MEDICAID LONG-TERM CARE ELIGIBILITY AND PLANNING STRATEGIES

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I. OVERVIEW OF MEDICAID LONG-TERM CARE BENEFITS

A. THE MEDICAID PROGRAM

Medicaid is a state- and federally-funded medical assistance program for certain people, including the elderly and disabled, who have income and assets below certain levels. It provides medical coverage for those persons, including long-term care.

For Medicaid purposes, states may not use eligibility criteria more restrictive than those used by the Supplementary Security Income (SSI) program. 42 U.S.C. § 1396a(a)(10)(C). This means that guidance can be found on various issues in the federal SSI statute, 42 U.S.C. §1381-1383, the federal SSI regulations, 20 C.F.R. § 416 *et seq* and in the federal SSI policy manual entitled the Program Operations Manual System (POMS).

At the state level, Medicaid is administered by the Washington State Health Care Authority (HCA) and the Washington Department of Social and Health Services (DSHS), Home and Community Services (HCS) department. The state regulations governing LONG-TERM care are primarily found in Chapter 182-500 *et seq* in the Washington Administrative Code (WAC).

B. THE APPLICATION PROCESS AND ELIGIBILITY DETERMINATION

Applications for Medicaid can be requested and submitted online, by mail, or in person. Medicaid long-term care applications are processed through the Home and Community Services Offices of DSHS. DSHS makes two separate determinations: whether the applicant meets the financial eligibility criteria and whether the applicant meets the physical eligibility criteria.

A person is physically eligible for long-term care benefits if he or she requires substantial assistance with two or more of the following activities of daily living: eating, bathing, toileting, ambulating, transferring, positioning, and medication management. However, an applicant with a significant cognitive impairment can qualify if he or she needs substantial assistance with only one of these activities of daily living.

A person is financially eligible if he or she meets both income and resource standards. Income is computed on a monthly basis and consists of what is received during that month by the person who is applying for or receiving care (not the whole household). Assets are determined on the first moment of the first day of each month and consist of property received before the first moment of the current month and that remain in the possession of the applicant. Thus, income in one month can become an asset in the following month.

In most cases, Medicaid long-term care coverage can begin no earlier than the date the application is submitted, although coverage of medical bills can begin up to three months prior in some cases.

An application for skilled nursing care can be approved for care retroactive to the date the person became financially eligible. An application for COPES, where a person is at home, in an adult family home, or in an assisted living facility can be approved for care to begin once a person has been determined to be physically eligible and they were also financially eligible.

When an application is approved, DSHS will send a letter awarding benefits. This letter will advise the applicant that he/she has been approved for Medicaid benefits and will specify how the applicant's income must be spent toward the cost of care in each month thereafter. A Medicaid recipient must participate a portion of their income toward their care each month.

If an application is denied, DSHS will issue a notice stating the reason for the denial and informing the applicant of the right to request an administrative hearing to contest the denial.

C. SKILLED NURSING BENEFITS

For persons eligible for nursing home coverage, Medicaid requires that all monthly income, after deductions for personal needs and some and some other deductions, be paid to the nursing home. The amount that the Medicaid recipient pays to the nursing home each month is called "participation." Medicaid will then pay the nursing home the difference between the recipient's participation and the Medicaid reimbursement rate for the resident at that facility.

When a person qualifies for nursing home coverage, Medicaid also provides coverage for most medical expenses, such as prescriptions and physician bills.

D. IN-HOME, ADULT FAMILY HOME, and ASSISTED LIVING BENEFITS

COPES is a Medicaid program that pays for care outside of skilled nursing facilities. It covers long-term care delivered at home, in adult family homes, and in assisted living facilities.

For eligible persons residing in their own home, COPES will pay for someone to come into the home to provide assistance with daily living activities and personal care. COPES will also cover care in an Adult Family Home or Assisted Living Facility. COPES recipients also get coverage for most medical expenses.

There is no retroactive COPES coverage. Coverage begins only when a plan of care and provider contract are approved by DSHS and the applicant is financially eligible.

E. COMMUNITY FIRST CHOICE

Community First Choice (CFC) is Medicaid long-term care program that is authorized by Section 1915(k) of the Social Security Act and was implemented in the state of Washington on July 1, 2015. The federal government pays a 6% higher proportion of the costs for this program than it does for other Medicaid services.

