Basic Medicaid Eligibility for Nursing Home Residents and the ADvantage Program

Tulsa Estate Planning Forum

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Travis Smith
Assistant General Counsel
Oklahoma Department of Human Services
P.O. Box 53025
Oklahoma City, Oklahoma 73152
(405) 521-3638
FAX 521-6816
travis.smith@okdhs.org

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I. INTRODUCTION

A. CAVEAT

This article is an **introduction** to Medicaid long term care eligibility. An exhaustive treatise on this subject would run a few hundred more pages.

The statements in this article do not constitute official statements of the Oklahoma Department of Human Services or the Oklahoma Health Care Authority and are not binding on those agencies. The only official statements regarding the Oklahoma Medicaid Program are found in Title 317 of the Oklahoma Administrative Code.

B. THE MEDICAID PROGRAM

The Social Security Act consists of 42 U.S.C. Chapter 7. Subchapter XIX of the Social Security Act establishes the Medical Assistance program, more commonly known as 'Medicaid'. Medicaid is a federal program administered by the states that provides medical insurance for certain categories of poor people. Medicaid is often confused with Medicare, which is an entirely separate program.

Medicaid law reminds lawyers of income taxes. There are a seemingly endless number of interconnecting definitions, exceptions, newly promulgated regulations, and informal federal guidance. To complicate things, each state is given a number of options to choose from and therefore no two states have Medicaid programs that are the same.

To further complicate things, the Secretary of Health and Human Services has the authority to waive provisions of the Medicaid statutes.[1] The result is that a state may have a Medicaid Program component which has rules that are in seeming conflict with federal statutes.

The courts have often commented on the complexity of the Medicaid Program.

> The Medicaid statute (as is true of other parts of the Social Security Act) is an aggravated assault on the English language, resistant to attempts to understand it. The statute is complicated and murky, not only difficult to administer and to interpret but a poor example to those who would like to use plain and simple expression.

[1] 42 U.S.C. §§ 1396a(10)(A)(ii)(IV), 1396n(b)-(e).

Friedman v. Berger, 409 F.Supp. 1225, 1225-1226 (S.D.N.Y. 1976).

> As program after program has evolved, there has developed a degree of complexity in the Social Security Act and particularly the regulations which makes them almost unintelligible to the uninitiated. There should be no such form of reference as "45 C.F.R. § 283.3(c)(1)(ii)(B)(2)" discussed below; a draftsman who has gotten himself into a position requiring anything like this should make a fresh start. Such unintelligibility is doubly unfortunate in the case of a statute dealing with the rights of poor people.

Friedman v. Berger, 547 F.2d 724, n7 (2nd Cir. 1976) [Medicaid Medically Needy spenddown.]

> There can be no doubt but that the statutes and provisions in question, involving the financing of Medicare and Medicaid, are among the most completely impenetrable texts within human experience. Indeed, one approaches them at the level of specificity herein demanded with dread, for not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase.

Rehabilitation Association of Virginia, Inc. v. Kozlowski, 42 F.3d 1444, 1450 (C.A. 4 1994).

The Medicaid Act contains complex, interrelated provisions, and it would be foolhardy to impute a plain meaning to any of its provisions in isolation. *Cleary v. Waldman*, 959 F. Supp 222, 228 (D. N.J. 1997).

C. STATE ORGANIZATION

The Oklahoma Medicaid program is administered by the Oklahoma Health Care Authority (OHCA). Through an interagency agreement, OKDHS determines who is eligible for Medicaid, using the rules promulgated by OHCA.

OKDHS and OHCA regulations refer to the Medicaid program as 'SoonerCare' or 'Medical Assistance'. All of OHCA's regulations can be found on the OKDHS web site, www.okdhs.org, by clicking on the 'Policy' link in the 'Quick Link' box on the left side of the screen, in the blue pane on the left of the screen. Then click on 'Policy'. The Medicaid rules are found in OAC 317. You can either navigate to the section you want or use the search function.

OKDHS Appendix C-1 contains the Medicaid income and resource amounts and is frequently referred to in Oklahoma's Medicaid rules. **Appendix C-1, and other OKDHS**

appendices, can be accessed at the OKDHS web site by going to 'Quick Links', clicking on 'Forms', then choosing 'Appendices' from the pick list. Do not type in 'C-1' as the form name, just click on 'GO' to the right of 'Appendix'. Then scroll down to see the list.

II. BASIC MEDICAID ELIGIBILITY

To understand Medicaid eligibility rules, you must begin with the rules for short term services. Short term services are defined as all services that are not related to long term medical care services. Long term care is care in an institution, or extended care at home, for someone whose condition is severe enough to justify institutional care.

A. CATEGORICAL RELATIONSHIPS

To be eligible for Medicaid in Oklahoma, a person must be in a category of people who can receive Medicaid (categorically related) and must meet the financial eligibility rules for that particular category. The three general categories of people who are eligible for Medicaid are children under 19 and some of their caretakers (**categorically related to AFDC**); pregnant women (**categorically related to pregnancy services**) and people who meet the Supplemental Security Income (SSI) definitions of aged, blind or disabled (**categorically related to ABD**).[2]

Since very few of the people needing long term care are categorically related to AFDC or pregnancy services, this discussion will be limited to the eligibility of those who are categorically related to ABD.

'Aged', 'blind', and 'disabled' are defined the same way that SSI defines the categories. "**Aged** means an individual whose age is established as 65 years or older." "**Blind** means an individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens." "**Disabled** means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can

[2]OAC 317:35-5-2.

be expected to last) for a continuous period of not less than 12 months."[3]

OKDHS accepts the determination of the Social Security Administration (SSA) that a person is, or is not, disabled. If a person claims to be disabled but has not filed an application with SSA, OKDHS accepts the Medicaid application, but directs the person to SSA for a disability determination. If SSA rejects the disability application for non-medical reasons, then OHCA will determine if the person is disabled.

