News You Need to Use – Michigan Medicaid Law

Victory at Sea; Defeat by Time

Tom Brokaw refers to my father's generation as the "Greatest Generation." They came of age during the Depression and fought World War II; went to school under the GI Bill and raised their children under threat of thermonuclear holocaust. "Saving Private Ryan" may give you a hint of the significance of World War II for them.

Although my father had excellent pension benefits from careers in business and academia, nursing care costs more than $9,000 per month–more than his and his wife's income. Therefore, unless there is another source, they would have had to use savings to pay for my father's care.

U.S. Senior Household Net Worth By Age Group						
	2004		2007		2010	
	Net worth		Net worth		Net worth	
	Mean	Median	Mean	Median	Mean	Median
Age of family head:						
..55 to 64 years old	$976,400	$290,000	$986,700	$266,200	$880,500	$179,400
..65 to 74 years old	$795,100	$218,800	$1,064,100	$250,800	$848,300	$206,700
..75 years old and over	$607,700	$187,700	$668,800	$223,700	$677,800	$216,800

Since a huge majority of U.S. households have a net worth of less than $200,000, the cost of nursing care is potentially ruinous and should be a part of any financial plan. Assuming an $8,500 monthly cost of care, $1,200 in retirement benefits, and a 3% rate of return, a single nursing home resident with $216,800 would zero out financially in 31 months. A couple, with a similar net worth and $2,000 in retirement benefits, would go bust in 20 months.

There are three alternatives to private pay for nursing care: long-term care insurance, or LTCI, Medicare, and Medicaid, each of which will be explained the next pages.

LTCI is relatively expensive, but provides flexibility in choosing a care setting and tax benefits for some. Benefits and premiums vary widely.

Long-Term Care Insurance

According to the U. S. Administration on Aging, long-tem care insurance pays less than 5% of nursing home bills. Why are so few people buying long-term care insurance? After all, everyone who has had to use their long-term care insurance is happy they bought it. A vigorous advocate for long-term care insurance, Martin K. Bayne learned at age 45 that he was afflicted with Parkinson's disease. Fortunately for him, he had purchased a long-term care insurance policy four years before his diagnosis. Why shouldn't all of us follow his example?

Bayne put his finger on it, at least in part. "Most people don't buy LTC insurance at age 40," he said in a February 2001 interview, "it's not their fault! Regardless of whether their employer has offered it to them, people in their 40s worry about sending their kids to college and paying their mortgage, among other financial concerns. Who would expect them to start thinking about paying for nursing home care?"

Working people buy insurance. They insure their homes and cars; they buy life and health insurance; many even buy disability insurance. However, the LTC insurance agent meets unusually stiff resistance. Partly this is due to the high cost and the fact that the favorable time to purchase it comes when many wage earners are still struggling with other commitments. It is also due to reluctance to admit the possibility of going into a nursing home.

Although the odds of a person who is 85 or more needing care in a nursing home are

greater than one in three, the nursing home population has been shrinking in comparison to the elder population. As the table shows, after a slight rise in 1990 and 2000, the nursing home population is now almost the same as it was in 1980 when the elder population was almost 40% smaller.

Increased reliance on pharmaceuticals, home care, rehabilitation and assisted living facilities has resulted in a lower likelihood that care in a nursing home will be necessary. It is impossible to say what care of older adults with disabilities will look like in 20 years, but it will almost certainly be more concentrated in the community rather than the facility.

U.S. Population 65 or More Years of Age

	1980	**1990**	**2000**	**2010**
United States	25,549,000	31,242,000	34,992,000	40,258,000
LTCF	1,232,958	1,590,763	1,557,800	1,252,635

The federal government encourages the purchase of LTC insurance through tax incentives. The federal government also attempted to establish a plan for federal employees, but there is little incentive, if any, to buy into the plan, compared to insurance purchased privately.

There is no lack of information on the Web about long-term care insurance. A lot of this comes from folks who have a vested interest in selling it. The American Health Care Association offers a number of "Issue Briefs" arguing that the government should subsidize the purchase of long term care insurance at http://www.ahca.org/news/briefs.htm. The information on this Web page is accurate, but not unbiased. The AHCA and its associated organization, the National Center for Assisted Living reflects the view of the nursing care industry that paying privately or through insurance is preferable to qualifying for Medicaid.

Similarly, the Center for Long-Term Care Financing (http://www.centerltc.com) warns that the long-term care system is in crisis and that the solution is for everyone to plan on paying privately for their long-term care needs, whether at home or in a nursing home. Of course, since most people don't have the money to do this, the CLTCF tells people to buy long-term care insurance.

Why should people buy long-term care insurance if Medicaid will pay the nursing home? The CLTCF says, "Medicaid is a means-tested public assistance program. It is welfare intended as a safety net for the genuinely needy. The program has a dismal reputation for problems of access, quality, reimbursement, discrimination and institutional bias." Is this true? Are nursing homes that accept Medicaid inferior to those that do not?

Consumer Reports found that to promote their products, long-term care insurance agents frequently disparaged Medicaid, implying it provides substandard care. But the magazine found the quality of a nursing home has little to do with who pays the bill. Long-term-care insurance is not for everyone, says Consumer Reports. The magazine advises against it "for those who qualify for Medicaid or will qualify soon after entering a nursing home. Nor is it for those who can afford to set aside roughly $160,000 for their care and still have enough left over to provide for their spouse. However, for the majority of nonrich, nonpoor Americans . . . long-term-care insurance is an option worth considering."

The United Seniors Health Cooperative cautions that if paying the premiums is going to cause financial hardship, the client should carefully consider the alternatives. They suggest that no more than 7% of annual income go toward the cost of this coverage.

The industry lobby says that the long-term care system is a wreck. Major nursing home

chains have filed for bankruptcy protection and some claim that liability suits against them are driving them out of some states. According to the voice of LTC insurance, Center for Long-Term Care Financing, it is the height of irresponsibility to advocate continuing reliance on Medicare and Medicaid. They say that only private money will save this system.

