

QUALIFYING FOR MEDICAID LONG-TERM CARE PROGRAMS

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The United States economy is based on a free-market system where no limits are placed on the extent to which individuals may succeed or fail. As a result, some individuals will become very wealthy and some individuals will become, or remain, very poor. To ensure that basic human needs are met, various safety nets have been created to provide basic support for poor individuals. One such safety net is the federal Medical Assistance Program, commonly referred to as Medicaid. Medicaid is provided for under Title XIX of the Social Security Act of 1935.¹

Total Medicaid spending in 2020 was \$597.6 billion.² Over 30% of Medicaid spending was for long-term care services.³

Although Medicaid is a federal program governed by federal law, each state administers the program for its own residents. Each state has its own requirements. The program is designed to provide medical assistance for poor individuals. In Oklahoma, the Medicaid program is called SoonerCare and is administered by the Oklahoma Health Care Authority. Eligibility for Medicaid is determined by the Oklahoma Department of Human Services. In Texas, the Medicaid program is administered by the Texas Department of Health and Human Services. Eligibility for Medicaid is determined by the Texas Health and Human Services Commission.

One facet of Medicaid provides medical care for the long-term needs of elderly, blind and disabled people. Long-term care typically refers to nursing home care, but there are other options as well. If the individual qualifies, they may receive help from Medicaid to pay for a nursing home level of care (“NFLOC”), either in a nursing home or in their own home. The U. S. Department of Health and Human Services estimates that approximately 70% of people turning 65 can expect to use some form of long-term care.⁴

Determining whether an individual qualifies for long-term Medicaid benefits is often a daunting task for the individual, their family and even many attorneys. Using Oklahoma and Texas as points of reference, this paper examines the law pertaining to Medicaid long-term care eligibility. The hope is that this paper will assist and guide those trying to determine whether an individual qualifies for Medicaid long-term benefits.

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¹ 42 U.S.C. § 1396a (1935).

² <https://www.medicaid.gov>, February 7, 2024.

³ *Id.*

⁴ <https://www.hhs.gov.>, February 7, 2024.

I. OVERVIEW OF THE MEDICAID PROGRAM

The Medicaid program is a complex arrangement of interrelated statutes, rules and regulations. Adopted and amended over many years, these provisions are very complicated and convoluted. As one court has noted, a practitioner would be very foolish to attempt to attribute meaning to any single provision without considering the entire body of law.⁵ The Medicaid rules contain numerous definitions and exceptions. In addition, the rules are constantly changing as statutes are amended and new regulations are adopted.

To further complicate matters, each state is allowed to select various options contained in the Medicaid program. Therefore, Medicaid rules will differ from state to state. An individual may qualify for medical assistance in one state when an individual in a different state with the same income and resources will not qualify. Texas, where 78% of people qualify for Medicaid on entering a nursing home and 96% need it within six months, is one of only seven states which does not supplement the federal Medicaid benefit.⁶ For purposes of this paper, the Medicaid rules as they currently exist in Oklahoma and Texas will be used to describe Medicaid eligibility.

In addition, the Secretary of Health and Human Services is authorized to grant waivers of Medicaid provisions.⁷ As a result, the operative Medicaid rules in a state may actually conflict with federal law. For example, both Oklahoma and Texas have waiver programs that allows individuals to receive in-home services if they meet the medical requirements for nursing home services but are able to live at home.⁸

The complexity of the Medicaid program affects not only the poor individuals who attempt to qualify for medical services, but also the administrative agencies and courts that are called upon to interpret the Medicaid rules. The assistant general counsel for the Oklahoma Department of Human Services has stated that the Medicaid rules within Oklahoma are subject to different interpretations by local county agencies.⁹ The complexity and poor draftsmanship of the Medicaid rules have been recognized by the courts as well.¹⁰

II. MEDICAID LONG-TERM CARE PROGRAMS

Medicaid services are divided into those services that are short-term in nature and those services that involve long-term medical care. Although this paper focuses on qualifying for long-term Medicaid programs, the eligibility rules overlap. Basically, to qualify for services and benefits, an individual must be within the class of individuals designated to receive benefits and must meet certain financial requirements.

The most recognized form of long-term medical care provided by Medicaid is nursing home care. This involves services furnished pursuant to a physician's order by licensed and professional nursing home employees. Care is also provided to individuals whose assets and income are limited but are able to remain at home, individuals who are 65 years of age and older,

⁵ Cleary v. Waldman, 959 F. Supp. 222 (D. N. J. 1997).

⁶ Texas Medicaid Eligibility: Income and Assets, The Garrett Law Firm, PLLC. February 7, 2024.

⁷ 42 U.S.C. §§ 1396a(10)(A)(ii)(IV), 1396n(b)-(e).

⁸ Oklahoma Administrative Code 317:35-17-3; Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.

⁹ Statement of Travis Smith at professional development seminar Resolving Legal and Financial Issues in Elder Care, Oklahoma City, Oklahoma, December 20, 2007.

¹⁰ Friedman v. Berger, 409 F.Supp. 1225 (S. D. N. Y. 1976); Matarazzo v. Rowe, 623 A.2d 470 (Conn. 1993).

individuals reside in mental health hospitals,¹¹ mentally retarded individuals who reside in an intermediate care facility,¹² and certain mentally retarded individuals who are able to live safely at home.¹³

Individuals may receive Medicaid benefits while residing in an assisted living center if they require the long-term medical care that a nursing home provides but prefer to receive such care in a Medicaid-approved assisted living center.¹⁴ This includes “memory care”, a type of specialized assisted living for individuals with Alzheimer’s disease and related dementias. Medicaid will pay for care costs but will not pay for the room and board costs of assisted living.

