State-by-State Medicaid Information

We've compiled the most pressing state-related information by expert Elder Law practitioners that we could. Included in the following list, you'll find information for Alabama, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, New Jersey, New York, Ohio, Oklahoma, Pennsylvania, South Carolina, Texas, Virginia, and Washington. If your state is not represented among this list, please visit the ElderLaw Answers Web site, www.elderlawanswers.com, for information on contacting elder law experts in your state.

Because this information changes so frequently and is subject to change within publication of this CD-ROM, we recommend you confirm your state's laws by visiting the ElderLaw Answers Web site for updates, www.elderlawanswers.com, or by researching Medicaid sites in your state.

Alabama

By Gregory L. Watt, J.D., B.B.A.
Elderlaw Practice of Gregory L. Watt, LLC
2246 Montgomery Highway, Suite 3
Dothan, AL 36303
Telephone: 1-334-671-7977
Toll-free number: 1-888-849-8155
E-mail: cwatt@wattelderlaw.com
Web site: http://www.wattelderlaw.com/

Introduction

If an Alabama resident does not have an adequate long-term care insurance policy or enough funds to pay privately then assistance from Medicaid will be needed to pay nursing home costs.

An applicant for Medicaid nursing home benefits in Alabama is entitled to have no more than $2,000 worth of countable assets. Non-countable assets include such items as clothing, furniture, a computer, television set, and one automobile. Additional assets that are non-countable are burial spaces for the applicant, his or her spouse, or for a member of his or her immediate family and amounts held in an irrevocable trust to meet the burial expense. Examples of items that are considered countable include cash in excess of the $2,000 limit, an additional automobile, land not attached to the homestead, and funds designated for burial in excess of $5,000, if not held in an irrevocable trust or other type of irrevocable arrangement.

Treatment of the Home

The home of an Alabama Medicaid applicant will be excluded as a resource as long as it is his or her principal place of residence and he or she has an intent to return home. If the equity interest in the home exceeds $500,000, the applicant will be ineligible for benefits unless the individual's spouse, child under 21, or child who is blind or permanently disabled lives in the home.

If the applicant's home is jointly-owned, it will not count as a resource if the sale of this home would cause undue hardship to the other owner because of his or her loss of housing. If the jointly-owned property is the principal place of residence for the other owner, a forced sale of that property would be considered an undue hardship.

An applicant who transfers his or her home will trigger a penalty period unless the transfer is to a spouse; a child under 21, blind or permanently and totally disabled; a sibling with an equity interest in the home and who has lived in it for at least one year immediately before the applicant entered a nursing home and who provided care that delayed the applicant's institutionalization; or a son or daughter who has resided in the home for at least two years immediately prior to the date of institutionalization.

Protection for the Community Spouse

If an applicant for Medicaid benefits in Alabama is married, the Medicare Catastrophic Coverage Act (MCCA) of 1988 provides protection for the spouse who remains at home, the *community spouse* (CS). The protection is provided to prevent the impoverishment of the CS. First, the CS is not required to spend his or her income for the nursing home spouse's care. Second, income belongs to the spouse whose name is on the check. Checks that are payable to both spouses are allocated according to their ownership interests. If there is no allocation of interest in the income then it is equally divided between them. Third, an allowance called the minimum monthly maintenance needs allowance (MMMNA) is made to the CS to help him or her meet his or her needs in the community. If the CS's income falls below the current MMMNA, he or she has a right to receive a minimum monthly income allowance paid out of the income of the spouse who is in the nursing home. The MMMNA amount is recalculated each year and the changes are effective in the month of July. In 2006, the MMMNA for all CSs is $1,650. Fourth, the CS is allowed to retain a certain amount of resources—the Community Spouse Resource Allowance (CSRA)—when the other spouse applies for Medicaid benefits. The CSRA calculation is dependent on the amount of assets owned by the couple as of the date of institutionalization of the nursing home spouse whether or not an asset is solely owned by a spouse or held jointly by the couple. The CSRA amount in 2006 is $99,540, and, like the MMMNA amount, it increases slightly each year

Treatment of Annuities

In the state of Alabama, a lump sum annuity that is cashed in, sold, surrendered, or revoked is considered a countable resource. An annuity that is an irrevocable non-sellable, non-transferable lump sum and was purchased prior to February 8, 2006, is an uncompensated value and is counted as an available resource transferred asset to an applicant for Alabama Medicaid benefits. The purchase of an annuity on or after February 8, 2006, includes an annuity purchased by or on behalf of an applicant for Medicaid benefits and will be treated as a transfer of assets for less than fair market value unless the annuity is

- within a retirement plan; or
- it is irrevocable and non-assignable, actuarially sound (as determined by the Social Security Administration), and provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made; and
- the state of Alabama is named as the primary remainder beneficiary for at least the amount of Medicaid benefits paid on behalf of the annuitant.

Treatment of Retirement Accounts

Under Alabama Medicaid rules, an individual's retirement account is considered to be an available resource if either he or his spouse applies for Medicaid nursing home benefits.

Estate Recovery Rules

The Alabama Medicaid Agency ("Agency") has a right under federal law to attempt to recover everything it has paid for an individual's long-term care in a nursing home. Typically, the only asset of value in the

estate of a Medicaid recipient is his or her home. Although the home is not a disqualifying asset at the time eligibility is determined, if it is owned by the Medicaid recipient, the Agency will place a lien upon it. The Agency can recoup funds from the Medicaid beneficiary's estate only after the death of his or her spouse, and when there is no child under age 21, or a blind or permanently disabled child.

The Agency is limited to claiming assets that are held within the probate estate of a Medicaid recipient. It makes no claim against non-probate property such as jointly-owned real estate and property in trust.

California

By Gene L. Osofsky, Esq.
Osofosky & Osofsky
1290 B Street, Suite 208
Hayward, CA 94541
Telephone: 1-510-247-2555
E-mail: osofskylaw@hotmail.com
Web site: http://www.osofskylaw.com/

Introduction

The Medicaid program in California is called *Medi-Cal* and is administered by the Department of Health Services (DHS) in Sacramento and by the individual counties. Applications for Medi-Cal long-term care are filed with the county Department of Public Social Services in the county wherein the applicant resides, and may be filed by the applicant, a family member, or an agent. The County is obliged to make a determination within 45 days of application, and a denial triggers a right to an appeal before an Administrative Law Judge.

Resource Ceilings

To qualify, an unmarried individual may not have more than $2,000 in countable resources. However, married couples are treated differently when only one needs nursing level care: the "At-Home" spouse may retain the full CSRA—currently $101,640 for calendar year 2007. Therefore, combined with the $2,000 resource ceiling allowed the ill spouse, a married couple is permitted to retain countable resources up to $103,640 (that is, $101,640 + $2,000).

Income Allowance to Spouse

Further, the CS is allowed to retain the maximum MMMNA—currently $2,541 for 2007. Both the CSRA and the MMMNA are adjusted at the beginning of each year based upon cost of living factors.

Gift Transfers

Pending implementation of the Deficit Reduction Act of 2005 (DRA), California still uses a 30 month *look-back* period for gift transfers, unless the gift involved transfers to a trust, in which case the look-back period would be 60 months. Gift transfers of savings and other countable resources are penalized, using the average private pay rate, which is adjusted each year and is uniform throughout the state. In the year 2007, that penalty divisor is $5,101, meaning that the applicant is disqualified for Medi-Cal long-term care benefits for a period of one month for each $5,101 of cash or other countable resources gifted away. Until the DRA is fully implemented, fractional months of disqualification are rounded down and the period of ineligibility begins with the month of transfer. Transfers of exempt resources are generally not penalized, but special rules govern transfer of the home (see the following section, "Treatment of the Home").

Status of DRA

California takes the position that the DRA requires the state to adopt implementing statutes and regulations before the DRA becomes effective. As of publication date, California had not yet adopted those statutes and regulations. Hence, most of the provisions of the DRA have not yet been implemented and will likely not be implemented until well into the calendar year for 2007, and some not until 2008. It is not yet known whether any provisions will be retroactive, but, historically, changes have only been forward looking. California has, however, adopted the provisions requiring applicants to prove citizenship in order to qualify for benefits and has directed adoption of the "income first" rule in administrative fair hearings. However, Superior Court judges are not necessarily bound by the income first rule, and planning opportunities may still be available for CSs using the probate courts and "substituted judgment" petitions.

Treatment of the Home

Pending implementation of the DRA, California treats the home, regardless of value, as an exempt resource for eligibility purposes. It is also one of the very few states that permits the transfer of the home during lifetime to anyone, so long as the transferor retains the right to continue to occupy the home, to return home, or both. This right must be preserved in appropriate writing, such as an Occupancy Agreement or an Affidavit of Right To Return Home.

The home may be used to shelter excess cash resources in order to accelerate eligibility: Money may be used to pay off a mortgage or improve the home, and the money thus used then converts from a countable resource into an exempt asset for qualification purposes. Such conversions may be accomplished at any time, even after the homeowner begins receiving Medi-Cal benefits. At the death of the Medi-Cal beneficiary, the home exemption ceases, unless there is a surviving spouse or for so long as other qualified dependent(s) still living in the home, and then only for so long as that qualified dependent continues to reside in the home. At that point, the state will seek recovery against the deceased beneficiary's interest in the home. At the present time, a beneficiary may avoid recovery against the home by transferring his interest during lifetime, while retaining either a Right of Occupancy or an irrevocable Life Estate. Presently, California has abandoned its plans to seek recovery against the value of a retained irrevocable life estate.

Once the DRA is implemented, home equity will then become a significant factor in determining eligibility, and excess home equity above the permissible ceiling will then be disqualifying for single individuals. Presently, California uses the property tax assessed valuation as a measure of value, which is usually much lower than the fair market value. It is presently unknown whether California will change its method of valuation or whether California will opt to raise the ceiling on permissible home equity from $500,000 to the permitted $750,000 cap allowed by the DRA. The state has experienced inflation in the value of housing, and this inflation promises to impact Medi-Cal eligibility and planning. Placing the home into a living (revocable) trust is not usually helpful for Medi-Cal planning purposes, as the home is viewed as still being owned by the grantor and, hence, subject to recovery.

Protections for the Community Spouse

California affords the CS the following protections, all designed to permit the CS the economic means to live at home with dignity while the ill spouse resides in a nursing facility:

Income Protections

First, in California as well as other states, all income received in the name of the CS (such as from wages,

pensions, annuities, social security, etc.) may be fully retained by him or her regardless of the amount and without undermining the institutionalized spouse's (IS) entitlement to a Medi-Cal subsidy. This is sometimes called the "name on the check" rule. Second, if the income thus received in the name of the CS only is below a minimum threshold, then the CS is entitled to a spousal allocation from the IS's income, in order to bring the total income of the CS up to the MMMNA. This MMMNA is indexed for inflation and adjusts every January. As of January 2007, the MMMNA is $2,541 per month. Thus, if the CS's own income is short, the CS may in effect "borrow" from the IS to close the income gap. This spousal allocation of income has the effect of reducing the IS's own share of cost for the nursing home and correspondingly increases the amount of the Medi-Cal subsidy and, for the same reason, the potential Medi-Cal recovery claim after the death of the beneficiary.

Resource Protections

Third, the law also affords the CS the right to retain a certain amount of savings or other non-exempt assets in his or her own name, the CSRA. This, too, is indexed for inflation and adjusts every January. As of January 2007, the CSRA is $101,640. Thus, the CS may retain from a couple's combined savings up to $101,640 without impairing the IS's right to a Medi-Cal subsidy. Since California now follows the "income first" rule in the administrative fair hearing context, it is usually not possible to increase the CSRA in that forum. However, it may still be possible to seek an increase by filing a petition in the Superior Court if there is a jurisdictional basis for doing so. For example, if the IS is mentally incapacitated, it may be possible to seek an increase in the CSRA by filing a petition under California Probate Code § 3100, invoking the Court's "Substituted Judgment" powers. Upon qualification for Medi-Cal, and except for the nominal $2,000 that may remain in the name of the IS, all other savings or non-exempt assets comprising this CSRA must be transferred into the name of the CS, usually within 90 days of qualification. Fourth, for a married couple, personal jewelry of an unlimited value is also exempt, whereas the jewelry exemption for a single individual is limited to $100.

Treatment of Annuities

For Eligibility Purposes

For purposes of eligibility, the treatment of annuities depends on when they were purchased and how they are structured: Annuities purchased before August 11, 1993, are treated as unavailable, so long as payments of income and principal in any amount are being made. Annuities purchased after August 11, 1993, are considered unavailable only if they pay out interest and principal in substantially equal periodic payments (over a term not to exceed the actuarial life expectancy of the annuitant according to specified mortality tables), are actuarially sound, and are irrevocable. If the annuity is purchased between August 11, 1993, and March 1, 1996, these requirements may be waived in the case of hardship (that is, where the annuitant has attempted to restructure the annuity with the insurance company, but without success. However, all annuities purchased after March 1, 1996, must meet the above requirements, and a hardship waiver is not available. California permits an annual COLA of 5 percent on these annuity payments.

For Recovery Purposes

In terms of recovery, annuities owned by the IS and purchased after September 1, 2004, are—to the extent of any remaining residual value—subject to Medi-Cal recovery after the death of the annuitant. By contrast, under present rules, annuities owned by the CS are not subject to recovery. However, this will change once the DRA is fully implemented in California as annuities owned by either spouse will then be subject to recovery.

Share of Cost Considerations

If an annuity is purchased in the name of the Medi-Cal beneficiary, then the stream of monthly payments count towards share of cost. However, if the payments are in the name of the CS, they do not directly

affect share of cost, unless the CS has also been receiving a spousal allocation of income from the IS. In that event, these annuity payments are treated as income to the CS and hence reduce or eliminate the CS's entitlement to a spousal allocation from the IS in order to achieve the MMMNA and, correspondingly, will then increase the IS's share of cost.

Other Issues

Deferred annuities are treated as a countable resource. Likewise, immediate annuities that are structured to pay out for a term longer than the actuarial life expectancy of the annuitant are, to that extent, treated as a partial transfer of assets with associated penalty.

California (Cont.)

By Dennis M. Sandoval
A Professional Law Corporation
3233 Arlington Avenue, Suite 105
Riverside, CA 92506
Phone: 1-951-787-7711
E-mail: dennis@cal-elder-lawyer.com

Treatment of Retirement Accounts

Institutionalized Spouse

A retirement account of the IS is considered unavailable as long as the IS is taking required minimum distributions as required by the IRS (uniform table under most circumstances). Required minimum distributions taken by the IS are considered income that will be applied toward share of cost of the nursing home unless they are deemed to the CS because of application of the MMMNA.

Community Spouse

The retirement account of the CS is considered unavailable and any distributions taken by the CS belong to the CS under the "name on the check" rule.

Estate Recovery Rules

California has adopted the expanded definition of estate; thus, recovery is not limited to just the probate estate. The residence is an exempt asset as long as the IS indicates on the Medi-Cal application that he or she intends to return to the home. There is no test as to whether or not it is realistic that the IS will return to the residence. No lien for recovery purposes can be placed on a residence while the CS is alive and remains living in the residence. Thus, the CS is free to sell or otherwise transfer the residence any time prior to the CS's death without having to repay Medi-Cal.

California adopted regulations in 2004 regarding recovery against immediate annuities issued after September 2004.

The Department of Social Services issued proposed regulations in 2006 providing for recovery against life estates after the death of the surviving spouse. After receiving substantial negative commentary, the state backed off from its position and reissued the regulations without the authorization to recover against life estates.

Officials at the California Department of Social Services have made statements that the department

intends to implement the DRA through its regulatory process sometime in 2008 or 2009. These officials have indicated that they do not intend to apply the new rules retroactively and the Medi-Cal application and recovery process will continue under the existing rules until the new laws and regulations have been implemented.

Colorado

By Marco D. Chayet, Esq., Joseph A. Dawson, Esq., & Dawn R. Hewitt, Esq.
Chayet, Dawson & Danzo, LLC
425 S. Cherry Street Suite 300
Denver, CO 80246
Phone: (303) 355-8500
Email: Marco@ColoradoElderLaw.com
Email: Joe@ColoradoElderLaw.com
Email: Dawn@ColoradoElderLaw.com
www.ColoradoElderLaw.com

Introduction

In Colorado, the majority of elderly people on Medicaid are receiving long-term care in a facility, such as an assisted living facility or nursing home. However, through Medicaid's Home and Community Based Services (HCBS) waiver program, individuals can also receive limited custodial care in the home. Colorado administers the program by strictly adhering to the federal and state Medicaid regulations, and this has lead to a reputation of being an "Eligibility Tough" state. Another unique aspect of the Medicaid program in Colorado is that the application process varies from county to county, even more so than in other states.

Although the entity administering Medicaid in Colorado is the Colorado Department of Health Care Policy and Financing (CDHCPF), the individual county departments of human or social services administer the Medicaid program at the local level. Colorado's Medicaid program is intended as a statewide program to be administered uniformly throughout the state. However, the individual counties seem to administer the Medicaid program individually. Because of this individualistic attitude, applicants and professionals may discover many discrepancies between the counties as to how they administer the program.

On February 8, 2006, the Deficit Reduction Act of 2005 was signed into law and Colorado incorporated the new Medicaid provisions within the act as being effective as of signing. This means that in Colorado, the new regulations under the Deficit Reduction Act of 2005 apply to all transfers of assets and applications made after February 8, 2006. Because the new rules have been in effect for almost two years in Colorado, Medicaid planning has shifted from a half a loaf type planning to alternative forms for retaining funds for paying for care during the penalty period. These alternatives may include the purchase of annuities, entirety transfers, or the use of certain insurance policies.

The Basics

Since Medicaid is a need-based program, a Colorado applicant will have to meet three financial and medical needs-based tests to become Medicaid eligible: 1) the medical test, 2) the income test, and 3) the asset test.

The medical test establishes that the applicant requires the type of custodial care covered by the Medicaid program. The applicant's doctor or other professional health care provider completes an assessment. If the applicant is currently receiving care in a facility, such as a nursing home, then this assessment is usually fairly easy to complete. If the applicant is applying for one of Colorado's waiver

programs to receive in-home care, an in-home assessment may also need to be performed.

The income test sets the applicant's allowable monthly income for Medicaid eligibility, which is three times the current SSI individual benefit. For example, in 2007, the individual SSI limit is $623, so Colorado's allowable monthly income is $1,869. However, if the applicant has income above this limit, but below the average cost of nursing home care in his or her region, then the applicant can still become eligible for Medicaid by setting up a special trust, known as an income trust, for the excess income.

The asset test establishes that unmarried applicants cannot have more than $2,000 in countable assets to become Medicaid eligible. A countable asset is an asset that is not considered exempt under one of the current Medicaid exemption regulations. The most common exemptions in Colorado are the residence, a vehicle, personal property items, insurance policies with low cash values or no cash values, and burial plots and plans.

Treatment of the Residence

In Colorado, a Medicaid applicant's home is considered an exempt resource if: (a) the home was the Medicaid recipient's principal residence; (b) the recipient (or spouse) actually lived in the home immediately prior to being institutionalized; and (c) the recipient intends to return home; or a spouse or dependent relative continues to live there.

Under the new DRA regulations, there is now a $500,000 equity value limit for all residences under the above exemption rules. For applications filed on or after January 1, 2006, an individual's home will be exempt if the individual's equity interest in the home is $500,000 or less, or if the individual's equity interest in the home exceeds $500,000, but the individual's spouse, dependent child under the age of 21, or blind or disabled child still resides in the home.

For planning purposes, it is sometimes necessary to reduce the equity value of a residence to below the $500,000 limit. Because the rule refers to equity value, applicants can reduce the equity value to below the $500,000 limit by encumbering the home in some way. The most common way to encumber the home is by taking out additional loans on the property. In certain circumstances, it is advisable to use reverse mortgages to reduce the equity, but these situations usually involve the need to increase the applicant's income for some reason, such as when the applicant remains in the home and is receiving care under the HCBS program.

Protections for the Community Spouse

For married couples, the income test becomes even more complicated. Colorado is an income first state. This simply means that, when determining if any income from the institutionalized spouse is to go to the community spouse, the state must first count the income of the community spouse towards any minimum amount to which the community spouse is entitled before the community spouse can receive any income from the institutionalized spouse.

For example, the community spouse may be able to receive a portion of the institutionalized spouse's income if the community spouse's income is not enough to pay for his or her monthly living expenses. If the community spouse's income is below the Minimum Monthly Maintenance Needs Allowance (MMMNA), a portion of the institutionalized spouse's income will be given to the community spouse in the form of a Monthly Income Allowance (MIA). The MMMNA can be expanded to a Maximum Monthly Maintenance Needs Allowance if the community spouse can prove that his or her bills exceed the minimum. For example, in 2007, the MMMNA is $1,711.25, but if the community spouse can prove bills over this amount, the MMMNA can be raised up to the maximum of $2,541. The bills required to raise the MMMNA must be for needed items only and not for things such as cable television, lawn care, and

cellular telephones.

Regarding asset limits in cases of married couples, the community spouse can retain a certain amount of countable resources without affecting the institutionalized spouse's Medicaid eligibility. The amount retained is called the Community Spouse Resource Allowance (CSRA). Colorado is one of the states that allows for the community spouse to hold the maximum CSRA. The maximum CSRA for Colorado in 2007 is $101,640.

The CSRA is an amount the community spouse is allowed to retain over and above any exemptions and is in addition the $2,000 the institutionalized spouse is entitled to retain. This means that in Colorado in 2007, a couple can retain $103,640 ($101,640 CSRA + the $2,000 individual limit), including all the exemptions, and still have one spouse become Medicaid eligible.

Treatment of Annuities

Colorado's annuity regulations are unique when it comes to annuities for the community spouse. If the annuity is intended for the community spouse, the county will determine the MMMNA of the community spouse, if applicable. If the monthly payment amount provided by the annuity to the community spouse exceeds the MMMNA, the amount of the annuity which causes the monthly annuity payment to exceed the MMMNA shall be considered a transfer without fair consideration in determining the institutionalized spouse's eligibility. This subsection applies only to the extent that the transferred amount causes the CSRA to exceed the maximum. This means that, if the community spouse is planning to purchase an annuity, he or she must be acutely aware of the MMMNA regulations and the difference between the community spouse's income and the MMMNA.

Annuities purchased before February 8, 2006 are treated differently than annuities purchased after February 8, 2006. If an annuity was purchased prior to February 8, 2006, and the annuity was purchased more than 36 months prior to the date of application, then the penalty period for a transfer without fair consideration has expired. Any income received from the annuity shall be considered as income in the month received.

The new DRA law changed how annuities are treated when determining an individual's eligibility for Medicaid long-term care services in Colorado. Under the new laws, the State becomes a preferred remainder beneficiary in any interest in any annuity or similar financial instrument of a recipient or spouse of a recipient of Medicaid long-term care services. This preferred remainder beneficiary interest is for the total amount of medical assistance provided to the individual and applies to any annuity purchased on or after February 8, 2006.

The new law requires that the purchase of an annuity on or after February 8, 2006 be treated as a transfer without fair consideration unless all of the following criteria are met: the annuity is purchased from a life insurance company or other commercial company that sells annuities as part of its normal course of business; the annuity is annuitized for the applicant or his or her spouse; the annuity is purchased on the life of the applicant or his or her spouse; and the annuity provides payments for a period not exceeding the annuitant's projected life. This information must be provided, regardless of whether the annuity is irrevocable or counted as an asset. Finally, current Medicaid long-term care services clients also must provide this information at redetermination.

The new law requires that the issuer of such an annuity be notified of the right of the CDHCPF as a preferred remainder beneficiary of the annuity. The new law also allows the CDHCPF to require the annuity issuer to provide notice when the amount of income or principal being withdrawn from the annuity changes. The CDHCPF will require annuity issuers to provide this notice.

Treatment of Retirement Accounts

In Colorado, self-funded retirement accounts, such as IRAs and 401(k)s, are deemed countable resources for Medicaid eligibility purposes. Many couples mistakenly believe that these retirement accounts will be what the well spouse can rely on for his or her future needs after the ill spouse becomes Medicaid eligible. However, since these accounts are deemed countable resources, and all resources owned by either spouse are deemed available to the applicant, these accounts must often be either spent down or transferred to complete Medicaid planning. The real concern for planners is that, if these retirement accounts have to be cashed out or transferred, the applicant may have to endure early withdrawal penalties or tax obligations just to become Medicaid eligible.

Estate Recovery Rules

The State of Colorado, through its Medical Assistance Estate Recovery Program, can seek recovery for the amount of medical assistance provided to an individual as long as the individual was 55 years of age or older at the time he or she received medical assistance or was institutionalized at the time that he or she received medical assistance. The state cannot recover from the estate of a recipient if there is a surviving spouse of the recipient, if there is a child of the recipient under age 21, or if there is a blind or disabled dependent of the recipient. Since the asset limits for a recipient are so low, and most of the exemptions, such as personal property items and cars, hold little value after many years of use, the main asset the state is trying to recover from is the home.

Procedurally, the State of Colorado is an interested party in that individual's estate because of the assistance that it provided to him or her. After the individual dies, the state must be notified of the death and be given notice of the individual's estate proceedings. The state will then try to assert a lien against the individual's estate to obtain reimbursement for the assistance that it provided to the individual. The state will file a claim against the individual's estate.

Due to budget constraints, Colorado has intensified its enforcement of estate recovery, and estate recovery proceedings and hearings are on the rise in the state. One should keep in mind that the State of Colorado can recover for the individual's Medicaid only to the limit of his or her equity or interest in the home. The state cannot recover against any other owners of the property.

Connecticut

By Paul T. Czepiga, JD, CELA, CPA, MBA
Czepiga Law Group, LLC
48 Christian Lane, 2nd Floor
Newington, CT 06111
Telephone: 1-860-594-7995
E-mail: pault@czepigalaw.com
Web site: http://www.czepigalaw.com/

Introduction

With the implementation of the DRA, qualifying for Medicaid benefits became more difficult. Although the look-back period remains at three years until it is increased incrementally in February 2009, the penalty period for transfers or gifts begins later than allowed under the previous Medicaid rules. Gifts made before February 8, 2006, are penalized as of the first day of the month in which the gift was made. For example, the penalty period for a gift made on January 31, 2006, would begin January 1, 2006. Under the new rules, however, gifts made on or after February 8, 2006, are penalized as of the day the person becomes institutionalized and otherwise eligible for Medicaid benefits.

