MEDICAID UPDATE

"DRA 2008 - How is it going so far?"

THE ESTATE PLANNING COUNCIL OF
HAMPDEN COUNTY
DECEMBER 9, 2008

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THE NUMBERS FOR 2008-2009

	2008	2009
1. Federal Standard Allowance (Changes July 1st of each year)	$1,750.00	$1,750.00
2. Maximum Minimum Monthly Maintenance Needs Allowance (MMMNA) without a fair hearing	$2,610.00	$2,738.00
3. Maximum Community Spousal Resource Allowance (CSRA)	$104,400.00	$109,560.00
4. Average Daily Cost of a Nursing Home (Divisor)	Pre-May 1, 2008: $256.00 ($7680 per month)	Since May 1, 2008: $267.00 ($8010 per month)

NEW DEVELOPMENTS

There have been significant statutory and procedural changes to the eligibility rules implemented in 2008 which have impact on how we counsel our clients. In addition, it appears that there has been a fundamental policy shift within MassHealth to interpret existing regulations and practices in the most restrictive and in some cases new and never before restrictive ways. The Medicaid application process has now, more than ever before, become an adversarial proceeding.

I. STATUTORY CHANGES

A. Massachusetts General Laws Chapter 118E, Section 61. The Medicaid eligibility statute has been amended to override the Defense of Marriage Act ("DOMA")provisions, 1 USCA, Section 7 with respect to the interpretation of marriage for Medicaid eligibility purposes in Massachusetts.

MGL Chapter 118E Section 61 states "notwithstanding the unavailability of federal participation, no person recognized aS spouse under the laws of the Commonwealth of Massachusetts shall be denied benefits otherwise available pursuant to 1 USCA, Section 7 or any other federal non-recognition of spouses of the same sex." The statute was signed by Governor Patrick on July 31, 2008 and is now in effect.

B. Mass General Laws 118E, Section 23A. The statute requires financial institutions to furnish five years worth of financial records without charge. Specifically, the statute states:

> Upon written request signed by an authorized employee or agent of the division, the treasurer of a financial institution shall provide, without charge, the deposit and withdrawal records of the preceding 5 years for an applicant for or recipient of medical assistance under this chapter to any authorized employee or agent of the division or to the applicant or recipient. A treasurer who unreasonably refuses to provide these records within the time limit provided in the request or who willfully provides false information in the reply shall forfeit $50 to the commonwealth.
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> For the purposes of this section, "financial institution" shall mean a national bank, federal savings bank, federal savings and loan association or federal credit union, if such bank, association or credit union is authorized to transact business and has its main office or a branch office in the commonwealth; or a trust company, credit union, co-operative bank or savings bank, if such company, credit union or bank is organized and exists under the laws of the commonwealth or any other state of the United States or is otherwise authorized to do business in the commonwealth and has its main office or a branch office in the commonwealth; or a benefit association, insurance company or safe deposit company authorized to do business in the commonwealth.

The new law requires banks to supply records without cost if the applicant presents a signed request from a MassHealth worker requesting such information.

C. Mass General Laws 111, Section 70E. The statute requires adequate discharge planning and a mechanism to challenge a discharge or transfer based upon inappropriate care plans. Specifically, MGS 111 Section 70E states

> "A resident who requests a hearing pursuant to Section 48 of Chapter 118E, shall not be discharged or transferred from the nursing facility licensed under Section 71 of this Chapter unless a referee determines that the nursing facility has provided sufficient preparation and orientation to the resident to ensure safe and orderly transfer or discharge from the facility to another safe and appropriate place."

This statute was signed by Governor Patrick on August 5, 2008 and is now in effect.

II. MASSACHUSETTS ELIGIBILITY OPERATION PROCEDURAL CHANGES

A. State Changes in Operations Policy.

1. Calculations of the Life Estate/Remainder Interests . Previously, life estates and remainder interests were calculated differently for Medicaid purposes than for Internal Revenue Service purposes. Generally, the calculation was more favorable for the sale or gift of a remainder interest under the Medicaid rules since the tables used by Medicaid were weighted more favorably to value the life estate at a higher value since the life estate was typically retained by the elder, the penalties imposed by the transfer were generally lower, based upon the Division's tables. Based on Eligibility Memo 07-18 which became effective December 1, 2007, the Division requires calculation of the value of the life estate remainder interest to use Internal Revenue Service Table S "Single Life Factors Based on Life Table 90 SM" on the current interest rate determined under Section 7520. The difference in calculation is as follows:

> December, 2008, 7520 rate is 3.45%. For property worth $200,000, the value of an 81 year old's Life Interest would be $44,184 and the Remainder Interest would be worth $155,816.
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> Under the prior method used by the Division, the Life Estate would be worth $83, 934 and the Remainder Interest would be worth $116,066.

