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On the Cover
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THE PERILOUS PATH TO LONG-TERM CARE

It's Not Really about Asset Protection

Medical Assistance has served as the safety net for those of limited means who require long-term care for almost half a century. The next half century promises unprecedented growth in our elderly population. Unfortunately, few have made adequate legal or financial arrangements to provide for themselves through a period of long-term care. And trying to navigate the ever-changing rules of the "safety net" has become a perilous path, fraught with dangers for the unwary.

***19 I**f you enter the phrase "asset protection" into your favorite search engine, you will find thousands of internet sites devoted to protecting wealth. Clients usually seek to protect assets from specific liability, taxes, or creditors by use of comparatively exotic techniques such as offshore trusts and shell companies. In long-term care planning and Medical Assistance in particular, however, asset protection has a much different meaning.

In this context, clients typically ask about asset protection for the first time when someone incurs an injury or receives a diagnosis that suddenly makes long-term care terribly real. All too frequently, the questions are first asked when it becomes clear someone isn't coming home from the hospital or long-term care facility. At that point, the ability to "plan" is limited at best.

Although the phrase "asset protection" is frequently used to frame the discussion, most clients aren't trying to protect wealth so much as to understand the frightening landscape in which they find themselves- Suddenly, there are landmines everywhere and a clear and concise explanation of the rules seems elusive.

Unfortunately, the rules governing Medical Assistance eligibility tend to be anything but clear or concise. Helping clients chart their course requires an exhaustive (and exhausting) awareness of the nuances, the layers, and the indefinable subjectivity that is implicit in application of Medicaid laws. Part of the complexity can be traced to the interrelationship and balance between state and federal law, referred to as cooperative federalism.[1] But federal Medicaid law alone has been described by some impressive legal minds as "among the most intricate ever drafted by Congress,"[2] "almost unintelligible to the uninitiated,"[3] and "an aggravated assault on the English language, resistant to attempts to understand it."[4] The fact that the laws, regulations and policies are subject to frequent change only adds to the confusion.

Basic Eligibility Criteria

Medicaid (called Medical Assistance in Minnesota), was first established by Congress in 1965 under Title XIX of the Social Security Act as a cooperative program between the state and federal governments to provide medical care for, among others, aged, blind or disabled individuals "whose income and resources are insufficient to meet the costs of necessary medical services."[5] Medicaid is administered by the secretary of the United States Department of Health and Human Services through

the Centers for Medicare and Medicaid Services ("CMS"). In Minnesota, the Medical Assistance program is administered by the Department of Human Services ("DHS") through each county's social services or economic assistance units.

Although originally intended as a safety net program, Medical Assistance has become the primary payer for long-term care services in the United States, due in part to the high cost of such services.[6] To be eligible for Medical Assistance a person must satisfy both categorical and financial criteria. Financial eligibility generally depends on meeting both asset and income limits, but the specific financial criteria will vary, depending on the applicant's age, whether the applicant is married or single, and whether the applicant is in a skilled nursing facility or a home- and community-based environment, such as a single family home, an assisted living facility, or a memory care facility.

As a general rule, an individual must have no more than $3,000 in available assets in order to be eligible for Medical Assistance.[7] The general rule is, of course, subject to exceptions. For example, an individual may retain additional assets on the Medical Assistance program for Employed Persons with Disabilities (MA-EPD) if they are employed and meet other criteria.[8] And if someone is applying for Medical Assistance under the expansion program for adults without children, there are no asset limits, but strict limits on income.[9]

Transfers of Assets

Any discussion of asset protection in long-term care planning logically requires an understanding of the transfer rules. This is the area of Medical Assistance law most likely to be misstated by family members, neighbors, the teller at the client's bank, or the stylist who cuts the client's hair. Misstatements can often be traced to some historically accurate guideline, but no one should expect their neighbor or banker to track changes in the law, much less changes to obscure regulations and policies.

