

CHANGES IN THE MEDICAID LAW

Resource Eligibility Prior to the DRA

11-5.2.1.2 Available Resources

Resources that are not otherwise exempt or unavailable considered available for the purposes of the MA eligibility determination. This includes resources in which the applicant has only a partial ownership interest.

An individual applicant may have available resources valued at no more than \$2,000, \$2,400, or \$8,000, depending upon the specific Medicaid eligibility pathway. For those individuals with less than 300 percent of the SSI benefit rate of monthly income, \$8,000 may be retained.

In general, all resources of the applicant and the applicant's spouse are considered available, subject to certain exclusions. Resources include cash and any other liquid or non-liquid assets, and any real or personal property that an individual owns and could convert to cash.

Examples of available resources (unless otherwise excluded or unavailable) include:

- Real property other than the applicant's principal place of residence
- Investment accounts, such as bank accounts, stocks, bonds, mutual funds, and certificates of deposit
- IRAs, Keogh accounts, or other pension and retirement plans exclusive of early withdrawal penalty
- Motor vehicles, boats, and other vehicles
- Cash surrender value of life insurance policies in excess of certain limits
- Elective share rights of a surviving spouse
- All other real or personal property that the applicant has or can make available for partial or total support, including equitable interests and partial interest.

11-5.2.1.3 Exempt or Excluded Resources

An individual is entitled to retain certain resources that are considered exempt or excluded for purposes of MA eligibility. These assets include the following:

Burial Expenses. Prepaid burial accounts for the applicant and the applicant's spouse are excluded, as are irrevocable funeral accounts. Cemetery plots are also excluded.

Automobiles. One automobile is excluded, regardless of value. Other motor vehicles are counted as their equity value.

Life Insurance. Life insurance policies having no cash surrender value, such as term insurance, are excluded; policies having a face value of \$1,500 or less are also excluded, regardless of cash value; if the total face value of all policies exceeds \$1,500, the total cash surrender value above \$1,000 is included.

Primary Residence. Prior to the DRA, Medicaid disregarded the full value of an applicant's primary residence, as long as the homeowner evidenced an intent to return home. The DRA makes a fundamental change in this treatment.

Under the DRA, substantial home equity may, in some circumstances, make the home owner ineligible for Medicaid benefits for nursing facility and other long-term care services. In Pennsylvania, an individual is ineligible for such Medicaid assistance if the individual's equity interest in the individual's home exceeds \$500,000.

The \$500,000 limitation does not apply if the applicant has a spouse, a child under age 21, or a child who is blind or disabled, who lawfully resides in the home. The limitation is also to be waived in the case of a demonstrated hardship.

The residence includes all of the surrounding contiguous land, and any buildings on that land. The actual home shelter can be real or personal property, fixed or mobile, and located on land or water. There is no acreage limitation.

Even if the home is not occupied by a spouse or a dependent relative, it can be exempt if the property was used as the institutionalized person's principal place of residence before institutionalization and the institutionalized applicant (or representative) states the intent to return to the home.

If the applicant does not intend to return to the residence, the property is not excluded. However, it will be excluded for six months while the applicant makes a good-faith effort to sell it. Proceeds from the sale of an excluded residence are also excluded if the applicant intends to purchase another excluded residence within three months.

Personal Effects and Household Furnishings. Items of tangible personal property customarily found in the home and used in connection with the maintenance, use, and occupancy of the home are excluded. Personal effects, such as clothing or jewelry, are also excluded.

Trusts. Trusts containing assets of disabled individuals that are established in accordance with statutory special needs trust rules are excluded. Bank accounts, certificates of deposit, or other similar accounts with an “in trust for” designation are treated as revocable trusts and fully available. See the further discussion of trusts below.

Property Used in Trade or Business. Property used in a trade or business that is essential to the self-support of an applicant, an applicant’s spouse, or dependents is excluded, regardless of value.

Nonbusiness Property Essential to Self-Support. Property used exclusively to produce items for home consumption and tools, equipment, uniforms, and similar items required by the applicant’s employer are excluded.

Retirement Accounts of Community Spouse. Pension funds, such as IRAs, 401(k)s, and other deferred compensation funds, owned by a spouse of the applicant who remains in the community, are excluded in Pennsylvania.

Community Spouse Resource Allowance. Assets can be set aside for the community spouse to avoid spousal impoverishment. See the discussion below.

11-5.2.1.3 Unavailable Assets

Certain assets are not included in the MA eligibility determination because they are considered “unavailable.” These assets include:

Real Estate with Multiple Owners. Jointly held real estate where the other joint tenant, not the spouse of the applicant, refuses to sell. The regulations indicate

what where an asset is owned jointly and each owner can sell his or her interest without the consent of the other, or if consent to the sale is not withheld, the interest is to be presumed available.

Personal Property with Multiple Owners. If an applicant/recipient is a joint owner of liquid resources, such as but not limited to, a checking or savings account, each owner is considered to own a share proportional to his or her net contribution to the resource. If there is no evidence of net contributions, each owner is presumed to own an equal share. The applicant's/recipient's share is considered available.

Nonresident Real Property. Nonresident real property that is not exempt and that can be converted to cash is considered unavailable for a period of six months as long as the applicant is making a bona fide effort to sell the property.

Other Unavailable Resources. Examples of other resources that will be counted as unavailable are funds that the applicant will inherit pending settlement of a decedent's estate or funds that the applicant expects to receive from a pending lawsuit. Such resources are considered available only when they actually become available to the applicant/recipient.

11-5.2.1.5.1 Definitions and Applicability

For Medicaid purposes, a trust is defined as an arrangement in which a grantor transfers property to a trustee with the intention that it be held, managed, or administered by the trustee for the benefit of the grantor or others, and includes any legal instrument or device that is similar to a trust. As discussed below, different rules govern the treatment of inter vivos trusts created before and after July 30, 1994.

Annuities may fall within the definition of trusts if similar to a trust, to the extent that the secretary of the Department of Health and Human Services specifies. However, federal guidance issued in 1994 states that annuities are contracts for fair consideration to the extent that the length of the payout is commensurate with the reasonable life expectancy of the beneficiary, which renders it actuarially sound. The treatment of annuities has now been codified by the DRA as discussed below.

11-5.2.1.5. Trusts Created Before July 30, 1994, and Trusts under Will

The resources or assets of trusts created before July 30, 1994, are available to the extent that the trust *permits* use of the resources for the applicant's food, clothing, shelter, or medical care, regardless of whether the trust is in fact used for those items. This rule applies to an *inter vivos* trust created by either the applicant or the applicant's spouse before July 30, 1994, and to testamentary trusts.

11-5.2.1.5.3 First Party Trusts Established On or After July 30, 1994

The rules for *inter vivos* trusts established on or after July 30, 1994, apply to trusts if the assets of the individual were used to form all or part of the corpus of the trust. 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 one or more of the following persons establish the trust other than by a will:

- (1) The individual.
- (2) The spouse of the individual.
- (3) A person or a court of administrative body with legal authority to act in place of, or on behalf of, the individual or the spouse of the individual.
- (4) A person or a court or administrative body acting at the direction of, or upon the request of, the individual or the spouse of the individual.

When the corpus of the trust includes the assets of an individual and the assets of other persons, the requirements of this section apply only to that portion of the trust attributable to the assets of the individual.

The regulations make further distinction between revocable and irrevocable trusts.

Self-settled Revocable Trust. In the case of a revocable trust, the corpus of the trust is a fully available resource, and payments from the trust to or for the benefit of the applicant are considered to be income to the applicant. Payments from the trust to others are treated as assets disposed of by the individual for less than fair market value, and are subject to a 60-month look-back period.

Any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual will be considered, as of the date of establishment of the trust or, if later, the date on which payment to the individual was foreclosed, to be assets disposed of by the

individual subject to possible transfer penalty if there was less than fair consideration for the transfer. It does not matter what the stated purpose of the trust is, whether the trustees have or exercise discretion under the trust, or whether there are restrictions on the timing or use distributions from the trust.

Statutory Special Needs Trust. An exception to the Medicaid resource and transfer rules exists for certain irrevocable trusts established for the benefit of and with the assets of individuals who are disabled (as defined by Social Security).

Pay-back Trust. No transfer penalty applies for a trust containing the assets of a disabled individual *under age 65* if the trust is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court, and the trust contains a provision that the Commonwealth will receive the amounts remaining in the trust upon the death of the individual, up to the amount of the Medicaid benefits paid on behalf of the individual. Although the trust must be settled by a parent, grandparent, legal guardian, or court, the assets used to fund the trust are those belonging to the beneficiary, which often consist of the proceeds of a personal injury action or an inheritance. The literal language of the statute does not allow a competent disabled person to be the settler of his or her own trust. This trust is also known as a (d)(4)(A) trust after the statutory section authorizing it.

