
Pennsylvania Medicaid Long Term Care Services

DISCLAIMER

The purpose of this document is to provide a general overview of eligibility for Medicaid Long Term Care (LTC) in Pennsylvania. It is intended to serve as a prerequisite to training required for insurance producers who sell, solicit or negotiate LTC Partnership (LTCP) insurance policies as part of the LTCP Program in Pennsylvania.

This document is **not** to be used to determine eligibility for Medicaid LTC services. Determining eligibility for Medicaid is the responsibility of the Department of Public Welfare (DPW) through the local County Assistance Office (CAO). **All Medicaid eligibility determinations shall be made only by the CAOs. Producers should refer consumers to the local CAO or the toll-free Welfare Helpline at 1-800- 692-7462 for assistance with Medicaid eligibility determinations.**

The information in this document relates primarily to the rules to qualify for Medicaid LTC and the interface with the LTCP program. This document includes Medicaid eligibility rules and dollar limits that are correct at the time of publication. These rules and the dollar amounts change periodically.

OVERVIEW OF MEDICAID

The Medicaid Program provides health care coverage to low income families and certain categories of aged and disabled individuals. Enacted in 1965, the program is jointly financed by Federal and State government. The Federal government through Health and Human Services establishes guidelines for its operation and each State administers its own program and determines eligibility criteria; the

type, amount and duration of services; and the rates for payment for services.

Medicaid LTC Services includes services received in an institutional setting or services received under one of the Home and Community Based Services (HCBS) programs.

NOTE: The phrase “Medicaid LTC Services” used in this document refers to individuals receiving Medicaid benefits in either setting unless otherwise noted.

Over the past decade, Medicaid has become a major payer of health care services for the elderly and disabled. As the population ages, the cost of providing these services continues to soar. In 2004, the Medicaid Program accounted for approximately 47% of the payment for LTC services.

LONG TERM CARE PARTNERSHIP (LTCP) PROGRAM

The LTCP program empowers individuals to plan for and finance for future LTC while reducing the financial strain on the Medicaid Program.

The Pennsylvania LTCP Program is a cooperative effort between private LTC insurers and Medicaid designed to encourage individuals to plan ahead and provide for their long term health needs. The LTCP Program benefits an individual by allowing the individual to retain resources in an amount equal to the insurance benefits paid under a qualified LTCP insurance policy that they would normally be required to spend on LTC. If the individual needs assistance in paying for LTC and applies for Medicaid, resources protected under Medicaid and Estate Recovery are equivalent to the amount of LTC insurance benefits paid under a LTCP policy.

An individual must still meet other eligibility criteria referenced below (non-financial, financial and medical) to qualify for Medicaid LTC. It is important to note that only resources are protected under a LTCP policy not income. Any pension, Social Security or other income must be used to help pay for LTC costs. An individual does not have to exhaust their qualified LTCP insurance policy benefits prior to applying for Medicaid LTC Services.

The LTCP program works like this: An individual buys a qualified LTCP policy. If LTC services are needed, the policy helps pay for care and the individual does not have to rely on Medicaid. If she continues to receive LTC services and eventually needs help paying for her care, she can apply for Medicaid LTC to help pay; however, she is not required to spend all her resources in order to qualify for Medicaid. When determining eligibility for Medicaid LTC, resources up to the amount the LTCP policy has paid in benefits will be excluded and the same amount of resources will also be excluded from estate recovery after the individual passes away.

EXAMPLES: Below are three examples illustrating how a LTCP policy works for an individual and interfaces with Medicaid (1) when the policy has exhausted benefits and (2) when the policy is still in force and paying benefits, and (3) when an individual does not own a LTCP policy.

1. Mr. Jones buys a qualified LTC insurance policy that meets the requirements of the LTCP Program. The policy provides for \$100,000 in coverage. Several years later, Mr. Jones needs nursing home care following a stroke. The LTCP policy covers most of the costs for three years but the benefits payable under the policy have been exhausted and paid \$100,000 for his care. Mr. Jones applies for Medicaid LTC at the local CAO. Applicants normally must spend down most of their available resources to qualify for Medicaid LTC but Mr. Jones is able to preserve \$100,000 of his resources and still qualify for Medicaid to help pay for his LTC if he meets the other eligibility criteria (discussed below).
2. Mr. Smith buys a qualified LTC insurance policy that meets the requirements of the LTCP Program. The policy provides for \$100,000 in coverage. Several years later, Mr. Smith needs LTC services but also applies for Medicaid to “supplement” payment for his care along with the LTCP insurance benefits. Mr. Smith currently has \$100,000 in resources which is the amount of assets he wants to protect. The policy paid out \$92,000 in benefits with \$8,000 remaining. Mr. Smith meets all the Medicaid LTC eligibility criteria therefore Medicaid along

with his LTCP insurance will pay for his monthly long term care needs. Mr. Smith is able to preserve \$92,000 in assets because the LTCP policy he purchased paid \$92,000 in benefits.

