

**MEDICAL ASSISTANCE ELIGIBILITY:
FUNDAMENTALS OF MINNESOTA HEALTH CARE
PROGRAMS FOR SENIORS**

I. MEDICAID (MEDICAL ASSISTANCE)

Medicaid is a joint federal-state program that provides health insurance coverage to low-income children, elderly persons and persons with disabilities. Medicaid also covers nursing home costs and long-term care costs in the community for those who meet specific program requirements.

Federal law governs Medicaid.¹ States that participate in the Medicaid program must comply with the federal law. However, there are variations in the law from state to state. Payments for covered services are made with both federal and state dollars. In Minnesota, the federal financial participation is approximately 50%. Recipients must meet program asset and income limits and other requirements in order to receive benefits through Medicaid.

Minnesota's Medicaid program is called Medical Assistance ("MA"). The applicable state law is found in Minnesota Statutes Chapter 256B. The Medical Assistance program is administered by the Department of Human Services ("DHS"). Each county's human services or economic assistance division takes in the applications and determines eligibility. DHS issues a Health Care Programs Manual ("HCPM") to the counties to direct the caseworkers as to how the law is applied. This manual can be found on line at <http://www.dhs.state.mn.us>.

A. Medical Assistance – Covered Services:

- Hospitalization, physician services, laboratory, and x-ray services
- Some dental and eye care, medical supplies, and treatments
- Transportation, prescription drugs (some), hospice, day treatment programs, and special education programs
- Occupational, physical, and speech therapies
- Hearing aids
- Mental health services
- See Minn. Stat. 256B.0625 for complete list

B. Long-term care Medical Assistance – Covered Services: For people who need assistance with activities of daily living, such as bathing, dressing, eating, transferring:

- Personal care assistants, private duty nursing
- Nursing home coverage
- Home health care
- Modifications to home or car
- Respite
- Case management, etc.

¹ 42 U.S.C. § 1396a, et seq.

II. MEDICAL ASSISTANCE: BASIC ELIGIBILITY.

- A. Coverage.** Medical Assistance will pay for most medically necessary services. Medications will be covered under Medicare Part D for “dual eligibles” (persons eligible for both Medicare and Medical Assistance). Medical Assistance covers medications for those persons eligible only for Medical Assistance. Some services require prior authorization.
- B. Residency.** To receive Medical Assistance, an individual must be a Minnesota resident. People establish Minnesota residence by being physically present in the state, residing here voluntarily, and not maintaining a home elsewhere. There is no durational requirement.
- C. Categorical Eligibility.**
- Elderly: 65 and older
 - Blind
 - Disabled
- D. Financial Eligibility.**
- Single
 - \$3,000 in available assets
 - Income spenddown
 - Married
 - Community spouse asset allowance plus \$3,000
 - Income spenddown

III. MEDICAL ASSISTANCE ASSET RULES. The general eligibility guidelines in this outline apply to individuals who are 65 years of age and older.

A. Asset limitations.

1. To be eligible for MA, the MA recipient is limited to \$3,000 in available assets.
2. A married couple, both of whom are applying for MA, are limited to \$6,000 in available assets.
3. For a married couple where only one spouse is applying for MA and resides in a nursing home or is receiving services under the Elderly Waiver program, spousal impoverishment rules apply. See Section III, below.

- B. Available assets.** Assets are available if the owner has both legal authority and actual ability to use them for self-support. Available assets include any personal property or real property with monetary value that is not determined to be excluded or unavailable. Available assets include, among other things, savings and checking accounts, stocks, bonds, certificates of deposit, contracts for deed, IRAs, investments in precious metals or gems, and the cash surrender value of insurance policies.

C. Excluded assets.² Property that is not counted in determining MA eligibility includes the following:

- 1. Homestead.³** The homestead is defined as "any property in which an individual (and spouse, if any) has an ownership interest and which serves as the individual's principal place of residence. This property includes the shelter in which an individual resides, the land on which the shelter is located and related outbuildings." There is no acreage limitation.⁴ Personal property used as a home (for example, mobile home) is excluded.

The home is excluded if it is the primary residence of:

- The spouse;
- A child under 21;
- A child of any age who is blind or permanently and total disabled as defined in the supplemental security income program;
- A sibling of the applicant who lived in the house for at least one year immediately before the applicant's nursing home admission and has an equity (ownership) interest in the home; or
- A child or grandchild of the applicant who lived in the house for at least two years immediately before the applicant's nursing home admission and has provided verified care to the applicant that has allowed the applicant to remain at home during that two years rather than in a nursing home.

