Atrium Medical Center Foundation

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Estate & Tax Planning
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Medicaid Law Update

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I. Medicaid – What is it?

- Federal/State program designed to help people pay for the high cost of long-term care and health insurance costs for the needy.

II. Medicaid – Nursing Care

- Requirements:
  - A. Medical Need, plus 65 or older, blind or disabled.
  - B. Income Eligibility:
    - 1. Countable Income – less than Special Income Level (300% of SSI in own household) - $2,382 or need QIT.
    - 2. Patient Liability: Amount of monthly income which must be paid over to pay for services.
    - 3. Allowances – Participant can retain certain amounts of monthly income, principally for: (i) personal needs allowance ($50, up to $140 for VA A&A beneficiaries); (ii) Monthly Income Allowance – to allow healthy spouse ("Community Spouse") retain part of Medicaid spouse's ("Institutionalized Spouse") income to maintain household; (iii) medical insurance premiums; and (iv) past medical expenses.

II. Medicaid – Nursing Care

- Requirements:
  - C. Resources – Long-Term Nursing Care and Waiver Benefits.
    - 1. Single Individuals: less than $2,000.
    - 2. Married: Less than $2,000 for Medicaid recipient; Community Spousal resource Allowance ("CSRA") for Community Spouse. This is measured as of first day of institutionalization and is one-hald of countable resources, with a minimum of $26,076 and a maximum of $130,380 (for 2021).

II. Medicaid – Nursing Care

- Resources – Example
  - Couple owns home ($200,000), older car, and $125,000 in cash. H enters NH on 8/20/2021. H will be Medicaid-eligible when couple's cash assets are reduced to $64,500 (W's CSRA = $62,500 and H can retain up to $2,000).

II. Medicaid – Nursing Care

- 3. Countable Resources. Almost everything except following: (i) residence (with value up to $603,000 for 2021); (ii) very small life insurance policies; (iii) irrevocable funeral arrangements; (iv) one motor vehicle; (v) IRAs and qualified retirement accounts in payout status; (vi) household goods; (vii) income in the month of receipt.

II. Medicaid – Nursing Care

- D. Transfers of Assets.
  - 1. 5-year lookback from Medicaid application date. Applies to transfers made with primary purpose of hastening Medicaid eligibility. Designation of improper transfer can be rebutted with clear and convincing evidence of other "exclusive" purpose.
  - 2. Calculation. Divide total amount of improper transfers by monthly private cost of nursing care in state. Ohio is currently $6,905 in gifts for one month of penalty.

II. Medicaid – Nursing Care

- Example:
  - Dad makes gifts to son as follows: $500,000 on 9/20/2015; $10,000 on 3/1/2021.
  - Dad enters NH on 3/1/2021, privately pays for care until 8/31/2021 and then applies for Medicaid on 8/31/2021.
  - Dad is eligible for Medicaid as of 8/1/2021 but with a period of "restricted coverage" of 1.4 months ($10,000 ÷ $6,905 = 1.4), starting 8/1/2021 through 8/31/2020. Dad has additional patient liability for 9/2021 of $3,905 in addition to his regular patient liability.

II. Medicaid – Nursing Care

- D. Transfers of Assets.
  - 3. Exceptions to Improper Transfer Rule:
    - (i) transfers of any asset to blind or disabled child; (ii) transfers of residence to spouse; (iii) transfers to a trust for sole benefit of person under age 65 who is blind or disabled; (iv) transfer of residence to adult child under 2-year of care rule); (v) transfer of residence to Medicaid applicant's sibling who had equity in home and lived there at least one year; (vi) transfers to QIT ("Qualified Income Trust").

II. Medicaid – Nursing Care

- III. Trusts
  - A. Medicaid Qualifying Trusts – from before 8/11/1993
  - B. Self-settled Trusts – post 8/11/1993.
  - C. Exempt Trusts: (1) Special Needs Trusts; (2) QITS; (3) Pooled Trusts; (4) Supplemental Services Trust (rarely used); totally discretionary trusts.

II. Medicaid – Nursing Care

- IV. Annuities.
  - These can be very useful in getting through a gifting penalty period or for increasing the monthly income for a community spouse. The rules, including having the State of Ohio as a potential beneficiary, are not onerous but must be closely followed.

