

HEALTH ED
Louisiana Elder Law 2009

Medicaid
Coverage for Long
Term Care

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Medicaid Coverage for Long-Term Care

I. Deficiencies of Private Insurance and Medicare

- A. The system for long-term care in this country impoverishes and makes destitute people who have worked all their lives to save and accumulate property.
- B. If you are poor or already on Medicaid the system does not make any difference.
- C. If you have more than \$1.5 or \$2 million, you can afford to pay an extra \$50,000 to \$100,000 a year for long term care.
- D. However, for all of us that are not already on a government program and do not have two million dollars to provide for our long-term care needs, the system is designed to take away everything that we have worked for and accumulate it all our lives.
- E. Most Americans do not realize that we are all one illness or fall away from becoming destitute.
- F. Why do I say that? Let's look at an example.

Case Study: Mr. and Mrs. Peter Boudreaux are both retired. They are living on their retirement and social security income. Mr. Boudreaux has \$950.00 a month coming in from social security and Mrs. Boudreaux has \$450.00 coming in from social security. Mr. Boudreaux also has a small pension that pays him \$400.00 a month. They have a home that they originally paid \$50,000.00 for that is now worth \$175,000.00. They own two cars and are living quite comfortably on their income and have savings of approximately \$200,000.00. What happens when Mr. Boudreaux falls and breaks his hip or develops dementia and no longer can stay at home and has to move into a nursing home?

Medicare will pay a maximum of one hundred days in the nursing home, after a three-day stay in a hospital. Medicare will full pay the first 20 days. Mr. Boudreaux has a supplemental Medicare policy so he is fully covered for the next 80 days, if he continues to improve from treatment or the treatment is necessary to prevent a decline in his condition.

After the first one hundred days, Mr. or Mrs. Boudreaux will have to start private paying for his care. This care will cost an average, in the State of Louisiana, \$4,000.00 a month. You can see that they will have to start spending from their savings in order to pay for Mr. Boudreaux's care. This will be at the rate of approximately \$50,000.00 a year. On a pro-forma basis, it looks like they will run out of money after four years. Based on my experience, because of the incidental expenses of being in a nursing home, the money will last approximately two and a half years. After Mr. and Mrs. Boudreaux have spent down their savings to \$109,560.00, he will qualify for Medicaid. They will give Mr. Boudreaux a \$38.00 per month personal needs allowance to provide for his disposable diapers, his optical and dental needs, his nonprescription drugs, his

snacks, soap, deodorant, cold drinks, etc. Although many people are very frugal and are able to stretch a dollar, it is practically impossible to make \$38.00 cover all the needs that Mr. Boudreaux will have.

The Medicaid system will leave Mrs. Boudreaux with a \$109,560.00 for the rest of her life; and, after she is gone, the State will come back and could recover against Mr. Boudreaux's share of the house for the cost of his care, hospitalization, and drug cost.

As you can see, the State of Louisiana will end up taking the house. An example of the letter that Medicaid sends out after the spouse has passed away is in your materials.

I will talk later about how we protect our clients and loved ones from becoming destitute. The system is like a railroad track and is designed to run them over and make them broke. We can help our clients get off the railroad track and not become destitute and preserve what they have worked a lifetime to accumulate.

One way to prevent this situation is to purchase long-term care insurance. The medical profession has done a good job of curing us, and therefore; most of us will experience some period of disability before we pass away. Of course, it was always the other guy and not ourselves. But if we look to the right and left of us that person we will probably experience the need for long-term care during their life. Over half of us, on a statistical basis, will need long term care once we reach 65. This percentage goes up as we grow older.

II. Long Term Care Insurance

A. Determining need for Long Term Insurance Coverage

Case Study: Mr. Pierre Thibodeaux and his wife, Marie Thibodeaux, are age 68 and 64 respectively. Both are in good health today, but both of them need to consider purchasing long-term care insurance in case they need to go into a nursing home.

The Thibodeauxs' own their home, two automobiles, household effects, and bank account assets of approximately \$300,000.00. Their annual income from social security and pension investments totals about \$40,000.00. They are considering several alternatives, including making gifts in advance of the 60-month look back rule for Medicaid, establishing an irrevocable trust or purchasing long-term care insurance.

Long-term care insurance should be considered for everyone. Mr. and Ms. Thibodeaux can purchase long-term care insurance because they are still currently in good health and have significant assets and income to protect.

