

**MEDICAID: WHAT EVERY PRACTITIONER NEEDS  
TO KNOW**

General Practice, Solo, and Small Firm Section

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**San Antonio**

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The Law Offices of  
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*Assisting Seniors, Helping Families*

## Brief Bio of Carol Bertsch

Carol Bertsch is an elder law attorney serving San Antonio and the surrounding communities. She received her Doctor of Jurisprudence degree from the University of Texas School of Law in 1992. Since opening her practice in 1996, Carol has been a champion of the elderly and disabled – she even makes “house calls” to those unable to get out so they can receive the full benefit of legal counsel. First and foremost, she treats clients with the dignity and respect and they deserve, always appreciative of the wonderful tapestry woven by their life experiences. With patience and understanding, she helps her clients plan for the challenges of aging.

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**ACID ROCK TO ACID REFLUX:  
HOW WILL BOOMERS PAY FOR DISABILITY?  
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As people age, they begin looking for ways to finance their care in the event they can no longer care for themselves. The most common ways to finance care for incapacity is:

- self-financed (“private pay”)
- Texas Veteran’s Nursing Home
- long-term care insurance or a hybrid insurance product
- Medicaid long-term care benefits

**A. Self-insurance.** With private pay, an individual will simply use his/her own resources to pay for the cost of care.

- Costs for care in a bed and board home may range from \$2,500.00 to \$3,500.00 per month (not including medical costs) resulting in an annual cost of up to \$42,000 per year.

- Assisted living facility costs will range from \$3,000.00 to \$4,500.00 per month costing up to \$54,000 per year.

- Semi-private room in a nursing home costs approximately \$4,500.00 to \$6,500.00 per month which would equal about \$54,000 to \$78,000 per year, not including medical costs.

- Private room in a nursing home costs approximately \$5,000.00 to \$8,500.00 per month which would equal about \$60,000 to \$102,000 annually.

- Twenty-four hour custodial home care could cost anywhere from approximately \$15.00 per hour to \$25.00 per hour which would result in a cost of between about \$131,400 to \$219,000 per year! That’s about \$11,000 - \$18,000 per month just for caregiver costs.

- In 2017, the average cost of nursing home care in Texas is about \$5,000 per month.<sup>1</sup>

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1 Determined by the Texas Health and Human Services Commission (“HHSC”) being \$162.41 per day x 30 days = \$4, 872.30 or 31 days \$5,034.71.

In 2015, individuals 65 and over had a median income of \$18,657 (about \$1,555 per month of gross income).<sup>2</sup>

Thus, you can see why individuals become concerned about financing the cost of housing.

One means of preparation might be to set aside a certain amount of money and invest that money as a means of self-insurance. But at today's investment returns, it would take about \$1,650,000 with an annual return of 4%<sup>3</sup> to generate income of \$66,000.00 per year to pay for a semi-private room in a nursing home and about \$4,375,000 to generate enough income to pay for 24 hour unskilled in-home care. Of course this calculation does not take into consideration tax or inflation issues. Nor does it take into consideration that these funds cannot be used for other daily costs such as utilities, food, et cetera.

**B. Veteran's Benefits.** This section is not meant to be a treatise on Veteran's benefits.<sup>4</sup> However, a practitioner should have a working knowledge of resources that might be available to a disabled veteran and/or the veteran's disabled spouse.

1. **Compensation and Pension.** When disability strikes, a client may find funds available to help pay for disability through Veteran's Compensation and Veteran's Pension. Veteran's Compensation are payments for service related disability. However, a Veteran's non-service-connected disability pension is available to a disabled veteran and/or the veteran's disabled spouse.<sup>5</sup>

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<http://www.pensionrights.org/publications/statistic/income-today%E2%80%99s-older-adults>

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A consistent 4% return in the current investment climate may be overly optimistic. Thus, planning for disability by setting aside a fixed sum may be insufficient if the investment fails to generate the necessary return.

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See Abshire, Farrell, Sitchler & Wright, *Elder Law*, Texas Practice Series Vol 51, Thomson-Reuters Westlaw, Chap. 12, 2015-2016.

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Applicants over age 65 are *per se* disabled but younger applicants must prove 100% disability to obtain a pension payment. Abshire, Farrell, Sitchler & Wright, *Elder Law*, Texas Practice Series Vol 51, Thomson-Reuters Westlaw, §12:9, 2013-2014

In order to spot the issue, the practitioner should know the basics for pension eligibility: (1) disability, (2) low net income, (3) limited assets and (4) at least 90 consecutive days of active duty with one day served during a wartime.<sup>6</sup> The practitioner should take care in limiting any legal advice for an application for pension benefits. Federal law provides that no legal fee can be charged unless the attorney has been certified to represent clients by the VA.<sup>7</sup>

2. **Texas Veteran's Nursing Homes.** The citizens of the State of Texas are so appreciative of the sacrifices made by Veterans that the taxpayers subsidize seven nursing homes throughout the State. The homes are in Temple, Floresville, Big Spring, Bonham, Amarillo, El Paso and McAllen. The cost is significantly discounted for veterans who have served for at least 90 consecutive days of active duty, one of which was during a wartime. Additionally, the Veteran must have lived at least one year in Texas and does not have a dishonorable discharge. A qualified veteran's spouse can reside in the nursing home but does not receive the same discounted rate. The spouse can continue to live in the nursing home after the death of the veteran spouse.

C. **Long-term care insurance.** This section is not meant to be a treatise on long term care insurance. But, in general, there are insurance policies available that can pay for the costs of nursing home care in a facility of choice or even costs of in-home care. The following is a brief over-view of just some of the reasons one could consider purchasing long-term care insurance.

1. **Considerations for long-term care insurance.** Why would one purchase long-term care insurance if there was the ability to private pay or if one could utilize Medicaid long-term care benefits? There are a number of reasons for purchasing long term care insurance. A primary reason is so that children are not burdened with a moral obligation to pay for long term care. However, long term care may be necessary to protect children from the obligation to pay for long term care in those states that enforce their filial responsibility laws. Filial responsibility laws place the burden of paying for medical expenses on family members. Thirty states have **filial responsibility laws**.<sup>8</sup> Eight states will excuse children from the

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6 38 U.S.C.A. §§1970(g), 5301(a).

7 38 C.F.R. §14.629.

8 Alaska, Ark, *Calif*, Conn, Del, Ga, Idaho, *Indiana*, Iowa, Ky, La, My, *Mass*, Miss, Montana, Nev, N.H., *N.Jersey*, N.Car, N.Dak, *Ohio*, Oregon, *Pa*, *R.Island*, S. Dak, Tn, Utah, Vt, *Virginia*, W.Vir. 86

obligation to pay for a parent's medicals for cause (parent failed to support kid during minority).<sup>9</sup>

(a) Preservation of assets. If the individual's intent is to pass assets to beneficiaries at death, then it may be wise to purchase long-term care insurance to have a means of paying for nursing home care and preserving assets at the same time.

(b) Choice of nursing homes. While most nursing homes accept private pay residents, not all of the most desirable nursing homes accept Medicaid benefits. Those nursing homes that do accept Medicaid benefits may limit the number of nursing home beds that will accommodate Medicaid applicants. Therefore, if an individual wants to choose the most desirable nursing home and does not have the means to private pay, long-term care insurance may be the answer.

2. Costs. Generally, the long-term care nursing home insurance policies are similar to your homeowners insurance. You either use it or you lose it. There are some exotic hybrid policies available but, generally speaking, the insurance goes away once the insured dies.

Long-term care policies are modular in that one can generally custom design the type of coverage that is desired. For example, "a 55-year-old couple now buying three years of \$150-a-day coverage that adjusts with inflation might pay \$2,860 a year for a policy that cost \$2,350 in 2011."<sup>10</sup> However, the cost of the policy should be closely scrutinized. Individuals should consider purchasing long term care insurance only if the premiums are less than 7% of their income and their liquid assets exceed \$30,000.<sup>11</sup>

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Marq.L.Rev. 401 (2002).

9 Calif, Indiana, Mass, N. Jersey, Ohio, Pa., R Island & Virginia

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<http://www.aaltci.org/long-term-care-insurance/learning-center/how-much-does-long-term-care-insurance-cost.php>

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The Federal Long Term Care Insurance Program,  
[http://www.ltcfed.com/start/aboutltci\\_buy.html](http://www.ltcfed.com/start/aboutltci_buy.html) citing to National Association of Insurance Commissioners (NAIC). "A Shopper's Guide to Long-Term Care Insurance," 2013.

When advising a client to consider long term care insurance, the client should be urged to obtain a comparison of policies by an insurance broker who has expertise in long term care policies. The following list, while not necessarily comprehensive, is a list of general issues that the consumer should consider when reviewing long term care insurance policies:

- The insurance company should be financially strong, rated A or better by such rating companies as A.M. Best, Standard & Poor's, Mood's, Fitch or Weiss Ratings.
- Coverage of care should include 100% benefits paid for nursing home care and in-home care.
- Inflation coverage should be considered.
- Determine if there are any waiting periods or elimination periods before the policy benefits will be paid.
- Determine if the policy is a "reimbursement" contract or an indemnity policy. A reimbursement policy will reimburse expenditures up to a contract amount. An indemnity policy will simply pay out the maximum daily benefit during the contract period.
- What triggers eligibility? Generally, benefits will pay when the insured can no longer perform a certain number (often 2) of activities of daily living. Activities of daily living can include continence, dressing, eating, transferring, toileting, bathing and mobility.
- Some long term care plans are "tax-qualified" policies, meaning that the premiums are deductible on Schedule A of the IRS form 1040 and receipt of the benefits is not considered income. However, not all long term care plans are tax-qualified.
- Ask about discounts. Some policies give marital or preferred health discounts.<sup>12</sup>

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12 *Retirement Report: Spotlight on Long-Term-Care Insurance*, March 2001, Kiplinger.com,

In 2017, long term care insurance is not the only choice to insure for future disability costs. Insurance companies are now offering a hybrid long term care life insurance policy (Life insurance with an accelerated death benefit or life insurance with a long term care rider.) Also being offered is an annuity with long term care coverage. The coverage on these new products vary widely and should be very carefully scrutinized.<sup>13</sup>

If the individual cannot pay for disability with personal wealth, Veterans' benefits or long term care insurance, the only other method of financing long term care is by obtaining benefits through the state Medicaid programs.

Author's Note: Currently there are two proposals in Congress that could significantly change Title XIX of the Social Security Act being the Medicaid program. HHS appointee Tom Price (formerly Rep from Ga) and Speaker Paul Ryan have proposed changes to Medicaid. Both plans would make Medicaid a block grant to states. Attached as Appendix I is an overview of the effect of converting Medicaid into a block grant.

**D. MEDICAID ASSISTANCE PROGRAMS.** Access to Medicaid is not simply by application. One can obtain Medicaid benefits only through a specific program, meeting that program's eligibility criteria. There are over 40 medicaid programs available in Texas and under certain programs, the recipient could receive nursing home costs, caretaker expenses, medical costs, rehabilitation, and durable goods. And each Medicaid program has unique criteria for eligibility. It is not within the scope of this paper to set out eligibility requirements for every Medicaid program but will be limited to Long Term Care Nursing Home benefit that includes cost-free health care<sup>14</sup> and a Waiver program that provides

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[www.kiplinger.com/retreport/archives/2001/March/manage3.html](http://www.kiplinger.com/retreport/archives/2001/March/manage3.html) .

13 See, for example, Pros and Cons of Life Insurance with a Long Term Care Rider, JRC Insurance Group, Dec. 10, 2015, <https://www.jrcinsurancegroup.com/life-insurance-with-a-long-term-care-rider/>; *Hybrid Long-Term Care Insurance Policies*, Wade Pfau, Forbes.com, Jan 21, 2016, <http://www.forbes.com/sites/wadepfau/2016/01/21/hybrid-long-term-care-insurance-policies/#5fd6ff0d72f5>

14 The Nursing home medicaid medical benefit does not replace Medicare health insurance. It



attendant care in a residential setting along with the cost-free health insurance.