B. FINANCIAL ELIGIBILITY

The rules that Medicaid uses to determine financial eligibility for short term services are, with a few exceptions, the same as the SSI rules. The basic rules are described below.

1. RESOURCES

There is a $2,000 limit on countable resources for an individual who is categorically related to ABD. The countable resource limit for a couple who are both applying as ABD individuals is $3,000.[4] All resources count towards the limit except the items specifically exempted. The more common exemptions are:

- The home the person lives in, including the land adjacent to it and the minerals under it. OAC 317:35-7-38;
- One car, as long as it is used at least four times a year to get medical treatment or prescriptions. OAC 317:35-5-41.3;
- Clothing, furniture, and household goods. OAC 317:35-5-41.2;
- Burial spaces. *Id.*;
- The face value of life insurance policies, up to $1,500. *Id.*;
- Designated accounts for burial up to $1,500. *Id.*;
- Irrevocable burial contracts or life insurance policies designated for funeral expenses up to $10,000 plus accrued interest. The cash value of life insurance policies not related to a burial and the value of a designated burial account count against the $10,000 limit. *Id.*;
- Property, both real and personal, used in a trade or business. OAC 317:35-5-41.1;
- Income producing property, not used in a trade or business, which is valued at $6,000 or less and which produces income at the rate of at least 6%. *Id.*;

The first of the two main exceptions to the basic SSI resource rules is that a

[3]OAC 317:35-5-2 through 35-5-5.

[4]OAC 317:35-7-38.

retroactive SSI payment is treated as a resource in the month after receipt.[5] For SSI eligibility purposes, a recipient has six months before a retroactive payment is considered at all.

The second exception to the basic SSI resource rules is trusts. For **trusts established before August 11, 1993,** 42 U.S.C. § 1396a(k)[6] and OAC 317:35-5-41.6(4) control. No matter who established and funded the trust, the trust is generally considered available to the full extent that the trustee can exercise discretion to use corpus or income for the beneficiary. The main exception to this rule is a Special Needs Trust, which contains language to the effect that the trustee must take into consideration the availability of public benefits before spending trust income or corpus. The undistributed income and corpus of a Special Needs Trust is not considered available for purposes of determining Medicaid eligibility.[7] See *Trust Company of Oklahoma v. OKDHS*[8] for an example of a Special Needs Trust.

For **trusts established after August 10, 1993**, the Omnibus Budget Reconciliation Act of 1993 (OBRA 93)[9] repealed the existing trust provisions[10] and substituted new law, at 42 U.S.C. § 1396p(d).[11] The new law does not consider trusts that are funded with another's money, that the Medicaid beneficiary never had a right to have. It considers trusts that are established by the beneficiary, or anyone acting on behalf of the beneficiary, with money belonging to the beneficiary or which the beneficiary had a right to have in their

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[5]OAC 317:35-5-42(c)(3)(C).

[6]Repealed by OBRA 93, but can be found in the statutory history in U.S.C.A.

[7]OAC 317:35-5-41.6(4)(C).

[8]825 P.2d 1295 (Okl. 1991).

[9]P.L. 103-66.

[10]42 U.S.C. § 1396p(c)

[11]SSI law has been amended in the years since and is now substantially identical to Medicaid law.

hands. The disqualifying provisions are substantially the same as in the old law.[12]

42 U.S.C. § 1396p(d)(4)(A) allows people who meet the SSA definition of 'disabled' to have a trust and retain Medicaid eligibility. The trust must:

- solely benefit a disabled person who is under 65 years old when the trust is established and funded;
- be established by the beneficiary's parent, grandparent, guardian, or a court;
- contain only the beneficiary's money;
- be irrevocable; and
- provide that upon the beneficiary's death, the Medicaid program is paid back for funds expended after establishment of the trust.[13]

If a trust meets these requirements, the income and undistributed corpus are not considered available to the beneficiary for purposes of determining Medicaid eligibility. The SSI statute on trusts was amended on January 1, 2000, to treat a trust as exempt if it conforms to the requirements in 42 U.S.C. § 1396p(d)(4)A). OKDHS has issued a sample trust which will also pass muster at SSA.[14]

These trusts are commonly referred to as Special Needs Trusts, but actually are not. There is no requirement in 42 U.S.C. § 1396p(d)(4)(A) that the trustee consider the special needs of the beneficiary or that expenditures do not displace public benefits. These trusts should be actually be referred to as Medicaid Disability Trusts, Medicaid Pay Back Trusts, or (d)(4)(A) trusts, instead of Special Needs Trusts.

The income or corpus of a trust that was established by a person other than the ABD person, spouse, guardian, or a court, and which is not funded by the ABD person's money, does not come within the provisions of 42 U.S.C. § 1396p(d)(4)(A) and OAC 317:35-5-41.6(6)(A). The income and corpus of such a trust is not considered available to the beneficiary unless the beneficiary has the power to force payment to him, or for his

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[12]OAC 317:35-5-41.6(5).

[13]See also OAC 317:35-5-41.6(6)(A).

[14]OKDHS Appendix M-12, which is not available on the Internet. If you would like a copy, please email me and tell me if you prefer MS Word or WordPerfect. I will send you three files: (1) A trust with blanks for Word or a merge form for WordPerfect; (2) A copy of the trust with the blanks filled in; and (3) A list which says how the trust has to be created and what it has to contain. You will see that the mandatory provisions of the trust are a small part of the total.

benefit, of trust income or corpus. An example of a trust that is not considered available is a trust established by a grandparent which contains none of the disabled person's money and which allows the trustee sole discretion to control income and corpus.

