

**TOP TEN THINGS  
ESTATE PLANNERS/GUARDIANS  
NEED TO KNOW  
ABOUT MEDICAID**

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**Austin Bar Association  
Estate Planning & Probate Law  
Section Seminar  
April 10, 2009  
Austin, Texas**

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Co-Author (with Joe C. Fiore), TEXAS CONSUMER LAW (1993), 3rd Ed.

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Editor, ELDER LAW ALERT (newsletter of the Texas Chapter of the National Academy of Elder Law Attorneys), 1995 continuously to present

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### **TOP TEN THINGS ESTATE PLANNERS/ GUARDIANS NEED TO KNOW ABOUT MEDICAID**

#### **INTRODUCTION**

Medicaid is the most comprehensive health insurance program available to Americans. Settling a personal injury case or planning an estate without taking it into account would place an attorney at high risk for a professional liability claim and/or a suit for payment of the Medicaid subrogation claim. This paper will guide attorneys who are not Medicaid specialists to understand better the scope and complexity of the program. It will identify some "traps for the unwary" and some strategies for winning superb results for clients, qualifying them for government-provided medical insurance for the rest of their lives.

#### **I. "MEDICAID" INCLUDES NUMEROUS DISTINCT PROGRAMS**

In general, "Medicaid" refers to Title 19 of the Social Security Act, 42 U.S.C. §1396 *et seq.* The Texas Health & Human Services Commission administers all Title 19 (Medicaid) programs in this state.

However, Title 19 provides for numerous distinct programs. For example, the Medicaid provided to all Supplemental Security Income (SSI) beneficiaries is available only to persons with countable incomes not exceeding \$637 per month; but as discussed below, there is no absolute income limit on nursing home Medicaid eligibility.

This section will identify the major Medicaid programs according to the names and categories most commonly used. For current income eligibility limits, see Appendix 1. However, almost all Medicaid programs have asset ("resource") limits as well; and they vary among themselves as to what counts as "income" and "resources." This paper is intended only to illustrate their diversity, not to provide a comprehensive guide to eligibility and benefits.

#### **A. SSI- or TANF-Linked "Community Medicaid"**

This is the most common and important Medicaid program for persons with disabilities, usually (but not always) the non-elderly. Many beneficiaries receive Medicaid automatically because they qualify for Supplemental Security Income (SSI) (1 T.A.C. §358.105(3)) or Temporary Assistance for Needy Families (TANF) (1 T.A.C. §358.105(1)(A)). For such clients, requirements for Medicaid eligibility are the same as for SSI or TANF.

In general, this kind of Medicaid is a comprehensive medical assistance program. It is broader in many respects than Medicare and does not require payment of premiums, deductibles and co-payments as does Medicare.

The most comprehensive listing of regular Medicaid benefits is in the current *Texas Medicaid Provider Procedures Manual*, at <http://www.tmhp.com/Homepage%20File%20Library/NetscapeAgreement.aspx?http://www.tmhp.com/default.aspx> (entire manual available for download). It should be consulted whenever an issue arises as to the scope of benefits available.

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### **B. Medicaid for Children and Pregnant Women**

Likewise, Medicaid is provided to beneficiaries of the Children and Pregnant Women Program (1 T.A.C. §354.1578). Generally, those are children under age 18 and pregnant women. The family income level required for eligibility depends on the age of the child. 1 T.A.C. §354.1576. There are also family asset limits for children's Medicaid but none for pregnant women. 1 T.A.C. §354.1577(2)(D).

### **C. Medicaid for Nursing Home Care**

Beneficiaries of nursing home Medicaid receive comprehensive medical insurance benefits, in addition to payment for nursing home care and related services. 1 T.A.C. §358.305.

The "income cap" for nursing home Medicaid in 2009 is \$2,022 per month. However, as discussed below, it is not an absolute limit. A community spouse (spouse of a nursing home resident who is not in a nursing home or hospital) can have unlimited income, and complex rules apply as to how much assets the couple can keep.

### **D. Medicaid "Waiver" Home Care Programs**

Six Medicaid programs, which provide home care, are called Medicaid "waiver" programs because the federal Medicaid agency has waived one or more requirements that ordinarily apply for receipt of Title 19 funds, under a procedure at Social Security Act §1915(c). They are Community Based Alternatives (CBA) (the most important, which pays for a few beds in Assisted Living Facilities as well as home care), Community Living and Support Services (CLASS), Medically Dependent Children (MDCP), Home and Community-Based Services (HCS), Deaf Blind With

Multiple Disabilities (DBMD) and Texas Home Living Program (TxHmLiv). In general, these programs have the same asset and income requirements as nursing home Medicaid. However, they differ greatly among themselves as to the medical conditions required for eligibility, availability of funds and types of services offered. They are not entitlement programs (there is no federal requirement that all who meet eligibility requirements will be served), so they are always underfunded by the Legislature. Therefore, they are available only to those who can afford to wait for years and to those with advocates able to show them how to "bypass" the waiting list. The "bypass" strategy involves applying and qualifying first for Medicaid nursing home care, then returning home.

### **E. "Disabled Adult Child" Medicaid**

This Medicaid program allows the adult child of a retired, deceased, or disabled worker to continue his or her eligibility for Medicaid even though the adult child is denied Supplemental Security Income (SSI) due to newly established entitlement to or increase in social security benefits (RSDI) based on the parent's earnings record. It comes into play when the parent dies, qualifies for Social Security Disability benefits or qualifies for Social Security Retirement benefits. This program is also sometimes referred to as "the Pickle Amendment," after Jake Pickle, the Texas Congressman who sponsored the relevant legislation. To be eligible, an adult child must be at least 18 years of age; have a disability the onset of which was before age 22 years old; and meet current SSI criteria apart from the RSDI income. Medicaid Eligibility Handbook §1111, 1 T.A.C. §358.105(9). Because the Social Security Administration does not notify beneficiaries

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of this program, it is common to encounter "adult disabled children" who have suffered for years after their Medicaid benefits were needlessly cut off.

### **F. "Medicare Savings Program" Medicaid**

Low income *Medicare* recipients who meet certain income and resource limits may be eligible for Medicaid programs known as the Medicare Savings Programs. The Qualified Medicare Beneficiary Program (QMB) pays the Medicare Part B premiums (usually \$96.40 per month) and pays Medicare copayments and deductibles (essentially provides a free Medicare supplement insurance coverage). The Specified Low-Income Medicare Beneficiary (SLMB) Program pays only Medicare Part B premiums.

In addition, qualification for either QMB or SLMB automatically confers eligibility for Medicare Part D "Extra Help" (prescription coverage with no premiums and tiny copayments). However, eligibility for QMB or SLMB does not confer eligibility for the full range of Regular Medicaid benefits.

The income limits for QMB and SLMB are in Appendix 1. The limit on countable assets for both programs is \$4,000 for unmarried individuals and \$6,000 for married couples.

### **G. The Medicaid Buy-In Program**

The Medicaid Buy-In Program allows disabled individuals of any age who are working to purchase Medicaid benefits by paying a monthly premium. It provides for comprehensive medical insurance with the same benefits as "regular Medicaid."