Pooled Trust. No transfer penalty applies for a trust containing the assets of a disabled individual if the trust is managed by a nonprofit association as trustee; the trustee can pool the assets of many beneficiaries for investment but must maintain a separate account for each beneficiary of the trust. The trust may be established solely for the benefit of the disabled individual by the parent, grandparent, legal guardian of the individual, or the court, but may also be established by the individual himself or herself. Federal Medicaid law provides that to the extent that funds remain in the beneficiary's account upon the death of the beneficiary, the funds may be retained by the nonprofit association for the use of other beneficiaries; otherwise, the funds remaining must be used to repay the Commonwealth the value of the Medicaid benefits paid for the beneficiary. The statute does not impose an age limitation for the transfer penalty exception to apply, but DPW interprets the statute to imply an age 65 limitation. This trust is also known as a (d)(4)© trust after the statutory section authorizing it.

With the enactment of Act 42 of 2005, Pennsylvania has attempted to impose some questionable limitations on the use of pay-back trusts and pooled trusts. Section 1414 of Act 42 reads as follow:

Section 1414. Special Needs Trust. –

- (a) A special needs trust must be approved by a court of competent jurisdiction if required by rules of court.
- (b) A special needs trust shall comply with all of the following:
 - (1) The beneficiary shall be an individual under the age of sixty-five who is disabled, as that term is defined in Title XVI of the Social Security Act (49 Stat. 620, 42 U.S.C. Section 1381 et seq).
 - (2) The beneficiary shall have special needs that will not be met without the trust.
 - (3) The trust shall provide:
 - (i) That all distribution from the trust must be for the sole benefit of the beneficiary.
 - (ii) That any expenditure from the trust must have a reasonable relationship to the needs of the beneficiary.
 - (iii) That upon the death of the beneficiary, or upon the earlier termination of the trust, the department and any other state that provided medical assistance to the beneficiary must be reimbursed from the funds remaining in the trust up to the amount equal to the total medical assistance paid on behalf of the beneficiary before any other claimant is paid: Provided, however, That in the case of an account in a pooled trust, the trust shall provide that no more than fifty percent of the amount remaining in the beneficiary's pooled trust account may be retained by the trust without any obligation to reimburse the department.

- (4) The department, upon review of the trust, must determine that the trust conforms to the requirements of Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), this section, any other State law and any regulations or statements of policy adopted by the department to implement this section.
- (c) If at any time it appears that any of the requirements of subsection (b) are not satisfied or the trustee refuses without good cause to make payments from the trust for the special needs of the beneficiary, and provided that the department or any other public agency may petition the court for an order terminating the trust.
- (d) Before the funding of a special needs trust, all liens and claims in favor of the department for repayment of cash and medical assistance shall first be satisfied.
- (e) At the death of the beneficiary or upon earlier termination of the trust, the trustee shall notify and request a statement of claim from the department, addressed to the secretary.
- (f) As used in this section, the following words and phrases shall have the following meanings:

“Pooled trust” means a trust subject to the act of December 9, 2002 (P.L. 1379, No. 168), known as the “Pooled Trust Act.”

“Special needs” means those items, products or services not covered by the medical assistance program, insurance or other third-party liability source for which a beneficiary of a special needs trust or his parents are personally liable, to assist in, and are related to, the treatment of the beneficiary’s disability. The term may include medical expenses, dental expenses, nursing and custodial care, psychiatric/psychological services, recreational therapy, occupational therapy, physical therapy, vocation therapy, durable medical needs, prosthetic devices, special rehabilitative services or equipment, disability-related training, education, transportation and travel expenses, dietary needs and supplements, related insurance and other goods and services specified by the department.

“Special needs trust” means a trust or an account in a pooled trust that is established in compliance with this section for a beneficiary who is an individual who is disabled, as such term is defined in Title XVI of the Social Security Act (42 U.S.C. Section 1382(a)(3)), as amended, consists of assets of the individual, and is established for the purpose or with the effect of establishing or maintaining the beneficiary’s resources eligibility for medical assistance.

Several of the limitations set forth in section 1414 of Act 42 appear on their face to be in violation of the federal Medicaid statute’s provisions regarding special needs trusts.

Act 42 defines a “special needs trust” as a trust that “consists of assets of the individual” who is the beneficiary. Thus, section 1414 would not appear to affect third party funded trusts.

11-5.2.1.5.4 *Third Party Trusts*

Whether a trust created by someone other than the applicant and the applicant’s spouse will be considered to be an available resource depends on whether the trust is accessible to the applicant for support and maintenance. A series of appellate decisions spanning the past two decades has provided examples of various issues that determine whether a trust will be considered an available resource for a person seeking Medicaid benefits. Traditional fiduciary principles are applied to determine the scope of the trustee’s duty to the beneficiary. If the beneficiary has a right of support that was enforceable against the trustee, the court has found the trust, or the relevant portion, to be an available resource for Medicaid purposes. Where support is not mandated but other discretionary standards are imposed, the courts have looked for the intent of the testator in determining whether the trust was designed to supplement or supplant public benefits.

In *Stoudt v. DPW*, 464 A.2d 655 (Pa.Comwlth. 1983), the trustee had discretion to “pay so much of income and principal as he in his sole discretion deems necessary for the maintenance and support” of the beneficiary under her father’s will. The Commonwealth Court held that because the trustee had a duty to administer the trust solely in the interest of the beneficiary, and the beneficiary had the right to compel the trustee to make distributions for her

support, the entire corpus was an available resource that disqualified the beneficiary from public benefits.

A different result obtained in *Lang v. DPW*, 528 A.2d 1335 (Pa, 1987). A discretionary support trust was created for the life of a mentally disabled child. Income could be sprinkled to the disabled child in the trustee's discretion or could be accumulated and added to principal, or, if not necessary for the support of the child, could be distributed to the other children of the testator. In addition, principal could be used for the "maintenance, welfare, comfort and support" of the beneficiary. The remainder was distributable to the other children of the testator. There, the Supreme Court held that since there was no duty imposed on the trustee to use the trust for the exclusive benefit of the disabled beneficiary and no intent was found in the will to create such a duty, the trust was not available resource.

In *Snyder v. DPW*, 598 A.2d 1238 (Pa. 1991), a testamentary sprinkle trust was created, consisting of the "bulk" of the estate for the benefit of two adult disabled children during their lives, with the remainder to the children of the testator. The trust provided for payment of income "as may be necessary or desirable for the support, maintenance and care" of the disabled beneficiaries; in addition, the trustee could use principal for the support, maintenance, and care of the beneficiaries in the trustee's discretion. There, the Supreme Court held that the income was available but the principal was not available, due to the existence of multiple beneficiaries and the receipt by one of the disabled beneficiaries of public benefits prior to the death of the testator.

In *Commonwealth Bank & Trust v. DPW*, 563 A.2d 1229 (Pa. Cmwlth. 1989), a \$25,000 trust was created under will for the sole benefit of the testator's mother for life, with income payable in the trustee's discretion, considering other income and principal resources available, with principal to be distributed as the trustee deems "needful or desirable for her support and maintenance, including medical, surgical, hospital or other institutional care." The Commonwealth Court held that the trust was an available resource to pay the mother's nursing home expenses.

In *Rosenberg v. DPW*, 679 A.2d 767 (Pa. 1996), a typical residuary credit-shelter trust was created for the testator's widow, which provided that the trustee pay the net income to the beneficiary, and was authorized, in his "sole discretion, to use principal for the comfort, welfare, and maintenance and support, for educational requirements, medical and surgical expenses, and other unusual needs" of the widow, and the remainder was distributable to the

testator's issue, per stirpes. On appeal to the Supreme Court, it was held that the trust was an available resource to pay the widow's nursing home expenses.

The foregoing cases have not only clarified how to analyze the availability of trusts created by third parties for the support of a beneficiary on public benefits, but have guided planners in the creation of supplemental needs trusts that will preserve present or future eligibility for beneficiaries who would otherwise qualify for public benefits. The cases demonstrate how the courts struggled to weigh various terms and family circumstances in order to glean the intent of the settler or testator, since there was no clear expression of intention. Drafting attorneys should insert provisions that unambiguously express that it is the intent of the settler or testator that the trust principal and income are to be used to supplement, not supplant, public benefits.

11-5.2.3.1 Income

11-5.2.3.1.1 Basic Income Rules

MCCA sets forth rules for the treatment of income after the institutionalized spouse becomes eligible for Medicaid. First, it specifies that the community spouse is permitted to keep all of his or her income. The community spouse's income is thus preserved for that spouse and does not affect the determination of whether the institutionalized spouse qualifies for Medicaid.