Treatment of the House

The house is treated differently depending on whether the institutionalized person is single or married. If the institutionalized person is married and his spouse lives in the house, the house is not counted as a resource and is not available to pay for the institutionalized person's care. There is no limit on the value of a house that is excluded when the CS lives in that house. However, if the CS later enters a nursing home, the house is treated as if the CS is a single person and the house becomes at risk.

If the institutionalized person is single, the house is counted as a resource available to pay for his care, unless the house is occupied by his child, if the child is under 21, blind, or disabled, or his sibling, if the sibling had an equity interest and has lived in the house for at least one year prior to the institutionalized person's institutionalization. The house may also be excluded if the institutionalized person is applying for home and community-based services or if the institutionalized person is in a nursing home and intends to return home. However, the state may place a lien on the house and seek reimbursement upon the sale of the home for medical expenses paid. Under any of the circumstances in which the house may be protected for a single person, only a house valued at or less than $750,000 is protected.

If the institutionalized person has a life use in real property, that life use is given a value. The life use is counted as a resource available to pay for the institutionalized person's care unless the person is able to return home within six months, as indicated by that person's physician.

Protections for the Community Spouse

The state will look at all assets owned by both the IS and the CS. The couple can keep the following assets, which are not included in the state's determination of the total assets owned by the couple: house (if the CS lives there), one motor vehicle of any value, life insurance of any amount if there is no cash value and life insurance policies with cash value if the total face value is no more than $1,500, and a funeral contract and burial space. The CS is allowed to retain one-half of the remaining total assets, but no more than $104,440 and no less than $20,880 (amounts are adjusted each year for inflation). The state expects that the remaining assets will be used to pay for the IS's care, although these assets can also be used for the benefit of the healthy spouse.

As an alternative, the CS may refuse to spend anything, under the doctrine of spousal refusal. There are four requirements for spousal refusal:

1. All assets must be titled in the healthy spouse's name.
2. The healthy spouse must refuse to spend any money, in writing.
3. The IS must assign his support rights to the state of Connecticut.
4. The state has the right to seek reimbursement from the CS (although Connecticut has yet to do so).

The state will also look at the income received by both spouses. The healthy spouse is entitled to a MMMNA, which is currently set at $1,711.25, but this amount is adjusted each year for inflation. If the CS's income falls below $1,711.25, the CS will be able to retain some or all of the IS's income to meet the MMMNA. If the CS's income still falls below $1,711.25 after retaining all of the IS's income, the CS may be allowed to retain enough of the IS's assets to generate monthly income to meet the rate set by statute.

Connecticut (Cont.)

By Henry Weatherby, J.D., CLU, CHFC, CEBS
Weatherby & Associates, PC
34 Jerome Avenue, Suite 310
Bloomfield, CT 06002
Telephone: 1-860-769-6938

E-mail: hank@weatherby-associates.com
Web site: http://www.weatherby-associates.com/

Annuities

Since the passage of the Omnibus Budget Reconciliation Act of 1993, amendments to the Medicaid law, evaluation of annuities, and their countability for Medicaid eligibility were primarily left up to state law. Connecticut chose to treat annuities similarly to trusts by applying a five year look-back period (each annuity being reviewed by the Department of Social Services [DSS] on a case-by-case basis). If an annuity is treated by the DSS as an asset, the DSS will (1) see if the annuity can be redeem for cash; (2) if not, force a sale on the open market (assignability and fair market value would be determined by DSS); and (3) when not assignable, determine whether the transfer (purchase of the annuity) was made to qualify for Medicaid and impose a penalty period if the applicant cannot prove that the entire transfer was made exclusively for some other purpose besides gaining eligibility for Medicaid assistance. If the annuity is treated as income (annuitized), all the income generated is considered available to pay for the annuitant's care. The amount of income that is available from the annuity and all other sources that must be used to pay for care can be reduced by the personal needs allowance of $61 per month, an allowance for private medical insurance premiums and allowable income that may be diverted to a CS under the Connecticut eligibility rules.

However, with the passage of the DRA on February 8, 2006, and the changes made to the Uniform Policy Manual (UPM) as of April 1, 2007, annuities purchased since February 8, 2006, will be subject to additional rules. First, the DSS will upon the provision of long-term care Medicaid benefits automatically become a remainder beneficiary of any annuity held by the person receiving Medicaid benefits. Second, the purchase of an annuity will automatically be considered to be a transfer of assets. To disprove this determination the applicant must show that the DSS has been named as the primary remainder beneficiary to the extent of all Medicaid benefits provided to the annuitant and the annuity must meet all of the following requirements:

- It must be actuarially sound.
- Payments made must be equal during the term of the annuity.
- There can be no deferred payments and no balloon payments.
- It must be irrevocable and non-assignable.

An exception to the DSS being named as the first beneficiary is that a spouse, minor under 21, or disabled child can be named first, provided that the DSS becomes entitled to become the first beneficiary should the spouse or qualifying child dispose of the annuity for less than fair market value. The state, upon initial application or re-certification of eligibility, will require the disclosure of any interest the individual or CS may have in an annuity regardless of its irrevocability or its treatment as an asset. Through the application process, it should be anticipated that, DSS will inform the issuer of the annuity of their right as a preferred remainder beneficiary (42 U.S.C. 1396p(c)(1)(F). Annuities purchased as part of an IRA or Roth IRA will not be considered asset transfers but will, as explained in the following section "Retirement Plans," be generally considered as an available asset.

Estate Recovery

The Omnibus Budget Reconciliation Act of 1993 requires each state to seek adjustment or recovery of amounts correctly paid by the state for Medicaid. For all individuals age 55 or older, states are required to seek recovery for payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. Having left the definition of "estate" up to state law, Connecticut has chosen to expand the federal definition of "estate" beyond those asset that pass through probate (the UPM defines a decedent's estate as "the assets and liabilities that a deceased person has at the time of his or her death"). Subject to additional restrictions, the state of Connecticut may recover against the estate of the following individuals upon their death: the parent of a

child who at any time received benefits from the DSS and any person who has been a recipient of any benefits from the DSS. While the UPM provides for recovery from a parent, this would only apply if Medicaid benefits were paid for the care of a minor child as a parent is not legally liable for the care provided to an adult child.

The DSS is put on notice when any estate is probated and the executor informs the court as to whether the deceased has ever received any benefit under Medicaid. The DSS's claim against an estate has priority against all other claims, except expenses for last sickness, funeral and burial expenses (reduced by the amount of any revocable or irrevocable burial fund owned), and administrative expenses (including probate fees, taxes, fiduciary, and attorney fees).The DSS will not recover certain benefits from an estate if the probate court rules that the surviving spouse, parent of the deceased, or dependent child of the deceased under 21 needs to retain the assets for support. In addition, an heir under the terms of a will or intestacy law may apply to the DSS for undue hardship relief in the form of a full or partial waiver or deferral of the state's claim for recovery against the estate.

Connecticut has procedures in place to establish a lien against real property owned by the decedent or a legally liable relative of the decedent. This lien must be satisfied out of the proceeds of any sale of the property. The state can compel the sale of the property to see that its lien is paid to the extent of the value of the property sold.

Connecticut is just one of a handful of states that, prior to the passage of the DRA, has collaborated with the insurance industry in the Partnership for Long-Term Care, a project intended to increase private insurance coverage for long-term care. This is a program that was an exception under Medicaid law prior to the DRA and is now allowed for in all states under the DRA. Among the benefits gained by purchasing a long-term care insurance contract that qualifies under Connecticut's Partnership program is that some or all of the assets of a Medicaid recipient may be exempt from the state's right of recovery from their estate. The amount of assets that are exempt can be equal to the sum of long-term care benefits paid by the long-term care insurance, if those assets were not spent prior to the death of the insured. The reason for this caveat is if the long-term care benefit paid and the available income of the long-term care recipient are insufficient to pay the entire cost of care, then assets will have to be converted to cash and spent to meet the short fall. Many people have not purchased long-term care insurance with a large enough daily benefit to cover the full cost of care even taking into account the available income.

Retirement Plans

As a general rule, retirement plans are countable assets for purposes of eligibility for Medicaid under Connecticut law. Retirement plans include all forms of tax favored plans, including, but not limited to, IRAs, 401(k)s, 403(b)s, 457 plans, profit sharing plans, defined benefit plans, and ESOPs. Section 4030.66 A of the Connecticut UPM deals with the exclusion of certain retirement plans under the asset test for eligibility for Medicaid. The cash value of pension plans, including contractual Keogh plans, is excluded so long as the funds are inaccessible (UPM 4030.66 A). A contractual Keogh plan is one set up by an employer that involves a contractual relationship with one or more non-assistance individuals in which the individual applying for assistance cannot withdraw money from the account without affecting the employer or other employees (UPM 4020.15 H). While this appears to provide protection, in virtually every case it will be found that withdrawals from the plan are allowed and that doing so will not adversely affect the employer or other individuals.

In counting assets for households with countable retirement plans, the DSS will include the total cash value of the account or plan minus the amount of the penalty (if any) that would result due to the early withdrawal of the entire amount in the account or the plan (UPM 4030.66 C). The payment of income taxes are not considered a penalty and, therefore, do not reduce the value of the account in determining its value as a countable asset. The only type of plan that would not result in being a countable asset would be a defined benefit plan benefit that is only collectable by the retiree as an income stream for his

or her lifetime.

District of Columbia

By Ron M. Landsman, P.A.
200-A Monroe Street, Suite 110
Rockville, MD 20850
Telephone: 1-240-403-4300
E-mail: rml@ronmlandsman.com
Web site:http://www.ronmlandsman.com

Introduction

The D.C. Medicaid program is run with the same competence, efficiency, sensitivity, and care that mark D.C. government as a whole. Its Medicaid manual is entirely on-line, but you cannot get print copies, it is almost impossible to find unless you have the Web address in advance, it is written in “Beltway Bandit” administrese, and it was ten years out of date on some rules when it was first published. The program is a procedural shambles in other ways: Public regulations made through notice-and-comment rule-making are a rarity; its computer generated eligibility notices are largely incomprehensible to the uninitiated; it does not require face-to-face interviews as required by federal law; it routinely accepts applications from third parties without a serious investigation of the applicant’s resources; it requires only three months of bank statements—and even those need not be the three months prior to the request eligibility date; notices are routinely sent to nursing homes rather than the representative who filed the application; and cases are continued from year to year without an annual re-certification procedure.

To be sure, there are many fine people within the departments that operate Medicaid, and without them practitioners would be lost, but they do not make up for the overall systematic chaos. Its defenders argue that a larger truth about the program is that the vast majority of applicants are easily eligible and the percentage requiring careful screening are, relatively, rare. But the fact remains that the program has little effective control over a wide variety of its operations.

Turning to substance, on the positive side, where its rules aren’t generous, its procedural slackness makes up for them. But planning is difficult in the sense that with an amorphous system, it is hard to anticipate when there will be resistance to a specific strategy or plan.

Treatment of the Home

In theory, D.C. is not generous with treatment of home property: The home loses its exempt status if the beneficiary is not medically likely to return after six months. And since homes are not exempt for extended periods, D.C. does not impose liens, sometimes called the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) liens, on real property during a beneficiary’s lifetime.

But D.C. does not, in fact, apply the rule rendering home property available after six months; caseworkers appear simply to ignore the home after initial eligibility and also on re-certification, so that the home is simply disregarded. D.C. has an estate recovery program, but D.C. treats it as a transfer of a deed conveying a remainder retaining a life estate with full powers and does not deny exempt status to homes owned in that form, thus providing a means for avoiding estate recovery.

Protections for the Community Spouse

D.C. permits all spouses to have the maximum spousal income allowance permitted under federal law. While its treatment of CS resources on paper follows the minimum federal standard, it acquiesces in “just

say no," disregards all assets of the CS, whenever transferred, and has no post-eligibility enforcement.

Annuities

D.C. has no policy on the treatment of annuities. Because of its generous application of "just say no," annuities are not needed to enable married individuals to qualify for benefits. And notwithstanding the DRA, D.C. appears to accept balloon annuities and does not require that it be named a contingent beneficiary after a spouse or disabled child.

Treatment of Retirement Accounts

D.C. treats the full value of a qualified plan as available to the owner of the plan.

Estate Recovery Rules

D.C.'s estate recovery program was laxly run until a series of successful rejections by personal representatives prompted a state plan amendment and promulgation of new rules. These rejections have culminated in a class action seeking to recover improperly collect funds, now pending in D.C. Superior Court (refer to Brown, et al. v. Payne et al., Civil Action No. 5079-06). As corrected, the estate recovery now

- covers all services provided by Medicaid. Prior to the change, D.C. could only recover for those items for which Congress made recovery mandatory (long-term care, waiver services, and related pharmaceutical and hospital services). D.C. routinely filed claims for all services, but would withdraw inappropriate claims when challenged.
- provides notice that recovery is not permitted if there is a surviving spouse or disabled child or where recovery would result in undue hardship. Prior to the regulatory changes effective August 4, 2006, no notice was given, and when pushed, D.C. would concede that absent such notice, its claim was defective.
- has a hardship standard that is strict and somewhat incomprehensible. It also has draconian deadline requirements that may trip up the unwary personal representative or estate planning lawyer.
- may still file claims for services provided when the individual was under age 55.

Florida

By Joseph S. Karp, CELA, Florida BAR Certified ElderLaw Specialist
The Karp Law Firm, P.A.
Trusts & Estates, Elder Law, Guardianship
2875 PGA Boulevard, Suite 100
Palm Beach Gardens, FL 33410-2910
Telephone: 1-561-625-1100
E-mail: klf@karplaw.com
Web site: http://www.karplaw.com

Introduction to Medicaid Rules and Planning

The information in the following section is valid as of this writing (9-26-07). Keep in mind that this information will likely change since Florida is in the process of revising its Medicaid regulations in light of the DRA.

In Florida, Medicaid may pay for an individual's skilled nursing care, custodial care, or both if the individual meets certain requirements. The individual must be in a nursing home or need placement in

one for medical reasons at the time of Medicaid application. The applicant's gross monthly income cannot exceed $1,869 per month. There is no limit on the CS's income, nor is the CS obligated to pay for the IS's care. If the CS's income is less than $1,711, a portion of the applicant's income may be diverted to the CS. Countable assets (those that are not exempt or are nonavailable for Medicaid purposes) may not exceed $2000 for the applicant. The CS may not have countable assets in excess of $101,640. (If both spouses are in a nursing home, together, they may retain $3,000 in countable assets.)

Among those assets considered exempt when determining Medicaid eligibility are

- the home, under certain conditions;
- one motor vehicle of any value;
- a second vehicle meeting certain circumstances;
- life insurance owned by the applicant when the face value of all policies does not exceed $2,500;
- life insurance owned by the CS when the face value of all policies does not exceed $2,500;
- burial plans for the applicant, the CS, or both if the plan does not exceed $2,500; and
- irrevocable burial plans in any amount.

Treatment of the House

The information in the following section is valid as of this writing (9-26-07). Keep in mind that this information will likely change since Florida is in the process of revising its Medicaid regulations in light of the DRA.

The homestead of the applicant or the CS is considered an exempt asset for Medicaid purposes, regardless of value, so long as it is the principal place of residence. However, when Florida enacts the new rule based on the DRA, the homestead will be protected up to $500,000 or $750,000. A temporary absence from the home does not affect the exclusion so long as a spouse or dependent relative continues to reside in the home, the sale of the home would cause undue hardship, or the individual intends to return to the home (even if it appears unlikely that the individual will be able to do so). Currently in Florida, although there is a Medicaid Recovery Law, the lien does not attach to bona fide homesteads if the homestead will pass to the children of the owner at the time of the owner's death. The exclusion is limited to one residence.

Florida (Cont.)

By Robert M. Morgan, JD, Adjunct Professor of Law at Florida Coastal School of Law
Ford, Bowlus, Duss, Morgan, Kenney, Safer, and Hampton, P.A.
Attorneys and Counselors at Law
10110 San Jose Boulevard
Jacksonville, FL 32257
Telephone: 1-904-268-7227
E-mail: rmorgan@flfirm.com
Web site: http://www.flfirm.com

Protections for the Community Spouse

In Florida, the CS is entitled to countable resources not to exceed $101,640 (the CSRA) and unlimited income in the calendar year 2007. Transfers from an applicant to the CS (that is, the applicant's spouse) carries no period of ineligibility or transfer penalty, regardless of amount; although, there is one case in Florida (the Feldman case) that may indicate that transfers could be limited in the future. The Department of Children and Family (DCF) has yet to ratify or adopt the conclusions of a State Court judge in the Feldman case. Checking with a Florida attorney is imperative prior to attempting to transfer anything in excess of the CSRA to a CS in case Florida chooses to follow the Feldman decision.

Since the spouse is entitled to unlimited income, transfers of income producing resources are preferable. If a CS requires an increase in her monthly income, she currently has three viable options:

1. There is a minimum monthly maintenance income allowance (MMMIA) that is the minimum amount a CS is entitled to receive, which in 2007 is $1,650. The MMMIA is automatic and there is no requirement of a hearing to obtain this. For example, a CS has gross income consisting of social security and interest of $630 and the IS has gross income of $2300 from his social security, pension, and interest income. The CS's gross income is $1,020 below the MMMIA amount of $1650 ($1650-$630= $1020). The CS in this example will be entitled to retain $1020 of the IS's income (that is, a diversion) to get her to the MMMIA amount. In accordance with the DRA, Florida has become an "income first" state. This change, effective as of November 1, 2007, could affect an attempt by a CS to obtain more assets of the applicant to increase the CS's income requirements.
2. The second source of income is based on an increase in the MMMIA due to excess shelter costs. To obtain this increase, the DCF case worker will need to obtain approval from a supervisor and a hearing is required. The Community Spouse Income Allowance (CSIA) is available in the event the CS can demonstrate she will have excess shelter costs (that is, mortgage payments, insurance, property taxes, etc.) that the MMMIA is insufficient to satisfy. The maximum amount a CS may receive using this calculation is $2,541 in 2007.
3. The last option available to help increase a CS's income is to utilize a domestic relations procedure known as a *petition to obtain support*. This is not a divorce. Under Florida law, a CS is entitled to claim support under the domestic relations law. Since most of the income in an elder situation (at least at present) is coming from social security and qualified assets, such as pensions and IRAs, the requirement of a support order, as well as a *qualified domestic relations order*, is necessary and must be served by any plan administrator to divert income. This should be done prior to filing an application for benefits.

The primary residence (that is, homestead) as indicated in Chapter 2, "Inheritance Planning," is an exempt resource and the CS is entitled to it until her death.

Treatment of Annuities

Prior to DRA's adoption, the use of annuities in Medicaid planning, assuming the annuity product complies with the Florida Economic Self-Sufficiency Manual (the Manual) promulgated by DCF, is permissible. The properly created annuities become income streams and not countable resources. This is a wonderful tool when clients are a married couple and you want to provide income to a CS.
Under the DRA, annuities are only permissible if

1. no balloon annuities can be utilized in any event.
2. a non-balloon Medicaid qualified annuity can be issued, if there is a CS, for the applicant with the applicant as owner and the CS as primary beneficiary so long as the state of Florida is named as the contingent beneficiary up to the Medicaid recovery amount.
3. the annuity, if there is no CS, names the state of Florida as primary beneficiary up to the Medicaid recovery amount so that it can collect any sums that it has expended on behalf of an applicant.

Florida (Cont.)

By Stephanie L. Schneider, CELA
Law Office of Stephanie L. Schneider, P.A.
1860 N. Pine Island Road, Suite 111
Plantation, FL 33322
Telephone: 1-954-382-1997
E-mail: sschneider@fl-elderlaw.com
Web site: http://www.fl-elderlaw.com

Treatment of Retirement Accounts in Florida

Under Florida Medicaid rules, retirement accounts can include annuities as well as work related plans that provide income when the employee retires (that is, IRAs, 401(k)s, self-employed plans, Keoghs, disability, pensions, etc.). The retirement account can be viewed by the DCF (the state agency that determines financial eligibility for Medicaid) either as a countable resource or as an income stream. If the owner of the retirement account is at an age where he or she can take the required minimum distribution (RMD) under the tax code, and receives regular periodic payments (that is, monthly) then the principal value of the asset is not counted. If the account owner can take RMDs but chooses not to, then the value of the account is a countable asset. Since Florida imposes an asset limit for the CS of the applicant, if the CS owns a retirement account and receives periodic payments, the fund will not be counted toward the couple's total countable assets (under the nursing home, institutional hospice, and home community-based waiver programs).

A retirement account is not a countable asset if an individual must terminate employment in order to obtain payment. If the account owner is not eligible to receive periodic payments from the retirement fund then the entire fund's value is a countable asset. An example of this would be where the CS owns the retirement fund, is under age 59, and, pursuant to the terms of the plan (and absent a disability), is not able to make withdrawals.

When the owner of a retirement account withdraws the required minimum distributions, the monthly distribution is treated as countable unearned income. This rule applies to both the applicant and the CS. If the Medicaid applicant owns a retirement account, the attorney must determine whether the RMD when added to other income sources will cause the client's total gross monthly income to exceed the monthly income limit. Florida is only one of a few states that imposes a monthly income requirement for the applicant as part of the Medicaid eligibility process. If the client's gross income exceeds the income limit then the client must create a Medicaid income trust in order to qualify. When the CS owns the retirement fund and receives periodic payments, it is viewed as unearned countable income; however, there is no limit to how much income the CS can have and it will not affect the applicant's eligibility.

Unique Rules Applied to Annuities

If assets are used to purchase an annuity or retirement fund after April 1, 1995, it is evaluated under additional rules to determine whether the annuity was purchased solely to shelter assets and qualify the individual for Medicaid. Such transfers will be penalized and the individual will be ineligible for Medicaid. If the retirement fund is purchased within the look-back period, it is reviewed to determine whether it will provide fair compensation to the individual during his or her lifetime. If the individual's remaining life expectancy equals or exceeds the payout term of the annuity, the individual is considered to receive fair compensation and there is no period of ineligibility for Medicaid. Only Social Security Administration actuarial tables can be used to determine life expectancy—the use of any other actuarial tables will not be accepted by the Center for Medicare & Medicaid Services or by the state of Florida.

In order for the annuity to be viewed as a non-countable asset, it must also be an immediate annuity (in a pay mode). Deferred annuities are countable assets.

New Rules Under the Deficit Reduction Act

On February 8, 2006, President Bush signed the DRA. A section of the DRA imposes more stringent financial eligibility requirements than ever before upon individuals applying for Medicaid. In particular, the DRA limits the use of annuities by individuals applying for Medicaid and enhances the state's right to seek recovery of its lien from the annuity at the owner's death for Medicaid benefits paid to the owner. The new law creates specific conditions that, if satisfied, will result in an annuity being excluded as a countable asset as well as not being viewed as a transfer of assets (which otherwise creates ineligibility for Medicaid

assistance).

Some of the new rules regarding annuities purchased on or after February 8, 2006, include the following:

- Individual retirement immediate annuities (26 U.S.C. section 408(b), (q)) owned by the applicant are not countable resources and are not viewed as a transfer of assets. They are not required to be actuarially sound. It is questionable whether such an annuity is required to name the state as beneficiary.
- Non-qualified immediate annuities owned by the applicant and purchased with proceeds from an IRA, an employer-created trust, a qualified salary reduction arrangement, a Simplified Employee Pension, or a Roth IRA are not countable resources and are not viewed as a transfer of assets. They are not required to be actuarially sound. It is questionable whether such an annuity is required to name the state as beneficiary.
- An immediate annuity owned by the applicant that is irrevocable, non-assignable, provides for payments in equal amounts, has no deferral of payments, and does not provide for balloon payments is required to be actuarially sound and is not viewed as a transfer of assets. It is questionable whether such an annuity is required to name the state as beneficiary.
- An immediate non-qualified annuity owned by the applicant or the CS that is irrevocable, non-assignable, provides for payments in equal amounts, has no deferral of payments, and does not provide for balloon payments is required to be actuarially sound and may be required to name the state as beneficiary.

The new rules are intricate and cannot be fully addressed in this section. We are still waiting to see how Florida implements the new federal changes. As such, the law and each client's situation should be carefully evaluated by a competent elder law attorney prior to an individual purchasing an annuity, applying for Medicaid, or both.

Medicaid Estate Recovery in Florida

Federal Medicaid law mandates that the states implement a recovery program to seek collection of Medicaid benefits paid. The acceptance of Medicaid assistance creates a debt. The government's right to recovery is referred to as the "Medicaid estate recovery lien." Under federal law the Medicaid estate recovery lien can only be collected at the death of the Medicaid recipient. This lien covers the period of time that a Medicaid recipient received Medicaid assistance during their life, unrelated to Medicaid benefits paid due to an accident (that is, a casualty lien). At a minimum, states are directed to seek recovery against assets that go through a probate court proceeding.

Florida has implemented an estate recovery program against probate assets only. Florida does not impose its lien against assets that bypass probate such as assets titled in a revocable *inter vivos* trust, life insurance proceeds, and accounts that designate a beneficiary. A personal representative and their counsel have an affirmative duty to notify the state Medicaid collection agency of the probate proceeding. The state's Medicaid lien has a Class Three level of priority for payment when an estate is ready to be concluded and the assets distributed.

There are limited exceptions to lien recovery. First and foremost, payments of Medicaid benefits to a person under age 55 do not create a debt. Consequently, there is no estate recovery from a Medicaid recipient who dies before age 55. Second, the debt is not enforced if the Medicaid recipient is survived by a spouse, a child under 21 years of age, or a child (minor or adult) who is blind or permanently and totally disabled as defined under the Social Security Act. Third, due to Florida's constitutional homestead protections, the homestead of a Medicaid recipient is not subject to the lien so long as it is devised to people who qualify as heirs.

