Special Report

Medicaid eligibility for persons in nursing homes

by Letty Carpenter

Presented in this article is an overview of Medicaid policies affecting persons in nursing homes and other institutions that provide long-term care—the criteria they must meet to qualify for Medicaid and the costs of care paid by the Medicaid program and by Medicaid recipients themselves. Underlying these complex policies, and creating sometimes peculiar consequences, is the fact that the population served in institutions and the nature of the benefit are different from the Medicaid program in general, although many of the rules affecting eligibility are the same.

Introduction

Medicaid is the major source of public funding for long-term institutional care, contributing about 45 percent of total expenditures on long-term institutional care by all sources. The other principal source of funding is long-term care patients themselves. Coverage of these services under private insurance and Medicare is extremely limited.

Despite the prominent role of Medicaid in financing long-term institutional care, the rules governing how individuals can qualify for assistance are not well understood. The purpose of this article is to outline major aspects of Medicaid eligibility policy affecting persons in long-term care.

Programs preceding Medicaid

Enacted in 1965, Medicaid grew out of and closely resembled the medical assistance programs that preceded it in the States. Although Federal funding was available for the Kerr-Mills[1] program from 1960 to 1965, and the Old Age Assistance program from 1935 to 1960, Federal requirements on States were minimal, resulting in considerable variability among the States. Medicaid only marginally reduced State-by-State variations because it was more an incremental expansion of earlier programs with a new name and some new Federal requirements rather than an entirely new program. This makes it difficult to make general statements about how Medicaid works on a national basis.

[1]The Kerr-Mills program was a transitional link between earlier programs that provided grants to States and later programs (Medicare and Medicaid) that entitled individuals to medical assistance.

Reprint requests: Letty Carpenter, 339 H Hubert Humphrey Building, Room 345-G, Washington, D.C. 20201.

Medicaid as an acute care program

As originally conceived, Medicaid was essentially patterned after health insurance available to the working population through private or employer-sponsored coverage and about to be made available to the elderly with the enactment of Medicare, that is, services would meet acute and ambulatory health care needs. The long-term care component of Medicaid grew less by purposeful design than by afterthought and reaction. Given these origins, it should not be surprising that Medicaid coverage of long-term care is often described as having gaps and being too medically oriented.

The original Medicaid legislation required States to cover services in a skilled nursing facility (SNF) as part of the basic minimum package of services, however, there is no suggestion in the original legislation or in the 1971 amendment adding intermediate care facilities (ICF's) as an optional Medicaid service that Congress ever intended Medicaid to be the major public funding source for long-term care. Rather, the Medicaid SNF benefit, like its Medicare counterpart, seems to have been viewed as a cost-effective alternative for recipients who would otherwise spend protracted stays in more expensive acute care settings. Similarly, the inclusion of ICF services in Medicaid was motivated by a congressional reaction to safety and quality of care problems in uncovered long-term care settings; it was hoped that the situation could be improved by imposing a Federal role in setting and enforcing standards.

Thus, Medicaid covers long-term institutional care in the following kinds of facilities: skilled nursing facilities, intermediate care facilities, including the facilities for the mentally retarded (ICF's/MR), as well as to certain long-term hospital stays, for example stays in psychiatric or rehabilitation hospitals. To receive Medicaid payments, these kinds of facilities must be certified as meeting Federal and State regulatory requirements and they must agree to participate in the program. Their distinguishing feature is that they serve persons who need relatively intensive levels of nursing care. However, there is an exception: Medicaid payments are prohibited for any services used by Medicaid eligible persons 22-64 years of age in institutions for mental diseases that have more than 16 beds. This prohibition perpetuates the States' long-standing responsibilities for funding large State mental institutions.

Other types of residential long-term care placements might be considered to be a logical component of a comprehensive long-term care program. They are not considered to be institutions under Medicaid, however, if the services they provide are essentially custodial or supervisory rather than medical in nature.

Such settings are known by a variety of different names, for example, boarding homes, homes for the aged, domiciliary or congregate care facilities, adult foster care, adult homes, and others.

In 1987, 37 States elected to spend State-only funds to support low-income residents of State-designated custodial care arrangements. These States make State supplemental payments (SSP's) to supplement the incomes of residents of these facilities whose income from other sources, including any assistance the person receives from the Federal Supplemental Security Income (SSI) program, is insufficient to cover monthly expenses in the facility plus incidental personal needs. Residents use their income, including any SSI or SSP payments they may receive, to pay the facility's rate for the total package of services that the facility provides. States have the option of providing Medicaid to persons receiving an SSP, but only if they meet all the eligibility criteria for SSI except for income.

Residents of such nonmedical facilities who qualify for Medicaid, either as an SSP recipient or under another eligibility category unrelated to the person's residential status, receive Medicaid assistance for covered services such as a hospital stay, physician visits, or prescription drugs provided by practitioners outside the facility.

Medicaid as a welfare program

Like the federally funded assistance programs for medical and long-term care that preceded it, Medicaid was originally viewed as a program for welfare recipients or for people who had been reduced to welfare-like circumstances by their medical expenses.

In keeping with its welfare origins, Medicaid eligibility rules are deeply rooted in the rules for the federally funded cash assistance programs (the Supplemental Security Income program for the Aged, Blind, and Disabled, and the Aid to Families with Dependent Children program). Because the principal categories of recipients in long-term care institutions are elderly or disabled, it is SSI rules that drive Medicaid eligibility rules for these individuals, even though the two programs serve different needs of somewhat different populations.

