QUESTIONS AND ANSWERS ON MEDICAID FOR NURSING HOME RESIDENTS

COLUMBIA LEGAL SERVICES JANUARY 2012

THIS PAMPHLET IS ACCURATE AS OF ITS DATE OF REVISION. THE RULES CHANGE FREQUENTLY.

1. What is Medicaid?

Medicaid is a government program that pays for medical services including nursing home care. It is administered by DSHS – the Washington State Department of Social and Health Services.

To get Medicaid payment for nursing home care, you must be financially eligible. The financial eligibility requirements are described below. Also, you must need the kind of care given in a nursing home.

You apply for Medicaid at a DSHS office. To find the right office for your application, you can call 1-800-422-3263.

2. What are Medicaid's basic financial eligibility requirements for nursing home care?

To get Medicaid for nursing home care, both your *income* and your *resources* must be within limits set by law.

In counting your *income* for a month, DSHS looks at what you *received that month*. Income typically includes such things as Social Security, VA benefits, and wages, in the month in which they are received.

In counting your *resources* for a month, DSHS looks at what you have on the first day of the month *that you already had* in the previous month. Resources typically include such things as real estate, bank accounts, and stocks. A payment that counted as income last month will count as part of your resources this month if you still had it as of the first of this month.

A. Income

Your monthly income must be less than the following total: the Medicaid rate for nursing home care plus your regular monthly medical expenses. The Medicaid rate – the rate charged for Medicaid residents – is different for different nursing homes. You can find out the rate for a particular nursing home by asking at the home or by calling DSHS at 1-800-422-3263.

Example:

Seaside Nursing Home Medicaid rate	*$5,000.00*
Your regular monthly pharmacy bill	*$275.00*
Total	*$5,275.00*

If your monthly income is less than $5,275, your income is within the Medicaid eligibility limit for care at Seaside Nursing Home.

If your income is more than the Medicaid nursing home rate plus your regular medical expenses, but less than the rate charged for non-Medicaid residents plus your regular medical expenses, you may still be eligible for assistance. If you apply and are eligible on this basis, the nursing home will charge you only the lower Medicaid rate.

Once you are determined eligible for Medicaid nursing home coverage, you will be allowed to keep $57.28 per month for your personal needs. The rest of your income will be used as follows:

(1) an amount for your spouse if you have one, as explained in the answer to Question 3 below;
(2) an amount for certain dependent family members;
(3) for a single person or an institutionalized couple only, an amount (not more than $908) for the maintenance of a home for up to 6 months, but only if a physician has certified that the person or a member of the couple is likely to return to the home within the 6-month period; even without any physician’s certification, if there is rental income from a home to which a Medicaid recipient or spouse intends to return, that income may be used for payment of home maintenance, taxes and insurance;
(4) an amount to pay health insurance premiums;
(5) an amount to pay medical bills for services not covered by Medicaid (usually services provided before you became eligible for Medicaid), if the bills are still owed and not covered by any insurance;
(6) an amount to cover certain miscellaneous items, such as guardianship fees that satisfy certain requirements.

Any remaining income must be paid to the nursing home for your care. The part of the cost of your care you pay for is called your “participation.” Medicaid covers the rest.

B. Resources

The limit for resources (assets, property, savings) that a single person may have is $2,000. Certain "exempt" resources are not counted in determining whether you fall within this limit. Exempt resources are described in the answer to Question 5 below. When a married person applies for Medicaid for nursing home care, his or her spouse is allowed to have substantially more resources. The rules relating to resources for married applicants and their spouses are explained in the answer to Question 4. Rules about the consequences of giving away your resources are described in the answer to Question 6.

3. What *income* can I keep if my spouse goes into a nursing home?

If your spouse goes into a nursing home and you remain at home, Medicaid always allows you to keep all income paid in your name, no matter how much.

In addition, if the income paid in your name is less than $1,839, Medicaid allows you to keep as much of your spouse's income as is necessary to bring your income up to $1,839 per month. And, if your housing costs (rent or mortgage, taxes, insurance, maintenance fee for a condominium or cooperative, and utilities) exceed $552 per month, then the $1,839 can be increased up to $2,841 by the amount of this excess. (In calculating housing costs, your actual costs for rent, mortgage, maintenance fee, taxes, and insurance are used. For utilities, however, a standard figure of $394 per month is used.)

Examples:

If $2,400 is paid in your name and $750 is paid in your spouse's name, you can keep $2,400.