CFC services include personal care provided at home, in adult family homes and in assisted living facilities. For many persons who are eligible under the COPES rules for personal care in those settings, CFC will pay for their personal care services.

The income requirements for CFC are different from COPES. In order to qualify for CFC at home, recipients can have no more than the Medically Needy Income Level (currently $841) and recipients in adult family homes and assisted living facilities must have income that is below the Medicaid Special Income Level (currently $2,523).

For resources, the CFC standards are similar to COPES with a couple of notable differences. The retirement assets of a spouse (like IRA or 401(k) funds) are completely disregarded for CFC eligibility. Also, the transfer of asset rules that apply for most LONG-TERM care services do NOT apply to CFC.

II. INCOME AND RESOURCE ELIGIBILITY RULES FOR A SINGLE PERSON

A. INCOME

In a nursing home, a single individual's income must be less than the private pay rate in the facility plus the applicant's regularly recurring monthly medical expenses. If an applicant's income is above the Medicaid rate and below the private pay rate, the applicant will be certified as eligible for Medicaid and will only have to pay the Medicaid rate.

A single COPES recipient can have income of $8,927 per month, and even this level can be increased in some circumstances.

B. RESOURCES

A single applicant cannot have more than $2,000 in non-exempt resources. Exempt or non-countable resources are defined below. Resource eligibility is always determined at the first moment of the first day of any month for which coverage is sought.
Resources are valued according to the fair market value of the applicant's equity interest in the resource. Mortgages and liens against resources are deducted when determining their value. Joint bank accounts are treated as if they are owned entirely by the applicant unless the applicant can show a different ownership structure.

Funds in retirement accounts are counted as assets if they are available to the applicant, even if subject to early withdrawal taxes and penalties.

Assets held in revocable living trusts are also counted as if they were owned by the applicant outright.

For skilled nursing recipients, if resources are above $2,000 on the first day of the month but less than the private pay rate at the facility, those excess resources can be paid to the facility during an initial month of eligibility. After that first month, participation will be calculated normally.

C. EXEMPT RESOURCES

The following resources are not counted when determining whether a single applicant for Medicaid has more than $2,000.

1. HOME. A home is exempt if the applicant is residing in the home or the applicant states that he/she intends to return home (the applicant does not have to show that he or she is able to return home, just that he or she intends to do so). A home includes all

contiguous property, and includes out-buildings on the property. Proceeds from the sale of a home are also exempt if used within three months of the receipt of the proceeds to purchase another home.

A portion of a Medicaid nursing home resident's monthly income may be used for up to 6 months to pay actual home maintenance costs if a physician certifies that it is likely recipient will return home in that period.

2. VEHICLE. A vehicle is exempt if it is used for the transportation of a recipient or a member of the recipient's household.

3. PERSONAL PROPERTY. Household furnishings and personal effects are exempt. This includes clothing, appliances, furniture, personal jewelry, and other items typically found in a home.

4. BURIAL PLOT. A burial plot or urn space is exempt.

5. LIFE INSURANCE/BURIAL FUNDS. A burial fund or life insurance policy of not more than $1,500 in face value is exempt. The $1,500 limit is an aggregate.

6. PREPAID BURIAL PLAN. A prepaid burial plan is exempt if it is irrevocable.

7. PARTNERSHIP POLICIES. A Long-Term Care Partnership insurance policy can increase the number of exempt resources that can be protected at the time of application and protected from Medicaid estate recovery.

8. ITEMS LISTED FOR SALE. Resources that can't be converted to cash in 20 working days are disregarded until they are sold, as long as the applicant is making an ongoing bona fide effort to convert them to cash. The proceeds from the sale of such resources are not exempt and will make the Medicaid recipient ineligible in the month following the sale unless spent in the month in which they are received.

9. SINGLE PREMIUM IMMEDIATE ANNUITY. An irrevocable annuity which has no cash surrender value, is not assignable, and which pays out in equal installments over five years (or the life expectancy of the annuitant) is not considered to have any value as a resource if the state of Washington is named as the contingent beneficiary of the annuity. The income from the annuity is countable income to the recipient when received – and will generally have to be participated toward the cost of care.