Is the LTC industry in crisis? Are we all destined to pay privately for quality long-term care? Joshua M. Wiener and David G. Stevenson of the Urban Institute assert that "the current method of Medicaid long-term care financing is quite economical. Payment rates are usually much lower than Medicare and the private sector. Persons receive government help only after depleting most of their assets. Finally, the institutional bias of the delivery system limits services largely to persons with the most severe disabilities who do not have family supports. Within this system it is difficult to obtain large savings." See *Weil, There's Something About Medicaid*, HEALTH AFFAIRS, Volume 22, Number 1, January-February 2003, 13-30).

For more perspectives on LTCI, please read "Long-Term Care Insurance – Smart Buy or Not?," https://topomyhead.com/2016/08/14/long-term-care-insurance-smart-buy-or-not/ and "FAQ – Long-Term Care Insurance" at http://law-business.com/long-term-care-insurance/.

Those who do not buy LTCI, will have to rely on Medicare, Medicaid, or their own funds to pay for care. This article will explain first Medicare, then Medicaid.

Medicare

Medicare is nationwide health insurance for the aged and disabled. Part A, paid for by payroll taxes, covers inpatient hospital services, skilled nursing care, and some home care. Part B, voluntary Supplemental Medical Insurance funded with enrollee premiums and federal general revenues, covers physician and other health care services. Neither Part A nor Part B will cover

the cost of long-term care after the first 100 days.

Individuals 65 or older who are eligible for Old Age, Survivor's and Disability Insurance (OASDI)[1] are eligible to receive the red, white and blue Medicare card. Disabled persons who have received OASDI for at least two years are eligible. The benefits and eligible group are uniform throughout the country, although there are different plans, depending on region. These plans are described as follows on the Medicare website:

> Medicare Advantage (formerly Medicare + Choice) Plans - Available in many areas. If you have one of these plans, you don't need a Medigap policy. Medicare Advantage Plans include:
>
> * Medicare Managed Care Plans
> * Medicare Preferred Provider Organization Plans (PPO)
> * Medicare Private Fee-for-Service Plans
> * Medicare Specialty Plans
>
> If you decide to join a Medicare Advantage Plan, then you will use the health care card that you get from your Medicare Advantage Plan (provider) for your health care. These plans often give you more choices and, sometimes, extra benefits, like extra days in the hospital.
>
> To join a Medicare Advantage Plan, you must have Medicare Part A and Part B. You will have to pay the monthly Medicare Part B premium of $78.20 in 2005 to Medicare. In addition, you might have to pay a monthly premium to your Medicare Advantage Plan for the extra benefits that they offer.
>
> If you're in a Medicare Advantage Plan, you don't need a Medigap policy because Medicare Advantage Plans generally cover many of the same benefits that a Medigap policy would cover, like extra days in the hospital after you used the number of days that Medicare pays for.
> http://www.medicare.gov/Choices/Overview.asp

Medicare Advantage does not always live up to its name. Plans have been opened for enrollment in areas where there are no plan doctors. Some plans do not provide the full 100 days

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[1] OASDI is commonly referred to as "Social Security." It may also be referred to as Retirement, Survivor's and Disability Insurance (RSDI).

of skilled care and appeal rights regarding a determination that skilled care is no longer needed may be diluted or hard to exercise. Clients should carefully review the options before making a plan choice. Unfortunately, the options are both numerous and complex and the information on the Medicare website is often wrong. Medicare enrollees are often forced to guess as to which plan is right for them.

Medicaid

Nursing home care is a terrifying subject for people who are at or beyond retirement age. There are two reasons for this: impending physical dependency and potential financial catastrophe. In the first place, a nursing home resident is extremely vulnerable and dependent. It is difficult for someone who is young and temporarily able-bodied to picture himself or herself as bed-ridden. However, as the infirmities of age creep up and make themselves known, a nursing home stay may become inevitable. It is important to prepare for physical incapacity by executing a document that will appoint someone to be the agent. It is also crucial to arrange for regular -- daily if possible -- visits by someone who will oversee the quality of care and ensure that the care that the patient is due is properly performed.

Financial matters are also extremely important. Most people do not have enough income to pay for care. The following paper is describes the government assistance that is available to assist middle-class Americans in avoiding poverty in paying for nursing home care -- Medicaid.

People assume that a person must be a poverty case before qualifying for Medicaid. Fortunately for spouses and heirs who are dependent on nursing home residents this government program has many provisions that allow the nursing home resident to preserve substantial estates for their families.

I have often been criticized for assisting people in qualifying for Medicaid. There are people who think that the government should abandon those who are helpless and leave them to their families to take care of or throw them on their own resources. I think that is an unreasonably heartless attitude. Most of my Medicaid clients are not wealthy. They want to leave at least a small legacy to their families. They are workers and homemakers who have devoted their lives to their country and their families: people like my father. Is it too much for the government to return a small portion of their investment to help them avoid destitution?

In "The Medicaid Gentrification Myth," https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1078304, I refute the claims of the LTCI lobby and others that people who do not need help are abusing the program. Furthermore, there is nothing unethical or against public policy for attorneys to advise and assist clients in qualifying for Medicaid, as explained in "Ethical and Public Policy Considerations Related to Medicaid Planning," https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2366056, published in the Pennsylvania Bar Association Quarterly in 2013.

Medical Assistance, Medicaid or MA, is federally subsidized grant-in-aid for low-income individuals and families; i.e., welfare. It varies from state to state but generally covers medically necessary services and most prescriptions. For the uninsured nursing home resident, MA is the payer of last resort. There is no cap on covered services, but there are stringent eligibility requirements. The most important eligibility requirements concern assets. A single applicant with no dependents would be permitted no more $2,000 in countable assets. The Community Spouse of a married applicant would be able to keep a larger portion. But the couple would still be required to reduce their countable assets by at least half before qualifying for MA. On the

other hand, once the Institutionalized Spouse qualifies for MA as a Michigan nursing home resident, the cost of care borne by husband and wife cannot be more than the patient's income, less $60. If the Community Spouse has low income, some of the income can be diverted to support him or her.

Because Medicaid approval is such a great advantage, I will explain Medicaid eligibility and planning in some detail. I will also explain how the Medicaid rules allow almost anyone to preserve hundreds of thousands of dollars while qualifying for MA.

