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VIRGINIA MEDICAID

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THE BASIC RULES OF NURSING HOME MEDICAID ELIGIBILITY
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For all practical purposes, in the United States the only "insurance" plan for long-term institutional care is Medicaid. Medicare only pays for approximately 2% of skilled nursing care in the United States. Private insurance pays for even less. The result is that most people pay out of their own pockets for long-term care until they become eligible for Medicaid. While Medi**care** is an entitlement program, Medi**caid** is a form of welfare - or at least that is how it began. So to be eligible, you must become "impoverished" under the program's guidelines.

Despite the costs, there are advantages to paying privately for nursing home care. The foremost advantage is that by paying privately, an individual is more likely to gain entrance to a better quality facility. The obvious disadvantage is the expense; in Northern Virginia, nursing home fees average $8,000 per month. Without proper planning, nursing home residents can lose the bulk of their savings.

For most individuals, the object of long-term care planning is to protect savings (by avoiding paying them to a nursing home) while simultaneously qualifying for nursing home Medicaid benefits. This can be done within the following rules of Medicaid eligibility.

The Medicaid program is a partnership of the federal government and the state government. Each state submits its Medicaid program to the federal government for approval. After approval, the federal government assists with the funding of the state Medicaid program. Every state program is different and the differences between the state programs are significant. This explanation is a summary of the Virginia program. The programs of other states will differ.

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THE ASSET RULES

In Virginia, Medicaid is administered by the Department of Medical Assistance. Eligibility is determined by the Department of Social Services (the "DSS"). In order to qualify for federal reimbursement, however, the state program must comply with applicable federal statutes and regulations. So the following explanation includes both Virginia and federal law as applicable. The basic rule of nursing home Medicaid eligibility is that an applicant, whether single or married, may have no more than $2,000 in "countable" assets in his or her name. "Countable" assets generally include all belongings except for (1) personal possessions, such as clothing, furniture, and jewelry, (2) one motor vehicle without regard to value, (3) the applicant's principal residence, (4) property used in a trade or business, (5) certain prepaid burial arrangements, (6) term life insurance policies, (7) a life estate in real property, and (8) assets that are considered inaccessible for one reason or another ("Excluded Resources").

The Home

The home will not be considered a Countable Resource and, therefore, will not be counted against the asset limits for Medicaid eligibility purposes as long as the applicant's spouse or other dependent relative lives there. If there is not a spouse or dependent living in the home, then the house may still be exempt for up to six months after the owner enters institutional care.

THE TRANSFER PENALTY

The other major rule of Medicaid eligibility is the penalty for transferring assets. Under the old rules (pre-2/8/06), if an applicant (or his or her spouse) transferred assets, he or she would be ineligible for Medicaid for a period of time beginning on the date of the transfer. Under the new rules, the period of ineligibility does not begin to run until the applicant would be otherwise eligible for Medicaid - so after being otherwise spent down. This new rule greatly restricts the use of gifts in planning.

The actual number of months of ineligibility is determined by (1) dividing the amount transferred by the average monthly nursing home cost in Virginia as determined by the DSS, and (2) rounding the result down. Effective July 1, 2011, the DSS has set that cost at $7,734 per month for the counties of Arlington, Fairfax, Loudoun and Prince William and the cities of Alexandria, Fairfax, Falls Church, Manassas and Manassas Park (the rest of the state uses a figure of $5,933). For example, if an applicant in Northern Virginia made gifts totaling $70,000, he or she would be ineligible for Medicaid for 9 months ($70,000 ÷ $7,734 = 9.05). Another way to look at this is that for every $7,734 transferred, an applicant will be ineligible for Medicaid nursing home benefits for one month.

Under the old rules (pre-2/8/06), transfers made more than 36 months before application for Medicaid were not considered (60 months in the case of some trusts). This is called the "look-back"

period. That period has now been lengthened to 60 months in all cases.