Georgia

By Ruthann P. Lacey, CELA
Ruthann P. Lacey, P.C.
3541-E Habersham at Northlake
Tucker, GA 30084
Telephone: 1-770-939-4616
E-mail: rlacey@elderlaw-lacey.com
Web site: http://www.elderlaw-lacey.com

Introduction

To qualify for nursing home Medicaid in Georgia, an individual must be at least 65 years of age, blind, or disabled and must meet certain financial requirements. The financial criteria for 2007 are

- a single person applicant can have up to $2,000 in resources (assets) in his name, plus his home (having up to $500,000 in equity), one vehicle, and certain personal property. He or she can also have up to $10,000 in resources designated for burial purposes (this figure includes the face value of life insurance policies, funds set aside for burial, and the equity value of prepaid burial contracts), plus certain burial space items such as a burial plot, crypt, mausoleum, casket, urn, or headstone.
- The CS can have up to $101,640 in resources in her name, plus her home (having up to $500,000 in equity), one vehicle, and certain personal property as well as up to $10,000 in assets designated for burial purposes.
- the applicant's total income (for example, Social Security, pensions, investment income, etc.) is limited to a maximum of $1,869 per month. If the applicant's gross monthly income exceeds this limit, it will be necessary for the applicant, his agent under a durable power of attorney, or his conservator to establish a qualified income trust (also known as a Miller Trust).

Treatment of the House

The home is property in which the Medicaid applicant has an ownership interest and which serves as the principal place of residence of the applicant, his spouse, or another dependent relative. The home of an applicant who resides in a nursing home is a countable resource, but the value (up to $500,000 of equity value under DRA) will be considered exempt as long as the applicant remains in the nursing home and retains ownership interest in the home. A penalty period is imposed for the transfer of the home.

Protections for the Community Spouse

The CS can have up to $101,640 in resources in her name, plus the home and certain other exempt resources (see the previous list under "Introduction"). Under the MMMNA rules, income from the applicant can be diverted to the CS to increase the CS's income to $2,541 per month.

Treatment of Annuities

The treatment of an annuity is determined by whether the applicant purchased the annuity as part of a legitimate retirement plan or as an attempt to shelter resources for purposes of becoming eligible for Medicaid. If it was purchased in order to shelter resources for Medicaid purposes, then it is considered as a countable resource unless it meets the following criteria.

If the annuity was purchased as part of a legitimate retirement plan, and if the applicant receives periodic payments that include a portion of the principal, the annuity is an exempt resource for Medicaid purposes. However, the income that is paid to the applicant is considered income to him.

An annuity purchased prior to February 8, 2006, that is actuarially sound is treated as a retirement fund. However, annuities purchased before this date may also be subject to the DRA rules if changes are made to the contract on or after February 8, 2006.

An annuity purchased on or after February 8, 2006, is subject to the new DRA requirements. Under the new DRA rules, the annuity must be amortized and payments must be made monthly; the spouse, a minor child, or a child with disabilities can be named as beneficiary; and the state must be named as contingent beneficiary. If these criteria are not met, a transfer penalty is imposed for the value of the annuity; however, if these criteria *are* met and the annuity is not a retirement fund, it is treated as a resource.

Treatment of Retirement Accounts

Retirement funds include annuities, pensions, IRAs, and some profit sharing plans. The value of a retirement fund is the amount of money that the applicant can currently withdraw from the fund. To be eligible for nursing home Medicaid benefits, the applicant must apply for periodic benefits. If he or she has a choice between periodic payments and a lump sum, he or she must choose the periodic payments.

If the applicant receives periodic payments that include a portion of the principal, the retirement fund is excluded as a countable resource. However, the income that is paid to the applicant is considered income to him. If an ineligible spouse owns a retirement fund, the value is excluded as a countable resource.

Estate Recovery Rules

Estate recovery went into effect in Georgia on May 3, 2006, and allows for recovery for care provided on and after that date. There is no recovery against an estate having a total value of less than $25,000. Assets subject to estate recovery include homestead property (even if held by joint tenants with right of survivorship or with a life estate interest), personal property, and other assets. Recovery is delayed if the applicant has a surviving spouse, child under 21 years of age, or child with a disability.

Idaho

By Peter C. Sisson, CELA
Sisson & Sisson, The Elder Law Firm
2402 West Jefferson Street
Boise, ID 83702
Telephone: 1-208-387-0729
E-mail: PeteSisson@IdahoElderLaw.com
Web site: http://www.idahoelderlaw.com/

Protections for the Community Spouse

Substantial assets can be protected for the CS while the IS qualifies for Medicaid benefits that will pay for long-term care services provided by a skilled nursing facility, an assisted living facility, or for in-home care services.

Under the federal spousal impoverishment rules, as adopted by Idaho, the CS is entitled to retain one-half of the spouse's countable resources up to the maximum CS resource allowance of $104,400 (2008 figure). The CS is also entitled to retain exempt assets including the primary residence, personal and household belongings, one vehicle, prepaid irrevocable burial plans, a small amount of cash value life

insurance, and other unavailable assets. Converting excess countable resources into exempt resources is one common planning technique to protect assets for the CS. It may also be possible, depending on the couple's factual circumstances, to increase the couple's countable resources pre-assessment, thereby raising the CS's resource allowance.

The CS may also be able to obtain an increased resource allowance through the administrative process. The couple's gross fixed monthly income and shelter expenses must be examined in light of their countable resources in determining whether this is possible. Seeking court approval of increased resource and income allowances for the CS is another option that should be considered and is a developing area of the law in Idaho. Only a few lower courts having ruled on such petitions with mixed results.

Treatment of Annuities

Idaho's temporary and proposed regulations implementing the DRA do not directly track the federal language addressing annuities. Idaho law imposes additional requirements beyond what federal law mandates, thereby chilling the use of annuities for Medicaid planning in Idaho. Idaho elder law attorneys have formally requested that the Department of Health and Welfare change the proposed regulatory language to bring it in line with federal law. At the time this summary was prepared, it was unknown whether the department would adopt the requested changes. This is another developing area of the law in Idaho.

Idaho Medicaid regulations define annuities and exclude from its definition the annuities described in 42 U.S.C. § 1396p(c)(1)(G)(i) (retirement annuities), thereby exempting those types of annuities from the asset transfer rule discussed in the following paragraph.

Idaho's regulation addressing annuities as an asset transfer (IDAPA 16.03.05.838) currently creates a presumption that assets used to purchase an annuity during the look-back period are asset transfers that give rise to a period of Medicaid ineligibility, unless the participant provides proof that clearly establishes that the annuity was not purchased to make the participant eligible for Medicaid or to avoid estate recovery.

Idaho law also currently requires that "under no circumstances can [an irrevocable annuity] be sold or traded for value, including the sale of the stream of income from the annuity." From a practice standpoint, if the department finds that an irrevocable annuity is saleable, it will consider the balance a resource for eligibility purposes—even if it meets all the other federal requirements under the DRA (that is, it is irrevocable, non-assignable, actuarially sound, and payable in equal amounts with no deferred or balloon payments).

Idaho addresses the actuarially sound requirement found in the federal statute by requiring that the purchase of an irrevocable annuity is an asset transfer if it does not provide fair market value to the participant. Determining fair market value requires the use of the department's life expectancy tables rather than the actuarial publication required by 42 U.S.C. § 1396p(c)(1)(G)(ii)(II). In addition, Idaho's regulation requires that the annuity must produce annual interest of at least 5 percent and the insurer must be rated excellent or superior by an insurance rating firm—further requirements not included in the federal scheme. To rebut the 5 percent presumption, the participant must show that single premium annuities were not offered by insurers when the annuity was purchased and it would not be practical to exchange the annuity for one with a higher interest rate.

Idaho has adopted language that incorporates the federal remainder beneficiary requirements, requires the annuity to provide for payments in equal amounts during the term of the annuity, and prohibits deferrals and balloon payments.

Idaho (Cont.)

By Susan M. Graham, CELA
The Graham Law Office, P.A.
1009 W. Fort Street
Boise, ID 83702
Telephone: 1-208-344-0375
E-mail: susan@graham-legal.com
Web site: http://www.graham-lawoffice.com/

Treatment of Retirement Accounts

Resource Rules

In Idaho, retirement or pension funds of the CS of the Medicaid applicant (participant) are not counted as a resource. This is an exception to the rule that states resources of a spouse are included with those of the applicant [see Aid to the Aged Blind & Disabled (AABD) 16.03.05.215.01]. The definition of a retirement fund includes annuities or work-related plans for providing income or pensions when employment ends. A retirement fund, owned by a participant, is a resource if he or she has the option of withdrawing a lump sum, even though he or she is not yet eligible for periodic retirement payments (see AABD 16.03.0.279).

Spouse of Adult Participant

When a participant is married, the participant's resources include those of the spouse. The resource limit is equals the amount eligible for a couple as soon as the spouse becomes a member of the household; the eligibility comes into effect as of the first moment of the benefit month. The AABD resource exclusions are subtracted. Pension funds the ineligible spouse has on deposit are excluded.

Transfer Rules

If a Medicaid participant transfers a retirement account to another for less than fair market value (that is, makes a gift of the funds), a penalty period is created. A penalty period means an applicant for Medicaid must wait out a period of time before they can qualify for Medicaid. The calculation of the penalty period divides the value of the gift by the average cost of nursing home care in Idaho in the prior year. For the year 2007, the divisor is the 2006 average cost of nursing home care, which was $4,910 or $164 a day. For example, a $10,000 gift of IRA funds would create a penalty period of 2.04 months. If this gift occurred prior to February 8, 2006, the penalty would expire two months after the date of the gift. If the gift was made after February 8, 2006, when the DRA was effective, the penalty period would be 60 days and run from the date the Medicaid applicant applied and qualified for Medicaid.

Estate Recovery Rules

After the death of the Medicaid recipient, who was 55 or older when they received assistance, the state of Idaho is required by federal law to recover the cost of the aid from the Medicaid recipient’s estate and the estate of the recipient’s spouse (see Idaho Code Section 56-218.) Idaho may not recover until both the Medicaid recipient and his spouse is deceased. In addition, Idaho may not recover for benefits paid if the recipient had a child who is under 21 years of age, is blind, or is permanently and totally disabled. Idaho may also look to be reimbursed from any assets that were gifted within three years of applying for Medicaid if the application was made prior to February 8, 2006, and within five years if the application was after February 8, 2011. For the time period in between those two dates, it appears there will be an ever-expanding period for gifts to be available to Idaho to be reimbursed for the aid provided.

Idaho law defines the term estate to include real and personal property and other assets included within the individual's estate, as defined for purposes of state probate law, as well as any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or other individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

Illinois

By Rick L. Law, Esq.
Law ElderLaw
2275 Church Road
Aurora, IL 60502
Telephone: 1-630-585-5200
Toll-free number: 1-800-810-3100
E-mail: rick.l.law@lawelderlaw.com
Web site: http://www.lawelderlaw.com

Introduction

The design and administration of the Medicaid program in Illinois follows broad federal rules. However, variability in Medicaid policy is common among states. This is due to the program's complexity, state interpretation of federal guidelines, and program options. For example and as described in the following paragraphs, Illinois currently does not combine the assets of a nursing facility resident and his spouse when establishing Medicaid eligibility. Illinois also allows for the maximum federal asset and income protections for the spouse of a nursing facility resident that resides in the community. Many states do not.

As of this writing, Illinois has not yet implemented changes as a result of the DRA. The DRA requires that states place a limit of $500,000 on the equity value of a person's home. As an option, states may increase this amount up to $750,000. The DRA also places restrictions on the treatment of annuities. However, given the ambiguity of the law, it is uncertain how Illinois will implement this change. It is also possible that Illinois will revise Medicaid policy to combine a couple's assets when establishing eligibility of the nursing facility spouse.

Treatment of the House

The individual's home is exempt as long as they occupy it. This exemption includes any surrounding property that is not separated from the home by someone else's property. If an individual lives in a nursing facility, the home remains exempt if the person intends to return to it. Illinois does not require a resident to prove their likelihood of returning home or impose any time limits for the return.

If a nursing facility resident does not intend to return home, the property remains exempt if the resident's spouse, sibling, child under age 21, or disabled child of any age occupies it. If not occupied by one of these individuals, it is treated as nonexempt. Illinois applies the equity value of a person's nonexempt home when establishing Medicaid eligibility. However, Illinois will exclude the equity value if the home is rented at a sufficient rate or is listed for sale with a realtor.

Protections for the Community Spouse

Asset Protection

Medicaid law provides a special asset protection for the spouse of a nursing facility resident who resides in the community (CS). Illinois refers to the asset protection as the community spouse asset allowance (CSAA). The federal maximum amount is applied and is increased annually in January.

Illinois currently differs from other states in the determination of the asset protection amount. States, excluding Illinois, combine the countable assets of both spouses when establishing Medicaid eligibility. An asset protection amount for a CS is then excluded from this determination. Assets in excess of the asset protection amount are applied to the nursing facility resident's cost of care. Illinois permits the CS to retain all assets held in their name, even when they exceed the 2007 federal maximum amount of $101,640. They are not applied to the nursing facility resident's cost of care.

The CSAA is the amount of countable assets a nursing facility resident may transfer to his or her CS, without affecting Medicaid eligibility. The amount permitted is determined by subtracting the CS's countable assets from the 2007 federal maximum of $101,640. If the CS's countable assets exceed $101,640, a transfer by the nursing facility spouse is not permitted. The CSAA may not exceed the 2007 federal maximum of $101,640 without a hearing or court order.

The 2008 CSAA has not yet been announced as of the date of this writing (December 12, 2007).

Income Protection

Medicaid law provides a special income protection for the spouse of a nursing facility resident who resides in the community (CS). To compensate for the loss of funds when one spouse enters a nursing facility, the income protection entitles the CS to some or all of the resident's monthly income. Illinois refers to the income protection as the Community Spouse Maintenance Needs Allowance (CSMNA). The federal maximum income protection amount is applied and is increased annually in January. In addition, all income of the CS is protected from use for support of the resident spouse.

The actual amount of income a CS is entitled to, as the CSMNA, is determined by subtracting the CS's gross income from the 2007 federal maximum of $2,541. If the CS's income exceeds the federal maximum, they are not entitled to any additional funds from the resident spouse. The CSMNA may not exceed the 2007 federal maximum of $2,541 per month without a hearing or court order.

The 2008 CSMNa has not yet been announced as of the date of this writing (December 12, 2007).

Illinois (Cont.)

By Martin W. Siemer
Siemer, Austin, Resch, Fuhr & Totten
307 N. Third Street
Effingham, IL 62401
Telephone: 1-217-342-9291
E-mail: msiemer@siemeraustin.com
Web site: http://www.siemeraustin.com/

Treatment of Annuities

In Illinois, an annuity will generally be counted as an asset to the extent that there is access to principal under the annuity contract. To the extent that access to the principal is not permitted under the terms of the annuity contract, the annuity is not counted as an available asset. If there is a penalty for withdrawing

some or all of the principal balance on the annuity, for example, only that portion that is available after imposition of the penalty is counted.

If the contract has been annuitized and periodic payments have started, all payments made to or for the benefit of the Medicaid applicant will treated as income.

The purchase of an annuity is treated as an asset transfer, and a transfer penalty is imposed to the extent that the applicant did not receive fair market value in return. To the extent the annuity is not actuarially sound, it is treated as a transfer subject to a penalty. In making this determination, compare the expected return of investment to the applicant based on the amount of approximately equal periodic payments over the life expectancy of the client. No payments other than approximately equal periodic payments may be considered in making this determination.

As of this writing, Illinois has not yet adopted new rules and regulations conforming to the DRA.

Treatment of Retirement Accounts

Illinois provides no special treatment for retirement accounts. The entire value of a retirement account will be treated as an asset and subject to the $2,000 asset limit for a single applicant, if the applicant's not married. It can be considered as part of the CS asset allowance, if the applicant is married and the rules protecting a CS otherwise apply.

Estate Recovery Rules

Illinois aggressively pursues recovery of benefits paid for long-term care. This is most often done by way of a lien on real estate or a claim in the estate of a deceased recipient of benefits. Liens on real estate will be filed, even against exempt real estate, if the recipient was in a medical institution for at least 120 days. The lien is not filed when the real estate is occupied by a spouse, a minor, a disabled or blind child, or by a sibling with an equity interest in the real estate who has lived there for at least one year prior to the recipient being institutionalized. The lien is also not filed when the stay at the medical institution is expected to be short. A short stay is generally defined as less than 120 days. Liens are enforced when the real estate is transferred, when there is fraud, or when the recipient dies. Whether a lien will be filed and enforced against real estate held in trust depends on whether the trust is revocable and whether the recipient was serving as trustee or otherwise had access to trust property.

Recovery from an estate is attempted when the recipient was at least 55 years of age or was in a medical institution for 120 days and a lien was filed on the recipient's real estate. The estate claim, once filed, is against both real and personal property. Only that property included in the probate estate of the recipient is subject to the claim, unless the recipient received benefits under the Illinois Long-term Care Partnership Insurance Program.

Estate recovery will not be pursued if there is a surviving spouse, a child under age 21, or a child who is blind or disabled. There is also discretion to waive recovery if it would cause an heir or beneficiary undue hardship. To qualify, it must be shown that recovery would cause them to become or remain eligible for certain assistance programs. Until recently, Illinois also pursued estate recovery in the estate of a recipient's spouse; however, this practice was suspended after the Illinois Supreme Court held against it in Hines v. Illinois Department of Public Aid (221 Ill.2d 222, 850 N.E.2d 148, 302 Ill. Dec. 711 (2006)).

Indiana

By Brian K. Carroll
Johnson, Carroll, Norton, Kent & Straus, P.C.

2230 West Franklin Street, P.O. Box 6016
Evansville, IN 47719-0016
Telephone: 1-812-425-4466
E-mail: bcarroll@jcglaw.com
Web site: http://www.jcglaw.com

Introduction

Medicaid is a state and federal program and both federal law and Indiana law and regulations serve as the source of Indiana Medicaid law. In order to be eligible for Medicaid in Indiana, an applicant must meet certain financial guidelines and also fit within one of the coverage categories or groups. Categories of coverage include persons who are age 65 or older, blind, or disabled due to physical or mental impairment that appears to reasonably be certain to last the person's lifetime and which substantially impairs the person's ability to work. Indiana's rules regarding limitations on assets (resources) and to some extent income are fairly similar to other states. Planning for Medicaid eligibility in Indiana often involves planned spend downs—converting countable assets to exempt assets, gifting, or transfers.

Treatment of the House

If the Medicaid recipient is not in a nursing home, ownership of a home will not disqualify the person from receiving Medicaid. If the person dies prior to age 55, there is no estate recovery.

If a Medicaid applicant is in a nursing home, the home does not count as an asset if the home is the principal residence of the applicant's spouse, minor children, disabled or blind children.

The home is not counted, too, if applicant intends to return to the home. The Indiana Medicaid Agency can require verification from the applicant's doctor that there is a possibility that the applicant can return home.

If one of the previous exemptions does not apply, then the home must be offered for sale or for rent as a condition of obtaining Medicaid eligibility.

Protections for the Community Spouse

Indiana Medicaid regulations follow the MCCA. Congress enacted the MCCA so that a CS would not find themselves impoverished due to the IS. The asset limit in Indiana is $1,500 for a single individual and $2,250 for a married couple. The MCCA alters the asset limitation where there is a CS. The MCCA rules apply once an IS has been institutionalized for at least 30 days. The date institutionalization commences is known as the *snapshot*. The CS can keep one-half of the snapshot amount, with a minimum of $20,328 and a maximum of $101,640. Any amounts above the snapshot must either be spent down for the IS's care, converted to assets that aren't counted, or transferred to a third party (but these transferred funds would be subject to a transfer penalty).

Planning strategies to protect the CS are varied. Assets that are counted in determining the snapshot generally include bank accounts, stocks, bonds, and what are viewed as *investable* assets. These assets could be used to purchase real estate solely in the CS's name or rental real estate, both of which are not counted as an asset for Medicaid purposes. The CS is entitled to keep one car of any value. Purchasing a more expensive car with the assets that make up a part of the snapshot amount is also a way of reducing the amount that has to be spent down. Prepaying the IS or the CS's funeral is another way of reducing the countable assets. Although assets are all grouped together in determining the snapshot amount, the CS's income, unlike the IS's income, does not have to be paid to the nursing home. Purchasing an immediate annuity in the CS's name, which is viewed as income, also reduces the countable assets. Indiana does permit a deduction of $52, a personal needs allowance, and the monthly cost of a Medicare

Supplement from the income of the IS. The balance of the IS's income must be paid to the nursing home.

Treatment of Annuities

Annuities that are in the deferred stage where the owners are not obligated to make withdrawals are considered a countable asset for Medicaid eligibility purposes. For the annuity to be considered as income but not as an asset, the annuity either has to have been annuitized (set payments for a specified period of time or for life) if previously in the deferral stage or an immediate annuity where the periodic payments are irrevocably determined by the owner. In order for the purchase of an annuity to not be considered a transfer that invokes a transfer penalty, the annuity must be issued by an insurance company and require periodic payments in the same amount, and be repaid to the owner within the owner's actuarial lifetime.

Upon Indiana fully implementing the DRA, in order to avoid a transfer penalty, the state of Indiana has to be named either the primary beneficiary or secondary beneficiary (if there is a spouse or disabled child) of the annuity, up to the amount of Medicaid benefits paid. Such a requirement does not apply if the annuity is part of an IRA or qualified plan.

Treatment of Retirement Accounts

If the applicant can take a lump sum distribution or a withdrawal from a retirement account, the amount that can be withdrawn is considered a resource. There is some question as to whether a retirement plan in the CS's name is countable or exempt. If the spouse must terminate employment to obtain payment, the amount in the account is exempt. Defined benefit plans, since benefits by their nature are only payable when the person would retire, would be exempt.

Estate Recovery Rules

Indiana has, for many years, had the authority to file claims in the estate of a Medicaid recipient for the amount of Medicaid benefits paid, after the recipient turned 55. Indiana has expanded the definition of an estate, and included certain non-probate transfers, in addition to including interest in real estate held jointly if the joint tenancy was created after July 1, 2002. Indiana has enacted legislation that allows for the Medicaid office to recover benefits from a spouse of a Medicaid recipient's estate, provided the IS has previously passed away. Although on the books, Indiana has not taken steps to assert claims in the estate of a spouse of a Medicaid recipient.

Indiana does permit the filing of liens against real estate of the Medicaid recipient. The law provides a procedure for filing and foreclosing the lien.

Kansas

By Randy Clinkscales
Clinkscales Law Offices, P.A.
201 West 11th Street
Hays, KS 67601
Telephone: 1-785-625-8040
E-mail: randy.clinkscales@eaglecom.net

Introduction

Kansas adopted the DRA on May 1, 2007, retroactive to February 8, 2006. The house in Kansas is a non-

countable resource for spend-down purposes, so long as either there is an intent to return to the house or the house is occupied by the spouse, a minor child, a disabled child, a child that provided care to the IS for two or more years to enable the IS from going into the nursing home for two or more years, a sibling that lived with the IS for one or more years in the house, and if that sibling has an equity interest in the home. If none of the exceptions apply, and even though there may be a statement of an intent to return, after six or more months, the state of Kansas can impose a lien against the house and is entitled to force a sale of the home. The proceeds then become resources, subject to spend down.

The CS and the IS can do a division of assets entitling the CS to not less than one-half of all the countable property, not to exceed $101,640 or less than $20,328. The MMMNA in Kansas is $1,712. The CS and the IS are entitled to certain exemptions, including the following:

- One vehicle
- A second vehicle if necessary for transportation of a disabled person
- A revocable burial fund of $1,500, if properly designated and segregated
- An irrevocable funeral trust of $5,000 and more if the state is named as the primary beneficiary for any excess funds
- Personal belongings

All annuities must qualify as Medicaid annuities to avoid being counted as a resource. An exception applies to annuities that were established prior to February 8, 2006, which have not undergone any significant change. Retirement plans of the IS will be considered a resource, unless they are in a pay-out position, in which case it will be treated as income. The CS's retirement is not counted as a resource.

Kansas has expanded estate recovery. It will bring back into the estate any interest the deceased had at the time of death, including life estates, joint tenancy, pay-on-death accounts, and transfer-on-death deeds. Kansas does offer a credit against estate recovery for all amounts of long-term care paid by long-term care insurance. Kansas just adopted the long-term care partnership.

Kentucky

By Bernard M. Faller, Attorney at Law
3630 Dutchmans Lane, Suite 1
Louisville, KY 40205-3216
Telephone: 1-502-581-1111
E-mail: KYElderLaw@aol.com
Web site: www.KYElderLaw.com

Introduction

Kentucky adopted the DRA on February 1, 2007, retroactive to February 8, 2006. Kentucky Medicaid rules are similar to those found in many other states. Applications must be filed at the local Medicaid office in the county in which the nursing home is located. It is not possible to file by mail or via the Internet, and most offices will not do field visits for nursing home applications.

Individual Medicaid offices are inconsistent in applying the rules. Local offices, especially smaller ones, seem to make up their own rules about what is and is not permissible. Some do not permit the transfer of a home, others do not allow any gifting while some state that lawyers are not permitted to accompany the applicant. All of these violate state regulations. Therefore, it is particularly important to be knowledgeable about the regulations. A request for a fair hearing, the first step after an eligibility denial, often brings a change of heart when wiser minds review the facts and see that the applicant is in compliance with the published regulations.

The Department for Medicaid Services can be found at http://chfs.ky.gov/dms/default.htm.

The Kentucky Administrative Regulations, 907 KAR, can be found at http://www.lrc.state.ky.us/kar/title907.htm.

The caseworkers follow the instructions contained in the operations manual Volume IVA. The manual is not readily available from the Department for Medicaid Services Web sites. It can be found at http://manuals.chfs.ky.gov/dcbs_manuals/DFS/VOLIVA/VOLIVATOC.doc.

The skill level of the caseworkers varies widely. There is a core of experienced and dedicated caseworkers who understand the system, but the Agency seems to have a turnover problem and newer workers can be defensive or hostile. In addition, offices are often understaffed and are commonly in physically unattractive condition.

The best advice in dealing with local offices is to be well prepared, courteous, gently firm when necessary but in a respectful way, and knowledgeable as to the documentation that the caseworker needs to approve your application or issue.

Treatment of the House

Homestead rules are found in 907 KAR 1:645 and can be accessed at http://manuals.chfs.ky.gov/dcbs_manuals/DFS/VOLIVA/VOLIVATOC.doc.

If there is a CS, the home is exempt, regardless of value, if the spouse or a dependent family member resides there.