10. JOINTLY-OWNED RESOURCES. A resource jointly-owned with another person is not counted as a resource when the joint-owner refuses to agree to sell that resource.

III. INCOME AND RESOURCE ELIGIBILITY RULES FOR MARRIED COUPLES

A. OVERVIEW OF COUPLE ELIGIBILITY RULES

Medicaid has a number of rules that are designed to protect the income and assets of a spouse who does not need long-term care, who we often call the "community spouse." These rules are designed to avoid impoverishment of the community spouse.

These Medicaid eligibility rules for a married couple apply only when one spouse is receiving Medicaid. If both spouses are applying for Medicaid, they will each be treated as though they were single and the Medicaid income and resource rules for single persons, discussed above, will apply for each.

The federal Medicaid statute expressly preempts state community property law for purposes of determining the ownership of income and assets.

B. INCOME ELIGIBILITY

For one spouse of a married couple to receive Medicaid coverage, the income of that spouse must be less than the facility's private pay rate plus his/her regularly recurring monthly medical expenses. The nursing home spouse's income is determined by first seeing what income comes in the name of that spouse. If this amount exceeds the eligibility standard, the person under certain circumstances may still be eligible if one-half of the income of both spouses is less than the eligibility standard.

C. RESOURCE ELIGIBILITY

All resources of both spouses are considered in determining eligibility, regardless of which spouse owns what resource or whether the property is separate or community property. Prenuptial and Separate Property Agreements are irrelevant to this determination.

When only spouse is applying, the combined non-exempt resources of a married couple must be less than $61,890 to qualify one of the spouses for Medicaid nursing home coverage or COPES.

The resource standard for a couple when one spouse is receiving skilled nursing care can be increased from $61,890 to up to a maximum of $139,400, if one-half of the couple's non-exempt resources exceeds $61,890 at the time one of them entered skilled nursing. In order to take advantage of this enhanced resource standard, the couple must submit a HCS Community Resource Declaration, which will list the assets of the couple at the time the applicant spouse entered the hospital or skilled nursing facility. If the Resource Declaration is submitted, the resource standard will then be increased to one-half of the

couple's non-exempt resources as of the date the first spouse is institutionalized, up to a maximum of $139,400.

The same resource rules and exemptions described above for single persons apply to couples, with the following additions:

1. The community spouse is allowed $59,980 in non-exempt resources (or up to $137,400 if other spouse is in a skilled nursing facility) in addition to the $2,000 in non-exempt resources allowed for the applicant spouse. The community spouse can be allowed more than this if additional resources are necessary to bring the community spouse's income up to the minimum spousal income allocation level described below.

All but $2,000 in non-exempt resources must be transferred into the name of the community spouse before the first regularly scheduled eligibility review, which is usually 12 months after initial eligibility is determined. After this first year, non-exempt resources of the Medicaid spouse must always remain below $2,000. However, after eligibility for one spouse is established, that eligibility is unaffected if the non-exempt assets of the community spouse later exceed resource limits.

2. Each spouse is allowed to have a burial fund or an irrevocable prepaid burial plan subject to the same rules explained above for single persons.

3. The home is exempt if the community spouse resides in the home, regardless of its value. Further, if the home is transferred into the name of the community spouse, it will not be subject to Medicaid estate recovery.

4. One automobile per couple is exempt regardless of value or use.

IV. TRANSFERS OF ASSETS

A. TRANSFERS AND ELIGIBILITY

A transfer of assets will make an applicant or recipient ineligible for Medicaid benefits for a specified period of time. This transfer penalty does not apply to persons applying for or receiving services under the Community First Choice program.

A transfer may result in a transfer penalty if the transfer is made for less than fair market value and none of the exceptions listed below applies to the transfer.

B. THE LOOK-BACK PERIOD

Only transfers made within 60 months before the application is made are subject to the transfer penalty. This is called the "look-back period." Transfers made before the lookback period have no effect on Medicaid eligibility.

C. CALCULATING THE TRANSFER PENALTY

The total amount of gifts made within five years of applying for Medicaid is divided by $355, which represents the average daily cost of nursing home care in the state of Washington. This calculation provides a number of days for which the applicant is ineligible for Medicaid. DSHS disregards gifts if the aggregate amount given away in the month is $355 or less.