Eligibility requirements are, in general as follows:<sup>1</sup>

- Disability: as defined by the Social Security Administration (SSA) for purposes of the federal Supplemental Security Income program (SSI), as explained in 20 CFR §§416.905 and 416.906, except the requirement that the person be unable to engage in any substantial gainful activity (a presumption that a person with earned income of \$980 or more per month in 2009 is not "disabled") does not apply.
- Minimum earned income: enough so each calendar quarter counts as a Qualifying Quarter, according to the Social Security Administration (SSA). For 2009 this amount is \$1,090 per quarter, and the amount changes annually.
- Maximum earned income: less than 250% of the Federal Poverty Income Level (FPIL), which is \$2,167 per month until April 1, 2009. Income limits change annually. Certain types of income are excluded:
  - Spouse's income.
  - Earned income tax credit payments and child tax credit payments.
  - Up to \$30 of earned income in a month, if infrequent or irregular.

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<sup>1</sup> For specifics in Buy-In Medicaid, see the following: HHSC rules at 1 T.A.C. Chapter 358, Subchapter I;

HHSC Memo at [http://www.dads.state.tx.us/handbooks/mepd\\_policy/12-16-08.pdf](http://www.dads.state.tx.us/handbooks/mepd_policy/12-16-08.pdf); and HHSC FAQ at <http://www.hhsc.state.tx.us/MBI.html> ; and HHSC Rules (copied below): at 1 T.A.C. Chapter 358, Subchapter I

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- Earned income of blind or disabled student children, subject to a monthly and yearly limit.
  - \$20 monthly general income exclusion.
  - \$65 + one half of the remainder monthly earned income exclusion.
  - Earned Income used to pay Impairment Related Work Expenses (IRWE) and Blind Work Expenses (BWE) – subject to reasonable limits.
  - Income set aside and used to fulfill an HHSC-approved PASS.
- financial institution used to save for future health care and work-related expenses for the purpose of increasing a person's independence and employment potential).
- Monthly premium: determined by examining both earned and unearned income. Unearned income premium amount is all unearned income over the SSI federal benefit rate, (\$674 per month in 2009). All participants whose net pay (gross income, minus mandatory payroll deductions) exceeds 150% of FPIL are required to pay a small additional amount (\$20-\$40) based on their earned income.
- Unearned income: There is no limit on *unearned* income for this purpose, but it is considered in calculation of the amount of the monthly premium (discussed below).
  - Disregard of spouse's assets and income: if the applicant is married, resources and income of his or her spouse is not considered, either in determination of eligibility or in determination of premium.<sup>2</sup>
  - Maximum assets: countable assets must be equal to or less than \$5,000. Certain types of resources that are (sometimes) counted under the SSI rules are not counted when determining eligibility. These include: retirement related accounts, including IRAs, 401(k)s, Tax Sheltered Annuities, and KEOGHS. Additionally, determination of eligibility does not take into account resources that are set aside under an HHSC approved Plan to Achieve Self-Support (PASS) and an Independence Account (a segregated account in a

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<sup>2</sup> 1 T.A.C. §358.815.

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### **II. BY USING THE RIGHT TRUST, ANYONE UNDER 65 WITH A DISABILITY CAN GET MEDICAID AS FAR AS ASSETS ARE CONCERNED**

#### **A. SSI--For Low-Income Persons With Disabilities**

If a person with a disability has less than \$674 in countable income, he or she can qualify for SSI (and therefore for Medicaid) once he or she has countable assets below \$2,000. This typically comes up when such a person wins a judgment or settlement in a personal injury case or receives a distribution from an estate or trust.

Sometimes the "asset problem" can be solved by buying "exempt" property like a residence, a vehicle, business property, a prepaid funeral contract and personal and household items. However, if more assets must be "disposed of," they can always be transferred to a trust. Likewise, as far as assets are concerned, a person *with a disability* may qualify for Children's Medicaid and other Title 19 programs by using a Medicaid self-settled trust.

##### 1. Individual Under-65 Self-Settled Trust

Under legislation effective as to trusts created on or after January 1, 2000, if a trust is established with assets of the individual or the individual's spouse, and the trustee can under any circumstances make any payment to the individual or the individual's spouse, the corpus will be treated as a resource of the individual. If not (i.e., an irrevocable trust by an SSI applicant of which the applicant is not a beneficiary), the transfer will be penalized, with a 36-month look-back period. However, the assets of a self-settled trust will not count as resources of the individual if the trust provides for repayment of Medicaid benefits

after the beneficiary's death and meets certain other requirements. Foster Care Independence Act of 1999, H.R. 3443, P.L. 106-169, §205, amending Social Security Act §1613, 42 U.S.C. §1382b, POMS SI 01120.203B. Specifically, the trust must meet the following requirements:

- *Who "establishes" the trust:* Established for the benefit of the client by a parent, grandparent, legal guardian of the client, or a court. By definition, however, these trusts are funded with assets belonging to or controlled by the beneficiary, so even where a parent or grandparent establishes the trust, they provide only a nominal contribution (typically, a \$10 bill attached to the trust instrument). If none of those is available, you can still use a "pooled trust" (discussed below).
- *"Payback provision":* The State will receive all amounts remaining in trust upon the death of the client, up to an amount equal to the total Medicaid payments made for the client.
- *Satisfaction of subrogation claims:* The Medicaid subrogation claim must be satisfied before the trust is funded, and any Medicare, insurance subrogation and hospital liens must be satisfied as well.
- *Source of funds:* Although the statute allows funding of the trust with any property owned by the beneficiary, agency representatives in some states allow such trusts to be funded only with personal injury awards and not with inheritances and property owned by the beneficiary. The Texas

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Medicaid program has not adopted any such limitation on the source of funds, nor is there any provision in the federal law apparently allowing such limits.

- *Irrevocability:* The trust must be irrevocable.
- *Trustee:* A trust created under Property Code §142.005 (by a trial court, typically in a personal injury case) or under Probate Code §867 (in a guardianship or for an incapacitated person) must have a corporate trustee. (This requirement under §867 does not apply if the trust's principal is under \$50,000 or if it can be shown that no financial institution is willing to serve as trustee. Tex. Prob. C. §867(c), (d).) That is not required if the trust is "established" by a parent or grandparent under 42 U.S.C. §1396p(d)(4)(a).
- *Distribution standards:* Although the statute is silent as to provisions for distributions to or for the beneficiary, such trusts usually either require that such distributions either be entirely discretionary with the trustee, or limited to distributions that will "supplement and not supplant" public benefits. Another variation is to provide for absolute discretion, with a statement of intent that the distributions be used to "supplement and not supplant" public benefits. Yet another option, to avoid the ambiguity of the latter type, is to provide expressly that the trustee may make distributions that disqualify the beneficiary for benefits, if the trustee in its

discretion determines that would be in the beneficiary's best interests.

### 2. Pooled Trust

An additional option is provided by "pooled trusts" as authorized by 42 U.S.C. §1396p(d)(4)(c). They must meet essentially the same requirements discussed above for an individual self-settled Medicaid trust. Such pooled trusts are available in most states. Forms and brochures may be found and downloaded at the website of The Arc of Texas at <http://www.thearcoftexas.org/>. On the home page click on Programs and Services, and on the page that comes up, scroll down and click on Master Pooled Trust.

