

Elder Law Overview and Medicaid Administration

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Nothing contained in this publication is to be considered as the rendering of legal advice for specific cases, and readers are responsible for obtaining such advice from their own legal counsel. This publication is intended for educational and informational purposes only.

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ELDER LAW OVERVIEW AND MEDICAID ADMINISTRATION

This paper provides an overview of what constitutes the practice of elder law, as well as provides a summary of the long-term care Medicaid rules and programs in Texas.

I wish to acknowledge and recognize H. Clyde Farrell of Austin, Texas, for generously allowing his volume of work, Financing Long Term Care in Texas, to be used as the basis of this paper and Kelley M. Bentley, attorney with Wright Abshire, for updating it.

I. ELDER LAW OVERVIEW¹

A. History and Development of Elder Law

The genesis of current day elder law occurred in the mid-1960s when both lawmakers and society in general began to perceive senior citizens as a special class of individuals possessing unique needs. While an argument may be made that the beginning of elder law occurred upon the enactment of the Social Security Act in 1935, many believe that July 30, 1965 actually marks the beginning of this legal specialty when one of the shining pinnacles of the “Great Society” was established via legislation envisioned by President John F. Kennedy and continued into law by then-President Lyndon Baines Johnson.

On July 30, 1965, President Johnson signed into law two separate massive federal acts known as Medicare and Medicaid. President Johnson signed the ground-breaking legislation into law in the Independence, Missouri office of former President Harry S. Truman. The location of the execution of the Medicare and Medicaid Acts was in deference to a speech regarding the need for Medicare and Medicaid made by Truman 20 years earlier and his role toward bringing these two great pieces of legislation to fruition.

Once Medicare and Medicaid were established, a multitude of bureaucratic agencies necessary to administer the new programs blossomed. In addition to these new agencies, a new set of administrative rules regarding appeals and legislation were created. Navigating these new laws introduced the “elder law attorney.” The first elder law attorneys worked primarily for government-funded legal services programs to ensure that the states were fair in the administration of the Medicare and Medicaid programs.

In recent years, the demand for elder law attorneys has greatly increased due to the increase in the elderly population in general. Even though the elderly have always been with us, due to improvements in health care and facilities for the elderly, elderly individuals have a longer life span. Additionally, the parents of the baby-boomer generation, and now the baby-boomers themselves, are reaching retirement age and correspondingly increasing the need for age-related services. This is a need that will continue to increase as more and more baby-boomers reach retirement age. Other factors giving rise to an increasing demand for elder law attorneys are the complications of accessing Medicaid, the high cost of nursing home care, the lack of access to long-term health care and guardianship reform.

In the late 1980s and early 1990s, the need for highly specialized attorneys in the area of elder law resulted in the formation of organizations addressing the emerging field of elder law. In 1988, the National Academy of Elder Law Attorneys (NAELA) was formed and has grown in size to over 4,000 attorneys dedicated to assisting elderly people with an array of legal needs. Following the establishment of NAELA, state organizations aligned with NAELA, such as the

¹ This section is based upon Chapter 1 from Texas Elder Law (Texas Practice Series), published by Thompson West Publishing, 2011.

Texas chapter of NAELA began to develop. Another organization, established in 1991, is the Disability and Elder Law Attorneys Association (DELAA) located in Houston, Texas. Motivated by nationwide guardianship reform, the attorneys who originally established DELAA were seeking greater knowledge and accountability in the assistance of the elderly and disabled.

B. Scope of Elder Law

While the practice of elder law may have been inaugurated by the creation of Medicare and Medicaid, the practice of elder law is the only area of law defined by a population rather than a discipline of law. Therefore, an elder law attorney may address issues including estate planning, guardianship, long-term care insurance, housing, Medicare, Medicaid, private pensions, Social Security retirement, disability, poverty issues, exploitation, neglect and abuse. This is not an exhaustive list. This focus on the elderly results in a higher degree of positive results for the client than would have been achieved had it not been for the intensification of effort made by the attorneys practicing in the area of elder law.

Many elder law practitioners disagree as to what constitutes an elder law practice. Some elder law attorneys practice solely in the area of estate planning, which can include Medicaid planning. Some practitioners focus on guardianship and elder advocacy issues, while others focus on estate planning, trusts (including special needs trusts) and probate. A practice in the field of elder law can be tailored to fit the needs and desires of the attorney, as well as the area in which he or she is servicing. When assessing whether or not it is viable to practice in the area of elder law, an attorney will want to consider the following questions: What level of expertise does the attorney feel comfortable with? What are the needs for services in the attorney's geographical area? What state does the attorney live in and what are the costs associated with long-term nursing home care in that state? What possible areas of law does an elder law practice consist of and what areas will allow the practitioner to develop and maintain an economically viable firm?

II. PLANNING WITH MEDICAID BENEFITS

A. Introduction

This paper summarizes the long-term care Medicaid rules in Texas and discusses planning strategies for clients. This paper presents the law as it is as of this writing. Be warned that everything in this paper is subject to change at any time.

B. Medicaid Long-Term Care Programs in Texas

1. Program Administration and Sources of Law

The Medicaid program is administered in Texas by the Texas Health and Human Services Commission ("HHSC") which has final authority and responsibility for the program. Long-term care ("LTC") Medicaid eligibility determinations were formerly the responsibility of the Department of Human Services ("DHS"). The DHS enabling statute, regulations and agency handbook (the Medicaid for the Elderly and People with Disabilities Eligibility Handbook or "MEPD") are important sources of law and policy for the program. Effective September 1, 2004, however, DHS ceased operations pursuant to the reorganization of health and human services as mandated by House Bill ("HB") 2292 enacted by the 78th Texas Legislature in June 2003. Beginning September 1, 2004, responsibility for LTC Medicaid eligibility policy development and LTC Medicaid eligibility determinations was transferred to HHSC. Consequently, the term "HHSC" is henceforth substituted for "DHS" wherever appropriate in this paper.

2. Focus of this Paper on Long-Term Care

The focus of this paper is on Medicaid long-term care benefits. The term “Medicaid” also applies to general medical insurance for recipients of Supplemental Security Income (“SSI”) and Temporary Assistance to Needy Families (“TANF,” formerly Aid to Families With Dependent Children (“AFDC”)). One reason the regulations and handbook provisions are so confusing is that they seem to refer to all types of Medicaid (which they call “Medical Assistance”), but critical parts of them do not apply to the long-term care programs. Nursing home care is not the only long-term care benefit available through the Medicaid program. Also available, in certain cases, is care at home and in assisted living facilities or personal care homes. These benefits are not as well known and are often underutilized. These community programs, as well as nursing home Medicaid, are described below in more detail.

3. Notes on Program Terminology

The statutes and regulations use certain terms that have a different meaning within the context of Medicaid planning. For example the term “Medicaid” is referred to by the public and press to encompass the entire Medicaid program. However, in the statutes and regulations, “Medicaid” is always referred to as the “Medical Assistance Program.” There are at least 42 individual “Medicaid” programs in Texas.

Also, the Texas Medicaid regulations and handbook provisions refer to persons eligible or applying for Medicaid benefits as “clients.” That terminology will be used generally in this paper, without an intention to imply that the attorney will necessarily be representing the applicant or beneficiary in every case. Obviously, too, such persons are not “clients” of HHSC in any fiduciary sense, but on the contrary are likely to take opposing positions regarding legal issues.

4. Long-term Care Medicaid Programs

a. Nursing Home Medicaid (HHSC Terminology: SSI Related MAO)

Nursing home Medicaid covers most medical and support needs, including any prescription medications, of a person who needs nursing facility care. A significant exception is dental care (which would be considered an “incurred medical expense”). Incurred medical expenses can be paid out of the resident's income, most of which ordinarily goes to pay nursing facility costs. The result is that the Medicaid program pays the majority share of the cost of nursing facility care as long as payments are being made for the non-covered services.

In order to qualify for nursing home Medicaid an individual must meet certain nationality/residence requirements, as well as be below defined income and resource limits. Also, an individual in the nursing home must have a medical necessity for nursing home care. It is important to note that there are different income/resource requirements for single individuals versus married couples. The requirements for qualifying for nursing home Medicaid are discussed later in the paper.

b. Community-Based Alternatives Program (“CBA”)

The Community-Based Alternatives Program (“CBA”) is one of the Medicaid waiver programs funded under 42 U.S.C. §1396n(c) It is available to persons age 21 and older with a medical need for nursing home care who elect home and community-based services as a cost-effective alternative to nursing home placement. As with all Medicaid waiver programs, there is a lengthy “interest” (or waiting) list. Services available under this program include the following: nursing services, personal assistance services, adaptive aids and medical supplies, assisted living, minor home modifications, and respite care.

c. Assisted Living

In Texas, Medicaid reimbursement for assisted living services is available only through the Community-Based Alternatives Program (see Section I.B.4.b.). The community care program has limited Title XX (non-Medicaid, block-grant) funds available for residential care. The LTC Medicaid program does not pay for room and board expenses incurred in an assisted living facility.

d. Home Health Care

All Medicaid recipients in Texas are entitled to professional home health services for up to 60 days with a current plan of care authorized by a physician. Services provided include skilled nurse services, home health aide services, physical/occupational therapy, durable medical equipment, and expendable medical supplies.

e. Community-Based Treatment Services

Texas has a number of Medicaid waiver programs that provide community-based treatment services as a cost-effective alternative to institutional placement. These programs are funded under 42 U.S.C. §1396n(c). Waiver programs include the following: (1) Community Living Assistance and Support Services (“CLASS”) for persons of any age with developmental disabilities; (2) Deaf, Blind, Multiple Disability Waiver (“DB/MD”) for persons who, in addition to blindness and deafness, have one or more disabling conditions; (3) Home and Community-Based Services (“HCS”) for persons with mental retardation; ; (4) Medically Dependent Children Program (“MDCP”) for medically fragile children under age 21; (5) the Community-Based Alternatives (“CBA”) program already discussed under Section I.B.5.; (6) the Consolidated Waiver Program (“CWP”), which operates only in Bexar County and combines the services of five waiver programs; (7) the Texas Home Living Waiver (“TxHML”), for persons with mental retardation living in the community with their families; (8) the Integrated Care Management Program (“ICM”), for disabled persons age 65 and older; and (9) the STAR + PLUS waiver, a managed care program that integrates acute and long-term care (“LTC”) services. Most of these waiver programs have “interest” (or waiting) lists, often of considerable length.

f. Hospital, Outpatient and Physician Services

Texas Medicaid recipients are entitled to 30 days of inpatient hospital care per spell of illness. The 30-day period may be intermittent or consecutive. After the 30 days of inpatient hospital care are exhausted, reimbursement for additional care is not considered until the patient has been out of an acute care facility for 60 consecutive days.

Outpatient hospital services available to Medicaid recipients include diagnostic, therapeutic, and rehabilitative services under the direction of a physician which are provided in a licensed hospital setting. There is no limit on the number of outpatient visits, but the services must be itemized by date of service. For multiple emergency room visits in one day, the time of day for each visit must be specified.

Physician services available through Medicaid include reasonable and medically necessary services ordered by and performed by a physician or under a physician’s supervision. These services may be provided in either an inpatient or outpatient setting.

UPDATE: Currently, pursuant to John Stockton, policy specialist with HHSC, there are no upcoming changes based on the healthcare reform legislation passed by Congress.

5. Medicaid Buy-In For Children

Beginning on January 1, 2011, there is a new Medicaid Buy-In program for children. The program is for children with disabilities who are not eligible for SSI. In order to be eligible to receive benefits from the program, the child must either be a citizen of the United States or a qualified permanent resident, have a disability (pursuant to the SSI/SSDI definition, although an SSI application is not required), be under the age of 19, unmarried, and not reside in a public institution, including a jail, prison or other correctional facility. Additionally, the child must apply for all benefits that the child may be entitled, and any parent or step-parent living in the home with the child must enroll in his or her employer-sponsored health insurance plan, if available, and the child must be able to contribute at least 50% of the cost for the program.

There is no asset limitation, however, the child and the child's family may not have income exceeding 150% of the federal poverty level, illustrated as follows:

Family Size	Monthly Income
1	\$1,361
2	\$1,839
3	\$2,316
4	\$2,794
5	\$2,794
6	\$3,271
7	\$3,749
8	\$4,226
Each Add's	\$4,704

The amount of income includes the income of the child applying for benefits, the child's parents (including step-parents) living in the household, and the income of the child's ineligible, unmarried siblings living in the household. However, the siblings income does not count if the sibling is over 18, unless the child is under the age of 22 and enrolled in school, college or job training; Earned and unearned income is defined according to the SSI rules. The total income is then multiplied by 2, plus \$85. The \$85 is then subtracted from the total and then divided by 2.

The benefits received in the program are the same as regular Medicaid benefits, however, the child generally must pay a premium for the insurance. The premium is calculated with the following formula: 5% of the family income, not exceeding 200% of the federal poverty level, plus 7.5% of the family income not exceeding 300% of the family poverty level, minus, the amount paid, if any, for employer-provided health insurance for the family. Premiums may be waived in certain circumstances.

6. Medicaid For Non-Elderly Individuals

Pursuant to the Health Care Reform Act, all states are required by January 1, 2014 to provide Medicaid coverage to individuals under the age of 65 whose incomes are below 133% of the Federal Poverty Level. There is no asset limitation for this program.

7. The Pickle Amendment Update

The Pickle Amendment allows recipients of SSI/Medicaid who also receive SSDI benefits to retain their Medicaid eligibility if such recipients receive a cost of living adjustment (COLA) on the SSDI amount which would push them over the SSI income limit (\$674 in 2011), thereby disqualifying the individual from SSI. Pickle disregards the increase in SSDI. However, in 2011 there is no COLA for SSDI recipients so individuals whose SSDI amount pushes them over the SSI income limit will be denied Medicaid benefits automatically in 2011. *MEPD §A-2330*.

C. Medicare and Medigap Rules

Any discussion of LTC financing would be incomplete without providing information on the federal Medicare program and its relationship to Medigap insurance. Medigap insurance, also known as Medicare supplement insurance, is designed to supplement benefits provided through Medicare by paying some of the amounts that Medicare does not pay. For example, Medicare has certain premiums, deductibles, and co-insurance costs for covered services that must be paid by the enrollee. For skilled nursing facility (“SNF”) care, Medicare pays 100% of the costs of care for the first 20 days after a hospital confinement. From day 21 through day 100, the enrollee must pay the co-insurance, which is \$133.50 in 2011, and varies depending on the level of care. Moreover, there are certain services that Medicare does not pay at all, such as more than 100 days of SNF care during a benefit period. Some or all of these costs may be assumed by Medigap insurance.

An advantage of most Medigap policies is that the choice of provider is left to the insured, and they pay the same supplemental benefits regardless of which provider is selected. However, Medicare SELECT, a special type of Medigap insurance, often offered at lower cost, does require the insured to use a specific network of providers in order to receive full benefits.

Medigap insurance has an open enrollment period, during which companies must allow potential enrollees free choice of the plans they offer and cannot refuse coverage. The open enrollment is six months from enrollment in Medicare Part B. During this open enrollment period, one may elect coverage, cancel the policy, and then purchase new coverage, provided the new policy is purchased within six months of Part B enrollment. The enrollee may cancel his/her Medigap policy for a full refund within 30 days of receiving it. It is wise to review the policy carefully. A policy which is returned for cancellation should be sent by certified mail with return receipt requested. The receipt serves as proof that the policy was indeed returned within the required 30-day limit.

It is important to remember that Medigap insurance is not for everyone. Persons who already have health insurance through a pension plan, who are enrolled in Medicare Advantage, who are retired military enrolled in TriCare for Life or who receive Qualified Medicare Beneficiary (“QMB”) coverage through the state Medicaid program probably do not need Medigap insurance.

D. Medicaid vs. Long-Term Care (“LTC”) Insurance

What is the relationship between Medicaid and LTC insurance, and why do some people choose one over the other? LTC insurance is a special type of private health plan that insures against the need for LTC services. Medicaid is a publicly-funded medical assistance program that helps pay LTC costs for persons who meet the eligibility criteria. Wealthy individuals who will never qualify for Medicaid often opt for LTC insurance. But the two are not mutually exclusive. Some people purchase LTC insurance, but find that they must rely on Medicaid to pay part of the shortfall or to help with LTC costs after the private insurance is exhausted. Indeed, LTC insurance coverage has no bearing on an individual's Medicaid eligibility, but is simply considered a third-party resource ("TPR"). This means that the LTC insurance must either be used before Medicaid (the "cost-avoidance" method) or used to reimburse the Medicaid program for services paid by Medicaid but covered under the private LTC policy (the "pay and chase" method). But the existence of a LTC insurance policy does not in and of itself disqualify an individual for Medicaid.

There are a variety of LTC insurance plans available, offering a wide range of options. Some plans only help pay for nursing home care; others help with assisted living and/or in-home services. LTC insurance was originally hailed as a wonderful solution to financing LTC, but few seniors are covered by LTC insurance. There are a number of reasons for this. Most people are convinced that they will never need LTC, until they are actually confronted with that need. Surprisingly, this is even true of the children of Alzheimer's patients, who know that the disease may be hereditary. When the need for LTC does arise, the individual either cannot qualify at all owing to health issues, or the premiums are so high as to be cost-prohibitive. Also, many people believe, mistakenly, that Medicare will cover their LTC needs. But in reality, Medicare pays only a minuscule portion of LTC costs and for a very short period of time. For these reasons, many people rely on Medicaid to assist with their LTC needs.

The rule in purchasing LTC insurance is that one should be insured only for the amount of his/her monthly income shortfall. For example, if the average monthly cost for private-pay nursing home care is \$4,500, and the amount of the individual's available income is \$2,000, the individual should be insured for \$2,500 per month (or \$30,000 per year). It is important to note that LTC insurance payments are not income to the insured for income tax purposes.

One of the problems with the purchase of LTC insurance is that people wait until they are older to purchase a policy. The primary consideration with regard to age and health factors is that one's health should not already be in an accelerated state of decline before deciding to purchase coverage. This is especially true with regard to dementia. Once the onset of dementia occurs, it is virtually impossible to obtain LTC insurance.

There is a joint effort between private insurance companies and the state to encourage individuals to purchase long-term care insurance. This new agreement is called the Long-Term Care Partnership. If an individual purchases a qualified long-term care insurance plan then when determining Medicaid eligibility an amount equal to the value of benefits can be disregarded from countable resources. Note: the individual does not automatically become eligible for Medicaid benefits and must meet all Medicaid eligibility requirements.

UPDATE: In order to qualify for the increase limit of countable resources, the LTC policy must be approved by the Long-Term Care Partnership. The amount of assets to be excluded is equal to the amount of benefits paid under the policy. Also, an individual can apply for Medicaid benefits while the policy is still paying, if necessary. During that time, payments by the LTC policy are not counted as income to the Medicaid recipient.

E. Why Become Eligible for Medicaid?

This section will highlight the reasons that for most Texans who need long-term care, avoiding Medicaid is not possible, without sacrificing more basic values.

