Basic Long-Term Care Medicaid Planning: A Focus on Protecting the Spouse

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I. What is the average cost of care?

According to a 2019 Cost of Care survey published by Genworth (Appendix A), the Virginia State-Specific Cost of Care is as follows:

Home Health Aide services, averaging $52,584 a year

Calculated based on 44 hours a week (not evenings, nights or weekends)

Adult Day Health Care, averaging $19,236 a year

Calculated based on five days a week

Assisted Living Facility Monthly Rate-$4,800 Median, $57,600 a year

Nursing Home Daily Rates-$241 Median, $88,200 a year for Semi-Private

Nursing Home Daily Rates-$270 Median, $98,556 a year for Private

Average length of stay considered to be 2 years 3 months, but varies widely, that would be $221,751 for a private room, without adjusting for inflation

To cover a "look back period" of five years you would need $492,780 per person set aside for facility expenses only

II. What are some options when planning for these expenses?

Savings and Investments

Long Term Care Insurance and Hybrids

Qualified Annuities

IRAs and Pensions

Gifting to Trusts

Veteran's Aid and Attendance

Medicaid

III. What is Medicaid?

Medicaid is a joint federal and state program of medical assistance to eligible needy persons. Medical services are provided by participating providers (i.e. Nursing Homes) reimbursed according to state formulas. Medicaid covers a variety of medical benefits as determined by each state and there are various categories of persons who may be eligible. In Virginia, Medicaid eligibility is determined by the local offices of the Department of Social Services (DSS). The DSS workers perform resource assessments and process Medicaid applications for category eligible applicants residing in their given locality.

A. WHAT ARE THE MEDICAID ELIGIBILITY REQUIREMENTS FOR LONG-TERM (NURSING HOME) CARE?

In the Commonwealth of Virginia there are three basic requirements for Medicaid applicants to be eligible for Medicaid to aid in the financial assistance of the payment of nursing home care. The three requirements are:

1. Aged/Disabled. The elderly (65 and over) represent a category of people who are potentially eligible for Medicaid assistance. If the Medicaid applicant is not 65 or older, they are not eligible for Medicaid unless they are in another category of eligible persons (i.e., disabled).

2. Need. The Medicaid applicant must be in need of skilled or intermediate care from a nursing home that participates in the Medicaid program. If the applicant is healthy enough to be in a custodial care environment, they are not qualified for Medicaid.

3. Impoverishment. Prior to eligibility for Medicaid, the applicant must be impoverished which means owning no more than $2,000 of asset value in his or her own name.

The third eligibility requirement relating to impoverishment causes most Medicaid applicants and their families the greatest concern. Reaching the required level of impoverishment, while at the same time preserving the financial life of a "well" spouse who may remain in the community is of utmost importance to families facing the situation of placing a spouse, parent or parents in a nursing home. The Medicaid qualification process is most easily dealt with by families through becoming familiar with the resource assessment and spend down provisions of the Medicaid eligibility laws.

B. ASSETS/RESOURCES

When Medicaid is needed to help cover the costs of nursing home care, a review of assets or resources owned by the applicant and applicant's spouse is required to determine a Medicaid applicants ***countable*** and ***exempt*** resources. This review is referred to as a ***Resource Assessment***. Except for exempt resources and the Community Spouse Resource Allowance (both described below), all other resources owned by the applicant and the applicant's spouse must be used toward payment of nursing home costs before Medicaid assistance will be available. In addition to exempt resources, Medicaid applicants/recipients may have the following dollar amounts in countable resources and still qualify for Medicaid assistance:

1. Individual - just $2,000.00 (2020)
2. Couple - just $3,000.00 (2020) (only if both spouses apply)

The Medicaid applicant/recipient's spouse is entitled to the use of the exempt assets and can somewhat preserve their own financial independence by claiming their Community Spouse Resource Allowance from the non-exempt asset list as later described herein.

See Appendix B for more figures and information regarding Medicaid income and asset limits.