2. Household goods and personal effects.

3. One motor vehicle is excluded regardless of its value if it is used for transportation of the client or a member of the client's household.

4. Capital and operating assets of a trade or business that are necessary to the individual's ability to earn an income.⁵

5. Insurance settlements to repair or replace lost, damaged, or destroyed property are excluded for nine full months after the client receives the payment.

6. Funds used to meet real estate tax, insurance, and upkeep expenses for real property when held in a separate account.

² See HCPM § 19.10.

³ See HCPM § 19.25.15.05.

⁴ Certain applicants and enrollees requesting or receiving MA payment of long-term care (LTC) services are limited to a home equity interest of \$500,000 or less. See HCPM § 19.55.

⁵ See HCPM §§ 19.10.05 and 19.10.10.

7. Cash surrender value of certain life insurance policies.

If the total face value of life insurance policies owned by the applicant or owned by the applicant's spouse is \$1,500 or less, the cash surrender value of each policy is excluded and the burial fund exclusion is reduced by the face value of the policies. Term insurance has no cash surrender value and is not counted as an asset.

If the total face value of the life insurance policies exceeds \$1,500, the cash surrender value must be verified and will be counted toward the burial fund exclusion described below or counted toward the \$3,000 asset standard.

8. Burial funds.

- a. "Burial funds" are defined as funeral arrangements and services that include transportation of the body, embalming, cremation, funeral or memorial services, flowers, clothing, etc., and are distinguished from burial space items that are used for interment of the decedent's remains.
- b. The MA applicant may set aside up to \$1,500 in a revocable burial fund for funeral services or mortuary functions for the applicant and/or the applicant's spouse.
- c. Burial funds may be liquid or non-liquid assets, including bank accounts, contracts, cash surrender value of life insurance policies, personal or real property, trusts, or any other asset that has value, and must be identifiable from other excluded and non-excluded funds.

9. Burial spaces and burial space items held for use by the MA applicant, his or her spouse, and any member of the immediate family are excluded as an asset, regardless of who owns them. "Burial space" is defined to include any conventional plot, gravesite, crypt, mausoleum, vault, casket, urn, etc. "Burial space items" are items used for the disposal of the body after all funeral services and mortuary functions (burial funds) have taken place, including the opening and closing of the grave, the headstone, urn, etc.

10. Prepayment of funeral expenses using a life insurance policy or annuity. Purchase of a life insurance policy or an annuity to pay for burial funds will be considered a transfer of assets, unless the policy or annuity names "any funeral home as its interest may appear" as the irrevocable beneficiary and the estate of the individual as the irrevocable contingent beneficiary, it is accompanied by a contract with the funeral home specifying the amounts to be paid for services and burial space items, and the amount paid for the policy or annuity does not exceed the amount of the contract. In such case, there is no limitation to the amount

spent either for burial funds or for burial space items.

11. Certain rental property, if (1) it is leased at market rate, (2) the amount of equity is less than \$6,000, and (3) it produces net income in an amount that is at least 6% of equity. This is rarely used as an exemption because of the requirement for extremely low equity in the property.

12. Other business property

Up to \$6,000 equity value in real or personal property the client currently uses to produce goods or services needed for daily activities and used solely by the client's household. This includes property and equipment used to produce food or clothing for the household.

Up to \$6,000 equity value in income-producing non-liquid personal property or real property, including rental property, not used in a trade or business if the property produces an annual net return equal to at least 6% of the equity value. Non-liquid personal property includes items such as household goods, machinery, vehicles, livestock, and non-cash business property.

D. Unavailable assets.⁶ Assets that are not available, while technically not "excluded," are not counted. When a non-excluded asset cannot be made available to pay for the applicant's medical needs and the applicant has made reasonable efforts to make the item available, it is considered unavailable and will not be counted in determining the \$3,000 limit, until such time as it becomes available. Examples of unavailable assets include:

1. Jointly held assets, other than jointly held bank accounts, when:

- a. The permission of the joint owner is required to sell or dispose of the asset, and
- b. The joint owner is not the spouse (or other member of the household or a financially responsible relative whose assets are deemed to the MA client), and
- c. The joint owner refuses to allow the sale or disposal of the asset.

