Illinois’ New Medicaid Long-Term Care Eligibility Rules

In January, 2012, new regulations became effective in Illinois substantially changing eligibility for Medicaid coverage of long-term care. Although effective in January, the local offices of the Illinois Department of Healthcare and Family Services, the agency making determinations of eligibility for Medicaid, did not implement these new regulations until July, 2012. Additionally, in June of 2012, Governor Quinn signed into law Medicaid reform, the SMART Act, which also made several significant changes to eligibility for Medicaid long-term care coverage. Both the new regulations and the SMART Act were implemented on July 1, 2012. Highlighted below are the most significant changes to eligibility for long term care Medicaid coverage.

1. The Medicaid Long-Term Care Coverage “Look Back” is Extended to 60 months.

To qualify for Medicaid coverage for nursing home, supportive living, or the community care program, an applicant is required to document that they did not make any transfers of assets for purposes of qualifying for Medicaid during the applicable “look back” period. Until January, 2012, the look back period was 36 months. The regulations effective in January, 2012, changed the look back to 60 months. However, it was not implemented until July, 2012.

All applicants for Medicaid long term care coverage who filed on or after July 1, 2012, are required to produce monthly statements for all assets held during the 60 months prior to the date of the Medicaid application.

2. All Non-Allowable Transfers Made During the 60 Month Look Back are Aggregated for Purposes of Determining a Penalty Period of Ineligibility for Medicaid.

Regulations effective in January, 2012, changed the method by which the Department penalizes an applicant for long term care Medicaid who transferred assets during the look back period. Unlike prior regulations, the new regulations require the Department to add together all transfers made during the look back period and use the total amount when calculating the penalty caused by the transfer. These new regulations were not implemented at the local office level until July, 2012.
3. A Non-Allowable Transfer Made During the 60 Month Look Back Results in Future Ineligibility for Long-Term Care Medicaid Coverage.

The Department imposes a penalty period of ineligibility for Medicaid coverage for any non-allowable transfers which occur during the look back period. Under prior regulations, the penalty period began with the month of the non-allowable transfer. Under new regulations, the penalty period, consisting of a number of months and partial months of ineligibility for Medicaid, does not begin until the month that the applicant is receiving long term care services and is eligible for Medicaid based upon an application which is approved, except for the imposition of the penalty period. In other words, a person who gave away assets does not begin the penalty period of non-eligibility for Medicaid until they are receiving nursing home care, supportive living or community care services, and have no assets other than Medicaid exempt assets.

For example, Mary Smith, in December of 2011, gave each of her two children $12,000.00. In April of 2012, she gave each of her 4 grandchildren $3000.00. She lives in a nursing home costing $6000.00 per month and applies for Medicaid, and is determined eligible (but for the penalty period) in July, 2012. Under the old rules, Mary would have incurred a four month penalty ($24,000.00 ÷ $6000.00 = 4) for the gifts to her children in December of 2011, beginning in December, 2011, and expiring March, 2012. She would have incurred a 2 month penalty ($12,000.00 ÷ $6000.00 = 2) for the gifts to her grandchildren in April, 2012, beginning in April and expiring in May, 2012.

Under the new rules implemented in July, 2012, as a penalty for having made the gifts to her children and grandchildren, Mary will be determined ineligible for Medicaid long-term care coverage beginning in July, 2012, the month that she was determined to be eligible for Medicaid but for the penalty period, through December, 2012. ($ 36,000.00 ÷ $6000.00 = 6)

Because any asset transfer made during the five years prior to the need for Medicaid coverage of long term care will result in future ineligibility, anyone who may need Medicaid within the next five years should not be making any significant gifts.

4. The Separate Assets of the Community Spouse are Considered Available for the Care of the Spouse Living in a Nursing Home and Must Be Disclosed.