If $750 is paid in your name and $2,400 is paid in your spouse's name, you can keep your $750 plus at least $1,089 of your spouse's income ($1,839 - $750 = $1,089). And if your housing costs are $800 per month, you can keep an ***additional*** *$248 of your spouse's income because the $1,839 level is increased by the excess of your housing costs over $552 ($800 - $552 = $248).*

A spouse at home may be allowed to keep more of an institutionalized spouse's income if a superior court judge orders higher support (for example, in a legal separation proceeding) or if an administrative law judge decides, in an administrative proceeding, that there are "exceptional circumstances resulting in extreme financial duress."

An additional amount may also be allowed for the care of a dependent family member.

4. What *resources* can we have when my spouse applies for Medicaid?

The amount of resources you can have when your spouse *applies* for Medicaid for nursing home care is different from the amount you can have once your spouse *is receiving* Medicaid.

A. When your spouse applies

At the time of application, all resources of both spouses will be added together to determine eligibility. It does not matter which spouse owns what resource or whether resources are community or separate property.

When your spouse applies for Medicaid for nursing home care, the two of you can have all of the resources that are "exempt" – a home and a car, for example. Exempt resources are explained in the answer to Question 5 below.

In addition, you are allowed to have non-exempt resources up to a set value limit. (Non-exempt resources include such things as cash, most funds in bank accounts and investments.) The limit includes the $2,000 that a single Medicaid applicant has plus an additional amount established by what is called the "Community Spouse Resource Allowance" or "CSRA." (Non-exempt resources include such things as cash, most funds in bank accounts and investments.)

The CSRA is at least $48,639. This means that if your spouse goes on Medicaid, you and your spouse can have at least $50,639 of non-exempt resources ($48,639 allowed for you and $2,000 allowed for your spouse). Remember, at the time of application, it does not matter which spouse owns what resource or whether the $50,639 or any part of it is community or separate property.

Sometimes the Community Spouse Resource Allowance can be more than $48,639. It can be more if one of the following exceptions applies:

(1) If your spouse is currently institutionalized (in a hospital or nursing home), and you can show that the combined resources of both spouses were more than $97,278 when the current period of institutionalization began, then you may be entitled to a CSRA of more than $48,639. If this exception applies, the CRSA is increased to half of the combined resources that the couple had at the time the period of institutionalization began. The maximum amount that the CSRA can be increased to is $113,640. To take advantage of this exception, you will have to be able to show what the combined resources were when the period of institutionalization began.

(2) You *may* be allowed to keep more non-exempt resources if the combined *income* of both spouses is not enough to provide what

is allowed by the rules explained in Question 3 above ($1,839 to $2,841). To keep more resources, a spouse not on Medicaid must request a decision from DSHS, at the time of application, that more resources are necessary to produce the permitted income level.

(3) If your spouse is currently institutionalized (in a hospital or nursing home) and the current period of institutionalization began before August 1, 2003, then your CSRA is $113,640.

You can reduce excess resources that make your spouse ineligible for Medicaid for nursing home care in various ways. You can spend the excess resources on such things as medical care, on home repair, on the purchase of exempt resources, or on consumable goods or services, so long as you receive fair value for your money. Or you can buy an annuity that converts the excess resources to monthly income, *if the annuity satisfies the requirements of DSHS regulations.* To determine whether a particular annuity satisfies the requirements and whether a particular financial plan makes sense for you, you should consult a lawyer familiar with Medicaid law.

B. When your spouse is on Medicaid

Although it does not matter which spouse owns the resources at the time of application, an entirely different rule applies once the application is approved.

Within a year after the application is approved, any of the couple's resources in excess of $2,000 must be transferred to the spouse who is not on Medicaid. After that, the spouse on Medicaid cannot have more than $2,000 in non-exempt resources in his or her name.

The spouse who is not on Medicaid can keep the resources transferred into his or her name and can increase resources without affecting the continuing eligibility of the spouse on Medicaid.

5. What resources are not counted to determine Medicaid eligibility?

A. What are exempt resources?

Some resources are considered exempt and are not counted toward the $2,000 and $48,639 to $113,640resource limits that were discussed in the previous section. Exempt resources can include your home, household goods and personal effects, some real estate sales contracts, a car, life insurance with a face value of $1,500 or less, most burial plots and prepaid burial plans, and certain other property and items used for self-support. Some of these are discussed in more detail below.

Also, *non-exempt* resources that cannot be sold within 20 working days are temporarily disregarded while they are being sold.

B. When is a home exempt?

A home (which may be a house and all surrounding land, a condominium or a mobile home) may be an exempt resource. The exemption applies as long as the recipient's spouse or, in some cases, a dependent relative continues to live in the home. The exemption also applies if a nursing home resident *intends* to return to the home and states that intention to DSHS. It applies even if it seems unlikely that the resident will be able to return.