C. RESOURCE ASSESSMENT AND SPEND-DOWN

Resource assessments are obtained through the Department of Social Services (DSS) office. A resource assessment can be requested only after the potential nursing home spouse enters the nursing home with the intent to remain there. A resource assessment may be sought at the time the potential nursing home spouse enters the nursing home or at a later date. The resource assessment is used by DSS to determine when a person becomes eligible to receive Medicaid by separating all assets into two lists identifying countable and exempt assets. All countable assets determine what is available for use or "spend down" by the potential nursing home spouse prior to becoming eligible for Medicaid assistance. Spend down requires the spending of the nursing home spouse's share of countable, non-exempt assets down to the $2,000 asset limit. The spend down includes the payment of nursing home costs, but can also include the purchase of exempt assets for the benefit of the Community Spouse (i.e., burial funds, home, car, personal property).

Although the income of a spouse is not deemed the applicants, married persons are considered to have available to them all resources held by their spouses. Countable assets are assets for which there is a meaningful possibility that they could be sold or otherwise converted into cash. All but $2,000 of countable assets must be spent before client will be eligible for Medicaid. If married, the community spouse will receive a notice of Medicaid resource assessment which will state the spousal share for the community spouse. The spousal share is the minimum value of assets which the community spouse may retain and protect from the necessary resource reduction before the institutionalized spouse achieves eligibility. The spousal share is determined by adding the couple's joint and individual countable resources and dividing them by two. The spousal share for 2020 is subject to a minimum amount of $25,728.00 and a maximum of $128,640.

D. ASSET SNAPSHOT

Regardless of the actual date a Medicaid applicant files a Medicaid application, eligibility will be determined by reviewing assets owned by the applicant and the applicant's spouse on the date of institutionalization. Institutionalization is considered to begin upon the first day of the month of entry into a nursing home. It is at that date that the DSS eligibility workers obtain what is referred to as a "***snapshot***" of the combined spousal resources for a determination of eligibility for Medicaid assistance. It would be prudent to request the resource assessment at the time of institutionalization in order to avoid later having to verify the assets owned on that date on a retroactive basis.

A resource is any property which a person owns; has the power to convert to cash; and is not legally restricted from using for his/her support and maintenance. It makes no difference at all which spouse owns it.

Examples of contrast between available assets and unavailable/income: Pension vs 401k, Whole life insurance vs Annuity, Traditional trust vs "Income Only" trust

Retirement Plans

Retirement plans can be counted as both an income stream AND a resource. Generally, retirement plans will need to be converted in some way to qualify, or simply spent down. If you have a large retirement plan and your spouse has very little income, look at ways to maximize the community spouse

resource allowance, and the income stream for your spouse. Contrary to what some believe, retirement plans are not exempt assets for Medicaid purposes.

E. EXEMPT RESOURCES

Certain resources of the Medicaid applicant spouse (herein sometimes Nursing Home Spouse) and the non-applicant spouse (herein "Community Spouse"), regardless of how they are owned, ***will be exempt*** from the spend-down requirement. It is essential to maximize the value of exempt resources. Exempt resources in determining an applicant's Medicaid eligibility, include the following:

1. ***Residence and all contiguous property***, provided that the residence is the home of the non-applicant spouse, or a minor child, or a permanently disabled child of the Medicaid applicant, the residence (and all contiguous property) is an exempt resource regardless of value, however, if a minor child or permanently disabled child of the Medicaid recipient does not reside in the home, there is an equity cap of $585,000 in order to qualify for Medicaid. ***After six months*** of being in a long-term care facility, the residence of the Medicaid recipient, if it is not occupied by one of the persons listed above, becomes an available resource.

2. ***Personal effects***, including clothing, jewelry, photographs, etc., are exempt resources regardless of value.

3. ***Household furnishings***, including furniture, antiques, paintings, appliances, and electronics are exempt resources regardless of value, but only while being used by or in the operation of the applicant's or the community spouse's home.

4. ***One automobile*** of any value for essential purposes such as transportation to work or for medical care is an exempt resource.

5. ***Term Life Insurance*** (insurance without cash value) is an exempt resource (subject to some limitations).

6. ***Cash Value Life Insurance*** with a face value up to $1,500 is exempt. If face value of all policies is over $1,500 total then the cash value is counted as a resource.

7. ***Certain income producing real estate***, specifically business and farm use real estate, as long as such property is producing income, can be retained, and non-business/non-farm income producing real estate with equity (value in excess of debt) of up to $6,000 is exempt if it is used to produce goods or services essential for consumption by the applicant's household or if it produces a return of at least 6% on the equity. Any income must be used to offset Medicaid expenses.

8. ***Lump sum insurance payments*** may be exempt depending upon the circumstances (e.g., house or other exempt property is destroyed and there is a lump sum insurance payment, which will be exempt if reinvested to replace the exempt property).

