Medicaid in Indiana for the Aged and Disabled

April 29, 2022

The Senior Law Project

Indiana Legal Services, Inc.

1200 Madison Ave., Suite 300

Indianapolis, Indiana 46225

Impact of COVID-19

- Telephone interviews only
- Case processing for applications is back to normal
- No Medicaid cases being terminated effective March 31, 2020 – until end of month Public Health Emergency (PHE) ends.
- Medicaid benefits cannot be reduced, except that liability payments can be increased effective March 1, 2021.

Impact of COVID-19

- Eligibility rules and procedures cannot be more restrictive than the rules in effect on 1-1-2020, until the calendar quarter after the PHE ends.
- Stimulus checks treated as federal tax refunds.
- Copayments are waived.

How Long Will This Last?

- The PHE was extended April 16, 2022. It will expire July 15, 2022, unless extended again.
- Biden Admin. says it will give 60 days' notice before the PHE expires. States and advocates have asked for more notice.

What Happens When the PHE Ends?

- If the PHE is allowed to expire in July, then terminations & changes can begin August 1, 2022.
- Once the PHE ends, FSSA will have 12 months to return to normal operations.
- FSSA plans to send out 4 notices about the end of PHE before issuing negative notices.
- Initial plan says disenrollments of recipients with resource requirements will be effective 7 months after end of PHE.
- But will some changes be implemented sooner?

Hoosiers on Medicaid

- 2,030,603 persons, about 29.8% of total population, on some category of Medicaid
- About 583,000 more than pre-COVID
- HIP: 769,891
- Medicaid for the Aged, Blind, Disabled
  - Aged: 64,671
  - Blind: 311
  - Disabled: 77,459
- SSI recipients: 140,128
- MED Works: 2,899

Hoosiers on Medicaid

- Breast and Cervical Cancer: 902
- QMB: 55,750
- SLMB/QI: 9,808
- Children: 879,452 children

Background/ History / Context

- 1965 - Medicaid started as a poverty health care program.
- 1972 – Medicaid tied to SSI, a new federal program. But Indiana opted to be more restrictive.
- 1988 – Spousal impoverishment rules enacted, effective Sept. 30, 1989

Background/ History / Context II

- More categories were added over the years to expand coverage
- 2010 – Affordable Care Act. Indiana began HIP as its Medicaid expansion category.
- July 1, 2014 – Indiana became an SSI state.
- March, 2020 – COVID!

What Does It Mean that Indiana is an SSI State?

- SSI recipients automatically receive Medicaid. Some former SSI recipients are protected.
- Follow SSI income & resource methods, with option to be less restrictive (higher income limit, real estate), but not always good fit for Medicaid.
- SSA decisions on disability control.
- State can choose to allow spend down, sometimes referred to as “medically needy;” Not Indiana.
- Covers “institutional” care (nursing home and waiver services) subject to an “income cap”

Where Are the SSI Rules that Indiana Must Now Follow?

- SSI Statute: Title XVI of the Social Security Act, 42 U.S.C. § 1381 *et seq*.
- SSI Regulations: 20 CFR 416
- SSI's Manual: Program Operations Manual System (POMS): secure.ssa.gov/apps10

The IHCPPM

- Indiana Health Care Program Policy Manual - www.in.gov/fssa/ompp/forms-documents-and-tools2/medicaid-eligibility-policy-manual
- Changes made are listed in a transmittals summary; upcoming changes are posted in advance.
- Changes are often just made in the Manual, rather than by a rule change.

Categories of People Covered

- There are about 40 categories of persons covered.
- There are several categories for children, plus for pregnant women and parents, in addition to those for the aged, blind, and disabled.
- Many of these programs use MAGI (Modified Adjusted Gross Income) with no asset (resource) test. E.g., HIP and children's programs.

Medicaid for the Aged, Blind, and Disabled

- Program with the broadest range of services, **including long term care**.
- Does not use MAGI to measure income.
- There is a resource (asset) limit.
- Must qualify as aged, blind, or disabled before consider financial eligibility.

Medicaid for the Aged, Blind, and Disabled

- Aged: Age 65 or Older
- Blind: Specific Vision Criteria
- Disabled: Uses the SSD / SSI definition of disability: Inability to do substantial gainful activity due to impairment expected to last at least one year. SSA's decision on disability controls.

Other Categories for the Aged and Disabled

- Persons on Kidney Transplant List
- Breast and Cervical Cancer Treatment
- Behavioral and Primary Healthcare
- MED Works for the Working Disabled
- MED 4 – Medicare "Buy-In" or Savings Programs (QMB, SLMB, QI, QDW)

Benefits of QMB Category

- Functions like a basic Medicare Supplement Insurance Policy
- Can have both QMB **and** Medicaid for the Aged, Blind, and Disabled
- QMB recipients – Medicaid covers Medicare copays and deductibles even if go to a non-Medicaid provider.

HIP 2.0: Indiana’s Version of Medicaid Expansion

- Catch all for persons age 19-65 without coverage and not eligible for subsidy to purchase health insurance through ACA.
- MAGI used. Income limit of 133% FPL (or 138% once 5% disregard included). No asset test.

HIP 2.0

- Health Savings Account Model. Recipients make deposits to POWER accounts. If income < 100 % FPL, deposits not required, but then have other higher costs.
- Basic Health Services Covered; full Medicaid services for the “medically frail”
- Coverage of nursing home care is limited. If need more than short term stay, need to convert to Medicaid for the Disabled.

Covered Services for the Aged, Blind, and Disabled

- Broad list of covered services
- Courts enforce right to receive medically necessary services
- Even some non- “medical” services are covered, especially through the waiver and MFP programs
- State pays Medicare Part B Premiums – “Buy in”
- Automatically qualify for full extra help for Medicare Prescription Drug Plan (Part D)

Managed Care Required for Some Recipients

- Hoosier Care Connect managed care program began April 1, 2015.
- It does not apply to persons in a nursing home, persons receiving waiver services, or persons on Medicare. (But FSSA wants to implement managed care for this group, possibly coming in 2023.)
- Advocacy may sometimes be needed to get needed care.

Waiver and PACE

- These programs offer additional non-medical services needed to remain out of a nursing home. Recipient must meet “nursing home level of care.”
- Waiver designed to help persons avoid going into nursing home or to move out.
- PACE, a type of managed care, combines Medicare and Medicaid payments; it has limited geographical coverage.
- These programs use the Special Income Level; spousal impoverishment resource rules apply.

Access to Waiver or PACE

- Waiver: AAA (BDDS for DD waivers) assesses to determine eligibility for a "waiver slot." Division of Aging (BDDS for DD) then approves. Is now no waiting list; only wait is processing time. (Are wait lists for TBI and DD Family Supports.)
- PACE: Must meet nursing home level of care and live in a PACE geographical area.

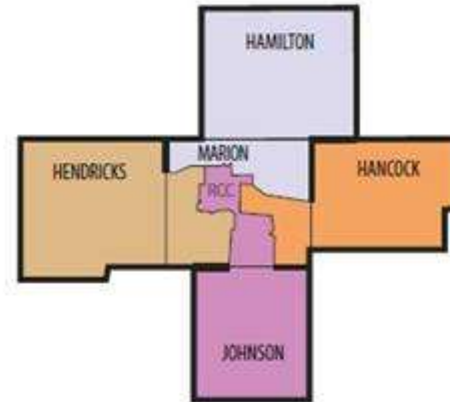
Expedited Waiver Eligibility Pilot Project

- Some AAAs and providers can now assess level of care **and** Medicaid eligibility and obtain immediate Medicaid eligibility without going through application process. May soon be expanded statewide.
- Limited to persons over age 65 or already approved for SSD or SSI
- Income must be below Special Income Level
- Cannot have complex assets. No spousal cases.
- Once approved, DFR to verify information, but once on, cannot terminate during COVID.