No one can say that the "Greatest Generation" turned away from its duty to its country. In many respects, the country appreciated and rewarded the efforts of the service personnel and civilian workers who sacrificed so much to protect her. However, now that they are reaching an age when so many require a high level of care, there are terrible inequities due to the variation in Medicaid plans from state to state and the lack of reliable information from the Medicaid agencies.

Medicaid policy has huge loopholes, but the agency does not explain them. When consumers call the agency, they are either turned away with no information or they are given answers that tell them nothing. The long-term care industry and the long-term care insurance associations promulgate their own interpretation of Medicaid policy. These explanations are generally intended to scare people into buying long-term care insurance or paying privately for care and do little to explain the loopholes.

I assisted a client who had spent $200,000–nearly three quarters of his savings–on his wife's care between 1993 and 1999. If I had advised him in 1993, he would have kept **all** of his savings. He was eligible to keep the amount remaining in 1999, $80,000, but the MA eligibility

worker miscalculated the amount and demanded that he spend down to $60,000. That was straightened out, but it shows that families can receive unfair treatment even when they play by the agency's rules.

Before getting to substance, however, I must issue a disclaimer. This information is like a ticket that says, "Good for this day and this destination, only." It is accurate today, but noone's property is secure while the legislature is in session and the policy is subject to change at any time. I also have to warn that eligibility workers will disagree with me on MA policy. They will tell family members that gifts must be returned, that assets must be assigned to the institutionalized spouse and spent for care, and that I am nuts. I cannot be responsible for what a bureaucrat says. My advice is based on the letter of the Medicaid manual and federal law. I very seldom fail to persuade the person whose decision counts – the judge – that the worker is wrong.

Avoiding Poverty through Medicaid

Where to Find the Law

The following pages will explain Medicaid law and agency policy to the best of my ability. To avoid having it read like a law review article, I have omitted most footnotes and legal cites. The primary legal sources are the Social Security Act, found in Title 42 of the United States Code, http://www4.law.cornell.edu/uscode/42/, and the policy manuals of the Michigan Department of Human Services, the Program Eligibility Manual, at http://www.mfia.state.mi.us/olmweb/ex/pem/pem.pdf and the Program Administrative Manual, at http://www.mfia.state.mi.us/olmweb/ex/pam/pm.pdf.

The two key sections of the Social Security Act are §§ 1917 and 1924, which are 42 USCA §§ 1396p and 1396r-5, respectively. In this paper all citations will be to the Code.

Section 1396p sets forth the rules that pertain to penalties for certain transfers and the treatment of trusts created by or for Medicaid claimants; while § 1396r-5 governs the treatment of resources–both income and asset–of husbands or wives who are institutionalized.

Household Concept and Spousal Support

The Medicare Catastrophic Coverage Act of 1988 (CCA), 42 USCA § 1396r-5, requires the welfare agency to include all of the countable resources of both husband and wife in calculating Total Joint Resources (TJR). It makes no difference whether they are estranged or together. Furthermore, state law relating to community property or division of marital property is irrelevant.

Limits on *Countable* Assets–No Community Spouse

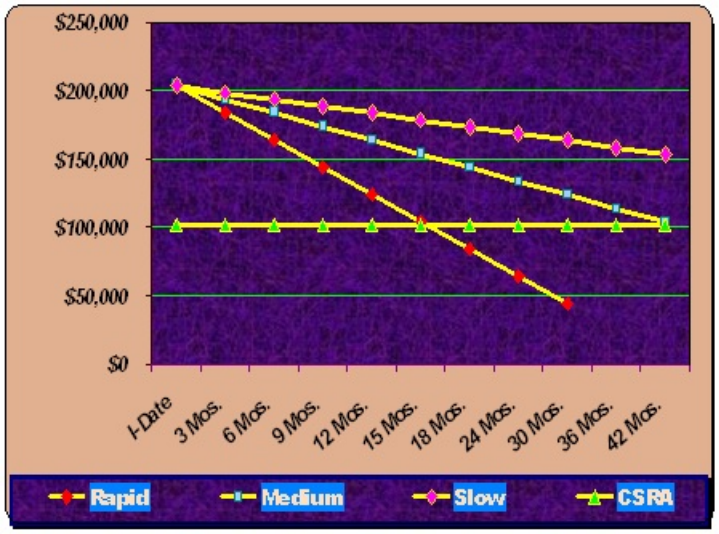
Assets are countable or excludable. Countable assets are subject to limitation. The limit for aged, blind, or disabled groups is $2,000 for a one-person group $3,000 for two. If a Michigan couple were both in long term care, each could retain $2,000 in countable assets. However, there is no limit on most excludable assets. Even if single, an MA applicant could retain $2,000 in cash, *plus a car and up to $500,000 in equity in the homestead*. This is an extremely important piece of the puzzle. Asset limits will be explained in the next few pages, but the limits do not apply to certain excluded property.

Limits on *Countable* Assets–Community Spouse

As I mentioned, if the Institutionalized Spouse is married and the spouse does not need nursing care, they can take advantage of more liberal asset allowances. The first step in determining the asset limit is to determine "total joint resources" (TJR) on the day one spouse enters LTC. This is commonly referred to as the "snapshot." Half of TJR, up to $104,400, may

be retained. This allocation is called the Community Spouse Resource Allowance (CSRA). The Community Spouse may retain a minimum of $20,880. Thus, if a couple have $26,000 in countable assets when one spouse enters a nursing home, the community spouse may still retain $20,880 and the institutionalized spouse $2,000.

The Institutionalized Spouse may transfer assets to the Community Spouse to bring his or her assets up to the spousal share. Therefore, if they have $220,000 in countable assets when the Institutionalized Spouse enters LTC, the Community Spouse may retain $104,400 and the Institutionalized Spouse $2,000. Once the Institutionalized Spouse is approved for MA, the Community Spouse's assets are no longer counted.



There is no incentive to be thrifty during the spend-down phase. The asset limit of $104,400 remains the same, regardless of the rate at which savings are depleted. Increased spending only moves the date of eligibility up, as shown in the graph.

Income Exclusion

Medicaid is approved for the entire month if the claimant's assets are within the asset limitation on any day. Barring divestment, the claimant's assets on any other day are of no consequence.