9. *Life estates* held in residential real property, as long as the purchaser who is a potential Medicaid applicant lives in the home for at least a year. For example, if a potential Medicaid applicant (whether it be a spouse or individual who later has to be institutionalized or the community spouse) moves in with his or her child, they can purchase a life estate in that child's house, as long as they live there for at least a year. Not only is the life estate not a resource, but the purchase is a valid transfer if the price is at fair market value, as opposed to a gift of the money used for purchase.

10. *Burial fund* for each spouse of $1,500.

11. *Burial space items* that are prepaid (e.g., casket, urn, vault, headstone, burial lot).

12. *Irrevocable Burial Contracts* or "pre-need burial contracts" with funeral homes can be used for the burial planning instead of Item #10. These contracts address prepaying funeral costs.

13. *Some annuity contracts*, both private and commercial, are exempt if the annuity provides (i) immediate payments, (i) is irrevocable and non-assignable, (iii) actuarially sound, (iv) provides for payments in equal amounts during the term of the annuity and (v) the state is the primary beneficiary at the death of the Medicaid recipient for at least the amount of medical assistance paid on behalf of the institutionalized spouse, or is the remainder beneficiary after the community spouse or minor child or permanently disabled child so long as that beneficiary does not dispose of that remainder for less than fair market value. The requirement that the state be named remainder beneficiary applies to both the institutionalized and community spouse. Does the policy have a cash value that will be treated as an asset? Can be used to convert a resource to an income stream, which helps in qualification. This is an often-overlooked option, that can be used to preserve income for the spouse, if done carefully.

14. **US EE or I Savings Bonds (this could cover up to $20,000)**

15. **Qualified Promissory Notes***

This list can be used to maximize asset value for the Community Spouse by improvements/repairs to the home and furnishings for Community Spouse, maximize equity*, purchase of accessible vehicle, paying off credit card debt or mortgage loan

All other assets owned by the Medicaid applicant or spouse (however titled) are Non-Exempt Countable Resources and are deemed to be available to the Medicaid applicant for use in the payment of nursing home care costs.

However, in addition to the Exempt Resources, the Community Spouse is allowed to keep a share of the Non-Exempt Resources and this share is referred to as the Community Spouse Resource Allowance, and in addition the Community Spouse is also entitled to benefit from a minimum level of income even if it comes from the Medicaid applicant.

Once assets are exempt and are owned solely by the Community Spouse, they remain exempt and protected for use by the Community Spouse, and the Community Spouse can give or bequeath these assets to family (or whomever they choose).

F. COMMUNITY SPOUSE RESOURCE ALLOWANCE

One-half of **non-exempt** assets (with a minimum of $25,728 and up to a maximum $128,640) can be claimed by the Community Spouse without the requirement of sharing the one-half with, or using the one-half for, the benefit of the nursing home spouse. This share is referred to as the Community Spouse Resource Allowance as follows:

1. Half of the couple's countable resources at the time of institutionalization, ***but not less than $25,728 (minimum community spousal amount for 2019) nor more than $128,640 (maximum community spousal amount 2019)***, will ***not be available*** to the Nursing Home spouse for spend-down if timely converted (as discussed below) into the community spouse's sole name <u>after</u> a resource assessment.

2. For example, if the total countable resources for the community and nursing home spouse equal $100,000 in value, one-half ($50,000) is considered available towards the nursing home spouse's care and must be spent down to $2,000 ($48,000 spend down) prior to the Nursing Home spouse becoming Medicaid eligible. The remaining half is the community spouses' protected "***community spouse resource allowance***". If half of the total countable resources exceed the maximum amount, then $128, 640 would be the protected community spouse resource allowance. The balance over the maximum amount must be allocated to the nursing home spouse and is subject to the spend-down (i.e. down to $2,000), prior to Medicaid eligibility.

3. This community spouse allowance should be transferred to the community spouse (i.e., assets need to be transferred or re-titled into the community spouse's name only) <u>within ninety (90) days</u> from receiving Resource Assessment results from DSS (initial eligibility determination) or at the latest, before the first ***annual determination of assets.***

G. GIFTS OR INHERITANCE RECEIVED BY COMMUNITY SPOUSE AFTER THE RESOURCE ASSESSMENT

Asset resources, such as gifts, inheritances, etc., received by the community spouse <u>after</u> Medicaid eligibility is established for the nursing home spouse will not be considered available as an asset to the nursing home spouse.