2. Share of an estate that has not been probated.

3. Property involved in a pending legal action.

4. Life estate.

5. Real property not used as a home. Non-homestead real property is considered unavailable as long as the applicant is making a reasonable effort to sell the property. A reasonable effort to sell includes:

⁶ See HCPM § 19.15.

- Listing the property with a real estate broker, or
- Having a readable sign on the property with the owner's name and telephone number and advertising it in the local newspaper.

The asking price can be no more than the "estimated market value" on the real estate tax statement or an appraisal from a licensed real estate appraiser. A reasonable offer is "no less than two-thirds of the estimated market value" and must be accepted. If it isn't, the non-homestead real property is no longer considered "unavailable," and its value must be counted toward the asset limit.

6. **Trusts.** Availability of assets in trusts depends on (1) the kind of trust involved, (2) who established the trust, (3) whose assets were used to fund the trust, (4) whether the trust is revocable or irrevocable, (5) whether it was established during lifetime or through a will, and (6) the provisions of the trust agreement.⁷
7. **Annuities.**⁸ Annuities may or may not be available assets, depending on their status.

IV. MEDICAL ASSISTANCE INCOME RULES

A. Income: General Eligibility Rules.

An individual receiving nursing home or EW services must apply his or her income to the nursing home or home care costs after subtracting the following allowable deductions, to be made in the order listed:

1. German Reparation payments, Japanese and Aleutian Restitution payments, Agent Orange Settlement Fund payments, Radiation Exposure payments, payments under the Domestic Volunteer Services Act, payments received under the White Earth Land Settlement Act, Netherlands Act payments to victims of Nazi persecution, Vietnamese Commando Compensation payments, payments to children of Vietnam veterans with spina bifida, Austrian reparation payments, Blood Product Settlement payments, and payments by the Secretary of Defense to people captured and interned by North Vietnam.
2. Medicare premiums of individuals who are not Qualified Medicare Beneficiaries.
3. Clothing and personal needs allowance, currently \$89.

⁷ See Elder Law Handbook, Chapter 8.; Mark Anderson, "Trust Availability" Medical Assistance 2010: What's Going On?

⁸ See HCPM § 19.25.30.

4. Guardianship or conservatorship fees paid to the individual's legally appointed guardian or conservator of 5% of the individual's monthly gross income up to a maximum of \$100 as reimbursement for services rendered.
5. Monthly income allocation for the community spouse (*see* Section III below).
6. Monthly allocation for a family member other than a community spouse in specific circumstances.
7. Health insurance premiums.
8. Other reasonable and necessary medical expenses not covered by MA.

V. SPOUSAL IMPOVERISHMENT RULES

A. Allocation of Assets between the Community Spouse and Long-Term Care Spouse

The spousal impoverishment rules apply to married couples where one spouse is living in the community (the "community spouse") and the other spouse (the "long-term care spouse") receives long-term care services either in the nursing home or under the EW program, and only the long-term care spouse applies for MA.

1. **Long-term care spouse.** The long-term care spouse must meet the MA standard for a single individual (\$3,000 plus excluded property).
2. **Assessment of assets.** The date of the asset assessment is one of the following two dates:
 - i. **The long-term care spouse is institutionalized.** All assets owned by both spouses, including their shares of jointly held assets, are reviewed as of the date the ill spouse is first admitted to a hospital and/or nursing home for a stay that is anticipated to last for at least 30 consecutive days. This is called the "first continuous period of institutionalization." The assets are added together, regardless of ownership, to determine the community spouse asset allowance.
 - ii. **The long-term care spouse is receiving home health services.** All assets owned by both spouses, including their shares of jointly held assets, are assessed and documented as of the later of the following dates:
 - The date on or after July 1, 1991, that the person is screened by a long-term care consultation team and

was receiving or is anticipated to begin home care services within 90 days of the long-term care consultation screening and will continue for at least 30 consecutive days;

- The date that home care services begin, where the services would be covered by the Elderly Waiver or Alternative Care program, are provided by a certified home health agency, and are expected to continue for at least 30 consecutive days.

iii. **Completed only once.** Once the effective date of the asset assessment is determined, it is never changed even if the individual begins a new period of institutionalization or begins receiving home care services. The same asset assessment is used at every MA application where a community spouse asset allowance is being calculated.

c. **Community spouse asset allowance.** The community spouse may retain an amount equal to half of the non-excluded assets, up to a maximum of \$109,560, and with a minimum of \$31,094 (assuming the assets of the couple equal at least this amount). This amount is called the "community spouse asset allowance." The remainder of the assets must be reduced to \$3,000 before the long-term care spouse will be eligible for MA.