In addition, the Medicaid statute generally does not authorize eligibility rules tailored to the specific needs or characteristics of persons in institutions. With a few exceptions, the rules are generally the same for the institutionalized as they are for persons living in the community even though, one could argue, the two populations are not comparable. Because the majority of Medicaid recipients live in the community, it is this population that the rules are principally designed around. An important exception, enacted July 1, 1988, as part of a legislative initiative to provide protection to the elderly and disabled against catastrophic medical costs, is the set of rules protecting income and resources for the spouses of Medicaid recipients in long-term care facilities at amounts higher than those that would be protected under SSI or AFDC guidelines.

From 1965 to 1977, the Federal agency responsible for administering Medicaid was the same agency that administered the AFDC program (the Welfare Administration, subsequently reorganized as the Social and Rehabilitative Services Agency). In 1977, Federal responsibility for Medicaid was shifted, along with responsibility for Medicare, to the newly established Health Care Financing Administration, which was created to provide a coordinated Federal approach to health care financing and prepare the administrative groundwork for President Carter's hoped-for comprehensive national health insurance program. However, this shift in responsibility was not accompanied by a rethinking of Medicaid eligibility rules that remained deeply rooted in the federally funded welfare program, SSI and AFDC.

Divided jurisdiction over Medicaid explains much of the complexity of the Medicaid eligibility policy. In Congress, the Ways and Means Committee of the House of Representatives has jurisdiction over SSI and AFDC, but not over Medicaid. Nevertheless, by changing those programs, that committee exerts a major influence over Medicaid eligibility, even for groups, like most Medicaid recipients in long-term care institutions, who are not and never have been SSI or AFDC recipients. The Energy and Commerce Committee has jurisdiction over Medicaid but not SSI or AFDC.

Divided responsibilities also exist in the executive branch of the Federal Government, with the Social Security Administration carrying responsibility for SSI, the Family Services Administration for AFDC, and the Health Care Financing Adminstration for Medicaid. At the State level, responsibility for administering Medicaid may also be fragmented, with general responsibility for administering Medicaid located in the State Medicaid agency but with control over eligibility located in the State welfare agency.

Mandatory eligibility for Medicaid

States are required to provide Medicaid to recipients of federally matched cash assistance, either SSI or AFDC. The more relevant program to the issue of long-term care eligibility is SSI because virtually all long-term institutionalized persons are aged, blind, or disabled, and are not part of the AFDC-related population. Therefore, the following discussion generally does not consider AFDC rules or families.

As of 1988, 36 States and the District of Columbia elected to cover all SSI recipients. The remaining 14 States—the so-called 209(b) States—covered only the SSI recipients who are also able to meet the State's more restrictive eligibility rules for Medicaid. These are States that employed more restrictive eligibility criteria for their income maintenance and Medicaid programs before SSI was enacted and that have chosen to provide Medicaid only to those SSI recipients who would be able to qualify under the State's more restrictive pre-SSI criteria. For example, a 209(b) State might set ceilings on income or assets at

levels below SSI, or it might factor in to the eligibility determination items that SSI disregards, such as accounts for burial expenses, a household automobile, or certain other real property. The purpose of the option was to enable States with relatively limited pre-SSI programs for the aged, blind, and disabled to protect themselves from the large and sudden increases in their Medicaid caseloads that would otherwise have occurred when SSI caused income maintenance caseloads to increase.

The majority of elderly and disabled Medicaid recipients live in community settings and qualify for Medicaid by virtue of receiving an SSI payment (or meeting 209(b) requirements where applicable). Just the opposite is true of Medicaid recipients in institutions, the majority of whom establish Medicaid eligibility under other eligibility provisions because they have too much income to qualify for a cash payment. In 1986, Medicaid served a total of 6.2 million elderly and disabled persons of whom 4.1 million, or 2 out of 3, also received cash assistance. By contrast, a little more than 330,000, or 1 in 5, of the 1.5 million Medicaid recipients of SNF or ICF services were poor enough to qualify for SSI.

One reason that relatively few Medicaid recipients in institutions receive an SSI payment is that the maximum SSI benefit for residents of Medicaid institutions is at the reduced standard of $30 per month—an amount meant to assist persons whose income from all other sources is inadequate to cover incidental personal expenses. By contrast, the standard for persons living in the community in 1988 is $354 for an individual and $532 for a couple.

The reduced rate means that institutionalized persons with incomes from all other sources of $50 per month or more ($30 plus $20 that SSI disregards from the income of all applicants) do not receive an SSI payment and cannot qualify for Medicaid assistance as members of this mandatory eligibility group.

Because most elderly persons receive social security retirement benefits, the majority of the institutionalized elderly are ineligible for SSI or for Medicaid under its mandatory eligibility provisions. Institutionalized persons who receive both SSI and Medicaid are more likely to be mentally retarded and mentally ill persons who have had little or no connection to the labor force and who, therefore, are not entitled to receive social security or other types of disability or retirement income that are common among the elderly.

The different standards for persons in the community and those in Medicaid institutions are based on the Supplemental Security Income statute. It is presumed that institutionalized persons need so much less in the way of income maintenance than persons in the community because most of their costs for basic living expenses (for example, shelter and food) are included as a medical expense in the facility's per diem charge and in the basic Medicaid reimbursement for the facility's services.