Generally speaking, transfers by the applicant or the applicant's spouse for less than fair market value within five years of the application for Medical Assistance (the look-back period) result in a period of ineligibility for Medical Assistance coverage for long-term care services.[10] The period of ineligibility, in months, is calculated by dividing the total uncompensated value of transfers by the then-current statewide average Medical Assistance reimbursement amount, currently $5,371 in Minnesota. For example, if $53,710 is transferred without compensation, the period of ineligibility is ten months. For the ten months following the application, the otherwise eligible applicant will be ineligible for Medical Assistance to cover the costs of long-term care.

For those concerned with protecting a particular asset, there is only one option with any certainty. That is to give the asset away with no retained ability to control or benefit from it, and avoid applying for Medical Assistance for at least five years after the transfer is complete. Few people are willing or able to give up that much control, and fewer still have sufficient resources to assure that they can pay their own way for five years. The complexity of the transfer rules is more problematic for the majority of people who find themselves unwittingly enmeshed in the Medical Assistance maze, oblivious of how their actions may be viewed when injury or illness strikes.

What is a Transfer? Initially, it is important to understand what is considered a potentially uncompensated transfer under Medicaid law. A transfer occurs when the applicant, the spouse of the applicant, or anyone with legal authority to act on behalf of the applicant or spouse, for less than fair market value in return, gives away, sells, conveys ownership and/or reduces control or disposes of any asset or an interest in an asset.[11]

Many such transfers are obvious. A cash gift to a child or grandchild (*e.g.*, a wedding or graduation gift) is an uncompensated transfer. A transfer may also occur, however, when an individual refuses to accept an asset they were entitled to. For example, disclaiming an inheritance or failing to elect against a will are both transfers subject to penalty. Refusing to take affordable legal action to obtain a court-ordered payment, such as child support, alimony, or personal injury settlements may also be considered a transfer.

As a matter of public policy, protecting an inheritance for family members is particularly frowned upon and has been the subject of multiple changes in Medicaid law.[12] Accordingly, paying a relative for services is subject to enhanced scrutiny, and will be considered a transfer unless one of two conditions is met. First, the parties can set up a notarized written agreement, dated at or before the time of the service, requiring payment for services. The agreement must state the service to be performed and the rate of payment. Alternatively, payment for services must be made within 60 days of when such services

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were rendered, and care should be taken to document those services.

***20** In both instances, compensation must be consistent with the customary fees charged for similar services in the community. Family members providing personal care or other services should also be advised to claim any compensation received as income for tax purposes; failure to do so may provide a caseworker with the basis for imposing a transfer penalty.

Another potential transfer occurs with the purchase or conversion to an income stream of an annuity during the look-back period.[13] To avoid being considered an uncompensated transfer, an annuity must be actuarially sound, irrevocable, and nonassignable and must provide for payments in equal amounts during its term with no deferred or balloon payments.[14] In addition, many annuities must name the Department of Human Services as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of an institutionalized individual.[15]

There are a number of exceptions to the general transfer prohibition detailed in the accompanying sidebar. However, each exception should be approached with caution.

Presumption of Intent. Uncompensated transfers do not result in penalties if the individual provides convincing evidence that a particular transaction was exclusively for a purpose other than to obtain or maintain eligibility for Medical Assistance payment of long-term care services. Convincing evidence is a steep (if not impossible) hill to climb in light of the presumption that all transfers during the look-back are made to obtain or maintain eligibility for Medical Assistance.[16] Although the presumption is rebuttable, advocates should be prepared to suspend logic.

In a recent case involving financial exploitation by the Medical Assistance recipient's daughter and attorney-in-fact, it seemed obvious that the so-called "transfer" was exclusively for a purpose other than to obtain or maintain eligibility. Nonetheless, the administrative law judge found that "the record contains no convincing evidence that the transactions were exclusively for a purpose other than to establish or maintain Medical Assistance eligibility."[17]

The transfer rules also highlight the subjectivity inherent in the administration of complex rules by disparate individual caseworkers in diverse county environments. What is viewed as a transfer subject to penalty in one county (or by one caseworker) may not be penalized in (or by) another. For example, this author once had a client penalized for providing essential financial assistance ***21** to an adult child following a suicide attempt despite evidence that the assistance had nothing to do with obtaining Medical Assistance. On the other hand, a client applying in a different county was not penalized for taking his adult children and grandchildren on several trips to Hawaii. Consequently, the rules do not lend themselves well to simple explanations.