- i. The maximum and minimum limits of \$109,560 and \$31,094 are increased as of January 1 of each year based on the Consumer Price Index, and the increased amounts are used for those individuals who apply for MA on or after January 1 of that year. The amounts listed here are for 2009.
- ii. The community spouse asset allowance is based on the minimum and maximum allowance amount in effect at the time the assessment is completed. However, the amount of the community spouse asset allowance is considered again at the time of MA application. When an asset assessment is completed in a year other than the year in which an MA application is filed, the calculated asset allowance at the time of the initial request is considered to be only an estimate.
- iii. After application for MA, the long-term care spouse may transfer assets to the community spouse to increase the community spouse's assets to the community spouse asset allowance. After application for MA and while the application is pending, all assets except the community spouse asset allowance are considered to be available to the long-term care spouse and must be used for his or her

health care or personal needs.

- iv. After the month in which the long-term care spouse is determined to be eligible for Medical Assistance and throughout the continuous institutionalization of the long-term care spouse, no assets of the community spouse are considered available to the long-term care spouse.

d. **Examples of allocating assets between spouses:**

- i. If together the spouses have \$35,000, half of that amount is \$17,500, which is less than the minimum community spouse asset allowance of \$31,094. Assuming application for MA in 2009, the community spouse will be allowed to retain the minimum \$31,094 and the long-term care spouse will be allowed to keep \$3,000 for a total of \$34,094. The couple must reduce all assets to \$34,094 before the long-term care spouse will be eligible for MA, assuming application in 2009.
- ii. If all the assets of the spouses total \$100,000, the community spouse asset allowance will be half that amount, which is \$50,000. The couple can retain the \$50,000 plus \$3,000, the MA eligibility limit, for a total of \$53,000. All assets must be reduced to this amount before the long-term care spouse will be eligible for MA.
- iii. If all the assets of the spouses total \$220,000, half is \$110,000, which exceeds the maximum community spouse asset allowance of \$109,560. The community spouse will be allowed to retain the maximum \$109,560 allowed under the law (assuming MA application in 2009) and the long-term care spouse can retain \$3,000, for a total of \$112,560. All available assets of the couple must be reduced to this \$112,560 before the long-term care spouse will be eligible for MA, assuming application in 2009.

- e. **Increase in the community spouse asset allowance.** The amount allocated to the community spouse may be increased by court order or if additional assets are needed to generate income to bring the community spouse's income up to the minimum monthly income allowance allowed by law.

B. Allocation of Income between the Community Spouse and Long-Term Care Spouse

- 1. **No contribution by the community spouse from his or her income.** The community spouse is not required to make a contribution from his or her income toward the long-term care spouse's nursing home or EW care.

2. **Minimum monthly income allowance.** The community spouse is allowed a minimum monthly income allowance that is a basic monthly allowance of \$1,823 (increased on July 1 of each year based on the Consumer Price Index), plus an excess shelter allowance. The minimum income allowance cannot exceed \$2,739, subject to annual increase.
 - a. **Excess shelter allowance.** The excess shelter allowance is the amount by which the community spouse's shelter expenses exceed 30% of the basic allowance, currently \$547. Shelter expenses include rent or mortgage payments, including principal and interest, insurance, taxes, required maintenance charges for a cooperative or condominium, and a utility allowance that is determined as follows:
 - i. **\$305:** Utility standard allowed if the community spouse pays heating or cooling costs. This includes telephone. If the community spouse has a required maintenance charge for a cooperative or condominium, the standard utility allowance must be reduced by the amount of utility expenses included in the required maintenance charge.
 - ii. **\$75:** Electric standard allowed when electric, but not heating or cooling, costs are incurred by the community spouse.
 - iii. **\$24:** Telephone standard allowed when telephone expenses are incurred by the community spouse who is not entitled to the full utility standard of \$305.
 - b. **Monthly income allocation to community spouse.** If the community spouse's income is less than the basic allowance plus the excess shelter allowance, the income is supplemented by the income of the long-term care spouse. This is called the "monthly income allocation." The steps to determine the income allocation to the community spouse are as follows:
 - i. Calculate the shelter expenses of the community spouse.
 - ii. Subtract \$547 (or 30% of the current basic allowance) from the total shelter expenses. The result is the excess shelter allowance.
 - iii. Add \$1,823 (or the current basic allowance) to the excess shelter allowance. The result, not to exceed \$2,739, is the monthly income allowance of the community spouse.
 - iv. Subtract the income of the community spouse from the monthly income allowance. The result is the income

allocation from the long-term care spouse to the community spouse (i.e., the spousal allocation).