3. Mr. Miller does not own a LTCP policy but needs LTC services due to an extended illness. Mr. Miller has \$100,000 in resources accumulated over the years and would like to preserve his resources to pass on to his heirs. Mr. Miller applies for Medicaid and is determined ineligible for Medicaid LTC until he reduces or spends his resources down to an amount of \$8,000 or less.

LONG TERM CARE INSURANCE POLICIES AND “QUALIFIED PARTNERSHIP” POLICIES

Long-term care insurance policies (LTC) are generally designed to provide coverage for long-term care services. However, the benefits provided under each LTC policy may vary due to the options available and benefits selected by the individual purchaser. For example, coverage under a LTC policy may vary based on the setting or services received, reimbursement method or benefit levels.

LTC policies may also be either federally tax-qualified or non tax-qualified policies. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established federally “tax-qualified” LTC policies. Therefore, LTC policies meeting HIPAA requirements are deemed to be “tax-qualified” and are given favorable tax treatment. Insurers may offer both federally tax-qualified and non tax-qualified LTC policies.

The Deficit Reduction Act (DRA) of 2005 facilitated the development of LTCP programs in states. The DRA also sets forth conditions that a policy must meet before it can be deemed a “Qualified Partnership” policy. Following are a few key requirements for a Qualified Partnership policy:

- The policy must cover an individual who was a resident of a Qualified Partnership State when coverage first becomes effective.

- The policy must be a federally tax-qualified LTC policy
- The policy must include inflation protection based on the individual's age at the time of purchase:
 - Individuals under age 61 must have annual compound inflation protection
 - Individuals age 61 to 76 must have some level of inflation protection.
 - Individuals age 76 or older must be offered an inflation protection option.

It is important to note that the purchase of a Qualified Partnership policy does **not** guarantee Medicaid eligibility or benefits. Individuals who have Qualified Partnership policies must still meet Medicaid eligibility requirements before they can qualify and receive benefits under Medicaid.

ELIGIBILITY CRITERIA – MEDICAID LTC

An individual applying for Medicaid LTC Services must submit an application to DPW through the local CAO. An individual must meet non-financial and financial criteria requirements and be certified medically eligible to receive LTC payments. DPW determines non-financial and financial eligibility. The Pennsylvania Department of Aging through the local Area Agency on Aging (AAA) certifies that an individual is medically eligible for LTC Services.

Non-Financial Criteria (includes but is not limited to):

- Age
- Social Security Number (Enumeration)
- Residence-No requirement to the length of time an individual resides in PA to be considered a resident. If an individual is admitted to a LTC facility in Pennsylvania and intends to remain in PA, the individual is considered to be a resident of PA. If the individual intends to return to another state he/she is not a resident of PA.
- Citizenship/Identity

- Medical Certification – A Medical Assessment to determine if an individual is in need of LTC Services. This includes a DPW medical assessment form completed by a qualified medical professional usually at the Hospital and/or in the LTC facility and completed by the local AAA which is then forwarded to the CAO.

Financial Criteria

There are two types of Medicaid LTC eligibility:

Categorically Needy Non-Money Payment (NMP) which covers individuals with low income (up to 300% of Federal Benefit Rate) and limited resources.

Medically Needy Only (MNO) covers individuals with slightly higher income and resources and who have incurred high medical or LTC expenses.

Categorically Needy NMP

Income Limit: \$1,869 monthly gross (adjusted annually)

Resource Limit: \$2,000 limit with an additional \$6,000 resource disregard. With the disregard an individual may have up to \$8,000.

NOTE: Individuals requesting HCBS are evaluated only under the Categorically Needy NMP criteria.

Medically Needy Only MNO

Income Limit:

- \$2,550 semi-annual net
- Eligibility for the MNO category includes unearned and earned income deductions plus medical expense deductions from an individual's gross income.
- Medical expense deductions include the six month projected cost of nursing facility care at the private rate.

Resource Limit: \$2,400

Income - Payment towards the Cost of Care

An individual receiving HCBS is not required to make a payment towards the cost of care.

An individual receiving Medicaid LTC Services in a LTC facility is required to make a monthly payment towards the cost of care to the facility. The payment is based on gross monthly income minus certain deductions.