2. INCOME

Income is defined as, ". . . that gross gain or gross recurrent benefit which is derived from labor, business, property, retirement and other benefits, and any other form which can be counted on as currently available for use on a regular basis."[15] Everything that meets this definition is income unless it is specifically excluded from income. Among the items that do not count as income are:

- Food Stamps;
- Loans;
- Indian payments (including judgement funds or funds held in trust) distributed by the Secretary of the Interior (BIA) or by the tribe subject to approval by the Secretary of the Interior;
- Benefits from State and Community Programs on Aging;
- Low Income Heating and Energy Assistance Program (LIHEAP) payments for energy assistance;
- Income up to $2,000 per year received by individual Indians, which are derived from leases or other uses of individually-owned trust or restricted lands;[16]

When determining the amount of income that is counted toward Medicaid eligibility, the entire amount of unearned income is counted. Countable earned income is calculated by deducting $85 from gross earned income and then dividing the remainder in half.[17] This method of counting income is slightly different than the SSI method, where the $20 income disregard is first used on unearned income and the remainder deducted from earned income.[18]

The income limit for an individual who is categorically related to ABD and who wants to receive both Medicaid short term services and a State Supplement Payment (SSP) is $739 in 2012. This number is calculated by adding the maximum SSI payment to an

[15]OAC 317:35-5-42(a).

[16]OAC 317:35-5-42(b)(24).

[17]OAC 317:35-5-42(d).

[18]20 C.F.R. §§ 416.1112(c) and 416.1124.

individual ($698 in 2012) to the maximum SSP paid to ABD individuals by OKDHS ($41).[19] The income limit for a couple who are both categorically related to ABD and who want to receive SSP is $1,130 per month in 2012. This number is calculated by adding the maximum SSI payment to a couple ($1,048) to the maximum SSP ($41 x 2) for each member of the couple.[20]

If a person is categorically related to ABD and has income in excess of the monthly SSP limit, he can still receive Medicaid short term services – but no SSP, as a Qualified Medicare Beneficiary Plus (QMB). The 2012 QMB income limit is $908[21] and the resource limit is $6,940. In 2012, a couple, both of whom are categorically related to ABD, qualify for QMB as long as their income does not exceed $1,226 and countable resources do not exceed $10,410.[22]

III. LONG TERM CARE

A. DEFINITION

Long-term medical care includes:

- Care in a nursing facility;
- Home and Community Based Waiver Services for frail elderly and adults with physical disabilities who do not have cognitive impairments (ADvantage Waiver);
- Care for persons age 65 years or older in mental health hospitals;
- Care in an intermediate care facility for the mentally retarded;
- Home and Community Based Waiver Services for In-Home Supports (In-Home Supports Waiver); and
- Home and Community Based Waiver Services for the Mentally Retarded (Community Waiver).[23]

[19]OAC 317:35-7-38.

[20]OAC 317:35-7-38.

[21]This increases every April 1st.

[22]OAC 317:35-7-40; OKDHS Appendix C-1, Schedule VI.

[23]OAC 317:35-9-1.

B. MEDICAL ELIGIBILITY

1. NURSING FACILITY

Nursing facility services are those services furnished pursuant to a physician's orders which require the skills of technical or professional personnel. This care is provided by nursing facilities licensed under state law to provide, on a regular basis, health related care and services to individuals who do not require hospitalization but whose physical or mental condition requires care and services above the level of room and board which can be made available to them only through a nursing facility.

To be medically eligible for Medicaid to pay for nursing facility services, the individual must:[24]

- require a treatment plan involving the planning and administration of services which require skills of licensed technical or professional personnel that are provided directly or under the supervision of such personnel and are prescribed by the physician;
- have a physical impairment or combination of physical and mental impairments;
- require professional nursing supervision (medication, hygiene and dietary assistance);
- lack the ability to care for self or communicate needs to others; and
- require medical care and treatment in a nursing facility to minimize physical health regression and deterioration.

2. ADVANTAGE WAIVER

The ADvantage Waiver provides in-home services to adults who meet the medical requirements for nursing facility services. The in-home services necessary for the person to live safely at home must cost no more than it would for the person to live in a nursing facility.[25]

3. PERSONS AGE 65 YEARS OR OLDER IN MENTAL HEALTH HOSPITALS

Services for persons age 65 years or older in mental health hospitals are mental health services provided in an inpatient hospital setting to eligible categorically needy

[24]OAC 317:35-19-3.

[25]OAC 317:35-17-3.

individuals whose condition cannot adequately be treated on an outpatient basis.[26]

4. INTERMEDIATE CARE FACILITY FOR MENTALLY RETARDED

Services in an Intermediate Care Facility for Mentally Retarded (ICF/MR) are provided to an individual with chronic mental retardation, a condition characterized by a significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and originating during the developmental period. Care also can be provided for the individual who is not mentally retarded but has developmental disabilities closely related to or requiring similar treatment to mental retardation. In addition to the developmental disability, the individual must have one or more handicapping conditions which prevent communication of basic needs, ability to meet basic self-help needs, or require care and treatment similar to that of a mentally retarded individual. To be eligible for ICF/MR services, mental retardation or developmental disability must have occurred prior to the individual's 22nd birthday.[27]

5. IN-HOME SUPPORTS WAIVER

The In-Home Supports Waiver provides services which are outside the normal scope of the Medicaid services. This Medicaid waiver allows OHCA to offer certain home and community based services to mentally retarded individuals who are at least three years old and who meet the requirement to live in an ICF/MR. Services will be provided only if the services necessary for the individual to live safely at home do not exceed the cost of institutional care. There are a limited number of people who can participate in the In-Home Supports Waiver at any one time.[28]

6. COMMUNITY WAIVER

The Community Waiver provides services which are outside the normal scope of the Medicaid services. This waiver allows OHCA to offer certain home and community based

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[26]OAC 317:35-9-7.

[27]OAC 317:35-9-4.

