

WHEN DOES MEDICAID PAY FOR LONG-TERM CARE?

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NOTE: Most of the dollar figures used in this outline are adjusted annually, at different times of the year, according to poverty guideline adjustments or cost of living increases. The figures used are current as of the date of the revised outline.

NOTE: The income and resource eligibility rules are different for an individual (without a spouse) versus a married couple when one spouse needs long-term care, so those sections of the outline are divided to describe the different rules.

DEFINITIONS

Activities of Daily Living (ADLs). Personal care tasks, e.g., bathing, dressing, toileting, transferring, and eating/feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and services.

Community-based care (CBC). Medicaid covers long-term care in a community based setting (not an institution) for individuals whose mental or physical condition requires nursing supervision and assistance with activities of daily living.
M1410.040.

Community Spouse. The spouse of a person receiving long-term care. Remember that the institutionalized spouse can be receiving long-term care at home through a waiver as well as in a nursing home.

Exempt resources. Not all resources a person owns are counted in determining eligibility for resources. Those resources that are not counted are exempt.

Long-term care. Medical care received in a nursing facility or in a community setting that is expected to last at least 30 days. Medicaid will not pay for this type of care unless it is determined, after a pre-admission screening, that the patient needs nursing facility care or community-based care. M1410.010.

Manual. The Virginia Department of Social Services Medicaid Eligibility Manual. Local social services eligibility workers use this manual. The Manual and relevant updates are available online at <http://www.dmas.virginia.gov/#/eligibilitypolicy> and at <http://www.dmas.virginia.gov/#/assistance>.

Non long-term care. Coverage of health care costs of a person who is not receiving long-term care, such as hospital, doctor and prescription bills.

Preadmission Screening. The process to evaluate the functional, nursing, and social supports of individuals referred for preadmission screening for certain long-term care services requiring nursing facility eligibility.

Qualified Individuals (QI). This is limited Medicaid coverage for a Medicare recipient whose income is between 120% and 135% of the federal poverty limit. Unlike SLMB recipients, persons eligible for QI will have to apply every year and only those who apply before the money allotted by DMAS for this coverage runs out will be covered. M0320.603.

Qualified Medicare Beneficiary (QMB). This is limited Medicaid coverage for a Medicare recipient whose income does not exceed 100% of the federal poverty limit. Medicaid will pay the Medicare Part B premium, deductibles and co-payments only. M0320.601.¹

Resources. Another name for assets owned by the person applying for Medicaid and his or her spouse.

Special Low-income Medicare Beneficiary (SLMB). This is limited Medicaid coverage for a Medicare recipient whose income is slightly above the QMB limit, but less than 120% of the federal poverty limit. Medicaid will pay the Medicare Part B premium only. M0320.602.

¹ All citations are to the Virginia Medicaid Claims Manual which is available on-line at <http://www.dmas.virginia.gov/#/assistance>.

MEDICAID COVERED GROUPS

There are many Medicaid covered groups. Most older Medicaid applicants must fit within one of the groups below to be eligible. However, this is *not* an exclusive list.

SSI. Most persons who are eligible for Supplemental Security Income (SSI) are also eligible for Medicaid. A person must be aged (65+), blind, or disabled, have limited income, and have countable resources below the SSI limit (\$2000 for an individual; \$3000 for a couple) to qualify for SSI. Virginia Medicaid has more restrictive eligibility rules than SSI regarding whether certain assets are exempt; therefore, some persons who are eligible for SSI are not eligible for Medicaid under this category but almost all will be eligible under the next category. (There may be some couples receiving SSI whose income exceeds 80% of the federal poverty line even after disregarding the SSI income).

Optional Categorically Needy

- Aged, blind, or disabled Virginians with income at or below 80% of the federal poverty line.
- Individuals receiving long-term care whose incomes are less than 300% of the SSI level.

Auxiliary Grant recipients. Aged, blind, or disabled individuals residing in Assisted Living Facilities or Adult Care Residences and receiving an auxiliary grant to help pay for their care.

QMB. Limited Medicaid coverage is available to a Medicare recipient with income less than or equal to 100% of federal poverty income limits and assets within the limits for Medicare Savings Program (MSP), which in 2017 is \$7,390 for an individual and \$11,090 for a couple (increased from \$7,280 and \$10,930, respectively, in 2016). M1110.003. Medicaid will pay the Medicare premiums, deductibles, and co-payments but not long-term care, prescriptions, etc.

SLMB. Medicare recipients with income over 100% but less than or equal to 120% of federal poverty income limits, and assets within the limits for MSP (see QMB above) are eligible for SLMB. Medicaid will pay only the Medicare premium, but not the co-payments or deductibles.

QI. Medicare recipients with income over 120% but less than or equal to 135% of federal poverty income limits, and assets within MSP limits (see QMB above) are eligible. Same coverage as SLMB except you must apply every year and it will be first-come, first-served, until the money runs out.

Medically Needy (M0310.120)

- The applicant is aged, blind or disabled; and
- His resources are below the SSI limit, but his income is more than 80% of the federal poverty line; and
- After deducting medical expenses incurred (but not necessarily paid), his income is below the medically needy income limit (MNIL). This is called an income spend-down.
- Usually, individuals will not qualify under this category unless they are receiving long-term care or have large unpaid medical bills.

