Protecting and Maximizing Public Benefits

H. Clyde Farrell &
Christina Lesher

Author contact information:
H. Clyde Farrell
Certified Elder Law Attorney
Farrell & Pak PLLC
1000 Mo-Pac Circle
Austin, TX 78746

cfarrell@txelderlaw.com
512-323-2977

Co-author contact information:
Christina Lesher
5615 Kirby Drive, Suite 412
Houston, TX 77005

clesher@lawlesher.com
713-529-5900

This outline presents the law as of this writing, with the warning that many public benefits in Texas are presently in a state of change. Nothing contained in this publication is to be considered as the rendering of legal advice for specific cases, and readers are responsible for obtaining such

advice from their own legal counsel. This publication is intended for educational and informational purposes only.

PROTECTING AND MAXIMIZING PUBLIC BENEFITS

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PROTECTING AND MAXIMIZING PUBLIC BENEFITS

INTRODUCTION

This is an overview of the most significant public benefits for persons with disabilities in Texas. It is intended to assist attorneys and other benefits counselors to identify the major benefits to which such clients may be entitled.

Its focus is primarily on the "means-tested" benefits, which are available only to persons with assets and income below certain limits. Therefore, particular attention is paid to rules relating to trusts and transfers of assets to assist attorneys and other professionals with estate planning for family members and with planning for dispositions of personal injury awards, inheritances and other assets of persons with disabilities.

Although much of the law discussed is federal law, many rules are state-specific. Accordingly, with regard to cases governed by the law of jurisdictions other than Texas, it must be used, if at all, with great caution.

This outline is intended as a "bridge" to help the practitioner better understand and use the voluminous statutes, rules and agency operating instructions applying to each program. Therefore, although it seeks to cover the most important rules, it cannot include every benefit, exclusion, exemption, etc. contained in the numerous sources of law, which are cited for further reference. The topic Long Term Care Medicaid, which is discussed only partially here, is covered more completely in another publication by the author titled *Financing Long Term Care in Texas*.

The authors gratefully acknowledge the contribution of Chris DeWitt, an attorney with much experience in the fields of Medicaid and disability, who updated the whole publication and expanded the discussion of state programs and laws in 2009.

I. OVERVIEW OF TEXAS HEALTH AND HUMAN SERVICE AGENCIES

A. Texas Agencies

The Texas Health and Human Services Commission (HHSC) administers the Texas Medicaid program, the Children's Health Insurance Program (CHIP), Family and Community Services (e.g., Family Violence Program, Refugee Affairs Program, and education and outreach relating to social services), Special Nutrition Programs, Lone Star Business Programs, Texas Works (which includes the Food Stamp Program, Medical Assistance Programs for Families and Children, and Temporary Assistance for Needy Families (TANF)), and Disaster Assistance programs.

HHSC is also responsible for the administrative functions of the other four health and human service (HHS) agencies of Texas:

Department of State Health Services (DSHS) – responsible for health and mental health services (including state mental health facilities and hospitals), as well as substance abuse programs;

Department of Aging and Disability Services (DADS) – responsible for intellectual disability (ID) services and State Supported Living Centers (residential intellectual disability) programs, nursing homes, community care services, and aging and long-term care services for the elderly (but not responsible for determining *financial* eligibility for Medicaid, which is done by HHSC);

Department of Assistive and Rehabilitative Services (DARS) – responsible for rehabilitation services, disability determination services, services for the deaf, blind, and visually impaired, and early childhood intervention services; and

Department of Family and Protective Services (DFPS) – responsible for adult and child protective services, investigations of abuse and neglect in homes and state facilities, the licensing and regulating of child care facilities, and prevention and early intervention services for child maltreatment and juvenile delinquency.

B. Medicaid Managed Care Covers the State

1. Historical Background

With approval of the 2011 Texas Legislature, the Texas Health & Human Services Commission applied for a new Medicaid waiver program that was approved by the federal Centers for Medicare & Medicaid Services December 12, 2011. By that approval, CMS "waived" certain requirements of federal Medicaid law, most notably the prohibition on payment of certain Medicaid funds to hospitals serving large numbers of low-income patients, when the hospitals participate in Medicaid managed care.[1] This is a five-year "demonstration program," to continue by its terms only through September 2016.[2] Historically, however, it is an acceleration of steady increases in the use of managed care by Texas Medicaid.

At this writing in January 2015, managed care affects individuals receiving long-term care Medicaid only to the extent they are in the Community Based Alternatives (CBA) Medicaid "waiver" home care program, who effective September 1, 2014 are all now in the "Star+Plus Waiver" managed care program. However, effective March 1, 2015, *nursing facility* services will be added to the "array of services" of the Star+Plus managed care program. That change is discussed in more detail below.

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[1] CMS has authority to do this for "demonstration projects" under Social Security Act §1115, 42 U.S.C. §1315. Therefore, this is sometimes referred to as the "1115 Transformation Waiver."

[2] TEXAS MEDICAID AND CHIP IN PERSPECTIVE, Texas Health and Human Services Commission (9th ed., 2013), at Chapter 4., available at http://www.hhsc.state.tx.us/medicaid/about/PB/toc.shtml .

At that point, Texas Medicaid almost becomes, as one HHSC attorney has put it, "all just one big waiver program." However, as discussed below, a few categories of individuals eligible for "traditional Medicaid" benefits will remain. Also, there will be no changes to the long-term care programs that do not involve comprehensive medical coverage, such as the non-waiver home care programs including Community Attendant Services; and managed care does not affect the Medicare Savings Programs (QMB, SLMB, QI-1).

2. Changes should not adversely affect eligibility, benefits or appeal rights

Under the Texas rules, the scope of benefits offered by a Managed Care Organization (MCO) must be at least equal to those required by federal law for Medicaid fee-for-service clients, unless explicitly changed by HHSC through a waiver.[3] That is required by the federal (CMS) rules, which state, "Each contract with an MCO [Managed Care Organization], PIHP, or PAHP must...require that the [services specified in the contract] be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in §440.230."[4] Therefore, the Star+Plus Handbook provides, "The STAR+PLUS program does not change Medicaid eligibility or services. It does change the way Medicaid services are delivered."[5]

The same Handbook states, "The [HHSC] Program Support Unit coordinates with Medicaid for the Elderly and People with Disabilities staff to determine financial eligibility for those individuals not already eligible for Supplemental Security Income (SSI) and uses financial determinations by the Social Security Administration for those individuals already eligible for SSI."[6] Thus, financial eligibility for long-term care Medicaid is still determined by the Texas Health and Human Services Commission as before (except it is becoming more automated as discussed below).

Likewise, delivery of services by managed care should not change the definition of "medical necessity" for services. The federal rules prove that the managed care contract must "specify what constitutes 'medically necessary services' in a manner that...is no more restrictive than that used in the State Medicaid program..."[7]

However, the development and delivery of a Star+Plus Waiver service plan is entrusted to a for-profit Managed Care Organization, which contracts with the state to provide all services at a certain "capitated" rate per member.[8] That gives the MCO a financial incentive to minimize

[3] 1 T.A.C. §353.409(b). S.B. 7 (2011 Texas Legislature) provides more generally, "The changes in law made by this article are not intended to negatively affect medicaid recipients' access to quality health care."
[4] 42 C.F.R. §438.210(a)(2).
[5] Star+Plus Handbook 1100.
[6] Star+Plus Handbook 1131; and see 3300 for more specifics as to functions of the PSU.
[7] 42 C.F.R. §438.210(a)(4)(i).
[8] "Capitated" managed care is required by Texas statute for acute-care Medicaid generally, unless the Texas Health and Human Services Commission determines that another arrangement, including a

services in order to maximize profit. Presumably in recognition of that concern, both the state and federal laws permitting Medicaid managed care have provisions for consumer protection and mandatory quality assessment studies.[9]

As discussed in more detail below, the right to appeal through the HHSC fair hearing procedure continues, even as to decisions made by a Managed Care Organization (MCO). In addition, MCO's are required to have their own appeal procedures, which the member may utilize instead of or in addition to an appeal to a fair hearing.

3. Changes in program names

However, the change to delivery of services by Managed Care Organizations has brought with it major changes in terminology, with little or no effort by the agency to translate descriptions of its programs (which supposedly have not changed as to their eligibility requirements or services) into the verbiage of the Star+Plus Handbook.[10] With some trepidation, your author attempts to provide a brief guide in the bullet points and table below.

- STAR stands for "State of Texas Access Reform." It is a transitional program in the sense that some categories that were once in STAR had by September 1, 2014 been moved to STAR+PLUS. However, it still includes the important Medicaid programs for children and pregnant women.

- STAR+PLUS now refers to all the Medicaid managed care services that have been moved from the STAR category, plus some that were never in that category—generally, that is, for adults who have Medicaid due to disability, including adults needing long-term care.

- STAR+PLUS WAIVER means the program formerly known as Community Based Alternatives, which was terminated as a separate program effective September 1, 2014.

- STAR+PLUS PROGRAM includes both STAR+PLUS and STAR+PLUS WAIVER.

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traditional fee-for-service arrangement, would be "more cost-effective or efficient." S.B. 7 (2011 Texas Legislature) §2.01(b), Tex. Gov. C. §533.0025(b).

[9] See, e.g., 42 U.S.C. §1396u-2(c); S.B. 7 §2.11, Tex. Gov. C. §533.00251 (studies due January 15, 2015 regarding the extension of managed care to nursing facilities).

[10] The agency does provide some helpful explanation of the terminology and history at its website dedicated to the transition to managed care, at http://www.hhsc.state.tx.us/medicaid/managed-care/mmc.shtml . However, the clearest and most authoritative guide is the rule at 1 T.A.C. §353.603.

Benefit Program Name	Managed Care Name	Eligibility Handbooks
Medicaid for Parents and Caretaker Relatives, Pregnant Women's Medicaid, Children's Medicaid, FFCC ages 21-25	STAR	Texas Works Handbook[11]
SSI-Related (Community, Acute-Care) Medicaid; DAC, Pickle, Widow/Widower Medicaid; Medicaid Buy-In; Medicaid Buy-In for Children[12]	STAR+PLUS	Eligibility automatic (and mandatory) through SSI, TANF, Children's Medicaid, Pregnant Women's Medicaid[13]
Nursing Home Medicaid	STAR+PLUS (eff. 3/1/15)	MEPD Handbook[14]
Community Based Alternatives	HCBS STAR+PLUS WAIVER (aka Star+Plus Waiver, aka SPW) statewide as of 9/1/14	Star+Plus Handbook[15] & MEPD Handbook
Other "1915(c) waiver" programs: CLASS, MDCP, HCS, DBMD	Still using Traditional Medicaid—"excluded" from Star+Plus HCBS Waiver,[16] *except* those age 21+ *not* on Medicare *must* enroll in HCBS STAR+PLUS WAIVER to receive Medicaid acute-care services.[17]	MEPD Handbook, CLASS Provider Manual[18] Case Manager MDC Handbook[19], HCS Handbook[20]DBMD Handbook,[21] 40 T.A.C. Chapters 45 and 48

[11] Texas Works Handbook is at http://www.dads.state.tx.us/handbooks/TexasWorks/index.htm .
[12] Enrollment in STAR+PLUS is voluntary for children under age 21 in the following categories: receiving SSI and not in a nursing facility; residing in an ICF-IID and not enrolled in Medicare; or enrolled in any of the following 1915(c) waiver programs and not enrolled in Medicare: HCS, CLASS, TxHmL and DBMD. 1 T.A.C. §353.603(a),(c).
[13] 1 T.A.C. §353.802.
[14] Medicaid for the Elderly and People With Disabilities Handbook at http://www.dads.state.tx.us/handbooks/mepd/
[15] Star+Plus Handbook at http://www.dads.state.tx.us/handbooks/sph/ . See especially 3240 re "Star+Plus Waiver" requirements, which appear to be the same as Community Based Alternatives requirements. Likewise, 3242.1 limits the cost of services to 200% of the Medicaid cost of care in a nursing home, as in CBA.
[16] Star+Plus Handbook 3222.
[17] 1 T.A.C. §353.603(b).
[18] CLASS Provider Manual, http://www.dads.state.tx.us/handbooks/classpm/ .
[19] Case Manager Medically Dependent Children Handbook, http://www.dads.state.tx.us/handbooks/cm-mdcp/ .
[20] Home and Community Services Handbook, http://www.dads.state.tx.us/handbooks/hcs/ .
[21] Deaf Blind With Multiple Disabilities Handbook, http://www.dads.state.tx.us/handbooks/dbmd/ .

Children and young adults in conservatorship of DFPS or in a DFPS foster care program[22]	STAR Health	
Non-waiver CCAD programs: Community Attendant Services, Primary Home Care, etc.	Not eligible for STAR+PLUS unless eligible for regular Medicaid through another program;[23] and Star+Plus members generally may not receive additional services from non-waiver CCAD programs[24]	Star+Plus Handbook & MEPD Handbook
Dual Eligibles (both Medicare and Medicaid)	Medicare provides acute care and medications. Through STAR+PLUS, Medicaid provides long-term care and other services not covered by Medicare[25]	Star+Plus Handbook
Health Insurance Premium Payment Program (HIPP)	STAR members are not eligible for HIPP. STAR+PLUS members are eligible for HIPP according to the HHSC website[26] but are not eligible according to the Star+Plus Handbook.[27]	No Handbook
Medicare Savings Programs (QMB, SLMB, QI-1)	MSP does not include "full Medicaid" so its beneficiaries are not eligible for any managed-care Medicaid thru MSP alone.	No Handbook

For more on terminology, see the Glossary of the Star+Plus Handbook.

Acronyms are at Appendix VII of the Star+Plus Handbook.

4. More choices in service delivery

The Star+Plus Handbook provides as follows at 1131:

> SPW members may choose to participate in the agency option, consumer-directed services (CDS) or service responsibility option (SRO) delivery models. Members who choose the agency model select an MCO to coordinate service delivery for each service in the ISP. Members who choose CDS are given the authority to self-direct designated services. If the member chooses to self-direct designated

[22] 1 T.A.C. §353.702.
[23] Star+Plus Handbook 3114.
[24] Star+Plus Handbook 3126.1
[25] Star+Plus Handbook 3111.
[26] http://www.hhsc.state.tx.us/medicaid/hipp/
[27] Star+Plus Handbook 3127.

> services, the MCO coordinates delivery of non-member-directed designated services.

Also in the "more choices" category are "value-added" services. Each MCO is required to provide certain "basic" benefits, presumably tracking the benefits of Traditional Medicaid required by federal law. In addition, they provide various other services, varying by location and MCO. A summary is at http://www.hhsc.state.tx.us/medicaid/managed-care/starplus/comparison-charts.shtml .

5. Extension of managed care to nursing facilities

a) History and authority

Under S.B.7 and the 1115 Transformation Waiver discussed above, effective March 1, 2015, nursing facility services will be added to the "array of services" of the Star+Plus managed care program.[28] As with other Medicaid managed care, that is also under the authority of a provision of the Social Security Act with provisions specifically relating to Medicaid managed care.[29] Rules of the Texas Health and Human Services Commission provide a well-organized and authoritative summary.[30]

b) Effect on dual eligibles

For Elder Law attorneys, a major question is how this change will affect "dual eligibles"—clients eligible for both Medicare and Medicaid who are nursing facility residents. That is expressed in the HHSC rules as follows:[31]

> Dual eligible clients who participate in the Star+Plus program receive most acute care services through their Medicare provider, and Star+Plus Home and Community-Based Waiver Services through the Star+Plus MCO. The Star+Plus program does not change the way dual eligibles receive Medicare services.

Another way this is sometimes expressed is that dual eligibles receive acute-care services through Medicare (and related coverages such as Medicare Supplement insurance, Medicare Advantage membership, QMB, SLMB or QI); and they receive *long-term care* (nursing home, home care) services through the Managed Care Organization (MCO). It may be the reason the rule quoted above refers to "most" acute care services as coming through Medicare providers is that a limited amount of such services in the form of "nursing facility add-on" and "value-added" services will be through the MCO, as discussed below.

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[28] S.B. 7 §2.02, Tex. Gov. C. §533.00251. The CMS documents containing the "waiver" are at http://www.hhsc.state.tx.us/1115-Waiver-Overview.shtml at the bottom of the page: "Waiver Amendment" and "Federal Approval Letter and Documents."
[29] Social Security Act §1932, 42 U.S.C. §1396u-2.
[30] 1 T.A.C. Chapter 353.
[31] 1 T.A.C. §353.603(f)(2).

Except as otherwise noted, the information below is from an HHSC web page devoted to explaining how the mandatory move of nursing home Medicaid services to managed care will affect nursing home residents.[32]

c) Mandatory MCO membership requirement

In November 2014, nursing facility residents on Medicaid or their representatives were sent packets asking them to choose a Managed Care Organization and a primary physician (in the MCO). Those who have not made that choice by mid-February 2015 will be assigned to an MCO and a primary care provider. If the resident's attending physician is not an MCO provider, one will be assigned.

Comment: Although this is stated without exception in the FAQ's, there surely must be a major exception for dual eligible clients whose physicians are paid by Medicare and related benefits, as the rules require that their acute care be paid by Medicare, etc. and not by an MCO.

d) Nursing facility contracts with MCO's

The rules go to great lengths to avoid the need for a current Medicaid beneficiary to have to move to a different nursing home as a result of the move to managed care, as follows:

- The Texas statute requires HHSC "to ensure a nursing facility provider authorized to provide services under the medical assistance program on September 1, 2013, is allowed to participate in Star+Plus."[33] Such facilities must be accepted as providers by any MCO to which they may apply, provided only they agree to the terms of the MCO's contract.

- Even if a nursing facility does not sign a contract with a resident's MCO, it can still be paid through the MCO as an out-of-network provider. It then receives the Medicaid fee-for-service rate, minus 5%.

However, there is no guarantee. The program contemplates that some facilities may decline to sign an MCO contract with the MCO selected by a particular resident—or with any MCO—or to accept 95% of the fee-for-service Medicaid rate. As a result, some residents may have to be moved to a network facility.

[32] http://www.hhsc.state.tx.us/medicaid/managed-care/mmc/starplus-nf-faq.shtml

[33] Texas Gov. C. §533.0251(d).

e) Responsibility for reporting medical data and determining medical necessity

The nursing facility will continue to be responsible for developing and transmitting to TMHP the Minimum Data Set (MDS) and Long Term Care Medicaid Information (LTCMI). No changes have been made in that.

f) Responsibility for determining and paying the nursing facility's fees

Likewise, TMHP will continue to determine the Resource Utilization Group (RUG) rate on which payment to the facility is based. It will also determine whether or not the resident meets the Medicaid medical necessity requirement, based on the data transmitted. The fee due the facility (the "Nursing Facility Unit Rate") will be the amount based on the RUG, plus (if applicable) additional amounts based on liability insurance coverage and "staff rate enhancements." No changes will be made to that determination process, except as follows:

- A facility caring for a resident who is not a member of an MCO with which the resident has contracted will receive 5% less than

- Services not included in the RUG rate, called "Nursing Facility Add-on Services" will be contracted, authorized and paid by the MCO. That could include, for example, emergency dental services, physician-ordered rehabilitative services, customized power wheel chairs, and augmentative communication devices.

- Likewise, "value-added services" will be contracted, authorized and paid by the MCO. Such services are also selected and advertised by the MCO as inducements to join.

g) The role of MCO's in collecting copayment

Nursing facilities are to continue to make reasonable efforts to collect the Medicaid copayment. However, after two unsuccessful attempts, they are to notify the MCO, and its service coordinator is to notify that if the copayment is not paid, the resident may not be allowed to stay in the nursing facility.

h) The role of MCO's in service coordination

One of the advertised benefits of managed care is to provide a new level of oversight over the qualify and continuity of nursing facility services, in addition to the (usually) annual surveys and the occasional complaint investigations by DADS. Each nursing facility resident on Medicaid is to have a named MCO service coordinator, and the same coordinator will be assigned to all members of the MCO who reside in a particular facility unless the number of residents requires an additional coordinator. The service coordinator is to be involved in care planning and in the monitoring of plan implementation, add-on services, value-added services and acute care

services. The service coordinator is to have a face-to-face visit with each member at least quarterly. Another duty is to ensure a smooth transition to the community when appropriate.

i) Changing MCO's

A nursing facility resident may change his or her MCO at any time by mail, phone, fax or at enrollment events. If by phone, the number to call is 1-800-964-2777.

C. Effect of Windsor on Medicare and Medicaid in Texas

The Centers for Medicare and Medicaid Services (CMS) continues to announce Medicare and Medicaid policy to implement the holding of the United States Supreme Court that the Defense of Marriage Act is unconstitutional.[34] The Court left open the question of whether a state may constitutionally restrict the definition of marriage to exclude same-sex couples. Pending a decision on that, the critical issue with regard to public benefits is whether for the purpose of benefit eligibility, validity of a marriage between persons of the same gender will be treated as valid according to the law of the state of celebration (in which the marriage is almost always valid) or the law of the state of residence (which for Texas residents, as this is written on October 27, 2014, means the marriage is not valid).

1. Effect of Windsor on Medicare and Social Security Benefits

Following the same policy as the IRS, CMS applies the law of the state of celebration in all aspects of the Medicare program, even for residents of states like Texas that do not recognize the marriage as valid.[35] In states where same sex marriage is recognized, the Social Security administration is processing benefits to applicants who were "married in a state that recognizes same sex marriage and live or have lived in a state that recognizes same sex marriages".[36] Benefits are being held in cases where applicants were legally married in a state that recognizes same sax marriages, but now reside in a state that does not recognize same sex marriage.[37]

2. Effect of Windsor on Medicaid

However, the agency applies virtually the opposite rule with regard to all types of Medicaid. In those programs, in a letter to state Medicaid directors dated May 30, 2014, CMS announced that each state agency has the option of determining marriage validity either according to the law of the state of celebration or of the state making the decision.[38] To the author's knowledge, the

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[34] *United States v. Windsor*, 570 U.S. 12, 133 S. Ct. 2675 (2013).
[35] http://medicare.gov/sign-up-change-plans/same-sex-marriage.html
[36] Thomas D. Begley Jr. and Angela E. Canellos, Special Needs Trusts Handbook §2-130-131 (2014). See also §2-14-2-15 for a more detailed discussion on the revised applicable POMS section for Social Security benefits relating to same sex married couples.
[37] Id.
[38] www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-005.pdf .

Texas Health and Human Services Commission has not announced a decision on this, but nobody doubts it will continue to apply the law of Texas until that law is declared unconstitutional by the courts (which may happen soon, as discussed below).

The status of these changes is well summarized in a report of National Senior Citizens Law Center.[39]

3. Status of the Texas law

On November 8, 2005, Proposition 2 was added to the Constitution of Texas banning same sex marriage in Texas. [40] In October 2013, Cleopatra de Leon filed suit in U.S. District court against Rick Perry in his capacity as Governor, challenging Texas' ban on same sex marriage. [41] District Court Judge Orlando Garcia found for the plaintiffs citing "even under the most deferential rational basis level of review" regarding equal protection. Regarding due process and the denial of a fundamental right, he wrote that the state's ban must be reviewed under the strict scrutiny standard.[42] He ruled that the state has "failed to identify any rational, much less a compelling, reason that is served by denying same-sex couples the fundamental right to marry.[43]The State of Texas appealed the Court's decision to the fifth circuit, and oral argument is set for early January 2015.[44]

Additionally, two state-court cases involve the question of whether a Texas court has jurisdiction to grant a divorce in a same-sex marriage celebrated in another state, which indirectly involves the issue of whether Texas' definition of marriage as applying only to a man and a woman is valid. The Attorney General of Texas has intervened in both cases to defend the Texas law.

In one case, the Dallas Court of Appeals upheld the Texas law.[45] In the other, the Austin Court of Appeals did not rule on the issue because it held the Attorney General's intervention to be untimely. *State v. Naylor*, 330 S.W.3d 434 (Tex. App.—Austin 2011, pet. granted 8/23/13). They have been consolidated in the Texas Supreme Court, which heard oral arguments in November 2013 but has not yet announced a decision.[46] If the Texas Supreme Court upholds Texas law restricting the validity of marriage to a man and a woman, the United States Supreme Court may review it on petition for certiorari.

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[39] http://www.nsclc.org/wp-content/uploads/2014/07/CMS-Medicaid-Alert-on-Windsor-guidance.pdf .

[40] http://trailblazersblog.dallasnews.com/2014/02/federal-judge-voids-texas-gay-marriage-ban-though-he-delays-order-from-taking-effect-immediately.html/ (last visited 12/17/2014).

[41] *De Leon v. Perry*

[42] http://trailblazersblog.dallasnews.com/2014/02/federal-judge-voids-texas-gay-marriage-ban-though-he-delays-order-from-taking-effect-immediately.html/ (last visited 12/17/2014).

[43] Id.

[44] http://theusconstitution.org/cases/de-leon-v-perry-5th-cir (last visited 12/17/2014).

[45] *In re J. B.*, 326 S.W.3d 654 (Tex. App.—Dallas 2010, pet. granted 8/23/13).

[46] *Texas v. Naylor and Daly.*

4. CMS Proposes Same-Sex Marriage Recognition in Facilities of All States

Centers for Medicaid and Medicare Services (CMS) has proposed a revision to regulations that allow for legal marriage to be defined by individual states, in regards to Medicaid and Medicare Eligibility.[47] CMS argues that the definitions undermine the holding of *United States v. Windsor*, which states, "Section 3 of the Defense of Marriage Act (DOMA) is unconstitutional because it violates the Fifth Amendment[48]."

The proposal consists of nine revisions to the regulations that dictate eligibility based on state definition, including those regarding ambulatory surgical centers, hospices, hospitals, long-term care facilities, and community mental health centers[49]. CMS aims to insure that persons in a same-sex marriage receive the full benefits that they are entitled to regardless of which state they currently reside in. In reference to the "celebration rule," the proposal is that all states must recognize a legal marriage (even those celebrated under a foreign jurisdiction) as long as at least one state recognizes the legitimacy of the union.[50]

II. SUPPLEMENTAL SECURITY INCOME (SSI)

Supplemental Security Income (SSI) is often confused with Social Security Disability Insurance (abbreviated SSDI or SSD) and other Social Security benefits for retirees, dependents and survivors, because some of those programs also have disability criteria and because SSI is also administered by the Social Security Administration (SSA). Even the telephone operators at SSA occasionally use the terms interchangeably and incorrectly. It is, therefore, imperative to distinguish which program applies to the circumstances of a given individual. A simple way to remember the most important difference is: SSI is a needs-based program (hence the name: *supplemental … income*); and SSDI is the program that most workers "buy" into to insure themselves in the event of a disability that renders them unable to work (hence the name: Social Security *Disability Insurance*). A person becomes eligible for SSDI upon the completion of a certain work history and a qualifying determination of disability, irrespective of financial need. In many instances, a person who has a disability and the requisite work history, but a small SSDI benefit, may be eligible for both SSI and SSDI, which would also entitle the individual in question to both Medicaid and Medicare respectively.

Another important distinction between SSI and the other Social Security benefits is that the latter are paid for through the Social Security taxes paid for by workers; whereas SSI is not paid for by Social Security taxes but rather from the general funds of the United States Treasury.[51]

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[47] Department of Health and Human Services, 79 Fed. Reg. 239 (proposed December 12, 2014) (to be codified at 42 C.F.R. pt. 416, 418, 482, 483, and 485).

[48] Id.

[49] Id.

[50] Id.

[51] *See* Social Security, http://www.ssa.gov/OP_Home/handbook/handbook.21/handbook-2105.html (last visited Dec. 17, 2014).

A. Eligibility[52]

1. "Categorical" Requirements: Disability, Age 65 or over, *or* Blindness

a) Disability

For an adult, the disability requirement is the same as for Social Security Disability Insurance: you must be unable to engage in any substantial gainful activity because of a medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of at least 12 months.[53] Presumptively, in 2015, a person who is not blind and is earning more than $1,090 per month[54] is able to perform "substantial gainful activity," and thus is not considered "disabled." The amount applying to persons with blindness is $1,820 per month.[55]

This is a very tough standard compared to the standards of most disability insurance policies and compared to many clients' expectations. For example, it rules out benefits in the following cases:

- The client is partially but not totally disabled.
- Although unable to do his or her previous job (e.g., teaching or driving a truck), the client is able to do a much lower-paying job (e.g., assembly-line work)
- Although no work is available to the client in the area where he or she lives, it is available somewhere else in the United States.

A child under age 18 is considered to have a disability if he or she "has a physical or mental condition(s) that very seriously limits his or her activities; and the condition(s) must have lasted, or be expected to last, at least 1 year or result in death."[56] The limitation or limitations must be such that "several activities or functions [of the child] are impaired, or even when only one is impaired, as long as the degree of limitation is such as to interfere seriously with the ability to function (based upon age-appropriate expectations) independently, appropriately, effectively, and on a sustained basis." [57]

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[52] *See* Social Security, http://www.socialsecurity.gov/ssi/text-eligibility-ussi.htm (last visited Dec. 17, 2014).

[53] *See* Social Security, https://faq.ssa.gov/link/portal/34011/34019/Article/3714/What-are-the-eligibility-requirements-to-get-Social-Security-disability-benefits (last visited Dec. 17, 2014).

[54] *See* Social Security, http://www.ssa.gov/pubs/10003.html (last visited Dec. 17, 2014).

[55] 42 U.S.C. § 1382c(a)(3)(A); 20 C.F.R. § 416.905.

[56] *See* Social Security Administration, http://www.socialsecurity.gov/disability/disability_starter_kits_child_factsheet.htm#disability (last visited Dec. 17, 2014).

[57] *See* Social Security Administration, http://www.ssa.gov/disability/professionals/bluebook/112.00-MentalDisorders-Childhood.htm (last visited Dec. 17, 2014).

b) Age

A person age 65 or over who meets the other eligibility requirements is eligible for SSI.

Practice Note: It is quite common for persons age 65 and over to meet the SSI requirements and not know it. In addition to an income subsidy, SSI eligibility carries with it Medicaid benefits, which are vastly superior to Medicare benefits as discussed below.

c) Blindness

Total blindness is not required. The requirement is for central vision acuity of 20/200 or less in the better eye with the use of correcting lenses or a limitation in the field vision that meets certain criteria.[58]

2. Citizenship/Immigration/Residency Status

a) Residency

The client must be a resident of one of the 50 states of the United States, the District of Columbia, or the Northern Mariana Islands. Puerto Rico residents do not qualify.[59] Absence from the United States for 30 consecutive days disqualifies, and the client cannot regain qualification until he or she has again resided in the United States for at least 30 days.[60]

b) Citizen or Entitled Alien

A U.S. citizen, either by birth in the United States or by naturalization, always meets this requirement.

An illegal immigrant never meets this requirement.[61]

A person who is a permanent resident alien, an asylee, a refugee, a person paroled into the U.S. for at least a year, a person whose deportation is withheld for certain reasons, or a person granted conditional entry is a "qualified" alien potentially eligible for SSI, *if* he or she meets *any* of the following requirements:

- Entered the United States before August 22, 1996. (An alien entering the U.S. on or after that date is ineligible unless he or she falls into one of the categories below.)

[58] *See* Social Security Administration, http://www.ssa.gov/ssi/text-eligibility-ussi.htm#blind (last visited Dec. 17, 2014).
[59] *See* Social Security Administration, http://www.ssa.gov/OP_Home/cfr20/416/416-0000.htm (last visited Dec. 17, 2014).; Social Security Administration, http://www.ssa.gov/OP_Home/cfr20/416/416-1603.htm (last visited Dec. 17, 2014).
[60] *See* Social Security Administration, http://www.ssa.gov/OP_Home/cfr20/416/416-1327.htm (last visited Dec. 17, 2014).
[61] 8 U.S.C. § 1611(a).

- An asylee, refugee or person whose deportation is withheld, for the first 7 years after being granted that status; *or* for the first 7 years, a Cuban, a Haitian, an Amerasian, certain Native Americans from Canada, and the non-citizen children of a battered parent.

- Active duty troops, their spouses, their un-remarried surviving spouses, unmarried dependent children, and honorably discharged veterans meeting the minimum service requirement (generally, 24 months active duty).

- Persons who have earned 40 qualifying quarters of Social Security coverage, or who can be credited with such quarters due to the work of a parent or spouse under certain specified rules.[62]

The general prohibition on benefits for aliens is also subject to the following important exceptions:

- Legal immigrants who were receiving SSI as of August 22, 1996 continue to be eligible.

- Immigrants who were legally in the United States on August 22, 1996 retain their potential SSI eligibility (i.e., they are not subject to the "qualified alien" rules summarized above, which in effect apply only to persons who were *not* legally in the United States on August 22, 1996.).[63]

Aliens receiving SSI only because of the August 22, 1996 exceptions are not eligible for food stamps.[64] However, all aliens receiving SSI are eligible for Medicaid.[65]

See page 166 for a chart summarizing the limits on eligibility of aliens for numerous types of public benefits.

3. Income[66]

a) General Rule

An unmarried person must have less than $733 per month of countable income in 2015. Both spouses of a married couple can be eligible if their countable income totals less than $1,100 per month. Because the first $20 of income is not counted, these numbers are sometimes expressed as $743 and $1,120, respectively. These numbers change with inflation on January 1 of each year.

Some states have an "SSI supplement" that gives SSI beneficiaries more than the federally mandated maximum of $733. Texas does not.

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[62] 8 U.S.C. § 1612.
[63] 8 U.S.C. § 1612(a)(2)(E),(F).
[64] 8 U.S.C. § 1612(a)(1), § 1612(a)(2)(E),(F).
[65] 8 U.S.C. § 1612(b)(2)(F).
[66] 20 C.F.R. Part 416, Subpart K.

"Income" is defined generally as cash (or property readily convertible to cash), food and shelter. "Shelter" includes "room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection services."

Unlike the income tax rules, the SSI rules count even gifts as "income." This general rule is subject to a long list of exclusions that can be important in some cases.[67]

Additional important exclusions applying to "earned" income and "unearned" income, respectively, are discussed next below. Appendix 3 contains instructions to a trustee of a Special Needs Trust for an SSI beneficiary. It incorporates these rules.

b) Rules applying to earned income

Earned income is defined as gross wages of an employee (without deductions for taxes, insurance, etc.), and net earnings from self-employment (after deduction of business expenses but also without deductions for taxes, insurance, etc.).

The following are examples of the things that are *excluded* from countable earned income:[68]

- The first $65 plus one-half of remaining earned income each month;
- Certain federal assistance payments (including food stamps);
- $30 per month of infrequent or irregular income;
- Certain additional exclusions for persons with blindness and disability (including, for example, work expenses due to disabilities); and
- The general $20 per month exclusion, to the extent it has not been taken against unearned income.[69]

c) Rules applying to unearned income

"Unearned" income is all income that is not earned, including without limitation annuities, pensions, alimony, support, dividends, life insurance proceeds, prizes, gifts and inheritances.[70]

Important exclusions from unearned income include most federal payments (for example, food stamps), up to $60 per month of irregular or infrequent income, one-third of child support

[67] 20 C.F.R. § 416.1103.
[68] 20 C.F.R. § 416.1112.
[69] 42 U.S.C. § 1382a(a); 20 C.F.R. §§ 416.1102, 416.1110, 416.1112.
[70] 42 U.S.C. § 1382a(a)(2); 20 C.F.R. § 416.1121.

payments, and certain special VA payments (though VA pensions count as income). Because the list of exclusions is quite lengthy, it should always be consulted.[71]

d) "In-kind support and maintenance"[72]

This term refers to *food and shelter* furnished or paid for by someone other than the SSI applicant. In general, because it is counted as unearned income, food and shelter reduces benefits dollar-for-dollar. However, a much better result for the client can be obtained by applying some important rules applicable only to this kind of "income":

- *One-Third Reduction Rule:* If the client is living in the household of another person who is providing *both* food *and* shelter, the client's SSI benefit will be reduced by 1/3 of the monthly federal benefit rate (maximum payment). In 2015, that amount is 1/3 X $733 = $244.33[73]

- *Presumed Maximum Value Rule:*[74] If the One-Third Reduction Rule does not apply, and the client is furnished *any* food *or* shelter by someone else, the agency *presumes* that the value of whatever is furnished is 1/3 of the federal benefit rate plus $20-- that is, in 2015, $244.33 + $20.00 = $264.33. This presumption is rebuttable--that is, by showing that the actual value of what is furnished is less than $264.33, the client can have his or her income reduced by the actual value rather than the full $264.33.

- *Exception:* If the SSI beneficiary lives in the household of someone part of whose income may be "deemed" to the beneficiary, then any support provided is *not* treated as income.[75] For example, income of a parent of a child under age 18 in the same household above a certain level is deemed to the child, so the parent's provision of food and shelter does not result in a reduction of the child's SSI payment--regardless of whether or not the parent actually has enough income for some of it to be deemed.

It is impossible for most persons with disabilities to live on $733 per month without falling into conditions of squalor and ill health that shock the conscience and constitute public health hazards. Therefore, it can be critical to the client's health and safety to apply the following planning techniques, which further protect the client from the harshness of the general rule that in-kind maintenance and support counts as "income":

- *Business Arrangement:* As long as the client pays a pro rata share of the actual cost of food and shelter, there is *no* reduction in benefits and no food or shelter value counts as income.[76] Simply by keeping records of household expenses and having the SSI-eligible person pay his or her share, the total household income can in this way be increased by

[71] 42 U.S.C. § 1382a(b); 20 C.F.R. § 416.1124.
[72] 20 C.F.R. § 416.1130.
[73] 20 C.F.R. § 416.1131; POMS SI 00835.210.
[74] 20 C.F.R. § 416.1140; POMS SI 00835.300.
[75] 20 C.F.R. § 416.1148; POMS SI01320.150.
[76] 20 C.F.R. §§ 416.1130(b), 416.1133.

$244.33. This can also allow a person with irreducible income (for example, from Social Security Disability) to achieve eligibility that would otherwise be impossible. As long as the beneficiary's actual cost of food and shelter does not exceed $733 per month (the SSI benefit rate plus the $20 amount of income that is disregarded), they can avoid reduction of the benefit with a business arrangement--unless they are unfortunate enough to have an irreducible benefit (such as Social Security Disability Insurance income) which, when added to the $244.33 + $20.00 = $264.33 amount, causes total countable income to exceed $733 per month. See Appendix 2 for a worksheet for pro rata share calculations.

- *Rent Subsidy--Pay 1/3 FBR + $20 to Landlord:* Under a settlement agreement, the Social Security Administration has agreed to apply in Texas a rule previously applied only in the Seventh Circuit--that a "business arrangement" will be deemed to exist whenever the rent paid equals or exceeds the presumed maximum value $264.33 in 2015). Therefore, even if the fair market value of the rent is $733, there will be *no* income attributed to a rent subsidy, so long as the client pays at least $244.33 to the landlord. In this way, a parent or child can subsidize an SSI recipient's rent without reducing the monthly SSI payment to the client. This rule applies only when the SSI beneficiary lives in his/her own household, and someone in the household is related as parent or child to the landlord or landlord's spouse. If the beneficiary is in the household of another person who pays both food and shelter, the one-third reduction rule applies, unless income of the other is deemed to the beneficiary.[77]

  Caution: The rent subsidy rule applies only to rent. To avoid a reduction of benefit based in in-kind support and maintenance, the SSI beneficiary must also pay for their own food and all "shelter" expenses other than rent, such as electricity, gas, water, sewerage and garbage collection.

