



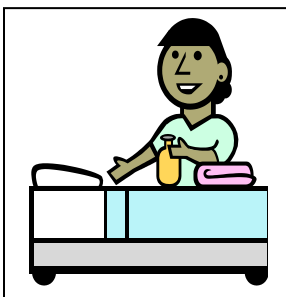
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INSTITUTIONAL CARE MEDICAID FACT SHEET (Updated January 1, 2017)

1. Does the state of New Mexico have a Medicaid program for people in nursing homes?

Yes. The New Mexico Human Services Department (HSD) administers a Medicaid program for individuals who are in a medical institution for at least 30 days when nursing home care is determined to be medically necessary.

2. What is the definition of "Medical Institution" for this program?



"Medical Institution" means a state licensed Medicaid qualified nursing home; an acute care hospital; an in-state, inpatient rehabilitation center; an Intermediate Care Facility for the Mentally Retarded; or a swing bed (long term care bed in a rural hospital). Inpatient psychiatric hospitals, out of state rehabilitation centers, and boarding and shelter homes ("assisted living") do not fall under the definition of Medical Institution. The resident must be found to meet the level of care required for eligibility in a nursing home or an Intermediate Care Facility for the Mentally Retarded. The nursing home can help with this.

3. Who runs the nursing home Medicaid program?

HSD contracts with four managed care organizations (MCOs) to provide almost all Medicaid services, including nursing home Medicaid, under the Medicaid program – called Centennial Care. If you are approved for Institutional Care Medicaid, you will have to select between the four current MCOs: Molina, Blue Cross Blue Shield, Presbyterian and United Healthcare.

4. How much income can a person receive and be eligible for Institutional Care Medicaid?

In order to be eligible, the individual's total countable monthly income must be less than \$2,205. The state disregards the first \$20 of most types of income, so in most instances, the individual can have up to **\$2,225** in *gross* monthly income.

If the person in the medical institution (the "*institutionalized spouse*") is married, community property principles may be used to determine the individual's income if it is advantageous to the applicant. This means that the institutionalized spouse's income may be calculated by adding up both spouses' income and dividing in half. For instance, if the husband in the nursing home has \$3,000 in monthly income, and the wife at home (the "*community spouse*") has zero income, the countable income for the husband is \$1,500, and he meets the income test for Medicaid coverage. If the applicant spouse's own income is less than **\$2,225**, s/he is clearly income eligible and the other spouse's income will not be considered.

Certain types of income, such as certain types of veteran's benefits (allowances for aid and assistance [A&A] and unusual medical expenses [UME]) and certain types of payments made to Native Americans, are not counted in determining eligibility. Sometimes individuals with incomes greater than **\$2,225** can be eligible, by using an Income Diversion Trust (IDT).

5. If a married person is found eligible for Institutional Care Medicaid benefits, can some of his/her income be contributed to the community spouse?

Yes. After certain deductions are made from the institutionalized spouse's gross income (e.g., a \$69/month "personal needs allowance"), the community spouse can receive as much of the remainder as is available to bring his/her monthly income as high as \$2,002.50.* [[As examples: If a husband in a nursing home has monthly income after deductions of \$1,900 and his wife at home has \$600/month, she is entitled to \$1,402.50/month of the husband's income. If the husband only has \$1,000/month after deductions, the wife would be entitled to all of it]]. A community spouse may be entitled to *more* of the institutionalized spouse's income, if available, if her allowable shelter expenses exceed \$600.75/month.* The maximum amount of this "excess shelter allowance" is \$1,020/month. The total monthly income of the community spouse cannot exceed \$3,022.50 unless an administrative law judge or court awards a greater amount. These amounts can increase each year; the amounts marked with a * increase on July 1.

6. Must the community spouse contribute his/her income to the institutionalized spouse?

No. The community spouse may keep all his/her income and is not required to contribute to the cost of the institutionalized spouse's institutional care once (s)he is receiving Medicaid regardless of the amount of the community spouse's income.

7. How much can the Institutional Care Medicaid applicant have in resources and still be eligible for Medicaid? How much of a married couples' combined resources can be protected for the community spouse?

The resource test is currently **\$2,000** for institutional Medicaid applicants but an additional **\$1,500** may also be set aside for burial expenses depending on the value of any life insurance owned by the applicant or other types of burial trusts for the applicant's benefit. Resources include cash on hand, savings, CDs, bonds, stocks, real property, and life insurance with a cash-in value. Some personal property, such as a car and home furnishings, are not counted as resources. Special rules may apply to certain assets, such as annuities. If a person intends to return to their home, the home is usually not counted as a resource. However, if an individual has greater than \$840,000 in equity in their home (in 2017), he or she will not qualify for Medicaid unless a spouse, or a dependent or disabled child, resides in the home.

If the institutionalized Medicaid applicant is married, the community spouse is entitled to retain one-half of the couple's combined countable resources; subject to a minimum of \$31,290 and a maximum of \$120,900. Any resources that the community spouse is not entitled to keep are counted as resources belonging to the institutionalized spouse for purposes of determining Medicaid eligibility.