For a single individual, the home is exempt for the first six months of institutionalization under the theory of “intent to return home.” The home will remain exempt for an additional six months if the institutionalized individual signs a statement that he or she intends to return home. The cost of maintaining the home is not a permitted expense for the institutionalized individual and must be borne by family members or other willing parties. After the above six or 12 months, the home must be sold unless the individual qualifies for one of the exemptions mentioned below. Following the sale, the individual reverts back to private pay status until the sale proceeds are exhausted. Medicaid must be notified within ten days of receipt of the proceeds of the sale of the house along with a copy of the closing statement and the deposit slip showing that the full proceeds were deposited into the account of the nursing home resident.

Ownership of a home with equity in excess of $500,000 will automatically disqualify a single applicant from Medicaid services unless a child who is under age 21, is blind, or is totally disabled resides in the home.

Transferring ownership of the house is generally a prohibited transaction subject to the same penalty as the transfer of any other resource. The value of the home is measured by the tax assessed value prior to any senior citizen exemption. For farm property, the value is the *fair cash value* listed on the tax assessment statement and not the lower *agricultural value* on which tax is actually paid.

Adding another party to a deed is considered a transfer of resources to the extent of the transferred interest. Deed transfers are considered to have occurred on the date they are recorded, not the date of signature and delivery, the law not withstanding.

Home transfers are permitted to the spouse, a child under age 21, a child of any age who is blind, or a child of any age who is disabled. There is no requirement for any of the above to reside in the home. An adult child who is receiving Social Security Disability Income (SSDI) meets the disability requirement. Persons receiving SSDI receive a Social Security award letter every year just like persons receiving Social Security retirement income. If not available, order a *proof of income* statement at www.ssa.gov. Do

not permit the transfer of a home to a disabled child until he or she produces his or her award letter.

A home may be transferred to a caregiver child who resided in the parent's house for at least two years immediately preceding the nursing home admission and provided care such that without that care, a nursing home admission would have been needed at least two years sooner. Proof required are letters from two unrelated parties attesting to the above. The family doctor, while not a required person, is usually a good choice. A neighbor or other medical provider could be used for the second letter. Make sure that these people had a relationship with the applicant for the full two-year period.

The home may also be transferred without penalty to a sibling who resided with the applicant for one year prior to admission and has an equity interest in the home. Any equity interest is sufficient, but make sure the interest is recorded.

Proceeds from the sale of a home shall be excluded from consideration for three months from the date of receipt if used to purchase another home. Theoretically, this is a very useful tool for the CS to preserve assets. As a practical matter, most elderly with a spouse in a nursing home are not willing or capable of handling the related upheaval of selling their home, buying a new home, and moving.

Protections for the Community Spouse

The CS is any spouse not confined to a facility or confined to a facility but not receiving intermediate or skilled nursing care. Generally, if a spouse is not in a nursing home, he or she is a CS.

The CS may keep half of the countable resources up to $101,640. This number is indexed for inflation and increases every January 1. The magic word is countable. At this stage, it does not matter if the resource is titled in the name of the husband, in the name of the wife, is jointly titled, or is titled in a living trust. Certain resources are excluded and, thus, not countable. The home, regardless of value, is excluded. Retirement accounts, including traditional IRAs and Roth IRAs, of both the IS and CS are excluded. One car of any value is excluded if used or available to provide transportation for medical care. The client will need a letter from the family doctor stating that the applicant is capable of being transported in that specific vehicle. This is a new interpretation of an existing rule. Prepaid irrevocable funeral contracts up to $10,000 each are excluded as a countable resource. Contracts in excess of $10,000 may be acceptable if paid by life insurance at the option of the Medicaid agency.

Check 907 KAR 1:645 Section 3 "Resource Exclusions," for the full list of excluded resources.

There is also a floor for the CS. To the extent that his or her share of the family countable resources falls below $20,328, he or she may keep the first $20,328. For example, if countable resources total $30,000, the CS keeps $20,328, and the remaining $9,672 must be spent down to $2,000 before the IS becomes Medicaid eligible.

The CS can keep all of his or her income. To the extent his or her income falls below the CSIA, currently $1,711 a month for 2007–2008, the CS may keep a portion of the IS's income. A shelter allowance may raise this number but in practice is only useful if the CS is renting or still has a sizeable mortgage. This number is indexed for inflation and adjusts every July 1.

To the extent that all available income of both spouses fails to bring the CS up to the CSIA, assets may be retained by the CS to generate income to reach the CSIA. This is a contentious process with Medicaid—the regulations not withstanding—and requires an administrative process called a fair hearing. Do not let the name be misleading. This process is much less than fair or impartial.

Once Medicaid qualification is established, transfer all assets from the IS to the CS within six months. The IS should have less that $2,000 of resources at all times, measured at the end of each month.

Treatment of Annuities

Annuities have had a tortured history in Kentucky. The current rules are found in 907 KAR 1:650, Section 2, "Transferred Resources (7) & (8)," but are subject to modification. Caseworkers send all annuities to Frankfort for review. Do not expect a reply for three to six months. It is especially important to know the annuity rules because annuities are often classified incorrectly as an available resource. It is far from unusual for identical annuities sent to Frankfort at the same time to be treated differently. (Check the Kentucky Cabinet for Health and Family Services Web site at http://chfs.ky.gov/ for updates.)

The purchase of an annuity is considered a transfer of resources unless it meets all of the following requirements. The expected return of the annuity must be commensurate with the life expectancy of the beneficiary, thus making the annuity actuarially sound. Use the life expectancy table found on the Kentucky Medicaid Web site (http://chfs.ky.gov/dms/default.htm); a new table may appear shortly. *Actuarially sound* means the annuity must pay out in full over the beneficiary's life expectancy. No lifetime payout with a period certain is permitted, as is typical in most annuities. If the life expectancy is nine years, payout may not exceed 108 months. To be safe, pick a slightly shorter time period for the payout than the life expectancy.

Monthly payments must be substantially equal, meaning total annual payout in any year may not vary by 5 percent from the previous year. To be safe, select a level payout.

The state must be named as a remainder beneficiary in the first position for the total amount of benefits paid or in the second position if there is a CS or minor or disabled child.

It is not clear at the time of this writing if the state must be a beneficiary if the CS is the annuitant. This point will likely be litigated over the next few years. For the present, assume that the beneficiary rules are the same regardless of which spouse is the annuitant.

The annuity should be irrevocable, non-assignable, non-transferable, and have no deferral or balloon payments.

A word of caution: Medicaid qualifying annuities are very specialized products and should only be purchased from agents familiar with this area. This eliminates 100 percent of banks and 95 percent of insurance agents and financial planners. Contact the National Academy of Elder Law Attorneys for a referral.

It appears that private annuities are acceptable if properly drafted. Private mortgages and notes also appear to be acceptable if actuarially sound, but self-canceling installment notes are not permitted. However, expect the review process for anything other than commercial annuities to be longer and the results to be less predictable, at least for the next few years.

As of late spring 2007, Kentucky is considering including all annuities as available resources on the basis of a secondary market existing for all annuities regardless of language in the contract that the annuity may not be assigned or transferred. The states' position would be directly contrary to the language and intent of federal law (DRA §6012.) Litigation is likely in this area as the states' position is unsupportable. For the reader, be aware that Kentucky often violates federal law on the theory that Medicaid applicants lack the time and resources to challenge adverse rulings. This is likely to be an unsettled area for a few years.

It's all about money. The Kentucky legislature has authorized Medicaid to establish the maximum an applicant can pay legal counsel to prepare and argue an adverse decision. For fair hearings and appeals to the Public Appeals Board, an attorney may charge up to $75 to prepare and argue at each level. To

litigate in Circuit Court, a process that can take several years and will pit a host of state attorneys against the Medicaid applicant, an attorney may charge up to $150.

In the upside down world of the Kentucky Medicaid administrative mindset, people who have never worked, never paid taxes, and spent much or all of their lives on public support are the good people. People who have worked their whole lives, paid the taxes that have supported Medicaid for the last four decades, followed the rules, and now want to leave a few crumbs to their families as a legacy of lifetime work and prudence are the evil people who are destroying the system.

Treatment of Retirement Accounts

Kentucky is more respectful of retirement accounts than many other states. As a resource, they are exempt. Retirement accounts do not count in calculating the CSRA and do not count towards the $2,000 maximum resource standard for a single applicant.

For IRAs, the recipient must withdraw at least the minimum annual federal requirement for the IRA to maintain its exempt status. Regular monthly withdrawals from IRAs make the job of the caseworker easier and avoid losing the exemption because a family member failed to take the required distribution. Distributions are income for Medicaid purposes and are treated like all other income.

Roth IRAs are treated like regular IRAs for purposes of minimum annual distributions. The rules are silent for minimum withdrawals for persons under age 70 and one-half and treatment is inconsistent in Kentucky. It would be prudent to take an appropriate distribution based upon life expectancy.

Take similar distributions from all other retirement plans. These rules all apply to both spouses.

Estate Recovery

Estate recovery is handled by the Public Consulting Group in Atlanta and is a much more pleasant organization to deal with than the Department for Medicaid Services in Frankfort. Telephone calls are returned, letters are answered quickly, and the answers relate to the questions asked. Regulations can be found at 907 KAR 1:585.

Kentucky uses the expanded definition of estate, which includes everything you owned at death, everything you owned at the moment before death, life insurance proceeds, joint property interests, life estates, living trusts, everything to which you had a right to claim title, and everything you ever thought about owning (just kidding).

Most Medicaid recipients are poor—a requirement for Medicaid—so there is no recovery from most estates. There is also no estate recovery where there is a surviving spouse, disabled child, or where the estate is less than $10,000 after subtracting unpaid final expenses.

A typical estate recovery case involves the decedent owing a house. Public Consulting Group takes a practical approach to these cases, allowing a deduction for broker's fees, executor's fees, and attorney's fees. Other deductions may be available to the extent that the home is in poor condition and independent arm's length documentation is provided to show that the home is worth less than the Property Valuation Administrator (PVA) (tax) value. Lacking such evidence, the PVA value is accepted as the fair market value of the home if the home has not been sold.

Kentucky claims that it has the right to life insurance proceeds although the legal basis for such a claim is unclear, and it does not appear that these claims are being pressed at this time.

Kentucky has begun to pursue interests in joint property owned at the time of death. Kentucky sends an

estate recovery claim to the executor or designated family member and will litigate if the claim is ignored or a *denial of claim* is issued. Kentucky courts have not ruled in these cases yet but Medicaid's position has been upheld in other states. Negotiation is a better posture.

Kentucky is also respectful of the surviving CS and does not pursue his or her estate when he or she eventually dies. If the CS survives the IS, there is no estate recovery.

Louisiana

By David R. Loveridge
Snellings, Breard, Sartor, Inabnett & Trascher, L.L.P.
1503 North 19th Street
P.O. Box 2055
Monroe, LA 71207
Telephone: 1-318-387-8000
E-mail: dloveridge@snellingslawfirm.com
Web site: http://www.snellingslawfirm.com/

Introduction

In Louisiana, single individuals who desire Medicaid assistance with nursing home costs are permitted countable assets in the amount of $2,000. If both husband and wife are institutionalized, the couple is permitted $3,000. If one spouse is "in the community," the so-called CS is permitted to keep countable assets in the amount of $99,540 (in 2006). (The term CS, in Medicaid parlance, refers to the spouse who is living in the "community," as opposed to living in a nursing facility. The term has nothing to do with Louisiana's community property laws; Louisiana Medicaid does not distinguish between separate and community property.) Certain assets, such as home equity, auto equity, and burial arrangements are excluded (within limits).

If an individual has made gifts during the applicable look-back period (three or five years, depending on when and to whom the gift was made), Louisiana imposes a penalty (waiting) period based on the amount of the gift. In 2006, the waiting period is one month for every $3,000 donated. For gifts made on or after February 8, 2006, the penalty begins when the individual meets all other eligibility requirements.

Treatment of the House

In Louisiana, nursing home residents do not have to sell their homes in order to qualify for Medicaid. The home will not be considered a countable asset for Medicaid eligibility purposes as long as the nursing home resident intends to return home. There is no equity limit if the Medicaid recipient's spouse or another dependent relative lives there. Otherwise, equity above $500,000 will be considered a countable asset.

Protections for the Community Spouse

Medicaid provides special protections for the CS to make sure he or she has the minimum support needed to continue to live in the community. The income of the CS will continue undisturbed, regardless of the amount. In addition, if the CS's income is below $2,488.50 (in 2006), the CS is entitled to some or all of the monthly income of the IS.

The CS is permitted to keep countable resources in the amount of $99,540 (in 2006). Certain assets, such as home equity, auto equity, and burial arrangements are not considered countable resources (within limits). If the income from this resource allowance, together with the income transferred from the

IS, is insufficient to raise the CS's income to $2,488.50 (in 2006), federal law provides for the opportunity for the CS to appeal for a higher resource allowance.

Treatment of Annuities

Non-employment–related annuities are considered to be available to pay for the cost of care, unless all of the following conditions are satisfied:

1. The annuity must be irrevocable.
2. The annuity is paying out principal and interest in equal monthly installments (no balloon payment) to the individual in sufficient amounts that the principal will be paid out within the actuarial life expectancy of the annuitant (as determined by Medicaid tables).
3. The annuity names the state of Louisiana, Department of Health and Hospitals, or its successor agency as the primary and permanent residual beneficiary of funds remaining in the annuity, not exceeding any Medicaid funds expended on the individual during the individual's lifetime (federal law permits the CS or minor child to be named beneficiary in the first position).
4. The annuity is issued by an insurer or other body licensed and approved to do business in the jurisdiction in which the annuity is established.

Note: For employment-related annuities, see the following section, "Treatment of Retirement Accounts."

Treatment of Retirement Accounts

Applicant/Recipient

If the applicant is eligible for periodic (usually monthly) retirement benefits, he or she is required to apply for benefits. If the applicant is not eligible for periodic payments, but has the option of withdrawing the funds, the retirement fund is counted as a resource. Funds in an IRA are considered a countable resource.

Spouse

Retirement funds owned separately by the CS are considered in the long-term care determination of combined countable assets—if the fund balance is available to the CS.

Estate Recovery Rules

Current (2006) practice is to allow an exemption of $15,000 or one-half of the median value of the homesteads in the parish from the homestead property. Recovery may be reduced in consideration of reasonable and necessary documented expenses incurred to upkeep the home during the period the decedent resided in the long-term care facility, if the homestead is part of the estate.

Recovery from the estate is deferred in situations where there is a surviving spouse, surviving child under age 21, surviving blind, or surviving disabled child. In addition, the Department of Health and Hospitals waives estate recovery when such recovery would work an undue hardship. Undue hardship exists when an heir's family income is 300 percent or less of the federal poverty income level (an heir is defined as a descendant in the first degree); the estate is the sole income-producing asset of the heir; and recovery would result in the heir's necessity to apply for and become eligible for public assistance, including, but not limited, to Medicaid.

Maryland

By Ron M. Landsman, P.A.
200-A Monroe Street, Suite 110
Rockville, MD 20850
Telephone: 1-240-403-4300
E-mail: rml@ronmlandsman.com
Web site: http://www.ronmlandsman.com

Basic Figures

Note: Maryland uses the minimum federal amounts for all spousal benefits.

Spousal benefits

Spousal resource standard	$99,540
Spousal income standard	$ 1,650
Excess shelter standard	$ 495
Personal needs allowance	$ 64
Institutionalized individual resource allowance	$ 2,500

Utility standard allowance

Heat included in rent	$ 183
Heat not included	$ 304
Maximum spousal maintenance standard	$ 2,498

Introduction

Although some elder law attorneys view Maryland as a cesspool of hostility to Medicaid planning ("I wake up in a sweat dreaming I practice elder law in Maryland," says one Florida lawyer), the reality is not nearly that bad. Procedurally, it has a well-run system: Public regulations made through notice-and-comment rule-making; an eligibility manual that is lengthy, if not always as clear and comprehensive as it might be; a procedurally-proper hearing process, even if the administrative law judges seem to have a little trouble with the supremacy clause; and its document requirements in application procedures are strict.

Turning to substance, on the positive side, its treatment of homes and former homes is relatively generous for institutionalized beneficiaries and it does not attempt to restrict the use of special needs trusts. On the negative side, it is not at all spouse-friendly, notwithstanding that its long-time senator, Barbara Mikulski, was a leading force in enacting spousal impoverishment rules in 1988; it continually attempts to use a standard for nursing home level of care that centers for Medicaid services (CMS) disapprove; and it has had a fairly aggressive estate recovery system—long before any recovery was made mandatory by Congress.

Treatment of the Home

Maryland follows the generous SSI rule for treatment of home property: It is exempt if lived in by a spouse, disabled child, or financially or medically dependent relative, or if the institutionalized owner "intends to return" to the home at some point. The home includes one residence and all contiguous land owned by the individual, however deeded. The intent to return rule is very generously applied, approaching a legal fiction; so long as a representative states there is an intent to return home—notwithstanding that it is medically inconceivable and the resident lacks the capacity to have any intent—the home is exempt. Moreover, Maryland recognizes that a person can be a resident of Maryland (intent to remain for an indefinite period of time) even though there is an exempt home in another state (to which they intend to return at some point). Although this rule is required by federal policy, not all states comply as Maryland does. This rule is particularly beneficial given the frequency with which former D.C.

residents, or parents who move to the area to be near children who came to the area for their professional lives, use Maryland Medicaid long-term care benefits.

Generous treatment of the home is offset by longstanding use of so-called TEFRA liens, which permit the state to recover back whatever it paid for the person's care on the sale of their former home, if not lived in by a spouse or disabled child. Maryland also has a well-organized and effective estate recovery program. However, both the liens and estate recovery are not, as a practical matter, very effective on out-of-state former homes.

Deeds that convey real property retaining a *life estate with powers*, sometimes called "Lady Bird deeds," can be used in Maryland and are the preferred means for avoiding liens and estate recovery for married individuals. However, Maryland does not permit their use when intent to return is the only basis for exempting the home.

Maryland (Cont.)

By Richard K. Abraham
Abraham & Bauer, L.L.C.
305 Washington Avenue, Suite 203
Towson, MD 21204
Telephone: 1-443-901-1333
E-mail: r-abraham@att.net

And

Valorie Leeb
Accent on Elder Law
305 Washington Ave., Suite 203
Towson, MD 21204
Telephone: 1-410-769-9001
E-mail: info@accentonelderlaw.com
Web site: http://www.accentonelderlaw.com

Post-DRA Protection for the Community Spouse

As of this writing, Maryland has yet to issue most of the new regulations to bring the state into compliance with the DRA.

The DRA significantly impacts the ability of the CS to protect assets via medical assistance (Medicaid) planning. In Maryland, the CS can still retain one-half of the total assets up to a maximum spousal resource limit of $99,540, adjusted annually for inflation, and up to $2,500 in the applicant's name. The state will examine assets titled in the name of either spouse individually, jointly, or with others. The resource allowance limitation does not include the primary residence, which can be protected up to a value of $500,000 under the DRA (said figure subject to being increased up to $750,000), cars, and personal effects. Furthermore, when the combined assets are less than $19,908, the entire amount is sheltered from Medicaid. The DRA also lengthens the look-back period, which is the period of time Maryland examines all assets titled in any manner in the applicant's name, the CS's name, or both of their names. The look-back period under the DRA is expanded from 36 months to 60 months. This correspondingly lengthens the period of time for which a penalty can be assessed to 60 months (and, in certain cases, beyond). It is accordingly imperative that families retain all financial records, so that at any given time, 60 months of information is available.

In Maryland, transfers between spouses are typically exempt from penalty. In addition, Maryland does not place an artificial ceiling on income. When taken together, these parameters for planning can be beneficial when dealing with real property, life insurance, variable annuities, and financial accounts. It is essential to remember that the previously stated resource limits will be strictly enforced. As a result, long-term care insurance, annuities, certain types of trust planning, care giver employment contracts, life estate deeds, and even gifting remain options to preserve assets. However, all must be examined under the confines of DRA. It is also significant that the preservation of assets above the spousal resource cap can be subject to penalty. Pre-DRA penalized certain transfers as of the first day of the month in which the transfer occurred. Penalty under the DRA will not commence until the Medicaid applicant is institutionalized and otherwise eligible for benefits except for the transfer that created the penalty.

Post-DRA Use of Annuities

The DRA specifically attempts to change the manner in which annuities can be utilized pursuant to the Maryland Medicaid program. The DRA attempts to treat the conversion of assets to income with a subsequent annuity purchase as a transfer of assets subject to penalty. The state will examine the purchase and attempt to show the annuity as a disposal for less than fair market value. DRA also enumerates that the state must be named as the primary or secondary beneficiary to the extent that benefits are paid on behalf of the annuitant. Upon the annuitant's family demonstrating he or she did not receive Maryland Medicaid benefits, the state should release its claim.

However, an annuity purchased by or on behalf of an annuitant who applied for Medicaid will not be treated as a transfer of assets under the DRA if the annuity is one that is described in §408 of the IRC of 1986, is purchased with proceeds from an account or trust described in (a), (c), or (p) of §408, is a simplified employee pension within the meaning of §408, is a Roth IRA described in §408A, or if the annuity is irrevocable, non-assignable, and is actuarially sound.

As with pre-DRA annuities, the purchase of post-DRA annuities must be actuarially sound so that the original investment is returned to the annuitant during the term of the contract and is pursuant to the annuitant's life expectancy. The term of the contract continues to be determined by the annuitant's age at the time of purchase. The annuity must still be irrevocable, non-assignable, and all payments of income must be in like amounts, none being deferred or in the form of a balloon. A single applicant can continue to use the annuity as an option to achieve Medicaid eligibility to the extent that it does not exceed the applicant's cost of care. However, if the annuity increases the applicant's monthly income to and exceeds the cost of care, Medicaid eligibility is jeopardized. Annuities remain an attractive option in spousal cases since they can be used to increase the CS's total income, but the planner must caution the client of certain negative aspects of the annuity purchase. By increasing the CS's income, the annuity may limit or eliminate that persons' spousal allowance. The CS is allowed a portion of the applicant's income if the CS's minimum income is below the Medicaid poverty line (adjusted annually for inflation). If, at a later time, the CS requires institutionalized care, the annuity payments are considered part of their income and will be paid to the care facility. At that point, the annuity will no longer protect assets.

Maryland (Cont.)

By Morris Klein, Attorney at Law
4550 Montgomery Avenue, Suite 601 N
Bethesda, MD 20814
Phone: 1-301-652-4462
E-mail: morrisk@capaccess.org
Web site: http://www.lawyers.com/morrisklein

IRAs

A Medicaid beneficiary's IRA account is considered as an available resource; the spouse's IRA is considered as an available resource when determining the snapshot and spend down. Income from the Medicaid beneficiary's IRA is countable income that is to be paid to the nursing home as part of the patient's contribution to the cost of care.

Estate Recovery

The state will place a lien on the Medicaid beneficiary's residence if the beneficiary is not expected to return home within six months. The state will assert the lien if the property is sold during the beneficiary's lifetime or from the beneficiary's estate. It will not assert the lien if the beneficiary's spouse or disabled child is residing in the property, or in the rare case when the state accepts a claim of hardship.

The state will also recover from the Medicaid beneficiary's estate those payments made for long-term care services (nursing home as well as home and community-based waiver services). Estate recovery is limited to persons who were 55 years or older when receiving Medicaid. Recovery is limited to the Medicaid beneficiary's probate estate. There is no augmented estate or tracing of assets owned by others back to the beneficiary.

The state may file a claim against the beneficiary's estate upon the earlier of six months after publication of notice of the first appointment of a personal representative or two months after the personal representative mails or otherwise delivers to the state the formal notice of creditors that is published in the newspaper or other written notice, notifying the state that the claim shall be barred unless the state presents its claim within two months from the receipt of the notice.

Maryland law permits a spouse to *elect against a will* and claim one-third of the estate if there is surviving issue or one-half of the estate if there is no surviving issue. When a Medicaid beneficiary survives a spouse who was living in the community and the decedent bequeathed to the Medicaid beneficiary less than the elective share, the state would treat the failure of the surviving spouse to elect against the will as transfer of assets subject to the penalty transfer rules.

Massachusetts

By Hyman G. Darling, Esq.
Bacon & Wilson, P.C.
33 State Street
Springfield, MA 01103
Telephone: 1-413-781-0560
E-mail: hdarling@bacon-wilson.com
Web site: http://www.bacon-wilson.com

In Massachusetts, the Medicaid program is operated by the Office of Medicaid, but is called MassHealth. Considerable information can be found at the MassHealth Web site, www.mass.gov.

Treatment of the House

The house, if it is the principal residence, is exempt for a married couple regardless of the value. Transfers between spouses are exempt without any disqualification period and a lien may be placed on a home when MassHealth services are being provided. Estate recovery does not become implemented so long as a spouse, disabled child, minor child, or other hardship may exist. Upon sale of the home, the lien amount must be paid, but a replacement home may be obtained with the net proceeds with approval of the state.

A single person will be entitled to have a home with an equity value of not greater than $750,000. In the event that there is a reasonable likelihood that the MassHealth applicant may return home, the house may be determined to be exempt. If not and if the home's equity exceeds this limit, the state will give the MassHealth applicant a period of up to nine months to sell the house. At that time, MassHealth will require repayment for the balance outstanding for services rendered through the date of the sale, and the MassHealth applicant will then become private pay upon receipt of the proceeds.

In any event, whether the applicant is married or single, as long as the MassHealth applicant has long-term care insurance that meets minimum requirements, a lien may not be attached to the home.

Massachusetts (Cont.)

By Philip Moran P.C.
265 Essex Street, Suite 202
Salem, MA 01970
Telephone: 1-978-745-6085
E-mail: philipmoranesq@aol.com

Protection for Community Spouses

When one spouse is institutionalized, the CS has two basic financial protections in addition to the marital home, which is a non-countable asset. The first is the CSRA and the second is the MMMNA.

Due to an override of the Governor's veto, as of July 1, 2006, Massachusetts is one of the states that allows the CS the maximum CSRA or $104,400, regardless of whether or not this amount represents one half of the couple's assets.

In addition to the $104,000 CSRA, the CS is allowed a MMMNA of at least $1,711.25, up to a maximum of $2,610. This protection includes the CS's shelter and utility costs in addition to federal standards. Thus, if the CS's monthly income is less than $1,711.25, then he or she is allotted the difference from the IS's monthly income.

