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Cutting Edge and Bleeding Edge Medicaid Planning

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Long term care costs represent perhaps the single most significant potential cause of catastrophic wealth loss for middle income Americans.¹ Few things strike fear in the hearts of older Americans like the specter of ongoing care costs eroding and ultimately destroying their financial security. The prospect of a monthly bill from a nursing home for any significant period of time might be more frightening for those without significant means than sickness or death.

As a partial and half-realized response, Medicaid was signed into law by President Lyndon Johnson alongside Medicare in 1965 as amendments to the Social Security Act.² President Truman attended the signing ceremony as the legislation was in some measure the

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¹ Long term care costs may very well represent one of the gravest concerns for state budgets as well as individual taxpayers. See Christopher Robertson, The Split Benefit: The Painless Way to Put Skin Back in the Health Care Game, 98 CORNELL L. REV. 921, 922 (2013) (“Last year, Medicaid spending was estimated to account for nearly a quarter of total state spending—the largest portion of their budgets—and it’s getting only more expensive.”), quoting Ezekiel J. Emanuel, What We Give Up for Health Care, N.Y. TIMES (Jan. 21, 2012, 5:41 PM), http://opinionator.blogs.nytimes.com/2012/01/21/what-we-give-up-for-health-care/.
culmination of efforts and aims he had initiated during his administration.\textsuperscript{3} Given the historical relatedness, the overlapping objectives, and especially the phonetic similarities of Medicaid and Medicare, some degree of confusion was sure to result, but the programs are markedly different in terms of structure, implementation, funding, eligibility, and aim.\textsuperscript{4}

\textbf{Medicare}

Medicare is primarily health insurance for Americans age 65 and older.\textsuperscript{5} Eligible beneficiaries are typically responsible for co-pays and deductibles.\textsuperscript{6} Four different components comprise Medicare: Medicare A (hospital insurance)\textsuperscript{7} Medicare B (supplemental medical insurance)\textsuperscript{8}, Medicare C or “Medicare Advantage” (a managed care option)\textsuperscript{9} and Medicare D

\textsuperscript{3} On July 30, 1965, President Johnson signed the bill, in Independence, Missouri. Johnson credited Truman with “planting the seeds of compassion and duty which have today flowered into care for the sick and serenity for the fearful.”


\textsuperscript{5} See 42 U.S.C. §§ 1395 et seq.; 42 C.F.R. §§ 405 et seq.

\textsuperscript{6} RALPH C. BRASHER, \textit{MASTERING ELDER LAW} 287 (Carolina Academic Press, 2010).

\textsuperscript{7} 42 U.S.C. §§ 1395c et seq. Medicare Parts A and B were part of the original Medicare plan and the great majority of individuals choose coverage under Parts A and B rather than the alternative Part C. Brasier, \textit{supra} at 286. Part A Medicare covers inpatient hospital care along with hospice care and, in limited circumstances, certain in-home health care services and skilled nursing facility (SNF) care. \textit{Id.} Part A is financed through the FICA tax. \textit{Id.} at 288.

\textsuperscript{8} 42 U.S.C. §§ 1395j et seq. Medicare Part B covers doctor’s services, outpatient care, services furnished by rural health clinics and ambulatory surgical centers, ambulance charges, diagnostic tests and, in limited circumstances, certain preventative care. Brasier, \textit{supra} at 286, 302. Part B is financed through insurance premiums and federal contributions. \textit{Id.} at 303.

\textsuperscript{9} 42 U.S.C. § 1395w-21 et seq. The Medicare Advantage plans described in Medicare Part C’s “Medicare + Choice” Program are privately managed, require approval by Medicare, and provide coverage under parts A and B. Brasier, \textit{supra} at 286. Thus, Medicare C is a closely regulated private insurance alternative to Medicare A and B. A Medicare C plan may include extra benefits such as some drug coverage and routine dental, vision, or wellness programs, but provider network limitations may offset these benefits. \textit{Id.} at 323.
(the prescription drug benefit). Medigap “wraparound insurance,” the Medicare Savings Program and Extra Help programs further supplement the availability of benefits. The United States Department of Health and Human Services, through its Centers or Medicare and Medicaid Services (or CMS) is responsible for administering the program; the program is “exclusively federal.” Except in limited circumstances, Medicare benefits do not extend to long term care costs.

**Medicaid**

Medicaid, on the other hand, does cover long-term custodial care costs. In fact, Medicaid is the primary payor of nursing home care in the United States. But Medicaid is emphatically the “payor of last resort.” It is a program which is means-tested and the availability of Medicaid benefits is restricted the financially needy and the impoverished.

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11 Id.
13 Medicare Part A includes coverage for skilled nursing facility costs for up to 100 days. During the first twenty days, Medicare covers the entire cost but thereafter a co-pay is required from the Medicare beneficiary. 42 U.S.C. §§ 1395d(a)(2), 1395e(a)(3). In 2014, the co-pay was $133.50/day. If a patient is terminally ill, Medicare Part A will cover two 90-day periods and an unlimited number of subsequent 60-day periods of skilled nursing facility care. 42 U.S.C. § 1396d(a)(4).
16 See Atkins v. Rivera, 477 U.S. 154, 147 (1986) (noting that Medicaid “is designed to provide medical assistance to persons whose income and resources are insufficient to meet the costs of necessary care and services.”).
States may voluntarily elect to participate in Medicaid, and every state has. Medicaid is jointly funded by the federal government and states, and is jointly administered as a federal-state partnership program. In South Dakota, Medicaid is administered by the Department of Social Services and its implementing regulations can be found at ARSD 67:46. Significant variation in coverage and eligibility requirements can be seen from state to state. Even the name of the program varies. It is Medi-Cal in California, MassHealth in Massachusetts, Sooner Care in Oklahoma, and ForwardHealth in Wisconsin.

