Human Resources Administration
Department of Social Services

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

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MAGI Consumers
Long Term Eligibility Rules

The purpose of this Alert is to advise of recent guidance received by the New York State Department of Health from the Centers for Medicare and Medicaid Services (CMS) regarding the application of long term eligibility rules for individuals who are eligible for Medicaid under a Modified Adjusted Gross Income (MAGI) eligibility group.

The following rules apply:

- Individuals in need of long-term care services may qualify for Medicaid under a MAGI eligibility group;
- MAGI individuals who are medically frail may receive coverage for medically necessary nursing facility services; The need for nursing home services qualifies an individual as medically frail and no further documentation is required;
- Individuals who qualify for Medicaid under a MAGI eligibility group do not require a disability review to receive nursing home services;
- Individuals whose eligibility is determined under MAGI rules are not subject to a resource test for purposes of determining Medicaid eligibility. However, several other statutory provisions apply when an individual seeks Medicaid payment for long-term care services. These provisions are detailed below:

Transfer of Assets

In accordance with Section 1917(c) of the Social Security Act, MAGI individuals who meet the definition of an institutionalized individual and who are seeking Medicaid coverage for nursing facility services are subject to the transfer of assets rules, including the review of assets for the 60 month look-back period and the imposition of a transfer penalty for assets that are transferred without compensation. For transfers, an institutionalized individual means an individual who is an inpatient in a nursing facility, including an intermediate care facility, or who is an inpatient in a medical facility and is receiving a level of care provided in a nursing facility. In the case of an individual who is enrolled in mainstream managed care, the review of assets for the look-back period begins when the institutionalized individual is determined to be in

permanent placement status. The look-back period is the 60 months prior to the first month of institutionalization. Any resulting penalty begins the first month in which the individual is both institutionalized and otherwise eligible for Medicaid.

For new applicants, recipients with fee-for-service coverage, and recipients enrolled in Managed Long Term Care who require up to 29 days of short-term rehabilitation, there is no transfer look-back. If more than 29 days of short tern rehabilitation is required or the individual is permanently placed in a nursing home, including alternate level of care in a hospital, the MAGI individual must document resources for the past 60 months.

Substantial Home Equity
The home equity limits outlined in ADM 06 OMM/ADM-5 apply to MAGI individuals in determining eligibility for long-term care services. Effective January 1, 2014, the home equity limit is $814,000.

Post-Eligibility Rules
Post-eligibility rules are used to determine the net available monthly income (NAMI) that a Medicaid eligible institutionalized individual must contribute toward the cost of care. CMS has advised that since the post-eligibility rules apply to discrete categories, they have concluded that current Federal regulations, specifically 42 CFR 435.725, do not include individuals whose eligibility is based on MAGI rules. Therefore, the post-eligibility rules (chronic care budgeting) do not apply. The MAGI income budgeting methodology will continue regardless of whether the MAGI individuals' admission to a nursing facility is considered permanent. MAGI individuals whose household income is at or below 138% of the federal poverty level will not have a NAMI amount to contribute toward the cost of nursing home care.

Since a permanently institutionalized MAGI individual is no longer residing with his/her spouse, only the institutionalized spouse's income is counted in determining eligibility under MAGI-like rules. Spousal impoverishment rules are not used for an institutionalized individual in a MAGI eligibility group. If the community spouse is in a MAGI eligibility category, the MAGI household does not include the institutionalized individual. For a MAGI individual who is also SSI related, if application of spousal impoverishment budgeting is more beneficial, spousal impoverishment rules will be used.

Additionally, once permanently placed, a MAGI individual in receipt of Medicare who was a parent or caretaker relative, is no longer considered a parent or caretaker relative for Medicaid purposes as they are not residing with a child or relative. Therefore, such consumers would no longer be considered for Medicaid eligibility as a MAGI consumer.

Liens on Real Property
Real property that is owned by a permanently institutionalized individual is subject to placement of a Medicaid lien when post-eligibility rules are used to determine any contribution toward the cost of care. Since post –eligibility rules are not used for MAGI consumers, MAGI individuals who are permanently institutionalized may not have liens placed on their real property.

Estate Recovery
Effective April 1, 2014, Section 369 of the Social Services Law was amended to limit the Medicaid costs that can be recovered from the estate of a deceased individual who received Medicaid under a MAGI eligibility group. Recovery from assets in a MAGI individual's estate is limited to the amount of Medicaid

paid for the cost of nursing facility services, home and community-based services, and related hospital and prescription drug services received on or after the MAGI individual's 55th birthday. Other than that, the same limitations and exceptions to estate recovery that are described in Section 369 of the Social Services Law apply to recoveries from the estates of both MAGI and non-MAGI individuals.

For more detailed information, please refer to **GIS 14 MA/16 Long Term Care Eligibility Rules and Estate Recovery Provisions for MAGI Individuals**.

Transition of Coverage to WMS

Additionally, please be reminded that, currently Medicaid fee for service consumers who need short term (up to 29 days) rehabilitation and all Medicaid consumers (fee for service or managed care) who need long term (permanent placement) nursing home care must have their coverage on WMS. If these consumers have Medicaid coverage on the Marketplace, it must be transitioned to WMS. Further information is available in the June 11, 2014 Alert, **Consumers with Medicaid Coverage on the NYSOH Marketplace whose Coverage Must be Transitioned to WMS**.

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