1. Defining the program. Medicaid Assistance Program and medicaid assistance waiver programs are governmental programs that can provide housing and medical care for those persons who meet certain physical and financial guidelines. When a disabled person has few resources (assets), a small monthly income and a medical need, the individual may be eligible for financial assistance for the nursing home costs or financial assistance with the cost of in-home caretakers along with cost-free health insurance. Medicaid should not be confused with Medicare Part A and Part B or the alternative Medicaid Advantage. Medicare does not pay for long term nursing home care benefits or in-home caretakers.<sup>15</sup> If an individual needs long term care and meets certain criteria, the Medicaid program may provide the necessary funding for care.<sup>16</sup>

*Author's Comment:* The following are interesting statistics that reflect the need for some kind of medical assistance for the elderly. As of 2014, the United States median household income was \$53,482, the median household income for Bexar County, Texas was \$50,867 and for Zapata County, Texas was \$30,758. Quickfacts.census.gov

The benefit programs that will be addressed in this paper are as follows:

a. The Star Plus Waiver ("SPW") formerly known as the Community Based Alternative Waiver program ("CBA") is a benefit program providing a residential alternative to nursing home care. A Texas Medicaid form

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simply supplements Medicare coverage in the same manner as a Medigap policy.

15 Medicare Part A pays for up to 100 days of nursing home care provided the care is for skilled services. 42 U.S.C. §1395x. The patient is entitled to the skilled nursing or skilled rehabilitative benefits in a skilled nursing facility (SNF) following a 3 day stay in the hospital. 42 C.F.R. §409.31 *et seq.* Part A will pay the costs of the first 20 days in the SNF provided they are pursuant to a physician's order, the patient requires professional or technical personnel, and the care is under the supervision of such personnel and the patient must require rehabilitative and/or skilled services on a daily basis. *Id.* Beginning day 21 through 100, the patient must pay a daily rate set each year. For example, in 2017, the daily co-pay rate for a SNF is \$164.50.

16 "In 2014, Medicaid provided health coverage for 80 million low-income Americans.... and served 31 million children, 19 million adults (mostly low-income working parents), 5 million seniors and 9 million persons with disabilities."  
<http://www.cbpp.org/research/health/policy-basics-introduction-to-medicaid> citing to Congressional Budget Office estimates.

1200 is used to apply for SPW.<sup>17</sup>

*Author's Comment:* No community program is going to give a recipient twenty-four hour care management. The Waiver program will provide caretakers for a calculated period of time in the community setting; however, in order to obtain a Waiver benefits, there must be a family or third party support system that will provide necessary care during those periods that Medicaid caretakers are not available.

b. Nursing Home Long Term Care benefits will assist with the cost of nursing home care as well as medical expenses. A Texas Medicaid form 12 is also used to apply for the nursing home medicaid program benefit.<sup>18</sup>

2. Enabling Statutes. The Omnibus Budget Reconciliation Act of 1993 ("OBRA '93") set out the general guidelines for current Medicaid eligibility.<sup>19</sup> In Texas, the Health and Human Services Commission (sometimes referred to as the "HHSC") administers the Medicaid Assistance Program. The Texas eligibility requirements and regulations for administering the program are found in Chapter 32 of the Texas Human Resources Code, Title 1, Part 15, of the Texas Administrative Code and in the various Handbooks that interpret the regulations for the agency caseworker.<sup>20</sup>

3. Eligibility for Medicaid Assistance Program. In order to qualify for the Medicaid Assistance Program, one must meet certain criteria. The Nursing Home Long Term Care benefits along with the Waiver program have substantially the same criteria. The following are the eligibility criteria for Nursing Home Long Term Care Benefits with noted differences for Star Plus Waiver found in the footnotes. There are essentially five criteria for Nursing Home Long Term Care benefits: (a) limited resources (2) limited income (3)

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17 See *Medicaid for the Elderly and People with Disabilities Handbook* and the *Star+Plus Handbook*, at <https://hhs.texas.gov/laws-regulations/handbooks>

18 See *Medicaid for the Elderly and People with Disabilities Handbook*, at <https://hhs.texas.gov/laws-regulations/handbooks>

19. 42 U.S.C.A. §1396p.

20 The various handbooks can be accessed online at <https://hhs.texas.gov/laws-regulations/handbooks>

medical need for care (4) in a facility that accepts medicaid payments<sup>21</sup> and (5) Texas residency.

a. Resources. If the individual has accumulated more than a limited amount of resources, then the individual will not be eligible for Medicaid. Resources are generally defined as liquid assets such as cash, real or personal property or assets owned by the applicant or the spouse that could be converted to cash.<sup>22</sup>

(1) Countable Resources for a Single Individual. To qualify for Medicaid, an individual's countable resources cannot exceed \$2,000.00.<sup>23</sup>

(2) Countable Resources for a Married Couple. If both spouses are applying for long term care nursing home benefits, then their combined resources generally cannot exceed \$3,000.00.<sup>24</sup>

If only one spouse is applying for Medicaid benefits, Congress has provided a means of protecting some resources for the spouse not applying for benefits. In the Medicare Catastrophic Coverage Act of 1988<sup>25</sup>, Congress provided that all non-exempt resources of both spouses will be counted as resources for eligibility purposes whether the property is classified as community or separate.<sup>26</sup> One-half of the couple's resources will be set aside for

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21 By definition, Waiver programs are based in the community and therefore the nursing home requirement that the facility accept medicaid payments does not apply.

22 1 T.A.C. §358.321 citing to 20 C.F.R. §416.1201.

23 Texas Medicaid Eligibility for the Elderly & People with Disabilities Handbook, §F-1300.

24 Texas Medicaid Eligibility for the Elderly & People with Disabilities Handbook, §F-1300.

25 42 U.S.C. §1396r-5.

26 One should keep in mind that a premarital or postmarital agreement is irrelevant for medicaid eligibility. Community property and separate property character has no meaning for medicaid eligibility. MEPPD Appendix XXXIII.

the spouse not applying for Medicaid benefits, with a minimum set aside amount of \$24,180 (for 2017) and a maximum of \$120,900 (for 2017).

For example, assume the combined community and separate property of a couple equaled \$13,000.00 on the first day of the month that the applicant entered a medical facility (hospital and/or nursing home) and spent a continuous period of 30 days. Then their total resources would be set aside for the non-applicant spouse (referred to as the "community spouse"). If their combined community and separate property equaled \$100,000, then one-half, or \$50,000, would be set aside for the community spouse and the couple would generally have to "spend down" \$48,000 (the applicant keeping \$2,000) to bring the applicant within the eligibility guidelines. While the general rule is to protect one-half or \$120,900 of the family's assets for the community spouse, under certain circumstances, all or part of the applicant's \$48,000 might be transferred to the community spouse.

For example, assume Husband's available income is \$1,500 per month and Wife's gross income is \$500 and their combined countable resources equal \$100,000. The HHSC regulations state that the community spouse needs a minimum monthly maintenance needs allowance ("MMMNA") of \$3,022.50 (for the year 2017) in order to survive in the community.<sup>27</sup> But in this example their combined income from pensions is only \$2,000. Wife would argue that she needs to invest their savings in order to generate an income for herself to bring her up to the MMMNA of \$3,022.50. HHSC will accept current one-year Certificate of Deposit rates to determine the income that Wife could generate from the \$98,000 (recall that the Applicant gets to keep \$2,000). Assume the current interest rate for a one-year CD is 1%. To calculate the income that \$98,000 would generate one can follow the following formula:

MMMNA = \$3,022.50 - \$2,000 = \$1,022.50/ month shortfall  
\$98,000 X .01 = \$980 annual income ÷ 12 months = \$81.67 per month  
Since only \$81.67 could be generated by hypothetically investing \$98,000 in a 1 year CD that generates 1% in interest, the spouse must

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27 MEPD SJ-2200; 4000; 4400 *et seq.*

be able to keep their entire savings to try to raise her income as close to the MMMNA as possible.

From the calculation, the countable assets must be protected for the Wife in order to generate income to attempt to bring her up to the minimum monthly maintenance needs allowance of \$3,022.50 per month. Thus, the caseworker would then ask the Wife to sign a form 1275 with the result that the \$98,000 would be protected for Wife. This calculation is referred to as the "income first" rule which means that the applicant's income must be diverted to the community spouse in order to provide for the MMMNA before resources will be protected.

Finally, if their combined community and separate property equaled \$300,000, then \$120,900 would generally be set aside for the community spouse and, as above, the couple would theoretically have to "spend down" \$177,100 (setting aside \$2,000 for the applicant) to bring the applicant within eligibility requirements with regard to resources.

(3) Excluded Resources. Certain resources are excluded from being considered countable resources:

(a) The principal residence of the applicant is generally excluded from consideration as a countable resource so long as the individual maintains a subjective intent to *return* to the home.<sup>28</sup> The equity in the home in excess of \$560,000 is a countable asset unless the spouse, a minor child or disabled child is living in the home.<sup>29</sup>

(b) A burial plot held for the applicant or the applicant's family will not be counted as a resource.<sup>30</sup>

(c) Term or burial insurance is not a resource if

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28 1 T.A.C. §358.348; *see also*, MEPD §F-3110; *See also*, <https://www.medicaid.gov/medicaid/eligibility/downloads/spousal-impoverishment/2017-ssi-and-spousal-impoverishment-standards.pdf>.

29 MEPD §F-3600.

30 1 T.A.C. §358.352.

it has no cash value.<sup>31</sup>

(d) Identifiable burial funds in the amount of \$1,500<sup>32</sup> or a prepaid irrevocable burial contract regardless of the value<sup>33</sup> is excluded from countable resources. The \$1,500 burial funds exclusion is offset by the face value of excluded life insurance policies and the value of any irrevocable burial arrangements.

(e) One automobile. A second automobile may be exempt if there is a second person in the household and the second vehicle is required for work or is modified for operation by, or the transportation of, a handicapped person.<sup>34</sup>

(f) Household goods and personal effects that are valued at less than \$2,000.00 are exempt.<sup>35</sup>

(g) Life insurance policies owned by the applicant with a face value of \$1,500.00 or less per insured are exempt.<sup>36</sup>

(h) Livestock that are held for business purposes or for consumption are not counted.<sup>37</sup>

(i) Business property essential for self-support is exempt but the income generated will be countable.<sup>38</sup>

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31 1 T.A.C. §358.353.

32 1 T.A.C. §358.346; MEPD §F-4227.

33 *Id.*

34 1 T.A.C. §358.354; MEPD §F-4221.

35 1 T.A.C. §358.371; MEPD §F-4222.

36 1 T.A.C. §358.371; MEPD §F-4223.

37 1 T.A.C. §358.347 citing to 20 C.F.R. §416.1201; MEPD §F-4250.

38 1 T.A.C. §358.371; MEPD §F-4330.

(j) Nonbusiness property essential for self-support is exempt at a value up to \$6,000.00 as long as the owner receives at least 6% net annual return on the investment. Again, the income generated will be included in the applicant's total income.<sup>39</sup>

(4) Transfer of resource rules. A nursing home or Star Plus Waiver applicant may wish to preserve his resources by transferring some or all of his nonexempt resources to, for example, his child/children, either outright or in trust, with a hope that the child/children would provide for the applicant's special needs.

(a) Effect of Disqualifying Transfer. If a nursing home or Waiver applicant makes a transfer of resources for less than fair market value for the purpose of qualifying for Medicaid, the applicant will be ineligible for certain Medicaid benefits for a calculated period of time.<sup>40</sup> The Health and Human Services Commission has determined that the average private pay cost for nursing home care in Texas is \$162.41 per day. The burden of proving that a transfer is not a disqualifying transfer is on the applicant. To determine the number of months of INELIGIBILITY for any transfer for less than fair market value, the Health and Human Services Commission will divide the amount transferred by \$162.41 and round down to the lower day. For example, if an applicant gifted \$10,000 to an individual, the applicant would be ineligible for Medicaid for 62 days of nursing care.

Under the Deficit Reduction Act of 2005, the Health and Human Services Commission can "look back" for 60 months to determine if an individual made an outright transfer for less than fair market value

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39 1 T.A.C. §358.371. This property is generally a mineral interest. The value of a mineral interest can be calculated by multiplying 40 times the monthly income averaged over the last twelve months. MEPD §F-4310, Appendix XVI.