For example, if the couple owns a home worth $300,000 and other assets of $200,000, and the IS's monthly income is $1,500 and the CS's monthly income is $550, the following calculations will show how the CS is protected. First, the home is a non-countable asset and the CS will be able to remain there, although an outright transfer to the CS would be recommended. As for the other $200,000, the CS would be allowed to keep $104,400, and the institutionalized could keep $2,000. The remaining $93,600 would have to be spent down. With respect to the MMMNA, the CS would receive at least $1,161.25 of the IS's monthly income to add to her $550 to meet the MMMNA.

Massachusetts (Cont.)

By Carol Cioe Klyman
Shatz, Schwartz, and Fentin, P.C.
1441 Main Street
Springfield, MA 01103
Telephone: 1-413-737-1131
E-mail: cklyman@ssfpc.com
Web site: http://www.ssfpc.com

Estate Recovery and Lien Rules

Massachusetts limits estate recovery to assets in the deceased beneficiary's probate estate. Massachusetts has a statutory lien on personal injury awards and, during the lifetime of a recipient, will record a notice lien on the home unless a spouse, a minor child, a disabled child, or a sibling with an equity interest resides in the home. Note that if the MassHealth recipient did not own the asset in his name alone or as a tenant in common, then the asset is not included in his or her probate estate. Individuals affected by the recovery rules include those who received MassHealth after age 55 and younger individuals who are permanently institutionalized.

In addition to the exemption noted above, if an individual who receives nursing home benefits has a long-term care insurance policy that meets certain requirements, Massachusetts will waive estate recovery. The rules currently require individuals to have at least two years of coverage paying $125 a day in place on the date he or she enters the nursing home.

The Office of Medicaid must receive notice when the petition for probate is filed for all Massachusetts decedents. The Estate Recovery Unit has the later of one year from date of death or four months from the date the estate fiduciary is appointed to file the claim against the probate estate.

Michigan

By Christopher T. Lindsay
Estate Planning Services, P.C.
42000 Six Mile Road, Suite 125
Northville, MI 48168
Telephone: 1-734-432-3132
E-mail: lindsay@formyplan.com
Web site: http://www.formyplan.com

Introduction

Michigan is not expected to incorporate the DRA rule changes into its state Medicaid plan until early 2007 and it is unclear how, or if, the new rules will be applied retroactively. The following guidelines are pre-DRA.

Michigan has Medicaid programs for both in-home and nursing home care. To qualify for Medicaid, an applicant must be in need of nursing home level medical care and must have sufficiently low countable gross income and assets. The nursing home income limit is equal to the monthly private pay rate for skilled care in the nursing home where the applicant is living, plus $20, while the in-home income limit is $1,809 a month.

The applicant is entitled to keep certain assets that are considered excluded or unavailable. All other assets are considered countable and the applicant can retain only $2,000 of those assets. Assets that are considered excluded or unavailable include the following:

- Household furnishings and personal goods (of unlimited value)
- One motor vehicle (of unlimited value)
- One homestead (of unlimited value)
- Employment related assets (of unlimited value)
- Income-producing property, with equity of up to $6,000 (if it produces net income equal to 6 percent of equity)
- A pre-paid funeral contract for applicant (up to $10,808)
- A burial fund for applicant, spouse, child and spouses of each (of unlimited value)
- The cash value in small life insurance policies owned by the applicant
- Omnibus Budget Reconciliation Act compliant annuities
- Installment loans secured with real or personal property (with no marketable value)

- Assets placed in a “solely for the benefit of” trust in favor of a spouse or disabled child
- Assets placed in certain special needs and Medicaid Exception trusts
- Money placed in a properly structured personal care agreement

Michigan has a three year look-back period for divestments (five years for transfers to trust). The monthly penalty for a divestment is equal to the value of the transfer or gift divided by the average cost of attendant nursing home care in Michigan ($5,549 in 2006). The monthly penalty begins to run immediately and partial month penalties are rounded down.

Treatment of the House

One homestead, of unlimited value, is excluded. It is considered a divestment to transfer the homestead to anyone but the applicant’s spouse, a blind or disabled child (regardless of age), a child under 21, a child over 21 who has resided with the applicant in the homestead immediately before nursing home admission and who provided two years of care that prevented the applicant from having to enter a nursing home, or a brother or sister who is part owner of the homestead and who lived there for one year immediately before the applicant entering the nursing home. Presently, there is no right of lien on the house, but there is legislation that has been introduced that would provide for such a lien.

Protections for the Community Spouse

The CS is entitled to a CSIA and a CSRA at the standard statutory minimum and maximum levels, subject to increase per court order. The DRA will likely prevent judicial increases of the CSRA, except in rare situations. Assets placed in a testamentary special needs trust are considered unavailable, as are assets transferred into a solely for the benefit of trust for the CS. Assets transferred to CS within one year of Medicaid approval are not divestments.

Treatment of Annuities

Funds, qualified or non-qualified, transferred into an annuity are considered unavailable and will not be treated as a divestment provided the annuity is commercially issued; purchased by the applicant or CS for the benefit of either; irrevocable; non-transferable; non-redeemable; non-commutable; actuarially sound; and pays out in substantially equal monthly payments. No balloon style annuities are allowed after September 1, 2005. Presently, there is no right of lien against such annuities. The monthly payments are considered countable income, unless paid to the CS, and are applied towards the applicant’s patient pay amount.

Treatment of Retirement Accounts

Retirement accounts are a countable asset, unless the funds are properly annuitized (see the previous “Treatment of Annuities” section). It is unclear whether Michigan will interpret the DRA to require the state be named as primary or contingent beneficiary of such retirement accounts.

Estate Recovery Rules

Michigan is the only state without an estate recovery law. Bills have been introduced in both houses of Michigan’s legislature and remain pending.

Minnesota

By Long, Reher and Hanson, P.A.
5881 Cedar Lake Road
Minneapolis, MN 55416
Telephone: 1-952-929-0622
E-mail: creher@mnelderlaw.com
Web site: http://www.mnelderlaw.com

Introduction

Minnesota's Medicaid program is called Medical Assistance (MA). MA will pay for most medically necessary services, although some services require prior authorization. To receive MA, an individual must be a Minnesota resident. People establish Minnesota residence by being physically present in the state, residing here voluntarily, and not maintaining a home elsewhere. There is no durational requirement.

In general, to be eligible for MA, the MA recipient is limited to $3,000 in available assets. A married couple, both of whom are applying for MA, is limited to $6,000 in available assets. For a married couple where only one spouse is applying for MA and resides in a nursing home or is receiving services under the Elderly Waiver program, spousal impoverishment rules apply. Assets are available if the owner has both legal authority and actual ability to use them for self-support. Available assets include any personal property or real property with monetary value that is not determined to be excluded or unavailable. Such assets include, among other things, savings and checking accounts, stocks, bonds, certificates of deposit, contracts for deed, IRAs or 401K accounts, investments in precious metals or gems, and the cash surrender value of insurance policies.

Treatment of the House

The homestead is excluded during the first six calendar months of a person's stay in a long-term care facility and for as long thereafter as the recipient can be reasonably expected to return home as documented by a doctor’s statement. It is also excluded if it is the primary residence of the nursing home resident's spouse, a child under 21, a child of any age who is blind or permanently and totally disabled, a brother or sister who has equity interest in the home and who resided in the home for at least one year immediately before the date of nursing home admission, or a child or grandchild of any age who resided in the home for at least two years immediately before the date of nursing home admission and provided care to the person that permitted the person to reside at home rather than in an institution.

In compliance with the DRA, the equity in the homestead is limited to $500,000, unless the spouse, child under 21, or blind or disabled child of the MA recipient is living in the home. The equity can be reduced through a reverse mortgage or home equity loan. This limitation would apply, for example, when a single person is living at home and is receiving services under a home- and community-based waivered program such as Elderly Waiver (EW) or Community Alternative Care (CAD). It would also apply to the exclusion of the homestead during the first six months of a single MA recipient’s stay in a nursing home, if no spouse or child is living in the home.

Protections for the Community Spouse

The spouse who is in the nursing home is called the IS and the spouse who lives at home is called the CS. All non-excluded assets owned by either or both spouses are assessed, documented, and added together as of the first day of the first continuous period of institutionalization. This is called the *asset assessment*. At the time of MA application, the CS is limited to assets in an amount equal to half of the total non-excluded assets as noted on the asset assessment, with a minimum of $19,389 and a maximum of $104,400 in 2008. This amount is called the *CS asset allowance*. The minimum and maximum

amounts of $29,289 and $104,400 increase each year, and the increased amounts apply for those individuals who apply for MA on or after January 1 of that year. After MA has begun and for as long as the IS is institutionalized, the CS's assets are no longer considered available to the IS for the on-going MA eligibility of the IS.

A CS is entitled to a minimum MIA, which is the lesser of $2,610, or the basic monthly allowance of $1,712 plus an excess shelter allowance. (The $2,610 is adjusted each January 1, and the $1,712 is adjusted each July 1, based on the cost of living increase.) The excess shelter allowance is the amount by which specific shelter expenses exceed 30 percent of the basic monthly allowance (as of this writing, this is $514). Shelter expenses include rent, mortgage including principal and interest, real estate taxes, insurance, required maintenance charges for a cooperative or condominium, and a standard utility allowance. If the CS's income is less than the minimum MIA, the CS may keep a portion of the IS's income, called the *monthly income allocation*, to raise his or her income to the MIA. The CS does not have to contribute any of his or her income to pay the IS's expenses.

Treatment of Annuities

Minnesota law provides that any asset or interest transferred to any annuity that exceeds the value of the benefit likely to be returned to the person or spouse during the person's life expectance is a transfer for less than fair market value. In addition, effective for annuities purchased on or after March 1, 2002, any annuity that is not purchased from an insurance company or financial institution subject to licensing or regulation by the Minnesota Department of Commerce, does not pay out principal and interest in equal monthly installments, or does not begin payment a the earliest possible date after annuitization will be considered a transfer of assets for less than fair market value.

The DRA has provisions that affect annuities, which apply to transactions (including the purchase of an annuity) occurring on or after February 8, 2006.

Effective for transactions occurring on or after February 8, 2006, the purchase of an annuity by or on behalf of an individual applying for or receiving long-term care services shall be treated as a disposal of assets for less than fair market value unless it is an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986 or purchased with proceeds from

- an account or trust described in subsection (a), (c), or (p) of section 408 of the Internal Revenue Code.
- a simplified employee pension within the meaning of section 408(k) of the Internal Revenue Code.
- a Roth IRA described in section 408A of the Internal Revenue Code.
- an annuity that is irrevocable and non-assignable, is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration, and provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

In addition, effective for transactions occurring on or after February 8, 2006, the purchase of an annuity by or on behalf of an individual who has applied for or is receiving long-term care services or the individual's spouse shall be treated as the disposal of an asset for less than fair market value unless

- the DHS is named as the remainder beneficiary in first position for an amount equal to at least the total amount of medical assistance paid on behalf of the individual or the individual's spouse.
- the DHS is named as the remainder beneficiary in second position for an amount equal to at least the total amount of medical assistance paid on behalf of the individual or the individual's spouse after the individual's CS or minor or disabled child.
- the DHS is named as the remainder beneficiary in the first position if the CS or a representative of the minor or disabled child disposes of the remainder for less than fair market value.

Any subsequent changes to the designation of DHS as a remainder beneficiary shall result in the annuity's being treated as a disposal of assets for less than fair market value. The amount of such transfer shall be the maximum amount the individual or the individual's spouse could receive from the annuity or similar financial instrument. Any change in the amount of the income or principal being withdrawn from the annuity or other similar financial instrument at the time of the most recent disclosure shall be deemed to be a transfer of assets for less than fair market value unless the individual or the individual's spouse demonstrates that the transaction was for fair market value.

Treatment of Retirement Accounts

Retirement accounts are considered available assets when applying for MA and receive no special treatment under Minnesota law.

Estate Recovery Rules

Estate recovery is the program through which the county will try to recover an amount equal to the MA benefits paid on behalf of a person either from the individual's probate estate if the person is single at the time of death or from the probate estate of the person's surviving spouse. The county cannot file a claim against the estate of a deceased MA recipient if the recipient was survived by a spouse. The county cannot make any recovery from the estate of the surviving spouse while the surviving spouse is living. However, when the surviving spouse dies, the county can make a claim against the surviving spouse's probate estate to recover MA benefits provided to either spouse. (Multi-party and securities accounts of the surviving spouse would also be subject to a claim. A claim may also be asserted against a life estate or joint tenancy interest in real property created on or after August 1, 2003.) The county's claim against the surviving spouse's probate estate, however, is limited to the value of any assets of the surviving spouse's estate that were joint or marital assets at any time during the marriage to the predeceased spouse.

The probate estates of most surviving spouses are primarily made up of assets that were either joint or marital assets during the marriage. This means that, if a surviving spouse has a probate estate, life estate or joint tenancy interest in real estate, multi-party or transfer on death (TOD) accounts (or both) at death, such assets most likely will be subject to a MA claim for benefits paid to a predeceased spouse. However, proceeds from life insurance policies or annuities that name a person as beneficiary or assets held in a revocable living trust are not currently subject to an MA claim. If a predeceased spouse received MA benefits, the surviving spouse may want to seek additional assistance on how to situate his or her estate to minimize the possibility of a MA claim at his or her death.

New Jersey

By Michael D. Weinraub, P.C.
Ventnor Professional Campus
Troy Building, Suite G3
6601 Ventnor Avenue
Ventnor, NJ 08406
Telephone: 1-609-823-4900
E-mail: Mike@ElderLawyerForYou.com
Web site: http://www.ElderLawyerForYou.com

Introduction

Medicaid is a federal program that is administered by the states. Consequently, you may have 50 different variations in how each state interprets the federal law. Medicaid is administered in New Jersey

by the Division of Medical Assistance and Health Services (DMAHS) of the DHS. New Jersey is an SSI state, meaning it follows the federal rules for SSI to determine eligibility for Medicaid. New Jersey is an *income cap* state with a *medically needy* program. This means New Jersey uses one income cap for Medicaid Only and a separate income cap for medically needy. The income cap for medically needy is 30 times the daily Medicaid reimbursement rate for the facility the individual is in or entering. The medically needy program allows for increased income and asset limits, but provides less covered medical services than the Medicaid Only program. Because New Jersey has a medically needy program, it does not allow the use of Miller Trusts to reduce the individual's excess income.

To date, New Jersey has not implemented any regulations that deal with the DRA, but it is operating using a phased-in five year look-back period for all transfers subsequent to February 8, 2006, as well as the change in the start date for transfer penalties. New Jersey has also incorporated the partial month penalties and the no rounding down rules of the DRA.

New Jersey (Cont.)

By Mary E. WanderPolo, CELA
129 Valley Road
Montclair, NJ 07042
Telephone: 1-973-744-5710
E-mail: wanderpolo@comcast.net
Web site: http://wanderpololaw.com/

Treatment of the House

In determining the available resources of a Medicaid applicant, the New Jersey Administrative Code, section 10:71-4.4 excludes the house occupied by the applicant, or the applicant's spouse, or minor, blind or disabled child as their primary residence. This regulation also excludes the home of a non-married Medicaid applicant (without minor, blind, or disabled children) when the applicant intends to return home. This means that short temporary absences from the home such as trips, visits, and hospitalizations will not affect the home exclusion so long as the individual intends, and may reasonably be expected, to return home. However, if the individual has been absent from the home in an institutional setting for six months or more, Medicaid will make the presumption that the home is no longer the principal residence. Thus, a single individual may be eligible for Medicaid upon entrance into a nursing home if their only resource is the home and they have not already been in another institution for more than six months.

New Jersey Administrative Code, Section 10:71-4.1 defines resources as any real or personal property that is owned by the applicant (or by the applicant's spouse) and that could be converted to cash to be used for his or her support and maintenance. Both liquid and non-liquid resources shall be considered in the determination of eligibility, unless such resources are specifically excluded under the provisions of New Jersey Administrative Code Section 10:71-4.4(b) (see the previous paragraph). However, pursuant to Medicaid Communication No. 87-26, any non-liquid resource may be excluded from determining Medicaid eligibility, provided a plan of liquidation is established. In a plan of liquidation, the applicant agrees to liquidate the real property within six months of the Medicaid application date. If six months is insufficient because of an inability to find a buyer, the plan of liquidation may be extended for an additional three months. The impact of this is that an individual Medicaid applicant, with a home and no spouse, minor or disabled child, may be Medicaid eligible (although he or sheowns a home), so long as there is a listing agreement for the sale of the home.

New Jersey Administrative Code Section 10:71-4.7(d) exempts from penalty the transfer of the home to a minor or disabled child of the applicant. In addition this section, the Code exempts the transfer of the home to a brother or sister of the institutionalized individual who already had an equity interest in the home prior to the transfer and who was residing in the home for a period of at least one year immediately before the individual became an institutionalized individual. The section of the Code also exempts from

penalty the transfer of the home to a son or daughter of the institutionalized individual who was residing in the individual's home for a period of at least two years immediately before the date the individual was institutionalized and who has provided care to such an individual that permitted the individual to reside at the home rather than in an institution.

Protections for the Community Spouse

When a nursing home Medicaid applicant has a spouse living in the community, the New Jersey Administrative Code Section 10:71-4.8 provides that the CS may retain one-half of the combined countable resources of the couple as of the first period of continuous institutionalization subject to a ceiling (maximum) of $104,400 (in 2008) and a floor (minimum) of $20,880 (in 2008). The total countable resources of the couple include all resources owned by either member of the couple, individually or together with another. It is important to note that the qualified plan accounts (IRA, 401(k), Keogh, etc.) of the CS are considered countable resources following the decision of the Supreme Court of the state of New Jersey in Mistrick v. Division of Medical Assistance and Health Services, 154 N.J. 158, 712 A.2d 188, 1998 N.J. To the extent that the CS's share of the combined resources are not already owned by the CS, the ownership of the share belonging to the IS must be transferred to the CS within 90 days of a determination of eligibility for institutional Medicaid. Resources not transferred by the end of the 90-day period will be counted in the determination of eligibility for the institutionalized individual. In New Jersey, the CS's share of the resources may be an amount higher than that authorized under the New Jersey Administrative Code if a Court has ordered that resources in excess of the CSRA be transferred to the CS. In addition, through fair hearing of court proceeding, additional resources may be authorized to be set aside for the CS in order to provide for a sufficient income maintenance level.

In compliance with the Medicare Catastrophic Coverage Act of 1988, New Jersey Medicaid provides that the CS is entitled to a MMMNA. If the CS's income falls below the MMMNA, the spouse is budgeted to receive additional income from the IS to bring the CS up to the MMMNA level. The MMMNA is made up of two components: a basic allowance and an excess shelter allowance. For the period July 2007 through June 30, 2008, the basic allowance is $1,711.25. In addition to the basic allowance, the CS may be entitled to a shelter allowance and a standard utility allowance, which can be determined by looking at her monthly expense for rent or mortgage and utilities. The shelter allowance is $513 (in 2007) and the standard utility allowances are $25 a month for heating, $156 a month for non-heating, and $29 a month for phone. These figures are adjusted on July 1 of each calendar year. The CS's actual income is subtracted from the MMMNA to determine how much of the IS's income should be converted to the CS. It is possible to increase this MMMNA through a fair hearing if you can demonstrate that the CS has extraordinary expenses.

New Jersey (Cont.)

By Donald D. Vanarelli
Law Offices of Donald D. Vanarelli
242 St. Paul Street
Westfield, NJ 07090
Telephone: 1-908-232-7400
E-mail: dvanarelli@dvanarelli.com
Web site: http://dvanarelli.lawoffice.com/

On February 8, 2006, as part of the DRA, the federal government imposed new restrictions on Medicaid planning techniques, including new rules for the treatment of annuities.

Before the DRA's enactment, the treatment of annuities was controlled by Health Care Finance Administration (HCFA) Transmittal No. 64, which treated annuities under the trust and transfer provisions.

Under the DRA, the treatment of annuity purchases is addressed in terms of the transfer of assets rules.

However, as of the writing of this article, New Jersey has yet to adopt regulations implementing the DRA, leaving many open issues regarding the use of annuities as a Medicaid planning technique.

Treatment of Annuities

With respect to Medicaid's resource rules, New Jersey's Appellate Division issued two decisions that impact on Medicaid's treatment of actuarially sound commercial annuities purchased for the benefit of the CS (refer to Estate of F.K. v. DMAHS, 374 N.J. Super. 126 (App. Div.), certif. denied, 184 N.J. 209 (2005), and A.B. v. DMAHS, 372 N.J. Super. 460 (App. Div.), certif. denied, 185 N.J. 38 (2005)).

Medicaid's treatment of these annuities was challenged on three fronts. The first is New Jersey Medicaid regulation N.J.A.C. 10:71-4.10(p)2i, which defines a commercial annuity purchased for the benefit of a CS as a countable resource to the extent that its purchase price exceeds the CSRA. The second is Medicaid's position that such an annuity is an available asset because it is readily marketable on the secondary market. The third is the requirement set forth in New Jersey Medicaid regulations N.J.A.C. 10:71-4.10(b)(8) and –4.10(f), that the state of New Jersey be named as the first remainder beneficiary on such annuities. Each of these three challenges was successful, and New Jersey's appellate court concluded that New Jersey Medicaid's current restrictive treatment of these annuities is impermissible.

With respect to the treatment of annuity payments as income, New Jersey considers such payments received to be included as unearned income (see N.J.A.C. 10:71-5.4(a)(3)). New Jersey's regulations regarding the post-eligibility treatment of income are set forth in N.J.A.C. 10:71-5.7(c), which provides that an amount shall be deducted from the IS's income for the maintenance of the CS, depending upon the gross income of the CS. Although the regulations do not directly address annuities, case law has held that a CS's entire annuity payment will be considered as income, for purposes of determining the CS's MMMNA (see J.M. and E.M. v. DMAHS, 96 N.J.A.R.2d 86 (1996)).

Treatment of Retirement Accounts

In New Jersey, the individual retirement account of a CS is considered an includable resource for determining the IS's Medicaid eligibility (see Mistrick v. DMAHS, 154 N.J. 158 (1998); see N.J.A.C. 10:71-4.2, 10:71-4.4).

Medicaid also treats retirement benefit payments as unearned income (see N.J.A.C. 10:71-5.4(a)(3)). As with annuity payments, retirement benefit payments to the CS are considered in determining the CS's MMMNA.

New Jersey (Cont.)

By Gerard J. Legato, Esq.
The Legato Law Firm, L.L.C.
757 Route 202/206 North
Bridgewater, NJ 08807
Telephone: 1-908-725-9800
E-mail: LegatoLaw@Verizon.net

Estate Recovery Rules

Upon the death of a Medicaid recipient, state governments are required to seek recovery from the estate of benefits paid to the recipient. For Medicaid recovery purposes, the estate includes, at a minimum, assets that pass through probate. However, state governments are permitted to adopt an expanded

definition of estate, and New Jersey has done so. The expanded definition adopted in New Jersey includes assets in which the decedent held “any legal title or interest at the time of death, to the extent of that interest,” in addition to assets that pass through probate. The state must file its recovery claim or lien within 90 days after receipt of actual written notice of the Medicaid beneficiary’s death. The state must provide advance notice of its claim or lien.

The state’s authority to seek estate recovery is not unlimited. Certain types of trusts and life estates are expressly excluded from the expanded definition of estate. Recovery does not apply to benefits paid to recipients under age 55, unless the recipient was permanently institutionalized, in which case, there is no minimum age restriction. The state may obtain recovery only in the absence of a surviving spouse or in the absence of a surviving child who is under 21, blind, or permanently and totally disabled. The state may waive or compromise its claim for recovery under some circumstances, including a demonstration of undue hardship as defined in the applicable regulations. Restrictions may apply to recovery from property that was the decedent’s primary residence if a family member has been residing there. Recovery cannot be obtained from a bona fide purchaser who paid fair market value for decedent’s property, although in that instance, recovery would still be sought from the decedent’s estate.

New York

By:
Ronald A. Fatoullah, J.D., CELA
425 Northern Boulevard
Great Neck, NY 11021
Telephone: 1-516-466-4422
E-mail: rfatoullah@fatoullahlaw.com

And

Neil T. Rimsky, J.D. CELA
Cuddy & Feder LLP
90 Maple Avenue
White Plains, NY 10601
Telephone: 1-914-761-1300
E-mail: nrimsky@cuddyfeder.com
Web site: http://www.cuddyfeder.com

And

Brian Andrew Tully J.D., CELA, CSA, CLTC
444 New York Avenue
Huntington, NY 11743
Telephone: 1-631-424-2800
E-mail: bat@estateplanning-elderlaw.com
Web site: http://www.estateplanning-elderlaw.com

Introduction

New York State has an extensive Medicaid program, including institutional care (nursing home care), community care, and a home-based program call the Lombardi Program (sometimes referred to as a nursing home without walls) that is designed to provide a range of services found in a nursing home, but maintain the individual in a home-based setting. An application for nursing home care must currently contain three years of information for the applicant and the applicant's spouse. The transfer of asset rules, which impose periods of ineligibility, applies to the institutional (nursing home) program. There are no periods of ineligibility associated with home care under the community Medicaid program that provides

basic home health aides and personal care aides or the Lombardi program. New York State has relatively generous protections for the CS and permits the CS to exercise a spousal refusal. New York is also one of four states that has approved and recognized partnership long-term care insurance prior to the DRA.

The DRA became effective in New York for Medicaid applications submitted as of August 1, 2006. Transfers of resources on or after February 8, 2006, are subject to the DRA, which now: 1) Impose a five year look-back; and 2) delays the commencement of any period of ineligibility until the later of, the month after the gift, or the month in which the individual is institutionalized, has applied for benefits and is otherwise eligible for Medicaid (except for transfers that were made during the look-back). The five year look-back will be phased from the current 3 year period commencing in February, 2009 when the look-back extends to 37 months. Thereafter, the look-back will increase monthly until February, 2011 when the five year look-back will be fully phased in. The DRA does not impact applications for community Medicaid, for which there are no periods of ineligibility. Only applications for institutional care are impacted. The DRA has no impact on spousal planning, other than provisions regarding annuities and promissory notes, which can impact spousal planning.