### **B. Anyone Needing Long-Term Care**

Individuals with disabilities frequently cannot qualify for SSI because they have income (such as Social Security Disability on their own work record) that is too high. However, if they need nursing home care or home care, their income may not disqualify them for Medicaid benefits providing that kind of care. In that case, they can always solve the "asset problem"--until age 65--by transferring their assets to one of the types of trust discussed above. 42 U.S.C. §1396p(d)(4)(a),(c)(Medicaid "OBRA 93").

### **C. Requirement of Paying Subrogation and Lien Claims First**

Before funding any of the types of trust discussed above--indeed, before the proceeds are distributed out of an attorney's trust account to anyone--it is necessary to pay any subrogation or "lien" claims of Medicare, Medicaid, hospitals, insurance companies and perhaps other creditors. Those important issues are not covered in detail in this outline, but the contact

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information for determining the amount to be paid is in Appendix 2. For more information, see, e.g., Randall Kauffman, *The War of the Cockatrice*, 60 Texas Bar Journal 310 (April 1997).

### **III. THIRD-PARTY TRUSTS USUALLY NEED NO "SPECIAL NEEDS" LANGUAGE**

#### **A. Medicaid Benefits Received Through SSI**

The SSI program does not require any particular "special needs" language in a trust to keep the trust's assets and income from counting against the beneficiary. As long as the beneficiary does not have the legal authority to revoke the trust or direct the use of the trust assets, the trust assets are not treated as "resources" of the individual. Moreover, there is no need for a "payback to Medicaid" provision, if the assets came from someone other than the SSI beneficiary--for example, testamentary trusts and inter vivos trusts established by a beneficiary's family member.

Unfortunately, these rules are not well known among Social Security claims representatives. Therefore, when reporting funding of a third-party trust to the Social Security Administration, the author includes in the letter the following:

This is a "Third Party Trust," not a "Trust Established By the Individual." Because the trust is established entirely with assets from the estate of the applicant's mother (a third party to the SSI application), it is necessarily not a trust established by the applicant. Put another way, it is physically impossible for any testamentary trust to be established

by the applicant, because 100% of the assets of testamentary trusts come from persons who are deceased.

Therefore, POMS SI 01120.200 applies, because as stated at A.2.b., "Generally, this section applies to trusts *not* subject to the statutory trust provisions in section 1613(e) of the Social Security Act, *instructions for which are found in SI 01120.201 -- SI 01120.204*. Use the instructions in this section to evaluate the following types of trusts:...b. Trusts established on or after 1/1/00 that contain *only assets of third parties...*" (emphasis added)"

Therefore, for example, the checklist at SI 01120.203D.1., which includes the requirement of specific language to reimburse the State for medical assistance paid upon the individual's death, does not apply to this case. This trust was not established with assets of the individual (\*Name of SSI Beneficiary) but rather is a Third Party Trust governed by SI 01120.200.

Likewise, SI 01120.201 (copy attached) states, "*See SI 01120.200 for...trusts established with the assets of third parties...*" (emphasis added)

Nothing in SI 01120.200 requires that the trust provide for repayment of Medicaid benefits for its assets to be excluded from resources of the trust beneficiary who applies for SSI. Rather, it requires at D. 2. as follows: "If an individual does not have the legal authority to revoke the trust or

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direct the use of the trust assets for his/her own support and maintenance, the trust principal is **not** the individual's resource for SSI purposes." (emphasis in original)

### **B. Long-Term Care Medicaid Benefits**

If the Medicaid beneficiary is not also an SSI beneficiary, the report of the trust's funding is not made to the Social Security Administration but rather to the Texas Health & Human Services Commission (the Texas Medicaid agency). Essentially the same rule applies, with a different citation because it is in the state Medicaid rules. HHSC requires all such matters to be referred to a regional attorney. Therefore, in the letter reporting funding of a trust, a shorter reference to the law will suffice:

Because the trust is established entirely with assets from the estate of the applicant's mother (a third party to the Medicaid application), it is necessarily not a trust established by the applicant. Therefore, it is not required to have a provision paying back Medicaid benefits at the death of the beneficiary. Rather, it is a testamentary trust governed by 1 T.A.C. §358.415(d), Medicaid Eligibility Handbook §2313.2. Because [Beneficiary] does not have access to the trust and cannot revoke it, and only the trustee may make withdrawals for his benefit, the value of the trust is not counted as a resource.

### **IV. THERE IS NO REAL INCOME LIMIT FOR NURSING HOME CARE MEDICAID (AND SOMETIMES, FOR HOME CARE MEDICAID)**

In calendar year 2009, the long-term care Medicaid "income cap" in Texas is \$2,022 per month in "countable" income of the Medicaid applicant. This amount changes on January 1 of every year with inflation.

The "income cap" for establishing eligibility is the same as for a single person. The critical question is how the income is apportioned between the spouses, i.e., whose "name is on the check," regardless of community property status of the income. Because countable income can be reduced by running it through a "Qualified Income Trust" (discussed below, sometimes called a "Miller Trust"), income never has to be a disqualifying factor.

After eligibility of one spouse is established, the income of the eligible spouse is paid to the ineligible spouse (the spouse at home), to the extent necessary to provide a spousal allowance (\$2,739 per month in 2009). Medicaid Eligibility Handbook §3232.21.

Most states have no "income cap," so Medicaid simply supplements the client's income to the extent necessary without requiring the "Miller Trust" procedure discussed below. The same result can be reached in Texas, but it takes some work. It is necessary to establish a "Miller Trust" (which HHSC calls a "Qualified Income Trust"). For an unmarried client, this has the effect of allowing eligibility for the Medicaid nursing home and waiver programs, provided that all the client's income above the usual personal needs allowance and other deductions is paid to the nursing home. Likewise, for a married client with a community spouse, this has no

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effect on how the income is treated after eligibility. That is, it allows for eligibility of the institutionalized spouse, and the community spouse receives enough total income (if available) to give her/him the \$2,739 (in 2009) spousal allowance.

A "Qualified Income Trust" can be used to reduce countable income for nursing home Medicaid and the six Medicaid "waiver" programs discussed above. It cannot be used for SSI, so it does not apply to the Medicaid linked to SSI. It is likewise ineffective for the non-waiver home care programs, various known as Primary Home Care, Family Care and other names.

Alternatively, income for a married client can be reduced by transferring to the spouse all assets, including income streams. For qualified retirement benefits being paid as annuity (pension) benefits, this requires a court order in the form of a Qualified Domestic Relations Order (QDRO). It should always be used instead of a "Qualified Income Trust" if it will give the community spouse more income.

In summary, because of the Miller Trust and QDRO strategies, too much income is never in itself a reason not to apply for nursing home Medicaid or a Medicaid waiver program. These strategies are essential for the client's well-being where income is not sufficient for the care needed, and assets are limited. However, if income is sufficient for current expenses--and particularly if there is no community spouse--it is important to question closely whether Medicaid eligibility is really in the client's best interests.

### **V. COUPLES WITH LOW INCOMES CAN PUT ONE SPOUSE ON MEDICAID WITHOUT SPENDING DOWN**

When only one spouse (the "institutionalized spouse") needs institutional care, some special rules go into effect to prevent "spousal impoverishment" of the other spouse ("the community spouse"). In the usual case, all resources of both spouses are combined. A "protected resource amount" for the community spouse is then determined, according to the rules discussed below, and the couple must "spend down" to that amount before they can establish eligibility for the community spouse. Then, within the first year of eligibility, all countable assets in excess of \$2,000 must be transferred to the community spouse. The following is a summary of the specific rules, showing, for example, how a couple with combined Social Security incomes of \$1,260 per month may be able to keep \$923,400 in assets.