DSHS calculates gifts based on the daily rate, but the monthly rate is sometimes necessary for calculating strategies. That figure is currently $10,785.

If a couple are both applying or receiving benefits, any transfer penalty is split between spouses.

D. OTHERWISE ELIGIBLE

The period of ineligibility begins on the date the client would be "otherwise eligible" for services, based on an approved application or the first day after any previous penalty period has ended. This means that an application has to be made in order to start the penalty period, and the applicant has to be determined eligible in all respects except for the imposition of the transfer penalty.

For a person already on Medicaid, the transfer penalty will begin on the first of the month following the transfer. Then, after the expiration of the penalty period, a new application must be made to start benefits again.

Examples

If a single person gifts $5,000,000 on July 1, 2017 and applies on August 1, 2022, there will be no period of ineligibility.

If a single person gives away $12,000 in March and is left with less than $2,000 on April 1, submitting a Medicaid application on April 1 would cause the 35-day period to begin April 1 and run through May 6.

If a single person gifts $87,000 in May, 2022 and applies in January, 2023 after all remaining assets have been reduced to $2,000, the 8-month period of ineligibility will begin January 1, 2023 and end on August 31, 2023.

If a single person gifts $10,000 on May 1, 2022 and applies on June 1, 2022 but has available resources of $5,000, the penalty period will not begin until those resources are spent down and the person is otherwise eligible for benefits.

E. TRANSFERS TREATED AS AVAILABLE RESOURCE

WAC 182-512-0250 has a section addressing a situation in which a transferred asset might still be considered an available resource:

(3) For long-term care (LTC) services, cash and other resources transferred by a WAH applicant or recipient, or his or her spouse to another to pay for the WAH applicant or recipient's LTC services are considered resources available to the applicant or recipient unless otherwise excluded in this chapter, chapter 182-513 WAC, or chapter 182-516 WAC.

What this means is that if an applicant or recipient transfers resources to someone with the intent that that person then use those resources to pay for care for the applicant or recipient, those resources are still counted as belonging to the transferor and may disqualify him or her from Medicaid based on asset levels.

If those assets are transferred to a d4A or d4c special needs trust, this rule does not apply.

F. TRANSFERS WHICH CAUSE NO PENALTY

The following transfers do not cause the imposition of a period of ineligibility.

1. Gifts not made during the look-back period.

2. Transfers for fair market value. With respect to payment for care provided by a family member, the compensation must be paid no more than 30 days from the time of the services.

3. Transfers not made for the purpose of qualifying for or remaining qualified for Medicaid and not for the purpose of avoiding estate recovery.

4. Gifts that are returned to the Medicaid applicant.

5. Transfers of exempt resources, except a home.

6. Transfer of the home to a caregiver child of the applicant who has lived in the home and provided care to the applicant that enabled him or her to not enter a facility for the two-year period immediately prior to institutionalization or COPES eligibility. A physician statement verifying the need for care to avoid institutionalization is required.

7. Transfer of the home to a sibling of the applicant who has an equity interest in the home and who has lived in the home for the one-year period immediately prior to institutionalization or COPES eligibility.

8. Transfer of the home to a child under age 21.

9. Transfers to a spouse.

10. Transfers to a disabled child or to an actuarially-sound trust for the sole benefit of a disabled child.

11. Transfers to a trust for the sole benefit of any disabled person under 65 years of age. Such a trust must be actuarially-sound, unless the trust provides for Medicaid to be repaid upon the death of the beneficiary.

G. WAIVER OF TRANSFER PENALTY

If the applicant can show that imposing the transfer penalty will put their health or life in danger, he or she can request a waiver of the penalty. If this waiver is granted, DSHS can impose a civil penalty on the transferee of up to 150% of the benefits paid by DSHS during the penalty period for the care of the applicant.

V. ESTATE RECOVERY

DSHS has a right to recover from the estate of a Medicaid recipient if services were paid after age 55. This right of recovery normally begins at death. The Office of Financial Recovery of DSHS pursues the enforcement of the Department's recovery rights.