1. Unavoidable Impoverishment

Ninety percent of Texas nursing home residents exhaust their resources and reach the poverty level after only 26 weeks of care; seventy-eight percent of all Texas nursing home residents (including those who have not yet exhausted their resources) are qualified for Medicaid. See AARP brochure “Campaign for Nursing Home Reform Now,” September 30, 1995, citing Texas Department of Human Services as source. For most people, the time they can postpone Medicaid eligibility by paying privately is at best very short; the cost is their entire savings. Especially when there is a spouse at home (sometimes with a long retirement to plan for), accelerating Medicaid eligibility can appear as a life or death imperative.

2. Protection of the “Community Spouse”

As will be demonstrated herein, in some cases, the spouse at home (the “community spouse”) can keep all of the couple's assets and income; and when income is relatively low in value, that spouse can keep all income as well. There is a public policy benefit to ensure that the spouse living in the community (i.e. the “healthy spouse”) has the resources and income available to be self-sufficient and able to live independently. The increased standard of living that may be available to the disabled spouse on a private pay basis may be purchased at unacceptable cost to the future well being of the other spouse, if Medicaid benefits are foregone.

F. Ethical Issues In Medicaid Planning

The Medicaid planner should become aware of the following relevant ethical issues often found in Medicaid planning scenarios.

1. Identify the Client

The individual in need of Medicaid benefits rarely is the person that contacts an elder law attorney for assistance. Usually, the spouse, children or other family and friends act on behalf of the individuals under a durable power of attorney or as guardian. It is important to recognize that conflicts of interest may exist in representing more than one family member in a Medicaid planning case. It is important to make sure proper waivers are executed in order to resolve those conflicts. See *Disciplinary Rule 1.06* for the elements of the disclosure of a conflict of interest that must be made if joint representation of spouses or other persons is undertaken.

Initial correspondence, contract or intake forms should include the identification of the client(s) in a written attorney client agreement. The following situations, for example, cannot be ethically managed until this has been done:

- A child wants to tell you a “secret” about a parent, the veracity of which is critical to the parent's decision.
- The younger generation argues strongly for Medicaid qualification, while the older person or persons have reservations.
- The disabled spouse expresses reservations about transferring to the other spouse title to all their countable property (which is required for continuing eligibility under the spousal impoverishment provisions, as discussed herein).
- One spouse discloses to you “in private” that he or she is considering filing for divorce, for non- Medicaid reasons.

Note that litigation is an exception to the rule that permits joint representation with adequate disclosure. Therefore, you cannot represent both spouses in a petition for a Qualified Domestic Relations Order (“QDRO”) to divert income to the community spouse, even though both spouses clearly agree that it is needed.

2. Avoiding Fraud

It is unethical to assist a client in committing fraud. *Disciplinary Rules 3.04, 3.10, and 4.01, reprinted in Tex. Gov’t Code Ann., tit. 2, subtit. G app.* This sounds obvious, but it can be difficult in application where the fraud pertains to the client’s intent. For example, transfer of the Medicaid applicant’s property must be reported to Medicaid and may be subject to transfer of asset penalties. Any attempt to circumvent this reporting is considered fraud. This is a tougher standard to meet than the intent requirements in the federal tax laws, which ordinarily do not penalize a transaction merely because tax avoidance was one motive for it.

It is important to remember that it is unethical to assist a client in failing to disclose a material fact. *Disciplinary Rules 3.04(a), 3.10, and 4.01(b), reprinted in Tex. Gov’t Code Ann., tit. 2, subtit. G app.* The fact that a transfer was in cash or consisted of tangible, untitled property and cannot be traced does not mean it does not have to be disclosed. The same applies to property owned by the client that cannot be traced in any legal records. Contrary to some clients’ beliefs and values, these disclosures are required in the Medicaid application and in the oral interview with the HHSC caseworker.

3. Diligent Representation

The client’s philosophy regarding public benefits, not the attorney’s, should govern. “There is no question that the use of ... Medicaid planning by competent persons is permissible and that proper planning benefits their estates.” *Matter of Klapper, NYLJ, Aug. 9, 1994, Sup. Ct., Kings Co., New York.* Therefore, attorneys should beware of advising their client that “there’s nothing you can do” when in reality a myriad of legal planning opportunities exists to preserve assets. Tax lawyers do not exhort their clients to decline tax benefits they (the lawyers) do not think are in the public interest. Public benefits lawyers cannot behave differently. To do so, or to advise incorrectly that planning would not be effective, would be inconsistent with the disciplinary rules and invite litigation for negligence, breach of fiduciary duty or malpractice. *In re Guardianship of Connor, 525 N.E. 2d 214 (Ill. App. 1988).* For example, attorneys should be aware that, if they simply advise their client to “just spend down” his assets because they have personal or political views which oppose Medicaid planning and the legal preservation of assets, their “advice” may be the basis for such claims against the attorney. At the same time, as argued above, it is not appropriate for an attorney to insist that a client apply for a benefit he or she does not want for strictly philosophical reasons, after full disclosure by the attorney of the client’s rights.

Never assume that Medicaid planning is a “one shoe fits all” practice. A “one shoe fits all” mentality applied to Medicaid planning results in a disservice to the client. Family dynamics and relationships play a huge importance in this arena. Medicaid planning is an area of the law that provides opportunity for creative legal thinking.

In general, the attorney should bring to the client’s attention the full range of relevant considerations. Fordham University’s 1993 Conference on Ethical Issues in Representing Older Clients resulted in the following recommendation for practice guidelines regarding “divestment of assets” of a client for the purpose of achieving Medicaid eligibility:

In representing clients where divestment of assets is or may be considered, the attorney should:

- Counsel clients about the full range of long term care issues, options, consequences, and costs relevant to the client’s circumstances;

- Endeavor to preserve and promote dignity, self determination, and quality of life of the elderly client in the face of competing interests and difficult alternatives; and
- Strive to ascertain the client's fundamental values in order to be responsive to the goals and objectives of the client. *Proceedings of the Conference on Ethical Issues in Representing Older Clients*, 62 *FORDHAM LAW REV.* 1063 (1994).

This approach is consistent with Rule 2.1 of the Model Rules of Professional Conduct:

Lawyer as Advisor: In representing a client, a lawyer shall exercise independent judgment and render candid advice. In rendering advice, a lawyer may refer not only to law but to other considerations such as moral, economic, social and political factors, that may be relevant to the client's situation.

Likewise, the Ethical Considerations speak to the breadth of advice required and permitted:

Ethical Consideration 7 8: A lawyer should exert his best efforts to insure that decisions of his client are made only after the client has been informed of relevant considerations. A lawyer ought to initiate this decision making process if the client does not do so. Advice of the lawyer to his client need not be confined to purely legal considerations...in assisting his client to reach a proper decision, it is often desirable for a lawyer to point out those factors which may lead to a decision that is morally just as well as legally permissible...In the final analysis, however,...the decision whether to forego legally available objectives or methods because of non-legal factors is ultimately for the client and not for himself.

One court in another jurisdiction made this statement:

The complexities of the law...should never be allowed to blind us to the essential proposition that a man or a woman should normally have the absolute right to do anything that he or she wants to do with his or her assets, which includes the right to give those assets away to someone else for any reason or for no reason...We would only amplify this by saying that no agency of the government has any right to complain about the fact that middle class people confronted with desperate circumstances choose voluntarily to inflict poverty upon themselves when it is the government itself which has established the rule that poverty is a prerequisite to the receipt of government assistance in the defraying of the costs of ruinously expensive, but absolutely essential, medical treatment. *In the Matter of Shah*, 711 *N.Y.S. 2d* 148 (2000).

4. Competent Representation

Medicaid law has been accurately characterized as “an aggravated assault on the English language.” That description was directed only at the basic federal statute and regulations, without consideration of the often inconsistent state laws and practices or the constantly changing (and often unpublished) HHSC and Centers for Medicare and Medicaid Services (“CMS”) interpretations. Competent practice in this area requires, at a minimum, the following:

- Access to and general familiarity with all sources of law in the area;
- Familiarity with all planning techniques; and
- Keeping up to date on changes in all the sources of law and currently practiced techniques.

5. Client Capacity and Gifting

A client who lacks legal capacity cannot make a gift. It would be unethical for an attorney to assist in such a transaction. Under Texas law, an agent under a durable power of attorney generally cannot make gifts of the principal's assets without specific gifting powers. *Gouldy v. Metcalf*, 12 S.W. 830 (Tex. 1889). Even if HHSC did not question such a gift, it would leave the agent – and the attorney – wide open to charges of exploitation by family members or other observers.

To assess capacity, use a standardized form. A form provides a disciplined way of recording observations on which you base your judgment. If the transaction is later challenged, you will have a written record of the basis for your judgment.

6. Medicaid Planning by Non-attorneys

Attorneys should be aware of the illegality of Medicaid planning by non-attorneys. Section 12.001, Prohibited Activities, of the Texas Human Resources Code states:

- (a) A person who is not licensed to practice law in Texas commits an offense if the person charges a fee for representing or aiding an applicant or recipient in procuring assistance from the department.
- (b) A person commits an offense if the person advertises, holds himself or herself out for, or solicits the procurement of assistance from the department.
- (c) An offense under this section is a Class A misdemeanor. *Tex. Hum. Res. Code §12.001*.

Furthermore, the unauthorized practice of law is a Class A misdemeanor which is punishable by jail time and/or fine. *See Tex. Penal Code §12.21*.

a. Typical Non-Attorney Operation

A typical operation will include non-attorneys who market themselves as financial planners (or annuity salesmen) and those willing to assist and/or represent persons in making a family member qualified for nursing home Medicaid. The operators attempt to hide their illegal activities by regularly claiming that they “work with attorneys.” Actually, a more appropriate characterization in many of these cases is that they have attorneys who work for them. Often a non-attorney either operates individually as a consultant or has a company with up to as many as 10 employees.

The violator maintains referral sources from social workers, nursing home administrators and hospital discharge planners. Some nursing home administrators actually favor some of these operators because the operator in many cases will sell annuities to the community spouse to solve his or her resource problem, which may allow the institutionalized spouse to obtain eligibility in a shorter time period than going through the more time consuming spousal impoverishment process. The operator steers the community spouse, regardless of whether or not the couple's income is low enough to sufficiently save all the resources, through a spousal impoverishment adjustment, to purchase an irrevocable annuity, albeit to the detriment of the client. This works to the detriment of the client because in many cases the assets could have been preserved in their original investment form as opposed to locking the assets into a historically low yielding form of investment, such as an annuity. By steering the client into the purchase of an annuity, the operator not only charges a fee for Medicaid planning advice, but also often receives an additional fee for the sale of the annuity. Furthermore, the salesperson often is not even licensed to sell the annuities in this state. However, for annuities purchased prior to February 8, 2006, the date of enactment of the federal Deficit Reduction Act of 2005 (“DRA 2005”), HHSC does require that the annuity be issued by a life insurance company licensed and approved to do business in the State of Texas. *1 T.A.C. §358.442(g)(1)(E)*.

b. Unauthorized Practice of Law Example

The following illustrates an Unauthorized Practice of Law (“UPL”) case involving Medicaid planning by non-attorneys. In this case, a non-attorney group assisted and represented clients in obtaining Medicaid benefits for a fee. In the course of this activity, non-attorney assistants reviewed wills and advised the clients to make changes, collected the information for those changes along with the information necessary to prepare Miller Trusts and durable powers of attorney for property. The company then faxed the information to the attorney who never consulted or met with the clients and who was also the attorney for the company. The attorney potentially is subject to disciplinary proceedings for representing a client when he has a conflict, case running or barratry, and fee splitting. This attorney also faces suit for aiding and abetting the unauthorized practice of law by the UPL.

Two cases in Houston revealed two separate non-attorney violators who had represented two different families both involving the use of Miller Trusts. In both cases, non-attorneys’ mishandling of the cases cost the two families \$10,000 and \$12,000, respectively.

c. Referrals

The practitioner should consider making the following referrals depending on the circumstances involved:

- The Unauthorized Practice of Law: The attorney may be the subject of a UPL investigation for aiding and abetting the unauthorized practice of law and the non-attorney for practicing law without a license.
- The Texas Attorney General’s Office: This agency may be authorized to investigate violations of THRC §12.001(a). An assistant attorney with the Texas Attorney General’s office, Consumer Division in Houston, has stated that he has reviewed THRC §12.001(a) and agrees that the practice of non-attorneys assisting or representing persons in obtaining Medicaid benefits from HHSC for a fee is illegal.
- The District Attorney’s Office: This law enforcement agency should be contacted since the subject activity is a Class A misdemeanor. Although they cannot speak for everyone, the authors contacted the Harris County District Attorney’s Special Crimes Division for comment on the activities of non-attorneys who violate THRC §12.001(a). A senior Assistant District Attorney in the Houston office has indicated that her office will follow the progress of any actions taken by the courts as a result of litigation filed by the UPL Committee. She stated that once respondents have been subjected to court injunctions due to UPL violations and the respondent thereafter continues to follow the same pattern of conduct, then her office will review each case referred to them for filing criminal cases. She additionally recommended that interested attorneys make every effort to educate the public about the statute that makes Medicaid planning by non-attorneys a Class A misdemeanor punishable by jail time and/or fine.
- The Texas Department of Insurance: The non-attorney may be criminally prosecuted by this department if the violator is an unlicensed annuity salesperson and causes financial damage to the consumer or if the annuity sale falls under the definition of “churning” which involves advising a consumer to sell one annuity and purchase another when there is no meaningful benefit.
- The State Bar of Texas Grievance Committee: If there is a disciplinary violation by an attorney involved, then a referral should be made to the local grievance committee. The Texas Disciplinary Rules of Professional Conduct Rule 8.03 sets the rules governing the reporting of professional misconduct. It states, in part, that a lawyer having knowledge that another lawyer has committed a violation of applicable rules of professional conduct that raises a substantial question as to that lawyer’s honesty, trustworthiness, or fitness as a lawyer in other respects, shall inform the appropriate disciplinary authority. *Tex. Disciplinary R. Prof. Conduct 8.03, reprinted in Tex. Gov’t Code Ann., tit. 2, submit. G app.* The attorney may receive disciplinary action in a grievance proceeding for case running, conflict of interest, and fee splitting.

- Texas Board of Legal Specialization: If the attorney is board certified, any grievance filed against him will be reported to the Texas Board of Legal Specialization, which may ultimately affect the attorney's board certification.
- Better Business Bureau: If the company belongs to the BBB then a referral should be made, and they may face termination as a member. Many elderly people rely upon the credibility of this private bureau and of a member's standing in such. Additionally, the BBB has a mediation and arbitration system that may help the aggrieved party receive a settlement for losses incurred.
- Civil Claim: If a financial loss results from the activity, the practitioner should consider filing suit or referring the case to a civil litigator.

G. Health Care Reform

On March 23, 2010, Congress enacted the Patient Protection and Affordable Care Act which overhauled the existing health care system. Of big concern is the effect that the Act will have on existing Medicaid regulations. The Act provides that for the period beginning on the date of enactment (March 23, 2010) through the date in which the Act is fully operational (fall of 2014), any state is not permitted to change its Medicaid policy to make it more restrictive than the policy which is in effect as of March 23, 2010. *42 U.S.C. §1396(a)(74)(gg)*. However, states still have the power to modify its Medicaid requirements to bring states into compliance with federal law, even if the change is more restrictive.

This "Maintenance of Effort," or the general requirement to maintain eligibility standards, is a political tool used by politicians and HHSC to reduce the Medicaid budget and to assist state governments in gaining control over federal Medicaid funds. It is important to note that the Maintenance of Effort provisions do not limit the ability of the state from reducing or eliminating option benefit programs, such as benefits for Community Care, dental and hearing aids.

This Maintenance of Effort is important to Medicaid attorneys when combating HHSC's interpretation of existing Medicaid rules, or HHSC's passage of new rules, that are more restrictive than existing Medicaid policy. As of the date of this paper, such rules and interpretations have not yet occurred.

H. The Federal High Risk Insurance Pool

Part of the Patient Protection and Affordable Care Act created a federal high risk insurance pool that is available in all fifty states. The federal high risk pool provides immediate health insurance coverage to citizens or permanent residents, who have not been covered under an insurance program, including Medicaid, for the previous six months, and have a pre-existing condition or has been denied coverage through a private health insurance company. Each state has the option of managing its own pool or having the federal government administer the program (Texas has elected to have the federal government administer the pool).

Enrollees in the federal high risk pool must pay premiums, deductibles and co-payments for health care services. The premiums vary by age, but generally range from \$174 to \$578 per month. Deductibles range from \$1,000 to \$3,000 each year. Co-payments for doctors visits are \$25, and the annual maximum out-of-pocket expenses are \$5,950 per year (for in-network expenses).

The federal high risk insurance pool differs from the Texas Health Insurance Risk Pool in several key areas. Unlike the Texas Risk Pool, the federal pool does not have a 12-month waiting period for benefits. Moreover, the premiums for the federal risk pool are substantially lower than the Texas Risk Pool.

The federal risk pool is a useful tool in public benefits planning in that it can be used to provide insurance for individuals on SSDI who are waiting for their Medicare benefits to begin and need immediate health insurance.

I. Texas Medicaid Budget Cuts

As of the time of this paper, HB 1, currently passed by the Texas House of Representatives, proposed to cut Medicaid benefits in Texas by \$9.3 billion (or 26%), with the biggest cut being felt by nursing homes. The Bill proposes to cut nursing home rates by 33% over the next two years.

The passage of the Bill provides draconian budget cuts to health and human services, including the following:

- 42% cut to the Texas Home Living Medicaid Waiver program;
- 26% cut to the CLASS program;
- 29% cut to the Medicaid Home and Community based Waiver programs;
- 29% cut to the Deaf, Blind, Multiple Disabilities program
- 28% cut to the Medically Dependent Children Program
- 37% cut to the Community Based Alternative (CBA) program.

The Bill also proposed to amend the DADS rider regarding the closure of one State Supported Living Center, as well for provisions performing a study regarding the feasibility of combining campus and buildings currently occupied by SSLC into the surrounding community.

However, there is good news. The House fully restored funding to the DARS Safety Net for persons with intellectual and developmental disabilities. This restoration is based on real-life stories from people benefitting from the program. It is important to get involved and contact your state representatives!!

The Senate is still working on their version of the budget. Some key provisions to Senate's budget are:

- Increase in the DADS fully-funded caseload. The current funding is at 63%. This funding would increase entitlement and Waiver programs;
- Attempt to find \$4-\$5 billion in funds to restore to the Medicaid budget. The Senate assumes that more federal funds will be available than the House budget;
- Several Medicaid cost-containment provisions, including repeal of the HCS Waiver program unannounced on-site reviews for individuals receiving foster and companion care, reducing the HCS supported home rate to match the CLASS waiver program attendant rate, reducing the amount to the 90th percentile for all non-Waiver non-essential services.

Again, the provisions to Senate bill are not verified and hearings are not expected to resume until after April 18th.

III. SUMMARY OF MEDICAID ELIGIBILITY REQUIREMENTS

A. Nationality and Residence

1. Nationality

The applicant must be (a) a U.S. citizen or (b) a qualified alien. Medicaid coverage is mandated for eligible qualified aliens who entered the United States ("U.S.") on or after August 22, 1996, and who are either honorably discharged veterans or who are on active duty in the U.S. military, or who are refugees/asylees (during the first 5 years after entry), or who have had their deportation withheld (for 5 years from the grant of withholding). *1 T.A.C. §358.203; 8 U.S.C.A. § 1613*. Other qualified aliens who entered the U.S. on or after August 22, 1996, are ineligible for regular Medicaid for

5 years after entering the U.S. , but may be eligible for coverage of an emergency medical condition. *1 T.A.C. §358.300(c)(1)*.