HHSC takes a "snapshot" of all the countable resources of both spouses, as of 12:01 a.m. of the first day of the month in which the first continuous period of institutionalization on or after September 30, 1989 began. Hospitals, as well as nursing homes, are "medical institutions," and a move from one institution directly to another does not stop the clock running on the 30-day period. Therefore, if a spouse goes into a hospital on November 30, moves to a nursing home on December 1, and stays in the nursing home at least 28 more days, the "snapshot date" will be November 1.

All property is included, without regard to its characterization as community or separate. The PRA is the *greater* of

- One-half the couple's combined countable resources, not to exceed the maximum set by federal law (\$109,560 in 2009) *or*

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- The minimum set by federal law (\$21,912 in 2009).

For example:

1. *If combined resources total \$200,000, PRA is \$109,560.*
2. *If combined resources total \$100,000, PRA is \$50,000.*
3. *If combined resources total \$20,000, PRA is \$21,912.*

However, if the spouses' combined incomes are low enough, the amount of assets they can keep may be increased above what this formula would indicate--sometimes to a very high level.

**(1) The spousal allowance.** Federal law provides for a "minimum monthly maintenance needs allowance" for the community spouse, which in 2009 is \$2,739 per month if the other spouse is in a nursing facility. If the community spouse's income (including that spouse's investment income but not including any income of the institutionalized spouse) is less than that amount, the community spouse is entitled to keep a "spousal allowance" consisting of enough of the income of the institutionalized spouse to give the community spouse the full spousal allowance. The rest of the income of the institutionalized spouse, if any, goes to incurred medical expenses (usually medical insurance premiums), the \$60 per month personal needs allowance, and applied income (i.e., to the nursing home).

**(2) The right to a PRA increase to provide for the spousal allowance.** In some cases, all the income of both spouses together is insufficient to give the community spouse the full spousal allowance. If either spouse establishes this, HHSC is required to increase the PRA to an amount sufficient to provide the full minimum monthly needs allowance.

An HHSC rule at 1 T.A.C. §358.503(j), Medicaid Eligibility Handbook §4133.8 and Appendix XXVII. has the following essential provisions:

- The total resources that can be protected are equal to cost of a one-year CD that will produce enough interest, when added to the couple's total *noninvestment* countable income, to give the community spouse a total of \$2,739 per month income (in 2009).
- The formula is: *annual income needed X 100 divided by interest on one-year CD = maximum dollar amount of resources to be protected.*
- The interest rate to be assumed in doing the calculation is the rate of a one-year CD as published in the local paper or as provided by a local bank.
- This formula is used regardless of the actual income paid by the couple's resources; and they need not actually buy a one-year CD.
- In determining the amount to be paid from the institutionalized spouse's income to the community spouse after eligibility, the Medicaid worker uses the actual dollar amount being produced by the investments if it is in excess of the amount a one-year CD would produce; but if it is *less* than that amount, the Medicaid worker uses the amount a one-year CD would produce.<sup>1</sup> T.A.C. §358.503(j)(5), Medicaid Eligibility Handbook §4133.8. However, in determining how much the "Protected Resource Amount" will be, only the CD rate is used, regardless of whether actual income is more or less.

## Top Ten Things You Need to Know About Medicaid

- Until eligibility is certified, the total protected may not exceed the total of the couple's resources on the "snapshot date."

*Example: The total of the noninvestment incomes (e.g., Social Security and pension incomes) of both spouses is \$1,260 per month. After the \$60 per month personal needs allowance, \$1,200 is left. A local bank offers one-year CD's with an interest rate of 2.0% per annum.*

*Income needed = \$2,739 - \$1,200 = \$1,539.00/month X 12 = \$18,468/year*

*Potential PRA = \$18,468.00 ÷ .02 = \$923,400*

To take a more extreme example, a couple with no income at all (other than investment income) can protect exactly  $(\$2,739 \times 12) \div .02 = \$1,643,400$  in assets, when the 1-year CD rate is 2.0%.

### **VI. WITH BOTH SPOUSES IN A NURSING HOME, ONE CAN ALWAYS GET MEDICAID**

When *both* spouses reside in medical institutions, whichever of them applies for Medicaid is treated as if he or she were unmarried, and only assets titled in his or her name are treated as "resources." Community property laws are disregarded, and there is no transfer penalty for transfers between spouses. Therefore, all that is required to qualify one spouse for nursing home Medicaid is to title all accounts, life insurance, real property other than residence, etc. in the name of the other spouse. This is true regardless of whether both spouses are in the same nursing home, or they are in different nursing homes, or one is in a nursing home and the other in a hospital. It

applies even if the spouse applying for Medicaid does not need to be in a nursing home and is staying there only to accompany the other spouse.

Most Medicaid eligibility workers are not aware of this rule. Therefore, when it applies, the author routinely includes the following paragraph in the letter transmitting the Medicaid application:

Please notice that «Client Name»'s spouse also resides in a nursing facility. Therefore, the "spousal impoverishment" rules do not apply. Resources and income of the non-applicant spouse are not deemed to the applicant spouse because they are not regarded as living in the same "household." Therefore, the resource limit for the spouse applying for Medicaid is \$2,000, and the non-applicant spouse can have unlimited resources. Regarding deeming of resources, see Medicaid Eligibility Handbook §2312.1; and regarding deeming of income, see Medicaid Eligibility Handbook §3213. Since there is no penalty for transfer of assets between spouses, either spouse can qualify by transferring all but a maximum of \$2,000 in countable resources to the other. Medicaid Eligibility Handbook §2322.

When this is done, the ineligible spouse does not have a right to any of the income of the Medicaid-eligible spouse. That is, there is no \$2,739 spousal allowance as there is when one spouse is not in a nursing home. However, getting to keep all the assets is usually a better deal.

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### **VII. THE MEDICAID AND INCOME TAX LAWS DEFINE "INCOME" VERY DIFFERENTLY**

#### **A. The SSI and Medicaid Definition of "Income"**

Fortunately, with few exceptions, the Texas Medicaid rules follow the same "methodology" for defining income and assets ("resources") as the SSI rules. That results from a provision in the federal Medicaid statute prohibiting the state Medicaid program from adopting methodology more "restrictive" than the SSI methodology. 42 U.S.C. §1396a(r)(2). Therefore, the definition of "income" generally should be the same for all Medicaid beneficiaries, regardless of whether they receive Medicaid because they qualify for SSI or under a Medicaid-only program. Important exceptions are that (1) the favorable SSI "earned income disregard" does not apply to long-term care Medicaid applicants; and (2) the "disregard" of \$20 per month for any income in the SSI rules does not apply to Medicaid-only. Because this "no less restrictive" rule is sometimes disregarded by state officials, one of the tasks of an attorney representing Medicaid beneficiaries is to find such errors and advocate their correction.