As their resources are presently structured, neither of them would qualify for Medicaid coverage for long-term care. However, because their assets are limited they will have difficulty paying privately for the immediate nursing home care without seriously depleting their assets.

Mr. and Mrs. Thibodeaux's income is insufficient to pay the additional cost of \$50,000.00 per year for nursing home care. The non-institutionalized spouse would have difficulty making ends meet in the community without spending down the couple's assets. The long-term care insurance will help protect their assets, their standard of living and the inheritance for their children.

Mr. and Mrs. Thibodeaux are in a financial situation where they should seriously consider a long-term care insurance.

III. Evaluating Long-Term Care Policies

There are number of standard policy provisions that should be considered in purchasing long-term care insurance. These include:

- Daily benefit rates.
- Elimination.
- Benefit.
- Eligibility to receive benefits.
- Inflation protection.
- Pre-existing condition provisions.
- Home health coverage.
- Non-forfeiture.

The National Association of Insurance Commissioners publishes a guide to help evaluate and compare policies on the Federal Long-Term Care Insurance Program website, <http://www.ltcfeds.com>.

- A. Mistakes that people make in purchasing long-term care insurance are first, they do not purchase long-term care insurance. Many people think that it is too expensive and do not even obtain a quote.
- B. The second mistake that most people make is that they do not purchase a long-term care policy that is part of a comprehensive life care plan. They simply go out and purchase a long-term care policy without a life care plan and considering their assets and how that policy fits into protecting them and their assets.
- C. The third mistake that people make is not purchasing enough coverage. This can result in making a person ineligible for Medicaid or Veterans Benefits in the future and not providing enough income to properly pay for their care.
 - 1. Long-term policies are the most complex insurance policy on the market. They are much more complex than a life insurance policy or homeowner's

policy or auto insurance. There are several reasons for why long term care policies are more complex.

- D. First, with an auto policy, a life insurance policy or homeowner's policy, the trigger that causes the company that has to pay is very simple, it's either death, auto accident or fire or damage to the home. However, with a long-term care policy they are gatekeepers that have to be met in order to qualify to receive the long-term care benefit.
- E. Eligibility
1. The long-term care policy usually is triggered by the insured not meeting a certain number of activities of daily living. Therefore, one has to look at the policy to see how it defines activities of daily living and how many of those ADLs must a person need assistance with before becoming qualified for benefits.
 2. Most long-term care services are collated with an individual's ability to perform six "activities of daily livings" or ADLs, specifically: eating, toileting, transferring, bathing, dressing and continence. Insurance policies are generally triggered by the insured's inability to perform at least two ADLs without assistance. This is referred to as the ADL trigger. Under the cognitive impairment trigger, an individual who is physically able but who has a cognitive impairment is treated the same as an individual who is unable to perform without substantial assistance.
 3. Where does the policy provide for care? Care can be provided in the home, assisted living facility, an independent living facility, nursing home. All policy sold in the State of Louisiana now provide for in-home care. However, the older policies may not provide for long-term home care. Furthermore, if the person is considering having a policy to provide home care, they must realize that the cost of care in the home is significantly higher than the care of being in a facility.
 4. There are 720 hours in a month and the average cost of care in the Baton Rouge area is about \$14.00 an hour. So that cost approximately \$10,000.00 a month to have a 24/7 care in the home compared to spending \$4,000.00 a month to be in a nursing home.
 5. Inflation Protection. Inflation Protection provides increased daily benefits over time. A given daily benefit rate will become inadequate over time.
 6. Waiver of Premium

Will the policy premium be waived during any period of institutionalization, how is the appearance when insured receives home

care health services.

7. Benefit

Of course everyone wants to purchase lifetime coverage. Again, lifetime coverage is the most expensive type of policy. Alternatively, a person may prefer to purchase coverage for say a three to five-year period anticipating that they will engage in Medicaid planning and transfer all their assets to a trust or their children and qualify for Medicaid once the policy benefit period has run. Of course, any such plan must include necessary legal documents such as trust and power of attorneys.

8. Daily Benefit Rate

Most policies provide care in \$10.00 per day increments. Long-term care currently averages about a \$130.00 per day in Louisiana. A steady increasing rate should be anticipated. Long-term care cost have increased at a much greater rate than can be accounted for by ordinary inflation.