The exemption does not apply to a home in which the Medicaid recipient has an equity interest of more than $506,000 unless one of the following exceptions applies: (1) the Medicaid recipient is receiving services based

on an application for DSHS long-term-care services filed before May 1, 2006; or (2) the Medicaid recipient's spouse or the recipient's child who is under 21 or blind or disabled resides in the home. (The disability criteria for this purpose are the same as those used for Social Security disability determinations.) Even when a home is exempt, a married Medicaid applicant or recipient still may wish to transfer his or her interest in it to a spouse. Such a transfer may be made in order to prevent future recovery of Medicaid costs from a Medicaid recipient's estate (discussed in the answer to Question 7 below), or in order to make it easier for the spouse to sell or otherwise dispose of the home. On the other hand, such a transfer is not always a good idea. It may, for example, have adverse tax or other consequences in some cases. It makes sense to consult with a lawyer familiar with Medicaid rules and estate planning before making such a transfer.

The proceeds from the sale of an exempt home are also exempt if, within three months of when they are received, they are used to purchase a new exempt home.

C. When is a sales contract exempt?

The seller's interest in any sales contract entered into before December 1, 1993 is an exempt resource unless it is transferred. A sales contract entered into after November 30, 1993 is exempt only if it was received for the sale of the seller's home and includes fair market terms. A sales contract entered into after May 2004 is exempt only if it is for the sale of the seller's principal residence at the time he or she began a period in a medical facility (including a nursing home) or on COPES and if it requires repayment of the principal within the seller's "anticipated life expectancy." *Payments* received under an exempt sales contract are treated as *income*.

D. When is a car exempt?

One car is exempt, regardless of value, if used for transportation for the nursing home resident. If the resident is married, only one car is exempt for the couple and the "used for transportation" requirement does not apply, unless the second spouse lives in a hospital or nursing home.

E. When is life insurance exempt?

The cash surrender value of life insurance may be claimed as exempt if the total *face* value (amount payable at death) is not more than $1,500. For couples, each spouse may claim $1,500. If the face value of an individual's life insurance is more than $1,500, the entire *cash surrender value* (the amount payable if the policy is canceled) is counted as a non-exempt resource. (It will count as part of the $2,000 or $48,639 to $113,640 resource limits discussed in the previous section.) Life insurance with no cash surrender value has no effect on Medicaid eligibility.

F. When are burial funds and burial spaces exempt?

A *burial fund* of $1,500 for an individual (and an additional $1,500 for a spouse) may be claimed as exempt if it is set aside in a clearly designated account to cover burial or cremation expenses. If an individual has life insurance that is claimed as exempt, then the face value of the life insurance will count as part of the individual's burial fund. So, for example, if a Medicaid recipient has exempt life insurance with a face value of $1,000, then only $500 more may be exempted in a designated account for burial expenses.

An *irrevocable trust* for burial expenses or a *pre-paid burial plan* may be claimed as exempt as long as it does not exceed reasonably anticipated burial expenses. The value of such a trust or plan will count against the exemption for burial funds or life

insurance. *Burial spaces* for Medicaid recipients and immediate family members are exempt no matter how much they are worth.

G. When are household goods and personal effects exempt?

Household furniture and other household goods, as well as clothing, jewelry, and personal care items are exempt regardless of value.

6. Can I transfer resources without affecting Medicaid eligibility?

A. Rules for transfers of a home

A *home* may be transferred without penalty to any of the individuals described below.

- A *spouse*
- A *brother* or *sister* who has an equity interest in the home and has lived there at least one year immediately before the date when their sibling's COPES coverage or institutionalization began
- A *child* who has lived in the home and cared for the parent for two years immediately before the date of the parent's current COPES coverage or institutionalization (If this requirement is met, it does not matter *when* the property is transferred to the child.)
- A *child* who is under 21, blind, or disabled (The disability criteria for this purpose are the same as those used for Social Security disability determinations.)

The person making the transfer does not need to live in the home at the time of the transfer to one of the people listed above.

B. Rules for other transfers to a spouse or disabled child

There is no Medicaid penalty for transferring resources to your spouse or to your disabled child. (The disability criteria for this purpose are the same as those used for Social Security disability determinations.) Remember that the resources of both spouses are added together in determining initial Medicaid eligibility. (See the answer to Question 4 above.) So, if a couple has more resources than are permitted at the time of the application, a transfer from one spouse to the other will not solve that problem.

A transfer to a spouse or disabled child may be made without penalty either before or after an individual qualifies for Medicaid.

C. Rules for other transfers to someone other than a spouse or disabled child

(1) Transfers without penalty

(a) There is no penalty if you sell your resources for their fair market value.