All or Nothing. One of the most recent changes in the transfer rules is Minnesota's "all or nothing" policy. Between February of 2006 and December 1, 2011, a penalty period for an uncompensated transfer of assets could still be reduced dollar-for-dollar by a partial return of the transferred assets. In 2009, the Minnesota Legislature amended the asset transfer penalty statute to allow a penalty period to be reduced or eliminated only if all transferred assets are returned within 12 months of the start date of the penalty period.[18] The amendment prohibits adjustment of a penalty period unless the full value of the transferred asset is returned. In 2011, Minnesota's Department of Human Services ("DHS") received permission from the Centers for Medicare and Medicaid Services ("CMS") to put most of the 2009 amendment into practice.[19] DHS issued an informational bulletin announcing implementation of the new policy, effective for penalty periods imposed on or after December 1, 2011.[20] Some of the intricacies of the "all or nothing" rule are particularly dangerous to the uninformed. For example, return of the same asset that was transferred in the first instance is insufficient to avoid a period of ineligibility if that asset has lost value. With the decline in real estate values over the last few years, this trap is particularly dangerous for the unwary.

Limited Protection Available

Excluded Assets. Some assets are specifically "excluded" by taw, and do not count against an individual's $3,000 limit on available assets. These ""excluded" assets provide a level of protection, although that protection is limited. For example, an individual's homestead may be excluded under a variety of circumstances, as described in the sidebar. Initially, it's necessary to determine whether the property meets the definition of a homestead. The homestead is defined as: "any property in which an individual (and spouse, if any) has an ownership interest and which serves as the individual's principal place of residence.

This property includes the shelter in which an individual resides, the land on which the shelter is located and related outbuildings.” There is no acreage limitation on a homestead, but that doesn’t mean, for example, that a 180-acre homestead will be fully excluded. The exclusion applies to the entire acreage only if the land is not separated from the home by any property owned by others. The term “homestead” includes personal property used as a home, for example, a mobile home, so long as the right person or persons are residing in it.

One motor vehicle is totally excluded, regardless of its value, if it is used for transportation of the Medical Assistance applicant or a member of the applicant’s household. Assets held in a properly established special needs or pooled special needs trust funded by the applicant are excluded, as are assets in a properly established supplemental needs trust established by someone other than the applicant (or spouse). And most household goods and personal effects are generally excluded, notwithstanding an apparently rampant rumor among seniors that “the state” will take everything they own.

Spousal Impoverishment Rules. For married couples over age 65 when one spouse requires long-term care services, another set of financial eligibility criteria is applied called the spousal impoverishment rules. In 1988, Congress enacted the Medicare Catastrophic Coverage Act (“MCCA”).[21] The chief purpose of the MCCA was to protect the “community spouse” from pauperization while preventing financially secure couples from obtaining Medicaid benefits.[22] To accomplish this purpose, Congress established a complex set of laws which states must comply with in allocating a married couple’s income and assets.[23] The MCCA sets aside a protected level of income and resources for the community spouse. The community spouse is permitted to retain a certain amount of assets not otherwise excluded, subject to both a ceiling and a floor. In 2013, the maximum community spouse asset allowance is $115,920, and the minimum is $32,890.[24] This amount, in addition to any excluded assets, is “protected” for the community spouse since it is not included when determining the institutionalized spouse’s eligibility for Medical Assistance. The protection generally disappears at death.