9. Benefit Period

The final determination of policy cost is the length of coverage of benefit. Plans can be purchased to cover long-term care cost for two, three or five years or lifetime. The limitation maybe a total dollar figure rather than a period of time; after benefits of say \$500,000.00 have been paid, the policy is terminated.

IV. Elimination

Other than the daily benefit rate, the two principal limitations on long-term care insurance (and the two of the most important determinations of price) are the elimination period and the benefit period. Usually, the elimination period is stated in terms of the number of days of institutionalization or disability required before the benefit begins, revenue, the dollar cost, the policyholder must incur before coverage begins. In most policies, the buyer may select from a handful of elimination periods, typically from immediate coverage to a hundred days. In some policies, the elimination period is a single lifetime figure while in others it must be met for each institutionalization.

V. Pre-existing conditions

The National Association of Insurance Commissioners in 1986 established a model act in regulations to consumer that offers various protections, including prohibitions against exclusion for pre-existing conditions.

VI. Guaranteed Renewability

Federal law requires renewability and forbids cancellation of long-term care policies. However, most insurers do not guarantee their premium rates will be fixed, or that rates will remain certain except for a certain period of time. The insurer may give itself the option to cancel upon expiration of the term of the insurance or have the option to cancel for reason other than the poor health of the insurer.

Medicaid Coverage for Long-Term Care

Medicaid income and resource eligibility requirements

I. Medicaid Overview

a. Program Structure

1. Medicaid is a federal program that provides necessary medical assistance for low income individuals and families. The program is structured as a federal state partnership. The federal government pays a percentage of each state's cost of operating a Medicaid program. In return for receiving federal funding, the state must administer its Medicaid program in accordance with federal guidelines. The federal contribution is usually the major source of funding for state Medicaid programs.
2. Although the state themselves administered Medicaid, federal guidelines determine who is eligible for Medicaid and which services will be covered by the program. The Center for Medicare and Medicaid Services, Department of United States, Department of Health and Human Services administers the federal grants and aid to the states. Each state must choose a single state agency to administer the program. In Louisiana, that agency is the Department of Health and Hospitals. LA.R.S. 36:254 (B)(1).
3. Each state Medicaid program must cover a minimum of basic medical services, but beyond basic medical services each state may opt to cover additional services allowed by federal law, and the federal government will provide funds so long as the services meet federal standards. Among the service options, states may choose coverage for long-term stays in nursing home, residential facilities for persons with mental retardation, and home and community services for persons who would otherwise require a level of care provided in a residential facility. Louisiana's Medicaid program has opted to provide this coverage.

b. Applicable Law

1. Federal

- a. Statute 42 U.S.C. Sec 39 C 1396 et seq. (Medicaid) 42 U.S.C. Sec

1382 et seq. (SSI).

- b. Regulations. 20 CFR Sec 430 et seq (Medicaid). 20 CFR Sec 4016 et seq (Section 7SSI)
- c. Guidelines. CMS issues federal guidelines interpreting the federal statutes and regulations. These guidelines are issued as HCFA Transmittals, CMS Transmittals and are implemented in the State Eligibility Manuals. However, they are not formally propagated as regulations under the APA.

2. State

- a. Statute - Louisiana Revised Statute 46:153 et seq.
- b. Regulations. Regulations governing state Medicaid program are published regularly in the Louisiana Register but had not been qualified in the Louisiana administrative code. Rules for the program are gathered in several departments' manuals but not all the manuals and these materials were promulgated in accordance with the APA. The most relevant manual is the Nursing Home Regulations: Standard for Payment manual (Department of Health and Hospitals). This manual is used to find available services which nursing facilities must provide in order to receive Medicaid payments.
- c. Covered Services

1. Mandatory Services

Federal law list 11 services that states are required to provide as a condition of participation in the Medicaid Program. They constitute basic medical care, and include: in-patient hospital care; outpatient hospital care; laboratory and x-ray services; physician services; nurse-midwife services; home health services; including medical supplies and equipment. 42 U.S.C. Sec 1396 D (a).

- 2. Optional services: In addition to the mandatory services, federal law listed more than 30 additional services that states may choose to include in their Medicaid program. Among the services Louisiana elected to cover in its Medicaid program are: nursing home facility services; prescription drugs; limited dental care; case management services; and services for mental health clinics. 42 U.S.C. Section 1396d (a).