- c. **Increased asset allowance.** If the income of the community spouse, including interest income from the community spouse's share of the assets, together with the income of the long-term care spouse, is less than the minimum monthly income allowance as calculated above, additional income-earning assets may be allocated to the community spouse. To qualify for transfer of additional assets to a community spouse, the following conditions must be met:
- i. The assets of the couple have been arranged so that the community spouse's share includes as many income-producing assets as possible; and
 - ii. The assets are invested at the maximum rate of return, defined as the average rate of return available from the financial institution holding the assets, or a rate determined by the commissioner to be reasonable according to community standards, if the asset is not held by a financial institution.

Income First Rule. All income of the institutionalized spouse that could be made available to a community spouse, in accordance with the calculation of the community spouse minimum income allowance, must be made available before the community spouse can be allocated an amount of assets adequate to provide the difference between the minimum monthly maintenance needs allowance and all income available to the community spouse

- d. **Court-ordered income.** If a court has entered an order against a long-term care spouse for monthly income for support of the community spouse, the community spouse's monthly income allowance shall not be less than the amount of monthly income ordered, even if it exceeds \$2,739.

V. TRANSFERS

A. Basic Rule.

If the Medical Assistance applicant or the applicant's spouse has transferred assets to individuals, entities, or a trust for less than fair market value within **60 months**⁹ ("look-back period") of applying for MA months, the applicant will be ineligible for Medical Assistance to cover the costs of long-term care for a certain period of time, called the period of ineligibility.

⁹ In Minnesota, the look-back period is being increased by one month each month, beginning in February of 2009, and ending in February of 2011, at which time we will have a full five year (60 month) look-back.

B. Calculating the Period of Ineligibility for Transfers.

The total uncompensated value of assets transferred in one month *divided by* the average monthly MA nursing home rate (currently \$5,006) = the period of ineligibility.

C. Services to Which Transfer Penalty Applies: Institutional Care.

A person can be eligible for Medical Assistance if he or she meets the eligibility criteria. However, if transfers have been made and a transfer penalty applies, Medical Assistance will not cover the costs of institutional care. Institutional care includes:

1. Nursing facility services;
2. A level of care in any institution equivalent to that of nursing facility services; and
3. Home or community-based services including EW, Alternative Care, CADI, TBI, CAC, and MR/RC.

D. Presumption.

Any transfer of assets within the look-back period is presumed to be for the purpose of establishing or maintaining MA eligibility, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. (The applicant must show that he or she had no reason to believe that long-term care services might be needed.) Even after MA eligibility is established for one spouse, it is presumed that a transfer made by a community spouse was to obtain or maintain eligibility for the long-term care spouse or for the community spouse. If the purpose of the transfer is to preserve the estate for heirs, avoid probate, or reduce taxes, the transfer will be considered to be “improper.”

E. Uncompensated Value of a Transferred Asset.

The uncompensated value of a transferred asset is the fair market value of the asset less the amount of encumbrances and the compensation received (including money, goods, or services).

F. When a Transfer Occurs.

1. **In general.** A transfer occurs when the applicant or spouse gives away, sells, conveys ownership and/or reduces control, or disposes of any asset or an interest in an asset. A transfer may occur through a sale, trade, or gift of an asset or income, or taking an action to reduce or eliminate the applicant or applicant's spouse's ownership or control of income or assets held in common with another person or persons. Any action taken to reduce or eliminate an individual's ownership or control of an asset held

in joint tenancy, tenancy in common, or similar arrangement, is considered to be a transfer by the individual.

2. **Not receiving an asset to which you are entitled.** A transfer may occur when a person or person's spouse is entitled to receive an asset but takes an action that causes the person or spouse not to receive the asset. This includes:

- Waiving the right to or refusing to accept an inheritance (also known as refusing to elect against a will) when doing so will result in receiving greater income or assets for the client. The signing of a consent not to elect against a will is not considered a transfer at the time of signing, but may be considered an improper transfer at the time of death, depending on the circumstances.
- Waiving pension income or diverting it to a trust or similar device for the benefit of another.
- Refusing to take affordable legal action to obtain court-ordered payment that is not being paid, such as child support or alimony.
- Not accepting or taking action to obtain personal injury settlements.
- Personal injury settlements diverted by a defendant into a trust or similar legal device to be held for the benefit of the plaintiff, unless the exception for a disabled person applies.