Income Limits and Countable Assets for the different types of coverage can be found in the table on the next page. Figures come from Medicaid Manual M0810.002, M1110.003, and M1480.430. The rest of the outline will focus on the financial criteria for Medicaid coverage of long-term care (both nursing home and community-based care), although some of the rules are also applicable to non long-term care eligibility.

Exempt Income. The following income does not count toward the income limit.

- \$20 per month of unearned income; and
- The first \$65 of earned income, plus half of the remaining earned income.

Income or Resource? A lump sum of money is considered income for the month in which it is received. If the person still has the money in the next month, it is considered a resource. (Manual, S0810.010).

Type of Coverage	Monthly Income Limits (2018)	Countable Assets Limits (2018)
Non Long-Term Care	<p>\$810/mo. for an individual (80% of 2018 federal poverty level) \$1,098/mo. for a couple</p> <p>Income Spend-downs available for higher incomes, but must spend-down to medically needy income level (MNIL)</p> <p>*Note: Medicaid Expansion, once implemented in 2019, will change eligibility requirements. See www.coverva.org/expansion for info</p>	<p>\$2,000 for an indiv.;; \$3,000 for a couple</p> <p>More restrictive rules concerning what type of property is exempt will apply if income is above 80% of poverty level after disregarding SSI income</p>
QMB	<p>\$1,012/mo. for an individual \$1,372/mo. for a couple</p>	<p>\$7,560 for an indiv.;; \$12,840 for a couple</p>
SLMB	<p>\$1,214/mo. for an individual \$1,646/mo. for a couple</p>	<p>Same as QMB</p>
QI	<p>\$1,366/mo. for an individual \$1,852/mo. for a couple</p>	<p>Same as QMB</p>
Long-Term Care Individual	<p>\$2,250/mo. Spend-down available</p> <p>Personal Needs Allowance Community Care: \$1,238 ('18). (M1470.410) *Note: Allowance for Community Care cannot exceed \$2,250 Nursing facility: \$40 ('07)</p>	<p>Same as non long-term care</p>
Long-Term Care Couple	<p>Community spouse (CS) is not required to contribute income--and CS's income is not deemed-- to institutionalized spouse. Only count any <u>actual</u> contribution by the CS to the institutionalized spouse. (M1480.300.B.3).</p> <p>The CS may be entitled to a portion of institutionalized spouse's income if her income is below the minimum spousal allowance of \$2,057.50/month. CS may be able to keep more than the minimum if she has high housing expenses (M1480.410).</p>	<p>Divide Assets and community spouse keeps one-half, subject to a minimum of \$24,720 (1/18) and maximum of \$123,600 (1/18)</p> <p>(M1480.231)</p>

MEDICAID COVERAGE OF LONG-TERM CARE

PREADMISSION SCREENING

Unless a nursing home stay is expected to last less than 30 days, applicants seeking Medicaid coverage of either community based care or nursing home care generally must be screened by a team to make sure they qualify functionally and medically for long-term care in addition to meeting the income and resource eligibility criteria. A person seeking a community based care waiver must meet the same criteria as a person seeking coverage of nursing home care. M1410.200; M1420.400.

To qualify, the person must be dependent in a number of activities of daily living (ADLs), which include bathing, dressing, eating, toileting, transferring, bowel and bladder function. The team will also assess the individual's mental orientation and behavior (e.g., whether the person wanders or is disoriented), mobility, joint motion, and ability to self-administer medications. The person's medical and nursing needs, including the need for medical or nursing services, observation or monitoring, potential for medical instability, etc. will also be evaluated.

When an individual is going through the pre-admission screening, it is very important to mention all ways he or she needs help. This is not the time to emphasize what the person can do for herself, but to recognize all the ways the person needs help. For example, if a person is asked whether she can feed herself, it is important to mention that she needs help cutting up meat, opening a milk carton, or pouring milk, etc. If the person has bladder or bowel accidents and is sometimes incontinent, this needs to be mentioned even though it may be embarrassing. If the person can essentially dress herself, but can't manipulate buttons or zippers or needs help tying her shoes, these limitations should be pointed out to the screening team. If the screeners are not told about ways the person needs help, they may decide the person does not need long-term care services and may not approve the person for coverage. Don't exaggerate the individual's limitations, but don't hide them.

A determination by the pre-admission screening team that the person is not functionally or medically in need of long-term care services can be appealed to the Department of Medical Assistance Services (DMAS or Medicaid).

ACTIVITIES OF DAILY LIVING AND OTHER FUNCTONS

The following definitions are taken from the Department of Social Services' Uniform Assessment Instrument (UAI) Manual.

Bathing. Getting in and out of the tub, preparing the bath (e.g., turning on the water), actually washing oneself, and towel drying. Some individuals may report various methods of bathing that constitute their usual pattern. For example, they may bathe themselves at a sink or basin five days a week, but take a tub bath two days of the week when an aide assists them. The questions refer to the method used most or all of the time to bathe the entire body.

Dressing. Dressing is the process of getting clothes from closets and/or drawers, putting them on, fastening, and taking them off. Clothing refers to clothes, braces and artificial limbs worn daily. Individuals who wear pajamas or gown with robe and slippers as their usual attire are considered dressed.

Toileting. Toileting is the ability to get to and from the bathroom, get on/off the toilet, clean oneself, manage clothes and flush. A commode at any site may be considered the "bathroom" only if, in addition to meeting the criteria for "toileting," the individual empties, cleanses, and replaces the receptacle, such as the bed pan, urinal or commode, without assistance from other(s).