40 See 1 T.A.C. §358.401 & .401. If a transfer is exclusively for a purpose other than to qualify for Medicaid, then the transfer should not be a disqualifying event." H.C.F.A. State Medicaid Manual, §3258.10.C. Appendix III. Additionally, "there are a number of instances (*i.e.*, exceptions) where, even if an asset is transferred for less than fair market value, the [disqualifying transfer] penalties do not apply." H.C.F.A. State Medicaid Manual, §3258.10. Appendix III. For example, assets transferred to the individual's spouse or to another for the sole benefit of the individual's spouse is an exception to the transfer rules. *Id.*

for the purpose of qualifying for Medicaid.<sup>41</sup>

The Deficit Reduction Act of 2005 ("DRA '05"), effective February 8, 2006, provides that:

(i). Look-Back period - The look-back period is 60 month for all transfers.<sup>42</sup>

(ii) When the Penalty Period Begins - The penalty period begins on the later of the following dates: "The first day of the month in which the transfer occurred; or The first day of the month in which the individual is eligible for Medicaid and would be receiving institutional care but for the transfer."<sup>43</sup>

(iii). Undue Hardship - With regard to undue hardship waivers under the DRA 2005, the nursing home may, with the individual's (or his personal representative's) permission, file an application on the individual's behalf for a waiver of the transfer penalty based on undue hardship. The nursing home may present on the individual's behalf and, with the written consent of the individual (or his/her personal representative), represent the individual in the appeal process.<sup>44</sup>

(b) Exemptions from Transfer penalty

(i) spouse

(ii) minor or disabled child

(iii) single child who lived with applicant keeping applicant out of the nursing home for two years

(iv) to an irrevocable education fund or

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41 See 1 T.A.C. §358.401.

42 1 T.A.C. §358.401 & .402; MEPD §I-2110, Appendix XLIV.

43 1 T.A.C. §358.401; MEPD §I-1320 & §I-5221.

44 1 T.A.C. §358.401; MEPD §I-4300.



custodial account for the benefit of a minor grandchild.<sup>45</sup>

(c) Federal Criminalization of Asset Transfers.

It was referred to as the "Grannie Goes to Jail" law. On August 21, 1996, President Clinton signed the Health Insurance Portability and Accountability Act into law (sometimes referred to as the "Kennedy-Kassebaum Bill") which became effective January 1, 1997. One effect of the Kennedy-Kassebaum Bill was to make it a crime if an individual gifted assets for the purpose of qualifying for Medicaid and the gift resulted in a period of disqualification. However, on August 5, 1997, President Clinton signed the Balanced Budget Act of 1997 (the "Act"). Section 4734 of the Act repealed the "Grannie Goes to Jail" portion of the law<sup>46</sup> and in its place created the "Lawyer goes to Jail" law. The statutory language of § 4734 is as follows:

BALANCED BUDGET ACT OF 1997

Section 4734. PENALTY FOR FRAUDULENT ELIGIBILITY

Section 1128B(a) (42 U.S.C. § 1320a-7b(a)), as amended by § 217 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191; 110 Stat. 2008), is amended:

1. by striking paragraph (6) and inserting the following:  
"(6) for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under Title XIX, if disposing of the assets results in the imposition of a period of INELIGIBILITY for such assistance under § 1917 c; ..."

Section 4734 further amended the penalty provisions of § 217 as follows:

- (ii) in the case of such a statement, representation, concealment, failure, conversion, or provision of counsel or assistance

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45 1 T.A.C. §358.401.

46 Section 217 of the Health Insurance Portability and Accountability Act of 1996 (public Law 104-191; 110 Stat. 2008).

by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both.

The effective date of this provision was August 5, 1997, the date the Act was signed by President Clinton.

Due to the way the statute was written, it was uncertain how § 4734 would be applied. Narrowly interpreted, an attorney could be criminally liable if that attorney counsels his client to transfer assets and then apply for Medicaid benefits, incurring a period of INELIGIBILITY.<sup>47</sup> A broad interpretation of the statute could find an attorney criminally liable if the attorney told the client not to apply for Medicaid during any period of INELIGIBILITY but the client did so anyway. Essentially the attorney's criminal acts would be dependent on whether the client followed the attorney's instructions.<sup>48</sup>

On September 14, 1998, Judge Thomas J. McAvoy (U.S. District Court, Northern District of New York) issued an opinion in a case styled *New York State Bar Association v. Janet Reno, et al*, declaring §4734 unconstitutional and issued a permanent injunction prohibiting the enforcement of the federal statute.<sup>49</sup> The federal government appealed the decision, but withdrew its appeal on March 13, 1999. While some commentators cite this case as precedent that the statute will not be enforced, this is a ruling out of the Second Circuit which has no precedential value in the Fifth Circuit. Therefore one needs to be aware of the law until such time as the U.S. Supreme Court finds it unconstitutional or it is repealed.

In addition to the Second Circuit's permanent injunction, in a March 11, 1998 letter to Newt Gingrich, then U.S. Attorney General Janet Reno wrote, in part,

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47 Congressional Research Service, The Library of Congress Report dated July 11, 1997.

48 *Id.*

49 *New York State Bar Association v. Reno*, 99 F.Supp. 710 (S.D.N.Y.).

"This is to respectfully inform you that, after close and careful scrutiny of the matter, the Department of Justice will not defend the constitutionality of § 1128B(a)(6) because the counseling prohibition in that provision is plainly unconstitutional under the First Amendment and because the assistance prohibition is not severable from the counseling prohibition."

It is very important to note the last paragraph of Ms. Reno's letter, which states:

"Finally, I would like to stress that the Department of Justice is available to assist Congress, if it so desires, in attempting to draft new legislation that would address the concerns of Congress in a manner that comports with contemporary First Amendment jurisprudence and that meets other policy objectives of the Congress and the Executive Branch."

It is very clear that this issue of gifting is not going to go away. Attorneys must be very clear regarding the status of the law at any given time so as not to subject the client and the attorney to adverse consequences.

Author's note: Interestingly, in a case styled *Zahner v. PA Dept. of Human Services*, the Medicaid agency asserted that the attorneys representing the plaintiff had committed a federal crime by assisting their client in applying for Medicaid under current law. While the New York Court had issued an injunction against the enforcement of the federal law, the New York holding had no application in Pennsylvania. "The court could not envision assisting a client with an asset transfer without counseling them about its effect, and so it concluded that the unconstitutional criminalization of counseling a client was inseverable from the act of assisting a client."<sup>50</sup>

b. Income. Under Texas Medicaid law, an individual must

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50 Thomas E. Simmons, "Granny Goes to Jail" Redux, NAELA News, APR/MAY?JUNE 2016, p. 28. [https://works.bepress.com/tom\\_simmons/38/download/](https://works.bepress.com/tom_simmons/38/download/)

also have a limited monthly income in order to qualify for the Medicaid Assistance Program.

(1) Texas Cap. An applicant's gross income generally cannot exceed \$2,205 per month for 2017.<sup>51</sup> If both spouses are applying for Medicaid, their combined income cannot exceed \$4,410 per month for 2017.<sup>52</sup> The non-applicant spouse's income is not considered for the purposes of the applicant's eligibility.<sup>53</sup> Further, the Federal Spousal Impoverishment Act sets out what is referred to as "the name on the check" rule<sup>54</sup> which means that income is attributed to the spouse whose name is on the check regardless of community or separate property characterization. For example, if applicant husband received a pension in the gross amount of \$1,900.00 per month and the husband and wife were holders of a Note receiving \$800.00 per month, the husband-applicant would be credited with \$2,300.00 per month of income which would disqualify him for Medicaid long term nursing home care benefits.<sup>55</sup> However, if the debtor made the Note payment check payable to Wife, then Husband would have only \$1,900.00 per month of income which is under the Texas income cap.

(2) Qualifying Income Trust ("Miller Trust"). Assume that the applicant meets all of the medicaid eligibility criteria except the individual's income exceeds the Texas income cap (\$2,205 for 2017). However, his income is substantially less than the \$4,500 to \$6,500 per month usually required for long term nursing home care. If the Applicant is single and ineligible for Medicaid benefits because of excess income, then someone (usually a family member) would have to pay the difference between his income and the cost of nursing home care (although there is no legal requirement for this payment). This places a tremendous burden on children who have their own obligations

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51 MEPD Appendix XII.

52 MEPD Appendix XII.

53 42 U.S.C. §1396r-5(b)(1).

54 42 U.S.C. §1396r-5(b)(2).

55 Husband's income would exceed \$2,205 income cap set for 2017 in Texas. See attached Appendix II

including possible education costs for their own children. If the Applicant is married, his nursing home costs may take all of the combined incomes of both spouses just to pay for private pay nursing home expenses. OBRA '93 provided the solution to this "income cap" problem.

An individual can create a trust and then transfer his income to the trust without penalty. He would not own the income and therefore would fall below the income cap. This trust is known as a "Qualifying Income Trust," "QIT" and is often referred to as a "Miller" Trust which gets its name from a Colorado case<sup>56</sup> that was codified in 42 U.S.C. 1396p(d)(4)(B). The trust must be irrevocable and the State must be reimbursed from any remaining assets in the trust after the beneficiary/applicant dies.<sup>57</sup> **A "MILLER TRUST" IS NOT A DEVICE TO PROTECT ASSETS OR RESOURCES. IT IS ONLY A DEVICE FOR INCOME AND IS USED TO OVERCOME THE INCOME CAP ISSUE.**

(a) Married Applicant. The "Miller" Trust is especially important for the community spouse because it allows her to remain independent while she is confident that her husband is receiving proper care in the nursing home.

Recall that the community spouse's income is not considered for determination of Medicaid eligibility of her applicant spouse. Therefore she can keep all of the income that she receives in her name. Additionally, if her husband qualifies for Medicaid benefits, she will be allowed to keep up to \$3,022.50 (as of 2017) of their combined income.<sup>58</sup> For example, husband receives gross income of \$2,082.50 per month in retirement and social security income, while wife receives gross income of \$1,000 per month. H's income is placed in a "Miller" Trust and assuming that H otherwise qualifies for Medicaid long term nursing home care assistance, W will get all but a \$60.00 (allowance paid to H) of their combined income of \$3,022.50 and H's nursing home and medical costs will be paid for by Medicaid.

With a Miller Trust in place, the applicant's

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56 *Miller v. Ibarra*, 746 F.Supp. 19 (D.Colo. 1990).

57 U.S.C. §1396p(d)(4)(B).

58 See Appendix II to this paper.

income placed in the trust will be paid as follows: (1) the institutionalized spouse will receive a monthly allowance of \$60<sup>59</sup>; (2) the community spouse will receive enough money to raise her gross income to \$3,022.50 (as of 2017); (3) if there are any dependents, the dependent allowance will be deducted; (4) if there are any "incurred medical expenses" such as allowable insurance premiums and costs of medical care not covered by Medicaid (which include guardian's fees<sup>60</sup>), those amounts will be paid; (5) "co-payment" formerly referred to as "applied income" will be the amount paid to the nursing home.<sup>61</sup> Generally, there will not be any income left over after the applied income is paid. If there is income remaining in the trust, it may generally be used to provide goods and services not provided by the Medicaid program but must be **paid out within 2 months of deposit.**<sup>62</sup>

(b) Single Applicant. An unmarried Applicant may also utilize a Miller Trust to overcome the income cap. With a Miller Trust in place, the single applicant's income transferred to the trust will be paid as follows: (1) the institutionalized person will receive a monthly allowance of \$60 and guardian fees, if any, will be paid<sup>63</sup>; (2) if there are any "incurred medical expenses" such as allowable insurance premiums and costs of medical care not covered by Medicaid, those amounts will be paid; (3) "co-payment" formerly referred to as "applied income"<sup>64</sup> will be the amount paid to the nursing home<sup>65</sup>;

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59 MEPD, Appendix XII

60 Texas MEPD §H-1400; *See also, Rudow v. Com. of the Division of Medical Assistance*, 707 N.E. 2d 339 (Mass. 1999)(holding that guardianship costs were necessary medical and remedial care expenses for recipients, which could be deducted from their incomes for purposes of determining the applied income.) Texas Estates Code §§1155.201-.202 was enacted effective September 1, 2009, limiting Guardian of the person fees paid out of the Medicaid recipient's co-payment (defined as applied income in the statute). **Guardian of the Estate is prohibited from taking a fee from the recipient's co-payment. 1 T.A.C. §358.439(8).**

61 1 T.A.C. § 358.438; MEPD Chap. H; H.C.F.A. State Medicaid Manual, §3259.7.B.5. Appendix III H.C.F.A. was the Health Care Finance Administration. Effective 2001, the name has changed to the Center for Medicare and Medicaid Services–CMS.