II. Medicaid – Nursing Care

- V. IRAs and Qualified Retirement Plans
- Since July, 2020, the Ohio Department of Medicaid has changed its previous position with regard to qualified retirement accounts (IRAs, 401(k) and similar plans). These accounts are EXEMPT, so long as they are in payout status. That is, so long as the owner is old enough to take distributions and is taking, at a minimum, required minimum distributions, the account will be ignored for Medicaid eligibility purposes. The withdrawals will be annualized and treated as monthly unearned income. OAC **5160:1-3-03.10.**

II. Medicaid – Nursing Care

- V. IRAs and Qualified Retirement Accounts.
  - The change in interpretation taken by the State of Ohio will significantly change Medicaid planning and favor Medicaid recipients and their families.
  - It appears that under Ohio's new position, IRAs and other qualified retirement accounts for either spouse will be considered exempt, so long as required minimum distributions are being taken.
  - Until the interpretation of the regulations is clarified, it is best to apply for Medicaid and have a resource assessment done prior to taken any significant actions. This would force a caseworker to let an applicant know how any potential planning measures would be treated.
  - One significant open issue is whether an IRA owned by someone who is under the age of 72 will be exempt.

II. Medicaid – Nursing Care

- VI. Estate Recovery.
  - A. Applies to both probate and non-probate assets.
  - B. Applies to Medicaid recipients age 55 and older.
  - C. No recovery can be made if there is a surviving spouse, or minor or disabled child.
  - D. Liens are frequently used to secure payment against real estate. Sometimes, “Affidavits of Facts Regarding Real Estate” are used where a lien cannot technically be recorded. In those instances, these Affidavits will be released quickly and easily if the property is to be sold and a lien still cannot be filed.

II. Medicaid – Nursing Care

- VII. Planning Ideas.
  - 1. Married Couple.
    - Facts: H (age 75) enters NH, W (age 75) at home. They own their home, have $200,000 in stocks, and H has a $100,000 IRA and W has a $150,000 IRA.
    - Plan: CSRA is $100,000 so couple needs to spend down to $102,000 for H to be eligible. IRAs are exempt. They need to spend $98,000, possibly on funeral arrangements, a new car for CS, and/or home improvements.

II. Medicaid – Nursing Care

- VII. Planning Ideas.
  - 2. Gifting + Annuity.
    - Facts: Mom, single, enters NH on 12/1/2021. Mom has $200,000 in cash assets, $1,500/month in income, and her NH cost of care is $10,000/month.
    - Plan: Out of total assets: (i) Pay NH $8,500, plus December income, to pay for December; (ii) pay bills, including attorney fees, of $5,000; (iii) give children a gift of $80,000 (preferably in an irrevocable grantor trust); (iv) purchase 11-month annuity for $104,500, paying out $9,500/month starting 1/1/2022; (v) establish QIT into which annuity income is transferred and used to pay NH. Mom retains $2,000 in bank account. Mom applies for Medicaid in December, 2021 and has a period of restricted coverage of 11.6 months, starting 12/1/2021, imposed.

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Medicaid Law Update

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I. MEDICAID – WHAT IS IT?

Medicaid is a federal program which is administered by the states to provide for the basic health care needs of poor individuals and families. For the elderly, Medicaid benefits provide for nursing care and several types of "waiver" programs which are designed to help those who would otherwise need nursing home care stay at home or in an assisted living facility.

II. MEDICAID – NURSING CARE

A. Covered Category and Medical Need.

In order to be eligible for Medicaid benefits for long-term nursing care, an individual must have a medical need and also fall within one of the categories of covered persons. These categories are: (i) age 65 or older; (ii) blind; or (iii) disabled. The medical need is established through a "level of care" assessment which establishes that the person needs an intermediate or skilled level of nursing care. OAC §5160-3-14.

B. Income Eligibility.

1. Countable Income.

   If an individual's "countable income" is equal to or less than the monthly cost of care, the individual meets the income eligibility test. A person's "countable income" is his or her gross income less certain disregards, such as up to $20 per month is unearned income. OAC §5160:1-3-03.2(A).

2. Patient Liability.

   Beginning with the month in which an individual becomes eligible for Medicaid benefits, all of his or her countable income, except several allowances discussed below, must be paid to the nursing facility. This is the person's "patient liability". Only the individual's income is used to establish the patient liability; it does not include the income of his or her spouse. OAC § 5160:1-6-07.1(G).