[28]OAC 317:40-1-1(d)(1).

services to mentally retarded individuals who are at least three years old and who meet the requirement to live in an ICF/MR. Services have no cost limit. There are a limited number of people who can participate in the Community Waiver at any one time.[29]

C. FINANCIAL ELIGIBILITY

1. SINGLE INDIVIDUAL

a. RESOURCES

With the exceptions set forth below, resources are counted the same as for short term eligibility.[30] The resource limit is $2,000.[31]

(1) Homes

A house owned by an applicant or recipient is exempt if his spouse, minor child or disabled child lives there. If no such people live in the home, the individual is ineligible if he has more than $500,000 equity in the home.[32] If home equity is less than $500,000, the home is exempt for 12 months after entry into the nursing home, as long as the person says he plans to return home. At the end of 12 months the home counts as a resource unless good faith efforts are being made to sell.[33] When the house is sold, the person is ineligible for benefits until resources are back below $2,000.

Except for the home, property that is otherwise exempt loses its exemption when placed in a revocable trust.[34]

(2) Transfers

A person cannot give away assets to become eligible. Medicaid looks back 60 months from application to determine if assets have been disposed of at less than fair

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[29]OAC 317:40-1-1(d)(1).

[30]OAC 317:35-9-65; OAC 317:35-15-6; OAC 317:35-17-10; OAC 317:35-19-19.

[31]OKDHS Appendix C-1, Schedule VIII.D.

[32]OAC 317:35-5-41.8(a).

[33]OAC 317:35-5-41.8(a)(3).

[34]OAC 317:35-5-41.8(a); OAC 317:35-5-41.6(5).

market value.[35] If so, the person is ineligible for Medicaid, from the date of transfer, for a period of days equal to:

(fair market value less encumbrances less value received)/$126.90.[36]

The date the penalty begins will be the later of (1) the date of the transfer; (2) Medicaid application; or (3) the date on which the person is both in a nursing home and would be eligible for Medicaid payment for nursing home care, were it not for the penalty.[37]

Two specific transactions are defined as a transfer. For purposes of transfer, an asset, ". . . includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage:

- has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration). This means that the note must pay out within the expected life of the applicant;
- provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and
- prohibits the cancellation of the balance upon the death of the lender."

The amount of the transfer is the outstanding payments remaining to be made as of the date of application.[38]

The purchase of a life estate in another person's home is an asset transfer unless the individual lived in the home at least a year prior to purchase.[39]

A penalty for transfer without receipt of fair market value in return is not applied if:[40]

- Ownership of the house was transferred to the person's spouse; the person's child under 21 or who SSA has found disabled; a sibling who has equity interest in the home and resided in the home for at least one year prior to the institutionalization of the individual; or the individual's son or daughter who resided in the home and provided care for at least two years prior to the individual's institutionalization.

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[35]42 U.S.C. § 1396p(c)(1)(B)(i); OAC 317:35-19-20(5).

[36]42 U.S.C. § 1396p(c)(1)(E); OAC 317:35-19-20(5)(E).

[37]42 U.S.C. § 1396p(c)(1)(D)(ii); OAC 317:35-19-20(5)(C).

[38]42 U.S.C. § 1396p(c)(1)(I).

[39]42 U.S.C. § 1396p(c)(1)(J); OAC 317:35-5-41.8(d)1).

[40]42 U.S.C. § 1396p(c)(2); OAC 317:35-19-20(5)(H).

- The transfer was to the community spouse, or to another for the sole benefit of the community spouse, in an amount that brings the community spouse's resources up to the Community Spouse Resource Allowance. (This will be explained in the next section);
- The person can show that his intent was to dispose of assets at fair market value;
- The person can show that the transfer was exclusively for a purpose other than Medicaid eligibility;
- The transfer is to a trust established solely for the benefit of a disabled individual under the age of 65;
- The penalty would result in undue hardship. 'Hardship' exists when application of a transfer disqualification would result in loss of medical care that would endanger person's life or health OR deprive them of food, clothing, shelter or other necessities.

(3) Annuities

Prior to February 1, 2005

Prior to February 1, 2005, a couple could, in effect, convert assets allocated to the institutionalized spouse into community spouse income by buying an annuity that pays the community spouse. The annuity has to be irrevocable and unassignable, and produce a return at the market rate when purchased. An annuity purchased after the institutionalized spouse enters the nursing home must pay out in a period no longer than his or her expected life at the date of purchase. An annuity purchased before entry into the nursing home may pay out within the life of either spouse. This has the effect of reducing, dollar-for-dollar, the amount of the institutionalized spouse's income that is paid to the community spouse.[41]

February 1, 2005

On February 1, 2005, the OAC was amended to reflect the fact that there is a market for irrevocable annuities. The amendment creates a presumption that an irrevocable annuity can be sold and that the value is the total of all remaining payments, discounted by the IRS Applicable Federal Rate for the month of application or review. The presumption of marketability and value may be rebutted by compelling evidence.[42]

OKDHS does not consider that an annuity purchased from a friend or relative to be

[41]OAC 317:35-5-41.7(1)(A).

[42]OAC 317:35-5-41.7(1)(B).

financially sound and therefore fair market value is not received when such an annuity is purchased.

February 8, 2006

The Deficit Reduction Act of 2005 (DRA) contains requirements regarding annuities that cross several sections of these materials. These will all be addressed here rather than spread across the materials.

The first requirement is that each time an individual applies, or is recertified for, Medicaid long-term care, he is required to disclose an interest the institutionalized or community spouse has in an annuity, or in a similar financial instrument. The documents signed by the individual must contain a statement that, ". . . the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance."[43]

If an annuity is disclosed, the State must notify an issuer of the annuity that the State is a preferred remainder beneficiary up to the amount expended by Medicaid. The issuer must notify the State when there is a change in the amount of income or principal being withdrawn.[44]

Purchase of an annuity is treated as transfer of an asset for less than fair market value unless:

- the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant under this title; or
- the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

For purposes of determining if purchase of annuity is a transfer of assets, an annuity is considered an asset if it was bought by, or on behalf of, a person who has applied for

[43]42 U.S.C. § 1396p(e)(1); OAC 317:35-5-41.8(c)

[44]42 U.S.C. § 1396p(e)(2);

Medicaid Long-Term Care unless the annuity is:[45]