Income is what the claimant receives after the first moment of the first day of the month

and before the first moment of the next month. Income is *not considered part of the assets* for the month in which it is received. This is a fact that many workers will ignore. I advise persons applying for single clients to keep the countable assets less than $1,000 at all times. I advise community spouses to reduce the countable assets to a figure that is at least $2,000 less than the permitted amount. That way, monthly receipts will not push the total funds over $2,000 and the worker will not deny the case.

There is often a two-, four-, or six-month wait for the Medicaid worker to act on an application. It is crucial to keep the countable assets below the asset limit throughout this time. When the worker processes the application, eligibility for the month in which the worker is processing the application is assessed first. Only if the applicant meets the asset limitation does the worker determine the next prior month. The worker stops this backward progression at any month in which there is no asset eligibility. This seems to be in conflict with "Presumptive Eligibility" discussed below. But until the wrinkle is smoothed out, it is necessary to keep the assets well below the limit until Medicaid has been approved.

Example One

Bill and Marian retired recently. They both worked and each receives social security and pension of approximately $1,200 per month. Their house is worth $75,000 and they have a home equity loan for $55,000 outstanding. They have a five-year-old car worth $4,000. They have $160,000 in savings and various stocks and bonds. For MA purposes, stocks, bonds, certificates of deposit, passbook accounts and cash are all considered countable liquid assets.

	BILL & MARIAN BEFORE PLANNING	

		Fair Market Value	Countable Liability	Exempt Liability	Total Joint Resources
Homestead		$75,000			
Mortgage				$55,000	
Savings		$160,000			$160,000
Car		$4,000			
		======	======	======	=====
		$239,000		$55,000	$160,000
Net Worth		$189,000			

Table A

Let's see what would happen if Marian went into a nursing home.

The home and one automobile are not counted, so Bill and Marian have countable assets of $160,000 when Marian enters LTC. This means that Marian can get MA when she has less than $2,000, and Bill has less than $80,000. Not all of the excess has to be spent on Marian's care, but the person who applies for Marian will have to account for the money.

Once Marian enters LTC and Bill's spousal share has been established by filing an application for MA with the Department of Health and Human Services, Bill can start to "spend down". He pays a couple of months of LTC, pays off the mortgage, buys a new car and pays for remodeling. If the countable assets are now less than $80,000, Marian can qualify for MA. The important counseling point is that increased spending advances Medicaid eligibility. Note that Bill would have ended up with less money if they had paid off the mortgage and made the other expenditures before Marian went into the nursing home.

Bill may also be entitled to some of Marian's income if he meets certain needs tests. Although most of Marian's income will probably go to the nursing home, he will be able to keep all of his income. If the spouse who has all of the income goes into a nursing home, the spouse at home may have a difficult time maintaining his or her standard of living.

The homestead is protected as long as either Bill or Marian is alive. There is no current program in Michigan to make a claim against a homestead after the death of a Medicaid recipient. Note that Bill would have ended up with a lower spousal allowance if they had paid off the mortgage and made the other expenditures before Marian entered LTC.

The two significant dates are the date the institutionalized spouse enters LTC or a hospital leading to long-term care and the date the community spouse meets the resource allowance. The first date, the snapshot, is determined by entry into LTC. The second date is not fixed. It is dependent on the rate the assets are expended.

Income Transfer

Bill may also be entitled to some of Marian's income if he meets certain needs tests. Although most of Marian's income will probably go to the nursing home, he will be able to keep all of his income. If the spouse who has all of the income goes into a nursing home, the spouse at home may have a difficult time maintaining his or her standard of living.

The income calculation is directed at determining the "Patient Pay Amount." This is the amount that must be paid out of the Institutionalized Spouse's income for his or her care. After adding up the Institutionalized Spouse's OASDI, pensions, net rental income, and annuity payments (dividends and interest from other assets do not count), $60 for incidental needs and health insurance premiums are deducted. If there is a community spouse and the Institutionalized

Spouse is willing to assign the income, the Community Spouse Income Allowance (CSIA) may also be deducted.

To determine the CSIA, the Community Spouse's needs must be determined. To the mortgage, taxes and assessments, home insurance and rent is added a heat and utility allowance of $575.[2] If the total shelter cost exceeds $609, this "Excess Shelter" is added to the Community Spouse's Minimum Monthly Maintenance Needs Allowance of $2,003 to derive the "Total Allowance" of up to $3,023. The Community Spouse's income is added up and subtracted from the Total Allowance, which gives the CSIA to be deducted from the Institutionalized Spouse's income, net of the $60 incidental needs and health insurance premiums. The resulting figure is the Patient Pay Amount.

This forces the Community Spouse to rely on income that will terminate on the death of the IS. The spouse's dilemma is illustrated by Karen McClusky on Desperate Housewives. She stashed her late husband in the freezer and did not report his death to continue to collect his Social Security and pension.

Presumptive Eligibility

Once The Institutionalized Spouse's and his The Community Spouse's combined assets are less than the Protected Spousal Amount, MA should be approved without regard to the portion of countable assets in his name. During the first year of benefits, assets may be owned by either spouse. This is referred to as the "Presumed Asset Eligible period." The policy manual

[2] The figures used in this paragraph are adjusted annually for increases in cost of living and are current as of July 1, 2017. For reasons known only to faceless bureaucrats, the heat and utilities allowance and the maximum total allowance increase on January 1, but the excess shelter standard and the basic allowance increase on July 1.

states, "Applicants eligible for the processing month and recipients eligible for the first future month are automatically asset eligible for up to 12 calendar months." The purpose of this period is to allow the institutionalized spouse to transfer assets to the community spouse. After the Presumed Asset Eligible Period, The Institutionalized Spouse will be permitted no more than $2,000 in countable assets. However, the manual directs the worker to count "only the client's assets, not the spouse's assets."

Post-Eligibility Asset Treatment

Once the Institutionalized Spouse has qualified for medicaid, the Community Spouse's assets are no longer counted. This is required by the language of the federal statute's use of the "first continuous period of institutionalization (beginning on or after September 30, 1989)" with regard to the asset assessment of the Community Spouse. 42 USCA § 1396r-5(c)(1)(A). *There is no second assessment of the Community Spouse.* Therefore, it is to the couple's benefit to transfer all of the assets to the Community Spouse as soon as possible after the Institutionalized Spouse is determined to be eligible for Medicaid.