H. INCOME

Medicaid regulations in Virginia require that a Medicaid recipient in a nursing home use and apply all income they earn to their bill before Medicaid assistance is made available. The community spouse is entitled to keep all of their own income, but there are exceptions to these requirements as discussed below.

Once eligible for Medicaid, client will be entitled to maintain a small amount of income for personal needs ($40) and funds for medical insurance premiums. If married, a spouse may be entitled to keep all his or her income and, if applicant spouse's income is less than $2,113. 75, he or she will be entitled to that portion of your income needed to raise it to $2,113.75. If you believe that the income allowance is insufficient to meet the spouse's income needs, it may be raised by a hearing, a court order of support, or under the excess-shelter-allowance formula. Expenses considered in determining whether or not to allow a spouse more income under the excess-shelter-allowance formula are: rent, mortgage, taxes, insurance, standard utility charges and any maintenance charges on condominiums. The maximum maintenance needs allowance is $3,216.00.

Income is the Key

Only income of the Medicaid Applicant Spouse ("MS") is counted when considering eligibility

Community Spouse ("CS") may keep all of their own income

I. IMPACT OF GIFTS (ASSET AND MONEY TRANSFERS) TO CHILDREN, ETC.

The Federal Omnibus Budget Reconciliation Act of 1993 (OBRA 93) mandated that all states implement a program of estate recovery for Medicaid costs, which includes both lifetime and testamentary gifts, therefore the state can require a period of ineligibility based on lifetime gifts, and can recover medical expenses from the estate of the Medicaid recipient upon their death.

When an application for Medicaid is entered, any uncompensated transfers of assets by the applicant or spouse (i.e., a transfer or gift of assets by the applicant or spouse for less than fair market value) made within the last five (5) years ("look back period") create Medicaid ineligibility of one (1) month for each $6,422 of value given away during the "look back" period. The $6,422 represents the figure Virginia uses as its statewide average monthly nursing home cost (this amount is higher for Northern Virginia). If the applicant or spouse has transferred assets, the amount transferred is divided by $6,422 at the time an application is filed to determine the months of ineligibility.

For example, a transfer of $50,000 will render a transferor/Medicaid applicant ineligible just under eight (8) months, so for planning purposes it is important for a family to arrange for the payment of medical care expenses during the eight (8) month period.

Resource Reduction

It is important to advise client not to give away property or transfer it for less than fair market value in an attempt to qualify for *Medicaid* eligibility without careful counsel; such action would disqualify client for *Medicaid* for a period equal to a period for which the uncompensated transfer would have paid for nursing home care at the state determined rate. The state determined rate is $9,032 for Northern Virginia and $6,422 for the rest of the state. An uncompensated transfer is a gift or a transfer made for less than fair market value. Certain transfers are valid and would not preclude *Medicaid* eligibility, *e.g.*, transfers between spouses, transfers made for fair market value, and, in certain cases, transfers of your home.

Consequences of A Gift:

1. There is a five year "look-back" period for Medicaid, but none presently for Veteran's Benefits with noted exceptions. The look-back date is the date that is 60 months before the first date the individual is both (a) an institutionalized individual and (b) has applied for Medicaid. The look-back date is the earliest date on which a penalty for transferring assets for less than fair market value can be imposed. Penalties can be imposed for transfers that take place on or after the look-back date. Penalties cannot be imposed for transfers that take place before the look-back date. TIMING OF TRANSFER IS CRITICAL. Medicaid benefits will not be available during the period of ineligibility even if the person making the transfer has to enter a nursing home and otherwise qualifies for Medicaid during the period of ineligibility. Advanced planning is essential to provide for the nursing home expenses/costs during this period.

2. Understand capital gains effects of transfers. - (i.e. - If parent is in bad health, it may not be worth the loss of step-up to remove asset from parent's name.)

3. Not all gifts are prohibited. Certain exceptions-transfers between spouse, to a disabled child, or to a child under the age of 21. Purchases of actuarially sound annuities or promissory notes or other transfers for fair market value excepted, opportunity to convert resources to community spouse income. "Caregiver child" exception.

