contract; Life insurance policies used to fund a burial contract that do not itemize the cost of each item are treated as life insurance policies. The cash surrender value of all life insurance policies having a face value of $10,000 or less may be excluded.	The cash surrender value of a policy is excluded as a resource only if the face value of the policy is used as part of the burial exclusion. If the face value is not used in the burial exclusion, the cash surrender value, regardless of the amount, counts as a resource and cannot be designated for burial.
Burial contracts • The entire refund value of nonitemized contracts counts as a resource or may be applied to the burial exclusion. • The refund value of all nonburial space items in a paid in full, itemized burial contract counts as a resource or may be applied to the burial exclusion. • The entire refund value of a burial contract, for someone other than the recipient or the immediate family, counts as a resource.	The value of a burial contract may be excluded as a resource only if it is: • For the benefit of the Medicaid recipient, spouse or immediate family • Paid in full (partially paid for contracts are a resource that count toward the $10,000 exclusion total) • Itemized (the refund value of burial space items are exempt from resources and the burial exclusion policy)
Burial accounts	Up to $10,000 each is allowed for the Medicaid recipient and his/her spouse but cannot be comingled with nonburial funds and is a part of the $10,000 total for each.
TOTAL BURIAL EXCLUSION	**$10,000 INCLUDES:** • Life insurance • Burial contract • Burial account

TREATMENT OF AUTOMOBILES UNDER NURSING HOME MEDICAID	
Resource	**Rules**
Automobiles	An automobile is considered any vehicle normally used for transportation even if it is broken down and junked. This includes recreational vehicles. Adaptive equipment used for handicapped vehicles does not add to the value for resource purposes.
Equity value is the current market value minus any amount owed on the automobile. Current market value: • Tax value assessed by the county tag office multiplied by 2.5; • The trade in value; or • A dealer's statement of value	The equity value of one automobile per household (even if one member is in a nursing facility) is excluded from consideration of eligibility for transportation. • If more than one automobile is owned, the applicant chooses to which automobile the exclusion will apply; but the exclusion most advantageous to the applicant will be applied and all others are a resource • As long as the car is used for transporting the eligible Medicaid recipient or a member of that recipient's household, the automobile is excluded

[NOTE: Leased vehicles are not a resource. Automobiles registered to or owned by others are not a resource. However, if purchased by the long term care recipient or spouse, it may be considered as a transfer of assets. Automobiles may never have their value designated for burial.]

What if I have a spouse, how is my spouse supposed to live if all the income and savings has to be spent because I'm going on Medicaid to pay for my nursing home care?

There is a program which is considered a companion to the Nursing Home Medicaid program. It is called the Spousal Impoverishment Program. This program is available only to couples when one is on Medicaid and the other continues to live in the community without the assistance of Medicaid.

The benefits of this program keep the community spouse (the spouse not in the nursing home or Medicaid funded long term care facility/program) from being completely without resources and income to maintain living expenses. In order to be eligible under the spousal impoverishment program, the following is allowed:

2018

The community spouse keeps his/her own income and the income of the nursing home Medicaid resident up to a total of **$3,090.00 per month**, minus the nursing home resident's personal need allowance of **$50.00** in the nursing home or **$90.00** if the income is Veterans Benefits.

Any amount over $3,090.00 must be used to pay the Medicaid spouse's long-term care expenses. (There are some exceptions for excess medical expense not paid for by Medicaid.)

The community spouse may keep up to $123,600.00 in resources and may have his/her own life insurance, burial contract and/or burial account of up to a total of $10, 000 in addition to the $123,600.00 resource limit.

The nursing home Medicaid spouse may still have up to $2,000 in resources and may still have his/her own burial contract, burial account and/or life insurance coverage limited to $10,000.

The community spouse may continue to live in the home place and once he/she applies for spousal impoverishment program, has up to 12 months to legally transfer the house into his/her name without a penalty for transfer of assets.

What if it doesn't look like I'm eligible under any of these programs listed here, does that mean that I can't qualify for Medicaid?

No, not necessarily. It just means that this document probably doesn't address the class of Medicaid for which you might be eligible. If you are interested in applying for Medicaid, you should contact the County DFCS office and let a Medicaid worker determine whether or not there is a class of Medicaid for which you might be eligible.

I don't have a spouse who can use my resources and I don't want to have to spend all of my money on long-term care because I have children and grandchildren who could use my money more. Why can't I just put in my Will that all of my money is supposed to go to them?