These facts must be kept in mind when comparing the costs of services for persons in institutions with those for persons in community settings. A common mistake is to consider just Medicaid costs in each setting. Ignoring costs for food and shelter when they are paid to persons being cared for in the community by SSI, food stamps, or other public funding sources, and counting such costs when Medicaid covers them as part of its payments to institutions makes community-based programs appear to be more cost effective than they really are.

Options for the institutionalized

There are essentially three State options under which the majority of institutionalized Medicaid recipients who are not poor enough to qualify for SSI may establish their eligibility for Medicaid. All States (except Arizona, which does not cover long-term institutional care under its Medicaid demonstration program) employ at least one of these options (Table 1).

States may also cover persons in institutions under other options, such as those whose incomes are below Federal poverty standards or those who would be eligible for SSI if they were not in a medical institution. However, the three options described in this article are more broadly inclusive and so are the relevant ones to consider when focusing on eligibility for long-term institutional care.

Types of coverable individuals

The categories of persons that States can cover under the various Medicaid options are basically the same as the categories covered by SSI and AFDC. (The Medicaid statute also authorizes coverage for certain categories of eligibles that are excluded from these programs, most notably certain pregnant women and children who are not covered by AFDC.) The most relevant categories for the population in long-term care facilities are the elderly and the disabled.

If a person fails to meet age or disability criteria (or criteria defining one of the other categories or types of persons coverable in Medicaid), then they cannot qualify for Medicaid no matter how poor or how extensive their need for medical care, even in States that cover the higher income medically needy.

State or local governments are free to establish programs to pay for the medical needs of persons who do not meet Medicaid categorical requirements. However, they may not claim Federal Medicaid matching payments for medical expenditures on behalf of these individuals. The Medi-Cal program in California is one of the largest and most widely known of this type of program.

The categorical criterion for the elderly is straightforward: anyone 65 years of age or over is coverable in all States if they also meet eligibility criteria regarding their income and assets.

Table 1
Medicaid income limits for long-term care eligibility as of September 1987

State	Limit	State	Limit
Alabama	$853	Montana	None
Alaska	$1,020	Nebraska	None
Arizona	—	Nevada	$734
Arkansas[1]	$1,020	New Hampshire	None
California	None	New Jersey[1]	$1,020
Colorado	$1,020	New Mexico	$871
Connecticut	None	New York	None
Delaware	$632	North Carolina	None
District of Columbia	None	North Dakota	None
Florida[1]	$881	Ohio[3]	None
Georgia[2]	$937	Oklahoma[1]	$1,020
Hawaii	None	Oregon	None
Idaho	$1,020	Pennsylvania	None
Illinois	None	Rhode Island	None
Indiana[3]	None	South Carolina	$1,020
Iowa[1]	$1,020	South Dakota	$1,020
Kansas	None	Tennessee	None
Kentucky	None	Texas[2]	$659
Louisiana[1]	$1,020	Utah	None
Maine	None	Vermont	None
Maryland	None	Virginia	None
Massachusetts	None	Washington	None
Michigan	None	West Virginia	None
Minnesota	None	Wisconsin	None
Missouri[3]	None	Wyoming	$1,020
Mississippi	$1,020		

[1]Six States (Arkansas, Florida, Iowa, Louisiana, New Jersey, and Oklahoma) cover medically needy elderly and disabled persons but do not offer long-term institutional care to this group, limiting these services to persons with incomes specified limites.
[2]Georgia and Texas cover medically needy pregnant women and children but not the elderly or disabled.
[3]Three States (Indiana, Missouri, and Ohio) are 209(b) States without medically needy coverage but which must allow aged, blind, and disabled persons to spend down to eligibility in a manner similar to the medically needy spend down.

NOTES: In 31 States, there is no fixed upper limit on the amount of income an institutionalized person may have. The remaining 19 States restrict coverage to persons with incomes below specified limits. In all States, Medicaid eligibles are required to use all but small amounts of their income to cover the cost of nursing home care. Medicaid pays the residual amount.

SOURCE: Health Care Financing Administration, Office of Legislative Policy, Office of Policy Analysis, September 1987.

Criteria for determining whether a person is disabled enough to qualify for Medicaid are somewhat more complicated. As of 1988, there were 36 States that used SSI criteria for determining whether a person is disabled enough to qualify for Medicaid. Under SSI, persons are considered disabled if they have a physical or mental impairment that prevents them from doing any substantial work, which is expected to last at least 12 months or result in death. Separate criteria are established for persons who are disabled because of blindness.

The 14 209(b) States may use criteria that are more restrictive than SSI. For example, they may exclude minor children altogether from the category of disabled persons, or they may impose more stringent medical criteria than SSI.

Whether a State uses the same or more restrictive eligibility criteria defining disability, it may not use a more liberal definition of the term. For example, persons with intermittent mental illness or curable physical problems are not disabled for SSI or Medicaid purposes no matter how dire their short-term medical needs or how limited their income or resources relative to their medical expenses. Similarly, disabled persons who are able to work despite their impairments may be unable to meet the definition of disability for SSI or Medicaid purposes. However, benefits are protected for disabled persons who formerly qualified for SSI and who have succeeded in employment to the extent that they would otherwise lose SSI and/or Medicaid. Congress enacted this protective feature in the Employment Opportunities for Disabled Americans Act of 1986 (Public Law 99-643). This was a response to criticisms that SSI recipients who might be able to work and perhaps eventually sever their dependence on cash assistance were deterred from even trying to do so by the threat of losing benefits, especially Medicaid. Many observers considered Medicaid to be vital to potentially employable disabled persons for whom private insurance was unavailable, unaffordable, or inadequate for their extensive medical needs.