Indiana Family & Social Services Administration

Division of Family Resources Regions

RCC =
Regional Change Center



Central Indiana Regions by Zip Code

- **Region 5** (Marion County Central): 46202,46204,46205,46208,46222,46228
- **Region 5:** (Marion County South): 46107,46203,46227,46237
- **Region 6** (Marion County West): 46113,46214,46217,46221,46224,46225, 46231,46241,462344,46254

Central Indiana Regions by Zip Code Continued

- **Region 9 (Marion County North)**: 46226,46235,26236,46240,46250,46256, 46260,46268,46278

- **Region 10: (Marion County East)**: 46201,46218,46219,46229,46239,46259

CONTACT INFORMATION

State Region	E-mail Contact	Regional Manager
Region 1 (Lake)	DFR.region1@fssa.IN.gov	Tamara Rollins
Region 2 (St. Joseph)	DFR.region2@fssa.IN.gov	Leticia Johnson
Region 3 (Allen)	DFR.region3@fssa.IN.gov	Kim Yann
Region 4 (Grant)	DFR.region4@fssa.IN.gov	Stacey Young
Region 5 (Marion)	DFR.region5@fssa.IN.gov	Tim Bolton
Region 6 (Vigo)	DFR.region6@fssa.IN.gov	Felecia Vaccaro
Region 7 (Vanderburgh)	DFR.region7@fssa.IN.gov	Donna Martin
Region 8 (Clark)	DFR.region8@fssa.IN.gov	Denise Harter
Region9 (Tippecanoe)	DFR.region9@fssa.IN.gov	Penny Yoho
Region 10 (Wayne)	DFR.region10@fssa.IN.gov	Mary A. Stenger

CLIENT ELIGIBLITY SYSTEM

- Clients are served by a team located in their region, instead of by staff located across Indiana
- TASK-BASED SYSTEM

PROCESSING OF CASES

- **Document Center:**
  Scan and attach documents to a client's case file
- **Local Offices:**
  Client inquiries, SNAP (food stamp) applications and recertifications, adult Medicaid applications, TANF applications
- **Regional Change Center (RCC):**
  Medicaid only redeterminations, Hoosier Healthwise processing, changes related to a client's case, processing of food stamp interim reports

I.C. 16-36-7

Authority to Access Financial Records and Apply for Public Benefits. My Health Care Representative shall have the authority to apply for public benefits on my behalf pursuant to I.C. 16-36-7-36(6), and shall have access to information regarding my income, assets, and banking and financial records for any purposes pursuant to this instrument.

APPLYING FOR BENEFITS

- BEST: Apply online @ www.in.gov/fssa
- Call 1-800-403-0864 toll-free from 7am to 7pm Mon. – Fri. local time to start an application or ask questions.

APPLYING FOR BENEFITS (cont.)

- Upload documents on the Portal, mail or fax copies of required application documents to the FSSA Document Center, P.O. Box 1810, Marion, IN 46952, or visit a local office to drop off the required paperwork. Fax number is 1-800-403-0864. Alternate fax number: 1-317-972-8970.

- To check on *status* of application, call the toll-free number or go online 24 hours a day

AUTHORIZED REPRESENTATIVE FORM

- Authorized Representative forms can be printed from the online screen during app.
- Name the law office as well as family member (typically, the AIF).
- Print the forms for your client’s signature. You cannot submit the form online while applying at this time.

BENEFITS PORTAL: Check Status

- To check status or report a change you must:

- Set up a user account through the Portal (one time event). You will use the same user ID and password for each client but you must be listed as A/R for the client to access the client's information. For each access, you will need:
  - Case Number, Last Name, Date of Birth, and Last Four Digits of Social Security Number.
  - Note: All of the above items need to be answered to check the status or report a change. Click "Search" after entering the required information.
  - If you are reporting a change, click the Report a Change link on the Case Status screen to print a Report a Change form.

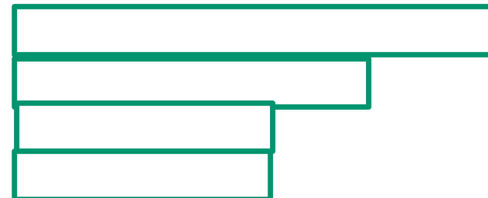
Application's Personal Information

Case Number:*

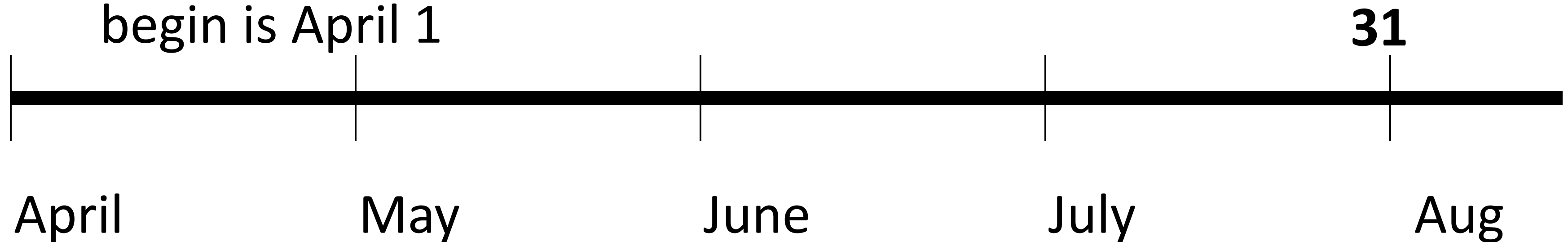
Last Name:*

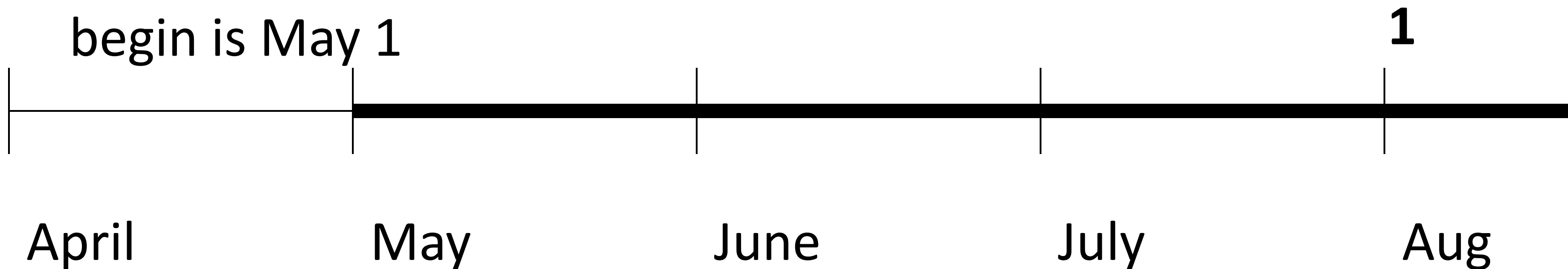
Date Of Birth (MM/DD/YYYY):*

Last Four Digits of SSN:*



TIME LINE: EXAMPLE





MEDICAID'S DEADLINES

- 45 Calendar Days to Process a Case
- 90 Calendar Days to Process if Case Involves A Disability Determination (For Person Under Age 65)

PROCESS FOR DISABILITY CASES

- SSI = automatically eligible for Medicaid
- Applications for SSI are treated as applications for Medicaid as well.

DISABILITY DETERMINATIONS

- Automatic determination of disability for persons determined disabled by SSA.

- If applicant for Medicaid has not applied for SSDI, Medicaid requires applicant to apply for disability.

DISABILITY DETERMINATIONS

- Medicaid will still determine eligibility for applicants who have not received an SSA disability determination.
- SSA determination is final if any conflict between SSA & Medicaid determination.
- If disability determined by MRT, must apply for SSA disability at next scheduled progress report, if there is one.

WHAT HAPPENS IF SSA DISABILITY DETERMINATION IS UNFAVORABLE?

FSSA won't decide on eligibility unless:

- Applicant alleges worsening or new disabling condition and more than 12 months have passed.
- Applicant alleges change of condition in last 12 months & SSA refuses to hear new evidence.

Process for Deceased Applicant IHCPPM §2005.05.10

- Interview can be completed ***only*** by a verified AR
- Interview cannot be completed if there is no AR or court-appointed PR
- No information can be released if no AR or court appointed PR.
- An interested person can ***provide*** info.

AVS

- Financial Institutions, Experian, BMV, Real Estate Records
- 5 year review for new applications; 4 months for reapplications
- AVS pinged when worker wraps up
- E-verification within 13 days

IHCPPM §2025.10.00 RESPONSIBILITY FOR OBTAINING VERIFICATION

The applicant or authorized representative has the responsibility for providing adequate data to substantiate his request for assistance insofar as it is possible.

IHCPPM § 2025.10.00 (cont.)

Good judgment is required on the part of caseworkers when determining what, if any, verifications can be furnished by the applicant or authorized representative. **The worker should accept any reasonable evidence** and will be primarily concerned with how adequately the evidence proves the statements on the application.

IHCPPM § 2025.10.00 (cont.)

- If it is difficult or impossible for the individual or authorized representative to obtain the evidence in a timely manner or the AG has presented insufficient documentation, **the worker MUST offer assistance.**

IHCPPM § 2025.10.00 (cont.)

- When neither the worker nor the applicant/recipient is able to secure the necessary documentation, **the applicant/recipient's statement is to be acceptable information,** except for citizenship status and Social Security number.

MY TOP 12 LIST FOR A SUCCESSFUL PROCESS

1. Send all verifications to the Doc Center OR upload.
2. Send all numbered pages of a document!
3. Number all pages of your packets.
4. Don’t highlight docs
5. **Ask about any resources owned within last 5 years.**

6. Waiver of 30 day free look – funeral plans

“By initialing here (________), the pre-need funeral agreement will be made irrevocable immediately.”

7. Use grid sheets or charts to show how resources are spent down.
8. If gifts are other than cash/checks, make this clear in packet. Use gift chart.
9. Upload documents or send packet in before interview/email packet to worker.