While you can leave that instruction, remember that a last will and testament has absolutely no effect on anything while one is alive. It is a legal document that states how you want your property distributed after you are dead. Eligibility is affected by resources that you own or have an interest in while you are alive.

If that's true, then I'll just give away everything I have so there won't be anything left to go to the nursing home and just let Medicaid take care of it. Who'll know the difference?

Simply giving away your money and your property so that you can become eligible for Medicaid to pay for your long-term care expenses can be a problem. Federal law requires states to impose a penalty against those who apply for Medicaid within a certain time after they have transferred some or all of their money and/or property for the purpose of becoming eligible for Medicaid.

TRANSFER OF ASSETS

Simply giving away your money and/or your property to become eligible for Medicaid to pay for your long-term care expenses or to avoid estate recovery is a problem. The following sections provide some of the changes that Federal law required states to make to strengthen the policy and penalties available for just such actions.

To give away or transfer assets without receiving the fair market value of the worth of those assets is strictly prohibited and is likely to incur penalties.

NOTE: A penalty can be avoided if the assets that were transferred are returned to the Medicaid recipient.

The Penalty For Transfers

The penalty is eligibility for Medicaid for the institutionalized applicant/recipient but disqualification from receiving Medicaid to pay the vendor portion to the nursing home for as many months as it takes for you to use the amount of money or value of property that you transferred. The amount that you transfer is divided by the average Georgia private pay nursing home billing rate to come up with the number of months of your penalty.

Example: $10,000 transferred ÷ $6,175 (the avg. Georgia nursing home rate since 4/2016) = 1.619 months.

The penalty would be 1.619 months (partial months are now applied)

The applicant/recipient would be responsible for paying the Medicaid rate for one month and for the partial month the applicant/recipient would pay the .619 share. For the remainder (.381), Medicaid would pay.

For home and community-based waivers (i.e. CCSP, ICWP, noninstitutionalized hospice), the applicant is simply not eligible and the case is denied or closed.

Multiple Transfers:
For applications on or after 2/1/2007, transfers for less than fair market value made after 2/8/2006 and within the 60-month look-back period in more than one month

will be combined and treated as one transfer.

Transferring assets for reasons other than becoming eligible for Medicaid or avoiding estate recovery may be allowable; but be sure before making such a transfer.

When does the penalty take effect?

The month the asset was transferred or the month that the applicant/recipient requests Medicaid and is in the long-term care setting, whichever is later, is when the penalty becomes effective. This includes the “three months prior” to the application date that is usually covered by Medicaid.

For reviews, transfer penalties will be assessed on transfers made on or after Feb. 8, 2006. The penalty will begin with the month following the month in which notice can be given.

If a penalty was already assessed on the transfer under the old rules, the transfer will not be reassessed under the new rules.

NOTE: Transfers made by a spouse to someone other than the applicant / recipient will result in a penalty to the applicant / recipient

What if my money is in a joint account or my property is in my name and someone else’s and that person takes the money or property without my permission or knowledge?

The fact that another person jointly owns an asset such as a bank account, certificate of deposit or is on a deed to real property (land) is not a transfer in and of itself. However, if the person who is on the account or deed with you takes money from the account or transfers the property, with or without your knowledge or consent, a penalty may be applied.

POINTS TO REMEMBER

Transferred assets may be recovered to avoid penalties.

Proof may be required to show what steps have been taken to recover transferred assets before any relief is given.

Generally, the burden of proof (the responsibility to convince others that what you say is true) is on the applicant/recipient. There is no "benefit of the doubt" that what you say is true.

Evidence that health or age indicated a need for long-term care may affect how a transfer is treated.

Is there no way that I can provide for my family who depends on me?

Resources may in certain and limited situations be properly used to provide for dependents. Some exceptions under the Federal law allow individuals to legally transfer property and money without being penalized.

See some of the acceptable and nonacceptable transfers in the lists that follow.