Methods for measuring income and assets

Even though States have the option to cover or not cover the following options, they are constrained by Federal rules regarding how income and assets are defined in the first place, which ones are counted, and how and when they are counted or disregarded.

As previously stated, the methods used by States to determine eligibility of persons under their optional groups must generally be the same as the methods developed for use in the SSI or AFDC programs, with

Table 2
State methodologies for the aged, blind, and disabled as of July 1988

State	Methodology	State	Methodology
Alabama	Medicaid eligibility for Supplemental Security Income (SSI) recipients is determined by the Social Security Administration, methods for determining eligibility of Medicaid-only applicants or recipients are no more restrictive than SSI rules.	Alaska	States that determine Medicaid eligibility for all aged, blind, and disabled persons, including SSI recipients, using methodologies that are no more restrictive than SSI.
Arkansas		Idaho	
California		Kansas	
Colorado		Nevada	
Delaware		Oregon	
District of Columbia			
Florida		Connecticut	States that determine Medicaid eligibility for all aged, blind, and disabled using criteria that are more restrictive than SSI.
Georgia		Hawaii	
Iowa		Illinois	
Kentucky		Indiana	
Louisiana		Minnesota	
Maine		Missouri	
Maryland		Nebraska	
Massachusetts		New Hampshire	
Michigan		North Carolina	
Mississippi		North Dakota	
Montana		Ohio	
New Jersey		Oklahoma	
New Mexico		Utah	
New York		Virginia	
Pennsylvania			
Rhode Island			
South Carolina			
South Dakota			
Tennessee			
Texas			
Vermont			
Washington			
West Virginia			
Wisconsin			
Wyoming			

SOURCE: (Howe and Terrell, 1987).

SSI policies largely determining Medicaid eligibility policies for the aged, blind, and disabled, including those in institutions and not receiving SSI and with AFDC policies determining Medicaid eligibility policies for families with children, including families not receiving an AFDC payment.

Of the exceptions to this general rule, two affect the aged, blind, and disabled in particular. First, 209(b) States may use methods for measuring income and assets of the elderly and disabled that are more restrictive than SSI's methods (Table 2). For example, they may count income or assets that SSI disregards. The second exception was originally enacted in the Deficit Reduction Act of 1984 (Public Law 98-369), clarified in the Medicare and Medicaid Patient Protection Act of 1987 (Public Law 100-93), and incorporated into the Medicaid statute by the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360). It allows States to use eligibility determination methods for Medicaid-only applicants that are less restrictive than SSI or AFDC. A less restrictive rule is defined as one that does not make anyone ineligible who would be eligible if the comparable SSI or AFDC rule were used instead. These amendments are still too new to assess how far States are likely to depart from SSI methods for their optional groups.

Medically needy option

Under this option, States cover persons who do not have enough income or assets to meet all their medical expenses but who, by the standards of the SSI or AFDC programs, have sufficient income and resources to meet basic living expenses. Basically, there is no absolute upper limit on the amount of income that a medically needy applicant can start with. Anyone who is otherwise eligible (e.g., who belongs to one of the groups that the State has chosen to cover and whose assets are within allowable ceilings) can potentially qualify, provided their medical expenses are high relative to their income.

In 1987, 36 States had elected to provide medically needy coverage. However, 2 of these 36 States restricted this optional coverage to pregnant women and children (the minimum eligibility groups that a State must cover if it elects to cover any medically needy groups at all). And 6 of these 36 States did not provide institutional long-term care to persons who established Medicaid eligibility as medically needy. This left 28 States that covered the medically needy for long-term institutional care.

In the process known as spend down, a medically needy person establishes eligibility once income, after deducting expenses the person has incurred for medical or remedial services, has been reduced to welfare-related thresholds. In spending down, the medically needy are assumed to use income in excess of these thresholds to pay their medical bills, including nursing home bills. States may not require them to pay their bills, but failure to do so can impede the person's ability to find or remain in good standing with a willing provider.

Once the person's or family's spend-down liability is met, Medicaid pays subsequent medical bills for services covered in the State's plan. Spend down is a recurring process. A medically needy person's spend-down obligations are determined for a period of time, anywhere from 1 to 6 months at the State's option. When one period ends and a new one begins, spend down must be repeated before benefits are available again.

Medically needy persons in institutions are not a distinct eligibility group. States cannot offer medically needy coverage to them without also extending it to all qualifying persons in the category that they have elected to cover, (e.g., all elderly persons or all the disabled).

In addition, the Medicaid statute requires States to use the same eligibility rules and standards for determining the eligibility of all medically needy persons in a category regardless of whether they are in an institution or live in the community. For example, States are not permitted to establish higher thresholds on income or assets, or use different rules in considering equity value in a person's home, or exclude burial funds of any amount for the elderly in institutions.