2. Personal Care Contracts. Personal care contracts have come under significant attack in the last year. Under Eligibility Operations Memo June, 2008 all personal care contracts (which constitute any contracts with future payments or future services) are considered disqualifying transfers to the extent there is no ascertainable fair market value. Further, all personal care contracts, promissory notes and annuities must be sent to the legal

division for review before the eligibility worker can proceed with the eligibility determination. (07-14B). The Division is litigating virtually all of the personal care contracts and they are being denied at the fair hearing level and requiring an appeal to the Superior Court under MGL 30A. While in the early stages of the administrative appellate process at the trial court level, several have been denied and one has been allowed and remanded. See Irene Lusignan v. Dr. Judy Ann Bigby, Bristol SS Superior Court Civil Action No. BBRC 2007-01114. The Division appears to hold strongly to the premise that while a person is in a nursing home there is no additional value added by a personal care contract and questions the value of the services given while in the community. The Court in the Lusignan case has recognized the validity of the contract but remanded for further hearing that the determination of fair market value since that issue was not reached at the fair hearing. The Division's position has had an obvious, and from the Division's standpoint, desired chilling effect upon this practice.

3. Annuities. The Division has clarified that the Community Spouse can be the owner and Annuitant and does not have to name the Commonwealth of Massachusetts as beneficiary of the Annuity. The language of the annuity regulation was changed from annuitant to institutionalized individual to clarify this. See 130 CMR 520.007 (j) (2) (a) (1).

4. Economic Stimulus. The economic stimulus check received by an institutionalized individual will not count as countable income in the month it is received and for the period of two months thereafter. Accordingly, if an institutionalized individual made a disqualifying transfer of the stimulus check within that time period it would not constitute a disqualifying transfer. After this time the traditional rules will apply.

B. Federal Interpretation Changes. The Center for Medicare and Medicaid Services ("CMS") issued a state agency regional bulletin (No. 2008-05) to Medicaid state agencies in May of 2008 stating that "a Pooled Trust established by an individual age 65 and older is not exempted from the transfer of assets provisions." Pooled Trusts, a vehicle specifically authorized under 42 USC 1396p(d)(4)(c) has been used in increasing favor since DRA 2006 primarily for unmarried individuals applying for Medicaid and whose assets were over the threshold limits.

Specifically, a Pooled Trust enables an individual to transfer excess assets to a charitable agency that has a Pooled Trust and establishes a separate account for the benefit of the institutionalized individual. During that institutionalized individual's lifetime, the Pooled Trust must use the resources to purchase items and services for fair market value which are for the sole benefits of the disabled individual. Upon the death of the disabled individual, the charitable institution administering the trust is entitled to a percentage of the remaining funds and in some cases the entire remaining balance) and next Medicaid is entitled to reimbursement for the amount of services it has rendered. Should there be an excess balance, after payment of the Charity and Medicaid, the disabled individual sets forth their dispositive provisions in the joinder agreement executed at the time they joined the Pooled Trust. In addition to filing the Medicaid application, and the Pooled Trust documentation, a disability rider must also be filed with the application which must be approved by the disability evaluation service for the Commonwealth of Massachusetts in order to qualify. The Commonwealth of Massachusetts has not implemented the policy announced by CMS issued in May. The bulletin appears to be flawed on several grounds:

1. It appears that the state Medicaid manual Section 3259.6A which was amended by HCFA Transmittal No. 64 (November, 1994) contains detailed provisions describing when the funding of a trust constitutes a disqualifying transfer. The transfer to an irrevocable trust under which payments can still be made to the individual is not treated as a Medicaid disqualifying transfer under that rule. The assets are deemed to be countable as an asset available to the individual. Congress has made it clear that a Pooled Trust may contain the assets of an individual who is disabled, with no age limit are not countable. It seems inconsistent to find that a transfer to a pooled trust is a disqualifying transfer and triggers disqualifying transfer penalties, when a disabled individual can be beneficiary of a Pooled Trust and not have the assets of the Pooled Trust be countable.