- an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986;
- purchased with proceeds from an account or trust described in subsection (a), (c), or (p) of section 408 of such Code;
- purchased with proceeds from a simplified employee pension (within the meaning of section 408(k) of such Code);
- a Roth IRA described in section 408A of such Code; or
- the annuity is: (1) is irrevocable and nonassignable; (2) actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and (3) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

Even if an annuity is not considered to be a transfer, a State will evaluate it and determine if it produces countable income or resources, which may cause Medicaid ineligibility.[46]

b. INCOME

A person can have income up to 300% of the current year maximum SSI payment to an individual. This is $2,094in 2012.[47] The institutionalized person keeps the first $50 as a personal needs allowance, pays medical insurance premiums, and then pays the rest to the nursing facility. Medicaid pays the rest.[48]

If an institutionalized person's income is more than $2,094, but does not exceed $3,000, he can become income eligible by establishing a Medicaid Income Pension Trust. All of the person's income goes into the trust. The trustee then takes out an amount equal to 300% of SSI, uses the first $50 for the personal needs allowance, pays medical insurance premiums, and then pays the rest to the nursing home.

The trust accumulates all the rest of the income, which can only be spent on:

- Medically necessary items not covered by Medicaid, other insurance,

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[45]42 U.S.C. § 1396p(c)(1)(G); OAC 317:35-5-41.8(c)(2).

[46]42 U.S.C. § 1396p(e)(4); OAC 317:35-5-41.7(1)(B)(ii).

[47]OAC 317:35-9-65, 317-35-9-67, 317:35-9-68; OKDHS Appendix C-1, Schedule VIII(B)(1).

[48]OAC 317:35-19-21, Instructions to Staff.

or the $50 personal needs allowance;[49]
- A reasonable cost of administering the trust.[50]
- "The trustee may claim a fee of up to 3% of the funds remaining in the trust monthly as compensation."[51] OKDHS takes the position that this means 3% of the amount placed in the trust monthly, not 3% of the accumulated amount.

When the person dies, the money left in the trust is used to pay back the Medicaid program, to the extent that funds were expended on behalf of the trust beneficiary after the date the trust was established.[52]

OKDHS has promulgated a Medicaid Income Pension Trust form which, if used by an applicant, will automatically be approved.[53] The IRS says that Medicaid Income Pension Trusts do not need a separate EIN.

2. AN INSTITUTIONALIZED INDIVIDUAL WITH A SPOUSE REMAINING AT HOME

The most complex Medicaid eligibility issues are presented when one spouse needs long term care while the other spouse does not. The spouse needing long term care is called the 'institutionalized spouse' and the spouse who does not need long term care is called the 'community spouse'.

The federal law in this area was contained in the Medicare Catastrophic Coverage Act (MCCA), passed in 1988. The MCCA contained 'spousal impoverishment' provisions, which deal with the division of income and resources between the institutionalized and community spouses. The U.S. Supreme Court included a good discussion of the spousal impoverishment provisions of the MCCA in *Wisconsin Department of Health and Family Services v. Blumer*, 122 S.Ct. 962, 534 U.S. 473 (2002).

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[49]OAC 317:35-5-41.6(6)(B)(viii).

[50]*Id.*

[51]OAC 317:35-5-41.6(6)(B)(ix).

[52]OAC 317:35-5-41.6(6)(B)(vii).

[53]OKDHS Appendix M-11. This is an appendix on the OKDHS website.

A. RESOURCES

The institutionalized spouse does not meet the Medicaid resource limit until the couple's total countable resources, less the amount allocated to the community spouse (described below) is $2,000 or less.[54] The amount allocated to the community spouse is called the 'spousal share' in Oklahoma Medicaid rules and the 'community spouse resource allowance' (CSRA) in the federal statute.

(1) Protecting Resources for the Community Spouse

The process to determine how much of a couple's resources are allocated to the community spouse begins by adding the value of all countable resources, including separate property and resources covered by a prenuptial agreement, **as of the date the institutionalized spouse entered long term care**. The total is then divided in half.[55]

The second step is to make sure that the community spouse has resources worth at least $25,000. If half of the total countable resources is less than $25,000, then enough of the institutionalized spouse's half of the resources are reallocated to the community spouse to bring the community spouse's resources up to $25,000.[56]

The third step is to make sure that the community spouse's resources do not exceed the maximum resource allowance, which is $113,640 in 2012.[57] If half of the total countable resources is greater than $109,560, then the community spouse's half of the resources in excess of $113,640 are reallocated to the institutionalized spouse.

Although not described in the OAC, pursuant to 42 U.S.C. § 1396r-5 and *Anderson v. OKDHS*, 916 P.2d 846 (Okl. App. 1995) (cert. denied), current practice at OKDHS is that a couple can increase the resources allocated to the community spouse by making use of the administrative hearing process. A couple can ask OKDHS to assess their income and

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[54]OAC 35-19-21(3)(B)0(2).

[55]42 U.S.C. § 1396r-5(c); OAC 317:35-19-21(3)(B).

[56]*Id.*

[57]OKDHS Appendix C-1, Schedule VIII(B). This amount is usually adjusted upward each year.

resources, without filing an application. If dissatisfied with the resources allocation, either spouse can ask for a hearing at which the resource allocation can be raised so that enough income can be generated to bring the community spouse's income up to the Maximum Monthly Maintenance Needs Allowance (MMMNA), which is $2,841 in 20121.[58]

At the hearing, the couple presents evidence showing the community spouse's income not generated by resources, and the amount of the money needed to buy a single premium lifetime immediate monthly payment annuity which will increase the community spouse's monthly income to $2,841. If the amount needed to buy the annuity is greater than previously allocated to the community spouse, then resources previously allocated to the institutionalized spouse are given to the community spouse to make up the difference. The annuity need not actually be purchased.

(2) Resource Spenddown

The last step in determining resource eligibility for the institutionalized spouse is to take the couple's total countable resources on the date of application, subtract the resources allocated to the community spouse, and then compare the remainder to the $2,000 resource limit.[59] If it is more than $2,000, then the institutionalized spouse has to 'spend down' resources to become eligible.