One confusing outgrowth of the requirement for comparability of rules within a category of medically needy recipients is that spend-down calculations determine the individual's liability for paying medical care expenses only if the individual lives in the community, but not if he lives in an institution. For institutionalized recipients, spend-down calculations only determine whether the individual is eligible or not. Once initial eligibility is established in these cases, then a separate calculation is made to determine the actual amount that the recipient is expected to pay for care in the institution and the amount that Medicaid will pay.

209(b) spend down States

Under regulations in effect in 1988, the 209(b) States must allow all aged, blind, and disabled persons, including those with too much income to qualify for SSI, to spend-down to Medicaid. Because 11 of the 14 209(b) States have elected to cover the medically needy, the 209(b) spend-down provision basically affects only 3 States: Ohio, Indiana, and Missouri. In these States, the aged, blind, and disabled may be covered in a manner similar to medically needy coverage even though the States have not elected the medically needy option and are not subject to the requirement to cover higher income pregnant women and children. As in the medically needy States, 209(b) States may not impose a fixed ceiling on the amount of income an aged, blind, or disabled person may have initially before spending down.

Income thresholds for the institutionalized

The 19 remaining States have elected an option that opens the door to Medicaid eligibility for many higher income persons in long-term institutional care without involving the State in the broader medically needy option, under which they would have to cover higher income persons in the community, including medically needy pregnant women and children. It also enables the six medically needy States not covering long-term institutional care for that population to nevertheless cover some higher income persons in institutions.

These States set a special eligibility threshold on income for persons in institutions that can be as high as 300 percent of SSI payment standards. In 1988, the maximum State threshold was $1,072, or three times the SSI level of $354 for an individual. Anyone with gross income over 300 percent of SSI or over the State-set ceiling is ineligible under this option, no matter how extensive their medical bills or how high the charges for nursing home care relative to their ability to pay.

Once they are determined to be eligible under this option, institutionalized recipients must use most of their to income to pay for their care. The amounts that they are expected to contribute are calculated under rules governing the post-eligibility process.

Since the enactment of the Omnibus Budget Reconciliation Act of 1981, States have had the option to use the same higher income ceiling to determine eligibility under their home- and community-based waiver programs. In such programs, States can provide the kinds of services that enable persons at risk of institutionalization to be cared for outside an institutional setting. In the absence of such programs, according to some observers, choices made by higher income persons with chronic impairments and living in States without medically needy programs are biased towards institutional care because that may be the way they can qualify for any Medicaid assistance at all. The availability of a home- and community-based waiver program with equivalent eligibility thresholds should neutralize this source of bias.

Once eligible under this option, recipients are treated in a manner similar to persons in institutions in that they are presumed to contribute all their income, except for welfare-based amounts allowable for basic living expenses, to offset the cost of their care. It remains for further study to determine whether and how the eligibility rules and the relatively steep cost-sharing requirements affect the choices made by persons needing long-term care.

Assets and eligibility

What are countable assets?

Assets include such things as savings accounts, shares in mutual funds, stocks, certain real property, other investments, or forms of wealth that a person has accumulated in the past and that could be converted to cash and used to meet current living needs. The overriding principle is that an asset is considered to belong to an applicant if that person

has the unrestricted right to liquidate or dispose of it.

If the individual's right to an asset are unrestricted, for example, he can legally close out a savings account on his signature only, then the entire value of the asset is counted as his and is considered to be available to cover his needs, even if the account is jointly owned with a spouse or other person. By contrast, if liquidation requires the consent and cooperation of another person, then the asset is not counted at all unless it has actually been liquidated.

A major exception to this general principle affects what are known as "Medicaid qualifying trusts," which are counted as available to the Medicaid applicant or recipient who is the beneficiary of the trust even though payments from the trust may not actually be available. Before the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1986 (Public Law 99-272), individuals could place their assets in such trusts and still benefit from their use. But because their rights to liquidate or dispose of the asset would be restricted by the terms of the trust, the assets would not be counted for Medicaid eligibility purposes, thus assuring that the assets would pass into their estates and ultimately to their heirs. The Medicaid amendment of 1986 aimed to limit this abuse. It required that funds placed in such a trust for whatever purpose by the individual or the spouse be counted as available in amounts equal to the maximum payments that could be made if the trustee exercised maximum discretion under the terms of the trust, whether or not the trustee actually made the maximum payment.

In other eligibility requirements, State Medicaid policies for determining what an asset is, what its value is, and the extent to which its value affects eligibility are based on the policies of the SSI program. There are two exceptions to this general rule. First, 209(b) States can impose rules on assets for Medicaid applicants that are more restrictive than SSI. For example, limits on excludable liquid resources could be lower, or funds set aside for an applicant's burial could be counted as available to pay for the owner's current expenses. Second, with the enactment of Public Law 100-360, assets of married couples of which one spouse is in an institution for long-term care will be counted according to a set of rules unique to that group of recipients.

Certain assets are excluded from consideration in SSI and Medicaid. Excluded assets that are most commonly owned by people in institutions include:

- Limited liquid assets (up to $1,900 for an individual and $2,850 for a couple in 1988).
- Life insurance with a face value of less than $1,500.
- Funds up to $1,500 designated for burial.
- Burial space.
- An automobile, within limits.
- A home, regardless of its value, provided it is the person's principal place of residence.