MCCA also sets out rules for determining whether income is attributable to the community spouse or the institutionalized spouse. The main rule is that if payment of income is made solely in the name of one spouse, that income is treated as available only to the named spouse. This is often referred to as the "name-on-the-check" rule.

11-5.2.3.1.2 Minimum Monthly Maintenance Needs Allowance

MCCA allows a Medicaid-eligible institutionalized spouse to allocate some or all of his or her monthly income to the community spouse if needed to maintain the community spouse's income at a minimum level. This minimum income level is called the community spouse minimum monthly maintenance needs allowance (MMMNA).

In Pennsylvania, the MMMNA is set at 150 percent of the federal poverty level for a family of two plus an excess shelter allowance. The excess shelter allowance is the amount by which certain housing-related expenses of the

community spouse exceed the standard shelter allowance that is built into the base MMMNA.

The income of the community spouse is not sufficient to yield income equal to or above the MMMNA, the amount of the shortfall is “deducted” from the income of the institutionalized spouse. This amount, called the “community spouse monthly income allowance” (CSMIA), can be paid to the community spouse as additional support.

The community spouse income allowance is adjusted each year for increases in the federal poverty level. It is subject to a ceiling as well as a floor. The ceiling is adjusted each January 1st. The floor, or base amount, is adjusted each July 1st.

In addition to any income allowance support paid to the community spouse, a married nursing home resident is allowed to deduct a personal needs allowance and sufficient income to pay medical expenses that are not covered by Medicaid. Once these items are deducted from the institutionalized spouse’s income, any remaining income is the co-pay that must be contributed toward the cost of his or her care in the institution. There is no-pay obligation for home care provided under the PDA 60+ Waiver program.

11-5.2.3.2 *Community Spouse Resource Allowance (CSRA)*

The MCCA spousal impoverishment provisions apply when one spouse is “institutionalized” – that is, enters a nursing facility and is expected to remain there for at least 30 days, or qualifies for Medicaid-funded home care under the PDA 60+ Waiver.

To determine resource eligibility of the married applicant, the couple must file a report of their resources with the County Assistance Office. The values of all of the countable assets owned by the spouses or either of them are pooled and a protected resource allowance for the community spouse (community spouse resource allowance or “CSRA”) is then calculated.

If the couple has countable resources in excess of the total of the CSRA plus the institutionalized spouse’s personal allowance, the institutionalized spouse will be ineligible for Medicaid. When the amount of countable resources falls below the combined resource allowances, the institutionalized spouse becomes resource-eligible for Medicaid.

The default CSRA may be increased in a number of ways:

By requesting an increase in resources through the fair hearing process. This includes requesting a determination of the CSRA through fair hearing application of the resource-first (or so-called modified “Hurley”) rules.

By seeking a court order for support. A court order takes precedence over DPW’s determination of the protected resource share under the default methodology.

11-5.2.3.3 *Spousal Refusal*

A community spouse may seek to avoid the pooling of spousal resources through a technique known as “spousal refusal.”

Pennsylvania’s regulations are silent regarding spousal refusal. As of the date of this writing, there appears to be no reported Pennsylvania case law on the subject. However, spousal refusal has long been employed in other states.

Section 441.5 of Act 42 provides:

Section 441.5 Penalty Period of Asset Transfer

- (a) Pursuant to section 1917(c) of the Social Security Act (49 Stat. 620, 42 U.S.C. Section 1396p(c)), the department shall impose a penalty of ineligibility for all ineligible days, whether for full months or for a partial month’s period of ineligibility, or both, when an applicant, recipient or spouse of an applicant or a recipient of the services set forth in subsection (b) transfers assets for less than fair market value within or after the look-back period as defined in section 1917(c) of the Social Security Act. Transfers

totaling five hundred dollars (\$500) or less a calendar month shall not be subject to the penalty.

- (b) The ineligibility period set forth in subsection (a) shall apply to all of the following:
 - (1) Nursing facility services.
 - (2) Services equivalent to those provided in a nursing facility.
 - (3) Home- and community-based services furnished under a waiver granted under section 1915(c) or (d) of the Social Security Act (42 U.S.C. Section 1396n(c) or (d)).

Here is an illustration of how the penalty rules work under Act 42 using the August 2005 transfer penalty divisors of \$6,062.35 per month and \$199.31 per day.

On August 22, 2005, Mr. Jones makes a non-exempt transfer of \$20,000. He applies for Medicaid benefits on August 29th. Under Act 42, the penalty period resulting from the transfer is calculated as follows:

Divide the \$20,000 by the average monthly private pay rate at the time of application ($\$20,000/\$6,062.35 = 3.29$ months). There are three whole months of ineligibility.

Determine the partial month penalty period by subtracting the value of the three whole months of ineligibility ($3 \times \$6,062.35 = \$18,187.05$) from the total amount of the transfer ($\$20,000.00$). Divide the result ($\$1,812.92$) by the average daily private pay rate of \$199.31.

Result: $\$1,812.95/\$199.31 = 9.09$ days (round down to 9 days).

Mr. Jones is ineligible for Medicaid-funded long-term care services for three whole months (August, September, October) and nine days (November 1, 2005 through November 9, 2005).

11-5.2.4.2.3 Extended Look-back for Trust

Under federal law and Pennsylvania regulations, transfers to or from a trust established after July 29, 1994, may be subject to a 60 month look-back instead of the 36-month look-back that is applicable to non-trust transfers.

Irrevocable Grantor Trusts. An irrevocable trust that prohibits any distribution of trust corpus to the settler can be a Medicaid planning tool. The funding of

the trust is an uncompensated transfer of assets subject to a 60-month look-back and the income will, if payable to the MA recipient, be treated as income available to pay care costs. Nevertheless, corpus may be protected. Income tax liability is attributable to the settler(s) if the trust is created as a “grantor trust” under the Internal Revenue Code.

Irrevocable grantor trusts are frequently structured to provide income to the settler (potential MA recipient or spouse) for the rest of his or her life and thus are sometimes referred to as irrevocable income only trusts (IOTs). However, an irrevocable grantor trust may be structured to accumulate income or pay income to persons other than the grantor. Thus, the name irrevocable grantor trust is more appropriate for this general class of planning tool.

For periods during which a residence is titled in a trust that is a grantor trust with respect to the taxpayer, the taxpayer is deemed the owner for purposes of meeting the two-of-five-year ownership requirement, and is deemed the owner for purposes of excluding the gain from the sale of the residence from income tax under I.R.C. Section 121.

11-5.2.4.2.4 Real Estate

The transfer of real estate for less than fair market value, except exempt transfers of the principal residence to certain individuals (as discussed below), constitutes an uncompensated transfer.

Life Estates. The transfer of a remainder interest in real estate, with reservation of a life estate, reduces the value of the transfer and the resulting number of months of ineligibility. The amount of the transfer will be the value of the remainder interest as calculated by the life estate and remainder table set forth in appendix F of the chapter 440 of the *Nursing Care Handbook*. Because the remainder tables are age-dependent, the value transferred increases with the age of the grantor. There should be no period of ineligibility if the remainder interest is purchased for fair consideration.

Creation of Joint Tenancy. The effect of a transfer of real property from sole ownership into a joint tenancy with a non-spouse is less than clear. Logically, it would seem that the period of ineligibility should be based on the value of the interest transferred, which would be based on the number of joint tenants added. For example, if Mom transfers the home to herself and her son as joint tenants with rights of survivorship, the value of the uncompensated transfer should be one-half of the value of the property. However the regulation may be susceptible to varying interpretations. There should be no period of ineligibility if the joint interest is purchased for fair consideration.

Principal Residence. The transfer of the residence to certain individuals, as further discussed below, will not result in a transfer penalty. A transfer of the residence to anyone other than these exempt transferees is treated as an uncompensated transfer of assets to the extent that fair consideration is not received.

11.5.2.4.3.1 General Exceptions to the Transfer Penalties

The transfer of assets without fair consideration will not create a period of ineligibility for Medicaid under the following conditions.

Intent to Receive Fair Market Value. The applicant can show that he or she intended to dispose of the assets at fair market value.

Purpose Other Than to Obtain Benefits. The applicant can show that the assets were transferred exclusively for a purpose other than to qualify for Medicaid.

To the Spouse. The assets were transferred to the applicant's spouse or to another for the sole benefit of the applicant's spouse.

To a Minor or Disabled Child. The assets were transferred to the applicant's child who is under 21 years of age, or to a child of any age who is blind or permanently or totally disabled (based on SSI criteria), or to a trust solely for the benefit of such child.

Undue Hardship. No period of ineligibility will be imposed where DPW determines that the imposition of a period of ineligibility would cause the applicant an undue hardship.

Gift is Returned. No penalty is imposed where the assets that were transferred for less than fair market value are returned to the applicant.