If you have assets that are extremely important to your family and which would be a hardship if sold, you should consider gifting them to a family member that is likely to remain healthy for a significantly longer period of time, or to the next generation

There are disadvantages to gifting, such as loss of "step up" in basis at death, but if the goal is to keep the property, it may be less of a priority to avoid capital gains and more of a priority to keep it

Report all gifts properly, the annual gift exclusion is $15,000 and the lifetime estate and gift tax exemption is $11.58M in 2020.

Anything gifted by you or your spouse five years within applying for Medicaid is FULLY COUNTED AS A RESOURCE.

J. ISSUES WITH REGARD TO THE HOME AND OTHER REAL PROPERTY:

a. If the client has a spouse, disabled child, child who has been living with parent for two years preceding need for care and provided care to the parent, or a sibling who has ownership in the home, the asset can be protected.

b. Don't have the spouse sell the home before eligibility is established so that it is converted into a non-protected asset. It is usually best to transfer the home into the community spouse's name.

c. Understand that if a house is sold for less than the tax assessed value established by the county, it may constitute a prohibited gift. May be able to use independent appraisal.

d. Carefully advise the client who may come in asking to sign over all their real estate to their children-particularly if more than one child and/or parent, more likely than not, will need care in the next five years.

e. Homes held in living trusts and/or limited liability companies may need to be put back into individual's name.

f. Life Estates are currently exempt so the client may purchase a life estate interest in their child's home provided they can remain there for at least one year. If your client holds a life estate, it is an exempt asset unless it is sold.

g. Home equity is a great planning tool and the value of the home should be maximized. It can provide a source of income or a sellable asset for the spouse if necessary.

K. ESTATE PLANNING ISSUES

1. *Revocable Living Trusts*

Revocable Living Trusts do NOT protect an individual's assets from counting toward resources and income for long-term care Medicaid.

2. *Joint Trusts*

Some joint revocable trusts include language preventing revocation or amendment of the trust at the incapacity of one of the settlors. Although this may be a prudent protection for the disabled spouse, it can become an issue in the Medicaid context. Since the revocable trust is almost always self-settled (the Grantor is also the beneficiary), even if it becomes irrevocable, it will still be treated as a countable asset if the beneficiary can gain access to the principal of the trust during his or her lifetime. This may prevent the transfer of countable assets out of the name of the institutionalized spouse and into the name of the community spouse to maintain eligibility for Medicaid benefits.

3. *Irrevocable Trusts*

Self-settled irrevocable trusts are also treated as available assets as long as the settler has the ability to receive principal from the trust, even if such receipt is at the discretion of a third-party trustee.

4. *Income Only Trusts*

When doing planning at least five years in advance, income only trusts can be an excellent tool. The following items must be considered:

-Must comply with five year look back rule, planning done well in advance.

-Fund with income producing assets.

- Use also counts as income (i.e. real estate or vehicles).

-Principal is irrevocably gifted to beneficiaries-no access at all to settlor/spouse.

-All income to settlor or settlor's spouse.

-Need an Independent Trustee*.

-Have separate tax identification number and must file trust income tax returns.

4. ***Special Needs Trusts ("SNT")***

A Special Needs Trust is not a resource of the beneficiary for Medicaid and SSI purposes. Transfers into a Special Needs Trust are not considered disqualifying transfers of assets. Any non-spousal beneficiary who is dependent on government benefits or who is qualified as disabled by the social security administration should receive any gift or inheritance within a special needs trust to protect their eligibility and the assets being inherited, trust can be set up during your lifetime or as a testamentary trust

What is a Special Needs Trust?

A Trust designed specifically to be excluded from countable resources for the purpose of qualifying for need-based government programs, such as Medicaid.

There are several different kinds of these Trusts that have very different rules and uses.

The assets of a special needs (or supplemental needs) Trust are used to cover the cost of items or services not covered by Medicaid or another similar program, which depending on the circumstances, can be substantial expenses.

Spousal Special Needs Trusts

The rules are different for spouses, since Medicaid looks at the assets of the couple as a whole. Bequests into a special needs trust for a spouse must be testamentary and satisfy spousal elective share requirements in order to avoid being treated as a disqualifying transfer of assets.

All income will go toward nursing home care, principal may be used for supplemental needs, and then at the second death principal passes to the children (or whomever is named).

Therefore, it is possible to provide for the long term care of your spouse by creating a special needs Trust under your Last Will and Testament.

Such a Trust CANNOT be created under a revocable trust.