Transferring. Transferring means the individual's ability to move between the bed, chair, and/or wheelchair. If a person needs help with some transfers but not all, the assistance rating should be coded at the highest level.

Eating/Feeding. Eating/feeding is the process of getting food/fluid by any means into the body. This activity includes cutting food, transferring food from a plate or bowl into the individual's mouth, opening a carton and pouring liquids, and holding a glass to drink. This activity is the process of eating food after it is placed in front of the individual. It does not include preparation, cooking, or cleaning dishes.

Continence. Continence is the ability to control urination (bladder) and elimination (bowel). Incontinence may have one of several different causes, including specific disease processes and side effects of medications.

Ambulation. Ambulation is the ability to get around indoors (walking) and outdoors (mobility), climb stairs and wheel. Individuals who are confined to a bed or chair must be shown as needing help for all ambulation activities.

SCORING ACTIVITIES OF DAILY LIVING

The screening team will assign a “score” for an applicant’s ability to perform each ADL. The score will indicate whether the applicant is **independent, semi-dependent, dependent, or totally dependent** in each category. The same scoring system is used for “Other Functions” (medication administration, behavior pattern & orientation, mobility, and joint motion). Chapter IV of DMAS’ Pre-Admission Screening Manual offers information on the criteria used to determine the score for each ADL or Other Function. It can be accessed at this address:

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>
(Select “Pre-Admission Screening” on the pull down bar, click the “Submit” button, then select Chapter IV – Nursing Facility and Waiver Services).

Summaries of independent, semi-dependent, dependent, and totally dependent follow:

Independent. Does not need help with the ADL or Other Function. **Coded as “I.”**

Semi-Dependent. The applicant may require mechanical help only for certain tasks, such as a walker or wheelchair for mobility; a grab bar or raised toilet seat for toileting; or specially designed clothing for dressing. For individuals with continence issues, less-than-weekly incontinence is marked as semi-dependent. For an applicant who needs ostomy supplies, semi-dependent means he or she can perform all required self care. **Coded as “d.”**

Dependent. The applicant may need human help only, or a combination of mechanical and human help. Human help may mean verbal cues/prompting for feeding or physical assistance when cutting meat; supervision or assistance when transferring; or supervision or assistance during the set-up or cleaning phases of bathing. Incontinence weekly or more is considered dependent, as well as when an individual requires ostomy supplies and cannot perform the required self care. **Coded as “D.”**

Totally Dependent. The UAI Manual also includes the term “totally dependent,” but does not associate a different grade from to “dependent.”

SCORING OTHER FUNCTIONS

Medication Administration. Refers to the needs of an applicant to keep up with his or her medications.

- **Independent:** An individual with no medications, or self-administered medications monitored less than weekly. **Coded as “I.”**
- **Dependent:** An individual who needs assistance by a layperson to administer or monitor medications, or an individual who needs a licensed or professional health personnel to administer or monitor medications. **Coded as “D.”**

Behavior Pattern and Orientation.

- **Behavior Pattern:** Behavior pattern is the applicant’s manner of conducting herself within her environment. It does not refer to personality characteristics (such as selfish, impatient, or demanding). Instead, it is based on direct observations of the applicant’s actions.
 - **Appropriate (Independent):** Able to adjust behavior to accommodate expectations in different environments and social circumstances. **Coded as “I.”**
 - **Inappropriate Wandering, Passive, or Other Behavior:**
 - Wandering is moving about aimlessly or being non-focused mentally
 - Passive behavior is a lack of awareness or interest in personal matters or activities taking place in close proximity.
 - Other behavior could be impaired judgment, regressive behavior, agitation, or hallucinations that are not disruptive.
 - If the above patterns occur less than weekly, the applicant is considered independent. **Coded as “I”.**
 - If the above patterns occur weekly or more, the applicant is considered semi-dependent. **Coded as “d”.**
 - **Inappropriate Abusive, Aggressive, or Disruptive Behavior:**
 - Acts that are detrimental to the life/comfort/safety/property of the individual or others. Applicants with these behaviors, regardless of frequency, are considered dependent. **Coded as “D”.**
 - **Comatose:** refers to the semi-conscious or comatose (unconscious) state. Considered dependent. **Coded as “D”.**

- **Orientation:** Orientation is the awareness of an individual within his or her environment in relation to time, place, and person (the 3 cognitive spheres).
 - **Oriented:** no apparent problems with orientation; aware of who he or she is, where he or she is, as well as the day of week, the month, and the people around him or her. Considered independent. **Coded as “I”.**
 - **Disoriented in some spheres:** a person who is disoriented in 1 or 2 of the 3 spheres, some or all of the time. Considered semi-dependent. **Coded as “d”.**
 - **Disoriented in all spheres:** a person who is disoriented in all 3 of the spheres, some or all of the time. Considered dependent. **Coded as “D”.**
 - **Comatose:** refers to the semi-conscious or comatose (unconscious) state. Considered dependent. **Coded as “D”.**

Joint Motion

Joint motion is the applicant’s ability to move his or her fingers, arms, and legs (active range of movement) or the ability of someone else to move the individual’s fingers, arms, and legs (passive range of movement).