Assets of a spouse or parents (in the case of minor disabled children) also affect a person's eligibility in Medicaid as they do in SSI, but the effects vary from family to family depending on whether the family members live together, whether the recipient is a spouse or a disabled child, and on the nature of each family member's rights to use or dispose of the asset.

If an individual is living with his family, SSI (and Medicaid) rules assume that the assets of the spouse (or parents) are available to meet the individual's needs. Therefore, a spouse's or parent's assets affect the determinations of whether the applicant is needy enough to qualify for assistance; they are deemed to be available regardless of whether the applicant actually has rights or access to the assets.

For example, a parent's savings account or other investments would be considered in determining the SSI or Medicaid eligibility of a disabled child living with them. If assets that are owned by the child in his own right, when added to a parent's assets that are deemed to be available to the child, exceed the applicable limits on assets, then the child is ineligible. The same principles apply in the case of spouses living together.

Assets of a disabled child living apart from its parents (for example, a child residing in a long-term care facility) are counted only if they actually belong to the child. The parents' assets are not assumed to be available to the child, no matter how extensive they may be, and therefore do not affect the child's eligibility for Medicaid.

Assets of institutionalized persons whose spouses live in the community have followed this same general principle until the recent enactment of Public Law 100-360, which establishes an entirely different set of rules for determining whether the assets of this group of recipients are within eligibility guidelines. Under the old rules, the extent to which a couple's assets would have to be used to pay for the cost of care depended on the nature of their ownership (e.g., whether the asset was owned in the name of one or the other spouse or jointly) and their foresight in planning for a long institutional stay (e.g., whether and when they succeeded in converting most or all of the couple's assets into assets belonging exclusively to the community spouse).

Under the new rules, which apply to all States, including 209(b) States and States with community property laws effective September 30, 1989, all assets owned in the names of either or both spouses will be considered to be available to the institutionalized spouse, except that certain amounts of the couple's assets will be protected for the community spouse. The minimum amount protected is the greater of $12,000 or one-half the couple's total assets at the time of institutionalization, up to a maximum of $60,000.

Homeownership and eligibility

In general, real property is considered to be a person's home and is excluded from SSI or Medicaid consideration if the person, a spouse, dependent children, or certain other relatives live in it. Under these circumstances, the homes of institutionalized Medicaid recipients with families still living in them

continue to be excluded from consideration, even if the recipient is the sole owner.

The homes of people without family members at home are also excluded if their institutional stay is temporary. For the elderly and disabled, SSI rules are used to determine whether a stay is temporary or permanent. Supplemental Security Income rules base this determination on the individual's statement of intention in the matter: As long as a person claims that he or she intends to return home, the property is excluded from consideration regardless of how much time passes or whether there is substantial medical evidence that the person will ever be able to return home.

As a practical matter, an institutionalized recipient who intends to return home may have to find the means to pay property taxes and other expenses. Medicaid post-eligibility rules afford some opportunity for the home owner to set aside limited amounts for home maintenance. However, the amounts allowed for this set-aside are limited and may not be adequate to cover all the expenses of maintaining a home.

Thus, in some situations, when there are no relatives living in the home and the individual no longer intends to return home or cannot pay all necessary home maintenance expenses, a recipient may have no practical alternative but to sell the property. Funds received from its sale will, in most cases, cause the individual to lose Medicaid eligibility because of excess resources, but this loss is not critical because the proceeds can be used until they are exhausted to pay for care. In other situations, when individuals maintain the intent to return home and find the means to pay upkeep expenses, their homes can be protected, become part of their estates, and be passed on to their heirs.

Disposition of excess assets

Many persons in institutions begin their stays as private-pay residents, paying their monthly expenses out of some combination of income and assets. If their stay is long enough to deplete assets to Medicaid levels, they may subsequently be able to qualify for assistance.

The process of asset depletion is also referred to by the term "spend down," an unfortunate double use of a term that originally and more technically refers to the periodic use of excess income in medically needy cases. The two processes—spend down of assets and spend down of income—are quite distinct as regards the rules that govern them and their effect on individuals.

The Medicaid program does not dictate how the individual must use excess resources during the period preceding Medicaid eligibility. Common sense dictates that the individual use resources, in combination with available monthly income, to cover nursing home and other medical expenses. However, except for the Medicaid penalties against those who give away assets, there are no other constraints on how the person uses his or her resources, and they may be used without limits to purchase personal items, gifts, or they may be converted into exempt resources such as burial contracts.

Estimates of the proportion of nursing home residents who began their stay as private pay patients and who converted to Medicaid after a period of time range from 20 to 60 percent. The range is large because of data limitations. Many studies are based on small-scale studies that are not nationally representative. Some studies are based on large-scale data bases that are so lacking in information specific to Medicaid that the conclusions are only as valid as the researcher's assumptions. Many studies examine the situation as of a particular point in time, causing them to undercount the high number and relatively rapid turnover of short stayers, who are more likely to be able to pay their bills without assistance, and to exaggerate the number of long stayers, who are more likely to have depleted their assets and converted from private pay to Medicaid. A true picture would require following a cohort of nursing home admissions over time to determine the probability that a person becomes Medicaid eligible at successive points in time after admission.