- *Rent Subsidy--Unlimited Where Landlord is Neither Parent nor Child:* If nobody in the household is related as a parent or child to the landlord, no rent subsidy will be treated as income.[78] However, this will apply only if the landlord owns the building, not if the landlord is leasing from the owner and subleasing to the SSI beneficiary.

- *Ownership of the residence by a trust:* If a trust of which the client is a beneficiary owns the residence, the fact that the trust allows the client to live there does not mean the client has "income" in the form of shelter.[79] However, if the trust pays for household expenses such as electricity, gas, water, sewerage and garbage collection, those payments are "income" to the extent they are not fully reimbursed by the client.[80] Of course, if persons other than the client live in the dwelling unit, their pro rata share of the expenses will reduce the amount the client must pay to avoid receipt of "income."

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[77] 20 C.F.R. § 416.1130(b); Social Security Administration Program Operations Manual System (hereinafter POMS) SI DAL00835.380; *see* settlement agreement in *Diaz v. Chater*, C.A. No. 3:95-CV-1817-X (N.D. Tex. 1996), unreported agreed order.
[78] POMS SI 00835.380A.
[79] POMS SI 01120.200F1.
[80] POMS SI 01120.200F3c.

Practice note: A simple and powerful technique where a supplemental needs trust is involved is to have the trust provide all food and shelter, in exchange for reducing the SSI payment by $264.33 per month, under the "presumed value rule." In addition, the trust can make unlimited payments to the providers of "supplemental" needs. In this arrangement, the only thing the trust cannot do for the beneficiary is to pay cash to him or her. The beneficiary then has $733.00 - $244.33 = $499.67 per month in cash from SSI to spend as she or he wishes, with Medicaid paying (usually) all medical needs and the trust paying everything else. ($264.33 counts as $244.33 in this equation because $20.00 is disregarded.)

Unfortunately, some trusts expressly prohibit the provision of food, clothing or shelter. This is an unduly restrictive provision and should be avoided.

Trusts with such restrictions can almost certainly be modified. A Texas trust can always be modified by a court if "because of circumstances not known to or anticipated by the settlor, the order will further the purposes of the trust."[81]

e) Deeming of Income

The income of an SSI client is "deemed" to include the income of certain persons related to the client; to the extent it exceeds certain levels.[82] The relationships that may give rise to deeming are summarized as follows:

- Ineligible spouse living in the same household
- Ineligible parent, or parent's spouse, living in the same household with a client under age 18
- Sponsor of a client who is an alien--i.e., someone who signed an affidavit of support for the alien's admission to the U.S. Certain limitations and exceptions apply.

Not all income is subject to deeming. For example, in-kind maintenance and support (ISM) received by a parent is not deemed to a minor child, nor is ISM of an ineligible spouse deemed.[83] Therefore, for example, a trust can pay housing expenses of a parent who is beneficiary of the trust without creating any income for the minor children who live with the parent—unless the children are also trust beneficiaries, in which case there is still no deeming, but there is ISM from the trust, limited by the Presumed Maximum Value Rule. See the POMS section just cited for a long list of other types of income not deemed.

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[81] TEX. PROP. CODE § 112.054(a)(2), as amended by Acts 2005, 79th Leg., ch. 148, § 7, eff. January 1, 2006; and in order to accommodate HHS and its beneficiaries, the Texas Legislature in 1997 specifically provided that trusts created by guardianship (probate) courts and trial courts as Supplemental Needs Trusts can be modified to allow the ward to be eligible for public benefits. TEX. PROB. CODE § 868(d) (now Texas Estates Code §1301.101), TEX. PROP. CODE § 142.005(g).

[82] For specific rules, *see* 20 C.F.R. §§ 416.1160-416.1169.

[83] POMS SI 01320.100B.11.

f) When is a Reimbursement "Income"?

In recent years, until a POMS change on February 8, 2013, it became a common occurrence for the Social Security Administration to treat any cash paid by a trust to a parent or guardian of an SSI beneficiary as income to the beneficiary. For example, a parent pays for attendant care for his or her minor child then is reimbursed by a Special Needs Trust. Until the POMS change, the agency justified that policy under a section of the POMS requiring, "Treat monies received by an agent acting on behalf of an SSI beneficiary as if the beneficiary received the monies directly."[84] "Agent" is defined as "all individuals who act in a formal or informal fiduciary capacity, regardless of his or her titles (e.g., representative payees, guardians, conservators, etc.)."[85] This was frequently applied to parents of minors due reimbursements, but agency representatives had gone so far as to include anyone due a reimbursement as within the definition an "agent," making any reimbursement whatsoever "income" of the beneficiary.

That stretches the definition of "agent" beyond anything the POMS drafters intended.[86] In response to complaints by trustees and their attorneys, the agency changed the policy by publishing the following on February 8, 2013: "Reimbursements made from the trust to a third party for funds expended on behalf of the trust beneficiary are not income."[87]

However, no change was made to the section initially quoted above, with the broad definition of "agent." Based on the history noted above, that probably means reimbursements to an "agent" are no longer subject to being treated as income, although other types of payments (such as SSI and other cash benefits paid to a representative payee or guardian) should be so treated. By that reading, a reimbursement to the parent of a minor child is not "income" to the child.

However, there is one class of payments by a trust to the parent of a minor child (under age 18) that is problematic: payment for care services. Such payments are likely to be characterized as income of the parent, which means they are subject to being included in the parent's total income for the purpose of deeming part of that income to the child. Some SSI and Medicaid programs also raise an issue as to whether such a payment to a parent violates the "sole benefit rule" discussed above (though the needs of most children with disabilities are so far beyond what is ordinarily expected of parents that payment for care is usually permitted).

One way of mitigating the problem of deemed income is to make sure distributions for child care will be treated as *earned* income, rather than *unearned* income. That way, the first $65 per month plus half the rest of such income is disregarded. That is, payroll taxes should be deducted and reported and a form 1099 filed, with the parent-caregiver treated as an employee of the trust. In many cases that will avoid any reduction of SSI from deeming, and if not, it will always limit the reduction substantially. It may also help the advocate's position regarding the sole benefit rule.

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[84] POMS SI 00810.120D.1.
[85] POMS SI 00810.120B.1.
[86] See POMS GN 00810.120E.1.
[87] POMS 01120.200E.1.d., 01120.201 I.1.f.

g) Calculators to Estimate SSI Income

The deeming rules are extremely complex. They can be applied efficiently only with automated calculators like those below.[88] Even relatively "simple" cases can benefit from the first calculator cited below:

- Simple SSI benefit calculation: enter earned & unearned income & IRWE to calculate SSI benefit. Does not help with deeming.

- Excel spreadsheets to determine SSI benefit with (1) spousal deeming or (2) parental deeming; good explanation of SSI income rules, including deeming, with worksheets.

h) Special Rules on Child Support

Cash child support received by the child or on the child's behalf counts as income to the extent of 2/3 of the actual amount, if the "child" is unmarried and under age 22 and a student.[89] Otherwise, if any of those conditions is not met, all the child support counts as income.

When an individual reaches the age of 22 and is no longer eligible for the one-third exemption of child support,[90] there are at least 3 possible strategies to consider. They can also be used for younger children:

- "Presumed Maximum Value" strategy: The supporting parent may pay the support in the form of food or shelter, as long as payment is not made directly to the offspring. For example, the supporting parent could pay rent for the offspring directly to the landlord or another party (such as another parent or roommate). This amount would thus be included in the total provided for food and shelter, which would be regarded as no more than $264.33 in income, even if the actual amount paid by the supporting parent exceeded this amount.[91]

- "Special Needs Payments" strategy: The supporting parent could pay the support to someone other than the offspring for something *other than* food and shelter. For example, the parent could pay the offspring's health insurance, medical care, training, counseling, etc., if payments were made directly to the provider of such services.

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[88] For a sample SSI calculator, see http://careersourcebrevard.com/job-seekers/disability-services/ticket-to-work/ticket-to-work-calculators/ssi-calculator-unearned-income-only (last visited December 17, 2014).

[89] 42 U.S.C. §§ 1382a(a)(2),(b)(1), (b)(9).

[90] POMS SI 00810.410.

[91] *See* POMS SI 00830.420. This applies by its terms to child support paid as in-kind support and maintenance in a situation in which one-third of child support is disregarded. Logically the same principle would apply if there were no disregard, and an official of the Social Security Administration has indicated to the author that that is their view. The same official concurred with the author's views as stated in the next two "strategies" as well.

Payment of such services fall into the category of "special needs," and are thus not counted as income at all.

- "Special Needs Trust" strategy: The supporting parent can pay the support directly into a Special Needs Trust pursuant to court order, with a provision for repayment of the Medicaid program as in any other self-settled trust. If the trustee of such a trust distributes funds only for "special needs," no income is actually ever produced and thus cannot be subject to the income limits.[92]

i) Special Rules on Spousal Support

Spousal support received by a divorced individual is generally considered unearned income taken into consideration for determining SSI eligibility. However, as with child support, this income can be made exempt by engaging one of the two strategies listed below:

If a court orders all spousal support payments to be made directly into a supplemental needs trust.[93] Notably, this supplemental needs trust must be court-created in order to meet the law's requirements. As long as the spousal support is irrevocably assigned to the court-created trust, the support payments are not counted as income for SSI purposes.[94]

If spousal support payments are irrevocably assigned to a pooled trust for the benefit of the disabled spouse before the disabled spouse reaches age 65, this stream of income will not be counted as income.[95] If the income is not assigned to the pooled trust is made after the disabled spouse turns 65, Social Security considers this to be a transfer of assets, resulting in a period of ineligibility.[96]

4. Resources[97]

a) General rule

An unmarried individual seeking SSI is limited to $2,000 in resources (countable assets). A married couple can have no more than $3,000 in resources for either one or both to be eligible for SSI.[98]

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[92] Rick Williams, *SSA and SSI and SNTs--Current Issues* (in Q&A, page 1), State Bar of Texas Advanced Guardianship Course (March 10, 2006). This is now (at last) incorporated in the POMS at SI 01120.200G.1.d.
[93] POMS SI 01120.203B.f.
[94] POMS SI 01120.200G.
[95] POMS SI 01120.203B.
[96] *See* CMS Threatening Transfers Into Pooled Trusts By Those 65+, THE ELDER LAW REPORT, Sept. 2008.
[97] 20 C.F.R. Part 416, Subpart L.
[98] 20 C.F.R. § 416.1205.

b) Definition of resources

Resources include cash, other liquid assets, and any real or personal property that the client or spouse owns and can convert to cash.[99] The important exclusions include the following:

- Entire value of the client's residence,[100] without limit, including all contiguous acreage. Leaving the residence for nursing home care or other institutionalization does not preclude exclusion of the residence, so long as there is a subjective intent to return.

- "Household goods" and "personal effects" without limit.[101] Household goods are defined as items found in or near the home, used on a regular basis or needed for maintenance, use and occupancy of the premises as a home. "Personal effects" are defined as items ordinarily worn or carried by the individual or having an "intimate relation to" the individual. Examples of personal effects are personal jewelry including wedding and engagement rings, personal care items, prosthetic devices, and educational or recreational items such as books or musical instruments. Items of cultural or religious significance and items required because of the individual's impairment do not count. However, items acquired or held "for their value or as an investment" are not considered "personal effects"--for example, gems, jewelry that is not worn or held for family significance, or collectibles. There is a maximum exemption of $2,000 for such items, with their value over that counting toward the $2,000 maximum for non-exempt resources. (Until March 9, 2005, personal and household goods were exempt only to the extent their total value did not exceed $2,000, though there was never any practical way this could be enforced on a consistent basis.[102])

- One vehicle used for transportation of the individual or a member of the individual's household. (Until March 9, 2005, the exempt value of a vehicle was limited to $4,500 unless it fell within several exceptions.[103])

c) Deeming of resources[104]

The following resources of others are deemed to the client:

- All resources of the claimant's spouse living in the same household

- Resources of the claimant's single parent in excess of $2,000, or parent and spouse together in excess of $3,000, if the claimant is under age 18 and living in the same household with a parent.

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[99] 20 C.F.R. § 416.1201.
[100] 20 C.F.R. § 416.1212.
[101] 20 C.F.R. § 416.1216.
[102] 20 C.F.R. § 416.1216.
[103] 20 C.F.R. § 416.1218.
[104] 20 C.F.R. § 416.1202.

- Certain resources of an alien's sponsor.[105]

B. Benefits

1. Cash Benefits

An eligible person with no other income receives the monthly "federal benefit rate" in 2015 of $733 (if single) or $1,100 (for a married couple with both spouses eligible). Countable income reduces the amount of cash benefits dollar-for-dollar (but see the discussion of eligibility above for a summary of what is "countable.")

2. Medicaid Eligibility[106]

SSI beneficiaries are automatically eligible for the comprehensive medical benefits of the Medicaid program. These benefits are often more important than the cash benefits. They are the "Regular Medicaid" benefits discussed below.

C. Trust Rules

1. Third-Party Settled Trusts

These are trusts whose assets are contributed by someone *other than* the beneficiary. Typically, they are created by parents or other family members of persons with disabilities, who are made beneficiaries. They may be created in wills (testamentary trusts) or by transfers during lifetime (inter vivos trusts).

So long as the beneficiary does not have the legal authority to revoke the trust or direct the use of the trust assets for his or her own support and maintenance, the trust principal is not the beneficiary's resource for SSI purposes.[107] "While a trustee may have discretion to use the trust principal for the benefit of the beneficiary, the trustee should be considered a third party and not an agent of the beneficiary, i.e., the actions of the trustee are not the actions of the beneficiary, unless the trust specifically so provides."[108]

Trusts settled by someone other than the beneficiary (all testamentary trusts and those inter vivos trusts not containing any assets of the beneficiary) need not have provisions for repaying Medicaid benefits after the beneficiary's death, nor are they affected by the age restrictions on "self-settled" trusts discussed below.[109]

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[105] 20 C.F.R. § 416.1204.

[106] *See* Social Security Administration, http://www.socialsecurity.gov/disabilityresearch/wi/medicaid.htm (last visited Dec. 17, 2014); See Department of Aging and Disability Services, Medicaid for the Elderly and People with Disabilities Handbook, http://www.dads.state.tx.us/handbooks/mepd/ (last visited Dec. 17, 2104).

[107] POMS SI 01120.200D.2.

[108] POMS SI 01120.200D.1.b.

[109] POMS SI 01120.200 provides in the introduction, "Generally, this section applies to trusts *not* subject to the statutory trust provisions in section 1613(e) of the Social Security Act, instructions for which are

Comment: Social Security Administration policy on trusts has undergone many changes over time. As a result, even the current versions of some of the standard treatises continue to state that the corpus of a trust is treated as available to an SSI applicant if it does not have a restriction to the effect that the trustee may "supplement but not supplant" public benefits. This is indeed the position of some state Medicaid programs (not including Texas Medicaid), but it is not the policy of the Social Security Administration. Thus, even a traditional "support" trust will not be counted as an asset of the beneficiary under the SSI program, despite the possibility that the beneficiary could compel support by seeking a court order, so long as the authority to compel distributions is not contained expressly in the trust's provisions.

Practice Note: Providing for such trusts should be seriously considered in any estate plan involving a beneficiary with a disability, either in a testamentary trust or inter vivos. An inheritance by or distribution to a person under 65 years old with a disability may usually be transferred into a self-settled trust, but that involves providing for a remainder to the Medicaid program (or a pooled trust) in order to preserve Medicaid benefits. Use of trusts is almost always preferable to disinheriting a person with a disability just to avoid loss of benefits.

2. Self-Settled Trusts

If an SSI beneficiary transfers his or her own assets into a trust of which he or she is beneficiary, the trust should provide that after the beneficiary's death, the trust will repay the Medicaid program for all benefits it has provided the beneficiary. This is because, under legislation effective as to trusts created on or after January 1, 2000, if a trust is established with assets of the individual or the individual's spouse, and the trustee can under any circumstances make any payment to the individual or the individual's spouse, the corpus will be treated as a resource of the individual. If not (i.e., an irrevocable trust by an SSI applicant of which the applicant is not a beneficiary), the transfer will be penalized, with a 36-month look-back period. However, the assets of a self-settled trust will not count as resources of the individual if the trust provides for repayment of Medicaid benefits after the beneficiary's death and meets the other requirements of 42 U.S.C. §1396p(d)(4)(a),(c) (the Medicaid "OBRA 93" requirements).[110]

Providing for the "payback" to Medicaid can also solve another problem: such a trust would be considered revocable (and therefore a resource of the beneficiary) if the settlor were the only beneficiary with a vested interest.[111] However, Social Security officials in Texas currently consider the trust to be irrevocable, thus resolving this issue, if the Texas Health & Human Services Commission is designated in the trust instrument as a “vested remainder” beneficiary.[112]

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found in SI 01120.201 -- SI 01120.204. Use the instructions in this section to evaluate the following types of trusts:…b. Trusts established on or after 1/1/00 that contain only assets of third parties…"

[110] Foster Care Independence Act of 1999 § 205, H.R. 3443, P.L. 106-169, amending Social Security Act § 1613, 42 U.S.C. § 1382b.

[111] POMS SI 01120.200D; *See also Seguin State Bank & Trust v. Locke*, 102 S.W.2d 1050 (Tex. 1937).

[112] Medicaid programs in other states have sometimes taken the position that they should *not* be named remainder beneficiaries but rather "super creditors." If they are only remainder beneficiaries, then all the creditors--even unsecured creditors--must be paid first. Anticipating a possible agency shift to this

Another way of making the trust irrevocable is to designate specific named persons (not simply "heirs at law") as vested remainder beneficiaries. This method is necessary in some states even where there is a "payback" provision. Because one can never be sure in what states the beneficiary may live in the future, it is prudent to include at least a nominal distribution (typically $10.00) to someone (typically a parent or grandparent who establishes the trust) as a vested remainder beneficiary.

Before a trust of this type is funded with proceeds of a settlement or judgment, it is ordinarily necessary to pay any subrogation or "lien" claims of Medicare, Medicaid, hospitals, insurance companies and perhaps other creditors.[113]

a) Individual Under-65 Supplemental Needs Trusts.

1. Purposes. The most common purpose of this type of trust is to insulate from consideration by Medicaid the proceeds of an award or settlement based on a legal claim, most commonly for personal injury. Another important purpose, especially where home care is involved, is simply to make the assets of the client go further by qualifying for Medicaid benefits before they are all used up.[114]

Practice Note: Using a Special Needs Trust where appropriate in a personal injury case is not an unusual or exotic practice. In 2004, a plaintiff's attorney and the guardian ad litem in the same case were held liable for $4.1 million in a malpractice judgment for failure to do this.[115]

2. Client eligibility requirements. This "exception" to the self-settled trust rules is available only to persons meeting the following requirements:

- Under age 65 at the time the trust is established. After the client reaches age 65, the trust's "exception" status continues as to assets transferred into it before age 65. Assets transferred after age 65 will not considered to be an asset if the trust complies with 42 U.S.C. § 1917(d)(4)(C), however the beneficiary will lose benefits due to a transfer of resources if funds are placed into the trust after age 65.[116]

- Disabled as defined in the requirements for Social Security Disability or SSI benefits.

3. Trust requirements. The trust must meet the following requirements:

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position, some attorneys, including the author, solve the problem by providing for a nominal amount of $100 to an individual as a vested remainder beneficiary.

[113] Medicaid for the Elderly and People With Disabilities Handbook D-7000 et seq., http://www.dads.state.tx.us/handbooks/mepd/D/D-7000.htm

[114] 42 U.S.C. § 1396p(d)(4)(A); 1 T.A.C. §358.417(f), Medicaid Eligibility for the Elderly and People with Disabilities Handbook (hereinafter MEPD) F-6710.

[115] *See Grillo v. Henry Cause*, 96-167943-96 (96th District Court of Tarrant County, Texas 2004).

[116] *See* Note under POMS SI 01120.203B.2.a.; *see also* POMS SI 01150.121.

- *Who "establishes" the trust*: Established for the benefit of the client by a parent, grandparent, legal guardian of the client, or a court. By definition, however, these trusts are funded with assets belonging to or controlled by the beneficiary, so even where a parent or grandparent establishes the trust, they provide only a nominal contribution (typically, a $10 bill attached to the trust instrument).

- *"Payback provision":* The State will receive all amounts remaining in trust upon the death of the client, up to an amount equal to the total Medicaid payments made for the client.

- *Satisfaction of subrogation claims:* HHSC currently requires the Medicaid lien to be satisfied before the trust is funded, and any Medicare, insurance subrogation and hospital liens must be satisfied as well.

- *Source of funds:* Although the statute allows funding of the trust with any property owned by the beneficiary, agency representatives in some states (for example, Colorado) allow such trusts to be funded only with personal injury awards and not with inheritances and property owned by the beneficiary.[117] The Texas Medicaid program has not adopted any such limitation on the source of funds, nor is there any provision in the federal law apparently allowing such limits.

- *Irrevocability:* The trust must be irrevocable to comply with the general trust rules discussed above, and in the case of Supplemental Security Income (SSI) recipients, to comply with the SSI rules.

- *Trustee:* A trust created under Property Code §142.005 (by a trial court, typically in a personal injury case) or (usually) under Texas Estates Code Chapter 1301[118] (in a guardianship or for a person with a disability who is not incapacitated) must have a corporate trustee. This requirement under Chapter 1301 does not apply if the trust's principal is under $150,000, or if it can be shown that no financial institution is willing to serve as trustee, or if the trust is for a person with a disability who is not incapacitated.[119] It is not required if the trust is "established" by a parent or grandparent under 42 U.S.C. §1396p(d)(4)(a).

- *Distribution standards:* Although the statute is silent as to provisions for distributions to or for the beneficiary, such trusts usually either require that such distributions either be entirely discretionary with the trustee, or limited to distributions that will “supplement and not supplant” public benefits.[120] Another variation is to provide for absolute discretion, with a statement of intent that the distributions be used to "supplement and not

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[117] Clifton B. Kruse, Jr., *O.B.R.A. ‘93 Disability Trusts--A Status Report*, 10 NAELA QUARTERLY No. 1 (Winter 1997).
[118] Now Codified in the Texas Estates Code Sections 1301.051 through 1301.057.
[119] Texas Estates Code Section 1301.057
[120] *See* Kruse, *supra* note 100.

supplant" public benefits. Yet another option, to avoid the ambiguity of the latter type, is to provide expressly that the trustee may make distributions that disqualify the beneficiary for benefits, if the trustee in its discretion determines that would be in the beneficiary's best interests.

Comment: The author is not aware of any Texas program, other than possibly the state-funded mental health and intellectual disability programs that would otherwise honor a self-settled trust, and requires that the trustee be prohibited from making distributions that would disqualify the beneficiary for benefits. It would seem to follow that the trustee of a self-settled trust should ordinarily not be prohibited from making distributions that would disqualify the beneficiary, if there is any possibility that the beneficiary would be better served by foregoing Medicaid at some point. The Medicaid programs of some states still require the mandatory supplemental needs language, which can almost certainly be added by modification of the trust if there is any statement of intent that the beneficiary should qualify for public benefits when that is in his or her best interests. An elegant way to provide for that is to follow the New York statute (which is based on case law) providing for a trust form saying, in effect, that the trustee has discretion to make disqualifying distributions; provided, if this provision alone causes disqualification of the beneficiary, it shall be treated as null and void. See MCKINNEY'S CONSOLIDATED LAWS OF NEW YORK ANNOTATED § 7-1.21.

Distinguish these self-funded "Special" Needs Trusts from similarly named instruments funded by persons other than the client, which need not have the "remainder to Medicaid" provision. See above for a discussion of the requirements for traditional Supplemental Needs Trusts not funded by the beneficiary.

Comment: HHSC rules expressly provide, "A payment to or for the benefit of the client is counted under trust provisions only if such payment is ordinarily counted as income."[121] *This is very important, because many beneficiaries can qualify for QMB and/or home care programs through application of the Presumed Maximum Value Rule even though a trust, or a parent, pays for all their food and shelter. This principle seems to offend some HHSC employees, who insist on applying different and more restrictive rules to distributions from trusts, despite clear authority to the contrary in the federal Medicaid law, their own rules and the decisions of their own hearing officers.*[122]

Practice Note: The rules on self-settled trusts usually come into play when an SSI beneficiary anticipates recovering a sum of money in a lawsuit, such as a personal injury case, or when he or she receives money or property through inheritance. If a trust is not utilized and SSI and Medicaid benefits are lost, the money or property may be used up quickly and the beneficiary returned to a status of poverty before again being eligible for benefits. With a trust, there is an

[121] Department of Aging and Disability Services, Medicaid for the Elderly and People with Disabilities Chapter F, §6610, http://www.dads.state.tx.us/handbooks/mepd/F/F-6000.htm (last visited Dec. 17, 2014).

[122] The author will provide sample briefing on this issue at no charge by reply to email sent to cfarrell@texas.net, requesting briefing on "when trust distributions are counted as income."

incentive to recover and use carefully the money or property, and it can last much longer if it merely supplements the public benefits.

b) Pooled Supplemental Needs Trusts

An additional option in the form of "pooled trusts" is provided in Texas by The Arc of Texas and The Center for Special Needs Trust Administration, Inc.

The Arc of Texas has developed four “pooled trusts” as authorized by 42 U.S.C. §1396p(d)(4)(c) that meet the requirements discussed above for a self-settled Medicaid trust. Forms and brochures may be found and downloaded at the website of The Arc of Texas at http://www.thearcoftexas.org . On the home page click on Programs and Services, and on the page that comes up, scroll down and click on Master Pooled Trust.

Client accounts may be of two types regarding source of funds: either self-settled (with a payback provision to Medicaid *or* the trust, as discussed below), or third-party-created (with no payback provision required). Each of those two types is further divided into one prohibiting "support" distributions (for food and shelter) (mandatory supplemental needs), and one allowing such distributions in the discretion of the trustee (discretionary support). The trusts are identified as follows:

TRUST I: Third-party-settled, mandatory supplemental needs (no payback required)
TRUST II: Self-settled, mandatory supplemental needs (payback or Arc trust remainder)
TRUST III: Third-party-settled, discretionary support (no payback required)
TRUST IV: Self-settled, discretionary support (payback or Arc trust remainder)

The Social Security Administration (the SSI program), the Texas Health & Human Services Commission (all the Medicaid programs), and the (former) Texas Department of Mental Health and Intellectual disability have all indicated in correspondence with the Arc of Texas that they will not count assets of either type account as resources of beneficiaries. They indicated no upper or lower limit on the value of trust assets that can be protected under this policy.

(1) Purposes.

A pooled trust established under 42 U.S.C. § 1396p(d)(4)(c) has essentially the same purpose as an Under-65 Special Needs Trust--allowing a person under age 65 to qualify for SSI and/or Medicaid without having to first spend or give away all their assets. The only such trust operating in Texas at this writing is the Arc of Texas Pooled Trust.

(2) Client eligibility requirements.

This "exception" to the self-settled trust rules is available only to persons meeting the following requirements:

- *Age*: There has been some question as to whether a transfer penalty might apply to a transfer by a client age 65 or over.[123] Initially, Texas agency representatives stated in a written memorandum that they did not intend to penalize such transfers, with no reference to an age limitation.[124] However, The Social Security Administration interprets the SSI law to provide for a transfer penalty for a contribution to a self-settled trust by a person age 65 or over, even if the trust meets all the requirements for an "Under-65 Supplemental Needs Trust" or a "Pooled Trust."[125] The Texas Health & Human Services Commission also has a handbook provision to this effect.[126] Therefore, long-term care Medicaid, as well as SSI-linked Medicaid, has this limitation.

- *Disability:* The applicant must be disabled as defined in the requirements for Social Security Disability and SSI benefits.

(3) Trust requirements

The trust must meet the following requirements:

- *Management:* The trust is established and managed by a non-profit association. However, because Texas law requires that a corporate trustee be a bank or licensed trust company, JPMorgan-Chase Bank serves as trustee of the Arc of Texas Pooled Trust.

- *Pooling of assets:* A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

- *Who may establish sub-accounts:* Accounts are established in the pooled trust by a parent of a minor child, an agent, a guardian, by the individuals themselves, or by a court. The Pooled Trust can be used pursuant to an order in a guardianship case under Texas Estates Code Chapter 1302. It may be more problematic if the order is from a trial court because of the requirement of Property Code §142.005(b)(1) that the minor or incapacitated person be the "sole beneficiary of the trust;" but it would seem that a "subaccount" in the pooled trust should be considered the functional equivalent of a trust with a single beneficiary, as the "pooling" is for investment purposes only.

- *Remainder beneficiaries:* To the extent that amounts remaining in the client's account upon the death of the beneficiary are not retained by the trust, the State will receive all

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[123] Medicaid for the Elderly and People with Disabilities F-6710, http://www.dads.state.tx.us/handbooks/mepd/F/F-6000.htm#secF-6710 .This interpretation is based on the restriction of the exceptions to the transfer rule to trusts for the benefit of an individual under age 65. 42 U.S.C. § 1396p(c)(2)(B)(iv).

[124] Memorandum dated February 3, 1999 from Jackie Johnson, Assistant Deputy Commissioner for Long Term Care Services, to all Regional Directors of Aged & Disabled Services.

[125] Foster Care Independence Act of 1999 § 206(a), P.L. 106-169, amending Social Security Act § 1613(c)(1)(C)(ii)(IV).

[126] Medicaid for the Elderly and People with Disabilities F-6710, http://www.dads.state.tx.us/handbooks/mepd/F/F-6000.htm#secF-6710.

amounts remaining in trust upon the death of the client, up to an amount equal to the total Medicaid payments made for the client.

Comment: If the sub-account is established by order of a guardianship court, follow carefully the requirements of Texas Estates Code Chapter 1302. In particular, notice that the guardian does not have the option of making the pooled trust the remainder beneficiary. The sub-account agreement must provide that the Medicaid program is the primary remainder beneficiary, because that is the only way there can be a possibility of assets being distributed to any of the required beneficiaries in Texas Estates Code §1302.005(2) (for example, having assets remaining after reimbursement of Medicaid go to the personal representative of the decedent's estate as required by that section). Likewise, even if a guardian is not involved, beware the option of making the pooled trust the primary beneficiary. That cuts out any possibility of family members receiving anything out of the remainder. The Arc of Texas Master Pooled Trust joinder agreement gives the settlor an option in that regard, but some pooled trusts require making the trust the primary beneficiary. Unless the proposed contributor to the pooled trust has capacity to decide and does decide to make the pooled trust a beneficiary, it should not be done.

- *Distributions:* The federal statute has no requirements as to what if any limitations must be placed on distributions. Although the Center for Medicare & Medicaid Services refers to such trusts as "supplemental needs trusts," it has never to the author's knowledge required that beneficiaries be forced into benefit programs, as occurs with narrowly drafted trusts and as has been required by some states (but not Texas). See the discussion above of the choices offered by the Arc Pooled Trust.

Comment: MEPD Appendix XXXVII states that disbursements from The Arc of Texas Master Pooled Trust may not include food, clothing or shelter. That is accurate with regard to Trusts I and II but incorrect regarding Trusts III and IV, which were created expressly for the purpose of allowing such disbursements (as discussed next below). It also states that distributions for food, clothing and shelter will be treated as income to the beneficiary. It is correct in a limited and literal sense with regard to most Medicaid programs, which apply SSI methodology for counting income. However, it is incorrect with regard to the "waiver" home care programs, such as Community Based Alternatives;[127] *and it obscures the fact that under the One-Third Reduction Rule and the Presumed Maximum Value Rule, the entire value of food and shelter is rarely counted as income. Note also that providing clothing no longer creates income under the SSI rules as discussed above. Appendix XXXVII is one instance of the continuing and mysterious resistance within the agency to the settled legal principle that trust distributions to program beneficiaries are treated the same as other distributions to the same beneficiaries.*

(4) Arc Pooled Trust Distribution Standards

The essential distribution standards of Trusts I and II are as follow:

[127] Department of Aging and Disability Services, Medicaid for the Elderly and People with Disabilities Chapter O, §1200, http://www.dads.state.tx.us/handbooks/mepd/O/O-1000.htm#secO-1200 (last visited Dec.17, 2014).

3.1. Settlor's Intent. …Assets of this Trust are not for any Beneficiary's support. The assets in this Trust are to be used only for supplemental needs and the supplemental care of the Beneficiaries…

3.3. Special Needs, Supplemental Needs and Supplemental Care. …It is not the intention of The Arc as Settlor nor of the Grantors to displace public or private financial assistance that may otherwise be available to any Beneficiary. It is the intention of The Arc as the Settlor and of the Grantor to limit the Trustee's disbursements to those for a Beneficiary's supplemental care only.

The essential distribution standards of Trusts III and IV are as follow:

3.l. Intent. …Further, the Trustee and/or Manager shall, to the extent they deem it reasonable and advisable, help the Beneficiary obtain governmental assistance and use the Sub-Account for that Beneficiary to supplement, and not supplant, such assistance. However, there may be situations where a Beneficiary could qualify for governmental assistance, but that the Trustee and Manager, nevertheless, determine that it is in the Beneficiary's best interests to make distributions from the Sub-Account even though such distributions will reduce the Beneficiary's governmental assistance or result in the Beneficiary's ineligibility for governmental assistance…

3.4. Discretionary Trust: Health, Education, Maintenance, and Other Needs. The Trustee shall make disbursements from a Beneficiary's Sub-Account in such amounts, from zero to the entire Sub-Account, as shall be directed by the Manager within the Manager's sole discretion for health, education, maintenance, and other needs of a Beneficiary, or may refuse to make disbursements, as directed by the Manager in the Manager's sole discretion.

Practice Note: The Arc pooled trust provides professional management at less than the cost charged by many corporate trustees. Its effectiveness for sheltering certain assets has been pre-established by negotiation with HHSC, Social Security and (the former) TDMHMR--a process not available to individuals. And it does not require paying an attorney fee to establish the trust (although legal counsel is definitely needed to determine whether or not this is the best disposition of the assets; to provide independent advice as to the alternatives; and frequently, to advise as to what distributions can be made under the laws governing the particular programs for which the client is eligible).

The amendment of the trust to allow payments for support of beneficiaries, even when they would reduce or eliminate public benefits, has opened up the trust for larger contributions. In the past, beneficiaries with amounts large enough to support them, if they had medical expenses paid, usually preferred individual trusts that could provide such support, usually under the SSI "presumed value rule." With the new Trust III and Trust IV, such distributions are be possible, even to the extent of providing full support to beneficiaries if the amount of the sub-account is sufficient.

To the extent the remainder may exceed reimbursements for Medicaid, the trust can pay the remainder to other designated beneficiaries (usually family members); and at the option of the grantor, the trust may retain all or a portion of the remainder before reimbursement to the

Medicaid program. Although HHSC representatives have stated that they believe Medicaid should be reimbursed before the trust receives anything, the trust instrument says otherwise. In the author's opinion, HHSC is clearly wrong on this, but this issue may yet be tested in an application for nursing home Medicaid or the Community Based Alternatives program.

The issue just discussed "muddies the water" somewhat in the decision as to whether a client should designate relatives to receive the remainder, or direct some or all of it to the trust. The latter choice is likely to be more attractive if the alternative is that Medicaid will take most or all of it otherwise. However, if it were clear that Medicaid got its cut first, it would be more difficult to decide to direct some or all of the remaining assets to the trust and away from family members. What we know is that any proportion of the remainder directed to the trust will not go to family members, and attorneys giving advice on this need to make that clear, documenting clearly that they have done so.

An advantage of the Arc pooled trust in the past has been that it could accept contributions from individuals age 65 and over for their own benefit, which cannot be done in other types of self-settled trusts. However, the new SSI law makes clear that there will be a transfer penalty for contributions to a self-settled pooled trust by persons age 65 and over, and the Texas Health & Human Services Commission has amended its rules to the same effect for the Medicaid programs with transfer penalties.

The Arc trust offers an attractive combination of low fees and administration by persons knowledgeable about the needs of persons with disabilities and the programs that serve them. Trusts I. and III. can accept assets of persons other than the beneficiary (such as testamentary gifts), in which case there is no "payback" provision. For more information, call the ARC at 800/252-9729 (454-6694 in the Austin area) or go to http://www.thearcoftexas.org/trust/index.php .

3. Restrictions on Early Termination Provisions in Self-Settled Trusts

Self-settled trusts for SSI beneficiaries often have provisions for termination of the trust during the lifetime of the beneficiary in specific situations. For example, the trust may terminate if the beneficiary is no longer disabled or if the trust is too small to administer efficiently. Likewise, it may terminate if the trustee determines it does not protect the assets from consideration by the SSI program (sometimes referred to as an "explosion" clause).

A POMS change effective November 8, 2010 imposes strict restrictions on such trusts with an "early termination provision." It is defined as a provision or clause that "would allow a trust to terminate before the death of the beneficiary."[128] Such a trust must meet *all* the following requirements, in addition to other requirements previously announced, for its assets to be excluded from resources for SSI purposes:[129]

[128] POMS SI 01120.199D.
[129] POMS SI 01120.199F.1.

Upon termination (even if it is prior to the beneficiary's death), Medicaid benefits must be paid back from the trust to the extent assets are available, after payment of allowable taxes, fees and administrative expenses; *and*
All trust assets that remain must be distributed to the trust beneficiary; *and*
Someone other than the trust beneficiary holds the power to terminate the trust

Those requirements are the same as to pooled trusts as well as individual under-65 SNT's, except a pooled trust is exempted from the requirements above as to a provision solely allowing for transfer of a beneficiary's assets from one qualified pooled trust to another.[130]

Comment: A provision allowing the trustee of an individual self-settled SNT to transfer assets to a pooled trust with a Medicaid payback provision would seem to protect Medicaid's interest. However, nothing in the POMS provides for such an exception. Therefore, unless and until such an exception is recognized, it would be prudent not to include such a power. However, there is no reason not to include it in a third-party-settled trust, and the author has used such provisions several times to turn over funds to the Arc of Texas Master Pooled Trust that could not be efficiently administered in the original third-party trust.

This POMS requirement applies to all trusts that as of November 8, 2010 had not yet been accepted by the Social Security Administration from the general requirement of counting assets of a self-settled trust as resources. It also applies to trusts previously excepted, if they are not amended within 90 days after the Administration informs the SSI recipient or representative payee of the need for amendment of the trust.[131]

Comment: The Social Security Administration does not tell us how we are supposed to amend trusts they require to be irrevocable. Fortunately, in Texas at least, that can be readily accomplished by filing a petition in a state District Court for modification of the trust on the ground that due to the POMS change, "because of circumstances not known to or anticipated by the settlor, the order will further the purposes of the trust."[132] Also, some trusts although irrevocable in name have provisions expressly allowing amendment in certain circumstances. The Arc of Texas Master Pooled Trust II and IV have such a provisions, which have been invoked to amend them to comply with this new requirement.[133]

4. Factors Affecting Type of Trust and Selection of Trustee

The attorney's most important and challenging task is to guide the client through the following important decisions:

- Who should be trustee?
- What distribution standards?

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[130] POMS SI 01120.199F.2.
[131] POMS SI 01120.199A.
[132] Texas Property Code §112.054(a)(2).
[133]The ARC of Texas, http://www.thearcoftexas.org/trust/index.php#enroll_forms (last visited Dec.17, 2014).

- Pooled trust or individual trust?

The following factors must be considered in making these decisions:

Who should be trustee?

- Is an appropriate individual trustee available?

- If so, is that person's administration preferable to administration by a pooled trust or other corporate fiduciary?