11.5.2.4.3.2 Additional Exemptions for the Transfer of the Residence

The above exemptions apply to the transfer of any asset. There are, however, other exemptions that apply solely to a transfer of the applicant's residence. If the transfer of the applicant's residence meets one of the following exemptions, no period of ineligibility is imposed:

Transfer to Minor of Disabled Child. A transfer of the home to the applicant's child who is under 21 years of age, or to a child of any age who is blind or permanently and totally disabled based on SSI Criteria, or to a trust solely for the benefit of such child.

Caregiver Child. A transfer of the home to the applicant's child who resided in the property for two years prior to the parent entering the nursing home and who provided care during the two-year period that permitted the parent to stay in the home rather than a nursing home.

Sibling With Equity. A transfer is a sibling who has an equity interest in the home and who lived in the home for at least one year immediately before the applicant entered the nursing home.

11-5.3.2 Lengthening the Look-Back Period (Section 6011(a))

The DRA lengthens the look-back period for non-exempt transfers to 60 months for all dispositions of assets made on or after the date of the enactment of the DRA (February 8, 2006). The previous look-back period was 36 months for most transfers and 60 months for certain transfers involving trusts.

11.5.3.3 Change in the Beginning Date for Period of Ineligibility (Section 6011(b))

Assets transfers made by an applicant (or spouse) during the look-back period must be reported and may be subject to penalty. The penalty is that the applicant is denied eligibility for Medicaid long-term care benefits for a period of time. The duration of the ineligibility period is based upon the uncompensated value transferred and the average monthly cost to a private patient receiving nursing facility services.

The DRA changes the date on which the penalty is imposed by delaying its start until the applicant would otherwise be eligible for MA. This change in methodology applies to all transfers that take place after the date of DRA enactment. For post-DRA transfers, the penalty period does not begin until:

- (1) the first day of a month during or after which assets have been transferred or
- (2) the date on which the individual is eligible for Medicaid and would otherwise be receiving an institutional level of care, based on an approved application for such care but for the imposition of the penalty period, whichever is later.

Thus, the penalty does not begin until the individual meets all other eligibility requirements. This means that the penalty period for a post-DRA transfer does not start to run until the applicant has already reached the limited resource

levels required for qualification (e.g., \$2,400 or \$8,000 in countable resources for an unmarried person).

11.5.3.4 Undue Hardship Waivers (Section 6011(d) and (e))

The change in the start date raises a potentially serious financial problem for nursing homes. How does a nursing facility get paid if a resident who has made transfers has no resources and Medicaid won't pay?

In response to this concern, the DRA expands Medicaid's undue hardship provision.

Medicaid law provides that the transfer penalty may not be imposed in situations where the denial of eligibility would work an undue hardship.

The DRA requires each state to specify the criteria by which an undue hardship request will be granted. A hardship waiver should be granted if the imposition of the transfer penalty would deprive the individual of medical care and endanger the individual's health or life or deprive the individual of food, clothing, shelter, or other necessities of life. Under the DRA, states are required to provide (1) notice to recipients that an undue hardship exception exists, (2) a timely process for determining whether an undue hardship waiver will be granted, and (3) a process under which an adverse determination can be appealed.

Nursing facilities may file undue hardship waiver applications on behalf of their residents, with the resident's consent. If a nursing facility applies for undue hardship for a resident, the state has the option of providing payments for nursing facility services to hold the individual's bed at the facility while the application is pending. Such payments cannot be made for longer than 30 days.

11-5.3.5.1 Overview

As a result of the DRA, annuities have become an increasingly useful planning tool for clients seeking to protect their resources from the costs of long-term care. The new law effectively authorizes the use of annuities to gain immediate eligibility for Medicaid if the transfer and remainder interest provisions of the law are met.

Prior to the DRA, annuities were most frequently employed to protect the assets of married couples. Annuities would convert the excess resources of a community spouse to exempt income. Prior to the DRA, annuities were rarely used in planning for unmarried individuals. For unmarried periods, assets

could usually be better protected through the use of “half a loaf” transfer planning or other techniques.

Under the DRA, annuities continue to be a vital planning option for married couples. Often, the purchase of a DRA-compliant annuity will be the primary planning required to protect the financial security of a community spouse. And, due to the DRA’s strict new restrictions on asset transfers, annuity-based planning has now become more significant for unmarried individuals.

11-5.3.5.2 Federal Law

Congress and federal regulators have historically given preferential treatment to annuities. In an Omnibus Reconciliation Act of 1993, Congress delegated the Medicaid treatment of annuities to the secretary of HHS. Transmittal 64 to the *State Medicaid Manual* contained the secretary’s determination of when an annuity is to be considered a transfer of assets.

Annuities, although usually purchased in order to provide a source of income for retirement, are occasionally used to shelter assets so that individuals purchasing them can become eligible for Medicaid. In order to avoid penalizing annuities validly purchased as part of a retirement plan but to capture those annuities which abusively shelter assets, a determination must be made with regard to the ultimate purpose of the annuity (i.e., whether the purchase of the annuity constitutes a transfer of assets for less than fair market value). If the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the beneficiary, the annuity can be deemed actuarially sound.

Transmittal 64 established that the actuarially sound immediate annuity could be purchased without a transfer penalty. The DRA continues this rule, subject to several modifications:

- (1) The DRA clarifies and codifies the rules regarding when an annuity transaction is to be treated as a transfer for less than fair value. To avoid treatment as a transfer of assets, a post-DRA annuity must either be
 - (A) a qualified retirement annuity; or
 - (B) it must meet three DRA requirements. These “DRA compliant” requirements are:

- (i) The annuity is irrevocable and non-assignable;
 - (ii) The annuity is actuarially sound;
 - (iii) The annuity provides for payments in equal amounts, with no deferral and no balloon payments made.
- (2) The DRA requires that the state be named as remainder beneficiary (subject to the preferred interest of the community spouse and minor and disabled children) to the extent of benefits paid. The DRA creates a state interest as a remainder beneficiary in annuities purchased post-DRA or modified post-DRA. The Medicaid application (or recertification) form must specify that the state will become a remainder beneficiary under such annuities and similar financial instruments.

Under the DRA an annuity must name the State as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the annuitant (institutionalized individual), unless there is a community spouse and/or a minor of disabled child...If there is a community spouse and/or any minor or disabled child, the State may be named in the next position after those individuals.

The extent of the state's interest is defined: "As a remainder beneficiary, the State may receive up to the total amount of medical assistance paid on behalf of the individual, including both long term care services and community services."

If the state is not named as a remainder beneficiary in the correct position, the purchase of the annuity by the applicant (or spouse) must be treated as a transfer of assets for less than fair market value.

- (3) The DRA requires that applicants for Medicaid-funded long-term care disclose their interests in annuities. To be eligible for Medicaid-financed long-term care services, the applicant must disclose any interests the applicant or spouse has in an annuity (or in similar financial instruments to be specified by the secretary of HHS). Reporting is required regardless of whether the annuity is irrevocable or is treated as an asset.

Note that the DRA gives special treatment to annuities purchased with the proceeds of certain retirement plan accounts. The new law's asset transfer provisions do not apply to such "qualified annuities." However, retirement

plan qualified annuities are still subject to the DRA's disclosure and remainder beneficiary provisions.

The new annuity rules apply to any annuity purchased after February 7, 2006, or involved in a transaction after that date.

In July 2006, CMS issued a letter to state Medicaid Directors that provided some guidance regarding CMS interpretation of the transfer and annuity provisions of the DRA. The CMS guidance letter reviews the annuity provisions of the DRA. It addresses the issue of how "actuarial soundness" is determined. (Nonretirement annuities must be actuarially sound to avoid transfer penalty.)

Under the *State Medicaid Manual*, if the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the beneficiary, the annuity can be deemed actuarially sound. The CMS letter directs states to "use the methodology for determining actuarial soundness that is found in the State Medicaid Manual Chapter III, Section 3258.9B. However, do not use the actuarial life expectancy tables published in that section. Instead, use the *current* actuarial tables published by the Office of the Chief Actuary of the State Security Administration. This tables may be accessed at <http://www.ssa.gov/OACT/STATS/table4c6.html>." (Emphasis in original.)

11-5.3.5.3 State Guidance

DPW's Operations Memorandum on the subject of annuities is available on the author's website, <http://www.paelderlaw.com>. The Operations Memorandum lays out DPW's interpretation of the rules regarding when the purchase of an annuity will be penalized as a transfer. The Operations Memorandum also addresses the issue of when an annuity is to be treated as a resource rather than as income.

