A Brief Introduction to New Jersey Medicaid Planning for the New York Elder Law Attorney

By Lauren I. Mechaly

Welcome to the wild west. West of the Hudson, that is. Everyone knows that Medicaid is a jointly funded federal and state program. What everyone may not know is just how different the Medicaid programs vary from state to state and, more importantly, how different the planning options really are just across the river. This article will serve as a brief overview of Medicaid eligibility rules in New Jersey, and the planning options available to us here, so that the New York practitioner has a basic understanding of both.

In New Jersey, the Division of Medical Assistance and Health Services (DMAHS) administers the Medicaid program, which is referred to as NJ FamilyCare. Eligibility requirements for Medicaid in New Jersey include residency and citizenship (or qualified alien status), and the applicant must meet income and resource standards that are program specific. As practitioners of elder law and special needs planning, most of our clients are applying for or enrolled in the Aged, Blind, Disabled Programs (or ABD Medicaid), which offer services and supports to those who are aged, blind or disabled. The name is quite creative. This article will focus only on this program.

The resource allowance for an applicant applying to the ABD Program is $2,000. This is far more restrictive than the New York resource allowance, which is currently $15,900. In addition, New Jersey is an income cap state (think 42 U.S.C. 1396p(d)(4)(B)). The income cap is currently $2,382 per month, which means that the applicant's gross monthly income must be no more than the income cap in order to be eligible for Medicaid. If it is, then the gross monthly income must be reduced below the income cap through the establishment and funding of a Qualified Income Trust (QIT). Established by the Omnibus Budget Reconciliation Act of 1993 and found in Social Security Act § 1917(d)(4)(B), a QIT must be funded with an entire income source.[1] It cannot contain any resources. The income is used to cover specific items post-eligibility (e.g., the personal needs allowance and health insurance premiums). There is a pay-back provision to the extent any funds remain in the QIT upon the Medicaid recipient's death.

A resource assessment[2] of the applicant's total assets (i.e., those in the names of the applicant, his or her spouse and in joint name) is taken as of the applicant's first day of institutionalization (admitted into the hospital or entered the nursing home); this is also known as the "snapshot," as it is in New York. The assets are pooled together to calculate what portion of the assets the community spouse may retain (called the "spousal share"). The spousal share for 2021 is equal to the greater of (1) $26,076 or (2) one-half of the combined assets when the institutionalized spouse entered the hospital or nursing home, but not to exceed $130,380. The remaining assets must be spent down and/or transferred, if a transfer of assets penalty can be sustained. The $130,380 "cap" on the spousal share may, in certain rare circumstances, be increased through an administrative hearing.[3] There is no spousal refusal in New Jersey.

Lauren I. Mechaly

The income of the community spouse is not considered in determining the institutionalized spouse's Medicaid eligibility. In addition, if the community spouse's personal monthly income from all sources, including Social Security, pension, interest and dividends, is less than the community spouse maintenance base allowance (currently $2,155), he or she may be entitled to receive income from the institutionalized spouse. The maximum community spouse monthly maintenance needs allowance is $3,216. In addition, there is an excess shelter allowance and a utility allowance for the community spouse.

Medical eligibility is determined by Medicaid through a pre-admission screening (PAS) performed within six months of the anticipated eligibility date, whereby the applicant must establish that he or she requires assistance with at least three activities of daily living.

Medical eligibility for home and community-based services varies just a bit. The Managed Long Term Services and Supports (MLTSS) program provides Medicaid benefits to individuals who are in need of assistance but are able to remain in the community. To be eligible for long-term custodial care in a community setting (such as at home or in an assisted living facility), the applicant must be either at least age 65 or, if under age 65, he or she must be disabled as defined by the Social Security Administration. All applicants must be determined by the Department of Health

Lauren I. Mechaly, Counsel at Schenck Price Smith & King, LLP, focuses her practice on elder law, special needs planning, estate planning and estate administration. As an elder law practitioner, she assists seniors with a variety of legal issues, including estate planning and long-term care planning. As a special needs practitioner, Lauren assists individuals with special needs and their families in promoting the best quality of life for disabled individuals.

and Senior Services as needing nursing facility level of care within a month of application, unless community-based services are provided.

When an application is made for MLTSS, a Medicaid case manager is assigned by a designated Managed Care Organization to assess the applicant's needs and work with the applicant and the applicant's family to develop a service package. These services are intended to supplement other care, such as that provided by family members. As a result, 24-hour care is not available. Generally, an individual is awarded a maximum of 44 hours per week.