- **Normal limits or corrected instability:** joints can maintain normal limits without restriction, or a joint that cannot do so has been corrected by an appliance or surgical procedure. **Coded as “I”.**
- **Limited Motion:** joint is partially restricted, including any inflammation of a joint that causes redness, pain, and/or swelling that also limits the motion of the joint. **Coded as “d”.**
- **Instability uncorrected or immobile:** joint can’t maintain function when pressure/stress is applied, and the problem hasn’t been corrected by appliance or surgery. **Coded as “d”.**

APPLYING THE SCORES

Once the UAI has been completed, the scores associated with each ADL/Other Function will be recorded in the below chart. An applicant must meet one of three categories to qualify for nursing home care. Keep in mind the codes for dependent (D), semi-dependent (d), and independent (I).

ADLs	Check if Semi-Dependent (d)	Check if Dependent (D)	OTHER FUNCTIONS	Check if Semi-Dependent (d)	Check if Dependent (D)
Bathing			Medication Administration		
Dressing			Behavior Pattern & Orientation (combination variable)		
Toileting			Mobility		
Transferring			Joint Motion		
Eating/Feeding					
Bowel					
Bladder					

Category 1: Three Requirements

- D in 2 – 4 ADLs; **and**
- D or d in behavior pattern and orientation; **and**
- **Either:**
 - d in joint motion; **or**
 - D in medication administration

Category 2: Two Requirements

- D in 5 – 7 ADLs; **and**
- D in mobility

Category 3: Three Requirements

- d in 2 – 7 ADLs; **and**
- D in mobility; **and**
- D in behavior and orientation

If an applicant meets one of the above categories, the last question is whether there exists a medical nursing need. A medical nursing need means one of the following:

1. The individual's medical condition requires observation and assessment to assure evaluation of needs due to an inability for self-observation or evaluation;
2. The individual has complex medical conditions that may be unstable or have the potential for instability; **or**
3. The individual requires at least one ongoing medical or nursing service.

INCOME ELIGIBILITY FOR MEDICAID COVERAGE OF LONG-TERM CARE

➤ **Individual applicant for long-term care:**

- An applicant for long-term care is eligible if her income is less than 300% of the SSI limit (\$2,250 per month in 2018). If her income exceeds that amount, she must qualify on an income spend-down.
- A nursing home resident generally must pay all of her income toward the nursing home bill except \$40 per month (the personal needs allowance which increased from \$30 to \$40 in July 2007 and is not adjusted annually). If the person is expected to return to her home in the community within six months and is responsible for shelter costs, she is entitled to a home maintenance deduction equal to the monthly medically needy income limit (between \$311.20 and \$466.80/month depending on the jurisdiction) to pay the mortgage or rent. M1470.240 and M0810.002A.4.
- A community-based care recipient on a waiver may keep \$1,238 per month in 2018 for his personal needs. M1470.410. The personal needs allowance changes annually and is calculated at 165% of the SSI level, which is \$750/month in 2018 (up from \$735 in 2017).
- Both nursing home residents and CBC recipients may also pay some medical insurance premiums and other medical expenses before contributing the rest of their income for the cost of the long-term care. This amount is called the patient pay obligation.

➤ **When one spouse is receiving long-term care:**

- **Does the community spouse have an obligation to support the spouse that is receiving long-term care?**
 - ❖ The community spouse's income is not deemed to be available to the institutionalized spouse in determining the institutionalized spouse's eligibility for Medicaid. Only the institutionalized individual's income is counted for eligibility and patient pay calculation purposes. M1480.300.B.3.
 - ❖ The community spouse's income is only used to determine whether he or she is entitled to receive an allowance from the institutionalized spouse's income (see section on community spouse's right to support from income of spouse). M1480.300.B.3.
 - ❖ Medicaid no longer requires a financial contribution from the community spouse toward the institutionalized spouse's cost of care. Only any amount that is actually contributed by the community spouse is counted as available.
- **What right to support does the community spouse have from the income of the spouse who is receiving long-term care?**
 - ❖ The community spouse is entitled to keep a minimum of \$2,057.50 per month from the couple's income for her living expenses before any of the couple's income must be used for the cost of the long-term care. This is called the monthly maintenance needs standard. M1480.410.
 - ❖ The community spouse can keep an additional amount, up to the maximum of \$3,090.00 in 2018 (up from \$3,022.50 in 2017), if the community spouse's "shelter" expenses exceed \$617.25. Shelter expenses are rent, mortgage, taxes and insurance, condominium maintenance charges, and the standard utility deduction of \$306.00 in a household with 1 – 3 members and \$381.00 in a household with 4 or more members (effective 10/17). M1480.410.
 - ❖ **Example.** A community spouse receives \$900 per month gross income from a pension and her institutionalized spouse has monthly income of

\$1,500 from Social Security. We will assume that the spouse receiving long-term care will be eligible for Medicaid after meeting a spend-down.