Oklahoma Medicaid (“SoonerCare”) long-term care for seniors will pay for care in a nursing home, a beneficiary’s home and other settings through one of three programs – Nursing Home Medicaid, Home and Community Based Services (HCBS) Waivers, or Aged, Blind, and Disabled (“ABD”) Medicaid.¹⁵ These programs differ from regular Medicaid which is for financially limited people of all ages.

The Texas Health and Human Services department also provides long-term care for seniors in a nursing home, a beneficiary’s home and other settings through one of three programs – Nursing Home Medicaid, Home and Community Based Services (HCBS) Waivers, or Medicaid for the Elderly and People with Disabilities (“MEPD”).¹⁶

For nursing home beneficiaries, both the Oklahoma and the Texas programs will cover the cost of long-term care in a nursing home for financially limited seniors who require a “Nursing Facility Level of Care.” Coverage includes payment for room and board, as well as all necessary medical and non-medical goods and services, including personal care assistance with the activities of daily living (mobility, bathing, dressing, eating, toileting), skilled nursing care, physician’s visits, prescription medication, medication management, mental health counseling, and social activities.¹⁷ Neither the Oklahoma program nor the Texas program will provide for a private room, specialized food, comfort items like tobacco and cosmetics, and any care services not considered medically necessary.

Nursing home beneficiaries are required to give most of their income to the State to help cover care expenses. They are only allowed to keep a “personal needs allowance” of \$75.00 per month, which can be used for personal items such as clothes, books, haircuts, etc.¹⁸ They can also keep enough of their income to make Medicare premium payments if they are “dual eligible” and enough of their income to make Medicaid-approved spousal income allowance payments to financially needy spouse who are not Medicaid applicants or recipients.

Nursing Home Medicaid in Oklahoma and Texas is an entitlement, meaning that qualified applicants are guaranteed by law to receive benefits without any wait. However, not all nursing homes accept Medicaid and those that do may not have a space available. So, while nursing home coverage is guaranteed, coverage may not be available in the closest or best facility available.

Oklahoma has approximately 300 nursing homes that accept Medicaid, which ranks 22nd on the list of states with the most nursing homes.¹⁹ There are approximately 50 nursing homes in

¹¹ Oklahoma Administrative Code 317:35-9-7.

¹² Oklahoma Administrative Code 317:35-9-4.

¹³ Oklahoma Administrative Code 317:40-1-1(d)(1).

¹⁴ <https://www.medicaidplanningassistance.org>, February 7, 2024.

¹⁵ *Id.*

¹⁶ <https://www.medicaidlongtermcare.org>; February 7, 2024.

¹⁷ *Id.*

¹⁸ <https://www.medicaidlongtermcare.org>; February 7, 2024.

¹⁹ <https://www.medicaidlongtermcare.org>; February 7, 2024.

the Oklahoma City area and 41 in the Tulsa area, with the rest being evenly distributed across the state. Also, Medicaid coverage approved in one state cannot be used to pay for care and support in another state. For example, an individual living in Guyman, Oklahoma would not be covered by SoonerCare for a stay in a nursing home in Amarillo, Texas.

Texas has approximately 1,200 nursing homes that accept Medicaid, the majority of which are clustered around the state's biggest cities.²⁰ There are approximately 100 nursing facilities in and around Dallas and another 75 in the Fort Worth area. There are 115 nursing facilities in the Houston area and about 50 in the San Antonio area. There are 20 nursing facilities in El Paso, 15 in Lubbock, 14 in Corpus Christi, 12 in Amarillo, and six in Odessa.

The Oklahoma HCBS Waivers program, known as the ADvantage Waiver Program, and the Texas HCBS Waivers program, known as STAR+Plus, pay for long-term care services and supports to financially limited seniors who require a Nursing Facility Level of Care but can remain in their home instead of living in a nursing home.²¹ Qualified beneficiaries can also receive support if they live in the home of a loved one or in a Medicaid-approved assisted living residence. The ADvantage Waiver program and the STAR+Plus Waiver program will not pay for room and board costs such as mortgage payments, rent, facility fees, utility bills and food expenses.

HCBS program benefits include adult day care, skilled nursing care, case management, meal delivery, home modifications, personal care assistance with activities of daily living, and Instrumental Activities of Daily Living (shopping, cooking, cleaning, scheduling, transportation, etc.)²² Benefits can be provided through licensed caregivers. In Texas benefits are provided through a single Medicaid plan by a managed care organization ("MCO") which has a network of healthcare providers. In both states, beneficiaries may also be able to self-direct certain benefits. This allows the beneficiaries to use select friends and family members to provide certain benefits, like care assistance and the Instrumental Activities of Daily Living.²³

Unlike Nursing Home Medicaid, the ADvantage Waiver program and the STAR+Plus Waiver program are not an entitlement. The number of beneficiaries is limited. Once that limit is reached, applicants are put on a waiting list. The maximum number in Oklahoma for 2023 was 24,375.²⁴ The maximum number in Texas as of 2022 was approximately 24,000.²⁵

The Oklahoma ABD Medicaid program provides healthcare coverage and long-term care services and support to financially limited Oklahoma residents who are age 65 or over, blind, or disabled and live in their home. ABD Medicaid is sometimes referred to as regular Medicaid for seniors. Like Nursing Home Medicaid, ABD Medicaid is an entitlement. However, since the beneficiaries are home-based, the availability of benefits and services will depend on the availability of funds, programs and caregivers in the area where the beneficiary lives.