II: Basic Eligibility

- A. Federal law requires the state to extend Medicaid coverage to all persons receiving Supplemental Security Income (SSI) benefits for blindness, age or disability. In addition, states may offer Medicaid benefits to residents of nursing homes or facilities for mentally retarded whose income and assets ("resources") do not exceed certain levels. The law allows states to choose from various formulas for determining Medicaid eligibility for these individuals.

Louisiana use a strict "income cap" formula. Under this rule, if an applicant's monthly income was even \$1.00 over the income cap, he or she would not be entitled to any Medicaid coverage, even if that monthly income was not sufficient for private pay rates in a nursing home. The state of Louisiana has adapted a spenddown option for applicants whose income exceeds the income cap".

B. Eligibility for benefits require that the applicant meet five tests:

1. **Citizenship.** A Medicaid long-term care recipient must be a US citizen or a "qualified alien" (a permanent resident, an asylee, a refugee, a person paroled in the United States for at least a year, a person whose deportation is held for certain reasons, a person granted conditional entry).
2. **Residency.** The applicant must be a resident of the State of Louisiana. Residence requirements are usually fairly simple to meet: physical presence in the state coupled with no current intent to move out of the state is a common test of residency.
3. **Medical need.** Before qualifying for long-term care assistance, the applicant must need long-term care to test his eligibility criteria. The state has adopted its own methodology. Typically, the applicant is scored on a test measuring functional disability; the applicant who is unable to complete at least several "activities of daily living" or "ADLs" without assistance will usually qualify. Greater medical needs (such as intubation, persistent decubiti, or other active medical procedures often administered to nurse and home residents) almost surely qualify the applicant under this test.
4. **Resources.** The first of two financial requirements, resource eligibility generally requires that the applicant have available resources worth less than \$2,000.00 for a single applicant and less than \$109,560.00 for a married couple.
5. **Income.** The State of Louisiana employs an income cap to determine eligibility. The State of Louisiana fixes income eligibility at 300% of the maximum federal benefit rate –the then current supplemental security income benefit for an individual. (42 U.S.C Section 1396a(a)(10)(A)). Thus, the 2009 amount is \$674.00 dollars per month of income.

C. Income

1. Louisiana applies the following rules when computing an applicant's income in terms of eligibility:
 - a. The applicant's gross income is countable before any deductions for such items as Medicare premiums.
 - b. For the medically needed spenddown option, the state allows one deduction from gross income, called the Medically Needed Eligibility Standard. This is a \$100.00 per month deduction to applicants in urban parishes and \$92.00 for those in rural parishes.
 - c. Any income payable to an applicant is considered available to the applicant and count against the eligibility limit. This is the "name on the check" rule.
 - d. Income payable to applicant's spouse is not counted unless the applicant is entitled to a portion pursuant to a support decree.
 - e. If the income is in both spouses' names, one half is considered available to each spouse. LA CH.19-E Manual. Section H-825.
2. The income includes retirement benefits from Social Security, Railroad Retirement, Social Security Administration, or private pensions; dividends, annuity payments, and income from trust. 42 U.S.C. §1396 a(a) (17); 42 CFR, § 435.600-800.
3. Not included as income are income tax refunds; the value of personal medical or social security, social services receipts; payments under Credit Life or Credit Disability policies; repayment of the principle of bona fide loan. 42 U.S.C. § 1382(d) (4); 20 CFR § 416.1103.
4. In computing the amount of applicant's income, we can ignore community property law. In some states community property principles have been used to reduce the amount of the income in the applicant's spouse's name. However, in a 1983 decisions, the Louisiana Supreme Court rejected an argument based on community property principles and upheld the state's application of the "name on the check" rule. Case of Hamner, 42 So.2nd 1188 (La.1983).

D. Patient Liability

1. Once an applicant is eligible for Medicaid, Louisiana Medicaid Program performs a second calculation to determine how much income the

individual must contribute towards the cost of his care. Medicaid will then pay the difference between the patient's monthly income and the allowable rate for nursing home care. In performing this post eligibility computation of "patient liability", Louisiana uses somewhat different rules for counting or excluding income.