To determine the total amount of a couple's countable resources, and the amount that can be protected for the community spouse, the "Institutional Care & Waiver" office of HSD's Income Support Division (*see* #13) will perform an "**assessment**" (a/k/a "snapshot"). The couple provides the necessary financial information and the caseworker lets them know how

much must be spent on things that benefit the applicant (including expenditures that benefit both) before eligibility can begin, and how much can be protected for the community spouse. The amount can be increased by a court or administrative proceeding. (Private attorneys who specialize in elder law should be consulted about Medicaid planning options.)

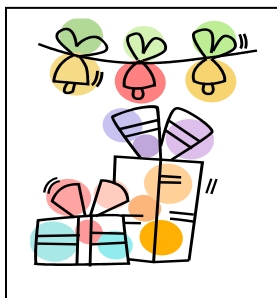
8. **Is the home counted as a resource to the institutionalized Medicaid applicant?**



The home is not counted as a resource in several instances. First, for single or widowed individuals entering a nursing home for long-term care, the value of the home is not counted if the individual *expresses an intent to return to their home*. Next, the home is not counted as a resource if it is transferred to a spouse or a dependent or disabled child; a brother or sister who has an equity interest in the home and who resided in the home for one year prior to institutionalization; or to a child who is not a dependent, but who had resided with and cared for the institutional Medicaid applicant for two years prior to the applicant's institutionalization.

9. **Can an individual transfer or gift their resources and be eligible for Institutional Care Medicaid coverage?**

Any transfers or gifts of property, other than those specifically allowed between spouses and dependent or disabled children, may cause ineligibility for Medicaid nursing home care for certain periods of time. Transfers or gifts are anything of value given away for the purpose of qualifying for Medicaid. They include selling property for less than the property's fair market value, removing someone's name from or adding someone's name to property or liquid assets such as bank accounts or other investments, or placing resources or income in trusts with limited availability.



Transfers occurring on or after February 8, 2006 will be evaluated if they occurred within 60 months (5 years) of the date of application for Institutional Care Medicaid. Ineligibility is calculated by dividing the value of the transferred asset by the average monthly nursing home cost. For 2017, the official average monthly nursing home cost is \$7,485. Since any transfer or gift not authorized under the Medicaid rules can result in a period of ineligibility, it is important that individuals who are considering a gift or transfer first speak with an attorney knowledgeable in Institutional Medicaid rules.

10. **Are there any exceptions to these rules that might allow an individual otherwise disqualified from receiving Medicaid to nonetheless obtain it?**

Yes. Although a person is usually disqualified from receiving Medicaid for a certain period of time when they make an unauthorized gift or transfer, the state Medicaid office may waive enforcement of this rule if the individual petitions for a "Hardship Waiver" based on the fact that the individual's health or life would otherwise be endangered or the individual would otherwise be deprived of food, clothing, shelter, or other necessities of life. Additionally, the state Medicaid office may waive enforcement of the rule requiring disqualification of individuals with home equity exceeding \$840,000 (see #7) if the individual can prove that they will suffer 'demonstrated hardship' if denied Medicaid.

11. Can an individual put their home or other resources in a trust and be eligible for Institutional Care Medicaid?

Federal law requires in most instances that the state count as income, income paid from a trust; and as resources, the trust corpus. There are exceptions for persons who are "disabled" under Social Security guidelines. In addition, individuals over the age of 65 who transfer assets to a trust may also be penalized for the transfer and denied Medicaid for a period of time. An attorney knowledgeable in Medicaid trust law should be consulted prior to establishing a trust for an elderly or disabled person.

12. After an individual becomes eligible for Institutional Care Medicaid, can his/her income be used to pay off old bills?

After eligibility is established, most of a single individual's income must be paid toward the cost of nursing home care. Sixty-nine dollars (\$69) per month is currently allowed for a "personal needs allowance," and additional amounts may be used for non-covered medical expenses, such as payment of the Medicare Part B premium, old medical bills, and medical services that are not a benefit of the New Mexico Medicaid program (such as chiropractic services, acupuncture, etc.). The personal needs amount can increase each year.

13. How does a person apply for Institutional Care Medicaid?

All applications for Institutional Care Medicaid statewide are processed by the "Institutional Care and Waiver" office of HSD's Income Support Division, based in Albuquerque (Ph: 505/383-2673; 1-866-507-1121). Application forms are available online, by calling the phone number listed, and from many nursing homes. The applicant must verify all factors of eligibility with appropriate documentation. Bring proof of the applicant's Social Security number, citizenship or alien status, residency, resources, income, spouse's income, expenses to maintain the home if married, and transfers within the past 60 months. Begin to gather all pertinent information as soon as possible as this will expedite the application process. Caseworkers can help applicants find necessary documentation.

If you wish additional advice on Institutional Medicaid issues, you may contact the following agencies for general information and referrals:

- Senior Citizens' Law Office
 - 265-2300 (Only residents of Bernalillo, Sandoval, Torrance and Valencia Counties age 60 and older)
- Legal Resources for the Elderly Program (Over 55; statewide)
 - 797-6005 (Albuquerque)
 - 1-800-876-6657 (New Mexico Residents outside of Bernalillo County)
- N.M. Aging & Disability Resource Center
 - 1-800-432-2080
 - 1-505-476-4846