
QUESTIONS AND ANSWERS ON MEDICAID FOR NURSING HOME RESIDENTS

COLUMBIA LEGAL SERVICES

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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 Health Care Authority (HCA)– the Washington State Department of Social and Health Services (DSHS) is the designee of HCA in administering the nursing facility program.

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 provided in a nursing home.

Apply for **Long Term Care Medicaid** for nursing home residents one of two ways: by filing an application online; or by submitting a paper application to a local DSHS Home and Community Services (HCS) office. The website for filing an on-line application is Washington Connection
<https://www.washingtonconnection.org/home/>

The website for downloading a paper application [form HCA 18-005 (3/14) *Washington Apple Health Application for Long-Term Care/Aged, Blind, Disabled Coverage*] is <http://www.hca.wa.gov/medicaid/forms/Documents/18-005.pdf>. You may also pick up the application form at a DSHS office.

A paper application may be returned to PO Box 45826 Olympia WA 98504 or to your local Home and Community Service (HCS) office. To find the right HCS office, call 1-800-422-3263 or use the online tool to find the HCS office in your county
<https://www.dshs.wa.gov/altsa/resources>.

Individuals under age 65 who are not on or eligible for Medicare may be eligible for health care, known as MAGI Medicaid, through the Health Benefit Exchange (<http://wahbexchange.org/>). MAGI Medicaid *includes* nursing facility coverage. The information in this publication addressing income, resources, and participation in cost of care does not apply to MAGI Medicaid clients requiring nursing facility care. However, the information addressing home equity limitations, transfer of assets, and estate recovery does apply to MAGI clients.

Note: The Washington State Health Care Authority (HCA) uses the term “Apple Health” to refer to all Medicaid and state medical programs, including long-term care programs. MAGI Medicaid (Medicaid medical for qualifying individuals under age 65 who are not on or eligible for Medicare) and Classic Medicaid (Medicaid medical for qualifying individuals age 65 and over) are both Apple Health programs.

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, pension payments and wages, in the month in which they are received.

In counting your resources for a month, DSHS essentially takes a snapshot of your resources as of the first moment of the first day of the month. Whatever resources exist at that exact moment are the resources counted. Resources typically include such things as real estate, funds in bank accounts (but not including this month’s income) and stocks. Funds from a payment that counted as income last month will count as resources this month if you still have them as of the first of this month. Not all resources count for purposes of determining resource eligibility.

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>\$6,000.00</i>
<i>Your regular monthly pharmacy bill</i>	<i>\$275.00</i>
<i>Total</i>	<i>\$6,275.00</i>

If your monthly income is less than \$6,275, 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 allowable 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 \$70 per month for your personal needs. The rest of your income will be used as follows:

- (1) an amount for mandatory income taxes owed;
- (2) an amount for wages from an approved training or rehabilitative program;
- (3) an amount for guardianship fees and administrative costs;
- (4) an amount for current and /or back child support garnished or withheld from the current month’s income according to a child support order;
- (5) an amount for your spouse if you have one, as explained in the answer to Question 3 below;
- (6) an amount for certain dependent family members;
- (7) an amount for unpaid allowable medical expenses including health insurance premiums and medical bills for services not covered by Medicaid that were incurred up to three months before the month of filing an application; bills must be still owed and not covered by any insurance (long term care expenses for nursing facility care are reduced to the state rate for the facility that provided care); and

- (8) an amount for a single person or an institutionalized couple only, an amount (not more than \$1,012) 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).

The list shown above is a hierarchy list. Deductions are allowed, in order, according to the list.

The total amount of the deductions for your PNA, income taxes owed, wages from an approved program, and guardianship fees/administrative costs cannot exceed \$771. The number and amount of deductions actually allowed will depend on the individual's income and the amount of each deduction.

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.

Note: A regulation, effective April 16, 2015, provides that resources transferred to another individual or entity to pay for your long-term care is still considered "available" to you. This will usually make you ineligible because you have excess resources. (See 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 \$2,058, you may be allowed to keep as much of your spouse's income as is necessary to bring your income up to \$2,058 per month. And, if your housing costs (rent or mortgage, taxes, insurance, maintenance fee for a condominium or cooperative, and utilities) exceed \$618 per month, then the \$2,058 can be increased up to \$3,161 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 \$430 per month is used.

Whether or not you can receive an allowance from your spouse's income will depend on the amount of your spouse's income; other deductions allowed, if any; and the amount of other deductions. Deductions from your income are allowed in a hierarchy order (see Section 2.A.).

Examples:

If \$2,400 is paid in your name and \$771 is paid in your spouse's name, you can keep \$2,400.