In Virginia, a spouse must claim the elective share. The nonexercised of that spousal right can be considered an uncompensated transfer.

L. LONG-TERM CARE INSURANCE

Long-term care insurance for nursing home and home health care may be an important planning tool to avoid asset depletion and to minimize the reliance on Medicaid assistance. Special policies integrating asset protection and Medicaid eligibility are available from most insurance companies. The older the applicant, the higher the premium will be. Persons interested in long-term care policies should shop and compare various policies prior to purchasing this insurance coverage to assure themselves the maximum amount of asset protection and the broadest range of nursing home care coverage they are able to afford.
Because the look back period is five (5) years long, a minimum of five (5) year long-term care coverage would help to ensure the ability to pay for a nursing home while waiting out the penalty period if you make significant gifts as part of your estate plan. However, since the income and resource thresholds are very low, and the look back period is subject to change as evidenced by the lengthening of the period from three (3) years to five (5) years in 2006, long-term care that covers a much longer period of

time may be appropriate if you do not have some other form of investment that you will be able to use to pay the high cost of nursing home care. It is important when working with your financial planner to weigh the costs and benefits of long-term care insurance.

M. Marital Rights, Prenuptial Agreements Ineffectual for Medicaid Purposes

In the Commonwealth of Virginia, surviving spouses have a right to up to half of their decedent spouse's augmented estate. Such rights can be waived in a pre-marital agreement HOWEVER, if you are applying for Medicaid, they may count that waiver as a disqualifying transfer if it prevents you from getting support from your spouse or their estate that you would otherwise be entitled to.

If you have signed a premarital agreement, but then your spouse goes into a nursing home, Virginia will STILL include both spouses' assets in the resource assessment, premarital agreement or not.

N. Appeals

If a *Medicaid* application is denied, the applicant has the right to receive written notice of the denial including the reason and specific regulation(s) supporting the denial and an explanation of the right to appeal. A hearing for appeal must be requested within 30 days of the notice of denial.

IV. Veteran's Aid and Attendance

If you are a Veteran, do not forget benefits you may be eligible for through the Department of Veteran's Affairs. Veterans Aid and Attendance can provide up to $2,230 a month toward the cost of home health care, nursing home or assisted living. The spouse of a veteran may also qualify for a lesser amount and you don't need to have a service-related injury if you are over 65. It is income and asset based, but the rules are different from Medicaid.

In addition to disability benefits, the VA offers residential programs, health benefits, and Aid and Attendance, which is similar to Supplemental Security Income(SSI).

If you think you may qualify for Veteran's benefits, plan carefully to make sure you get the most that you can qualify for, it is possible to get some Aid and Attendance while receiving other governmental need based benefits.

For more information I also highly recommend the outline so graciously provided freely online to anyone by R. Shawn Majette at:

http://majette.net/wp-content/uploads/2019/01/Medicaid_Planning_Through_1-10-2019-Update-with-lines-1-12-2019.pdf

Virginia Medicaid Income & Asset Limits for Nursing Homes & In-Home Long Term Care

Last updated: July 17, 2019

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Virginia Medicaid Definition

Medicaid is a wide-ranging, jointly funded state and federal health care program for low-income persons of all ages. That being said, this page is categorically focused on Medicaid eligibility for older Virginia residents, aged 65 and over, and specifically for long term care, whether that be at home, in a nursing home, or in an assisted living facility. In Virginia, the Department of Medical Assistance Services (DMAS) administers the Medicaid program, and one's local Department of Social Services (DSS) determines one's eligibility.

The American Council on Aging now offers a free, quick and easy Medicaid eligibility test for seniors.

Income & Asset Limits for Eligibility

There are several different Medicaid long-term care programs for which Virginia seniors may be eligible. These programs have slightly different eligibility requirements, such as income, assets, and functional ability, as well as differing benefits. Further complicating eligibility are the facts that the criteria vary with marital status and that Virginia offers multiple pathways towards eligibility.

1) Institutional / Nursing Home Medicaid – is an entitlement (anyone who is eligible will receive assistance) & is provided only in nursing homes.

2) Medicaid Waivers / Home and Community Based Services – Limited number of participants. Provided at home, adult day care or in assisted living.
3) Regular Medicaid / Aged Blind and Disabled – is an entitlement (benefits are guaranteed if one meets the eligibility requirements) and is provided at home or adult day care.