- If the trustee is not a professional fiduciary, more extensive guidance in the trust instrument may be desirable.

- Is the amount of the corpus sufficient to attract a corporate fiduciary other than the Arc Pooled Trust?

- Are the fees of the proposed trustee reasonable in relation to the services to be performed?

- If the proposed trustee is an individual, does he or she (or the various co-trustees) have the ability and motivation to handle the challenging tasks of making distribution decisions, keeping good trust records and making investment decisions?

- Does the proposed individual trustee have a conflict of interest (such as a remainder interest in the trust) that would hinder or preclude fair and effective service as trustee?

- Does the proposed individual trustee have a relationship to the beneficiary that would be endangered by the potential conflict between trustee and beneficiary? (For example, sibling rivalry and parent-child conflict may be enhanced.)

- On the other hand, is the proposed trustee's service as hands-on manager so important to the beneficiary that selection of the pooled trust or another corporate fiduciary is precluded?

What distribution standards?

- Is there a likelihood of the beneficiary's moving to another state? If so, the choices may be limited to Arc Pooled Trust I or II, or to an individual trust with similar "mandatory supplemental needs" language.

- Are trust assets sufficient to provide the beneficiary a level of support better than would be available from a trust with a "mandatory special needs" distribution standard? If so, that argues for avoiding Arc Trusts I and II, and instead using Arc Trust III (if third-party-settled) or IV (if self-settled), or drafting an individual trust giving the trustee discretion to use the trust's assets in place of public benefits.

- Is the beneficiary disqualified from receiving SSI (and the accompanying Medicaid) because SSDI income is too high? If so, that argues for discretion in the trustee to provide support, as limiting distributions to "supplemental needs" is unlikely to give the beneficiary access to any benefits not otherwise available. (An important exception is long term care Medicaid benefits, in some states other than Texas, which may require a mandatory supplemental needs standard.)

Pooled trust or individual trust?

- Does the need for management of distributions by someone who knows the SSI and Medicaid rules indicate a preference for the Arc Pooled Trust?

- Are the fees of the Arc Pooled Trust lower than other available fiduciary fees?

- Is the client (and/or the client's legal representative) comfortable with the Arc Pooled Trust? Do they have an affiliation with it or with another potential trustee?

- In a self-settled trust situation, is there a preference for directing the remainder to the Arc Pooled Trust rather than to the Medicaid program?

The careful reader will notice that these factors sometimes conflict. For example, the corpus may be large enough to provide support (assuming medical benefits are paid by Medicaid), but the beneficiary is likely to move outside Texas. The former would indicate giving the trustee discretion to supplant benefits, while the latter would indicate a strict "mandatory supplemental needs" standard protecting benefits to the greatest extent possible wherever the beneficiary may be. Some of these conflicts simply have to be considered and decided by the client or the client's representative. However, the following are some techniques that can sometimes harmonize them:

- Where the conflict is between forcing the client to accept all public benefits and allowing the trustee to supplant benefits, a two-trust approach may be indicated. A highly protected "nest egg" could go into a "mandatory supplemental needs" trust, while the rest of the available assets go to a trust that can be used for support. For example, a young child with a substantial personal injury award or inheritance, and an uncertain future, may be an appropriate beneficiary for such planning. This could take the form of two individual trusts, or it could involve two accounts in the Arc Pooled Trust: Trusts I and III (if third-party-settled) or Trusts II and IV (if self-settled).

- Individual trusts can provide for a "trust protector." For example, the client may want an individual family member trustee with broad discretion. The risks inherent in that combination could be reduced by giving someone else the authority to remove and replace the trustee or, if desired, to veto particular decisions of the trustee.

- Where the corpus is so small that support distributions would not be appropriate anyway, the best decision is probably to limit distributions to mandatory supplemental needs (as in

Arc Trusts I and II). In that case, it may be helpful to emphasize the need for care coordinators to utilize public benefits as effectively as possible, as a "supplemental need" that pays big dividends. For example, this can be done as a recommendation to the trustee in the trust instrument, or the instrument may direct the trustee to commission an annual care status report by a care manager.

- Explore with family members the following as possible contributions to a third-party-settled trust: life insurance policies, retirement plan and IRA accounts,[134] and testamentary bequests by family members.

- To give the trustee added flexibility, draft all third-party trusts to allow the trustee (perhaps at the direction of a trust protector) to transfer the trust's corpus to a sub-account in the Arc Pooled Trust.

[134] For qualified retirement plans and IRAs, if a trust is to be beneficiary of the account, be sure the trust's individual beneficiary qualifies as the "designated beneficiary" under Proposed Treasury Reg. § 1.401(a)(9)-1D. Otherwise, valuable tax deferral opportunities may be lost.

SPECIAL NEEDS TRUST DECISION MATRIX

Issue	Pooled Trust	Individual Trust Created by Parent, Grandparent or Guardian	Individual Trust Created by Court[135]
Distribution Decisions	Arc personnel determine distributions, guided by designated the beneficiary or his/her representative	Trustee (may be individual(s) or bank or trust company)	Trustee (a bank or trust company), unless corpus is small and certain other conditions are met[136]
Investment Decisions	JPMorgan-Chase Bank	Trustee (may be individual(s) or bank or trust company)	Same as above
Remainder beneficiary if self-settled (settlor can name any remainder beneficiary if settlor is not also the beneficiary)	To the extent of Medicaid benefits paid, must be either Medicaid program or the pooled trust;[137] may provide for others by designating Medicaid only to the extent of benefits	Medicaid program, to the extent of benefits paid; residuary determined by settlor	Medicaid program, to the extent of benefits paid; residuary determined by settlor (with court approval)
Formalities of establishing self-settled trust	Beneficiary or his/her legal representative completes forms required by the Pooled Trust, including an agreement establishing a subaccount, and pays a fee if applicable	Attorney drafts trust; parent or grandparent signs as settlor, making a nominal contribution; beneficiary funds the trust	Attorney drafts trust; court approves it; trust is funded by defendant or defendant's insurer (if proceeds of lawsuit); by guardian of the estate; or by Beneficiary with capacity

[135] If created in a guardianship under Texas Estates Code §§1301.051-057, this will be a Probate Court or other court with jurisdiction over the guardianship; if created in a trial court (typically in a personal injury case), it will be under TEX. PROP. CODE § 142.005.

[136] In a guardianship case, Texas Estates Code §1301.57 requires a bank or trust company be trustee if corpus is more than $150,000 unless certain conditions are met. In a trial court case involving a trust to be established under TEX. PROP. CODE § 142.005(m)(n), the court may allow an individual to be trustee if the corpus is under $50,000 and it would be in the beneficiary's best interests; or if the corpus exceeds that amount, if the court also finds that no financial institution is willing to serve.

[137] Note that whenever the pooled trust is a remainder beneficiary, its manager and trustee have a conflict of interest. Every dollar distributed for the beneficiary is a dollar less potentially available to the trust later. The author believes it is unlikely that the Arc's personnel would be influenced by this, but the client may have a different opinion if distributions turn out not to be as generous as anticipated. This is a conflict of interest that should be disclosed by the attorney to the client from the beginning.

Issue	Pooled Trust	Individual Trust Created by Parent, Grandparent or Guardian	Individual Trust Created by Court[138]
Formalities of establishing third-party-settled trust	Settlor (e.g., parent or grandparent of beneficiary) completes forms required by the Pooled Trust, including an agreement establishing a subaccount, and pays a fee if applicable	Trust may be inter vivos or testamentary. If inter vivos, it may either be funded immediately, or funded later by life insurance, retirement accounts and/or distribution under a will or revocable trust. (Settlor may be anyone, not just parent or grandparent.)	Not applicable
Distribution standards	Choice between supplemental needs only, prohibiting distributions other than for food and shelter (Trusts I and II); or discretionary support (Trusts III and IV)	May provide for other standards, such as supplemental needs allowing use of Presumed Value Rule, unlimited trustee discretion, or "spigot trust."	May provide for other standards, such as supplemental needs allowing use of Presumed Value Rule, unlimited trustee discretion, or "spigot trust."
Requirements for amendment (for example, if beneficiary moves out of state or Texas programs establish more restrictive standards)	No provision for amending as to a subaccount alone; but the entire trust may be amended either by the Manager or Trustee without court approval, or by a court, to accomplish its purposes.	In Texas and in most states, a trust can be amended with court approval, upon a showing that the amendment is necessary to accomplish settlor's intent to qualify the beneficiary for benefits	May be amended, modified or revoked by the establishing court at any time

This outline does not discuss fully all the procedural rules and drafting considerations applicable to establishment of trusts to preserve public benefits. For more complete discussions, see articles for the University Of Texas School Of Law Special Needs Trust Conferences in 2006-2015; and Glenn M. Karisch, *Court-Created Trusts in Texas* (2008), available for downloading at http://www.texasprobate.net/articles/.

5. The Sole Benefit Rule

a) The Hobbs Case

In 2009, the 10th Circuit issued an opinion in a case concerning public benefits and a supplemental needs trust for a young boy who had suffered a traumatic brain injury as a result of a serious accident.[139] This decision has already begun to have a far-reaching impact for disabled individuals, as what has been dubbed the "sole benefit rule" is considered by attorneys, corporate trustees, and caretakers.

[138] If created in a guardianship under Texas Estates Code §§1301.051-057, this will be a Probate Court or other court with jurisdiction over the guardianship; if created in a trial court (typically in a personal injury case), it will be under TEX. PROP. CODE § 142.005.

[139] *See Hobbs v. Zenderman*, 579 F.3d 1171 (10th Cir., 2009).

Case Summary:

In May 2000, Steffan Hobbs of Farmington, New Mexico was struck by a vehicle, resulting in a traumatic brain injury which caused frequent seizures, behavioral issues, and a need for constant care. In February 2003, the Hobbs' attorneys reached a settlement with the defendant, and the New Mexico State District Court signed an order approving a special needs trust appointing MassMutual as trustee.[140]

Built into Steffan's trust were provisions which allowed distributions for Steffan's particular circumstances and medical needs. For instance, the trust allowed for the purchase of livestock for therapeutic purposes because Steffan related to animals in a way he could not with other people. The instrument also allowed the trustee to compensate Steffan's parents for their caretaking services, to purchase a portion of the family home, and to pay expenses related to the home.[141]

Steffan later qualified for Supplemental Security Income (SSI), and as a result, he began receiving Medicaid benefits through the state of New Mexico. The special needs trust, compliant with 42 U.S.C. §1396p(d)(4)(A), was submitted to both Social Security and to Medicaid for legal review.[142] Social Security approved the trust, but the New Mexico Human Service Department (NMHSD) did not.[143]

In a letter to Steffan's personal injury attorney, General Counsel for NMHSD concluded the trust would be considered a countable asset because it allowed impermissible disbursements. The letter went on to say, "under state Medicaid policies, special needs trust funds may not be used, for example, to purchase land and a family home, pay property taxes and insurance on that home, pay for home furnishings (unless related to the beneficiary's disabilities), purchase farm animals and outbuildings, compensate a parent for taking care of her disabled child, pay the beneficiary's personal income taxes, or pay advisory fees to the trustee's affiliates."[144] The state was primarily concerned with trust distributions made to Steffan's mother to compensate her for her caregiving services.

After losses at an administrative hearing and in district court, Steffan's parents filed for an appeal on his behalf with the 10th Circuit. This Court concluded that a very narrow reading of the "sole benefit" requirement of 42 U.S.C. §1396p(d)(4)(C)(iii) was appropriate. As construed by the Court, this statute requires that a trustee must consider four questions when determining whether a distribution from a special needs trust is appropriate: (1) Will the distribution be for the sole benefit of the named beneficiary?; (2) Is the beneficiary the only beneficiary of the trust?; (3) Will a disbursement be in the beneficiary's best interest?; and (4) Is any benefit to family or other household members merely incidental? If the trustee can answer in the affirmative to each of these questions, then the distribution is permissible under the sole benefit rule.

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[140] *Id*. at 1175.
[141] *Id*..
[142] *Id*. at 1176.
[143] *Id*.
[144] *Id*.

Ultimately, the Court concluded that 42 U.S.C. § 1396p(d)(4)(A) did not "unambiguously impose a binding obligation on the State"[145] and "Congress left the States free to decide whether and under what conditions to recognize" (d)(4)(A) trusts.[146] Thus, NMHSC was left to determine whether Steffan's trust, which otherwise met with federal guidelines, would be a countable resource when evaluating his eligibility for Medicaid benefits.

A "Chilling" Effect on Trust Distributions

What effect has the *Hobbs* decision had on trust administration and the decisions of trustees? In the months following the opinion, corporate trustees have begun to withhold distributions which would benefit the beneficiary but also have even small benefits for family and household members. In particular, trustees may be more hesitant to pay family members for their caretaking services, requiring the utilization of third party home health care staffing even though parents and other members of the household may be more qualified to provide the individualized care. It may also have a chilling effect on the purchase of homes wherein a trust and family members would have a joint ownership agreement.

Although *Hobbs* is a product of the 10th Circuit, its effects have already begun to be felt in Texas. The author has already been faced with a corporate trustee who cited Hobbs in declining to make a distribution toward the purchase of a much-needed family home, and unless Texas courts or the 5th Circuit make a determination adverse to Hobbs, the sole benefit rule will likely continue to arise in the practice of special needs planning.

The holding in a more recent Third Circuit case appears to be contrary to the *Hobbs* rationale.[147] In that case, the federal appeals court held squarely that Pennsylvania's effort to add restrictions to pooled trusts violated the federal Medicaid law. The same reasoning would appear to apply to an individual Special Needs Trust.

b) Implications of the Sole Benefit Rule for SNT Administration

For those clients who are Medicaid eligible or who are seeking Medicaid coverage, it is advisable to work with the caseworker, the Health and Human Services Commission (HHSC), the courts, and the family to work out a plan of distribution that will support proper care while allowing for maintenance of public benefits. Before making distributions to family members as compensation for caregiving services, it may be in the client's best interest to seek written confirmation from the caseworker or agency stating that such distributions will not disqualify the disabled individual from receiving benefits.

If a written confirmation is not available or proves difficult to obtain, it may be necessary to seek a court order approving a caregiver compensation proposal and providing notice to the agency.

[145] *Id*. at 1179, citing *Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997).
[146] *Id*. at 1180, citing *Keith v. Rizzuto*, 212 F.3d 1190, 1193 (10th Cir. 2000).
[147] *Lewis v. Alexander* (3rd Cir., No. 11-3439, June 20, 2012).

Such an order may be obtained fairly routinely if a guardianship is involved, or it may be obtained in District Court in a suit for a declaratory judgment.

When establishing a special needs trust, it is essential to consider the following in the planning stage:

- Do the parents or other family members have an expectation of payment for caregiving services?
- What formal services does the beneficiary require beyond standard parental duties of care? Can these needs be documented by a third party?
- What is the proper rate of payment for caregiving services? How is this rate to be adjusted in the future?
- Are wages paid to a family member tax deductible as a medical expense?
- Is there a way to monitor and verify the hours worked and services provided?
- Is the trust or the parent responsible for payment of taxes and insurance?
- Should a formal contract with the caregiver be drawn up?
- What additional steps can be taken to avoid disqualification from public benefits?

Though formal answers and solutions to all of these questions may not be required in every situation, it is important manage expectations of all stakeholders as early in the process as possible. This planning may also affect the trust language, but considering SSA's shifting policies in 2013 discussed above, it may be prudent to document the parties' understandings in other ways.

6. Revised POMS Trust Provisions and the Sole Benefit Rule

In 2014, the Social Security Administration (SSA) provided the following new policy in interpretations regarding the sole benefit rule[148]:

- Payments to Family Members for Travel to Visit the Beneficiary;
- Payments to Family Members as Caregivers;
- Payment for Companion to Accompany Trust Beneficiary on Vacation; and
- Treatment of UTMA accounts.

[148] SSA has interpreted the sole benefit rule to mean that expenditure must be used for the sole benefit of the trust beneficiary. Any provisions that allow to provide for benefits to other individuals or entities or that allow for early trust termination prior to the trust beneficiary's death to another will disqualify the trust beneficiary for the special needs trust exception. SI 01120.201F.2.

a) Payment to Family Members for Travel to Visit Beneficiary

In 2012, SSA amended POMS to prohibit a trust from paying for travel of family members to visit the beneficiary. The SSA reasoned that paying for travel for the beneficiary would be for the sole benefit of the beneficiary, but paying for a third party, even an immediate family member's travel, would not be for the sole benefit of the beneficiary. This holds true even if the family member was accompanying the beneficiary on a trip.[149] The SSA did however state that payment for a skilled healthcare professional to accompany the beneficiary on a trip would not violate the sole benefit rule, if the care was required for the beneficiary to travel.[150] As of January 1, 2014, these examples have been deleted from POMS without explanation so the question of whether family member travel expense is reimbursable without violating the sole benefit rule is left open.[151]

b) Payments to Family Members as Caregivers

Recently, the SSA's position on family member caregivers is that a trust can only pay for family members for care giving services provided to the beneficiary if the caregiver is "medically trained."[152] "Medically trained" has been interpreted to mean that the parent or family caregiver is educated to the same level as what would be required if a third party individual was hired.[153] SSA clarified that experience is not the same as educational requirements and is not a substitute for it. However, there are some Medicaid-certified forty hour courses for certain levels of care that would constitute properly educated.[154]

c) Payment to Family Members or Other Third Parties to Accompany Beneficiary on Vacation.

As denoted in the section above, payment from the trust for family member travel to accompany the beneficiary, even in situations where the beneficiary cannot travel without a companion, is in potential violation of the sole benefit rule if certain qualifications are not met. The qualification or exception to the sole benefit rule and third party travel permits skilled health care professionals to have their travel paid by a Special Needs Trust when the beneficiary requires such care.[155]

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[149] POMS SI 01120.201.2; *see also* Thomas D. Begley, Jr. and Angela E. Canellos, *Self Settled Special Needs* Trusts, Special Needs Trust Handbook, 2013-2 Supplement, 6-30, § 6.02[A][4][e] (Wolters Kluwer 2014).
[150] *See* Thomas D. Begley, Jr. and Angela E. Canellos, *Self Settled Special Needs* Trusts, Special Needs Trust Handbook, 2013-2 Supplement, 6-30, § 6.02[A][4][e] (WoptlersKluwer 2014).
[151] *See id.* It should also be noted that improper reimbursement is not treated by SSA as "violating" the sole benefit rule, but is considered to be income to the beneficiary, which has other implications. *see id*. at §9.04[C][14].
[152] *See id.* at § 6.02[A][4][f].
[153] *See id.*
[154] *See id.*
[155] See id. at § 6.02[A][4][g].

d) Treatment of UTMA Accounts

If the minor's funds are placed into an UTMA account, SSA will likely consider it a "device similar to a trust," because the assets are contributed by and available to the minor, and the account is not a (d)(4)(A) trust.[156] However, the same POMS provision contains an example in which an UTMA account established with assets *not* belonging to the minor beneficiary are *not* to be treated as resources of the minor. The same example applied the income rules to a disbursement from an UTMA account in the same way as if it were a trust.[157] Therefore, it appears SSA is consistent in applying the same policy to an UTMA account as to a trust: if it is self-settled and does not have a Medicaid payback provision (which no UTMA accounts do), its assets are resources of the beneficiary; but if it is third-party-settled, its assets are not resources of the beneficiary; and trust disbursements are treated as income or not under the same rules as any other gifts to the beneficiary.

It is unclear if funds in an UTMA account may be transferred to a third party supplemental needs trust. Some scholars argue that the answer should be a definite no because the funds in an UTMA account belong to the beneficiary, and in essence are the beneficiary's funds.[158]

7. New System for Evaluating SSI Trusts

Effective April 23, 2014, all SSI applications involving trusts are to be routed through a new Regional Trust Reviewer Team.[159] This consists of specialists in trust review. The purpose is to improve the speed, consistency and correctness of SSI decisions involving trusts, which previously were made in field offices, with review by a regional trust specialist only when requested by a field office.

The trusts specialists are to be guided by a *Fact Guide for National Trust Training.*[160] However, NAELA leader Thomas D. Begley, Jr. warns that the new *Fact Guide* "probably raises more questions than it answers."[161]

Comment: I have seen two cases in the last month in which clients came in terrified by a Social Security notice from "out of the blue" asking them to provide basic information about trusts in connection with SSI cases in which eligibility was determined years ago, with full disclosure as to the trusts. The trusts were perfectly compliant, but in one case Social Security had sent a notice of termination of SSI based on a misinterpretation of the trust. I believe this is likely the work of the new Regional Trust Reviewer Team and that all we need to do is reassure the clients,

[156] POMS SI 01120.205E.2.; *See id.* at § 6.06[C][1][b].
[157] POMS SI 01120.205G.
[158] *See id.* at §6.06[C][1][b][2].
[159] . https://secure.ssa.gov/apps10/reference.nsf/links/04232014010832PM
[160] http://www.frgalaw.com/dox/fact_guide.pdf
[161] http://www.begleylawyer.com/2014/10/fact-guide-for-national-trust-training-the-impact-on-special-needs-trusts/

advise that they comply with the requests, and be sure an appeal is filed when mistakes are made.

8. SSI Approves Court-Created Trusts Only When Nobody Requests Them

One clearly erroneous provision in the new *Fact Guide for National Trust Training* deserves special mention. It carries forward a curious misconception that arose about a year ago, when the agency began treating self-settled trusts as not meeting the "exception trust" requirements in almost every case in which they were created by courts. The agency's reasoning was that whenever an "appointed representative" of the SSI applicant/beneficiary requests that a court establish a trust, the trust should be treated as if it was established by the beneficiary personally. That appears in section F.1.E.3 of the *Fact Guide.* It creates the strange situation in which presumably, a trust is considered court-created only if the judge comes up with the idea and implements it with no suggestion from the litigants.[162] The authors of the article just cited indicate they have asked the Social Security Administration to change this.

Comment: This is quite revealing as to why trusts create such difficulties for the Social Security Administration and nightmares for our clients. Apparently the agency's trust policy is made and implemented with no supervision by an attorney who has ever set foot inside a courthouse. Otherwise, it could not be based on the assumption that courts can be expected routinely to know all the applicable laws and grant remedies requested by nobody before the court.

Practice Note: Until this is straightened out, the problem can be sidestepped in most cases by having trusts established only by a parent, grandparent or guardian. They can then be funded, if necessary, by order of the court in which litigation is pending. Alternatively, a pooled trust can be used.

9. ABLE Act Accounts

At the end of 2014, Congress passed legislation providing for accounts for certain persons with disabilities whose assets will in most circumstances not be counted as resources by SSI and other means-tested programs.[163] Such accounts are in some ways similar to educational savings accounts under Internal Revenue Code §529 but are different in important ways. The following are major characteristics of ABLE accounts:

- At this writing (January 2015), they are available to nobody, as their use in each state is contingent on that state's passing enabling legislation;[164] and it is possible some states will

[162] For further discussion, see Winston and Begley, SSA Trust Reviews: The Impact of the New Training and Guide," *The ElderLaw Report* (July/August 2014) (not available online).
[163] Achieving a Better Life Experience Act of 2014 (referenced below as "ABLE Act"), H. R. 647, 113th Congress 2nd Session, adding §529A to the Internal Revenue Code (26 U.S.C. §529A), effective January 1, 2015.
[164] ABLE Act §102(b), 26 U.S.C. §529A(b).

never do this, as it is not required by the law. Full implementation will also require passage of rules by the IRS.

- Only individuals with blindness or a disability that occurred before age 26 are eligible to be beneficiaries.[165]

- Contributions may be made either by a beneficiary or by a third party; but regardless of who contributes, any assets remaining when the account terminates at the death of the beneficiary must be paid to the Medicaid program up to the amount of Medicaid benefits received.[166]

- Each eligible individual may have only one ABLE account.[167]

- Only cash contributions may be made, and contributions to the account in any year are limited to the amount of the gift tax annual exclusion ($14,000 per year as of this writing)—regardless of how many individuals may contribute to the account.[168]

- The beneficiary may direct the investment of account assets, but that is limited to two times per calendar year.[169]

- The beneficiary is the "owner" of the account so apparently has authority to direct distributions from the account.[170]

- With regard to any means-tested benefits under federal law, the assets, earnings, contributions to and distributions for "qualified disability expenses" from an ABLE account are disregarded, *except* the SSI program does not disregard distributions for housing expenses (they are treated as "income" so are essentially prohibited) nor any amount of account assets in excess of $100,000.[171] However, an individual who loses SSI benefits solely as a result of this provision continues to be eligible for Medicaid.[172]

- Income of the account is not taxed, to the extent distributions for the tax year do not exceed the "qualified disability expenses," defined generally as "any expenses related to the eligible individual's blindness or disability which are made for the benefit of an eligible individual who is the designated beneficiary, including the following expenses: education, housing, transportation, employment training and support, assistive technology and personal support services, health, prevention and wellness, financial management and administrative services, legal fees, expenses for oversight and monitoring, funeral and

[165] ABLE Act §102(e), 26 U.S.C. §529A(e).
[166] ABLE Act §102(f), 26 U.S.C. §529A(f).
[167] ABLE Act §102(b)(1)(B), 26 U.S.C. §529A(b)(1)(B).
[168] ABLE Act §102(b)(2), 26 U.S.C. §529A(b)(2).
[169] ABLE Act §102(b)(4), 26 U.S.C. §529A(b)(4).
[170] ABLE Act §102(e)(3), 26 U.S.C. §529A(e)(3).
[171] ABLE Act §103(a).
[172] ABLE Act §103(b).

burial expenses, and other expenses, which are approved by the Secretary under regulations and consistent with purposes of this section."[173]

Comment: If and when the Texas Legislature passes a law enabling establishment of ABLE accounts, they will provide an efficient and inexpensive way of setting aside relatively small amounts of assets owned by SSI and Medicaid beneficiaries with onset of disability before age 26. For example, they may be used for inheritances under $14,000 and for setting aside small amounts of cash that would otherwise cause resources to exceed the $2,000 limit. From the perspective of many beneficiaries, they will allow welcome autonomy of the beneficiary in making decisions as to investments and, most importantly, distributions. Because of the Medicaid payback requirement, they will be of little if any use for third-party contributions. The $14,000 per year limit will also prevent their use in any but the smallest of personal injury cases.[174]

D. Transfer Rules[175]

An individual may be subject to a period of ineligibility for having transferred (or disposed of) assets or resources prior to applying for SSI that would otherwise have disqualified the applicant. This is known as a "transfer penalty" or "look-back period."

When an individual applies for SSI, the agency asks if any uncompensated transfers occurred within the 36 months prior to the date of application or the date of the transfer, whichever is later (this is the "look-back period").[176] If not, there is no penalty, regardless of how much was transferred. If so, then unless an exception to the transfer penalty applies (as discussed below), an ineligibility period is determined by dividing the total uncompensated values of all resources disposed of during the look-back period, by the maximum monthly SSI benefit (including any state supplement, of which there is none in Texas) effective on the date of application. Fractions are rounded to the nearest whole month, and the entire calendar month in which the transfer was made is included as a penalty month.

For example, if an application is filed in year 2015, a transfer of $2,000 on January 14, 2015 will result in a penalty period of $2,000 ÷ $733 = 2.73, rounded down to 2 months. Ineligibility will begin January 1, 2015, and end February 28, 2015.

If there are multiple transfers with overlapping penalty periods, the amounts transferred are added together and treated as one transfer, occurring on the date of the first of the overlapping transfers. If in the above example a second transfer of $2,000 is made on February 14, 2015, the calculation will be as follows: $4,000 ÷ $733 = 5.46, rounded to 5 months. Ineligibility will begin January 1, 2015 and end May 31, 2015.

The maximum penalty period is 36 months from the date of the transfer. Unlike the Long Term Care Medicaid transfer penalty for transfers on or after February 8, 2006, the SSI law still begins

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[173] 26 U.S.C. §529A(c)(1)(B), (e)(5).
[174] Fleming & Curti, PLC, "The ABLE Act—How Will You Bet Able to Use It?" (December 29, 2014).
[175] 20 C.F.R. § 416.1240.
[176] Foster Care Independence Act of 1999 § 206, H.R. 3443, P.L. 106-169.

the penalty period on the first day of the calendar month in which the transfer is made, not at some time in the future when the applicant would have been eligible but for the transfer.

A transfer penalty is applied to a transfer *from* a trust whose corpus is treated as a resource of the individual, if it is transferred to or for the benefit of someone other than the individual. Likewise, if an event occurs precluding payments to the individual from such a trust, the assets that are no longer subject to distribution to or for the individual are treated as a transfer of assets subject to the penalty.[177] The latter provision appears aimed at a self-settled "trigger trust" whose unavailability to the settlor is triggered by an event such as the settlor's own need or application for SSI.

The following types of transfers are not penalized:

- Transfers to a trust that is considered a resource of the settlor (in which case the settlor will be disqualified by the existence of the trust as long as the corpus treated as a resource exceeds $2,000)

- Transfers to the spouse of the transferor or to another for the sole benefit of the spouse, or from the transferor's spouse to another for the sole benefit of the transferor's spouse (e.g., in trust)[178]

- Transfers to, or to a trust (including an "Under 65 Special Needs Trust" under 42 U.S.C. §1396p(d)(4)), established solely for the benefit of the transferor's child who is blind or has a disability

- Transfers to a trust established solely for the transferor if he or she is under age 65 and has a disability, and the trust is created under 42 U.S.C. § 1396p(d)(4)(a),(c) (self-settled under-65 SNT's and pooled trusts)

- Transfers proven by the individual to have been with intent to receive fair market value

- Transfers proven by the individual to have been transferred exclusively for a purpose other than to qualify for SSI

- Transfers in which all resources transferred have been returned to the transferor

- Transfers of a residence of the transferor to any of the following:

- Transfers of the residence to the spouse of the transferor

[177] Foster Care Independence Act of 1999 § 206(a), H.R. 3443, P.L. 106-169, Social Security Act § 1613(c)(1)(B)(ii), 42 U.S.C. § 1382b.

[178] However, bear in mind that resources of the spouse are deemed to the SSI applicant, so this exception appears to be of no practical use in the SSI context, though it is extremely important in the context of Long Term Care Medicaid's "spousal impoverishment" rules.

- Transfers of the residence to a child of the transferor under 21 years of age, or who is blind or has a disability

- Transfers of the residence to a sibling of the transferor who has an equity interest in the residence and who was residing in the residence for at least a year immediately before the date the transferor became an institutionalized individual

- Transfers to a son or daughter of the transferor who was residing in the residence for at least two years immediately before the date the transferor became an institutionalized individual, and who provided care permitting the transferor to reside at home

Social Security may waive denial of eligibility for a transfer on a finding that it would work an "undue hardship" under criteria established by the agency.[179]

E. Application

Filing of an application is required, and entitlement to cash benefits cannot begin until the application is filed. However, entitlement to Medicaid can be retroactive to the first day of the third month before the month in which the application is filed, *if* all other requirements for eligibility are met at that time.

Although part of the application process can be done online, the application cannot be completed until a phone or in-person interview with SSA has been completed. To arrange the interview, call your local SSA office or call 1-800-772-1213 or TTY 1-800- 325-0778. Additional information is available at the Social Security website at http://www.ssa.gov/d&s1.htm#dibap.

F. SSI Sources of Law

Federal statute: Social Security Act § 1611 *et seq.*; 42 U.S.C. § 1382 *et seq.*

Federal regulations: 20 C.F.R. Part 416

Social Security administrative interpretations & procedures: Program Operations Manual System (POMS) at https://secure.ssa.gov/apps10/poms.nsf/partlist!OpenView.

Comment: The law as applied by the courts is, of course, in the statute, the regulations and the cases. However, the law as applied by the agency is in the POMS. Moreover, the POMS is a great deal more comprehensive in scope than the regulations. Therefore, most of the time, the first place to look for answers is the POMS.

Here are some tips for POMS research:

[179] Foster Care Independence Act of 1999 § 206(a), H.R. 3443, Pub. L. No. 106-169, Social Security Act § 1613(c)(1)(C), 42 U.S.C. § 1382b.

- To do a word search, click "Search" at the top of any table of contents screen. Notice that you can't search just the SSI rules, so when you get the results, look for section numbers starting with "SI."

- You can search on phrases by enclosing in quotation marks.

- The Tables of Contents at the beginning of main headings can shortcut your browsing (or they can cause you to miss critical sections)

- Caution: The main Tables of Contents are several pages long. Click "Next Page" at the bottom of each screen, or you will be browsing only part of the contents for that subject.

- You can search any open screen if your browser allows. For example, you can search the one page of the Table of Contents you currently have open. In Windows Explorer, open the Edit menu and select Find, then type in the word or phrase you want on that screen.

III. REGULAR MEDICAID BENEFITS

The term "Medicaid" applies generally to all benefits provided under Title XIX to the Social Security Act, codified at 42 U.S.C. § 1396 *et seq.* In addition to "regular Medicaid," it includes a host of programs sometimes referred to as "Long Term Care Medicaid," which are discussed at page 72 below. This part will cover only those programs that are sometimes called "regular Medicaid," which are available to most (but not all) recipients of Long Term Care Medicaid and other Medicaid programs.

A. Eligibility

Many "regular Medicaid" beneficiaries receive their Medicaid automatically because they qualify for Supplemental Security Income (SSI)[180] or Temporary Assistance for Needy Families (TANF).[181] For such clients, requirements for Medicaid eligibility are the same as for SSI or TANF, so no further discussion is required here.

Likewise, regular Medicaid is provided to beneficiaries of the Children and Pregnant Women Program.[182] In fact, it is the only benefit provided by the CPW program. It is also provided to beneficiaries of nursing home Medicaid in addition to payment for nursing home care and related services.[183]

In addition, a Medicaid program known as "Adult Disabled Children" allows the adult offspring of retired, deceased, or disabled workers to continue their eligibility for Medicaid even though the offspring is denied Supplemental Security Income (SSI) assistance due to newly established entitlement to or increase in social security benefits (RSDI) based on the parent's earnings

[180] 1 T.A.C. §358.105.
[181] 1 T.A.C. §366.705.
[182] 1 T.A.C. §§366.307, 366.507.
[183] 1 T.A.C. §358.105.

record. To be eligible, an adult child must be at least 18 years of age; have a disability the onset of which was before age 22 years old; and meet current SSI criteria apart from the RSDI income.[184]

Practice Note: These individuals may receive a notice from HHSC simply informing them that they have been denied or dis-enrolled from Medicaid (because of the entitlement to or increase in their RSDI benefit above the SSI income limits). That's it. Not a hint that they can re-establish eligibility. Your job is to let them know that they can continue their Medicaid coverage by applying to HHSC for the Adult Disabled Children program. Of course, if they are denied or their coverage is reduced, they also have a right to request a fair hearing, as required by both federal and state law. [185]

Low income Medi*care* recipients who meet certain income and resource limits may be eligible for Medicaid programs known as the Medicare Savings Programs (sometimes referred to as the Qualified Medicare Beneficiary (QMB) and related programs), discussed at page 133, which pay some or all of the Medicare premiums, deductibles, and co-pays.[186] Medicare beneficiaries who are eligible for the Medicare Savings Programs and also for other Medicaid programs are often referred to as "dual eligibles." However, eligibility for QMB or SLMB does not automatically confer eligibility for the full range of Regular Medicaid benefits.

Beneficiaries of home or community care programs for the aged and disabled, such as Community Based Alternatives, Community Attendant Services, and CLASS (discussed below) may not be eligible for all the benefits of regular Medicaid but do receive some important medical benefits, which vary from one program to another.[187]

B. Benefits

1. General Scope of Benefits

In general, Medicaid is a comprehensive medical assistance program. It is broader in many respects than Medicare and does not require payment of premiums, deductibles and co-payments as does Medicare.

The exact scope of benefits available to the participants in the various Medicaid programs is set out in the State Medicaid Plan, which in Texas is prepared by the Texas Health and Human Services Commission. Legal parameters are found in the federal Medicaid legislation and rules.[188] Texas legislation generally requires that the Texas Medicaid program provide the minimum necessary to obtain federal matching funds, with some flexibility for providing additional benefits if available funding permits.

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[184] 1 T.A.C. §358.107(b)(3)(2012); Department of Aging and Disability Services, Medicaid for the Elderly and People with Disabilities, Chapter A, § 2310, http://www.dads.state.tx.us/handbooks/mepd/A/A-2000.htm#secA-2310 (last visited Dec. 17, 2014).
[185] 1 T.A.C. Chapter 357.
[186] 1 T.A.C. Chapter 359.
[187] 40 T.A.C. Chapter 48.
[188] 42 U.S.C. § 1396d(a), 42 C.F.R. § 440.1 *et seq*..

The most comprehensive listing of regular Medicaid benefits is in the current *Texas Medicaid Provider Procedures Manual*,[189] which should be consulted whenever an issue arises as to the scope of benefits available. This article is not intended to provide a complete summary.

With a few exceptions (called "non-TPR" programs), Medicaid is a payer of last resort. That is, it is "secondary to" private insurance, Medicare and other payers (called "Third-Party Resources" (TPR's). On the positive side, a Medicaid provider may not charge a Medicaid beneficiary anything for a covered service, even if it is not fully covered by the TPR. For example, if the patient is a "dual-eligible" covered both by Medicare and Medicaid, the provider may not bill the patient for Medicare copayments and deductibles. It may only bill Medicaid for any amount not covered by Medicare.[190]

2. Texas Health Steps (THSteps)[191]

Federal Medicaid law requires that the state Medicaid plan provide for a comprehensive preventive, diagnostic, and treatment health program for Medicaid recipients under the age of 21.[192] The law also requires the state to perform comprehensive outreach to inform recipients of the array of services available under THSteps.[193] At the federal level, the program is known as "Early and Periodic Screening, Diagnosis, and Treatment Services" or "EPSDT," but is referred to in Texas as "THSteps."[194] It includes comprehensive checkups when eligibility is first established, regular physical exams (and travel thereto if needed[195]), immunizations, lab tests, health education, and vision, dental and hearing services. THSteps is administered by the Texas Department of State Health Services (DSHS).

In addition, "[p]ayment will be considered for any service considered medically necessary and for which federal financial participation is available," subject to only a few limitations.[196] The federal statute requires the state Medicaid program to provide to persons *under age 21* "such other necessary health care…to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services whether or not such services are covered

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[189] Texas Medicaid Healthcare Partnership, http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx (last visited Dec. 17, 2014) (entire manual available for download). Chapter 4 of the manual provides a comprehensive list of client eligibility requirements for both regular and restricted forms of Medicaid.
[190] Medicaid Provider Procedures Manual (2008), § 4.9.
[191] 25 T.A.C. Chapter 33.
[192] 42 U.S.C. § 1396a(a)(43).
[193] 25 T.A.C. §33.3.
[194] 25 T.A.C. §33.2(4).
[195] Texas Department of State Health Services, http://www.dshs.state.tx.us/thsteps/about.shtm#clients (last visited Dec. 17, 2014).
[196] 25 T.A.C. §33.20(d).

under the State plan."[197] The following services are included within this expanded definition of "medically necessary and appropriate" coverage:[198]

- Psychiatric hospital care
- Speech therapy
- Occupational therapy
- Augmentative Communication Devices/Systems
- Private duty nursing

Practice Note: In determining which services are required under THSteps, one should also look to a recent class action settlement regarding the THSteps program, known as the Alberto N. v. Hawkins case.[199]

3. Prescription Medications

Medicaid prescription medications are distributed under the Texas Vendor Drug Program,[200] which is limited to three outpatient prescriptions per month per client,[201] *except for* the following:[202]

- Beneficiaries under age 21 (who are eligible for unlimited "medically necessary and appropriate" prescriptions under the federally mandated Texas Health Steps program)
- Residents in skilled nursing facilities
- Beneficiaries of the "waiver" home care programs, including CBA, HCA, MBDB, CLASS and several smaller programs
- Managed care (e.g., STAR Program) beneficiaries

There is no limit on the number of inpatient prescriptions for hospital patients.