3. Allowances.

   In calculating the individual's patient liability, several deductions are permitted:

   i. Personal needs allowance of $50 each month (only $30 for an SSI recipient). This amount is increased by $90 per month for those individuals receiving VA benefits.

ii. Monthly Income Allowance. If the Community Spouse's ("CS") income is below a certain level, which is currently a minimum of $2,177.50 and a maximum of $3,2159.50[1] (the "Minimum Monthly Maintenance Needs Allowance" or "MMMNA"), the community spouse may retain enough of the institutionalized spouse's income to reach monthly minimum. This additional amount of income from the institutionalized spouse is called the Monthly Income Allowance ("MIA"). OAC §5160:1-6-07.

iii. Medical insurance premiums.

iv. Past Medical Expenses.

v. Family Allowance.

C. Resource Eligibility - Long-Term Nursing Care Benefits.

1. Single Individuals.

A single individual must have no more than $2,000 in countable resources to be eligible for nursing home Medicaid benefits.

2. Married Individuals.

A married person must, also, have no more than $2,000 in countable resources to be eligible for Medicaid benefits. However, where a married couple is involved, the community spouse is entitled to retain a "Community Spousal Resource Allowance", or "CSRA", which is equal to one-half of the couple's countable resources as of the first day of institutionalization, with a minimum amount of $26,076 and a maximum amount of $130,380.00[2]. OAC § 5160:1-6-04.

EXAMPLE

Paul and Mary, both age 75, are married. Paul entered a nursing home on August 20, 2021. As of August 20, 2021, Paul and Mary owned their own home, a 1999 Buick and have about $125,000 in countable resources. Paul will be eligible for Medicaid benefits to pay for his nursing care when they have spent their countable resources down below $64,500 since Mary is entitled to retain a CSRA of $62,500 and Paul is entitled to retain up to $2,000. Please note that in

[1] These numbers are for 2020 and are typically changed annually.
[2] Id.

determining countable resources, any income received for the month of application is ***not*** considered a countable resource.

3. Countable Resources.

"Countable resources" include all of a person's or a couple's cash, savings, brokerage accounts, stocks, annuities, IRAs which are not in payout status, the cash value of life insurance policies, real property, promissory notes, life estates which can be transferred, and any other asset which can be liquidated. OAC § 5160:1-3-05.1.

4. Exempt Resources.

Certain resources are not included in the definition of countable resources:

i. The residence, if occupied by the individual's spouse, dependent (under 21), blind or disabled child; child over age 65; or a sibling with a verified equity interest in the home who has lived there at least a year. OAC § 5160:1-6-06. The home is exempt, also, so long as the Medicaid applicant ***intends*** to return and signs a statement to that effect. OAC §5160:1-3-05.13.

ii. Life insurance with a face value less than $1,500.

iii. Irrevocable funeral arrangements for both spouses, plus burial spaces for family members. See Exhibit "A", attached hereto.

iv. One motor vehicle regardless of value if for community spouse or for medical transportation.

v. Income producing property with a value of **up** to $6,000 which produces at least 6% return on equity.

vi. Lump sum payment, such as Social Security or SSI benefits, for the first six months after receipt.

vii. Household goods.

viii. IRAs and qualified retirement plan accounts which are in "payout" status.

D. Transfers of Assets.

Even if all other eligibility requirements have been met, a person might not be eligible for Medicaid benefits if the applicant or his or her spouse has transferred assets in an attempt to hasten Medicaid eligibility.

1. Look-Back Date.

   When applying for Medicaid, there is a 5-year look-back period for all improper transfers. The penalty period for making improper transfers starts running when the Medicaid applicant has applied, and otherwise been found eligible, for assistance. Large transfers (e.g., $1,000 +) are rebuttably presumed to have been made in order to hasten Medicaid eligibility and are, therefore, considered improper. However, since the presumption is rebuttable, if a large transfer can be shown to have been made for non-Medicaid related reasons, it should not be treated as improper and should not cause a penalty period to be imposed. OAC § 5160:1-6-06(A).

2. Calculation of Penalty Period.

   If an improper transfer has been made, a period of "restricted coverage" for Medicaid benefits is calculated. The period of restricted coverage is calculated by dividing the amount of the improper transfer by the average monthly private cost of care in a nursing facility which is currently $6,905. OAC § 5160:1-3-07.2. The penalty period is imposed as of the first day of the month in which the person has applied for and otherwise been found eligible for Medicaid. Rather than create a penalty period which includes a fractional month, the person's "patient liability" is simple increased the first month of eligibility. OAC § 5160:1-6-06.

EXAMPLE

Paul applied for nursing home Medicaid benefits on August 25, 2021. On September 20, 2015, he gave his son $500,000, hoping to qualify for Medicaid as soon as possible if he needed nursing care. He entered a nursing home on March 1, 2021 and gave his son another $10,000. Paul privately paid for his care from March 1, 2021 to the end of August, 2021, when he ran out of money.