TRANSFERS WHEN PENALTIES DO NOT APPLY

- Transfer of the home from the applicant/recipient to the spouse, dependent children (under age 21), disabled children, siblings who were living in the home for one year before you went into the nursing facility and has equity in the home, or to your children if they were living in your home for at least two years and taking care of you before you went into the nursing home
- Transfer to the spouse or to another person for the sole benefit ("no other person or entity can benefit from this transfer") of the spouse
- Transfer from the spouse to someone else for the sole benefit of the spouse
- Transfer to a trust for the benefit of your blind or disabled child
- Transfer to a trust for the benefit of a disabled person who is under the age of 65 years old (The law does not require that this person be a relative.)
- There is proof that the transfer was intended for fair market value or other valuable consideration but it was not received due to fraud or exploitation
- The asset that was transferred was owned by the community spouse and transferred by the community spouse after eligibility was established (Exception: annuities and homeplace property)
- The transfer was made to pay a valid debt
- The asset transferred was a valid loan
- The asset was excluded under Nursing Home Medicaid rules and it was transferred into a trust. For Supplemental Security Income Medicaid, the transferred resource was excluded (not including the homeplace which has specific transfer rules)
- AZsets were transferred but fair market value was received for them
- The assets were transferred exclusively for a reason other than to qualify for Medicaid (not including the homeplace which has specific transfer rules)
- The transferred assets have been returned

TRANSFERS WHEN PENALTIES DO APPLY

- The spouse of an applicant/recipient transfers assets including income to anyone for purposes other than the sole benefit of the spouse during the applicable look back period.
  An applicant/recipient gives away or sells an asset for less than its current market value or refuses an inheritance, during the applicable look back period or any time after that.

- The applicant/recipient or his/her spouse purchases a life estate interest in another person's home without living in the home for at least 12 consecutive months after the date of purchase, gives away the life estate or pays less than fair market value for it

- The applicant/recipient transfers non-excluded assets into a trust during the look back period or any time after that

- The applicant/recipient transfers the homeplace to someone other than those persons listed in the previous chart

- Assets owned by the applicant/recipient jointly with another person are considered transferred by either person when the applicant/recipient's ownership or control is eliminated or reduced. This is true regardless of whether the applicant/recipient had knowledge of the action or gave his/her consent. This includes withdrawals from joint accounts by the other account holder.

- The community spouse transfers an annuity or homeplace to anyone for purposes other than the sole benefit of the community spouse during the 60-month look back period (This affects transfers made on or after Feb. 8, 2006.)

- The applicant/recipient's asset is transferred or given away to someone (other than the spouse) who provided free care to the applicant/recipient. The transfer to a relative or others for this care provided at no cost to the applicant/recipient in the past will be considered transferred for less than fair market value. Evidence can be presented to rebut this presumption.

HARDSHIP PROVISIONS

Undue hardship provisions only protect the applicant/recipient. They do not apply to or protect the community spouse unless he/she is applying for the classes of Medicaid previously discussed in this information.

When it is not undue hardship:

- The application of the penalty only inconveniences or restricts the lifestyle of the applicant/recipient
- After the institutionalized spouse transfers assets to his/her spouse, the community spouse refuses to use or make those assets available to the institutionalized spouse
- If applicant/recipient's total available income and assets or the applicant/recipient and his/her spouse's income and assets, when combined, are sufficient to cover the costs of the applicant/recipient's medical care and food (remember, the spouse's protection is not a consideration for hardship)
- Applicant/recipient's health or life would not be endangered (his/her health would not be irreparably harmed and a doctor can certify that application of the penalty will not kill the applicant/recipient)

One of these three must be true to qualify for undue hardship:

- An institutionalized spouse has excess resources/assets that would normally cause him/her to be ineligible for Medicaid, but to do so would cause an undue hardship on the applicant/recipient
- Distribution is received from a Medicaid qualifying trust that would normally cause an individual to be ineligible for Medicaid and denial of Medicaid would cause an undue hardship to the applicant/recipient
- Assets were transferred into a trust or for less than fair market value, which would normally cause ineligibility for Medicaid for nursing facility services or home and community based services, but to do so would cause undue hardship to the applicant/recipient

MEDICAID ESTATE RECOVERY

See **www.dch.georgia.gov** for the latest information
(http://dch.georgia.gov/medicaid-estate-recovery)

What is estate recovery?

Estate recovery is a federally mandated and state operated program that seeks to recover from the estate of the person who received long-term care Medicaid benefits, dollars to reimburse the state for what the Medicaid Program spent on the recipient.

When did this change occur?