The table below provides a quick reference to allow seniors to determine if they might be immediately eligible for long term care from a Virginia Medicaid program. Alternatively, one may take the Medicaid Eligibility Test. **IMPORTANT**, not meeting all the criteria below does not mean one is ineligible or cannot become eligible for Medicaid in Virginia. More.

2019 Virginia Medicaid Long Term Care Eligibility for Seniors

Type of Medicaid	Single			Married (both spouses applying)			Married (one spouse applying)		
	Income Limit	Asset Limit	Level of Care Required	Income Limit	Asset Limit	Level of Care Required	Income Limit	Asset Limit	Level of Care Required
Institutional / Nursing Home Medicaid	$2,313 / month	$2,000	Nursing Home	$4,626 / month	$4,000	Nursing Home	$2,313 / month for applicant	$2,000 for applicant & $126,420 for non-applicant	Nursing Home
Medicaid Waivers / Home and Community Based Services	$2,313 / month	$2,000	Nursing Home or Hospital	$4,626 / month	$4,000	Nursing Home or Hospital	$2,313 / month for applicant	$2,000 for applicant & $126,420 for non-applicant	Nursing Home or Hospital
Regular Medicaid / Aged Blind and Disabled	$832.66 / month	$2,000	None	$1,127.33 / month	$3,000	None	$1,127.33 / month	$3,000	None

What Defines "Income"

For Medicaid eligibility purposes, any income that a Medicaid applicant receives is counted. To clarify, this income can come from any source. Examples include employment wages, alimony payments, pension payments, Social Security Disability Income, Social Security Income, IRA withdrawals, and stock dividends. However, when only one spouse of a married couple is applying for institutional Medicaid or a Medicaid waiver, only the income of the applicant is counted. Said another way, the income of the non-applicant spouse is disregarded. However, the same does not hold true for a married couple with one spouse applying for Aged Blind or Disabled Medicaid. In this case, the income of both spouses counts towards the income limit, even if only one spouse is an applicant. (Click here for more information on Medicaid and income considerations).

There is also a Minimum Monthly Maintenance Needs Allowance (MMMNA), for non-applicant spouses of Medicaid nursing home care applicants and applicants seeking home and community based services via a Medicaid waiver. The MMMNA is the minimum amount of monthly income to which the non-applicant spouse is entitled. As of July 2019, this figure on the low end is $2,113.75 / month, which will increase in July 2020. On the high end, a non-applicant spouse may be entitled to as much as $3,160.50 / month (this figure will increase in January 2020). This rule allows the Medicaid applicant to transfer income to the non-applicant spouse to ensure he or she has sufficient funds with which to live.

What Defines "Assets"

Countable assets include cash, stocks, bonds, investments, credit union, savings, and checking accounts, and real estate in which one does not reside. However, for Medicaid eligibility, there are many assets that are considered exempt (non-countable). Exemptions include personal belongings, household furnishings, an automobile, irrevocable burial trusts, and one's primary home, given the Medicaid applicant or his or her spouse lives in the home and the home is valued under $585,000 (in 2019).

In 2019, for married couples with one spouse applying for nursing home Medicaid or a HCBS Medicaid waiver, the community spouse (the non-applicant spouse) can retain 50% of the couple's joint assets, up to a maximum of $126,420, as the chart indicates above. There is also a minimum resource allowance of $25,282. Therefore, the non-applicant is entitled to whichever is greater; 100% of the assets, up to $25,282, or half of the assets, up to $126,420. This, in Medicaid speak, is referred to as the Community Spouse Resource Allowance (CSRA).

It's important to be aware that Virginia has a 5-year Medicaid Look-Back Period. This is a period of 5 years in which Medicaid checks to ensure no assets were sold for less than their value or given away as a means to meet Medicaid's asset limit. If one is found to be in violation of the look-back period, a period of long-term care Medicaid ineligibility will ensue.

Qualifying When Over the Limits

For Virginia elderly residents, 65 and over, who do not meet the eligibility requirements in the table above, there are still other means to qualify for Medicaid.

1) Medically Needy Pathway – Virginia's Medically Needy Pathway is referred to as a Medically Needy Program. This program allows individuals who have income over the limit for other pathways of eligibility to still gain Medicaid eligibility if they have high medical bills relative to their monthly income. Also commonly referred to as a "Spend-down" program, one must "spend-down" their excess income on medical bills (health insurance premiums, physician visits, hospital bills, prescription drugs) in order to meet the income limit for the Medically Needy Program. Once one's income has been spent down to the income limit, Medicaid services will be available for the remainder of the eligibility period.