10. Know where your client lives – which NF or AF - & whether facility, and bed, is Medicaid certified.

11. If it's a spousal case, know and prove the snapshot date.

12. Tip from Regional Managers: The mailbox is there for problem solving. – Don't use to check on something you just sent in two days ago!

REDETERMINATION PROCESS

1. An Eligibility Review Form or "Medicaid Mailer is sent to all ARs.
2. The Eligibility Review Form has a deadline on it indicating when the form must be returned unless the recipient is auto-renewed.
3. All A/Rs will receive notice indicating who receives the Eligibility Review Form.

For Office Use ONLY

MEDICAID/HOOSIER HEALTHWISE ELIGIBILITY REVIEW

It is time for the annual review of your eligibility for Medicaid/Hoosier Healthwise. Please take a few minutes to fill out this form and gather the requested documents. If you don't have the papers that we ask for or need more time to get them, complete this form and send it in without them. Attach another page if you need more space.

PLEASE RETURN THIS FORM AND DOCUMENTS TO US NO LATER THAN FEBRUARY 08, 2012.

DON'T FORGET TO SIGN YOUR FORM ON THE BACK OF THE SECOND PAGE.

1. List your address and telephone number(s) where we can reach you. List the community address here. Provide an institution address and/or representative's address in the next questions.

_______________________________ Home phone: ____________________

_______________________________ Other phone: ____________________

Email: ______________________________

1a. If the Review Form is being completed by an Authorized Representative, please provide your name and telephone number(s) where you can be reached. Please update your current address if needed.

_______________________________ Daytime phone: ____________________

2. We show the following persons living in your household. (This includes an eligible member who may be living in a health care or residential facility.) Please make any corrections in the fourth column such as a name change or correct spelling, a correction to birth date or comment "no longer living here". If an eligible Medicaid or Hoosier Healthwise member is no longer living at this address please give the current address if you know it.

Name	Birth Date	Current Status	Corrections
		ELIGIBLE	____________________
		INELIGIBLE	____________________

Additional members are listed on the back of the second page.

2a. For a member living in an institution, please list member's name, and give name and address of the facility:

____

____

MORE ON REDETERMINATION

4. Document Center scans the Redetermination documents into the system.
5. A 2032 Pending Verifications may or may not be sent to the A/R, depending on whether items are still needed.

THE FINAL STEP IN REDETERMINATION

6. A State Worker determines client eligibility.

7. Case MAY BE terminated if the Eligibility Review Form has not been sent in – even if verifications submitted in timely fashion.

LTC INSURANCE MARKET ISSUES

- **LTC market in state of uncertainty**
- **State regulators receiving rate request for more than 100%**
  - **Low interest environment**
  - **Lower lapse rates than companies expected**
  - **Overall mispricing**
- **DOI approves requests while considering**
  - Interests of the consumer
  - Viability of the LTC insurance market

INDIANA PARTNERSHIP PROGRAM

ASSET DISREGARD

Dollar for Dollar ***OR***

Complete Asset Disregard:

2022 - $451,515

2023 - $474,091

I.C. 12-15-1.3-22

- Eliminate current Indiana Long Term Care Partnership Program
- Creates new program, if state plan amendment approved by Health & Human Services
- No approval from CMS at this time!

INDIANA PARTNERSHIP COMPANIES

- Bankers Life & Casualty Co.
- Thrivent Financial for Lutherans

LOOK AT THE LONG TERM CARE INSURANCE POLICY LABEL!

THIS POLICY {CERTIFICATE} QUALIFIES UNDER THE INDIANA LONG TERM CARE INSURANCE PROGRAM FOR MEDICAID ASSET PROTECTION. THIS POLICY {CERTIFICATE} MAY PROVIDE BENEFITS IN EXCESS OF THE ASSET PROTECTION PROVIDED IN THE INDIANA LONG TERM CARE INSURANCE PROGRAM

IHCPPM § 2615.25.15

"The available policy disregard is in effect for the lifetime of the member and their spouse."

IC 12-15-39.6-10

(b) When the office determines whether an individual is eligible for Medicaid under IC 12-15-3, the office shall: (1) make an asset disregard adjustment for any individual who purchases a qualified long term care policy; and (2) if the assets owned by the individual's spouse are included in the individual's eligibility determination, **include the assets of the individual's spouse in the asset disregard adjustment.**

IHCPPM § 2615.25.15

When an insured individual applies for Medicaid, the insurance company is required to provide the client with a service summary report. **This service summary is required documentation that workers will need in order to verify that a policy is qualified under the ILTCP** and the amount of the resource disregard to be applied in the Medicaid eligibility determination of an applicant/recipient.

IHCPPM § 2615.25.15

To view the State Set dollar amounts for certain years, please, see the Total Asset Chart, https://www.in.gov/iltcp/2358.htm

TOTAL ASSET CHART

If the original effective date of your policy is:	The State-Set dollar amount is:	If the original effective date of your policy is:	The State-Set dollar amount is:
1998 or before	$140,000	2011	$263,990
1999	$147,000	2012	$277,190
2000	$154,350	2013	$291,050
2001	$162,068	2014	$305,603
2002	$170,171	2015	$320,883
2003	$178,679	2016	$336,927
2004	$187,613	2017	$353,773
2005	$196,994	2018	$371,462
2006	$206,844	2019	$390,035
2007	$217,186	2020	$409,537
2008	$228,045	2021	$430,014
2009	$239,447	2022	$451,515
2010	$251,419	2023	$474,091

Budgeting When Partnership Policy is Involved

- Income is not protected under a Partnership Policy.

- Use same budget rules as for any applicant/recipient. – A qualified income ("Miller") Trust could be needed.

State Partnership Programs and Reciprocity

THE MEDICAID BASICS
Part 1

- Preparation of good legal documents and review of existing documents
- PAS and LOC
- Medicaid-certified bed!

THE MEDICAID BASICS
Part 2

- Resource rules
- Protection against estate recovery
- Complex transfer of asset laws/evaluation of gifts

THE MEDICAID BASICS
Part 3

- Proper budgeting
- Proper allowances for Community Spouse?
- Miller Trust?

RESOURCE LIMITS

- $2,000 for Single Person
- $3,000 for Married Couple if both in community or both in an institution See later slides for spousal impoverishment limits
- MED Works: $2,000 for single person; $3,000 for married couple

Higher limits for other programs:

  – QMB, SLMB, QI: $8,400 for single person; $12,600 for married couple

NON-LIQUID PROPERTY IHCPPM §2615.95.00

- Automobiles
- Machinery
- Livestock
- Noncash business property
- Buildings & other real property

EXEMPT
PERSONAL PROPERTY

- Household goods, furniture & personal effects
- Personal property used to produce food for home consumption
- Durable medical equipment

Funeral Planning - It was once so simple.

EXEMPTION FOR PREPAID FUNERALS

- Irrevocable funeral trusts or assignment of life insurance for funeral & burial

- BEWARE FUNERAL ACCOUNTS:

  See St. Bd. of Funeral & Cemetery Service v. Settlers Life Ins. Co. 5 N.E.3d 1170 (Ind. Ct. App. 2014)

Definition of “Immediate Family”

SSI: regulations at 20 CFR 416.1231(a)(4):

“An individual's **minor and adult children, including adopted children and step-children; an individual's brothers, sisters, parents, adoptive parents, and the spouses of those individuals.**”

IHCPPM §2640.10.25.40

“Burial spaces” include burial plots, gravesites, crypts, mausoleums, urns, niches and other customary and traditional repositories for the deceased's bodily remains.

Also includes vaults, headstones, markers, plaques, or burial containers and arrangements for opening and closing the gravesite for burial of the deceased.

§2615.25.05.15

If the life insurance policy has been transferred to an irrevocable funeral trust or an irrevocable prepaid funeral agreement, then it can be exempted if it designates the state or the applicant’s/recipient’s estate to receive any remaining amounts after the goods and services are paid for. Please send to PAL for review.

- **Example 2 in IHCPPM §2615.25.05.15:** A member has a life insurance policy with a face value of $20,000. The policy was transferred over to the funeral home and created an irrevocable funeral agreement which **did not** designate the state or the estate to receive any remaining funds after all services have been paid….

- **A transfer of property penalty should be imposed.**

RETIREMENT ACCOUNTS OWNED BY NON-RECIP SPOUSE

IHCPPM §2615.15.00 exempts:

- Individual Retirement Accounts (IRAs)
- Keogh Plans
- 401K Plans
- Pensions, annuities and work related

if owned by non-recipient spouse.

I.C. §4-22-2-13

(a) The chapter “applies to the addition, amendment, or repeal of a rule in every rulemaking action.”

Is rulemaking required?

FSSA: Rulemaking is not required because FSSA's proposed change in policy mirrors federal law and is a correction of interpretation, not a change in policy

IN NAELA: I.C. 4-22-2-3(b)(2) defines a rule as an agency statement designed to have the effect of law that "Implements, **interprets,** or prescribes" law or policy.