Estate Recovery & Liens

Federal law requires states to attempt to recover the amount Medical Assistance paid on behalf of an individual over age 55, or a person of any age who received Medical Assistance and resided in a nursing home for six months or longer.[25] If the Medical Assistance recipient is married, the claim is deferred until after the death of the surviving spouse. (Note, however, that if the community spouse dies first, the institutionalized spouse must receive at least his or her spousal elective share in order to avoid a transfer penalty.)

Historically, an estate recovery claim could be made only against probate assets. Federal law now gives states the option to change their definition of ““estate” to include nonprobate property as well.

***22** Since 2009, Minnesota law has permitted a claim, under certain circumstances, against trust assets, jointly held assets including real property, life estate interests, and multiparty cash and securities accounts.[26]

In addition, the state may file a lien against nonhomestead real property owned by a Medical Assistance recipient on or after the time when the recipient is institutionalized. The amount of the lien is the amount of Medical Assistance provided to the recipient for care in a medical institution- The lien cannot be filed if the property is the homestead of the recipient’s spouse, the recipient’s child who is under age 21 or is blind or permanently and totally disabled, the recipient’s child or grandchild who has lived in the homestead for at least two years immediately before the recipient began receiving long-term care services and who provided care to the recipient that permitted the recipient not to require long-term care services, or the recipient’s sibling who has an equity interest in the property and has resided in the property for at least one year. A Medical Assistance lien cannot be filed until the agency has sent written notice of its lien rights to the Medical Assistance recipient and their spouse and there has been an opportunity for a hearing. The lien must be released if the recipient is discharged from the medical institution and returns home.

Conclusion

Today’s Medical Assistance planning isn’t really about asset protection; at least not in any traditional sense. Rather, it is a matter of understanding the rules and how they may apply to a client’s specific fact situation. For most clients, any protection of assets is temporary, limited by both time and circumstance. Ultimately, the state will seek to recover Medical Assistance

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benefits paid either by asserting a lien against nonhomestead real property, or pursuit of an estate recovery claim after death.

Those of us who focus our practice on elder law attempt to stay on top of an ever-changing landscape of laws, rules, and regulations. Unfortunately, those who try to navigate the system alone all too frequently learn the hard way that what they believed were appropriate choices for themselves and their loved ones may have catastrophic consequences. For families already facing chronic illness or injury, getting good information as early as possible is essential. In the face of long-term care costs, they simply cannot afford missteps.

EXCEPTIONS TO THE TRANSFER PROHIBITION

Homestead Exceptions. There will be no penalty if the homestead is transferred as follows:

1) to the individual's spouse, child under the age of 21, or blind or disabled child of any age;

2) to a sibling who has an equity interest in the home and who was residing in the home for a period of at least one year immediately before the date of the individual's admission to the nursing home;

3) To a son or daughter who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the facility, and who provided care to the individual that permitted the individual to reside at home, rather than in an institution (note that this exception does not apply to the caregiver grandchild);

4) if someone shows they intended to dispose of the homestead at fair market value or for other valuable consideration;

5) if denial of eligibility would cause undue hardship to the individual, based on imminent threat to the individual's health and well-being.

Other Exceptions. There will be no period of ineligibility for transfers if one or more of the following situations exist:

1) The assets are transferred to the individual's spouse, or the assets are transferred from the individual's spouse to another for the sole benefit of the individual's spouse. "For the sole benefit of means that no other individual or entity can benefit in any way from the assets or income at the time of transfer or at any time in the future.

2) The assets are transferred to the individual's blind or permanently and totally disabled child, or to a trust (including a supplemental needs trust defined in federal law) established solely for the benefit of such child.

3) The assets are transferred to a trust, including a supplemental needs trust, established solely for the benefit of any individual less than 65 years of age who is disabled as defined under the Social Security Act.

4) The transferred assets are excluded assets other than the homestead.

5) All assets transferred for less than fair market value have been returned to the individual.

6) A showing is made that the individual intended to dispose of the assets either at fair market value or for other valuable consideration.

7) Denial of eligibility because of the transfer would cause undue hardship to the individual, based on imminent threat to the individual's health and well-being.