2. Residence

The applicant must be a resident of Texas. That is, he or she must have established residence in Texas and intends to remain here. *1 T.A.C. §358.207*. No period of residency within Texas is required. Travel out of Texas does not terminate residency here, if there is an intent to return.

B. Age, Blindness or Disability

An applicant for nursing home care must be either age 65 or over, blind or disabled (under the Social Security Disability definition). *1 T.A.C. §358.211*. In practice, this requirement is never an issue, because the “medical necessity” requirement (discussed next below) is more stringent than the “disability” requirement.

C. Medical Necessity For Nursing Home Care

For nursing home and CBA programs an applicant must meet the “medical necessity” requirement both for nursing home Medicaid and for CBA. *40 T.A.C. §19.2403*. The initial assessment is made on Form 3652 A (the CARE form) upon admission, and a follow up is done annually in most cases. The assessment is usually done by the Director of Nurses at the nursing home and by a nurse and physician employed by the insurance company contracted by HHSC (currently ACS State Healthcare, L.L.C., a subsidiary of Affiliated Computer Systems (“ACS”) of Dallas.). The decision is appealable through the “fair hearing” process discussed herein.

Essentially, “medical necessity” requires a medical disorder or disease requiring attention by registered or licensed vocational nurses on a regular basis. Inability to attend to “activities of daily living,” such as bathing, grooming, dressing and eating, is not sufficient. *40 T.A.C. §19.2409*.

D. Income Limits

1. Income Limitation for an Unmarried Person

In calendar year 2011, the “income cap” in Texas is \$2,022 in “countable” income of the Medicaid applicant. *See Section III* herein regarding what income is countable and attributed to the applicant. This amount changes on January 1 of every year. However, the amount has been \$2,022 for the past several years due to a lack of a COLA increase for Social Security recipients.

2. Income Limitation for a Married Person with an Ineligible Spouse

The “income cap” for a married person with an ineligible spouse is the same as for a single person. The critical question is how the income is apportioned between the spouses. See the discussion below of the “name on the check rule.”

3. Income Limitation for Married Couple, Both of Whom Apply for Medicaid

If both spouses reside in the same nursing home, the incomes are combined, and the income cap for the combined income is twice the cap for an individual (currently \$4,044). *MEPD Appendix XII*. However, if the combined incomes

exceed this cap, one spouse can still be eligible as long as his or her income alone is within the individual cap (currently \$2,022); or they can use a “Qualifying Income Trust.” *42 U.S.C.A. §1396p(d)(4)(B)*.

E. Resources (Assets)

1. Resource Limitation for an Unmarried Applicant

The resource limit for countable assets of an unmarried Medicaid applicant is \$2,000. This amount has remained the same since 1989. See the discussion of “resources” herein for how to determine what resources are “countable.” *MEPD § F-1300*.

2. Resource Limitation for a Married Couple, with an Ineligible Spouse

The resource limit for a married couple, with one spouse ineligible for benefits is half the couple’s combined resources, subject to a minimum protected resource amount (“PRA”) of \$21,912 and a maximum of \$109,560. *MEPD Appendix XIII*. These amounts may be increased in certain circumstances as discussed below. The minimum and maximum amounts change every January 1. Note, these amount have not increased for the past two years.

3. Resource Limitation for a Married Couple, Both of Whom Apply for Medicaid

The resource limit for a married couple who are both in the nursing home and applying for Medicaid is \$3,000. The resources of both spouses are counted toward this limit. *MEPD § F-1300*.

4. Resource Limitation for a Married Couple, Both of Whom Live in a Nursing Facility, if Only One Applies for Medicaid

If both of the spouses reside in the nursing home and only one is applying for Medicaid, the resource limit for the spouse applying for Medicaid is \$2,000. Resources of the non-applicant spouse are not deemed to the applicant spouse because they are not regarded as living in the same “household.” *MEPD § F-1300*. Therefore, the non-applicant spouse can have unlimited resources.

F. Medicaid Facility, Medicaid Bed

To be eligible for Medicaid, a Texas resident must be in a Medicaid certified facility, and in a Medicaid or dually-certified (Medicare and Medicaid) bed.

IV. INCOME AND RESOURCE REQUIREMENTS

A. Income Definitions and Exclusions

1. Income Definition

Income is receipt of any property or service a client can apply, either directly or by sale or conversion, to meet basic needs for food or shelter. Countable income is the amount of a client’s income after all exemptions and exclusions.” *MEPD E-1200*. This definition of income is broader than the income tax definition. For example, income for Medicaid purposes includes gifts and personal injury awards, whereas such items are not considered income for income tax purposes. *26 U.S.C.A. §102*.

Generally, when food or shelter are provided to the client by someone else, they are counted as income under complex rules developed in the SSI program for counting “in kind support and maintenance.” *MEPD E-8000*. However, “in kind support and maintenance” is not counted as income by the nursing home Medicaid program or by the Medicaid “waiver programs” (specifically, CBA, Community Living Assistance and Support Services, Home and Community Based Services, Medically Dependent Children’s Program, etc.). *MEPD E-8000*.

Payments received on a negotiable note (regardless of whether it is secured) are counted as “income” only to the extent of the amount of interest paid. However, effective July 1, 2007, interest payments from a promissory note which is a countable asset are not counted in the income eligibility determination, but are counted in the applied income calculation. The full amount of all payments on a non-negotiable note, including both principal and interest, are counted as “income” for both eligibility and applied income purposes. *MEPD E-3331*.

2. Exempt Income Definition

Exempt income is “income that is not counted in the eligibility or applied income determination.” *MEPD E-1700-E-2420 and E-9000*. (“Applied income,” now referred to as a co-payment, is the amount of the client’s income that is paid toward (“applied to”) his or her nursing home or other care.) Important examples of exempt income include the value of medical services provided free or for which someone else pays the provider directly; payments to providers of social services by a government program; and interest earned on excluded burial funds.

VA aid and attendance allowances, VA housebound allowances, and VA reimbursements for unusual medical expenses are not income for either Medicaid eligibility or applied income purposes. *MEPD E-4300-4315*.

3. Excluded Income Definition

Excluded income is “income that is not counted when determining eligibility but that is counted to determine applied income.” *MEPD E-9000*. “Infrequent or irregular” income is erroneously listed as an income “exemption” in the Eligibility Handbook. It is actually an income “exclusion,” because infrequent or irregular income is not counted in the eligibility determination but is counted in the applied income determination. The general exclusion (\$20 for unearned income and \$10 for earned income) and the earned income exclusion (\$65 plus one-half of the remainder) do not apply to Type Program 14 (Nursing Home Medicaid) and 1929b (Home Care) cases so they are useful primarily to persons receiving Medicaid through the SSI program, the Title II Social Security exclusion programs, and the Medicare cost sharing assistance available under the Medicare Savings Programs (such as Qualified Medicare Beneficiaries or “QMB,” Specified Low Income Medicare Beneficiaries or “SLMB,” and Qualifying Individuals or “QI”). An additional rule sets out what deductions from employee compensation are excluded in the determination of applied income. *1 T.A.C. §358.465(a),(b)*.

4. Certain VA Income Automatically Reduced by Medicaid Eligibility

VA non-service connected pensions (which are paid only to veterans or their surviving spouses with incomes below certain levels) are automatically reduced to \$90 per month when Medicaid eligibility is established in a nursing home, unless the veteran or surviving spouse has a dependent. *38 U.S.C.A. §5503(f)(2)*. Therefore, only that amount is counted for determining eligibility (unless it is identified as aid and attendance), and a Miller Trust is not necessary for a single veteran receiving such income. Note, however, that this does not apply to service connected disability or to military retirement pay, nor does it apply to a married veteran.

5. “Name on the Check Rule”

The federal “spousal impoverishment” rules require that for the purpose of allocating the income of a married Medicaid beneficiary and his or her spouse after eligibility is established, community property rules are disregarded. Rather, income is allocated according to the person or persons to whom it is payable on the check or other instrument by which it is paid, unless the instrument specifically provides otherwise. That is, if a check or direct deposit is payable only to the CS, none of it is attributed to the IS (or vice versa), even if it is clearly community property. If it is payable to both spouses, it is attributed to them equally. *42 U.S.C.A. §1396r 5(b)(2)*.

The federal statute requires this treatment only regarding post-eligibility treatment of income. Although the Texas rules and manual do not address this issue regarding determination of eligibility, the practice of HHSC is to apply the same rule for determining eligibility.

6. Long Term Care Insurance Benefits

Such benefits are not counted as income, but rather as “third party resources.” The LTC insurance payments must be assigned to the Medicaid program. Medicaid refunds to the beneficiary the difference between the LTC insurance payments collected and the amount Medicaid paid for nursing home care. Any such refund is income upon receipt. Also, other types of medical insurance benefits, such as benefits from Medicare supplement policies, are considered third-party resources. The effect of the benefits will be to reduce or eliminate the amount the Medicaid program will have to pay for nursing home costs.

7. VA Benefits

Likewise, payment of nursing home care by the Veterans Administration does not affect Medicaid eligibility. *1 T.A.C. §358.455(c)(3)(D)*. Therefore, it is clear that clients may apply immediately for Medicaid, despite potential VA eligibility; and subsequent establishment of VA eligibility will not result in a break in Medicaid benefits. This can be important if Medicaid is needed for services not covered by Medicare, such as medications, and to avoid Medicare’s co-payments and deductibles.

B. Rules Affecting Rental Income

Rental income is most commonly a concern when an exempt residence is being rented for cash. It can also be a factor when a rental property is part of the community spouse’s PRA (discussed immediately below). In general, countable rental income is gross income received, less actual expenses such as (but not limited to) property taxes, utilities, maintenance, repairs and advertising. *MEPD §E-3340*. Additionally, the following provisions apply:

- Expenses are deducted only for the month in which they are paid, regardless of when they are incurred.
- Payments made to a client’s agent under a power of attorney are always treated as received by the client. Payments to other “responsible parties” who provide a statement that they are not making the payments available to the client are not treated as received by the client, if they (the “other responsible parties”) made the rental agreement with the tenant; but a referral may be made to Adult Protective Services (for investigation of possible financial exploitation).
- Mortgage payments made by a tenant to the mortgage company are treated as countable income to the client; but if the residence is vacant and someone other than the client pays the mortgage, those payments are not treated as income.

C. “Spousal Impoverishment” Rules Protecting Income of the Community Spouse

The income of the community spouse (determined under the “name on the check rule” discussed above) is disregarded in determining eligibility of the institutionalized spouse. *42 U.S.C.A. §1396r-5(b)(1)*. Therefore, planning techniques often focus on re-characterizing income to put it in the name of the community spouse; or re-positioning assets to convert them from countable resources to non-countable community spouse income.

1. The Qualified Domestic Relations Order (“QDRO”)

It is frequently advantageous to transfer income of the institutionalized spouse to the community spouse. This may be essential for eligibility, or it may be valuable for increasing the income available to the community spouse when “applied income” (income paid to the nursing home or other provider) is determined after eligibility. Most commonly, the income involved consists of qualified retirement benefits. Under the Internal Revenue Code, these cannot be voluntarily alienated; but they can be transferred to a spouse by means of a QDRO. *26 U.S.C.A. §414(p)*. HHSC accepts such re-characterization of income and does not insist on being cited in the suit.

The name and social security number (“SSN”) on an individual retirement account (“IRA”) cannot be changed. But if the institutionalized spouse irrevocably assigns the IRA to the community spouse, and the assignment is approved by the IRA plan administrator, who verifies that access to the funds is foreclosed to the institutionalized spouse, HHSC considers the IRA to be the resource of the community spouse as of the first moment of the calendar month following the month in which the irrevocable assignment is made. However, income paid on the account is countable to the institutionalized spouse under the “name on the check rule.” *MEPD E-3320*.

2. Purchasing an Annuity for the Community Spouse

In an appropriate case, it is possible to convert resources to community spouse income by purchasing an annuity. For example, a couple has \$100,000 more than the PRA. If countable property of that value is used to purchase a single premium annuity of and that annuity produces \$1,000 per month for a term of years not greater than the life expectancy of the community spouse, the couple has effectively reduced their countable resources to the protected amount and the \$1,000 per month does not affect eligibility. Refer to Section III.E. for detailed rules pertaining to annuities.

D. Reducing Income Through a Miller Trust (“Qualifying Income Trust”)

1. The Income Problem

The Miller Trust, also known as a Qualifying Income Trust or QIT, addresses a cruel anomaly in Medicaid law in Texas and in the 12 other states with an “income cap.” The average nursing home cost when paid privately is determined by the state as \$142.92 per day. Texas has no medically needy provision for the aged and disabled population, where income is disregarded based on medical expenses, so nursing home Medicaid is denied persons whose income exceeds the \$2,022 cap. Therefore, many people who need nursing home care have too much income to qualify for Medicaid but too little to afford nursing home care. This phenomenon is sometimes referred to as the “Utah Gap.”

2. The Solution

Arguably, the most important change in Medicaid law contained in OBRA ‘93 was the provision allowing for some relief from the “income cap” by transferring income into a trust with certain required provisions. *42 U.S.C.A.*

§1396p(d)(4)(B). Such trusts are called “Miller Trusts” after the case *Miller V. Ibarra*, which approved a somewhat similar trust in Colorado. *746 F. Supp. 19 (D. Colo. 1990)*.

The Miller Trust solution works only for institutional (nursing home) Medicaid and the CBA program, and other “home or community-based waiver services,” such as the Medically Dependent Children Program (“MDCP”) and CLASS. It is expressly excluded by HHSC regulations as a way of reducing countable income for Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and 1929(b) (“Primary Home Care,” “Frail Elderly”). *1 T.A.C. §358.417(f)(3)(D)*. A Miller Trust cannot be used to gain eligibility for other home-care (“Community Care”) programs such as Family Care, because these are not Title XIX (or Medicaid)-funded services.

The practitioner should never assume that the client only needs a Miller Trust. Many lay persons have received incorrect information that leads them to believe that the Miller Trust solves problems other than income related problems; it does not. Therefore, the practitioner should always inquire about assets. Also, clients frequently believe that a Miller Trust can be utilized to achieve resource eligibility. It is important to explain to clients that a Miller Trust is only for income and cannot be used to hold the resources of a client to achieve Medicaid eligibility.

3. The Requirements for a Miller Trust

OBRA ‘93, as codified in 42 U.S.C. §1396p(d)(4)(B), and interpreted by CMS and HHSC, requires that the trust have the following features:

- Funded only with pension, Social Security, and other income of the individual (and accumulated income in the trust);
- No resources may be placed in a QIT, but nominal amounts of the Medicaid client’s resources (or another party’s funds) may be used to initiate the trust account without invalidating the trust or being counted as income to the Medicaid client; once the trust account is established, however, only the Medicaid client’s income should be directed to the trust account; *1 T.A.C. §358.417(f)(3)*
- Income need not be directly deposited to the trust account, but it must be deposited during the same calendar month in which it is received and any income not directed to the trust account in the month of receipt is countable for eligibility purposes (e.g., if the Medicaid client receives \$2,000 total income in July but does not deposit it to the trust until August 1, the client loses eligibility for July); *1 T.A.C. §358.417(f)(3)*.
- Irrevocable;
- The State will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid by Medicaid on behalf of the individual; and
- Require that the trustee:
 - Pay to the beneficiary a monthly personal needs allowance (currently \$60);
 - Pay to the spouse (if any) of the beneficiary a sum sufficient to provide a minimum monthly maintenance needs allowance (currently \$2,739.00);
 - Pay medical expenses not subject to payment by a third party; and
 - Pay from the funds remaining the cost of medical assistance provided to the beneficiary.

UPDATE: In the QIT declaration all sources of income must be listed. Failure to list the sources of income will result in an unsatisfactory QIT and the denial of Medicaid benefits.

In addition to the CMS requirements, HHSC requires that the trust identify the sources of income to be transferred to the trust. Also, HHSC “recommends” that the trustee not be the beneficiary “because of potential problems relating to discretionary distributions.” *DHS Memo of October 30, 1996*.

As to the signing of the QIT, this may be done by the settlor (i.e., the Medicaid client), the settlor's agent, the settlor's guardian, or someone with authority over the settlor's funds. Practitioners should ensure that signatures on the QIT document are duly acknowledged. While Texas law does not require acknowledgment, many banks do. Therefore, good practice dictates that the signatures be acknowledged.

CMS regulations state, "...a trust which provides that the trust can only be modified or terminated by a court is a revocable trust since the grantor (or his/her representative) can petition the court to terminate the trust." *CMS State Medicaid Manual §3259.1.A.5*. The regulation disregards the fact that any Texas trust can always, as a matter of law, be modified by a court if "because of circumstances not known to or anticipated by the settlor, compliance with the terms of the trust would defeat or substantially impair the accomplishment of the purposes of the trust." *Texas Property Code §112.054(a)(2)*. Nevertheless, to avoid running afoul of this rule, practitioners must delete from all forms involving trusts that must be irrevocable under CMS rules (including Miller Trusts), any reference to modification or amendment by trustees, courts or any other parties. An example of a QIT is included in Appendix IV.

4. The Trust Administration Requirements

After the trust is set up, it is imperative that the trustee properly fund and administer the trust for Medicaid eligibility to be attained and maintained. See Appendix III for an example of an instruction letter to the trustee. The trust is not counted as a resource. HHSC has the following policies pertaining to trust administration:

- The client may place all or only a portion of his or her income in the trust; but if only a portion is placed into it, the entire amount coming from the same source must be placed in the trust. Income tax refunds are not counted as income for the purpose of eligibility so should not be placed in a Miller Trust. However, to the extent they were deducted from applied income (owing to withholding tax) in the past, they are added to applied income in the month of receipt and HHSC may request restitution. "Restitution" refers to voluntary repayment by the Medicaid client of the state's vendor overpayment to the nursing home for a given calendar month. *1 T.A.C. §358.450(g)*.
- Distributions must be made no later than the last day of the month next following the month of receipt. *1 T.A.C. §358.417(f)(3)(E)*.
- The trust is effective for the first month that all the following have occurred:
 - the client has a valid, signed trust;
 - a trust bank account has been established;
 - and enough income has been placed in the trust to reduce the remaining income below the income cap.

If all other eligibility requirements have been met as of the first day of that month, benefits will be paid from that date, provided an application is filed within three months from that date.

Any trust expenses, including attorney fees, may be paid from the trust account. *MEPD Appendix XXXVI*. If any payments are made from the trust other than for "deductions from applied income" (personal needs allowance of \$60, medical premiums and expenses, income diversion to the CS, and income applied toward nursing home expenses, all of which must be paid first), those additional payments are either countable income for eligibility purposes (if made to or for the Medicaid recipient) or a transfer of assets (if made to someone other than the Medicaid recipient or community spouse). Funds that are deposited to the QIT during one month, and which are retained in the QIT account beyond the end of the following month, are also subject to transfer-of-asset provisions.

