

QUESTIONS AND ANSWERS ON MEDICAID FOR NURSING HOME RESIDENTS

COLUMBIA LEGAL SERVICES

JULY 2006

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 meet the financial eligibility requirements described below. Also, you must need the 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. 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:

<i>Seaside Nursing Home Medicaid rate</i>	<i>\$4,880.00</i>
<i>Your regular monthly pharmacy bill</i>	<i>275.00</i>
<i>Total</i>	<i>\$5,155.00</i>

If your monthly income is less than \$5,155, 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 \$53.68 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 \$798) 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 \$1,650, Medicaid allows you to keep as much of your spouse's income as is necessary to bring your income up to \$1,650 per month. And, if your housing costs (rent or mortgage, maintenance fee for a condominium or cooperative, taxes, insurance, and utilities) exceed \$495 per month, the \$1,650 level can be increased up to \$2,489 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 \$334 per month is used.)

Examples:

If \$2,400 is paid in your name and \$700 is paid in your spouse's name, you can keep \$2,400.

*If \$700 is paid in your name and \$2,400 is paid in your spouse's name, you can keep your \$700 plus at least \$950 of your spouse's income (\$1,650 - \$700 = \$950). And if your housing costs are \$550 per month, you can keep an **additional** \$55 of your spouse's income because the \$1,650 level is increased by the excess of your housing costs over \$495 (\$550 - \$495 = \$55).*

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?

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. 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 \$41,943. This means that if your spouse goes on Medicaid, you and your spouse can have at least \$43,943 of non-exempt resources (\$41,943 allowed for you and \$2,000 allowed for your spouse). At the time of application, it does not matter which spouse owns what resource or whether the \$43,943 or any part of it is community or separate property. All resources of both spouses will be added together to determine eligibility.

Sometimes the Community Spouse Resource Allowance can be more than \$41,943. 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 the current period of

institutionalization began before August 1, 2003, then your CSRA is \$99,540.

(2) If your spouse is currently institutionalized (in a hospital or nursing home), but the period of institutionalization began on or after August 1, 2003, then a further calculation is required. If you can show that the combined resources of both spouses were more than \$83,886 when the current period of institutionalization began, then you may be entitled to a CSRA of more than \$41,943. If this exception applies, the CSRA 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 \$99,540. 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.

(3) You *may* be allowed to keep more non-exempt resources if the combined *income* of both spouses is not enough to give you what is allowed by the rules explained in Question 3 above (\$1,650 to \$2,489). To be allowed to keep more resources, a spouse who is 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.

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 DSHS requirements and whether a particular financial plan makes sense in your particular

case, you should consult a lawyer familiar with Medicaid law.

The explanation above responds to the question "What resources can I have when my spouse applies for Medicaid?" An entirely different rule applies once your spouse is already on Medicaid. After an application is approved, continuing eligibility of the spouse on Medicaid will not be affected by increases in the resources of the spouse who is not on Medicaid. In other words, if one spouse is already on Medicaid, the other spouse's resources can increase above the limit that applied at the time of the eligibility determination. The increase will not affect the eligibility of the spouse on Medicaid.

Although it does not matter which spouse owns the resources at the time of application for Medicaid, any excess over \$2,000 must be transferred to the spouse not on Medicaid within a year after a Medicaid application is approved. After that, the spouse on Medicaid must not have more than \$2,000 worth of non-exempt resources in his or her name.

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 \$41,943 to \$99,540 resource 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 \$500,000 unless one of the following exceptions applies: (1) the Medicaid recipient is receiving services based on an application for DSHS-administered 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.)

The equity limit was imposed by Congress in February 2006 and applies in Washington to individuals whose Medicaid applications were filed after April 30, 2006.

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 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 the COPES program and if it requires repayment of the principal within the seller's "anticipated life expectancy." The *payments* received under an exempt sales contract will be treated as *income*.