- The community spouse's shelter expenses are mortgage, taxes, and insurance totaling \$437 per month. She is also entitled to the standard utility allowance of \$306, assuming her household is made up of less than 4 members.
 - Her shelter costs are: $\$437 + 306 = \743 per month.
 - Excess shelter allowance is $\$743 - 617.25 = \125.25 .
 - Therefore, the spousal minimum monthly maintenance needs allowance is $\$2,057.50 + 125.25 = \$2,183.25$.
 - This community spouse may keep \$1,283.25 per month of the institutionalized spouse's income in addition to her own income ($\$2,183.25 - \$900 = \$1,283.25$ [This is called the community spouse's monthly income allowance from the institutionalized spouse's income.]
- The spouse receiving long-term care in a nursing home can keep \$40 per month for his "**personal needs allowance**" (the personal needs allowance increased from \$30 to \$40 in July 2007; there is no annual cost of living increase for the personal needs allowance). Generally, after deductions for the community spouse and \$40 for his personal needs allowance (and sometimes a deduction for non-covered medical expenses – see M1470.230), the remainder of the resident's income will be owed to the nursing home as his monthly **patient pay obligation**. In the above example, the institutionalized spouse's patient pay obligation would be \$176.75 ($\$1,500$ income – $\$1,283.25$ income allowance for the community spouse – $\$40$ for the personal needs allowance = $\$176.75$). Individuals without a community spouse may, under some circumstances, also be entitled to a home maintenance deduction (M1470.240) or a dependent child allowance (M1470.220) in the calculation of their patient pay obligation.

RESOURCE ELIGIBILITY FOR MEDICAID COVERAGE OF LONG TERM CARE

Countable Resources. The resource limits refer to the value of property owned by a Medicaid applicant or his spouse that is not exempt.

Individual applicant for long-term care:

- An individual may have no more than \$2,000 in countable assets.
- An individual's home is exempt while he is living there and his former home may be exempt after he leaves it (see section of this outline on exempt resources).
- **Long Term Care Partnership Policies** (M1460.160): If an applicant has an approved Long Term Care Partnership policy issued after 9/1/07 which helps pay for assisted living or long term care services, Medicaid will disregard assets in the Medicaid eligibility determination equal to the dollar amount of benefits which have been paid by the policy to or on behalf of the individual as of the month of application for Medicaid, even if additional benefits are available under the terms of the policy. In other words, if a Medicaid applicant has an approved Partnership policy which has paid out \$100,000 in long term care benefits as of the month the person applies for Medicaid, then \$100,000 of the person's assets will be disregarded in determining Medicaid eligibility. For a policy to be considered a Partnership Policy it must have been issued on or after 9/1/2007; contain a disclosure statement that it meets requirements of § 7702B(b) of the Internal Revenue Service Code of 1986; and provide appropriate inflation protection.

When one spouse is receiving long-term care:

- The community spouse may keep all the exempt resources.
- Nonexempt resources are divided as of the date that one spouse begins receiving long-term care. The community spouse may keep one-half of the couple's countable assets and is entitled to a minimum of \$24,720 and a maximum of \$123,600 of the nonexempt assets in 2018. M1480.231.

- A "resource assessment" should be requested from Social Services whenever one spouse begins receiving long-term care even if the couple has too many assets to qualify for Medicaid immediately. M1480.200. The resource assessment will determine how much of the nonexempt resources the community spouse will be allowed to keep and still qualify the spouse in the nursing home for Medicaid assistance to cover his nursing home care. An explanation of the resource assessment process follows the section on exempt resources.

EXEMPT RESOURCES

Certain resources are not counted for purposes of Medicaid eligibility. The following is a list of the major exemptions.

One automobile, regardless of value, is exempt (M1130.200.A.3).

The Home. (M1130.100, S1130.100 and M1480.220). The home and land surrounding it are exempt if the Medicaid applicant is residing there. For those with income under 80% federal poverty line (FPL), the home and all land adjoining the home lot are excluded. For those with income over 80% FPL, the home lot is excluded and the adjoining property is exempt to the extent the value of the adjoining property (not counting the home lot) is less than \$5,000 or is essential to the dwelling. For a married couple when one spouse is in a nursing home, all the property contiguous to the residence is excluded. M1480.210.B.1, M1480.220.B.2.

A Life Estate in real property generally is exempt, depending on when the life estate was created. If the life estate was created prior to August 28, 2008 or on or after February 24, 2009, the value of the life estate is excluded, whether or not the Medicaid applicant is living on the property. However, a life estate created on or after August 28, 2008 but before February 24, 2009, is a countable resource to the owner unless it is excluded under another real property exclusion. M1110.515.

The former home (M1460.530; S1130.100)

- The applicant's home will continue to remain exempt after he moves away if certain relatives are still living there:
 - His spouse, or
 - His minor dependent child (under age 18 or under age 19 and attending school), or
 - His parent or adult child who is:
 - 65 years of age or older, or disabled per Medicaid disability definition, and;
 - Is dependent on him for shelter (the person is presumed dependent if his income does not exceed the SSI limit); and
 - The parent or adult child has lived in the home for at least one year prior to his moving to a nursing facility.
 - For Medicaid recipients with income less than 80% FPL, the former home may still be excluded if any relative dependent on the shelter lives there, if the resident intends to return home, or if the sale of the home would cause undue hardship, due to loss of housing, to a co-owner. S1130.100, S1130.130, S11 Appendix 2.
- Even if none of the relatives specified in the previous section are living there, a former home is exempt for six months beginning with the month following the month institutionalization begins. M1460.530.
- For nursing facility and Community Based Care patients who meet the requirements for LTC on or after January 1, 2006 and until 1/1/11, if the equity value of the home property exceeded \$500,000, the individual is not eligible for Medicaid payment of LTC services unless the home is occupied by a spouse, a dependent child under 21, or a blind or disabled child of any age. As of 1/1/11, the home equity limit increased and became subject to change annually. Effective 1/1/18 the home equity limit is \$572,000 (up from

\$560,000 in 2017). The home equity limit applied is the limit on the date of application or request for LTC coverage. An individual with substantial home equity who meets all other Medicaid eligibility criteria may be eligible for Medicaid payment of other covered services, but not for LTC services. M1460.150, M1480.015.