*If \$771 is paid in your name and \$2,400 is paid in your spouse's name, you can keep your \$771 plus at least \$1,287 of your spouse's income (\$2,058 - \$771 = \$1,287). And if your housing costs are \$800 per month, you can keep an **additional** \$182 of your spouse's income because the \$ 2,058 level is increased by the excess of your housing costs over \$ 618 (\$800 - \$ 618 = \$182).*

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?

A. When Your 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. 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 \$55,547. This means that if your spouse goes on Medicaid, you and your spouse can have at least \$57,547 of non-exempt resources (\$55,547 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 \$57,547 or any part of it is community or separate property.

Sometimes the Community Spouse Resource Allowance can be more than \$55,547. 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 \$111,094 when the current period of institutionalization began, then you may be entitled to a CSRA of more than \$55,547. 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 \$126,420. 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 (\$2,058 to \$3,161). 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 \$126,420.

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 \$55,547 to \$126,420 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 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 \$585,000 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. For example, it may 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 they are used to purchase a new exempt home within three months of receipt.

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, no matter how much it is worth, if it is used for transportation either for the Medicaid recipient or a member of the recipient's household.

E. When is life insurance exempt?

The cash surrender value of life insurance is 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 \$55,547 to \$126,420 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.

H. When is an entrance fee paid to a continuing care retirement community or life care community exempt?

An entrance fee paid by a long term care Medicaid applicant to a continuing care retirement community or life care community is still considered a resource available to the applicant to the extent that: (1) the applicant has the right to use the fee (including it using to pay for care); (2) the contract allows for the refund of any remaining entrance fee on death or termination of the contract and leaving the community; and (3) the fee does not convey an ownership interest in the community.

I. When is the dollar value of insurance proceeds paid out under a long-term care policy considered exempt?

The dollar value of insurance proceeds paid out for long-term care expenses, under a Long-Term Care Partnership insurance policy, will be deemed exempt at the time of Medicaid application and will not be subject to Medicaid estate recovery at death (the exemption applies only to the value of insurance proceeds paid out under a qualified Long-Term Care Partnership insurance policy).

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.) The care must have enabled the parent to remain in the home, it must be verifiable, and it must not have been paid for by Medicaid. A physician’s statement of needed care is required.
- 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 \$323 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 and was not made to avoid estate recovery.

(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.

To determine the period of ineligibility, take the total of all gifts made within 60 months before applying and divide the total by 323. The number of days of ineligibility is the result of this division.

The period of ineligibility does not begin to run until 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.

Note: The example below applies to Medicaid applications made between October 1, 2018 and September 30, 2019. The divisor number, which is currently 323, changes each year on October 1st. This divisor of 323 is the current daily statewide average of private nursing facility rates, which is \$323.

Example:

If you made gifts totaling \$20,000 between October 2018 and January 2019, and enter a nursing home and apply for Medicaid in

September 2019, you would calculate the period of ineligibility by dividing 20,000 by 323 to produce 62 days of ineligibility resulting from those gifts. ($20,000 \div 323 = 61.9195$, which rounds up to 62). The period of ineligibility would begin on September 1, 2019, assuming that you are otherwise eligible for Medicaid on that day.

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 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) Transfers Affecting Resource Eligibility

A new regulation, effective April 16, 2015, provides that the transfer of cash and other resources by an applicant or current recipient of long-term care services (or his or her spouse) to another person or entity to pay for the applicant's or recipient's long-term care services are considered resources available to the applicant or recipient, unless otherwise excluded. This will usually make you ineligible because you have excess resources. In that situation, the period of ineligibility because of a gift will not begin to run.

(5) Waiver of periods of ineligibility

DSHS may waive a period of ineligibility if it finds that denial of benefits would cause undue hardship. A waiver may be granted in cases where there has been denial or termination of benefits based on transfer of assets or excess home equity. 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.

A hardship waiver may be granted for transfers between same-sex couples who are married or for transfers between registered domestic partners.

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

DSHS may be entitled to recover, from a Medicaid client's estate, the amount the State of Washington paid for the client's care. Whether or not Medicaid is entitled to recover depends on the type of services the client received and the dates when the services were provided to the client. See the Columbia Legal Services publication entitled *Estate Recovery for Medical Services Paid for by the State*, which is available online at <http://www.washingtonlawhelp.org>. 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. Note regarding TEFRA (pre-death) liens: Effective July 1, 2005 the state may file a pre-death lien on property owned by clients residing in a long-term care facility who are "permanently" institutionalized, with no potential for discharge. However, MAGI clients are excluded from TEFRA (pre-death) liens because they do not pay towards the cost of their care.

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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**Prepared by COLUMBIA LEGAL
SERVICES
101 Yesler Way, Suite 300, Seattle, WA
98104**