In States that follow SSI procedures, the amount of countable recipient assets is determined as of the first day of each month. If a person has assets in excess of the allowable thresholds on that day, he or she is ineligible throughout that month, regardless of the extent of the excess assets or how adequate they are for the person's medical or nursing home bills that month. Overages on the first day of the month can occur among institutionalized persons who are still in the process of depleting relatively substantial assets to Medicaid levels, or small overages can occur when a recipient earns interest on small savings accounts and allows it to accumulate rather than spending the interest as soon as it is earned. It is not yet clear whether, or to what extent, States will use the flexibility conferred by Public Law 100-360 to be less restrictive than SSI in this regard.

Loss of eligibility caused by excess assets, like ineligibility caused by any other reason, means that payment of that month's nursing home bill is the individual's responsibility. Medicaid rules do not apply during this period. For example, the program has no authority over how much the facility can charge the individual for care in that month; the facility can treat (and bill) the person as a private paying patient in that month.

Uncompensated transfers of assets

States have the authority to deny Medicaid eligibility for a period of time to persons who have disposed of assets for less than fair market value in cases where those assets, if retained, would have made the person ineligible. The State makes the presumption that the individual gave the asset away for the purposes of meeting Medicaid eligibility

thresholds, but the individual has the right to rebut that presumption.

Before the enactment of Public Law 100-360, a State could elect to impose such penalties within broad Federal parameters. The Supplemental Security Income (SSI) program also imposed penalties on persons who gave away assets without receiving fair compensation. These penalties potentially applied to any SSI or Medicaid recipient in the State, although in practice they were most relevant to persons anticipating entering a nursing home and attempting to qualify for Medicaid as soon as possible while avoiding the depletion of their assets.

Public Law 100-360 revised SSI and Medicaid rules on transfers of assets such that they target institutionalized persons applying for Medicaid.

The Supplemental Security Income provisions are essentially replaced with a requirement that the Social Security Administration inform SSI applicants of potential Medicaid penalties and provide information to States about uncompensated transfers of assets by SSI recipients.

States are required to deny eligibility to persons who give away an asset, including their home, within the 30 months prior to application without receiving adequate compensation for it. This provision only applies to institutionalized persons. States no longer have the authority to impose similar penalties on noninstitutionalized applicants.

The State counts the uncompensated value of the asset the same as if the person still owned it. This value is combined with the value of assets the person currently owns and the total value is compared with the State's eligibility threshold on assets. If the total value exceeds these thresholds, then it may cause the person to be ineligible. The period of ineligibility starts with the date the asset was disposed of and lasts for the shorter of 30 months or the number of months of nursing home care that the uncompensated value could have paid for.

Excepted from these penalties are transfers of assets from an institutionalized spouse in amounts sufficient to bring the community spouse's assets up to protected levels. Also excepted are transfers of the institutionalized person's home to the spouse or, subject to certain conditions, to a child or sibling.

Income and eligibility

Income generally includes anything that the individual receives in a particular month from any source that can be used to meet the person's basic living expenses. The most common sources of income for persons in institutions include social security checks, pensions or other benefits, and earnings on investments. Much less common among persons in institutions is earned income from employment, although some recipients, especially the mentally retarded and developmentally disabled, receive wages from their employment in sheltered workshops.

Income and recipient's families

Under the Medicaid statute, States can hold spouses financially responsible for each other and parents responsible for their minor or disabled children. States are prohibited from requiring, as an official part of their State Medicaid plan, financial support from other relatives such as adult children of elderly recipients. However, outside the State Medicaid plan and under State laws of general applicability on issues of family support for all citizens in the State, States may require financial support payments by other relatives. Many States have considered imposing such requirements, viewing them as potential alternatives to Medicaid funding, but only one State, Idaho, briefly enacted policies requiring adult children to make financial contributions toward their parents' care. Further movement along these lines has been impeded by the attendant political controversy and administrative difficulties, especially since a law of general applicability appears to prohibit targeting support requirements just at the relatives of Medicaid recipients in nursing homes.

In general, the methods for determining the availability of a spouse's or parent's financial income are derived from the rules of SSI and resemble, in principle, the rules on assets of family members.

If the family members live together, income of the spouses or parents is assumed, or deemed, to be available to meet the needs of the other spouse or children. Eligibility and amount of benefits are determined based on this assumption. The SSI program (and Medicaid) use different accounting methods depending on which family members are applying for benefits, but the general assumption of financial responsibility is made in all cases.

If one family member lives separately, for example, in a long-term care facility, that family member is considered to have a separate household, and SSI and Medicaid do not assume that the income of the family members in one household is available to meet the needs of the other. Only the income belonging to each household is counted in establishing that household's Medicaid eligibility. This separation into two households for eligibility purposes happens on the first day of institutionalization if only one spouse or child is applying and eligible, and shortly after separation in other cases.

The practical consequence is that children or married women are likely to qualify readily for Medicaid after they are admitted to an institution if they have little or no income in their own right, even if their parents or husbands have substantial income.

States may elect to tap spousal or parental income to offset the cost of care to Medicaid by pursuing support payments through such approaches as enforcing State family support laws, making requests for voluntary payments, or by pursuing support orders in court. However, they may not assume that the support is provided, as they do when the family lives together, but may only count funds that the

family actually makes available to the Medicaid applicant or recipient. These family contributions may be treated as the institutionalized person's income, the same as any other income that the person may have, or the State may treat it the same way it treats payments collected from medical insurance or other financially liable third parties. States generally have viewed these approaches to eliciting family financial contributions for cost sharing as not cost effective enough to pursue.