In the case of an unmarried person or where both spouses are eligible, there is probably an additional use of any funds left over after payment of all applied income that will probably be approved: any use for the benefit of the client, so long as those funds plus other countable income do not exceed the income cap of \$2,022 per month. *State Medicaid*

Manual §3259.7.C.5c. “Countable income” does not, under the HHSC regulation, include at least that income paid into the trust and paid out as applied income or for other medical services, and other statements in the regulations indicate it does not include any income directed to the trust. Therefore, income may be paid out of the trust in an amount that will supplement the Medicaid client’s total income up to \$2,022 per month, if such amounts are available after payment of personal needs allowance, applied income, medical expenses and spousal allowances, if any. However, see further discussion herein regarding the use of excessive direct income.

PRACTICE NOTE: Given the complexity of the forgoing rules, it is not surprising that clients and trustees find them difficult to follow. Here is an informal checklist for supervising client followup:

- Be sure the following documents are in proper form and copies are submitted to HHSC: the trust instrument, the bank form showing that the trust account has been opened, and a deposit slip or other document verifying the initial funding of the trust.
- Do not allow more than \$20 in funds other than client’s income to be used to establish the trust. Otherwise, it may be considered “invalid.”
- Before eligibility is established, the practitioner should advise the client of estimated amounts to be paid from the trust for the following: personal needs (\$60), medical insurance, spousal allowance (if any) and applied income. In doing so, the practitioner should leave a wide margin for error, even to the extent of paying 100% of the income to the nursing home until the caseworker determines how much should be paid.
- The practitioner must ensure that the client understands that all income received during a given calendar month must be deposited to the QIT account by the last day of the month in which it is received. A check which is received on the last day of the month may be deposited to the client’s personal checking account, and a check for that exact same amount must be written against the client’s personal checking account and deposited to the QIT account on that same day. It is immaterial that the check does not clear the bank the same day it is deposited. However, the trustee cannot wait until the first day of the following month (or later) to deposit the check lest the client lose eligibility for the month of receipt.
- Many highly competent individuals have difficulty following written instructions for establishing and administering a QIT. The rules governing QITs are complicated and non-intuitive. Therefore, the trustee who complies only with instructions that make sense to him or her is likely to render a disservice to the client. Good practice dictates that the trustee sends all bank records to the practitioner’s office to be reviewed for compliance with the rules before those records are forwarded to the HHSC caseworker. Additionally, shortly before the end of that all-important first month of planned eligibility, the practitioner should contact the trustee to ensure that he/she followed the practitioner’s instructions.

UPDATE: It is now possible to use an existing account as the Miller Trust account so long as the account is only used to deposit the QIT income. MEPD Appendix XXXVI. However, this may only be used in situations where the financial institution will re-style the account as a qualified income trust. Since most banks will not re-style existing accounts, this provision will likely not have much benefit to clients.

5. Termination of the Trust

If the Medicaid client no longer requires a QIT, he or she should stop directing income to the trust account. When the Medicaid client dies, the HHSC caseworker determines the amount of vendor payments that Medicaid has made to the nursing home on that client’s behalf, and sends written notice to the client’s responsible party requesting that Medicaid be repaid from residual funds in the trust, up to the total amount of vendor payments made on that client’s behalf.

Repayment is made to the Department of Aging and Disability Services (not to HHSC) in whole dollar amounts and may be made by cashier's check, money order, or personal check. A receipt is issued for the payment.

E. Rules Pertaining to Annuities

1. General Annuity Rules

In general, annuity payments are treated as "income." *I T.A.C. §358.455(d)(5)*. There are two types of annuities: employment related annuities (annuities that provide period payment calculated on annual basis which are a return on prior services (*I T.A.C. §358.333*) and a non-employment related annuity (which is a contract or agreement for an amount to be paid yearly or at other regular intervals in return for prior payments made by the individual. For this type of annuity, the language of the annuity dictates whether disbursements are countable income and describes the payment schedule. *I T.A.C. §358.334*.

Annuities which represent a return on prior services (e.g., civil service annuities) produce only a stream of income and are not a countable resource. *I T.A.C. §358.333*. For an annuity contract that makes periodic payments based on prior payments made by the individual, the terms of the contract determine whether or not it is a countable resource. A revocable annuity is a countable resource, with its value being the amount refundable upon revocation. Selling a revocable annuity for less than this amount is a transfer of assets. *I T.A.C. §358.334*. Moreover, under current Medicaid rules, an annuity that does not meet the current annuity requirements and is irrevocable may result in transfer of assets penalty.

2. Pre-DRA Annuity Rules

For Medicaid applications filed from September 1, 2004, through September 30, 2006, and for annuities purchased prior to February 8, 2006, the following rules apply. The annuity must:

- Be irrevocable;
- Pay out principal in equal monthly installments;
- Pay out interest in equal monthly installments, or in amounts that result in increases in the monthly installments at least annually;
- Pay out all principal over the individual's life expectancy, plus a reasonable amount of interest;
- Name the State of Texas as the remainder beneficiary up to the amount of Medicaid payments made on the individual's behalf; and
- Be issued by a life insurance company licensed to do business in Texas. *I T.A.C. §358.442(g)*.

The requirement that the State of Texas be named the remainder beneficiary does not apply if the annuity is for the community spouse who is not on Medicaid. Thus, an irrevocable annuity for the community spouse which meets all of the above requirements, except naming the State of Texas as remainder beneficiary, is not a countable asset.

For an irrevocable annuity which does not meet all of the above requirements, its market value is presumed to be 80 percent of the total remaining payout. However, this presumption may be successfully rebutted by providing credible evidence to the contrary. *I T.A.C. §358.442(g)(3)*. For an annuity which is not guaranteed to return the entire principal investment within the annuitant's life expectancy (see Item #3.d. in the preceding paragraph), a transfer-of-assets has occurred to the extent that the principal is not returned during the annuitant's life expectancy. For example, if the life expectancy is six years and the payout is nine years, the amount payable during the last three years is an uncompensated transfer. *MEPD §F-7200*.

An annuity which does not pay out a “reasonable amount of interest” (see Item #3.d. in the preceding paragraph) is also a countable resource. In LTC ME Bulletin Number 05-05 (cited above), HHSC sets forth the following policies for determining reasonableness of the interest rate:

If the Annuity Is Actuarially Sound as to Principal But Pays No Interest - The annuity is a countable resource; its market value is presumed to be 80 percent of its remaining payout, but this may be rebutted by providing written appraisals of the annuity’s value from two reputable companies that sell annuities. If counting the value of the annuity does not cause resource ineligibility, a transfer-of-assets penalty is assessed using the following formula: Purchase Price of Annuity x One-Year Certificate of Deposit (“CD”) Interest Rate = Uncompensated Value. *[Id.]*

EXAMPLE NO. ONE: The purchase price of the annuity is \$100,000, and the one-year CD interest rate is 3 percent. ($\$100,000 \times .03 = \$3,000$ Uncompensated Value). If the Annuity Is Actuarially Sound as to Principal and Pays Some Interest - The individual must provide comparisons of two comparable annuities. These comparisons may be from the company that sold the individual the annuity or from other companies licensed to sell annuities in Texas. The comparisons must be for annuities with the same principal investment and payout period as the annuity being scrutinized. If the interest rate for the annuity under scrutiny does not equal or exceed the interest rates on the comparisons, the annuity is considered to be a countable resource. Again, HHSC presumes that the market value of the annuity is 80 percent of the remaining payout, unless successfully rebutted by providing written appraisals of the annuity’s value from at least two reputable companies that sell annuities. If counting the annuity as a resource does not cause resource ineligibility, a transfer-of-assets penalty is assessed using the following formula: Purchase Price of Annuity x One-Year CD Interest Rate = Amount Transferred - Actual Guaranteed Interest Payout = Uncompensated Value. *[Id.]*

EXAMPLE NO. TWO: The purchase price of the annuity is \$100,000 and the one-year CD rate is 3 percent; the actual interest guaranteed payout is \$2,500. ($\$100,000 \times .03 = \$3,000 - \$2,500 = \500 Uncompensated Value)

3. Post-DRA Annuity Rules

For Medicaid applications filed on or after October 1, 2006, involving an annuity purchased on or after February 8, 2006 or an annuity that has a transaction date on or after February 8, 2006, the Deficit Reduction Act of 2005 requires that the Medicaid application request disclosure of any interest that the individual or spouse has in an annuity, regardless of whether the annuity is irrevocable or treated as assets. *1 T.A.C. §358.334.*

The annuity is neither a countable asset nor a transfer of assets if it is “described in subsection (b) or (q) of section 408 of the Internal Revenue Code,” or if it is purchased with proceeds from: (1) “an account or trust described in subsection (a), (c) or (p) of section 408 of the Code; (2) a simplified employee pension (within the meaning of section 408(k) of the Code; or (3) a Roth Individual Retirement Account described in section 408A of the Code.” *1 T.A.C. §358.333.*

If the annuity does not fit the terms above, in order to not be considered a countable assets it must meet the following five requirements:

- Be irrevocable and non-assignable;
- Pay out in equal monthly installments;
- Not contain any provision for deferral of payments or for balloon payments;
- Be actuarially sound; and

- Name the State of Texas as the remainder beneficiary. *1 T.A.C. §358.334.*

If the institutionalized individual is the annuitant, the contract must name the State of Texas as the remainder beneficiary in the first position for the amount of medical assistance paid on behalf of that individual, or in the second position if the community spouse or the individual's minor/disabled child is named in the first position. *1 T.A.C. §358.335(c).*

If the community spouse is the annuitant, the contract must name the State of Texas as the remainder beneficiary in the first position for the amount of medical assistance paid on behalf of the institutionalized spouse, or in the second position if the institutionalized spouse or minor/disabled child is named in the first position. *1 T.A.C. §358.335(c).*

Thus, under the Deficit Reduction Act of 2005 ("DRA 2005"), the State of Texas must be named the remainder beneficiary of an annuity, even if the community spouse is the annuitant.

Under the DRA 2005, annuities which do not meet the above requirements are subject to transfer-of-asset penalties. *MEPD F-7240.*

F. Rules Pertaining to Notes and Similar Instruments

Payments received on a negotiable note (regardless of whether it is secured or not) are counted as "income" only to the extent of the amount of interest paid. However, effective July 1, 2007, interest on a promissory note which is a countable asset is not counted as income in the eligibility determination but is counted as income in the applied income calculation. The full amount of all payments on a non-negotiable note, including both principal and interest, is counted as "income." *MEPD § E-3331.*

With regard to determining the amount of the client's "resources," the following rules govern the valuation of notes and other contractual arrangements in which the client is a creditor. These rules apply to promissory notes, loans and other property agreements. *MEPD §F-4150.* Those rules are important also in applying the transfer rules. The rules are summarized as follows:

1. Transferable, Secured Instrument

If the instrument is both negotiable (actually, transferable) and secured, its principal balance is a countable resource. Therefore, there is no transfer penalty for taking a note that is secured. However, the outstanding principal balance is a countable resource since the owner of the note owns an interest that can be converted to cash. The terms of the note may be oral or in writing, however, if the terms are oral, it is best to provide a written statement of the agreement signed by the obligor of the instrument. The amount countable is generally the amount owed on the note, however, the client may furnish a statement from someone in the business of purchasing notes to the effect that the note is worth less than its principal balance, the lower value will be accepted. *MEPD § F-4150.*

2. Transferable, Non-secured Instrument

If the instrument is transferable but not secured, its value is also a countable resource and could also potentially be a transfer of assets. Its value of the instrument is the "actual fair market value" of the note. The fair market value of unsecured notes tend to be lower than that of secured notes. The difference between the value of the resource sold and the instrument's fair market value is treated as a transfer without consideration. As in any other transfer for less than adequate consideration, it is assumed that Medicaid qualification was the purpose of the transfer unless the client proves

otherwise. If payments are made, the interest is treated as income (for applied income purposes), and the principal “reduces the transfer penalty.” *MEPD § F-4150.*

3. Non-Transferable, Non-secured Instrument

A non-negotiable instrument is not countable as a resource because it has no market value. However, the dollar value of the resource sold is considered to have been transferred without consideration, and the transaction is subject to a transfer of assets penalty. If payments are received, the transfer penalty is reduced by the amount of principal received. Both interest and principal portions of each payment are countable income. The transfer penalty is recalculated at each annual review to reflect the payments to the principal that are made during the year. *MEPD § F-4150.*

4. Value of Original Property

Even though title to the original property subject to the promissory note is kept in the name of the seller, the value of the original property is not a countable resource (because the negotiable instrument is the resource). The property is considered not available while the buyer is making payments on the note. *MEPD § F-4150.*

5. Transfer Penalty for the Purchase of a Promissory Note, Loans or Mortgages

Clients who purchase a promissory note, loan or mortgage on or after October 1, 2006, there is a potential for a transfer of asset penalty if certain requirements are not met. Specifically, the purchase of a promissory note, loan, or mortgage is considered to be a transfer of assets, unless all of the following conditions are met:

- The repayment term must be actuarially sound;
- Payments must be made in equal amounts during the term of the loan with no deferral of payments and no balloon payments; and
- The promissory note, loan, or mortgage must prohibit the cancellation of the balance upon the death of the lender. *MEPD § I-6220.*

If the above requirements are not met, the amount transferred is considered to be “the outstanding balance due as of the date of the individual’s application for Medicaid. *Id.*”

If the above requirements are met, and there is no transfer of assets, then the rules regarding the countability of a note as an asset still apply.

PRACTICE NOTE: A promissory note, loan, or mortgage purchased for less than fair market value is a transfer of assets, regardless of when the application is filed or when the transaction occurred.

CAUTION: With the recent economic downturn, many individuals have not been able to obtain financing for the purchase of a home. Many sellers have been enticed into accepting a promissory note for the sale of the home, however, many of these promissory notes do not meet the requirements outlined above. If the client has accepted a note that does not meet the above requirements, you will need to defend the sale of the property to prevent a transfer of assets penalty.

G. Resource Requirements

1. General Definition of “Resources”

“Resources are cash, other liquid assets, or any real or personal property or other nonliquid assets that a person, a person’s spouse or parent could convert to cash to be used for his or her support and maintenance. Support and maintenance assistance not counted as income is not considered a resource.” *MEPD § F-1210.*

2. When Counted

Resources are counted only as of 12:01 a.m. on the first day of each month. *1 T.A.C. §358.321.* Changes from that time until one month later do not affect countable resources for that month. *MEPD § F-1310.* Countable resources are reduced by the amount of funds encumbered before 12:01 a.m. of the first day of the month. That is, if a check is outstanding at that time, the bank balance at that time is reduced by the amount of the check for the purpose of determining countable resources. *MEPD § F-1311.*

UPDATE: Beginning in September of 2011, there will be a new asset verification system that will check a certain number of banks in the area that a Medicaid applicant resides in order to find closed accounts or other accounts not reported by the Medicaid applicant on the application. This system will have the authority and capability to look back 5 years on closed accounts.

3. Requirement of “Accessibility”

To be counted, a resource must be both owned (solely or in part) by the client and “accessible to” the client. *MEPD § F-1220.* An asset is considered accessible if a client has the right, authority or power to liquidate the property or his share of it, the property is a resource. If a client would be required to seek court action to access or dispose of property, that property is not considered a resource. A client’s resources are considered available to him when they are being managed by a legal guardian, agent under power of attorney, or other fiduciary agent of the client, unless a court denies the guardian or agent access to the resources. *MEPD § F-1231.*

4. Co-Owned Resources Generally

If the resource can be reduced to cash without consent of the co-owner, or if the co-owner gives the required consent, the full value is counted. If the co-owner’s consent is required and is withheld, the property is not counted; provided, if the co-owner who is refusing to consent is an ineligible spouse living with the client, the property is counted. Provided further, if the property is an undivided interest in real property, its value is counted anyway, on the theory that an undivided interest can be sold, barring a legal restriction, without the co- owner’s consent. *MEPD § F-1221.*

5. Joint Bank Accounts

If a client has a joint bank account and can legally withdraw funds from it, all the funds in the account are considered a resource of the client. However, this is only a presumption, and the client must be allowed an opportunity to prove that some or all of the funds are the property of someone else. *MEPD § F-4121.*

6. Trusts

Generally, property in a trust is a resource if the client has the authority to revoke the trust; or if the trustee has discretion to make distributions to the client, and the client contributed the property to the trust. See VII. herein on trusts for more detail and for descriptions of some important “exception” trusts.

7. Discovery of Unknown Assets

If a client is unaware that he or she owns an asset, it is not a resource during the period the individual was unaware of ownership. It is counted as income in the month of its discovery, and if it is not spent down during that month, it will be a resource as of the first day of the next month. *MEPD § F-1240.*

8. “Conversion of Resources” and “Lump Sums”

If a client converts one type of property to another, whether or not the new property is counted as a resource depends on the policy regarding that type of property. Any cash received from the sale of a resource is considered a resource, not income. *MEPD § F-1260.* By contrast, a “lump sum payment” other than from conversion of a resource is countable income in the month of receipt (so will usually result in at least one month’s disqualification) and is a countable resource thereafter. *MEPD §§ E-1310, 1400-1500, and 2420.* Examples of “lump sums” would be inheritances, death benefits, personal injury awards, and payments of retroactive public benefits. Although counted as income when received, social security and SSI retroactive lump sum payments are excluded as a resource for six (6) months following the month of receipt. Death benefits are excluded as income “when they are used to pay the last illness and burial expenses of the deceased;” and they are excluded as resources except to the extent they have not been so used by the first day of the second calendar month after the month of receipt. *MEPD §§ F-2150 and F-1220.*

9. Insurance Proceeds As Excluded Resources

Insurance proceeds resulting from losses to excluded resources (for example, the residence or an excluded automobile) are not counted as resources, provided they are used to repair or replace the excluded resources. Such use must be within 9 months of receipt. *MEPD § F-1270.* The initial nine month period can be extended for good cause for a reasonable period of up to an additional nine (9) months. “Good cause exists if circumstances beyond the client’s control prevent repair or replacement” during the initial nine month period. *MEPD § F-1270.*

10. Life Estates and Remainder Interests

If countable, these interests are presumptively valued according to the life estate holder’s age and the equity value of the property, by application of a table of values in Appendix X of the Medicaid Eligibility Handbook. The client may rebut this presumption by presenting a statement from a knowledgeable source. *MEPD § F-4212.*

Under the DRA 2005, for applications filed (or program transfer requests made) on or after October 1, 2006, as well as for caseworker actions taken on or after that date, the purchase of a life estate in someone else’s home on or after April 1, 2006, results in a transfer-of-assets penalty, unless both of the following requirements are met:

- The individual who purchased the life estate in someone else’s home actually resides in that home; and
- The individual continues to reside in the home for at least one year (i.e., 12 consecutive months) after the date of purchase.

H. Excluded Resources

The Medicaid programs allows for several different types of resources to be excluded when determining Medicaid eligibility. The value of these resources are not considered in the calculation for determining Medicaid eligibility.