The September 20, 2015 gift was made more than 5 years before the Medicaid application was filed, and, therefore, does not fall within the look-back period. Accordingly, it is no longer treated as an improper transfer. However, the March 1, 2021 gift of $10,000 creates a penalty period of 1.4 months ($10,000 ÷ $6,905 = 1.4). The penalty period will run from August 1, 2021 to August 31, 2021. In

addition, Paul will have an increase to his monthly patient liability for September, 2021 in the amount of $3,095 [the amount of the gift minus (the average monthly private pay rate for a nursing facility in Ohio times the number of whole months of ineligibility)][$10,000 – ($6,905 x 1) = $3,095].

3. Exceptions to the Improper Transfer Rule.

   The following are permissible transfers:

   i. Transfers of non-homestead property to a blind or disabled child.

   ii. Transfer of the residence to the community spouse.

   iii. Transfers to a trust established for the sole benefit of an individual under age 65 who is blind or totally disabled.

   iv. Transfers of the residence to the individual's spouse, child under age 21, adult child who is blind or disabled, sibling who had an equity interest in the residence for at least one year, or adult child who lived with applicant for at least 2 years and provided care which delayed institutionalization. OAC § 5160:1-6-06(D).

4. Undue Hardship.

   A person who is ineligible for Medicaid because of an improper transfer can still qualify for assistance upon a showing of undue hardship. To qualify for the undue hardship exception, the applicant must show, by clear, convincing and credible evidence, that he or she has made "a good faith attempt to recover or make the [transferred] resource available" and that an undue hardship will be created. The person (or his or her authorized representative) must first exhaust all legal remedies and appeals to the planned discharge and the facility must document that it has exhausted all legal remedies to collect or recover improperly transferred assets. OAC § 5160:1-6-06.6.

5. SPLIMPA - Transfer of Additional Resources to Community Spouse.

   If a community spouse's income is below the MMMNA (after also taking the maximum MIA), he or she can opt to take an additional amount of the assets from the institutionalized spouse (over and above the CSRA) in order to generate more income for the community spouse. The amount of additional resources which can be allocated to the community spouse is calculated based on how much additional income the additional assets would generate. OAC § 5101:6-7-02.

For instance, if the community spouse's MMMNA were $2,200 and he or she had $800 per month in income, the community spouse would be entitled to an MIA from the institutionalized spouse of $1,400. If the institutionalized spouse only had income of $900/month, the community spouse could take additional assets which could be used to generate an additional $500 in income. This is called the "SPLIMPA" option because the community spouse must obtain at least three written estimates of the cost of a "single premium lifetime immediate monthly payment annuity" to qualify for this.

In order to use the SPLIMPA option, the applicant's initial Medicaid application is denied and that denial must be appealed. An appeals officer is then presented with the annuity estimates and approves the Medicaid application.

III. TRUSTS

Because of the use, or misuse, of trusts in Medicaid planning, there are a number of rules specific to trust planning:

A. Medicaid Qualifying Trusts.

These trusts, established prior to August 11, 1993, are not treated as countable resources if there is no discretion to invade principal for the applicant.

B. Self-Settled Trusts – After August 11, 1993.

These trusts are considered countable resources to the extent income and/or principal can be used for the applicant's benefit. To the extent irrevocable transfers are made into such a trust and cannot be used for the applicant's benefit, an improper transfer has occurred.

C. Exempt Trusts.

1. Special Needs Trusts. These are established for disabled persons under age 65. Requires Medicaid payback. See OAC § 5160:1-3-05.2.

2. Qualifying income trusts ("QITs"). These trusts, also referred to as "Miller Trusts," are used to provide supplemental benefits for a Medicaid recipient if the recipient's income exceeds the Medicaid income limit. T**hese trusts are required for any Medicaid recipient who has more than $2,382/month in gross income.**

3. Pooled Trusts. A trust established by a non-profit entity in which all participants' assets are pooled and used for supplemental benefits. There is a Medicaid payback provision.

4. Supplemental Services Trusts. Established by a third party as a testamentary trust (parent, usually) for the benefit of a person receiving benefits through MR/DD or county board of mental health. Maximum limit of $254,000 (for 2021)(increases by $2,000/year). At least 50% of trust assets must be paid to State at beneficiary's death. See ORC §5815.28(E).