The rules have different effects when it is the principal family breadwinner—usually the husband—who is institutionalized. When an institutionalized Medicaid recipient leaves a financially dependent spouse in the community, that spouse's financial distress is mitigated under a provision of Medicaid post-eligibility rules that protects certain amounts of the institutionalized person's income to meet her needs and the needs of any minor children.

Post-eligibility contributions

Once an institutionalized person has been determined to be eligible for Medicaid, then a different set of post-eligibility rules comes into play to determine how much the individual is actually expected to pay for the cost of care and how much Medicaid will pay. Post-eligibility rules are the same for all institutionalized recipients in all States, whether they have established their eligibility as medically needy, or under the special income standard for the institutionalized, or as 209(b) spend-down cases, and whether they were eligible when they were admitted to the institution or converted from private-patient status after depleting their assets.

Post-eligibility rules require that States reduce the payment they make for an eligible recipient's institutional care by the amount that the recipient is presumed to pay out of his monthly income. The State Medicaid program does not explicitly require the person to pay that amount to the facility, but the individual's failure to do so could jeopardize his or her standing with the facility.

The recipient's presumed payment to the institution equals total income from all sources in the month, minus certain amounts set aside for the following purposes:

- The first $30 (more at State option) is set aside to cover personal needs that are not included in the facility's basic service package, (e.g., toiletries, beautician services, and/or entertainment). The minimum level is the same as the reduced benefit rate that SSI uses for persons in Medicaid-funded institutions.
- Next, the State must allow the person to set aside amounts for the maintenance needs of a spouse and minor children if those family members have little or no income of their own. However, Public Law 100-360 increased the minimum amount of income that States must protect for these individuals from SSI, AFDC, or medically needy levels to a percent over poverty levels. For community spouses, the amount is raised to 122 percent of Federal poverty guidelines for a two-person family, effective September 30, 1989, growing to 150 percent by July 1, 1992. States will also be required to set aside additional income allowances equal to one-third of the spousal income allowance for certain other dependent relatives living with the community spouse.
- For single homeowners, States have the option of allowing funds to be set aside for up to 6 months to maintain the person's home if a physician certifies that the person is likely to return home in that 6-month period.
- Last, the recipient may retain amounts to cover expenses incurred for medical insurance, such as Medicare Part B premiums as well as any other medical or remedial care that the individual is personally liable to pay. For example, if eyeglasses or dentures are purchased out of pocket because they are not covered by Medicaid or some other third party, the individual's presumed payment for institutional care is reduced by a commensurate amount. Similarly, current month contributions to cost of care would be reduced by any unpaid liability for nursing home bills from a previous month in which the person was ineligible for Medicaid.

Conclusion

Medicaid rules governing who qualifies for assistance and for how much are often characterized as among the most complicated of any program administered by the Federal Government. This is explained by these basic reasons. First, the basic eligibility framework was borrowed from public assistance programs that provide income maintenance for poor people living in their own homes. The basic framework has been adapted from time to time to accommodate the particular characteristics of persons needing medical assistance. Although each adaptation may have made sense in the narrow context of fixing a particular problem, the overall result is a patchwork crazy quilt. Second, responsibility for long-term care eligibility rules is extremely diffuse. Many players in Congress, in the Federal executive branch, and at the State level, who do not have direct responsibility for Medicaid still have a significant impact on the program, although it is not always deliberate and not always in collaboration with those who have a direct responsibility for Medicaid. As long as the basic public assistance framework and diffusion of responsibility remain in place, one may anticipate the addition of more quick fixes and more complexity in national policy on who gets public help paying long-term care bills.

Additional reading material can be found in the References section.

References

Burwell, B.: Shared Obligations: Public Policy Influences on Family Care for the Elderly. Medicaid Program Evaluation Working Paper 2.1. U.S. Department of Health and Human Services, Health Care Financing Administration, May 1986.

Department of Health and Human Services: *Report to Congress: Medicaid Moratorium Report, Section 2373(c), Deficit Reduction Act*, 1987.

Howe, C., and Terrell, R.: *Analysis of State Medicaid Characteristics, 1986. Health Care Program Statistics.* HCFA Pub. No. 03249. Office of the Actuary. Health Care Financing Administration. Washington. U.S. Government Printing Office, Aug. 1987.

Neuschler, E.: *Medicaid Eligibility for the Elderly in Need of Long-Term Care.* National Governors' Association, Center of Policy Research. Washington, D.C. Sept. 1987.

Stevens, R., and Stevens, R.: *Welfare Medicine in America: A Case Study of Medicaid.* New York, New York. McMillan Publishing, Inc., 1974.

Rigby, D., and Ponce, E.: *Characteristics of State Assistance Programs for SSI Recipients, January 1986.* SSA Pub. No. 13-11975. Social Security Administration. Washington. 1986.

Code of Federal Regulations: Supplemental Security Income for the Aged, Blind, and Disabled. Title 20, Part 416. Office of the Federal Register, National Archives and Records Administration. Washington. U.S. Government Printing Office, Apr. 1988.

Code of Federal Regulations: Eligibility in the States, District of Columbia, and the Northern Marianas. Title 42, Part 435. Office of the Federal Register, National Archives and Records Administration. Washington. U.S. Government Printing Office, Oct. 1987.