To meet the spenddown amount, the institutionalized spouse has to show that resources, not income, have been spent for the benefit of one of the spouses after entry of the institutionalized spouse into the nursing home. This can take place either before or after the application.

The couple cannot meet the spenddown by giving it away. Ways to meet the spenddown include, but are not limited to, buying exempt resources, paying debts, and doing household repairs or remodeling.

If the couple acquires resources after the date of entry into long term care, the new

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[58] *Id.* The amount is usually adjusted upwards yearly.

[59] 42 U.S.C. § 1396r-5(c); OAC 317:35-19-21(3)(B).

resources are allocated to the institutionalized spouse and must be spent down.

(3) The Home

The home of the institutionalized spouse is not counted as a resource as long as the community spouse, minor child or a relative who is aged, blind or disabled or a TANF recipient lives there.[60] If none of these people live in the home, and it becomes apparent that the institutionalized person will not return home, or in 12 months – whichever comes first – then the house counts as a resource unless good faith efforts are being made to sell the house.[61] When the house is sold, the person is ineligible for benefits until resources are back below $2,000.

The institutionalized spouse can transfer the home, without penalty, to the community spouse; the person's child who is under 21 or who SSA has found disabled[62]; a sibling who has equity interest in the home and resided in the home for at least one year prior to the institutionalization of the individual; or the individual's son or daughter who resided in the home and provided care for at least two years prior to the individual's institutionalization.

(4) Transfers

For transfers made by either spouse prior to the institutionalized spouse becoming eligible for Medicaid, the penalty is the same as for a single person. This includes resources given away by either spouse before the day the institutionalized spouse is found to be eligible for Medicaid.

Transfers made by the institutionalized spouse after he becomes eligible for Medicaid are penalized the same way, except that the institutionalized spouse must make one kind of transfer which is not penalized. The institutionalized spouse must transfer all interest in the resources allocated to the community spouse within 12 months of becoming

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[60]OAC 317:35-5-41.8)(a)(2)

[61]OAC 317:35-5-41.8(a)(1).

[62] OAC 317:35-19-20(3)(A)(ii).

eligible for Medicaid. If this is not done, the resources allocated to the community spouse will be considered available to the institutionalized spouse at the end of the 12 months. If the institutionalized spouse transfers resources to the community spouse in excess of the allocation described above, the excess resources are considered a transfer and penalized accordingly.[63] Transfers made by the community spouse after the institutionalized spouse becomes eligible for Medicaid do not result in penalties for the institutionalized spouse. However, the transfers would result in penalties to the community spouse if she applies for Medicaid during the applicable lookback period.

(5) Special Situations

While not included in the DRA, OHCA adopted two rules at the same time the first batch of DRA rules were passed.

The first is that if the community spouse and institutionalized spouse get a separate maintenance or divorce, it is presumed to be a transfer if the institutionalized spouse does not end up with at least their separate income plus half of joint income, and half of the couple's resources. This presumption may be rebutted.[64]

The second is that if the community spouse dies first, the institutionalized spouse must receive at least their statutory share of the community spouse's probate estate – free and clear. If the institutionalized spouse receives less than the statutory share, or the statutory share is left in trust, then a transfer to the other heirs.[65]

b. INCOME

To determine income eligibility for an institutionalized spouse, the couple's income is allocated by counting his income as his, hers as hers, and joint income split in half.[66] The income limit for an institutionalized spouse is the same as for a single individual -

[63]42 U.S.C. § 1396r-5(f)(1); 42 U.S.C. § 1396r-5(a)(1); OAC 317:34-19-20(4)(F)(iii).

[64]OAC 317:35-19-20(5)(G)(i).

[65]OAC 317:35-19-20(5)(G)(ii).

[66]42 U.S.C. § 1396r-5(b); OAC 317:35-19-21(3)(A).

$2,094 per month.[67] The institutionalized spouse keeps the first $50 as a personal needs allowance, pays health insurance premiums, and then gives money to the community spouse, if necessary, to bring the community spouse's income up to $2,841 per month.[68] The remainder goes to the nursing facility.[69]

If an institutionalized person's income is more than $2,094 but not more than $3,000, he can become income eligible by establishing a Medicaid Income Pension Trust. All of the person's income goes into the trust. The trustee then takes out an amount equal to 300% of SSI, uses the first $50 for the personal needs allowance, pays health insurance premiums, and then gives money to the community spouse, if necessary, to bring the community spouse's income up to $2,841 per month. The remainder is paid to the nursing facility. The remainder of the provisions relating to the Medicaid Income Pension Trust are the same as for a single person.[70]

Although not described in the OAC, pursuant to 42 U.S.C. § 1396r-5, current practice at OKDHS is that if the community spouse needs more income than $2,841 per month, the couple can use the OKDHS administrative hearing process to give the community spouse more of the institutionalized spouse's income. If, at a hearing, the community spouse can show that more than $2,841 is needed per month, "due to exceptional circumstances resulting in significant financial duress," then more of the institutionalized spouses's income can be allocated to the community spouse.

3. INSTITUTIONALIZED COUPLE

If the institutionalized person has a spouse and the spouse is also institutionalized, income and resources are divided according to the formula that his income is his, hers is

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[67]OAC 317:35-9-65(3), 317-35-9-67, 317:35-9-68, 317:35-19-21(3), 317:35-17-11; OKDHS Appendix C-1, Schedule VIII(B)(1).

[68]OAC 317:35-19-21(3)(C).

[69]OAC 317:35-19-21, Instructions to Staff.

[70]42 U.S.C. § 1396p(d)(4)(B); 317:35-5-41.6(6)(B); OAC 317:35-19-19(a)(3).

hers, and joint is split in half. Eligibility is then separately determined for each individual.[71]

D. SERVICES

A person in a nursing facility gets nursing facility care plus all the short term services that an adult in fee for services Medicaid gets. However, there is no limit on medically necessary prescriptions, which have no co-payment.[72] The person also receives dentures, eye exams, and glasses.[73]

A person eligible for the ADvantage waiver gets all the services that an adult in fee for services Medicaid gets.