Under prior Illinois law, the separately owned assets of a community spouse were not counted towards the eligibility of the spouse applying for Medicaid coverage of long term care. Additionally, the community spouse was allowed to refuse to disclose his or her separate assets without affecting the Medicaid eligibility of the nursing home applicant. As of July 1, 2012, the spouses of married applicants for long-term care Medicaid must disclose their assets. Failure by the community spouse to disclose assets will result in the denial of the nursing home applicant’s Medicaid application.
In determining eligibility for Medicaid, all assets owned by either the spouse in the nursing home or the community-based spouse will be counted. The nursing home spouse will not be eligible for Medicaid coverage until the combined assets (in addition to the home, 2 cars, personal property and funeral plans) are reduced to $109,560.00

5. **The Community Spouse Maintenance Needs Allowance is Reduced to $2,739.00**

In January, 2012, the standard used to calculate the community spouse maintenance needs allowance was $2,841.00. The SMART Act reduced that standard to $2,739.00.

In addition, without further legislation, there is no provision in the SMART Act for any increase in the standard of $2,739.00 in the future.

6. **The Community Spouse Asset Allowance is Reduced to $109,560.00**

In January, 2012, the standard used to calculate the community spouse asset allowance was $113,640.00. The SMART Act reduced that standard to $109,560.00.

In addition, without further legislation, there is no provision in the SMART Act for any increase in the standard of $109,560.00 in the future.

7. **The State has Expanded Rights to Pursue Support from a Non-cooperating Spouse of a Medicaid Recipient.**

Although the community spouse is now required to disclose his/her separate assets to prevent the denial of the nursing home spouse’s application for Medicaid, the community spouse may still refuse to use those assets for the nursing home applicant’s care. The regulations require the Department to approve an applicant’s Medicaid application in spite of the community spouse’s assets if the Medicaid applicant executes an assignment of his/her rights to support from his or her spouse to the State of Illinois.

The SMART Act significantly expands the rights of the State of Illinois to legally pursue support from a non-cooperating community spouse.

8. **In Order to Receive Three Months Retroactive Medicaid Eligibility, Applicants Need to Prove Eligibility During Each of Those Months.**

A Medicaid applicant may ask for Medicaid coverage for the three months prior to the month of application. Under the old rules, the Department allowed retroactive eligibility without actually determining whether the applicant was eligible in each of those prior three months. Under the new rules, the Department will not allow for eligibility during the three months prior to the month of application unless the applicant has proved that they were eligible in each of those three months.
9. **During the 60 Month Look Back Period, Any Payments to Family or Friends for Caregiving or Rent Requires a Written Contract.**

The Department will presume that any services, care or accommodations provided to a Medicaid applicant by a friend or family member are gratuitous and without expectation of compensation. If a Medicaid applicant has paid a friend or family member for services or accommodations, there must be a contemporaneous written agreement spelling out the services or accommodations provided and the amount of compensation. The amount of compensation must be at or below prevailing market rates. Further, there must be additional documentation establishing that the services were provided - such as logs or receipts.

Any person who may require Medicaid in the next five years and is paying rent to a family member must have a lease. Any person who may require Medicaid in the next five years and is paying a family member as a caregiver must have a caregiver contract in place.

10. **Equity in Homestead Property is Limited to $525,000.00 and the Title May Not be Held in a Trust.**

An applicant for Medicaid is allowed to continue to own their principal residence, known as homestead property. Under old rules, there was no limit on the value of the equity that the applicant held in homestead property and no restriction on the ownership of the property. Under the new rules, unless the homestead property is occupied by a community spouse or disabled child, the equity that the applicant may own in the home is limited to $525,000.00 which must be documented by the applicant, and the home must not be titled in a trust.

**Author: Janna Dutton, Attorney and Partner**

These changes to Medicaid make planning and applying for Medicaid benefits even more difficult. Now, more than ever before, people considering the potential need for Medicaid require the comprehensive advice of knowledgeable attorneys.

The attorneys at **Dutton & Casey** have over 50 combined years of legal experience and are **highly recognized** in the fields of estate planning, probate, and elder law.

**Contact Information:**
312-899-0950 (Chicago)
847-906-3584 (Arlington Heights)
847-261-4708 (Skokie)
847-886-9456 (Vernon Hills)
contact@duttonelderlaw.com
www.duttonelderlaw.com

(rev. 10-11-12)