A denial of Medicaid/LTC benefits may result if an annuity is treated as either a transfer or as an available resource. Thus, for planning purposes, *the ideal annuity is one that will not be an available asset and whose purchase will not involve a penalized transfer of assets*. The Operations Memorandum sets out the path to be followed to meet these goals with no objection from the state.

The Operations Memorandum policies apply to applicants, recipients, and spouses of applicants and recipients who purchase a nonqualified annuity or make a transaction involving a non-qualified annuity on or after February 8, 2006.

11-5.3.5.3.1 What is a Transaction?

A annuity “transaction” is any action taken by the individual affecting the payment from the annuity or a change affecting the payment of the income or principal of the annuity. Examples of transactions are purchases, additions to principal, elective withdrawals, requests to change distribution of the annuity, elections to annuitize the contract, and similar actions.

11-5.3.5.3.2 Disclosure

As a condition of eligibility for medical assistance, an applicant or recipient, and the spouse of an applicant or recipient, is required to disclose any interest that he or she has in an annuity.

11-5.3.5.3.2 Nonrecognition of Non-assignability Clauses

Reflecting a similar provision in Act 42, the Annuity Operations Memorandum states:

Any provision in an annuity or similar contract for the payment of money owed an applicant, recipient or spouse of an applicant or recipient, limiting the right to sell, transfer or assign the right to receive payments or restricting the right to change the beneficiary will not be recognized by DPW. It will be presumed that any annuity or similar contract to receive money is marketable.

11-5.3.6 Income-First Mandate (Section 6013)

In the past, Pennsylvania has allowed use of resource-first based methodologies as an optional means of determining the community spouse resource allowance (CSRA). The resource-first approach can allow the community spouse to retain additional resources and thereby limit the potential for delayed spousal impoverishment.

States are no longer permitted to use a resource-first methodology to allow low-income community spouses to keep financial resources in excess of the base CSRA. The DRA requires states to use an income-first methodology in determining the CSRA. This income-first mandate applies to transfers and allocations made on or after the date of enactment by individuals who become institutionalized spouses on or after such date. Thus, Pennsylvania must now use an income-first methodology for married couples. Pennsylvania has set out

the new complicated spousal protection procedures in its Operations Memorandum on spousal impoverishment.

In effect, the Operations Memoranda provide a community spouse with two avenues to protect excess resources: the spousal impoverishment rules and the annuity rules. It appears that most community spouses with excess resources will be better advantaged by using the annuity rules.

11-5.3.7 *Limit on Home Equity (Section 6014)*

Prior to the DRA, the equity value of an applicant's home was generally not counted as a resource. The home equity was unavailable if a spouse or other designated family members resided in the home or if the Medicaid recipient declared the intent to return home. Under the DRA, substantial home equity may now be counted.

The DRA requires states to place a \$500,000 to \$750,000 ceiling on this home equity exemption. Pennsylvania has elected to provide the minimum exemption of \$500,000. However, home equity will not be deemed to be an available resource if a spouse, a child under age 21, or a child who is blind or disabled lawfully resides in the applicant's home.

In determining the value of home equity, States should follow the basic policies of the Supplemental Security Income (SSI) program. The equity value of a resource is the current market value minus any encumbrance on it. Current market value is the going price of the home, or the amount for which it can reasonably be expected to sell on the open market in the particular geographic area involved. An encumbrance is a legally binding debt against the resource. This can be a mortgage, reverse mortgage, home equity loan, or other debt that is secured by the home. States should follow their existing policies to determine current market value. States should also apply their usual verification procedures if an encumbrance is alleged.

If the home is held in any form of shared ownership, e.g., joint tenancy, tenancy in common, or other arrangement, only the fractional interest of the applicant for medical assistance for nursing facility or other long-term care services should be considered. For example, if the home is owned in joint tenancy by an applicant and a sibling, one-half of the home's current market value should be used in calculating the equity value of the

individual, unless the individual can rebut the presumption that he or she has equal ownership interest in the property.

The new home equity limitations apply to applications for benefits made on or after January 1, 2006.

11-5.3.8 Enforceability of CCRC Provisions (Section 6015)

Admission agreements of some continuing care retirement communities (CCRCs) and life care communities require that residents spend the resources that were declared for the purpose of admission on care before the resident may apply for Medicaid. DRA section 6015 establishes the enforceability of this type of provision.

The DRA also specifies that the usable or refundable portions of entrance fees for CCRCs or life care communities are generally countable resources for purposes of Medicaid eligibility determinations. The following three conditions must all be met in order for the entrance fee to be considered an available resource:

- The entrance fee can be used to pay for care under the terms of the entrance contract, should other resources of the individual be insufficient; and
- The entrance fee (or remaining portion) is refundable when the individual dies or terminates the contract and leaves the CCRC or life care community; and
- The entrance fee does not confer an ownership interest in the community.

States should note that in order to meet the first condition listed above, it is not necessary for CCRCs or life care communities to provide a full, lump-sum refund of the entrance fee.

The provisions of the entrance contract are subject to the rules relating to the prevention of impoverishment of a community spouse. Therefore, any contractual provision requiring the expenditure of resident entrance deposits must take into account the required allocation of resources or income to the community spouse before determining the amount of resources that a resident must spend on his or her own care.

11-5.3.9 Inclusion of Certain Notes and Loans (Section 6016(c))

Section 6016(c) of the DRA sets forth criteria under which a promissory note must be treated as a transfer of assets. Since federal law is controlling, this codification means states have less discretion in determining when the purchase of a note or loan is to be treated as a transfer.

Section 6016(c) specifies that the purchase of a promissory note, loan, or mortgage is a transfer of assets unless the note, loan, or mortgage (1) has a repayment term that is actuarially sound, (2) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made, and (3) prohibits the cancellation of the balance upon the death of the lender. The countable value of a promissory note, loan, or mortgage that does not satisfy these requirements is the outstanding balance due as of the date of the individual's application for Medical Assistance.

Promissory notes appear to offer fertile ground for planning under the DRA. Unlike annuities, DRA-compliant notes do not have to name DPW as a beneficiary to the extent of MA/LTC benefits paid (although estate recovery may someday apply). But, planners should appreciate the likelihood of DPW opposition, as shown by the DPW Operations Memorandum on notes, to the use of notes in Medicaid planning.

11-5.3.10 Inclusion of Transfers to Purchase Life Estates (Section 6016(d))

Section 6016(d) of the DRA establishes criteria under which the purchase of a life estate in another individual's home will be treated as a transfer of assets. As a result, the DRA may establish "safe harbor" criteria under which the purchase of life estate will not be treated as a transfer.

Section 6016(d) specifies that the purchase of a life estate interest in another individual's home constitutes a transfer of assets unless the purchaser resides in the home for at least one year after the date of purchase.

11-5.3.11 Other DRA Changes

The DRA also codifies asset-transfer rules regarding partial months of ineligibility and multiple transfers of assets. These new provisions are generally consistent with already existing Pennsylvania policy.

The act also authorizes states to amend their Medicaid state plans to provide for state long-term care insurance partnership programs, and sets forth requirements for partnership policies. This type of program is designed to

encourage the purchase of private long-term care insurance. Prior to the DRA, partnership policies were sold in only four states: California, Connecticut, Indiana, and New York. If Pennsylvania decides to authorize a partnership program, policyholders who buy a designated private long-term care insurance policy that is used to pay for long-term care services will be allowed to protect additional resources from Medicaid spend-down requirements. Individuals must still meet Medicaid income requirements. Existing long-term care insurance policies are not grandfathered.

Standards for documentation of proof of citizenship are tightened by section 6036.

The DRA also includes a number of provisions intended to facilitate the Medicaid funding of long-term care services in home and community settings.

11.6 MEDICAID-FINANCED HOME – AND COMMUNITY-BASED PROGRAMS

11.6-1 Medicaid State Plan Benefits

Since 1970, states participating in the Medicaid program have been required to provide some home-health services for persons entitled to nursing facility care. Federal regulations specify that the services must be ordered by a physician as part of a written plan of care. Services must be medically necessary. Federal regulations require that Medicaid home-health services include nursing, home-health aides, medical supplies, medical equipment, and appliances suitable for use in the home.

In Pennsylvania, Medicaid state plan benefits will provide payment for various home-health-related services to persons who meet the program's medical and financial criteria. Eligibility requirements and services are detailed in 55 Pa.Code ch. 1249, Home Health Agency Services.

11-6.2 Pennsylvania Department of Aging 60+ Waiver Program

The Pennsylvania Department of Aging (PDA) 60+ Waiver Program (PDA Waiver Program) is operated under a federal waiver obtained under section 1915 of the Social Security Act. Waiver programs are alternative programs initiated by the states to offer Medicaid to residents in a manner that deviates from normal Medicaid requirements. The PDA Waiver program is jointly

administered by the Department of Aging and Department of Public Welfare, and provides federal Medicaid funds to persons 60 years or older who are nursing facility clinically eligible, but may appropriately receive services in their homes rather than in a nursing facility.