5. Trusts established by someone else for the applicant's benefit and which are totally discretionary.

6. Trusts established by Will for the benefit of the surviving spouse.

IV. ANNUITIES

A. Eligibility Criteria for Annuities.

1. Under OAC § 5160:1-6-06.1, effective September 1, 2017, annuity purchases are required to be reviewed as an improper transfer unless: (i) the State of Ohio is the primary remainder beneficiary, up to the total amount of medical assistance furnished to the Medicaid applicant; or (ii) the State of Ohio is named as the secondary beneficiary to the surviving spouse, up to the total amount of Medicaid assistance furnished to the Medicaid applicant, and primary beneficiary if the spouse disposes of a remainder for less than fair market value.

B. Annuity Breakthrough.

1. In recent years, many Medicaid applicants have used the annuity rules to purchase immediate annuities for the CS, trying to increase the CS' income while also spending down assets in order to qualify the IS for Medicaid. The Ohio Department of Job and Family Services ("ODJFS") has denied many of those applications on the basis that a married couple is not permitted to convert countable resources in excess of the CSRA into an income stream for the CS without a "SPLIMPA" (single premium lifetime immediate monthly annuity) hearing. Under OAC Section 5101:1-39-07, a married couple is not permitted to convert countable resources in excess of the CSRA amount into income for the CS unless the couple goes through a SPLIMPA hearing. Even if the couple goes through the SPLIMPA process, the amount of excess assets which can be used for the CS' benefit is limited, as set forth above. This proscription against buying annuities for the CS, even when the annuities otherwise meet the very stringent requirements set for annuities to be Medicaid "compliant", is currently the source of significant litigation.

2. After much litigation on the issue, the State of Ohio Department of Medicaid issued MEPL No. 112, a copy of which is attached as Exhibit "B", which clarifies that Ohio will now respect annuity purchases so long as they comply with all regulatory requirements. This is a breakthrough for consumers, insofar as they now have clarity as to what this portion of the Medicaid regulations means.

V. IRAs AND QUALIFIED RETIREMENT ACCOUNTS.

IRAs and other qualified retirement accounts, which are not in payout status, are generally considered countable resources, without any reduction for income taxes which may be due when distributions are taken. A retirement account, such as an IRA or 401(k) account, will be typically considered exempt only if it cannot be cashed-in, if an individual must terminate employment to cash it in, or if it is in payout status. See OAC § 5160:1-3-03.10.

VI. ESTATE RECOVERY

A. Probate and Non-Probate Assets Are Subject to Estate Recovery.

Ohio is required by the federal government to seek recovery for what it has paid in Medicaid benefits. Prior to July 1, 2005, Ohio sought recovery only from a decedent's probate estate, although the State had been very aggressive in asserting that any transfers which avoided a probate administration were fraudulent as to the State's claim for reimbursement. As of July 1, 2005, however, the State is authorized to seek recovery from both probate and non-probate assets that pass from a Medicaid recipient or his or her surviving spouse. See OAC § 5160:1-2-07.

B. Other Estate Recovery Requirements.

In order for the State of Ohio to be entitled to recovery, the Medicaid recipient must have been at least 55 years old when services were rendered and lived in a nursing facility or received home and community-based services. Recovery is sought against the "estate" (which includes non-probate assets) of the survivor of the Medicaid recipient and his or her surviving spouse. Recovery can only be sought if there is no surviving child under age 21 or who is blind or permanently disabled. Estate recovery can also be waived upon a demonstration of undue hardship.

C. Liens.

Effective September 29, 2005, liens can be filed by the State of Ohio against real estate owned by an institutionalized individual and/or his or her spouse with certain exceptions. No lien may be imposed against the residence of the Medicaid

recipient if any of the following people live there: the Medicaid recipient's spouse, children (under age 21 or blind or disabled), or sibling who had an equity interest in the property and resided there at least one year immediately before the Medicaid recipient's entrance to the nursing home.

VII. PLANNING IDEAS.

1. Gifts + Annuities.

EXAMPLE

On July 1, 2021, Bertha Bush, age 70 and in a nursing home, has life savings of about $230,000. She transfers $115,000 to her children. She still has about $115,000 in cash assets which she immediately uses to buy herself an annuity of $6,400 per month for 18 months. Her monthly cost of care in the nursing home is $7,500 and her other income is $1,000 per month. The $115,000 transfer should make her ineligible for about 16.9 months, just long enough for her annuity to help her pay for her care through the period of ineligibility. Her children will need to help cover any monthly shortfall at the nursing home for the 16.9-month penalty period. This is a small price to pay compared with the value of the $115,000 gift. **Please note that since the income is more than $2,382 per month, Bertha will need a QIT!**

2. Pooled Medicaid Payback Trust.

Money placed into Pooled Medicaid Payback Trusts will not be counted against a Medicaid applicant's $2,000 resource limit. OAC §5160:1-3-05.2. The reason? When the Medicaid recipient passes away, the money remaining in the trust will pay the state back to the extent the state has paid for his/her care via Medicaid.