E. REPAYMENT[74]

The Omnibus Budget Reconciliation Act of 1993 mandates the state to seek recovery against the estate of certain Medicaid recipients who received medical care on or after July 1, 1994, and who were 55 years of age or older when the care was received.[75] The payment of Medicaid by OHCA on behalf of a recipient who is an inpatient of a nursing facility, intermediate care facility for the mentally retarded or other medical institution creates a debt to OHCA subject to recovery by legal action either in the form of a lien filed against the real property of the recipient and/or a claim made against the estate of the recipient. Only Medicaid received on or after July 1, 1994, will be subject to recovery. Recovery for payments made under Medicaid for nursing care is limited by several factors, including the family composition at the time the lien is imposed and/or at the time of the recipient's death and by the creation of undue hardship at the time the lien is imposed or the claim is made against the estate. State Supplemental Payments are not considered when determining the countable income. The types of medical care for which recovery can

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[71]OAC 317:35-19-21.

[72]OAC 317:30-3-57.

[73]OAC 317:30-5-133.1(b)(17) & (18).

[74]OAC 317:35-9-15; OAC 317:35-19-4.

[75]42 U.S.C. §§ 1396p(a) & (b).

be sought include:

- nursing facility services,
- home and community based services,
- related hospital services,
- prescription drug services,
- physician services, and
- transportation services.

OHCA may file and enforce a lien, after notice and opportunity for a hearing (OHCA will conduct hearings), against the real property of a recipient who is an inpatient in a nursing facility, ICF/MR or other medical institution in certain instances.

A lien may not be filed on the home property if the client's family includes:

- a surviving spouse residing in the home, or
- a child or children age 20 or less lawfully residing in the home, or
- a disabled child or children of any age lawfully residing in the home, or
- a brother or sister of the recipient who has an equity interest in the home and has been residing in the home for at least one year immediately prior to the recipient's admission to the nursing facility and who has continued to live there on a continuous basis since that time.

A lien may be filed only after it has been determined, after notice and opportunity for a hearing, that the recipient cannot reasonably be expected to be discharged and return to the home. To return home means the recipient leaves the nursing facility and resides in the home on which the lien has been placed for a period of at least 90 days without being re-admitted as an inpatient to a facility providing nursing care. Hospitalizations of short duration that do not include convalescent care are not counted in the 90 day period. Upon certification for Medicaid for nursing care, OKDHS provides written notice to the recipient that a one-year period of inpatient care shall constitute a determination by the Department that there is no reasonable expectation that the recipient will be discharged and return home for a period of at least three months. The recipient or the recipient's representative is asked to declare intent to return home by signing the Acknowledgment of Intent to Return Home/Medicaid Recovery Program form. 'Intent' is defined here as a clear statement of plans in addition to other evidence and/or corroborative statements of others. Should the intent be to return home, the recipient must be informed that a one-year

period of care at a nursing facility or facilities constitutes a determination that the recipient cannot reasonably be expected to be discharged and return home. When this determination has been made, the recipient receives a notice and opportunity for hearing. This notification occurs prior to filing of a lien. At the end of the 12-month period, a lien may be filed against the recipient's real property unless medical evidence is provided to support the feasibility of his/her returning to the home within a reasonable period of time (90 days). This 90-day period is allowed only if sufficient medical evidence is presented with an actual date for the return to the home.

Once a lien is filed, the property does not count against the $2,000 resource limit.[76]

Enforcement of a lien can be waived if enforcing a lien or a recovery from an estate would create an undue hardship. Undue hardship exists when enforcing the lien would deprive the individual of medical care such that his/her life would be endangered. Undue hardship exists when application of the rule would deprive the individual or family members who are financially dependent on him/her for food, clothing, shelter, or other necessities of life. Undue hardship does not exist, however, when the individual or his/her family is merely inconvenienced or when their life style is restricted because of the lien or estate recovery being enforced. Decisions on undue hardship waivers are made at OKDHS State Office, Family Support Services Division, Health Related and Medical Services Section.

If the recipient was age 55 or older when the nursing care was received, adjustment or recovery may be made only if:

- the individual's spouse has left the home;
- there are no children of the individual who are under 21 living in the home;
- there no disabled children of the individual living in the home;
- there is no sibling of the individual who has lived in the home continuously since at least one year prior to the admission of the individual into the nursing facility;
- there is no child of the recipient who has continuously lived there for at least two years prior to the admission into the nursing facility and who provided care to the individual which allowed him to live at home

[76]OAC 317:35-5-41.8(3)(H)

rather than an institution.[77]

The estate consists of all real and personal property and other assets included in the recipient's estate as defined by Title 58 of the Oklahoma Statutes.

F. APPEALS

A Medicaid recipient can appeal any denial of eligibility or services.[78] Appeals regarding financial eligibility are heard through the OKDHS Fair Hearing process.[79] The process begins with a hearing before an administrative hearing officer who is not a lawyer. The next step is review by the Director of Human Services. The next step is appeal to the district court in the county in which the individual lives. The district court is limited to review of the administrative record, except that new evidence can be introduced to show irregularities in the proceedings not appearing in the record.[80]

Appeals regarding medical services are heard through OHCA hearing process.[81] The OHCA hearing process has a Program Review Panel as the first step. The panel is made up of three OHCA employees who are appointed by the OHCA CEO. The panel members are in jobs related to the problem being complained about.[82] The panel usually does not hold a hearing, but reviews the papers involved and issues a decision. The next step is a hearing *de novo* before a hearing officer, who is a lawyer. The next step is a review by the CEO of the hearing officer tape and exhibits. [83] The next step is appeal to the state district court in the county where the recipient lives. The cases are handled there just like OKDHS appeals.[84]

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[77]OAC 317:35-19-4(b)(5).