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[197] 42 U.S.C. § 1396d(r).
[198] Texas Department of State Health Services , http://www.dshs.state.tx.us/thsteps/clients.shtm (last visited Dec. 17, 2014).
[199] http://www.hhsc.state.tx.us/medicaid/Alberto-N-Settlement-Agreement.pdf.
[200] Texas Department of State Health Services , http://www.txvendordrug.com/about/ (last visited Dec. 17, 2014).
[201] TEXAS HEALTH AND HUMAN SERVICES COMMISSION, *Vendor Drug Program Pharmacy Provider Procedures Manua*l 4.3.4, Dec. 2011, available at: http://www.txvendordrug.com/downloads/procedure-manual.pdf.
[202] *Id*.

More information on which drugs Medicaid pays for in Texas, and phone numbers to call, are found in Appendix E of the *Medicaid Provider Procedures Manual.*[203]

Medicaid beneficiaries who are also Medicare beneficiaries ("dual eligibles") are no longer eligible for prescription medications through Medicaid, effective January 1, 2006. Instead, they are eligible to enroll in a Medicare Part D plan with no premiums, no deductibles, and small (approximately $1 to $6) copayments.[204]

C. Application

Information on applying for Medicaid may be obtained by visiting the website of the Texas Health & Human Services Commission at http://www.hhsc.state.tx.us/about_hhsc/contact/contact.shtml or https://www.yourtexasbenefits.com/wps/portal or by calling 2-1-1.

However, eligibility for Medicaid for many depends on eligibility for SSI. For information on SSI, contact the Social Security Administration (SSA). The toll-free number (which operates from 7 a.m. to 7 p.m., Monday through Friday) is: 1-800-772-1213. The toll-free TTY number is: 1-800-325-0778. Be sure to have the individual's Social Security number available when you call.

IV. SOCIAL SECURITY DISABILITY INSURANCE (SSDI)[205]

A. Eligibility

1. Work History

Coverage depends upon the client's having paid Social Security taxes on sufficient income during certain time periods to meet the legal requirements. Generally, a person satisfies the work history requirement if he or she has had significant employment under the Social Security system for at least 10 years, and if the person has had such employment for at least 20 of the 40 preceding quarters. Persons who have disability that begins under age 31 are eligible with less work experience; and those who have a disability due to blindness need meet only the 10-year work requirement.[206]

The mind-numbing formulas for determining this are beyond the scope of this outline. The practical approach in the event of a disabling condition is to apply for benefits, then in the event of a denial based on work history, compare carefully the Social Security summary of work history to what the client reports, and apply those particular rules that appear to affect that client.

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[203] This manual can be downloaded from http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_Manual.aspx ,
[204] For more information, go to http://www.txvendordrug.com/claims/medicare.shtml.
[205] Social Security Administration, http://www.ssa.gov/pubs/10029.html#part1(last visited Dec. 17, 2014).
[206] Social Security Administration, http://www.ssa.gov/pubs/10029.html#part2 (last visited Dec. 17, 2014).

For the purpose of long-range planning, ensuring that all the client's actual work history is credited to him or her is a good reason to advise the client to send in Form SSA-7004.[207] Erroneous denials of benefits based on incomplete work records of the Social Security Administration are not unusual, and the earlier the omissions are caught, the better the chance of correcting them.[208]

2. Disability

The client must be unable to engage in any substantial gainful activity because of a medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of at least 12 months.[209] See the SSI section above for a brief discussion of the meaning of this standard.

There is a waiting period of 5 months from the date of onset of disability before benefits may begin.

Recent rules limit substantially the availability of benefits to claimants whose drug addiction or alcoholism is a factor material to the determination of disability. Essentially, an applicant with drug or alcohol addiction must be able to prove that he or she would still have a disability if the addiction ended.[210]

B. Benefits

1. Cash Benefits

Amount of monthly payments is determined by a complex formula based on contributions to the Social Security system. To obtain an estimate of a particular person's benefits, have them fill out and sign Form SSA-704-SM-OP1, or make the same request at http://www.ssa.gov/mystatement/ .

Eligibility for and amount of benefits does *not* depend on amount of income from other sources. Even the wealthiest Americans qualify, if they meet the contribution, disability and other requirements. However, as noted below, the amount of *earned* income can affect eligibility if it is high enough to indicate the person no longer has a disability.

The cash benefits cannot be waived or assigned. This rule is sometimes greatly to the disadvantage of lower-income beneficiaries, who may be disqualified from receiving SSI and Medicaid by Social Security Disability benefits slightly over the SSI income limits. This precludes their receiving the immediate and the Medi*caid* benefits that go along with SSI, which are generally more comprehensive than the Medi*care* benefits (Medic*aid* has no 2-year wait, in

[207] Call 1-800-772-1213 to receive Form SSA-7004.
[208] 42 U.S.C. § 405(c)(5); *see*, Social Security Administration, http://www.ssa.gov/OP_Home/rulings/oasi/33/SSR65-42-oasi-33.html (last visited Dec.17, 2014).
[209] 42 U.S.C. § 423.
[210] 20 C.F.R. §§ 404.315, 404.316, 404.321, 404.332, 404.335, 404.337, 404.350, 404.352, 404.402, 404.470, 404.480, 404.902, 404.1535, 404.1536, 404.1537, 404.1538, 404.1539, 404.1540, 404.1541.

contrast to the Medi*care* benefits attached to most Social Security Disability Insurance;[211] plus Medic*aid* has no deductibles or copayments, and 3 prescription drugs are included.)

2. Medicare Benefits

Most recipients of Social Security Disability benefits have to wait 24 months from date of onset of disability to be eligible for Medicare benefits.[212] However, persons with end-stage renal disease (e.g., kidney failure) are eligible for Medicare Part A (hospital insurance) after 3 months from the beginning of dialysis, and persons with ALS (Lou Gehrig's Syndrome) are eligible immediately. (The 3-month waiting period is waived in certain cases.)[213]

See page 66 below for a summary of Medicare Part A and Part B benefits.

C. Application

Filing of an application is required, but in the case of Social Security Disability Insurance benefits, the client may recover retroactive benefits up to 12 months before the date of filing the application.[214]

It is now possible to apply for Social Security Disability Insurance online at https://secure.ssa.gov/iCLM/dib, or by calling your local SSA office or by calling SSA at1-800-772-1213 or TTY 1-800-325-0778.

V. MEDICARE

A. Eligibility

1. Eligibility at Age 65

Most Americans become eligible for Medicare at age 65. Because there is no "means test," even the wealthiest are eligible. All who are eligible for Social Security retirement benefits or for railroad retirement benefits become eligible for Medicare at age 65, regardless of whether they begin receiving the monthly payments before, at or after age 65.[215] Dependents and survivors of an insured worker are also entitled to Medicare.[216]

There is a requirement of working a certain number of quarters in a job covered by Medicare. This is usually satisfied by 40 quarters (10 years) of covered employment.

Even persons age 65 or older who are not automatically eligible through covered employment can become eligible for Medicare by paying the required premiums.[217]

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[211] Medicare, http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf (last visited Dec. 17, 2014).
[212] 42 U.S.C. § 1395c; 42 C.F.R. § 406.12(a).
[213] 42 U.S.C. § 1395c; 42 C.F.R. § 406.13(c).
[214] 20 C.F.R. § 404.621.
[215] 42 U.S.C. § 1395c; 42 C.F.R. § 406.10(a).
[216] 42 C.F.R. § 406.10(a).
[217] 42 C.F.R. §§ 406.20 - 406.26.

2. Eligibility in Connection With Social Security and Railroad Retirement Disability Benefits

After 24 months of entitlement to receive cash payments of Social Security Disability or Railroad Retirement Disability benefits, beneficiaries are also entitled to Medicare benefits.[218] However, persons with end-stage renal disease can qualify can qualify for Medicare after a 3-month waiting period (which may sometimes be waived), and persons with ALS (Lou Gehrig's Syndrome) are eligible immediately at date of onset of disability.[219]

3. Medicare Premiums

Persons eligible for Medicare in connection with Social Security or Railroad Retirement benefits pay no premium for Medicare Part A. Persons not so eligible and who purchased Part A voluntarily pay a premium of $426 per month in 2015.[220] However, Medicare beneficiaries who meet the income and resource requirements for the QMB and QDWI programs (discussed at page 133) are eligible to have those programs pay the Medicare Part A premium (in addition to the Part B premium) if one is required.

All persons eligible for Medicare Part A are also eligible for Medicare Part B but must pay a premium for Part B (usually $104.90 per month in 2015).This premium can be paid through the QMB/SLMB/QI-1 programs for eligible beneficiaries.

4. Continuation of Medical Coverage After Total Disability Ends

Until recently, free Medicare benefits extended for only 24 months after an SSDI beneficiary returned to work and no longer received SSDI, and the beneficiary was able to purchase coverage for a longer period. The Ticket to Work and Work Incentives Improvement Act of 1999 (H.B. 1180, P.L. 106-170) provides for a longer period of extended free Medicare coverage.[221] In addition, it provides for optional state programs to allow workers who previously had a disability to "Buy-Into" Medicaid coverage without limitations on their resources and income; and it pays for "tickets to work" that purchase vocational counseling and other support for returning to work. Effective September 1, 2006, Texas adopted a new "Medicaid Buy-In" program.[222]

Comment: The rules on what constitutes disqualifying return to work have always been complex, and the new law adds to the complexity. However, it also adds to the opportunities for returning to work without the terrible "drop" from loss of medical benefits. In the central Texas area, a good resource for help on this is Central Texas Benefits Planning Services, at http://www.arcil.com/.

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[218] 42 U.S.C. § 1395c; 42 C.F.R. § 406.12(a).
[219] 42 U.S.C. § 1395c; 42 C.F.R. § 406.13(c).
[220] Medicare, http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf (last visited Dec. 17, 2014).
[221] 42 U.S.C. § 1320b-19 note; Pub. L. No. 106-170, 106th Congress, 113 Stat. 1860, December 17, 1999; Social Security Administration, http://www.ssa.gov/work/overview.html; http://www.socialsecurity.gov/disabilityresearch/wi/medicare.htm#works (last visited Dec. 17, 2014).
[222] http://www.hhsc.state.tx.us/MBI.shtml

B. Benefits[223]

Medicare is divided into Part A (primarily hospital and very limited nursing home benefits) and Part B (primarily physicians, tests, medical equipment, etc.). It can be important to know whether a particular service is covered under Part A or Part B, because they have different appeal procedures.

Effective January 1, 1998, a new "Part C" (now called "Medicare Advantage") became available, to allow beneficiaries to elect various combinations of managed care and private-pay service delivery.[224] Because the federal government has declined to fund Medicare HMO's and other "choice" programs to the extent expected by the insurance companies that sponsor them, and they were unsuccessful in their efforts to attract only the healthiest of seniors as members, the promise of Part C has not been fulfilled. On the contrary, due to closings of many Medicare HMO's, Medicare beneficiaries in large parts of Texas no longer have access to any Medicare coverage other than the "traditional" Parts A and B.

Medicare Part D offers all Medicare beneficiaries a variety of prescription drug plans with monthly premiums starting at about $30,[225] together with deductibles[226] and co-pays. Low income beneficiaries with few assets are eligible for assistance with the premiums and deductibles. That is discussed further below.

1. Hospital Services

Part A covers inpatient hospital services, post-hospital extended-care services, home health services, and hospice services. Hospital coverage is for 90 days per spell of illness, plus a lifetime reserve of 60 days of hospital care.

In 2015, Medicare beneficiaries must pay a deductible of $1,260 for Medicare Part A inpatient hospital services per benefit period. The beneficiary must also pay co-payments of $315 per day for the 61st – 90th day of hospitalization for each benefit period, and $630 per day for the 91st – 150th days of hospitalization.

2. Nursing Facility Services

This coverage includes up to 100 days in a skilled nursing facility if all the requirements are met, including the following:

- Care must be "skilled care" (not "custodial" or "intermediary") needed, "as a practical matter," in an inpatient facility on a daily basis.

- The nursing facility stay must be preceded by a hospital stay of at least three consecutive days, not counting the day of discharge.

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[223] Medicare, http://www.medicare.gov/Pubs/pdf/10050.pdf (last Dec. 17, 2014).
[224] 42 U.S.C. § 1395w-21.
[225] Centers for Medicare and Medicaid Services, http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/index.html .
[226] *See id.*

- Admission to the nursing facility must occur within 30 days after discharge from the hospital, unless it would be medically inappropriate.[227]

Even during the 100 days of nursing facility coverage, Medicare pays the full cost for only the first 20 days. For days 21 through 100, there is a co-payment of $157.50 per day in 2015. However, the co-payment is usually (but not always) covered by Medicare Supplement insurance, if the individual has purchased such insurance (commonly known as a "Medigap policy"), or by a Medicare Advantage plan, or by the Qualified Medicare Beneficiary program for eligible clients.

3. Home Health Services[228]

Under the Balanced Budget Act of 1997, home health services are being transferred in stages from Part A to Part B. Part A still covers the first 100 visits per spell of illness; but Part B then covers an unlimited number of visits.[229] In any case, the following requirements exist for Medicare home health services:

- Confinement to a home that is not a hospital or nursing facility ("homebound")
- Under care of a doctor who establishes the care plan
- In need of intermittent skilled nursing care, physical or speech therapy, or occupational therapy.
- Services provided by or through a Medicare-certified home health agency
- For Part A coverage, home health services must have begun within 14 days of discharge from a hospital stay lasting at least 3 days. However, Part B covers home health if this requirement is not met.[230]

4. Hospice Services[231]

Medicare Part A includes fairly comprehensive services for supportive and palliative assistance for terminally ill beneficiaries who elect hospice coverage. The following requirements apply:

- Medical determination of terminal illness, that is, a life expectancy of six months or less
- Waiver of Medicare coverage that would include efforts to cure the terminal condition

The beneficiary is entitled to two 90-day periods of hospice care[232] and an unlimited number of subsequent periods of 60 days each. The election for hospice care may be revoked at any time.[233]

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[227] 42 U.S.C. § 1395d(a)(2); 42 C.F.R. § 409.61.
[228] *See* Medicare, http://www.medicare.gov/Pubs/pdf/10050.pdf (last visited Dec. 17, 2014).
[229] 42 U.S.C. § 1395d.
[230] 42 U.S.C. §§ 1395f(a)((2)(C), 1395x(m); 42 C.F.R. § 409.42.
[231] Center for Medicare and Medicaid Services, http://www.medicare.gov/Publications/Pubs/pdf/02154.pdf (last visited Dec. 17, 2014).

5. Physician Services and Other "Part B" Benefits

Medicare Part B includes physicians' services, diagnostic tests, medical equipment, ambulance services, outpatient physical and speech therapy, certain limited prescription drugs, and certain preventative services.[234]

For most Medicare beneficiaries who opt for Medicare Part B coverage, the monthly premium in 2015 is $104.90, but due to recent changes in the law the premium is higher for beneficiaries above certain income limits.[235] The Part B deductible for the 2015 calendar year is $147.[236] Both payments may be made by the State for persons eligible under the Qualified Medicare Beneficiary (QMB) program, and the Part B premium may be paid under either the Specified Low-Income Beneficiary (SLMB) program or the Qualified Individual-1 (QI-1) program discussed at page 133.

In addition, Part B requires a co-payment of 20% of the Medicare-approved charge. This co-payment can also be paid by the QMB program for eligible beneficiaries. A provider who "accepts assignment" can bill no more than 20% of the Medicare-approved charge, plus the $147 annual deductible. One who does not accept assignment can also bill for an additional amount, not to exceed 15% of the approved charge.

Medicare supplement insurance and Health Maintenance Organizations pay varying amounts of the Medicare co-payments and deductibles; and HMO's sometimes provide non-covered items, such as limited prescription medications.

6. Prescription Drugs[237]

Medicare Part D is an optional program, which you need only if you do *not* currently have health insurance with drug coverage at least as good as this program will provide. To determine that, contact your current health insurance company and ask them. If the answer is "Yes," ask them for something in writing to that effect and keep it in your records. If they later terminate or reduce your prescription coverage, you may need proof that it was as good as Part D in order to avoid an increased premium as a result of delaying your application.

Also, you do not have to enroll in Part D to avoid future increases in the premium if you have prescription drug coverage through the Veteran's Administration, TRICARE, Federal Health Employee Benefit Plan, Railroad Retirement Board, PACE or Indian Health Services; and if you are in a Medicare HMO or other "Medicare Advantage" plan with prescription drug coverage, you must continue with that coverage if you want to stay in the plan.

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[232] *Id.*
[233] 42 U.S.C. § 1395d; 42 C.F.R. § 418.28.
[234] 42 U.S.C. § 1395k(a); 42 C.F.R. § 410.10.
[235] Social Security Administration, http://www.socialsecurity.gov/pubs/10161.html (last visited Dec. 17, 2014).
[236] Social Security Administration, http://www.socialsecurity.gov/pubs/10536.html (last visited Dec. 17, 2014).
[237] Medicare.gov, http://www.medicare.gov/Pubs/pdf/11109.pdf (last visited Dec. 17, 2014).

Most people who join a Medicare Part D plan will pay a premium of approximately $25 to $50 per month (depending on the plan selected) and will have substantial co-payments and deductibles. However, you will pay little or nothing if you apply for help[238] and if you have income below 150% of the Federal Poverty Income Limits (for the number of people in your household) and countable assets (not counting your home, one vehicle and most kinds of personal property) below these levels (adjusted annually for inflation):[239]

Unmarried individuals: $13,300 countable assets
Married couples: $26,580 countable assets

The income amounts assume that all income is unearned. Because income is measured the same as for the SSI program, you can have substantially more actual income if some of it is earned; and there are some types of income that do not count at all. Also, all the SSI "in-kind support and maintenance" rules and strategies discussed at page 25 apply to Part D Extra Help.

If you are a beneficiary of Medicaid, Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary or Qualified Individual, you need to enroll in Part D. It is not legally required, but there is no reason not to because there will be no premium or deductible (if one of the "basic plans" will meet your needs), and co-pays will be very low. Even if you are not in one of these programs but your income and assets are under the levels indicated above, you can qualify to pay little or no premium, and co-pays will be very low. These price breaks are collectively known as "Extra Help."

If you do not have "creditable" coverage from an employer and are not in any of the programs listed above, you probably should enroll in Part D. It is heavily subsidized; and if you do not have at least as good coverage, the monthly premium you pay when you do enroll will increase 1% for every month during which you could have been in Part D.

You will be able to enroll each year only between October 15 and December 7, with coverage starting January 1.[240] The enrollment periods do not apply to individuals qualifying for "Extra Help," either by application for that program alone or as a result of establishing eligibility for QMB, SLMB, Regular Medicaid or (if nursing home care is involved) Long-Term Care Medicaid. To select a plan and enroll, do the following:

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[238] In principle, dual eligibles should be automatically enrolled in a Medicare Part D plan, but there have been problems, as noted at: United States Government Accountability Office, http://www.gao.gov/new.items/d07824t.pdf (last visited Dec. 17, 2014); http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf (last visited Dec. 17, 2014).

[239] Social Security Administration, https://secure.ssa.gov/i1020/start (last visited Dec. 17, 2014).

[240] For exceptions to this enrollment period, *see* Medicare.gov, http://www.medicare.gov/Pubs/pdf/11109.pdf (last visited Dec. 17, 2014). The dates indicated are for 2014 and may change in future years.

If you think you may qualify for "extra help," go to: https://secure.ssa.gov/i1020/start and apply online. If not, start with Step 2.

Here are several sources of information on the Medicare prescription drug benefit:

1. Go to http://www.medicare.gov/Pubs/pdf/11111.pdf and read through that brochure.

2. Go to https://www.medicare.gov/find-a-plan/questions/home.aspx to find a Medicare Part D drug plan provider.

If you need more information, here are some additional resources:

- http://www.medicare.gov/Pubs/pdf/11109.pdf (discussed above, or you can call 1-800-MEDICARE, and if you ever get an answer, they can help you on the phone.)

- http://www.aarp.org/health/medicare-insurance/medicare_partD_guide/

- Dial "211" and ask for the Health Information Counseling & Advocacy Program (run by the Texas Department of Insurance) or call the 1-800-252-9240 to speak to the Area Agency on Aging in your area about "Medicare prescription drug coverage."[241]

7. Medicare Preventive Care Benefits

In 2005, new preventive benefits were added to Medicare. These include: a one-time initial wellness physical exam within 6 months of the day one enrolls in Medicare Part B; screening blood tests for early detection of cardiovascular diseases; diabetes screening for beneficiaries at risk of getting diabetes.[242]

8. Medicare Improvement Standard Abrogated

Many clients are told that their loved one no longer qualifies for skilled nursing services by Medicare if the beneficiary no longer "improves". These services are found in skilled nursing facilities, home health and outpatient therapy settings. However, a recent settlement in the U.S. District Court for the District of Vermont, *Jimmo vs. Sebelius,* now resolves this critical issue.[243] Under the revisions published by the Centers for Medicare & Medicaid Services (CMS) on Friday, December 6, 2013, "No 'improvement standard' is to be applied in determining Medicare Coverage for maintenance claims that required skilled care." [244] It is now clear that a beneficiary does not have to improve to continue receiving skilled nursing facility or home care services under the Medicare program, and services covered by Medicare cannot be terminated simply

[241] http://www.tdi.texas.gov/pubs/consumer/cb036.html (last visited Dec. 17, 2014).
[242] Medicare.gov, http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf (last visited Dec. 17, 2014).
[243] *Jimmo v. Sebelius*, No. 5:11-CV-17-CR (D. Vt. filed Jan. 18, 2011); *see also* Centers for Medicaid and Medicare Services, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf (last visited Dec. 17, 2014).
[244] Center for Medicare Advocacy, Inc., http://www.medicareadvocacy.org/medicare-info/improvement-standard (last visited Dec. 17, 2014).

because the beneficiary has reached a therapeutic "plateau."[245] Services may be continued if the skilled care is necessary and reasonable. [246]

Prior to this settlement Medicare beneficiaries were denied services by contractors who deemed them to "lack restoration potential, even though the beneficiary did in fact require a level of skilled care in order to prevent or slow further deterioration in his or her clinical condition."[247] The settlement specifically states that there is no expansion of Medicare coverage for skilled services, but rather clarifies its policy manual and sets forth an education campaign so that beneficiaries who need skilled maintenance care should receive coverage, as long as they meet any additional Medicare requirements for coverage.[248] In addition to the policy clarification, and an educational campaign, CMS will review a random sample of Medicare beneficiaries from a sample of skilled nursing facilities, home health and outpatient therapy to review if any determinations were not made in line with the settlement agreement.[249]

Medicare beneficiaries and their caregivers who believe they have been incorrectly denied coverage may look to the Center for Medicare Advocacy for a Self Help Packet available at medicareadvocacy.org. [250]

C. Application

An individual should be automatically enrolled in Medicare in three situations:

- Already receiving Social Security or Railroad Retirement benefits at age 65
- Has received Social Security Disability (SSDI or RSDI) benefits for 24 months; or
- Applying initially for Social Security or Railroad Retirement benefits at age 65

If a Medicare card does not arrive after the above events, or if the person becomes eligible in other situations (for example, beneficiary with end-stage renal disease or retiree not applying for Social Security retirement until after age 65), an application for Medicare should be filed at the local Social Security office. If the application is not filed within certain time periods, eligibility may be lost.

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[245] *See* Center for Medicare Advocacy, Inc, http://www.medicareadvocacy.org/medicare-info/improvement-standard (last visited Dec. 17, 2014)).
[246] *See* Center for Medicare Advocacy, Inc, http://www.medicareadvocacy.org/medicare-info/improvement-standard (last visited Dec. 17, 2014).
[247] *See* Center for Medicare and Medicaid Services, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf, (last visited Dec. 17, 2014).
[248] *See* Center for Medicare and Medicaid Services, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf (last visited Dec. 17, 2014).
[249] *See id.*
[250] *See* Center for Medicare Advocacy, http://www.medicareadvocacy.org/take-action/self-help-packets-for-medicare-appeals (last visited Dec. 17, 2014).

It may also be necessary to take action to preserve the right to obtain benefits through an appeal, after eligibility is established. If the provider denies coverage, the beneficiary has a right to require the provider to submit a claim for Medicare reimbursement. Otherwise, there is no decision from which to appeal.[251] Meanwhile, however, the client must arrange to pay privately for the services, if they are to be provided pending appeal. The effect of a successful appeal, then, is usually to reimburse the client for payments made pending appeal.

VI. "LONG TERM CARE" MEDICAID

A. Eligibility

1. Income

With some exceptions, all receipts of money or property are counted, including even gifts.[252]

a) Income limitation for an unmarried person.

In calendar year 2015, the "income cap" in Texas is $2,199 per month in "countable" income of the Medicaid applicant. This amount changes on January 1 of every year with inflation. Most states have no "income cap," so Medicaid simply supplements the client's income to the extent necessary without requiring the "Miller Trust" procedure discussed below.

b) Income limitation for a married person with an ineligible spouse.

The "income cap" for establishing eligibility is the same as for a single person. The critical question is how the income is apportioned between the spouses, i.e., whose "name is on the check," regardless of community property status of the income. Because countable income can be reduced by running it through a "Qualified Income Trust" (discussed below, sometimes called a "Miller Trust"), income never has to be a disqualifying factor.

After eligibility of one spouse is established, the income of the eligible spouse is paid to the ineligible spouse (the spouse at home), to the extent necessary to provide a spousal allowance ($2,980.50 per month in 2015).[253]

c) Income limitation for a married couple, both of whom apply for Medicaid.

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[251] 42 C.F.R. § 405.704; Home Health Agency Manual § 265.1.

[252] Department of Aging and Disability Services, Medicaid for the Elderly and People with Disabilities Handbook, Chapter E, §§ 1300, 1400, 1500, 2420, http://www.dads.state.tx.us/handbooks/mepd/E/index.htm .

[253] Department of Aging and Disability Services, Medicaid for the Elderly and People with Disabilities Handbook, Appendix XXXI, http://www.dads.state.tx.us/handbooks/mepd/appendix/XXXI/index.htm Except as otherwise indicated, the "eligibility numbers" below are from this table.

If both spouses reside in the same nursing home, the incomes are combined, and the income cap for the combined income is twice the cap for an individual (currently, in 2015, $4,398 per month).

However, if the combined incomes exceed this cap, one spouse can still be eligible as long as his or her income alone is below the individual cap (currently $2,199). Alternatively, the income can be run through a "Qualified Income Trust."

d) Reduction of countable income

To qualify for nursing home Medicaid and the Medicaid "waiver" programs, income can always be reduced with a “Miller Trust” (which HHSC calls a "Qualified Income Trust"). For an unmarried client, this has the effect in most cases of allowing for Medicaid eligibility, provided that all the client’s income above the usual personal needs allowance and other deductions is paid to the nursing home. For a married client with a community spouse, this has no effect on how the income is treated after eligibility. That is, it allows for eligibility of the institutionalized spouse, and the community spouse receives enough total income (if available) to give her/him the $2,980.50 (in 2015) spousal allowance.

Alternatively, income for a married client can be reduced by transferring to the spouse all assets, including income streams. For qualified retirement benefits being paid as annuity (pension) benefits, this requires a court order in the form of a Qualified Domestic Relations Order.

Practice Note: Because of the Miller Trust and QDRO strategies, too much income is never in itself a reason not to apply for Medicaid. These strategies are essential for the client’s well-being where income is not sufficient for the care needed, and assets are limited. However, if income is sufficient for current expenses--and particularly if there is no community spouse--it is important to question closely whether Medicaid eligibility is really in the client’s best interests.

2. Resources (Countable Assets)

a) Resources for an unmarried applicant.

This limit is $2,000. This amount has remained the same since 1989. All assets except “exempt” assets are counted. Exempt assets include one residence located in Texas of any acreage, with value up to $552,000 (with some exceptions regarding value); one automobile used for transportation; personal and household goods; unlimited value of a prepaid, irrevocable funeral contract for the applicant; and certain other property.

b) Resources for a married couple, with an ineligible spouse not living in a medical institution.

This limit is half the couple's combined resources, subject in 2015 to a minimum "Protected Resource Amount" of $23,844 and a maximum of $119,220. These amounts can often be increased under the rules allowing for an expanded "Protected Resource Amount" (not covered in this outline). The maximum and minimum change every January 1 with inflation for new

applications filed that year; but once a "Protected Resource Amount" is established for a couple, it does not change.

c) Resources for a married couple, both in a nursing home and applying for Medicaid.

This limit is $3,000. Resources of both spouses are counted toward this limit.

d) Resources for a married couple, both in nursing home, only one applying for Medicaid

The resource limit for the spouse applying for Medicaid is $2,000. Resources of the non-applicant spouse are not deemed to the applicant spouse because they are not regarded as living in the same "household."[254] Therefore, the non-applicant spouse can have unlimited resources. Usually in this case, the applicant spouse simply re-titles all assets in the name of the other spouse.

e) Limit of $552,000 equity in residence

The Deficit Reduction Act added a limit on the residence exemption applicable to applications filed on or after January 1, 2007: unless an exception applies, a client is not eligible for nursing home or "waiver" home care Medicaid if his or her equity interest in a home exceeds $552,000.[255] The exceptions, which allow unlimited residence value, are for a home occupied by any of the following:

- The individual's spouse; or
- The individual's child under age 21; or
- The individual's child who is blind or disabled as defined by the Social Security Act

Also, this limit can be waived "in the case of a demonstrated hardship."

This does not apply to Family Care nor to any of the other programs that are not under Title XIX of the Social Security Act.

[254] Regarding deeming of resources, see MEPD § F-1410; and regarding deeming of income, see MEPD § G-6120.
[255] S. 1932 § 6014(a), amending 42 U.S.C. § 1396p(f); 1 T.A.C. §358.348. The dollar amount is indexed to inflation beginning with the year 2011.

f) Limit on purchasing life estate in a residence

If the client does not own an interest in a residence, they may decide to purchase only a life estate in a residence. Under the rules in the Medicaid Eligibility for the Elderly and People with Disabilities Handbook, this should be treated as a transfer for full consideration as long as the client pays no more than the fair market value of the life estate as determined from Medicaid Eligibility for the Elderly and People with Disabilities Handbook Appendix X.

Under the Deficit Reduction Act, assets used for purchase of a life estate are treated as transferred without consideration if they are for "…the purchase of a life estate interest in another individual's home made on or after April 1, 2006, unless the purchaser resides in the home for a period of at least one year after the date of the purchase.[256] Therefore, a client already residing in a nursing home or who needs nursing home care within a year after the purchase cannot benefit from this strategy.

g) Exclusion of Unmarketable Assets

The major revision of the Medicaid for the Elderly and People with Disabilities Handbook in 2009 deleted a section that helpfully explained that assets that cannot be reduced to cash are not countable as "resources." In some cases, that may have led workers incorrectly to count as resources clearly unmarketable interests such as small contingent or undivided interests in real property. However, the same principle is still in the Handbook at F-1100, buried in cross references. That section quotes 1 T.A.C. § 358.321, which provides as follows:

> (a) The Texas Health and Human Services Commission (HHSC) follows § 1613 of the Social Security Act (42 U.S.C. § 1382b) and 20 C.F.R. § 416.1201 regarding the general treatment of resources.

20 C.F.R. § 416.1201 provides as follows:

> (a) Resources; defined. For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.
>
> (1) If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource. **If a property right cannot be liquidated, the property will not be considered a resource of the individual** (or spouse)…
>
> (c)Nonliquid resources are evaluated according to their equity value except as otherwise provided. (See Sec. 416.1218 for treatment of automobiles.)
>
> (2) For purposes of this subpart L, the equity value of an item is defined as:

[256] S. 1932 § 6016; MEPD § I-6110-6121.

(i) **The price that item can reasonably be expected to sell for on the open market in the particular geographic area involved**; minus

(ii) Any encumbrances.

Dictionary definitions of "unmarketable" include "not fit for sale," "impossible to sell."(Free Online Dictionary)

If property cannot be sold, it cannot be liquidated or reduced to cash. That is, the "price that item can reasonably be expected to sell for on the open market" is zero, and it has no value as a resource. That is often the case, for example, with undivided interests in real property, life estates and remainder interests. Likewise, assets over which an executor or administrator has control cannot be sold by a beneficiary of the estate so are not countable as resources either by SSI or by the long-term care Medicaid program.

3. Medical Need Requirements

a) Nursing Home, CBA and CLASS Programs

An applicant must meet the "medical necessity" requirement for nursing home Medicaid and for the Community Based Alternatives and CLASS Programs.

Essentially, "medical necessity" under the Texas rules requires a medical disorder or disease requiring attention by registered or licensed vocational nurses on a regular basis. Inability to attend to "activities of daily living," such as bathing, grooming and eating, is not sufficient in itself.[257]

b) Home care

The Community Care programs (such as Community Attendant Services, Primary Home Care and Family Care) have a less stringent disability requirement. They require disability as defined by SSI, with need for assistance in some activities of daily living as determined by the assessment interview.[258]

[257] 40 T.A.C. § 19.2401 et seq. See also forms and instructions of TMHP at http://www.tmhp.com/Pages/LTC/ltc_home.aspx. On November 6, 2008, the highest court of Maryland held that the Maryland "medical necessity" standard, which was essentially the same as the Texas standard, was invalid because it required a higher level of care than the federal standard. *Maryland Department of Health and Mental Hygiene v. Ida Brown*, 406 Md. 466, 959 A.2d 807 (Md. Ct. App. 2008)**.** This is a per curiam order incorporating by reference the opinion of the lower court, the Court of Special Appeals of Maryland, at 177 Md. App. 440, 935 A.2d 1128 (2007).

[258] 40 T.A.C. Chapter 48.

4. Citizenship/Immigration/Residence Status

The applicant must be (a) a U. S. citizen or (b) an alien lawfully admitted for permanent residence or (c) otherwise permanently living in the U. S. under color of law (as defined in the regulation).[259] In addition, an alien who entered the United States on or after August 22, 1996 is ineligible for five years, unless he or she is within one of the exceptions (e.g., for refugees, veterans or service members).[260]

The applicant must be a resident of the state in which he or she is applying for Medicaid. That is, in Texas, he or she must have established residence in Texas and intend to remain here.[261] No period of residency in Texas is required. Travel out of Texas does not terminate residency here, if there is an intent to return.

5. Age, Blindness or Disability

An applicant for nursing home care must be either aged (65 or over), blind or disabled (under the Social Security Disability definition).[262] In practice, this requirement is never an issue with regard to nursing home care or the Community Based Alternatives program, because the "medical necessity" requirement is more stringent than the "disability" requirement.

B. Benefits

1. Nursing Home Medicaid

This covers most medical and support needs of a person who needs nursing facility care. A significant exception is dental care. See *Nursing Facility Requirements for Licensure and Medicaid Certification* (most of which is at 40 T.A.C. Chapter 19) for services Medicaid-certified nursing facilities must provide and standards they must meet.

When a Medicaid-eligible resident needs dental care or other non-covered medical services not reimbursed by any insurance or benefit program (called “incurred medical expenses”), the cost can be paid out of the resident's income, most of which ordinarily goes to nursing facility costs. The result is that the Medicaid program pays a larger share of the cost of nursing facility care as long as payments are being made for the non-covered services.

2. Home Care Under the “Community Care” Programs

Although the Community Based Alternatives program sometimes is listed with "Community Care" programs, it is discussed separately herein because its requirements are different in many respects from Community Attendant Services, Primary Home Care, Family Care and other non-"waiver" programs, which are referred to in this discussion as "Community Care."[263]

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[259] For Medicaid policy on proof of citizenship and identity, see MEPD Appendix V.
[260] 8 U.S.C. § 1613.
[261] 1 T.A.C. §358.207.
[262] 1 T.A.C. §358.211.
[263] The following are helpful in sorting out the differences among the various "Community Care" programs and their sources of law: 47 T.A.C. § 47.3 and *Case Manager Community Care for the Aged and Disabled Handbook* §1110, Appendix XXIV. Distinguish this group of programs from the Medicaid

These programs provide assistance with bathing, dressing, toileting, food preparation, housekeeping, etc. Number of hours per week varies according to the caseworker's determination based on an assessment form filled out from responses provided by the client or client's representative. These programs do not include medical benefits other than limited attendant care.

For an unmarried individual, financial requirements are the same as for nursing home Medicaid, except the resource limit for individuals is $2,000 (for Community Attendant Services) or $5,000 (for Family Care). For a married couple, maximum income of both spouses combined is $4,398, regardless of whether one or both are applying. Maximum resources for a couple, even if one spouse is ineligible, are $3,000 (for Community Attendant Services) or $6,000 (for Family Care). Achieving eligibility for a married person is often difficult, as the "spousal impoverishment" provisions do not apply.

Income eligibility cannot be attained by use of a "Miller Trust" (Qualified Income Trust).

There is no transfer penalty.

3. Consumer Directed Services, Service Responsibility Option and Agency Staffing[264]

When in-home services are provided, a parent will often ask: “Can I hire a relative to take care of my child?” The answer is that the Medicaid Agency allows several methods for staffing in-home caretakers. And a parent can move from one option to another to find the most comfortable method of providing for in-home caretakers. The three methods are: (1) Consumer Directed Services; (2) Services Responsibility Option; and (3) Agency Option.

1. Consumer Directed Services allows the parent to recruit, hire, train, schedule and determine wages for the employee. The parent must keep up with the time sheets for the employee. A provider agency helps with payroll taxes and the actual payment of the salary and travels to the parent’s home to help the parent formulate a budget and determine the salary for workers. The parent has flexibility in setting the hourly rate, potentially paying a worker a higher wage than through an agency. Excess funds may be diverted to other needs of the child. Because the parent is the quasi-employer, the parent would have to establish a back-up plan including substitute workers in the event the employee could not or did not show up to work.

2. Service Responsibility Option is a management partnership between the parent and the provider agency. The parent is the manager of the home services, having the ability to choose the attendant from a pool of attendants provided by a home health agency. The parent is not responsible for recruiting, but the parent is the supervisor, determining the scope of assistance. So the parent will train, supervise the schedule and approve the time records of the employee, but the agency takes care of pay scale, payroll, and making sure there is a back-up worker available.

"Waiver" programs (discussed below), which also provide home care but have a common origin in Social Security Act § 1915(c).

[264] This section is based on materials provided to the authors by Attorney Patty Sitchler.

The provider agency will also train the parent in supervisory skills. While there is worker supervision under this program, there is no budgeting or employee records to keep.

3. Agency Option allows the parent to choose a provider agency, but rely on the agency to handle all of the hiring, supervising, training, scheduling and paperwork. The parent can still suggest a family member to provide the care, but the agency would hire the family member to provide the services.

4. Home and Community Care under the Medicaid "Waiver" Programs

The programs in this category are all under Social Security Act §1915(c), which allows the federal Medicaid program to "waive" the requirement of residing in a nursing home or ICF-IID facility by approving state programs for home and community-based care. The programs listed below all have the following in common:

- They require a need for *institutional* care--either “medical necessity” for nursing home care, or a diagnosis of intellectual disability (or related condition) qualifying the individual for an Intermediate Care Facility-Intellectual Disability (ICF-IID) facility.