A. MEDICAID LIEN

Medicaid's right to file a lien exists at the death of the Medicaid recipient. In some cases, the state can file a lien against the home of a Medicaid recipient while he or she is alive. This is applicable when the recipient is receiving skilled nursing care and DSHS determines the recipient cannot reasonably be expected to be discharged and return home. The determination can be appealed. The lien must be removed if the recipient returns home.

B. ESTATE

Medicaid estate recovery only applies to the "estate" owned by the Medicaid recipient at death. This includes all probate assets and nonprobate assets, but does not include the assets of the surviving spouse.

Life estate interests are valued as of the moment immediately prior to death. Joint tenancy interests are valued as if the Medicaid recipient held the property as a tenant in common.

C. RECOVERY DELAYED

Estate recovery will be deferred until the death of the community spouse, disabled child, or minor child. The state will release the lien if the surviving spouse wishes to sell the property. If the couple leaves any assets in the name of the nursing home spouse, including title to the home, there could be a Medicaid lien against the nursing home spouse's share of the property.

Medicaid recovery may be waived where it will cause undue hardship as defined in WAC 182-527-2750. If a Medicaid recipient is survived by a registered domestic partner, the Department shall recognize an undue hardship and defer recovery as it would in the case where a spouse survived the Medicaid recipient.

Assets which are deemed exempt for eligibility purposes because of coverage paid by a Long-term care insurance partnership policy are also exempt from Medicaid estate recovery.

VI. STRATEGIES FOR MARRIED COUPLES

A. ANNUITY FOR THE COMMUNITY SPOUSE

Excess resources can be used to purchase a single-premium immediate annuity for the community spouse that provides for periodic income payments. The annuity must be irrevocable, non-transferable, have no cash surrender value, and the payout term must be at least five years or the life-expectancy of the annuitant.

The State of Washington must be listed as the remainder beneficiary on the annuity. This means that if the spouse does not live the full term of the annuity, any remaining payments will go to the State to reimburse DSHS for the money it has expended on behalf of the Medicaid spouse. The State of Washington does not have a recovery right against payments made to the community spouse during his or her life.

B. DIVORCE

A couple can get divorced before the Medicaid spouse applies for benefits. A divorce decree separates assets and the couple can ask that the judge give a majority or all of the assets to the community spouse. Once the decree is final, those assets belong to the community spouse (now ex-spouse) and are not counted in connection with the application.

This strategy can be useful if there is a good reason not to use an annuity. However, if the Medicaid spouse does not have capacity, the court will likely appoint a guardian ad litem, who will be unlikely to agree to a lopsided distribution of assets in the decree.

C. REQUEST AN EXCESS RESOURCE ALLOWANCE

If a couple's combined income is less than the minimum spousal maintenance income level (currently $2,178), then a couple may request an increase in the amount of assets that the community spouse is allowed to keep. A court or administrative law judge must make a determination that the excess resources are necessary to generate income for the maintenance of the community spouse.

VII. STRATEGIES FOR SINGLE PERSONS

A. SPEND DOWN/UP

An applicant can convert non-exempt resources into exempt resources. He or she can buy a newer, more valuable vehicle or home (as long as the equity does not exceed $636,000). They can purchase a pre-paid burial plan or plot.

An applicant can also spend excess resources on personal property, clothes, etc. that he or she might need. Once that person is on Medicaid, the personal needs allowance is all they get each month to pay for these things.

An applicant can spend any other excess resources on their care until they are spent down to $2,000, then apply for Medicaid.

B. GIFT ASSETS AND WAIT OUT THE LOOKBACK PERIOD

The applicant can gift assets and then wait 60 months before applying for Medicaid. Those gifts will not carry a penalty period if they are outside the lookback period.

C. TRANSFER THE HOME

The applicant can transfer their home to a disabled or caregiver child and will not be penalized for the transfer.

D. UTILIZE COMMUNITY FIRST CHOICE

If the applicant's income is low enough to allow him or her to qualify for Community First Choice, then he or she can utilize that program to cover costs during a penalty period for gifting.

If an applicant gifts money and then applies for Medicaid when he or she is otherwise eligible, then a penalty period for COPES will begin. If that applicant also qualifies for CFC, the COPES penalty period will begin to run, but CFC benefits will still pay for that person's care.