Federal Law changed in 1993, and though a change was reflected in the Georgia Code, Georgia did not implement the program until the Georgia General Assembly in 4/2004 passed an appropriations bill requiring the implementation of Medicaid Estate Recovery by the Department of Community Health (DCH), Georgia's Medicaid agency. In the 2006 General Assembly, necessary changes were made to Estate Recovery and the final rules were completed to allow implementation of Estate Recovery effective May 2006.

Who is affected by estate recovery?

Affected by estate recovery are those Medicaid recipients who received Medicaid payment and are:

a. A resident of a nursing facility, regardless of their age;

b. A resident of an intermediate care facility for the mentally retarded or other mental institution, regardless of age; or

c. At least 55 years of age or older and received medical services consisting of home and community-based services, (this includes Medicaid waiver programs such as the Community Care Services Program), nursing facility services, personal care services, hospital services and prescription drug services provided in nursing facilities or while receiving home and community based services.

What is meant by recovery?

The state will place a lien on the property that it identifies as eligible to be used to reimburse the state for the dollars spent on the Medicaid recipient. That property

may include the house and any other property owned by the Medicaid recipient at the time of his or her death or in which s/he held an interest. This includes real property that passes by joint tenancy, right of survivorship, reserved life estate, trust, annuity, and any other arrangement. It also includes excess funds from a burial trust or contract, promissory notes, cash and personal property. The Rules allow for certain exemptions such as estates valued at $25,000 or less.

When does recovery take place?

Federal law does not allow recovery to begin as long as the:

- Medicaid recipient is still alive;
- Medicaid recipient's spouse is still alive whether or not the spouse is living in the home;
- Recipient's child (if under the age of 21) is alive, whether or not the child is living in the home;
- Recipient's child is alive, if that child is blind or permanently and totally disabled, regardless of whether or not that child is living in the home.

What is a lien?

A lien means a claim, encumbrance or charge against the Medicaid recipient's real or personal property because of Medicaid dollars paid to the recipient correctly under the State plan. A lien may be placed on the real property of a recipient who is an inpatient of a nursing facility, intermediate care facility for the mentally retarded, or other institution or a lien may be placed on both real and personal property of a recipient after his/her death.

Is there any provision for the state releasing a lien?

The state may release a lien if a Medicaid recipient who was deemed permanently institutionalized leaves the institution and returns home or at the closing if the property upon which there is a lien is sold. Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, P.L. 97-248 liens are tools used to keep Medicaid recipients from selling their home while they are in the program. If a recipient is in a nursing home for 6 consecutive months he/she is considered permanently institutionalized and DCH will send him/her an Estate Recovery letter stating they will put a TEFRA lien on the property. At that time the recipient may reply that there is a community spouse, sibling or child (exemptions) to keep DCH from placing the lien on the

home. If the exemptions do not apply or the recipient does not request the exemptions then the TEFRA lien will be placed on the home. The TEFRA lien must be removed if the recipient leaves the nursing home or dies. DCH can place a different type of lien on the property after the recipient's death but they are more interested in working with the family or personal representative on figuring out how the debt will be paid.

What are the exceptions to enforcement of a lien on the home?

The state may not enforce a lien under any of the following circumstances:

- While an adult child of the recipient is living in the home, if that child lived in the home for at least two years on a continuous basis prior to the recipient's admission to the nursing home and provided care that kept the recipient from entering the nursing home; or,
- While the brother or sister is living in the home, if he or she lived there at least one year prior to the recipient's admission to the nursing home.

When the notice is sent after the Medicaid recipient's death and there is no spouse, if the only property is legitimately held in joint ownership, will the state require that the property be sold to recover the accrued debt if the estate has no other assets and this interest exceeds $25,000?

This is not clearly established. The only thing that is definite is that the state will try to collect the debt from the value of the deceased recipient's property (personal and real) if the value exceeds $25,000. They are willing to work with the personal representative in any way possible.

Are there any provisions for a waiver?

The Rules explain under what conditions a hardship waiver can be applied for and granted.

Some grounds for granting a waiver included:

- The asset to be recovered is an income producing farm of one or more of the heirs and the annual gross income is limited to $25,000 or less, or
- Recovery of assets would result in the applicant becoming eligible for governmental public assistance based on need and/or medical assistance programs.

Who can apply for an undue hardship waiver and how is it done?