In addition to age and functional need eligibility criteria, the PDA Waiver program has a countable resource limit of \$8,000, and an income limit of 300 percent of the federal benefit rate. Act 42 changed the methodology used in calculating the spousal income and resource allowances and extended the MCCA spousal pooling of resource rules of Medicaid-funded home care under the PDA Waiver program. Since Medicaid funding is used for the PDA Waiver Program, Medicaid estate recovery applies to the cost of services provided.

No co-payments are required from recipients of these waiver services.

The local Area Agencies on Aging serve as the coordinators of services and perform regular assessments, develop and maintain an adequate and appropriate care plan, select service and product providers, and monitor the services provided. Services may include home-health and personal care, home support, respite care, adult day care, transportation, home modification, specialized medical equipment, and home-delivered meals.

11-6.3 *LIFE (Long Term Care Capitated Assistance) Program*

A home- and community-based program of increasing importance to seniors needing long-term care services is Pennsylvania Long Term Care Capitated Assistance Program (LTCCAP). Nationally, the program is known as PACE, but in order to avoid confusion with the state pharmaceutical program, the state decided to use a Pennsylvania-specific name. In Pennsylvania, the program is commonly referred to as LIFE, which stands for “Living Independently for Elders.” Its goal is to enable frail, older adults to be able to continue to live in their homes and in the community as long as feasible.

LIFE integrates Medicare and Medicaid funding to serve primarily individuals who qualify for both programs (“dual-eligibles”). However, otherwise qualified non-Medicaid-eligible individuals may participate by privately paying the Medicaid rate to the provider.

Medicare and Medicaid make monthly capitated payments to the LIFE provider, which delivers a comprehensive, all-inclusive package of services to participants. The focal points for service delivery are adult day health centers. Services include primary medical care, nursing, therapies, personal care, pharmaceuticals, monitoring, transportation, meals, and recreational and

socialization activities. Other services may be provided as needed. Once the consumer becomes a member of the LIFE program, the provider must continue to provide needed health-care services even though the consumer's health has declined to the point of needing institutional services.

Participant eligibility criteria include: (1) age 55 or older, (2) determined to be nursing facility eligible, (3) determined eligible for Medical Assistance benefits or able to private pay, (4) resides in the area served by LIFE provider, and (5) determined by the LIFE provider to be able to be safely served in the community.

11.6-4 DRA Home- and Community-Based Services Provisions

The DRA includes a number of provisions intended to facilitate the Medicaid financing of long-term care services in home and community settings. The DRA establishes home- and community-based services as an optional Medicaid benefit for individuals whose income does not exceed 150 percent of the federal poverty level. To participate, a recipient need not be nursing facility clinically eligible. Beginning in 2007, states will have increased latitude to use Medicaid money to provide community services, in-home aides, or other community care.

11-7 MEDICAID ESTATE RECOVERY

11-7.1 In General

In compliance with federal law, Pennsylvania seeks to recoup Medicaid payments expended to pay nursing home, home-care, and certain other Medicaid benefits expended for long-term care. No recovery is sought from the surviving spouse or the estate of the surviving spouse. Recovery is enforced only from the estate of the deceased Medicaid recipient.

The estate subject to recovery includes all real and personal property and other assets within the individual's probate estate, as defined by state probate law. States are given the option of also recovering against nonprobate property in which the recipient had legal title or interest at death, including assets conveyed to a successor, heir, or beneficiary of the decedent through joint tenancy, tenancy in common, right of survivorship, life estate, living trust, or other

arrangement. As of the date of this writing (October 1, 2006), Pennsylvania has not opted to implement expanded estate recovery.

As a result of estate recovery, assets such as the home may be exempt during a Medicaid recipient's lifetime may nevertheless be subject to costs of Medicaid at the recipient's death.

Pennsylvania's Medical Assistance Estate Recovery (MAER) regulations are found at 55 Pa.Code ch. 258.

11-7.2 *ESTATE RECOVERY IN PENNSYLVANIA*

11-7.2.1 *Estates Subject to Estate Recovery*

A MAER claim arises at the death of an MA recipient who was 55 or older when nursing facility services, home- and community-based services, and other hospital and prescription drug services were received. The claim arises only upon the death of the Medicaid recipient and no lien or claim of any kind is placed against any property during the recipient's lifetime. Upon the death of an individual who received benefits subject to MAER, the state has a claim against the decedent's probate estate in the amount of the covered payments that were made.

The MAER regulations give Pennsylvania the status of a creditor with a claim against the MA recipient's estate. The portion of the MAER claim that relates to MA benefits paid for services rendered during the decedent's last six months of life receives priority over most other estate creditors. However, the reasonable costs of administering the estate, including attorney's fees and funeral expenses, are given priority over MAER.

In addition to seeking recovery from the traditional probate estate of the decedent, the regulations permit DPW to recover against assets payable to persons other than the personal representative under section 3101 of the Probate, Estates and Fiduciaries Code (PEF Code). These "nonprobate" assets that are nevertheless subject to MAER include:

1. Accounts distributed under PEF Code section 3101(b), which allows banks and other third parties to pay the amount on deposit up to \$3,500 directly to designated family members of a decedent (when provided with proof that arrangements for funeral payment have been made);

2. Accounts distributed under PEF Code section 3101(c), which allows nursing homes to pay up to \$4,000 remaining in a resident's patient care account directly to family members of a deceased patient if burial expenses have been paid;
3. Accounts distributed under PEF Code section 3101(d), which allows insurance companies that owe insurance or annuity payments of up to \$11,000 to the estate of a decedent to make payment instead to designated family members if no written claim has been received by the company from the personal representative of the estate.
4. Accounts distributed under PEF Code section 3101(e), which allows the state treasurer to pay unclaimed property of a value up to \$11,000 to the spouse or other family members of a decedent.

The regulations provide specific examples of property that is not subject to MAER, including property held as joint tenants with right of survivorship or tenants by the entirety, life insurance payable to a named beneficiary other than the estate, trust assets that are not payable to the estate, irrevocable burial trust assets, and disability trusts that comply with 55 Pa.Code Section 178.7(f).

The Commonwealth does not assert a claim against resources of the surviving community spouse unless inherited from the probate estate of the institutionalized spouse.

11-7.2.2 Duty of Personal Representative

The personal representative of the estate has a duty to ascertain whether the decedent received Medicaid services during the five years preceding death and, if so, to request a statement of claim from DPW. Notice to DPW must include (1) a statement that the personal representative is requesting a statement of claim against the estate, (2) the decedent's name, (3) the decedent's last address, (4) the decedent's date of birth, (5) the decedent's date of death, (6) the decedent's social security number, (7) the personal representative's name, address, and telephone number, and (8) a statement of the gross value of the decedent's estate. It is prudent to send the notice by certified mail so that the personal representative will have proof of compliance, although the request can be faxed to 717-772-6553. The mailing address for requesting a statement of claim is:

Third Party Liability Section

Department of Public Welfare

Estate Recovery Program

P.O. Box 8486

Harrisburg, PA 17105-8486

DPW must submit its statement of claim within 45 days after it receives the notice from personal representative. However, it may amend its statement of claim after the 45-day period if new or updated information is received, which may occur if the Medicaid application was still pending at the date of death, but subsequently approved.

Under section 3392 of the PEF Code, a tiered classification and order of payment scheme is created for estates in which the assets are insufficient to pay all creditors in full. Services provided by the Medical Assistance program within six months of death are priority 3 claims, and those outside that period are priority 5.1 claims. The statement of claim issued by DPW will differentiate the time periods of the claim.

11-7.2.3 Postponement of Estate Recovery Claim

The regulations provide that DPW's claim will be postponed until the last of the following to occur: (1) the death of a surviving spouse, (2) the death of a child who is blind or totally disabled, (3) the date a child turns 21, and (4) the death of, property transfer by, or vacating of the residence by a sibling with an equity interest in the property, who had been living in the property for at least one year.

If a claim is postponed, the personal representative is obligated to act to protect the department's claim during the postponement period.

The personal representative will be deemed to have complied with his responsibilities to protect the Department's claim during the postponement period if, after liquidating the assets as appropriate and paying all expenses of administration and superior claims of creditors against the estate, the personal representative takes one or more of the following actions until the Department's claims is fully protected, or until all protectable assets are protected.

1. If the decedent's estate contains real estate, the personal representative shall cause a mortgage or other recorded encumbrance to be placed against the real estate in favor of the Department.