62 1 T.A.C. §358.438; MEPD Chapter H.

63 MEPD, Appendix XII.

64 1 T.A.C. §358.103(16).

65 State Medicaid Manual, §3259.7.B.5; Appendix III.

and (4) any remaining income can be used by the beneficiary for his or her own medical needs but, practically speaking, seldom will there be any funds left after payment of the applied income.

(c) Creating a Qualifying Income ("Miller") Trust. A Qualifying Income Trust is a "self-settled" trust; therefore, the Applicant should be the person signing the trust as Grantor. However, often the Grantor is incapacitated and does not have the capacity to sign the trust.

The alternative, of course, is to have the agent, under a Durable Power of Attorney, sign on the Grantor's behalf. Unfortunately, all too often, there is no durable power of attorney. However, if you look closely at the statute, there is nothing in the statute that requires the person funding the trust with his income to be the original creator of the trust. Region 8 Health and Human Services Commission (central Texas) takes the position that it does not matter who signs the trust as long as the beneficiary's funds can be transferred into the trust.

c. Other Eligibility Requirements. An applicant for the Medicaid Assistance Program must be a U.S. citizen or a "qualified alien" meeting certain requirements<sup>66</sup> and must be a Texas resident.<sup>67</sup> If the applicant is applying for nursing home care assistance, then he/she must be over 65, disabled or blind.<sup>68</sup> Finally, if the applicant is applying for nursing home care or a waiver program, the applicant must have a "medical necessity" for the care.<sup>69</sup> Once eligible, any

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66 1 T.A.C. §§358.107 & 358.203; MEPD §D-5200.

67 1 T.A.C. §358.207. Under the DRA of 2005, a Medicaid applicant declaring to be a U.S. citizen must provide evidence of citizenship, such as a U.S. passport, a Certificate of Naturalization (N-550 or -570), a Certificate of U.S. Citizenship (-560 or -561), or other documentation. [HHSC, LTC Medicaid Bulletin Number 06-11, "Revised Citizenship Documentation Requirements for Medicaid," August 21, 2006, p.1]

68 1 T.A.C. §358.211. Disability is defined pursuant to the Social Security Act as found in 42 U.S.C. §1382c(a)(3)(A) as follows: "An individual shall be considered to be disabled for purposes of this subchapter if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity). MEPD §D-1200 *et seq.*

69 40 T.A.C. §19.101(73).

change of circumstance must be reported to the Medicaid caseworker within 10 days of the occurrence.<sup>70</sup>

4. Trusts and Medicaid Eligibility. In planning for Medicaid eligibility, clients often ask if they can put their resources into a trust and then qualify for Medicaid long term nursing home care benefits. Generally speaking an applicant may not place his own money in a trust for himself and then immediately qualify for Medicaid benefits. For example, if an individual creates a “living trust” that is revocable, HHSC considers the assets in the trust as available assets since the trust can be terminated by the grantor.<sup>71</sup> In the alternative, if the Grantor transfers his/her assets into an irrevocable trust, the transfer is subject to the look-back period and transfer penalties.<sup>72</sup> Additionally, with the irrevocable trust if the trustee has the discretion to make distributions from income for the benefit of the grantor, then that amount of income that the trustee COULD distribute will be attributed to the grantor.<sup>73</sup> If the trustee has the discretion to make distributions from principal for the benefit of the grantor, then that amount of principal that the trustee COULD distribute will be attributed to the grantor.<sup>74</sup>

However, there are exceptions to the rule that the trust is a countable, or in some way, a disqualifying resource. As we have discussed, an applicant may generally put income in a Qualifying Income Trust (the "Miller" Trust) and become eligible for Medicaid benefits, provided the applicant meets all other eligibility criteria. The following are the Self-settled trust exceptions created by Congress.

a. OBRA’93 Self-settled Trust Exceptions. If your client is under the age of 65, then the client may find it advantageous to have assets placed

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70 1 T.A.C. §358.605 “Fraud Referral and Restitution;” MEPD §H-8320.

71 1 T.A.C. §358.336; MEPD §F-6400.

72 1 T.A.C. §358.336; MEPD §F-6400.

73 1 T.A.C. §358.336.

74 1 T.A.C. §358.336.



in a Supplemental Needs Trust<sup>75</sup> created pursuant to OBRA 93 which allows the

75 A supplemental or special needs trust is a trust for supplemental or special needs. The client should understand that generally, a supplemental needs trust does not pay for necessities – food and shelter– nor does it generally allow for distributions of cash, IF those distributions would disqualify the individual for governmental benefits. Note that as of March 9, 2005, SSI eliminated “clothing” from its definition of in-kind income.

Payments directly to the provider for the special or supplemental needs of an individual could be for such items or services as follows:

- Automobile/Van;
- Accounting Services;
- Acupuncture/Acupressure;
- Appliances (TV, VCR, stereo, microwave, stove, refrigerator, washer/dryer);
- Bottled water or water service;
- Bus pass/public transportation costs (no cash);
- Camera, film, recorder and tapes, development of film;
- Computer hardware, software, and internet service;
- Conferences;
- Courses or classes (academic or recreational) including supplies;
- Curtains, blinds, drapes, and the like;
- Dental work not covered by Medicaid, including anesthesia;
- Down payment on home or security deposit on apartment;
- Dry cleaning and/or laundry service;
- Elective surgery;
- Fitness equipment;
- Funeral expenses;
- Furniture, home furnishings;
- Gasoline and/or maintenance for automobile;
- Haircuts/salon services;
- Holiday decorations, parties, dinner dances, holiday cards;
- Home alarm and/or monitoring/response system;
- Home purchase (to the extent not covered by benefits)
- House cleaning
  - Insurance (automobile, home, and/or possessions) [provided the home, car and possessions are owned by the trust beneficiary or the Trustee];
- Legal fees (advice and advocacy);
- Linens and towels;
- Massage;
- Musical instruments (including lessons and music);
- Non-food grocery items (laundry soap, bleach, fabric softener, deodorant, dish soap, hand and body soap, personal hygiene products, paper towels, napkins, tissues, toilet paper, any household cleaning products);
- Over-the-counter medications (including vitamins and herbs, etc.);
- Personal assistance services not covered by Medicaid (ie., companion);
- Pet and pet supplies, veterinary services;
- Physician specialists if not covered by Medicaid;
- Private counseling if not covered by Medicaid;
- Repair services (appliances, automobile, bicycle, household, fitness equipment

creation of such trusts. OBRA '93 carved out three exceptions to the inclusion of grantor trust assets in the determination of an applicant's eligibility. The exceptions are found at 42 U.S.C. § 1396p(d)(4)(A), (B) and (C) and are often referred to by their subsection letter.

(1) "A" Trust. This trust is especially designed for a disabled person<sup>76</sup> under the age of 65. Assuming the disabled person meets the income cap requirement, a Supplemental needs trust can be funded with the disabled person's assets and the person will automatically qualify for the Medicaid Assistance program provided that (i) the trust is created by the applicant, the applicant's parent, grandparent, legal guardian or the court and (ii) upon the death of the beneficiary/applicant, the State will receive any remaining funds in the trust up to a total of all of the State's Medicaid payments made on behalf of the

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[owned by the trust beneficiary or the Trustee];

- Sporting goods/equipment/uniforms/team pictures;
- Stationary, stamps, cards, etc.;
- Storage units;
- Taxicab;
- Telephone service and equipment;
- Therapy (physical, occupational, speech) not covered by Medicaid;
- Tickets to concerns or sporting events (and an accompanying companion);
- Transportation (automobile,..bicycle,..gas, bus passes);
- [Travel for medical purposes;]
- Trustee fees.

*See Regan, Gilfix, Morgan, English, Tax, Estate and Financial Planning for the Elderly, Forms and Practice, (Matthew Bender) §I:19[4], 2009.*

Disqualifying distributions could\* include payment of the food, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewage, and garbage collection services. 20 C.F.R. §416.1130(b). This is called "in-kind support and maintenance" or ISM and is considered income to the beneficiary. However, there is no ISM if the medicaid benefit is a received through a waiver program. 1 T.A.C §358.339(a); MEPD §§F-6700 & F-6800. \*A distribution for food and/or shelter would not be a disqualifying distribution for Medicaid Waiver programs. Thus, a person receiving the Star Plus Waiver benefits in their home could have their food and shelter paid by someone else including their trustee within disqualifying income.

76 Disability is defined pursuant to the Social Security Act as found in 42 U.S.C. §1382c(a)(3)(A) as follows: "An individual shall be considered to be disabled for purposes of this subchapter if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity); Texas MEPD §D-1400.

beneficiary/applicant.<sup>77</sup>

By the terms of this statute, no one 65 years or older can utilize this exception. Therefore, if a 65+ year old person who is receiving Medicaid long term nursing home care benefits obtains a personal injury recovery or inherits property, that person cannot put the funds into a (d)(4)(A) trust<sup>78</sup> and remain eligible for Medicaid benefits.

(2) "B" Trust, Qualified Income Trust or "Miller Trust".

As previously discussed *supra*, an Applicant for Medicaid long term nursing home care benefits can utilize this self-settled trust exception.

(3) "C" Trust. Finally, the third exception to the self-settled trust rules is the creation of a "pooled supplemental needs trust." This trust is a supplemental needs trust created by the Grantor, the grantor's parent, grandparent, court or guardian for a disabled person.<sup>79</sup> The trust must be managed by a non-profit association. This trust must also be drafted so that, at the beneficiary's death, the State will be reimbursed, from the remaining assets in the trust, for all expenditures made on behalf of the beneficiary.<sup>80</sup> The Arc of Texas in Austin, Texas, is presently administering this trust as its "Master Pooled Trust II or IV."<sup>81</sup>

The Texas Medicaid program assesses a period of

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77 42 U.S.C.A. §1396p(d)(4)(A).

78 An individual must be very careful in **disclaiming** an interest in an estate in order to preserve Medicaid eligibility. While Texas law and Internal Revenue Code generally treat a disclaimer as if the person predeceased the testator, federal Medicaid laws and state regulations do not. If a person disclaims an interest prior to its vesting, there is no disqualifying penalty. However, HHSC considers vesting on the death of the testator. Thus, if an applicant disclaims property after the death of a testator, the DHS will consider the disclaimer a disqualifying transfer of assets. Texas MEPD §E-3372.

79 42 U.S.C.A. §1396p(d)(4)(C).

80 42 U.S.C.A. §1396p(d)(4)(C).

81 The Arc of Texas Master Pooled Trust has four specific trusts available for funding: Trust I is a third party trust with very strict distribution terms; Trust II is a self-settled trust with very strict distribution terms; Trust III is a third party trust with broad discretionary distribution rules that includes discretionary support distributions; and Trust IV is a self-settled trust with similar broad discretionary distribution rules.

INELIGIBILITY against a person age 65 and older who transfers funds to a sub-account with The Arc of Texas Master Pooled Trust. The HHSC position is based on the Center for Medicare and Medicaid Services' rule that limits the transfer of asset disqualification exception to only those persons under age 65.<sup>82</sup> Thus, a person age 65 or older who is presently eligible for Medicaid long term nursing care benefits (or Star Plus Waiver) will suffer transfer of asset penalties when funding a pooled trust with a lump sum of funds from a personal injury award, inheritance or sale of an exempt asset.

b. Third Party Trusts. Can a trust beneficiary qualify for or continue to receive Medicaid benefits? Other than the three Self-settled Trust exceptions under 42 U.S.C. §1396p(d)(4) discussed above, a person generally cannot put his own assets into a trust for his benefit and then qualify for Medicaid.<sup>83</sup> However, trusts created by someone other than the applicant and funded with funds that do not belong to the applicant may not be considered a countable resource provided the disabled beneficiary has no control over distributions.<sup>84</sup> For example, Wife suffers from Alzheimers disease and is being currently cared for by her Husband. H can revise his Will to leave his estate in a totally discretionary trust or supplemental needs trust for W and if H predeceases W, his estate should not be a countable asset if W must apply for Medicaid assistance.

