A. Medicaid defined

1. Medicaid is a government program that is designed to provide comprehensive medical care, including nursing home care, to poor individuals who are aged, blind, disabled, or members of families with dependent children. Federal and state governments jointly fund and have joint responsibility in implementing, the Medicaid program. Each state sets rules for eligibility, subject to federal guidelines. The rules may differ from state to state. Medicaid is administered in NC by the Division of Medical Assistance of the Department of Human Resources and by county departments of social services.

2. Medicare does not cover prescription drugs or long-term nursing care.

3. Residency (which determines where the application must be filed) is generally based on county of domicile prior to entering a nursing facility or adult care home. just when those who administer the program have become proficient in administering it, the laws, rules and guidelines are frequently changed. For example, by federal statute, states must begin requiring birth certificates or passports from applicants prior to eligibility.

B. Application Process

1. An individual needing Medicaid or anyone acting on his behalf may apply for Medicaid at DSS (as well as many public hospitals if a patient there)

2. DSS must explain and offer all program categories for which the individual may qualify and DSS must offer to assist the applicant in obtaining verification of his eligibility.

3. Retroactive medicaid coverage is available for up to 3 calender months prior to the month in which an application is filed, as

well as on an ongoing, prospective basis. The individual must have been eligible for Medicaid at the time the medical services were received.

4. Recipients of Supplemental Security Income automatically receive Medicaid and do not need to apply separately at DSS. Individuals approved for SS disability benefits but not SSI must apply separately for Medicaid at DSS.
5. The better practice for persons not yet approved for SSI is to immediately apply separately for Medicaid.

Also, a pdf version of a mail-in application can be printed from the DMA website, http://www.dhhs.state.nc.us/dma/publications.htm, and mailed in to the local County DSS office.

Once someone qualifies for Supplemental Security Income (SSI) they are automatically covered for Medicaid.

The Medicaid application is the step that many legal professionals overlook and, many times, this failure can be costly. The planning process may have been long and complicated, the Medicaid rules are certainly long and complicated. It is foreseeable that a Medicaid applicant may get confused by questions asked by a Medicaid caseworker and make inaccurate statements or fail to provide essential information. When clients try to save legal fees by filing the application themselves, often it results in many more hours of a lawyer's time to correct the problems created.

C. Appeal Rights

1. Any DSS decision affecting Medicaid eligibility may be appealed within 60 days by requesting a hearing from DSS.
2. An individual terminated from SSI based on a disability determination automatically receives Medicaid during the SSI appeal.

D. Categories of Eligible Persons

1. Medicaid is available for over a dozen specific categories of low income persons with medical needs. These primarily include

a. children under age 21 and their caretakers,

b. pregnant women,

c. individuals age 65 or over, and

d. individuals who are disabled or blind.

Medicaid recipients are considered "categorically needy" if they receive or are eligible for SSI, Work First Family Assistance (also called TANF, formerly AFDC), or State/County Special Assistance benefits (which pays for assisted living or rest home care). Any individual receiving SSI, TANF, or Special Assistance benefits in a month automatically receives a Medicaid card for that month.

2. A new Medicaid category covers uninsured women under 65 with breast cancer regardless of income and assets if they have been screened by the county health department.

E. Services Covered

1. Medicaid, in NC, covers:

a. physician treatment

b. inpatient and outpatient hospital care

c. prescription drugs,

d. insulin,

e. eyeglasses and optometrist care,

f. lab and x-ray tests,

g. chiropractors,

h. home health care,

i. hospice care,

j. some durable medical equipment

k. medical transportation

l. payment of Medicare premiums,

m. co-payments and deductibles, and

n. nursing home care at the skilled or intermediate levels.

2. Care in assisted living facilities (rest homes or adult care homes) is covered by a different program with somewhat different eligibility requirements, state-county Special Assistance.
3. Medicaid covers many skilled care services normally provided by a home health agency and home health aide services if Medicare coverage is unavailable, and the care needed is part-time or intermittent.
4. Medicaid pays for up to 60 hours per month of personal care services (but no more than 3.5 hours per day.)
5. When a state wishes to make home and community services (HCBS) available only to certain distinct groups of Medicaid beneficiaries (e.g., adults who have a physical disability), it must seek federal approval of an HCBS waiver program.
6. NC's HCBS programs are generically referred to as Community Alternative Programs (CAP) and include the following populations:
    a. Disabled Adults (SAP-DA);
    b. Mentally Retarded/Developmentally Disabled (CAP-MR/DD);
    c. HIV+/AIDS (CAP-AIDS);
    d. Children (CAP-C).