(b) *Exempt* resources *other than the home or a sales contract* may be given to anyone without penalty. (Exempt resources are described in the answer to Question 5.)

(c) There is no penalty for gifts made after April 2006 as long as the total amount of gifts made in any calendar month is $246 or less. (Different rules apply if you made gifts before May 2006 *and* you applied for Medicaid before May 2009.)

(d) There is no penalty for gifts of any value made more than 60 months before applying for Medicaid for nursing home care.

(e) No matter when a transfer is made, there is no penalty if you can demonstrate that the transfer was not made to qualify for Medicaid.

(2) Transfers resulting in penalties

There may be a penalty if you transfer *non-exempt* resources, or sales contracts, or a home (except to one of the people listed above), for less than fair market value within **60** months of applying for Medicaid. The penalty is a period of ineligibility for Medicaid. The length of the period of ineligibility depends on the value of the resource given away and when they were given. There is no maximum length for a period of ineligibility.

(3) Calculating periods of ineligibility

The process of calculating periods of ineligibility is a little bit complicated. After reading the following explanation, if you are left with questions about the effects of gifts you have made or gifts you are considering, you should talk with a lawyer who is knowledgeable about Medicaid.

Note: The explanations below apply to Medicaid applications made between October 1, 2011 and September 30, 2012. (The numbers change each year in October.)

To determine the period of ineligibility, take the total of all gifts made within 60 months before applying and divide the total by 246. The number of days of ineligibility is the result of this division.

The period of ineligibility does not begin to run until the first day of the month in which an applicant for Medicaid-funded long-term-care services is eligible in all other respects except for the period of ineligibility. This means that the applicant must satisfy the income and resource eligibility requirements and must meet the level-of-care requirements for Medicaid-funded long-term care. Also, to start the period of ineligibility running the Department requires that an individual make an application – in effect, seeking a determination by the Department that he or she is "otherwise eligible."

If the gift is made when an individual is already receiving Medicaid-funded long-term care, in a nursing home or in another setting, then the period of ineligibility normally begins on the first day of the month following a notice of the penalty period, but not later than the first day of the month that follows three full calendar months from the date of the report or discovery (by the Department) of the transfer. There is one exception to this norm. The penalty period will begin later if another penalty period is already in progress. In that case, the new penalty period starts after the current one is completed.

Example:

If you made gifts totaling $20,000 between May and August 2011 and entered a nursing home and applied for Medicaid in October 2011, you would calculate the period of ineligibility by dividing 20,000 by 246 to produce 81 days of ineligibility resulting from those gifts. (20,000 ÷ 246 = 81.3, which rounds down to 81.) The period of ineligibility would begin on October 1, 2011, assuming that you were otherwise eligible for Medicaid on that day.

Remember that a gift will not make an applicant resource eligible in the month of the gift if resources were too high on the first day of the month.

Generally, before you apply for Medicaid for nursing home care, the same restrictions apply to transfers by either you or your spouse. This means that if you give or your spouse gives away resources either gift may result in a period of ineligibility for you. Once you are receiving Medicaid, however, subsequent gifts made by your spouse will not affect your continuing eligibility.

(4) Waiver of periods of ineligibility

DSHS may waive a period of ineligibility if it finds that denial of benefits would cause undue hardship. Such a waiver may lead to imposition of a civil fine on the recipient of a gift that was made for the purpose of qualifying for Medicaid if the recipient of the gift "was aware, or should have been aware," of the purpose.

7. Will DSHS have a lien or claim against my estate?

DSHS can normally recover from a nursing home resident's estate most of what Medicaid paid for the resident's care after the resident turned 55. Recovery will be delayed if, at the time of death, a Medicaid recipient has a surviving spouse or registered domestic partner or a surviving child who is under 21 or blind or disabled.

The DSHS estate-recovery claim only applies to property owned at death by a Medicaid recipient. *No claim can be made against property solely owned by a spouse or child.* This may be an important reason to consult a lawyer familiar with Medicaid rules about permissible transfers of property.

More information about estate recovery is available in the Columbia Legal Services pamphlet "Estate recovery for medical services paid for by the State."

8. What if I need help with the Medicaid application process?

Many people need help applying for Medicaid. Often there are family members or friends, or staff members of a hospital or nursing home or other agency, who are able to help. Help is also available from DSHS staff, especially for people who have physical or mental impairments that make it hard to get through the application process on their own.

If you need help in the application process from DSHS, you or someone else should tell a DSHS representative that you need help. DSHS rules require what are called "necessary supplemental accommodation services" when they are needed. These services include help filling out forms and help finding information or papers needed for your application.

Medicaid eligibility rules are complicated. Before taking steps you don't fully understand, you should get individualized legal advice.

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