5. Medicaid Estate Recovery. In 1993, in the Omnibus Budget Reconciliation Act, Congress mandated that states recover certain long-term care ("LTC") expenditures made for a medicaid recipient over the age of 55.<sup>85</sup> The Texas Legislature resisted implementation of estate recovery for ten years. However, on June 10, 2003, Governor Perry signed House Bill2292, allowing the State of Texas to recover payments made on behalf of a person who receives Medicaid benefits. The law effecting estate recovery was brief:

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82 The Center for Medicare and Medicaid Services is the successor to HCFA, the Health Care Finance Administration. The transfer penalty arising from State Medicaid Manual, §3259.7B, see Appendix III.

83 State Medicaid Manual, §3259. Appendix III

84 1 T.A.C. §358.336; MEPD §F-6100.

85 42 U.S.C. §1396p(a) & (b).

“SECTION 2.17. Subchapter B, Chapter 531, Government Code, is amended by adding § 531.077 to read as follows: Sec. 531.077. RECOVERY OF MEDICAL ASSISTANCE. (a) The commissioner shall ensure that the state Medicaid program implements 42 U.S.C. §1396p(b)(1). (b) The Medicaid account is an account in the general revenue fund. Any funds recovered by implementing 42 U.S.C. § 1396p(b)(1) shall be deposited in the Medicaid account. Money in the account may be appropriated only to fund long-term care, including community-based care and facility-based care.

The federal law, 42 U.S.C. § 1396p(b)(1), requires a state to recover expenditures from the estate of a deceased person who received Medicaid benefits--thus the name “estate recovery.” The federal statute does not set out the rules for estate recovery--leaving the rule making to the Commissioner of the Texas Health and Human Services Commission (“HHSC”) heading up the State Medicaid program. Federal law does set out basic requirements along with guidelines and options in the law and in § 3810 of the Federal State Medicaid Manual. After studying the rules implemented in other states, HHSC published the proposed framework of the rules on January 26, 2004 for discussion purposes and scheduled six (6) regional forums to take public comment on the proposed framework. On April 30, 2004, the Texas Health and Human Services Commission (“HHSC”) published its proposed Estate Recovery rules (sometimes referred to as “MERP”). The rules had to be approved by the Centers for Medicare and Medicaid Services (“CMS”) prior to being effective. After much discussion with CMS, revisions to the rules were made and those revisions were published in the December 3, 2004 *Texas Register*. A number of organizations including the Texas Chapter of the National Academy of Elder Law Attorneys submitted comments on the revised rules. On February 18, 2005, the agency’s response to the comments and those rules that were changed pursuant to the comments were published in the *Texas Register*. The resulting rules are found in 1 Texas Administrative Code Chapter 373. The following is a short summary of the rules and a few concerns.

- a. Who is subject to the Medicaid estate recovery program

(“MERP”)? Estate recovery will only effect those persons who are age 55 or over, are in a nursing home, intermediate care facility for the mentally retarded (referred to as “ICF-MR”) or are receiving Community Attendant Services (1929(b) and home and community-based services) and apply for Medicaid on or after the effective date of the rules.<sup>86</sup> **Grandfathering:** There is no estate recovery from the estate of a person who initially applies for Medicaid benefits prior to March 1, 2005 and ultimately received medicaid benefits as a result of that application.

b. What is the effective date of the MERP? The rules were effective March 1, 2005.<sup>87</sup>

c. What is the definition of an “estate” that is subject to a claim for recovery? MERP is limited to the probate estate of a deceased medicaid recipient. A nursing home resident who is receiving Medicaid benefits might own the following assets, known as exempt assets, on the date of death:

- homestead;
- personal property including family heirlooms, antiques and other sentimental items;
- automobile;
- family burial plots;
- family ranch or farm considered a business necessary for the person’s self-support;
- farm or ranch equipment used in the business;
- poultry or cattle for business or consumption;
- small oil or gas interest that was considered non-business property necessary for self-support valued less than \$6,000;
- no more than \$2,000.00 in cash assets.<sup>88</sup>

d. What expenditures will the State recover? All expenditures arising from payments for nursing home, ICF-MR, home and community services and the related costs of prescription drug services and

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86 1 T.A.C. §373.103.

87 1 T.A.C. §373.105(5).

88 1 T.A.C. §373.105.

hospital.<sup>89</sup>

e. How will the State recover? First and foremost, **MERP IS NOT A LIEN STATUTE**. The law and the rules make the state of Texas a Estates Code §355.102 Class 7 creditor.<sup>90</sup>

Texas Estates Code §355.102 classifies claims against a decedent's estate in a priority from Class 1 to Class 8 claims. Class 7 claims are "claims for repayment of medical assistance payments made by the state under [the medicaid program] to or for the benefit of the decedent." Therefore, payment of up to \$1500 for funeral and last illness, expenses of administration (which include attorneys fees), secured claims, child support claims, claims for taxes, penalties and interest all have priority over payment of the Medicaid costs. The Estate Recovery rules, as written, require that as soon as the State finds out that a nursing home resident is deceased, the State will send a Notice of Intent to File a Claim from a nursing home resident's estate. The State has up to 30 days from being notified of the individual's death to send the Notice of Intent to File a Claim.<sup>91</sup>

f. Will the State place a lien on the homestead to secure its right to recover? The Texas Legislature requires the Commissioner to implement 42 U.S.C. §1396p(b)(1). This subsection of the statute requires a State to recover expenditures from an estate, similar to a creditor. The federal statute allowing the State to place a lien on a homestead is found in 42 U.S.C. §1396p(a).

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89 1 T.A.C. §373.103.

90 1 T.A.C. §373.201 still refers to Probate Code §322, Class 7 creditor.

91 *Concern:* According to the rules, as written, the State can give the notice to an executor or administrator if an estate administration is opened and the State knows who the executor or administrator is. However, it may take some time to open an estate administration, so instead of waiting for an estate administration to be filed and opened, the State may give notice to a guardian, a person who acted under a power of attorney or even the person who communicated with the caseworker while the nursing home resident was alive. 1 T.A.C. §373.307. The problem is these persons have no authority to act for other heirs.

*Concern:* Not only will the home have to be sold to pay the State debt, but the family heirlooms and antiques may have to be sold. When a person dies owning property, the person's creditors will send the bill for the debt to the executor or administrator of the estate. The executor or administrator must pay off all bonafide creditors before the executor can transfer the estate to the beneficiaries under the Will or to heirs.

Additionally, the Legislature did not repeal the Constitutional homestead protections or Texas Estates Code §102.004 that exempt the homestead from creditors claims if there is a surviving spouse, minor child or unmarried adult child. HHSC recognizes that the 2003 legislation did not grant the right to place a lien on the Medicaid recipient's property to secure the payment of the Medicaid expenditures. **THIS IS NOT A LIEN STATUTE.**

g. Can a family try to pay off the MERP debt in order to preserve the homestead, family heirlooms and antiques, and other estate assets? Yes, according to the Texas Rules, the family can negotiate a payment installment plan but interest on the unpaid portion of the claim will be calculated according to a law in the Texas Government Code.<sup>92</sup>

h. Are there any exemptions to MERP? There will be no estate recovery if the Medicaid beneficiary leaves

- a surviving spouse.
- a child under the age of 21 or a child of any age who is blind or disabled;
- an unmarried adult child residing continuously in the decedent's homestead for at least one year prior to the time of the Medicaid recipient's death.<sup>93</sup>

Additionally, 1 T.A.C. §373.207 provides that the state will not recover from an estate when it is not cost effective. There will be no estate recovery when:

“(1) the value of the recoverable estate is \$10,000 or less,  
(2) the recoverable amount of Medicaid costs is \$3,000 or less, or  
(3) the cost involved in the sale of the property would be equal to or greater than the value of the property.”

I. If there is no exemption from MERP, then are there any other considerations? Yes. Certain defined persons can claim that estate recovery would be an undue hardship and ask the State to waive recovery. The Texas Rules

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92 1 T.A.C. §373.219

93 1 T.A.C. §373.207



set out six cases that would constitute undue hardship, found in 1 T.A.C. §373.209(c) and (d):

(1) “The estate property subject to recovery has been the site of the operation of a family business, farm or ranch at that location for at least 12 months prior to the death of the decedent; is the primary income producing asset of heirs and legatees, and produces 50 percent or more of their livelihood; and recovery by the State would affect the property and result in the heirs or legatees losing their primary source of income.”<sup>94</sup>

(2) “Heirs and legatees would become eligible for public and/or medical assistance if a recovery claim were made.”<sup>95</sup>

(3) “Allowing one or more survivors to receive the estate will enable him or her or them to discontinue eligibility for public and/or medical assistance.”<sup>96</sup>

(4) “The Medicaid recipient received medical assistance as the result of a crime, as defined by Texas law, committed against the recipient.”<sup>97</sup>

OR

(5) “Other compelling reasons.”<sup>98</sup>

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94 1 T.A.C. §373.209(c)(1). *Concern:* A family farm or ranch is generally not a cash producing asset. It provides food and shelter while, often, one of the household members will work at a second job to provide working cash. According to *USDA/ERS Agricultural Income and Finance Outlook* statistics citing in the *Texas Agriculture*, a publication by the Texas Farm Bureau, **68 percent of Texas farm household earnings are from off-farm sources.** By requiring the farm or ranch to produce 50 percent of the heirs or legatees livelihood in order to obtain the waiver from estate recovery, the rule essentially negates the undue hardship waiver and virtually all family farms or ranches would be subject to MERP. In fact, the rule would benefit large corporate farms while penalizing the small family farm.

95 1 T.A.C. §373.209(c)(2)

96 1 T.A.C. §373.209(c)(3)

97 1 T.A.C. §373.209(c)(4)

98 1 T.A.C. §373.209(c)(5).

(6) Additionally, an undue hardship waiver can be granted to avoid MERP against the decedent's homestead.<sup>99</sup> The regulations setting out the homestead waiver are extensive but essentially may be granted to heirs or lineal descendants whose gross family income is less than three times the federal poverty rate (see Appendix V). The waiver will allow \$100,000 of the fair market value to be exempted from MERP for qualified claimants.

In order to obtain an undue hardship waiver, a family member will have to ask for the waiver, in writing, immediately after the Notice of the intent to recover is sent. The State has up to 70 days from the date it finds out about the nursing home resident's death to send a Notice of intent to recover<sup>100</sup>; but that notice could come just days after death. Regardless, once that notice is received, the person requesting a waiver has only 60 days from the date on the notice to request the waiver.<sup>101</sup> Additionally, that notice can be sent to the administrator or executor of the estate, the surviving spouse, the agent under a durable power of attorney or medical power of attorney or any person who represented the recipient before the Department.<sup>102</sup>

Additionally, the Commission will not grant a waiver just because the person requesting it would lose an inheritance or legacy.<sup>103</sup> This rule also states: "An undue hardship does not exist solely because the

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99 1 T.A.C. §373.209(d). *Concern:* If multiple heirs do not all meet the financial requirement, then only the qualified heir's or legatee's undivided interest can qualify for the undue hardship waiver. It will be interesting to see how the heir with the least income will be able to buy out the more prosperous heirs or legatees in order to preserve the homestead.

100 1 T.A.C. §373.205

101 1 T.A.C. §373.209.

102 1 T.A.C. §373.307. *Concern:* If a person wants to claim an undue hardship or ask for reimbursement for the expense of caring for the homestead, the person will have less than 60 days from the date of Notice of the Intent to Recover to make a claim AND provide supporting documentation for a claim. The person who wants to make such a claim may not be the person who receives the Notice of Intent to Recover and may lose the right to make the claim.

103 1 T.A.C. §373.209.

circumstances giving rise to the hardship were created by, or the result of estate planning methods under which assets were sheltered or divested contrary to the requirements of Medicaid law in order to avoid MERP.”<sup>104</sup>

j. Are there any deductions from MERP? Yes. Texas Rules allow for deductions of direct costs of care that one paid that resulted in keeping the Medicaid recipient out of the nursing home and for maintenance of the homestead. “Necessary and reasonable expenses for maintaining the home include real estate taxes, utility bills, home repairs, and home maintenance expenses such as lawn care.”<sup>105</sup> The person claiming the deductions must request the deduction in writing on or before 60 days from the receipt of the State’s notice of intent to recover and that request for deduction must have all necessary supporting documentation.<sup>106</sup>

k. Can a person appeal a denial of an undue hardship or deduction for out-of-pocket expenses? The Texas Rules state that a person who is denied an undue hardship or reduction for out of pocket expenses would only be entitled to an informal reconsideration.<sup>107</sup>

l. Can a person avoid MERP by gifting away assets prior to death? Please keep in mind that if the nursing home resident gives away cash or land or personal property or any asset, the nursing home resident may be ineligible for Medicaid benefits for a period of time. In order to determine the period of ineligibility, the amount of the gift is divided by the average cost of nursing home care.<sup>108</sup>The gifting penalty calculation is as follows:

$$\text{\$100,000 gift} \div \text{\$162.41 (average cost of nursing home care)} \approx 20$$

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104 1 T.A.C. §373.209.