"Income" is defined generally in the SSI and Medicaid rules as the value of cash (or property readily convertible to cash), food and shelter received by the beneficiary during a calendar month. Unlike the income tax rules, the SSI rules count even gifts as "income." This general rule is subject to a long list of exclusions that can be important in some cases. 20 C.F.R. §416.1103; Medicaid Eligibility Handbook §2420, 2430.

Additional important exclusions applying to "earned" income and "unearned" income, respectively, are discussed next below.

#### **B. SSI Rules Applying To Earned Income**

Earned income is defined as gross wages of an employee (without deductions for taxes, insurance, etc.), and net earnings from self-employment (after deduction of business expenses but also without deductions for taxes, insurance, etc.).

The following are examples of the things that are *excluded* from countable earned income:

- The first \$65 plus one-half of remaining earned income each month
- Certain federal assistance payments (including food stamps)
- \$30 per month of infrequent or irregular income
- Certain additional exclusions for persons with blindness and disability (including, for example, work expenses due to disabilities)
- The general \$20 per month exclusion, to the extent it has not been taken against unearned income.

42 U.S.C. §1382a(a); 20 C.F.R. §§416.1102, 416.1110, 416.1112.

This different treatment of earned income does not apply to long-term care Medicaid. Therefore, in the unusual situation in which a person in a nursing home or in need of home care has earned income, it all counts as "income" dollar for dollar with regard to Medicaid benefits to pay for those types of care. However, a person who receives Medicaid through the SSI program can take advantage of this more favorable "income methodology" for earned income.

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### **C. SSI & Medicaid Rules Applying to Unearned Income**

“Unearned” income is all income that is not earned, including without limitation annuities, pensions, alimony, support, dividends, life insurance proceeds, prizes, gifts and inheritances. 42 U.S.C.A. §1382a(a)(2); 20 C.F.R. §416.1121.

Important exclusions from unearned income include most federal payments (for example, food stamps), up to \$60 per month of irregular or infrequent income, one-third of child support payments, and certain special VA payments (though VA pensions count as income). Because the list of exclusions is quite lengthy, it should always be consulted. 42 U.S.C.A. §1382a(b); 20 C.F.R. §416.1124

#### 1. “In-Kind Support And Maintenance” Rules

This term refers to *food and shelter* furnished or paid for by someone other than the SSI applicant. 20 C.F.R. § 416.1130. In general, because it is counted as unearned income, food and shelter reduces benefits dollar-for-dollar. However, a much better result for the client can be obtained by applying some important rules applicable only to this kind of “income”:

- *One-Third Reduction Rule:* If the client is living in the household of another person who is providing *both* food *and* shelter, the client’s SSI benefit will be reduced by 1/3 of the monthly federal benefit rate (maximum payment). In 2009, that amount is  $1/3 \times \$674 = \$224.67$ . 20 C.F.R. §416.1131.
- *Presumed Maximum Value Rule:* If the One-Third Reduction Rule does

not apply, and the client is furnished *any* food *or* shelter by someone else, the agency *presumes* that the value of whatever is furnished is 1/3 of the federal benefit rate plus \$20-- that is, in 2009,  $\$224.67 + \$20.00 = \$244.67$ . This presumption is rebuttable--that is, by showing that the actual value of what is furnished is less than \$244.67, the client can have his or her income reduced by the actual value rather than the full \$244.67. 20 C.F.R. § 416.1140.

- *Exception:* If the SSI beneficiary lives in the household of someone part of whose income may be "deemed" to the beneficiary, then any support provided is *not* treated as income. 20 C.F.R. §416.1148. For example, income of a parent of a child under age 18 in the same household above a certain level is deemed to the child. Therefore, the parent's provision of food and shelter does not result in a reduction of the child's SSI payment--regardless of whether or not the parent actually has enough income for some of it to be deemed. 20 C.F.R. §416.1160.

#### 2. “In-Kind Support And Maintenance” Strategies

It is impossible for most persons with disabilities to live on \$674 per month without falling into conditions of squalor and ill health that shock the conscience and constitute public health hazards. Therefore, it can be critical to the client’s health and safety to apply the following planning techniques, which further protect the client from the harshness of the general rule that in-kind maintenance and support counts as “income”:

## Top Ten Things You Need to Know About Medicaid

- *Business Arrangement:* As long as the client pays a pro rata share of the actual cost of food and shelter, there is no reduction in benefits, and no food or shelter value counts as income. 20 C.F.R. §416.1130(b), 416.1133. Simply by keeping records of household expenses and having the SSI-eligible person pay his or her share, the total household income can in this way be increased by \$224.67 if the One-Third Reduction Rule applies (or \$244.67 if it does not). This can also allow a person with irreducible income (for example, from Social Security Disability) to achieve eligibility that would otherwise be impossible. As long as the beneficiary's actual cost of food and shelter does not exceed \$694 per month (the SSI benefit rate plus the \$20 amount of income that is disregarded), they can avoid reduction of the benefit with a business arrangement--unless they are unfortunate enough to have an irreducible benefit (such as Social Security Disability Insurance income) which, when added to the  $\$224.67 + \$20.00 = \$244.67$  amount, causes total countable income to exceed \$674 per month.

- *Rent Subsidy--Pay 1/3 FBR + \$20 to Landlord:* Under a settlement agreement, the Social Security Administration has agreed to apply in Texas a rule previously applied only in the Seventh Circuit--that a "business arrangement" will be deemed to exist whenever the rent paid equals or exceeds the presumed maximum value (\$244.67 in 2009). Therefore, even if the fair market value of the rent is \$674, there will be *no* income attributed to a rent subsidy, so long as the client pays at least \$244.67 to the landlord. In this way, a parent or child can subsidize an SSI recipient's rent--including even other "shelter" expenses such as electricity, gas, water, sewerage and garbage collection--without reducing the monthly

SSI payment to the client. This rule applies only when the SSI beneficiary lives in his/her own household. If the beneficiary is in the household of another person who pays both food and shelter, the one-third reduction rule applies, unless income of the other is deemed to the beneficiary. 20 C.F.R. §1130(b); POMS SI DAL00835.380.

- *Rent Subsidy--Unlimited Where Landlord is Neither Parent nor Child:* If nobody in the household is related as a parent or child to the landlord, no rent subsidy will be treated as income. However, this will apply only if the landlord owns the building, not if the landlord is leasing from the owner and subleasing to the SSI beneficiary.

- *Ownership of the residence by a trust:* If a trust of which the client is a beneficiary owns the residence, the fact that the trust allows the client to live there does not mean the client has "income" in the form of shelter. POMS SI 01120.200F1. However, if the trust pays for household expenses such as electricity, gas, water, sewerage and garbage collection, those payments are "income" to the extent they are not fully reimbursed by the client. POMS SI 01120.200F3c. Of course, if persons other than the client live in the dwelling unit, their pro rata share of the expenses will reduce the amount the client must pay to avoid receipt of "income."

A simple and powerful technique where a supplemental needs trust is involved is to have the trust provide all food and shelter, in exchange for reducing the SSI payment by \$244.67 per month, under the "presumed maximum value rule." In addition, the trust can make unlimited payments to the providers of "supplemental" needs. In this arrangement, the only thing

## **Top Ten Things You Need to Know About Medicaid**

the trust *cannot* do for the beneficiary is to pay cash to him or her. The beneficiary then has  $\$674.00 - \$244.67 = \$429.33$  per month in cash from SSI to spend as she or he wishes, with Medicaid paying (usually) all medical needs and the trust paying everything else.

