

IMPORTANT CONTACTS



For a referral to an attorney who can provide advice and counseling regarding the Medicaid Income and Asset Rules for Nursing Home Residents, contact the **NH Lawyer Referral Service** at

(603) 229-0002 or apply online at

<https://www.nhbar.org/lawyer-referral-service>



If you have any questions regarding the treatment of a resident in a nursing home or assisted living facility, you should contact the **Office of the Long-Term Care Ombudsman** at

1-800-442-5640 or (603) 271-4375

or by email at LTCOP@dhhs.state.nh.us.



If you are 60 years of age or older and are being transferred or discharged from a nursing home or assisted living facility, you may contact the **New Hampshire Legal Assistance Senior Law Project** at 1-888-353-9944.

Date of issue: January 2020

MEDICAID INCOME AND ASSET RULES FOR NURSING HOME RESIDENTS

As of January 2020

GUIDE FOR NEW HAMPSHIRE RESIDENTS SEEKING MEDICAID COVERAGE FOR NURSING HOME CARE

Prepared by the Elder Law, Estate Planning, and Probate Section
of the New Hampshire Bar Association
and
New Hampshire Legal Assistance



New Hampshire
BAR ASSOCIATION
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I. THINGS TO CONSIDER BEFORE NURSING HOME PLACEMENT

Whenever a person's failing health raises the issues of nursing home care and Medicaid coverage, everyone involved should keep three important goals in mind:

1. Considering options that will enable him/her to remain at home as long as possible;
2. Protecting the health and financial security of the community spouse, if any; and
3. Obtaining Medicaid coverage when necessary if nursing home care is eventually required.

Before placing someone in a nursing home, all other alternatives should be considered. Many disabled and elderly people can remain at home if they can obtain services in their homes, such as meals-on-wheels, home health care, chore services, and visiting nurses. In addition to paying for nursing home care, Medicaid operates the Choices for Independence program (formerly called Home and Community-Based Care), which pays for a variety of services for frail elders and disabled people who are ill enough to be in nursing homes but wish to remain at home or in a residential care facility. Financial eligibility for Choices for Independence may vary from the rules discussed in this pamphlet. To find out more about Choices for Independence, contact your local Medicaid office or ServiceLink at 1-866-634-9412.

In making placement decisions, it is vital to consider the well-being of the healthy, or "community spouse." That spouse's health should not be jeopardized by continuing to care for a disabled spouse who needs care that is beyond the capacity of the healthy spouse to provide.

C. Transfers of the Home

A disqualification penalty will not be assessed if the home was transferred to a spouse or to a minor or disabled child. Also protected are transfers of the home to a sibling who has an equitable interest in the property and who was residing in the home for at least one year immediately prior to the applicant's entry into a nursing home. The transfer of the home to an adult (non-disabled) child is protected only if that child lived in the home for two years immediately prior to the applicant's entry into a nursing home, and if the adult child can prove that he/she provided care that helped delay the applicant's institutionalization.

V. GET ADVICE

The Medicaid rules are complex and subject to change. Anyone considering entering a nursing home or applying for Choices for Independence, or anyone considering nursing home placement for a spouse or family member, should always seek up-to-date advice on these issues from a knowledgeable attorney. For help in finding an attorney who can assist you, contact the Lawyer Referral Service at (603) 229-0002 or <https://www.nhbar.org/lawyer-referral-service>.

IV. TRANSFERS OF PROPERTY AND TRUSTS

A. Disqualification for Transferring Assets – General Rule

For years, the State of New Hampshire and the federal government have sought to prohibit wealthy persons from giving away all their property so as to impoverish themselves deliberately and thus qualify for Medicaid. The State will inquire about any transfer of property that took place 60 months prior to the Medicaid application. A transfer for less than fair market value during the 60-month "look-back" period may be disqualifying.

The disqualification period does not begin to run until an application for Medicaid has been filed, and the applicant is found to be eligible for Medicaid, but for the fact that a disqualifying transfer was made. The length of the disqualification is calculated by dividing the value of the property transferred by the average monthly "private pay" nursing home bill. This average is currently \$10,753. Therefore, a transfer of \$150,000 would disqualify an applicant for just under 14 months ($\$150,000 \div \$10,753 = 13.95$). A transfer of \$100,000 would have to be disclosed on any Medicaid application filed within the next 60 months. If an applicant has made multiple transfers, the penalties for each transfer are added together so that the disqualification is lengthened.

No disqualification period is ever assessed if transfers were made to the Medicaid applicant's spouse or to a child who is permanently and totally disabled.

B. Trusts

The State will inquire about transfers of property into an irrevocable trust that took place within 60 months of the Medicaid application. You should consult with an attorney before creating an irrevocable trust, or if you have questions about how the Medicaid rule applies to a trust already created.