RETIREMENT ACCOUNTS OWNED BY APPLICANT

May 1, 2019: Exempt only if retirement plan has been annuitized.

BUT BEWARE – transfer of asset rules.

Exception: Med Works (MADW & MADI).

IHCPPM §2615.45.00

EE & I bonds: exempt during the 1st 12 months after purchase.

ANNUITIES

- Must be irrevocable and non-assignable

- BUT: Remember the transfer of asset analysis (state as beneficiary, term of annuity vs. life expectancy, etc.)

PROMISSORY NOTES

- A negotiable mortgage, loan, or promissory note is a countable resource. §2615.50.00

- Negotiable = no legal barrier to the transfer of ownership

- The value counted as a resource is the amount of the outstanding principal balance.

PROMISSORY NOTES IHCPPM §2640.10.25.30

Improper transfer unless all of the following criteria are met:

a) Actuarially sound.

b) Payments in equal amounts during the term; no deferral of payments and no balloon payments, ***and***

c) Prohibition of cancellation of the balance upon the death of the lender.

PROMISSORY NOTES (Cont.)

- If the mortgage, loan, or note is non-negotiable, it is not a resource.
- ***ONLY*** interest is counted as income.
- Same terms apply to land sale contracts * See IHCPPM §2615.55.15
- Remember the transfer of asset implications!

Motor Vehicle Exemptions

- Vehicle used for transportation = exempt
- Vehicle used to produce income = exempt
- Count equity value of all other vehicles

TRUSTS

Count as a resource

- Revocable trust assets
- Portion of an “irrevocable” trust that can be distributed to the Medicaid applicant

TRUSTS

Do not count as a resource:

- Portion of a trust that can’t be distributed
  (e.g., corpus of an “income-only” trust)
- Pooled trusts
- Trusts for the benefit of an individual under age 65 who is disabled
- Testamentary trusts

Miscellaneous Exemptions

- **Casualty Insurance Payments**: IHCPPM § 2615.25.10 – exempt for 9 months from date of receipt.
- **Federal Tax Refunds**: Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 – exempt for 12 months after receipt. Also not subject to transfer of asset penalty per CMS.

IHCPPM §2615.90.00 Prorated Income

Income that is prorated (educational income, self-employment income) cannot be counted as a resource for any month during the prorated period.

Additional Exemptions

- Business Accounts: IHCPPM §2615.10.05.05 – must be clearly labeled

- HSA accounts: IHCPPM §2627.00.00

- ABLE accounts for those whose disability began before age 26

529 PLANS: §2615.10.20 EXEMPT

EXEMPT REAL ESTATE

- Home of applicant, recipient, spouse

- Income producing property
- Property used to produce food for home consumption
- Burial spaces

Exempt Real Estate (cont.)

- Property owned JTWROS
  - By recipient / applicant & other not financially responsible for recipient / applicant
- Life estates – offer for rent or sale
- IHCPPM § 2620.15.30: Real estate owned in name of CS if:
  - Applicant / recipient spouse resides in nursing home or hospital or receives waiver services

JOE & MARY

- **Joe 67 years old**
- **Mary 64 years old**
- **<u>Both</u> live at home**
- **Own a home**
- **Own a farm that is income producing $3,000 / year**
- **Small bank account**
- **Life Ins. policy on Joe, beneficiary is Mary**
- **Own two vehicles**

ASSETS : JOE & MARY

Home on two acres	$120,000 Equity / CMV
Small farm in Kokomo –	$55,000 Equity / CMV
Vehicle #1	$4,600 (exempt)
*Vehicle #2	$ 100
*Bank Acct., jointly held	$2,000
*Life Insurance Policy	$7,700 CSV ($5,000 Face)
Beneficiary is Mary	
*Countable resources:	$9,800
Resource limit for couple	$3,000

DANIEL & REGINA

- Daniel is 75 years old
- Regina is 72 years old
- Both enter a nursing home
- Own a home & intend to return home
- Vehicle used for Drs. appointments & pleasure
- Life Ins. Policy on Regina, beneficiary is Daniel

ASSETS: DANIEL & REGINA

Home	$50,000 Equity / CMV
Vehicle	$8,000
*Checking acct.	$3,800
*Certificate of Deposit	$5,000
*Certificate of Deposit	$5,000
*CU share acct.	$4,500
*CU Christmas Club	$800
*Money Market	$2,200
*Life Ins. (FV $5,000)	$1,800 Cash value
(Names spouse as benef)	

COUNTABLE ASSETS

- Bank & CU accounts
- Certificates of deposit
- Life ins. Policy – cash value
- Spousal Impoverishment Rules Do Not Apply

Total resources	$23,100
Resource Allowance	-$ 3,000
Resource Spend down	$20,100

COMMON OPTIONS IN PLANNING

- Funeral trust for applicant
- Funeral trusts / burial spaces for applicant's family (per SSI rules)
- Payment of fees for services
- Gifts to family members (use annuity or promissory note income to pay per diem during penalty)
- "Quality of life" expenditures
- Can this be a MCCA situation?

PLANNING WITH A PERSONAL SERVICES AGREEMENT

- Use to establish rate of pay for care provider.
- Use to define services to be provided by care provider.
- Use to establish responsibilities of care recipient.

MCCA: The Spousal Impoverishment Rules

SPOUSAL IMPOVERISHMENT RULES

One spouse is in the community, and other:

- Institutionalized on or after September 30, 1989 for at least 30 days; or likely to be in a facility for at least 30 days
- Receiving waiver services

SNAPSHOT DATE

First day of the first period of continuous institutionalization of 30 or more days since on or after September 30, 1989.

IHCPPM §3320.05.00 SPOUSAL PROTECTION

If the waiver spouse has never had a prior continuous period of institutionalization nor received waiver services, the snapshot date is either the date of application or the date on which the waiver **Cost Comparison Budget** (CCB) is approved, whichever is later.

WAIVER "SNAPSHOT"

- Date of *Successful* Medicaid application

OR

- Date of waiver approval – whichever is later.

RICK & LUCY: WHAT IS HER SNAPSHOT?

2-10-21:	Lucy to hospital for 5 days on observation status, then home
3-20-21:	Lucy admitted to hospital for 3 days, then goes to sub-acute rehab hospital for 28 days, then home.
7-4-21	Lucy in hospital for one week, then to nursing home through 8-30-21, then home.
4-29-22:	Lucy receive approval for waiver.
4-29-22:	Lucy submits MA application online.

WHOSE RESOURCES COUNT?

	Institutional spouse	At home spouse	Joint
Snapshot	√	√	√
Initial eligibility	√	√	√
Post eligibility	√	X	√

SPOUSAL SHARE RESOURCE LIMITS 2022

- Floor (Minimum) $27,480
- Ceiling (Maximum) $137,400
- ½ the total countable resources
- Indexed to inflation

$274,800 or greater	Ceiling: $137,400
$100,000	$50,000
$27,480 to $54,960	Floor
$27,480 or less	All

Real Estate Owned by I.S.

The equity value of nonexempt real property owned solely or jointly by the institutionalized spouse is a countable resource. (The "agree to sell" rule is applied only to eligibility determinations, not for purposes of calculating the spousal share.)

IHCPPM §2635.10.10.05

(Regular real estate exemptions also apply.)

Special Exemptions

- Up to $2,000 of any separately identifiable funds or assets which have been set aside for burial can be excluded.
- One motor vehicle of any value is exempt
- Equity value of real property owned **solely** by CS (or jointly with someone other than IS) IHCPPM §§ 2620.15.30, 2635.10.10.05.
- **Retirement accounts owned by CS** ***

MCCA Case Study:

- On the snapshot date of 1-15-22, John (IS) & Paul (CS) have $200,000 in countable
- On the eligibility date of 3-1-22, John & Paul have $90,000 in countable resources.

Do you need to verify resources on 4-1-22?

IHCPPM §2635.10.10.10

If countable resources are equal to or less than the current standard, the institutionalized spouse is eligible for assistance for that month, which is the initial month of special resource eligibility for the institutionalized spouse. For subsequent months during the continuous period of institutionalization, resources owned solely by the community spouse are exempt.

The 90 Day Grace Period

If, for the initial month of eligibility under this provision, resources in the name of the *institutionalized* spouse exceed the single individual standard, a post-eligibility transfer of resources will be required within a specified time limit as explained in IHCPPM § 2635.10.10.15.