The Texas MEPD Medicaid program also provides healthcare coverage and long-term care services and support to financially limited Texas residents who are age 65 or over, blind, or disabled and live in their home. MEPD beneficiaries who show a medical need for long-term care services and supports can receive those benefits through the following programs²⁶:

²⁰ *Id.*

²¹ <https://www.medicaidlongtermcare.org>; February 7, 2024.

²² <https://www.medicaidlongtermcare.org>., February 7, 2024.

²³ *Id.*

²⁴ <https://www.medicaidlongtermcare.org>., February 7, 2024.

²⁵ *Id.*

²⁶ <https://www.medicaidlongtermcare.org>., February 7, 2024.

1. Community First Choice – covers long-term care services for MEPD beneficiaries who require a Nursing Home Level of Care.

2. Primary Home Care (“PHC”) – covers long-term care services for MEPD beneficiaries who show a need for the services but do not require a Nursing Home Level of Care. Program beneficiaries can receive up to 50 hours of care per week through the PHC program. This can include housekeeping, laundry, shopping, cooking, companion services to appointments and personal care assistance with the Activities of Daily Living.

3. Day Activity and Health Services (“DAHS”) – offers weekday daytime supervision and care at health centers around the state for MEPD beneficiaries with chronic health problems. This can include conditions like Alzheimer’s disease, arthritis, diabetes, and vascular disease. DAHS applicants must have a physician’s order stating their condition and their need for DAHS services, but they are not required to need a Nursing Home Level of Care.

4. Program of All-Inclusive Care for the Elderly (“PACE”) – coordinates all medical and personal care services for dual-eligible MEPD beneficiaries. PACE program participants are required to need a Nursing Home Level of Care but must live in the community. PACE programs can be used by people who are “dual-eligible” for Medicaid and Medicare. PACE also administers vision and dental care, and PACE centers provide meals, social activities, exercise programs and regular health checkups and services to program participants. Texas’ PACE programs are located in El Paso, Lubbock, and Amarillo.

The terms aged, blind and disabled are given the same meaning for Medicaid purposes as for Supplemental Security Income (“SSI”). Aged means individuals who are 65 or older. Blind means an individual whose vision is 20/200 or less, even with corrective lenses. Disabled means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months.²⁷ An individual will be deemed disabled if the individual has been determined to be disabled by the Social Security Administration.

III. DETERMINING MEDICAID ELIGIBILITY

To be eligible for Medicaid benefits, beneficiaries must meet certain financial requirements and certain medical or functional requirements. Therefore, for those individuals who have significant resources and, or income, Medicaid benefits are not available. Likewise, for those individuals who do not require a certain level of medical care, Medicaid benefits are not available. To further complicate matters, the eligibility requirements will vary depending on the individuals’ marital status, whether their spouse is also applying for Medicaid benefits, and the Medicaid program for which they are applying.

A. Nursing Home Medicaid and HCBS Waivers Financial Eligibility Criteria

The financial requirements for Nursing Home Medicaid and the HCBS Waivers programs, known as the ADvantage Waiver program in Oklahoma and the STAR+Plus program in Texas, correspond with the requirements for Supplemental Security Income (“SSI”). An applicant must satisfy both a resource test and an income test. With respect to the resource test, for a single

²⁷ Oklahoma Administrative Code 317:35-5-2 – 35-5-5; Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.

applicant in 2024, the applicant's assets cannot exceed a cumulative value of \$2,000.00.²⁸ All assets are counted unless they are specifically exempted under the Medicaid rules.²⁹ Assets that are exempted and do not count toward the \$2,000.00 limit include the following:

1. Under most circumstances, the individual's home plus all adjoining land and minerals interests³⁰, if any, so long as the individual or their spouse continues to reside in the home, or have an intent to return to the home (a more detailed discussion of the treatment of the home is discussed later in this paper).

2. The individual's car, regardless of value, if it is used for medical purposes at least four times a year. In Texas an additional vehicle may be exempted if a family member requires it for work, or a family member requires disability accessible transportation.³¹

3. Clothing, furniture and household goods.

4. Burial plots.

5. The face value of life insurance up to \$1,500.00.

6. Irrevocable burial contracts up to \$7,500.00.

7. Property used in a trade or business.

8. Income producing property such as cattle or equipment valued at \$6,000.00 or less which produces income at the rate of at least 6%.³²

If an individual's countable assets exceed the \$2,000.00 limit, the individual must spend down assets in order to qualify. One common strategy is to use resources to purchase any of the exempt assets listed above. For example, an individual could put money into their home, purchase a burial contract, or purchase a new car. Even if the individual cannot drive, as long as the car is used at least four times a year to assist the individual with his or her medical care, the car will be exempt. This could include driving the individual to a doctor or picking up medicine from a pharmacy.

When the applicant is married, the combined resources of the couple are considered regardless of whose name is on the title. With respect to the resource test for married applicants who are both applying for Medicaid benefits, the combined resource limit is \$4,000.00 in Oklahoma and \$3,000.00 in Texas. For a married applicant whose spouse is not applying for Medicaid, in both states the applicant's resource limit in 2024 is \$2,000.00 and the non-applicant spouse's resource limit is \$154,140.00.³³ As discussed later in this paper, a resource and income reallocation is permitted when one spouse resides in the nursing home and one spouse remains at home.

The second financial requirement for Medicaid eligibility is that the applicant must satisfy an income test. Income includes any money or benefit received on a regular basis.³⁴ Examples would include wages, dividends, rental income, interest, and retirement benefits. Food stamps,

²⁸ Oklahoma Administrative Code 317:35-7-38; Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.