Exceptions to the Transfer Penalty

Transferring assets to certain recipients will not trigger a period of Medicaid ineligibility. These exempt recipients includes:

(1) A spouse (or anyone else for the spouse's benefit);
(2) A blind or disabled child;
(3) A trust for the benefit of a blind or disabled child; or
(4) A trust for the benefit of a disabled individual under age 65 (even for the benefit of the applicant under certain circumstances).

Special rules apply with respect to the transfer of a home. In addition to being able to make the transfers without penalty to one's spouse or blind or disabled child, or into a trust for other disabled beneficiaries, the applicant may freely transfer his or her home to :

(1) A child under the age of 21;
(2) A sibling who has lived in the home during the year preceding the applicant's institutionalization and who already holds an equity interest in the home; or
(3) A "caretaker child", who is defined as a child of the applicant who lived in the house for at least two years prior to the applicant's institutionalization and who during that period provided such care that the applicant did not need to move to a nursing home.

Recently enacted legislation provides a very important escape hatch considering the transfer penalty. A transfer can be cured by the return of the transferred asset in its entirety. Returning even one dollar less than the original gift will provide no cure.

LIENS AND ESTATE RECOVERY

Virginia does not place liens against a beneficiary's property. After the beneficiary's death, the State has the right to recover from his or her estate whatever benefits it paid for the care of the Medicaid recipient. The definition of "estate" includes (1) all real and personal property and other assets held by the individual at the time of death, and (2) any other real and personal property and other assets in which the individual had any legal title or interest (to the extent of such interest) at the time of death. This definition is very broad and would appear to include life estates and jointly owned property.

The state can NOT initiate estate recovery if the beneficiary is survived by his spouse or a

dependent or disabled child.

TREATMENT OF INCOME

When a nursing home resident becomes eligible for Medicaid, all of his or her income, less certain deductions, must be paid to the nursing home. The deductions include a $30 per month personal needs allowance, a deduction for any uncovered medical costs (including medical insurance premiums), and, in the case of a married applicant, an allowance he or she may pay to the spouse that continues to live at home.

SPOUSAL PROTECTIONS

Assets

Assets of a married applicant, the applicant's spouse, and any joint assets are all considered to be available resources to the applicant. Medicaid law provides for special protections for the spouse of a nursing home resident, known in the law as the "community" spouse. Under the general rule, the spouse of a married applicant is permitted to keep one-half of the couple's combined assets (as of the date of institutionalization) up to $115,920 (the "Community Spouse Resource Allowance"). In addition, there is a minimum resource allowance for the community spouse of $23,184.

So, for example, if a couple owns $90,000 in countable assets on the date the applicant enters the hospital, he or she will be eligible for Medicaid once their assets have been reduced to a combined figure of $47,000 ($2,000 for the applicant plus $45,000 (one-half of $90,000) for the at-home spouse). If the couple owned $200,000 in assets, the spouse in need of care would not become eligible until their savings were reduced to $117,920 ($2,000 for the nursing home spouse plus a maximum of $115,920 for the community spouse).

The determination of the level of the couple's assets is made as of the date of institutionalization of the nursing home spouse. That date is the day on which he or she enters either a hospital or a long-term care facility in which he or she then stays for at least 30 days. It is advantageous for the couple to try to have as much money as possible in their names on that date up to $231,840 ($115,920 times 2) so that the amount the community spouse is allowed to keep will be as high as possible.

Income

Except as described in the following paragraph, the income of the community spouse will continue undisturbed; he or she will not have to use his or her income to support the nursing home spouse receiving Medicaid benefits. In some cases, the community spouse is also entitled to share

in all or a portion of the monthly income of the nursing home spouse. The DSS determines an income floor for the community spouse, known as the Minimum Monthly Maintenance Needs

Allowance (MMMNA). The MMMNA (as of July 1, 2013) is calculated as follows:

(1) $1,939 plus
(2) An excess shelter allowance equal to the amount by which the following expenses exceed $568; to include rent, mortgage payments, taxes, insurance and utility standard of $274 ($345 if household is 4 or more)
(3) The MMMNA cannot exceed $2,898 unless a court orders support a greater amount.