    Eligibility for each requires a demonstration of a need for instiutional (such as cursing facility of ICF/MR care as certified by a physician.

F. Service Denial Appeals

1. NC has a separate appeal process for Medicaid denial of coverage for services than for eligibility appeals.
2. A frequent issue on appeal is whether the procedure is medically necessary.
3. Another issue on appeal may be whether the procedure is experimental, which is another permissible basis for denial of coverage under state Medicaid regulations.

G. How Medicaid Coverage Works

1. Medicaid is a payor of last resort and will not cover bills for which Medicare, private insurance, or any other third party is responsible. Long-term care insurance is limited by it's lack of affordability to those in the middle class , relative unavailability to those over 65 or with medical conditions, and coverage limits. *Simply stated, the result is that most people pay out of their own pockets for long-term care until they become eligible for Medicaid.* Despite the higher costs, there are possible advantages to paying privately for nursing home care: (1) the likelihood of gaining placement at a facility with higher quality of care; (2) the choice of a private room and added amenities; and (3) the likelihood of individualized planning and attention.
2. Medicaid recipients must report to DMA any recovery that is made.
3. Medical providers generally may choose not to accept Medicaid from all patients for all services.

   EX/ A nursing home may certify some of its beds for Medicaid patients, reserving the rest for private patients.
4. If a provider does agree to accept Medicaid as payment, it must accept Medicaid as full payment.

H. Disability Determinations for Medicaid

1. If an individual is under age 65 and has no minor children in his care, disability must be established to obtain Medicaid. Medicaid uses the same standard used by the SSA, i.e., inability to perform substantial gainful activity which is expected to last 12 continuous months or result in death.
2. EXAMPLE: Mary, a widow is in a long term nursing facility. Her income is $1175 per month in SS. She has prescriptions not covered by Medicaid of $70 per month. Her patient liability is $1075 (1175-30-70) and that amount must be paid by her to the nursing facility each month. Medicaid pays the remainder of the cost of her care and other medical bills.

3. Deductions included expenses incurred when the individual was over the Medicaid resource limit or subject to a transfer of assets sanction. The effect of this deduction is to permit the advocate to arrange a repayment plan by which the individual's monthly income is applied to past bills.

**I. Nursing Home Eligibility requirements**

To be eligible for Medicaid nursing home benefits, the following requirements must be met.

The applicant must have a continuous period of institutionalization.

The applicant must be in an approved medical facility.

The Division of Medical Assistance ("DMA") FL-2 Form must confirm that the Medicaid applicant needs the skilled or intermediate level of nursing home care.

The applicant must meet income and resource (asset) eligibility requirements.

There can be no transfer penalties currently in effect against the applicant.

Medicaid approved medical facilities include:

Skilled nursing facility which is a long-term care facility that provides twenty-four hour skilled nursing care with an RN or LPN on duty at all times.

Intermediate care facility which is a long-term care facility that provides eight hours per day of nursing supervision by either an RN or an LPN.

Others.

To the extent possible, a nursing home patient is expected to pay for his or her care. Medicaid benefits are available only to patients who have limited income and resources. To qualify, a nursing home patient must meet both an income test and an asset test.

J. **The income test**

If the patient's monthly allowable costs are greater than his or her countable monthly income, the patient meets the income test. Countable income includes wages, pension benefits, Social Security benefits, and interest on savings. The rules allow the patient

to set aside some income for certain expenses other than nursing home costs. These expenses include the following.

- The patient may keep $30 per month for his or her personal needs, such as clothing, toiletries, and magazines.
- The patient may pay all medical expenses, such as health insurance premiums, deductibles, copayments, and other medical costs not covered by insurance or government benefits.
- The patient's spouse may be entitled to receive an allowance from the patient's income.
- Certain family members dependent upon the patient also may qualify to receive an allowance from the patient's income.
- The patient is entitled to a home maintenance allowance if his or her nursing home stay is less than six months and there is no spouse living in the home.

If the patient does not have enough income to cover nursing home costs after deducting allowable expenses, he or she meets the income test. [Medicaid will not authorize a Medicaid recipient to receive assistance with long-term care unless the recipient's income is below the Medicaid Reimbursement Rate for the facility (which varies between $3,000 and $3,500, depending on the facility).]