3. **Transfer of real estate.** In general, the transfer of real estate is complete when both execution and delivery of the deed have been completed. Delivery is either giving the deed to the grantee or recording the deed.

More extensive rules apply to the transfer of a life estate or joint tenancy interest as of 2005, when Minn. Stats. § 256B.15 was amended by adding a new Subdivision 6, effective retroactively from August 1, 2003. This new subdivision provides:

For purposes of subdivision 1 [estate recovery] and section 526.981, subdivision 6 [liens against life estate and joint tenancy interests], a life estate or joint tenancy interest is established upon the earlier of:

(1) the date the instrument creating the interest is recorded or filed in the office of the county recorder or registrar of titles where the real estate interest it describes is located;

(2) the date of delivery by the grantor to the grantee of the signed instrument as stated in an affidavit made by a person with knowledge of the facts;

(3) the date on which the judicial order creating the interest was issued by the court; or

(4) the date upon which the interest devolves under section 524.3-101.

4. **Payment for services rendered by relatives.** Payment for services provided by relatives will be considered a transfer unless one of the following conditions is met:

- The parties have a notarized written agreement, dated at or before the time of the service, requiring payment. The agreement must state the service to be performed and the rate of reimbursement, and the rate of reimbursement must be consistent with a charge for a similar service performed in the community.

OR

- Payment for services is made within sixty (60) days of when such services were rendered.

5. **Transfers made after MA eligibility.** If transfers are made by a Medical Assistance recipient or his or her spouse and are reported to the county financial worker too late for the financial worker to issue a timely notice regarding termination of long-term care benefits because of that transfer, the state will have a cause of action against the transferee for the amount transferred.

G. Start Date of the Period of Ineligibility

1. **Already on Medical Assistance.** If the Medical Assistance recipient is receiving long-term care services and the recipient or spouse makes a transfer of assets, then the period of ineligibility begins in the month after the month of the transfer.

2. **Applying for Medical Assistance while receiving long-term care services.** If an individual is receiving institutional services and applies for Medical Assistance and has met the criteria for eligibility, but has made a transfer within the look-back period, the period of ineligibility will begin the date on which the individual is eligible for Medical Assistance but for the transfer. The individual must actually apply for Medical Assistance so that a determination can be made that he or she is eligible for Medical Assistance but for the period of ineligibility resulting from an uncompensated transfer.

3. **The period of ineligibility begins when the applicant needs Medical Assistance.** When a person runs out of money and needs Medical Assistance, this is the point at which the transfer penalties will be imposed. Unless an exception applies, any and all transfers made by an applicant or spouse to a person or entity such as charitable donations, holiday gifts, help with college tuition, gifts to religious institutions, or

political donations made on or after February 8, 2006, and within 60 months of application must be reported and will affect eligibility.

H. Multiple Transfers.

All transfers within the look-back period will be added together and treated as one transfer in order to calculate the period of ineligibility.

I. No Cap to the Period of Ineligibility.

For any transfers made during the 60-month look-back period, the period of ineligibility will be the full number of months determined by dividing the uncompensated transfer by the average monthly MA rate. There is no cap to the length of the period of ineligibility.

J. Purchase of Promissory Note, Loan, or Mortgage.

With respect to a transfer of assets, the term “assets” includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage:

(i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration;

(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; **and**

(iii) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the individual’s application for Medical Assistance for long-term care services.

K. Purchase of a Life Estate Interest.

With respect to a transfer of assets, the term “assets” includes the purchase of a life estate interest in another individual’s home unless the purchaser resides in the home for a period of at least one year after the date of the purchase.

L. Purchase of Annuities and Annuitization.

M. Homestead Exception to the Transfer Prohibition.

Generally speaking, if a long-term care recipient transfers the homestead within the applicable look-back period, the transfer will result in a period of ineligibility. However, there will be no penalty if the homestead is transferred as follows:

1. To the individual's spouse, child under the age of 21, or blind or disabled

child of any age.

2. To a sibling who has an equity interest in the home and who was residing in the home for a period of at least one year immediately before the date of the individual's admission to the nursing home.
3. To a son or daughter who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the facility, and who provided care to the individual that permitted the individual to reside at home, rather than in an institution. Note that this exception does not apply to the caregiver grandchild.
4. If the individual shows he or she intended to dispose of the homestead at fair market value or for other valuable consideration.
5. If denial of eligibility would cause undue hardship to the individual, based on imminent threat to the individual's health and well-being.