2. If the decedent's estate contains one or more individual items of personal property with a fair market value in excess of \$10,000, the personal representative shall cause a properly perfected security interest to be placed against the items of personal property in favor of the Department. A properly perfected security interest is a lien on property for payment of a debt, for which the necessary legal steps, as specified in 13 Pa.C.S. Subsection 9101-9507 (relating to the Uniform Commercial Code), have been taken to make the lien valid and enforceable against all third parties.
3. If the estate contains cash or cash-equivalents in an aggregate amount in excess of \$50,000, the personal representative shall cause that money to be placed in trust, with terms and trustees approved by the Department. The trust shall name the Department as remainderman and shall allow the spouse or child, or both, to consume income without court approval, shall allow the consumption of principal to pay reasonable medical expenses of the spouse or child, or both, and shall or the consumption of principal for the benefit of the spouse or child, or both, with court approval. The personal representative may serve as trustee and a reasonable trustee fee may be provided by the trust document. A remainderman is a person entitled to receive money in a trust, upon termination of the trust.
4. If the decedent's estate contains protectable assets which are not adequately protected by the procedures in paragraphs (1)-(3), the personal representative shall appropriately protect the assets by another method, as approved by the Department.

In some cases, the implementation of the department's postponement policies may conflict with federal estate recovery law and Pennsylvania regulations.

11-7.2.4 *Personal Liability of Personal Representative and Transferees*

The estate regulations impose personal liability on the personal representative if the statement of claim is not presented to the court, if the property subject to claim is transferred without valuable and adequate consideration to an heir or

other person without protecting the department's claim, or if the personal representative fails to disclose the existence of property subject to the claim. The personal representative will be discharged from this liability only if DPW is served with a copy of the proposed distribution at least 30 days in advance of court approval; the court records show that the request for a statement of claim was made; the claim is presented to the court for payment and paid, unless the court records show there were insufficient assets to pay the full amount claimed; and the personal representative serves the court with a copy of the final distribution order and pays the amounts due.

A transferee of property that is subject to a MAER claim is liable to the extent that fair market value is not paid. Transferee liability is limited to the difference between the fair market value of the property and the amount received by the estate in exchange for the transfer. However, the arm's-length sale of the decedent's real property at fair market value by the personal representative to a party unrelated to the decedent or personal representative is deemed to be supported by valuable and adequate consideration.

11-7.2.5 Waiver and Undue Hardship

The regulations create a number of exceptions to estate recovery.

11.7.2.5.1 Residence

A claim against a personal residence will be waived if the person requesting the waiver satisfies three conditions: (1) the person resided in the residence for at least two years immediately preceding the decedent's receipt of Medical Assistance, (2) the person has no other alternative permanent residence, and (3) the person provided care or support to the decedent for at least two years during the period during which the decedent needed care or support to remain at home.

11-7.2.5.2 Income-producing Assets

DPW will also find undue hardship and waive its claim with respect to an income-producing asset if a spouse, child, parent, sibling, or grandchild of the decedent meets both of the following conditions: (1) the asset is used to generate the primary source of income for the household, and (2) there would be a gross family income of less than 250 percent of the federal poverty guideline without use of the asset. An income-producing asset is defined as property used in a trade or business such as a family farm, family business, or rental property, excluding cash, stocks and bonds, mutual fund shares, or other marketable financial instruments.

11-7.2.5.3 Home Maintenance Expense Waiver

DPW will waive from its recovery claim an amount equal to the necessary and reasonable expenses for maintaining the decedent's home while the decedent was receiving home- and community-based services, or the decedent's vacant home while the decedent was in a nursing home. Real estate taxes, utility bills, home repairs, and home maintenance, such as lawn care and snow removal, which are necessary to keep the home in condition for the decedent to return home or to sell at fair market value, are considered necessary and reasonable. If the home was occupied, these expenses will not be allowed.

11-7.2.5.4 Administered Estates under \$2,400

If there is an heir, DPW will waive its claim if the estate is administered but less than \$2,400. Note that while low-income Medical Assistance recipients may be allowed to retain assets up to \$8,000 during life, the MAER exemption is limited to \$2,400.

11-7.2.5.5 Waiver Requests

No specific form has been promulgated for waiver requests, but a letter request may be directed to Estate Recovery Program, P.O. Box 8586, Harrisburg, PA 17105-8486.

11-7.2.5.6 Unadministered Estates

If no one applies for appointment as a personal representative of a deceased MA recipient, DPW may provide a list of estates to the probate section of the county bar association for their administration by willing attorneys. The regulations authorize the payment of a combined personal representative's commission and attorney fee of the greater of \$1,000 or 6 percent of the gross estate. DPW may also cause one of its employees to administer an estate.

11-7.2.5.7 Enforcement and Appeals

DPW may administratively assess liability upon a personal representative or transferee. Appeals by persons adversely affected by a MAER decision of DPW must be filed within 30 days of notice of the decision to the Bureau of Hearings and Appeals. Appeals should be mailed to Bureau of Hearings and Appeals, Department of Public Welfare, P.O. Box 2675, Harrisburg, PA 17105.

The Bureau of Hearings and Appeals has exclusive jurisdiction over disputes involving a request for waiver, compromise, or postponement of collection. The standard of review is abuse of discretion for those matters that involve an exercise of discretion; otherwise, the review is de novo. The Bureau of Hearings and Appeals has concurrent jurisdiction with the courts of common pleas over disputes involving the computation of the department's claim or assessment of liability against a personal representative or transferee.

11-8 EFFECT OF DRA ON PLANNING FOR MEDICAID PAYMENT FOR LONG-TERM CARE

For persons of modest means, effectively planning to pay for long-term care requires a thorough understanding of the federal and state laws and regulations dealing with available and excluded resources, methods of increasing the GSRA for the community spouse, and the transfer rules. With this understanding, the lawyer can help the client obtain needed care while minimizing the loss of the financial security of the client and family members.

Medicaid estate planning has undoubtedly become more difficult due to the DRA. The Deficit Reduction Act of 2005 was enacted with the intent of limiting the opportunities for individuals to use Medicaid eligibility to protect their assets for themselves and their families. Nevertheless, planning opportunities continue to exist. The determination of which planning techniques will be most appropriate and effective under the DRA will be dependent to a great extent upon future regulatory and case law developments.

In this uncertain environment, lawyers who advise clients about the complicated maze of eligibility rules will need to stay abreast of the latest developments. The practitioner must proceed with the utmost knowledge, skill, and caution when advising clients about the use of Medicaid in paying for long-term care.

Public Law 109-171

Deficit Reduction Act of 2005

TITLE VI – Medicaid and SCHIP

CHAPTER 2 - LONG-TERM CARE UNDER MEDICAID

Subchapter A – Reform of Asset Transfer Rules

Sec. 6011. LENGTHENING LOOK-BACK PERIOD; CHANGE IN BEGINNING DATE FOR PERIOD OF INELIBILITY.

(a) Lengthening Look-Back Period for All Disposals to 5 Years. – Section 1917(c)(1)(B)(i) of the Social Security Act (42 U.S.C. 1396p(c)(1)(B)(i) is amended by inserting “or in the case of any other disposal of assets made on or after the date of the enactment of the Deficit Reduction Act of 2005” before “,60months”.

(b) Change in Beginning Date for Period of Ineligibility. – Section 1917(c)(1)(D) of such Act (42 U.S.C. 1396p(c)(1)(D)) is amended—

(1) by striking “(D) The date” and inserting “(D)(i) In the case of a transfer of asset made before the date of the enactment of the Deficit Reduction Act of 2005, the date”; and

(2) by adding at the end of the following new clause:

“(ii) In the case of a transfer of asset made on or after the date of the enactment of the Deficit Reduction Act of 2005, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.”.

(c) Effective Date. - The amendments made by this section shall apply to transfers made on or after the date of the enactment of this Act.

(d) Availability of Hardship Waivers. – Each State shall provide for a hardship waiver process in accordance with section 1917©(2)(D) of the Social Security Act (42 U.S.C. 1396©(2)(D)) -

(1) under which an undue hardship exists when application of the transfer of assets provision would deprive the individual –

(A) of medical care such that the individual’s health or life would be endangered; or

(B) of food, clothing, shelter, or other necessities of life; and

(2) which provides for –

(A) notice to recipients that an undue hardship exception exists;

(B) a timely process for determining whether an undue hardship waiver will be granted; and

(C) a process under which an adverse determination can be appealed.

(e) Additional Provisions on Hardship Waivers. –

(1) Application by facility. – Section 1917©(2) of the Social Security Act (42 U.S.C. 1396(c)(2)) is amended –

(A) by striking the semicolon at the end of the subparagraph (D) and inserting a period; and

(B) by adding after and below such paragraph the following:

“The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the personal representative of the individual.”.

(2) Authority to make bed hold payments for hardship applicants. – Such section is further amended by adding at the end of the following: “While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for

payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.”.