K. The asset test

Assets are either exempt or nonexempt for Medicaid purposes. Most of the patient's nonexempt assets must be used to pay for nursing home care or other allowable expenses before Medicaid benefits are available. The patient can keep up to $2,000 worth of nonexempt assets or $3,000 if married in "countable" assets in his or her name. "Countable" assets generally include everything except: (a) the home, the applicant's principal residence (under certain circumstances); (b) personal possessions, such as clothing, furniture, and jewelry; (c) one motor vehicle; (d) assets that are considered inaccessible for one reason or another; and (e) other assets defined as exempt under the guidelines. The rest must be spent down or converted to exempt assets before the patient qualifies for Medicaid nursing home benefits. Exempt assets are not counted

L. Exempt assets

In addition to $2,000 worth of nonexempt assets, the patient may own exempt assets which include the following.

*Homesite*. The equity of the homesite that is used as the patient's principal place of residence (and all land contiguous to the homesite) is an exempt asset if any of the following conditions are met. equity in the home beyond a threshold that can be set by the state between $500,000 and $750,000.

The nursing home stay will be for six months or less.

There is a spouse or dependent minor children or disabled adult children living in the home (including minor stepchildren or disabled adult stepchildren).

The home is rented and produces a net annual income of at least six percent of its equity after all expenses related to producing income are deducted. *Note:* If the home is rented, it becomes income-producing property and is no longer treated as the homesite.

(*Please note:* If the Medicaid applicant or financially responsible person has no ownership interest in the principal place of residence, the tax value of contiguous property in excess of $12,000 is a countable resource.)

If the home does not qualify as an exempt asset, it must be spent down before the patient qualifies for Medicaid nursing home benefits.

*Property used for certain purposes.* If currently in use for certain purposes, property may be excluded.

**Property used to produce income.** Real and tangible personal property is exempt if it produces a six percent net profit. This rule does not exempt liquid assets, such as bank accounts or stocks and bonds.

**Property used in a trade or business.** Business Property. Any personal property used in the operation of a trade or business, self-employment, or farm is not counted as an asset as long as: 1) Any liquid assets are not co-mingled with personal funds; 2) The

Medicaid applicant or spouse is active in the business on a day-to-day basis. regardless of the value and the amount of profit. Property excluded includes real property (land and buildings necessary to produce income), personal property (operating capital and assets of the business, such as equipment, livestock, inventory, vehicles, etc.), and liquid assets (only if not commingled with personal funds).

**Property used to produce goods or services for the home.** Real and personal property used **solely** to produce goods and services for the home is exempt. For example, land used for a vegetable garden may be exempt if the vegetables are grown solely for home consumption. The tractor used to till the garden is also exempt.

If the property is not currently being used for one of these purposes, it may be exempt if the property has been in use within the past 12 months and the use will resume within 12 months.

*Certain interests in land.* Certain ownership interests in land are exempt: life estates, tenancies in common, and remainder interests if there is more than one remainder holder (married couples count as one).

*Burial spaces.* Burial spaces for the patient and the patient's spouse are exempt. Burial spaces for members of the immediate family also may be exempt.

*Rights of use.* Rights of use are tied to the land or the natural resources of land and may have countable value separate from the land. Rights of use include mineral rights, timber rights, and hunting or fishing rights. The value of the right of use, if owned separately by the Medicaid applicant, is exempt if it meets the six percent income producing criteria.

*Tobacco allotment.* Tobacco allotments provide the right to produce a certain number of pounds of tobacco for harvest. The value of a tobacco allotment is not counted, even if it is not being used. The land that is tied to the tobacco allotment may be exempt if certain requirements are met.

*Uncleared land, woodlands, forests.* If the property meets the six percent income producing test, it is exempt if

The Medicaid applicant has a written contract to sell the timber on a specified date, **and**

The Medicaid applicant can produce documentation that the timber is cut on a regular

basis.

*Property agreements/promissory notes.* Any property agreement that is not legally negotiable (cannot be sold) is excluded.

*Tangible personal property.* Certain items of tangible personal property are exempt. Personal property is everything that is not land or part of the land. Jewelry, furniture, and cars are examples of tangible personal property. Exempt tangible personal property includes the following.

Personal effects and household goods.

A mobile home used as the homesite.

One licensed vehicle.

Junked cars.