So why do it? 2 reasons:

i. The trust pays the state back at the *state* nursing home Medicaid pay rate, which is almost always cheaper than the private-pay rate. Often the rate is $1,500-$3,000/month cheaper.

ii. The Medicaid recipient can draw on the trust to improve his/her quality of life. Remember, while on Medicaid, the recipient only gets to keep $50/month from his/her income. Often, that will not even cover a couple of trips to the beauty parlor. Yet, with a pooled trust in place, the recipient can draw on it each month to buy things for his or her room such as a new television or

specialized chair. The Medicaid recipient can use the funds to go out to dinner or buy other supplemental needs. Best of all, the Medicaid recipient can use the funds to upgrade to a private room while remaining on Medicaid.

EXAMPLE

Take Bertha Bush again. She has $230,000. Instead of gifting, she establishes a Pooled Medicaid Payback Trust and places her assets in the trust. She lives 2 years in the nursing home, with Medicaid paying her cost of care, before passing away. Had she paid privately, she would have spent $7,500 per month. However, the state payback rate for her nursing home is only $5,500. After subtracting the $1,000/month of her income that went to help pay her bill, the payback from the trust will be $4,500 per month. $4,500 x 24 = $108,000. $108,000 is taken out of the $230,000 to pay the state back leaving $122,000. Bertha can then leave that $122,000 to her heirs/beneficiaries. Had she paid privately she would have spent an additional $48,000 in medical bills, leaving a smaller legacy to her children. Alternatively, she could have taken $2,000/month out of the trust to make up the difference between the private room and the Medicaid rate. This way she could have remained in a private room while on Medicaid (which typically only pays for a semi-private room).

The risk inherent in this plan is that all of the funds in the Pooled Medicaid Payback Trust might need to be paid to the state if Bertha lives long enough.

3. Gifting + VA Application.

There is a benefit available to veterans and their surviving spouses called the "VA Aid and Attendance Benefit". It is a benefit which is available to any veteran, or the veteran's surviving spouse, where the veteran or surviving spouse has unreimbursed medical expenses. To be eligible, the applicant's unreimbursed medical expenses must exceed his or her ability to pay, the veteran had to have served in the military for at least 90 days (one of which had to be during a time of "war"), and the veteran had to have been honorably discharged. For 2021, the actual benefit can be as high as $2,295/month for a veteran and living spouse; $1,936/month for a single veteran; and $1,244/month for a surviving spouse.

The VA Aid and Attendance Benefit can be dovetailed with a Medicaid application to help pay for a Medicaid applicant's cost of care during a period of restricted coverage for Medicaid purposes.

VIII. MEDICAID – PASSPORT & ASSISTED LIVING WAIVERS

A. PASSPORT (Medicaid to pay for Home Care)

1. Process - Must be found care eligible by the Council on Aging as well as financially eligible through the Ohio Department of Job and Family Services.

2. Eligibility- To be eligible for Passport:

    a. The individual is 60 or older and agrees to participate in PASSPORT.

    b. Must have assets less than $2,000 and monthly income less than $2,382 (unless a QIT is in place).

    c. The cost of the services over a year must not exceed an annual cost cap, which is 60% of the total Medicaid cost of nursing home care (unless health declines while on PASSPORT, requiring 100% of the Medicaid cost).

    d. The needed services are not readily available through another source at the level required to allow the individual to live in the community.

    e. The individual's health related needs can be safely met in a home setting as determined by the PAA.

    f. Prior to PASSPORT enrollment, the attending physician must approve that the services are appropriate to meet the individual's needs.

    g. The individual must be determined to meet the criteria for an intermediate or skilled level of care in accordance with rule 5101:3-3-05 or 5101:3-3-06 of the Administrative Code and, in the absence of PASSPORT, would require NF services.

    h. PASSPORT has slots available.

    i. The individual must not be under Medicaid or Medicare hospice at the time of enrollment.

j. If eligible, the following services may be available: adult day services; chore services; emergency response system services; home medical equipment and supplies services; homemaker services; minor home modification, maintenance and repair services; nutrition consultation services; personal care services; social work counseling; transportation services; home delivered meal services; independent living assistance services; and some non-medical transportation services.