The CAO computes the payment towards the cost of care as follows:

- Gross monthly income
- Minus \$45/month personal needs allowance (Standard)
- Minus potential deductions:
 - Home Maintenance Deduction (amount in 2007 is \$650.40/month),
 - Spousal/Dependent Maintenance Allowance (specific to each case).
 - Guardian Fee (up to \$100/month).
- = Resulting amount is paid monthly by the individual.

NOTE: Certain medical expenses not covered by Medicaid are deducted by the LTC Facility.

Example:

Individual's gross monthly income includes monthly Social Security income in the amount of \$800 and a monthly pension in the amount of \$500. Individual has total gross income of \$1,300.

Gross income	\$1,300
Personal needs allowance	- <u>\$45</u>
Individual's cost of care payment	\$1,255/month

NOTE: The individual may be entitled to other deductions that may include one or more of the deductions listed above.

RESOURCES

The CAO will evaluate each resource owned by the applicant and the spouse of an applicant if a married individual is applying for Medicaid LTC services. The CAO will determine if the resource can be obtained and if the resource should be counted or excluded.

Countable Resources:

Countable resources include but are not limited to:

- Personal property that includes cash, all bank accounts that can be liquidated such as checking, savings and Certificate of Deposit accounts, mutual funds, IRAs and investment accounts, savings bonds etc.
- Life Insurance-applicant and/or a spouse of a married applicant must own policy for the policy to be counted. If the total face value of all insurance policies owned by the same individual is more than \$1500, than the cash value of the policy and/or policies is/are countable. The first \$1000 of the cash value of countable policy/policies is exempt for each insured individual.
- Vehicles (one vehicle is excluded). All vehicles are considered whether they are inspected, licensed, unlicensed or inoperable.
- Real Property Residential. Ownership will have to be reviewed by the CAO. If the applicant intends to return to the residential property, the residential property is excluded at application but may be subject to Medicaid Estate Recovery.

Non-countable resources:

Non-countable or exempt resources include but are not limited to:

- Household goods, jewelry, furniture
- One vehicle
- 1 home (if there is intent to return and Equity Value is less than \$500,000 or if a spouse, dependent or disabled child lives in the home).

- Burial spaces/plots (subject to limits)
- Cash surrender value of life insurance up to \$1,000 if face value of policy is more than \$1,500.

Trusts can be counted and/or excluded as a resource and/or income. Trust documents will be reviewed by the CAO. Trusts are often reviewed by DPW legal counsel if a decision can not be made by the CAO.

Annuities: In determining Medicaid LTC eligibility, an annuity is evaluated as either qualified or non-qualified.

1. Medicaid Qualified - employer established account or individual retirement plan such as an IRA.
2. Medicaid Non-Qualified – annuity purchased outright by an individual and not part of a retirement plan.

A Medicaid qualified annuity belonging to the community spouse (CS) is not considered an available resource. Medicaid non-qualified annuities belonging to the CS may or may not be treated as an available resource depending on if the income generated from the annuity meets the Community Spouse's Monthly Maintenance Needs Allowance (CSMMNA to be discussed under Spousal Impoverishment section)

As of March 5, 2007, a change in Federal law required that if an applicant or a recipient of Medicaid LTC Services owns an annuity that was purchased on or after February 8, 2006, it must meet the following requirements:

- Is irrevocable and non-assignable;
- Is actuarially sound;
- Provides for payments in equal amounts, with no deferral and no balloon payments made; and
- Names DPW as primary beneficiary for at least the total amount of Medicaid paid on the behalf of the applicant or recipient.

Or

When a CS, minor child or disabled child exist and are named as the primary beneficiary, DPW is named as the beneficiary in the second position.

TRANSFER OF ASSETS

Assets include all income and resources of the individual and of the individual's spouse if the individual applying for Medicaid LTC Services is married.

Transfer of Assets for less than fair market value (FMV):

If assets were transferred by a Medicaid applicant or the spouse of the applicant or a recipient within the look-back period, the transfer is reviewed to determine if FMV was received. If FMV was not received, the transfer could result in a period of ineligibility. The individual would be ineligible for payment of Medicaid LTC Services during this period. The individual would, however, qualify for other Medicaid benefits if otherwise eligible.

- This policy applies to applicants who submit a Medicaid LTC application on or after March 5, 2007 **and** who transferred assets on or after February 8, 2006. It also applies to recipients who transferred assets on or after March 5, 2007.
- The period of ineligibility is calculated as follows:
 - All periods of ineligibility are calculated in days. Currently the daily rate is \$222.17 (adjusted annually)

Example: Applicant gives a \$5,000 cash gift to their child. 5,000 divided by \$222.17 results in 22 days of ineligibility for payment of Medicaid LTC Services.