1. The Home

The Medicaid program excludes the Applicant's principal place of residence. *MEPD §F-3110*. In order for the home to be an excluded residence, the applicant must intend to return home and the home must usually be located in Texas.

a. Home must be in Texas (usually)

A home located outside Texas cannot be excluded on intent to return. A client who intends to return to an out-of-state home is not a Texas resident. *MEPD §F-3500*. However, if the CS lives outside Texas, his or her home can be excluded for the purpose of initial eligibility, subject to the requirement that title be transferred to the CS before the first annual review. *MEPD §F-3500*.

b. Sale of the home

For clients in institutional living arrangements, home and community based waiver programs, and demonstration projects, placing the home on the market for sale does not make it a resource. Out-of-state home property placed for sale is also an excluded resource. *MEPD §F-3130*. If the client is purchasing a replacement home, the proceeds of the sale of the original home are not countable resources until the end of the third full calendar month following the month of their receipt. *MEPD §F-3400*.

UPDATE: In a speech at the UT Estate Planning, Guardianship and Elder Law Conference in Galveston, Texas on August 12-13, 2010, John Stockton policy specialist with HHSC, stated that new homestead rules are on the horizon within the next couple of months. He did not indicate what the rule changes would be; however, careful attention must be made at this time to any changes regarding the homestead.

2. Real Property Place for Sale

The Texas Medicaid rules exclude real property, including the home, life estate or remainder interest if the property is placed for sale. *MEPD §F-3130*.

UPDATE: In the same speech at the UT Estate Planning, Guardianship and Elder Law Conference, John Stockton indicated that the exclusion of the property will last for 9 months. After the nine month period has expired, if an offer on the property is made of at least 2/3 of the value of the property, the seller must accept such an offer or lose the exclusion on the property.

3. Burial Spaces

A "burial space" or agreement that represents the purchase of a burial space held for the burial of the client, his or her spouse, or any other member of the client's "immediate family" is excluded, regardless of value. "Burial space" includes a burial plot, grave site, crypt, mausoleum, casket, urn, niche or other repository, plus reasonable improvements or additions including vaults, headstones, markers or plaques, arrangements for the opening and closing of the grave site, and contracts for maintenance of the grave site. Of items that serve the same purpose, only one per person may be excluded. "Immediate family" includes the client's spouse, minor and adult children, stepchildren, adopted children, brothers, sisters, parents, adoptive parents, and the spouses of those individuals. It does not include grandchildren or the client's spouse's immediate family. If the relationship is by marriage only, the marriage must be in effect for the exclusion to apply. *MEPD §F-4214*.

4. Burial Funds

A maximum of \$1,500 of separately identifiable burial funds, plus interest or other earnings after designation, is excluded for the client and the client's spouse. *MEPD §F-4227*. Such funds may be in cash, financial accounts, securities or revocable burial arrangements. The designation is done on Form H-1252. The value of irrevocable burial arrangements and face value of excluded life insurance is set off against the \$1,500 exclusion.

The designation can be made retroactively, and caseworkers are instructed to allow clients to do so if that will make them eligible. *MEPD §F-4227.1*.

5. Prepaid Burial Contracts

An irrevocable, prepaid burial contract is excluded, regardless of value. *MEPD §F-4160*. All prepaid burial contracts sold before September 1, 1993, were required by law to be revocable as to 90% of the proceeds. Therefore, unless such a contract is made irrevocable, 90% of its value (less the prorated exclusion for burial spaces) counts toward the \$1,500 allowed in burial funds.

Until a policy change on March 1, 2007, a client could have a burial contract for the client's immediate family, as well as for the client. However, under current rules, a client can no longer have a prepaid funeral contract for funeral services, but can still have such a policy for burial space items. *MEPD §F-4214*.

6. Automobiles

Generally, the Medicaid program excluded one vehicle regardless of value. *MEPD §F-4211*. A second vehicle may be exempt if:

- It is specially equipped for a handicapped person who resides in the household; or
- There is more than one individual in the household and the additional individual needs the second vehicle to travel to and from work because the Medicaid client needs the first vehicle available at all times for medical transportation.

7. Household Goods and Personal Effects

For an unmarried individual, or both spouses if they are both seeking eligibility the client can have household goods and personal effects if the total value for such items does not exceed \$5,000. If the value does exceed \$5,000, the excess amount is counted as a resource. However, caseworkers are instructed not to develop the value of household goods and personal effects unless a client lists items exceeding \$500 on the Medicaid application (Form H-1200) or discusses these items in the interview. Further, the instructions state that items used for everyday living, such as a set of silver or an antique table, are not counted. Also, one wedding ring and one engagement ring are exempt, as are "prosthetic devices, dialysis machines, hospital beds, wheelchairs, and similar equipment required because of a person's physical condition."

For a married client with one spouse in the community all personal and household effects are excluded, regardless of value. *42 U.S.C.A. §1396r 5(c)(5)*.

8. Life Insurance

A term life insurance policy, with no cash value is excluded, regardless of amount of death benefit. *MEPD §F-4223*.

For all other life insurance policies that have a cash value, i.e. a whole life policy, the cash value is counted as a resource; provided, if the total face value of policies owned by the client (or a spouse, if any) per insured is \$1,500 or less, the cash value is excluded. *MEPD §F-4223*. Dividend additions are not included with the face value of a policy in determining if the policy is a countable resource.

9. Livestock

Livestock that is maintained as part of a trade or business or exclusively for home consumption is not counted. *MEPD §F-4250*.

10. “Resources Essential to Self Support”

This exclusion applies to certain types of property that produce income, which are excluded as resources, but the income they produce is counted like any other income. *MEPD §F-4300*. This is divided into business property and non-business property, as follows:

a. Business property

Property used in the client’s trade or business is excluded regardless of value or rate of return. The property must be in current use, or it must have been used previously and there must be a reasonable expectation of its being used again. It may be land and buildings, equipment and supplies, inventory, livestock, motor vehicles, and liquid assets needed for the business. *MEPD §F-4330*.

The critical question is whether the owner “materially participates” in the farm or other business. If so, the income should be reported on Schedule F (for a farm) or C (for another business) to the federal income tax return. Self employment tax is due, and the property is exempt from consideration by Medicaid. However, if it is property reported on Schedule E and Form 4835 as rental income, it is not exempt as business property.

Also excluded is personal property used in a client’s trade or business, such as tools, safety equipment, and uniforms. *MEPD §F-4330*.

b. Non-business income property

“Non-business” property such as rental property, leased farm property and income producing mineral rights is excluded to the extent its equity value does not exceed \$6,000, and the client receives a net annual rate of return of at least 6% of the equity value. There is some flexibility if the rate of return drops below 6% due to “unusual or adverse circumstances.” *MEPD §F-4310*. This exclusion applies only to real property or a degree of interest in real property, such as mineral rights. *MEPD §F-4310*. This is consistent with the federal SSI regulation on which this exclusion is based. *20 CFR §416.1220*.

11. Retirement Benefits

Both the Texas Medicaid Eligibility Handbook and the SSI rules provide, “Pension funds owned by an ineligible spouse or parent are excluded from resources for deeming purposes.” *MEPD §F-1410 and 20 C.F.R. §416.1202(a)*. However, HHSC does not apply that rule to “spousal impoverishment” cases involving an ineligible spouse in the community, because such situations do not involve “deeming” as that term is used by SSI. Pension funds include IRAs, Keogh accounts, and monies held in a retirement fund under a plan administered by an employer or a union.

The countable amount is the amount that could be withdrawn immediately after mandatory deduction for early withdrawal penalties if any. The following rules apply:

- If the account can be withdrawn only upon termination of current employment, it is not countable.
- Availability of a loan secured by the account does not make it countable. Therefore, the CS is not required to quit her job or take out a loan.
- The retirement accounts of both spouses are treated the same under these rules (i.e., no exemption for pension funds of the CS, although they often can be exempted for the reasons stated above).

12. Uniform Gifts to Minors Act (“UGMA”) Accounts

Funds comprising a UGMA account (with the Medicaid/applicant/recipient as custodian), which is for the benefit of a child who was under age 21 at the time the account was established, are exempt assets. This is because UGMA accounts are, by definition, irrevocable. Moreover, setting up such an account is not a disqualifying transfer of assets. Similarly, a UGMA-funded §529 college tuition plan (for the benefit of a child who was under age 21 at the time the account was established) is not a countable asset, nor is the setting up of such an account a disqualifying transfer of assets.

V. SPOUSAL IMPOVERISHMENT RULES

A. Purpose of Spousal Impoverishment Rules

When one spouse goes into a nursing home, the other spouse’s living expenses ordinarily continue much as before. If all the disabled spouse’s income went to pay the nursing home bills, the spouse at home would usually have substantially less income than before; and if the spouses could have only \$3,000 in resources between them, the spouse at home would be truly impoverished. This was, in fact, often the case before the law was changed effective September 30, 1989, and it resulted in many “Medicaid divorces.” Accordingly, the purpose of the federal law effective that date was to prevent “spousal impoverishment.” *42 U.S.C.A. §1396r-5*.

The true original intent of the spousal impoverishment rules was to allow one spouse to become eligible for Medicaid benefits and the exclusion of the other spouse becoming eligible.

B. Eligibility for Spousal Impoverishment Rules

1. Institutionalization

One spouse must have resided in a “medical institution or nursing facility” for at least 30 days beginning on or after September 30, 1989. If institutionalization began before that date and has been continuous since, the rules in effect before that date apply.

Moreover, the community spouse must not be in a “medical institution” or “nursing facility.” *42 U.S.C.A. §1396r- 5(h)*. As long as medical services are not included in the basic monthly fee, a personal care home (or the personal care part of a continuous care retirement center) is not a “medical institution,” so a spouse living in such a facility is a “CS.” *1 T.A.C. §358.503(b)(5)*.

2. Limitations on Income

The same income limits for individuals (\$2,022 in 2011) apply in spousal impoverishment cases. *MEPD §J-2100*.

3. Limitations on Resources

In summary, all resources of both spouses are combined. A “protected resource amount” (“PRA”) for the community spouse is then determined, according to the rules discussed below. Then, within the first year of eligibility, all countable assets in excess of \$2,000 must be transferred to the community spouse. Indeed, it is advantageous that all assets be shifted to the community spouse as soon as possible. The following is a summary of the specific rules:

C. The Protected Resource Amount

The protected resource amount (“PRA”) is the amount protected for the use of the community spouse. Married couples with one spouse in the nursing home and one spouse living at home are allowed to protect a minimum of \$21,912 and a maximum of \$109,560 for the community spouse, in 2011. In certain situations discussed below, the amount of the PRA may be expanded to protect more of the couple’s resources.

1. When the PRA is Calculated

The “snapshot,” or calculation of the PRA, occurs only once, as of 12:01 a.m. on the first day of the month in which the first continuous period of institutionalization on or after September 30, 1989 began. *MEPD §J-4300*.

2. How the Protected Resource Amount is Calculated

All property is included, without regard to its characterization as community or separate, except that the home, household goods, and one automobile are excluded regardless of value. *MEPD §J-4400*.

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 2011) or
- The minimum set by federal law (\$21,912 in 2011).

The PRA is set to increase in 2012 to a minimum of \$22,728 and a maximum of \$113,640.00.

EXAMPLES:

1. If combined resources total \$220,000, one-half is \$110,000 and the PRA is the maximum of \$109,560.
2. If combined resources total \$100,000, the PRA is \$50,000.
3. If combined resources total \$25,000, one-half would be \$12,500 and the PRA is the minimum of \$21,912

3. How the PRA Can Be Increased to Provide for the Spousal Allowance

Federal law provides for a “minimum monthly maintenance needs allowance” (“MMMNA”) for the community spouse, which in 2011 is \$2,739.00 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 (after deduction of the \$60 personal needs allowance 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 and applied income (i.e., to the nursing home).

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 maintenance needs allowance.

In Texas, the expanded PRA equals the dollar amount that is equal to the cost of a one year CD that will produce enough interest, when added to the couple’s total non-investment countable income, to give the community spouse a total of \$2,739. per month income (in 2011). 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. *1 T.A.C. §358.503(j)*.

The formula for determining the amount of the expanded PRA is: annual income needed X 100 divided by interest on one year CD = maximum dollar amount of resources to be protected. *1 T.A.C. §358.503(j)(4)*. However, the expanded PRA may not exceed the couple’s combined countable resources as of the PRA date.

CAUTION: If the “snap-shot” date is prior to September 1, 2004, the expansion of the PRA is calculated using the resource-first method. This means that there is \$1 diversion from the institutionalized spouse. This method allows for a greater expansion. *MEPD J-6400*. The calculation is basically the same as for the income-first method, but the amount from the IS is reduced to \$1.

4. The Right to Increase the Minimum Monthly Maintenance Needs Allowance

If it is established at a fair hearing that the community spouse needs income above the level of the minimum monthly maintenance needs allowance (\$2,739.00 in 2011), due to “exceptional circumstances resulting in significant financial duress,” the minimum monthly maintenance needs allowance can be increased. *42 U.S.C.A. §1396r 5(e)(2)(B)*. The MMMNA will increase in 2012 to \$2,841.00.

5. Post Eligibility Treatment of the CS’s Resources

The federal statute clearly states that after eligibility is established, “...no resources of the community spouse shall be deemed available to the IS.” *42 U.S.C.A. §1396r 5(c)(4)*.

UPDATE: Normally any transfer or increase in the community spouse’s assets during the first year of eligibility for the institutionalized spouse will cause a penalty or disqualify the institutionalized spouse for Medicaid benefits. However, pursuant to John Stockton with HHSC, due to a staffing shortage at HHSC, such transfers or increases will not affect the institutionalized spouse’s Medicaid eligibility. However, such actions must be reported because it could affect the amount of the diversion to the community spouse. Proceed with caution when advising the community spouse to transfer funds or regarding the effects of an increase in assets during that initial 1-year eligibility period.

VI. TRANSFER (“GIFTING”) RULES

A. Purpose and Nature

If there were no restrictions on making gifts, many individuals would become eligible for Medicaid simply by giving their assets to family members. Therefore, to protect the integrity of the program, the federal statute requires states to penalize transfers for less than fair market value. In Texas, the transfer penalty affects payments for institutional facility services and eligibility for home and community based waiver programs (e.g., CBA MDCP, CLASS, etc.). *1 T.A.C. §358.430(a)(2)*.

Many people, mostly non-lawyers, frequently confuse the gifting concepts in Medicaid planning. Practitioners should not inappropriately advise people to gift pursuant to the federal gift tax annual exclusion and assume that this is the protected gifting standard. Understanding that there are two sets of gifting rules from separate legal sources is paramount to successfully advising clients regarding gifting as an asset preservation technique.

This paper includes treatment of pre-DRA transfer rules for information purposes, since the pre-DRA rules apply to transfers occurring prior to February 8, 2006. Since the 60-month look-back rule has expired for pre-February 8, 2006 transfers, these transfers no longer have to be reported to HHSC on the Medicaid application and therefore the penalty for all pre-February 8, 2006 transfers has expired.

B. Pre-DRA Transfer Rules for Applications Filed (And Program Transfer Requests Made) Prior to October 1, 2006, and for Transfers Occurring Prior to February 8, 2006

The following rules apply to transfers of assets if the application was filed (or the request for a transfer to an institutional or waiver program was made) prior to October 1, 2006:

1. Look-Back Period

Only transfers occurring during the look-back period are subject to penalty. The look-back period is 36 months (or 60 months for certain transfers to and from trusts) prior to the month of Medicaid application or month of institutional entry, whichever is later. *42 U.S.C. §1369p(c)(1)(B)(i)*.

2. Exempt Transfers

Transfer of the home is exempt from penalty, if transferred to:

- The individual’s spouse;
- The individual’s child under age 21;
- The individual’s child of any age who is blind/disabled within the meaning of the Social Security Act;
- The individual’s sibling with an equity interest who lived in the home for at least one year prior to the individual’s institutionalization; or
- A son/daughter who lived in the home for at least two years prior to the individual’s institutionalization and who provided care that delayed that event. *42 U.S.C. §1396p(c)(2)(A)*.

As well, transfers of assets are exempt from penalty if transferred to:

- The individual’s spouse;
- Another for the sole benefit of the spouse;

- The individual's child of any age who is disabled within the meaning of the Social Security Act, or to a trust for the sole benefit of such a child;
- To a trust for the sole benefit of an individual under age 65 who is disabled within the meaning of the Social Security Act. *42 U.S.C. §1396p(c)(2)(B)*.

In addition, there is no penalty if a satisfactory showing is made that:

- The individual intended to dispose of the asset(s) at fair market value;
- The transfer occurred exclusively for reasons other than to qualify for Medicaid;
- All of the assets that were transferred have been returned to the individual;
- Application of the penalty period would work an undue hardship. *42 U.S.C. §1396p(c)(2)(C)*.

CAUTION: Effective September 1, 2009, Texas Medicaid adopted a rule that seems to restrict the ability of individuals to make transfer to a disabled child. The current rules seem to exempt such transfers if they are made in trust. *1 T.A.C. §358.401(d)(2)(B)(iv)*. However, the federal rule clearly states that transfers to a disabled child can either be directly to the child or in trust for the benefit of the child. *42 U.S.C. §1396p(c)(2)(B)(iii)*. When this is an issue, several practitioners have indicated that the state has followed the federal rule. The rationale was the rule was inconsistent with federal law or the rule can also be challenged based on the Maintenance of Effort provision in the Affordable Care Act (since the rule was not incorporated into the agency's handbook prior to March 23, 2010).

Another issue regarding transfers to a disabled child is when the child no longer receives disability benefits (i.e. the child has reached retirement age and now receives retirement benefits). A source from the agency has indicated that in such cases, that they will require an independent disability determination with HHSC's disability determination unit. This differs from the past where HHSC has accepted a statement from an expert witness regarding the disability determination.

3. Rules for Calculating the Penalty Period for Applications Filed During September 2005 and October 2005

In summary, here is how to calculate the penalty period in any transfer for less than fair market value:

- Determine the difference between the value of the property or money transferred, and the value paid (if any) to the client. If the client received nothing, use the full value of the asset(s) transferred.
- Divide that number by \$3,549.
- Round down to a whole number of months.
- Count the month in which the transfer is made as the first month of the penalty period (even if it was on the last day of the month).
- The first date on which payment for institutional services or eligibility for home and community-based waiver services can be established despite the transfer is the first day of the first month after the penalty period.

EXAMPLE: The client applies for Medicaid on September 1, 2005. On September 20, 2005, he transfers \$5,000. ($\$5,000 \div \$3,549 = 1.41$ or 1 month) The penalty period begins on September 1, 2005, and continues through September 30, 2005. The client is penalty-free beginning October 1, 2005.

4. Rules for Calculating the Penalty Period for Applications Filed from November 1, 2005, through September 30, 2006 (And for Applications Filed on or After October 1, 2006, If the Transfer Occurred Prior to February 8, 2006)

In summary, here is how to calculate such a penalty period:

- Determine the difference between the value of the property or money transferred and the value paid (if any) to the client. If the client received nothing, use the full value of the asset(s) transferred.
- Divide that number by \$122.50 (for case actions taken on or after September 1, 2007).
- Round down to the lower day.
- The penalty count begins on the first day of the calendar month in which the transfer occurred, even if the transfer occurred late in the month.
- The first day on which payment for institutional services or eligibility for home and community-based waiver services can be established is the first day after the penalty period ends. *HHSC's LTC ME Bulletin Number: 05-09, "Effective Date of Daily Penalty Calculation for Transfer of Assets," September 29, 2005.*

NOTE: This methodology allows for partial-month transfer penalties.