GENE & DIANE

- Gene lives at home
- Diane entered nursing home from home on March 1, 2022
- No prior institutionalizations
- Snapshot is March 1, 2022
- Own a home
- Vehicle
- Gene has an IRA

ASSETS: GENE & DIANE

Home	$100,000 Equity / CMV
*Money Market	$ 50,000
*Regular Checking Acct.	$ 10,000
IRA (Gene)	$350,000
Car	$ 20,000
*Countable resources	$ 60,000

ALLOWANCES

- Gene's spousal share ½ of $60,000 = $30,000
- Diane's resource allowance = $2,000
- Total allowance is $32,000 ($30,000 + $2,000)
- No more than $32,000 allowed on 1st day of 1st month of desired Medicaid eligibility

OPTIONS

- Medical or other Bills
- Home repairs or improvements
- Furnishings or appliances
- Irrevocable annuity or Promissory Note
- Purchase of U.S. government savings bonds by CS

DONALD & EMILY

- Emily & Donald live at home
- Donald receives approval for waiver services on April 13, 2022
- Medicaid application filed online on April 13, 2022
- No prior institutionalizations
- Snapshot date is April 13, 2022
- Own a home & two vehicles
- Life Ins. owner is Donald, beneficiary is Emily

ASSETS: DONALD & EMILY

Home	$150,000 Equity / CMV
*Stock portfolio	$120,000
*Certificate of Deposit	$80,000
*Money Market	$30,000
*Annuity	$38,000
*Reg. Checking Acct.	$20,000
*Life Ins. Cash value	$4,500
Vehicle #1	$24,000
*Vehicle #2	$7,500

COUNTABLE ASSETS

- Stock portfolio
- Certificates of deposit
- Money market
- Regular Checking Acct.
- Annuity
- Life ins. Policy – cash value
- Vehicle #2

Countable resources	$300,000
Emily’s Share	($137,400)
Donald’s allowance	($2,000)
Resource Spend down	$160,600

OPTIONS

- Medical or other bills
- Home repairs or improvements
- Furnishings or appliances
- Irrevocable annuity or promissory note
  - Income to Emily
  - Emily as owner on annuity & lender on prom. note
  - Caveat re: Transfer issues
- Income producing real estate
- Real Estate in Emily's name alone
- U.S. Government savings bonds

Tracking Your Medicaid Case

- Have a process!

- Know what to expect!
- Keep your client informed!

PABLO & MARIA

- Pablo in Nursing Home
- Snapshot Date is April 3, 2022

Pablo & Maria

- Countable Resources: $364,095.94
- CS Allowance: $137,400
- IS Allowance: $ 2,000
- Pablo & Maria must have ≤ $139,400 for Pablo to qualify

OPTIONS FOR SPEND DOWN

- Prepaid Irrevocable Funerals
- Pay off debt (mortgage, credit cards, etc.)
- Buy items for CS & IS
- Immediate, Medicaid Compliant Annuity
- Promissory note
- Real Estate in the name of CS

AFTER THE APPLICATION

- Follow up with FSSA Doc Center to determine application status/ **Check Portal**
- **Advise client to pay liability while Medicaid application is pending**
- Advise NF of pending status and liability

AFTER THE APPROVAL

- No more than $2,000 for *IS* as of first day of any month after 90 day grace period.
- Change assets to name of *CS* alone.
- Make sure all legal documents are in good order, including will for *CS* containing SNT for *IS*.
- Instruct on Medicare Part D issues
- Instruct on Medicare Part B buy-in
- Instruct on Redeterminations

THE END

THAT'S ALL FOLKS

Income Issues

Eligibility and Post – Eligibility

General Income & Liability Budgeting Principles

- See IHCPPM Chapter 2800 for income eligibility rules.
- See IHCPPM Chapter 3400 for liability budgeting rules.
- See IHCPPM Chapter 3300 for waiver liability rules.
- Most income counts, whether earned or unearned.
- Rules are different for different Medicaid programs. Don’t get them confused!

General Income & Liability Budgeting Principles

Types of income that do NOT count:

- Income tax refunds. Remember that this includes stimulus payments, which are a form of income tax refund.
- Principal received from the payback of a promissory note. The interest DOES count.
  - ***Note that principal and interest both count with annuity payments.
- Interest earned from exempt resources.
- Generally speaking, conversion of resources from one form to another, except retirement accounts that have been annuitized.
- Unanticipated and non-recurring lump sum payments.
  - These count for eligibility purposes in processing an application.
  - These do NOT count for liability purposes. But remember they'll count as resources in the month following receipt!
- Certain VA benefits (see next slide)

General Income & Liability Budgeting Principles

Treatment of VA Benefits

- Compensation counts as income.
- Any portion of the benefit which is allowed for a dependent is treated as income of the dependent (and not the applicant).
- Any portion that is paid for unreimbursed medical expenses does NOT count as income.
  - Aid and attendance
  - Housebound benefit.
- Need to show what portion of the benefit is reimbursement for medical expenses.
  - Ask the VA for a breakdown statement.
  - The initial award letter usually provides the most detail.
- Remember to promptly report Medicaid approval to the VA, along with any change in medical expenses.

Rules for “Institutional” Medicaid

This includes people who are:

- In a skilled nursing facility for more than 30 days;
- Waiver recipients
  - At home
  - In assisted living
- PACE

Two types of Income Budgets

1. Eligibility
2. Liability (Referred to as "post- eligibility" in the IHCPPM)

Eligibility Budgeting for "Institutional" Medicaid

Eligibility budget =

calculation that determines whether the Medicaid applicant/recipient is income-qualified for Medicaid in a given month

Eligibility Budgeting for "Institutional" Medicaid

- Only the applicant's income counts.
- "Name on the check" rule.
- Use GROSS income, except:
  - Only the net income from rental properties is counted.
  - Deduct amount of VA benefits that is paid for unreimbursed medical expenses.
  - Long-term care insurance payments if you can show they are spent on medical expenses.
- No deduction for most garnishments, i.e. child support
- Income must be no more than 300% FPL ($2,523).
  - This is a soft cap.
  - If income is higher, the applicant can still qualify if the excess is put into a Qualified Income Trust (QIT aka Miller Trust).

Eligibility Budgeting for "Institutional" Medicaid

Miller Trust

- This is only for the applicant's/recipient's income!
  - Not for spouse's income.
  - Not for deposit of excess resources.
- Must provide for payment to the State of Indiana at death, up to the amount that the State has expended on the decedent's Medicaid benefits.
- Must be irrevocable.
- Use the beneficiary's Social Security Number. Do NOT need an EIN.
- Can be created by a POA or third party, if necessary.
- See sample QIT in the appendices, or FSSA template at https://www.in.gov/fssa/ompp/home/miller-trust/

Eligibility Budgeting for "Institutional" Medicaid

How to Use the Miller Trust -- Deposits

- Applicant/Recipient must deposit *at least* the amount of gross income above the SIL ($2,523) for every month in which eligibility is sought.
    - Better to deposit too much than too little.
    - Client can choose to deposit all income into the Trust, or any portion of it.
    - Clients with multiple income sources often choose to direct deposit one source into the Miller Trust.
    - Can also make the deposit by transferring from another account.
- Deposit can be at any time during the month.
- Deposits cannot be retroactive for months that were missed. There is no "fix" for failing to deposit.
- Don't forget to make deposits for all months where coverage is sought, including while application is pending and 3 months retro.

Eligibility Budgeting for “Institutional” Medicaid

How to Use the Miller Trust -- Payments

- Typically used to pay liability.
- No limits on transfers to spouse.
- Can be used on anything except food and shelter.
  - If Miller Trust payments are used for food and shelter, they will count as income for that month. This may cause client’s income to go over the SIL and lose coverage.

Liability Budgeting

See IHCPPM 3400

Liability = “cost share”

Liability budget = Recipient’s gross income – allowable deductions

***PACE program participants do not have a liability. See IHCPPM 3380.00.00

Liability Budgeting

- Start with GROSS income
  - This includes income placed in the Miller Trust
- No deductions for:
  - Miller Trust trustee fees
  - Bank fees
  - Attorney fees (except guardianship)
  - Garnishments (i.e. child support)

Liability Budgeting

Allowable deductions:

- Personal needs allowance
  - $52 for nursing home residents
    - additional $90 if resident gets VA benefits
  - $2,523 for waiver recipients
- Health insurance premiums
- Medical expenses not covered by Medicaid
- Court-ordered guardianship fees of not more than $35/month
- Federal, state, and local income taxes (once per year)
- Spousal and/or family allocation (see next slide)*

Liability Budgeting

Spousal or family allocation:

- The community spouse is entitled to a certain level of income. If her own income is less, part of the institutionalized spouse's income will be allocated to her.
- The Minimum Monthly Needs Allowance (MMNA) is $2,178.
- The Maximum Monthly Needs Allowance is $3,435, unless:
  - Request a fair hearing and FSSA agrees that spouse needs more
  - Court order

Liability Budgeting

Calculating the spousal allocation.

- Formula provided on p. 143 of the manual.

Rent/mortgage

+Utilities (actual or standard allowance)*

+property taxes/insurance

= Shelter expenses

- $653 shelter standard

= Excess shelter allowance

+ Spousal maintenance standard of $2,178

= Spousal maintenance amount (cannot be higher than $3,435)

- Community spouse gross income

= Spousal income allocation

Liability Budgeting

*Standard Utility Deduction

- $447 if it includes heating or cooling
- $266 if no heating or cooling but two other utility expenses
- $59 if one utility expense but no heating, cooling, or telephone; or
- $32 if telephone only

Liability Budgeting

Family allocation for tax dependent children, dependent parents, or dependent siblings, of either spouse, who live with CS

Allowance per family member =

($2,178 – member's income) divided by 3

***No Allocation if dependents do not live with spouse. So no allocation for minor children living with ex-spouse or other family member.