Personal effects and household items comprise the clothing, jewelry, furniture and other personalty of the applicant and his or her spouse. Personal possessions are usually never counted as assets. However, if a personal possession were recently purchased by the applicant, then the transfer of funds for the purchase (if negotiated within the previous thirty six months) will be reviewed by the Medicaid Eligibility Specialist of DSS. Purchases that raise eyebrows, and are clearly out of the ordinary, may be challenged as abusive. The recent acquisition of a ring for more than $100,000; the purchase of new furniture for more than $50,000 (especially when the applicant is the only occupant of the home and is the one being placed in a nursing home); or the purchase of a full length mink coat for more than the value of the home place are those purchases that may be challenged.[1] Please keep in mind the new exploitation statute when children of elderly clients want to, as attorneys-in-fact for their parent, buy mom and dad a new Hummer with mom or dad's money that will likely only be used by the children.

Property Not Otherwise Excluded. The value of property such as boats, motors, campers,

[1] And even if the purchase is not challenged, and the applicant receives Medicaid assistance for long term care, the purchase may still be captured as an asset of the applicant's estate and subject to the Medicaid Estate Lien.

trailers, farm and garden equipment (not part of actual farm) equipment from a discontinued business, mobile home (not used as homeplace) are all countable as a resource.

*Liquid Assets.* Liquid assets include cash, bank accounts, certificates of deposit, or any asset which can be converted to cash. Exempt liquid assets include the following:

Cash value of whole life insurance when the total face value of all policies does not exceed $10,000. If it does exceed $10,000 in total face amount, then the cash value in these policies is countable.

Term life insurance (except for dividends paid).

Retirement accounts that cannot be withdrawn in a lump sum payment. Monthly payments upon retirement are counted as income.

Annuities, if certain conditions are met. Payments by an annuity are income.

Irrevocable pre-need burial contract or trust.

Certain types of trusts. If the trust is exempt, all assets in the trust are exempt, which may include land and personal property that would not otherwise be exempt.

Burial exclusion of $1,500, if not otherwise used.

M. Financial Rules For Long Term Care Recipients

Medicaid pays for medically necessary nursing home care for patients in skilled or intermediate care nursing homes or in intermediate care facilities for the mentally retarded. The patient's income must be less than the cost of care in the facility at the Medicaid rate, and there is a limit on resources. If the patient or his representative gives away assets or sells them for less than market value, he may be ineligible for payment of the cost of care for a period of time. The sanction period is based upon the value of the assets transferred away.

**N. Financial Protection for a Spouse**

Medicaid policy specifies that when a legally married individual needs Medicaid to help pay for nursing facility services, a portion of the couple's income and assets may be protected for

the spouse at home, the community spouse. The following is a summary of spousal protection rules:

- Medical services: nursing home care, hospital care that exceeds 30 days, or services provided by the Community Alternatives Program (services which enable an individual to remain at home who would otherwise be institutionalized)
- The community spouse is allowed to keep one half of the couple's assets, with a minimum of $20,328 and a maximum of $101,640 (current as of 7/1/2007).
- For example, if a couple owns $90,000 in countable, non-exempt assets on the date the applicant enters the hospital, he or she will be eligible for Medicaid once their assets have been reduced to a combined figure of $47,000 - $2,000 for the applicant and $45,000 (one-half of $90,000) for the at-home spouse. If the couple owned $250,000 in assets, the spouse in need of institutional care would not become eligible until their non-exempt resources were reduced to $103,640.00 ($2,000 for the nursing home spouse plus a maximum of $101,640.00 for the community spouse).
- The protected share is calculated by assessing the value of all assets owned separately or jointly by either spouse at the point the individual becomes institutionalized. The homesite is generally not counted in determining the value of assets since the homesite is protected for the spouse.
- The nursing facility spouse must spend his half of the assets on his care prior to becoming Medicaid eligible. A nursing home recipient is allowed a maximum of $2,000 in assets.
- The protected assets, including the homesite, must be transferred to the name of the community spouse.
- Once assets have been allocated following spousal impoverishment rules, and the spouse in the nursing facility is found eligible for Medicaid, spousal financial responsibility ends and each spouse will be treated separately for Medicaid purposes.
- In all circumstances, the income of the community spouse will continue

undisturbed; he or she will not have to use his or her income to support the nursing home spouse receiving Medicaid benefits, or to contribute to the patient monthly liability of the spouse.

In some cases, the community spouse is also entitled to share in all or a portion of the monthly income of the nursing home spouse (the Minimum Monthly Maintenance Needs Allowance - "MMMNA").[2] The DMA determines MMMNA floor for the community spouse, which, under a complicated formula, is calculated for each community spouse based on his or her housing costs. The MMMNA may range from a low of $1,712 to a high of $2,541 a month. If the community spouse's own income falls below his or her MMMNA, the shortfall may be made up from the nursing home spouse's income. If the community spouse's income does not meet the minimum MMMNA level, then the DSS eligibility specialist will "deem" that portion of the institutional spouse's to be allocated to the community spouse.