Reasonable effort to sell real estate (M1130.140):

Real property is exempt while the Medicaid applicant/recipient is attempting to sell it **if** the Medicaid rules to establish the initial **and** continuing effort to sell are strictly followed. **Note that as of 10/4/16, “current market value (CMV)” equals either the certified appraised value of real estate or its tax-assessed value. Previously, the definition was limited to tax-assessed value. M1110.400.A.1.a.**

- **Initial effort to sell** (M1130.140.B.1)
 - ❖ Property is listed with a real estate agent at current market value **and** the agent verifies that it is unlikely to sell within 90 days due to one of the circumstances listed in the Medicaid Manual; or
 - ❖ At least two realtors refuse to list the property because it cannot be sold at current market value, **and** documentation of the property’s deficiencies are provided; or
 - ❖ Applicant has personally tried to sell the property for 90 days using the methods listed in the Medicaid Manual; or
 - ❖ If an individual who is incompetent owns the property and no general power of attorney exists, court action must be initiated for appointment of a guardian to sell the property—an initial effort to sell is established once the date for a hearing on the guardianship is placed on the court docket and continues until the court authorizes sale of the property or 6 months, whichever is less; or
 - ❖ For jointly owned property, all other co-owners refuse to purchase the applicant's share and at least one co-owner refuses to sell.
- **Continuing effort to sell.** (M1130.140.B.3) Even if property is exempted because the applicant has made an initial effort to sell, he must make a

continuing effort to sell for the property to remain exempt. A continuing effort to sell is made by:

- ❖ Continually renewing a listing agreement at no more than 100% of the tax-assessed or certified appraised value until the property is sold.
- ❖ If two realtors have refused to list the property, the Medicaid recipient must personally try to sell the property.
- ❖ If an applicant has personally advertised the property for one year without success (efforts to sell must make up at least 90 days in the 12 month period), the applicant must then list with a real estate agent at or below current market value, OR show evidence that two realtors have refused to list it because it is unsaleable in at market value.
- ❖ For jointly owned property that the co-owners have refused to sell, a partition suit must be filed within 60 days to have a court order the property sold; the continuing effort to sell will continue until the property is sold or 9 months, whichever is less. Any period in excess of 9 months to sell is not considered to be reasonable and the property loses this exemption.

Household goods and personal effects are exempt. (M1130.430).

- Household goods are items of personal property customarily found in the home, such as appliances, furnishings, etc.
- Personal effects are things that are worn or carried or that have an intimate relation to the individual, such as clothing, jewelry, prosthetic devices, and educational or recreational items such as musical instruments, books, hobby materials, etc.

Life Insurance (M1130.300).

- Term insurance (no cash value) is exempt.
- Policies with cash surrender value are not exempt unless the total face value of all policies with cash surrender value is less than \$1,500. However, these

policies will reduce the amount that can be set aside as burial funds. If the policies are not exempt, the cash surrender value of the policies will be counted toward the resource limit.

Burial Expenses (M1130.400).

- Cemetery plots are exempt.
- “**Burial space items**” are exempt regardless of value. (M1130.400). The following are burial space items:
 - ❖ Gravesite, crypt, mausoleum, casket, urn, niche, or other "repository of bodily remains";
 - ❖ Necessary and reasonable improvements such as vaults; headstones, markers or plaques; burial containers (e.g., for the casket);
 - ❖ Arrangements for opening and closing of the gravesite; and a contract for care of the gravesite.
 - ❖ The applicant does not have to purchase the burial space items and store them at his home. He may sign a contract with a burial provider (e.g., a funeral home) for a burial space to be held for him. The burial space item will be "held for" him when he obtains title to the burial space, or when he signs a contract with a funeral service company for the burial space item. He must pay for the item *in full* for it to be "held for" him and therefore exempt.

Burial Funds. (M1130.410).

- An individual applicant may set aside up to \$3,500 for "burial funds" as exempt.
- If one spouse is receiving long-term care, each spouse may only set aside \$1,500 for completion of the resource assessment and calculation of the spousal share. M1480.210.B.1 and M1480.220.B.2. However, after the resource assessment is completed, the institutionalized individual is considered an individual for eligibility and can set aside up to \$3,500 for burial. M1480.230.B.1.

- Types of burial funds:
 - ❖ Cash
 - ❖ Financial accounts
 - ❖ Revocable burial contracts
 - ❖ Revocable burial trusts
 - ❖ Other revocable burial arrangements, including the value of installment sales contracts for burial space
 - ❖ Other financial instruments *with a definite cash value*, for example, stocks, bonds, certificates of deposit, life insurance policies, etc.; or
 - ❖ Irrevocable burial trust established on or after August 11, 1993.

- These "burial funds" must be explicitly designated as such, and must not be mixed together with other funds. Any appreciation on burial funds, such as interest on a bank account, is also exempt. M1130.410.C.2 and C.3

- An applicant may not be able to use the full exemption if he owns other insurance or trusts that are intended to pay for burial expenses. The burial fund exemption is reduced by:
 - ❖ The face value of any non-term life insurance policies whose cash value is not counted as a resource (total value less than \$1,500);
 - ❖ The value of any burial insurance or burial contract (excluding the value of any burial space items);
 - ❖ Amounts placed into an irrevocable burial trust for burial expenses that are not for burial space items. (M1130.410.C.1.b).