Liability Budgeting

Example

Mrs. Brown is in a nursing home and has $2,800 per month total income. Mr. Brown still lives in their home but is in poor health himself. He has income of $1,600 and pays a mortgage of $700 per month, which includes taxes and insurance. They have a 16 year old son at home who does odd jobs and earns $150 per month. Mr. Brown's sister moved in to help care for him and the son; she has no income. Mrs. Brown's health insurance premium costs $150 per month, and she wants to maintain the policy. She is under a guardianship, and the attorney for the guardian is owed fees of $800.

Liability Budgeting

Example (cont’d)

Mrs. Brown must have a Miller Trust to be eligible. She must deposit at least $277 ($2,800 - $2,523) per month into trust. She can deposit more if she wants.

Next, compute the community spouse and family allocations.

Liability Budgeting

Example (cont'd)
SPOUSAL ALLOCATION CALCULATION

Spousal Allocation Formula	Mr. Brown
Rent/Mortgage	$700
+Utilities (actual or standard allowance)	$447
+Property taxes/insurance	$0
= Shelter expenses	$1,147
- Shelter standard ($653)	- $653
= Excess shelter allowance	= $494
+ Spousal maintenance standard of $2,178	+ $2,178
= Spousal maintenance amount (cannot be higher than $3,435)	= $2,672
- Community Spouse Gross Income	- $1,600
= Spousal allocation	**= $1,072**

Liability Budgeting

Example (cont'd)

FAMILY ALLOCATION CALCULATION

*** Remember that both must be considered dependents in order to receive an allocation.

Family Allocation Formula	**The Browns' son**
[$2,178 – (dependent's income)]/3 = family allocation	($2,178 - $150)/3 = $676

Family Allocation Formula	**Mr. Brown's sister**
[$2,178 – (dependent's income)]/3 = family allocation	($2,178 - $0)/3 = $726

Liability Budgeting

Example (cont'd)
Mrs. Brown's liability

Liability calculation	Mrs. Brown
Gross Income	$2,800
- Guardianship fees	-$35
- Health insurance premium	- $150
- Personal Needs Allowance	- $52
- Community Spouse Allowance	- $1,072
- Family allowance for son	- $676
- Family allowance for sister	- $726
= Liability	**= $89**

Liability Budgeting

Example (cont'd)
Mrs. Brown's liability

Mrs. Brown must deposit at least $277 (= $2,800 - $2,523) per month into her Miller Trust account. She can pay her liability and any of her liability deductions from the Miller Trust and the rest from her checking account or automatic withholding from her income (such as Medicare premiums withheld from Social Security check).

***Note that there is no way to pay the $800 attorney fees at one time from Mrs. Brown's income. The guardian could choose to use his $35/month allocation toward those fees.

Liability Budgeting

Waiver Budgeting

- Same as for a NH resident except the personal needs allowance equals the SIL ($2,523).
- If in Assisted Living or Adult Family Care, pay $841 room & board from Personal Needs Allowance. May pay more for larger room, phone, cable TV, etc.

Liability Budgeting

Waiver Budgeting Example

Laura has gross Social Security income of $1,600 and a pension of $1,500 for a total gross income of $3,100. She has a monthly health care premium of $70 which is auto-debited from her regular checking account.

Liability Budgeting

Waiver Budgeting Example cont'd

Laura's $3,100 income exceeds the SIL of $2,523. She needs to deposit $577 (=$3,100 - $2,523) per month into a Miller Trust.

As a waiver recipient, Laura's Personal Needs Allowance is $2,523.

Liability Budgeting

Waiver Budgeting Example cont'd

Waiver Liability Calculation	**Laura's liability**
Gross Income	$3,100
- Personal Needs Allowance ($2,523)	-$2,523
- Health insurance premium ($70)	- $70
Laura's Liability	**= $507**

Liability Budgeting

Waiver Budgeting Example cont'd

- Laura must deposit at least $577/month into her Miller Trust.
- Laura's Trustee should pay her $507 monthly liability from her Trust.
- The Trustee can arrange to pay $70 premium from the trust or transfer $70 from the trust to Laura each month to reimburse her for the payment of the premium.
- If Laura is in an assisted living facility or in adult family (foster) care, she will need to pay $841 for her room and board out of her $2,523 PNA. The assisted living facility could charge her more for a larger room, cable TV, etc.

Liability Budgeting

Deviation of liability

- Liability can be used for old medical bills, including nursing home bills accrued before Medicaid eligibility.
- Deviation CANNOT be used for:
  - A nursing home bill accrued during a penalty period
  - Unpaid liability payments.

Liability Budgeting

Paying the liability:

- For nursing home residents, liability is paid every month. Remember this includes the estimated liability during months when application is pending.
- For waiver recipients:
  - No waiver liability if the income is below the SIL ($2,523).
  - If in assisted living, the recipient will pay $841 for room and board from the Personal Needs Allowance.
  - The waiver liability is owed to whichever provider(s) files its claim(s) first.

Liability Budgeting

Other things to know about liability:

- There is no liability for the first partial month of coverage.
- Liability begins with first full month of institutionalization.
- There is a liability for the last partial month.
- Pay the estimated liability while the application is pending.
    - This avoids a bill which the resident won’t be able to pay.
    - If the resident doesn’t pay, the facility could discharge.

Rules for the Non-Institutional Medicaid Programs

- Spouse's income is considered for eligibility purposes, if they live together or are separated for medical reasons.
  - Except for MEDWorks, where only applicant's income is considered for eligibility. Both spouses' incomes considered when determining the premium.
- There is a hard cap on income. You cannot use a Miller Trust to meet the income requirement.

Rules for the Non-Institutional Medicaid Programs

- Medicaid for the Aged for persons who are 65+ but not institutionalized for at least 30 days. (MA A)
  - Limit is 100% FPL ($1,133/$1,526)
- Qualified Medicare Beneficiary (QMB) – MA L
  - Limit is 150% FPL ($1,699/$2,289)
- Special Low-Income Beneficiary (SLMB) – MA J or Qualified Individual (QI) – MA I
  - Limit is 185% FPL ($2,096/$2,823)
- Medicaid for the Working Disabled (MEDWorks) – MADW
  - Limit is 350% FPL ($3,964) – only applicant's income is considered for eligibility

Rules for the Non-Institutional Medicaid Programs

Deductions Used to Determine Countable Income

- Standard disregard of $20 (whether married or single)
- Allocation for minor child or essential person
- Less than 50% of gross earnings are counted
  - Subtract $65, then divide by 2

Rules for the Non-Institutional Medicaid Programs

Joan is 70 years old. She receives Social Security Retirement of $1,000 (gross) per month. She also has a part-time job, making $500/month. Can Joan income qualify for any of the Non-Institutional Medicaid programs?

Rules for the Non-Institutional Medicaid Programs

Formula	Joan
Unearned income	$1,000
-$20 disregard	- $20
+ (Earned income - $65)/2	+ $217.50 = (500 - $65)/2
Countable Income	$1,197.50

Joan's income qualifies her for QMB, which has a countable income limit of $1,699 for single persons. She will also have to meet the resource limit of $8,400.

Transfer of Asset Penalties, Liens, and Estate Recovery

When Planning, Be Aware of How Each Area Impacts Another

- Resource Rules – How many assets can one have and qualify for Medicaid?
- Transfer of Assets Penalties: Can assets be transferred to obtain eligibility or avoid repayment to State?
- Liens on Real Estate – Will the state place a lien against real estate?
- Estate Recovery – Will the state recover from assets after death of recipient?

Liens on Real Estate

- FSSA can use liens, but is not now using.
- If there is a lien, then State gets repaid if recipient’s property is sold. No payback during recipient’s lifetime is required if no lien is in place.
- Lien gives the State two years to pursue recovery after death of recipient.
- Are limits on when State can get a lien: In institution and will not return home, and no protected person living in the home.

Issues on Transfers

- How do past transfers affect Medicaid payment for long term care?
- Can the client use her assets to meet future needs?
- Can the client use his assets to help family members or others?

Roadmap When Considering Transfers

- How far back are transfers considered? (Look back)
- Is this transaction a “transfer of assets?”
- Is this transaction exempt from a penalty?
- What is the “uncompensated value” of the transfer?
- If there is a penalty, how long is it and when does it run?

Penalty Period

- A period of time during which Medicaid will not pay for nursing home care or waiver services. One is not ineligible for Medicaid
- One is eligible with no liability during a penalty period. If income is above SIL, must continue to make deposits to Miller Trust to continue to be eligible.

Impact of COVID

- Because assessing a penalty period against a recipient reduces benefits, penalty periods **cannot** be assessed against recipients during the national health emergency.
- Penalty periods can be assessed against applicants.