²⁹ 20 CFR §416.1202.; Texas Administrative Code Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.324.

³⁰ Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.351.

³¹ Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.354; Appendix XXXIII, Medicaid for the Elderly and People with Disabilities Information, Revision 21-2, March 1, 2021.

³² Oklahoma Administrative Code 317:35-5-41; Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.

³³ <https://www.medicaidlongtermcare.org.>, February 7, 2024.

³⁴ Oklahoma Administrative Code 317:35-5-42(a); Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.381.

loans, benefits received from certain government programs, the Veteran’s Aid & Attendance Allowance, and certain Indian payments are excluded.³⁵

Under the Nursing Home Medicaid program and the HCBS Waivers program, the income limit for a single applicant in 2024 in both Oklahoma and Texas is \$2,829.00 per month.³⁶ This amount is known as the Categorically Needy Standard and is adjusted over time to equal 300% of the Federal Benefit Rate (\$943.00 in 2024). The Federal Benefit Rate is the maximum dollar amount paid to an aged, blind, or disabled person who receives Social Security Disability benefits under Supplemental Security Income (“SSI”). Adjustments are linked to the consumer price index.³⁷

As stated above, except with respect to a personal needs allowance of \$75.00 per month, and funds necessary to pay for Medicare premiums and the needs of an at-home non-Medicaid recipient spouse, Nursing Home Medicaid beneficiaries are required to give their income to the State to help cover care expenses.

When the Medicaid applicant is married, the combined income limit in 2024 in both Oklahoma and Texas is \$5,658.00 if both spouses are applying for Medicaid benefits. For a married applicant whose spouse is not applying for Medicaid, the applicant’s income limit in 2024 is \$2,829.00 per month and the non-applicant spouse’s income is not counted. Therefore, income of the non-applicant has no impact on the eligibility of their spouse. Furthermore, some of the applicant’s income may be re-allocated to the non-applicant community spouse to prevent spousal impoverishment, as discussed below.

If an individual's income exceeds \$2,829.00 per month, but is less than \$6,833.00 per month (supposedly representing the average cost of nursing home care per month), the individual may become eligible to receive Medicaid benefits by establishing a Medicaid Income Pension Trust.³⁸ Also known as Miller Trusts, these trusts accumulate income to the extent that it exceeds the income allowance amount. Trust funds may only be used to pay medically necessary items not covered by Medicaid, the reasonable costs of administering the trust, and a trustee fee not to exceed 3%.³⁹ When the individual dies, the money remaining in the trust is used to reimburse the Medicaid program for money paid on behalf of the individual after the trust was established.⁴⁰ The trust must be irrevocable and include only income. Resources cannot be included in the trust.

B. ABD and MEPD Medicaid Financial Eligibility Criteria

The financial requirements for the Aged, Blind, and Disabled (“ABD”) Medicaid program and the Medicaid for the Elderly and People with Disabilities (“MEPD”) program also include satisfaction of both a resource test and an income test.⁴¹ In Texas, if the Social Security

³⁵ Oklahoma Administrative Code 317:35-5-41(b); Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.387.

³⁶ <https://www.medicaidlongtermcare.org>, February 7, 2024.

³⁷ *Id.*

³⁸ Oklahoma Administrative Code 317:35; Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.

³⁹ Oklahoma Administrative Code 317:35-5-41(d)(9)(F).

⁴⁰ *Id.*

⁴¹ Oklahoma Administrative Code 317:35; Texas Administrative Code Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.

Administration determines that an applicant is eligible for SSI, the applicant will also be eligible for Medicaid.⁴²

With respect to the resource test, for a single applicant as of 2023, in Oklahoma, the applicant's assets cannot exceed a cumulative value of \$9,430.00.⁴³ For a married applicant, the combined resource limit is \$14,130.00 through March 2024. This limit applies whether only one spouse is applying for Medicaid benefits or both spouses are applying for benefits.⁴⁴ In Texas, for a single applicant in 2024, the resource test limit is \$2,000.00.⁴⁵ For a married applicant in Texas, the combined resource limit is \$3,000.00.⁴⁶

For the regular Medicaid for seniors, the income limit in most states for an individual is equal to 100% of the Federal Benefit Rate for an individual, or 100% of the Federal Poverty Level for a household of one. In Oklahoma, the limit for ABD Medicaid is \$1,215.00 per month through March 2024.⁴⁷ In Texas, the limit for MEPD Medicaid is \$943.00 per month.⁴⁸

For couples, the income limit is typically 100% of the Federal Benefit Rate for a couple, or 100% of the Federal Poverty Level for a household of two. In Oklahoma, the combined income limit for a couple is \$1,643.00 per month through March, 2024.⁴⁹ In Texas, the combined income limit for a couple is \$1,415.00 per month.⁵⁰ Again, the limit applies whether only one spouse is applying for Medicaid benefits or both spouses are applying for benefits.⁵¹ This means that the income of the non-applicant spouse impacts the income eligibility of their spouse.

C. Nursing Home Medicaid and HCBS Waivers Medical Eligibility Criteria

To receive Nursing Home Medicaid and HCBS Waivers Medicaid long-term medical care benefits, an individual must be medically eligible. The medical, or functional criteria is used to determine whether the applicant needs a Nursing Facility Level of Care ("NFLOC"). An NFLOC is the kind of full-time care that is normally associated with a nursing home. Each state agency makes this determination using an assessment tool which considers the applicant's ability to complete the Activities of Daily Living as well as their cognitive abilities. The medical requirements are as follows:

1. The individual must require treatment prescribed by a physician involving the services of licensed technical or professional providers.
2. The individual must have a physical impairment or a combination of physical and mental impairments.
3. The individual must require professional nursing supervision.
4. The individual must lack the ability to care for themselves or communicate their needs to others.