- Income limit is the same as for Medicaid nursing home care ($2,199 per month in 2015)

- However, the income limit can always be avoided with a "Qualified Income Trust"

- In those relatively few cases in which a "Qualified Income Trust" is needed, the income exceeding the income cap is paid to the provider as a copayment (after payment of other "incurred medical expenses" such as medical insurance premiums). The beneficiary may keep all income up to the income cap amount.

- Asset limit is the same as for Medicaid nursing home care

- The "spousal impoverishment" rules apply (usually)

- The programs for children do not "deem" parents' assets and income (as does SSI)

- There is a brief summary of the "waiver" programs at Medicaid Eligibility for the Elderly and People with Disabilities Handbook § 4810 et seq. Each has its own set of agency regulations and most have handbooks available on the Internet, which are cited in the summaries below.

Comment: The "waiver" programs have been more successful in attracting applicants than in motivating members of the Texas Legislature to provide the necessary funding. Therefore, they have developed long waiting lists. Because they do not "deem" parents' assets and income, many children qualify for them who do not qualify for SSI, which has strict deeming rules.

It costs nothing to join the interest lists. Call 888-902-9990.

a) Community Based Alternatives (CBA)

CBA provides personal care services at home or in a licensed Assisted Living Facility. However, only a few Assisted Living Facilities are Medicaid certified. Because of the waiting lists both for CBA and at each Assisted Living Facility, relatively few individuals receive CBA benefits in an Assisted Living Facility.

The cost must not exceed the cost of nursing home care.

The client must meet all "medical necessity" requirements for nursing home care.

See 40 T.A.C. Chapter 48 for regulations governing the Community Based Alternatives Program. It has an entire handbook devoted to it, at http://www.dads.state.tx.us/handbooks/cm%2Dcba%2Dhb/ .

b) Community Living Assistance and Support Services (CLASS)

Eligibility is limited to persons with a severe, chronic disability attributed to cerebral palsy, epilepsy or any other condition, other than mental illness, found to be closely related to mental retardation, manifested before the person reaches age 22 and likely to continue indefinitely.[265]

See 40 T.A.C. Chapters 45 and 48 for regulations governing the CLASS Program. Handbook provisions at MEPD § O-1300.

c) Deaf-Blind Multiple Disabilities (DBMD)

This is a home care program serving individuals have both deafness and blindness and who have, in addition, one or more other disabling conditions.

It is available only to individuals age 18 or older.

It requires an ICF-IID-RC VIII need for level of care (intellectual disability or related condition)

Regulations are at 40 T.A.C. Chapter 42, handbook provisions at MEPD § O-1500. Its handbook is at http://www.dads.state.tx.us/handbooks/dbmd/ .

d) Home and Community-Based Services (HCS)

This provides home care to individuals with a diagnosis of mental retardation. Although it has a requirement of "must be living in the community," it finances services of many small "group homes."

[265] 40 T.A.C. § 45.201; MEPD § O-1300. "Related" conditions include, for example, muscular dystrophy, cerebral palsy and spina bifida.

Regulations are at 40 T.A.C. Part I Chapter 9 (§ 9.51 et seq.). The handbook is at http://www.dads.state.tx.us/handbooks/hcs/ .

e) Medically Dependent Children's Program (MDCP)

This provides home care plus regular Medicaid benefits for children under age 21. When they reach 18, most beneficiaries qualify for SSI and are transferred to regular Medicaid (which includes home care under the Community Assistant Services benefit). Those who still are not on SSI at age 21 are usually transferred to the Community Based Alternatives program.

Regulations are at 40 T.A.C. Chapter 51.

f) Consolidated Waiver Program (CWP)

This is a pilot program currently in operation only in Bexar County. It combines all five Medicaid waiver programs discussed above (CBA, CLASS, MDCP, HCS and DBMD). Regulations are at 40 T.A.C. Chapter 50.

C. Trust Rules

1. Third-Party-Settled Trusts

The discussion above at page 32 pertaining to treatment of third-party-settled trusts by the SSI program applies to Texas Long Term Care Medicaid as well. The fact that restrictive supplemental needs language forcing acceptance of public benefits is not required is even clearer, because the Texas Long Term Care Medicaid program has a rule expressly providing that it will not count the corpus of a non-grantor trust as a resource, even if the trust contains "support" requirements.[266] Many state Medicaid programs in states other than Texas do, however, require that distributions be limited by the terms of the trust to "supplemental needs."

2. Self-Settled Trusts

The discussion of "Under 65" and "pooled" self-settled trusts under the SSI program at page 33 also applies to the long term care Medicaid programs.[267] However, this part will discuss some special planning situations that tend to be important for older clients.

a) Benefits of a Testamentary Trust for a Spouse

A trust established with property owned by the *spouse* of a Medicaid recipient would seem at first glance not to be subject to the self-settled trust rules, because it is property of the spouse rather than the Medicaid recipient. However, under Medicaid law, the term "assets" is defined to

[266] 1 T.A.C. §358.336(b); MEPD § F-6100.
[267] Texas Long-Term Care Medicaid rules and policy on self-settled trusts are at 1 T.A.C. §358.339 and MEPD §§ F-6300-6610.

include assets of the *spouse* as well.[268] Therefore, the language "by will" in the statute quoted above is critical, and property in a supplemental needs trust created under a revocable trust during the settlor's lifetime may be treated as available to the surviving spouse, even after the settlor's death. The preferable technique is, therefore, to use wills rather than a revocable trust for estate planning for a couple with one spouse who is likely to be on Medicaid, and make the gift of the other spouse to a supplemental needs trust rather than to the survivor (Medicaid-eligible) spouse directly.

Technique: If there is a community spouse, consider transferring all the institutionalized spouse's property to the community spouse in a marital property agreement (with deeds if real property is involved), and provide for a supplemental needs trust for the institutionalized spouse in the community spouse's will. If the community spouse dies first, the property will be available for the benefit of the institutionalized spouse, because it will fall under the "except by will" exception above. That is, the trust will be treated as having been established by someone other than the applicant. Another advantage of this arrangement is that it will probably avoid the risk of estate recovery (discussed below) at the death of the institutionalized spouse, in the event the community spouse dies first, because the trust property will not be in the institutionalized spouse's probate estate.

b) Rules applying to revocable trusts established by the client

(1) Corpus**.** The corpus is considered an available resource for Medicaid purposes. Effective December 1, 2006, this is true even of a residence in a revocable trust.[269] However, Texas Health and Human Services Commission representatives have indicated that other exempt assets (such as personal items, business property and vehicles) do not lose their exempt status by reason of being in a revocable trust.

(2) Income**.** Both income and assets withdrawn from a trust are treated as "income" for Medicaid purposes.[270]

c) Rules applying to irrevocable trusts established by the client

(1) Corpus. Any portion of the corpus from which payments may be made to the client is considered an available resource.

(2) Income. Any portion of the income from which payments may be made to the client is also considered an available resource.

(3) Payments from the trust. Payments from any portion of the corpus or income from which payments may be made to the applicant are considered income, if paid to the client; or if paid to anyone else, are subject to the transfer rules with a 60-month lookback period.

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[268] 42 U.S.C. § 1396p(e)(1).
[269] MEPD §§ F-3210-3211; State Medicaid Manual §3259F.
[270] 42 U.S.C. § 1396p(d)(3); MEPD § F-6400.

(4) Transfers to the trust are penalized. To the extent that the corpus or income may not be paid to or for the benefit of the client, transfers to the trust are subject to a 60-month lookback period, as discussed above under "Transfer Rules.[271]

(5) Hardship exception. The federal statute requires States to establish procedures under which the agency waives these trust rules if the individual establishes that their application would "work an undue hardship" on the client.[272] CMS defines this as follows: "Undue hardship exists when application of the trust provisions would deprive the individual of medical care such that his/her health or his/her life would be endangered. Undue hardship also exists when application of the trust provisions would deprive the individual of food, clothing, shelter, or other necessities of life."[273]

Strategy: A planning strategy used extensively in some states, and available to a limited extent in Texas, is for the client to establish an irrevocable trust of which the client is not a beneficiary. The client can transfer assets to the trust in a lump sum and wait out the penalty period (up to five years) before applying for Medicaid.

However, the Texas policy as stated in the Handbook creates a "trap for the unwary," by adding trust distributions to the amount penalized and treating trust income that is added to the trust as additional "transfers."[274] The policy as written discourages investment of trust property in income-producing assets and almost mandates that the trust be used, if at all, only as a vehicle for sheltering assets for the next generation. Also, because Texas' nursing home costs are substantially lower than those of most states, clients who have enough assets to consider waiting out the five-year lookback period (at least $238,856) often find they are better advised to plan on paying privately rather than relying on Medicaid.

Arguably, if the client retains the right to income from the trust and waits at least 60 months before filing a Medicaid application, the trust should not count as a resource and its income should simply be treated as income of the client. That "income-only irrevocable trust" strategy is approved by Centers for Medicare & Medicaid Services.[275] Policy-wise, it makes no sense to treat a trust more harshly when income is retained (so it has to be paid as a copayment to the nursing home) than when it is not (and it goes to the next generation rather than to Medicaid). The Texas language treating income of the trust as an additional transfer originated in a Texas rule,[276] which was repealed effective September 1, 2009 and replaced by a rule incorporating the SSI trust rules[277]. The same language, though, was retained in the Handbook as a policy statement. This may have been unintended, and it leaves the policy subject to attack on grounds both of state rules and the federal Medicaid statute as interpreted by CMS.

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[271] MEPD § F-6500; 42 U.S.C. § 1396p(d)(3)(B)(ii).
[272] 42 U.S.C. § 1396p(d)(5).
[273] State Medicaid Manual §3259.8A; MEPD § F-6900.
[274] MEPD F-6500.
[275] State Medicaid Manual §3259.6C and in at least one letter to an Elder Law attorney.
[276] 1 T.A.C. §358.417(e)(4) (2009).
[277] 1 T.A.C. §358.321.

3. Exceptions to General Rules Governing Trusts "Established By" The Client

a) Under-65 Supplemental Needs Trusts

See the discussion at page 34 above pertaining to SSI eligibility. Because a self-settled trust will be treated as a resource of an SSI beneficiary unless it meets the Medicaid requirements, the requirements are the same for both SSI and long-term care Medicaid.

b) Miller Trusts (Qualified Income Trusts).

(1) The problem

The Miller Trust addresses a cruel anomaly in Medicaid law in Texas and in the 12 other states with an "income cap." Although the average nursing home cost when paid privately is determined by HHSC as $156.34 per day ($4,755.34 per month), the Texas Legislature has seen fit to deny nursing home Medicaid benefits to anyone with more than $2,199 per month in income. Therefore, many people who need nursing home care have too much income to qualify for Medicaid but too little to afford nursing home care.

Arguably, the most important change in Medicaid law contained in "OBRA 93" was the provision allowing for some relief from the "income cap" in states like Texas clinging to this particular barrier to eligibility, by transferring income into a trust with certain provisions.[278] Such trusts are called "Miller Trusts" after the case *Miller v. Ibarra*,[279] which approved a somewhat similar trust in Colorado. (They are also called "qualified income trusts" and, by OBRA 93 mavens, "d4b trusts.")

The Miller Trust solution works only for institutional (nursing home) Medicaid and "waiver" programs, including CBA, HCA, MBDB, CLASS. It is expressly excluded by HHSC regulations as a way of reducing countable income for Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and 1929(b) (“Community Attendant Services,” “Frail Elderly”).[280]

(2) The requirements for the trust

OBRA 93, as interpreted by CMS and HHS, requires that the trust have the following features:

[278] 42 U.S.C. § 1396p(d)(4)(B).
[279] 746 F. Supp. 19 (D. Colo. 1990).
[280] 1 T.A.C. §358.339(c)(4)(B).

a. Funded only with pension, Social Security, and other *income* of the individual (and accumulated income in the trust)[281];

b. Irrevocable;

c. The State will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid by Medicaid on behalf of the individual; and

d. Require that the trustee:

(1) Pay to the beneficiary a monthly personal needs allowance.

(2) Pay to the spouse (if any) of the beneficiary a sum sufficient to provide a minimum monthly maintenance needs allowance, and

(3) Pay from the funds remaining the cost of medical assistance provided to the beneficiary.[282]

In addition to the CMS requirements, HHSC requires that the trust identify the sources of income to be transferred to the trust. Also, HHSC "recommends" that the trustee not be the beneficiary "because of potential problems relating to discretionary distributions."[283]

c) Pooled Supplemental Needs Trusts

See the discussion at page 37 above pertaining to SSI eligibility. Because a self-settled trust will be treated as a resource of an SSI beneficiary unless it meets the Medicaid requirements, the requirements are the same for both programs.[284] However, the provision that there is a transfer penalty for transfers to such a trust by persons age 65 and over often limits their usefulness for clients needing long term care.

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[281] Any transfer of "resources" to the trust will make the trust “invalid,” except a small deposit of not more than $20 of the client’s resources or another party’s funds, if required by the bank to open the account, will be disregarded. The Miller Trust rules are found at MEPD § F-6700, and additional agency policies are at MEPD Appendix XXXVI.

[282] This does not accurately state the required disposition of funds, as it excludes dispositions for Medicare Part B premiums, other medical insurance, unreimbursed medical expenses; and there is a possibility in some cases for a further disbursement to the spouse if money is left over after making full payment for the Medicaid-covered items. However, CMS put this language in its Transmittal No. 64 (cited below), and HHSC accordingly requires it in the trust. This clearly does not alter the scheme for "deductions from copayment," discussed below, which is required by law.

[283] HHSC memo of October 30, 1996. The author knows of one case in which the Commission did refuse to honor a QIT because the beneficiary sought to serve as trustee.

[284] 42 U.S.C. § 1396p(d)(4)(C); 1 T.A.C. §358.339, MEPD §F-6720-6723.

d) Trust Modification: Requirements for Payback and Notice to HHSC

It is sometimes necessary to modify a third-party trust to preserve eligibility of a beneficiary who otherwise qualifies for Medicaid. For example, the trust may provide for distribution directly to the individual at age 21.

In response to a recent report that HHSC was requiring that any such modification also add to the trust a "payback to Medicaid" provision, the author conferred with an agency representative. The representative said "payback" will be required only if at the time of modification the trust should be treated as a resource of the beneficiary under the Medicaid rules—for example, if in the example above, the beneficiary has already reached age 21. However, if at time of modification the trust corpus is not a resource—in this example, if the beneficiary has not yet reached age 21—then no payback is required.

If modification of a trust affects Medicaid eligibility, it is logical to assume that HHSC should be given notice and an opportunity to be heard. In the past, agency attorneys have informally asked that they not be notified, and this has been the general practice. However, according to an HHSC attorney, CMS has recently indicated it expects the agency to be represented in such matters. Therefore, the attorney announced that such notice will be required, suggesting it be served on HHSC General Counsel at 4900 North Lamar, Austin, TX 78752.

e) Availability of Court-Created Trusts for Persons with Physical Disabilities

Effective for applications filed on or after September 1, 2011, an amendment to Texas Estates Code Chapter 1301 allows courts to create management trusts for the benefit of those who are not under a guardianship. With this change, any person with a physical disability can have a trust created by a probate court as long as the court has jurisdiction.[285] Further, a physically disabled individual can petition for creation of a management trust on his or her own behalf.

This change means an added tool for elder and special needs planners. In cases where a first or third party supplemental needs trust is not an option or would not be economical, the probate courts are now an available venue for creation of a trust that would allow clients to plan for public benefits. Clients can be made to be Medicaid eligible while allowing the beneficiary to utilize trust assets to purchase life enhancing goods and services that would not otherwise be available from Medicaid.

[285] Texas Estates Code § 1301.057.

D. TRANSFER ("GIFTING") RULES

1. Nature and Purpose

If there were no restrictions on making gifts, many individuals would become eligible for Medicaid simply by giving their assets to family members. Therefore, to protect the integrity of the program, the federal statute requires states to penalize transfers for less than fair market value.

The basic rule (subject to exceptions discussed below) is that a person making a transfer for less than fair market value is ineligible for Medicaid for one day for every $156.34 gifted. The $156.34 amount represents HHS' estimate of the average private-pay cost of nursing home care in Texas. The HHSC rules are contained in the Medicaid Eligibility for the Elderly and People with Disabilities Handbook.[286] The amount is different in every state and is changed from time to time with inflation.

Practice Note: Whenever gifts exceeding $14,000 in value are made to any individual in a calendar year, a gift tax return should be filed. However, this dollar amount has nothing to do with whether or not there is a Medicaid transfer penalty. Since there is now a $5.43 million lifetime exemption on taxable gifts, gift tax is a concern of few if any Medicaid applicants in Texas.

2. Rules for Calculating the Penalty Period

In summary, here is how to calculate the penalty period in any transfer for less than fair market value:

1. Determine whether an **exception** to the transfer penalty may apply. For example, the transfer may have been to the client's child with a disability or entirely for purposes other than Medicaid eligibility (and you can prove it). If so, go no further.

2. Determine whether or not the transfer was within the "**lookback period**" before filing or intended filing of a Medicaid application. Generally, if the transfer was on or after February 8, 2006, the period is 60 months before month of application for all transfers. If the transfer was *before* the "lookback period," go no further. There is no transfer penalty, and the transfer need not be disclosed to Medicaid.

3. Determine the "**uncompensated amount"** of the transfer. Begin with the amount of cash, or the fair market value of other assets transferred, then subtract any "compensation" received by the transferor.

4. Subtract any amount or value of the original transfer that has been **returned** by the transferee at any time since the transfer.

[286]Medicaid Eligibility for the Elderly and People With Disabilities Handbook, Chapter I and §J-3100 (especially §I-5000).

5. Determine number of days in the **penalty period** by dividing amount of uncompensated transfer by $156.34 and rounding down.

6. Determine the "**start date**" of the penalty period. Begin the count with the "Medical Effective Date" (first date the client is entitled, retroactively, to the limited benefits in "Mason Manor").

7. Add the number of days in the penalty period to the start date, to determine when it ends. Here is a high-tech (and very efficient) way of doing that:

    - Go to http://www.timeanddate.com/date/dateadd.html and enter the start date.
    - Enter the number of days in the penalty period (calculated in Step 5 above).
    - Click "Calculate New Date." It tells you when the penalty period ends.

3. Treatment of multiple transfers

For transfers covered by the DRA (applications filed on or after October 1, 2006 in which a transfer was made on or after February 8, 2006), it does not matter whether the penalty periods overlap or not, because no penalty starts until the start date, and they are applied cumulatively thereafter.[287] Therefore, the discussion below applies only to transfers *not* covered by the DRA.

If there are multiple uncompensated transfers in which the penalty periods *overlap*, all such transfers during the lookback period are totaled, and the total value is divided by the average private pay cost (currently, $156.34 per day), to calculate the penalty period.[288] This prevents application of the pre-OBRA 93 rule that allowed penalty periods of multiple transfers to run concurrently, thus allowing disposal of a much larger amount of property in a given time period.

However, if the penalty periods of two pre-DRA transfers do *not* overlap, they are treated as separate transfers.[289] This is designed to prevent clients from making a small transfer to "start the clock running," then making a larger transfer later if Medicaid eligibility is needed, and including the entire period between the two transfers as a penalty period.

For applications filed before November 1, 2005, it was possible to make monthly transfers just under two times the private-pay rate (then, under 2 X $2,908 = $5,816). This worked because there was no partial month penalty (you rounded down after dividing by $2,908, and as long as the penalty period was exactly one month, there were no "overlapping" penalty periods that would require aggregating the various transfers). This has not worked for applications filed on or after November 1, 2005. It obviously does not work under the DRA because all transfers during the lookback period are added together.

[287] LTCME Bulletin No. 07-01 (September 25, 2006), page 10.
[288] 42 U.S.C. § 1396p(c)(1)(E); MEPD § I-5000.
[289] State Medicaid Manual §3258.5G-I; MEPD § I-5000.

4. Only Transfers Within the "Lookback Period" are penalized

The "lookback period" ends on the date a Medicaid application is filed (or, if later, date of entry into a nursing home or other medical institution) and begins--

1. 60 months before the calendar *month* of the later of institutionalization or application, for transfers to most trusts before February 8, 2006 and for all transfers on or after that date.[290]

2. 36 months before the calendar *month* of the later of institutionalization or application, for transfers to individuals before February 8, 2006.

Technique: Transfer an unlimited amount of property, then wait the applicable period from the date of the transfer before applying for Medicaid. For transfers to one or more individuals, it is 60 months for transfers on or after February 8, 2006 or 36 months for transfers before that date. If the transfer is to an irrevocable trust whose corpus cannot be disbursed to or for the benefit of the client (i.e., whose corpus is not counted as a resource of the client), the waiting period has always been 60 months. Remember that you have to wait to apply until 36 months or 60 months after the calendar month of the transfer, not after the date of the transfer.

Note that the lookback period in most cases is actually **more** than 36 months or 60 months, and if an application is filed within the lookback period, the possible limitation on penalties offered by the limited lookback period is lost. For example, if a client transfers $300,000 to an individual on September 15, 2009 then applies for Medicaid on September 16, 2015, the total penalty period will be $300,000 ÷ ($156.34 X 30) = 63.94 months or approximately 1,918.9 days. Had the client waited until the next **calendar month**, the transfer would have been outside the lookback period so would have been disregarded. This is a trap for the unwary.

Another trap, from which you can escape readily, is for transfers occurring on February 1, 2006 through February 7, 2006. Medicaid Eligibility for the Elderly and People With Disabilities Handbook § I-2000 has the following explanation: "Beginning with applications received in March 2009, add one month to the look-back period until the full 60-month look-back period is fully implemented in February 2011." Taken literally, that would extend the lookback period beyond 36 months for all transfers during February 2006. However, the law is clear that those before February 8, 2006 are still entitled to a 36-month lookback. Therefore, they cannot be penalized in any case in which the later of application or institutionalization occurred on or after March 1, 2009.

5. How to Determine the "Start Date" of the Penalty Period

If the transfer was before February 8, 2006, begin the count with the first day of the calendar month during which the transfer was made. If it was on or after that date, begin the count with

[290] 42 U.S.C. § 1396p(c)(1)(B); MEPD § I-2000. The federal statutory language refers only to transfers *from* a trust, but CMS interprets this to include also transfers *to* a trust, if the trust is such that the corpus is not treated as a resource of the individual. State Medicaid Manual §3258.4E. The purpose of this appears to be to discourage establishment of irrevocable trusts that are not treated as resources of the grantor.

the "Medical Effective Date" (first date the client is entitled, retroactively, to the limited benefits in "Mason Manor").

The specifics of what must be done to have a "start date" are addressed in HHSC "Clarification Bulletins."[291] The Act says the client "must be eligible for medical assistance under the State plan and would otherwise be receiving institutional level care…based on an approved application for such care but for the application of the penalty period…"[292] This also describes what has been done for many years regarding a nursing home resident whose only barrier to full eligibility is the transfer penalty: they are "admitted to Mason Manor,"[293] a mythological nursing facility occupied only by persons in this category. They are eligible only for "extra help" Medicare Part D and for Medicaid reimbursement of co-payments and deductibles not reimbursed from another source. The start date for the transfer penalty, then, is the Medical Effective Date of admission to Mason Manor. Although other issues remain, the author believes from the published materials and discussions with agency officials that the following policies are being applied:

A client need not be in a "Medicaid bed" on the Medical Effective Date to get a start date or to have Mason Manor status (payment by Medicaid of medical expenses other than nursing home care).

While in Mason Manor, clients can be required to pay at the private-pay rate.

Once admitted to Mason Manor, a client has a start date that continues without interruption. Therefore, the client could be over-income, over-resources or even discharged, and the penalty period would continue to run (though the limited benefits of Mason Manor would be lost).

An applicant for a "waiver" home care program (such as Community Based Alternatives or Community Living Assistance and Support Services) or for State Supported Living Center services will not have a start date unless and until they are admitted to a nursing home then admitted to Mason Manor there.[294]

However, a person who has been admitted to Mason Manor in a nursing home and who later applies for waiver home care or State Supported Living Center services has a start date and can qualify for such services when the penalty period has expired (doesn't have to wait until after the lookback period).[295]

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[291] LTCME Bulletin Number 07-06.
[292] S. 1932 § 6011(b); 1 T.A.C. §358.401(d); MEPD § I-5200.
[293] MEPD § I-5400 and Appendix XXIII. Oral history has it that a Medicaid official named Mason originated the idea of keeping track of clients in this status by "admitting them to Mason Manor" on the books of the agency.
[294] If the client is discharged before establishing eligibility for full Medicaid services, he or she may not be able to bypass the long waiting list for "waiver" home care programs. The bypass procedure applies only to individuals determined eligible for Medicaid nursing facility services. *Community Care for Aged and Disabled Handbook* § 2742.2. Therefore, although nursing home admission and Mason Manor eligibility will give the client a start date, it will not in itself allow them to bypass the waiting list. That must await running of the penalty period and full Medicaid eligibility.
[295] MEPD §I-5000 (last example).

Comment: The refusal of the Texas program to provide for a start date for applicants for home and community-based "waiver" programs and State Supported Living Center residents seems inconsistent with the intent both of the DRA and of the Texas rules. It means there is no end date either, and the transfer penalty period is limited only by the 60-month lookback period. Both the federal statute and the Texas rules require a start date when "the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level of care described in subparagraph (C) of this paragraph…" Subparagraph (C) includes "(III) Home or community-based services furnished under a waiver granted under the Social Security Act §1917, subsection (c) or (d)…"[296] It appears that the agencies are interpreting too literally the phrase "eligible for medical assistance" to restrict eligibility for a start date--even for State Supported Living Centers or home care-- to that narrow category of individuals, heretofore relatively rare, who are admitted to "Mason Manor" because they apply for nursing home benefits while a transfer penalty period is running. Both the intent of the rule and the reference to subparagraph (C) appear to mandate a start date when the individual would have been eligible for Medicaid benefits but for the transfer penalty. This may have to be decided in court. Alternatively, state officials may learn the error of their ways when they have to decide what to do with applicants for State Supported Living Center benefits, 100% of whom have mental retardation, whose family members have separated them from inheritances or other assets.

6. Medicaid Programs Subject to the Transfer Penalty

The following Texas programs are subject to the transfer penalty:

- Nursing Home (and State Supported Living Center) Medicaid (SSI-Related MAO, Type Program 14);
- Community Based Alternatives Program (1915(c) Waiver Program);
- CLASS Program (also a 1915(c) Waiver Program); and
- Home and Community-Based Services (HCS, Waiver Program involving mental retardation).

The following Texas programs are not subject to the transfer penalty:[297]

[296] 1 T.A.C. §358.401(d); S. 1932 § 6011(b)(ii). This is not just a Texas problem. In a letter to the Texas program dated August 16, 2006, Suzette Steng states, "The penalty for HCBS waiver recipients is the withholding of waiver services, the receipt of which is an eligibility requirement for that particular category. The individual would remain ineligible until the 60 month look back period had expired, or until such time as he/she entered a nursing facility…" In other words, Congress intended that any transfer by a waiver program applicant is to be subject to a penalty period that starts on the first day of the month after the month of the transfer and continues for five years, unless the applicant abandons the goal of staying at home (which HCBS waiver programs are intended to support) and goes to a nursing home. The argument proves too much.

[297] MEPD § I-1200.

- Family Care;
- Community Attendant Services (formerly called Primary Home Care);
- Qualified Medicaid Beneficiary Program (QMB);
- Specified Low-Income Medicaid Beneficiary Program (SLMB); and
- Qualified Individual (QI).

Technique: There are many cases in which gifting modest amounts makes sense. Assuming the income and other requirements are met, it may qualify a low-income person for QMB benefits (paying the Medicare Part B premium plus Medicare co-payments and deductibles) or SLMB benefits (paying only the Medicare Part B premium). Moreover, if the client qualifies for either of those programs, he or she will qualify automatically for "extra help" Medicare Part D, which provides for prescription medications with no premium and co-payments of only $2 to $5 per prescription. Even if income is a little higher, the client may still qualify for one of the two levels of Medicare Part D "extra help." There is no penalty period, and eligibility for QMB, SLMB and/or Part D "extra help" is immediate (assuming the income and other requirements of the program are met).

Remember that if the client later needs Medicaid "waiver" home care or nursing home care, the transfer penalty will apply even though the purpose of the transfer was to gain eligibility for a program not subject to the penalty. If the transfer was on or after February 8, 2006, the start date for the penalty period will not begin to run until the client is institutionalized and all other Medicaid requirements are met. However, as discussed below, the transfer penalty period can be managed (eliminated or reduced) by strategic "returns" of transferred assets. For example, if by the time a Medicaid application is filed the transferee has returned the entire amount in cash or in kind and can document that, there may be no transfer penalty at all.

7. Disclaimers as Transfers

For purposes of federal gift tax and rights of creditors, property subject to a qualified disclaimer is treated as if it had never been owned by the disclaiming party. However, the Medicaid rules treat such property as if it was received by the disclaimant and immediately transferred.[298]

Practice Note: Disclaimers often do not direct property to the desired recipients. For that reason, as well as their being treated as assignments under Medicaid law, they should almost always be avoided where Medicaid eligibility is a concern of the disclaimant.

8. The Post-DRA Rules Pertaining to Annuities

The term "DRA" in Medicaid law refers to the Deficit Reduction Act of 2005.[299] It made such significant changes in treatment of annuities that every annuity must now be characterized as

[298] 42 U.S.C. § 1396p(e)(1); MEPD § E-3372.

"pre-DRA" or "post-DRA." Because "pre-DRA" annuities are infrequently encountered now, this discussion begins with "post-DRA" annuities.

First, it is essential to distinguish a "pre-DRA annuity" from a "post-DRA annuity." The following rules apply:[300]

- If the application filing date is before October 1, 2006, use pre-DRA annuity policy;
- If the application filing date is on or after October 1, 2006, and the annuity was purchased or the last annuity transaction date (for example, conversion from deferred to immediate-pay status) was before February 8, 2006, use pre-DRA annuity policy;

If the application filing date is on or after October 1, 2006, and the annuity was purchased or the last annuity transaction date was on or after February 8, 2006, use post-DRA annuity policy.

Comment: It is unlikely that this publication will be used by anyone dealing with an application filing date before October 1, 2006. Therefore, the issue as to whether it is a pre-DRA or post-DRA annuity will almost always be whether the annuity contract was either purchased or converted to immediate-pay status before February 8, 2006. If so, it is pre-DRA; if not, it is post-DRA.

The DRA fails to define the critical term "annuity." Fortunately, in the rules effective September 1, 2009, Texas Health & Human Services Commission takes on this challenge to some degree by distinguishing between an "employment-related annuity" and a "retirement-related annuity" as follows:[301]

An *employment*-related annuity "provides a return on prior services, as part of or in a similar manner to a pension or retirement plan. Examples of employment-related annuities are traditional pension plans payable only as an annuity (monthly payments), such as Teacher Retirement, Employees Retirement System of Texas and U. S. Civil Service.

A *retirement*-related annuity is "purchased by or on behalf of an annuitant in an institutional setting." That is, the person who has applied for Medicaid nursing home or waiver program eligibility, or his or her " Employment-related annuities are never resources, regardless of whether they are established before or after the DRA effective date of February 8, 2006. spouse, is the purchaser of the annuity. Also critical to the definition is that the annuity meets any of the following requirements:[302]

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[299] Specifically, the sections affecting annuities are the following: S. 1932 §6012(a), amending 42 U.S.C. §1396p(e); and S. 1932 §6012(b), amending 42 U.S.C. §1396p(c)(1)(F),(G). It is effective regarding annuities by its terms on February 8, 2006. S. 1932 §6012(d).

[300] MEPD § F-7120. The date referred to in the text above as "application filing date" is referred to in the Handbook as "application file date or program transfer request date." The program transfer involved would be a transfer from one of the Community Care Medicaid programs that are not waiver programs (such as Community Attendant Services) to the nursing home program or a waiver program. Such transfers are disregarded in the text above because it is highly unlikely an annuity issue will arise after publication of this paper that involves a program transfer before October 1, 2006.

[301] 1 Tex. Admin. Code §358.333.

[302] 42 U.S.C. §1396p(c)(1)(G); 1 Tex. Admin. Code §**358.333(d);** MEPD §F-7210.

- An annuity described in subsection (b) *[Individual Retirement Annuity]* or (q) *[Deemed IRA, §457 Deferred Compensation]*of Section 408 of the Internal Revenue Code of 1986; or
- An annuity purchased with proceeds from:
    - an account or trust described in subsection (a) *[Tradition IRA]*, (c) or (p) *[SIMPLE IRA]*of Section 408 of the Code;
    - a simplified employee pension (within the meaning of Section 408(k) of the Code) *[SEP- IRA]*; or
    - a Roth Individual Retirement Account described in Section 408A of the Code.

Thus, all annuities may be divided into two classes: "employment and retirement-related annuities" afforded the favorable treatment discussed above; and all other annuities, which are subject to strict criteria discussed below.
Annuities in the "all other annuities" category are further divided into two categories: those purchased by a Medicaid applicant without a community spouse, and those involving a community spouse.

An annuity purchased for a Medicaid applicant *without a community spouse* will not be treated as a resource, nor the purchase treated as a transfer of assets, if the annuity meets *all* the following conditions:[303]

- irrevocable and non-assignable.
- in the institutionalized individual's name;
- provide for payments in equal amounts during the term of the annuity;
- not have any provision for deferral of payments or balloon payments;
- guarantee to return within the person's life expectancy at least the person's principal investment (life expectancy is calculated using life expectancy tables available from the Social Security Administration's (SSA) online Period Life Table);[304] and
- name the state of Texas as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual.

The same requirements apply if the Medicaid applicant has a community spouse, with the following exceptions:

- If the annuity *pays in the name of the institutionalized spouse* (including a waiver program applicant): in the alternative to naming the state of Texas as primary beneficiary of the annuity, the beneficiary designation may name the community spouse or a minor or disabled child as primary beneficiary, with the state of Texas as secondary beneficiary.
- If the annuity *pays in the name of the ineligible community spouse*, it must name the state of Texas as primary beneficiary, unless there is a minor or disabled child, in which case the minor or disabled child may be primary beneficiary and the state of Texas secondary beneficiary. Also, it must guarantee to return at least the principal

[303] MEPD §F-7200.
[304] http://www.ssa.gov/OACT/STATS/table4c6.html .

investment within the life expectancy of the community spouse according to the Period Life Table.

Comment: This forced remainder interest after the lifetime of the community spouse discourages the purchase of annuities paying for his or her full life expectancy. Although shorter-term annuities will sometimes increase the amount of co-payment to the nursing home, clients will have to weigh this against the risk that the community spouse might die before the end of the guarantee period; and in cases in which all institutionalized spouse income must be paid as copayment anyway, clients will want to buy the shortest annuity contracts possible.

Comment: When the client (or one spouse) owns an IRA or one of the other types of accounts excepted from the generally harsh DRA annuity rules, be sure to recognize that as a planning opportunity. Most importantly, there is no requirement that Medicaid be a remainder beneficiary, regardless of whether there is a community spouse or not. On the other side of the coin, you certainly want to avoid making Medicaid a remainder beneficiary of such an annuity.
The following are the consequences of a Medicaid applicant's having a post-DRA annuity that is not employment- or retirement- related and does not meet the criteria above:[305]

- *If it is revocable: it is a countable asset valued at current fair market value; and the amount that has been paid out in the past is treated as a transfer of assets.*
- *If it is irrevocable: the purchase price is treated as a transfer of assets; or if a deferred annuity has been converted to immediate-pay status, the "remaining payout value" at the time of the conversion is a transfer of assets.*

Comment: Many contracts for immediate-pay annuities do not expressly say they are irrevocable. As a matter of law, a contract cannot be revoked by either party at will unless it so provides. However, the Medicaid program disregards the law in this regard and treats annuity contracts made by a Medicaid applicant or spouse as revocable unless they provide otherwise. Therefore, if the contract does not say it is irrevocable, ask the insurance agent for a statement to that effect and give it to HHSC, to avoid delay in processing the application. Also be sure it does not have a provision saying it is <u>assignable</u>, which would give it a cash value. Another problem with some annuities is that they are not irrevocable until the first check is cashed, or the expiration of a certain period of time, so HHSC may count the amount available by revocation as a resource until they are truly irrevocable.

The following addendum to the immediate annuity contract should solve all the foregoing problems: "Notwithstanding any contrary provision herein, this contract is immediately irrevocable and non-assignable from its inception." However, some insurance companies refuse to agree to this.

Comment: It is common for individuals to buy non-compliant post-DRA annuities, usually because at the time of purchase, they were just trying to pay their own way without having to ask the government for help. The following are at least some of the possible "fixes" when that happens and a Medicaid application is later needed:

[305] MEPD § F-7240.

- *If the problem is that it does not say it is irrevocable, sign an endorsement making it irrevocable and a beneficiary designation making the State of Texas primary beneficiary if required; or alternatively, take the cash value and spend it down and/or buy a compliant annuity.*
- *Oppose any transfer penalty by showing there was no Medicaid intent in buying or annuitizing the contract if that is the case; and/or showing the client intended to receive fair market value; and/or the client would experience undue hardship from application of the transfer penalty.*
- *If it is irrevocable, sign a beneficiary designation making the State of Texas primary beneficiary (and if necessary, negotiate an endorsement making any other needed changes).*
- *If it cannot be cashed in or sold at any price, then under the resource rules, it has no market value so should not affect eligibility.*

In general, regardless of whether an annuity is under the pre-DRA or post-DRA rules, annuity payments are treated as "income," without regard to how much is actually "return of principal."[306]

9. The Pre-DRA Texas Rules Pertaining to Annuities

Annuities covered by the pre-DRA rules are subject to important rules having to do with whether or not the annuity contract is also treated as a "resource." Those rules restrict the use of annuities by counting them as a resource unless they meet all the following requirements:[307]

- The annuity is "irrevocable." This is interpreted by the agency as requiring that the word "irrevocable" appear in the contract.
- Principal must be paid in equal monthly installments and interest paid either in equal monthly installments or in amounts that result in increases of the monthly installments at least annually.[308]
- It must be guaranteed to return within the payee's life expectancy at least the principal plus a reasonable amount of interest.[309] If it does not meet this requirement, then in addition to being treated as a resource, the annuity (to the extent of payments to come due after the client's life expectancy) is treated as a transfer of assets. To

[306] MEPD §E-3340
[307] 1 Tex. Admin. Code §358.334, MEPD §F-7310.
[308] This reference to equal payments of principal and interest presumably refers to the constant ratio of return on investment that is used for income tax reporting of fixed annuity income. If "interest" were really being paid (as on a note), the declining balance of principal would necessarily require a declining amount of interest in each successive payment. This is also suggested by the consistent use of the term "interest" throughout the rule, indicating that the drafter uses that term as synonymous with "return" or "buildup" in an annuity.
[309] MEPD §F-7310 provides, "To determine life expectancy, use the available online actuarial publication from the SSA Online Statistical Tables." This refers currently to the Social Security Period Life Table updated April 22, 2005, which is at http://www.ssa.gov/OACT/STATS/table4c6.html.

show that the amount of interest is reasonable, the client must document availability of at least two comparable annuities paying the same or less interest.