II. MEDICAID INCOME AND ASSET RULES FOR SINGLE NURSING HOME RESIDENTS

A. Assets

In order to qualify for Medicaid, a single person can have no more than \$2,500 in countable assets. A person's home as long as the equity value is less than \$595,000, vehicles, furniture, clothing and other personal effects are not countable. All liquid assets such as stocks, bonds, bank accounts, and IRAs are countable. The equity value of life insurance policies is countable if the combined cash surrender value of all policies is greater than \$1,500. If the total combined value is less than \$1,500 or if the state has been made the beneficiary of the policies, the life insurance policies are not a countable resource. A person can qualify for Medicaid for up to three months, even if the value of her life insurance policies exceeds the asset limit, if her medical and nursing home bills offset the excess countable assets and the life insurance policy proceeds are used to pay these bills. Assets placed in a joint account which was created on or after November 1, 1995, are considered entirely available to the person applying for Medicaid, unless it can be shown that the other joint owners also contributed to the account.

B. The Home

Since homes with less than \$595,000 in equity are not countable assets, most homeowners may qualify for Medicaid. If, however, the Medicaid applicant is the sole owner of the home and has no spouse or children living with her, the State requires that the home be sold within six months, unless the recipient's institutionalization is temporary and she is likely to be able to return to her home. (See Section III.D below, for a discussion of the rights of the spouses, siblings, and children who reside in the Medicaid recipient's home.) The State will extend the six-month period if the recipient can show that she has been trying without success to sell the home.

The State will allow a Medicaid recipient to use a limited portion of her income to maintain her home, instead of paying it to the nursing home, only if the recipient's physician states that she will likely be able to return home within three months.

If the recipient rents her home or if it is otherwise income-producing, she is not required to sell it. Likewise, if it is owned jointly with another person who refuses to sell, she will not be disqualified for failing to sell her home.

Whenever a recipient does sell a previously excluded residence, the proceeds from the sale become a countable asset. The recipient may then lose eligibility for Medicaid until she has spent down this lump sum to the point where her total countable resources are again \$2,500 or less.

C. Income

A single person in a Medicaid certified nursing home will be eligible for Medicaid if her monthly income does not exceed the Medicaid reimbursement rate assessed for her particular nursing facility. Because the monthly Medicaid rates for nursing homes generally exceed \$4,500, only a person with significant monthly income will not be income eligible. A single person is allowed to keep a small monthly personal needs allowance (personal spending money) and to pay for health insurance premiums. All the rest of her income must be paid over to the nursing home.

III. MEDICAID INCOME AND ASSET RULES FOR MARRIED RECIPIENTS

The Medicaid rules protect the “community spouse” (i.e. the healthy spouse at home) by allowing the spouse to keep some of the institutionalized spouse’s income, if needed, and a portion of the couple’s assets.

A. Spousal Income Allowance

Although married couples generally combine their incomes to meet their household expenses, the original Medicaid rules required that the institutionalized spouse’s entire income be paid over to the nursing home. Since the early 1990’s, however, spousal protection rules allow the healthy spouse at home to receive an allowance from the income of the spouse in the nursing home.

Furthermore, if a minor or disabled child still lives in the home, no forced sale can be made. Likewise, if a sibling of the Medicaid recipient still lives in the house and has some claim of title to the property and had lived there for at least one year prior to the recipient's entering into the nursing home, no forced sale can be made. Finally, a forced sale of the home cannot occur if an adult child is living there, and that adult child had lived with his/her parent for at least two years prior to the parent's entry into the nursing home, and can prove that he/she had provided care that delayed the parent's entry into the nursing home. (See also Section IV C, below, relating to “Transfer of the Home”).

E. State Recovery of the Cost of Medical Assistance

New Hampshire may file a claim to recover the cost of Medicaid spent on behalf of an individual from that individual’s probate estate, but not if the individual is survived by a spouse, or a minor or disabled child. There also are restrictions on the State’s ability to recover against a primary residence. (See Section III D above). A Medicaid recipient’s probate estate is defined to include a life estate interest in real estate, as well as property owned jointly with another person. No sooner than 45 days after the death of a Medicaid recipient, DHHS shall notify the other joint owner(s) of its claim for recovery. Recovery is limited to the amount of the Medicaid funds expended on behalf of the recipient, and cannot exceed the recipient’s interest in the property. Moreover, DHHS shall not pursue recovery if it creates an undue hardship for the surviving joint owner(s).

C. Ask for a "Resource Assessment"

Under the rules, a couple is entitled to have the State do a "resource assessment" or "snapshot" at the time that one spouse enters a nursing home, whether or not the nursing home spouse is eligible for Medicaid at that time. This assessment enables the couple to find out as early as possible the maximum share of their assets that can be protected. The resource assessment helps prevent the couple from spending more than necessary and unduly jeopardizing the at-home spouse's financial security. The resource assessment is not a Medicaid application. To apply for Medicaid, an application must also be submitted. Both a resource assessment and Medicaid application are completed at local offices of the NH Department of Health and Human Services (DHHS) or ServiceLink Resource Centers.