Look Back

- Look Back 5 Years. Look forward indefinitely.
- Look Back from “Baseline” Date: first date is in a nursing home (or receiving waiver services) and has applied for Medicaid. If was first on community Medicaid, will be date enters nursing home or begins waiver services. **Each person has one Baseline Date.**

Remember Forward Effect of Transfers

- Transfer now will be considered for 5 years forward if one needs institutional Medicaid within 5 years.

When Does the Penalty Period Start?

The later of:

1) The date on which the individual would be otherwise eligible for Long Term Care Services under Medicaid **based on an approved application** if not for the penalty;

2) The 1st day of a month during which assets have been transferred for less than FMV

AND the penalty does not occur during any other transfer of property penalty

Penalty Period for a Recipient (Post – COVID)

- Because start date is beginning of month in which transfer made, DFR cannot start the penalty on time, which should mean the most DFR can do is assess an overpayment for the initial month(s).
- Have been reports that FSSA has pulled back payments from the nursing home, resulting in a bill owed by recipient.

Computing the Penalty Period

- Formula used. Divide all amounts of uncompensated value not exempt within look back period by average monthly nursing home cost to determine number of months of penalty.
- Nursing home rate is $6,873 for applications filed between 7/1/2021 and 6/30/2022. Note that different rate will be used for a recipient with an earlier application date.

Computing Partial Month Penalty

- Divide Uncompensated Transfer by $6,873 and round up at second decimal place (hundredths) E.g., $50,000 / $6,873 = 7.275 rounds to 7.28. Take fractional part times 30.42 days/mo. and round up to get number of days. .28 x 30.42 = 8.52 rounds up to 9 days
- In this example, penalty is 7 months, 9 days.

Odd Result of Small Penalty

- Suppose Mabel enters nursing home April 15, 2021, applies for Medicaid, and is eligible for Medicaid effective April, 2021, subject to a penalty of 10 days. Penalty always starts at beginning of a month, so penalty runs from April 1 to April 10 and expires before April 15.

Is there a “transfer of assets”?

- “Assets” include income and resources using SSI rules, except for home, where specific rules apply.
- There is no penalty for transferring resources (exc. home) exempt under SSI
  - Vehicle used for transportation
  - Household goods
  - Federal tax refund, including stimulus payments, within 12 months of receipt
  - Property used in a trade or business (if actively managed)

Is there a "transfer of assets"?

- Includes transfer of income, or right to receive income
- Includes Assets or Income not Received Because of Action Taken
- Includes total or partial divestiture of control or access
- Transfer by either spouse is considered

Exempt Transfers

- Adequate Compensation, or intended as adequate
- Transfers to spouse
- Transfers to disabled child, or trust for disabled
- Exclusively other than to qualify for Medicaid
- The home if certain criteria met
- Assets protected by Partnership Policy
- Undue Hardship
- De Minimis Gifts

When Transfer of Home Is Exempt

- To Spouse or Disabled Child
- To child residing in home at least 2 years immediately before institutionalized and gave care to keep from being institutionalized.
- To sibling with equity interest who resided in home at least one year before institutionalized.

De Minimis Gifts Are Exempt

- Disregard $1,200/yr to Family or Charity
- Way to avoid small partial month penalties
- Gift needs to be made by applicant

IHCPPM Instructions on De Minimis Gifts

- Gift made to family member related by blood, adoption, or current marriage.
- Gift made to nonprofit qualified under Section 501 (c) of the Internal Revenue Code

REQUIRED DOCUMENTATION

Signed statement by applicant & family member must include:

- Name of donee
- Date of birth
- Relationship lineage

DRA Rules on Annuities

- Apply to annuities purchased on or after 11/1/09
- Also apply to annuities with significant changes on or after 11/1/09, such as annuitized, change in ownership, etc.
- Do not apply if minor changes only, such as change of address, notification of death of a beneficiary, etc.
- Look back rules still apply, so applies to annuities purchased or significant change(s) within the look back period.

To Avoid Penalizable Transfer

- Annuity purchased by applicant or spouse MUST name state as the remainder beneficiary for at least the total amount of medical assistance paid **on the behalf of the applicant for medical assistance**
- State can be in 2nd position if there is a community spouse and/or minor or disabled child

Annuity purchased by applicant not a transfer of assets if:

- It is a retirement annuity. See list in IHCPPM 2640.10.25.10.
- Is irrevocable, non-assignable, actuarially sound, with payments in equal amounts.
- CMS says must still name state as remainder beneficiary to not be penalized. FSSA not consistent in enforcing this.

Annuity Purchased by Community Spouse within Look Back not Penalizable if:

- Purchased from commercial entity
- Is irrevocable, non-assignable, actuarially sound, with payments in equal amounts
- Names state as remainder beneficiary for Medicaid received by institutionalized spouse.

To Avoid Penalty, Promissory Notes Must:

1. Have a repayment term that is actuarially sound
2. Provide for payments to be made in equal amounts during term of loan with no deferral and no balloon payments made
3. Prohibit cancellation of the balance upon the death of the lender

Use of Pooled Trust for Over Age 65

- Cannot use individual (d(4)(A)) trust if over age 65, but funds deposited into a pooled trust for person over age 65 are exempt as a resource **if the person is disabled**.
- Some states exempt the resources but assess a transfer penalty. Indiana has not assessed a transfer penalty for deposits into a pooled trust.

Example of Problem Caused by Typical Transfers

5/18/18: Brad gives son $5,000 for house down payment

6/3/19: Brad pays daughter's medical bill of $8,000

April, 2022 Brad has entered a NH and paid privately until his resources are below $2,000 and he now applies for Medicaid

BRAD IS SUBJECT TO A TRANSFER PENALTY, UNLESS HE CAN SHOW DONE EXCLUSIVELY NOT TO QUALIFY FOR MEDICAID OR GETS HARDSHIP WAIVER

Planning Strategy No. 1

- Transfers can be made so long as Retain Sufficient Assets or have Long Term Care Insurance so there will be no need for Medicaid within 5 years of any Gifts. It can be hard to predict outlays that will be needed over a 5 - year period.

Planning Strategy No. 2

- Only make transfers that will not cause a penalty period. This is especially important if Medicaid will be needed within five years.

Transfers to Benefit Oneself

- If disabled and under age 65, can use d4A SNT. If disability began before age 26, can use ABLE account. If disabled and over age 65, can place funds into a pooled trust.
- Promissory note. Since only the interest counts as income, the principal payment back can be used to have additional personal spending money.

Planning Strategy No. 3

- Make gifts that result in a penalty period, but use exempt assets (either already existing or ones converted, such as annuity or promissory note) to privately pay during the penalty period. Calculation is needed to determine how much can be gifted.
- May need a Miller Trust to be eligible, depending on income.

Estate Recovery

Medicaid's Means to Obtain Repayment After Death

Repayment to State is not Necessarily Bad

- Repayment to State is at Medicaid rate rather than paying provider at private rate
- No interest is being added to the claims for delay in payment.

Extent of Estate Recovery

- Medicaid benefits paid after age 55 for services provided on or after Oct. 1, 1993
- Medicaid benefits paid after age 65 for services provided before Oct. 1, 1993
- No recovery for Part B premiums paid; appears should be no recovery for benefits paid under QMB.

Extent of Estate Recovery

- If born before October 1, 1928, subject to recovery for MA provided after age 65.
- If born between October 1, 1928 and September 30, 1938, subject to recovery for MA provided on or after October 1, 1993.
- If born after September 30, 1938, subject to recovery for all MA provided after age 55.

When There is No Estate Recovery

- Property is needed for support of surviving Spouse, dependent child under age 21, or disabled dependent
- $2,150 for funeral / burial
- Assets protected under Long Term Care Insurance Partnership Program
- Undue Hardship
- No recovery against non-Recipient spouse

What Property (or Transferee) Can be Claimed Against?

- Property in Probate Estate
- Transferee for Property passed by Non-Probate Transfer, unless transferred out of Probate Estate Before May 1, 2002
- Transferee for JTWROS Interest in Real Estate, if created after June 30, 2002
- Amounts due after death on annuity contract purchased after May 1, 2005

State Must Open an Estate to Pursue its Claim

- State sometimes sends out demand letter to family member. No obligation to send funds.
- Creditor cannot use a small estates affidavit to claim against assets.
- Nursing homes should not send funds remaining after death back to the state.

Time Limit For Real Property to be Sold in Probate Estate and Proceeds be Paid to Creditor(s)

- Petition for Probate must be filed within 5 months of death and letters issued within 7 months of death (or later if petitioner complied with rules and clerk delayed).

Recovery Against Non-Probate Transfers

- Liability is against the transferee, not the property.
- Time limits do not apply to **assets** not reported to DFR.

Recovery Against Non-Probate Transfers

- 5 months after death to file claim in estate and deliver copy to each non-probate transferee.
- 7 months after death (or 30 days after final allowance of claim) to demand PR sue Transferee(s)
- 9 months after death for Creditor to sue transferee(s), or earlier of: 30 days after PR files that will not sue, or within 90 days after final allowance of claim if PR does not file notice that not suing.