N. Other Exceptions to the Transfer Prohibition. There will be no period of ineligibility for transfers if one or more of the following situations exist:

1. The assets are transferred to the individual's spouse, or the assets are transferred from the individual's spouse to another for the sole benefit of the individual's spouse. "For the sole benefit of" means that no other individual or entity can benefit in any way from the assets or income at the time of transfer or at any time in the future.
2. The assets are transferred to the individual's blind or permanently and totally disabled child, or to a trust (including a supplemental needs trust defined in federal law) established solely for the benefit of such child.
3. The assets are transferred to a trust, including a supplemental needs trust, established solely for the benefit of any individual under 65 years of age who is disabled as defined under the Social Security Act.
4. The transferred assets are excluded assets other than the homestead.
5. All assets transferred for less than fair market value have been returned to the individual. (The period of ineligibility can be reduced by a return of some of the transferred assets.)
7. A showing is made that the individual intended to dispose of the assets either at fair market value or for other valuable consideration.
8. Denial of eligibility because of the transfer would cause undue hardship to the individual, based on imminent threat to the individual's health and well-being.

O. Cause of Action against the Transferee.

1. Transfers made by an applicant but not reported on the application. If a transfer was not reported to the local agency at the time of application, and the applicant received long-term care services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for the cost of long-term care services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received. Minn. Stats. § 256B.0595, Subd. 2(a).

2. Transfers by a recipient of Medical Assistance. If Medical Assistance is to be terminated whether in whole or in part (for long-term care services only), the County must give notice of the termination to a Medical Assistance recipient at least 10 days before the first day of the affected month. If a transfer is made in the last 10 days of a month, even if reported immediately, no period of ineligibility can be imposed for the next month. This has enabled a recipient or recipient's spouse to transfer up to the divisor each month without affecting the recipient's ongoing Medical Assistance eligibility for long-term care services. This "loophole" was "fixed" by Minn. Stats. § 256B.0595, Subd. 2(b) as follows:

If the transfer was reported to the local agency after the date that advance notice of a period of ineligibility that affects the next month could be provided to the recipient and the recipient received medical assistance services or the transfer was not reported to the local agency, and the applicant or recipient received medical assistance services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for the cost of medical assistance services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received.

3. Criteria for determining whether cause of action exists. Effective for transfers made on or after March 1, 1996, involving persons who apply for medical assistance on or after April 13, 1996, no cause of action exists for a transfer unless:

(1) the transferee knew or should have known that the transfer was being made by a person who was a resident of a long-term care facility or was receiving that level of care in the community at the time of the transfer;

(2) the transferee knew or should have known that the transfer was being made to assist the person to qualify for or retain medical assistance eligibility; or

(3) the transferee actively solicited the transfer with intent to assist the person to qualify for or retain eligibility for medical assistance.

V. MEDICAL ASSISTANCE LIENS AGAINST REAL PROPERTY

A. Filing of lien.

1. The State may file a lien against **non-homestead** real property located in Minnesota and owned by a Medical Assistance recipient on or after the time when the recipient is institutionalized. No lien can be filed unless the recipient receives care in a nursing facility, immediate care facility for persons with mental retardation, or inpatient hospital. The amount of the lien is the amount of Medical Assistance provided to the recipient for care in a medical institution.
2. An exception to the non-homestead property rule is that a lien may be filed against the homestead of a single person whose homestead is excluded for Medical Assistance eligibility purposes during the first six months of nursing home stay and who receives medical assistance benefits.

B. Restrictions against filing a lien.

The lien cannot be filed if the property is the homestead of the following persons and they are lawfully living there:

1. The recipient's spouse;
2. The child of the recipient who is under age 21 or is blind or permanently and totally disabled according to the supplemental security income criteria;
3. The child or grandchild of the recipient if the child or grandchild lived in the homestead for at least two years immediately before the recipient began receiving long term care services, and the child or grandchild provided care to the recipient that permitted the recipient not to require long term care services (for MA, this also applies to the caretaker grandchild); or
4. The sibling of the recipient if the sibling has an equity interest in the property and has resided in the property for at least one year immediately before the date the recipient began receiving long-term care services.

C. Notice and opportunity for a hearing.

The lien cannot be filed until the Medical Assistance recipient and his or her legal representative has been sent written notice of the agency's lien rights and there has been an opportunity for a hearing.