B. Assisted Living Waiver (Medicaid to pay for Assisted Living)

1. Process: Similar to Passport**.** Must be found care eligible by the Council on Aging as well as financially eligible through the Ohio Department of Job and Family Services.

2. Eligibility. To be eligible:

i. The applicant must be 21 or older.

ii. Must have assets less than $2,000 and monthly income less than $2,382, unless a QIT is used.

iii. The individual must have an intermediate or skilled level of care (needs help with at least 2 activities of daily living).

iv. If the individual requires skilled nursing care beyond supervision of special diets, application of dressings, or administration of medication, it must only be required on a part-time, intermittent basis for not more than a total of one hundred twenty days in any twelve-month period. A part-time, intermittent basis means that skilled nursing care is needed for les less than eight hours a day or less than forty hours a week.

v. The individual must be: (i) a nursing facility resident who is seeking to move to a residential care facility and would remain in the nursing facility for long term care if not for the assisted living waiver; or (ii) participates in another waiver program (like PASSPORT or regular Medicaid) and would move to a NH if not for the wavier; or (iii) has resided in a residential care facility and privately paid for 6 months.

vi. The cost of the services over a year must not exceed an annual cost cap, which is 60% of the total Medicaid cost of nursing home care.

vii. The individual must have the ability to make room and board payments at the current supplemental security income (SSI) federal benefit level minus fifty dollars.

viii. The individual is age twenty-one or older at the time of enrollment.

ix. There are Assisted Living Slots Available.

x. The individual's health related needs, as determined by the PASSPORT administrative agency, can be safely met in a residential care facility.

xi. The individual may not already be enrolled in hospice.

EXAMPLE

Mary has resided in an ALF for 7 months. Her assets are down to $1,900 and she makes $2,400 income per month in Social Security and Pension. Her income is too high for her to be eligible for the Assisted Living Waiver (the income cap is $2,382). Therefore, she establishes a Qualifying Income Trust and each month, after her income is deposited into her regular checking account, she writes a $100 check to her Qualifying Income Trust account. This brings her countable income down to below $2,382/month and she is then income and asset eligible to receive the Assisted Living Waiver.

IX. MEDICAID – TOP 10 REASONS TO FILE AN APPEAL

1. No 10-day letter.

2. No period of restricted coverage calculated where there is an improper transfer and/or no credit given for returned gifts.

3. Payments to child were for services and were not a gift.

4. Countable real property was listed for sale at an amount which was not *exactly* at the county auditor's value.

5. Deposit at a retirement community is treated as a life lease or a countable resource.

6. Medicaid caseworker does not process case in a timely fashion.

7. Caseworker treated income as a countable resource in month it was received.

8. Property contiguous to exempt house is treated as a countable resource.

9. Medicaid office fails to properly comply with a State Hearing or Administrative Appeal Decision.

10. County treats a transfer as improper even where it has been rebutted by clear and convincing evidence.

X. Additional Resources.

A. Immediateannuities.com. This website provides good estimates of how much an annuity might cost or how much of a monthly annuity can be produced with a given single premium payment. The estimates available on the website are useful in counseling clients as to what the approximate cost of an annuity might be.

B. Medicaidannuity.com. This is the website for Krause Financial Services. Not only does Krause Financial Services sell annuities as short as three months in length, its website can be a good resource for both attorneys and their clients to help them determine whether an annuity can be helpful as a part of a Medicaid plan.

C. http://www.odjfs.state.oh.us/HearingsAppeals/. This is the web address to search for the Ohio Department of Job and Family Service's state hearing and administrative appeal decisions. Cases can be searched by topic and is an invaluable resource to better understand the Medicaid regulations.

Exhibit “A”

5160:1-3-05.7 Medicaid: burial spaces.

(A) This rule describes the treatment of burial spaces for the purposes of determining eligibility for medical assistance.

(B) Definitions.

(1) "Agreement," for the purpose of this rule, means a contract with a burial provider for a burial space held for the individual or a member of the individual's immediate family.

(2) "Burial space," means a burial plot, gravesite, crypt, mausoleum, casket, urn, niche, or other repository customarily and traditionally used for the deceased's bodily remains. The term also includes a contract for care and maintenance of the gravesite, sometimes referred to as an endowment or perpetual care and necessary and reasonable improvements or additions to such spaces, including but not limited to vaults, headstones, markers, or plaques, burial containers (e.g., for caskets) and arrangements for the opening and closing of the gravesite.