- Look-Back Period

Asset transfers that occur during a certain period of time prior to an application for Medicaid LTC are evaluated by the CAO. This period is called the Look-Back Period.

 - The look-back period for transfer of assets for less than FMV made on or after February 8, 2006 has increased from 36 months to 60 months beginning 02/08/2006.

- There will be no impact of this policy until February 9, 2009. Beginning 02/09/2009 it will be a month by month increase in the look-back period. A full 60 month look-back will be in effect February 9, 2011.
- Begin date for the period of ineligibility.
 - If the asset transfer occurred on or after February 8, 2006 **and** the Medicaid LTC application was submitted on or after March 5, 2007, the period of ineligibility begins the first date that Medicaid LTC Services are needed.

Example: Mr. and Mrs. S transfer \$10,000 to their child in August 2006. Mr. S submits a Medicaid LTC application on or after March 5, 2007. Their income and resources are within the Medicaid limits on April 1st of 2007. The period of ineligibility is determined for 45 days (\$10,000 divided by \$222.17) beginning April 1, 2007 through May 15, 2007. Mr. S would not be eligible for payment of Medicaid LTC Services until May 16, 2007.

NOTE: Mr. S would be eligible for other services provided by the Medicaid Program during the period of ineligibility. Mr. S would be responsible for paying the cost of care services charged by the LTC facility.

Spousal Impoverishment Protection Provisions

Special Medicaid rules apply to couples to ensure that the CS who does not need LTC Services does not become impoverished when the other spouse needs Medicaid to help pay for the cost of LTC services.

The CS may retain an amount equal to one-half of the couple's combined countable resources, up to a maximum of \$101,640. If one-half of the couple's combined countable resources are less than

the minimum resource level of \$20,328, then the CS may retain resources up to \$20,328. The amount that the CS is allowed to retain is known as the “protected share”.

The couple must submit a Resource Assessment Form in order for the CAO to compute the total resources owned by the couple.

NOTE: The minimum and maximum resource standards change annually in January.

Examples:

- If a couple owns a total of \$210,000 in countable resources on the day of admission to the LTC facility, the CS can protect the maximum resource standard amount of \$101,640.
- If a couple owns a total of \$150,000 in countable resources on the day of admission to the LTC facility, the CS can protect one-half of the total resources in the amount of \$75,000.
- If a couple owns a total of \$35,000 in countable resources on the day of admission to the LTC facility, the CS can protect the minimum resource standard of \$20,328.

NOTE: A Resource Assessment Form is not required if both spouses are applying for or receiving Medicaid LTC Services. In this situation, both spouses are evaluated as individual applicants.

The monthly amount of income that the CS needs for food, clothing, shelter and personal needs is known as the Community Spouse Monthly Maintenance Needs Allowance (CSMMNA). The minimum monthly amount of income that the CS is permitted to prevent impoverishment is \$1,650 and the maximum amount is \$2,541.

The CS does not have to use his or her income to help pay for the LTC Services received by the spouse applying for or receiving LTC Services.

In some cases, additional resources above the protected share of resources may be protected for the CS in order to provide additional

monthly income for the CS. Effective March 5, 2007 the Institutionalized Spouse (IS) must first make available his/her monthly income to the CS to meet the CSMMNA. If the CS still does not have sufficient monthly income to meet the CSMMNA, additional resources above the protected share may be used to generate monthly income for the CS.

If a consumer has questions related to Medicaid LTC eligibility and the current financial limits, they should contact the Welfare Helpline at 1-800-692-7462.

MEDICAID ESTATE RECOVERY PROGRAM

The Medicaid Estate Recovery Program was established under Federal law and requires the DPW to recover specific Medicaid payments from the probate estates of certain Medicaid recipients who have died.

An estate of an individual includes property or assets owned entirely or in part by the deceased. Estate Recovery will only recover property and/or assets belonging to the estate of the deceased.

Medicaid Estate Recovery applies only to the estates of deceased Medicaid recipients:

- age 55 and over
- who received Medicaid LTC Services after August 15, 1994 including nursing facility care, HCBS, hospital and prescription drug services provided while receiving nursing facility care and/or HCBS.

Medicaid Estate Recovery occurs **only** after the death of an individual who meets the criteria above.

Questions may also be directed to the Medicaid Estate Recovery hotline at 1-800-528-3708.

NOTE: Insurance benefits paid under a LTCP policy are excluded from Medicaid Estate Recovery.