D. Discharge of lien upon return home.

The lien must be released if the recipient is discharged from the medical institution and returns home.

VI. ESTATE RECOVERY

A. General Rule.

If an individual receives any Medical Assistance, upon the individual's death, if single, or on the death of the survivor of a married couple, either or both of whom received Medical Assistance, the local county agency may file a claim against the probate estate of the individual or estate of the surviving spouse, in the court having jurisdiction to probate the estate, for the value of Medical Assistance rendered to the individual and/or spouse.

B. Circumstances Under Which a Claim Will be Filed.

1. The person was over 55 years of age, and received Medical Assistance and/or Alternative Care services.
2. The individual resided in a medical institution for six months or longer, received MA, and, at the time of institutionalization or application for MA, whichever is later, the individual could not have reasonably been expected to be discharged and returned home, as certified in writing by the individual's treating physician. For purposes of this provision only, a "medical institution" means a skilled nursing facility, intermediate care facility, intermediate care facility for individuals with mental retardation, nursing facility, or inpatient hospital.
3. The individual received general assistance medical care services.

C. Assets Included in the Estate for Purposes of Estate Recovery.

2009 Minnesota legislation has considerably broadened the estate recovery rules in order to recapture a much larger part of the estate. For purposes of the Medical Assistance claim, the estate now consists of the following:

1. The person's probate estate;
2. All of the person's interests or proceeds of those interests in real property the person owned as a life tenant or as a joint tenant with a right of survivorship at the time of the person's death;

3. All interests or proceeds from interests in securities owned in beneficiary form at the time of death;
4. All interests in joint accounts, multiple-party accounts, and pay-ion-death accounts, brokerage accounts, investment accounts, or the proceeds of those accounts owned at the time of the person's death;
5. If the person's predeceased spouse received Medical Assistance, all legal title and interests the person's predeceased spouse had in jointly owned or marital property at the time of the predeceased spouse's death and the proceeds of those interests that passed to the person or someone else through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement at the time of the predeceased spouse's death.
 - a. "Other arrangement" includes any means by which title to all or any part of the jointly owned or marital property or interest passed from the predeceased spouse to another including transfers between spouses.
 - b. "Marital property" includes and all real or personal property of any kind or interests in such property the predeceased recipient spouse and his/her spouse, or either of them, owned at the time of their marriage to each other or acquired during their marriage regardless of whether it was owned or titled in the names of one or both of them. Both spouses are considered to have a legal title or interest in the undivided whole of all of the marital property regardless of the form of ownership and regardless of whether it was owned or titled in the names of one or both the recipient and the recipient's spouse. The recipient spouse and the surviving spouse of a deceased recipient spouse shall not encumber, disclaim, transfer, alienate, hypothecate, or otherwise divest themselves of these interests before or upon death.

D. When No Claim May Be Filed.

No claim may be filed against the probate estate if any of the following survive a single recipient or the surviving spouse of a married couple:

1. A child who is under age 21.
2. A child who is blind or permanently and totally disabled according to the supplemental security income program criteria.

However, if there is a life estate or joint tenancy interest in real estate owned by the recipient that was created on or after August 1, 2003, that interest will continue to exist and shall be subject to a claim. The claim will be converted to a lien against the property for 20 years. Recovery will be made under the lien only at a time when the child as listed above has died.

E. Limitation of the Claim to the Value of Non-Homestead Property.

If the decedent who was single or the surviving spouse of a married couple is survived by one of the following persons, a claim exists against the estate in an amount not to exceed the value of the non-homestead property included in the estate:

1. A sibling who resided in the decedent MA recipient's home at least one year before the decedent's institutionalization and continuously since the date of institutionalization; or
2. A son or daughter who resided in the decedent's home for at least two years immediately before the parent's institutionalization and continuously since the date of institutionalization, and who establishes by a preponderance of the evidence that he or she provided care to the parent who received MA, the care was provided before institutionalization, and the care permitted the parent to reside at home rather than in an institution.

However, if the decedent has a life estate interest or joint tenancy interest in property at the time of his or her death, a claim shall be placed against the estate, and it shall be converted to a lien against the life estate or joint tenancy interest in the real property. No recovery under the lien can be made until none of the persons listed above is residing in the property or until the property is sold or transferred.

NOTE: The information in this presentation is current as of June 2010. This is an overview of very complex rules – specific program requirements may vary and should be analyzed before providing advice.