Medical Assistance – 2021 Update

By: Renee C. Rock, Esquire, Shober & Rock

Medical Assistance, known nationally as "Medicaid," is a federal and state program that provides healthcare coverage for certain individuals, including the elderly and disabled. Federal law provides the broad outline for coverage, but states interpret and adjust access to coverage. In Pennsylvania, the program is administered by the Department of Human Services ("DHS") whose responsibility is to establish rules and standards and to determine eligibility. Applications are processed by County Assistance Offices ("CAO"). In Bucks County, the single Assistance Office is in Bristol.

In order to qualify for Medical Assistance (MA), a patient must be medically and financially eligible. The review of eligibility is accomplished by the CAO and the Area Agency on Aging (AAA). The AAA determines medical eligibility, and the CAO determines financial eligibility.

A patient entering a long-term care facility that is part of the MA program (not all nursing homes accept this coverage) will receive an admissions packet explaining the program and containing an application of admission. Many people receiving this package begin to fill out the form without realizing that they need to qualify in order to receive benefits. They may even start working with the nursing home providing personal and financial information prior to determining whether they can even obtain these benefits. This adds additional stress and confusion to an already-difficult process for a family.

To add to the confusion, many people are admitted to nursing homes for "rehab" and not long-term care. Rehab or skilled nursing care is medical treatment, which is either covered by Medicare or private health insurance or some combination of these programs. Surprisingly, many people know very little about how their Medicare coverage works and what it pays.

In our practice, most people buy Medicare coverage based on price alone. This is a risky thing to do. Many patients have Medicare HMO coverage which costs less and basically replaces Medicare coverage with a managed care insurance plan. These plans, while less expensive, are very stingy with coverage. Patients find that they are discharged long before they are ready and certainly before the 100 days that these HMOs may provide. This places a burden on the patient, the patient's family, and the nursing home. And the surprise that awaits the patient is that he or she is suddenly "private pay". With an average daily rate of about $350, this is quite a shock for people.