105 1 T.A.C. §373.213.

106 1 T.A.C. §373.213.

107 1 T.A.C. §373.211

108 1 T.A.C. §358.430

months.<sup>109</sup>

m. Are there any exceptions to the disqualifying transfer rule? If a person is applying or is eligible for Medicaid nursing home benefits, that person may gift without penalty in certain instances.

- To the spouse
- To a minor child
- To a child who is blind or disabled (according to the Social Security Administration definition of disability)
- To a child who lived with the applicant in the home for at least 2 years prior to admission to a nursing home or other medical facility and provided care that enabled the applicant to remain home during that 2 year period.
- To a sibling with an equity interest who has lived with the applicant in the home for at least one year prior to admission to a nursing home or other medical facility
- To a trust for a person under age 65 who is disabled according to the Social Security Administration definition of disability.<sup>110</sup>

Looking back at paragraph “h” above, notice that the first three transferees are the same as the exemptions to MERP but not the last three.

Concern: Congress has never been opposed to transfers of assets to family members, as illustrated by the rules found in 1 T.A.C. §358.339 allowing a transfer of assets into trust while maintaining eligibility for benefits. When the federal laws were originally written and remain today, the congressmen allowed transfers of assets to family members, noting that if such transfers were not allowed, it would have the “unfortunate effect of discouraging family members and friends from caring for the frail elderly or disabled and helping them

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109   MEPD §I-5100.

110   1 T.A.C. §358.430.

remain independent for as long as possible.” So, under present medicaid law, a person who applies for or is receiving medicaid nursing home benefits can transfer assets, without penalty, to persons noted above, including those other than persons who would create an exemption. However, if the nursing home resident dies before the gift is made, those last three sets of persons may lose out and the State can then request recovery without consideration of those persons. Psychologically, it may be detrimental for a nursing home resident to give away all of his/her assets before death but, as this rule is written, if the resident wants to make sure that family members who have sacrificed receive some reward, the nursing home resident may be forced to gift prior to death. Additionally, such pressure on transfers may cause family members to pressure nursing home residents into such transfers subjecting the family to discord and possible claims of exploitation and abuse.

Author’s comment: The author is concerned about increased exploitation of elder persons by transferring homesteads prior to death in order to avoid MERP. Because of the look-back penalty, transfers might occur in anticipation of possibly needing nursing home care. Unforeseen debts or downright meanness could cause an elderly person’s loss of the homestead for naught.

Concerns then arise when planning for an elderly person. Does a practitioner assist in transferring the house to the child or sibling or refrain from transferring the property? What about issues of exploitation? Remember, Texas Human Resources Code §48.002 (3) defines exploitation of an elderly person as follows:

“‘Exploitation’ means the illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with the elderly or disabled person using the resources of an elderly or disabled person for monetary or personal benefit, profit, or gain without the informed consent of the elderly or disabled person.”

n. Should one consider transferring property in anticipation of death? So long as the asset is not owned by the estate of the deceased medicaid recipient, then the medicaid agency will not look to enforce MERP. One might transfer the property in anticipation of death. A period of ineligibility will be assessed and the recipient will lose Medicaid program benefits.

o. Does the four year creditor statute of limitations apply to MERP? No. “[T]he State in its sovereign capacity, unlike ordinary litigants, is not subject to the defenses of limitations, laches, or estoppel.”<sup>111</sup> However, the four month Statutory Estates Code Notification to unsecured creditors does apply to MERP.<sup>112</sup>

p. Land title issues and MERP. Following the implementation of the MERP statute, many title underwriters misread the statute, believing that MERP created a lien on the Medicaid recipient’s real property that had to be satisfied at closing. As stated above **MERP is NOT a lien statute**. It creates a Class 7 unsecured creditor right in the state, similar to the right VISA or Sears would have against a decedent’s estate. When representing an executor or administrator of an estate , it would be wise to obtain a release from the state showing that there is no claim for MERP. If there is a claim, then resolve it before the decedent’s real estate is sold. Resolution of any MERP claim should now be part of any estate administration so that if the title company incorrectly requests a release from the State as part of closing, there matter will be resolved.

q. Estate administration and MERP. Executors owe a fiduciary duty to the beneficiaries of the estate.<sup>113</sup> An executor/administrator has no fiduciary duty to unsecured creditors.<sup>114</sup> Texas Estates Code §403.051 provides that the Independent Executor shall approve, classify and pay or reject

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111 *State v. Durham*, 860 S.W.2d 63, 67 (Tex. 1993).

112 *See* Estates Code §§355.051, 355.052 & 355.064.

113 *See e.g., Humane Soc’y v. Austin Nat’l Bank*, 531 S.W.2d 574, 577 (Tex. 1975) (fiduciary duty of bank arose because it was executor of estate)

114 *Mohseni v. Hartman*, 363 S.W.3d. 652, (Tex. App.—Houston [1st Dist.] 2011, no pet. h.).

claims according to Section 355.102 Classification of Claims against Decedent's Estate. If a claim is not paid, Texas Estates Code § 403.059 provides that the appropriate method of collecting the claim is by suit against the independent executor. Additionally, if the specific property inherited has been sold, the distributees can be held personally liable for the value of the property received."<sup>115</sup>

"A personal representative may be held personally liable for damages to an estate or its heirs or beneficiaries for the value of estate property lost or damaged due to the representative's failure to properly carry out his or her duties. TEX. PROB. CODE ANN. § 233(a). Any interested person may file suit against the representative for breaching his or her fiduciary duty. TEX. PROB. CODE ANN. § 233(a). Both the personal representative individually and his or her surety, if any, can be held liable for the resulting damages. TEX. PROB. CODE ANN. § 233(a)."<sup>116</sup> Thus, an executor must audit any claim against Estate assets made by the State under MERP. The State must fulfill eight requirements according to the Texas Administrative Code in order to have a valid claim against the Estate.<sup>117</sup> The State has the burden of proof that it has complied with the law. Paying a MERP claim without properly auditing the claim, is in the Elder Law author's opinion, a breach of the Executor's fiduciary duty to the beneficiaries. It is the author's further opinion that the executor would be liable to the beneficiaries to the extent of any improper payment to the State and any other creditor. Even though it is clear in the law that the State's claim against a decedent's estate is unsecured with no claim against real property, many underwriters issued memorandums to their escrow officers stating, in effect, that if the chain of title revealed a predecessor in title who died after March 1, 2005, with a creditor's claim filed in probate, the title company was to contact the creditor (HMS, Inc.) inquiring

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115 C. Boone Schwartzel, *Unsecured Claims and MERP Claims in Probate*" State Bar of Texas Advanced Elder Law Course, April 2010, Dallas, p. 7-8 citing to *McFarland v. Shaw*, 45 S.W.2d 193 (Tex.Comm'n App. 1932, holding approved).

116 Nichols, Webb & Klein, *Fiduciary Litigation*, State Bar of Texas Advanced Family Law, 2011, San Antonio, p. 55. Now Estates Code §351.151.

117 The state must satisfy the threshold notice requirements of 1 T.A.C. §373.305, the 30 day notice requirement in 1 T.A.C. §373.307(a) and the 70-day claim filing requirement in 1 T.A.C. §373.205(b).

if the claim had been paid and if it was unpaid, the claim should be paid prior to insuring the title. There is no instruction as to whether the claim is valid. The claim in the chain of title simply must be paid. Unfortunately, the seller, if unrelated to the predecessor in title, has no standing to obtain creditor records from the State and determine if there were exemptions that could set aside the claim or if the creditor properly followed regulatory requirements.

Notwithstanding that unsecured creditors have no claim against property many title companies state that they are beginning to see claims from these unsecured creditors, especially when relying on affidavits of heirship. Although if the title companies fight such a claim, they would likely win. It is typically cheaper to pay the claim than it is to fight it in court. Therefore, the companies have taken the position that any claim that is known about at the time of filing must be paid before title insurance will be issued.

r. Avoiding MERP before the death of the Medicaid recipient. As noted above, the federal law found in 42 U.S.C. §1396p(b)(1) is a creditor statute,<sup>118</sup> requiring a state to recover expenditures from the estate of a deceased person who received Medicaid benefits--thus the name "estate recovery." It is important to note that the Texas legislature chose (b)(1) of the federal law to implement as opposed to (b)(2), the lien statute.

The federal statute does not set out the rules for estate recovery--leaving the rule making to the Commissioner of the Texas Department of Health and Human Services heading up the State Medicaid program. Federal law does set out basic requirements along with guidelines and options in the law and in Section 3810 of the Federal State Medicaid Manual. Upon passage of the Medicaid Estate Recovery Statute, the Texas Legislature sent a strong message to the HHSC rule maker to make rules that would be lenient yet comply with the federal legislative intent noted above. In compliance with that mandate, HHSC ultimately fashioned rules that would limit Medicaid estate recovery to the "probate estate" of a deceased Medicaid beneficiary, thus clearly allowing for assets to pass outside of probate to avoid Medicaid Estate Recovery. The State

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118 "(B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate, but only for medical assistance consisting of— (I) nursing facility services, home and community-based services, and related hospital and prescription drug services,..." *See also, 1 T.A.C. sec. 373.103.*



complied with the federal law but respected its history of protecting families and their needs as they age. Thus, it is not against public policy to plan to avoid Medicaid Estate Recovery. In fact, it was anticipated by the State Legislature as well as Congress.<sup>119</sup>

Because it was not against public policy to avoid Medicaid Estate Recovery, attorneys began transferring the homestead (the only significant asset in the Medicaid Recipient's estate) to pass outside of the probate estate. There are two ways in which to affect the transfer: through a deed conveying title but retaining a life estate in the property with the power of appointment and as a joint tenant with rights of survivorship.

➤Transferring property via Ladybird deed: A Ladybird Deed also known as an Enhanced Life Estate Deed or a Deed with a Power of Appointment is appropriate to transfer real property outside of the probate Estate. A grantor transfers property to a grantee retaining a life estate along with the power to sell the property retaining the proceeds of the sale thus cutting off grantee's right to the property pursuant to Texas Estates Code Sec. 111.051 *et seq.* Because the property passes outside of probate there is no Medicaid Estate Recovery. Additionally, since the grantor retains the right to sell the property and keep the proceeds, there is no Medicaid transfer penalty.

➤Transferring property via statutory Transfer on Death Deed that was created in the 84<sup>th</sup> Legislature (SB462) will most probably be a Medicaid-permissible transfer since no title transfers until the death of the grantor. However, a title company may not immediately insure title in the sale of property obtained via the statutory transfer on death deed. Texas Estates Code §114.106(a) provides that "to the extent the transferor's estate is insufficient to satisfy a claim against the estate, expenses of administration, any estate tax owed by the estate or an allowance in lieu of exempt property...the personal representation may enforce that liability against real property transferred under a ToDD...."

➤Transferring property via Joint Tenancy with Rights of

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119 Congress allows states to opt into a very lenient form of estate recovery as evidenced by the rules approved in Texas. The Texas Department of Aging and Disability Services Reference Guide (2006) states: "MERP was written into Texas law as part of House Bill 2292, passed in 2003 by the 78<sup>th</sup> Regular Session of the Texas Legislature. As the state's Medicaid agency, the Health and Human Services Commission was responsible for developing the program requirements. The MERP rule finalized in the Texas Administrative Code in December 2004, was fashioned as a very lenient program within the federal parameters." p.19.