- Income is allocated for the needs of the community spouse if the community spouse's income is less than 150% of the poverty level (currently $1,604). It is also possible to allocate additional income to the community spouse for excessive shelter costs. (Where the community spouse can show hardship, the DMA may award a larger MMMNA, but only after an appeal to a fair hearing.)
- Income may also be allocated for the needs of other dependents.

The determination of the level of the couple's assets is made as of the date of application ("snapshot"), or the date of institutionalization of the nursing home spouse, which ever is later. That date is the day on which he or she enters either a hospital or a long-term care facility in which he or she then stays for at least 30 days. It is advantageous for the couple to try to have as much money as possible in their names on that date up to $203,280 so that the amount that the community spouse is allowed to keep will be at the highest possible level. Remember too that transfers of non-exempt assets may be made between spouses without penalty.

O. Penalty Periods

If the transfer of countable assets is for less than fair value, the applicant will be ineligible for Medicaid for a period of time beginning on the date of the transfer. The actual number of months of ineligibility is determined by dividing the amount transferred by $4,800. For instance, if an applicant makes a gift totaling $85,000.00, he or she would be ineligible for Medicaid for 17 months ($85,000/$4,800 = 17.70) (It is important to note that North Carolina Medicaid rules require that the ineligibility period be rounded down.) Another way to look at this is that for every $4,800 transferred, an applicant will be ineligible for nursing home Medicaid benefits for one month. However, the Omnibus Budget Reconciliation Act of 1993 for the first time provided for the return in full of the asset to the transferor without penalty.

For transfers made on or before August 10, 1993, Medicaid provides a maximum of 36 months of ineligibility. For transfers made after that date, there is no cap on the period of ineligibility. So, for instance, the period of ineligibility for the transfer of property valued at $480,000 would be 100 months ($480,000/$4,800 = 100). However, DMA may only consider transfers made during the 60-month period preceding an application for Medicaid, the "look back" period. Effectively, then, there is now a 60-month cap on periods of ineligibility resulting from transfers for less than fair value.

**WARNING: Advising a client on when to file a Medicaid application is very important because of this rule. If the application is filed too early, then the 60-month look back will not protect you from being ineligible indefinitely.**

There has been the assertion that criminal sanction should be imposed on the professional who, for a fee, provides counsel, advice or assistance to the applicant in making the transfer if the applicant applies for Medicaid eligibility during the period of sanction or ineligibility.[3] It is not often, if ever, that the transfer is itself illegal (unless concealment is attempted), but that the applicant would apply for Medicaid eligibility during the sanction period. For example, consider the situation where a Medicaid applicant makes a $100,000 transfer to an otherwise qualified trust, and four years later applies for Medicaid. Having made the transfer to a trust, the sixty-month look back period is triggered. However, the penalty or sanction period is ($100,000/$4800) 20 months. There would

[3] See § 4734 of BBA 1997.

be no question that problems will occur if the application is made during the time in which the sanction time is still running.

P.Medicaid Planning

In order to understand "Spend Down", there must be a clear understanding of what is a countable resource, and what is not. A non-countable resource is described as exempt. As mentioned above, what is countable begins with liquid assets. The maximum amount of countable resources that a single person may have is $2,000.00 in order to remain eligible for Medicaid. The range of countable resources that a married couple may have is from a minimum of $19,908.00, to a maximum of $99,540.00. When a Medicaid applicant has countable resources greater than these amounts, then there must be a spend down. That is the available assets must be depleted through compensated transfers, transfers that are exchanged in any number of forms that is equal to or greater than the fair market value of the transferred asset. The exchange may be in the form of services, benefits, tangible objects or money as long as it amounts to or is more than the value of the asset that is transferred.

1. Acquisition of exempt resources
    a. Residence or Residential Improvements
    b. Tangible Personal Property
    c. Other Purchases
    d. Burial Contract or Accounts
    e. Burial Plots
    f. Vehicles
2. Exemption of countable assets

    There are many ways by which the character of countable assets may be changed to exempt status without incurring any period of ineligibility or sanction. There are also transfers that are not counted because of who the recipient of the transfer is, creating exceptions to the transfer penalty.
3. Exempt Recipients Medicaid law prohibits the transfer of assets for less than market value by an institutionalized Medicaid applicant/recipient or anyone acting on their behalf.
4. The look back period is 3 years (5 years for transfers to a trust) from the date of application or institutionalization, whichever occurs later.