D. When is a car exempt?

For an unmarried nursing home resident, one car is exempt, no matter how much it is worth, if it is used for transportation for the resident. If a nursing home resident is married, an additional car, regardless of its value, is exempt for the resident's spouse, unless the spouse is also in a nursing home or on COPES. (A rule change permitting only one exempt vehicle per couple is expected later this year.)

E. When is life insurance exempt?

The cash surrender value of life insurance may be claimed as exempt if the total *face* value (the amount payable at death) of the policy or policies 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 the insurance company will pay if the policy is canceled) is counted as a non-exempt resource. (This means it will count as part of the \$2,000 or \$41,943 to \$99,540 resource limits that were discussed in the previous section.) Life insurance with no cash surrender value does not count as a resource. It 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 a Medicaid recipient and for 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:

- A *spouse*, or
- A *brother or sister* who has an equity interest in the home and has lived there at least one year immediately before the date of their sibling's institutionalization, or
- A *child* who either: (a) has lived in the home and cared for the parent for two years immediately before the date of the parent's current institutionalization, or (b) is under 21, or 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 totaling no more than \$1,000 in any calendar month before May 2006 or for gifts totaling no more than \$189 in any calendar month after April 2006.

(d) There is no penalty for gifts of any value made more than 60 months before applying for Medicaid, or (except for certain transfers involving trusts) more than 36 months before May 1, 2006

(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 it was given. There is no maximum length for a period 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. (The calculation explanations below apply to Medicaid applications between February 8, 2006 and September 30, 2006. The numbers change each year in October.)

Separate calculations must be made for each of the following periods during which gifts may have been made: (1) gifts after April 2006, (2) gifts before May 2006 but after March 2003, and (3) gifts before April 2003.

To determine a period of ineligibility for gifts made after April 2006, calculate as follows: take the total of all gifts made after April 2006, and divide the total by 190. 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 begins on the first day of the month of the gift.

The decision to delay the beginning of periods of ineligibility until the time Medicaid eligibility would otherwise begin was made by Congress in February 2006, and is only expected to apply in Washington to gifts made on or after May 1st. (Washington regulations have not yet been adopted.) Previously,

periods of ineligibility based on gifts in any month generally began on the first day of the month in which the gifts were made.

To determine a period of ineligibility for gifts made after March 2003 and before May 1, 2006, calculate as follows: take one month at a time; first look at the first month after March 2003 in which gifts were made and add that month’s gifts together; then calculate the period of ineligibility based on that month’s gifts by dividing the total by 190. The number of days of ineligibility is the result of this division, rounded down to the nearest whole number. The period begins to run on the first day of the month in which the gifts were given, unless there is already another period of ineligibility in progress. If there is, then the new period begins when all earlier periods are through. This calculation is repeated for each month after March 2003 in which gifts were given.

Examples:

After April, 2006: *If you made gifts totaling \$20,000 between May and August 2006 and entered a nursing home and applied for Medicaid in September 2006, you would calculate the period of ineligibility by dividing 20,000 by 190 to produce 105 days of ineligibility resulting from those gifts. The period of ineligibility would begin on September 1, 2006, assuming that you were otherwise eligible for Medicaid on that date.*

Before May 2006 and after March 2003: *If you made gifts of \$3,000 in April 2004, \$5,000 in May 2004 and \$6,500 in June 2004, only the last gift would result in a period of ineligibility beyond the month of the gift (assuming no other gifts). The \$3,000 gift would result in a 15 day period of ineligibility from the first day of April ($3,000 \div 190 = 15.7$, which rounds down to 15). The \$5,000 gift would result in a 26 day period of ineligibility from the first day of May ($5,000 \div 190 = 26.3$, which rounds down to 26). The*

\$6,500 gift in June would result in a 34 day period of ineligibility, extending into July (6,500 ÷ 190 = 34.2, which rounds down to 34).

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.

(3) 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 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 a surviving child who is under 21 or blind or disabled.

The DSHS 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.

NH Q&A 7-06 (6-16-06)