E. Spousal Income Allowance

A nursing home resident ("institutionalized spouse"), who has a spouse at home ("community spouse") can shelter some of his monthly income for the benefit of the community spouse. The income of this shelter will not be considered available for contribution towards the institutionalized spouse's cost of care. The rules for determining how much of the institutionalized spouse's income the community spouse can retain are as follows:

The community spouse is allowed to keep up to \$2,739 per month (2009) of the couple's income. If the court orders spousal support greater than the amount allowable by Medicaid, the court order is used to determine the amount to go to a community spouse. 42 U.S.C. § 1396 R.

F. Spousal Resource Allowance

1. The spousal resource allowance is intended to protect the spouse living at the home "community" from impoverishment in the event of institutionalization of the other spouse. The community spouse can retain up to \$109,560.00 (2009) of the couple's countable assets without jeopardizing the institutionalized spouse's eligibility for Medicaid. 42 U.S.C § 1396r-5 (c).
2. The spousal resource allowance is available to the nursing home resident who entered the institution on or after September 30, 1989. 42 U.S.C. § 1396 r-5(c)(1). A HCFA interpretation of the statute applies this rule to any person who resides in a medical institution for more than 30 days.
3. In terms of eligibility for a married applicant, Medicaid will consider all of the couple's countable resource. Exclusion from countable resources are identical to those listed above in section IV.
4. Separate property of a community spouse will not be considered available to the institutionalized spouse, but it will be counted in meeting the spouse's resource allowance LaCh 19-E Man. § 1-1664.
5. The amount of property community spouse may retain is determined based on the value of the couple's countable resources at the time of the Medicaid application. After eligibility is established, none of the community spouse's resources are considered available to the community

spouse. Thus, any additional resources received by the community spouse (such as gift, inheritance, sell a home, accessory) are not counted. 42 U.S.C. § 1396r-5 (c) (2), (4). LA.CH.19-E man. § 1-1667.

6. The Louisiana Chapter 19-E Manual Act § 1-1664 sets out the following steps for calculating the community spouse's resource allowance and the institutionalized spouse Medicaid eligibility:
 - A. Determine the maximum allocation to the community spouse by subtracting the value of the community spouse's separate property from the spousal resource standard.
 - B. Determine the couple's countable resources by adding the couple's joint property and the institutionalized spouse's separate property.
 - C. Determine the institutionalized spouse's countable resources by subtracting the maximum allocations of community spouse from the couple's countable resource.
 - D. Determine resource eligibility by comparing the institutionalized spouse's countable resources to resource standard for an individual (\$2,000.00).
5. If resources to be allocated to the community spouse are in the institutionalized spouse's name, the institutionalized spouse has one year from the day of Medicaid eligibility to transfer those resources to the community spouse. The Medicaid program can grant extension of a one year period. 42 U.S.C. § 1396r-5 (f). Louisiana LaCh 19-E Man. § 1-1665. There is no penalty to such transfer.

V. Transfer Prohibition.

- A. Transfer of assets rule; OBRA '93 expanded substantially the transfer of assets rules in an attempt to close loopholes planners had found in the prior rules.
 1. Medicaid will penalize an applicant or spouse who transfers any asset for less than the fair market value within 60 months proceeding the date on which the individual is a resident of an institution and applies for Medicaid. This transfer rule applies to transfers of any asset. 42 U.S.C. § 1396p (c) (1).

VI. Penalty period

The Deficit Reduction Act (DRA) provides that for any transfer of assets made on or after the date of enactment of the Deficit Reduction Act (February 8, 2006), the look-back period is 60 months.

- A. Start date of the penalty period. The DRA amended the start date of the penalty period, which is the period in which an individual is ineligible for Medicaid payment for long-term care services because of a transfer of assets for less than fair market value.
- B. Prior to the amendment, the penalty period began either the month of the transfer or the month following the month of transfer.
- C. For transfers of assets made on or after February 8, 2006, the period of ineligibility will begin with the later of:

The first day of the month during, or at the state's option, the month after which the assets have been transferred for less than fair market value, or,

The date on which the individual is eligible for medical assistance under the state plan and is receiving institutionalized level of care services (based on approved application for such services) that, were it not for the imposition of the penalty, would be covered by Medicaid.

- D. The penalty period cannot begin until the expiration of any existing period of ineligibility.
- E. The penalty period will continue to run for the number of months determined by dividing the total value of assets transferred within the look-back by the state's average monthly cost to a private patient of nursing home facility services in the state. For 2009, the divestment penalty divisor is \$4,000.