2. The proposed policy set forth in the bulletin would penalize only those 65 and over who fund a Pooled Trust and not those under age 65. An argument similar to this was successfully challenged when the Division applied more stringent financial eligibility criteria to individuals 65 and older than those under age 65 with regard to obtaining personal care attendant services. The Commonwealth of Massachusetts settled litigation and agreed to apply the same eligibility criteria to all disabled individuals regardless of age. See Hermanson v. Commonwealth of Massachusetts, Civil Action No. 00-CV-30156MAP.

From a policy perspective it also does not make sense to penalize individuals over age 65 from funding a Pooled Trust in that most agencies and funding mechanisms are now focused on assisting elders to safely receive care at home. If elders have spent down to $2,000.00 to remain in the institution, and are then transferred home, they will do without sufficient resources to pay for their transition to home. However, if they have transferred their assets to a Pooled Trust they retain the option to return home and have the trust pay for the services that they require. The Americans with Disabilities Act requires states to provide service in the most integrated setting appropriate to the needs of the qualified individual with disabilities. See 28 CFR Section 35.130(d). In Olmstead v. L.C. 527 US 581, 591-592 (1999), the US Supreme Court considered this integration mandate regulation and concluded that it was required by the underline a purpose of the ADA stating "that unjustified institutionalization of persons with disabilities is a form of discrimination" Olmstead at 2187.

The impact of the change in policy and procedures outlined above has significantly affected the options and planning tools available to individuals and couples applying for assistance from the Division of Medical Assistance.

III. **LITIGATION UPDATE**

The days of the quiet estate planning and elder law practice may have gone the way of the horse and buggy. Today, filing a Medicaid application is the first salvo in a litigation posture in many instances. Policies change and priority within the Division shift with little if any notice and techniques that have been used successfully for decades are now subject to challenge.

For example:

A. Purchase of Remainder Interest. A child purchased remainder interest from the parent. While not paying cash, the child executed a promissory note, paying appropriate interest and the promissory note met all of the criteria set forth in the regulations to be a valid promissory note (not exceeding actuarial life expectancy, equal payments of principal, non-cancellable, etc.) and, child was making payments as required under the promissory note to the elder. While all of the regulations were complied with at each step of the transaction i.e. valuation of a life estate and remainder interest, terms of promissory note, and payment was actually being made, nevertheless, the Division has still challenged this and is in the appeal process in Superior Court. The Division has taken the position that the promissory note was not reasonably enforceable, in spite of the fact that (1) it was being paid, (2) would continued to be payable even if the elder died as it would be an asset of the elder's estate , and (3) the Division could seek payment in through estate recovery as a creditor of the estate. It is up to the Superior Court to sort through this issue.

B. Personal Care Contracts. There has been a significant amount of litigation surrounding personal care contracts. The one bright light to date has been Irene Lusignan vs. Dr. Judy Ann Bigby, In that case the Superior Court held the contract was deemed to be valid and remanded the case back to the Division to determine the fair market value of the services rendered. However, other cases have been denied 30A appeal level. The Division standard arguments are (a) services are duplicative, (b) the services are not valued properly, (c) there is no one to police the contract, (d) these are services that would have been performed any way and (e) it is not a valid contract.

While it does appear that personal care contracts have been under heavy artillery, many of the arrangements have not been carefully crafted, or if carefully crafted, not well executed. A properly drafted personal care contract with appropriate safeguards i.e. evaluation by a geriatric care manager to determine the amount of services required, full delineation and actual performance of such services, or reasonable charge for the services rendered, have not been followed in many of the cases that have been denied to date, it is unclear until we get an appellate decision how the courts will ultimately require the Division to treat them. However, the chilling effect has occurred, because unless practitioners are ready to fight this matter through 30A appeal or further to the appellate level, this planning technique has lost considerable popularity based on the Division's challenges.

Awaiting decision of a 30A appeal, is a case in the eastern part of the estate in which the personal care contract for the services rendered required a payment of $2,500.00 a month. Most of the payments were made prior to DRA becoming effective and continued on for four (4) months afterwards. The Division only challenged as disqualifying transfers those payments made after the DRA. As a practical matter it appears that the Division only challenged the later transfers as the penalty period would have run out on the transfers made prior to DRA and such transfers would be deemed "old and cold". The Division is only challenged the post DRA transfers as the penalty period for such transfers would not have run. This matter was argued recently and is awaiting decision.