This presents a problem for "Brady Bunch" families. Depending on whether Carole or Mike is the community spouse, one set of children or the other will be cut out of any possible inheritance. Medicaid law has absolutely no respect for pre-nuptial agreements. However, since **all** of the couple's assets can be preserved, a coordinated estate and Medicaid plan may provide an inheritance for everyone.

Exempt Property

Items of property that are not counted in determining eligibility may be retained or purchased with countable funds. The most important of these for families is the homestead.

Michigan asserts a claim for reimbursement after the death of a MA recipient under a program known as “Estate Recovery.”.

Homestead

The major exclusion is the homestead, which is available for all persons, in all states, with community spouses or dependents. Michigan continues the homestead exemption for long term care patients, even absent a spouse or dependent. The exclusion applies to the house and adjoining land, but not if the property is in any kind of trust. Possessed by whimsy that day, whoever wrote the policy stated that a homestead is countable if it is in a trust.

The homestead may be occupied by others during the patient's absence. The home may also be rented, but income derived from the homestead must be reported. Net rental income is added to the amount the client must pay for care.

The CCA permits the transfer of a home and title to the spouse or a specified relative. The permitted relatives include a dependent child or a child who resided in the home for at least two years, whose care enabled the person to remain in the home, or a sibling with an equity interest who resided in the home for at least a year.

Under the Deficit Reduction Act there is a $560,000 cap on home equity (effective January 1, 2017), unless there is a Community Spouse or disabled or minor child residing in the home.[3] The Program Eligibility Manual was revised to provide as follows:

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[3] This amendment to the Social Security Act is codified as follows:

> (f)(1)(A) Notwithstanding any other provision of this subchapter, 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

MA will not pay the client's cost for:

• Home Help services

• Home Health services

• Home and Communtiy based services (MIChoice Waiver)

• LTC services

When the equity in the cilent's homestead exceeds $500,000.

PEM Item 400(19) (January 1, 2008).

$500,000.

(B) A State may elect, without regard to the requirements of section 1396a(a)(1) of this title (relating to statewideness) and section 1396a(a)(10)(B) of this title (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 subchapter XVI of this chapter) 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 1382c of this title, 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.

42 U.S.C.A. § 1396p(f).

However, the manual directs the worker not to "apply the home equity limit to the client if the spouse, child under 21, or the client's blind or disabled child is residing in the home." Id.

Household and Personal Goods

Household goods and personal goods comprise another major exclusion. Household goods are customarily found in the home and used in conjunction with maintenance or occupancy. Personal goods are incidental items intended for personal use by a household member. Excluded household and personal goods generally are not reported on the application. As a rule of thumb, it is important not to report information on the application that is not required. The worker may attempt to count items reported even if the items are properly excludable.

Personal goods held for investment purposes may not be excluded. Items with ready market value which are not used in day-to-day living would probably be counted.

Motor Vehicle

One motor vehicle of any value is excluded. If more than one vehicle is owned, the most expensive may be excluded. An additional vehicle may also be excluded if it serves as the homestead, or if it is necessary for self-support.

Income-Producing Real Property and Assets Used in Trade or Business

Michigan's policy concerning income-producing assets was very liberal until April 1, 2007. Income producing real property (IPRP) and personal property used in a trade or business were excluded without limit. However, a new revision to PEM Item 400 limited the equity in IPRP to $6,000, the same as the SSI limit. The annual income of real property must be at least 6% of the group's equity interest.

Whether the exemption for “assets used in a trade or business” will be useful remains to be seen. Its utility will probably be limited to situations where a Community Spouse has a small business.

Funeral and Burial Arrangements

There are four separate exemptions for final arrangements. Any combination of investments is permitted, except that certain combinations of life insurance, life insurance-funded funeral and burial fund cannot exceed $1,500. Medicaid policy must be carefully analyzed with regard to each investment and with regard to each combination. I advise bringing items that are thought to be excluded to the worker's attention early in the application process to get a determination of which investments will be excluded.

- Irrevocable Funeral Contracts

Up to $12,540[4] may be tied up in an irrevocable funeral agreement. This may be established at any time, except to avoid penalties for fraud. The Agency's form must be used and the Agency must certify the agreement.

- Burial Fund

Up to $1,500 per person may be set aside in a separate fund for burial expenses. Burial expenses are generally those related to preparation of the remains for final disposition. This can be a bank account, certificate of deposit, bond or other type of fund. It may be in the client's name or in another's. To be exempt, the burial fund must be "clearly designated" for that purpose. This requires a signed statement from the client stating the value and ownership of the

[4] As adjusted June 1, 2017. Department of Health and Human Services, Bridges Administrative Manual, Item 805(6) (June 1, 2017).

asset, the name of the person for whose burial the funds are set aside, the type of account or investment in which the funds are held, and the date the fund was set aside. The $1,500 maximum per person is reduced by the face amount of life insurance policies owned by the person.

This exclusion may be claimed *ex post facto*. It can be used when a stray savings account has turned up after the month for which Medicaid is needed. The burial fund designation can be signed with an earlier "effective" date to exclude the account back to the desired month.

- Life Insurance

The cash surrender value of life insurance is excluded when the total face value of all policies one owner has for the same insured are $1,500 or less. Term insurance policies are not considered at all.

- Life Insurance Funded Funerals

Life insurance policies may be excluded if the proceeds will be used for funeral expenses. The life insurance proceeds must be assigned for funeral expenses and the ownership of the policies may be transferred to a trust, funeral director or other third party. If the proceeds are assigned and the ownership transferred, there does not appear to be a maximum exclusion. This type of arrangement has no *ex post facto* effect.

Annuities

Annuities that are being paid out in installments and that meet the test of being "actuarially sound" do not count as assets. This is because they are an income stream, not a fund that can be liquidated. By placing assets into an annuity, assets can be taken out of the pool of "countable" assets and become "excludable."