Long-Term Care Partnership Policies (M1460.160)

- A Long-term Care Partnership Policy is a type of Long Term Care insurance which helps pay for assisted living or long-term care services. If a policy was issued after 9/1/07 and it meets certain IRS and inflation protection provisions, a LTC policy may qualify as a Partnership Policy.
- A person who has a qualifying Partnership Policy is allowed a disregard of assets in the Medicaid eligibility determination which is equal to the dollar amount of benefits paid to or on behalf of the individual as of the month of application, even if additional benefits remain payable under the terms of the policy.

When and How is a Resource Assessment done?

- ❖ A resource assessment must be completed when an institutionalized spouse with a community spouse applies for Medicaid coverage of long term care services and may also be requested, without a Medicaid application, to determine the spousal share of the couple's countable resources. It is a compilation of the couple's reported resources which existed at the first moment of the month when the first period of institutionalization began and calculates both the couple's total countable resources at that point and the spousal share of those countable resources. M1480.200.A.
- ❖ Total all nonexempt assets owned by the couple at the beginning of the first continuous period of institutionalization (receipt of 30 consecutive days of care in a medical institution or CBC services). See the section of this outline on exempt resources.
- ❖ Property owned by either spouse is counted, if it is not exempt, even if it is in the name of the community spouse only.
- ❖ The community spouse may keep one-half of the nonexempt resources, but not less than \$24,720 or more than \$123,600 in 2018 M1480.231. This is called the resource allowance or the spousal protected resource amount.
- ❖ In addition to the resource allowance for the community spouse, the institutionalized spouse may keep \$2,000 in nonexempt resources.
- ❖ ***Example of a resource assessment.*** On the day husband enters a nursing home, he and his wife own the following assets: one car, their home, \$23,000 in a bank account in his name only, \$9,000 in a bank account in her name only, and a life insurance policy with cash value of \$2,000.
 - The resource assessment finds countable assets totaling \$34,000 (both bank accounts plus the insurance policy).
 - The car and the home are exempt. All of the rest of the assets are included no matter whether they are in the name of the institutionalized spouse or not.

- One half of \$34,000 is \$17,000; however, the community spouse is entitled to keep a minimum of \$24,180 for her resource allowance.
 - The value of the rest of the nonexempt resources is \$9,280 (\$34,000 - \$24,720). Because this is more than the \$2,000 resource limit for the institutionalized spouse, the husband is not yet eligible for Medicaid, but will be as soon as he reduces his resources to less than \$2000.
- ❖ All nonexempt resources owned by the spouse receiving long-term care, including jointly-owned property, must be transferred out of his name into the name of the community spouse within 90 days of the initial determination of Medicaid eligibility or the resource will be counted in determining eligibility after the 90-day protected period. (M1480.240).

RESOURCE TRANSFERS (M1450.000)

A Medicaid applicant (*or his spouse*) who transfers ownership of his property within the “look back period” without receiving adequate compensation may be ineligible for Medicaid to pay for long-term care during a penalty period. ***There is no transfer penalty imposed on Medicaid eligibility for care other than long-term care.***

Look-back period (M1450.003.J):

- This is the length of time, prior to the month in which a Medicaid application is made, that uncompensated transfers will be examined to determine whether any penalty periods apply.
- For applications processed on or after July 1, 2006, for transfers made on or after February 8, 2006, there is a 60 month look-back period. For applications processed before July 1, 2006 for transfers made before February 8, 2006, the look-back period was generally 36 months (except that for transfers to or from a trust created after August 10, 1993, the look-back period was 60 months).
- Example. If a Medicaid applicant transferred her home to her daughter in January 2006, she would only need to wait 36 months before she could apply for Medicaid coverage of long term care, without potentially incurring a penalty. However, if an applicant transferred her home in March 2006, she would need to wait at least 60 months from March 2006 to apply for Medicaid

coverage of long term care in order to avoid a possible transfer penalty (unless one of the transfer exceptions applies).

Uncompensated value (M1450.610):

- The penalty applies if property is given away or sold for less than its fair market value.
- For purposes of calculating the penalty period, fair market value of real estate is the tax-assessed value or, as of 10/4/2016, the certified appraised value. M1450.610.H.2 and 12VAC30-40-240.B.1.
- Uncompensated value is the difference between the fair market value of the property and the compensation received for the transfer after liens or other encumbrances have been satisfied.
 - If an individual gives away his home and retains a life estate, the value of the property transferred is determined as follows: The fair market value of the home, less any liens such as a mortgage, less the value of the life estate.
 - **Example.** Mrs. Smith, who is 60 years of age, transferred her home to her friend in January 2007 as a gift, but she reserved a life estate in the home for herself. The tax-assessed value of the home was \$100,000 and \$10,000 is owed on the mortgage. The value of the property transferred would be determined as follows: \$100,000 - \$10,000 (amount owed on the mortgage) - \$55,868 (value of the life estate) = \$34,132 in uncompensated value.
- However, if property is sold for less than fair market value due to foreclosure, or if property is ordered to be sold at a judicial sale or a court has approved the sale of property for less than fair market value, the sale is considered a compensated transfer and is not subject to the transfer penalty. M1450.400.