⁴² Appendix XXXIII, Medicaid for the Elderly and People with Disabilities Information, Revision 21-2, March 1, 2021.

⁴³ Oklahoma Administrative Code 317:35-5-41(d)(9)(F).

⁴⁴ <https://www.medicaidlongtermcare.org>, February 7, 2024.

⁴⁵ *Id.*

⁴⁶ <https://www.medicaidlongtermcare.org>, February 7, 2024

⁴⁷ *Id.*

⁴⁸ Texas Administrative Code Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.323.

⁴⁹ <https://www.medicaidplanningassistance.org>, February 7, 2024.

⁵⁰ *Id.*

⁵¹ <https://www.medicaidlongtermcare.org>, February 7, 2024.

5. The individual must require medical care and treatment in a nursing home to minimize physical health regression and deterioration.⁵²

Under the ADvantage Waiver program and the STAR+Plus Waiver program, exceptions to the medical requirements exist for individuals who otherwise meet the requirements for nursing home services but have the cognitive ability to remain at home. These programs allow frail elderly and adults with physical disabilities to receive in-home services necessary for the individual to live safely at home. The in-home services must cost no more than it would cost for the individual to live in a nursing home.⁵³ The monthly income that would otherwise be paid to a nursing home is retained by the individual. At present, more Oklahoma residents are receiving in-home long-term medical care under the ADvantage Waiver program than are receiving long-term medical care in nursing homes.⁵⁴

D. ABD and MEPD Medicaid Medical Eligibility Criteria

The only functional requirement to receive basic healthcare coverage through the Oklahoma ABD Medicaid program is that the individual be 65 years of age or older, blind or disabled. For ABD Medicaid applicants and beneficiaries who require long-term care services and supports, the state will administer an assessment of their ability to perform Activities of Daily Living and Instrumental Activities of Daily Living to determine the kind of long-term care benefits the state will provide.

Likewise, the only functional requirement to receive basic healthcare coverage through the Texas MEPD Medicaid program is that the individual be 65 years of age or older, blind or disabled.⁵⁵ Applicants must need care for thirty (30) consecutive days. To determine if applicants meet that level of care requirement, Texas uses a Medical Necessity and Level of Care (“MN/LOC”) Assessment. This tool takes into account an applicant’s ability to complete the Activities of Daily Living (mobility, bathing dressing, eating, toileting), and well as behavioral and cognitive issues.⁵⁶

IV. SPECIAL ISSUES AFFECTING MEDICAID ELIGIBILITY

In the complex morass that is the Medicaid program, there are several ancillary factors that will affect an applicant’s ability to qualify for Medicaid programs. The most pertinent topics that warrant further discussion involve the treatment of assets held in trust, the treatment of the applicant’s home, the ability of an applicant to reallocate resources and income when one spouse goes into a nursing home and one spouse remains in the home, and the treatment of asset transfers.

⁵² Oklahoma Administrative Code 317:35-19-3; Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.

⁵³ Oklahoma Administrative Code 317:35-17-3; Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.

⁵⁴ Statement of Travis Smith at professional development seminar Resolving Legal and Financial Issues in Elder Care, Oklahoma City, Oklahoma, December 20, 2007.

⁵⁵ Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.211, September 1, 2009.

⁵⁶ <https://www.medicaidlongtermcare.org.>, February 7, 2024.

A. Treatment of Assets Held in Trusts

When applying the resource test to determine eligibility, special rules apply to trusts.⁵⁷ If a trust was established prior to August 11, 1993, the corpus and income of the trust are counted toward the resource limit if the trust was established by a grantor for his or her own benefit and the grantor as trustee has discretion to use the corpus or income of the trust for the grantor beneficiary's benefit.⁵⁸ Known as support trusts, these trust often contain language such as “to provide for the support, maintenance, medical expenses, care, comfort and general welfare.”⁵⁹ Most grantor trusts or living trusts would be within this category.

Assets in a Medicaid Qualifying Trust are also counted toward the resource test.⁶⁰ These are trusts established by an individual or his or her spouse that give the trustee discretion to make distributions to the individual. The assets are counted even if the trust is irrevocable and even if the trust is established for a purpose other than enabling the individual to qualify for benefits.⁶¹ It also makes no difference whether assets are actually distributed.

Corpus and income will not be counted for some trusts if the trust is a special needs trust that requires the trustee to consider the availability of public benefits before distributing trust corpus or income.⁶² Obviously, the presence of a trust created more than 30 years ago will be rare.

For trusts created after August 10, 1993, the provisions of the Omnibus Budget Reconciliation Act of 1993 apply.⁶³ This Act expands the types of trusts that will disqualify an individual from receiving benefits. No longer are special needs trusts exempt. Essentially, if a trust is established and assets of the individual were used to form all or part of the principal of the trust, such assets will still be counted as available resources of the individual.⁶⁴ Payments or distributions from the trust to the individual or for the individuals' benefits are regarded as income of the individual and counted toward the income limitations.