**Complexity of Medicaid**

The reasons for the high degree of variability in state-specific Medicaid programs are fourfold: First, many of the federal Medicaid regulations expressly delegate options as to how states administer the program. Second, states can apply for waivers from certain federal requirements. Third, states differ in their interpretations of federal Medicaid rules which are often, on account of poor draftsmanship, ripe for divergent readings. And fourth, although the

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17 Huberfeld, et al., *supra* at 15.
18 West Virginia Dep’t of Health and Human Resources v. Sibelius, 649 F.3d 217, 218 (4th Cir. 2011).
19 The South Dakota Department of Social Services (DSS) website is helpful and contains forms, for example, for applying for Medicaid as well as consumer-friendly brochures on topics like estate recovery. [http://dss.sd.gov](http://dss.sd.gov). The Administrative Rule are available at [http://legis.sd.gov](http://legis.sd.gov). The State Medicaid Manual is updated by the State Bar Elder Law Committee annually and is available at [http://www.sdbar.org/new/members/elderdocuments.html](http://www.sdbar.org/new/members/elderdocuments.html). The State Medicaid Manual is not a source of law and is typically helpful only for attorneys seeking to identify a probable explanation of policy justification for a given position by DSS.
20 To locate the website of a specific state Medicaid program, see [http://www.nasmd.org/links/state_medicaid_links.asp](http://www.nasmd.org/links/state_medicaid_links.asp).
21 Nina A. Kohn, *Elder Law: Practice, Policy, and Problems* 277 (2014). In Arizona, Medicaid is called the Arizona Health Care Cost Containment System; in Kansas, Medicaid is called the Kansas Medical Assistance Program, in Maine, it is MaineCare, in Minnesota it is Medical Assistance, it is the Oregon Health Plan, in Pennsylvania, it is Medical Assistance, and in Tennessee, it is TennCare. *Id.* In most states, Medicaid at the state level is simply referred to as Medicaid.
doctrine of preemption otherwise bars states from restricting Medicaid eligibility or narrowing coverage from federal parameters, many state restrictions of Medicaid simply go unchallenged, especially in view of the fact that Medicaid recipients are, by definition, lacking in financial resources and therefore often without the means to mount a preemption legal challenge to a given state Medicaid rule.

Thus, despite the central importance of Medicaid benefits for individuals requiring long term care, the degree of non-uniformity, ambiguity, and opaqueness is astonishing. Frustrated judges embarking on a reading of Medicaid rules have described them as “Byzantine” and “an aggravated assault on the English language.” 22 Moreover, most Medicaid issues require a nuanced reading of at least two sets of often unmatched rules, both federal and state, along with implementing regulations (both federal and state), Medicaid manuals, case law, and holdings from one state which may or may not carry weight in neighboring states. Relevant authority can

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There can be no doubt but that the statutes and provisions in question, involving the financing of Medicare and Medicaid, are among the most completely impenetrable texts within human experience. Indeed, one approaches them at the level of specificity herein demanded with dread, for not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase.

Id.
be contained in agency transmittals. Cross-referencing Social Security rules and regulations may also be required. Despite the efforts of organizations like the National Academy of Elder Law Attorneys (NAELA) and state bar elder law committees, the number of attorneys truly versed and capable in their state’s Medicaid law is relatively few. Medicaid applicants or recipients therefore are facing a dauntingly complex and often adversarial system with qualified legal advocacy and assistance often a rarity.

Medicaid is a broad-based program whose recipients include children and young parents, but for purposes of this article, attention is directed to the long term care benefits. There are two basic tests for Medicaid eligibility: the “categorically needy” test and the “medically needy” test. Two subsets of categorically needy exist depending on the state in question: SSI states and 209(b) states. In an SSI state, an individual is eligible under the categorically needy test so long as he or she is eligible for Supplemental Security Income (SSI), a benefit administered by the Social Security Administration. Most states are SSI states and in most SSI states, no separate

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application for Medicaid is required since eligibility automatically follows SSI eligibility.\textsuperscript{27} In a 209(b) state, eligibility requirements may be more stringent than SSI standards.\textsuperscript{28}

Generally speaking, “medically needy” individuals are those who have excess resources to meet the definition of “categorically needy” yet still have insufficient resources to pay for their medical care.\textsuperscript{29} The medically needy category extends coverage on a more generous basis than the categorically needy category and states are barred from using methodology for aged individuals any more restrictive than that used in the SSI program.\textsuperscript{30} Two subsets of medically needy tests exist. In some states, an individual is eligible under the medically needy Medicaid test by meeting the same income and resource requirements of the categorically needy after taking account of qualified out-of-pocket health care expenses.\textsuperscript{31} Thus, certain out-of-pocket health care costs are deductible in order to meet the income and resource requirements. In other states, out-of-pocket health care costs are not deductible, but monthly income limits are typically increased to 300 percent of the SSI level.\textsuperscript{32}

\textsuperscript{27} Beshair, \textit{supra} at 352. “SSI states are not required to cover the medically needy, but they may choose to do so.” \textit{Id.} at 353.