It is important to note that CFC does *not* pay for skilled nursing care. Therefore, if the person requires skilled nursing care, no benefits will be available to pay for their care during the penalty period.

E. HALF-LOAF GIFTING

If the applicant owns a home, a half-loaf gift may be a good way to preserve some assets.

In this scenario, you will want to get the person qualified for Medicaid before selling the home. A home is an exempt asset when qualifying for Medicaid. Once the person is receiving benefits, they will then sell the home.

After the home is sold, the Medicaid recipient must gift the proceeds before the end of the month in which they are received. DSHS must be notified of the gift, and a penalty will be imposed because of the gifting.

The Medicaid recipient should retain enough funds to pay for his or her care during the penalty period. Those funds will put the person over the resource limit; thus, it is important that the gifting be done during the same month they are received. If this is not done, the recipient will not be "otherwise eligible" but for the gift if they retain part of the sale proceeds.

EXAMPLE:

Client has a home with $250,000 in equity. Cost of care is $6,000 per month, and income is $2,000 per month. The client sells the home while on Medicaid and gifts $168,000 to his daughter and retains $72,000. He is penalized for 504 days, or just over 17 months. During that time, he will need about $68,000 to pay for his care. At the end of the penalty period, he will need to spend down about $2,000 to once again be under asset limits, and then he can reapply for Medicaid. He has paid for his care and preserved $168,000 in assets.

VIII. PLANNING SCENARIOS AND EXAMPLES

*** NOTE: Check the monthly penalty divisor on the most current Key Medicaid Standards at the time you use these examples in your practice. Here, $10,000 is the monthly penalty divisor to make the calculations simple. ***

A. **Single Person**

Income: $2,500/mo
Cost of Care: $5,000/mo

Assets: Vehicle
Pre-paid Burial Plan
$25,000 IRA
$5,000 bank account

Cost of care deficit: **$2,500**/month

Options: Spend down
Spend up
Purchase and transfer exempt asset (newer vehicle)

B. **Single Person**

Income: $2,500/mo
Cost of Care: $5,000/mo

Assets: $100,000 Home
$ 25,000 IRA
$ 5,000 bank account

Cost of care deficit: **$2,500**/month

Options: Spend down
Spend up
Purchase and transfer exempt asset (vehicle)

Half-loaf gift:

Spend down to $2,000 plus the home.
Qualify for Medicaid
Sell the home, net $100,000
Client gifts $80,000.00 to child, and retains $20,000
Client is penalized for 8 months.
Client's cost of care during the penalty period is: 8 x $2,500 = $20,000

Client pays for care during the penalty period and is back down to $2,000.
Client reapplies for Medicaid and is now eligible.
Client's child has $80,000 for client's supplemental needs.

C. **Couple – Spouse 1 needs care**

Income: $1,000/mo (Spouse 1)
$2,200/mo (Spouse 2)
Cost of Care: $5,000/mo (Spouse 1)

Assets:	$250,000	Home
	$100,000	IRA (Spouse 2)
	$50,000	Bank account

Cost of care deficit: **$4,000**/month

Options: Spend down
Spend up (cash out IRA and purchase larger home)
SPIA

D. **Couple – Spouse 1 needs care**

Income: $2,200/mo (Spouse 1)
$1,000/mo (Spouse 2)
Cost of Care: $5,000.00/mo (Spouse 1)

Assets:	$250,000	Home
	$100,000	IRA (Spouse 1)
	$50,000	Bank

Cost of care deficit: **$2,800**/month

Options: Spend down
Spend up
Cash out IRA, transfer, and then SPIA
Income transfer without SPIA

E. **Couple – Both spouses need care**

Income:	$2,200/mo (Spouse 1)	
	$1,000/ mo (Spouse 2)	
Cost of care:	$5,000/mo (Spouse 1)	
	$4,500/mo (Spouse 2)	
Assets:	$250,000	Home
	$100,000	IRA (Spouse 1)
	$50,000	bank account

Cost of care deficit: **$6,300.00**/month

Options: Spend down
Spend up
Half-loaf gift

Half-loaf gift:

$250,000 from house sale
$173,000 gift, retain $57,000
Penalty period = 9 months for each spouse
$56,700 required during penalty period