The only way an individual can establish a trust and avoid inclusion of the trust assets is to establish an irrevocable trust, appoint a disinterested trustee, and include a provision that prevents the trustee from making distributions to the individual grantor of the trust under any circumstances.⁶⁵ Even then, the assets used to fund the trust are subject to the sixty (60) month look-back period provision, which includes as available resources assets transferred without consideration within sixty (60) months of an application for Medicaid benefits.⁶⁶

Under law, three types of trusts are exempt. The assets of these trusts are not included as available recourses of the Medicaid applicant. The first exempt trust is one containing assets of a

⁵⁷ Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.336.

⁵⁸ 42 U.S.C. § 1396a(k); Oklahoma Administrative Code 317:35-5-41(d)(9)(D); Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.

⁵⁹ Oklahoma Administrative Code 317:35-5-41.6(4)(A).

⁶⁰ Oklahoma Administrative Code 317:35-5-41.6(4)(B); Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.337.

⁶¹ Oklahoma Administrative Code 317:35-5-41.6(4)(B); Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.337.

⁶² Trust Company of Oklahoma v. Oklahoma Department of Human Services, 825 P.2d 1295 (Okl. 1991).

⁶³ P. L. 103-66; 42 U.S.C. § 1396p(d).

⁶⁴ Oklahoma Administrative Code 317:35-5-41.6(5); Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.339.

⁶⁵ Oklahoma Administrative Code 317:35-5-41.6(5); Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.

⁶⁶ *Id.*

disabled individual under the age of 65.⁶⁷ A Supplemental Need Trust would be an example of this type of trust. There are numerous requirements for this type of trust, including the requirements that it be irrevocable, that it only contains assets of the individual, and that it cannot be amended without the State approval. The exemption continues after the individual reaches the age of 65 but does not apply to any additions to the trust after the age of 65.

The second exemption applies to Medicaid Income Pension Trusts.⁶⁸ These trusts are established when an individual is in need of long-term care and has countable income above the categorically needy standard for long-term care, but less than the average cost of nursing home care per month. The trust must be irrevocable and include only income. Resources cannot be included in the trust.

The third exemption also applies to trusts established individuals with disabilities. These are irrevocable trusts established and managed by non-profit associations for a disabled individual and approved by the State.⁶⁹ These trusts are referred to as Medicaid Disability Trusts and are additionally restricted as follows:

1. The trust must be for the sole benefit of a disabled person.
2. The trust must be approved by the State.
3. The trust must be established by the beneficiary, the beneficiary's parent, grandparent, guardian, or a court.
4. The trust must contain only the beneficiary's money.
5. Trust funds must be maintained in a separate account.
6. The beneficiary must not be permitted to invade the trust.
7. The trust must provide that upon the beneficiary's death and to the extent of available trust assets, the trust will use a portion of the trust assets (not less than 70%) to re-pay the State for Medicaid benefits received by the beneficiary after the trust was established.⁷⁰

If a trust is created by someone other than the recipient of Medicaid funds and the trust is funded with income or assets from a third party, the trust is not subject to the trust Medicaid rules and the corpus and income of the trust are not counted toward the recipient's resource limit. To benefit from the exclusion, the trust must also not grant the beneficiary the authority to direct payment of corpus or income to the beneficiary. An example of this type of trust would be a trust established by a parent that contains none of the disabled person's money and gives the trustee sole discretion with respect to distribution of corpus and income. Establishing this type of trust may be one way to preserve family assets.

B. Treatment of the Applicant's Home

As noted above, an applicant's home is generally excluded as a resource for purposes of determining the applicant's available resources and applying the resource limitation test.⁷¹ In Oklahoma and Texas, if the applicant lives in their home and the equity interest in the home is less

⁶⁷ Oklahoma Administrative Code 317:35-5-41.6(6)(A); Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.

⁶⁸ Oklahoma Administrative Code 317:35-5-41.6(6)(B); Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.

⁶⁹ Oklahoma Administrative Code 317:35-5-41.6(6)(C); Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.

⁷⁰ Oklahoma Administrative Code 317:35-5-41(d)(9)(F)(i); Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.

⁷¹ Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.348.

than \$713,000.00 (as of 2024), the home is exempt.⁷² The value limitation was first introduced in the Deficit Reduction Act of 2005.⁷³ If the home is occupied by the individual's spouse, a minor child or a relative who is aged, blind or disabled, the home is exempt regardless of its value and regardless of where the applicant lives.⁷⁴

If the home is not occupied by the applicant, their spouse, a minor child or a relative who is aged, blind or disabled, the home may still be exempt for a period of time if the applicant files an "Intent to Return Home" statement and the equity interest in the home is at or below \$713,000.00. The period of time during which the home remains exempt varies by state. In addition, some states require a physician statement stating that there is a possibility the applicant could return home.

An Intent to Return Home is a documented assertion that even though an individual intends to enter a nursing home, assisted living center or the home of a family member, the individual still regards their home as their primary residence and intends to return to their home if their health permits.⁷⁵ The statement applies to homes, condominiums, mobile homes and even house boats as long as the applicant's primary residence.⁷⁶

In Oklahoma, if the individual is moved to a nursing home, the home remains exempt for 12 months. After an individual has resided in a nursing home for 12 months, medical evidence must be provided to show the feasibility of returning to the home within 90 days. Otherwise, the individual must undertake good faith efforts to sell the home, or the home will be counted as a resource. Once the home is sold, the person is ineligible to receive benefits until the proceeds are spent and the individual is reduced back to the \$2,000.00 resource limit.

In Texas, there is no length limit and no physician statement or statement indicating a probability of return to the home is required.⁷⁷ Therefore, if an Intent to Return Home is filed and the equity interest in the home is at or below \$713,000.00, the home remains exempt indefinitely.