\textsuperscript{28} 42 U.S.C. § 1396a(f). “The 209(b) states include Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, Nebraska, New Hampshire, North Dakota, Ohio, Oklahoma and Virginia.” Beshair, \textit{supra} at 352. 209(b) states must provide coverage for the medically needy. \textit{Id.} at 353.

\textsuperscript{29} 42 U.S.C. § 1396a(10)(a)(ii); Brashear, \textit{supra} at 347.

\textsuperscript{30} 42 U.S.C. § 1396a(1)(C)(i).

\textsuperscript{31} 42 C.F.R. § 435.725.

\textsuperscript{32} 42 U.S.C. §§ 1396a(10)(A)(ii)(V), 1396b(f)(4)(C). States adopting this methodology are “income cap” states. Beshair, \textit{supra} at 355. Individuals with depleted resources but excess income will typically utilize a “Miller trust” to attain eligibility. \textit{Id.;} 42 U.S.C. § 1395p(d)(4)(B). A Miller trust exempts the individual's income (including SSI and pension income) from calculations of income and resources if the state is reimbursed from the trust for Medicaid expenses. An individual could use this trust if the individual's income exceeds the income cap but is still lower than the average cost of a nursing home in the region where the individual will receive care. The individual assigns all nonexempt income to the trust, the trust directly pays the nursing home the maximum allowable amount, and Medicaid pays the nursing home the remainder of the bill.
Resources

In either case, the thresholds for countable assets for a Medicaid applicant are $2,000 for a single person and $3,000 for a married couple.\(^{33}\) The amounts are not indexed for inflation. Certain assets are “exempt” or non-countable. One vehicle which is used for transportation is exempt.\(^{34}\) Certain burial funds are exempt.\(^{35}\) Personal effects and household goods are exempt\(^{36}\), along with a very small life insurance policy.\(^{37}\) A house up to a certain value may be

\(^{33}\) See 42 U.S.C. § 1396a(m)(1)(C) (incorporating the resource tests under the Supplemental Security Income (SSI) program at 42 U.S.C. § 1382b).


\(^{35}\) 42 U.S.C. § 1382(a)(2)(B). Excluded from resources are “the value of any burial space or agreement (including any interest accumulated thereon) representing the purchase of a burial space (subject to such limits as to size or value as the Commissioner of Social Security may by regulation prescribe) held for the purpose of providing a place for the burial of the individual, his spouse, or any other member of his immediate family.” Id.

\(^{36}\) 42 U.S.C. § 1382b(a)(2)(A); 20 C.F.R. § 416.1216. “[I]tems that we acquired or are held for their value or as an investment” such as “[g]ems, jewelry that is not worn or held for family significance, or collectibles” are not excluded as personal effects. 20 C.F.R. § 416.1216(b)(2).

\(^{37}\) 42 U.S.C. § 1382b(a). A life insurance policy “shall be taken into account only to the extent of its cash surrender value; except that if the total face value of all life insurance policies on any person is $1,500 or less, no part of the value of any such policy shall be taken into account.” Id.; see also Miller v. State Dep’t of Human Services, 2001 WL 278001 * 4 (Tenn. Ct. App. 2001) (holding that four life insurance policies with face values ranging from $2,500 to $5,000 were all non-countable resources where none had any cash surrender value). Term policies are excluded assets since they have no cash value. See id. citing 20 C.F.R. §§ 416.1230(a), 416.1230(b)(5). Medicaid applicants have difficulty retaining term policies, however, given the ongoing need to maintain the policy with premium payments.
exempt depending on the applicable state rules and the circumstances of the applicant. The remaining exempt resource categories are relatively few.

**Gifts**

In addition to meeting the income and resource requirements as of the date of application, a Medicaid applicant must also demonstrate that they did not voluntarily impoverish themselves as a means to qualify. Thus, Medicaid penalizes gifts or transfers for less than fair market value within five years of an application. An applicant is required to truthfully report any gifts

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38 See 42 U.S.C. § 1382(a)(1) (excluding from countable resources the value of "the home (including the land that appertain thereto)"); 42 U.S.C. § 1396p(f) (capping the non-countable home equity at $500,000, with inflationary adjustments). The home is a non-countable resource and the equity cap does not apply if a spouse is residing in the home. 42 U.S.C. § 1396p(f)(2)(A). For various states' treatment of the home exclusion rule, compare Idaho A.P.A. 16.03.05.871.01.d (providing that the home loses its non-countable character if held in a revocable trust); see also Stafford v. Idaho Dep't of Health & Welfare, 181 P.3d 456 (Idaho 2008) (construing this rule) with Ohio Admin. Code 5160:1-3-31(C)(2) (providing that the home loses its exempt treatment when the owner has continuously lived in a nursing facility for thirteen months), N.J. A.D.C. 10:71-4.4(b)(1)(i) (providing that the home loses its exempt character if the owner has been absent from it for more than 6 months) and N.Y. McKinney’s Social Services Law § 366 subdiv. 2(A)(1)(ii) (excluding a “homestead which is essential and appropriate to the needs of the household” without regards to occupancy of the home); see also Moffett v. Blum, 424 N.Y.S.2d 923, 925 (N.Y.A.D. 1980) (construing this rule and overturning a determination that funds expended on the installation of essential services in a home in order to make it habitable such as heating, plumbing, septic systems and a waterwell could be considered countable resources as “not reasonable and humane”).