The MMMNA may range from a low of $1,939 per month to a high of $2,898 per month. If the community spouse's own income falls below his or her MMMNA, the shortfall can be made up from the nursing home spouse's income.

In years past, the DSS was required to inform a community spouse of his or her legal obligation to provide support. If the community spouse's monthly gross income exceeded $1,700, the DSS was required to pursue a contribution from the community spouse toward the cost of the institutional care. That contribution by the community spouse is no longer required.

Increased Resource Allowance

Those community spouses whose own income is less than their MMMNA have an alternative to receiving the shortfall from the nursing home spouse. Instead, they may petition the DSS for an increase in the standard resource allowance so that these additional funds may be invested in order to generate income to make up the shortfall. Given current low rates of return, this often can permit the community spouse to retain a substantial level of savings. In some instances, even with the award of the higher resource allowance, the community spouse will need to draw on the nursing home spouse's income to some extent. Unfortunately, the DSS may not award an increased resource allowance upon application. The intake worker must award the standard allowance described above, and the applicant must appeal the determination through a fair hearing.

THE MEDICAID APPLICATION

You may obtain an application for Medicaid benefits from the DSS for the city or county in which you live. Applicants must report all assets under the penalty of perjury. The DSS considers an application for Medicaid benefits for nursing home care as a priority. They will approve or deny the application within 45 days of the date on which you complete the application. You have the

right to appeal adverse determinations.

The Medicaid Eligibility rules are complex. Errors are easily made which will result in delayed eligibility. All entries on the application must be accompanied by supporting documentation.

Many applicants will benefit from legal assistance by an Elder Law Attorney in the application process. In addition, after Medicaid eligibility is achieved, it must be redetermined every year.

PRESERVING RESOURCES AND INCOME

An experienced Elder Law Attorney can assist a senior in qualifying for Medicaid assistance while preserving assets and income for the senior's community spouse, dependent children, disabled children or other family members. Medicaid planning includes:

(1) Maximizing the Community Spouse Resource Allowance and the Minimum Monthly Maintenance Needs Allowance;
(2) Identifying and maximizing Excluded Resources;
(3) Transferring assets (both exempt and nonexempt) to the community spouse and other family members;
(4) Converting countable resources into Excluded Resources;
(5) Converting resources into income for the community spouse;
(6) Calculating penalty periods;
(7) Preparing legal instruments, including wills, special needs trusts, powers of attorney, deeds, private annuities and personal care contracts to implement or facilitate the Medicaid Plan;
(8) Providing advice about the timing of and implementation of planning strategies;
(9) Assisting with resource assessments and the Medicaid application.

Some of the strategies considered in Medicaid planning are:

(1) Transferring of the home and Community Spouse Resource Allowance solely into the name of the community spouse;
(2) Converting liquid assets into Excluded Resources, for example: (a) buying a home, (b) repairing or improving the home, (c) purchasing a car, (d) prepaying real estate taxes and homeowner's insurance and (e) paying outstanding debts;
(3) Transferring assets to family members, but retaining sufficient assets to pay for long-term care during the period of ineligibility(now 5 years);
(4) Purchasing an annuity payable to the community spouse;
(5) Compensating family members performing significant personal services pursuant to a written agreement.
(6) Borrowing money prior to the snapshot date to increase the Community

Spouse Resource Allowance

The timing of the implementation of these strategies is frequently important to maximize the Community Spouse Resource Allowance where a couple owns countable assets having a value of less than twice the maximum Community Spouse Resource Allowance. This is accomplished by timing the implementation of some strategies after the institutionalized spouse enters the nursing home and a Resource Assessment has been obtained.

When one member of a family enters a nursing home, the estate plans of the community spouse and other family members may need revision to ensure that the institutionalized family member is not disqualified if the community spouse or other family member dies first and leaves the institutionalized family member an inheritance. The community spouse or other family member's will should be revised to provide that any gift to the institutionalized family member is left in a special needs trust.