EXAMPLE: The client transfers \$5,000 on November 20, 2005, and applies for Medicaid in January 2006. The transfer divisor in 2006 was \$117.08. ($\$5,000 \div \$117.08 = 42.71$ or 42 days) The penalty period begins on November 1, 2005, and continues through December 12, 2005. The client is penalty-free beginning December 13, 2005.

5. Treatment of Multiple Transfers

If there are multiple uncompensated transfers in which the penalty periods overlap, all such transfers during the lookback period are totaled, and the total value is divided by the average private pay daily rate (currently \$122.50, for case actions taken on or after September 1, 2007), to calculate the penalty period. *42 U.S.C.A. §1396p(c)(1)(E)*. This prevents application of the pre OBRA '93 rule that allowed penalty periods for multiple transfers to run concurrently, thus allowing disposal of a much larger amount of property in a given time period.

However, if the penalty periods of two transfers do not overlap, they are treated as separate transfers. This is designed to prevent clients from making a small transfer to "start the clock running," then making a larger transfer later if Medicaid eligibility is needed, and including the entire period between the two transfers as a penalty period.

6. When the Penalty Period Begins

The penalty period begins "the first day of the month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility. *42 U.S.C. §1396p(c)(1)(D)*. HHSC has also applied the penalty beginning the first day of the month in which the transfer occurred.

C. Post-DRA Transfer Rules for Applications Filed on or After October 1, 2006, Which Apply to Transfers Occurring on or After February 8, 2006

1. Look-Back Period

Currently, the look-back period is 60 months prior to the first month in which the individual is both institutionalized and files a Medicaid application. *42 U.S.C. §1396p(c)(1)(B)(I)*. The effect of this longer look-back period is to attempt to reduce the amount of bulk transfers. This penalty period begins when the individual is in the nursing home, applies for Medicaid and would be eligible but for the penalty. *MEPD §I-2110, Appendix XLVV*.

UPDATE NO. 1: If an individual other than the Medicaid recipient paid the nursing home on behalf of a Medicaid applicant with the intent to reimburse themselves after Medicaid LTC benefits are approved, such an agreement must be memorialized in writing, otherwise the transfer of asset penalties will apply.

UPDATE NO. 2: Pursuant to John Stock with HHSC, transfers that occur *prior to* February 3, 2006 do not have to be reported on a Medicaid application, even though they may have occurred during the five year look-back period.

UPDATE NO. 3: For waiver services, there is an automatic 60-month look-back period because in order for the penalty to begin to run, the Medicaid recipient must receive services from the Medicaid program.

2. Exempt Transfers

The DRA 2005 did not change the types of transfers that are exempt from penalty, as outlined in Section V.D.2.

3. Hardship Waivers

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 information 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. *42 U.S.C. §1396p(c)(2)(D)*.

Moreover, while an application for an undue hardship waiver is pending, Medicaid may pay bed-hold charges to the nursing home for up to 30 days on the individual's behalf, if certain criteria to be specified by the Secretary of Health and Human Services are met. *Id.*

4. Rules for Calculating the Penalty Period

The DRA 2005 does not change the methodology for calculating the penalty period. The penalty period is calculated as explained in Section V.D.4.

5. Multiple Transfers

Texas treats the total cumulative value of all assets transferred in different months during the look-back period as a single event. Thus, the issue of overlapping transfer penalties does not exist as it did under the old law. *MEPD §I-5220*.

EXAMPLE: An individual transfers \$5,000 in February 2007 and an additional \$5,000 in April 2007. He enters a nursing home and applies for Medicaid in October 2007. He is eligible but for the transfer beginning October 1, 2007.

ANALYSIS:

Month	Amount Transferred
February 2007	\$5,000
April 2007	\$5,000

Total Transferred	\$10,000
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$\$10,000 \div \142.92 (daily rate beginning 9/1/11) = 69 days.

This penalty period begins on October 1, 2007, and it continues through December 13, 2007 (69 days). Thus, the first full month in which the individual is penalty-free is January 1, 2008.

This new treatment of multiple transfers lengthens penalty periods in many cases. Moreover, the combined effect of partial-month transfer penalties, coupled with treating multiple transfers as a single event, eliminated aggressive monthly gifting as a Medicaid planning strategy. Also, when penalty periods for pre-DRA and post-DRA transfers overlap, the penalty periods run separately but consecutively. *MEPD §I-5400.*

6. 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. *MEPD §I-5200.*

However, the penalty period cannot begin while another penalty period is running. *Id.* However, while the penalty period is running, the individual is eligible for “Mason Manor.” This means that the individual is eligible for all Medicaid benefits except for vendor payments to the facility. The individual will be eligible for vendor payments once the penalty has expired. *MEPD §I-5400.*

EXAMPLE #1: The individual transferred \$25,000 on November 1, 2006. She enters a nursing home and applies for Medicaid on October 1, 2007. She meets all Medicaid eligibility criteria but for the transfer beginning October 1, 2007.

ANALYSIS: Since the application is filed on or after October 1, 2006, and since the transfer occurred on or after February 8, 2006, the post-DRA 2005 transfer rules apply. The length of the penalty period is calculated as follows: $\$25,000$ (amount transferred) \div $\$142.92$ (daily rate used by HHSC) = 174-day penalty period.

Penalty Begins: October 1, 2007
 Penalty Ends: March 21, 2008

7. Return of Transfers

The Texas Medicaid program allows for the nullification of any penalty period if the recipient of the transfer for less than fair market value returns the item transferred. The asset is treated under the rules as if it were never transferred. *MEPD § I-5700.*

8. Administrative Procedures for Transfers of Nominal Amounts

Under current HHSC procedures, no penalty is imposed if the total amount of all transfers in a given calendar month does not exceed \$200.00.

VII. WHAT HAPPENS TO CLIENT INCOME AFTER ELIGIBILITY?

A. Co-Payment

After eligibility is established, the HHSC caseworker is responsible for calculating the applicant's co-payment to the nursing home. This used to be called the applicant's "applied income" payment. Ordinarily, the co-payment is less than the Medicaid approved rate charged by the nursing facility, and the Medicaid program pays the balance.

A similar process occurs in the CBA program. Essentially, under that program, the client in a community living arrangement may keep an amount equal to the income cap (\$2,022 in 2011); and in addition, if the client is married to an ineligible person, the spouse can have a spousal allowance equal to the SSI federal benefit rate (\$674 in 2011) minus income paid in the name of the spouse. *40 T.A.C. §48.6009*. Any additional income must be paid as a co-payment. Since a client in a community living arrangement with more than \$2,022 per month income can be eligible only by use of a Miller Trust (unless the income can be shifted with a QDRO, which would ordinarily reduce it to below the income cap), the co-payment provisions apply only in Miller Trust cases.

B. Calculation of Net Income

To the extent applicable, the following mandatory deductions from earned income are disregarded (treated as already distributed) in the applied income determination: income tax, Social Security tax, required retirement withholdings, and required uniform expenses. (Note that these deductions are not made when calculating income for the eligibility determination.)

UPDATE: The Texas Medicaid programs allows a deduction for any guardianship fees from the co-payment amount. However, there is a limit on the amount of fees that may be deduction in the determination of the Medicaid recipient's co-payment. Pursuant to the Texas Probate Code Section 670, a guardian may deduct up to \$175 per month in compensation to the guardian. The guardian is also allowed \$1,000 to begin the guardianship and \$1,000 to terminate the guardianship. No retroactive payments of these expenses are allowed.

C. Unmarried Clients

Income of unmarried clients is distributed according to the following priorities:

1. Personal needs allowance (\$60, except for certain veterans' benefits capped at \$90 per month, the full \$90 is the allowance).
2. Guardian fee allowance, if any
3. "Incurred medical expenses" (Medicare and other general health insurance premiums, deductibles and coinsurance; and cost of medical care and services not covered by Medicaid, such as dental care, and Medicare Part D prescription drug cost-sharing expenses paid by persons receiving both Medicare and Medicaid)
4. The "home maintenance allowance" (applies to institutionalized individuals who are certified by a medical practitioner as likely to return home within six months).

5. Co-payment to the nursing home
6. If any income remains, it can be used within limits, for the client's other needs. (This last category is likely to apply only when a Miller Trust is being used and the applied income exceeds the applicable Medicaid reimbursement rate to the nursing home.) There is no limit on the amount that can be used for medical services (including services of a private health aide). Amounts used for other purposes count as income so cannot exceed in any calendar month the amount of the income cap (currently \$2,022 per month in 2011). The trustee may allow it to accumulate in the trust, but transfer-of-asset provisions apply to funds retained in the trust beyond the month next following the month of deposit.

D. Couples With Both Spouses Eligible

Where both spouses are Medicaid eligible and reside in the same nursing home, their income is aggregated and distributed according to the following priorities:

1. Personal needs allowance of \$60 for each spouse (except that for certain veterans' benefits capped at \$90 per month, the full \$90 is allowed in addition for the recipient spouse); or \$4,044 if living at home; or if in an Assisted Living Facility, \$890 to the ALF and \$170 to the clients.
2. Guardian fee allowance, if any.
3. "Incurred medical expenses" (Medicare and other general health insurance premiums, deductibles and coinsurance; and cost of medical care and services not covered by Medicaid, such as dental care).
4. Home maintenance allowance if applicable.
5. "Co-payment" to the nursing home if any; otherwise, paid to the home care provider or Assisted Living Facility and called a "co-payment."

E. Spousal Impoverishment Cases

Where there is an ineligible spouse in the community, only the net income of the institutionalized spouse is considered. The community spouse can keep all income coming in his or her name, without limit (although the amount of it will affect the amount of the institutionalized spouse's income the community spouse may keep).

Where the institutionalized spouse is in a *nursing home*, his or her income is allocated according to the following steps:

1. Determine the net earned and gross unearned income of the institutionalized spouse.
2. Subtract the personal needs allowance of \$60 and guardian fee allowance if any.
3. Add in the community spouse's net earned and gross unearned income.
4. Subtract the minimum monthly needs allowance (in 2011, \$2,739).
5. If there are dependents, determine the dependent allowance.

In 2011, the complex formula for a dependent allowance yields an allowance per dependent of \$607.33 per month, if the dependent has no income. A dependent may be the couple's child (minor or adult), or a parent, sibling, half-sibling, step-sibling or adopted sibling of either spouse. The dependent must have been living in the client's home before the client's absence, must continue to live with the community spouse, and must "be unable to support himself outside the home because of medical, social or other reasons". Single parents need not apply, as there must be a community-based spouse for there to be a dependent allowance. *MEPD Chapter J*.

AUTHOR'S COMMENT: The dependent allowance is important and often overlooked. Also, in several cases, the worker has erroneously interpreted Form 1201 Section 10 to allow only one dependent allowance for all dependents together rather than multiplying the allowance by the number of dependents, which the rule requires.

1. Subtract "incurred medical expenses" (Medicare and other general health insurance premiums, deductibles and coinsurance; and cost of medical care and services not covered by Medicaid, such as dental care)
2. Pay the co-payment to the nursing home.
3. Any remaining income should be paid to the community spouse.

Where the institutionalized spouse is *at home* under the Community Based Alternatives program, his or her income is allocated according to the following steps:

1. Determine the net earned and gross unearned income of the institutionalized spouse.
2. Subtract the personal needs allowance of \$2,022 and guardian fee allowance if any.
3. Subtract the amount (if any) by which \$674 exceeds the community spouse's income. That amount (if any) goes to the community spouse.
4. Subtract dependent allowance if any.
5. Subtract "incurred medical expenses" (Medicare and other general health insurance premiums, deductibles and coinsurance; and cost of medical care and services not covered by Medicaid, such as dental care)
6. Pay what is left, if any, as a "co-payment" to the CBA home care provider

Where the institutionalized spouse is in an *Assisted Living Facility* under the Community Based Alternatives program, his or her income is allocated according to the following steps:

1. Determine the net earned and gross unearned income of the institutionalized spouse.
2. Subtract the room and board allowance of \$445 (which goes to the Assisted Living Facility) and guardian fee allowance if any.
3. Subtract the personal needs allowance of \$85 (which the institutionalized spouse may keep)

4. Subtract the amount (if any) by which \$674 exceeds the community spouse's income. That amount (if any) goes to the community spouse.
5. If there are dependents, determine the dependent needs allowance.
6. Subtract "incurred medical expenses" (Medicare and other general health insurance premiums, deductibles and coinsurance; and cost of medical care and services not covered by Medicaid, such as dental care)
7. Pay what is left, if any, as a "co-payment" to the Assisted Living Facility

AUTHOR'S COMMENT: The tiny spousal allowance of \$674 under the Community Based Alternatives program precludes use of that program where the community spouse does not have enough of his or her own income to live on. The PRA can almost never be increased, and the requirement of paying "room and board" (currently, \$445 per month) out of the income of the Institutionalized Spouse further impoverishes the community spouse. This is a "marriage penalty" that forces some clients into nursing homes when home care or Assisted Living Facility care would be more appropriate. In the author's view, it is a product of legislative oversight in the federal Medicaid law and should be changed. However, the intentional underfunding of the program by the Texas Legislature has overshadowed all other problems. The underfunding of the program has caused a lengthy waiting list which forces some who wish to bypass the list to qualify for home care under the Community Based Alternatives program, one must first leave home, qualify for Medicaid in a nursing home, and apply for Community Based Alternatives there.

F. Payment of Attorney's Fees in Indigent Cases

Never assume that you cannot get paid in an indigent guardianship case when the ward is receiving Medicaid benefits in a nursing home. An otherwise hopeless case for the payment of attorney's fees in an indigent guardianship case may start looking better if one applies a little known Medicaid rule. If the guardian/fiduciary fee is approved by court order, the order may then be submitted to HHSC for payment from the ward's Social Security or other income which otherwise would have been paid to the nursing home as an applied income payment. *IT.A.C. §358.502(f)*.

However, the amount of guardianship fees that will be approved by the court has been limited. The guardianship court can now limit the amount paid from the applied income of a Medicaid beneficiary to the following:

1. \$175 per month in compensation to the guardian,
2. Costs relating to the establishment or termination of a guardian, including ad litem and attorney's fee to not more than \$1,000, and
3. Administrative costs, not to exceed \$1,000 over a three year period. Texas Probate Code §670(b).

Note, the court does have the option of increasing the amount approved for attorney's fees and costs associated with the establishment or termination of the guardianship. Texas Probate Code §670(c).

VIII. TRUSTS AFFECTING MEDICAID ELIGIBILITY

A. General Rules on Trusts "Established By" the Client

1. History and Purpose of Trusts Established By the Client

In the past, the term “Medicaid Qualifying Trust” was sometimes used to refer to a trust into which the client transferred his or her property in order to qualify for Medicaid, while giving the trustee authority to distribute assets for the client’s benefit for needs not met by Medicaid. The federal statute was then amended by the Consolidated Budget Reconciliation Act of 1985 (“COBRA 1985”), using that term to apply to any self-settled trust in which the trustee had the discretion to transfer funds back to the settlor, and providing that all assets of such a trust would be treated as “available resources” of the settlor. Thus, such trusts became in reality Medicaid disqualifying trusts. The current statute (known popularly as OBRA 1993) continues and refines this principle. *42 U.S.C.A. §1396p(d)*.

2. Definition of “Established By” the Client (i.e. Self Settled Trusts)

A trust is “established by” an individual “if the assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will: (1) the individual; (2) the individual’s spouse; (3) a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual’s spouse; or (4) a person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual’s spouse.” *42 U.S.C.A. §1396p(d)(2)(A)*.

A trust established with property owned by the spouse of a Medicaid recipient would seem at first glance not to be subject to these rules, because it is property of the spouse rather than the Medicaid recipient. However, under Medicaid law, the term “assets” is defined to include assets of the spouse as well. *42 U.S.C.A. §1396(p)(e)(1)*. Therefore, the language “by will” in the statute quoted above may be critical, and property in a supplemental needs trust created in a revocable trust may be treated as available to the surviving spouse. The preferable technique is, therefore, to use wills rather than a revocable trust for estate planning for a couple with one spouse who is likely to be on Medicaid, and make the gift of the other spouse to a supplemental needs trust rather than to the survivor (Medicaid eligible) spouse directly.

3. Revocable Trusts Established by the Client

The corpus of an revocable trust is considered an available resource for Medicaid purposes. Moreover, a homestead placed in the revocable trust is considered a countable resource and in order to be excluded, must be removed from the trust.

Both income and assets withdrawn from the trust are treated as income for Medicaid purposes, unless used to purchase medical/social services for the Medicaid client. *MEPD §F-6400*.

Transfers to such a trust are not penalized. Transfers from a revocable trust have a 60-month look-back period; and if the trust becomes irrevocable by its terms (for example the death of the first spouse or upon the need for LTC), that is treated as a transfer with a 60-month look-back period. *MEPD. §F-6400*.

4. Rules Applying to Irrevocable Trusts Established by the Client

Any portion of the corpus from which payments may be made to the client is considered an available resource. *42 U.S.C.A. §1396p(d)(3)*. Any portion of undistributed income from which payments may be made to the client is also considered an available resource.

Payments from any portion of the corpus or income from which payments may be made to the applicant are considered income, unless used to purchase medical/social services for the Medicaid client *1 T.A.C. §358.417(d)(1)(B)*.

If trustee payments from any portion of the irrevocable trust are not foreclosed to the Medicaid client, any trust payment from that portion which benefits someone other than the Medicaid client is a transfer of assets with a 36 month look back period. *42 U.S.C.A. §1396p(c)(1)(B)(i)*. (NOTE: All transfers which are subject to the provisions of the DRA 2005 have a 60-month look-back period.)

Any portion of the corpus (or income generated by the corpus) from which payments may not be made to the client is considered to have been transferred for less than fair market value. The date of the transfer is the later of: (1) the date the trust is established, or (2) the date payment was foreclosed to the client. *42 U.S.C.A. §1396p(d)(3)(B)(ii)*. The lookback period for this type of transfer is 60 months. *42 U.S.C.A. §1396p(c)(1)(B)(i)*.

The federal statute requires states to establish procedures under which the agency waives these trust rules if the individual establishes that their application would “work an undue hardship” on the client. *42 U.S.C.A. §1396p(d)(5)*. Centers for Medicare and Medicaid Services defines this as follows: “Undue hardship exists when application of the trust provisions would deprive the individual of medical care such that his/her health or his/her life would be endangered. Undue hardship also exists when application of the trust provisions would deprive the individual of food, clothing, shelter, or other necessities of life.” *State Medicaid Manual §3259.8A*.

B. Exceptions To General Rules Governing Trusts “Established By” the Client

There are two types of special needs trusts (“SNT”) that are exempt from the transfer of asset penalties: a self-settled SNT and a pooled SNT. It is important to note that a Miller Trust established for the Medicaid applicant is exempt from the transfer penalties, however, that trust is discussed in more detail in Section III.D.