Survivorship: One of the techniques that attorneys have used to transfer property outside of the probate estate is a survivorship agreement. Survivorship Agreements are recognized by title companies as long as they meet the requirements of the Texas Estates Code. For unmarried couples Section 111.001 of the Estates Code sets forth the requirements. For community property owned by spouses the requirements of the Survivorship Agreement is found in Section 112.051 of the Texas Estates Code. As long as the Survivorship Agreement meets the requirements set forth in these sections of the Estates Code title will pass to the survivor without further action by the individuals or the court. It is important to understand that both parties to the Survivorship Agreement must sign the document. Many times clients will request that when property is deeded to them the deed will state "as joint tenants with rights of survivorship". This alone is insufficient. The deed must contain the additional language and the grantees must sign the deed in addition to the grantor signing the deed.

However, beware of using the Right of Survivorship deed as a technique for avoiding Medicaid Estate Recovery. The State has, on occasion, assessed a Medicaid transfer penalty because of a belief that selling an undivided interest in the real property makes the property unmarketable resulting in a transfer of asset penalty. The author does not agree with the State. If there is a valid agreement existing that clearly requires the grantee to sell if the grantor/Medicaid recipient wants to sell the property, there should be no loss of value. However, the State has disregarded such written agreements in the past.

➤Transferring property using powers of attorney: All estate planning attorneys, and especially elder law attorneys, prepare Powers of Attorney for their clients. Powers of Attorney can be used by the agent to transfer the principal's property. However, particular care must be taken when transferring property using a Power of Attorney. Title companies and the State Medicaid Agency scrutinize transactions that involve Powers of Attorney. If the Power of Attorney is not recorded or if the transfer is either to the agent or not for fair market value many title companies will not insure the transaction or subsequent transactions. This is true no matter how broadly the POA is drafted.

## 6. Medicaid Fraud.

(a) Medicaid Planning. As previously discussed, some individuals decide that they may transfer assets and submit to the Medicaid

transfer penalty rules in order to pass on assets to family members. It is prudent to look to see if state **Fraudulent Transfers laws** apply to a transfer in anticipation of death or at anytime before application and eligibility. In an excellent article in the Fall 1994 NAELA Quarterly, Frances M. Panteleo and Robert M. Freedman set out the argument that there are no fraudulent transfers in anticipation of medicaid eligibility. Medicaid benefits arise out of Title XIX of the Social Security Act found in 42 U.S.C. §1396p. In the Omnibus Budget Reconciliation Act of 1993, mandatory transfer penalties were enacted. 42 U.S.C. §1396p(c). Prior to that time, transfer penalties were permissive. Now with mandatory penalties, once penalized for the transfer, there can be no fraudulent transfer. Notwithstanding the 1993 mandatory transfer penalties, there is no penalty for transfers between spouses and other specific individuals. *Id.* Besides requiring states to penalize certain transfers, states are not allowed to establish transfer penalties that are broader than the federal statute. State laws that conflict with federal statutes are preemptively invalid under the Supremacy Clause of the United States Constitution, Article VI, clause 2.

A case out of the New York Court is instructive. In *Bourgeois v. Stadler*, a couple transferred assets to a trust. The husband qualified for medicaid assistance and upon the wife's death the assets in the trust passed to their sons. The medicaid agency tried to recover expenditures from the assets that validly passed to the sons alleging that the transfer was fraudulent. The Court found no fraudulent transfer since the agency knew of the trust and the couple were properly qualified for benefits. "Under both Federal and State law, plaintiff's recovery of medical assistance correctly paid is precluded except under limited circumstances not applicable here (*see*, 42 U.S.C. § 1396p[b][1]; [the estate recovery state]..." *Bourgeois v. Stadler*, 256 A.D.2d 1095, 685 N.Y.S.2d 166 (N.Y. 1998), writ ref'd 93 N.Y.2d 805 (1999).

But one must also take note of the *Estate of Lucille Bergman v. N.Dakota Dept of Human Services*, 688 N.W.2d 187 (N.D. Sup.Ct. 2004). In this case the husband qualified for medicaid assistance and, as allowed by federal law, transferred his property to his wife. Wife did not apply for medicaid assistance for herself. Just before Wife died, she gifted her property out of her estate with the knowledge that the state would try to recover for the expenditures made on behalf of her husband. The court stated that "under the Uniform Fraudulent Conveyance Act, a debtor's transfer of property is constructive fraud as to a creditor if the debtor made the transfer without receiving a reasonably equivalent value in exchange for the transfer and the debtor was insolvent at the time of, or

became insolvent as a result of, the transfer.”<sup>120</sup>

In Texas, it is not a fraudulent to engage in Medicaid planning such as transferring assets and waiting the five years to allow the lookback period to pass; transferring assets and accepting the penalty period; transferring assets that meet transfer exceptions such as to a disabled child or via a Ladybird deed.

(b) It is a crime to obtain Medicaid through fraudulent measures. Texas Penal Code §35A.02 states, in part:

(a) A person commits an offense if the person:

(1) knowingly makes or causes to be made a false statement or misrepresentation of a material fact to permit a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized;

(2) knowingly conceals or fails to disclose information that permits a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized; ...

Offenses run from Class C misdemeanor for a benefit of less than \$50 to a state jail felony if the amount is over \$1,500. If the amount of payment exceeds \$20,000 to \$100,000, the offense is a 3<sup>rd</sup> degree felony, and so on.<sup>121</sup> Two bills have been filed in the 84<sup>th</sup> Legislative Session that takes a hard line on Medicaid Fraud. A new subsection (g) is proposed:

(g) It is not a defense to prosecution under this section that the Medicaid program has received or recouped funds representing repayment, wholly or partly, for the fraudulent act or acts that are the basis for the criminal

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120 *State N.D. v. Bergman*, 688 NW2nd 187 (N.D. 2004).

122 Texas Penal Code §35A.02(b).

charge for which the defendant is indicted.<sup>122</sup>

To date, the author is only aware of one prosecution in the last 20 years against an individual filing a fraudulent Medicaid application for nursing home benefits. However, it is crucial to caution all clients to answer all questions honestly. Clients will sometime ask: “But how with the Medicaid Agency ever find out?” If a social security number is involved at any point, the Agency *will* ultimately discover an omission. Additionally, fraud in smaller communities is simply more difficult because the local medicaid worker most likely knows all of the local residents.

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123 HB 334 and SB 187, 84<sup>th</sup> Legislative Session.

## Appendix I

Medicaid funding under block grants would not be Medicaid funding as it is known today. On February 1, 2017, the Center for Medicare Advocacy published the CMA Alert copied, in part, below. The link is:

<http://www.medicareadvocacy.org/what-will-happen-to-nursing-home-residents-if-medicaid-becomes-a-block-grant-program/>

### What Will Happen to Nursing Home Residents if Medicaid Becomes a Block Grant Program?

Nursing home residents could lose Medicaid coverage of their nursing home care. Under a Medicaid block grant program, many people who are currently entitled to comprehensive nursing home care could lose coverage entirely. States could change the income, resource, and medical need eligibility rules, making some current residents completely ineligible for any further coverage.

More likely, under block grants, states would continue Medicaid coverage of nursing home care to some extent. However, there could be substantial changes in who would be covered, what type of care and services residents would receive, and how long coverage would continue. Under a block grant, states could limit coverage to only the poorest and sickest people and even then, for only limited periods of time.

Under block grants, nursing home residents with Medicaid could face new financial obligations since a Medicaid block grant will not require states to continue current federal protections (discussed below) for Medicaid coverage of nursing home care.

Even if states choose to pay for nursing home care under a block grant program, Medicaid's current financial rules and protections for residents and their families would disappear. Four of the most significant current financial protections enacted over the 50+-year history of the Medicaid program could be lost under a block grant. They are:

Relative Responsibility [filial responsibility laws]. Since 1965, the Medicaid program has prohibited nursing facilities from requesting or requiring contributions from residents' families.[9] Adult children have never been legally responsible for their parents' nursing home care under the Medicaid program. That provision disappears if Medicaid is repealed. States could require residents' families to contribute to the cost of their relatives' care, even as they address their own health care needs, plan for their own retirement, or seek to help a child attend college.

Supplementation. Currently, the Medicaid program requires that nursing homes accept the Medicaid rate as payment in full for covered services.[10] This provision means that nursing homes are not allowed to ask residents or their families to pay any amount above the Medicaid rate for services that are covered by Medicaid – to "supplement" the Medicaid rate. Loss of this protection means that residents receiving Medicaid coverage could be asked to pay an additional amount to the facility, over and above the Medicaid payment, using their (or their families') personal funds. If a resident or prospective resident failed to pay these additional charges, the facility could deny admission (or discharge a resident who did not pay).

Liens and Estate Recovery. Under current law, states cannot place a lien on a home where a Medicaid beneficiary's spouse, dependent or disabled children, or certain siblings live. States cannot foreclose on a lien on a beneficiary's home if adult children live there who cared for the Medicaid beneficiary before the beneficiary received Medicaid. Similarly, states cannot recover from a deceased beneficiary's estate while a spouse or dependent child are living. These protections are lost if Medicaid becomes a block grant program. States could place liens on residents' homes and force foreclosure, or recover from a deceased resident's estate, depriving the resident's spouse and dependent or disabled children of their home or other assets on which they may depend.

Spousal Impoverishment. Since 1987, the Medicaid program has recognized that the spouse of a nursing home resident needs to retain

some of the couple's income and assets in order to be able to continue living in the community.[11] The loss of this statutory protection could return the country to the time when all of a couple's money was required to be used for nursing home care and the spouse in the community was left with, literally, no income at all.

Prescription drug cost-sharing. Under federal law at present, residents with Medicaid have no cost-sharing obligation for their prescription drugs. If Medicaid is block-granted, residents could be required to pay for prescription drug coverage under Medicare Part D.

### At Present, Medicare and Medicaid Establish the Standard of Care In Nursing Facilities

The Medicare and Medicaid programs do more than provide funding for nursing facility residents' care. The Nursing Home Reform Law,[12] enacted during the Reagan Administration as part of the 1987 budget reconciliation law, amended the Medicare and Medicaid statutes to set out a comprehensive framework for quality nursing home care. The law established the standards of care that facilities must meet, and a regulatory structure to ensure the standards are met. If both Medicare and Medicaid are repealed, the Nursing Home Reform Law will be gone, with all of its provisions governing the care of residents and enforcement of those standards.[13] Even if the Medicare provisions remain, questions could be raised about the applicability of Medicare standards to Medicaid-covered residents.

Standards of care that will be lost if Medicare and Medicaid are repealed include requirements that:

Facilities' multi-disciplinary teams comprehensively assess each resident and develop an individualized plan of care to meet each resident's medical, nursing, therapy, activities, and social services needs;

Facilities actually provide each resident with care and services to attain or maintain each resident's "highest practicable physical,



mental, and psychosocial wellbeing;"

Facilities respect residents' rights, including rights to privacy, access and visitation rights, protection from discrimination, protection of resident funds, and transfer and discharge rights;

Nurse aides be trained and demonstrate competency before providing care to residents;

Facilities not require residents to waive their rights to coverage by Medicare or Medicaid and not require residents to pay out-of-pocket for designated periods of time before being allowed to use Medicaid.

The Nursing Home Reform Law also requires annual unannounced surveys and investigations of complaints and sets out a system of remedies that may be imposed against facilities that fail to provide residents with the quality of care and quality of life they need and are entitled to receive.

But is all of this concern about Medicaid block grants hypothetical? Actually, no. In 1996, the Aid to Families with Dependent Children (AFDC) was converted to a block grant as Temporary Aid to Needy Families (TANF).

In Texas, between 1995 and 2014 the number of poor families with children rose from 552,200 to 707,100. Meanwhile, the TANF caseload plummeted 87 percent, so that in 2014, for every 100 poor families with children, only 5 received TANF cash assistance. The block grant program was touted as a success because of the flexibility. However, TANF gave the states so much flexibility that Texas used part of the funds to pay for general revenue expenditures for child protection and foster care rather than using all of the funds to help people out of poverty—the original intent for the funds. (Example taken from Peter Germanis August 30, 2016 article *TANF in Texas: The Need for "A Much Better Way": A Cautionary Tale for Ways and Means Chairman Brady* Peter Germanis has worked for the Heritage

Foundation, the American Enterprise Institute and the White House under both President Regan and President George H.W. Bush.

[9] 42 U.S.C. §1307a(a)(17)(D).

[10] 42 C.F.R. §447.15

[11] 42 U.S.C. §1396r-5.

