BASICS OF MEDICAID PLANNING

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Medicaid is a federal and state program that provides health insurance coverage to low income children, seniors, and persons with disabilities. It also covers nursing home care for those individuals who meet certain income and resource eligibility requirements, which is typically referred to as "Adult Medicaid." This article will focus on Adult Medicaid coverage for both skilled and intermediate levels of nursing home care and planning steps that can be taken to qualify for coverage under the Medicaid program. Adult Medicaid does not cover rest home or assisted living care for indigent seniors or those with disabilities. However, this level of care is covered by the "Special Assistance" program in North Carolina which is similar to Adult Medicaid but has different eligibility requirements.

In North Carolina, Adult Medicaid is administered by the Division of Medical Assistance of the Department of Health and Human Services ("DMA"). Throughout the state, the county Departments of Social Services ("DSS") assist DMA with local program management.

DSS is tasked with reviewing Adult Medicaid applications and determining that eligibility requirements have been satisfied. In order to qualify for Adult Medicaid benefits, the individual must first medically require intermediate or skilled nursing home care and be a resident of an appropriate facility providing such care. Next, the individual may have no more than $2,000 in "countable" assets if single or $3,000 for a married couple where both are in a nursing home facility. Finally, the individual's maximum allowable income is tied to the Medicaid reimbursement rate for the facility at which the individual resides. The individual's net monthly income must be paid to the nursing home, with the Adult Medicaid benefits covering any deficiency. Some relief is provided from the income eligibility requirements in order to provide for the individual's non-institutionalized spouse.

"Countable" assets for this purpose generally include all property except the following: (1) prepaid burial contract, (2) a personal residence, (3) income-producing property, (4) tenancy-in-common interest in real property, (5) term life insurance, (6) one motor vehicle, and (6) personal possessions such as clothing, furniture, and jewelry. This is a general non-exclusive

list, and there are limitations and exceptions that may need to be considered in any individual case.

Some individuals will attempt to impoverish themselves in order to meet the Adult Medicaid eligibility requirements by making transfers of assets to family members. Some transfers are permitted under the Adult Medicaid rules; however, the rules can be complex and discourage transfers of assets for less than their fair market value. If the transfers do not comply with the rules, benefits eligibility can be denied. Currently, DSS will review all transfers made during the 5-year period beginning when the applicant is institutionalized and has applied for Adult Medicaid. Any uncompensated transfers or transfers not otherwise complying with the rules will result in a sanction period during which benefits will not be paid. The sanction period is for a specified number of months and is calculated by dividing the total of all amounts transferred during the look-back period by $6,300.

Medicaid planning is a complex matter with many regulations and potential planning opportunities available. If you have any specific questions about your personal planning situation, please contact our office so that we can discuss planning for your particular situation.