Penalty period (M1450.600, M1450.630):

- The length of time an applicant will be ineligible for Medicaid coverage of LTC is based upon the uncompensated value of the transferred property.
- If an applicant is applying for long-term care, the uncompensated value of the transferred property is divided by the average monthly cost of nursing home care (at the time of application for Medicaid) to determine the penalty period. Effective 7/1/2018, the average cost of nursing home care is \$9,032 in the northern region of Virginia and \$6,422 in the rest of the state (up from \$8,367 and \$5,933, respectively). M1450.630.D.
 - ❖ *Example.* Mrs. Jones, who lives in Richmond, gives her daughter \$35,000 in July 2018. Assuming she applies before her five year “look back” period, she is ineligible for Medicaid to pay for long-term care for 5.45 months (35,000 divided by 6,422 = 5.45). Under current law, for transfers made after February 8, 2006, the fractional number is rounded down to the day when the penalty period is calculated.

Timing of the penalty (M1450.630):

- For transfers made on or after February 8, 2006, the period of ineligibility begins “when the individual would otherwise be eligible for Medicaid coverage for LTC services if not for the penalty period.” M1450.630.A.
- *Example.* Mrs. Jones (see above) would be ineligible for Medicaid to pay for long-term care for 7.06 months after she would otherwise have been eligible for Medicaid coverage of long term care services, but for the transfer penalty period. In other words, the penalty period does not begin to run when the transfer occurs but only when she would be eligible for Medicaid coverage of long term care services except for the transfer penalty. **Remember, if she meets all other Medicaid eligibility requirements, Mrs. Jones would be eligible for Medicaid payment for all other Medicaid covered services (other than LTC) during the penalty period.**

Exceptions to the transfer penalty (M1450.300, M1450.400):

Certain transfers do not trigger the penalty, including:

- A transfer to a spouse or to a blind or disabled child or to a child under the age of 21.
- The transfer of an automobile or household goods (M1450.300).
- The transfer of a home if it is transferred to:
 - ❖ A brother or sister who has an equity interest in the home **and** who was residing in the home for at least one year immediately before the nursing home resident began living in the nursing home (or began receiving community-based care); or
 - ❖ An adult son or daughter who was residing in the home for at least two years immediately before the nursing home resident entered the nursing home **and** who provided care during that two-year period that kept the parent out of a nursing home. See M1450.400.C.3 for the proof that is needed to meet this exemption.
- Transfers into certain trusts.
- Transfers made with the “intent to receive adequate compensation.”
- Transfers for reasons other than to become eligible for Medicaid.
- If property is sold for less than fair market value due to foreclosure, or if property is ordered to be sold at a judicial sale or a court has approved the sale of property for less than fair market value, the sale is considered a compensated transfer and is not subject to the transfer penalty. M1450.400.
- Purchase of a life estate in another’s home on or after 2/8/06 may be considered a penalizing transfer unless the purchaser resides in the home for at least 12 consecutive months. M1450.545.

- Purchase of an annuity on or after February 8, 2006 may be considered an uncompensated transfer unless the state is named as the remainder beneficiary as set out in M1450.520.B and, among other requirements, it is shown to be actuarially sound, is irrevocable and non-assignable, and provides for equal payments with no deferral and no balloon payment. M1450.520.
- Purchase of a promissory note, loan or mortgage on or after 2/8/06 may be considered an uncompensated transfer unless it has a repayment term that is actuarially sound, provides for payments to be made in equal amounts during the term of the loan with no deferral and no balloon payments, and prohibits cancellation of the balance upon the death of the lender. M1450.540.
- Virginia DMAS has determined that transfers with a cumulative value of less than \$1,000 per year will not be penalized and transfers with a cumulative value of \$1,000 to \$4,000 per year may not be penalized if a pattern of giving for at least 3 years prior to applying for Medicaid coverage of LTC can be documented. M1450.400.H.
- The penalty period may be reduced or eliminated by the partial or complete return of the transferred assets or their fair market equivalent. M1450.640.
- **Claim of Undue Hardship** (M1450.700). A penalty may not be imposed if the individual claims and proves “undue hardship”—that the penalty would deprive the individual of medical care such that his health or life would be endangered or that the penalty would deprive the individual of food, clothing, shelter or other necessities of life. The individual must also prove that the transferred resource cannot be recovered and that there would be an immediate adverse impact, such as removal from the institution or being unable to receive life-sustaining medical care, food, clothing, shelter or other necessities of life. M1450.700. An applicant, recipient, authorized representative, or a nursing facility authorized by the resident or his authorized representative, may submit a claim of undue hardship. Certain documentation must be provided when requesting an undue hardship claim. M1450.700.B.1.a. Denial of a claim of undue hardship may be appealed. M1450.700.1.e. In the past, policy suggested that only one undue hardship claim for a particular transfer would be considered by DMAS. In 2017, DMAS clarified its policy: after a claim is denied, DMAS will consider another claim based on the same transfer in the event of a change in circumstances (for example, receiving a discharge notice,

becoming unable to receive life-sustaining medical care, food, clothing, shelter or other such necessities) while still in the penalty period. M1450.700.B.3.

- If an undue hardship claim is approved and the amount of the uncompensated transfer is \$25,000 or more and was made within 30 months of the individual becoming eligible for or receiving Medicaid LTC, DMAS may seek recovery from the transferee. M1450.810.B; Va. Code 20-88.02.