EXCLUSION OF HOMESTEAD

The home is excluded from the calculation of "available assets" under the following conditions:

1) For the first six calendar months of a person's stay in a long-term care facility, and after that period for as long as the person can be reasonably expected to return home;

2) if it is the primary residence of the spouse, child under 21, or handicapped child of the applicant;

3) if it is the primary residence of a sibling of the applicant who lived in the house for at least one year immediately before the applicant's nursing home admission and has an equity interest in the home; or

4) if it is the primary residence of a child or grandchild of the applicant who has lived in the house for at least two years immediately before the nursing home admission and has provided care to the applicant that has allowed the applicant to remain at home during that two years rather than be in a nursing home.

Footnotes

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[1] *Harris v. McRae*, 448 U.S. 297, 100 S. Ct. 2671, 65 L.Ed.2d 784 (1980).

[2] *Schweiker v. Gray Panthers*, 453 U.S. 34, 101 S. Ct. 2633, 69 L.Ed. 2d 460 (1981).

[3] *Friedman v. Berger*, 547 F.2d 724, 728 fn. 7 (2nd Cir. 1976).

[4] *Friedman v. Berger*, 409 F.Supp. 1225, 1225-1226 (SDNY 1976).

[5] 42 U.S.C. §1396.

[6] Medicaid's Role in Meeting the Long-Term Care Needs of America's Seniors, *http://www.kff.org/medicaid/8403.cfm*

[7] Minn. Stat. §256B.056, Subd. 3. "Available" assets include any property interest or right that can be liquidated and converted to cash for self-support.

[8] Minn. Stat. §256B.057, Subd. 9.

[9] Minn. Stat. §256B.055, Subd. 15.

[10] 42 U.S.C. §1396p(c); Minn. Stat. §256B.0595.

[11] Minnesota Department of Human Services. *Health Care Programs* Manual § 19.40.

[12] *E.g.*, Tax Equity & Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. 97-248, §132, 90 Stat. 370-373; Omnibus Budget Reconciliation Act of 1993 (OBRA 93), Pub. L. 103-66, 107 Stat. 312 (increased the look-back period to 36 months for most uncompensated transfers and 60 months for transfers involving certain trusts); Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171 (extending the look-back to 60 months and changing commencement of the penalty period to the later to occur of the first day of the month in which the transfer was made, or on the date on which an individual (a) has applied for medical assistance; (b) is eligible for medical assistance benefits without regard to the uncompensated transfers; and (c) is receiving institutional level of care).

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13 *See*, 42 U.S.C. §1396p(e); Minn. Stat. §256B.0595, Subd. 1(e). The Minnesota statute addressing transfers has been amended 19 times since 1986.

14 42 U.S.C. §1396p(c)(1)(G)(ii).

15 *Id.* 42 U.S.C. §1396p(c)(1)(F)(I).

16 42 U.S.C. 1396p(c)(2)(ii); Minn. Stat. §256B.0595, Subd. 1(b).

17 *Decision of State Agency on Appeal*, Docket #100077 (2008).

18 Minn. Stat. §256B.0595, subd. 2. See, Laws of Minnesota 2009, Ch. 79, Art. 5, Sec. 21.

19 All of the amendment was allowed, except the requirement that all assets transferred for less than fair market value must be returned within 12 months of applying for medical assistance.

20 Minnesota Department of Human Services. *Instructional Bulletin* 11-21-10, available at: *http://www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs16_164914.pdf*.

21 H.R. 2470, 100th Cong. 1st Sess., 102 Stat. 683 (1988).

22 *Wisconsin v. Blumer*, 534 U.S. 473, 480, 122 S. Ct. 962, 151 L. Ed. 2d 935 (2002).

23 42 U.S.C. §1396r-5. *See also*, Minn. Stat. §256B.059.

24 Minnesota Department of Human Services. *Health Care Programs* Manual §22.40.

25 42 U.S.C. § 1396p.

26 Minn. Stat. §256B.15.

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