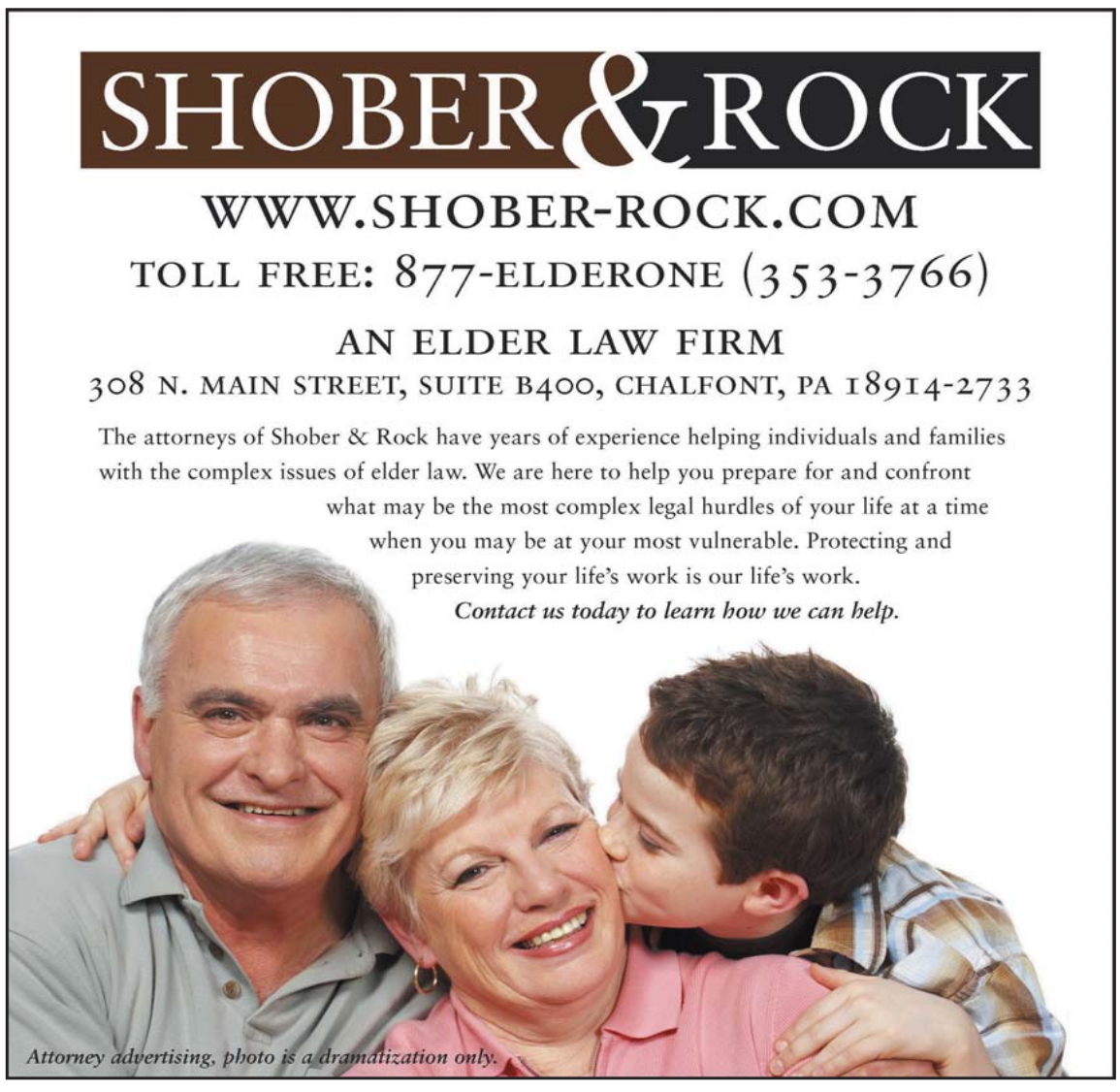
If patients and their family are aware of how Medicare coverage works, they will plan for the transition to MA. The idea is to achieve eligibility at the time that Medicare coverage ends. Given the shorter stays paid for by HMOs, this is a difficult if not impossible task. It is always better to address this before one is admitted to a facility. Unfortunately, again, most people do not think about this until it happens. This results in patients paying far more than they need to pay. Or worse, it results in the patient's family or children having to pay for the nursing home bills.

Pennsylvania law requires children of indigent parents to pay for parents' medical bills. Our planning focus has recently shifted from protecting parents' assets to assuring that children don't have liability. The two primary reasons that people are denied coverage is lack of documentation and gifting. Since it takes quite a while to get a decision by the CAO, there is often a nursing home bill of many thousands of dollars before an applicant finds out there is a problem. This results in a time-consuming and stressful appeal.

As to gifting, the CAO looks to see what money a person or couple has given away within the five years preceding the application for assistance. Statements and checks are reviewed. ANYTHING paid out without obtaining "fair consideration" is considered a gift. If an applicant closes an account for cash and does not deposit that cash into another account, it is deemed a gift. If an applicant transfers a home into joint names with his or her child, it is a gift. Any unexplained spending that exceeds a total of $500 in any month will be added to the gifting total.

And what happens when you make gifts? You CANNOT obtain coverage from MA for the period of time that the gifted money would have paid for care. In other words, if you gift $20,000 three years before applying for assistance, at the time you otherwise qualify (when you are broke), the program will not pay for the first two months of care. This is determined by taking the $20,000 and dividing it by the average price of a nursing home in PA (around $10,428). Therefore, the patient, the patient's spouse, or the patient's children are liable for this care. And the yearly gift tax exclusion of $15,000 has nothing to do with MA. If you make $15,000 gifts, they will affect your MA eligibility.

The best advice we can give you is to prepare early. If you are married, this is even more important. There are a lot of things married couples can do to prepare for the eventuality of long-term care and to preserve assets. This is a complicated program. Do not accept advice from nursing homes or from any professional other than a qualified elder law attorney. Unless you work within this system every day, you are not going to be able to provide sound advice to families. Act early and obtain competent advice so your experience will be difficult but not catastrophic. Call us at (215) 345-4301.



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