There are four requirements for an annuity to shelter funds: irrevocability, unassignability, actuarial soundness, and a beneficiary designation naming the state the beneficiary for Medicaid payments expended on behalf of the annuitant or the Institutionalized Spouse if the annuitant is a Community Spouse.

In addition to the above conditions an annuity purchased or amended on or after February 8, 2006 must name the state of Michigan as the remainder beneficiary, or as the second remainder beneficiary after the community spouse or minor or disabled child, for an amount at least equal to the amount of the Medicaid benefits provided. Proposed BEM Item 401(5-6) (April 1, 2017).

Savings Bonds

Savings bonds have also been used to render funds inaccessible. Federal regulations state that a savings bond may not be hypothecated, pledged, or used as security for the performance of an obligation. (See, e.g., 31 CFR §§ 353.16 & 360.16). Since bonds also have a mandatory initial holding period of one year, they become unavailable--and therefore non-countable--assets during the initial holding period.

Department of Human Services frowns on this use of savings bonds. The Program Eligibility Manual was revised in 2004 to require that the client request waiver of the holding period before the agency will consider U.S. Savings Bonds unavailable. Since waivers are routinely granted by the U.S. Treasury Department, savings bonds do not shelter assets.

IRAs & Other Qualified Retirement Accounts

The treatment of qualified retirement accounts varies from state to state, depending on

how the state views the interplay between SSI and Medicaid rules. Some states, for example Colorado, Michigan and New Jersey, consider IRA and § 401(k) funds accessible, and therefore countable. If the state's annuity rules permit the annuitization of excess funds, this may provide a workaround. Ohio, Pennsylvania and Wisconsin, which have very restrictive Medicaid rules in other respects, exempt retirement accounts if they are owned by the community spouse. In Michigan a retirement fund is only considered unavailable if the participant must leave his or her job in order to make a withdrawal.

Jointly-Held Liquid Assets

The Agency will consider jointly-held liquid assets to be totally available to the MA applicant or recipient. Assets over which an institutionalized person has unrestricted access and control are countable in determining his SSI and MA eligibility. Therefore, most joint liquid assets in which he is a joint tenant will be considered totally available to him.

If he is made a joint tenant for estate planning, but has neither a current claim of right in the funds, nor unrestricted access, the assets are supposed to be unavailable and not counted. The policy provides that jointly held assets which are capable of division, such as bank accounts, are *presumed* to be entirely available to the applicant or recipient. The other joint owner may rebut the presumption by showing that the a portion of the funds do not belong to the recipient. This, however, is extremely difficult. Joint accounts are considered divested when the funds are removed.

All joint accounts bearing the applicant's name, except one, should be dissolved. Withdrawal of a portion of the funds, it could be argued, is evidence of ownership of those funds

by the joint tenant. Since the policy refers to assets held at the time the worker is determining eligibility, if a joint account was broken up before the application was filed, the assets now held individually by the former joint tenant would only be counted with regard to the applicant if it is determined that divestment occurred.

Jointly Held Real & Personal Property

Assets which cannot be divided, such as parcels of real property, securities, or vehicles, may be considered unavailable if held jointly with rights of survivorship. The institutionalized person would have to show that his share could not be sold without the consent of the other owners and that the other owners do not consent to the sale.

The policy says that joint assets are not considered transferred until the other joint owner refuses to sell. It may be wise to have the joint owner sign an intent letter shortly after the property is put in joint tenancy.

Creating a joint tenancy may be divestment since it reduces the client's ownership or control of the asset. However, assets which have been joint since before the look-back period calculated for divestment, as explained in the next section, should be neither available nor disqualifying. Any problem with such an asset would arise on sale or other disposition, or on the death of the claimant.

Divestment

If The Institutionalized Spouse or the Community Spouse disposed of assets for less than fair market value on or after a look-back date, they would become ineligible for certain benefits. They would lose MA for nursing home care, for home health services, and for certain other

services for a number of months. The number is determined by dividing the amount divested by the monthly cost of nursing home care for a private-pay patient. Despite the penalty, they would be considered "eligible for MA." However, nursing home and home care costs would not be paid.

Look-Back

The look-back period is measured from the "Baseline Date." The Baseline Date is the first date that the client is eligible for Medicaid and in a long-term care facility or approved for waiver, home health, or home help services. The baseline date does not change even if the client leaves long-term care or is no longer approved for waiver services. The look-back period is 60 months, except for certain transactions before February 8, 2006.

DRA 2005 applies the 60-month to any disposal of assets on or after February 8, 2006. This is extremely confusing to workers and clients, alike because the five-year look-back applies to transactions in 2007, but when an application is filed, the look-back, as it pertains to any transaction before February 8, 2006, is truncated. For example, if an application is filed on October 5, 2007, only transactions after October 5, 2004 are subject to scrutiny. However, workers are demanding five-years' bank statements and tax returns even in the summer of 2007. This is overreaching except for transactions involving trusts.

When applications are filed after February 8, 2009, the effective look-back will begin to stretch. So, for an application filed on March 8, 2009, the look-back will cover any transaction dated February 8, 2006, or later; so the look-back will be three years and one month. The look-back will not be fully effective at 60 months until February 8, 2011.

The 60-month look-back applies to payments, even those that pre-date the DRA, from a revocable trust that are not made to the Institutionalized Spouse or Community Spouse and any portion of an irrevocable trust from which no payment could under any circumstances be made to them. Because there is some applicability of the 60-month look-back, Medicaid workers have a basis to demand five years of financial records. It is better to avoid revealing a transfer that is before the look-back date. Many workers will try to apply a penalty to a large transfer, even if it is technically not within the look-back. Therefore, resist demands for documentation that exceed the period the worker has the right to count.

If the last transfer was more than 60 months before the date of application, there is no disqualification. If the claimant applies too early, he or she cannot apply again later and avoid a disqualification period that exceeds the look-back period. The Baseline Date remains unchanged despite denials and re-applications. The look-back period is measured from the first application date. Therefore, when there has been a divestment it is crucial to calculate penalty periods and look-back dates *before* filing an application.

Penalty Period

According to the proposed revision of the divestment rules, "the penalty period starts on the date which the individual is eligible for medicaid and would otherwise be receiving institutional level care LTC, MIChoice waiver, or home help or home health services, and is not already part of a penalty period."