1. Under 65 Supplemental Needs Trusts

The most common purpose of this type of trust is to insulate from consideration by Medicaid the proceeds of an award or settlement based on a legal claim, most commonly for personal injury. Another important purpose, especially where home care is involved, is simply to make the assets of the client go further by qualifying for Medicaid benefits before they are all used up. *42 U.S.C.A. §1396(d)(4)(A)*.

This “exception” to the self settled trust rules is available only to persons meeting the following requirements:

- Under age 65 at the time the trust is established. After the client reaches age 65, the trust’s “exception” status continues as to assets transferred into it before age 65, but assets added after the client turns 65 are subject to transfer-of-asset provisions, and
- Disabled as defined in the requirements for Social Security Disability or SSI benefits.

The trust must meet the following requirements:

- Established for the benefit of the client by a parent, grandparent, legal guardian of the client, or a court.
- 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.
- The Texas Medicaid program currently requires the Medicaid subrogation lien to be satisfied before the trust is funded.

- Although the statute is silent as to provisions for distributions of corpus to or for the beneficiary, it is probably necessary that such distributions either be entirely discretionary with the trustee, or limited to distributions that will “supplement and not supplant” public benefits. If “support” requirements are included, Social Security or HHSC may argue that the corpus is “available” because the beneficiary could compel distributions. (At present, neither of those agencies in Texas has taken that position, but agencies in some states do.)
- Although the statute allows funding of the trust with any property owned by the beneficiary, agency representatives in some states have sometimes erroneously allowed such trusts to be funded only with personal injury awards and not with inheritances and property owned by the beneficiary.
- The trust must be irrevocable to comply with the general trust rules discussed above, and in the case of Supplemental Security Income (“SSI”) recipients, to comply with the SSI rules.

2. Pooled Supplemental Needs Trusts

These trusts have essentially the same purpose as the Under-65 Supplemental Needs Trust. *42 U.S.C.A. §1396(d)(4)(c)*. The “pooled” trusts do not have a maximum age requirement. However, transfers by settlors 65 years of age or older that occur after September 1, 2000, are subject to the transfer penalty to the same extent as other Medicaid motivated transfers. Generally, pooled trusts may offer more professional and efficient management and lower per client setup costs.

This “exception” to the self-settled trust rules is available only to persons meeting the following requirements:

- No age requirement. Assets transferred to a pooled trust by a qualified client do not count as resources. However, under a rule referenced above, a transfer penalty applies to a transfer by a client age 65 or over. *State Medicaid Manual §3259.7B*.
- Disabled as defined in the requirements for Social Security Disability or SSI benefits.

The trust must meet the following requirements:

- The trust is established and managed by a non-profit association.
- A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.
- Accounts are established in the pooled trust only for individuals who are disabled (as defined for Social Security and SSI benefits) by a parent, grandparent, or legal guardian of such individuals, by the individuals themselves, or by a court.
- To the extent that amounts remaining in the client’s account upon the death of the beneficiary are not retained by the trust, 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. *42 U.S.C. §1396p(d)(4)(c)*.

The Association for Retarded Citizens (“ARC”) has established a pooled trust that accepts contributions from persons residing anywhere in Texas. The ARC Pooled Trust provides professional management at less than the cost charged by many corporate trustees. Its effectiveness for sheltering certain assets has been pre-established by negotiation with the state Medicaid program - a process not available to individuals. And it does not require paying an attorney fee to establish the trust (although legal counsel is definitely needed to determine whether or not this is the best disposition of the assets and to provide independent advice as to the alternatives).

To the extent the remainder may exceed reimbursements for Medicaid, the trust can pay the remainder to other designated beneficiaries (usually family members); and at the option of the grantor, the trust may retain all or a

portion of the remainder (for other disabled trust beneficiaries) before reimbursement to the Medicaid program. Although HHSC representatives have stated that they believe Medicaid should be reimbursed before the trust receives anything, the trust instrument says otherwise.

C. Rules Affecting Trusts Not “Established By” The Client (i.e. Third-Party Settled Trusts)

1. Nature and Purpose of Third-Party Settled Supplemental Needs Trusts

A third-party settled trust is one that is established and funded by someone *other than* the client. Such trusts may, for example, be established by parents or other relatives of disabled persons receiving SSI; by wills of CSs of nursing home residents; or (by will) by recipients of gifts in the planning process. They may also be established by defendants in personal injury cases (or their insurers), for recipients of SSI and/or Medicaid. However, they may preclude Medicaid eligibility if they do not comply with the rules discussed above for trusts established by the client.

Trusts established with assets belonging to someone other than the client need not have provisions for repaying Medicaid benefits to the State, nor are they affected by the age restrictions nor other provisions discussed above. Instead, they have their own requirements, which are found nowhere in the statutes or regulations, but have been developed by 50 years of common law.

The purpose of such trusts is to provide for the needs of the beneficiary not met by public benefits programs. Accordingly, if the client receives Medicaid through SSI, distributions from them are highly restricted, as discussed below. The public policy supporting such trusts is to encourage private support for disabled persons eligible for public benefits.

2. Requirements for Third-Party Settled Supplemental Needs Trusts

In order to be considered a third-party settled SNT the corpus of the trust must have been contributed by someone other than the beneficiary.

Also, the beneficiary must have restricted access to the trust property. In order for the trust assets not to be considered a countable resource, the beneficiary must not be empowered to revoke the trust or to compel distributions for his/her own support and maintenance. *SSI, Program Operations Manual System (“POMS”), §01120.200D.2.*

Discretion of the trustee to utilize corpus and income for support and maintenance may not make the corpus an available resource. If the client receives Medicaid in conjunction with SSI, the trust should not contain “support” language and should either be totally discretionary, or should state clearly that trust assets are to be used to supplement, not supplant, governmental benefit programs. However, in Texas, the Long-Term Care Medicaid program will not count the corpus of a non-grantor trust as a resource, even if the trust contains “support” requirements. Rather, all distributions of income or principal are treated as follows for SSI/Medicaid eligibility purposes:

- Cash disbursements to the beneficiary (or to his/her guardian) are considered income to the beneficiary and are counted dollar for dollar. *POMS §SI 01120.200E.1.a.*
- Disbursements to vendors which result in the beneficiary receiving food or shelter are considered to be income in the form of in-kind support and maintenance (“ISM), which is capped in value at \$244.67 per month (in 2011). *POMS §SI 01120.200.E.1.b.*
- Disbursements to vendors which result in the beneficiary receiving items/services which are neither food nor shelter are not income to the beneficiary at all. *POMS §SI 01120.200E.1.c.*

Finally, the trust must be irrevocable.

IX. MEDICAID ESTATE RECOVERY PROGRAM

Medicaid estate recovery was mandated by the Omnibus Budget Reconciliation Act of 1993 (“OBRA 1993”). The estate recovery provisions of that statute are codified at *42 U.S.C.A. §1396p(b)(1)*. The law mandates recovery for individuals who were 55 years of age or older at the time that they received the following services for which recovery is required: nursing home services, home and community-based services, and related hospital and prescription drug services. *42 U.S.C.A. §1396p(b)(1)(B)*. In addition to recovering for the mandatory services, states have the option of recovering the costs of any and all items and services provided to the Medicaid client under the State Medicaid plan. *42 U.S.C.A. §1396p(b)(1)(B)(ii)*.

The purpose of this section is to provide a brief overview of the program and is not intended to be an exhaustive discussion on MERP and the strategies of defeating a MERP claim.

A. Applicability of Estate Recovery

In Texas, a Medicaid estate recovery claim may be filed against the estate of a deceased Medicaid recipient for covered Medicaid services if the recipient was 55 or older at the time the services were received and initially applied for Medicaid on or after March 1, 2005. *1 T.A.C. §373.103(a)*.

Services covered under the estate recovery program include nursing home services, ICF-MR services, home and community-based waiver services (e.g., CBA, CLASS, etc.), certain Medicaid-funded attendant services; and related hospital and prescription drug services. *1 T.A.C. §373.103(c)*. Acceptance of one of these Medicaid-funded covered services provides the basis for a Class 7 probate claim. *1 T.A.C. §373.201*. Note: A March 5, 2008 bulletin from Chicago Title to all of its agents and operators in Texas, advised them to pay all MERP claims without exception in order to insure title, effectively placing a lien on the property. DADS and HHSC were not aware of the existence of the memo. This Chicago Title memo has since been withdrawn.

B. Basis of the Claim

A MERP claim is considered a Class 7 probate claim under Section 322 of the Texas Probate Code. Class 7 claims are based on the acceptance of Medicaid medical assistance, as defined by Title XIX of the Social Security Act, including mandatory and optional payments under the Social Security Act.

C. Definition of Estate

The “estate” for MERP purposes is defined as real or personal property (including additions, accretions, and substitutions) which is included in the probate estate, as defined at §3(1), Texas Probate Code. *1 T.A.C. §373.105(b)*. This is a key definition because it does not allow for recovery against non-probate assets, such as remainder interests and the interests of survivors in multi-party accounts (i.e. POD or JTROS accounts).

D. Notice Requirements

Written notice of the MERP provisions will be provided to individuals for Medicaid-covered services with an application packet. The notice must contain a description of MERP, information as to covered Medicaid long-term care services subject to estate recovery, a description of the claim procedure found in Section 322 of the Texas Probate Code, information regarding transfer of asset penalties and the look-back period and a description of the undue hardship procedures and information regarding the MERP Notice of Intent to File a Claim upon the death of the Medicaid recipient.

E. MERP Claim Procedure

The MERP claims procedure begins when the program receives information regarding the death of a Medicaid recipient. Within 3 days after the receipt of such notification, MERP will send a Notice of Intent to File a Claim to the estate's personal representative and to other specified representatives and family members. *1 T.A.C. § 373.307(a)*. This Notice will include a MERP Questionnaire to be completed and returned to MERP. The purpose of this questionnaire is to gather information regarding the deceased beneficiary's estate, as well as to determine if a statutory exemption exists that would preclude estate recovery.

Within 60 days after the date of the Notice of Intent to File a Claim, the Undue Hardship Request must be made. *1 T.A.C. § 373.307(c)*. Also within 60 days, any requests for deductions from the amount of the claim must be made. Allowable deductions from the claim are for home maintenance or home care expenses. *1 T.A.C. § 373.213(a)*. Such requests must be supported with receipts and/or other written documentation.

Within 40 days of the receipt of the request for an Undue Hardship Waiver, a determination of the waiver must be made. *1 T.A.C. § 373.209(e)*. If the waiver is denied, the person requesting the waiver has 60 days to request an informal review. *1 T.A.C. § 373.211(a)*. There is no right to a hearing or an appeal of a denial of an Undue Hardship waiver.

Within 70 days after the date MERP has actual notice of the death, MERP files a claim "in accordance with applicable provisions in the Texas Probate Code." *1 T.A.C. § 373.203(b)*. That is, if there is an independent executor or administrator, it should not be filed in court but can be in any form and should go directly to the independent executor or administrator. If there is a dependent executor or administrator or a guardian, the claim must be filed in the probate court as a sworn claim meeting all of the requirements of the Texas Probate Code.

F. MERP Exemptions

The estate is exempt from recovery efforts if there is either a(n):

- Surviving spouse,
- Surviving child under age 21,
- Surviving blind/disabled child, or
- Unmarried adult child residing in the decedent's home continuously since at least 1 year prior to the decedent's death. *1 T.A.C. § 373.207(a)*.

There are also exemptions for certain assets of American Indians and/or Alaska Natives (*1 T.A.C. § 373.207(b)*) or for government reparation payments to individuals in special populations. *1 T.A.C. § 373.207(d)*.

G. Undue Hardship Waivers

MERP will not recover from an estate if recovery would cause an undue hardship. An undue hardship does not exist solely because recovery would prevent heirs or legatees from receiving an anticipated inheritance or due to circumstances giving rise to a hardship created by, or are the result of, estate planning methods under which assets were sheltered or divested contrary to requirements of Medicaid law in order to avoid estate recovery. *1 T.A.C. §373.209(b)*.

The bases (i.e., grounds) for an undue hardship waiver are as follows:

- The estate has been operated as a family business, farm, or ranch for at least 12 months prior to decedent's death;
- The estate produces 50% or more of the income of the heirs/legatees; and recovery would cause heirs/legatees to lose their primary income source;
- Recovery would cause heirs/legatees to become eligible for public/medical assistance;
- Waiving recovery would allow one or more survivors to quit public/medical assistance;
- The decedent received Medicaid as the result of being a crime victim; or
- Other compelling reasons. *1 T.A.C. §373.209(c)*.

There is no blanket exemption on the value of the homestead. However, up to \$100,000 of the tax value of the home may be exempt under undue hardship provisions if the following conditions are met: (1) siblings or lineal descendants of the decedent will inherit the home; and (2) each sibling or lineal descendant has gross family income of less than 300% of the federal poverty level ("FPL"). If the home will pass to multiple heirs not all of whom qualify for an undue hardship waiver, then only the percentage of the home that corresponds to the qualifying heir(s)'s share is exempt from recovery. *1 T.A.C. §373.209(d)*.

For purposes of determining whether the 300% FPL threshold is met, the heirs are not aggregated into a single family. Rather each heir is considered separately. The term "family" is defined as follows: (1) for adults age 18 and older and emancipated minors, the family consists of the heir, the heir's spouse, and the heir's minor children (including step-and adopted); (2) for children under age 18, the family consists of the heir, the heir's parent(s), the heir's stepparent, and the heir's minor siblings (including half-, step -, and adopted -) residing in the household. *1 T.A.C. §373.209(d)(5)*.

The survivors have the right to a review of the denial of an undue hardship waiver request. The request for a review must be submitted within 60 days of the denial notice, and the review is an informal process - not a fair hearing. The MERP must review the request within 40 days of receipt. *1 T.A.C. §373.211(a)*.

H. Deductions from the Claim

There are certain allowable deductions from the estate recovery claim. These are as follows: (1) reasonable and necessary expenses incurred in maintaining the decedent's home (i.e., property taxes, utility bills, homeowner's insurance, home repairs, and lawn care; expenses incurred in paying the decedent's costs of care (including attendant care) that delayed nursing home entry. Supporting documentation (e.g., receipts) must be provided. *1 T.A.C. §373.213*.

Requests for allowable deductions from the estate recovery claim must be submitted to the MERP within 60 days of receipt of the Notice of Intent to File Claim (after decedent's death).

I. Recovery Not Cost-Effective

Waivers of the estate recovery claim for lack of cost-effectiveness may be granted in the following situations:

- The value of the recoverable estate is \$10,000 or less;
- the recoverable Medicaid costs are \$3,000 or less; or
- the costs of selling the property equals or exceeds its value. *1 T.A.C. §373.215.*

X. CONCLUSION

We have provided herein a comprehensive overview of the long-term care Medicaid program in Texas. While long-term care does include institutional programs, it also includes various community-based programs which are designed to prevent inappropriate institutionalization and to serve as a cost-effective alternative to institutional placement. As well, we have reviewed some of the services available to all Medicaid recipients in Texas.

The elder law practitioner must be mindful of ethical issues involved in Medicaid planning, such as identifying the client, providing competent and diligent representation, and avoiding fraudulent misrepresentation of facts to state Medicaid officials. Medicaid eligibility criteria relative to income and assets are exceedingly complex and specific. Especially complicated are “spousal impoverishment” cases, where one spouse is in a nursing home and the other spouse remains in the community. In such cases, the elder law practitioner is challenged to apply his/her craft wisely to protect the interests (financial and medical) of both spouses. OBRA 1993 made significant changes to how the Medicaid program views self-settled trusts, but also provided for the exemption of certain types of trusts from consideration as assets available to the Medicaid client. Moreover, OBRA 1993 prescribes penalties for transferring (or gifting) assets for less than fair market value and for less than adequate consideration.

The DRA of 2005, effective February 8, 2006, made important changes that affect Medicaid planning. These changes include lengthening the look-back period to 60 months for all transfers, changing the beginning date of the transfer penalty to the date the individual would otherwise be eligible but for the transfer, imposing a transfer penalty for purchasing a life estate in someone else’s home (unless the purchaser lived there at least one year after purchase), denying nursing home vendor payments on behalf of someone whose home equity exceeds \$500,000, requiring the “income-first” methodology in PRA expansions, and changing the rules pertaining to annuities and promissory notes.

APPENDIX I
“CRIMINALIZATION” OF MEDICAID-MOTIVATED TRANSFERS

The following are changes to 42 U.S.C.A. §1320a-7b(a) contained in §4734 of H.R. 2015 (*Balanced Budget Act of 1997*):

(I) Whoever...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 section 1917© shall

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

In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under subchapter XIX of this chapter is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provisions of that subchapter or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

Effective Date: August 5, 1997

Note: Enforcement of this law has been enjoined in *New York State Bar Association v. Reno*, 97 CV 1768 TJM DRH, (S.D.N.Y.).

APPENDIX II BIBLIOGRAPHY OF MEDICAID ELIGIBILITY IN TEXAS

I. STATE LAW

A. State Statutes

Texas Human Resources Code Chapter 32: Medical Assistance Program (This provides little guidance because its primary purpose is to authorize rules to comply with federal statutes and rules governing the Medicaid program. The federal statutes and rules, cited below, are the ultimate authority.)

B. State Rules

1 T.A.C. Chapter 358: Medicaid eligibility rules of Health and Human Services Commission. Make an open records request for the full text of the current version of 1 T.A.C. Chapter 358 in Word Perfect on computer disk, which at this writing is provided at no cost. It can be ordered from the Health and Human Services Commission at 4900 North Lamar, Austin, Texas 78751. The telephone number is (512) 424-6500. Copies of 40 T.A.C., Chapter 19, (Nursing Facility regulations) and Chapter 48 (Home Care programs) may be obtained from the Department of Aging and Disability Services (“DADS”) at 701 West 51st. Street, Austin, Texas 78751. The telephone number is (512) 438-3011.

40 T.A.C. Chapter 19: DADS rules governing conditions in nursing homes. Includes important Medicaid rules on requirements for transfer and discharge of Medicaid beneficiaries (Subchapter F); “medical necessity” for nursing home care, which is required for Medicaid eligibility (Subchapter Y); and PASARR rules, to divert certain individuals with mental illness and mental retardation from nursing facilities to other institutions (Subchapter Z). These rules are available from the Department of Health & Human Services as a separate set called “Nursing Facility Requirements for Licensure and Medicaid Certification.” Or get the regulations free as indicated above.

40 T.A.C. Chapter 48: Community Care (primarily financed by Medicaid)

C. State Administrative Procedures

Medicaid Eligibility Handbook: 2 volumes (Text and Forms), available from HHSC (see below). Recent price \$150. Incorporates rules, adds administrative procedures and policies.

The Medicaid Eligibility Handbook is online at: <http://www.dads.state.tx.us/handbooks/meh/>

The foregoing manuals, including updates, are available from the Health and Human Services Commission. To obtain the manual and updates, contact the Health and Human Services Commission at (512) 424 6500 for current prices and ordering information.

For the Medicaid eligibility rules on floppy disk in Word Perfect at no charge, send a written request to the Health and Human Services Commission, 4900 North Lamar, Austin, Texas 78751.

For proposed and recently adopted rules, go to the Texas Register at: <http://texinfo.library.unt.edu/texasregister/>

D. Materials on State Law

1. “Long-Term Care Medicaid Eligibility in Texas (Title XIX)”: HHSC summary sometimes called the “Pickle Paper.” Very useful summary. Distributed free at HHSC offices.