For the Medically Needy Program, as a general rule of thumb, the income limit is 49% of the Federal Poverty Level, which, in 2019, is currently $510.09 for a single person and $690.41 for a married couple. Please note, not all regions of the state have the same income limits. However, the asset limit is the same regardless of the area of the state and is $2,000 for an individual and $3,000 for a married couple.

Unfortunately, the Medically Needy Pathway does not assist one in spending down extra assets for Medicaid qualification. Said another way, if one meets the income requirements for Medicaid eligibility, but not the asset requirement, the above program cannot assist one in "spending down" extra assets. However, one can "spend down" assets by spending excess assets on ones that are not counted towards eligibility, such as home modifications (wheelchair ramps, chair lift, grab bars, etc.), prepaying funeral and burial expenses, and paying off one's mortgage or credit card debt.

2) Medicaid Planning – the majority of persons considering Medicaid are "over-income" or "over-asset" or both, but still cannot afford their cost of care. For persons in this situation, Medicaid planning exists. By working with a Medicaid planning professional, families can employ a variety of strategies to help them become Medicaid eligible. Read more or connect with a Medicaid planner.

Specific Virginia Medicaid Programs

The Virginia Medicaid program pays for nursing home care, but it also offers a "Medicaid Waiver", which pays for care outside of nursing homes. Care paid for by Medicaid, outside of a nursing home is called "home and community based services" or HCBS. Virginia recently re-designed its HCBS waivers, consolidating the old Elderly or Disabled Waiver and the Technology Assisted Waiver into the new Commonwealth Coordinated Care Plus Waiver.

This waiver, called CCC+ for short, includes benefits such as adult day care, home care, and financial support to make home modifications that help residents remain living in their homes. Unfortunately, unlike nursing home Medicaid, which is an entitlement, CCC+ is not an entitlement program. This means, CCC+ has limited enrollment and waiting lists can exist. Furthermore, it unclear at this point whether CCC+ would consider "assisted living" as someone's home and whether services could be provided in such a location. The same uncertainty applies to "Independent Living". That said, the state does offer the Auxiliary Grant that can be used to pay for assisted living care.

How to Apply for Virginia Medicaid

To apply for Medicaid in Virginia, seniors can apply online at CommonHelp or via the phone by calling Cover Virginia's Call Center at 855-242-8282. There is also the option to complete and submit a paper application (Cover Virginia Application for Health Coverage and Help Paying Costs), which can be downloaded and printed from this webpage. Seniors should be aware that supplement forms may also need to be submitted with the application. For instance, for adults over 65 years of age or persons who need long term care, Appendix D: ABD, LTC Application is also required, which can be found on this webpage. Persons can also call their local Department of Social Services (DSS) office and request that paper applications and additional forms be mailed to their home. Completed applications should be returned to one's local Department of Social Services office. For questions about applying for Medicaid, seniors should contact their local DSS office.

Prior to submitting an application for Medicaid benefits in Virginia, elderly applicants should be certain that all eligibility requirements (discussed above) for the program in which they are applying are met. Having income and / or assets over the limit(s), or uncertainty if eligibility criteria are met, can result in a denial of benefits without Medicaid planning. For additional information about Medicaid planning click here and for more information applying for long-term care Medicaid, click here.

Determine Your Medicaid Eligibility

Get Help Qualifying for Medicaid

START HERE ▸

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Cost of Care

Genworth

Monthly Cost	Virginia - State 2019
Home Health Care	
Homemaker Services	$4,195
Homemaker Health Aide	$4,382
Based on annual rate divided by 12 months (assumes 44 hours per week).	
Adult Day Health Care	
Adult Day Health Care	$1,603
Based on annual rate divided by 12 months.	
Assisted Living Facility	
Private, One Bedroom	$4,800
As reported, monthly rate, private, one bedroom.	
Nursing Home Care	
Semi-Private Room	$7,350
Private Room	$8,213
Based on annual rate divided by 12 months.	

The information shown above is based on a specific scenario generated by the Genworth 2019 Cost of Care. Future years are calculated by assuming an annual 3% growth rate. For more information and location comparison, visit genworth.com/costofcare.

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206401A3D 10/09/2019