- *Unless a community spouse is named as the annuitant*, the State of Texas or HHSC must be named as the residual beneficiary of funds remaining in the annuity at the client's death, to the extent of Medicaid funds expended on the purchaser.[310]
- The annuity must be issued by a licensed insurance company (which prevents use of private annuities and similar devices such as non-negotiable and self-canceling installment notes).[311]

An important exception is that as with a post-DRA annuity (discussed above), an "employment-and retirement-related annuity" is not a countable resource and its purchase is not a transfer of assets.[312]

A pre-DRA annuity meeting all five criteria is not counted as a resource, its payments are counted as unearned income, and there is no transfer penalty.

When a pre-DRA annuity does *not* meet these criteria, unless it is an "employment-and retirement-related annuity," it has the following disadvantages:[313]

- Its fair market value is counted as a resource.
- Also, if it does not pay the principal plus a reasonable amount of interest within the annuitant's life expectancy, it is a transfer of assets. This can occur if (a) the guaranteed payment period extends beyond the life expectancy or (b) the amount of interest is not reasonable.
- In either case, if the annuity does not pay out the principal plus a reasonable amount of interest within the annuitant's life expectancy, the amount transferred (to which the transfer penalty is applied, beginning on the date of purchase or annuitization) is the payout remaining after the life expectancy.

See the Comments above regarding possible “fixes” for noncompliant post-DRA annuities, which may solve problems with pre-DRA annuities as well.

10. The "Return of Transferred Asset" Rule

If a transferred asset is returned to the client, the transfer is nullified to the extent of the value returned. If the asset is an excluded asset (such as a residence), the nullification is applied retroactively to the date of the transfer. However, if it is a countable asset (such as a CD), it is

[310] 1 Tex. Admin. Code §358.334(c).
[311] The HHSC theory appears to be that non-negotiable notes have no market value, so the purchase of one is a transfer of the purchase price that is subject to a transfer penalty.
[312] MEPD §F-7210.
[313] 1 Tex. Admin. Code §358.334(d), MEPD § 7321-7322.

treated as if the client owned it until the date it was returned. The following handbook language underscores this part of the rule:[314]

> If a countable asset such as a certificate of deposit was transferred and subsequently returned, its value is added to the value of other countable assets when determining current eligibility, as well as eligibility for those months in which the asset was in someone else's possession.
>
> For a penalty period to be nullified or erased retroactively, all of the asset in question or its equity value must be returned to the client. When only part of an asset or its equivalent value is returned, the penalty period is not nullified or erased retroactive [sic]but is recalculated based on the remaining amount of uncompensated transfer and the penalty period will be for a shorter length of time.

The first passage above is sometimes read to produce a surprising result: if part of the value of a transferred asset is returned *even after the penalty period has run*, some Medicaid workers will continue the period of ineligibility until the first day of the next month after the last amount was returned. That is, the transferee can inadvertently extend the period of ineligibility by returning *too much* of the transferred asset. For example, if the transferee is paying the transferor's nursing home expenses, paying one too many months will cost Medicaid eligibility for the extra month.

Comment: The intent of the rule as stated in the CMS State Medical Manual (cited in the last footnote) is obviously to provide that when a countable asset is transferred, the transfer penalty period continues until the penalty period has run; and when an excluded asset is transferred, the penalty period is erased retroactively by its return. When the penalty period is reduced by partial return of a countable asset, eligibility should begin when the reduced period has ended. The reference to resources in the state rule is just a way of expressing that and was never intended to penalize transferees for paying the nursing home after the penalty period has run. However, unless and until the agency clarifies this policy, advisers must be careful to calculate very precisely the date on which the penalty period ends and to caution against making any payments to the nursing home after the end of the calendar month in which that date falls.

Advise the transferee to keep careful records of the amount returned to the client--for example, to pay the nursing home and other expenses not covered by the client's income. The transfer penalty period will then commence to run, plus the amount returned to the client or spent for the client's benefit will reduce the penalty period one day for every $156.34. The transferee will then be able to keep whatever is left after the transfer penalty period has run.

There are four options for returning part of the assets transferred:

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[314] MEPD § I-5700. State Medicaid Manual §3258.10.C.3 provides, "When only part of an asset or its equivalent value is returned, a penalty period can be modified but not eliminated. For example, if only half the value of the asset is returned, the penalty period can be reduced by one-half.

(1) The transferee pays the nursing home and other expenses of the client to the extent they cannot be paid from the client's income. This has the advantage of allowing Mason Manor eligibility to continue, which will (in some cases) reduce total expenses by allowing for free Medicare Part D benefits to pay for medications and for Medicaid payment of non-hospital co-payments and deductibles. It has the disadvantage of exposing the client to the risk that the necessary funds might not be available when needed, due to death, insolvency, etc. of the transferee (see discussion of the risks of transfers below).[315]

(2) Once the client has established Mason Manor eligibility, the transferee returns directly to the client the amount of assets that, according to the projection discussed below, will be needed by the client during the period of ineligibility. This has the advantage of reducing the risk of the assets not being available when the client needs them. It has the disadvantage of terminating the free medications, co-payments and deductibles potentially available from Mason Manor eligibility.[316]

(3) Do the calculation in (2) above, required for determining how much will be needed by the client during the period of ineligibility. Instead of transferring all assets and returning some, use the amount the client will need to buy an annuity paying to the client (with a Medicaid payback provision as required by the post-DRA rules) and transfer the rest of the assets. Then apply for Medicaid, running the annuity income through a "Qualified Income Trust." The monthly payment of the annuity should be the amount the client will need during the period of ineligibility (from the transfer of the other funds), divided by the number of months of ineligibility.

(4) Same as (3) above, except instead of buying an annuity with the funds that will have to be paid to the nursing home, pay those funds to the nursing home directly. Until recent changes in policy, this would not have worked because the potential for a refund from the nursing home would have made the amount paid that exceeded the required payment countable as a resource. However, the current Handbook clearly allows this, and agency representatives have confirmed that is their interpretation.[317] However, agency representatives have subsequently warned that this can be taken too far and that it would be risky to pay in advance more than is likely to be needed during the period the Medicaid application is pending. This strategy can best be presented on a spreadsheet like the following:

[315] It has been suggested that the transferor's attorney may also be liable to the nursing home on a fraudulent transfer theory. The author has not researched this.

[316] Some clients will benefit more than others from Mason Manor. Those with medical insurance that covers substantially all medications, copayments and deductibles will enjoy little if any benefit from it.

[317] MEPD § F-1312.2. Agency representatives discussed this in response to written questions at the Estate Planning, Probate and Elder Law Conference sponsored by the University of Texas School of Law in August 2009.

MONTH BY MONTH PROJECTION OF SPEND-DOWN WITH RETURNED GIFTS

Assets Transferred	$50,000.00
Nursing home/mo.	$3,500.00
Other expenses/mo.	$300.00
Monthly Income	$1,800.00

Month	Nursing Home Expense	Other Expenses	Income	Returned Gifts	Balance-End of Month	Months Left
1	$3,500.00	$300.00	$1,800.00	$2,000.00	$48,000.00	11.88
2	$3,500.00	$300.00	$1,800.00	$4,000.00	$46,000.00	10.35
3	$3,500.00	$300.00	$1,800.00	$6,000.00	$44,000.00	8.81
4	$3,500.00	$300.00	$1,800.00	$8,000.00	$42,000.00	7.27
5	$3,500.00	$300.00	$1,800.00	$10,000.00	$40,000.00	5.74
6	$3,500.00	$300.00	$1,800.00	$12,000.00	$38,000.00	4.20
7	$3,500.00	$300.00	$1,800.00	$14,000.00	$36,000.00	2.66
8	$3,500.00	$300.00	$1,800.00	$16,000.00	$34,000.00	1.12
9	$3,500.00	$300.00	$1,800.00	$18,000.00	$32,000.00	0

In summary, by filing a "Mason Manor" application and documenting what is returned, the donee is able to qualify the client for Medicaid after 9 months instead of 14 months and is able to keep $32,000 instead of nothing.

11. What is "Compensation" Reducing a Transfer Penalty

The following rules govern when a transfer penalty will be offset or eliminated by something the transferee does or provides for the transferor (the client) as "compensation":[318]

- An agreement to provide something in the future to the client is not treated as any "compensation," until something of value is actually provided.

- Compensation may be in the form of payment or assumption of a legal debt of the client.

- If a client makes a payment to family members for services they provide (or agree to provide) that "would be normally provided by a family member," the payment is treated

[318] Except as otherwise indicated, these rules are from MEPD §§ I-4000 – I-4160.

as a "transfer" without consideration. Examples of such services that are never "compensation" when rendered by family members are house painting or repairs, mowing lawns, grocery shopping, cleaning, laundry, preparing meals, and transportation to medical care.

- An exception is that the value of lost wages of a person who quits work to care for the client is "compensation" that can be repaid by the client without a transfer penalty.[319]

- When expenses are incurred or services provided that can be treated as "compensation" under these rules, written receipts or statements are required.

- Repayment by a client of out-of-pocket expenses paid by anyone (including a family member) will be treated as consideration for a transfer only if there was agreement *before* the expenses were paid that they would be repaid by the client. The agreement may either be written or it may be oral and informal. However, if the expenses were paid without agreement for repayment, the repayment will be treated as a transfer without consideration.

- If payment of out-of-pocket expenses of the applicant is made *after* the applicant has made a transfer to the person paying the expenses, the repayment reduces the amount of "transfer" subject to a penalty, dollar for dollar, as of the date the out-of-pocket expenses are paid. That is further explained in the discussion of the "Return of Transferred Asset" rule discussed above.[320]

12. Certain Transfers Excepted From Penalty

The following transfers are *not* subject to transfer penalties:[321]

1. Transfers of a *home* to

a. The client's spouse; or

b. A child of the client who is (1) under age 21 *or* (2) blind or permanently disabled; or

[319] MEPD §§ I-4100 – I-4160, first example. In the past, an exception was made where a family member provided "professional" services--for example, a daughter who is a nurse being paid by her parent for nursing services. That is a logical extension of the qualification "normally provided by a family member," but it does not appear in the MEPD as of this writing.

[320] Medicaid workers sometimes fail to make this distinction and insist on proof of a pre-existing agreement before they will reduce a transfer by amounts returned. However, the "consideration" issue arises only when a transfer by a Medicaid applicant is being scrutinized. It does not apply to a payment made to the applicant, which can never create a transfer penalty and will often reduce one under the returned-asset rule.

[321] 42 U.S.C. § 1396p(c)(2); MEPD §§ I-3000-3200.

c. A sibling of the client who has an equity interest in the home and who resided there for at least one year immediately before the date the client became institutionalized; or

d. A son or daughter of the client who was residing in the client's home for at least two years immediately before the date the client became institutionalized and who provided care to the client which permitted the client to reside at home rather than in an institution or facility.[322]

2. Any transfers to the client's spouse or to another for the sole benefit of the client's spouse (e.g. annuities meeting the numerous requirements for not being treated as resources or transfers without consideration)

3. Any transfers from the client's spouse to another for the sole benefit of the client's spouse (again, certain annuities)

4. Any transfers to a trust established solely for the benefit of the client's blind or disabled child (regardless of age of the "child"), or to such a child of the client directly.[323]

5. Any transfers to a trust established solely for the benefit of an individual less than 65 years of age who is disabled

6. Any transfers of income to a Miller Trust ("Qualified Income Trust")

7. Transfers in which the client intended to dispose of the property at fair market value (even if actual consideration turned out to be less)

8. Transfers made exclusively for a purpose other than to qualify for Medicaid (discussed below)

Technique: If a transfer creating an unwanted penalty period has already been made, determine whether it was made exclusively for some purpose other than qualification for Medicaid. If you can prove that at a fair hearing, the penalty period will be avoided.

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[322] This requires "a written statement from the person's attending physician or a professional social worker familiar with the case documenting the care provided by the son or daughter. If the person is or has been receiving services through a home and community-based waiver program, a statement from the DADS case manager or a professional social worker familiar with the case is required if the person transfers the home to a son or daughter who lives in the home, thereby preventing institutionalization…" MEPD § I-3100.

[323] MEPD § I-3200-3300; *State Medicaid Manual* §3258.10B. The term "solely for the benefit" contains a trap for the unwary. It is interpreted by CMS to mean the trust instrument or other document must provide for the spending of the funds on the beneficiary during the beneficiary's actuarial life expectancy. *State Medicaid Manual* §3257B.6. Presumably, HHSC would use the life expectancy table that it uses in evaluating annuities--that is, Period Life Table 2005 published by the Social Security Administration, currently at http://www.ssa.gov/OACT/STATS/table4c6.html .

9. Transfers of property that has since been returned to the client (discussed above)[324]

10. Imposition of a penalty would cause "undue hardship (discussed below)"[325]

11. The client changes a joint bank account to establish separate accounts to reflect correct ownership of and access to funds (for example, if funds of client's child have been placed in an account with funds of the client, the child's funds can be transferred without a penalty to the client, if it can be shown they were in fact contributed by the child).326

12. The client purchases an irrevocable funeral arrangement or assigns ownership of such an arrangement to a third party.327

13. Transfers to a Uniform Transfers to Minors Act (UTMA) account for the benefit of a person under 21 years of age.

13. Exception: Transfers Solely for Non-Medicaid Purpose

No penalty period is assessed if the client can prove that a transfer of assets was "solely for some purpose other than to obtain Medicaid services."[328]

The Medicaid law presumes that any transfer of assets for less than fair market value is for the purpose of obtaining Medicaid services.[329] After the worker notifies a client of intent to impose a transfer penalty, the client has only 10 working days after written notification (the date on the written notice, not date of receipt by the client) to present oral or written rebuttal of the presumption.

The Texas rules require the following information in any effort to rebut the presumption:[330]

- purpose for transferring the asset;
- attempts to dispose of the asset at fair market value;
- reason for accepting less than fair market value for the asset;

[324] MEPD § I-5700.
[325] MEPD §§ I-3200, I-4300-4310. In addition to the standards at § I-4300, an informal requirement of the Commission is that a good-faith effort must be made to have the asset transferred back, unless such effort would put the client in danger of harm.
[326] MEPD § I-3000.
[327] MEPD § I-3000.
[328] MEPD § I-4210.
[329] 42 U.S.C. § 1396p(c)(2)(C); MEPD § I-4220.
[330] MEPD § I-4220.

- means of or plan for self-support after the transfer; and

- relationship to the person to whom the asset was transferred

MEPD § I-4221 contains additional comments that may be useful in developing a case.

Practice Note: MEPD § I-4210, which imposes the limit of 10 workdays after the date on the written notice, applies by its terms only to the client's right to **rebut the presumption** that the transfer was to obtain Medicaid benefits. However, the form for the written notice (Form H1226) refers to two other actions pertaining to transfers the client must take within 10 days after the worker fills out the form: proof of additional **consideration ("compensation")** and proof of **undue hardship** (discussed below). If it sits on the worker's desk for two days and takes three days in the mail to reach the client, the time the client has to respond after actual notice is reduced to five days. Therefore, anyone who calls your office saying they have been told they are ineligible due to a transfer should be seen immediately if at all.

14. Exception: Transfer Penalty Would Result in "Undue Hardship"

"Undue hardship" is an affirmative defense to the transfer penalty that must be asserted within 10 days of the date the worker fills out the notification form. The Texas rule is set out in full below (as quoted in Medicaid Eligibility for the Elderly and People With Disabilities Handbook §I-4300):[331]

> A person may claim undue hardship when imposition of a transfer penalty would result in discharge to the community and/or inability to obtain necessary medical services so that the person's life is endangered. Undue hardship also exists when imposition of a transfer penalty would deprive the person of food, clothing, shelter or other necessities of life. Undue hardship relates to hardship to the person, not the relatives or responsible parties of the person. Undue hardship does not exist when imposition of the transfer penalty merely causes the person inconvenience or when imposition might restrict lifestyle, but would not cause risk of serious deprivation.
>
> Undue hardship may exist when any one of the following conditions exists:
>
> - location of the receiver of the asset is unknown to the person, other family members or other interested parties, and the person has no place to return in the community and/or receive the care required to meet the person's needs;
> - person can show that physical harm may come as a result of pursuing the return of the asset, and the person has no place to return in the community and/or receive the care required to meet the person's needs; or
> - receiver of the asset is unwilling to cooperate (such as an Adult Protective Services exploitation or potential fraud case) with the person and HHSC, and the person has no

[331] 1 T.A.C. §358.401(k)(2)(m); MEPD §I-4300.

place to return in the community and/or receive the care required to meet the person's needs.

Practice Tip: The undue hardship defense is notoriously difficult to establish, probably because if interpreted literally, it would excuse almost all transfers. However, it should always be asserted when appropriate, if only to avoid blame for failing to raise it.

15. Gifting by Guardians

In 2011, the Texas Legislature amended provisions of the Texas Probate Code (TPC). Of particular importance to elder and special needs planners is an amendment to Section 865, Power to Make Certain Gifts & Transfers. Now, recodified in the Texas Estates Code, Sections, 1162.001 through 1162.008.

Under the old statute, gifts of the ward's personal property and real estate were allowed only if the gift was tax-motivated. Transfers could be made (upon authorization of the court) to a charitable organization, the ward's spouse or descendants, a devisee under the ward's last validly executed will or trust, or the ward's guardian if the guardian was related to the ward by blood.

Pursuant to the newly amended Section 865, gifts and transfers can now also be made to qualify the ward for public benefits. Specifically, guardians are able to "transfer a portion of the ward's estate as necessary to qualify the ward for government benefits and only to the extent allowed by applicable state or federal laws, including rules, regarding those benefits, on a showing that the ward will probably remain incapacitated during the ward's lifetime."

In making this amendment to the TPC, a door has been opened to allow guardians and legal counsel to make arrangements for qualification of wards for Medicaid and other public benefit programs before those wards are rendered entirely destitute. Guardians are now permitted to take part in gifting strategies previously available only to clients who have capacity or a validly executed power of attorney. For example, under current policy, rather than spending down a ward's assets month by month on out-of-pocket medical expenses, a gift could be given to an UTMA account for a grandchild (or any other young person) under the age of 21 to assist with the costs of higher education or for other purposes – a choice that would almost certainly have been made by the ward if he or she had capacity to express such a desire.

This change signals recognition by the legislature that public benefits planning is essential to the well-being of wards and provides options to guardians. It does leave some uncertainty, however, as to the meaning of the limitation "only to the extent allowed by state or federal laws." That might be interpreted restrictively to permit only transfers not subject to a transfer penalty, such as transfers to a spouse or to an UTMA account. However, it could at least as well be construed to permit any transfer that is lawful in the sense that it is fully disclosed and is lawfully accomplished (without fraud, undue influence, lack of authority, etc.). One of the authors of the bill has stated the latter, broader interpretation was intended.[332]

[332] Deborah Green, comment at presentation at the Annual Meeting of the Texas Chapter of the National Academy of Elder Law Attorneys on September 10, 2011.

16. Fees of Guardians Deductible From Copayment

Fees and expenses of a Medicaid beneficiary's guardian may be deducted from co-payment, subject to the following limits:[333]

- The guardian's compensation may not exceed $175 per month;
- Fees of ad litems and the attorney for the guardian for establishing or terminating a guardianship may not exceed $1,000 (unless amounts in excess of $1,000 are "supported by documentation acceptable to the court and the costs are approved by the court"); and
- Other administrative costs may not exceed $1,000 during any three-year period.

An amendment effective September 1, 2011 adds a §1155.202(c) providing that the deduction from co-payment cannot take effect before the later of (A) the month in which the court order is signed or (B) the first month of Medicaid eligibility. Moreover, there can be no deduction for services provided before the effective date of the deduction" (i.e., in most cases, before the date of the order authorizing compensation for the services).

With regard to initial establishment of the guardianship, it is a logical impossibility for a court to approve fees at the beginning of the case when it has not yet been decided whether a guardian will be appointed or not. However, the Texas Health & Human Services Commission's rule does not include the prohibition of a deduction for services provided before the order. Therefore, it appears the agency interprets this statute so as to make it workable.[334]

HHSC interprets this to apply only to fees and expenses of a guardian of the person, not of a guardian of the estate.

E. Application

Application is made to the Texas Health & Human Services Commission. Information is available at https://www.yourtexasbenefits.com/wps/portal .

F. Agreements of Exclusivity Between Attorneys and Skilled Nursing Facilities

This aside on the preparation of applications by attorneys is a result of a recent experience had by co-author Christina Lesher. Ms. Lesher was contacted by a client who wished to file an application for Medicaid benefits. Upon inquiring into the application process at the nursing facility, the family was told that in order to have their loved one placed in a Medicaid-certified bed, they would be required to utilize the legal services of a particular attorney with whom the facility had an agreement. The family was provided with an information packet produced by the attorney's office (notably with incorrect and incomplete legal advice). However, because of the pre-existing relationship, the client chose to contact Ms. Lesher's office for assistance.

[333] Texas Estates Code §1155.202(a), effective September 1, 2009.
[334] 1 T.A.C. §358.439, as revised effective March 8, 2012.

Upon learning of this agreement, research was conducted to determine whether or not an agreement of exclusivity between an attorney and a skilled nursing facility is legal. The Texas Business and Commerce Code provides guidance on the issue:

> "Every contract, combination, or conspiracy in restraint of trade or commerce is unlawful."[335]

Insofar as the nursing facility requires families to utilize the legal services of a particular attorney or law firm, they are restricting trade and commerce. Expressing a preference for a certain member of the Bar is not on its face unlawful. But by denying a resident access to a Medicaid-certified bed unless a referral is utilized, the facility has effectively restrained the family from engaging in a business agreement with any other attorney.

This arrangement also appears to violate the Texas rules regulating nursing homes, which provide as follows:[336]

> (1) A facility must not require recipients to purchase supplies or services, including pharmaceutical supplies or services, from the facility itself or from any particular vendor.

Additionally, if the attorney of the family's choice and the nursing facility happen to lie in different states, there may also be a violation of the U.S. Code, under which restraint of trade or commerce across state lines is prohibited by Federal law.[337]

G. Medicaid Estate Recovery Program

Under the new Medicaid "estate recovery" program, (MERP), Medicaid can sometimes force sale of a Medicaid recipient's residence (and other assets if any) after their lifetime. This program applies only to people who have received Medicaid benefits at or after age 55 *and* first qualified for Medicaid in an application filed on or after March 1, 2005. People who filed a Medicaid application before that date are exempt from estate recovery, provided the application led to certification of eligibility. There are some important exemptions and waiver provisions. For a summary, Frequently Asked Questions, the state rules and forms, go to http://www.dads.state.tx.us/services/estate_recovery/index.html#rules.

H. Lady Bird Deed

There are some possible ways to avoid Medicaid Estate Recovery of one's home. One such technique that may work is to execute a Lady Bird Deed (LBD), also referred sometimes to as an enhanced life estate deed. The LBD allows a transfer of a remainder interest to family members or a Revocable Living Trust (RLT), while the Medicaid beneficiary retains a life estate interest.

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[335] 2 TEX. BUS. & COMM. CODE § 15.05(a).
[336] 40 TAC 19.406(c)(1).
[337] 15 U.S.C. § 1.

A "Life estate" is an ownership arrangement for land which allows the homeowner to retain the use of the home during his/her lifetime; and it also transfers title to the home at the time of death without the need for probate. Listing the grantee as a Revocable Living Trust (RLT) also takes the home out of the probate estate while creating a mechanism for convenient sale and/or distribution of the home property after the homeowner dies.[338]

A "Lady Bird" is an *enhanced* life estate deed that adds one feature to reservation of a life estate: the owner keeps the right to sell or give away the land without anyone's consent or participation. Essentially with a Lady Bird Deed, the owner has the unilateral right to cancel the remainder interest. Even though in this situation the owner retains full ownership rights, pursuant to MEPD Handbook, Chapter I, the home is an exempt asset for Medicaid eligibility purposes.[339]

The difference between a lady bird deed and a regular life estate deed is that the owner keeps the right to sell or give away the land without consent of remainder interest holders. In a regular life estate deed, the owner keeps the "life estate" and conveys a "remainder interest." This means that the owner cannot sell the property without agreement of and participation by the holder of the remainder interest.

If the arrangements under the Lady Bird Deeds are not cancelled, then when the owner dies the life estate expires automatically. The remainder interest then matures into full, unrestricted ownership. This ownership change happens without probate. It is the passing of title without the necessity of probate that will potentially save the homestead from Medicaid Estate Recovery. MERP is currently only seeking recovery from those assets that are in a decedent's probate estate.[340] If the Legislature changes the law, it may change the definition of estate to include assets that pass outside of the probate estate, thus making the lady bird deed an ineffective method to avoid estate recovery. Additionally, some title companies may not insure title with the use of a lady bird deed.

I. LTC Medicaid Programs New in 2015

1. "Community First Choice" to reduce the home care Waiver interest lists

Effective March 1, 2015, a new federally financed option will add approximately 12,000 slots to the Star+Plus Waiver program. Because those slots will be filled from the waiver program

[338] A RLT is established during life and all assets owned by the grantor are retitled in the name of the RLT. At the grantor's death, the trust assets will be distributed according to the trust agreement. Since no assets are titled in the grantor's name, the grantor essentially owns no assets at death where probate is not needed. In addition, other assets other than a home such as a vehicle may also be added to the RLT.
[339] *See* Department of Aging and Disability Services, Medicaid for the Elderly and People with Disabilities Handbook, Chapter I, http://www.dads.state.tx.us/handbooks/mepd/I/I-3000.htm (last visited 12/17/14).
[340] *See* The Department of Aging and Disability Services, Medicaid Estate Recovery, http://www.dads.state.tx.us/services/estate_recovery/faqs.html (last visited 12/17/14).

interests lists, this should (at least temporarily) reduce the waiting time for individuals on the lists. The program is called "Community First Choice."[341]

2. "Texas Dual Eligible Integrated Care Project" affects 6 counties

Also effective March 1, 2015, Texas will implement in six counties a demonstration project providing for managed care services to "dual eligibles"—that is, individuals eligible for both Medicare and Medicaid. The six counties are Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant.[342] The cost of the program will be paid in monthly premiums shared by the state and federal governments. Approximately 168,000 Texans are eligible to participate.

Participants must meet all the following requirements:

- Age 21 or older
- Receiving Medicare Parts A, B and D *and* full Medicaid
- In Star+Plus or Star+Plus Waiver

Individuals residing in ICF-ID facilities and those with developmental disabilities on waiver programs will not be included.

Enrollment packets will be sent in early January 2015. Individuals receiving packets will be *required* to participate *unless* they opt out.

J. 2015 Update: Life Settlements

This discussion of Life Settlements is from a State Bar of Texas webinar paper by H. Clyde Farrell and Bruce Gardner, "Life Insurance and Annuities in Planning for Long-Term Care," presented June 18, 2014. The authors are grateful to Mr. Gardner for his permission to reprint it.

1. Introduction to Life Settlements

"Life Settlements" have an unsavory and ghoulish reputation. Their history is spotted. Viatical settlements in the 1980's preyed upon those with AIDS and the concept as applied to so many in painful and life-threatening situations engendered a reaction of revulsion in the public at large. There has been abuse by unscrupulous insurance agents of seniors who sold policies for quick cash against their best interests, unaware of other options. Stranger-Originated Life Insurance ("STOLI"), purchased by a stranger to the beneficiary in violation of insurable interest laws has been notorious in Texas. In addition, there are tax issues around Life Settlements that complicate their use by attorneys and advisors.

[341] www.hhsc.state.tx.us/medicaid/managed-care/community-first-choice/ .
[342] www.hhsc.state.tx.us/medicaid/managed-care/dual-eligible/ .

This review will look at four areas to explain the concept of Life Settlements (hereinafter "LS") and illustrate how these may be used in long-term care planning, including Medicaid planning.

2. Definitions of Life Settlements

There are two types of life settlements used for the planning discussed in this review, but first a general definition. A life settlement is the lawful sale of a lawfully owned life insurance policy by a lawful owner. The policy owner sells a life insurance policy for more than the policy's cash value and less than its face value. With a life settlement, the policy owner can generate significantly more cash than what they would have received during lifetime from the issuing life insurance carrier through a lapse or surrender. The entire concept of a LS springs from the fact that a life insurance policy is property and as such a LS recognizes the fundamental right of policy owners to assign their policies to a third party for cash. For policies having cash value, nonforfeiture laws provide for surrender of the policy back to the life insurer for cash or exchange for a reduced paid-up benefit. Because both options are based on a value determined by the issuing life insurer, the policy owner's asset is frequently undervalued. The introduction of a secondary market enables policy owners to benefit from the market value of the policy, providing more value than a traditional exchange based on the cash surrender value. In its simplest terms the entire purpose of a LS is for a consumer to realize more cash from the policy compared to cashing the policy in or borrowing out the cash value, otherwise there is no rationale for a LS. The new policy owner that is a state licensed life settlement company immediately changes the beneficiary to the LS company. In Texas life settlement transactions are highly regulated and transparent and are made to a licensed life settlement provider under the Texas Life Settlement Law that became effective Sept. 1, 2011.[343] The effect of such transactions on Medicaid eligibility is governed by a more recent amendment to the Texas Human Resources Code effective Sept. 1, 2013, which is set out in full in Appendix A below.[344]

The term "viatical" is now generally used for the sales of a life insurance policy by an insured with a life expectancy of less than 24 months. The terms "life settlement" and "viatical" are often used interchangeably and incorrectly. This CLE only focuses on life settlements and not viatical settlements.

There are two very different marketplaces for the LS sale of life insurance policies. There are the "traditional" LS market and the Long-Term Care Benefit Plan Conversion LS market.

3. "Traditional" Life Settlements

The "traditional" LS involves the sale of a life insurance policy with a face amount of generally $250,000 or more, from an insured age 65 and older with a life expectancy of 13 years or less. These transactions generally take 3-6 months to effect. Policies are valued by assessing the insured's life expectancy. In other words, mortality is the factor used; the shorter the life expectancy the higher the offer made by the LS company since the new owner will likely be paying the previous owner's premiums for a shorter time. There is often much time and expense to obtain extensive medical records to assess the policy owner's shortened life expectancy. As general rule, the amount of the cash received is 10-15% of the face value. The length of time and

[343] Texas Insurance Code Chapter 1111A.

[344] Texas Human Resources Code §32.01613.

complexity are such that a "traditional" LS is not generally useful for Medicaid planning unless there is sufficient time to plan.

The use of the term "traditional" in describing a LS is a novel one and is used herein for a LS fitting the previous criteria. The market place for these is generally for more affluent clients and the reasons for selling a life insurance policy are quite different than when one applies for Medicaid. A "traditional" LS would not be appropriate to most Medicaid situations because of the three- to six-month processing period. Often when one applies for Medicaid eligibility they may be in a skilled nursing facility and the 100 day maximum clock is running or they are at home and the spouse/partner/family no longer has a viable system to provide care so a nursing home is the only and urgent remedy.

There are a variety of situations where a "traditional" LS may be of benefit. The following are some examples:

- Long-term care funding – a policy owner who needs assistance funding long-term care can sell their life insurance and use the proceeds to help offset the cost for themselves or another. A goal may be to avoid Medicaid or at least postpone Medicaid eligibility as long as possible.
- Recouping term premiums – a policy owner who no longer needs their convertible term policy can use a life settlement to eliminate future premiums and recoup a portion of their overall premium outlay.
- Restructuring cash flow – a policy owner with limited cash flow can use the proceeds from a life settlement to fund a reduced policy with lower premiums.
- A need to eliminate premiums and retain a portion of coverage – a policy owner may find they need to retain a certain level of coverage. Through a life settlement, a policy owner can keep a portion of their coverage while eliminating future premium obligations, in lieu of a cash payment.
- The policy owner has outlived the risk insured against (Many elderly have paid up policies they purchased years ago and their house is paid off, children grown)
- When a spouse has passed away
- When the policy is no longer affordable
- When there is no longer a need for business life insurance to fund business agreements such as buy-sell agreements, defined benefit plans, key-person, etc.

In addition, the low interest rate environment of the last six years has made many life insurance policies underperform. For the more affluent client, life insurance has long been a valuable estate planning tool for income replacement, charitable gift planning, ILITs, etc. However, the cost of maintaining insurance for older, affluent individuals presents significant challenges due to the underperformance of many policies. Underperforming policies, due to low interest rates, combined with longer life expectancies, often put the annual premium outlay beyond what a policy owner chooses or can maintain.

4. Long-Term Care Benefit Plan Conversion Life Settlements

This is a relative new and unique use of the concept of a LS. It is radically different from a "traditional" LS in that it "converts" a life insurance policy settlement into proceeds that are paid directly to a senior care provider in regular payments, beginning in 30-45 days after application.
As discussed above, for Medicaid planning and long-term care planning the typical methods by which life insurance cash values can be made uncountable are by borrowing them out and spending down; by cancelling the policy and receiving the cash value; or by selling the policy to a close family member in exchange for the cash value, thus preserving the entire death benefit instead of only a part of it. In many situations the circumstances are such that the Medicaid applicant is running out of resources to pay for current private nursing home care or cannot be cared for at home. In these emergency situations, quickly borrowing or surrendering the cash value is the prudent tactic since there is usually is little or no delay in eligibility. Term policies are not considered in Medicaid planning.

This new type of LS is likely to be of interest to more people because the minimum policy size is $50,000, rather than the $250,000 that is typically the minimum in traditional LS transactions. The Long-Term Care Benefit Plan is the conversion of an in-force life insurance policy into a funded, irrevocable FDIC insured bank account. The account is set up to make automatic monthly payments *directly* to a long-term care provider selected by the account owner.
Policy owners with all health conditions are accepted, and there are no waiting periods, no care limitations, no costs to apply, no requirement to be terminally ill, and there are no premium payments.

The following are major features of a Long-term Care Benefit Plan LS:

- Designed specifically for people with an immediate (usually within 90 days) need for senior care of any form: Home Care, Assisted Living, Adult Day Care, Nursing Home, Memory Care and Hospice. Independent Living is usually not involved.
- The average amount of a Long-Term Care Benefit Plan LS is 40% of the face amount of the policy compared to 10-15% for a "traditional" LS.
- Can work for smaller policies with a face amount as low as $50,000 and for term insurance (convertible or non-convertible), universal life, whole life and even group life insurance. There are no carrier prohibitions and all 50 states qualify. These are in stark contrast to a "traditional" LS where the financial rating of the seller's insurance carrier, type of policy, age and face amount are major roadblocks to the average policy owner's being able to convert a policy.
- Simplified underwriting requirements (review medical records from last 2 years and phone interview to confirm need for care and type of care to be funded with Benefit Account).
- Life expectancy reports are not required; those require extensive medical records and numerous actions from the insured.
- The entire proceeds from sale of the policy will go into an irrevocable trust account in an FDIC insured bank.
    - The account is irrevocable to protect the money for the account holder
    - As discussed below, the account is excluded from being counted as a resource under the Medicaid rules

    - The account is tax-advantaged because either it can be tax-free based on HIPAA/viatical rules or the funds are tax-deductible when spent, under the IRS rules allowing deduction of most long-term care expenses as medical expenses
    - The Account preserves a funeral benefit for the family of at least 5% or $5,000 or it will pay the entire balance to the family if the account holder dies before the account has been spent-down.
    - The Account pays a monthly benefit directly to the care provider of choice.
- Amount and provider can be changed with 30 day notice
- Additional amount can be drawn for one-time special need circumstances since as retrofitting a bathroom, installing an elevator in the home, buying a motorized wheelchair, etc.
- Fast and easy process to apply and enroll in a Long-Term Care Benefit Plan. That is a major difference from the "traditional" LS that takes 3-6 months since numerous parties are involved such as a life insurance brokerage, LS brokerage organization, LS funding sources (hopefully more than one to get the best offer) and medical team for evaluation of records.
- Average time to enroll and start receiving first benefit payments is 30-45 days

At this time there is only one company in the country that has a Long-Term Care Benefit Plan LS that meets the above requirements for Texas Medicaid qualification as well as federal qualifications. That is Life Care Funding of Portland Maine. Other LS companies will undoubtedly enter the market.

The "new" life settlement contracts have the following potential disadvantages:

- As mentioned above, there is presently only one company in the business.
- The Medicaid policy (discussed below) was announced only last month, and it did not include rulemaking. Therefore, it is likely the program will formulate unwritten policies as issues develop, which may involve unpleasant surprises for planners and their clients.
- There is a serious risk of by policy beneficiaries against all involved in these contracts, by beneficiaries of the policies. For example, a second spouse may be involved in sale of her husband's policy, which names his children as beneficiaries. Her actions (and her advisors') will likely be scrutinized for undue influence, lack of capacity of the principal, lack of authority under power of attorney, fraud, unconscionability, etc. Many (perhaps most) securities broker-dealers will not permit their agents to sell such contracts for that reason.

All life settlements have potential income tax consequences. With careful planning, the tax can usually be avoided or minimized. Those issues are beyond the scope of this article.

5. Using the New Life Settlements for Medicaid Planning

The value of the Benefit Account funded with the proceeds of a sale of the policy is exempt from counting as a resource under the Medicaid rules, if the funds remaining at the death of the owner/seller of the policy are payable to his or her estate *or* to a beneficiary named by the

owner.[345] Other requirements for that treatment appear in a Medicaid policy bulletin, as follow:[346]

- Must direct proceeds of the life settlement contract to an irrevocable state or federally insured account
- Specify that the proceeds must only be used for payment of long-term care support services expenses
- Specify the total amount payable for long-term care support services expenses; and
- Indicate the irrevocable beneficiary of any reserved death benefit.

Although the statute and bulletin are silent as to whether there is a transfer penalty, we think it safe to assume there will not be, because that would defeat the legislative purpose. Moreover, there is full consideration to the seller of the policy, because the policy is sold for its full market value and the funds are protected in an irrevocable account that is only used to pay for long-term care services.

The statute provides, "the medical assistance program may act only as the secondary payor" This option may be used to extend the time a person can remain in private pay and delay their entry into Medicaid. Alternatively, it may *accelerate* Medicaid eligibility, with the benefit that long-term care services are provided at the Medicaid rate instead of at the (usually higher) private-pay rate. The first option will be viable in situations in which the planner perceives that better care will be available in a non-Medicaid setting, such as an Assisted Living Facility memory-care unit. The second option may be considered when the client plans to be in a Medicaid-certified facility (for example, a secure unit in a Medicaid nursing home) in any case, regardless of whether payment is fully private-pay or in part by Medicaid.

Comment: Because the Medicaid Estate Recovery Program operates only on the probate estate, it would be a big mistake to make the estate of a Medicaid applicant the beneficiary of one of these accounts. Any other person(s) or entity(ies) may and should be designated as beneficiary(ies).

The Legislature's purpose is believed to be to encourage the use of life insurance policies to pay privately for long-term care and delay their need for Medicaid. The point of the new law is to make sure people know they have the legal right to use their life insurance to pay for long-term care. Therefore, the law requires that the policy owner be informed of this private pay option by the Texas Health and Human Services.[347]

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[345] Texas Human Resources Code §32.01613(d)(2).
[346] MEPD Policy Bulletin 14-07 (May 21, 2014), at http://www.dads.texas.gov/handbooks/mepd_policy/05-23-14_1407.pdf/. The only other reference to life settlements in the MEPD Handbook is at F-4225. It appears obsolete because it was effective December 1, 2009, and it states without exception that "accelerated life insurance payments" are income in the month received and a resource if retained into the following month and not otherwise excludable.
[347] Texas Human Resources Code §32.01613(l)

As of 2014, twelve states had introduced "Policy Conversion Consumer Disclosure" legislation to educate policy owners about this option to remain in private pay and to codify the Long-Term Care Benefit Plan structure : California, Florida, Kentucky, Louisiana, Maine, Maryland, Massachusetts, New Jersey, New York, Pennsylvania, Texas, and Washington. Texas and Kentucky are the first states to enact the legislation into law. "It saves the state money, because otherwise you would just cash in the value of the life insurance and get $5,000 or something, and go on the Medicaid roll immediately," Texas Rep. Craig Eiland, a Galveston Democrat who introduced the bill in the Texas House, told the Wall Street Journal. "The policyholder benefits because he has cash he can direct to his own care and expenditures."