39 See, e.g., 42 U.S.C. § 1382b(a)(3); 416 C.F.R. §§ 416.1220-1224 (property essential to self-support such as tools, machinery, livestock or an unimproved lot on which vegetables are grown for one’s own consumption); § 1382b(a)(5) (an Alaskan Native’s shares of stock in a village corporation during the period in which the stock is inalienable); § 1382b(a)(17) (payments for participating in a clinical trial involving the testing of treatments for a rare disease).

40 See 42 U.S.C. § 1396p(c)(1)(A) (“[T]he State plan must provide that if an institutionalized individual or the spouse of such an individual (or, at the option of a State, a noninstitutionalized individual or the spouse of such an individual) disposes of assets or less than fair market value on or after the look-back date specified in subparagraph (B)(i), the individual is ineligible for medical assistance …”).

41 42 U.S.C. § 1396p(c)(1)(B)(i). The 60-month look-back is made from the date that the Medicaid applicant is both institutionalized and has applied for Medicaid benefits. 42 U.S.C. § 1396p(c)(1)(B)(ii)(I). An “institutionalized individual” is defined as a person who is (1) an inpatient in a nursing facility; (2) “an inpatient in a medical institution and with respect to whom
as part of the application itself. A Medicaid application requires disclosure of gifts by both the applicant as well as the applicant’s spouse.\textsuperscript{42} The penalty for a gift is a period of ineligibility for Medicaid benefits based on the size of the gift (or the cumulative size of more than one reportable gift).

The length of a penalty period deriving from a gift within the five year “look-back” period is derived from a formula linked to the average monthly cost of long term care in a given state.\textsuperscript{43} If the average cost of nursing home care is $7,000, a gift of $7,000 four years prior to the date of the application will result in a period of Medicaid ineligibility of one month. A gift of $70,000 within the look back period would trigger Medicaid ineligibility for a term of ten months.\textsuperscript{44}

\textsuperscript{42} See 42 U.S.C. § 1396p(c)(1)(A) (providing “that if an institutionalized individual or the spouse of such an individual ... disposes of assets for less than fair market value on or before the look-back date specified in subparagraph (B)(i), the individual is ineligible for medical assistance ...” (emphasis supplied); see also 42 U.S.C. § 1396p(c)(4) (requiring, where the spouse of a Medicaid applicant has made a disqualifying transfer, states “using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual’s spouse if the spouse otherwise becomes eligible for medical assistance”). By its terms, subsection (c)(4) only requires apportionment when both spouses are Medicaid eligible. See Woytisick v. Novello, 309 A.D.2d 869, 869 (N.Y. Slip Op.) (holding that the statute and state administrative rule “clearly contemplate that before the penalty period may be apportioned between spouses, both spouses must be eligible for Medicaid.”).

\textsuperscript{43} 42 U.S.C. § 1396p(c)(1)(E).

\textsuperscript{44} See, e.g., Evans ex rel. Durbin v. State ex rel. Dept. of Human Services, 2013 WL 6823089 (IL App. 4\textsuperscript{th} 2013). There, a nursing home resident transferred $16,000 in assets and was assessed a four-month period of Medicaid ineligibility. \textit{Id.} ¶ 7. The State Medicaid Agency utilized a private pay-rate of $120/day (or $3,600/month) in effect at the date of the application to calculate the period of ineligibility (as opposed to a $4,050/mo. rate in effect not at the time of the date of the agency’s decision). \textit{Id.} ¶ 8. The court affirmed, holding that “the divisor is determined by the pay rate at the time of application.” \textit{Id.} ¶ 30.
The starting date for the running of a penalty period incurred by reason of a gift within the look back period is the date on which the Medicaid applicant is otherwise eligible for Medicaid benefits.\textsuperscript{45} In other words, the transfer penalty does not commence until the applicant qualifies for Medicaid under both the income and resource tests. This starting date for the transfer penalty was enacted as part of the Deficit Reduction Act (DRA) of 2005; previously, the starting date had been the same date as the gift itself.\textsuperscript{46} Because the starting date for a transfer penalty is now deferred, an individual Medicaid applicant may find herself impoverished (i.e., with less than $2,000 in countable resources) yet ineligible for nursing home cost coverage through Medicaid for a significant period of time.\textsuperscript{47}

Medicaid rules cast a broad definition over the word “gift.” Gifts include outright gifts, bargain sales, even purchases of life estates and certain types of annuities.\textsuperscript{48} Gifts include

\begin{footnotes}
\textsuperscript{45} 42 U.S.C. § 1396p(c)(1)(D)(ii).
\textsuperscript{46} Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6044(a), 120 Stat. 4, 88-2 (2006); see also 42 U.S.C. § 1396p(c)(1)(D)(i) (preserving the commencement date for penalty periods as of the date of the transfer when the transfer was made before February 8, 2006).
\textsuperscript{47} Charles A. LeFebvre & Martin W. Siemer, Survey of Illinois Law: Elder Law, 32 S. ILL. U. L.J. 865, 869-70 (2008). The DRA thus eliminated the “half a loaf” planning strategy whereby an individual would make a gift to intentionally trigger the imposition of a penalty period, retaining sufficient assets so as to have spent down to Medicaid eligibility levels at about the time the penalty period would run. Id.; Gene V. Coffey, et al., Analysis of Changes to Federal Medicaid Laws under the Deficit Reduction Act of 2005, 2 NAELA J. 189, 198 (2006).
\textsuperscript{48} The applicable South Dakota rule states:
The department shall treat an annuity as a resource countable toward the resource limit established in § 67:46:05:30. If the fair market value of the annuity does not cause ineligibility under § 67:46:05:30, the department considers the purchase of an annuity by or on behalf of an applicant or recipient after February 7, 2006, to be a transfer of an asset for less than fair market value unless it meets the requirements of 42 U.S.C. § 1396p(c)(1)(G), as amended to August 1, 2006, and one of the following additional requirements:

(1) The department 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; or
(2) The state is named as the remainder beneficiary in the second, third, or fourth position after the noninstitutionalized spouse or a minor or disabled child and the state is
\end{footnotes}
transfers to individuals as well as to irrevocable trusts. Gifts include qualified disclaimers even though a qualified disclaimer is construed as a non-gift for purposes of the federal gift tax. Gifts also include a Medicaid applicant’s failure to avail himself of all available resources. Thus, for example, the failure to sue a third party for financial compensation can be treated as a gift, as can the failure to timely file a petition for an elective share against a decedent spouse’s estate. The broad definition of a gift aligns with the Medicaid program’s underlying objective of closing any perceived loopholes that would permit individuals to voluntarily impoverish themselves as a means to accelerate eligibility for Medicaid benefits.

Unless a gift or transfer for less than full value falls under a delineated exception, the only means of avoiding a transfer penalty are under the rubric of “undue hardship,” by establishing that at the time of the gift the donor intended the gift exclusively for some reason other than accelerating or establishing eligibility for Medicaid, or by proving that the transferor simply made a “bad bargain.” The burden is on the applicant to rebut the presumption that all transfers were made with Medicaid in mind, and the evidence must be “convincing.”

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51 2 U.S.C. § 1396p(c)(2)(C)(ii). The Medicaid applicant must show that “the assets were transferred exclusively for a purpose other than to qualify for medical assistance ...” Id.
52 2 U.S.C. § 1396p(c)(2)(C)(i). The applicant must show that he or she “intended to dispose of assets either at fair market value, or for some other valuable consideration.” Id.
53 20 C.F.R. § 416.1246(e). The transfer of an asset for less than fair value is presumed to have been made for the purpose of establishing Medicaid eligibility. Id. “The burden of rebutting the presumption ... rests with the individual (or eligible spouse).” Id.
proves difficult or impossible for the great majority of gifts, especially since it is not uncommon for the donor to have diminished capacity at the time of a Medicaid eligibility issue being presented and therefore unable to testify convincingly, or testify at all, as to the reasons behind a gift. An “undue hardship” showing will also avoid the imposition of a transfer penalty but is also notoriously difficult to establish. Gifted assets can be returned to the applicant to cure or partially cure a transfer penalty.\textsuperscript{54}

There are certain limited exceptions to the Medicaid “no gift” rule. Transfers of assets to a disabled child in trust, or the transfer of one’s personal residence to an adult child who has resided in the house and provided care for at least two years do not trigger transfer penalties.\textsuperscript{55} A transfer of one’s personal residence to a sibling who has resided in the home at least one year is permissible.\textsuperscript{56} Transfers to a spouse do not result in Medicaid transfer penalties, but, as will be seen below, rarely advance Medicaid eligibility on account of the way in which marital wealth is considered in the context of Medicaid.\textsuperscript{57}

\textsuperscript{54} 42 U.S.C. § 1396p(c)(2)(C)(iii). Some states permit “partial cures” of a penalty period when some, but not all, of the transferred assets are returned. The federal Medicaid statute, however, suggests that partial cures are impermissible, and that “all assets transferred for less than fair market value” must be returned for the penalty period to be waived. 42 U.S.C. 1396p(c)(2)(C)(iii) (emphasis supplied); accord, Tjaden ex rel. Tjaden v. State, 2013 WL 6822752 ¶ 45 (IL App. 4th 2013) (noting the parties’ agreement that “federal law leaves it to individual states to decide whether to accept partial returns.”).

\textsuperscript{55} See 42 U.S.C. § 1396p(c)(2)(B)(iii) (allowing transfers of assets to a trust established for a disabled child); 42 U.S.C. § 1396p(c)(A)(iv) (allowing transfers of a home to an adult child who resided in the home “at least two years immediately before the date the individual becomes an institutionalized individual and who (as determined by the State) provided care to such individual which permitted such individual to reside in the home rather than in such an institution”); see also 42 U.S.C. § 1396p(c)(2)(B)(iv) (allowing transfers of assets to a trust for a disabled individual under the age of 65 years of age, whether or not related to the transferer).

\textsuperscript{56} 42 U.S.C. § 1396p(c)(2)(A)(iii) (allowing the transfer of a home to a sibling “who has an equity interest in such home and who was residing in such individual’s home for a period of at least one year”).