5. A sanction is applied for a period of time based on the value of the asset and begins the month the asset is transferred. The length of the sanction is determined by dividing the value of the transferred assets by the average monthly private cost for nursing home care (currently $4,800). The sanction begins with the month of the transfer.
6. During the sanction period the individual may be eligible for Medicaid but Medicaid will not pay for institutional services.
7. The ineligibility period is calculated in North Carolina using $4,800 per month for the cost of care. There is no cap on the number of months the applicant is ineligible. The look back period is extended to 60 months for transfers involving trusts and annuities. by example, the ineligibility period would be calculated as follows if were to transfer, for example, $12,000 to a family member by gift:

$$\text{\# of months of sanction} = \frac{\text{Value of interests}}{\text{Avg NC monthly cost}} = \frac{\$12{,}000}{\$\ 4{,}800} = 2.5\ [=\ 2\ \text{months}]$$

The look-back period begins on the date of admission to a nursing home or the date of application for Medicaid whichever occurs last**.** Once the three years has passed, however, the look back ends and there would be no penalty period assessed.

Transferring assets to certain recipients will not trigger a period of Medicaid ineligibility. Exempt recipients include:

a. A spouse;
b. A blind or disabled child;
c. A trust for the benefit of a blind or disabled child (under certain restrictions);
d. A trust for the benefit of a disabled individual under age 65 (even for the benefit of the applicant under certain circumstances).
e. Special rules apply with respect to the transfer of a home. In addition to being able to make the transfer without penalty to one's spouse or blind or disabled child, or into trust for other disabled beneficiaries, the applicant may freely transfer his or her home to:
    (1) A child under age 21;

(2) A sibling who has lived in the home during the year preceding the applicant's institutionalization and who already holds an equity interest in the home; or

(3) A "caretaker child," who is defined as a child of the applicant who lived in the house for at least two years prior to the applicant's institutionalization and who during that period provided such care that the applicant did not need to move to a nursing home.

(4) transfer your home to your heirs, reserve a life estate. protect against being evicted by your donee children, eliminates any liens against a Medicaid recipient's estate after his or her death. A life estate by definition terminates upon death.. Also, provides the donee (under IRC Secs. 1014 and 2036) with a stepped up basis upon the death of the donor

(5) Medicaid Planning

is still permissible to transfer large amounts of assets, if the individual then waits 36 months to apply for Medicaid. Some individuals simply give away a portion of their assets, and use the remainder to pay for care during the transfer sanction period. "half a loaf," is used by people who need nursing-home care immediately. They give half their assets to their heirs. The other half of their nest egg pays for their care during the "penalty period" until they are eligible for Medicaid.

Examples of strategies include:mily members (plots only);b. purchase items that will not be excluded as household goods or personal effects (e.g. paintings, jewelry, furniture), which may be given away without penalty;c. purchase a motor vehicle(or trade in for a more expensive vehicle), which may be given away without penalty; d. purchasing services which have no continuing value as resources (e.g. home repairs);e. pay off mortgage on an exempt home and other debts; f. purchase an annuity for the community spouse if there is no need to protect other income through the community spouse allowance;

establish a special needs trust for disabled individuals under age 65.

Transferring title to income producing property to the community spouse, converting income producing assets to assets which don't produce income, changing the income beneficiary of an annuity to the community spouse or to a special needs trust, appealing the amount of income protected for the community spouse based on hardship.

1. Annuities

Annuities must meet actuarial requirements, based on tables that are found in HCFA Transmittal 64, and restated in the Medicaid Manual. The life of the Medicaid recipient must be the measured life for the term of the annuity to meet requirements. The annuity must be for the Medicaid beneficiary and have irrevocable construction. If it is shown that the Medicaid recipient has access to anything other than fixed installments over the course of the life of the annuity, then the annuity may be counted as a resource. An annuity can be a beneficial tool to turn a countable asset to noncountable income if there is a community spouse that can purchase the annuity and receive the income. This also may be a planning tool in the future if the interpretation of the federal budget bill Medicaid provisions requiring annuities to have a state payback provision only apply to annuities owned by the applicant/recipient. If an annuity is purchased and annuitized for a single person, then all of the annuity income will have to be paid to the nursing home as Patient Monthly Liability.