The disqualification period may be shorter than the length of time that it would have taken to expend the assets. The amount divested is divided by an amount that approximates the

monthly nursing home bill. If the Baseline Date (application) is in 2017, the divisor is the state average private-pay nursing home rate, $8,018. This gives the length of the disqualification. Since there will be monthly income received during the disqualification period, the amount that must be retained to pay for care while disqualified can be reduced by the anticipated income.

The problem with the new policy is that the penalty does not start until "the individual is eligible for medicaid and would otherwise be receiving institutional level care LTC," or one of the other Medicaid LTC benefits, but for the penalty–that is, out of assets. How does the Medicaid applicant get through the penalty period when he or she has nothing to pay for care?

Under Pre-DRA Medicaid policy, the penalty started when the gift was made. This permitted the potential Medicaid applicant to give away half of his or her assets. The half retained would nearly always cover the cost of care during the penalty. Under the new regime, this plan–known as half-a-loaf–must be modified. Instead of giving away half and retaining the other half to pay for care, the person must impoverish himself or herself, but arrange for payment for care during the resulting penalty.

One simple method is to give approximately half of the assets to a family member and use the other half to cover the cost of care during the penalty and pay for attorney fees..

For example, let's assume that Myrtle has $100,000 and wants her daughter Dotti to keep as much as possible of her money. Myrtle gives Dotti $50,000 and uses the rest to fund an immediate annuity, then applies for Medicaid. The penalty divisor is $8,018. Myrtle's income is $1,100 and the cost of care is $8,600 per month. Myrtle's gift results in a six-month disqualification and her family ends up with approximately half of the original $100,000.

Permitted Transfers

The transfer of a home to the spouse and certain qualified donees is permitted. Special attention should be paid where a child or sibling of a potential MA applicant resides in a home in which the applicant has an ownership interest.

A transfer is not divestment if the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, or that the assets were transferred exclusively for a purpose other than to qualify for medical assistance. Transfers between spouses, in any amount, are expressly permitted at any time.

A disqualification may also be avoided if all assets transferred for less than fair market value are returned to the patient. As noted, return of a portion of the assets will shorten the disqualification period *pro rata*.

Conversion

Converting an asset from one form to another, such as using cash to purchase stock of equal value, would not be divestment, even if the new asset is exempt. The new law recognizes divestment when any action is taken that reduces or eliminates the claimant's ownership or control of an asset, not necessarily when names are added to the claimant's account. Since a joint account is totally available to each joint account holder, no divestment occurs when names are added to the account.

Conversion is permitted at any time. This is because the value that is returned to the person is equal to the value that is given away. It is this principle that allows a person to purchase an annuity or income-producing real property. If an institutionalized person pays

$100,000 for an annuity and the value of the future payments is $100,000, he or she has not made a gift. Since there is no gift, there is no penalty. Likewise, if he or she pays $100,000 for a car, jewelry, or an addition to his home, he or she receives property of equal value for the money transferred. There is no gift, no penalty, and no waiting period before applying for MA.

Undue Hardship

Federal law requires the state to recognize an exemption from the divestment rules where application of the disqualification would result in an "undue hardship." The definition in Michigan's policy manual is problematic. There are two elements of undue hardship:

- necessary medical care is *not* being provided, **and**
- the client needs treatment for an emergency condition. [emphasis in original]

Undue hardship must be substantiated by the statement of a treating physician. The condition must require immediate treatment to avoid death or permanent impairment of health, but the definition of emergency does not include sudden onset of illness.

It is also very difficult for a nursing home resident to satisfy the first element. If treatment is being provided, there is no emergency.

This definition could be difficult to meet if The Institutionalized Spouse miscalculated the divestment disqualification and were in a nursing home when his money ran out. The Agency would refuse to recognize that an undue hardship existed until he was out on the street.

Trusts

Funding a trust or other device from which payments may be made to the patient or spouse does not result in a penalty, but any amount of income or corpus that could be distributed *under any circumstance* is considered a resource. That is, any portion that *could* be distributed is treated as cash in hand. The patient is considered to have established a trust even if the assets are placed in trust by a person, including a court or administrative body acting on his behalf or at the direction of the spouse. If a trust contains assets of a person other than the patient or the patient's spouse, the resource rules do not apply to those assets. These new rules even apply to trusts established by others for aged and disabled individuals unless the state is assigned the residue on the death of the individuals and certain other conditions are met.

Creating an irrevocable trust should not constitute divestment, provided the Institutionalized Spouse or the Community Spouse is the only beneficiary during his or her life. The Social Security Act provides that a transfer does not constitute divestment if resources are transferred to another (i.e. in trust) for the sole benefit of the spouse of the claimant.

Income-Only Trusts

Income-only trusts may preserve corpus for a Medicaid recipient's heirs. However, entrustment of assets to such a trust would result in a period of disqualification.

Community Spouse Example

The timing of certain expenditures is important. Married persons may take advantage of more liberal asset allowances if one spouse will not be in long term care.

The amount of assets which the community spouse may retain is based on TJR, as of the date of institutionalization. It may be wise to establish as high a level of TJR as possible on the

date the spouse enters long term care.

For example, assume that Al and Ann Ayers have $90,000 in savings, a $25,000 car with a $15,000 chattel mortgage, a $30,000 boat with a $20,000 chattel mortgage, and a $100,000 house owned free and clear. Table A shows that the countable assets would be $100,000. The community spouse would be able to keep $50,000.

Table A		**AL & ANN BEFORE PLANNING**			
		FMV	CT. LIAB.	XMT LIAB.	TJR
HOMESTEAD		$100,000			
MORTGAGE					
SAVINGS		$90,000			$90,000
CAR		$25,000		$15,000	
BOAT		$30,000	$20,000		$10,000
		======	======	======	=====
		$245,000	$20,000	$15,000	$100,000
NET WORTH		$210,000			

Now let's assume that they borrow $60,000 against the home. They pay off the boat and put the rest in the bank. Without changing their net worth, they have increased their TJR for MA purposes to $160,000. If one spouse enters long term care at this point, the community spouse will be able to keep $80,000. This is shown in Table B.