2. "How to Get Help Paying Nursing Home Costs" (2002): 6 page summary of the Texas Medicaid program prepared for consumer use by the author of this bibliography. Updated frequently.
3. State Bar of Texas Elder Law Institutes, 1992, 1994, 1996, 1999, 2001: Useful Texas specific articles. The 1992 and 1994 articles are somewhat dated now because of OBRA 93.
4. Texas Medicaid in Perspective: Summarizes all Texas Medicaid programs, including long-term care. Excellent source of readable program descriptions, with extensive data in charts, graphs and well written text. Most recent edition at this writing is 3rd Edition (1999). Available from Texas Health & Human Services Commission, P.O. Box 13247, Austin, TX 78711.

II. FEDERAL LAW

A. Federal Statutes

1. 42 U.S.C.A. §1301 1320c 13: General administration of Medicare and Medicaid programs
2. 42 U.S.C.A. §1382 1383c: Supplemental Security Income ("SSI") program. Contains many provisions incorporated by reference into the Medicaid statutes. See especially 42 U.S.C.A. §1396a(a)(10)(ii)(V).
3. 42 U.S.C.A. §1396 1396u: Provisions applying specifically to "Medical Assistance Programs" (Medicaid)

B. Federal Rules

1. 20 C.F.R. §416: Supplemental Security Income program rules, whose resource and income requirements form the basis for most Medicaid requirements under the provisions of 42 U.S.C.A. §1396a(a)(10)(ii)(V).
2. 20 C.F.R. §430 et seq.: Federal requirements for State Medicaid programs
3. 20 C.F.R. §435 et seq.: Federal eligibility requirements (giving states many options)

C. Federal Administrative Procedures

1. Social Security Program Operations Manual System (P.O.M.S.): Operating policies and procedures, to which HHSC looks for detailed guidance on its rules, policies and procedures. Now online at <http://policy.ssa.gov/poms.nsf>.
2. Centers for Medicare & Medicaid Services (formerly Health Care Financing Administration) State Medicaid Manual: contains important instructions to State agencies as to how CMS interprets the federal requirements. See especially the sections on transfers, trusts and spousal impoverishment. Browse or download free from <http://www.cms.hhs.gov/manuals/>

D. Materials on Federal Law

1. CCH Medicaid and Medicare Guide: full texts of statutes and regulations; summaries of cases, new policies, etc. Costs about \$1,100.
2. Mezzulo & Woolpert, Advising the Elderly Client. 3 volume treatise with extensive chapters on Medicaid
3. Regan, Morgan, English & Gilfix, Tax, Estate & Financial Planning for the Elderly. 2 volume treatise (Text and Forms) with the most readable summaries of Medicaid available (though not state specific). Full text of both volumes, including forms, is on Matthew Bender's Elder Law Authority CD (see below).

4. Kruse, Third Party and Self Created Trusts: a Lawyers Comprehensive Reference, 2nd Ed. (1998). Treatise and forms on how to draft trusts that do not disqualify their beneficiaries for receipt of Medicaid and other public benefits. Published by American Bar Association Section of Real Property, Probate and Trust Law.
5. Matthew Bender, Elder Law Authority. A CD product that includes the Regan, et al. treatise, with links to most of the source law and voluminous other materials. Approximately \$600 for a one year subscription.
6. West Group, Estate & Elder Mezzulo & Woolpert Treatise and Koren, Estate and Personal Financial Planning. Much stronger on federal tax materials than the Matthew Bender product; but the Regan treatise is so valuable that owners of the West CD who practice public benefits law will probably want to purchase it separately, either in hard copy or on the Matthew Bender CD.

III. INTERNET RESOURCES

Benefits Checkup (automated benefits analysis): <http://www.benefitscheckup.org/>

Caregiver resources: <http://www.caregiver.org>; <http://www.alzheimers.org>; <http://www.strokenetwork.org>;
<http://www.seniornavigator.com>; <http://www.eldercare.gov>; <http://www.aarp.com>

Elder Law as a profession: <http://www.naela.com>

Elder Law information and links (including U.S. Code and CFR's): <http://www.keln.org>; <http://www.elderweb.com>;

Federal Medicaid and Medicare information (Centers for Medicare & Medicaid Services, formerly HCFA):
<http://www.cms.hhs.gov/>

Elder Law information and links, and referrals to Elder Law attorneys: <http://www.elderlawanswers.com>

Federal rules: <http://www.access.gpo.gov/>

Federal statutes (including recent and proposed legislation): <http://thomas.loc.gov>

Federal programs, services and resources for persons with disabilities: <http://disability.gov>

Health related information: <http://www.healthfinder.gov>

Kaiser Family Foundation (information on Medicaid and health care delivery): <http://www.kff.org/>

Social Security information: <http://www.ssa.gov/>

State Bar of Texas CLE downloads: <http://www.statebarcle.com/CLE/home.asp>

Texas administrative code: <http://sos.state.tx.us/tac/>

Texas and federal statutes and regulations (links to): <http://suefaw.home.texas.net/>

Health and Human Services Commission program information: <http://www.hhsc.state.tx.us/>

Texas Health & Human Services Network: <http://www.tx.net/default.asp>

Texas Health & Human Services Information & Referral: <http://www.hhsc.state.tx.us/>

Texas Probate website: <http://www.texasprobate.com>

IV. ANNOTATED BIBLIOGRAPHY

For a much more comprehensive bibliography on Elder Law in general, see SUSAN WHITMAN, Elder Law Resource Bibliography, 2nd ed. (article in conference materials for the University of Texas School of Laws Second Annual Elder Law Conference, 1998).

APPENDIX III MILLER TRUST INSTRUCTION LETTER

Date

&&

###

Re: @@ Income Trust

Dear Mr./Ms. :

This letter is intended to provide you with instructions for establishing and managing the @@ Income Trust, a “Miller” Trust, of which you have agreed to be trustee.

Purpose of the Trust

The purpose of this trust is to make @@ eligible for Medicaid long term care benefits by reducing the amount of his income that is counted for eligibility purposes. Under the law, any income that goes through the trust is not counted. If any income accumulates in the trust, then at his death, it will be paid to the state to reimburse the Medicaid program for benefits he has received. This allows Mr. ## to receive more in benefits than could be obtained with his income alone.

Steps Required to Establish the Trust

1. Sign the document. You will need to sign the original Miller Trust in front of a notary public. Please fax a copy of the signed, notarized trust document to our office once that has been accomplished.
2. Open a bank account. Go to the bank or credit union of your choice, and open whatever account is most convenient for writing a few checks per month. It can be the same type of account an individual would use, but the bank will need to see the trust instrument. Until recently, Miller trusts required a separate taxpayer identification number obtained from the IRS, but this is no longer necessary. @@’s Social Security number can be used for the trust account. Only you should be authorized to draw on the account, and there should be no survivorship provision. The account should be in the name of the trust only. Bank policies may vary slightly on the styling of trust accounts, but typically the account will be styled “@@ Income Trust, \$\$, Trustee.”
3. Transfer income to the bank account. Income must be transferred into the trust account in the same month in which the income is received. Even if the income is initially paid directly to the beneficiary or is direct deposited to another account, you can transfer it to the trust, as long as you transfer it into the trust account during the same month. For convenience, and to be sure it goes into the trust account during the month of receipt, I recommend that you arrange for direct deposit of the income into the trust account.

Depositing Income into the Trust Account

Deposit *only* current income of the beneficiary into the trust account. Do not, for example, deposit funds received before the month the trust is established.

Transfer all of Mr. ##’s monthly income, or certain income, e.g. Social Security or pension income into the trust account each month during the month the income is received. Do *not* transfer only a part of the e.g., pension income; all of the income from a particular source must be deposited into the trust. Also, do *not* transfer any other asset of any kind into the trust account, whether it belongs to Mr. ## or to someone else.

Administration of the Trust

Writing checks to make distributions from the trust is just like writing checks on your own account, except that you will sign the checks “\$\$, Trustee.” **However, it is very important that you administer the trust according to the rules of the Medicaid program, to maintain Mr. ##’s eligibility.** If you make a payment in the wrong amount or for the wrong purpose, he may lose eligibility for a month or more.

In general, @@'s income (including that which goes through the trust and that which does not, if any) should be paid in the following priority: (1) a personal needs allowance for any needs of Mr. ## (currently \$60 per month is allowed); (2) an allowance for Mr. ##'s spouse as specified by TDHS to bring her income up to the level of the Minimum Monthly Maintenance Needs Allowance (currently \$2,541.00 per month); (3) all unreimbursed medical expenses, such as the Medicare Part B premium if any (usually that is deducted from the Social Security check before it is received), private medical insurance premiums if any, and medical expenses not covered by public benefits or insurance; (4) Applied Income, which is income that must be "applied" for Mr. ##'s care--usually for nursing home expenses--to reduce the amount paid by Medicaid.

In Mr. ##'s case, once the applied income is paid, there is virtually no chance that any income will remain in the trust. If there is any income left in the trust after all the listed payments have been made, it must be retained and accumulated in the trust, to be paid to the State upon Mr. ##'s death.

This general summary is not intended to replace the caseworker's specific instructions. If you have questions about payments or about any instructions you have received from TDHS, please contact my office.

Make a record of all checks written. For each check, record in your checkbook or computer record the check number, date written, payee, purpose, and amount. This is essential for making sure you can prove that the checks have been made for permissible purposes. If you write in your checkbook all the information indicated above, then the checkbook and your monthly statements from the bank will be the only records you will need, assuming the trust is not generating enough interest income to require filing an income tax return for the trust--a very unlikely event. You will, of course, want to have a file containing the trust instrument, a copy of the Medicaid application and related documents, and correspondence from TDHS, our office and others related to this case.

If @@ ceases to be a Medicaid beneficiary for any reason, the money in the trust can be used for any needs he may have. However, if any money is left in the trust at his death, it will go to the State.

It is unlikely that you will need to file an income tax return for the trust, because it is unlikely that the trust will have enough income of its own to require a return. Under current law, the trust will be required to file an income tax return (form 1041) only if (1) it has over \$100 in income in a calendar year, after all deductions (including estate administration expenses and income distributed to or for the benefit of Mr. ##) or (2) its gross income is over \$600 in a calendar year. If you decide to put some of the money in an interest-bearing account, you should consult with a tax advisor about the reporting responsibilities that will result. Because the State receives the money at @@'s death, and because the potential trust income should be minimal, it may be best to use only a checking account that pays no interest, and which has no fees if possible.

I hope these instructions are helpful. If you have any questions, do not hesitate to call me.

Sincerely,

**APPENDIX IV
MILLER TRUST DOCUMENT**

**TRUST DECLARATION
OF
@@**

This declaration of trust is made by @@, hereinafter referred to as the “settlor”, who is also a beneficiary of this trust.

**ARTICLE I
NAME OF TRUST AND TRUST PURPOSE**

This trust shall be known as the @@ INCOME TRUST. The settlor of this trust requires continuing medical and nursing supervision and is dependent upon others for her personal care. The overriding purpose of this trust is to obtain the necessary care from whatever sources may be available. To that end this trust is designed to assist the settlor in meeting the requirements of eligibility for benefits under the Medical Assistance Program in the State of Texas, under the provisions of 42 U.S.C.A. §1396p(d)(4)(B) as amended by The Omnibus Budget Reconciliation Act of 1993 (effective August 10, 1993) and all other applicable laws, regulations and administrative procedures.

**ARTICLE II
SETTLOR**

The settlor and the Texas Department of Human Services shall be the sole beneficiaries of the trust. The settlor’s Social Security number is _____ The settlor presently resides at _____.

**ARTICLE III
APPOINTMENT OF TRUSTEE**

The settlor hereby appoints ## as the trustee of this trust. The trustee shall serve without bond or supervision of any court.

**ARTICLE IV
TRUST ESTATE**

4.1. Income Trust. It is the settlor’s intent to transfer all or part of her income into the trust, to be held and managed as the trust estate. Only “income” of the settlor, as defined by the rules and laws governing the Medical Assistance Program in Texas, may be transferred to the trust.

4.2. When Income Transferred. Income of the settlor to be transferred to the trust shall be so transferred in the same month in which it is received by the settlor, unless a longer time is authorized by regulation or written directive by the agency administering the Medical Assistance Program. Income may be transferred directly from the income source to the trust.

4.3. All Income From Same Source. If income from any source is transferred to the trust in a given month, all income from that source shall be transferred to the trust in the same month. For example, the trustee may not transfer to the trust only a part of the settlor’s Social Security income to the trust in any given month; either all or none must be transferred in that month.

ARTICLE V

DISPOSITION OF PRINCIPAL AND INCOME

5.1. Distributions for the Benefit of the Settlor. To the extent required by the Medical Assistance Program, income placed in the trust must be paid out of the trust for medical care provided to the settlor, including nursing facility or ICF/MR or home/community-based waiver services provided to the settlor. Such payments must be made by the trustee not later than the last day of the month following the month of receipt of the income, or within any other time period that may be required by the Medicaid program. Subject to the requirements of the following sections of this article, the trustee may make other distributions of principal and/or interest for the settlor's health, education, maintenance and support, as the trustee may in the trustee's discretion deem advisable. Such other distributions may include payment of the administrative fees of the trust, income tax owed by the trust, attorney fees which the trust is obligated to pay (in proportion to whatever part of the trust benefits the settlor), food or clothing for the settlor, or mortgage payments for the settlor's home.

5.2. Maintenance of Qualification for Public Benefits. The overriding purpose of this trust is to assure eligibility of the settlor for Medical Assistance Program benefits. Therefore, the trustee shall make distributions from the trust in amounts and for the purposes necessary to maintain such eligibility, and only in amounts and for purposes which do not defeat such eligibility, notwithstanding any other provision of this instrument. Among the requirements of the Medical Assistance Program at the time of establishment of this trust, which the trustee shall meet as long as and to the extent required, is the requirement that the trustee make payments from the trust in the following priority:

- a. A monthly personal needs allowance (\$60.00 per month as of this date) for the needs of the settlor; then
- b. If the settlor is married, a sum to the settlor's spouse sufficient to provide the minimum monthly maintenance needs allowance for the spouse; then
- c. From the funds remaining, if any, the cost of medical assistance provided to the settlor.

5.3. Payments for Settlor's Spouse. Subject to the provisions of sections 5.1 and 5.2, all trust funds that can be paid to the settlor's spouse, if any, without reduction or loss of the settlor's eligibility for public benefits, shall be used by the trustee for the benefit of the settlor's spouse. The trustee may exercise discretion in determining the purposes for which such payments are made but shall have no discretion to make such payments to or for the benefit of any person or entity other than the settlor's spouse. The trust cannot be terminated and distributed to any other individuals or entities for any other purpose.

ARTICLE VI TERMINATION OF TRUST

6.1. Irrevocability. This trust is irrevocable.

6.2. Termination. This Trust shall terminate upon the settlor's death. Upon termination, the remaining trust property, if any, shall be distributed as set forth in section 6.3 below.

6.3. Distribution Upon Termination. At the settlor's death, the trustee shall distribute to the Texas Department of Human Services or its successor agency any remaining trust property up to an amount equal to the total medical assistance paid on behalf of the settlor, @ @, by the Texas Medical Assistance Program, as reimbursement. All trust property remaining thereafter shall be distributed to the named beneficiaries of the last will and testament of settlor in the amounts and/or proportions therein required, or in the event settlor dies intestate, to her heirs at law as provided by Texas law at the time of her death.

ARTICLE VII TRUST ADMINISTRATIVE AND PROTECTIVE PROVISIONS

7.1. Jurisdiction. This trust shall be administered expeditiously and consistently with its terms, free of any judicial intervention and without order, approval or other action by a court, subject only to the jurisdiction of a court which is invoked by the trustee or other interested parties or as otherwise provided by law.

7.2. Reports. Periodic reports shall not be made unless required by the regulations of the Texas Department of Human Services. The trust records shall be open at all reasonable times to inspection by the settlor of the trust, the Texas Department of Human Services, and their properly appointed representatives.

ARTICLE VIII
POWERS OF TRUSTEE

In addition to all of those powers specifically granted herein, the trustee may exercise those powers set forth in the Texas Trust Code, together with any amendments to such Code after the date of this document.

ARTICLE IX
TRUSTEE SUCCESSION AND ADMINISTRATIVE PROVISIONS

9.1. Resignation of the Trustee and Appointment of Successor Trustee. Any trustee may resign by giving thirty (30) days written notice to the settlor, or to the guardian, conservator or other legal representative of the settlor. Such resignation shall be effective 30 days from the date notice is given. In the event the trustee resigns or dies while holding office, _____, shall serve as successor trustee. Any trustee may, while serving as trustee, appoint one or more successor trustees and may thereby alter the succession of trustees set forth herein. If any trustee ceases to act as trustee at a time when no successor trustee who is able and willing to serve has been appointed either by this instrument or by such trustee, any interested person may apply to be appointed successor trustee as set forth in Texas Property Code Sec. 113.083.

9.2. Representative of Settlor. The guardian of the settlor or, if none, the agent of settlor acting under a general power of attorney may act for the settlor for all purposes under the administrative provisions of this trust.

9.3. Rights of Successors. Every successor trustee shall have all the title, rights, powers, privileges and duties conferred on or imposed upon the original trustee, without any conveyance or transfer. No successor trustee shall be responsible for any act or omission to act on the part of any previous trustee.

9.4. No Bond. No trustee acting hereunder shall be required to give any bond in any jurisdiction, and if, notwithstanding this direction, any bond is required by any law, statute or rule of court, no sureties shall be required.

ARTICLE X
DEFINITIONS

10.1. Reference to Codes. Except as otherwise provided, definitions of terms in this trust shall be in accordance with the Texas Probate Code and Texas Property Code, as amended.

10.2. Successor Agencies and Programs. All references in this trust to the Texas Department of Human Services and the Medical Assistance Program shall include any successor public agency or program.

ARTICLE XI
CONSTRUCTION

11.1. Conformity with Statutes. In case of ambiguity or conflict, this trust shall be construed so as to comply with the provisions of Texas Property Code, Title 9 Trusts, as amended.

11.2. Applicable Law. The validity of this trust shall be determined by reference to the laws of Texas. Questions of construction and administration of this trust shall be determined by reference to the laws of Texas.

11.3. Headings of Articles and Sections. The headings of articles and section are included solely for convenience of reference, and shall have no significance in the interpretation of this agreement.

11.4. Construction of Number and Gender. Unless the context requires otherwise, words denoting the singular may be construed as denoting the plural, and words of the plural may be construed as denoting the singular, and words of one gender may be construed as denoting another gender as is appropriate.

Signed by @@, settlor herein, and by ##, who accepts the office of Trustee, on this _____ day of _____, 2011.

@, Settlor, by ##, Agent under
Durable Power of Attorney

##, Trustee

State of Texas §
County of Harris §

This document was acknowledged before me on this the _____ day of _____, 2011, by ##, in the above-stated capacities.

Notary Public in and for the State of Texas

Notary's name printed

My commission expires: _____

Exhibit "A"

Income for _____

Income Source

Net Amount

Social Security	\$
Pension/Retirement	\$ _____

Total	\$
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