Treatment of the House

The house in which the individual or the individual's spouse resides, or to which the individual has an intent to return, remains an exempt resource. There are specific rules that permit exempt transfers of the primary residence (without any period of ineligibility). These include the caretaker child who is an adult child who has been providing care to the parent for at least two years immediately prior to the institutionalization of the parent. Transfer of the home to a sibling with an equity interest, and transfer to a blind or disabled child, or child under the age of 21 also remain exempt transfers. New York State regulations have specifically recognized the transfer of the home when the transferor retains a life estate. Tables originally issued by HCFA Transmittal No. 64 define the discount value attached to such transfers. An administrative directive specifically indicates that life estates vanish on the death of the grantor and that the sale of a life estate cannot be coerced. However, if a home subject to a life estate is voluntarily sold, the holder of the life estate receives value based on HCFA Transmittal No. 64 tables.

The Department of Health can impose a lien on the primary residence in certain situations. No lien can be imposed if the applicant, the applicant's spouse, or the applicant's blind or disabled child resides in the home. If neither the applicant nor any of the above individuals reside in the home at the time of the application, but later return, then any lien that may have been imposed must be dissolved. When the applicant/recipient (the A/R) has expressed an intent to return home thus making the home an exempt resource, Medicaid can place a lien on the home when it can show that it is not likely that the A/R will be able to go home. Again, if the A/R later returns home, the lien must be dissolved. Where a caretaker child or sibling with an equity interest resides in the home, the lien will not be enforced as long as they are living there.

Protections for the Community Spouse

The CS can retain resources, called the CSRA, in the amount of $74,820 or the amount of one-half of the couple’s resources up to a maximum of $104,400, whichever is greater. The CS’s monthly income allowance is currently $2,610, called the MMMNA. However, there are certain caveats to keep in mind: If the CS income is less than $2,610, then the CS will receive as much of the IS's income that is needed to bring the CS's income level up to $2,610. In the event that the CS has resources and income above these respective levels, then the CS has the option of signing a spousal refusal letter.

If the CS executes a spousal refusal, the Department of Social Services has the right to recover its expenses paid for the A/R from the CS. If the CS refuses to pay back Medicaid, then the Department of Social Services can sue the CS for reimbursement of sums paid on behalf of the IS. These lawsuits are commonly referred to as spousal support suits. If the CS can make a showing that he or she needs to

retain assets greater than the CSRA in order to generate $2,610, then he or she will be entitled to an enhanced CSRA. The determination of an enhanced CSRA must be made via a fair hearing or court order. The Department of Social Services has taken the position that the CS must first use the income available from the IS before requesting the enhanced resource allowance. This is referred to as the income first rule.

Treatment of Annuities

Annuities can be used to convert assets into an income stream. In order to obtain this result, the annuities must be single premium, irrevocable, and non-assignable annuities. In order to ensure that these annuities do not constitute a transfer of resources, the annuities have to be actuarially sound. Actuarially sound means that the term of the annuity can not exceed the life expectancy of the annuitant. For annuities purchased on or after February 8, 2006 (the date the DRA was signed into law), the state must be named the remainder beneficiary. If there is a surviving spouse, a minor, or a disabled child, then the state can be in the second position after these family members. In addition, the DRA provides that such annuity provide for equal monthly payments during its term with no deferral and no balloon payments.

Treatment of Transfer to Purchase Loans, Notes, and Mortgages Post-DRA

In accordance with the DRA, the transfer of assets provisions are amended to require that funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, will be treated as an uncompensated transfer of assets (that is, not a gift that would create a penalty period) unless the note, loan, or mortgage meets the following criteria:

- It has a repayment term that is actuarially sound.
- It provides for payments to be made in equal amounts during the term of the loan with no deferral and no balloon payments made.
- It prohibits the cancellation of the balance upon the death of the A/R.

It has now become commonplace in New York to protect approximately one-half of the A/R's assets at the last minute with the use of a promissory note plan. Such a plan involves the gifting of roughly one-half of the institutionalized A/R's assets and lending the other half in return for a promissory note that meets DRA requirements. The payments on the promissory note will be used to pay for the A/R's care in the nursing home during the period of ineligibility created by the gift.

Treatment of Retirement Accounts

In the context of an individual receiving chronic care Medicaid benefits, the *New York State Department of Health Medicaid Reference Guide* defines retirement funds as annuities or work-related plans for providing income when employment ends. The amount of income received from a retirement fund is treated as unearned income of the Medicaid applicant on a monthly basis, regardless of the actual frequency of payment. In order for the retirement account to be deemed an exempt asset for Medicaid purposes, the A/R must receive periodic payments the account over his or her life expectancy. The individual is required to choose the *maximum income payment available* over the individual's lifetime. It has been determined by most Medicaid districts that withdrawals of the minimum distribution amount under IRS tables will satisfy the income requirement. Therefore, if the retirement account is in periodic payment status, then it is not a countable resource. If the A/R is not entitled to periodic payments, but is allowed to withdraw any of the funds, then the retirement fund will be deemed a countable resource. The value of the resource is the amount of money that can be withdrawn less the amount of any penalty for early withdrawal. Income taxes due are not deductible.

One type of retirement plan that is not addressed in the New York Medicaid regulations is the Roth IRA. Although this special category of IRAs is treated differently for tax purposes, most Medicaid districts in New York will not treat a Roth IRA as a countable resource if payments are taken from the account periodically over the individual's life expectancy. Clearly, minimum required distribution rules do apply to

the beneficiary of a Roth IRA after the owner's death. Therefore, if a spouse is the beneficiary of a Roth IRA and begins taking minimum distributions from it, presumably it would be considered in periodic payment status and it would not be an available resource should the spouse seek Medicaid.

As clarified in a 2006 directive, effective January 1, 2006, if a CS is not receiving periodic payments from his or her available retirement fund, the fund is considered a countable resource for purposes of determining the CSRA. This includes situations where the retirement fund of the CS exceeds the CSRA. Prior to the regulation change, it had been the department's policy to count the resource amount of any retirement fund belonging to the CS first toward the CSRA and to disregard any amount that exceeded the CSRA.

If the CS has elected to receive periodic payments from his or her retirement account, the retirement account is not a countable resource in determining the IS's eligibility. However, the periodic payments are countable income for the CS and will be budgeted by Medicaid accordingly.

Estate Recovery Rules

The New York State Social Services Law authorizes recovery efforts against the estate of an individual who has received Medicaid assistance during his or her lifetime.

Recovery is possible under the following circumstances:

1. against the estate of a person who was 55 years of age or older when receiving services
2. against a legally responsible relative (or the estate of a legally responsible relative), provided that the relative had sufficient income and resources that he or she failed to make available

In pursuing its claims, Medicaid is a preferred creditor of an estate. As a preferred creditor, Medicaid's claim must be satisfied first, prior to other creditors and before any bequests or distributions to beneficiaries are made. Administration costs, such as attorney's fees, are paid before all creditors, including Medicaid. The statute of limitations for Medicaid to file a claim is six years premised on an implied contract theory. Therefore, Medicaid may still file a claim after the customary seven month filing period and maintain a preferred creditor status, but it may have to enforce the claim against the beneficiaries if the fiduciary distributed the decedent's property in good faith.

When determining Medicaid's right of recovery against an estate, New York State distinguishes between benefits that were correctly paid and those that were incorrectly paid. If benefits are correctly paid, Medicaid can recover after the recipient's death and only under specific circumstances. If benefits were incorrectly paid, Medicaid can seek recovery of those costs during the recipient's life and after death.

Federal law requires active recovery efforts in all states. However, it allows each state to define the scope of recovery and gives each state the option to expand recovery beyond the traditional probate estate. At the present time, New York defines estate as all real and personal property and other assets included within the individual's estate and passing under a valid will or by intestacy. Therefore, Medicaid may not attach estate assets that pass via an *inter vivos* trust, assets with a designated beneficiary, or assets with joint tenancy with right of survivorship. Furthermore, a life estate may not be attachable as it is not probated or administered, and further, because the life estate extinguishes at the death of the life tenant, it is not part of the probate estate.

If a Medicaid recipient is survived by a spouse, no estate claim can be made against the recipient's estate until after the death of the surviving spouse. Recovery is limited to the benefits paid during the ten years preceding the death of the recipient's spouse. Since the estate recovery will be deferred, Medicaid may seek recovery against the recipient's spouse during life or from his or her estate if the recipient's spouse executed a spousal refusal as part of the application process.

No recovery of correctly paid Medicaid may be made at a time when the recipient has a surviving child who is under 21 years of age or who is certified blind or certified disabled. In the case of a lien on the recipient's home, no recovery of correctly paid Medicaid may be made if a sibling of the recipient resided in the home for at least one year immediately before the recipient's admission to the nursing home and continues to reside in the home or a child who has been living in the home for at least two years immediately prior to admission to the nursing home and who provided care to the recipient. The lien will remain on the home should the individual no longer reside in the home and the property is liquidated.

New York State has unsuccessfully proposed legislation to expand the definition of an estate to include recovery from all real or personal property, tangible or intangible, in which the individual at the time of his or her death had any right, title or interest including any property in which the individual had an interest as a joint tenant, joint tenant with right of survivorship, life tenant, or beneficiary of a trust.

Medicaid Resource & Income Levels:

Medicaid Figures	2007	2008
Income level for one person	$700*	$725*
Income level for two people	$900	$1,067
Resource level for one person household	$4,200	$4,350
Resource level for household of two people	$5,400	$6,400
Minimum monthly maintenance needs allowance	$2,541	$2,610
Maximum community spouse resource allowance	$101,640	$104,400**

* plus an additional $20 monthly per household for aged, blind, or disabled applicants
** minimum of $74,820 or one-half of the married couple's resources, up to a maximum of $104,400

Regional Rates As Of January 1, 2008

The following rates are to be used for calculating the penalty period for uncompensated transfers by institutionalized individuals applying for Medicaid coverage on or after January 1, 2008:

New York City: $9,636
Long Island: $10,555
Northern Metropolitan: $9,316
Central: $6,696
Northeastern: $7,431
Rochester: $8,089
Western: $7,066

The New York State Department of Health issued these regional rates that are used to calculate penalty periods for institutionalized individuals who apply for Medicaid on or after January 1,

2008. All of the rates have increased as of January 2008, and this will result in shorter waiting periods for Medicaid eligibility under current law.

The following is an example of how to use these rates: If a New York City applicant gifted $96,360 in January 2008, he or she will be ineligible for Medicaid nursing home benefits for ten months ($96,360 divided by $9,636 = 10).

Note: As a result of the DRA, the penalty period will not commence until the applicant is in a nursing home, has assets of no more than $4,350 (plus other exempt assets), and has applied for Medicaid nursing home benefits.

Ohio

By Michael J. Millonig
Michael Millonig Law Group, LLC
7601 Paragon Road, Suite 103
Dayton, OH 45459
Telephone: 1-937-438-3977
E-mail: mjmillonig05@choiceonemail.com

Introduction

The basic rule regarding Medicaid in Ohio is that a single applicant can have only $1,500 of assets. If both a husband and wife are applying for coverage, they may have only $2,250. If assets are above this amount, a couple must be spent down until resources are within eligibility limits. There are a number of items that are non-countable resources.

Treatment of the Home

The residence of the applicant is non-countable with no dollar limit if it is occupied by the applicant's spouse. The deed must be in the name of the applicant or CS. It cannot be in the name of a trust.

However, for a single or widowed person, the residence is only non-countable for a 13 month period beginning in the first month that the applicant is both residing in a nursing facility and met all requirements for Medicaid eligibility. After said 13 month period, the residence is a countable resource that will cause ineligibility.

If the residence is sold, it must be listed for sale at a value not less than the appraisal established by the county auditor. You cannot refuse any offer that is at least 90 percent of the auditor’s appraised value. Any expenditure for household improvements or repairs would also be a permitted expenditure. After this 13 month period, if the home is not sold, it will be counted as a resource and cause ineligibility for Medicaid. The proceeds from the sale will also be counted as a resource and cause ineligibility for Medicaid.

The DRA includes a new limitation on the residence exemption. The DRA provides that an individual is not eligible for Medicaid if the equity interest in their home exceeds $500,000. However, this does not apply if the spouse of the Medicaid applicant is residing in the home.

Some nursing homes and continuing care retirement communities (CCRC) require a substantial deposit upon entry into an independent living unit. The person usually does not receive any equity interest similar to a deed to real estate. The deposit may or may not be refundable in some amount depending on the terms of the contract. Under prior law, there was no clear rule

concerning the status of such deposits as countable assets. In practice, many caseworkers interpreted such deposits as exempt under the above residence exemption. However, now the DRA specifically sets forth requirements for determination of the status of such deposits. These deposits are considered to be countable resources for purposes of Medicaid eligibility if all of the following conditions are met:

1. The person has the ability to use the entrance fee to pay for care.
2. The person is eligible for a refund if they die or leave the CCRC.
3. The entrance fee does not confer an ownership interest.

Protections for the Community Spouse

Cars

A CS can have one car of any value as a non-countable resource. A single or widowed person can have one car up to a $4,500 value.

Community Spouse Resource Allowance

In determining eligibility of the applicant spouse, the total resources of both spouses are counted. However, the CS is entitled to a resource allowance of 50 percent of the combined countable assets but not exceeding $101,640 and at least $20,328 (2007 amounts). Non-countable assets (for example, residence) are not included in this calculation. Resource values are determined as of the first date of institutionalization. This generally is the first date of entry into a nursing home if residency is at least 30 consecutive days.

Antenuptial agreements are disregarded under Medicaid law in the determination of eligibility and calculation of the CSRA. Medicaid law is a federal law and, thus, supersedes any state property law.

Treatment of Annuities

The first question regarding treatment of annuities in Ohio is whether an annuity owned by an applicant is considered a countable resource. The answer depends on whether the terms of the annuity contract allow the owner to cancel the contract or withdraw the balance. To the extent funds can be withdrawn, it is a countable resource. A deferred annuity typically will be a countable resource since the owner can withdraw funds. If the annuity has been annuitized, the owner often does not have a right to cancel or withdraw funds. This is called an *immediate annuity.*

Transfer Issues (Pre-DRA)

If the annuity is not a countable resource, the Medicaid regulations set forth an additional test to determine if there has been an improper transfer (see CMS State Medicaid Manual §3258.9(B) and former O.A.C §5101:1-39-228). An actuarial analysis is made to determine if the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the beneficiary. If the annuity is paid over the life of the applicant according to the life expectancy tables in the rule, then it will pass the actuarial test. If it is paid out over a period longer than life expectancy, then it is not actuarially sound and, to the extent of the excess, is considered a transfer of resources.

The state of Ohio has not applied the test set forth in federal annuity rules and has determined

that the purchase of an annuity is an improper transfer based on grounds not found in the rule. The most recently enacted version of the annuity rule in Ohio sets forth additional tests and criteria applying to annuities not set forth in the federal rule.

Although most states comply with the federal actuarial test for annuities, some states like Ohio do not, and this issue has been the subject of some litigation with mixed results (see Dempsey v Dept of Public Welfare, 756 A2d 90 (Pa Cmwlth 2000), Johnson v. Guhl, 166 F.Supp2d 42 (D.N.J. 2001) , 91 F.Supp2d 754 (2000) & 357 F. 3d 403 (3d Cir. 2004), McNamara v Ohio Dept of Human Services, 139 Ohio App 3d 551 (2000)). CMS has issued an informal opinion letter stating that the McNamara decision was incorrect and that there is no CSRA limit on such transfers. Other courts have held that the specific actuarial test must be applied without any determination of intent or limitation of the CSRA (see Mertz v. Houstoun, 155 F. Supp. 2d 415 (E.D. Pa. 2001), Dean v. Delaware Dep't of Health and Soc. Servs., No. 00A-05-006, 2000 Del. Super. LEXIS 490 (Del. Super. Ct., Dec. 6, 2000), aff'd. 2001 Del. LEXIS 205 (Del. May 15, 2001). See also The Elder Law Report, Effective Arguments in Medicaid Annuity Litigation, Michael J. Millonig (February 2001) and Elder Law Advisory, Spousal Annuity Trust: Denied, Michael J. Millonig (October, 2001)).

Pre-DRA Annuity Rule

Annuity. A right to receive fixed periodic payments either for life or a term of years.

The definition of annuity as shown here is correct and does comply with the required federal definition (refer to CMS SMM § 3259.1(A)(9)). However, the rule later states that an annuity must be purchased from a bank, insurance company, or other person engaged in the business of the sale of commercial annuities to the public. In addition, the rule also states that the purchase of a private annuity agreement is an improper transfer (see §5101:1-39-22.8(F)). These two provisions are clearly not part of the federal definition and thus are a violation of federal law. The required federal definition does not limit itself to commercial annuities issued by insurance companies. This, of course, is the most common and obvious form of an annuity and most people are familiar with this type of annuity. However, annuities are used in many other types of situations and in many other forms. A *charitable remainder annuity trust* is an estate planning vehicle used by persons making a contribution to a charity. Private annuity contracts are often used in the context of estate planning for persons who own a family business. These are validly recognized legal arrangements recognized by the courts, the Internal Revenue Code, and other legal authorities. The federal form of the annuity definition recognizes this economic reality.

Treatment of Annuities: Purchase After Nursing Home Entry

If an annuity is purchased after the first date of institutionalization in an amount in excess of the CSRA that is payable to the CS, this is an improper transfer. You can purchase an annuity in an amount up to but not exceeding the CSRA. However, this amount is already an exempt resource for the CS and thus does not protect any more of the estate for the CS. The federal rule has no such limitation on the purchase amount based upon whether it is purchased prior to or after the first date of institutionalization. This provision in the Ohio rule is not in compliance with federal law.

Treatment of Annuities: Prior to Nursing Home Entry

An annuity can be purchased with the CS as the sole annuitant at any time before first entry into a nursing home. Resources in excess of the CSRA can be used for such purchase. Note that the first continuous period of institutionalization starts upon entry into a hospital if this is followed by entry into a nursing facility. The annuity payments must provide for all payments to be made during the life of the annuitant as determined under the life expectancy tables. It must be annuitized prior to nursing home entry and cannot be a deferred annuity. A deferred annuity is a

countable resource.

Annuities after DRA (February 8, 2006)

The DRA enacts specific provisions governing annuities. Prior to the DRA, there was no federal statute governing annuities. The new statute does not affect the determination of whether the annuity is a countable asset. This will be determined as before with the result that deferred annuities will generally be considered countable assets. The provisions do govern whether the purchase of the annuity (that is, an immediate annuity) is considered a transfer of assets. The general rule is that such a purchase is a transfer.

However, the DRA provides the following exception for a purchase of an immediate annuity that will not be considered a transfer:

1. The state is named as beneficiary for at least the total amount of benefits paid under Medicaid.
2. The CS is named primary beneficiary with the state as the secondary beneficiary.

Another separate exception is provided for the purchase of an annuity in either of the following categories:

1. an annuity that is part of an IRA, simplified employee pension (SEP)-IRA, or Roth IRA; or
2. an annuity that is irrevocable, non-assignable, actuarially sound, and provides for equal payments.

These latter two categories must also name the state as the beneficiary as provided in the first exception. For a more in-depth discussion of this issue, see *The Elder Law Report*, "The DRA's Annuity Provisions: An Analysis," by Michael J. Millonig (September-October issue, 2006).

The person who receives the annuity payments is the annuitant. After the death of the annuitant, it is the beneficiary who continues to receive the payments.

Promissory Notes

The DRA includes a new provision for loans, promissory notes, and mortgages. It provides that, if the loan is not a countable resource by its terms, the transfer of funds upon creation is not considered to be an improper transfer if it meets the actuarially sound test. This test is the same one applied to annuities. A loan document can be drafted so that it is not a countable resource. Thus, transfers to family members can be accomplished in a manner similar to a commercial annuity under this DRA loan provision.

Planning with Post-DRA Annuities

The DRA provision is actually an improvement over the pre-DRA Ohio annuity rule. On or after February 8, 2006, a married couple may purchase an annuity with the CS as the owner of the annuity contract and with the payment being made to the CS. It should not be a deferred annuity, but should be annuitized with payments beginning immediately. The owner should have no right under the contract to cancel it, withdraw the balance, or assign the rights to payments. Such annuity funds are not countable for Medicaid eligibility purposes and there is no transfer penalty as long as the annuity complies with the DRA annuity requirements.

Many insurance agents are aggressively marketing annuities that are Medicaid friendly, representing that they are not countable resources under Medicaid law. Agents are also giving legal advice incident to such a sale of an annuity by making representations about the status of the annuity contract or the transaction under Medicaid law. The agent and the insurance

company could be sued for misrepresentation related to this type of sale of an annuity. In addition, if the annuity is not structured to comply with the DRA Medicaid annuity rule it could be found to be a transfer causing ineligibility or a countable resource. The case may not be able to be resolved simply by refunding the original annuity purchase amount. The lawsuit could be for the amount of the nursing home bill that could have been covered by Medicaid if proper planning was done by an attorney plus punitive damages. The agent can be protected by insisting that the client obtain the representation of a lawyer before purchasing the annuity. Such a client would have a more difficult time successfully suing the agent when an attorney advised them concerning the legal consequences of Medicaid eligibility.

Qualified Pension, IRA, and Keogh Accounts

The Ohio rule sets forth the Medicaid provisions governing employer retirement and income supplementing account (ERISA) pension plans, IRAs, any other pension and retirement plans, or any other similar financial vehicles administered by an individual, employer, or union. The term used in the rule is *retirement and income supplementing accounts* (RISA).

Even though ERISA and state law provide protection from creditors for such accounts, there is no such provision in the Medicaid rule. The issue for purposes of Medicaid eligibility is whether the account is a countable resource and whether eligibility is approved. This is not a creditor issue and the state does not force a liquidation of any particular asset.

The RISA is a countable resource if the person has an ownership interest and the legal ability to convert it to cash. Thus, if the plan allows withdrawal of any or all of the plan balance, then it is countable. This may be the case even if the person is still working. Many plans provide for in service withdrawals based upon hardship or other criteria. However, there is no requirement for the persons to terminate employment if this is the only way to obtain a withdrawal. The RISA of both husband and wife will be evaluated to determine availability.

The amount of the resource is the amount available for withdrawal less any penalty imposed by the plan. However, income taxes due cannot be deducted from the amount.

If the RISA is not an available resource, then it may still be considered as income. The person must elect the maximum available amount. If a spousal waiver is required to obtain the maximum amount, the person must prove they made a good faith attempt to obtain this spousal waiver. This provision is in violation of ERISA, which, of course, preempts state law. It is an egregious violation of spousal rights guaranteed under federal law. The result is that, by not electing a joint and survivorship pension payment, the CS is left with no pension income after the death of the IS. What is the point of requiring a good faith effort when there is no right to demand a waiver? The only point of this is for Ohio Department of Job and Family Services (ODJFS) to intimidate and coerce a waiver.

An argument can be made under ERISA that qualified pensions, since they are not subject to levy or attachment by creditors, should be non-countable resources (see ERISA § 206(d)(1), 29 U.S.C. § 1056, I.R.C. § 401(a)(13) and 20 C.F.R. § 416.1210(j)). However, cases have not supported this argument (see Blaylock v Harris, 531 F. Supp 24 (1981); Mistrick v. Division of Med. Assistance and Health Servs., 154 N.J. 158 (1998); Martin v. Ohio Dept. of Human Serv. (1998), 130 Ohio App.3d 512, 720 N.E.2d 576; Mannix v Ohio Dept of Human Serv 134 Ohio App.3d 594, 731 N.E.2d 1154. (1999)).

Planning for Qualified Pensions & IRAs

Rolling over into an IRA out of a company pension plan may not be a wise choice. Election of an annuity payout may be the best option to preserve the resource.

If an IRA or other pension is considered a countable resource, then it is very important to elect 20 percent withholding for income taxes or make an estimated payment. This should be done as part of a spend down to avoid an unexpected tax bill on April 15 after there are little or no resources left.

In an appropriate circumstance, a spousal refusal (discussed below) by the CS with a pension plan or an IRA can be an effective way to preserve the pension plan balances. The creditor exemption under law may then protect the claim by the state.

Ohio Estate Recovery Election

Ohio has passed legislation implementing estate recovery and making choices for the state options discussed in the previous section.

The Ohio statute initially adopted the narrow probate property definition of estate. Thus, there was no estate recovery against any property that did not require probate (for example, joint and survivorship property, property in a trust, and life insurance proceeds). However, in June of 2005, Ohio House Bill 66 was enacted into law, expanding the Medicaid estate recovery program to reach all non-probate property such as life insurance, annuities, joint tenants with rights of survivorship accounts, payable on death bank accounts, TOD securities accounts, TOD real estate, IRAs, life estates, trusts, and any other property in which the Medicaid recipient or spouse had any partial legal title or interest at the time of death. The effective date of the estate recovery provisions is September 29, 2005, for decedents dying on or after such date.

O.R.C. 5111.11 provides in pertinent part

- "any other real and personal property and other assets in which an individual had any legal title or interest at the time of death (to the extent of the interest), including assets conveyed to a survivor, heir, or assign of the individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement."
- "any legal title or interest." This means any partial ownership or lesser estate in property. Interpretation of this phrase may lead to law school type questions of what is an interest in any particular property.
- "to the extent of the interest." This should prove to be the most important phrase in this provision. Thus, a determination will need to be made as to the extent of any partial interest and its valuation on the date of death.
- "time of death." This is specifically defined in the statute. There is no such provision in the federal estate recovery statute. The following example might indicate the legislative intent for inclusion of this definition: Mary, the spouse of a Medicaid recipient subject to estate recovery, transferred her residence to her children retaining a life estate. After both spouses have passed away, an estate recovery claim is made against the property. The executor argues that the value of the life estate is zero based upon valuation the moment after Mary's death. The statutory definition would require valuation at the moment prior to Mary's death. Alternatively, the life estate deed or some other contractual arrangement might specifically provide that Mary's interest would terminate at the moment of her death or even one minute before death. The statutory definition seems to indicate that such drafting would not lead to a determination that Mary had no interest on the date of her death. However, note that if all legal title or interest is clearly conveyed prior to Mary's death (for example, general warranty deed transfer from Mary to her children) then there would be no estate recovery even if the transfer is completed one day prior to her death. There is no three year look-back period as there is with the transfer rule governing

eligibility determinations. This rule only has application for a determination of eligibility.
- "joint tenancy." This would include joint tenants with right of survivorship property.
- "tenancy in common." This type of interest would be subject to probate administration and, thus, estate recovery even under the prior version of the Ohio statute.
- "life estate." This is defined as "an estate whose duration is limited to the life of the party holding it, or of some other person" (see Black's Law Dictionary, 4th ed). This would include a life estate deed and any other type of life estate interest.
- "living trust." This should include only a revocable trust but only to the extent of the interest.
- other arrangement. This may include TOD deeds, TOD securities accounts, life insurance, IRAs, other pension plan benefits, annuity contracts, and any other contractual benefits paid to beneficiaries.