[78]OAC 317:2-1-2(a).

[79]OAC 340:2-5-6(4).

[80]56 O.S. § 168; OAC 340:2-5-50 through 2-5-80.

[81]OAC 317:2-1-2(b).

[82]OAC 317:2-1-2.2.

[83]OAC 317:2-1-2.2.

[84]63 O.S. § 5052.

Example #1 - A Widow

Resources		Income	
$60,000.00	Home	$750.00	Gross Social Security
$10,000.00	Household Goods	$1,000.00	Gross Civil Service pension
$5,000.00	Car	$1,750.00	
$10,000.00	Bank account		
$85,000.00			

Example #1 - Answer

Resources

Gross Resources		Countable Resources	
$60,000.00	Home	$0.00	Home
$10,000.00	Household Goods	$0.00	Household Goods
$5,000.00	Car	$0.00	Car
$10,000.00	Bank account	$10,000.00	Bank account
$85,000.00		$10,000.00	
		$2,000.00	Medicaid resource limit
		$8,000.00	Resource spenddown

Income

$750.00	Gross Social Security
$1,000.00	Gross Civil Service pension
$1,750.00	Countable Income
$1,750.00	Available to disburse
$50.00	Personal needs allowance
$99.00	Medicare Part B Premium
$1,601.00	To nursing home

Example #2 - A Widow

Resources		Income	
$60,000.00	Home	$1,000.00	Gross Social Security
$10,000.00	Household Goods	$1,300.00	Gross Private pension
$5,000.00	Car	$2,300.00	
$10,000.00	Bank account		
$85,000.00			

Example #2 - Answer

Resources

Gross Resources		Countable Resources	
$60,000.00	Home	$0.00	Home
$10,000.00	Household Goods	$0.00	Household Goods
$5,000.00	Car	$0.00	Car
$10,000.00	Bank account	$10,000.00	Bank account
$85,000.00		$10,000.00	
		$2,000.00	Medicaid resource limit
		$8,000.00	Resource spenddown

Income

$1,000.00	Gross Social Security
$1,300.00	Gross private pension
$2,300.00	Countable Income
$278.00	To Medicaid Income Trust
$2,022.00	Available to disburse
$50.00	Personal needs allowance
$99.00	Medicare Part B Premium
$1,873.00	To nursing home

Example #3 - A couple with husband in Nursing Home

Gross Resources		Countable Resources	
$60,000.00	Home - $10,000 mortgage	$0.00	Home - $10,000 mortgage
$15,000.00	Household Goods	$0.00	Household Goods
$5,000.00	Car	$0.00	Car
$40,000.00	Bank account	$40,000.00	Bank account
$120,000.00		$40,000.00	

Income

Institutionalized Spouse		Community Spouse	
$1,000.00	Gross Social Security	$500.00	Gross Social Security
$1,250.00	Gross Private pension	$500.00	Gross private pension
$33.33	Interest	$33.33	Interest
$2,283.33		$1,033.33	

Example #3 - Answer

Resources

Institutionalized Spouse		Community Spouse	
$20,000.00	½ Countable Resources	$20,000.00	½ Countable Resources
$5,000.00	To Community Spouse	$5,000.00	From Institutionalized Spouse
$15,000.00	Resources after OKDHS division	$25,000.00	Resources after OKDHS division
$10,000.00	Mortgage payoff		
$2,000.00	Medicaid resource limit		
$3,000.00	Resource spenddown		

Income

Institutionalized Spouse		Community Spouse	
$1,000.00	Gross Social Security	$500.00	Gross Social Security
$1,250.00	Gross Private pension	$500.00	Gross private pension
$33.33	Interest ($2,000 @ 2%)	$41.67	Interest ($25,000 @ 2%)
$2,283.33	Gross Income	$1,799.33	From Inst. Spouse
$189.33	To Medicaid Income Trust	$2,841.00	Total Income = MMMNA
$50.00	Personal needs allowance		
$99.00	Medicare Part B Premium		
$1,799.33	To Community Spouse		
$145.67	To Nursing home		

Example #4 - A couple with husband in Nursing Home

Gross Resources		Countable Resources	
$100,000.00	Home - $25,000 mtg	$0.00	Home - $25,000mtg
$25,000.00	Household Goods	$0.00	Household Goods
$15,000.00	Car	$0.00	Car
$150,000.00	Mutual funds	$150,000.00	Mutual funds
$100,000.00	Bank account	$100,000.00	Bank account
$390,000.00		$250,000.00	

Income

Institutionalized Spouse		Community Spouse	
$1,000.00	Gross Social Security	$500.00	Gross Social Security
$1,000.00	Gross Private pension	$500.00	Gross Civil Service
$500.00	Interest/Dividends	$500.00	Interest/Dividend
$2,500.00		$1,500.00	

Example #4 - Answer

Resources

Institutionalized Spouse		Community Spouse	
$125,000.00	½ Countable Resources	$125,000.00	½ Countable Resources
$11,360.00	From Community Spouse	$11,360.00	To Institutionalized Spouse
$136,360.00	Resources after OKDHS division	$113,640.00	Resources after OKDHS division (Equals maximum CSRA)
$25,000.00	Mortgage payoff		
$2,000.00	Medicaid resource limit		
$109,360.00	Resource spenddown		

Income

Institutionalized Spouse		Community Spouse	
$1,500.00	Gross Social Security	$500.00	Gross Social Security
$1,000.00	Gross Private pension	$500.00	Gross Civil Service
$3.33	Interest ($2,000 @ 2%)	$189.40	Interest/dividend ($113,640 @ 2%)
$2,503.33	Gross Income	$1,549.60	From Institutionalized Spouse
$409.33	To MIPT	$2,739.00	Total Income
$2,094.00	Distributed by trustee		
$50.00	Personal needs allowance		
$99.40	Medicare Part B		
$1,549.60	To Community Spouse		
$395.00	To nursing home		