**WARNING: If you annuitize an annuity for a single person, watch out for pushing the Medicaid applicant's income over the facilities' Minimum Reimbursement Rate as**

described above.

5. Use of the Medicaid Penalty

For transfers made on or before August 10, 1993, until February 8, 2006, Medicaid provided a maximum of 36 months of ineligibility w/ careful use of the look-back rule and proper planning. Then-current Medicaid rules provided that the ineligibility penalty period begins on the date the transfer has been completed. By planning for potential Medicaid eligibility in advance of a need for nursing home care or, by reserving from transfer sufficient assets to pay privately for nursing home care during ineligibility, one can preserve up to $4,800 of assets from nursing home costs per month.

Estate Recovery Generally

When a Medicaid recipient in a nursing home or receiving CAP services dies, Medicaid files a claim against the estate to recover expenses paid by Medicaid.

There are no estate recovery liens imposed on real or personal property during the lifetime of the recipient in North Carolina. An estate recovery claim will be filed in the estates of all persons age 55 or older who have accepted Medicaid for long-term care payment. Estate recovery will be waived when the recipient is survived by a spouse (This bar on recovery is permanent, not merely postponed until the spouse's death.), a child under 21, a disabled adult child living on the property owned by the estate, when the estate is worth less than $5,000, or when the estate recovery claim is less than $3,000, or in cases of hardship.

**KKKKKK.** The Deficit Reduction Act of 2005, Medicaid Changes:

1. Homeplace Limit.

   _ Placed exemption limit or value of applicants' home $500,000 of equity

   _ Will likely affect farmers – traditionally could exempt house and all surrounding land;

   _ If have spouse, disabled or minor child home is still exempt.

2. Annuity

   _ State must be irrevocable primary beneficiary – law does not say "only to amount of lien"

   _ Can still use to give the Community Spouse an income stream

3. Lookback

   _ Increased to 60 months for all transfers not just trusts. Reduces disadvantage of doing irrevocable trusts.

4. Penalty Start Date.

   _ Change in penalty start date. penalty does not begin until "applicant is otherwise qualified but for application of penalty"

5. Round down.

   _ NC old rule was a penalty divisor was rounded down.

   _ States are expressly forbidden from rounding down.

6. Asset Transfer rules.

   _ Now apply to home based Medicaid.

7. Income first rule.

_ If over the resource limit

_ If income under $1600 can keep assets to keep to $1600

_ If over income maximum can access 100% of institutionalized spouses' income and 25% of community spouses income.

8. Life Estate

_ Permits individual to buy a life estate in another's home

_ Must reside in home for 1 year

9. LTC Insurance.

_ Extension of partnership policy available in all 50 states. This allows a person who purchases a policy in the same state where they need LTC to exempt the amount of assets equal to policy coverage or states can waive asset rules completely.

_ Still subject to income rule

_ States must elect to be included

_ Will require LTC policies to contain very specific terms:

1. compounded inflation protection if issued under 61
2. some inflation protection over 61
3. must be IRS qualified
4. meet long term care insurance model Act requirements

_ only effective for policies issued after state adopts amendment

10. Loans

_ Must be actuarially sound

_ Note paid back over life expectancy doesn't permit deferral, balloon payment or cancellation at death.

_ Payments must be equal.

Medicaid Planning:

_ One-half loaf won't work because clock doesn't start ticking until otherwise would qualify

_ Reverse one-half loaf may work

_ Possible give from parents to children then Promissory note for home

**Since passage of the DRA, non-countable, or ("exempt") assets may now include:**

1. **The homesite (personal residence) and contiguous real property is exempt up to $500,000 in equity (individual states may choose to increase the exemption for the home to $750,000 in equity)**

Changes to Personal Residence Rules:

**DRA eliminates Medicaid eligibility for those single individuals having more than $500,000 in equity value in a primary residence. An unlimited exemption for the home remains if it is occupied by a spouse, child under age 21, or disabled/blind child of any age.**

Changes to Life Estate:

**DRA essentially penalized creating any life estate other than through the purchase of a life estate in property which the Medicaid applicant/recipient then uses as his/her primary residence for at least one year.**

**The provision that will most commonly affect seniors is imposition of a transfer penalty for gifting a remainder interest in land to children. Single individuals who wish to gift a remainder interest in property must do so well in advance of needing institutionalized care due to the new five-year look-back period. Otherwise, they will incur a significant penalty**