C. Special Eligibility Rules for Spouses

The Medicaid eligibility rules discussed above differ when an individual applying for Medicaid benefits enters a nursing home and the individual's spouse remains in the home. Since the passage of the Medicare Catastrophic Coverage Act in 1988, the Medicaid rules include spousal impoverishment rules aimed at preserving sufficient resources and income for the community spouse. Such rules have been codified as amendments to the Social Security Act.⁷⁸ The most recent amendments are contained in modifications of Section 2404 of the Patient Protection and Affordable Care Act enacted December 29, 2022 which extend the spousal impoverishment rules for Home and Community Based Services through 2027.⁷⁹ The spousal

⁷² <https://www.medicaidlongtermcare.org>, February 7, 2024.

⁷³ P. L. 109-171.

⁷⁴ Oklahoma Administrative Code 317:35-5-41(c)(6)(F); Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.

⁷⁵ <https://www.medicaidlongtermcare.org>, February 7, 2024.

⁷⁶ *Id.*

⁷⁷ <https://www.medicaidlongtermcare.org>, February 7, 2024.

⁷⁸ 42 U.S.C. § 1396r-5.

⁷⁹ Department of Health and Human Services, CMCS Informational Bulletin, August 15, 2023; Consolidated Appropriations Act, 2023 (P.L. 117-328).

impoverishment rules were discussed by the United States Supreme Court in a case involving the proper allocation of income between institutionalized and community spouses.⁸⁰

For Nursing Home Medicaid and the HCBS Waivers programs, under the resource test the institutionalized spouse is still limited to resources of \$2,000.00 or less. The allocation process begins by determining the value of all countable assets owned by both spouses at the time the institutionalized spouse entered the nursing home. Separate property and assets that are the subject of a prenuptial agreement are also counted. The total value of all assets is then divided in half.

Under the spousal impoverishment rules, the community spouse is allowed to keep resources of between \$30,828.00 and \$154,140.⁸¹ If the value of half of the total countable assets is less than \$30,828.00, countable resources may be re-allocated from the institutionalized spouse to the community spouse, thereby reducing the resources of the institutionalized spouse. Known as the Community Spouse Resource Allowance (“CSRA”), this ensures that the community spouse will not be destitute if their spouse enters a nursing home. If the value of half of the total countable assets is greater than \$154,140.00, countable resources will be re-allocated from the community spouse to the institutionalized spouse, thereby increasing the resources of the institutionalized spouse.

Once resources have been allocated, if the resources of the institutionalized spouse exceed \$2,000.00, the institutionalized must spend down resources to get below the \$2,000.00 limit. Resources may be spent for the benefit of either spouse but may not be gifted to third parties. Acceptable spending would include buying exempt assets, paying debts, and spending resources on the home. If resources are acquired after the institutionalized spouse enters the nursing home, such resources are allocated to the institutionalized spouse and must be spent down.

With respect to ABD Medicaid and MEPD Medicaid, since both spouses continue to reside at home, there is no Community Spouse Resource Allowance. For a married applicant, the combined resource limit in Oklahoma is \$14,130.00 through March 2024. For a married applicant in Texas, the combined resource limit is \$3,000.00.⁸²

For Nursing Home Medicaid and the HCBS Waivers programs, under the income test, the institutionalized spouse must count all of his or her income and one half of all joint income. The recipient of income is basically determined by whose name is on the check. The income limit is the same as for an unmarried individual, \$2,829.00 per month. Under the spousal impoverishment rules the community spouse is assured a Minimum Monthly Maintenance Needs Allowance (“MMMNA”) of \$3,853.50 per month.⁸³ Therefore, if the income allocated to the community spouse is less than \$3,853.50 per month, income up to that amount, known as the Spousal Income Allowance, may be re-allocated from the institutionalized spouse to the community spouse to achieve such level. The net income of the community spouse combined with the Spousal Income Allowance cannot exceed \$3,853.50 per month.

For ABD Medicaid and MEPD Medicaid, the income of both spouses is considered, with a combined income limit is \$1,643.00 per month in Oklahoma⁸⁴ and \$1,415.00 per month in

⁸⁰ Wisconsin Department of Health and Family Services v. Blumer, 534 U.S. 473, 122 S.Ct. 962, 151 L.Ed.2d 935 (2002).

⁸¹ 42 U.S.C. § 1396r-5.

⁸² <https://www.medicaidlongtermcare.org.>, February 7, 2024

⁸³ Oklahoma Administrative Code 317:35-19-21(3)(C); Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.420.

⁸⁴ *Id.*

Texas.⁸⁵ The limit applies whether only one spouse is applying for Medicaid benefits or both spouses are applying for benefits.⁸⁶ There is no Minimum Monthly Maintenance Needs Allowance for non-applicant spouse of ABD Medicaid and MEPD Medicaid beneficiaries.⁸⁷

If after income is allocated between the institutionalized spouse and the community spouse, the institutionalized spouse's income exceeds \$2,829.00 but is less than \$6,833.00, the institutionalized spouse may nevertheless qualify for Medicaid benefits by establishing a Medicaid Income Pension Trust as described above.⁸⁸

D. Treatment of Asset Transfers

As noted above, Medicaid programs contain a resource test to determine eligibility. To prevent abuses, rules were implemented to prevent individuals from transferring assets in order to qualify for Medicaid. Current rules provide that an individual may not give assets away in order to qualify for Nursing Home Medicaid and the HCBS Waivers programs. With respect to the Oklahoma ABD Medicaid program and the Texas MEPD program, there are no restrictions or penalties for transfers of assets (i.e. no look-back period).⁸⁹