SEC. 6012. DISCLOSURE AND TREATMENT OF ANNUITIES.

(a) In General. – Section 1917 of the Social Security Act (42 U.S.C. 1396p) is amended by redesignating subsection (e) as subsection (f) and by inserting after subsection (d) the following new subsection:

“(e)(1) In order to meet the requirements of this section for purposes of section 1902(a)(18), a State shall require, as a condition for the provision of medical assistance for services described in subsection (c)(1)(C)(i) (relating to long-term care services) for an individual, the application of the individual for such assistance (including any recertification of eligibility for such assistance) shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.

“(2)(A) In the case of disclosure concerning an annuity under subsection (c)(1)(F), the State shall notify the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State’s remainder interest under such subsection.

“(B) In the case of such an issuer receiving notice under subparagraph (A), the State may require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure described in paragraph (1). A State shall take such information into account in determining the amount of the State’s obligations for medical assistance or in the individual’s eligibility for such assistance.

“(3) The Secretary may provide guidance to States on categories of transactions that may be treated as a transfer of asset for less than fair market value.

“(4) Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1).”.

(b) Requirement for State To Be Named as a Remainder Beneficiary. – Section 1917(c)(1) of such Act (42 U.S.C. 1396p(c)(1)), is amended by adding at the end of the following:

“(F) For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless –

“(i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant under this title; or

“(ii) the State is named as such beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value”.

(c) Inclusion of Transfers to Purchase Balloon Annuities. – Section 1917(c)(1) of such Act (42 U.S.C. 1396p(c)(1)), as amended by subsection (b), is amended by adding at the end of the following:

“(G) For purposes of this paragraph with respect to a transfer of assets, the term ‘assets’ includes an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services under this title unless –

“(i) the annuity is –

“(I) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or

“(II) purchased with proceeds from –

“(aa) an account or trust described in subsection (a), (c), or (p) of section 4008 of such Code;

“(bb) a simplified employee pension (within the meaning of section 408(k) of such Code); or

“(cc) a Roth IRA described in section 408A of such Code;
or

“(ii) the annuity –

“(I) is irrevocable and nonassignable;

“(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

“(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.”.

(d) **Effective Date.** – The amendments made by this section shall apply to transactions (including the purchase of an annuity) occurring on or after the date of the enactment of this Act.

Sec. 6013. APPLICATION OF “INCOME-FIRST” RULE IN APPLYING COMMUNITY SPOUSE’S INCOME BEFORE ASSETS IN PROVIDING SUPPORT OF COMMUNITY SPOUSE.

(a) **In General.** – Section 1942(d) of the Social Security Act (42 U.S.C. 1296r-5(d)) is amended by adding at the end of the following new subparagraph:

“(6) Application of ‘income first’ rule to revision of community spouse resource allowance. – For purposes of this subsection and subsections © and (e), a State must consider that all income of the institutionalized spouse that could be made available to a community spouse, in accordance with the calculation of the community spouse monthly income allowance under this subsection, has been made available before the State allocates to the community spouse an amount of resources adequate to provide the difference between the minimum monthly maintenance needs allowance and all income available to the community spouse.”.

(b) **Effective Date.** – The amendment made by subsection (a) shall apply to transfers and allocations made on or after the date of the enactment of this Act by individuals who become institutionalized spouses on or after such date.

SEC. 6014. DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY.

(a) **In General.** – Section 1917 of the Social Security Act, as amended by section 6012(a), is further amended by redesignating subsection (f) as

subsection (g) and by inserting after subsection (e) the following new subsection:

“(f)(1)(A) Notwithstanding any other provision of this title, subject to subparagraphs (B) and (C) of this paragraph and paragraph (2), in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, the individual shall not be eligible for such assistance if the individual’s equity interest in the individual’s home exceeds \$500,000.

“(B) A State may elect, without regard to the requirements of section 1902(a)(1) (relating to statewideness) and section 1902(a)(10)(B) (relating to comparability), to apply subparagraph (A) by substituting for ‘\$500,000’, an amount that exceeds such amount, but does not exceed \$750,000.

“(C) The dollar amounts specified in this paragraph shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest \$1,000.

“(2) Paragraph (1) shall not apply with respect to an individual if –

“(A) the spouse of such individual, or

“(B) such individual’s child who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614,

is lawfully residing in the individual’s home.

“(3) Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual’s total equity interest in the home.

“(4) The Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship.”.

(c) Effective Date. – The amendment made by subsection (a) shall apply to individuals who are determined eligible for medical assistance with respect to nursing facility services or other long-term care services based on an application filed on or after January 1, 2006.

SEC. 6015. ENFORCEABILITY OF CONTINUING CARE RETIREMENT COMMUNITIES (CCRC) AND LIFE CARE COMMUNITY ADMISSION CONTRACTS.

(a) Admission Policies of Nursing Facilities. – Section 1919(c)(5) of the Social Security Act (42 U.S.C. 196r(c)(5)) is amended –

- (1) in subparagraph (A)(i)(II), by inserting “subject to clause (v),” after “(II)”; and
- (2) by adding at the end of subparagraph (B) the following new clause:

“(v) Treatment of continuing care retirement communities admission contracts. – Notwithstanding subclause (II) of subparagraph (A)(i), subject to subsections (c) and (d) of section 1924, contracts for admission to a State licensed, registered, certified, or equivalent continuing care retirement community or life care community, including services in a nursing facility that is part of such community, may require residents to spend on their care resources declared for the purpose of admission before applying for medical assistance.”.

(b) Treatment of Entrance Fees. – Section 1917 of such Act (42 U.S.C. 1396p), as amended by sections 6012(a) and 6014(a), is amended by redesignating subsection (g) as subsection(h) and by inserting after subsection (f) the following new subsection:

“(g) Treatment of Entrance Fees of Individuals Residing in Continuing Care Retirement Communities. –

“(1) In general. – For purposes of determining an individual’s eligibility for, or amount of, benefits under a State plan under this title, the rules specified in paragraph (2) shall apply to individuals residing in continuing care retirement communities or life care communities that collect an entrance fee on admission from such individuals.

“(2) Treatment of entrance fee. – For purposes of this subsection, an individual’s entrance fee in a continuing care retirement community or life care community shall be considered a resource available to the individual to the extent that –

“(A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;

“(B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

“(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.”.

SEC. 6016. ADDITIONAL REFORMS OF MEDICAID ASSET TRANSFER RULES.

(a) Requirement To Impose Partial Months of Ineligibility. – Section 1917(c)(1)(E) of the Social Security Act (42 U.S.C. 1396p(c)(1)(E)) is amended by adding at the end of the following:

“(iv) A State shall not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) with respect to the disposal of assets.”.

(b) Authority for States To Accumulate Multiple Transfers Into One Penalty Period. – Section 1917(c)(1) of such Act (42 U.S.C. 1396p(c)(1)), as amended by subsections (b) and (c) of section 6012, is amended by adding at the end of the following:

“(H) Notwithstanding the preceding provisions of this paragraph, in the case of an individual (or individual’s spouse) who makes multiple fractional transfers of assets in more than 1 month for less than fair market value on or after the applicable look-back date specified in subparagraph (B), a State may determine the period of ineligibility applicable to such individual under this paragraph by

–

“(i) treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual’s spouse) during all months on or after the look-back date specified in subparagraph (B) as 1 transfer for purposes of clause (i) or (ii) (as the case may be) of subparagraph (E); and

“(ii) beginning such period on the earliest date which would apply under subparagraph (D) to any of such transfers.”.

(c) Inclusion of Transfer of Certain Notes and Loans Assets. – Section 1917(c)(1) of such Act (42 U.S.C. 1296p(c)(1)), as amended by subsection (b), is amended by adding at the end the following:

“(I) For purposes of this paragraph with respect to a transfer of assets, the term ‘assets’ includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage –

“(i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

“(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

“(iii) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the individual’s application for medical assistance for services described in subparagraph (C).”.

(d) Inclusion of Transfers to Purchase Life Estates. – Section 1917(c)(1) of such Act (42 U.S.C. 1396p(c)(1)), as amended by subsection ©, is amended by adding at the end the following:

“(J) For purposes of this paragraph with respect to a transfer of assets, the term ‘assets’ includes the purchase of a life estate interest in another individual’s home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase.”.

(e) Effective Dates. –

(1) In general. – Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to payments under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for calendar quarters beginning on or after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) Exceptions. – The amendments made by this section shall not apply -

- (A) to medical assistance provided for services furnished before the date of enactment;
- (B) with respect to assets disposed of on or before the date of enactment of this Act; or
- (C) with respect to trusts established on or before the date of enactment of this Act.

(3) Extension of effective date for state law amendment. – In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1296 et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