Note that the Ohio statute and corresponding federal law clearly set forth the validity and enforceability of this claim against the individual's estate. Thus, regardless of whether the notice provisions apply, there is a valid claim, and the administrator of the estate recovery program is directed to seek estate recovery.

Ohio Liens

The Ohio lien statute states that the lien may also be filed whether the property is in the name of the Medicaid recipient or his or her spouse. However, it is also provided that a lien cannot be filed if the spouse is residing in the property. The ODJFS present practice is not to utilize liens. However, some of the private attorneys handling estate recovery claims are using liens. There may be an issue if a lien is placed against property in the sole name of the CS. The federal statute only refers to a lien against the Medicaid recipient. The Ohio statute specifically refers to a lien against the recipient's spouse. However, the same statute also incorporates the federal law as a limitation of the program ("to the extent that federal law and regulations permit the implementation of a program of that nature" and "in circumstances under which federal law and regulations and this section permit the imposition of a lien"). The Ohio lien statute clarifies that no lien may be imposed against recipients of PASSPORT (Preadmission Screening System Providing Options and Resources Today).

The "Estate" Issue

If the IS dies first, the prior practice of ODJFS had been to close its file and not pursue estate recovery at the later death of the CS. This is no longer the case. The question also arises about whether the estate of the CS can be subject to estate recovery. The federal statute refers to recovery against the individual's estate. There is no specific authorization for recovery against the CS's estate. Thus, it can be argued that no recovery is permitted under the statute against the estate of the CS.

One Ohio court has held that recovery may be made against the estate of the CS (see Ohio Dept of Job and Family Services v Tultz, 152 Ohio App 3d 405, 2003-Ohio-1597 (Summit Co 2003)). Note that the Court did not cite or discuss the relevant federal statute (refer to 42 U.S.C. §1396p(b)(1)(B) & (b)(4)).

Undue Hardship

The Ohio regulations on estate recovery set forth more specific rules on undue hardship. This rule gives examples of circumstances where undue hardship would be found and circumstances that are not considered undue hardship.

Planning for Estate Recovery

You do not need to begin planning until someone becomes eligible for Medicaid. This does not mean that you wait until the caseworker has made the official determination of eligibility. Once the person has spent down or has otherwise become eligible, the client (usually the CS) should implement a plan to avoid estate recovery. However, be careful making any transfers to trust or other accounts for this purpose until after eligibility is granted. Such transfers could cause problems with eligibility under the Medicaid transfer rule.

Most single or widowed Medicaid recipients will have little left to worry about in terms of an estate recovery claim. However, the CS may have substantial property such as a house, car, and the CSRA. If the IS has been on Medicaid, then we know there will be an estate recovery claim.

In general, to avoid this claim, the CS will need to make outright transfers or perhaps establish an irrevocable trust with no retained legal interest. He or she must have no legal title or interest in any property on the date of their death. However, in making any transfers you must consider the effect on Medicaid eligibility for the CS.

You may also be able to successfully defend against estate recovery against life insurance and annuity proceeds (See O.R.C. § 3911.10). This statute provides that proceeds from life insurance and annuity contracts payable to the spouse, children, or dependent of the insured or annuitant are protected against claims of creditors. There is no exception for claims of the state or estate recovery and, thus, this should be a valid defense.

Qualified pension plans and IRAs should also be protected from estate recovery pursuant to statutes protecting such plans from creditor claims.

Federal Protection

ERISA generally provides that pension plan benefits may not be assigned or alienated. This means that creditors have no right to sue the plan participants and get the balance in the pension plan. This ERISA protection covers qualified pension plans, profit-sharing plans, 401(k) plans, and Keogh plans. It does not cover an IRA.

Ohio State Law Protection

The Ohio exemption statute (O.R.C. §2329.66) provides protection from creditors for an IRA, specifically including a Roth IRA and an educational IRA. However, an SEP or a simple IRA are not covered by this protection. Thus, there is no federal or state creditor protection for an SEP or simple IRA.

You should assert your best argument to limit the extent of recovery based the extent of the decedent's interest and valuation of such interest in the property that is subject to recovery. This will most likely apply to a life estate interest or interests in trusts.

If the IS and CS get divorced after Medicaid eligibility, there should be no recovery permitted against the CS since he or she is no longer a spouse under the provisions of the estate recovery statute. If the CS is awarded all remaining assets in the divorce, he or she should pass free of estate recovery to the intended beneficiaries. Although this will not be an acceptable alternative for most clients, it is a legal option that should be communicated to the client.

Oklahoma

By Jerry D. Balentine, P.C.
Jerry D. Balentine, P.C., & Associates
6303 North Portland, Suite 305
Oklahoma City, OK 73112
Telephone: 1-405-946-4500
E-mail: jbalentine@balentinelaw.com
Web site: www.balentinelaw.com

Introduction

The laws governing Medicaid eligibility include both federal and state law. Medicaid eligibility in Oklahoma is determined by the rules adopted by the Oklahoma Health Care Authority (OHCA). The administration of the application of these rules is the job of the Oklahoma Department of Human Services (OKDHS). The Oklahoma Administrative Code (OAC), unofficial interpretations, federal court cases, state court cases, DHS state office interpretations, and case-worker interpretations all impact the determination of an applicant's eligibility based upon financial need, lack of resources, income level, aged, blind, and physical and mental disability.

The Oklahoma Healthcare Authority is the state Medicaid agency; however, Oklahoma Department of Services still determines who is eligible for Medicaid using the rules promulgated by OHCA.

Oklahoma DHS and OHCA regulations refer to the Medicaid program as MA. All of OHCA regulations can be found on the OKDHS Web site (www.dhs.org) by clicking on the library link on blue pane on the left of the screen. After selecting "Policy," the Medicaid rules are found in OAC 317.

OKDHS Appendix C-1 contains the Medicaid income and resource amounts and is frequently referred to in Oklahoma's Medicaid rules. Appendix C-1 can be accessed at the OKDHS Web site, www.okdhs.org, by selecting "Library," then "Forms," and then "Appendices" from the list.

OHCA published proposed rules revised to comply with the DRA on January 5, 2007. Written and oral comments were accepted between February 1, 2007, through March 5, 2007, and a public hearing was held on Monday, March 5, 2007. As of this writing, OHCA has not issued any final rules complying with the DRA. As of this writing, the observations will be based upon the proposed rules as published, which we have been led to believe in all likelihood would not differ substantially from the final rules to be published soon.

Eligibility Requirements

Before an applicant can apply for long-term care benefits under the Medicaid program, Medicaid requires that the nursing home resident needs nursing home-level care. This level of care is more than simple custodian care. The applicant will be required to satisfy two tests, mainly an income test and asset test. Oklahoma is an income cap state and the income cap for Oklahoma for 2007 is $1,869 per month for the person who is the Medicaid applicant. If an IS's income is more than $1,869, but does not exceed $3,000, the person can become income eligible by establishing a Medicaid income pension trust, sometimes referred to as a Miller trust. To determine income eligibility for an IS, the couple's income is allocated by counting the husband's income as his and the wife's income as hers with joint income split in half. The income limit for the IS is the same for a single individual—mainly $1869 per month (2007). The IS keeps the first $50 as a personal needs allowance, pays healthcare premiums, and then gives money to the CS, if necessary, to bring the CS's income up to $2,541 per month (see OAC 317:350-19-21(3)(C)). The remainder

goes to the nursing facility.

Although not described in the OAC, pursuant to 42 USC section 3196 r-5, current practice at OKDHS is that if a CS needs more income than $2,541 per month, the couple can use the OKDHS administrative hearing process to give the CS more of the IS's income. If, at the hearing, a CS can show that more than $2,541 is needed per month "due to exceptional circumstances resulting in significant financial duress," then more of the IS's income can be allocated to the CS. If both husband and wife are institutionalized, income and resources are divided according to the formula that his income is his and her income is hers with joint income split in half. Eligibility is then separately determined for each individual (see OAC 317:35-19-21).

Treatment of the House

If a Medicaid applicant is not married, the personal residence of the applicant while the applicant is living in the home is considered an exempt asset up to a maximum equity of $500,000. A home the Medicaid applicant does not live in is not a countable resource as long as it is occupied by a person who is a minor child, a temporary assistance for needy families (TANF) recipient, or a relative who is aged, blind, or disabled.

If none of these people live in the home, the home is still exempt for 12 months after entry into the nursing home as long as the person maintains their intention to return home. At the end of 12 months, the home counts as a resource unless good-faith efforts are being made to sell it. When the house is sold the person is ineligible for benefits until resources are below $2,000.

Protections for the Community Spouse

The IS does not meet the Medicaid resource limit until the couple's total countable resources, less the amount allocated to the CS is $2,000 or less. The amount allocated to the CS is called *spousal share* in Oklahoma Medicaid Rules and the CSRA in the federal statute. The home of the IS is not counted as a resource as long as the CS, minor child, a relative who is aged, blind, or disabled, or a TANF recipient lives there. If none of these people live in home and it becomes apparent that the institutionalized person will not return home or in 12 months (whichever comes first), then the house counts as a resource unless good-faith efforts are made to sell it. When the house is sold, the person is ineligible for benefits until resources are back below $2,000. The IS can transfer the home without penalty to

- the CS;
- the person's child under 21 or who SSA has found disabled;
- a sibling who has equity interest in the home and resided in the home for at least one year prior to the institutionalization of the individual; or
- individual's son or daughter who resided in the home and provided care for at least two years prior to the individual's institutionalization.

Generally the income eligibility standards for a married applicant are the same as for an unmarried applicant. To determine whether the income is considered the husband's income or the wife's income, Oklahoma assumes that the income belongs to the spouse whose name is on the check, unless documentation can prove otherwise. The OKDHS allows a CS an MMMNA to help prevent the CS from living in poverty. The MMMNA is $2,541 for 2007. Under certain circumstances, the law allows the MMMNA to be increased by a court order or a fair hearing.

The CS is permitted to keep 50 percent of the non-exempt pooled assets of the couple, with the CS having a minimum of $25,000 up to a maximum of $101,640 for 2007. The maximum allowance is indexed and has increased every January 1st. The minimum has not changed.

An exception to this maximum exemption rule may occur when the CS proves in an appeals hearing that a larger amount of assets must be retained to generate the income needed to raise the CS's income to the MMMNA. In addition to the CSRA, exempt assets for the CS are

- a personal residence so long as one spouse continues to reside there (Once exempt, it remains exempt if owned by the CS. It should be noted that in Oklahoma a home owned by a revocable grantor trust can be exempt);
- one car or vehicle not owned by a trust, with no limitation on market value;
- assets acquired by the CS after the snapshot day, but prior to applicant being approved for Medicaid benefits will be added to the assets to be spent down to the CS's resource allowance; and
- assets acquired by the CS after the applicant has been approved for Medicaid benefits will not be considered assets subject to spend-down requirements for the IS.

Treatment of Annuities

On February 1, 2005, the Oklahoma Heathcare Authority amended OAC 317:35-5-41d(10) to reflect the fact that there is considered to be a market for irrevocable annuities. The amendment creates a presumption that an irrevocable annuity can be sold and that the value is total of all remaining payments discounted by the IRS applicable federal rate for the month of application of review. The presumption of marketability and value may be rebutted by compelling evidence. OKDHS does not consider an annuity purchased from a friend or a relative to be financially sound and, therefore, fair market value is not received when such annuity is purchased. It is anticipated that final written rules to be release by the OHCA will incorporate the provisions of DRA in regard to the requirements that will be needed for an annuity to qualify as not being a transfer or considered an asset.

Treatment of Retirement Accounts

Under Oklahoma Law any interest in an IRA, 401k, 403b, pension, profit sharing plan, Roth IRA, or similar retirement accounts are specifically exempt from claims of creditors. However, for Medicaid qualification, all interest in all retirement accounts of a married couple is considered part of assets taken into consideration in spend-down requirements. In Oklahoma retirement accounts do not have any special exemption from the requirement of allocation of assets between spouses and spend-down requirements.

Transfers

For transfers made by either spouse prior to the IS becoming eligible for Medicaid, the penalty for giving away resources is the same as for a single person. This includes resources given away by either spouse before the day the IS is found to be eligible for Medicaid.

Transfers made by the IS after he or she becomes eligible for Medicaid are penalized the same way. However, the IS can make one kind of transfer that is not penalized. The IS must transfer all interest in the resources allocated to the CS within 12 months of becoming eligible for Medicaid. If this not done, the resources allocated to the CS will be considered available to the IS at the end of the 12 months. If the IS transfers resources to the CS in excess of the allocation described above, the excess resources are considered to still be available to the IS (see OAC 317:34-19-20(4)(f)(iii)).

Transfers made by the CS after the IS becomes eligible for Medicaid do not result in penalties for the IS. However, the transfers would result in penalties to the CS if she or he applies for Medicaid during the applicable look-back period.

Although not enacted yet, OHCA has proposed rules that will apply the DRA penalty requirements retroactively to transfers made after February 8, 2006.

Estate Recovery

The Omnibus Budget Reconciliation Act of 1993 mandates the state to seek recovery against the estate of certain Medicaid recipients who received medical care on or after July 1, 1994, and who were 55 years of age or older when the care was received. The payment of Medicaid by OHCA on behalf of a recipient who is an inpatient of a nursing facility, intermediate care facility for the mentally retarded, or other medical institution creates a debt to OHCA subject to recovery by legal action either in the form of a lien filed against the real property of the recipient, a claim made against the estate of the recipient, or both. Only Medicaid received on or after July 1, 1994, will be subject to recovery. Recovery for payments made under Medicaid for nursing care is limited by several factors, including the family composition at the time the lien is imposed or at the time of the recipient's death, or both, and by the creation of undue hardship at the time the lien is imposed or the claim is made against the estate. State supplemental payments are not considered when determining the countable income. The types of medical care for which recovery can be sought include the following:

- nursing facility services
- home and community-based services
- related hospital services
- prescription drug services
- physicians services
- transportation services

OHCA may file and enforce a lien after providing notice and opportunity for a hearing (OKDHS will conduct hearings) against the real property of a recipient who is an inpatient in a nursing facility, intermediate care facility for people with mental retardation, or other medical institution in certain instances.

A lien may not be filed on the home property if the client's family includes the following:

- a surviving spouse residing in the home
- a child or children age 20 or less lawfully residing in the home
- a disabled child or children of any age lawfully residing in the home
- a brother or sister of the recipient who has an equity interest in the home and has been residing in the home for at least one year immediately prior to the recipient's admission to the nursing facility and who has continued to live there on a continuous basis since that time.

A lien may be filed only after it has been determined, after notice and opportunity for a hearing, that the recipient cannot reasonably be expected to be discharged and return to the home (to return home means that the recipient leaves the nursing facility and resides in the home on which the lien has been placed for a period of at least 90 days without being re-admitted as an inpatient to a facility providing nursing care). Hospitalizations of short duration that do not include convalescent care are not counted in the 90-day period. Upon certification for Medicaid for nursing are, OKDHS provides written notice to the recipient that a one-year period of inpatient care shall constitute a determination by the department that there is no reasonable expectation that the recipient will be discharged and return home for a period of at least three months. The recipient or the recipient's representative is asked to declare intent to return home by signing the Acknowledgment of Intent to Return Home or Medicaid Recovery Program form. Intent is defined here as a clear statement of plans in addition to other evidence, corroborative statements of others, or both. Should the intent be to return home, the recipient must be informed that a one-

year period of care at a nursing facility or facilities constitutes a determination that the recipient cannot reasonably be expected to be discharged and return home. When this determination has been made, the recipient receives a notice and opportunity for hearing. This notification occurs prior to filing a lien. At the end of the 12 month period, a lien may be filed against the recipient's real property unless medical evidence is provided to support the feasibility of his or her returning to the home within a reasonable period of time (90 days). This 90-day period is allowed only if sufficient medical evidence is presented with an actual date for the return to the home.

Once a lien is filed, the property does not count against the $2,000 per month resource limit (see OAC 317:35-5-41 (c)(6)(H)).

Enforcement of a lien can be waived if enforcing a lien or a recovery from an estate would create an undue hardship. Undue hardship exists when enforcing the lien would deprive the individual of medical care such that his or her life would be endangered. Undue hardship exists when application of the rule would deprive the individual or family members who are financially dependent on him or her for food, clothing, shelter, or other necessities of life. Undue hardship does not exist, however, when the individual or his or her family is merely inconvenienced or when their life style is restricted because of the lien or estate recovery being enforced. Decisions on undue hardship waivers are made at OKDHS State Office, Family Support Services Division, Health Related and Medical Services Section.

If the recipient was age 55 or older when the nursing care was received, adjustment or recovery may be made only if

- the individual's spouse has left the home.
- there are no children of the individual who are under 21 living in the home.
- there no disabled children of the individual living in the home.
- there is no sibling of the individual who has lived in the home continuously since at lest one year prior to the admission of the individual into the nursing facility.
- there is no child of the recipient who has continuously lived there for at least two years prior to the admission into the nursing facility and who provided care to the individual that allowed him to live at home rather than an institution (see OAC 317:35-19-4(b)(5)).

Appeals

A Medicaid recipient can appeal any denial of eligibility or services (see OAC 317:2-1-2(a)). Appeals regarding financial eligibility are heard through the OKDHS fair hearing process (see OAC 340:2-5-6(4)). The process begins with a hearing before an administrative hearing officer who is not a lawyer. The next step is review by the Director of Human Services. The next step is appeal to the district court in the county in which the individual lives. The district court is limited to review of the administrative record, except that new evidence can be introduced to show irregularities in the proceedings not appearing in the record (see 56 O.S. § 168; OAC 340:2-5-50 through 2-5-80).

Appeals regarding medical services or medical eligibility for long-term care are heard through OHCA hearing process (see OAC 31 7:2-1-1(b)). The OHCA hearing process has a program review panel as the first step. The panel is made up of three OHCA employees who are appointed by the OHCA CEO. The panel members are in jobs related to the problem being complained about (see OAC 317:2-1-2.2). The panel usually does not hold a hearing, but reviews the papers involved and issues a decision. The next step is a hearing *de novo* before a hearing officer, who is a lawyer. The next step is a review by the CEO of the hearing officer tape and exhibits (see OAC 317:2-1-1.2). The next step is appeal to the state district court in the county where the recipient lives. The cases are handled there just like OKDHS appeals (see 63 O.S. §

5052).

Pennsylvania

By Robert M. Slutsky, Esq.
Robert M. Slutsky Associates
470 Norristown Road, Suite 100
Blue Bell, PA 19422
Telephone: 1-610-940-0650
E-mail: robslutsky@comcast.net
Web site: www.slutskyelderlaw.com

Introduction

Medicaid is a joint state and federal health insurance program. Medicaid (unlike Medicare) is not an entitlement. One must qualify financially to be eligible for Medicaid. For older adults, Medicaid will pay for services in a nursing home when one has run out of funds. The Medicaid waiver program pays for other services such as homecare or adult daycare services if the older adult otherwise qualifies physically for nursing care. In this discussion, the IS is the one needing a nursing level of care (and getting Medicaid) and the CS is the healthy spouse not in need of care.

Medicaid planning is the process of managing your assets so that you will qualify for Medicaid funding of services while preserving some of the money for the CS or the next generation. On February 8, 2006, President Bush signed into law enormous changes to the Medicaid law. The law gave states almost two years to implement it. Pennsylvania implemented the law as of March 5, 2007. However, it has been implemented via operations memorandums from the Department of Public Welfare (DPW, who administers Medicaid in Pennsylvania) to the local county assistance offices rather than by more common regulations; it is likely changes will occur as legal challenges are made to the changes that are out of compliance with the federal law.

In general, the two biggest changes were the imposition of a five year look-back period and the change in the calculation of the ineligibility period for gifts. Under the old law, applicants for Medicaid were required to disclose any gifts made for three years prior to the date of application for Medicaid. That has been extended to five years under the new law.

The biggest change is how transfers are accounted for. Under the old law, you became ineligible for Medicaid for one month for every month of care you gave away. If the average cost for a month of care in Pennsylvania is $6700, and you gave away $67,000, you would have been ineligible for nursing care under Medicaid for ten months from the date of the gift. Under the new law, this period of ineligibility does not start until you are in the nursing home, qualify for nursing care medically, and are otherwise eligible for Medicaid (poor). This is very troubling for elder care advocates. Under this scenario, a healthy 75-year-old grandmother can make a gift of $67,000 to her grandson to pay for college, have a stroke two years later, spend down her funds for her care a year later and then, once she is destitute, have to wait an additional ten months before Medicaid kicks in, although she has no money to pay for the care.

Treatment of the Home

Under past law and presumably under the new law, the family home gets special treatment as an asset. If there is a CS, the house is exempt (meaning that it need not be liquidated to pay for nursing care before the IS qualifies for Medicaid). Under the new law, there is a cap in the value of the equity protected. That limit is $500,000. If Pennsylvania determines that the amount of equity in the home exceeds the statutory amount (and at this time we have no idea if the DPW

will use the assessed value of the home or force an appraisal in every case where there is a home), you will be required to access that equity to reduce it. Accessing that equity will require either a mortgage to be taken for the excess equity and that amount spent on nursing care or for the house to be sold and the excess equity used for care.

Past practice in Pennsylvania was that even if there was no one living in the home (in the case where there was no spouse), it was protected as long as the Medicaid applicant put in writing his or her intent to return to the home. This does not stop the DPW from going after the home under the estate recovery rules, discussed in the following section "Protection for the Community Spouse." Further, the home is protected if a sibling is residing in the home and that sibling owns a one-half interest in the home. A home can be transferred penalty free to a disabled child, a child under the age of 21, or a child that provides care under certain circumstances.

Protection for the Community Spouse

The CS is provided protection under the law to prevent total impoverishment. The following are exempt assets for the CS (that is, these assets can be kept and the IS can still be eligible for Medicaid):

1. There are no penalties for transfers (gifts) to the CS from the IS in the nursing home.
2. The CS may keep one vehicle.
3. The CS may keep the family home (with equity restrictions noted above).
4. The CS may keep his or her retirement plans (IRAs, 401(k)s, etc).
5. The CS may keep all income they generate from their assets.
6. The CS may keep assets used in a business necessary for self support.
7. The CS may set up exempt prepaid burial accounts for them and the IS.

When the IS applies for Medicaid, the state divides the available resources (those legally available to pay for care). The CS may retain one-half of the available resources (after the exempt resources noted above are taken out) up to a maximum of roughly $100,000. If the amount of resources is very modest, there is a minimum of roughly $20,000 that the CS can keep regardless of how few assets he or she owns. The IS's one-half must be spent for his or her own nursing or medical care or for needs of the CS—it cannot be given away. If the family has in excess of $200,000, any amount over the spousal share of $101,000 must be spent for the care of the IS or on the CS.

The CS is also allowed to keep a minimum amount of monthly income (between roughly $1600 and $2500) based on his or her monthly housing expenses. If he or she does not make enough income, income from the IS can be transferred. If that still is not enough, additional assets may be protected to generate the desired minimum income.

Treatment of Annuities

Annuities that are deferred and not in payment status are considered available resources and must be spent before the IS is eligible for Medicaid. If otherwise available resources are converted into an annuity within the five year look-back period, under prior Pennsylvania practice, Pennsylvania viewed all annuities as suspect, even if they were in payment status and, therefore, considered them to income instead of assets. Although it was in conflict with prior federal guidance, annuities that were annuitized in accordance with guidelines set out in HCFA Transmittal No. 64 were still considered available resources.

Under the new law, the purchase of an annuity is not considered a transfer if it is an IRA or purchased with the proceeds from an IRA, an SEP, or a Roth IRA; the annuity is irrevocable, non-assignable, and actuarially sound as determined in accordance with the actuarial publications of

the Office of Chief Actuary of the Social Security Administration; and it provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments. Further, annuities that name the state the first beneficiary up to the amount of Medicaid paid may be exempt resources (although the income, if received by the IS, would have to be used to pay for care). Under the old law, Pennsylvania took the position that even annuities that followed all of the rules above were available arguing that they could be sold on the open market and converted to cash, which is an available resource. Pennsylvania's operations memorandums have indicated a more generous approach on annuities that allow additional resources to set up an annuity for the CS, which allow him or her to bring his or her income up to the MMMNA.

Treatment of Retirement Accounts

Pennsylvania includes the retirement accounts (IRAs, 401(k)s, 403(b)s, etc.) as an available resource that must be spent down to receive Medicaid if owned by the IS. Pennsylvania currently excludes those retirement accounts if owned by the CS.

Estate Recovery

Pennsylvania, following federal law, has an estate recovery program to get back some of the money it paid out for a Medicaid recipient. Pennsylvania has a statutory lien against the probate estate of a Medicaid recipient. If the personal representative of the estate (executor or administrator) has funds left over after selling the home (usually the only asset left if the person was on Medicaid), he or she must pay back the state before paying other unsecured creditors. The probate estate includes assets with only the owner's name on it. Assets that are joint with others or transfer automatically on death (such as life insurance policies, IRAs, 401(k)s, annuities, and payable on death bank accounts) are not part of the probate estate and, thus, not subject to the lien.

South Carolina

By Franchelle C. Millender, CELA
Sherrill Roof Millender LLP
1122 Lady Street, Suite 700
P.O. Box 11497
Columbia, SC 29211
Toll-free number: 1-800-267-2382
E-mail: millender@srmlaw.com
Web site: www.srmlaw.com

Introduction

Medicaid in South Carolina provides assistance to the elderly and disabled for long-term care in a nursing home or under a home and community-based waiver. In order to qualify for assistance, the individual must meet institutional level of care requirements and must meet financial requirements. In analyzing financial eligibility, Medicaid considers both resources (assets) and income.