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### **VIII. GIVING AWAY ASSETS USUALLY CREATES A PERIOD OF INELIGIBILITY FOR MEDICAID-- BUT NOT ALWAYS**

#### **A. SSI-Linked Medicaid**

An individual may be subject to a period of ineligibility for having transferred (or disposed of) assets or resources prior to applying for SSI that would otherwise have disqualified the applicant. This is known as a "transfer penalty" or "look-back period."

When an individual applies for SSI, the agency asks if any uncompensated transfers occurred within the 36 months prior to the date of application or the date of the transfer, whichever is later (this is the "look-back period"). If not, there is no penalty, regardless of how much was transferred. If so, then unless an exception to the transfer penalty applies (as discussed below), an ineligibility period is determined by dividing the total uncompensated values of all resources disposed of during the look-back period, by the maximum monthly SSI benefit (including any state supplement, of which there is none in Texas) effective on the date of application. Fractions are rounded to the nearest whole month, and the entire calendar month in which the transfer was made is included as a penalty month. Ineligibility begins on the first day of the calendar month of the transfer. Social Security Act §1613(c)(1)(C), 42 U.S.C. §1382b.

For example, if an application is filed in year 2009, a transfer of \$2,000 on January 14, 2009 will result in a penalty period of  $\$2,000 \div \$674 = 2.97$ , rounded to 3 months. Ineligibility will begin January 1, 2009, and end March 31, 2009.

If there are multiple transfers with overlapping penalty periods, the amounts transferred are added together and treated as one transfer, occurring on the date of the

first of the overlapping transfers. If in the above example a second transfer of \$2,000 is made on February 14, 2009, the calculation will be as follows:  $\$4,000 \div \$674 = 5.93$ , rounded to 6 months. Ineligibility will begin January 1, 2009 and end June 30, 2009.

The maximum SSI penalty period is 36 months from the date of the transfer. Unlike the Long Term Care Medicaid transfer penalty for transfers on or after February 8, 2006, the SSI law still begins the penalty period on the first day of the calendar month in which the transfer is made, not at some time in the future when the applicant would have been eligible but for the transfer.

The transfer penalty does *not* apply to the following:

- Transfers to a trust that is considered a resource of the settlor (in which case the settlor will be disqualified by the existence of the trust as long as the corpus treated as a resource exceeds \$2,000)
- Transfers to the spouse of the transferor or to another for the sole benefit of the spouse, or from the transferor's spouse to another for the sole benefit of the transferor's spouse (e.g., in trust)
- Transfers to, or to a trust (including an "Under 65 Special Needs Trust" under 42 U.S.C. §1396p(d)(4)), established solely for the benefit of the transferor's child who is blind or has a disability
- Transfers to a trust established solely for the transferor if he or she is under age 65 and has a disability, and the trust is created under 42 U.S.C. §1396p(d)(4)(a),(c) (self-settled under-65 SNT's and pooled trusts, discussed above)

## Top Ten Things You Need to Know About Medicaid

- Transfers proven by the individual to have been with intent to receive fair market value
- Transfers proven by the individual to have been transferred exclusively for a purpose other than to qualify for SSI
- Transfers in which all resources transferred have been returned to the transferor
- Transfers of a residence of the transferor to any of the following:
  - Transfers of the residence to the spouse of the transferor
  - Transfers of the residence to a child of the transferor under 21 years of age, or who is blind or has a disability
  - Transfers of the residence to a sibling of the transferor who has an equity interest in the residence and who was residing in the residence for at least a year immediately before the date the transferor became an institutionalized individual
  - Transfers to a son or daughter of the transferor who was residing in the residence for at least two years immediately before the date the transferor became an institutionalized individual, and who provided care permitting the transferor to reside at home

Social Security may waive denial of eligibility for a transfer on a finding that it would work an "undue hardship" under criteria established by the agency.

### **B. Long-Term Care Medicaid**

The long-term care Medicaid transfer rules are essentially the same as the SSI rules, with the following important exceptions:

- The divisor for calculating the period of ineligibility is much higher, resulting in a shorter period of ineligibility. Instead of being the maximum SSI benefit rate (one month for every \$674 transferred), it is the average cost of nursing home care (one month for every \$3,726 transferred, expressed as one day for every \$122.50 transferred).
- The lookback period is 5 years for long-term care Medicaid rather than 3 years for SSI.
- The start date for the penalty period is not first day of the calendar month of the transfer. Instead, it is the first day the transferor *would* meet all the requirements for Medicaid nursing home care, but for the transfer. That is, the transferor must actually be residing a Medicaid nursing home, meet the asset and income and "medical necessity" requirements, file an application, and be denied. Then, the period of ineligibility starts as of the first date he or she would have qualified for nursing home payment but for the transfer penalty. (Actually, the application is "certified," but only for benefits other than payment of nursing home care, such as free Medicare Part D prescription medications and Medicaid payment of Medicare copayments and deductibles.)

### **C. Disclaimers as Transfers**

For purposes of federal gift tax and rights of creditors, property subject to a qualified disclaimer is treated as if it had never been owned by the disclaiming party.

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However, the Medicaid rules treat such property as if it was received by the disclaimant and immediately transferred. 42 U.S.C. §1396p(e)(1); 1 T.A.C. §358.455(e)(5)(D)(iii)(II); Medicaid Eligibility Handbook §2353.52

### **IX. MEDICAID ESTATE RECOVERY CAN USUALLY BE AVOIDED OR REDUCED**

#### **A. Most Medicaid Beneficiaries Are Not Subject to Estate Recovery**

##### 1. Estate Recovery Applies Only to Long-Term Care Medicaid

The Medicaid estate recovery program can recover the cost of only the following Medicaid benefits:

- Nursing facility services;
- Intermediate Care Facilities for the Mentally Retarded (ICF-MR);
- Home and Community-Based Services ("waiver" Medicaid home care) and Community Attendant Services (aka Primary Home Care); and
- Related costs of hospital and prescription drug services for beneficiaries of the above three types of program

1 T.A.C. §373.103(c). Therefore, the following Medicaid services are *not* subject to reimbursement under the Medicaid estate recovery program:

- Medicaid linked to SSI or TANF
- Medicare Savings Programs (QMB, SLMB, QI-1)
- Disabled Adult Child Medicaid

- Medicaid for Children and Pregnant Women

Note, however, that all Medicaid services for persons of any age are subject to the "payback" requirement of a self-settled Special Needs Trust--including even services provided before the trust was funded. Likewise, recoveries from a third party liable for medical expenses paid by Medicaid (typically, expenses paid by insurance coverage) are also subject to the Medicaid subrogation claim in all cases. Those are grounds of recovery entirely separate from the Medicaid estate recovery program.

##### 2. Estate Recovery Applies Only to Beneficiaries Age 55 and Over

Estate recovery applies only to the cost of services provided to persons age 55 years or older at the time the services were received. Therefore, the estate of a person who dies before age 55 cannot be subject to estate recovery; and the estate of a person who dies at or after age 55 will not have to reimburse services provided before his or her 55<sup>th</sup> birthday.