VII. CHILDREN'S MEDICAID

Certain low-income children (and pregnant women, discussed in the next section below) are eligible for Regular Medicaid benefits although they are ineligible for TANF.[348]

A. Eligibility

1. Residence and Citizenship

Texas residence is required, but there is no minimum time limit.[349] Applicants must also be U. S. citizens or aliens meeting certain specific requirements.[350]

2. Age 18 or Under

To qualify, children must be under the age of 19, with the household income limits varying according to age as set out in the "Monthly Income Limits" table below.[351]

There is a separate program for young people 18 - 20 years of age (to age 21), called Medicaid for Transitioning Foster Care Youth.[352] It is not discussed further in this paper.

3. Resources

Under the Affordable Care Act, effective January 1, 2014, Children's Medicaid and CHIP no longer have a resource limit.[353] However, Texas Health and Human Services Commission has announced it will continue to collect information about vehicles and bank accounts owned by applicants.[354]

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[348] 1 T.A.C. Chapter 366, Subchapter E.
[349] 1 T.A.C. §366.517.
[350] 1 T.A.C. §366.513; and see Appendix 4 to this paper re alien eligibility for Medicaid generally
[351] 1 T.A.C. §366.507.
[352] 1 T.A.C. §366.601-647.
[353] 42 U.S.C. §1396a(e)(14); 1 T.A.C. §§366.505, 366.507 (Medicaid); 1 T.A.C. §370.809 (CHIP).
[354] HHSC newsletter "In Touch" (Jan-Feb. 2014); 1 T.A.C. §366.1109.

4. Income

The Affordable Care Act made the following changes in income limits of Children's Medicaid:[355]

- Income is defined according to what is included in Modified Adjusted Gross Income under the federal income tax law, with certain exclusions. For example, income of a child who lives in the household of a parent and who is not required to file a federal income tax return is excluded.
- As before, it is household income that is considered, but the definition of "household" has changed. In most cases, it will include only a child's parent(s) and sibling(s) living with the child.
- The Federal Poverty Level (FPL) percentage limit for children ages 6-18 years was increased from 100% FPL to 133% FPL, same as for children ages 1-5. However, because of the Affordable Care Act requirement that application of the new MAGI rules must not disqualify anyone who was previously eligible, at this point the MAGI income limits (in the table below) are not precise multiples of the Federal Poverty Level.[356]
- Because MAGI does not provide for some deductions and exclusions previously in effect, the income limit is increased according to calculations by each state and approved by CMS to ensure that no person who was eligible before the ACA is made ineligible by the ACA.

The change in income methodology to MAGI and the elimination of a resource test affect Medicaid for Children and Pregnant Women, CHIP and Medically Needy Medicaid. They do *not* affect Medicaid for the Elderly and Persons With Disabilities or SSI or the Medicaid linked to SSI.

Practice Note: Now only potentially taxable *income is counted by Children's Medicaid. Therefore, trust distributions of cash are counted only to the extent they include income taxable to the trust that is carried out in the distributions. Gifts from individuals are not counted at all because they are never taxable income to the donee.*

[355] 42 U.S.C. §1396a(e)(14); 1 T.A.C. §§366.507, 366.523, Subchapter K.

[356] This is required by the ACA at 42 U.S.C. §1396a(e)(14), to continue "during the transition" when maintenance of effort requirements are in effect under 42 U.S.C. §1396a(gg). For children under age 19, that appears to be until September 30, 2019.

Children's Medicaid Income Limits Effective 3/1/2014

Family Size	Under Age 1	Ages 1-5	Ages 6-18
1	$1,926	$1,401	$1,294
2	$2,596	$1,888	$1,744
3	$3,266	$2,375	$2,194
4	$3,936	$2,862	$2,644
5	$4,606	$3,350	3,094
6	$5,276	$3,837	$3,544
7	$5,945	$4,324	$3,994
8	$6,615	$4,811	$4,444
Each Added Person	$670	$488	$450

For 2014 income limits of all Medicaid and CHIP programs affected by the Affordable Care Act, see http://www.dads.state.tx.us/Handbooks/texasworks_bulletins/09-29-14_1405.pdf.

B. Benefits

Benefits provided to children and pregnant women are the same as for Regular Medicaid, described at page 59. They are provided through managed care organizations under the STAR program, as discussed above.

C. Trust and Transfer Rules

Since there is no longer a resource limit, trust and transfer rules are not relevant.

VIII. PREGNANT WOMEN'S MEDICAID

A. Eligibility

The applicant must be a pregnant woman and must meet the following requirements.

1. Residence and Citizenship

Texas residence is required, but there is no minimum time limit.[357] Applicants must also be U. S. citizens or aliens meeting certain specific requirements.[358]

2. Resources

Pregnant Women's Medicaid has no resource limit.[359]

[357] 1 T.A.C. §366.317.
[358] 1 T.A.C. §366.313; and see Appendix 4 to this paper re alien eligibility for Medicaid generally
[359] 1 T.A.C. §366.321.

3. Income

The Pregnant Women's Medicaid income limit under the Texas rules is 185% of the federal poverty level. However, because of the Affordable Care Act requirement that application of the new MAGI rules must not disqualify anyone who was previously eligible, at this point the MAGI income limits are not precise multiples of the Federal Poverty Level. For 2014 income limits of all Medicaid and CHIP programs affected by the Affordable Care Act, see http://www.dads.state.tx.us/Handbooks/texasworks_bulletins/09-29-14_1405.pdf.

Pregnant Women's Medicaid Income Limits—Effective 3/1/2014

Family Size	Income Limit
1	$1,926
2	$2,596
3	$3,266
4	$3,936
5	$4,606
6	$5,276
7	$5,945
8	$6,615
Each added person	$670

B. Benefits

Benefits provided to children and pregnant women are the same as for Regular Medicaid, described at page 59. Virtually all are provided through managed care organizations under the STAR program, as discussed at page 12

C. Trust and Transfer Rules

Since there are no resource limits for a pregnant woman, there are no trust or transfer rules.

IX. PARENTS & CARETAKER RELATIVES MEDICAID

A. History and Relation to TANF

Previous editions of this paper have included a summary of the Temporary Assistance for Needy Families (TANF) program. It provides cash assistance and does not require disability as a condition of eligibility. However, it was included because TANF eligibility was an important requirement for Medicaid eligibility for some individuals, and the TANF income and resource methodology was followed by the Medicaid programs for children and pregnant women and the medically needy.

With full implementation of the Affordable Care Act in 2014, as discussed above, those particular Medicaid programs no longer have resource limits, and TANF methodology has been replaced by MAGI income methodology. Furthermore, TANF eligibility as a route to Medicaid eligibility has been replaced by Children's Medicaid (for household members under age 19) and as of January 1, 2014, Parents and Caretaker Relatives Medicaid (for adult household members of TANF households and those meeting the TANF income limits).[360] Therefore, this discussion of the Parents and Caretaker Relatives Medicaid program is substituted for the previous summary of TANF.

B. Eligibility

1. Relationship to Dependent Child

Eligibility requires that the applicant be a "caretaker or second parent of a dependent child who receives Medicaid."[361]
A "dependent child" is one who meets both the following requirements:[362]

- Either under age 18 or 18 and a full-time student and
- "Deprived of parental support by reason of the death, absence from the home, physical or mental incapacity, or unemployment of at least one parent"

A "caretaker" is "a person who supervises and cares for a dependent child," lives in the child's home and meets the relationship requirements."[363]

The "relationship" requirement is met if the person is by law, marriage or adoption a child's father or mother; grandparent (or more distant ancestor to the degree of "great great great" grandparent); brother or sister; uncle or aunt, to the degree of "great, great" uncle or aunt; first cousin; nephew or niece, to the degree of a "great, great" nephew or niece; stepfather or stepmother; stepbrother or stepsister; or first cousin once removed.[364]

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[360] Rules are at 1 T.A.C. Chapter 366, Subchapter G.
[361] 1 T.A.C. §366.707.
[362] 1 T.A.C. §366.703(5).
[363] 1 T.A.C. §366.703(3).
[364] 1 T.A.C. §366.719(c).

2. Resources

Under the Affordable Care Act, effective January 1, 2014, Parents and Caretaker Relatives Medicaid has no resource limit.[365]

3. Income

The income limits for TANF in the *Texas Works Handbook* apply, except to the extent altered by the Affordable Care Act. Because MAGI does not provide for some deductions and exclusions previously in effect, the income limit is increased according to calculations by each state and approved by CMS to ensure that no person who was eligible before the ACA is made ineligible by the ACA. The following income limits of the Parents and Caretaker Relatives Medicaid Program reflect those adjustments:[366]

Parents and Caretaker Relatives Medicaid Income Limits		
MAGI Household Size	**One-Parent MAGI-Converted Limits**	**Two-Parent MAGI-Converted Limits**
1	$103	N/A
2	$196	$161
3	$230	$251
4	$277	$285
5	$310	$332
6	$356	$367
7	$389	$412
8	$441	$447
Each added person	$52	$52

Comment: When considering how low these income limits are, remember they are determined under the MAGI rules, which count only income subject to tax. Gifts are not subject to income tax. Therefore, caretaker relatives supported largely or entirely by trust distributions or assistance by family members may qualify for Medicaid under the MAGI rules.

C. Benefits

Benefits provided under Parents and Caretaker Relatives Medicaid are the same as for Regular Medicaid, described at page 59. Virtually all are provided through managed care organizations under the STAR program, as discussed at page 12.

D. Trust and Transfer Rules

Since there is no longer a resource limit, trust and transfer rules are not relevant.

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[365] 42 U.S.C. §1396a(e)(14).

[366] http://www.dads.state.tx.us/Handbooks/texasworks_bulletins/09-29-14_1405.pdf

E. Application

Application for Parents and Caretaker Relatives Medicaid is to the Texas Health and Human Services Commission by paper application, online at www.yourtexasbenefits.com , by telephone or in person at an HHSC office. It can be made by any "person acting responsibly" for the applicant.[367]

X. MEDICALLY NEEDY PROGRAM

A. Eligibility

1. Age, Gender & Resources

Children under age 19, as well as pregnant women without any TANF-eligible children, whose incomes exceed the limits for the CPW program may be eligible for medical assistance under the Medically Needy Program.[368]

2. Income

The Medically Needy Program also provides an important opportunity for meeting the income eligibility requirements by allowing applicants to qualify for the program if their income exceeds the limits for this program by "spending down" the excess income on certain medical expenses.[369] Essentially, there is no income limit for qualifying, provided that all income above the "Medically Needy Income Limit" is needed to pay medical expenses.

To determine how much income an individual must spend down in order to qualify, one must subtract the monthly Medically Needy Income Limits (MNIL) from the applicant's monthly net income. The difference is generally referred to as the "spend down amount." Essentially, the individual or family is required to "spend down" the difference, by applying that part of their income to their unpaid medical bills. Their remaining medical expenses, which may be quite substantial, are paid by Medicaid (provided, of course, that they are for services and providers covered under Medicaid). Thus, the "spend-down" operates essentially as a copayment for medical expenses. The following are the Medically Needy Income Limits:

[367] 1 T.A.C. §366.709.
[368] 1 T.A.C. Chapter 366, Subchapter H.
[369] 1 T.A.C. §366.829; 42 C.F.R. § 435.831.

Medically Needy Income Limits	
Family Size	Income Limit
1	$104
2	$216
3	$275
4	$308
5	$357
6	$392
7	$440
8	$475
Each added person	+$57

If, for example, a family of 3 applying for a 7 year old child in 2015 has a monthly net income of $1,408, the calculation would be: $1,408 - $275 = $1,133, and the family would thus have to provide proof of medical expenses totaling at least $1,133 and would have to pay that amount monthly on medical expenses.

Income methodology is the same as for Children's Medicaid and CHIP, discussed above ("modified adjusted gross income").

3. Resources

The resources requirement for Medically Needy is met is the applicant's household has no more than $2,000 in countable resources; or if the applicant lives in the same physical residence with an individual who is aged or disabled and meets relationship requirements, the limit is $3,000.

B. Benefits

Medically Needy benefits are the same as for Regular Medicaid, described at page 59, subject to the requirement of "spending down" the family's income to the extent it exceeds the Medically Needy Income Limit in the table above.

Eligibility on the first day of the month of application on which all eligibility requirements are met, and it may be retroactive for as long as 3 months previous if all eligibility requirements are met.[370]

C. Trust Rules

Because there is no longer a resource test, there are no trust rules.

D. Transfer Rules

The Medicaid Needy Program has no transfer penalty.[371]

[370] 1 T.A.C. §366.827.

E. Application

Information on who is eligible and how to apply is available by calling 211.

XI. THE TEXAS CHILDREN'S HEALTH INSURANCE (CHIP) PROGRAM

A. Eligibility

1. Age

A child may be eligible for CHIP from birth until the end of the month in which the child reaches age nineteen.[372]

2. Residence/Citizenship

The applicant-child must be a U. S. citizen or permanent resident alien and resident of Texas, and documentation to prove citizenship and residence must be submitted. However, the citizenship and immigration status of the *parents* does not affect the child's eligibility and is not reported on the application form.[373]

3. Waiting Period

For a child who is enrolling in CHIP for the first time and has had private health insurance, there is a 90-day waiting period from the time the child was enrolled in the private health plan to the time CHIP coverage begins.[374] There are, however, some important exceptions[375] to this rule. For example, children who lose their health insurance due to a divorce or other change in the marital status of their parents are not subject to the waiting period, nor are children who lose health insurance due to the layoff of a parent.[376] Under certain situations, the Commission may also grant an exception to the waiting period for "good cause." For a complete list of exceptions, see the last two footnotes.

4. Income

The CHIP income limit under the Texas rules is 200% of the federal poverty level.[377] However, because of the Affordable Care Act requirement that application of the new MAGI rules must not disqualify anyone who was previously eligible, at this point the MAGI income limits are not precise multiples of the Federal Poverty Level.

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[371] 1 T.A.C. §366.843(e).
[372] 1 T.A.C. §370.42.
[373] 1 T.A.C. §370.43.
[374] 1 T.A.C. §370.46.
[375] 1 T.A.C. §370.46 (c)-(d).
[376]. http://chipmedicaid.org/en/Previous-Coverage.
[377] 1 T.A.C. §370.44.

Children's Health Insurance Program Income Limits—Effective 3/1/2014	
Family Size	**Income Limit**
1	$1,955
2	$2,635
3	$3,315
4	$3,995
5	$4,675
6	$5,355
7	$6,036
8	$6,716
Each Added Person	$681

For 2014 income limits of all Medicaid and CHIP programs affected by the Affordable Care Act, see http://www.dads.state.tx.us/Handbooks/texasworks_bulletins/09-29-14_1405.pdf.

5. Resources[378]

Effective January 1, 2014, under the Affordable Care Act, there is no resource limit for CHIP. However, the Texas Health and Human Services Commission will continue to collect information on assets of applicants.[379]

6. Exclusions

Even children whose families meet the income limits are ineligible for CHIP if they are in any of the following categories:

- Eligible for any Medicaid (Title XIX) program;[380] *or*
- Covered by other "adequate" health insurance.[381]

B. Benefits and Costs

Children who qualify for CHIP receive health insurance coverage comparable to that available to state employees and their families.[382] Although families at or below 100% of the federal poverty level pay no enrollment fee or monthly premium, families between 101% and 200% of the federal poverty level pay a small but progressively increasing premium.[383] All families must

[378] 1 T.A.C. §370.44(h).
[379] 1 T.A.C. §370.809.
[380] 1 T.A.C. §370.45(c).
[381] Adequacy is determined by the Health and Human Services Commission. TEX. HEALTH & SAFETY CODE § 62.101(a)(3).
[382] 1 T.A.C. §370.321.
[383] 1 T.A.C. §§370.321, 370.325. http://www.chipmedicaid.org/en/Costs.

pay co-pays, but most of these range from only $3 to $10 depending on the family's income and the type of service received. [384]

The program is administered by HHSC, which determines CHIP eligibility and administers enrollment in the plans that deliver services. Health care is provided by managed care organizations in urban areas and in rural areas by a network of providers assembled specifically for CHIP.

C. Trust Rules

Because there is no longer a resource test, there are no trust rules.

D. Transfer Rules

Because there is no longer a resource test, there is no transfer penalty.

E. Application

An application form can be obtained online from HHSC or through the TexCare Partnership in any of the following ways:[385]

- By calling a toll-free number: 1-877-543-7669 (877-KIDS-NOW). Callers who are deaf or hard-of-hearing can contact these numbers through Texas Relay by calling 1-800-735-2988.

- By completing an application online or downloading an application from http://www.chipmedicaid.org/en/Apply-Now or http://www.chipmedicaid.org/

Enrollment is for a continuous 12-month period, with some exceptions, after which the recipient's eligibility must be re-determined.[386]

XII. THE AFFORDABLE CARE ACT

A. Introduction

The two bills known jointly as the Affordable Care Act were passed by Congress in March 2010.[387] They are also known as "Health Care Reform" and "Obamacare."[388]

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[384] http://www.chipmedicaid.org/en/Costs.
[385] http://chipmedicaid.org/sites/default/files/documents/1205-eng_-_08-2014.pdf
[386] 1 T.A.C. §370.307.
[387] Patient Protection and Affordable Care Act of 2010 (PPACA), signed by the President on March 23, 2010, and Health Care and Education Reconciliation Act of 2010 (HCERA) signed on March 30, 2010.
[388] The author has drawn heavily in this section from Begley and Canellos, *Special Needs Trusts Handbook* Chapter 2A. This treatise and formbook is an essential tool for any attorney working with Special Needs Trusts.

Constitutionality of the essential features was upheld by the U. S. Supreme Court on June 28, 2012. However, the same opinion held unconstitutional the sanction of withholding of federal Medicaid funds from states refusing to adopt the expanded Medicaid coverage permitted by the legislation.[389]

This landmark legislation may be thought of as a major "program" offering persons with disabilities new choices, most importantly including for some, the option of avoiding Medicaid eligibility entirely by buying into the same health insurance available to other Americans.

B. Changes Put Into Effect Before 2013

1. The "Federal Risk Pool"

This pool, known as the Pre-Existing Condition Insurance Plan (PCIP), is available in every state and to be administered either by the states, if they choose to do so, or by the federal government. Texas has opted to allow the U. S. Department of Health & Human Services to operate PCIP for Texas residents. Coverage became available on July 1, 2010. The program will continue through 2014, when other provisions of the ACA will go into effect making PCIP no longer be needed.

2. Eligibility

To qualify for coverage under PCIP, applicants must meet the following requirements:

> Be a citizen or national of the U.S., or be lawfully present in the U.S.;
> Have been uninsured for the 6 months prior to submitting an application; and
> Have a pre-existing condition or have been denied coverage by a private health insurance provider because of a health condition.

The program has no income or resource requirements.

3. Premiums, Deductibles and Co-Payments

The premiums for PCIP depend upon age and the insurance plan the enrollee selects, but generally range from $174 to $578 per month. Specific rates can be obtained at https://webaccounts.geha.com/public/pcip/rates/rates.asp?id=20.

Deductibles range from $1,000 to $3,000 each year. Co-payments for doctor's visits are $25, and the rate for prescription drugs ranges from $4 to $40 depending on the availability of generic brands. The co-payment for all other services is 20%, though an enrollee's out-of-pocket expenses cannot exceed $5,950 per year as long as the enrollee stays within the plan's network.

4. Differences from the Texas Health Insurance Risk Pool

In contrast to the Texas Health Insurance Risk Pool (discussed in more detail below), no waiting period can be imposed on enrollees based on a pre-existing condition. The Texas Health

[389] *National Federation of Independent Business v. Sebelius,* 2012 U.S. LEXIS 487, http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf

Insurance Risk Pool mandates a 12-month waiting period for those with a pre-existing condition, but PCIP was created to fill the gap for those whose health prevents them from obtaining immediate coverage, either through their states of residence or through a private provider.

Additionally, premiums with PCIP are approximately half the rate of the premiums with the Texas Health Insurance Risk Pool, depending on factors such as age and the plan of coverage selected. As a result, even those clients who might meet the requirements of the Texas Health Insurance Pool or have already fulfilled the waiting period may benefit from enrolling in PCIP.

Comment: This program is literally a lifesaver for many who are shut out of the health insurance system. For example, it is available to individuals waiting the 29 months from onset of disability to Medicare coverage. Such an individual with a Special Needs Trust will pay a lot less for care if the trust has to pay only the premiums for coverage rather than the full cost of medical care at the private-pay rate.

5. Improvements to "Money Follows the Person"

The "Money Follows the Person" program, which has been implemented in Texas, allows nursing home residents to "bypass" the years-long waiting periods for the home and community-based Medicaid "waiver" programs once they qualify for nursing home Medicaid benefits. The ACA reduces the minimum nursing home stay to qualify for this "bypass" and other MFP benefits from 6 months to 90 days. It also extends the program through September 2016.[390] The 90-day rule has already been implemented in Texas.

6. Coverage for Children With Pre-Existing Conditions

Minor children must be offered coverage under their parents' health insurance policies regardless of pre-existing conditions.[391] (This became effective 6 months after passage of the ACA, although the elimination of pre-existing condition exclusions in other circumstances will not be effective until January 1, 2014.)

7. Coverage for Children Until Age 26

Children who are covered by their parents' individual or group health plans must be offered continued coverage until age 26.[392]

8. Medicare Part D "Donut Hole" Reduction

The Medicare Part D "donut hole" is to be reduced gradually with various supplements beginning in 2011, until it

[390] PPACA §2403(a)(i).
[391] PPACA §2714.
[392] PPACA §2714.

9. Part D Cost Sharing Eliminated for Waiver Program Beneficiaries

Beneficiaries of Medicaid waiver programs for home and community-based services no longer have to pay Medicare Part D copayments.[393] Therefore, they will no longer be subject to the dreaded "donut hole." That affords them equal treatment to nursing home residents on Medicaid.

10. Nursing Home Disclosures Required

Nursing homes receiving Medicare and/or Medicaid payment must make certain disclosures on a website regarding ownership, expenditures, accountability requirements, staff turnover, wages and benefits. There is also a new program requiring background checks for staff.[394]

C. Changes Effective January 1, 2014

Now that the ACA is fully effective, many individuals who need Special Needs Trusts to access Medicaid now will have a better option. Here is why.

1. No Pre-Existing Condition Requirement

Prohibition of a pre-existing condition requirement for qualifying for health insurance is the most important effect of the ACA.[395] It will be the key that opens the door to non-Medicaid acute-care health insurance for persons with chronic medical conditions. There is no disability requirement, no income or asset test, no estate recovery. Anyone can qualify by paying a health insurance premium, and persons with severe or chronic medical conditions will pay no more than anyone else.

Unfortunately, the benefits available under the "exchanges" are not expected to include much long-term care. However, individuals whose needs can be met by acute-care health insurance will be able to opt out of Medicaid, provided they have the means to pay the premiums.

2. Sliding-Scale Premiums Based on Income

For individuals and families with incomes no more than 400% of the federal poverty level, a complex system of tax credits will reduce premiums.[396] To illustrate, based on 2013 poverty levels, maximum premiums for lower-income persons look like this:

[393] PPACA §3309.
[394] PPACA §6101-6107, 6121, 6201.
[395] PPACA §2704.
[396] PPACA §1412.

% FPL	Monthly Income in 2014	% of Income Paid	Premium/Month
100%-133%	$1,297	2.0%	$25.94
150%	$1,459	4.0%	$58.36
200%	$1,945	6.3%	$122.54
250%	$2,432	8.05%	$195.78
300%	$2,918	9.5%	$277.21
400%	$3,892	9.5%	$369.74

For federal poverty levels of larger households, see Appendix 1.

The chart above shows only the breakpoints. The actual premiums change continuously between the breakpoints of 133% FPL, 150% FPL, etc.

There is no asset test for this indirect subsidy.

Because Texas government has declined to adopt expanded Medicaid, households of Texas residents with less than poverty-level income are neither eligible for subsidized health insurance under the ACA nor eligible for Medicaid (unless they happen to fall into a Medicaid-eligible category pre-existing the ACA). See below for further discussion of that issue.

"Income" is defined as "modified adjusted gross income," which is adjusted gross income (as reported on page 1 of form 1040 to which is added untaxed foreign income and interest from tax-free securities. "Household income" is defined as modified adjusted gross income of the taxpayer and all individuals for whom the taxpayer can claim a personal exemption *and* who must file a tax return.[397]

The mechanism for applying the subsidy is a tax credit. However, it is applied when health insurance premiums are determined, so apparently will be based on a previous tax year's income. If the credit for a tax year is greater or less than the estimate used in calculating the premium, it will be adjusted on the next year's income tax return.

3. Sliding-Scale Cost Sharing Based on Income

Cost sharing (copayments and deductibles) will also be based on income.[398]

On average, Americans with private health insurance pay (in copayments and deductibles, not counting premiums) approximately 40% of the cost of goods and services covered by their insurance. Insurance companies pay the other 60%. Under the ACA, those shares will change to

[397] PPACA §1401(a), as amended by HCER §1004(a)(1)(A), codified at Internal Revenue Code §36B(d)(2)(A).
[398] PPACA §1402.

an average of 28% and 72%, respectively.[399] That is largely if not entirely due to federal subsidies to be paid to insurers of individuals with incomes not exceeding 400% of the federal poverty level. Here are the breakpoints of that benefit:

% FPL	Monthly Unmarried Amt. in 2014	% Benefits Paid by Insurance Company	% Benefits Paid by Insured
100%-150%	$1,436	94%	6%
150-200%	$1,915	87%	13%
200-250%	$2,395	73%	27%
250-400%	$3,832	70%	30%

4. Spousal Impoverishment Rules Apply to Waiver Programs

In Texas, most but not all the protections against spousal impoverishment of the Medicaid nursing home program apply to the waiver programs. A major difference is that it is possible to qualify for an increased "Protected Resource Amount" in a waiver program only if the income of the ineligible spouse (including income of the eligible spouse to the extent it exceeds the income cap) does not exceed the SSI federal benefit rate ($733 per month in 2015).[400]

The ACA requires that the spousal impoverishment rules apply also to the waiver programs.[401]Hopefully, the Medicaid program will allow use of the same formula as in nursing home Medicaid for calculating an enhanced PRA for the waiver programs.

5. No Annual or Lifetime Caps

As of January 1, 2014, neither group nor individual health insurance coverage may limit "essential health benefits," either on an annual basis or as a lifetime limit. Until that date, subject to certain restrictions, annual benefit limits may be imposed.[402]

6. Medicaid Coverage Based on Low Income

Consistent with the objective of providing universal health insurance coverage, Congress provided for coverage of individuals with incomes less than 133% of the federal poverty level by requiring states accepting Medicaid funds to create a new coverage group for such individuals. The new group could not be limited by old or young age, disability, assets or any other requirements but income. As indicated in the introduction above, the U. S. Supreme Court struck down that program as a *requirement*, leaving it in place as an option for the states.

As of this writing (December 2014), the governor of Texas and leaders of his party have declined to implement this program. However, with the election of a new governor and increasing

[399] "Money's Essential Guide to the Health Care Law," *Money Magazine* (September 2012).
[400] Medicaid Eligibility for the Elderly and People With Disabilities Handbook §J-6300.
[401] PPACA §2404, amending 42 U.S.C. §1396r-5(h)(1)(A).
[402] PPACA §1001(5).

complaints from health care providers, it is possible that decision may be reconsidered. The concern is that if it is not reversed, Texas will see the following results:

- Continued high use of emergency rooms for primary care by uninsured individuals

- Continued upward pressure on health insurance premiums to pay hospitals and other providers for uncompensated care

- Failure of the intended purpose of the ACA to the extent this low-income group that most needs help will receive none

- Loss of federal funds that would have paid virtually 100% of the cost

- Emigration of individuals in desperate need of medical care to states that offer it and

- Continued need for individuals with assets derived from personal injury awards, inheritances, etc. to qualify for Medicaid by transferring those assets to Special Needs Trusts

Comment: This is not a foregone conclusion, however. In the authors' opinion, it is quite possible the demands of the health care industry in Texas, the needs of persons with disabilities, and third-grade arithmetic applied to the state budget will lead to a change of heart by state leaders. That would be bad for our "special needs" practices but very good for our clients, as discussed further in the next section.

7. Effect of the ACA on Special Needs Practices

The authors have already seen effects of the new law, in cases involving clients struggling to work despite serious disabilities. As of January 1, 2014, are longer required to choose between working despite clear disability entitlement, and using that entitlement to qualify for SSI and Medicaid (and/or SSDI and Medicare). If they can work enough to meet their financial needs, they can qualify for acute-care health insurance the same as anyone else, with no exclusion for pre-existing conditions. This came as a great surprise to several clients, who came to us in part to find what they could do to keep the dreaded "Obamacare" from ruining their lives.

A recent newsletter article presented the comments of five advanced practitioners of Special Needs Trust law on their practices.[403] Here is a sampling:

- **Cynthia Barrett**: The ACA will have relatively little effect on retired persons who are Medicare beneficiaries. Its major effects will be on individuals under age 65. Some low-income individuals will relocate from states opting out of the Medicaid expansion to those opting in. Special Needs practitioners will need to develop new skills in advising about management of "modified adjusted gross income," which is the key both to Medicaid expansion eligibility (in states adopting it) and to reduction of premiums and cost sharing.

[403] "The Health Care Ruling's Effect on Practices: Five Commentaries," *The Elder Law Report* (September 2012).

- **David Lillesand**: Elimination of the pre-existing condition requirement and annual and lifetime limits on benefits will enable many individuals with large personal injury awards to avoid Medicaid in favor of private health insurance, which they will prefer to Medicaid. That will allow them to get better care, to avoid the "Medicaid payback," and to avoid the attorney fees and complexity associated with qualifying for Medicaid. However, individuals with disabilities who have relatively small amounts of assets will still need Medicaid and Special Needs Trusts because they will not have the means to pay even subsidized health insurance premiums. "Our practice will be ruined by the portions of ObamaCare upheld by the Court—and we couldn't be happier for our clients!"

- **Thomas D. Begley, Jr**.: Whether or not the ACA permits a person with a disability to opt out of Medicaid will largely depend on whether or not the person needs long-term care. Because the exchange coverage under the ACA provides for no more long-term care than private health insurance, most individuals needing home care or nursing home care will still need Medicaid, and therefore they will need Special Needs Trusts. It is uncertain how much coverage will cost under the new health benefit exchanges and how extensive the coverage will be. Therefore, it is too early to tell how much effect the ACA will have on Special Needs Trust practices.

- **Paul Nathanson**: Medicare beneficiaries are already benefitting from enhanced preventive care and the closing of the Part D "donut hole." It provides important opportunities to states to deinstitutionalize through optional programs like the Balancing Incentive Payment Program (BIPP). Extending spousal impoverishment protection to all waiver programs will also help with long-term care.

- **Mary Alice Jackson**: The ACA is one more step in the right direction, toward providing a "fair and comprehensive health care coverage system for all Americans." Dealing with long-term care will be the next challenge. "In the 21st century, we need a comprehensive effort to scrap the Medicaid program we all know and hate, and replace it with a unified program that makes personal and economic sense for persons with any type of illness, be it acute, chronic or disabling."

XIII. THE TEXAS HEALTH INSURANCE RISK POOL [404]

Under the Affordable Care Act, effective January 1, 2014, the Texas Health Insurance Risk Pool has been eliminated. Its purpose was to enable certain individuals who lose health insurance coverage to acquire it without exclusion of pre-existing conditions within 63 days after termination of the previous coverage. Since the Affordable Care Act prohibits exclusion of pre-existing conditions in all health insurance policies (other than certain exceptions such as Medicare Supplement coverage), the Risk Pool is no longer needed.

[404] http://www.txhealthpool.org/.

XIV. EMERGENCY ASSISTANCE TO UNDOCUMENTED ALIENS

A. Eligibility

Aliens not lawfully admitted for permanent residence in the United States generally are excluded from all Medicaid benefits, with the exception that they are eligible for treatment of an "emergency medical condition" if they would have been eligible for a regular Medicaid program but for their alien status.[405] This is known as "Type Program 30."

B. Benefits

The definition of "emergency medical condition" required for making Medicaid services available to such undocumented aliens is as follows:[406]

The sudden onset of a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in one of the following:

- Placing the client's health in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

It appears that this benefit would cover imminent childbirth to a woman who would be eligible for the Medically Needy program but for her alien status, which may be its most frequent use.

XV. QMB AND OTHER MEDICARE SAVINGS PROGRAMS

Under these programs, State Medi*caid* programs pay for all or some of the Medi*care* premiums, deductibles, and co-payments of Medicare beneficiaries who meet certain income and resource limits.[407] Because Medi*caid* pays these Medi*care* benefits, they are known by a variety of names, including: “Medicare Savings Programs,” “Medicare Cost-Sharing Programs,” or “Dual Eligible Programs."

Comment: These are oft-overlooked programs that can be essential to the well-being of low-income persons who may not be eligible for Regular Medicaid’s more comprehensive benefits. At a minimum, three of the four programs (QMB, SLMB, and QI-1) save eligible individuals the monthly Medicare Part B premium, which is for most individuals $104.90 in 2015, and annually

[405] 1 T.A.C. Chapter 366, Subchapter I; see especially §366.903(b). This program is required by the federal Medicaid statute. 42 U.S.C. §1396 et seq..; 42 C.F.R. § 435.139
[406] 1 T.A.C. §366.903(B)(3), incorporating by reference 42 C.F.R. §440.255(c).
[407] 1 T.A.C. Part 15 Chapter 359; 42 U.S.C. §1396a(a)(10)(E); MEPD Chapter Q.

$1,258.80. QMB, the most comprehensive of these programs, can save thousands of dollars in medical costs for eligible individuals.

A. Eligibility and Benefits

In all the four programs discussed below, SSI definitions of "income" apply. Therefore, for example, the first $65 per month of earned income is excluded, as is one-half of earned income above $65 per month. Since $20 per month of any type of income is excluded, the eligibility amounts below are correct for total income, assuming all is unearned and not subject to any other exclusion. If there is earned income, or if an exclusion other than the $20 per month applies, the amount of actual income that can be received by a beneficiary will be higher.

Another principle applying to all four programs is that a married person whose spouse is not eligible for a non-financial reason (for example, not eligible for QMB because not eligible for Medicare Part A) will meet the income requirement, if the incomes of both spouses together do not exceed the limit for a couple. This is sometimes expressed as a "deeming allowance," that is, only the countable income of the ineligible spouse that exceeds the difference between the couple income limit and the income of the potentially eligible spouse is "deemed" to the latter. For this purpose, the ineligible spouse's countable income is reduced by an allowance for every dependent child equal to the difference between the couple and individual income limits (but any income of the child counts against the reduction dollar for dollar).[408]

1. Qualified Medicare Beneficiaries (QMB)

State Medicaid programs are required to pay Medicare Part A and B premiums, copayments and deductibles for persons whose incomes are below the poverty line and whose assets are at or below twice the SSI resource limit.

The monthly income limit for 2015 is $993 per month for an individual and $1,333 per month for a couple. These amounts include the $20 per month that is "exempt."

The resource (asset) limit is $7,160 for an unmarried person, $10,750 for a married couple.

2. Specified Low-Income Medicare Beneficiaries (SLMB)

The SLMB program requires states to pay the Medicare Part B premiums (usually $104.90 per month in 2015) of Medicare beneficiaries who meet the resource requirements for QMB and whose monthly incomes are higher than the QMB (poverty level) limits but under $1,187 for an individual, and under $ 1,593 for a couple, in 2015. (These amounts are equal to 120% of the federal poverty limits + the $20 disregard.)

The resource (asset) limit is $7,160 for an unmarried person, $10,750 for a married couple.

[408] MEPD § Q-1000.

3. Qualifying Individuals-1

This program also pays the Medicare Part B premium. The primary difference is that it is available only to persons who are *not* certified for any other Medicaid funded program in the same month.

It is available to individuals with monthly incomes greater than $1,187 and not more than $1,333; and couples with monthly incomes greater than $1,593 and not more than $1,790. Those amounts include the $20 per month that is "exempt."

The resource (asset) limit is $7,160 for an unmarried person, $10,750 for a married couple.

The reader is cautioned that there has been continuous talk of this program expiring, although no expiration date has been set.

4. Qualified Disabled and Working Individuals (QDWI)

This pays the Medicare Part A premium ($426 per month in 2015) for persons who have not yet reached age 65, who are entitled to enroll in Medicare Part A by paying a premium, and who are not eligible for any Medicaid program (other than QDWI). These are people who previously received Social Security Disability and Medicare but have lost those benefits because they have regained the ability to work. They must, however, still have a "disabling impairment."

The QDWI *countable* income limits for 2015, are $1,965 for an individual, and $2,642 for a couple.[409] These numbers represent 200% of the FPL + the $20 disregard. It is, however, very important to note that if all the income is earned income, then those amounts equate to $3,995 actual income for an individual, and $5,309 actual for a couple (because the first $85 of earned income and half the rest does not "count").

The resource (asset) limit is $4,000 for an unmarried person, $6,000 for a married couple.

B. Trust and Transfer Rules

Because QMB, SLMB and the related programs are Medicaid (Social Security Act Title XIX) programs, the same trust rules apply to them as to the other Title XIX programs. That is, in general, the assets of third-party supplemental needs or discretionary support trusts are not counted; nor are the assets of self-settled trusts if they are settled by persons under age 65, have a remainder to the Medicaid program, and meet the other requirements of 42 U.S.C. § 1396p(d)(4)(a),(c).

A "Miller Trust" cannot be used to qualify persons with excess income disqualifying him or her for these programs.

[409] MEPD § Q-6200.

There is no transfer penalty applying to these programs, though transfers for this purpose may affect eligibility for "Long Term Care" Medicaid (specifically, the Nursing Home Medicaid and the Community Based Alternatives Programs) and SSI.[410]

C. Application

Application is made to the Texas Health & Human Services Commission (*not* Social Security). Forms are available at: http://www.dads.state.tx.us/forms/H1201%2DEZ/ .

XVI. MEDICAID BUY-IN PROGRAM

The Medicaid Buy-In Program allows disabled individuals of any age who are working to purchase Medicaid benefits by paying a monthly premium. Eligibility is determined based on income and resources available to the individual, as discussed below.

A. Eligibility

1. Disability

The applicable rule provides as follows:[411]

To be eligible for MBI, a person must meet the definition of disabled as defined by the Social Security Administration for purposes of the federal Supplemental Security Income program, as explained in 20 CFR §416.905 and §416.906, except the requirement that the person be unable to engage in any substantial gainful activity does not apply.

Practice Note: When the SSI exclusions of $85 plus one-half of remaining earned income apply, a person with $4,950 per month actual gross earned income has countable earned income of $2,395 per month. As discussed below, even that much countable earned income (250% of federal poverty level) would not disqualify a person with a disability for Buy-In.