\textsuperscript{57} 42 U.S.C. §§ 1396p(c)(2)(A)(i), 1396p(c)(2)(B)(i), (ii).
Trusts

Although many individuals assume that planning with trusts can work real magic when it comes to eligibility for Medicaid, the availability of trust planning is severely constrained by Medicaid rules.\(^5\) The following rules apply whenever an individual—or the individual’s\(^5\)

\(^5\) The federal statute provides:

1. For purposes of determining an individual's eligibility for [Medicaid], subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.
2. (A) For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:
   i. The individual.
   ii. The individual's spouse.
   iii. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.
   iv. A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.
3. (B) In the case of a trust the corpus of which includes assets of an individual (as determined under subparagraph (A)) and assets of any other person or persons, the provisions of this subsection shall apply to the portion of the trust attributable to the assets of the individual.
4. (C) Subject to paragraph (4), this subsection shall apply without regard to—
   i. the purposes for which a trust is established,
   ii. whether the trustees have or exercise any discretion under the trust,
   iii. any restrictions on when or whether distributions may be made from the trust,
   iv. any restrictions on the use of distributions from the trust.
5. (D) In the case of a revocable trust—
   i. the corpus of the trust shall be considered resources available to the individual,
   ii. payments from the trust to or for the benefit of the individual shall be considered income of the individual, and
   iii. any other payments from the trust shall be considered assets disposed of by the individual for purposes of subsection (c) of this section.
6. (B) In the case of an irrevocable trust—
   i. if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income—(I) to or for the benefit of the individual, shall be considered income of the individual, and (II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c) of this section; and
spouse—has transferred property or funds to a trust, with only two narrow and frequently unhelpful exceptions.\textsuperscript{59}

The use of revocable trusts (commonly known as “living trusts”) neither advances nor impairs Medicaid eligibility since the assets in a revocable trust remain fully available to the

\textsuperscript{59} 42 U.S.C. § 1396p(d).

(ii) 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 shall 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 by the individual for purposes of subsection (c) of this section, and the value of the trust shall be determined for purposes of such subsection by including the amount of any payments made from such portion of the trust after such date.

(4) This subsection shall not apply to any of the following trusts:

(A) A trust containing the assets of an individual under age 65 who is disabled ... and which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter.

(B) A trust established in a State for the benefit of an individual if--

(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust),

(ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter, and

(iii) the State makes medical assistance available to individuals described in section 1396a(a)(10)(A)(ii)(V) of this title, but does not make such assistance available to individuals for nursing facility services under section 1396a(a)(10)(C) of this title.

(C) A trust containing the assets of an individual who is disabled (as defined in section 1382c(a)(3) of this title) that meets the following conditions:

(i) The trust is established and managed by a nonprofit association.

(ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled ... by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

(iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under [Medicaid].

42 U.S.C. § 1396p(d).

\textsuperscript{59} 42 U.S.C. § 1396p(d). “The term ‘trust’ includes any legal instrument or device that is similar to a trust ...” 42 U.S.C. § 1396p(d)(6).
settlor. The use of self-settled irrevocable trusts is problematic because any transfer to an irrevocable trust within the five year look back period is considered a disqualifying gift to the same extent as a transfer to an individual. Moreover, a gift to an irrevocable trust wherein the settlor retains any ascertrollable rights as a beneficiary may result in the entire value of the trust estate being a countable resource for eligibility purposes. Transfers by one spouse in trust for the benefit of the other spouse are treated as if the trust were self-settled with one exception explained in the next paragraph.

There are two general exceptions to the general trust rules set forth above. The first is that a disabled individual under the age of 65 may transfer assets to an irrevocable supplemental needs trust. This exception—while commonly utilized when younger individuals receiving settlements or substantial verdicts wish to preserve Medicaid eligibility—is unavailable for the typical individual in their 70’s or 80’s requiring long term care. More accurately, this exception

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61 The applicable South Dakota rule states:
   A trust or similar legal device ... is subject to this section regardless of the purpose for which it is established, whether the trustee has or exercises any discretion under the trust, whether there are restrictions on when or whether distribution may be made from the trust, or whether there are restrictions on the use of any distribution from the trust. ...
   If the trust is an irrevocable trust and contains any provisions under which payment from the trust may be made to or for the benefit of the individual, the entire portion of the principal or income on the principal from which payment to the individual could be made is considered a resource and any payment from that portion of the principal or income to or for the benefit of the individual is considered income to the individual. Except for trustee and legal fees, any other payment made from the trust is considered a resource which was disposed of by the individual to establish eligibility for Medicaid. The department considers any portion of the principal or income on the principal from which a payment to the individual or for the benefit of the individual may not be made under any circumstances to be a resource which was transferred for purposes of establishing eligibility for Medicaid.
   ARSD 67:46:05:32.02 (emphasis supplied).
comprises two different varieties of irrevocable trusts, common known as “under-65 trusts” and “pooled trusts,” and in a few states, pooled trusts remain viable options for individuals regardless of their age. The trend, however, is towards imposing transfer penalties whenever an individual age 65 or older has funded a pooled trusts and individuals age 65 or older, by statutory fiat, simply may not fund an under-65 trust.

The second exception to the general rule governing trusts for Medicaid eligibility purposes relates to testamentary trusts created for the benefit of a spouse. This exception permits a wife, for example, to create a testamentary discretionary trust in her will and shield the trust assets from Medicaid eligibility considerations for her surviving husband as a trust beneficiary. There are two limitations to the attractiveness of this exception as illustrated in the foregoing example: first, the wife must first die since only testamentary trusts fall within the exception; second, the husband’s acceptance of an inheritance in trust when local law permits him to overturn his wife’s estate plan by exercising elective or forced share rights, may constitute a gift with accompanying transfer penalties for Medicaid eligibility purposes.