#### **B. Many Applied Before the "Grandfathering" Date: March 1, 2005**

Anyone who filed an application for a kind of Medicaid subject to the Medicaid estate recovery program before March 1, 2005, and who was certified eligible as a result of that application, is not subject to estate recovery. That is true even if he or she lost eligibility later and was re-certified after a gap in eligibility. 1 T.A.C. §373.103(a)(2).

#### **C. There Are Many Exceptions to Estate Recovery**

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If the decedent was survived by any of the following, the Medicaid estate recovery program does not apply:

- Spouse
- Decedent's child under age 21
- Decedent's child of any age with blindness or a disability
- Decedent's unmarried adult child residing continuously in the decedent's homestead for at least one year immediately before death, who had a relationship of dependence with the decedent and who intends to continue to reside in the home

### **D. There Are Several Grounds for Waiver of Estate Recovery**

Estate recovery should be waived if it is shown to be a potential cause of "undue hardship," including the following:

(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;

(2) Estate distributees would become eligible for public and/or medical assistance if a recovery claim were made;

(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;

(4) The Medicaid recipient received medical assistance as the result of a

crime, as defined by Texas law, committed against the recipient; or

(5) Other compelling reasons.

1 T.A.C. §373.209(c).

If a homestead is involved, then to the extent the estate's equity does not exceed \$100,000, the interest of a distributee of the estate with income less than three times the federal poverty level can be set aside under a waiver request. 1 T.A.C. §209(d).

### **E. There Are Several Potential Offsets Against Estate Recovery**

#### 1. Home Maintenance, Property Taxes and Insurance

MERP rules allow deduction of the cost of home maintenance, property taxes and insurance from the estate recovery claim, provided adequate records are maintained. 1 T.A.C. §373.213(a). DADS officials have stated they interpret this as follows, in written responses to questions at the University of Texas School of Law, *Estate Planning, Guardianship and Elder Law Conference*, August 10-11, 2007:

DADS interprets this provision to mean that home maintenance costs are allowed and limited to the expenses incurred for *vacant homes of institutionalized individuals. With the exception of property taxes and homeowner's insurance*, MERP does not permit claim deductions when a family member is residing in the recipient's home." (emphasis added)

#### 2. Direct Payment of the Costs of Care

MERP rules also allow the following deduction from estate recovery, at 1 T.A.C. §373.213(b):

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An amount equal to the necessary and reasonable expenses for the direct payment of the costs of care (including payment of personal attendant care) provided for a deceased Medicaid recipient that enabled the recipient to remain in his or her home and thereby delayed the institutionalization of the Medicaid recipient may be deducted from the MERP claim, provided that sufficient supporting documentation of these expenditures, such as receipts, is provided to MERP by estate personal representatives, heirs, or legatees.

### **X. THE MEDICAID PAYBACK REQUIREMENT IN A SELF-SETTLED TRUST CAN NEVER BE AVOIDED**

This point is included primarily to emphasize the distinction between Medicaid estate recovery and the Medicaid right of recovery against assets of a self-settled trust. For discussion and authorities regarding self-settled "payback" trusts, see II.A. above.

Two important planning principles follow:

- Always consider first putting assets of the person with a disability into a form in which they do not interfere with benefits, *instead of* putting them into a trust. For example, if the person with a disability was injured in an accident and is receiving a cash settlement, consider advising purchase of a residence (or a life estate or another interest in a residence), a vehicle, personal and household items, a prepaid funeral contract and other exempt items, before funding the trust. Likewise, if that person owes money to family members or others, pay it first before funding the trust. Once it goes into the trust, it is irrevocably subject to the Medicaid

payback claim upon the death of the beneficiary.

- After funding of a self-settled payback trust, use that trust's assets first before any other available resources (other than resources to which the beneficiary has a legal right, such as parental support). For example, if there is a third-party trust for the same beneficiary, don't use it at all until the assets of the self-settled trust have been exhausted.

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### APPENDICES

#### Appendix 1: 2009 Eligibility Numbers for Means-Tested Public Benefits in Texas

##### Medicaid & SSI

##### Dollar Amounts Effective as of January 1, 2009:

	2008	2009
Medicaid Single Income/Mo.	\$1,911	\$2,022
Medicaid Couple Income/Mo.	\$3,822	\$4,044
SSI Single Income/Mo.	\$637	\$674
SSI Couple Income/Mo.	\$956	\$1,011
Protected Resource Amt. Min.	\$20,880	\$21,912
Protected Resource Amt. Max.*	\$104,400	\$109,560
Spousal Monthly Allowance	\$2,610	\$2,739
Gift Penalized**	\$122.50/day	\$122.50/day
Personal Needs Allowance	\$60	\$60

\*The Community Spouse can sometimes keep more by applying for an increase. For example, if countable income of both spouses together is \$1,500 per month, and the 1-yr. CD rate is 5.0%, they can keep \$280,800.

\*\*For applications filed before 9/1/07, the divisor is \$117.08/day; thereafter it is \$122.50/day. For transfers discovered on or after 9/1/05 in applications filed previously, the divisor is \$117.08/day.

##### Medicare & Social Security & VA

##### Dollar Amounts Effective

##### January 1, 2009:

	2008	2009
Part A Premium/Mo. <sup>3</sup>	\$423	\$443
Part B Premium/Mo. <sup>4</sup>	\$96.40	\$96.40
Skilled Nursing Facility Copayment	\$128	\$133.50
Hospital Stay (Part A) Deductible	\$1,024	\$1,068
Hospital Copayment, Days 61-90	\$256	\$267
Hospital Copayment, Days 91-150	\$512	\$534
Part B (Medical) Annual Deductible	\$135	\$135
QMB max income single (gross incl. \$20 exempt amt)	\$887	\$923*
QMB max income couple (gross incl. \$20 exempt amt)	\$1,187	\$1,235*
SLMB max income single (gross incl. \$20 exempt amt)	\$1,060	\$1,103*
SLMB max couple (gross incl. \$20 exempt amt)	\$1,420	\$1,477*
QI-1 max income single (gross incl. \$20 exempt amt)	\$1,190	\$1,239*
QI-1 max income couple (gross incl. \$20 exempt amt)	\$1,595	\$1,660*
"Substantial Gainful Employment" (Non-Blind)	\$940	\$980
Max Earnings Taxed for SS	\$102,000	\$106,800
Max Earnings/Yr, Under 65	\$13,560	\$14,160
Max Earnings in Yr of Full Retirement Age**	\$36,120	\$37,680
Max Earnings after Yr of Full Retirement Age**	No Max!	No Max!
SS COLA	3.3%	5.8%
VA Pension With "Aid & Attendance"--Married (eff 12/1)	\$1,843	\$1,950
VA Pension With "Aid & Attendance"--Unmarried Vet (eff 12/1)	\$1,555	\$1,645
VA Pension With "Aid & Attendance"--Widow(er) (eff 12/1)	\$999	\$1,057

\*Effective 4/1/2009

\*\*Full Retirement = 65 and 10 months if born in 1942 or age 66 if born in 1943-1954. Full retirement age will gradually increase to age 67 for those born in 1960 and later.

<sup>3</sup> 99% of Social Security beneficiaries have sufficient Medicare covered quarters that they pay no Part A premium.

<sup>4</sup> In 2009, the Part B premium is more for those with over \$85,000 income (individual return) or \$170,000 (joint return).