C. Reverse Half a Loaf. When DRA first came out it was unclear whether or not the technique of reverse half a loaf would work. In using reverse half a loaf, a disqualifying transfer of assets is made and the institutionalized individuals purchases an annuity in an amount sufficient to cover the cost of care during the disqualification penalty period. Since an annuity in payment mode is income and not an asset, there were practitioners who thought this technique held promise. The individual had no assets, the income from the annuity paid for the care during the penalty period and then the individual would hopefully qualify for assistance. The Division has taken the position that while an individual's nursing home stay is being paid for (whether it is during the time of Medicare eligibility or through payments from income), the penalty period does not begin to run until they are down to $2,000.00 and the date they are otherwise eligible for MassHealth payment. Since the income being paid by the annuity would rendered them ineligible for MassHealth payments under 130 CMR 520..019(G)(3), the Division takes the position that reverse half a loaf technique does not work. This case hinges on the interpretation of the word "payment" and is awaiting judicial interpretation on a 30A appeal in the eastern part of the state.

D. Purchase of a Joint Interest. When an applicant has excess assets, one of the techniques frequently employed is the purchase of exempt assets. Until recently, an individual could purchase a joint interest in the home, or a joint interest in a business venture that generates income used for self-support, and both are exempt assets. The Division has been challenging the purchase of these joint interests saying that it is of no benefit to the elder. The fact that an elder is entitled to have a home as an exempt asset, (and may wish to return home if clinically eligible at some point) does not seem to have deterred the Division's latest draconian disallowance efforts.

E. Income Only Trust. Intentionally defective income only trusts have been a wonderful tool in the elder law planning. The trusts, when properly drafted, allow the elder to retain the IRC Section 121 exclusion from capital gain as well as the 1014 step up in basis (query after 2010?) at death, and avoid estate recovery by the Division. The irrevocable grantor trust proved to be a wonderful mechanism for long term planning when an individual wished to shield certain assets. Typically, our office has, and continues to, use the intentionally defective income only trust when the elder either has sufficient resources or long term care insurance to pay for their care for a minimum period five (5) years (the period of disqualification for the transfer of assets into the irrevocable trust.). While the elder cannot be the trustee, they can be the income beneficiary. The elder can not have any rights to principal within the trust. The Medicaid penalty is triggered when the trust is funded with the property.

The Division has recently challenged such a trust in which the trust made distributions of principal as loans, which raised issues as to whether or not the principal was available to the elder. This matter is currently on a 30A appeal.

PLANNING

So what do we do for planning? It is still critical that the basic tools be in place:

1. Durable Power of Attorney;

2. Health Care Proxy

3. Long Term Care Insurance, if insurable

While these are uncertain times, there are still some techniques that are available without challenge (at least presently) and which we continue to use:

1. The Community Spouse can purchase an annuity with excess assets payable to the Community Spouse and then third parties (i.e. the children)

2, The purchase of a home

3. Purchase of prepaid funeral and burial account

4. The purchase of an interest business property that will generate income for self-support with a conversion of property to business property that would generate income for self-support

5. Transferring assets to the Community Spouse and establishing a supplemental needs trust upon the Community Spouse's death for the benefit of the Institutionalized Spouse established by or through a will.

Techniques that we believe will prevail but are currently under fire:

1. Use of Pooled Trust for disabled individuals aged 65 or over

2. Purchase of joint interest in homes and businesses

3. Personal care contracts that are properly drafted and implemented

HYPOTHETICAL

1. Nancy and Ed have been married for twenty years. It is the second marriage and Ed has children from a prior marriage. Ed, who had retired, owned a home on a lake and the couple used it seasonally. The principal residence was in Ludlow (had been Nancy's originally) and both homes are currently held in joint names as tenants by entirety. Both Nancy and Ed received pensions in their own names and they have approximately $200,000.00 in liquid assets. Ed has moderate to severe dementia and is likely that a nursing home placement will occur in the next three to six months. Ed and Nancy had done some planning previously and they each have a durable power of attorney, health care proxy and sweetheart wills. What would you advise?

2. Jane who is 67, suffers from Huntington's Disease. While mentally competent, her body has deteriorated significantly and she requires 24/7 care. Her needs for care can no longer be met in the assisted living facility where she has resided for the last few years. She has pension and social security income of approximately $3,000.00 a month and assets in the amount of $350,000.00. It has been recommended that Jane go to Western Mass Hospital where her care costs $18,000.00 per month. What would you advise?

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