64 Id. The under-65 payback trust is described in subsection (A) (and is sometimes referred to as a (d)(4)(A) trust) while the pooled trust is described in subsection (C) (and is sometimes referred to as a (d)(4)(C) trust). Id.

65 See Center for Special Needs Trust Administration, Inc. v. Olson, 676 F.3d 688 (8th Cir. 2012) (holding that North Dakota may penalize transfers to a pooled trust by individuals age 65 or older); accord, In re Pooled Advocate Trust, 813 N.W.2d 130 (S.D. 2012). Your author unsuccessfully defended the appeal in the Pooled Advocate Trust case. See http://pooledadvocatetrustinc.com.

66 See 42 U.S.C. § 1396p(d)(2)(A) (providing that an individual is treated as having established a trust if her assets were used to form any part of the trust and if the individual or her spouse established the trust “other than by will”); Skindzier v. Commissioner of Social Services, 2001 WL 51663 (Conn. Super. 2001).
Income

In addition to satisfying the resource requirements for Medicaid eligibility, applicants must also satisfy income requirements. Generally, SSI rules apply in the characterization and counting of income. Income is defined broadly as “anything you receive in cash or in kind that you can use to meet your needs for food and shelter.” Income tax refunds, however, are specifically designated as non-countable income. The payment received on the sale or exchange of an asset is not considered income but “resources that have changed their form.” Most social service benefits are non-countable income.

The CSRA View of Spousal Wealth

As explained above, Medicare provides little assistance with long term care costs; Medicaid covers long term care costs, yet requires impoverishment as an eligibility requirement. Thus, when a married individual requires ongoing long term care, his healthier spouse may be capable of remaining non-institutionalized (as a “community spouse”) and live independently. But if Medicaid requires both spouses to spend down to only $3,000 in countable resources, the community spouse may be so financially devastated by care costs that she loses the ability to

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67 Medicaid recipients must also be U.S. citizens or permanent resident aliens. 42 U.S.C. § 1396b(v). In addition, an applicant must demonstrate residence of the state in which they are applying for Medicaid benefits. See 42 U.S.C. § 1396a(b).
68 See 20 C.F.R. § 416.1100 et seq.
69 20 C.F.R. § 416.1102.
70 20 C.F.R. § 416.1103(d).
71 20 C.F.R. § 416.1103(c). “If you sell your automobile, the money you receive is not income; it is another form of a resource.” Id.
72 20 C.F.R. § 416.1103(b).
73 An “institutionalized spouse” means an individual who is in a medical institution or nursing facility and is likely to remain there at least 30 days; a “community spouse” means the spouse of such an individual. 42 U.S.C. § 13964-5(h)(1), (2).
maintain even a modest lifestyle. To protect the community spouse from total impoverishment, Congress enacted the Medicare Catastrophic Coverage Act of 1988 (the MCCA).\textsuperscript{74}

With regards to income, the MCCA provides that the community spouse’s income is unavailable to the institutionalized spouse for purposes of assessing Medicaid eligibility.\textsuperscript{75} Thus, except to the extent that the community spouse’s income is so great that it results in the accumulation of excess resources, there is no limit on the level of the community spouse’s separate income. The community spouse’s income is irrelevant for purposes of Medicaid eligibility for their institutionalized spouse.

Moreover, the MCCA recognizes that the community spouse’s separate income is typically not excessive, and may even be inadequate for their basic needs if all of the institutionalized spouse’s income is diverted to their care costs. Thus, post-Medicaid eligibility, the community spouse may be entitled to a monthly income allowance (or MIA) payable from the income of the institutionalized spouse. The community spouse’s MIA is computed by deducting her income from a minimum monthly maintenance needs allowance (or MMMNA).\textsuperscript{76} In fact, if a court has entered an order awarding the community spouse a portion of the institutionalized spouse’s income for her support, this ordered amount constitutes the community spouse’s MIA.\textsuperscript{77}

\textsuperscript{75} 42 U.S.C. § 1396r-5(b).
\textsuperscript{76} 42 U.S.C. § 1396r-5(d). The MMMNA is comprised of two separate amounts, a basic allowance computed by reference to federal poverty guideline figures and an excess shelter allowance (or ESA). 42 U.S.C. §§ 1396r-5(d)(3)(A), 1396r-5(d)(4). The poverty guideline figure is capped at $1,500 and indexed for inflation. 42 U.S.C. § 1396r-5(d)(3)(C).
\textsuperscript{77} 42 U.S.C. § 1396r-5(d)(5).
With regards to resources in a community spouse/institutionalized spouse context, the MCAA essentially allows the community spouse to retain one-half of the total marital net worth, with a ceiling and floor for the wealth to be retained post-eligibility, an amount known as the community spouse resource allowance (CSRA).\(^78\)

**Estate Recovery**

Estate recovery in the Medicaid context is a relatively unique concept in means-tested benefits.\(^79\) After a Medicaid recipient dies, the state Medicaid agency is entitled to recover the costs of Medicaid benefits from the deceased recipient’s probate—and, depending on the state rules, their nonprobate—estate. Estate recovery must be deferred if the Medicaid recipient leaves a surviving spouse.\(^80\) But at the death of the surviving spouse, the Medicaid agency will pursue the assets of the spouse’s estate. Thus, even after qualification for Medicaid has been obtained, the State retains the right to take actions against the individual’s estate, or the individual’s spouse’s estate.