For example, a gift of \$48,000.00 will result in a penalty period of 12 months.

- F. Once the penalty period is imposed, it will not be tolled but will continue to run even if individual stops receiving institutionalized level of care.
- G. The imposition of the penalty period for new applicants for Medicaid requires a denial notice.
- H. Partial month transfer. Louisiana is now required to impose penalty periods even in the case of smaller asset transfers where the period of ineligibility would be less than a full month. In imposing penalties on such transfers, if the calculation of the penalty period produces a fractional amount, the penalty must include a partial month disqualification based upon the relationship between the fractional amount and the monthly nursing home rate used to calculate the penalty period (divestment penalty divisor).
- I. Exceptions. There is no penalty for the following transfers:

1. Transfers to or from "(or to another for the sole benefit of)" the applicant

spouse or to a minor or to a blind or disabled child. 42 U.S.C. §1396P (c) (2). LaCh. 19-E Man. §1-1673.

2. Transfers of the home to:
 - a. Spouse,
 - b. A sibling with an equitable interest in the property who has lived in the house for the year prior to the applicant's entrance to the institution or
 - c. A caretaker, son or daughter, who has lived in the house for two years prior to the applicant's entrance to the institution and whose care enabled the parent to remain in the community for those two years. 42 U.S.C. §1396p (c) (2) (A). LaCh. 19-E Man. §1-1673.
3. Transfer of the applicant's spouse to another "in sole benefit of" of the spouse. 42 U.S.C. §1396p (c) (2).
4. Transfers to a trust for the benefit of a disabled individual under 65 years old. Note: The beneficiary of this transfer need not be a family member, but the statute specifies that the transfers must be to trust in order to qualify as exempt.
5. Transfer is made exclusively for a purpose other than to qualify for Medicaid. 42 U.S.C. §1396p (c) (2) (C). LaCh. 19-E Man. §I-1679.
6. Applicant intended to dispose of the resource either at fair market value or other valuable consideration.
7. Transferred assets are returned to the applicants. 42 U.S.C. §1396p (c)(2).
8. Where denial of eligibility would work as undue hardship. 42 U.S.C. §1396p (c) (2) (B). Louisiana will make a finding of undue if denial will result in the denial of necessary medical care or lost of permanent residence.

VII. Resource Rules

A. Countable versus Exempts Assets

1. To qualify for Medicaid an applicant must not have countable resources in excess of \$2,000.00. Medicaid will count as resources any property the applicant can access that can provide cash in excess of \$2,000 for his own support. The property will be counted at its fair market value. LaCh 19-E

MAN section I-1634.

2. Exclusions. Certain assets are not counted as an applicant resource. Louisiana rules for exclusion from countable resources can be found at La Ch. 19-E man. sec I-1634. These rules are supposed to apply resource rules to the federal SSI program, which can be found at 20 CFR 416.120 1et seq. The SSI rule should be consulted to resolve ambiguities in the Louisiana Medicaid rules. Excluded from accountable assets are:
 - A. A home in Louisiana, if the applicant intends to return the home or a spouse or dependent resides in the home.
 - B. Household furnishings while being used in applicant's home.
 - C. Personal effects.
 - D. One vehicle per household, if used for medical appointments, essential daily activities.
 - E. Burial spaces, funds held in irrevocable trust or contracts, as well as up to \$1,500.00 set aside for burial expenses.
 - F. Cash value of permanent life insurance policy up to \$1,500.00 in face value and all term policies with no cash value.
 - G. Up to \$6,000.00 of income producing property that produces income at an annual net rate of return of at least 6%.
3. Bank accounts: there is a rebuttable presumption that an applicant owns an equal share of funds in shared/joint accounts and owns all funds in single accounts. LaCh 19-E Man. § I-1635.

VIII. Spenddown

- A. Spenddown means the amount by which the Medicaid applicant's allowable resources (whether a single or married applicant) must be reduced before eligibility can be obtained.
- B. One way of reaching Medicaid's allowable level of resource is to spend the "excess" resources for the benefit of the applicant, usually for the cost of long-term care. This approach is usually referred to as the "spenddown".
- C. However, there are different strategies available to protect the applicant's resources including reverse half-a-loaf, re-allocating the portfolio to non-resource assets, and certain transfer exceptions.