The look-back period for all programs in New Jersey is 60 months. The value of the transfer will be divided by the statewide daily nursing home rate, which is currently $357.67 ($10,879 per month), to obtain the number of months of the penalty period. The transfer rules in New Jersey[4] are similar to those in New York.

New Jersey has expanded estate recovery.[5] This means that the estate consists of any property, whether in sole or joint name, that the beneficiary had any legal title or interest in at the time of his or her death including a residence, personal or real property, bank accounts, a living trust or other arrangement, and proceeds of life insurance policies. The funds need not be probate assets. There is an exception to a home held pursuant to a life estate. Recovery may be deferred if there is a community spouse or disabled child, or a child under the age of 21.[6]

Unless there is a surviving spouse, a minor child or a surviving child of any age who is blind or disabled, Medicaid will place a lien on property after the death of the Medicaid beneficiary if (1) the amount to be recovered is in excess of $500 and (2) the estate is in excess of $3,000.[7] The personal representative of the estate of the Medicaid beneficiary, i.e., the executor or administrator, must contact Medicaid in writing to ascertain whether Medicaid has a right to recovery. Medicaid then has 90 days from receipt of the letter to respond.

The planning opportunities in New Jersey are limited since the rules here are so restrictive. For example, as mentioned, we do not have spousal refusal except in very limited circumstances (such as, an absent spouse who has literally refused to contribute or participate). In addition, all resources are considered available to the applicant, including retirement assets. Lastly, all else being equal, if a single person goes into a nursing home for long-term care, the home is only exempt for six months. After that, it must be put on the market, regardless of an intent to return home.

Medicaid planning in New Jersey generally includes a five-year plan. The beginning of the plan looks very similar to the beginning of a plan in New York. The applicant's income is considered, and an estimate of the care costs over five years is calculated. The shortfall is the amount the applicant must keep in order to get through the five years of private pay. The balance is the amount that can be gifted.

Because of the expanded estate recovery, irrevocable trusts do not work in New Jersey in the same way as they do in New York. While the asset may be exempt for purposes of establishing Medicaid eligibility during lifetime, Medicaid may still have a right of recovery upon death. While this may be acceptable to some, for others it is not an appealing or desirable outcome.

For this reason, more often than not we use a Donee Trust or a Family Trust. An outright gift is made to the child(ren) of the applicant, and the child(ren) then funds a trust with that money. The funds are held for the benefit of the child(ren) for a period of time, for example 20 years, and during that time the trustee has broad discretion to distribute trust income and/or principal to the applicant's descendants. The trust is designed to serve as a "checks and balances" management vehicle for the assets transferred and may provide some protections against the children's future creditors during the trust term.

For an applicant without sufficient assets for a five-year plan and who may need to accelerate eligibility for Medicaid, a Medicaid Qualifying Annuity (MQA) works in a similar way to the Promissory Notes used in New York. A MQA effectively converts countable excess resources otherwise subject to a spend-down into a stream of income payable to the community spouse, for his or her care and support. Recall that income payable to the community spouse is exempt when establishing Medicaid eligibility for the institutionalized spouse. MQAs must be irrevocable, non-assignable, non-transferable and provide equal payments throughout the annuity term (balloon payments are not permitted). MQAs also must name the State of New Jersey as the second annuitant after the community spouse's death.

The potential downsides to funding MQAs include (1) a reduction in the amount of the institutionalized spouse's monthly income that would otherwise be allocated to the community spouse; (2) Medicaid's possible right of recovery; (3) the payment of MQA income to the institutionalized spouse to cover his or her nursing home expenses if the community spouse predeceases him or her, and Medicaid's right of recovery has been satisfied; and (4) the potential income tax triggered by the conversion of qualified funds (such as individual retirement accounts).

As always, it is important to discuss Medicaid planning rules, tools and strategies with a local elder law attorney.

Endnotes

1. N.J.A.C. 10:71-5.1, *et seq.*
2. N.J.A.C. 10:71-4.1, *et seq.*
3. Med. Comm. No. 21-01.
4. N.J.A.C. 10:71-4.10.
5. HCFA Transmittal 63; N.J.S.A. 30:4D-7.2 *et seq.*; N.J.A.C. 10:49-1, *et seq.*
6. N.J.A.C. 10:49-14.1(a).
7. N.J.A.C. 30:4D-7.2a.