If an individual successfully spends down assets to where he or she qualifies for Medicaid and then incurs expenses which are paid by Medicaid, the State Medicaid Agency can seek reimbursement from the person’s estate. There is no recovery from the first-spouse-to-die’s estate when he or she leaves a surviving spouse, so long as there was not attempt to hide assets or income when Medicaid assistance was sought. There could be and likely will be recovery, however, from the surviving spouse’s estate.

\(^{78}\) 42 U.S.C. § 1396r-5(c)(A). The computation of the spousal share is computed as of the beginning of the first continuous period of institutionalization of the institutionalized spouse. *Id.* This date is known as the “snapshot date.” Beshair, *supra* at 364.

\(^{79}\) 42 U.S.C. § 1396p(d).

\(^{80}\) *Id.*
The State Medicaid Agency is also empowered to file a lien against the real property which is owned by either the individual receiving Medicaid assistance or that person’s spouse. The agency may file a claim against the estate of a surviving spouse for medical assistance provided to a spouse. A surviving spouse is defined as "a person who was married to the deceased medical assistance recipient when the recipient became eligible for medical assistance, who has not divorced the medical assistance recipient, and who has not remarried after the recipient's death."\(^{81}\)

The state’s right of recovery extends to assets which were exempt for qualification purposes. For a person under the age of 55, estate recovery is limited to expenses paid out by Medicaid for nursing facilities and institutional type care expenses including home and community based services, hospital services, or prescription drug services. However, nursing home type care expenses are recoverable. The State Medicaid Agency will seek to recover from the estate of a decedent who leaves a surviving spouse when the agency believes that assets have been hidden or wrongfully transferred.\(^{82}\)

Once an individual begins to receive Medicaid benefits, the state begins to accrue a running tally of the dollar amount of the benefits provided. When the individual dies, if not survived by a spouse, the State is actually required by federal law to undertake some level of estate recovery efforts against the deceased individual’s probate estate.\(^{83}\) The idea of estate

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\(^{81}\) SDCL § 28-6-23.

\(^{82}\) See generally, Sol Lovas, Medicaid Estate Recovery, 39 MONT. LAW. 19 (2013). “Many Medicaid recipients have few assets, so estate recovery for them is not an issue. But a person can be on Medicaid and still own certain exempt assets, such as a home, a car, and a self-employment farm or business.” Id. at 19. Notably, Medicaid estate recovery is unavailable against completed lifetime gifts. Id. at 20.

\(^{83}\) See also South Dakota’s recent enactment of the Uniform Real Property Transfer on Death Act (HB 1077) at section 21:
recovery is to pursue a claim against a deceased Medicaid recipient’s estate for the dollar amount of benefits provided during the person’s life.

Different states have very different types of estate recovery procedures. Some states are very aggressive, some much less so. Some states pursue recovery against all types of assets — assets held in joint tenancy, assets held in revocable trusts, life insurance proceeds, etc. Other states essentially only pursue recovery against probate assets — those assets passing through the probate process.

If an individual successfully spends down assets to where he or she qualifies for Medicaid and then incurs expenses which are paid by Medicaid, the State Medicaid Agency can seek reimbursement from the person’s estate. There is no recovery from the first-spouse-to-die’s estate when he or she leaves a surviving spouse (so long as there was not attempt to hide assets or income when Medicaid assistance was sought). There could be and likely will be

[A] creditor or personal representative of the deceased transferor may institute an action in any court of competent jurisdiction, within six months after the death of the transferor, against the beneficiary setting forth such claim, unless the action is for recovery of medical assistance initiated by the Department of Social Services pursuant to Title 28, in which case the action must be commenced within the shorter of two years after the death of the transferor, or within six months of written notice to the Department of Social Services with information of the transferor's death, social security number, and if available upon reasonable investigation, the transferor's deceased spouse's name and social security number.

*Id.* (emphasis supplied).

84 Katie L. Summers, *Medicaid Estate Recovery: To Expand or Not to Expand, That is the Question*, 118 Penn St. L. Rev. 465 (2013). “The main question the states have to answer is from what assets to recover. At a minimum, the states must recover from an individual's probate estate. At a maximum, the states may recover from any assets in which an individual has an ownership interest.” *Id.* at 468. “[E]state recovery rules surrounding Medicaid are complex and establish many traps and pitfalls for the unwary and uninformed.” Sean R. Bleck, Barbara Isenhour & John A. Miller, *Preserving Wealth and Inheritance Through Medicaid Planning for Long-Term Care*, 17 Mich. St. U. J. Med. & L. 153, 196 (2013).

85 See, e.g., In re Estate of Melby, 841 N.W.2d 867 (Iowa 2014) (holding that the right of estate recovery even extends to irrevocable trusts).

86 Summers, *supra* at 470.
recovery, however, from the surviving spouse’s estate. The State Medicaid Agency is also
empowered to file a lien against the real property which is owned by either the individual
receiving Medicaid assistance or that person’s spouse. Thus, as if often the case, the State
Medicaid Agency will place a lien upon the house and the homeowner’s heirs will be forced to
sell the house after the homeowner’s death to satisfy the lien.

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