Once a couple provides the necessary financial information, they will get a written assessment explaining how much may be retained by the community spouse as a resource allowance, and how much must be spent before the institutionalized spouse will qualify for Medicaid. If the community spouse needs a greater portion of the assets because of the monthly income it provides, she can request a fair hearing after a Medicaid application has been submitted and denied.

D. The Home

Contrary to persistent rumors, a couple is not required to sell their home in order to obtain Medicaid coverage. Instead, the healthy spouse is permitted to remain in the home as long as she/he lives, even after the death of the Medicaid recipient, and no forced sale can be made. In addition, a surviving spouse of a Medicaid recipient does not have to worry about a "Medicaid lien" being filed on his/her home.

As an example of how the income allowance rules work, consider a couple with monthly income of \$2,500, consisting of \$750 in Social Security for the wife, and \$900 in Social Security and \$850 from a pension for the husband. If the husband is in a nursing home on Medicaid, his wife, as the community spouse, is entitled to as much of his income (after a monthly deduction of \$70 for his personal needs allowance in the nursing home) as is necessary to bring her total income up to a **minimum of \$2,114 per month.** Therefore, she will be permitted to retain at least \$1,364 of her husband's income:

\$2,114	(Minimum total spousal income)
- 750	(Wife's income)
\$1,364	(Spousal allowance from husband's income)

If the community spouse has monthly shelter costs (rent, mortgage, property taxes, insurance, utilities or monthly condominium fee) **in excess of \$635** (the "shelter deduction"), she can obtain a higher allowance (assuming the nursing home spouse has sufficient income), **up to a maximum limit of \$3,216.** For example, if the wife from the prior example has shelter costs of \$808, she would be entitled to an additional \$190 from her husband's income:

\$808	(Actual shelter costs)
- 635	(Shelter deduction)
\$173	(Excess shelter allowance)

This would mean that instead of keeping \$1,364 from her husband's income, she could retain \$1,537 to add to her own income of \$750, for a total income allowance of \$2,287.

When more of the institutionalized spouse's income is given to his wife to protect her financially, less of his income goes to pay the nursing home bill. The services he receives at the nursing home remain unchanged.

The minimum monthly maintenance allowance for spouses, now \$2,114, generally increases on July 1st of every year in accordance with the consumer price index, as does the shelter deduction, now \$635. The maximum maintenance allowance, now \$3,216, generally changes every January 1st.

If the community spouse can show she cannot meet her reasonable expenses even with the minimum allowance and excess shelter allowance, she can request a fair hearing to seek a higher allowance. She will have to produce verification of her expenses at the fair hearing. If the community spouse obtains a support order from a court, even if it is higher than **the maximum maintenance allowance of \$3,216**, the state must honor it.

B. Spousal Resource Allowance

In addition to permitting the community spouse to receive an income allowance, the Medicaid rules protect a portion of the couple's "assets" or "resources" for the community spouse. Currently, the resource allowance granted to a community spouse is **the greater of:**

- 1) **\$25,728 or**
- 2) **one-half of all the couple's assets, up to a maximum of \$128,640.**

The minimum and maximum spousal resource allowance generally increases on **January 1st** of every year.

When the community spouse's resource allowance is calculated, all of the couple's assets are pooled together, regardless of whether they are actually owned separately or jointly, and regardless of any prenuptial agreement to the contrary. Which assets are countable is explained in Section II.A of this pamphlet. All but \$2,500 of the assets in excess of the allowance must be spent before Medicaid coverage will begin.

The following table shows what the community spouse's resource allowance will be in New Hampshire depending on the total value of all the assets:

In New Hampshire

Assets at or less than \$51,456	Assets between \$51,456 and \$257,280	Assets more than \$257,280
\$25,728	One-half	\$128,640

Under these rules, if a couple has \$10,000 in assets, the community spouse would be allowed to keep all of these assets, and his/her spouse would be immediately eligible for Medicaid. A couple with \$45,000 in assets could protect \$25,728 for the healthy spouse and \$2,500 for the ill spouse, but would have to "spend down" the remaining \$16,772. A couple with \$60,000 in assets would be able to protect \$30,000 (1/2 of \$60,000 being greater than \$25,728) for the community spouse and \$2,500 for the institutionalized spouse; they would have to spend \$27,500 before Medicaid would find the ill spouse eligible. A couple with \$260,000 in liquid assets can only protect \$128,640 for the community spouse and \$2,500 for the institutionalized spouse. All the rest would have to be spent before Medicaid eligibility could be established.

It is important to note that the money which must be spent down can be used for any purpose that would benefit either spouse, such as home repairs, vehicles, life insurance, prepaid funerals, furniture, travel, etc. However, it cannot be given away. (See the discussion of "Transfers of Property and Trusts" in Section IV, below).

As with an unmarried applicant, the couple's principal residence and certain other assets such as furniture, vehicles, burial plots, and irrevocable funeral trusts are not counted at all in determining eligibility.¹ (See Section II, above).

¹ The principal residence will be considered a countable resource if titled in the name of a revocable trust. Once removed from the trust, it again will be treated as an exempt resource.