(3) "Immediate family" includes the individual's:

(a) Parents, including adoptive parents;

(b) Minor or adult children, including adoptive and stepchildren;

(c) Siblings, including adoptive and stepsiblings; or

(d) Spouses of immediate family if the marriage is in effect at the time of determination or renewal of eligibility for medical assistance.

(C) A burial space or burial space contract, described in rule 5160:1-3-05.6 of the Administrative Code which represents the purchase of a burial space held for the burial of the individual, the individual's spouse, or any other member of the individual's immediate family is an excluded resource, regardless of value.

(D) A burial space is held for an individual when someone currently has:

(1) Title to and/or possesses a burial space intended for the individual's use (e.g., has title to a burial plot or owns a burial urn stored for his own use); or

(2) A contract with a funeral service company for specified burial spaces for the individual's burial (i.e., an agreement which represents the individual's current right to the use of the items at the amount shown).

(E) Until the purchase price is paid in full, a burial space is not held for an individual under an installment sales contract or similar device and the installment payments shall be considered burial funds in accordance with rule 5160:1-3-05.6 of the Administrative Code.

(F) Administrative agency responsibilities. The administrative agency shall:

(1) Determine whether the burial space is held for the individual or member of the individual's immediate family if the agreement shows the purchase of a specified burial space at a specified price.

(2) Of items that serve the same purpose, exclude only one per person. For example, exclude a cemetery lot and a casket for the same person, but not a casket and an urn.

(3) If the agreement calls for installment payments, determine whether the value of the burial space must be treated as burial funds in accordance with rule 5160:1-3-05.6 of the Administrative Code.

Replaces: 5160:1-3- 05.7 **Cite as Ohio Admin. Code 5160:1-3-05.7** Effective: 8/1/2016

Exhibit "B"

Ohio Department of Medicaid
John R. Kasich, Governor
John B. McCarthy, Director

Medicaid Eligibility Procedure Letter No. 112

Effective Date:	**February 26, 2016**
OAC Rules:	**5160: 1-3-05.3 and 5160:1-3-07.2(G)**
To:	**All Medicaid Eligibility Manual Holders**
From:	**John B. McCarthy, Director**
Subject:	**Treatment of Annuities**

Reason for Change: The Ohio Department of Medicaid (ODM) is revising its policy about how to treat the purchase of an annuity by an individual or the individual's spouse after the date of institutionalization, but before the eligibility determination date, in an amount that is above the Community Spouse Resource Allowance (CSRA).

Prior Policy: Currently, caseworkers are required to treat the purchase of the annuity by an individual or the individual's spouse after the date of institutionalization, but before the eligibility determination date, as an improper transfer if the purchase price is above the CSRA.

New Policy: Effective immediately, the purchase of annuity by an individual or the individual's spouse after the date of institutionalization, but before the eligibility determination date, in an amount above the CSRA shall not be determined improper if the purchase of the annuity meets the requirements listed in Ohio Administrative Code 5160:1-3-05.3. Those requirements include, that the State of Ohio be named as a remainder beneficiary in the correct position.

Action Required: Effective immediately, when determining eligibility for long-term care services, caseworkers must determine whether the purchase of an annuity meets the requirements listed in Ohio Administrative Code 5160:1-3-05.3. One of those requirements is that the State of Ohio must be named as the primary remainder beneficiary (or as the second remainder beneficiary after a community spouse or minor or disabled child) for at least the value of the Medicaid assistance provided. If the annuity does not name the State of Ohio as a remainder beneficiary in the correct position, the annuity must be treated as an improper transfer. The full purchase price of the annuity is the amount that is subject to penalty. If any of the other applicable requirements listed in Ohio Administrative Code 5160:1-3-05.3 are not met, the purchase of the annuity must be treated as an improper transfer. The full purchase price of the annuity is the amount that is subject to penalty.

Please contact ODM Eligibility Technical Assistance at Medicaid_Eligibility_TA@Medicaid.Ohio.gov for further assistance or clarification regarding the processing of specific cases. If additional assistance is needed, please contact the CRISE Help Desk at CRISE_HELPDESK@jfs.ohio.gov.

This information is also available on the Internet. The information may be accessed on the ODM website under the header "Medicaid Policy" and found under Behavioral Health, Eligibility, & CHIP - Medicaid Eligibility Procedure Letter (MEPL):
http://www.medicaid.ohio.gov/RESOURCES/Publications/ODMGuidance.aspx#1535541medicaid-policy