Undue hardship waiver requests may be made by the personal representative or heirs of the Medicaid recipient's estate within 30 days of receiving the Medicaid notice against the estate, or upon the sale, transfer or conveyance of the real property subject to a TEFRA lien. The Estate Recovery Unit will provide detailed instructions on how to file for an undue hardship waiver in the Medicaid notice.

Where in the line of debts does the state's claim fall?

The state will not pursue the recovery of an estate until the six month expiration of the date the personal representative is qualified by the probate court to handle matters of the estate. The following is a list of the debt priorities and where the Medicaid claim falls in this list.

- Year's support
- Funeral expenses $5,000 or less ($0 if there was a prepaid funeral contract covering the expenses)
- Administration expenses for the estate
- Reasonable expenses of the Medicaid recipient's last illness
- State and/or federal taxes
- Medicaid Estate Recovery is a debt due the state and is equal with state taxes

When does the state's claim against the estate expire?

It does not expire, nor is it barred for lack of timeliness or because the Probate of the estate is closed.

What expenses must be reimbursed?

In accordance with the State's plan, expenses incurred by Medicaid, for any service provided in a long-term care facility and for individuals receiving institutional services in the home, Medicaid payments for nursing facility services, home and community based services, related hospital services and prescription drug services are recoverable. Recovery is for medical expenses incurred beginning Aug. 1, 2001, or the first month of Medicaid eligibility, whichever is later.

What assets are considered subject to recovery?

Estate includes all real and personal property (i.e. homes, real estate, vehicles, cash and other financial instruments) held individually or jointly. Assets subject to recovery also includes property held with a life estate interest.

How will the value of the property be determined?

Regarding real property, DCH will review the tax appraisals and allow family members to help them determine the value through clear and convincing evidence.

How will Medicaid go about recovering assets?

Estate recovery will occur when the State files a notice of claim against the estate of a deceased Medicaid recipient. No action to recover debt due by the deceased recipient will be taken against the personal representative or heirs until six months after personal representative or heirs have been notified.

Can I transfer my assets to avoid the Estate Recovery Program?

If you are thinking of transferring your assets, you should contact your county DFCS case worker prior to the transfer to evaluate how the transfer may affect your Medicaid eligibility to find out what penalties may be applicable.

Because Medicaid recipients with spouses had up to 12 months to make the transfer prior to the implementation of this program, does the state intend to recover property that was transferred by a recipient to his/her spouse after qualifying for Medicaid?

Whatever the recipient does under the eligibility rules is still allowed. DCH simply recommends that the recipient confirm any transfer with the caseworker because DCH will speak to the caseworker after the recipient's death and if the caseworker did not know about the transfer, did not authorize it and indicates that it was not done under the eligibility rules then DCH will also have a problem with it. DCH's look-back for estate recovery to determine sales and/or transfers was 36 months prior to 2006 and is 60 months thereafter.

How much money will my estate owe back to the Medicaid program?

If you meet the criteria for estate recovery, your case will be evaluated to establish the exact amount owed to Medicaid at the time of death. The amount requested

will be limited to the amount that Medicaid has paid on qualified expenses and the available assets.

How do I find out how much has been paid for Medicaid services?

Recipients may request this information by fax at (678) 569-0066 or call the estate recovery unit at (770) 916-0328.

Does this program apply to me if I am not receiving home and community-based waiver services or nursing home services?

No. However, if in the future you enroll in one of these services, yes it will apply to you.

FOR MORE INFORMATION

For additional information, contact the Medicaid Estate Recovery Office at **770-916-0328** or visit **www.dch.georgia.gov**.

Questions on Medicaid Estate Recovery can be submitted to **GAEstateRecovery@dch.ga.gov**.

This is not all there is to Medicaid for long-term care. Other issues/factors may need to be considered.

Each situation could be different from another person's situation; what works for your neighbor may not work for you.

Even if it looks like you may be eligible because of what you read in this document, for other reasons, you may not be eligible.

Even if it looks like you may not be eligible because of what you read in this document, for other reasons, you may be eligible.

For legal advice specifically tailored to your situation, speak with an attorney knowledgeable about this subject.

For other information about how the Georgia Department of Human Services Division of Family and Children Services applies the rules of Medicaid, call your county DFCS office.

Remember that laws and rules change from time to time. Always check your information before making major decisions.

For transfer alternatives to nursing home placement, please contact the Aging & Disability Resource Connection within your Area Agency on Aging at **1-866-552-4464** or **www.georgiaadrc.com**.

NOTES

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