**in Medicaid eligibility.**

**In reality, few seniors purchase life estates. Far more life estates are created by the gift of a remainder interest in property to children. Prior to the DRA, there was significant reason to advise seniors to reserve a list estate. [1]Retained life estate interests offered important protections for the grantor against losing control of the residence. [2]Remainder interest holders benefit from a possible step-up in basis reducing capital gains tax. [3]Transfer of a remainder interest resulted in a shorter Medicaid transfer penalty versus transferring the entire property.**

**DRA will significantly impact retained life estates. Although the retained life estate interest may still be Medicaid-exempt, the gift of the remainder will not be penalized until the applicant is "otherwise eligible" for Medicaid.**

Spousal Impoverishment Protections

**One area in which DRA significantly changes planning for married couples is the purchase of an annuity.**

Medicaid Planning Techniques

**Many important elements of traditional "Medicaid planning" will remain unchanged. Married client will still need to have Will with a discretionary trust for the benefit of the spouse if there is any likelihood of institutionalized care. "Will alternative" to bypass the probate estate where there is any possibility of future estate recovery claims. Concepts of transforming countable assets into exempt resources and wise divestment of assets remain largely unchanged.**

Alive and Well in 2006

**a) Permissible Uncompensated Transfers**

**The uncompensated transfers that are permitted under Medicaid remain unchanged by DRA. An uncompensated transfer of the home-site is an allowable transfer only when the home is transferred to one of the following:**

1. **Legal Spouse**
2. **Natural, adopted, or step children under 21 at time of transfer**
3. **Blind/disabled child of any age**
4. **Siblings who:**
   - **a. co-owner of the home and**
   - **b. has been residing in the home for at least one year**
5. **Natural, adopted or step child age 21 or over who:**
   - **a. resided in the home for at least two years immediately before the applicant entered a nursing facility or requests CAP and**
   - **b. provided care to the applicant to permit him to live at home and**
   - **c. provides documentation**

Special Needs Trust

**The Deficit Reduction Act of 2005 does not directly affect existing rules and regulations that govern Special Needs Trust.**

Purchase of Life Estate Interests

**Deficit Reduction Act of 2005 now penalizes purchasing a life estate unless it is in a residence and the applicant/recipient actually lives in the home for one year following the purchase. The DRA penalizes purchased of a life estate in any property other than a residence.**

Purchase of an Annuity

**DRA establishes new rules for the treatment of annuities, including that the State be named as the remainder beneficiary for certain annuities.**

**Under DRA, purchase of an annuity is treated as a uncompensated transfer of assets unless: (1) the State is named as the first residuary beneficiary for an amount up to the total of all medical assistance provided to the annuitant or (2) the State is named as the second residuary beneficiary after the Community Spouse, a minor child or a disabled child.**

**Where the annuity is actuarially sound (returns its entire value during the annuitant's life expectancy) it may not be considered an available resource for eligibility purposes. The client must purchase an immediate annuity rather than a deferred annuity in which payments under the contract must begin within one year following the initial premium payment.**

Reverse Mortgage

**Reverse mortgages may become useful now that DRA reduces the options for intergenerational gifting. In life of the more severe restrictions on government long-term care assistance, children should very closely account for the assistance they provide and treat such assistance as a loan, secured against assets (more likely the house) owned by the parent.**

Commencement Date of Penalty Period

1. **Pre-DRA Law**
   **Before the DRA, the penalty period began on the date of the transfer or the month following.**
2. **Post-DRA Law**
   **Under the DRA the penalty period commences on the latter of the first day of the month in which the transfer was made or the date on which an individuals is eligible**

**for Medicaid benefits and would otherwise be receiving Medicaid but for the imposition of a penalty period.**

**One approach for short term planning under the DRA involves the use of a short-term immediate annuity, a person can become "otherwise eligible" by keeping less than the resource allowance, and still maintain a source of funding nursing home payments during the penalty period. For an example, an individual who has assets worth $40,000 might transfer $20,000 to his children and as the same time purchase an immediate annuity that pays $5,000 per moth for a period f 4 months; following day the individual enters a nursing home. The penalty period begins to run upon the filing of an application for benefits. The nursing home payments are made through the four-month penalty by using the monthly annuity payments.**

**Irrevocable grantor trusts remain viable, as an advance planning technique for individual who can retain sufficient resources to pay for five years.**

**Factors which must be considered include loss of control and income level of the senior. Include options that should be explored in spousal planning, caregiver agreements, use of DRA-compliant annuities or promissory notes, and the use of pooled trusts.**

Post DRA-Law

**The Medicaid applicant or her spouse must disclose interest in ann**