Table B		**AL & ANN SNAPSHOT**			
		FMV	CT. LIAB.	XMT LIAB.	TJR

HOMESTEAD		$100,000			
MORTGAGE				$60,000	
SAVINGS		$130,000			$130,000
CAR		$25,000		$15,000	
BOAT		$30,000			$30,000
		======	======	======	=====
		$285,000	$0	$75,000	$160,000
NET WORTH		$210,000			

After the spouse enters long term care, the community spouse can put a chattel mortgage on the boat and pay off the mortgage on the homestead. As shown in Table C, the community spouse is now within $5,000 of the spousal share. Again, the net worth has not been affected.

Table C		**AL & ANN AFTER LTC**			
		FMV	CT. LIAB.	XMT LIAB.	TJR
HOMESTEAD		$100,000			
MORTGAGE					
SAVINGS		$75,000			$75,000
CAR		$25,000			
BOAT		$30,000	$20,000		$10,000
		======	======	======	======
		$230,000	$20,000	$0	$85,000
NET WORTH		$210,000			

Only the equity of countable assets is used in determining eligibility. This means that the indebtedness is a deduction for MA purposes. On the other hand, unsecured debt, or mortgages on exempt property are not taken into account. This is the reason that the manipulations outlined above reduce the amount that must be spent so impressively.

Planning for married couples often must be done in two or more stages. The assets retained by the community spouse are at risk if that spouse then requires nursing home care. This calls for careful analysis of the assets, the likelihood that the second spouse will need LTC in the near future, and Medicaid policy. The last analysis will be based on guesswork, but the planner can be assured that promulgation of the most restrictive policies will be the cherished goal of the Department of Human Services.

Preserving Funds with an Annuity

A Medicaid applicant may place funds in an annuity. Once the funds are "annuitized," that is, once periodic payments have commenced, the principal or corpus of the annuity cannot be returned to the annuitant. Because the corpus cannot be returned, it is no longer considered an "asset." The annuity is just considered an income stream for Medicaid budgeting.

This is a useful device to preserve funds for the community spouse. Consider the first "Al & Ann" spreadsheet. Because TJR is $100,000 when one spouse enters the nursing home, the community spouse may retain $50,000. If the excess funds were put into an annuity, the institutionalized spouse could be immediately eligible.

There are four limitations on the use of an annuity. First, the owner and annuitant must be the Medicaid applicant or the applicant's spouse. Second, any period of guaranteed payments

must end within the annuitant's actuarial life expectancy, according to the actuarial tables in the Medicaid manual. For example, a male at age 80 has a 9.11-year life expectancy, according to these tables. If an 80-year-old, male applicant or spouse put money in an annuity and annuitized it with guaranteed payments for 108 months, there would be no divestment. However, if the annuity had guaranteed payments for twenty years, the applicant would be considered to have divested the payments for the last 11 years. The policy manual does not explain whether or how present value is calculated.

Third, the payments must be equal, although payments for life are not required. Finally, as noted above, "an annuity purchased or amended on or after February 8, 2006 must name the state of Michigan as the remainder beneficiary, or as the second remainder beneficiary after the community spouse or minor or disabled child, for an amount at least equal to the amount of the Medicaid benefits provided."

Income Eligibility

As discussed above, the applicant must establish asset eligibility by showing that his or her total countable assets are lower than the asset limit. Income is not an eligibility criterion in Michigan. DHHS calculates the amount the applicant is obligated to pay based on his or her income and other circumstances. This is called the Patient Pay Amount. If the applicant's Patient Pay Amount is less than the monthly MA payment rate for that nursing home, plus other medical expenses, the applicant can receive MA for the difference. If there is no deficit, the applicant receives no benefit because there is no need for assistance.

Other DRA Changes

The Deficit Reduction Act made changes in the way low-income Community Spouses are allowed to augment their income, the treatment of Continuing-Care Retirement Community entrance deposits, and the rules for establishing that loans are not gifts. Finally, the Act created a minimum period of residence for life estates purchased by Medicaid applicants.

Income-First

Under the DRA, states are required to apply an income-first rule with regard to the income of Community Spouses. This is a complicated rule that allows community spouses to get some of the income of the Institutionalized Spouse to bring him or her up to a poverty standard or needs allowance. Formerly, most states would allow the community spouse to keep additional assets to bring the income up to the needs allowance. "Income-first" means that the institutionalized spouse's income must be applied first to make up the deficit before additional assets can be kept. This is unfavorable to community spouses because pensions on which they must rely under the income-first rule often end when the institutionalized spouse dies.

Continuing Care Retirement Community Contracts

The DRA requires that entrance deposits or fees for continuing-care retirement communities (CCRCs) be considered available and be used to pay for care before the resident can apply for Medicaid for nursing services. A CCRC is a retirement community that has a continuum of living arrangements, usually apartments for independent living, assisted living units or rooms, and a nursing facility. The advantage to this type of facility is that the transition to greater levels of assistance does not require the resident to leave the campus.

The rule is easy to apply in the case of a single resident, but many couples move into

CCRCs. There is no explanation of how the entrance deposit is to be treated if one spouse remains in the retirement apartment when the other spouse needs nursing care. It can be inferred that the entrance deposit would be considered part of the assets that the community spouse would be allowed to keep under the spousal anti-impoverishment rules. However, the largest amount the community spouse can keep in 2007 is $101,880 and many CCRC entrance deposits are $150,000 or higher. This is extremely problematic and the new law does not provide guidance or relief for community spouses.

Notes & Loans

Persons who apply for Medicaid after loaning money come under strict rules. Loans that do not meet the requirements are treated as gifts. The repayment must be "actuarially sound." That means equal payments with no deferral. No balance may be cancelled on the lender's death.

Life Estates

Once the DRA becomes effective, the purchase of a life estate in another's home is considered a gift unless the purchaser resides in the home for a period of at least one year after the date of the purchase.

Conclusion

As the discussion above explains, there will be dramatic changes in Medicaid for nursing home residents. Before purchasing an annuity or making a gift, anyone over 60 should consult an Elder Law attorney to determine possible Medicaid consequences in case the person or the person's spouse ever needs care in a nursing home.