Medicaid Appeals
And
Litigation

3 LEVELS OF ADMINISTRATIVE APPEAL

- Administrative hearing before ALJ—evidentiary record created
- Agency Review—paper review of administrative hearing
- Judicial Review –Trial court review of administrative proceedings, similar to an appellate case with briefing and oral argument but no oral argument

MEDICAID APPEALS: Evaluating the Case

- Is there a good legal basis for pursuing the appeal?
- Is there a better solution than filing an appeal?
  - Will a new application cover all needed months?
  - Can it be corrected through the Regional Mailbox?

EXAMPLES--NO APPEAL: Fix It & Reapply

- Denied due to over resource bank account balance
- Denied due to lack of documentation—failed to provide verification of income
- Terminated for failure to rent or sell real estate

ANALYSIS—IF THE DECISION IS WRONG

- Contact Call Center to correct the problem
- E-mail the Regional Mailbox / Regional Manager
- Consider a new application, if new application covers needed period. Can both reapply and appeal.
- APPEAL before time limit expires, if needed to get full relief, even while taking other remedial steps. Preserve the right to a fair hearing

FAILURE TO COOPERATE

Sometimes really means:

- DFR did not receive your documentation
- Documentation was not complete
- Documentation was not read/understood/acknowledged
- You failed to do the impossible that was requested
- Your request for help was ignored
- Failed to provide what was requested and failed to explain why
- One should do all possible during application to cooperate, or notify DFR of issues related to verification.

Effective Date of Terminations (Post-COVID)

- For recipient, notice must be mailed at least 10 days before the effective date
- IHCPPM says 13 days (3 days for mailing but FSSA counts the mailing date)
- Notice may be invalid if less than 13 days
- Exceptions to 10-day rule (i.e. death, withdrawal, whereabouts unknown, etc.)

DEADLINES

- The time limit to appeal is 33 days:
  from mailing date of denial for applicants, or
  from effective date for recipients.
- **Continue existing benefits by appealing before effective date of an adverse notice, but *caution: overpayment claim if appeal is unsuccessful***

HOW TO APPEAL

- Complete appeal form on FSSA website or submit a letter of appeal – reason for appeal does not need to be stated.
- Enclose copy of adverse notice or refer to date of notice and action taken
- MAIL, FAX, or DELIVER TO:
  - **Document Center**
  - Local DFR office
  - OALP (copy to Document Center)

WHAT TO REQUEST

- All hearings are telephonic now due to COVID.
- If client or witnesses need an interpreter, request interpreter with hearing request.
- Ask for the hearing packet and request receipt prior to hearing date. Should get automatically for telephone hearings.
- Ask for any needed accommodation
- Request expedited appeal if qualifies.

APPEARANCE

- Submit Appearance (letter) to OALP to receive notices from OALP, with copy to Document Center—include case number & appeals number, if available. Letter appealing should be sufficient for appearance; can file appearance form.
- Have Authorized Representative or Authorization for Disclosure form on file with DFR to be able to talk to DFR staff

PRE-HEARING

- Talk to DFR to try to resolve or clarify issues
- Pre-hearing conference
  - Be sure that client directs calls to you
  - DFR may attempt to call client within a few days of receiving appeal request without including you
  - Request correction of processing errors
  - Ask for information about denial
  - Review calculations

PRE-HEARING-
Discovery

- Informal: talk to DFR at 800# to discuss adverse action—figure out the issue(s)
- Check to see what documents have been received
- Request all DFR notices and documents, if you do not have them
- Request DFR running comments—*read carefully for additional evidence*
- Formal discovery rules apply if needed.

PRE-HEARING

- Identify and prepare witnesses for testimony/questioning by the ALJ
- Prepare exhibits—show calculations, for instance – submit 7 days before telephone hearing
  - Do not assume that DFR will submit all information; should receive packet with its exhibits before hearing
  - Some notices are more readable on the form sent to client rather than DFR's computer screen
  - Summarize expenses and show calculations
- Consider cross-examination questions—can DFR rep provide helpful information? Sometimes YES!

PRE-HEARING—Trial Memorandum

- If there is a complex legal issue, prepare a Trial Memorandum. E.g., are arguing IHCPPM is contrary to an SSI rule.
- Keep it simple/avoid a treatise
- Organize the case facts and important issues
- Explain legal arguments—why you should win

HEARING FORMAT

- ALJ conducts the hearing
- Hearing is recorded
- Rights explained
- Opening statements allowed but you may have to ask
- DFR goes first—usually only rep presents evidence
- Burden of proof—depends if termination or application
- Rules of evidence do not apply

OPENING STATEMENTS

- ALJ will not have reviewed the file prior to the hearing and typically will not know the reason for the appeal
- Allows the ALJ to focus on what is important
- Sets the stage for your case
- Keep it concise

PRESERVING THE RECORD

- Preserve the record—think "transcript"
- Make sure all testimony is audible and clear
- Make sure exhibits are marked & admitted
- Raise objections which could be a basis for appeal
- If ALJ refuses to admit evidence, make an offer of proof (*summarize what the evidence would show*)

HEARING--Appellant

- Opening statement
- Cross-examine DFR appeals rep
- Present witnesses--explain facts of the case
- Identify and present exhibits—foundation not required but can strengthen credibility
- Make legal arguments/submit memo, if any
- Request specific relief/closing statement

ALJ DECISION

- A written decision is required.
- Must state findings of fact—not recite testimony
- Must relate the facts to the applicable law
- Result:
  - Sustain the DFR action
  - Reverse the DFR action
  - Modify the DFR action
  - Find that the DFR erred but harmless

AGENCY REVIEW

- Any losing party, **even DFR**, may appeal
- Appeal request must be filed within 10 days of receipt of ALJ decision
- No further evidence can be presented and no hearing is held.
- Legal memorandum to be filed within 20 days of receipt of ALJ decision
  - Preserve all legal arguments—*waived if not raised*
  - Attach key exhibits for easy reference
  - Can be in letter form—consider submitting with notice of appeal to save time

FINAL AGENCY ACTION

- Agency Review is the **final agency action**
- Decision is usually brief and often boilerplate
- Likelihood of prevailing on substantive issue is slight
- Best chance of success is on typographical/ mathematical/procedural issues
- It is a necessary step to exhaust administrative remedies before pursuing Judicial Review.

JUDICIAL REVIEW—Overview

- Consider reapplying for benefits **even if** pursuing the appeal
- Administrative record must contain information to support Judicial Review—pointless otherwise
- Petition, file record, briefing, oral argument, & proposed order—Brief writing will take the most time

JUDICIAL REVIEW--Timeframe

Judicial Review is likely to take at least 4 to 6 months

- Obtaining the record and filing it (30 or more days)
- Briefing (Petitioner’s brief, FSSA’s brief, Petitioner’s reply brief) (80+ days)
- Oral argument set (depends on court’s schedule)
- Order (proposed order (7-14 days)) + judge’s time to decide

JUDICIAL REVIEW—Venue & Service

- VENUE: Local county or Marion County
- PARTIES: FSSA & each party to agency proceedings (others for HIP & PA cases)
  - No need to list local DFR office
  - Secretary of FSSA **must** be served
  - Indiana Attorney General **must** be served
  - Any other party to proceedings (such as Managed Care Entity)

JUDICIAL REVIEW--Petition

Indiana Orders & Administrative Procedures Act (IOAPA) I.C. 4-21.5-5-7

- Name & address of petitioner
- Name & address of agency
- List agency action at issue + attach ALJ decision & Notice of Final Agency Action
- Identify parties to proceedings
- Facts as to entitlement to judicial review & prejudice
- Request for specific relief

Judicial Review and/or §1983

42 U.S.C. §1983 Claims

- Ongoing Violation of Federal law or U.S. Constitution
- Damages may be available against private entities, such as state contractors
- Attorneys' fees are available
- Discovery available
- Must add appropriate defendants (DFR is not "person")
- Can join with judicial review or file separately in federal or state court

JUDICIAL REVIEW--Verification

- Verification is jurisdictional
- Petition must be verified
- Failure to verify can result in dismissal
- Client/family member should verify
- Attorney may verify—be cautious

JUDICIAL REVIEW--Record

- File within 30 days of filing the petition (**jurisdictional**)
- FSSA must prepare record
- Always request an extension of time to file the record
- File Motion to Compel if necessary
- Fee waiver is available

JUDICIAL REVIEW—Record

- **Check to make sure that the record is complete—do not assume**
- Prepare a table of contents
- Make a working copy—3-hole punch for binder
- Scan original and e-file with court with Notice of Filing

JUDICIAL REVIEW--Brief

- Briefing schedule—to establish deadlines and move the case along—consult w/AG
- Brief—follow appellate model App. R. 46
- Oral Argument
- Findings of Fact and Conclusions of Law—required under Tr. R. 52(A)—prepare proposed findings for the Court

Sample pleadings are included in the Appendices.