Prior to the passage of the Deficit Reduction Act of 2005, an agency charged with determining Medicaid eligibility would look back three years to determine whether an asset was disposed of for less than fair market value in order to qualify for Medicaid benefits.⁹⁰ For transfers made after the effective date of the Deficit Reduction Act, February 8, 2006, the look-back period is five years.⁹¹

Under prior law, if a transfer was made for less than fair market value within the three-year look-back period, the individual would be ineligible for a period of months measured from the date of the transfer. The number of months of ineligibility would be calculated by taking the difference between the fair market value of the asset transferred and the amount received by the individual, if any, and dividing by \$2,000.00.⁹² Therefore, gifts or transfers of less than \$2,000.00 per month would not affect eligibility. A five-year look-back period was applied for transfers made to trusts of which the individual is not a beneficiary, and transfers from a grantor living trust to a third party.

For transfer made after February 8, 2006, current law provides that if a transfer was made for less than fair market value within the five year look-back period, the individual will be ineligible for a period of days measured from the later of (1) the date of the transfer, or (2) the date on which the person has been found to be eligible for Medicaid payment for nursing home care absent the transfer.⁹³ The number of days of ineligibility is calculated by taking the difference

⁸⁵ Oklahoma Administrative Code 317:35-19-21(3)(C); Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.420.

⁸⁶ <https://www.medicaidlongtermcare.org>, February 7, 2024.

⁸⁷ <https://www.medicaidplanningassistance.org>, February 7, 2024.

⁸⁸ Oklahoma Administrative Code 317:35; Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.

⁸⁹ <https://www.medicaidplanningassistance.org>, February 7, 2024.

⁹⁰ Oklahoma Administrative Code 317:35-9-67(4).

⁹¹ P.L. 109-171, § 6011(a), 42 U.S.C. § 1396p(c)(1)(B), Oklahoma Administrative Code 317:35-19-20(5)(A); Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.348.401.

⁹² Oklahoma Administrative Code 317:35-9-67(4), Oklahoma Administrative Code 317:35-17-10(3); Oklahoma Administrative Code 317:35-19-20(4); Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.348.

⁹³ P.L. 109-171, § 6011(b), 42 U.S.C. § 1396p(c)(1)(D)(ii), Oklahoma Administrative Code 317:35-19-20(5)(C).

between the fair market value of the asset transferred and the amount received by the individual, if any, and dividing by \$224.64, representing the average per day nursing home private pay rate.⁹⁴

The significance of the change in the law is that individuals are now penalized from the date they enter the nursing home and otherwise qualify for Medicaid benefits rather than the date of the transfer. Therefore, the ability to make significant transfers prior to entering the nursing home, but within the look-back period, is now removed. With the look-back period now five years and the penalty period being measured in days rather than months, individuals desiring to preserve family assets will be forced to undertake long-term planning if they intend to transfer assets for less than fair market value in order to qualify for Medicaid benefits. The penalty imposed under the Medicaid rules is a period of ineligibility. Individuals are not forced to recover assets.

Certain transfers for less than fair market consideration are not penalized under Medicaid rules.⁹⁵ An individual will not be penalized if he or she can show any of the following:

1. The transfer was of the individual's home and was made to the individual's spouse, a child under 21 or disabled, a sibling with an equity interest in the home who resided in the home for at least one year prior to the individual entering the nursing home, or the individual's son or daughter who resided in the home and provided care for at least two years prior to the individual entering the nursing home.

2. The individual can show that the intent was to transfer the asset for fair market value.

3. The individual can show that the transfer was exclusively for a purpose other than Medicaid eligibility.

4. The transfer was to a trust established for the sole benefit of a disabled person under the age of 65.

5. The penalty would result in a hardship, defined to mean a loss of medical care that would endanger the individual's life or health, or deprive the individual of food, clothing, shelter, or other.⁹⁶

Prior to the institutionalized spouse becoming eligible for Medicaid, transfers made by either spouse for less than fair market value are subject to the same penalty provisions as transfers made by an individual. Transfers made by the institutionalized spouse after he or she becomes eligible for Medicaid are penalized in the same way. The one exception to the normal rules is that after resources are allocated between the spouses, the institutionalized spouse must transfer all of his or her interest in the resources allocated to the community spouse within 12 months of becoming eligible for Medicaid.⁹⁷ Transfers made by the community spouse after the institutionalized spouse is determined to be eligible for Medicaid benefits do not result in penalties for the institutionalized spouse.

V. CONCLUSION

Qualifying for Medicaid long-term care programs is a very complicated process. The rules are convoluted and vary among different jurisdictions. A complete understanding of the Medicaid rules is perhaps an unattainable goal. Nevertheless, attorneys that advise clients in this area should

⁹⁴ P.L. 109-171, § 6016(a), 42 U.S.C. § 1396p(c)(1)(E)(iv), Oklahoma Administrative Code 317:35-19-20(5)(E).

⁹⁵ Oklahoma Administrative Code 317:35-19-20(4)(F).

⁹⁶ P.L. 109-171, § 6011(e), 42 U.S.C. § 1396p(c)(2)(D), Oklahoma Administrative Code 317:35-19-20(5)(H)(vii); Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.348.401.

⁹⁷ Oklahoma Administrative Code 317:35-19-20; Texas Administrative Code, Title 1, Part 15, Chapter 358, Subchapter B, Rule §358.348.401.

achieve some level of competence in order to make proper recommendations. Attorneys play an important role in this process because the individuals who are in most need of Medicaid services are arguably the individuals who are least likely to understand the Medicaid rules.