Resources

The applicant must have countable resources of no more than $2,000. Some assets are excluded

for eligibility purposes. These include the home (limited to $500,000 of equity unless there is a spouse, child under 21, or disabled adult child living in the home), one vehicle, irrevocable pre-need burial contracts for the individual and spouse, household goods and personal effects, life estate in real property, up to $1,500 cash value of life insurance (or all cash value of life insurance if the total face value of all policies combined is $10,000 or less), and burial spaces for the individual and immediate family members.

Income

South Carolina is an income cap state. If the applicant's income exceeds $1911 per month (in 2008), it is necessary to establish an income trust in order to qualify for Medicaid. The income trust receives all income and the trustee then distributes the funds monthly in accordance with the Medicaid rules.

Treatment of the House

In South Carolina, the home is an exempt resource for eligibility purposes so long as the equity does not exceed $500,000 and the applicant states an intent to return home. This is a subjective intent and is not dependent on the likelihood of such a return. If there is a CS, a child under 21, or a disabled child over 21 residing in the home, there is no equity limit. If the home is held in the name of the IS, it may be subject to estate recovery. If it is held in the name of the CS, it will not be subject to recovery against the estate of the IS. It is, therefore, often advisable to transfer the home to the CS.

Protections for the Community Spouse

Because the CS will need resources to be able to continue living independently, the CS is allowed additional resource exclusions. He or she may exempt up to $66,480 in countable resources and may also exempt amounts held in qualified retirement plans.

If the CS's monthly income is less than $2,610, a portion of the IS's income may be diverted to the CS to make up the difference. This is called the MMMNA.

Treatment of Annuities

Annuities are sometimes utilized to convert countable resources into an income stream. The DRA changed the treatment of annuities purchased on or after February 8, 2006. These changes may also affect annuities purchased before that date, if changes are made in the annuity contract on or after February 8, 2006.

All annuities owned by the individual or by the CS must be disclosed on the application for Medicaid. In order to exempt the annuity as a countable resource, it must be a qualified retirement plan annuity or it must be irrevocable, non-assignable, actuarially sound, and provide for equal payments with no deferral and no ballooning.

Annuities owned by the individual or spouse must name the state as remainder beneficiary in first position or in second position after a spouse or minor child or disabled adult child for the total amount of Medicaid assistance paid on behalf of the annuitant.

Treatment of Retirement Accounts

The qualified retirement accounts of the Medicaid applicant are countable resources. The qualified retirement accounts of a CS are not countable. The individual may annuitize the retirement account, which converts the resource into an income stream. However, under the new law, the state must be named remainder beneficiary in first position, unless there is a spouse or a disabled child in which case they can be named ahead of the state.

Estate Recovery Rules

South Carolina enacted estate recovery provisions in 1994 mandating recovery by Medicaid against the probate estate of Medicaid recipients who were inpatients at the time of death or were 55 years of age or older when medical assistance was received. A claim may be made against the estate for amounts paid on behalf of a person in a nursing home or one who receives services under a home and community-based waiver. The state must file a claim as a creditor of the estate in order to preserve its rights.

If there is a living spouse, a minor, or a disabled child, recovery will be deferred until such person is deceased.

South Carolina has enacted undue hardship provisions that require the waiver of the right of the state to recover if the criteria are met. These include the following:

- Recovery against the home if it could have been transferred without penalty to a spouse, a surviving child under 21, a surviving child who is blind or totally disabled, a surviving sibling who has an equity interest and lived in the home for at least one year immediately prior to the date the decedent was institutionalized, or a surviving child who lived in the home for a period of at least two years immediately before the decedent was institutionalized and who provided care that allowed the decedent to delay institutionalization. The person to whom the property could be transferred must be residing in the home at the time the hardship is claimed. The statute protects only $100,000 value of the home property.

- Recovery against the home and one acre of land if an immediate family member who has resided in the home for at least two years prior to the decedents death is residing there when hardship is claimed, owns no other real property (or agrees to liquidate other real property and turn over the proceeds), and has a gross annual family income below 185 percent of the federal poverty guidelines.

- Recovery against an income-producing asset if the spouse's or immediate family member's annual gross family income would fall below federal poverty guidelines without the income from this asset and the asset is not producing income in excess of 185 percent of the federal poverty guidelines (or the excess goes to the department) at the time of death.

The Statute defines an *immediate family member* as a child, parent, brother, or sister of the deceased.

Complete current information on South Carolina's Medicaid programs may be found in the South Carolina Medicaid Policy and Procedures Manual at https://medsweb.scdhhs.gov/mppm.

Texas

H. Clyde Farrell
Law Office of H. Clyde Farrell
1411 West Avenue, Suite 100
Austin, TX 78701
Telephone: 1-512-323-2977
E-mail: cfarrell@texas.net

Introduction

The Texas Medicaid rules and agency policies are readily accessible in the Medicaid Eligibility Handbook at www.dads.state.tx.us/handbooks/meh/. Each section quotes applicable administrative rules (the law) and adds instructions to eligibility workers, including examples (agency policies, not the law—but that doesn't matter to the workers). The Web site supports single-word searches, but if you try to find a phrase, you get every place any word in the phrase appears. For phrases, try pasting the foregoing URL into Google's advanced search feature (located toward the bottom), then search on the phrase in Google. Notice that in addition to the Medicaid Eligibility Handbook, the Web site just referenced includes links to appendices, forms, revisions, policy clarifications and policy transition bulletins. All of these can important sources of law and policy.

Treatment of the Home

Texas applies a permissive *subjective intent* test: If the Medicaid applicant (or person acting for him or her) has ever lived in the home and declares an intent to return to it during the application process, that property will automatically be treated as exempt. There is no inquiry as to whether there may be a reasonable prospect for returning home. The only exception is for a residence in which the applicant owns equity with value exceeding $500,000; that exception does not apply if the residence is occupied by the applicant's spouse or by the applicant's child who is under age 21, blind, or disabled. There is no limit on the acreage that can be exempted, as long as it is contiguous and its value does not exceed $500,000 (if applicable). An applicant's interest in a residence located outside Texas is not exempt, unless it is occupied by a CS or is listed for sale.

Effective December 1, 2006, an interest in a residence held by a trust cannot be treated as exempt. Therefore, Medicaid beneficiaries who hold their homes through a revocable trust must require reconveyance of title back to them to maintain eligibility.

Protections for the Community Spouse

As in most states, the CS may keep half the countable assets both spouses had on the snapshot *date*, which is the first day of the first month the IS was placed in a nursing home, hospital, or a combination of both for at least 30 days running. Provided that the protected resource amount (PRA) cannot be less than the minimum ($20,880 in 2008) and that it is not enhanced, it cannot exceed the maximum ($104,400 in 2008). The PRA may be enhanced if the total of the countable incomes of both spouses is below the MMMNA ($2,610 in 2008). Countable incomes for this purpose are gross incomes minus the personal needs allowance ($60). The couple may keep enough assets to raise total countable income to the MMMNA, assuming the assets are all invested at the current one-year CD rate. For example: Assume countable incomes total $1,800 and the one-year CD rate is 4 percent. PRA may be increased to $2,610 - $1,800 = $810 × 12 = $9,720 (income needed per year) .04 = $243,000.

After the first annual review, there is no limit on the value of countable assets the CS may have.

From that time on (approximately one year from the date on the notice of Medicaid certification), the IS may not have more than $2,000 in countable assets. For these purposes, community property laws are ignored and assets are treated as if they were owned only by the spouse in whose name they are titled. Therefore, community funds (or even separate funds) can simply be transferred from an account bearing the name of the IS to one titled only in the name of the CS. However, retitling of real property requires conveyance by deed. This can be a problem if advance planning has not included drafting of a power of attorney authorizing an agent to convey assets to the CS without consideration.

Treatment of Annuities

Deferred annuities are treated as assets to the extent of the cash surrender value minus surrender charges and income tax due. Likewise, annuities in pay status are treated as assets to the extent that they can be surrendered or sold for cash. The same applies to annuities sold before February 8, 2006, even if they are irrevocable, unassignable, actuarially sound (guaranteed payments do not exceed the annuitant's life expectancy), and paid in equal monthly payments, unless a CS is annuitant or the Medicaid program is remainder beneficiary to the extent of Medicaid benefits paid.

Regarding annuities purchased on or after February 8, 2006, the Medicaid application or recertification form of the purchaser or spouse must contain a statement that "the state becomes a remainder beneficiary under such annuity or similar financial instrument by virtue of the provision of such medical assistance." This is accomplished by a notice sent to the annuity issuer by the Medicaid program and by changing the beneficiary designation. In addition, unless the annuity is irrevocable, unassignable, actuarially sound, and paid in equal monthly payments, its purchase is treated as a transfer of assets without consideration.

These rules allow for continued use of the strategy of spending down to the PRA by purchasing an annuity for the CS, provided that the annuity is irrevocable, unassignable, actuarially sound, and paid in equal monthly payments. In the application process, the Medicaid program asserts its remainder interest with a notice to the issuer, so if the CS dies before the end of the guaranteed payment period, Medicaid has a claim against the remaining payments. The current rules also allow an unmarried person to purchase an annuity that is irrevocable, unassignable, actuarially sound, and paid in equal monthly payments, as long as the Medicaid program has a similar remainder interest.

Treatment of Retirement Accounts

Texas Medicaid treats retirement accounts as countable assets to the extent they can be reduced to cash, unless the account owner would have to leave his or her job to gain access to the cash. Although the rules are not clear, it has been the author's experience that the possibility of reducing a retirement account to cash through a loan or a discretionary payment by the plan administrator does not cause the account to be counted as an asset.

These rules are applied the same way for long-term care Medicaid, whether the account owner is the applicant or a CS. If the account belongs to the CS, it is sometimes advantageous to convert it to an immediate-pay annuity within an IRA so it will count as income and not as an asset (though the income tax consequences may preclude this in some cases). To avoid a transfer penalty, the annuity would have to be irrevocable, unassignable, actuarially sound, and paid in equal monthly payments; and the Medicaid program would claim a remainder interest in payments coming due after the death of the CS.

Estate Recovery Rules

For a brief summary and links to the Texas estate recovery rules, visit www.dads.state.tx.us/services/estate_recovery/index.html. The full text of the rules is in the Texas Administrative Code at the first link below "Rules and Statutes," located at the bottom of that page.

Texas was one of the last states to adopt a Medicaid estate recovery program (MERP), which it did by statute in 2003 and by administrative rules going into effect on March 1, 2005. Under a grandfather provision, persons filing an application for any program subject to MERP before March 1, 2005, who subsequently qualified for such a program as a result of that application, were not subject to MERP. As a corollary, the program can recover only for payments made for services on or after March 1, 2005.

The program extends (at this writing) only to the probate estate and not to non-probate interests such as trust remainders, remainders after life estates, survivorships, and payable-on-death interests. However, see the discussion above to the effect that a residence held by a trust (even a revocable trust) cannot be claimed as exempt. (That policy was made to deter Medicaid beneficiaries from avoiding MERP by transferring their residences into revocable trusts, from which they could have passed to remainder beneficiaries outside the probate estate.)

An estate is exempt from Texas estate recovery if

- there is a surviving spouse;
- there is a surviving child or children under 21 years of age;
- there is a surviving child or children of any age who are blind or permanently and totally disabled under Social Security requirements; or
- there is an unmarried adult child residing continuously in the Medicaid recipient's homestead for at least one year before the time of the Medicaid recipient's death.

There are also fairly generous waiver provisions, including an unusual one applying only to a residence worth less than $100,000 (or to that amount of equity after estate recovery takes the excess): The interests received by descendants with incomes under three times the federal poverty level can be protected with a waiver application.

Virginia

Evan Farr, CELA, CEA
The Law Firm of Evan H. Farr, P.C.
10640 Main Street, Suite 200
Fairfax, VA 22030
Telephone: 1-703-691-1888
E-mail: evanfarr@farrlawfirm.com
Web sites: www.FarrLawFirm.com/; www.VirginiaElderLaw.com;
www.VirginiaEstatePlanning.com

Introduction

In 1994, the United States Court of Appeals for the Fourth Circuit (just below the U.S. Supreme Court), called Virginia's Medicaid plan one of the "most completely impenetrable texts within human experience" and "dense reading of the most tortuous kind" (refer to Rehabilitation Association of Va. v. Kozlowski, 42 F.3d 1444, 1450 (4th Cir. 1994)). Since then, it has only gotten worse.

Virginia implemented the DRA on June 23, 2006, retroactive to February 8, 2006, the date of its enactment. Virginia's Medicaid Policy Manual is accessible on-line at http://www.dss.virginia.gov/benefit/me_famis/manual.cgi.

Due to the tremendous complexity of the Medicaid laws, the Medicaid application process is also extremely complicated, and many people who file for Medicaid without professional assistance will wind up with the application being rejected for a variety of reasons. Rejection often occurs due to financial issues—either excess resources, excess income, or improperly-timed gifts or transfers. Rejection in many cases is due to missing or incomplete information or verifications. Applications are also sometimes improperly rejected by an eligibility worker (most of whom are underpaid and overworked), who has not had the time to carefully and thoroughly review the application and verifications or who has improperly applied the legal or financial requirements for eligibility.

Worse yet, an application that is filed at the wrong time can result not only in rejection, but in the imposition of significant penalties against the applicant that could have been avoided with a timelier filing. For these and many other reasons, an experienced Virginia elder law attorney should always be hired to represent the applicant through the entire Medicaid process—including planning for eligibility, preparing and filing the application, working with the local department during the application and verification process, filing an appeal when necessary, and representing the applicant in connection with any required hearings and appeals.

Virginia is a medically needy state rather than an income cap state, meaning that for Medicaid long-term care assistance, if an applicant is medically in need of nursing home care, the applicant will qualify for Medicaid benefits (providing the applicant is otherwise eligible) so long as the applicant's gross income is below the private cost of care. Also unlike most states, Virginia is also a 209B state, meaning that Virginia uses its own eligibility criteria in determining Medicaid eligibility for the elderly and disabled, rather than extending Medicaid coverage to all who qualify for federal SSI benefits.

Assets

In Virginia, an unmarried applicant for Medicaid long-term care assistance may have no more than $2,000 in countable resources in his or her name in order to be resource eligible for Medicaid.

Income

The nursing home resident must pay all of his or her income, less certain deductions, 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 possibly be able to pay to the spouse that continues to live at home.

Community-Based Care Waiver Services

Community-based Care (CBC) Waiver services can be authorized as an alternative to nursing facility care only when the individual meets the level-of-care criteria and is at risk of nursing facility placement. "At risk" is defined as needing services within 30 days or less. The financial eligibility rules for CBC Waiver services are the same as for nursing home long-term care services.

Treatment of the House

For Medicaid payment of nursing home long-term care, the applicant's principal residence is excluded from countable resources for the first six months of continuous institutionalization provided the applicant intends to return home and provided the equity in the home property does not exceed $500,000. Regardless of the amount of home equity, after six months of continuous institutionalization, the IS's home will become a countable resource, unless the home is occupied by a spouse, dependent child under age 21, or a blind or disabled child.

Protections for the Community Spouse

CSRA

All countable assets owned by the married couple as of the first day of the month that the applicant enters the nursing home, regardless of how titled, are divided (for purpose of calculation) into equal halves. One-half of the countable assets, up to $101,640, is then allocated to the CS. This amount that is allocated to the CS is called the CSRA. The other half of the countable assets is allocated to the IS and must be spent until only $2,000 remains, at which time the IS will then qualify for Medicaid. There is also a minimum resource allowance for the CS in the amount of $20,328.

Example: If a married couple has $100,000 in countable assets on the date the husband enters a nursing home, he or she will be eligible for Medicaid once the couple's assets have been reduced to a combined figure of $52,000—$2,000 for the applicant and $50,000 for the CS.

MMMNA

In Virginia, the MMMNA ranges from a low of $1,650 per month to a high of $2,541 per month and cannot exceed $2,541 unless a court orders support in a greater amount. In Virginia, the MMMNA is calculated as $1,650 plus the *excess shelter allowance*, which equals the amount by which the at-home spouse's shelter expenses exceed the *excess shelter standard* of $495. Shelter expenses specifically include rent, mortgage payments, taxes, insurance, and a utility standard of $281.

If the at-home spouse's income falls below his or her MMMNA, the shortfall can be made up from the nursing home spouse's income.

Treatment of Annuities

Before February 8, 2006. An annuity issued prior to February 8, 2006, is considered a countable resource if the annuity can be surrendered. The countable value of the annuity is the amount of the funds in the annuity minus any fees required for surrender (see Virginia Medicaid Manual § M1140.260).

After February 8, 2006. A non-employment related annuity purchased by or for an individual on or after February 8, 2006, using that individual’s assets will be considered an available resource unless the annuity is irrevocable, non-assignable, actuarially sound, and provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made. All annuities purchased by the IS or a CS on or after February 8, 2006, must name the Commonwealth of Virginia as the primary beneficiary for at least the total amount of medical assistance paid on behalf of the institutionalized individual. If there is a CS or a minor or disabled

child, the Commonwealth must be named as the remainder beneficiary behind the spouse or minor or disabled child (see Virginia Medicaid Manual § M1140.260).

Transfer Rules

Before February 8, 2006. If the expected return on the annuity is commensurate with a reasonable estimate of the beneficiary's life expectancy, the annuity is actuarially sound and its purchase is a transfer of assets for fair market value (see Virginia Medicaid Manual § M1450.520).

After February 8, 2006. An annuity purchased by an IS or CS on or after February 8, 2006, will be treated as an uncompensated transfer unless the state is named as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the annuitant. An annuity purchased by the IS on or after February 8, 2006, will be considered an uncompensated transfer unless the annuity is described in one of the relevant subsections of section 408 of the IRS Code. An annuity purchased by the IS on or after February 8, 2006, will be considered an uncompensated transfer unless the annuity is irrevocable, non-assignable, actuarially sound, and provides for equal payments with no deferral and no balloon payments (see Virginia Medicaid Manual § M1450.530).

Treatment of Retirement Accounts

The value of a retirement fund is the amount of money that an individual can currently withdraw from the fund. If there is a penalty for early withdrawal, the fund's value is the amount available to an individual after penalty deduction. However, the taxes due are not deductible in determining the fund's value. If the individual is a married IS with a CS, the retirement funds are evaluated as resources in the resource assessment and the eligibility determination (see Virginia Medicaid Manual § S1120.210).

Estate Recovery Rules

Under federal regulations and state law, DMAS may make a claim against a deceased enrollee's estate when the recipient was age 55 or over. The recovery can include any Medicaid payments made on his or her behalf. This claim can be waived if there are surviving dependents (see Virginia Medicaid Manual § M1700.300).

Washington

Rajiv Nagaich, J.D., C.I.C
Johnson and Nagaich, P.S.
31919 Sixth Avenue South, Suite A-100
Federal Way, WA 98003
Telephone: 1-253-838-3454
E-mail: rnagaich@eldercounselor.com
Web site: www.eldercounselor.com

Introduction

The state of Washington allows qualified residents to be able to access Medicaid benefits in a nursing home setting and outside of a nursing home setting under a waiver program referred to as the Community Options Program Entry System (COPES). The nursing home program is

generally available to those whose monthly income is less than the average statewide private pay monthly cost of a nursing home. The COPES program is available to all Washingtonians, but is limited in its effectiveness to those with incomes exceeding $1,869 per month (as of April 2007).

Benefits in a nursing home setting are quite standard in that the program will cover all costs incurred while in the nursing home. The applicant's income will be used as a participation amount, or deductible, with the state paying what the income leaves uncovered. Benefits under the COPES program are limited by the state. The state uses a CARE (Comprehensive Assessment Reporting and Evaluation) tool to determine the number of hours of care it will provide the applicant. The general range of covered hours ranges between 0 and 184 hours per month, with exceptions available to account for cases requiring additional hours. As is the case with nursing home benefits, the applicant's income will be used as a participation amount, or deductible, with the state paying what the income leaves uncovered.

Treatment of the House

In Washington State, recipients of Medicaid benefits do not have to sell their homes in order to qualify for Medicaid. Under the DRA, equity in the amount of $500,000 in the principal residences is deemed non-countable, as long as the applicant intends to return home. The equity limit does not apply if the Medicaid applicant's spouse, minor child, or another dependent relative lives there. It is important to note that though the applicant can have the house declared to be a non-countable resource, the state of Washington has the right to impose a lien on the house, where it will be collected upon the death of the applicant (or the last of the applicant of applicant's spouse, if the applicant is married). For this reason, the exemption turns out to be mostly illusory.

Protections for the Community Spouse

The Medicaid law provides special protections for the spouse of a Medicaid benefits recipient in order to make sure the spouse has the minimum support needed to continue to live in the community.

For a Medicaid benefits recipient housed in a nursing home, the protections generally aim to allow a spouse to have a minimum amount of resources, which in Washington includes a house with no more than $500,000 in equity, a car of any value, and between $41,943 and $101,640 (as of April 2007) in other resources.

If the Medicaid recipient is accessing benefits outside of a nursing home setting, the maximum amount of resources a CS is allowed to have is $41,943 (as of April 2007). The spouse can always petition the Department of Social and Health Services (DSHS) or obtain a court order to increase this limit. This protection, however, is limited to those spouses where the benefit recipient is classified as a *categorically needy* client by DSHS (meaning that the client can have no more than $1,869 per month in income). If the recipient's income exceeds the $1,869 limit, the client will be classified as a medically needy client and the spouse will not have the protections discussed above, rendering the Medicaid plan quite useless for most clients.

Example: If a couple has $200,000 in countable assets on the date the applicant enters a nursing home, he or she will be eligible for Medicaid once the couple's assets have been reduced to a combined figure of $103,640—$2,000 for the applicant and $101,640 for the CS.

Example: If a couple has $100,000 in countable assets on the date the applicant applies for benefits outside a nursing home, under the COPES, he or she will be eligible for Medicaid once the couple's assets have been reduced to a combined figure of $43,943—$2,000 for the applicant

and $41,943 for the CS.

In addition to resource protection, a CS also has income protections and is allowed to maintain a minimum level of income under the MMMNA. The MMMNA is calculated for each CS according to a complicated formula based on his or her housing costs and ranges between $1,650 (from July 1, 2006, through June 30, 2007) to a high of $2,489 a month (in 2006). If the CS's own income falls below his or her MMMNA, the shortfall is made up from the nursing home spouse's income. (In some states, the CS is permitted to increase the MMMNA by retaining more resources, as discussed in “Long-term Care Planning, Increased CSRA.”)

Example: Mr. and Mrs. Smith have a joint income of $3,000 a month, $2,300 of which is in Mr. Smith's name and $700 of which is in Mrs. Smith's name. Mr. Smith enters a nursing home and applies for Medicaid. The Medicaid agency determines that Mrs. Smith's MMMNA is $1,700 (based on her housing costs). Since Mrs. Smith's own income is only $700 a month, the Medicaid agency allocates $1,000 of Mr. Smith's income to her support. Mrs. Smith would be entitled to a minimum income of $1,650, so even if her housing costs did not warrant the $1,700 per month in income, she would be entitled to have at least $950 of Mr. Smith’s income allocated to her.

In exceptional circumstances, CSs may seek an increase in their MMMNAs either by appealing to the state Medicaid agency or by obtaining a court order of spousal support.

Treatment of Annuities

Annuities have been and continue to be a favored method of protecting assets under the right circumstances, though DRA places some new conditions on the use of annuities. Generally speaking, assets that exceed the exempt resource limits may be placed in a Medicaid qualifying immediate annuity thereby converting an asset into a stream of income. As long as the income comes in the name of someone other than the Medicaid benefits recipient, the income will not be subject to the participation rules, although if the income comes in the name of someone other than the applicant’s spouse, the resources placed in the annuity will be looked upon as having been disposed for less than fair market value and will trigger a penalty period during which the applicant would be ineligible to receive any Medicaid benefits. If the income comes in the name of the applicant, such income will be subject to participation.

The conditions that must be met to make an annuity qualify as a Medicaid qualifying annuity include the naming of the state of Washington as the primary or secondary beneficiary. The state will be the primary beneficiary up to the amount of money the state has expended on the applicant’s care needs in the first position unless the applicant has a spouse, a minor, or a disabled child, in which case the spouse of the child will be named as the primary beneficiary and the state will be named as the secondary or contingent beneficiary subject to the condition that upon the applicant’s death any withdrawal triggered by the spouse or child will be subject to the state’s right to recovery.

Under the DRA, language suggests that an annuity funded with certain retirement funds and any annuity that is irrevocable, non-assignable, actuarially sound, and provides payments in equal amounts without deferral or a lump sum payment at the end of the term will also be considered to be a valid annuity. However, there is controversy whether or not the naming of the state is a requirement in such annuities or not.

Example: The married applicant has a house, a car, and $200,000 in assets. The applicant is looking at nursing home placement and under the rules has $96,360 in excess assets. The applicant can apply for a Medicaid qualifying annuity, name the spouse as the primary beneficiary and the state of Washington as the secondary beneficiary up to the amount expended by the

state on applicants long-term care needs financed by Medicaid, and be able to qualify for Medicaid benefits. Upon the applicant's death, if the beneficiary changes the payout options or dies before final payout, the state's right to recovery will be triggered.

Treatment of Retirement Accounts

In Washington, retirement accounts are treated as any other resource and do not receive any preferential treatment as they do in certain other states. This means that all funds in retirement accounts are considered available resources and may have to be liquidated if the resources exceed the exempt limit.

Example: The married applicant and his spouse have a house, a car, and $200,000 in the applicant's retirement account. The $200,000 exceeds the allowable limit by $156,057. This will require the couple to liquidate up to $160,000 of the retirement account by making a withdrawal and paying the requisite taxes on the withdrawal or annuitize $156,057 of the funds in order to minimize the immediate tax bite resulting from withdrawal of the funds.

Estate Recovery Rules

Under Medicaid law, following the death of the Medicaid recipient, the state of Washington will attempt to recover from the recipient's estate whatever benefits it paid for the recipient's care. However, no recovery can take place until the death of the recipient's spouse or as long as there is a child of the deceased who is under 21 or who is blind or disabled.

Under Washington State's expanded recovery system, the state will attempt recovery not only from the recipient's probate estate but also from property in which the recipient had an interest but that passes outside of probate. This includes jointly held assets, assets in a living trust, or life estates.