## Top Ten Things You Need to Know About Medicaid

FEDERAL POVERTY GUIDELINES			2009				Excluding Alaska & Hawaii			
Family Size	100% Annual	100% Monthly	120% Monthly	133% Monthly	135% Monthly	150% Monthly	158% Monthly	185% Monthly	200% Monthly	300% Monthly
1	\$10,830	\$903	\$1,083	\$1,203	\$1,218	\$1,354	\$1,426	\$1,670	\$1,805	\$2,708
2	\$14,570	\$1,214	\$1,457	\$1,619	\$1,639	\$1,821	\$1,918	\$2,246	\$2,428	\$3,643
3	\$18,310	\$1,526	\$1,831	\$2,034	\$2,060	\$2,289	\$2,411	\$2,823	\$3,052	\$4,578
4	\$22,050	\$1,838	\$2,205	\$2,450	\$2,481	\$2,756	\$2,903	\$3,399	\$3,675	\$5,513
5	\$25,790	\$2,149	\$2,579	\$2,865	\$2,901	\$3,224	\$3,396	\$3,976	\$4,298	\$6,448
6	\$29,530	\$2,461	\$2,953	\$3,281	\$3,322	\$3,691	\$3,888	\$4,553	\$4,922	\$7,383
7	\$33,270	\$2,773	\$3,327	\$3,697	\$3,743	\$4,159	\$4,381	\$5,129	\$5,545	\$8,318
8	\$37,010	\$3,084	\$3,701	\$4,112	\$4,164	\$4,626	\$4,873	\$5,706	\$6,168	\$9,253
Each										
Add'l:	\$3,740	\$312	\$374	\$416	\$421	\$468	\$492	\$577	\$623	\$935

### Programs With Poverty-Level-Related Income Limits (Above limits effective 4/1/09-3/31/10)

<b>QMB:</b>	100% of poverty + \$20 (\$4,000 resources unmarried, \$6,000 married)
<b>SLMB:</b>	120% of poverty + \$20 (\$4,000 resources unmarried, \$6,000 married)
<b>QI-1</b>	135% of poverty + \$20 (\$4,000 resources unmarried, \$6,000 married)
<b>Part D Max</b>	135% of poverty + \$20 (\$7,506 resources unmarried, \$15,006 married)
<b>Part D Min</b>	150% of poverty + \$20 (\$12,510 resources unmarried, \$25,010 married)
<b>MERP Waiver</b>	300% of poverty (up to \$100,000 tax appraised residence value, for shares of low-income descendants)
<b>CPW* Under 1</b>	185% of poverty (\$2,000 resources/household, or \$3,000 if any member disabled or age 60 or over)
<b>CPW* Preg W</b>	158% (no resource limit for pregnant women)
<b>CPW* 1-5</b>	133% of poverty (\$2,000 resources/household, or \$3,000 if any member disabled or age 60 or over)
<b>CPW* 6-18</b>	100% of poverty (\$2,000 resources/household, or \$3,000 if any member disabled or age 60 or over)

\*CPW = Children & Pregnant Women Medicaid. Pregnant minors have same income limit as children under age 1.

--TANF resource & income methodology generally applies to CPW; SSI methodology to the other programs.

For example, SSI methodology disregards \$20 of income in every case and \$65 of earned income plus 1/2 the rest of earned income.

--Multiples of poverty level income are rounded in Excel. Agencies may round differently, creating a difference of \$1.00 one way or the other in actual income limits.

## Top Ten Things You Need to Know About Medicaid

### **Appendix 2: How to Obtain Medicare & Medicaid Claim Information in Texas**

Because public benefits issues often come to attorneys in connection with personal injury litigation, probate and trusts in which the Medicaid program is a remainder beneficiary, the following information is provided.

Before any personal injury suit is settled, in which an injured party received any assistance from Medicare or Medicaid for injuries involved in the case, the plaintiff's attorney must determine how much has been paid by those programs as a result of such injuries. That is because both programs are "subrogated to" any claims resulting from the injuries; and any person (including an attorney) through whose hands the funds to pay the claim have passed will be liable to the program if they fail to pay the subrogation claim. Likewise, the "hospital lien" must be satisfied out of the settlement or judgment. For cites to the relevant laws and a clear summary, see Randall Kauffman, *The War of the Cockatrice*, 60 Texas Bar Journal 310 (April 1997).

It is sometimes possible to negotiate waivers of part or all of these subrogation claims. See Susan G. Haines, "Structuring Personal Injury Settlements for Claimants Receiving Public Benefits," seminar paper for National Academy of Elder Law Attorneys Year 2000 Symposium; and Kathleen A. Miller, "Handling Liability Cases Involving Medicare," seminar paper for the State Bar of Texas Elder Law Institute (1996).

*Caution: The following information pertains to the State of Texas only. It does not apply in other states.*

Because the Texas contact information for both Medicare and Medicaid has changed since publication of Mr. Kauffman's article, the following is offered to supplement it. This information is current as of May 2008 and is subject to change at any time.

#### **For Medicare Parts A & B**

**(any Texas resident):**

MEDICARE-Coordination of Benefits

P.O. Box 5041

New York, NY 10274-5041

800-999-1118

<http://www.cms.hhs.gov/COBGeneralInformation/>

(Call first if you are not familiar  
with this process)

## **Top Ten Things You Need to Know About Medicaid**

### **For Medicaid Subrogation & Trust Claims (See Below for Estate Recovery)**

**Any beneficiary of Texas Medicaid must check with *both* the following:**

*For hospital, physician services., etc:*  
Texas Medicaid & Healthcare Partnership  
ATTN: Tort Department  
P. O. Box 202948  
Austin, TX 78720-2948  
12365-A Riata Trace Parkway  
Austin, Texas 78727  
Phone: 512-506-7546  
Fax 512-514-4225

*For long term care expenses:*  
Texas Department of Aging  
and Disability Services  
Provider Claims Services (E-400)  
P.O. Box 149081  
Austin, Texas 78714  
Phone 512-438-2219  
Fax 512-438-3400

**NOTE:** Medicaid providers have 95 days from the date of service to submit their claims to this office. Consequently, TMHP is unable to provide an accurate amount until the expiration of the 95 day period.

General types of documents to fax or mail for *Medicare* and/or *Medicaid* information (but call or check website for specific current requirements):

1. A written request from the attorney indicating representation of the Medicare beneficiary, with the beneficiary's name, Medicare (HIC) number (usually the Social Security number, but not always; found on the Medicare card and on "Explanation of Benefits" forms); date of the accident or onset of illness; description of the type of injury or illness
2. A medical authorization signed by the beneficiary (or the beneficiary's legal representative such as agent under power of attorney, guardian, executor, administrator or parent)
3. If the authorization is signed by a legal representative, a copy of the power of attorney, letters testamentary (or of administration) or letters of guardianship

### ***For MERP-Medicaid Estate Recovery Program***

Texas Department of Aging and Disability Services  
Accounts Receivable (MC E-411)  
P. O. Box 149030  
Austin, TX 78714-9030  
General Questions: 800-641-9356  
Fax: 512-438-5344

*Make checks payable to: Texas Department of Aging and Disability Services*

## **Top Ten Things You Need to Know About Medicaid**