IX. Treatment of Trusts

- A. Since the adoption of the Omnibus Budget Reconciliation Act of 1993, the usefulness of trusts in Medicaid planning has been dramatically reduced.
- B. In the current law, a revocable trust is treated as fully available to the beneficiary, 42 USC section 1396p(d)(3)(A).
- C. An irrevocable trust established by a Medicaid applicant, his or her spouse, or someone acting on his or behalf will be treated as an available resource and distributions as income if there's any discretion in the trustee to make any distributions whatsoever to the applicant, 42 USC section 1396p(d)(3)(B). In other words, "self-settled" discretionary trust will not protect the assets or preserve eligibility for Medicaid.
- D. However, four important exceptions to this rule are available.
- E. OBRA'93 added three new exceptions to the harsh treatment of trusts.
 - 1. Irrevocable trust for the benefit of a disabled individual under the age of 65 that provide for pay back of Medicaid expenses upon the death of the beneficiary, 42 USC §1396p(d)(4)(A).
 - 2. Income Trust to handle the applicant's income and to make him or her eligible, 42 USC §1396p(d)(4)(B). This type of trust does not apply in Louisiana, because Louisiana is an income cap state.
 - 3. Trust establishes an account for disabled individual under age 65 in a pooled asset trust held by nonprofit organization, 42 USC §1396p(d)(4)©.
- F. In addition, OBRA'93 added another trust concept. It exempted certain transactions from transfer penalty rules. Transfers in trust made to a spouse or disabled children invoking the language "to or for the sole benefit of" the respective favored beneficiary, 42 USC section 1396p (c)(2)(B). This exception has given rise to sole benefit trusts to handle those transfers to disabled children and spouses.
- G. OBRA'93 states at 42 USC section 1396p(d)(2)(A) that

(2)(A) For the purpose of this subsection, an individual shall be considered to have established a trust if assets to the individual were used to form all or part of the corpus of the trust and if any of the following individuals establish such trust other than by will:

 - (i) The individual.

(ii) The individual's spouse.
(iii) A person, including court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.

(iv) A person, including any court or administrative body acting at the direction or upon the request of that individual or the individual's spouse.

H. The essential term in this paragraph is "other than by will." This rule, making the trust asset an available resource of any discretionary trust established by applicant's spouse, does not apply to testamentary trusts. This means that one spouse can name the other in his or her will as beneficiary of the discretionary trust that gives the trustee the right to withhold payments without affecting the surviving spouse's benefits, and without the trust being subject to the state lien on the surviving spouse's death.

I. This is an important strategy for spouses likely to pass away first.

J. The state will be reimbursed for Medicaid benefits granted to the extent that the funds remain in the beneficiary's account upon his death. 42 USC Section 1396p (4)

X. Estate Recovery

A. Louisiana seeks to recover Medicaid benefits from a recipient's estate.

1. Estate recovery will apply to an individual who is 55 older when he receives Medicaid benefits.
2. Recovery must apply to benefit's received after October 1, 1993 for nursing home facility, home and community based services, and related hospital and prescription services.
3. Recovery cannot occur so long as a child under 21, spouse or a disabled child of any age survives.
4. Estate is defined as all real and personal property included in a person's estate under the estate and probate law.

B. Louisiana has established an estate recovery program.

XI. Appeals

A. Right to hearing: Every applicant or recipient has a right to request a hearing if a claim for Medicaid is denied or not acted upon with reasonable promptness or if an agency takes action which results in a suspension, reduction or discontinuance of a assistance. 42 CFR Section 431.200

- B. Time limits: The recipient must request a hearing within 30 days from the date the agencies notice is mailed. If the request is made within 10 days, recipient has a right to continued benefits depending on the outcome of the hearing. Recipient has a right to receive a hearing decision within 90 days. 42 CFR Section 431.231, 431.244
- C. Hearings: Hearings are held before administrative law judges employed by the state, Department of Health & Hospitals. Due process rules apply.
- D. Judicial review: Recipients have a right to seek judicial review of an adverse hearing decision under the State Administrative Procedures Act. Petitions must be filed within 30 days after mailing of the agency's decision and they must be filed in 19th Judicial District Court in Baton Rouge or in the district where the applicant resides. La.R.S.49:964.