[12] 42 U.S.C. 1395i-3(a)-(h), 1396r(a)-(h), Medicare and Medicaid, respectively.

[13] More than 90% of nursing facilities participate in both Medicare and Medicaid. American Healthcare Association, LTCStats: Nursing Facility Operational Characteristics Report, Table 3, page 5 (March 2011), [http://www.ahcancal.org/research\\_data/Pages/default.aspx](http://www.ahcancal.org/research_data/Pages/default.aspx) (click on the report), based on CMS Form 671:F9. As a result, the repeal of Medicaid would not lead to the immediate loss of the Reform Law's protections as long as a facility continued to participate in Medicare. However, with immediate changes to Medicaid and changes to Medicare on the horizon, it seems likely that the federal standards of care would soon be substantially compromised.

APPENDIX II  
 MEDICAID REFERENCE AMOUNTS FOR 2016-2017

MEDICAID BENEFIT	2016	2017
Income Cap	\$2,199.00	\$2,205.00
Income Cap for husband & wife applicants	\$4,398.00	\$4,410.00
Supplemental Security Income (single) (note that the income cap is calculated by multiplying the SSI amount X 3 = \$2,205) The first \$20.00 of non-SSI income is disregarded	\$733 / \$753	\$735 / \$755
Supplemental Security Income (couple) The first \$20.00 of non-SSI income is disregarded	\$1,100/\$1,120	\$1,103/\$1,123
Spousal Protected Resource Amount ("PRA") minimum	\$23,844	\$24,180
Spousal PRA, maximum	\$119,220	\$120,900
Minimum Monthly Maintenance Needs Allowance for Spouse ("MMMNA")	\$2,980.50	\$3,022.50
Qualified Medicare Beneficiaries' income limit (QMB) (single) The first \$20.00 of income is disregarded, effectively raising the limit. [Asset limit: \$7,280 (single)/\$10,930 (couple)]	\$1,013/\$1,351* March 1, 2015 to February 28, 2016	\$1,013/\$1,351* March 1, 2016 to February 28, 2017
Specified Low-Income Medicare Beneficiaries (SLMB) (single) The first \$20.00 of income is disregarded, effectively raising the limit. [Asset limit: \$7,280 (single)/\$10,930 (couple)]	\$1,187/\$1,613* March 1, 2014 to February 28, 2015	\$1,187/\$1,613* March 1, 2015 to February 28, 2016
Qualifying Individuals (QI) (single). The first \$20.00 of income is disregarded, effectively raising the limit. [Asset limit: \$7,280 (single)/\$10,930 (couple)]	\$1,353/\$1,810* March 1, 2014 to February 28, 2015	\$1,353/\$1,810* March 1, 2015 to February 28, 2016
Average cost of nursing home care in	\$162.41 daily	\$162.41 daily

<p>Texas          (divide \$162.41 into the value of gift(s) in order to estimate the number of months of ineligibility. Fractional remainders are converted to additional days of ineligibility beginning December 1, 2005)</p>	<p>beginning          September 1,          2015, ending          August 31, 2016</p>	<p>beginning          September 1,          2015, ending          August 31, 2017</p>
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\*<https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html#collapse-2614>

### APPENDIX III

The Center for Medicare and Medicaid Services (formerly H.C.F.A.) State Medicaid Manual is too large to reproduce. It can be accessed at

<https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html> (last accessed February 12, 2017).

APPENDIX IV  
 MEDICARE REFERENCE AMOUNTS FOR 2016 - 2017  
 Table 1

MEDICARE BENEFIT	2016	2017
Part B Premium (The 2017 income threshold remains at \$85,000.00.) * The \$109 premium will be adjusted so that the SS recipient does not receive a lower net SS check than in 2016.	\$104.90 for all enrollees up to the modified adjusted gross income limits \$85,000/\$170,000 premiums are higher above the threshold	\$109*for all <b>existing enrollees</b> up to the modified adjusted gross income limits <b>new enrollees</b> shall pay \$134.80 \$85,000/\$170,000 premiums are higher above the threshold
Part A Premium	\$0.00 for 40 quarters or more of employment \$226.00 for 30-39 quarters of employment \$411.00 for less than 30 quarters of employment	\$0.00 for 40 quarters or more of employment \$227.00 for 30-39 quarters of employment \$413.00 for less than 30 quarters of employment
Part D basic (Benchmark Premium for Texas)	\$28.05	\$27.34**
Part B Deductible	\$166.00	\$183.00
Skilled Nursing Facility ("SNF") co-insurance payment (amount that individual must pay, per day, before Medicare pays; co-	\$161.00	\$164.50

insurance begins on day 21 in a SNF)		
Hospital Deductible (Part A) per spell of illness	\$1,288.00	\$1,316.00
Hospital co-insurance payment for days 61-90	\$322.00	\$329.00
Hospital co-insurance payment for days 91-150 ("Lifetime Reserve Days")	\$644.00	\$658.00

\*\*<http://www.q1medicare.com/PartD-2017MedicarePartD-PlanStatistics.php?crit=TX> (last accessed December 29, 2016)

APPENDIX IV

Table 2

<p>Under recent Medicare law, higher income beneficiaries pay higher <b>Part B premiums</b> than lower income beneficiaries. The <b>2016</b> amounts are shown below.</p>		
Married individuals with annual incomes of	\$85,000 to \$170,000 will pay	\$134.00
Unmarried individuals with annual income below	\$85,000	\$134.00
Married couples with annual incomes of	\$170,000 to \$214,000 will pay	\$187.50
Unmarried individuals with annual income of	\$85,000 to \$107,000 will pay	\$187.50
Married couples with annual incomes of	\$214,000 and \$320,000 will pay	\$267.90
Unmarried individuals with annual income of	\$107,000 to \$160,000 will pay	\$267.90
Married couples with annual incomes between	\$320,000 and \$428,000 will pay	\$348.30
Unmarried individuals with annual incomes of	\$160,000 to \$214,000 will pay	\$348.30
Married couples with incomes greater than	\$428,000	\$428.60
Unmarried individuals with annual income greater than	\$214,000	\$428.60
<p><b>Rates for Married Beneficiaries Filing Separate Tax Returns from Spouse</b></p>		
Income that is less	\$85,000	\$134.00



than or equal to		
Income	\$85,001 to \$129,000 will pay	\$348.30
Income	greater than \$129,000 will pay	\$428.60

**Appendix V**  
**Federal Poverty Guidelines for 2017**

Persons  in Family	48 Contiguous 3 times the States
	Poverty Rate
1	\$11,880 \$35,640
2	\$16,020 \$48,060
3	\$20,160 \$60,480
4	\$24,300 \$72,900

<https://obamacare.net/2017-federal-poverty-level/> (last accessed December 29, 2016)





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**Medicaid Eligibility Quick Reference 2017**

	Single Person	Married Couple
<b>Income Limits</b>		
<i>Income is never an obstacle to eligibility because the Qualified Income Trust (aka "Miller Trust") is available</i>	\$2,205.00 per month	\$4,410.00 per month <i>Applies only when both spouses seek long-term care Medicaid</i>
<b>Resource Limits</b>		
<b>Applicant Resource Limit</b> <i>Maximum amount of countable assets a person seeking long-term care Medicaid may have</i>	\$2,000.00	\$3,000.00 <i>Applies only when both spouses seek long-term care Medicaid</i>
<b>Maximum Community Spouse Protected Resource Allowance</b> <i>Maximum amount of countable assets a spouse at home may own unless eligible for Expanded Protected Resource Allowance</i>	N/A	\$120,900.00
<b>Minimum Community Spouse Protected Resource Allowance</b> <i>If couple's total countable assets are less than \$20,880.00, the community spouse keeps all assets</i>	N/A	\$24,180.00
<b>Spousal Monthly Allowance</b> <i>Nursing home spouse's income will be diverted to community spouse until their combined gross income reaches this amount</i>	N/A	\$3,022.50
<b>Penalty Divisor</b> <i>Calculate the period of ineligibility resulting from gifts by dividing the total gift amount by the penalty divisor</i>	\$162.41/day	\$162.41/day
<b>Medicaid Estate Recovery</b>	<i>Applies only at death of Medicaid recipient Never applies if there is a surviving spouse Applies only to probate assets of the Medicaid recipient</i>	



# MEDICAID

What Every Practitioner Needs To Know

June 22, 2017



# Long-term care Medicaid Today

- State / Federal program
- Entitlement (except for waiver programs)

# Eligibility Requirements

- Nationality & Residence
- Income
- Resources
- Age/blindness/disability & Medical Necessity

# Nationality

- US Citizen
- Alien lawfully admitted for permanent residence
- Otherwise permanently living in the US legally

# Residency

- Resident with intent to remain in Texas
- No length of residency required



# Medical necessity

“...requires the services of licensed nurses in an institutional setting to carry out the physician’s ...”

“need for custodial care in a 24-hour institutional setting **does not** constitute a medical need...”

# Income

- Gross monthly income cap: \$2,205.00
- Otherwise need a Qualified Income Trust (Miller Trust)

Income is never an  
obstacle for  
nursing home Medicaid

# Resources

- Countable Resources limit: \$2,000.00

# Resources

## Exempt Resources

- Homestead with equity limit of \$552,000.00
  - *All contiguous land*
- One vehicle
- Pre-paid funeral plan

# Prevention of Spousal Impoverishment

## Part I – Spousal Protected Resource Amount “SPRA”

- Spouse at home keeps one half of countable resources up to **\$120,900.00**
- Minimum SPRA - **\$24,180.00**
- SPRA calculated at 12:01 a.m. on first day of month of continuous institutionalization lasting more than 30 days

# Prevention of Spousal Impoverishment

## Part II – Income diversion

- Spouse at home keeps all of her monthly income (no matter how much)
- If community spouse gross monthly income less than **\$3,022.50** then institutionalized spouse's income is diverted to community spouse to bring income up to that amount

# Example

Institutionalized spouse's gross income is \$2,000.00

Community spouse's gross income is \$1,500.00

Divert \$1,522.50 of IS income to CS to bring her gross monthly income up to \$3,022.50

# Prevention of Spousal Impoverishment

## Part III - Expanded SPRA

- Spouses' combined gross monthly income is less than **\$3,022.50**
- Community spouse keeps **MORE** than the SPRA
- Medicaid uses a formula to determine how much more based on the one year CD interest rate



# Example

Institutionalized spouse gross monthly income \$1,600.00

Community spouse gross monthly income \$1,000.00

Total gross monthly income = \$2,600.00

\$422.50 less than \$3,022.50

With a one year CD rate of .01% could preserve enough resources to generate \$422.50/month (\$5,070.00 per year) – over 5 million dollars

# Spenddown Strategy

- Spend on exempt resources
  - *Repairs to house*
  - *New vehicle*
  - *Pre paid funeral plan*

# Transfer Rules

A person is ineligible for Medicaid for one day for every **\$162.41** transferred for less than fair market value (\$4,872.30/month)

# Example

Give daughter \$10,000.00

Divide \$10,000.00 by \$162.41 = 61 days of ineligibility or 2 months

Give son \$50,000.00

Divide \$50,000.00 by \$162.41 = 307 days of ineligibility or 10 months

# Transfer Rules

- Transfer penalty starts when applicant would otherwise be eligible for benefits
  - *Down to \$2,000.00 in resources*
  - *In a Medicaid certified nursing home*

# Transfer strategy

- Make a gift of about one half of the resources
- Use the other one half to purchase an immediate annuity that will pay the nursing home during the penalty period

# Estate Recovery

Recovery of Medicaid payments from the estate of a deceased Medicaid recipient

- Services received at age 55 or older
- Initial application for services after March 1, 2005

# NO ESTATE RECOVERY

## Surviving Spouse

Surviving Child Under Age 21

Surviving Child of Any Age Who is Blind or Disabled

Unmarried Child Residing Continuously in Home at least one year immediately preceding Medicaid recipient's death



# Other estate recovery exceptions

- Sibling or direct descendant inheriting the homestead has gross family income less than 300% of the Federal Poverty Level
- Recovery not cost effective
  - *Value of estate is less than \$10,000*
  - *Recoverable amount less than \$3,000*
  - *Cost of sale of property greater than value of the property*

# Avoiding estate recovery

- Ladybird Deed
- TOD Deed