Herein lies an issue and a possible opportunity for individuals with "severe" impairments. Under the Social Security Disability rules, a person with actual gross earned income exceeding $1,090 per month is (with some exceptions) presumed not disabled. The above-quoted rule removes that presumption. Where does that leave us? The answer would appear to require reference to the Social Security Administration's disability determination rules, which state that a person who is not currently engaging in "substantial gainful activity" as defined in the rules may or may not meet the disability definition. The next inquiry is whether the person's impairments are "severe." If so, they ask whether the person has an impairment that meets or equals the definition of a "listed impairment." If the answer to that question is also "Yes," then the person meets the definition of "disabled."[412] This may resolve the apparent paradox that one can be engaging in

[410] 1 T.A.C. §358.402.
[411] 1 T.A.C. §360.107; MEPD Chapter M.
[412] The basic rule on the 5-step process is at 20 C.F.R. § 404.1505. It is broken down more specifically at POMS DI 22001.001 *et seq.* See especially the chart at DI 22001.035. The author does not practice in the

substantial gainful activity (making over $1,090 per month) as defined by the Social Security Disability rules, yet still meet the "disability" requirement of Medicaid Buy-In. Notice that an individual in this category is likely to lose the Social Security Disability benefit and, after 24 months, the Medicare benefit. However, they can still have full medical coverage under Medicaid (for a very low premium if they have no unearned income) and over $4,000 per month earned income.

2. Income

A rule provides as follows: "To be eligible for MBI, a person must be working and earning income. The person must provide evidence of earnings that is satisfactory to HHSC."[413]

Until October 2010, the Medicaid Eligibility for the Elderly and People With Disabilities Handbook required that earned income be at least enough to be a Qualifying Quarter, according to the Social Security Administration (SSA). For 2015 this amount is $1,220 per quarter. However, that standard was changed effective October 26, 2010 to the "working and earning income" standard.[414]

Comment: Until the October 2010 change, this writer thought the $1,220 per quarter standard would be applied as a minimum requirement despite the more general standard in the rule. Taken literally, the change bringing policy in line with the rule appears to remove the minimum income requirement entirely. However, at this writing I have not confirmed that with agency officials.

Although the Bulletin just cited states that Bulletins 09-09 and 09-10 otherwise continue in effect, those bulletins have been removed from the online Handbook. Apart from this reference, it would appear they were entirely replaced by the new Chapter M, consisting of the rules at 1 T.A.C. Chapter 360. However, it now appears that Bulletins 09-09 and 09-10 continue in effect as unpublished sources of policy.

A person's countable earned income must be less than 250% of the Federal Poverty Income Level (FPIL), which is $2,432.50 per month for 2015. Income limits change annually. Certain types of income are excluded:

- Spouse's income.

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area of disability determination, and these complex rules can be difficult to apply. Therefore, it is particularly important that the planning decision in such a case be based on advice from a specialist in this practice.

[413] 1 T.A.C. §360.109.

[414] Medicaid Eligibility for the Elderly and People With Disabilities Handbook Bulletin 11-06 (in the "Policy Clarifications" of the Handbook). Although this Bulletin states that Bulletins 09-09 and 09-10 otherwise continue in effect, those bulletins have been removed from the online Handbook. Apart from this reference, it would appear they were entirely replaced by the new Chapter M devoted entirely to the Medicaid Buy-In Program and consisting of the rules at 1 T.A.C. Chapter 360. However, it now appears that Bulletins 09-09 and 09-10 continue in effect as unpublished sources of policy.

- Earned income tax credit payments and child tax credit payments.
- Up to $30 of earned income in a month, if infrequent or irregular.
- Earned income of blind or disabled student children, subject to a monthly and yearly limit.
- $20 monthly general income exclusion (applied first to unearned income)
- $65 monthly earned income exclusion
- Half of remaining earned income after deduction of $20 + $65 = $85
- Earned Income used to pay Impairment Related Work Expenses (IRWE) and Blind Work Expenses (BWE) – subject to reasonable limits.
- Income set aside and used to fulfill an HHSC-approved PASS.

There is no limit on *unearned* income for this purpose, but it is considered in calculation of the amount of the monthly premium (discussed below).

If the applicant is married, resources and income of his or her spouse is not considered, either in determination of eligibility or in determination of premium.[415]

Practice Note: The fact that income and assets of the spouse are not considered is unique to this Medicaid program. There may be many cases in which it makes it the program of choice, especially for home care benefits for married persons with disabilities.

3. Resources

A person's countable resources must be equal to or less than $5,000 (the SSI limit, which is $2,000, plus an additional $3,000 Medicaid Buy-In Resource Exclusion).

Certain types of resources that are (sometimes) counted under the SSI rules are not counted when determining eligibility. These include: retirement related accounts, including IRAs, 401(k)s, Tax Sheltered Annuities, and KEOGHs. Additionally, determination of eligibility does not take into account resources that are set aside under an HHSC approved Plan to Achieve Self-Support (PASS) and an Independence Account (a segregated account in a financial institution used to save for future health care and work-related expenses for the purpose of increasing a person's independence and employment potential).

4. Calculation of Monthly Premium

The individual's premium is determined by examining both earned and unearned income. Unearned income premium amount is all unearned income over the SSI federal benefit rate,

[415] 1 T.A.C. §360.115.

($733 per month in 2015). All participants whose net pay (gross income, minus mandatory payroll deductions) exceeds 150% of FPIL are required to pay a small additional amount ($20-$40) based on their earned income. However, the maximum premium in any case is $500 per month.

B. Benefits

The individual will have access to the same Medicaid services available to adult Medicaid recipients, which include office visits, hospital stays, X-rays, vision services, hearing services, and prescriptions. Recipients are also eligible for attendant services and day activity health services, if they meet the functional requirements for these programs. However, a person cannot participate in the Medicaid Buy-In program and receive long-term care waiver services at the same time.

XVII. MEDICAID BUY-IN FOR CHILDREN PROGRAM

Medicaid Buy-In for Children is a new program effective January 1, 2011. Its purpose is to provide Medicaid benefits to children with disabilities who are not eligible for SSI for reasons other than disability—usually, because parents' income and/or assets exceed SSI requirements. However, an SSI application is not required as a condition of eligibility.[416] It is an optional Medicaid program (permitted but not required by the federal Medicaid statute).[417] A summary by HHSC is at http://www.hhsc.state.tx.us/help/healthcare/MBIC.shtml .

A. Eligibility

1. Nonfinancial Requirements

Medicaid Buy-In for Children has the following nonfinancial requirements for eligibility:[418]

- Citizenship/Immigration Status/Residency: The requirements are the same as for Texas Medicaid programs in general, summarized on page 77.

- Disability: This requirement is the same as for SSI, discussed above beginning on page 21. Since an SSI application is not required, the determination will have to be made in some other way.

- Age: Eligibility ends at the end of the month of the child's 19th birthday.

- Marital status: Must be unmarried

[416] 1 T.A.C. §361.101(b).
[417] 42 U.S.C. § 1396a(cc); Texas Government Code § 531.02444.
[418] 1 T.A.C. §361.107.

- Living arrangement: Must not reside in a "public institution, including a jail, prison, reformatory, or other correctional or holding facility, as defined in CFR §435.1009 and §435.1010. This type Medicaid ends if the child is admitted to a nursing home or ICF-IID facility where he or she qualifies for long-term care Medicaid, but not until that eligibility has been established.

- Application for other benefits: Must apply for all other benefits to which the child may be entitled.

- Buying employer-sponsored health insurance: a parent or step-parent living in the same household with the child must enroll in any available employer-sponsored health insurance, provided the employer offers group coverage including the child and contributes at least 50% of the cost of the annual premiums.

2. Income

The child's "family" must have monthly countable income not exceeding 150% of the federal poverty level, as shown on the following table.[419] However, because of the formula applied (discussed below), actual income can be about twice the amounts shown in this table:

150% of 2014 Federal Poverty Level*

Family Size	Monthly Income
1	$1,459
2	$1,966
3	$2,474
4	$2,981
5	$3,489
6	$3,996
7	$4,504
8	$5,011
Each Add'l:	$508

*Because the federal poverty guidelines will not be announced until after the deadline for this paper, we are unable to include the income limits effective 4/1/2015-3/31/2016.

The following rules are applied in determining countable income:[420]

[420] 1 T.A.C. §361.111.

- Income of the "family" used in the calculation includes income of the child applying for benefits, the child's parents (including a step-parent if any) living in the household, and the income of the child's ineligible, unmarried siblings living in the household.

- However, a sibling's income does not count of the sibling has passed his or her 18th birthday, except it will count until his or her 22nd birthday if the sibling is regularly attending school, college or job training.

- Earned and unearned income is defined according to the SSI rules, discussed above beginning on page 23.

To determine eligibility, income as determined above is adjusted then compared to 150% of FPL as follows:

DETERMINING MBIC ELIGIBILITY

Step:	For Example:
First, total the following:	
1) Monthly countable income of the applicant child	$0.00
2) Parents' combined monthly incomes	$5,200.00
3) Income of each ineligible sibling that is in excess of the following: 150% of FPL for a household of one, multiplied by 2, plus $85	$50.00
Total =	$5,250.00
Then, subtract $85 from the total above =	$5,165.00
Then, divide the total by 2 =	$2,582.50
Example: *maximum* income for family of 4 if only the parent(s) have income:	
150% FPL for family of 4 =	$2,981.25
Minus $85 =	$2,896.25
Multiplied by 2 = monthly maximum =	$5,792.50
Annual maximum (X12) =	$69,510.00

DETERMINING MBIC PREMIUM

The following is for a family of four in 2014 with maximum income for eligibility:	
First, total the following:	
1) 5% family income not exceeding 200% of FPL	$198.75
2) 7.5% family income between 200% & 300% of FPL	$149.06
Total =	$347.81
Then, subtract premium paid for employer-provided health insurance[421]	-200.00
Equals MBIC premium	$147.81

3. Resources

There is no resource (asset) limit for the child or the family.

B. Benefits

Benefits are the same as for "Regular Medicaid," discussed above beginning at page 59.

Comment: Generally, Medicaid benefits are more comprehensive than private health insurance. For example, Medicaid includes Community Attendant Services home care benefits, which may be critical to families with a child who has a severe disability. Therefore, even if employer health insurance is utilized, Medicaid Buy-In for Children may provide home care while a family is on the interest list for waiver program eligibility.

C. Premiums

In general, MBIC premiums are calculated as follows:[422]

- 5% of family income not exceeding 200% of federal poverty level, *plus*

- 7.5% of family income over 200% but not exceeding 300% of federal poverty level, *minus*

[421] If there is employer-provided insurance, its premium is either paid by the HIPP program (discussed next below), or the MBIC beneficiary's family pays the premium and is therefore exempt from paying an MBIC premium. Therefore, in theory, there never should be a deduction for this premium.

[422] 1 T.A.C. §361.115, which incorporates by reference the maximum permissible premium as provided at 42 U.S.C. § 1396o(i)(2)(A).

- Amount paid (if any) for employer-provided health insurance for the family

See the sample calculations in the table above, which begins with eligibility calculations and ends with premium calculations.

Practice Note: Precise calculation of the premium requires reference to the state rule and the federal statute cited in the last footnote. It also requires reference to the federal poverty level table in Appendix 1 at page162. This outline does not include all the possible issues covered in the rule and statute.

Premiums may be waived in the following situations:[423]

- Certain American Indians and Alaska Natives are exempt.

- Beneficiaries who are enrolled in employer-sponsored health insurance and are not eligible for Health Insurance Premium Payment Program (HIPP) are exempt from paying a premium for MBIC. HIPP is discussed at page 143.

- Residents of a federally declared disaster area are exempt for three months beginning with the month the disaster was declared.

- Upon application, a beneficiary may be granted a waiver of premiums for three months for "loss of income" in any of the following situations: termination of employment because of a layoff or business closing; involuntary reduction in work hours; a parent's leaving the household because of divorce or separation; or a parent's death. Only one such waiver may be granted every 12 months.

D. Trust and Transfer Rules

Since there are no asset limits, there are no trust or transfer rules for the Medicaid Buy-In for Children Program

E. Application

Application for the Medicaid Buy-In for Children Program is to the Texas Health & Human Services Commission.

XVIII. HELP WITH INSURANCE PREMIUMS - THE HIPP PROGRAM

The HIPP (Health Insurance Premium Payment)[424] program is a Medicaid program that reimburses the cost of insurance premiums for employer-provided medical insurance of a

[423] 1 T.A.C. §361.115(e).
[424] http://www.gethipptexas.org/. HIPP is an optional Medicaid program authorized by 42 US.C. §1396e. The authors have not found any Texas rules nor other publicly available program information except what is at the websites cited herein.

household member of a Medicaid beneficiary, if the insurance covers the Medicaid beneficiary and if payment of the premium is cost effective to Medicaid. HIPP also pays copayments and deductibles of the Medicaid beneficiary, but only if services are from a Medicaid provider.

It is cost effective to Medicaid if the premium paid by Medicaid will be less than the benefits Medicaid would have to pay but for the insurance coverage. The program makes that determination based on information it has about the Medicaid benefits paid in the past and insurance premium information provided by the applicant.

HIPP will reimburse even for the cost of medical insurance premiums paid for household members who are not on Medicaid. The health insurance that is reimbursed by HIPP may cover services that are not covered under Medicaid.[425] Once HIPP begins paying, it is mandatory (required for continued Medicaid eligibility) as long as it is available from the employer and HIPP determines it is cost-effective.

The program is administered by the State Contractor, Texas Medicaid and Healthcare Partnership (TMHP).

Application is made by telephone to 800-440-0493 or by filling out a form available at http://www.gethipptexas.org/apply-now.html.

STAR members are not eligible for HIPP. STAR+PLUS members are eligible for HIPP according to the HHSC website[426] but are not eligible according to the Star+Plus Handbook, which provides as follows: "Individuals who participate in the HIPP program may not participate in any Medicaid managed care program, including STAR+PLUS. HIPP program participation requires individuals to access their benefits through traditional fee-for-service Medicaid."[427]

Comment: When available, this is a very valuable and underused program. Typically, it is useful when the parent of a Medicaid beneficiary is a member of the beneficiary's household and has an employer offering health insurance. Notice that the program pays the entire premium for everyone on the policy, regardless of income or assets.

XIX. FOOD STAMPS (SNAP)[428]

Comment: Because it is available to many persons with disabilities who are eligible for no other benefits, this program is frequently overlooked as a vital source of support. Note too that ***the eligibility requirements (e.g., income and resource limits) do not apply to households in which everyone is categorically eligible on the basis of receiving TANF and/or SSI.***[429] *Therefore, for*

[425] http://www.texmed.org/Template.aspx?id=2619.
[426] http://www.hhsc.state.tx.us/medicaid/hipp/
[427] Star+Plus Handbook 3127.
[428] 1 T.A.C. §372.1(2); http://www.hhsc.state.tx.us/help/Food/snap.shtml; http://www.fns.usda.gov/snap/.
[429] 1 T.A.C. §372.153, incorporating 7 C.F.R. § 273.2(j)(2)(D),(E).

example, an SSI beneficiary in a single-person household is categorically eligible for SNAP benefits, even if the SSI eligibility depends on trust rules different from the SNAP trust rules.

A. Eligibility

1. Resources

According to the agency's rules, maximum allowable resources for a household is $2,000 or less in countable liquid resources (or $3,000 if a member of the household is at least 60 years of age and disabled).[430]

Resources that are countable include fair market value of all assets that can be converted to cash, other than exempt assets. Some important assets exempted from the definition of "resources" are the following:

- Home and surrounding property[431]
- Household goods, personal effects, one burial plot per household member, and cash value of life insurance policies
- Cash value of pension plans or funds, except IRA's and certain Keogh plans[432]
- Licensed vehicles of any value if they are income-producing or "equity exempt" under certain rules; otherwise, the highest valued countable vehicle of a household is exempt up to $15,000 of its fair market value (FMV); the value of all other countable vehicles is exempt up to $4,650 FMV.[433] Excesses over any of these FMVs is counted toward the combined resource limit.
- Income-producing property as determined by specified standards[434]
- Property in irrevocable trusts meeting certain requirements[435]

The website of the Texas Health & Human Services Commission provides general information as to income limits and maximum benefit values, but it cannot be used to make a definite determination as to eligibility or exact value of benefits.[436]

Trust rules for food stamps are the same as for Temporary Assistance for Needy Families.

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[430] 1 T.A.C. §372.354(b)(1).
[431] 7 C.F.R. § 273.8(e)(1).
[432] 7 C.F.R. § 273.8(e)(2).
[433] 1 T.A.C. §327.354.
[434] 7 C.F.R. § 273.8(e)(4).
[435] 7 C.F.R. § 273.8(e)(8).
[436] http://yourtexasbenefits.hhsc.texas.gov/programs/snap/ .

2. Transfer Rules[437]

Knowing transfer of resources for the purpose of qualifying or attempting to qualify for food stamps is penalized by disqualification of the household for up to one year from the date of discovery (by the Texas Health & Human Services Commission) of the transfer. The length of the disqualification period is based on the amount by which nonexempt transferred resources, when added to other countable resources, exceeds the allowable resource limits. If the nonexempt resources that are transferred exceed the resource limit by $5,000 or more, the full one-year period of disqualification is assessed.[438]

The penalty is the same whether the transfer was before or after application. However, there is a "lookback period" of only 3 months. That is, an applicant who waits at least 3 months after the transfer to apply for food stamps will not be denied eligibility as a result of the transfer.

3. Income

Both eligibility for and amount of benefits (food stamp "allotments") depends upon household income. If the household has an elderly (age 60 or over) or member with a disability, net income after certain deductions is used. Otherwise, gross income is used.[439] See http://www.hhsc.state.tx.us/help/Food/snap.shtml .

4. Citizenship/Immigration Status[440]

Only U. S. citizens and aliens lawfully admitted for permanent or temporary residence can be eligible for food stamps.[441]

Moreover, even permanent resident aliens are excluded from the food stamp program unless they fall into one of the following categories:

- An asylee, refugee or person whose deportation is withheld, for the first 5 years after being granted that status; *or* for the first 5 years, a Cuban, a Haitian, an Amerasian, certain Native Americans from Canada, and the non-citizen children of a battered parent.

- Active duty troops, their spouses, their un-remarried surviving spouses, unmarried dependent children, and honorably discharged veterans meeting the minimum service requirement (generally, 24 months active duty).

- Persons who have earned 40 qualifying quarters of Social Security coverage, or who can be credited with such quarters due to the work of a parent or spouse under certain specified rules.[442]

[437] 7 C.F.R. § 273.8(h).
[438] 7 C.F.R. § 273.8(I).
[439] 7 C.F.R. § 273.9(d).
[440] 1 T.A.C. §372.203.
[441] 7 C.F.R. § 273.4(a).
[442] 8 U.S.C. § 1612.

In general, resident aliens who do not fall into the categories above are excluded from the food stamp program, even if they resided in the United States on August 22, 1996, and even if they are receiving SSI benefits.[443] However, a subsequent act restored benefits for aliens who resided legally in the United States on August 22, 1996 *and* were either 65 years of age or over on that date, *or* have a disability. P.L. 105-185 (effective November 1, 1998). Moreover, all aliens receiving SSI *are* eligible for Medicaid.[444]

5. Work Requirements

Generally, food stamp benefits will be available for no more than 3 months in any 36-month period, unless the recipient is working or participating in a work program at least 20 hours per week.[445] However, persons in the following categories are *not* subject to this rule:

- Under 18 or over 50 years of age
- Medically certified as physically or mentally unfit for employment
- A parent or other member of a household with responsibility for a dependent child
- A pregnant woman[446]

B. Benefits

Beneficiaries receive plastic debit cards ("Lone Star Cards") that can be used to purchase food at participating stores. (Literal food "stamps" or coupons are no longer used in Texas.)[447]

C. Application

Information about where and how to apply is available at: https://www.yourtexasbenefits.com/wps/portal.

XX. TEXAS MENTAL HEALTH AND INTELLECTUAL DISABILITY PROGRAMS

Mental *health* services that were once provided by Texas Department of Mental Health and Mental Retardation (TDMHMR) are now administered by the Texas Department of State Health Services (DSHS), and *intellectual disability* services are now administered by the Department of Aging and Disability Services (DADS). At the community level, however, the local MHMR centers still administer the programs for both mental health services and intellectual disability services. Thus the local MHMR centers which were once overseen by TDMHMR are now overseen at the state level by both DSHS and DADS.

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[443] 8 U.S.C. § 1612(a)(2)(E).
[444] 8 U.S.C. § 1612(b)(2)(F).
[445] 7 C.F.R. § 273.24(b).
[446] 7 U.S.C. § 2015.
[447] http://www.hhsc.state.tx.us/providers/LoneStar/EBT/EBThowto.html.

The Texas statutes and rules generally refer to persons with mental health needs as “patients” and to mental health institutions as “hospitals” or “outpatient facilities.” They refer to persons with intellectual disability as “residents” and to their residential facilities as “State Supported Living Centers.” Persons utilizing local outpatient facilities are referred to as “clients,” and the outpatient facilities are more commonly called “centers.”

A. Eligibility

1. Medicaid-Funded Services

Medicaid does not cover services for patients age 21 through 64 in an “institution for mental diseases.”[448] In Texas, Medicaid-funded “institutions for mental diseases” are for individuals age 65 or older who have one or more mental disease and meet certain other criteria.[449] In part for that reason, many DSHS services, particularly in the mental health area, are *not* funded by Medicaid and therefore are governed only by state laws. In particular, many services of the "state hospitals" and other DSHS residential mental health facilities are not covered by Medicaid.

That leaves important categories of services that *are* covered by Medicaid and therefore involve the Medicaid financial eligibility rules, even though DSHS is the provider. However, the "medical necessity" requirement for nursing home Medicaid does not apply, but rather, different standards must be met for services to be authorized.

The determination as to whether those standards are met is made by DADS for the Intermediate Care Facility-Intellectual Disability (ICF-IID) program (residential care for persons with mental retardation), which is available to all ages because it does not involve an "institution for mental diseases." DSHS makes that determination for applicants age 65 and over seeking mental health residential care. For applicants seeking such care who are under age 21, it is made by a private intermediary.

Except as otherwise indicated, the discussion below will assume that Medicaid funding is either not involved or does not affect the general principles discussed. If Medicaid funding is involved, see the more comprehensive discussion of the Regular Medicaid and Long Term Care Medicaid rules above regarding financial eligibility.

Practice Note: The first step in planning for a client of either DSHS or DADS is to determine whether or not Medicaid funding is involved, or is likely to be involved in the future. As will be shown below, the Medicaid rules are far clearer and more objective than the rules of the purely state programs administered by DSHS and DADS. The Medicaid rules therefore lend themselves more readily to coordinating all resources of the family, community and government with long-term planning for the client’s benefit.

2. Non-Medicaid-Funded Services

a) Right to Mental Health Services

[448] 42 U.S.C. § 1396d(a); 42 C.F.R. §§ 440.1 - 440.180; *Connecticut Department of Income Maintenance v. Heckler,* 471 U.S. 524 (1985).
[449] 25 T.A.C. Chapter 419, Subchapter J.

State law requires the State to support, maintain and treat both indigent and non-indigent patients at the expense of the state. However, the state is entitled to reimbursement for the support, maintenance and treatment of a non-indigent patient. Moreover, a patient who does not own a "sufficient estate" is to be maintained at the expense of the patient's spouse, if able to do so; or, if the patient is younger than 18 years of age, of the patient's father or mother, if able to do so.[450]

A "patient" is defined as an individual who is receiving voluntary or involuntary services in the Texas Health & Safety Code. Such services may be provided in a "mental hospital," which is for inpatient care and treatment for persons with "mental illness." "Mental illness" is defined as an illness, disease or condition, other than alcoholism or mental deficiency, that (a) substantially impairs a person's thoughts, perception of reality, emotional process or judgment; or (b) grossly impairs behavior as demonstrated by recent disturbed behavior. Such services may also be provided in a "community center" or other "mental health facility," which are not defined as necessarily serving only persons with "mental illness."[451]

b) Right to Intellectual Disability Services

The right to services extends to "persons with intellectual disability." "A "person with intellectual disability" is defined as a person determined by a psychologist licensed in Texas or certified by DADS to have sub-average general intellectual functioning with deficits in adaptive behavior.[452]

c) Responsibility to Pay for Services

The same rules regarding client and family responsibility for payment apply both to mental health and to intellectual disability services (assuming Medicaid is not paying). In general, the client and/or the client's spouse or parents (if under 18) are responsible for paying part or all of the cost of support, maintenance, and treatment ("SMT") on a sliding scale, based on their ability to pay, as determined by either DADS or DSHS.[453] Those determinations are "guided" by rules of DADS at 40 T.A.C. Chapter 7, Subchapter C (for residential facilities) and 40 T.A.C. Chapter 2, Subchapter C (for community-based services)[454] and by rules of DSHS at 25 T.A.C. Chapter 417, Subchapter C (for residential facilities) and 25 T.A.C. Chapter 412, Subchapter C (for community-based services).[455]

A person responsible for payment may appeal the payment determinations made by either DSHS or DADS. The appeals processes and where to appeal depend on whether the charges are for

[450] TEX. HEALTH & SAFETY CODE § 552.013.
[451] TEX. HEALTH & SAFETY CODE § 571.003(14).
[452] TEX. HEALTH & SAFETY CODE §§ 591.003(13), (15-a), (16), 593.005.
[453] TEX. HEALTH & SAFETY CODE §§ 552.012-552.019; TEX. HEALTH & SAFETY CODE §§ 593.072-593.081.
[454] 25 T.A.C. Chapter 419, Subchapter J; 40 T.A.C. Chapter 2, Subchapter C.
[455] 25 T.A.C. Chapter 417, Subchapter C; 25 T.A.C. Chapter 412, Subchapter C.

services in a mental health or intellectual disability facility or for mental health or intellectual disability services in the community.[456]

The requirement of payment for services in a state hospital is enforceable by a civil suit to be filed by a county or district attorney, or alternatively by the Attorney General.[457]

This requirement of payment is also enforceable by "the department" (either DSHS or DADS) or a community center placing a lien on all nonexempt real and personal property owned or later acquired by a client or by a person legally responsible for a client's or patient's support.[458]

B. Benefits

1. Mental Health Facilities

There are "state hospitals" in Austin, Big Spring, Kerrville, Rusk, San Antonio, Terrell, Vernon, Waco, and Wichita Falls.[459] They provide a broad range of in-patient and out-patient mental health services.

2. Intellectual Disability Services

State law requires DADS to make "all reasonable efforts consistent with available resources" to:

- assure that each person with intellectual disability who needs services is given quality care, treatment, training and rehabilitation appropriate to their needs
- initiate, carry out and evaluate procedures to guarantee to persons with intellectual disability their rights under this subtitle (Subtitle D, Title 7, TEXAS HEALTH & SAFETY CODE)
- carry out the requirements of this subtitle, including planning, initiating, coordinating, promoting and evaluating all programs
- provide, either directly or by cooperation, negotiation, or contract with other agencies, a continuum of services to persons with mental retardation, including treatment and care, education and training, sheltered workshop programs, counseling and guidance, and develop community residential facilities (including group homes, halfway houses and day-care facilities)[460]

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[456] For appeal of charges for services in a mental health facility: 25 T.A.C. § 417.106; for appeal of charges for mental health services in the community: 25 T.A.C. § 412.109(e); for appeal of charges for services in intellectual disability facilities: 40 T.A.C. § 7.106; for appeal of charges for intellectual disability services in the community: 40 T.A.C. § 2.109(e).
[457] TEX. HEALTH & SAFETY CODE § 552.019(a),(f).
[458] TEX. HEALTH & SAFETY CODE § 533.004.
[459] http://www.dshs.state.tx.us/mhhospitals/default.shtm.
[460] TEX. HEALTH & SAFETY CODE § 591.011.

The "State Supported Living Centers" for persons with mental retardation are located in Abilene, Austin, Brenham, Corpus Christi, Denton, Lubbock, Lufkin, Mexia, Richmond, San Angelo, and San Antonio.[461] DADS also funds and provides administrative and support services to numerous group homes, halfway houses and day-care facilities throughout the state.

3. Community Services

DSHS and DADS approve and to some extent supervise local MHMR organizations that operate "community centers" for mental health, mental retardation, or both. Such organizations are for most purposes local governmental entities, though they may have substantial funding from non-governmental sources.[462]

The local MHMR centers are intended to provide a continuum of services to Texans who have mental illness or mental retardation, and they may provide services to persons with chemical dependency.[463] They are required to provide screening services for admission to DSHS and DADS facilities and to provide continuing mental health services to persons referred by facilities.

State law provides that a community center shall charge reasonable fees for its services if not prohibited by other laws or contracts, and it may not deny services to a person because of inability to pay. A center "has the same rights, privileges, and powers for treating patients and clients that … [DSHS/DADS have] by law," and the county or district attorney of the center's county is to represent the center in collecting fees.[464]

Community centers are required by law to ensure that the following services, at a minimum, are available in their service areas:

- 24-hour emergency screening and rapid crisis stabilization services
- community-based crisis residential services or hospitalization
- community-based assessments, including the development of interdisciplinary treatment plans and diagnosis and evaluation services
- family support services, including respite care
- case management services
- medication-related services, including medication clinics, laboratory monitoring, medication education, mental health maintenance education, and the provision of medication

[461] http://www.dads.state.tx.us/services/SSLC/index.html.
[462] TEX. HEALTH & SAFETY CODE § 534.001.
[463] TEX. HEALTH & SAFETY CODE § 534.0015.
[464] TEX. HEALTH & SAFETY CODE § 534.017.

- psychosocial rehabilitation programs, including social support activities, independent living skills, and vocational training

- appropriate community-based services, including the assignment of a case manager, for each person discharged from a department facility who is in need of care

- to the extent resources are available, the department is required to ensure that the services listed above are available to children, including adolescents, as well as adults, in each service area; emphasize early intervention services for children, including adolescents, who meet the department's definition of being at high risk of developing severe emotional disturbances or severe mental illnesses; and ensure that services are available to certain criminal defendants required to submit to mental health treatment.[465]

4. Support Services

The department provides assistance to clients and families of clients with mental disabilities for the following expenses necessary for living independently in the community:

- purchase or lease of special equipment or architectural modifications to improve or facilitate the care, treatment, therapy, or general living conditions

- medical, surgical, therapeutic, diagnostic and other health services made necessary by the person's mental disability

- counseling and training programs

- attendant care, home health aide services, homemaker services, and support with training, routine body functions, dressing, preparation of food, and ambulation

- respite support for a family that is the client

- transportation services

- transportation, room and board costs for evaluation or treatment, if pre-approved by the department[466]

Assistance for the above needs is limited to not more than $3,600 per year, except the client may receive in addition a one-time grant of not more than $3,600 for architectural renovation or other capital expenditure to improve or facilitate the care, treatment, therapy, general living conditions, or access of a person with mental disability.[467]

Comment: While the services described in the statutes appear to be broad and appropriate, funds for State programs do not cover all Texans who qualify for services. Estimates vary, but

[465] TEX. HEALTH & SAFETY CODE § 534.053.
[466] TEX. HEALTH & SAFETY CODE § 535.004.
[467] TEX. HEALTH & SAFETY CODE § 535.007.

as many as 16,000 to 20,000 Texans around the State may qualify for services yet remain on lengthy waiting lists, not receiving services. Advocates say that is the tip of the iceberg--as the number of Texans who qualify for DSHS and DADS services but who do not even keep their names on a waiting list is likely to be a much higher number.

5. Group Homes

Group homes include Intermediate Care Facilities for Persons with Intellectual Disability (ICF-IID facilities),[468] with six to several hundred residents, as well as small group homes with as few as four residents. The smaller homes are funded by the Home and Community-Based Services Program, a Medicaid "waiver" program.[469] However, most of the larger group homes are funded by Medicaid for residents meeting the Medicaid financial requirements. Most are privately owned, but some are owned by DADS, which also determines Medicaid eligibility for that purpose.

To be eligible for an ICF-IID, the client must be Medicaid eligible under either SSI or Medical Assistance Only (MAO) protected status, and must meet the income and resource limits for nursing home Medicaid (i.e., for 2015, the income limit for an individual is $2,199).[470]

In addition, the client must have been determined to have a disability by Social Security, as well as a determination of intellectual disability or a related condition.

C. Trust Rules

If a patient, resident or client is the beneficiary of a trust that has an aggregate principal of $250,000 or less, the corpus or income of the trust is not considered to be the property of the patient and is not liable for the patient's support. If the aggregate principal of the trust exceeds $250,000, only the portion exceeding that amount and the income attributable to that portion can be considered the patient's property and liable for his or her support.[471]

Under the statutes just cited, the following are not considered "trusts" and are not entitled to the exemption:

- a guardianship established under the Texas Probate Code
- a trust established under Chapter 142, Texas Property Code (by a trial court for an incapacitated plaintiff)
- a facility custodial account established under TEXAS HEALTH & SAFETY CODE §551.003

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[468] TEX. HEALTH & SAFETY CODE Chapter 252; 40 T.A.C. Chapter 90.
[469] HCS group home information is at http://www.dads.state.tx.us/services/faqs-fact/hcs.html.
[470] 40 T.A.C. § 9.236.
[471] TEX. HEALTH & SAFETY CODE § 534.0175(a) ("clients" served by community centers), § 552.018(a) ("patients" in mental health hospitals), and § 593.081 ("residents" of a state school for persons with intellectual disability). H. B. 1316, which was passed by the Legislature in 2001, increased the $50,000 trust limit applying to patients and clients to $250,000, which was the limit applicable to residents under a bill passed in 1999 (Acts 1999, 76th Leg., Ch. 498, § 1).

- the provisions of a divorce decree or other court order relating to child support obligations

- an administration of a decedent's estate

- an arrangement in which funds are held in the registry or by the clerk of a court

The case apparently cited most frequently for the State's authority to proceed against trusts is *State v. Rubion*, 308 S.W.2d 4 (Tex. 1958). *Rubion* held that the State did not have a right at common law to demand payment from third-party trusts, but that such authority could be provided by statute. The Texas statutes now include the Health & Safety Code provisions addressing trusts, which are referenced above.

The various agencies involved have not fully shared with members of the public their policies as to what is required for a trust to protect more than the $250,000 statutory amount. Because of the paucity of reported cases, a number of "understandings" and attorney comments are all we have to go on. Attorneys have reported to this author that they understand certain agency positions regarding *third-party-settled trusts* (not containing assets contributed by the beneficiary) to include the following:

The State almost always wins or settles favorably to the State claims for reimbursement from trusts where the trust distribution standards include "support" and "maintenance." This appears to be true where the trustee is mandated to make distributions for support and/or for maintenance--and even when the trust terms provide that support and maintenance distributions are within the sole discretion of the trustee.

However, if the trust instrument includes a statement of intent to avoid disqualification of the beneficiary for public benefits, the agency does not ordinarily seek to recover against it.

There are no reported cases dealing with State claims against fully discretionary trusts. Although the program has in some cases in the past taken the position that they are subject to reimbursement, the program has also applied the rule generally followed in the case law, that the issue is whether the beneficiary or the beneficiary's creditors could compel distributions. Trust language expressly precluding legal action to compel distributions could make the difference in a close case so may be prudent.

To the author's knowledge, the State has not sought reimbursement from third-party supplemental care or special needs trusts that do not reference support and maintenance.

An attorney with TDMHMR indicated in a letter to The Arc of Texas that the Department does not seek reimbursement from the Arc Pooled Trust (discussed at page 37 above), regardless of whether the account is self-settled or third-party-settled. However, agency representatives have stated informally that they do not regard other *self-settled* trusts as providing any protection at all, even to the extent of the statutory $250,000 amount.

As indicated, an issue not expressly addressed in the trust statutes is whether or not the protection of the first $250,000 applies to a trust created by or on behalf of the beneficiary with his or her own property. The "142 trust," created by a trial court under Texas Property Code § 142.005, is arguably of this type, because it is funded by assets that otherwise would have gone to the beneficiary (or to his or her guardianship estate). As indicated above, such trusts, and guardianship estates, are expressly excluded from favorable treatment in the statute.[472] In general, property of self-settled trusts is not insulated from the claims of creditors of the beneficiary, even if they have a "spendthrift" clause, so may be regarded as not insulated from the state's statutory claims. Moreover, public policy as expressed by the Medicaid laws and the cases in other states indicates that such trusts will not protect the beneficiary's assets from consideration by providers of public benefits, lest all who seek such benefits throw the cloak of a self-settled trust over their property. By contrast, respecting the wishes of a third party who creates a supplemental needs or discretionary trust has the effect of promoting policies favoring assistance of persons with disabilities by family members and others, with assets that otherwise would be denied to them. Accordingly, it is the author's opinion that self-settled trusts are likely not to provide protection from mental health/intellectual disability reimbursement claims.

If the benefit being sought is "Long Term Care Medicaid" in a mental health or intellectual disability facility, involving only *Medicaid* funds, then a very different set of trust rules comes into play. The $250,000 limitation does not apply to a trust settled by a third party, and the corpus is not counted as a resource, even if the trust requires payments of "support." See the discussion above at page 81.

For a thorough discussion of how similar issues have been dealt with in many jurisdictions, see CLIFTON B. KRUSE, JR., THIRD-PARTY AND SELF-CREATED TRUSTS, 3d ed. (American Bar Association 2002).

D. Transfer Rules

The statutes and rules governing MHMR hospitals, State Supported Living Centers and community centers contain no provisions as to the effect of a beneficiary's transferring assets in order to avoid claims for reimbursement.

The author has been told by agency representatives that in establishing the charges for support, maintenance, and treatment ("SMT"), they consider only assets owned by clients at the time they seek or receive services (e.g., at the time of voluntary or involuntary commitment to a state hospital). Under this view, a transfer may result in the agency's disregarding such assets, if the transfer is made before services are applied for or received. However, depending on the evidence of intent, the agency may take the position that such transfers are in fraud of creditors and seek to recover the assets from transferees on that ground. If the person waits until he or she is receiving MHMR services or has an outstanding bill for such services, the agency is highly likely to treat the transfer as a fraudulent conveyance.

[472] It is unclear whether trusts established by guardians under Texas Estates Code Chapter 1301 are entitled to the statutory protection of a maximum of $250,000 or not.

In short, advice regarding transfers for the purpose of avoiding financial responsibility for MHMR services should be given under the same constraints as any other advice regarding transfers of assets with protection from creditors in mind. A transfer is fraudulent as to a creditor, whether the creditor's claim arose before or within a reasonable time after the transfer, if the debtor made the transfer with actual intent to hinder, delay or defraud any creditor.[473] Moreover, it is unethical for an attorney to assist or counsel a client to engage in conduct the attorney knows is fraudulent.[474]

Different rules appear to apply to transfers to qualify for public benefits for which there is no right of reimbursement to the governmental entity, in which case the provider is probably not a "creditor" under the laws governing fraudulent conveyances. In particular, refer to the Medicaid laws if the benefit sought is financed entirely by Medicaid. Under those laws, it is permissible to advise and assist in transfers to qualify for Medicaid.

XXI. LOCAL MEDICAL ASSISTANCE PROGRAMS & OTHER BENEFITS

The following is a short summary of miscellaneous benefits not discussed above.

A. Local Medical Assistance Programs

In some areas, there are medical programs providing physician care and other services to persons who "fall through the cracks" because they cannot afford medical care, do not have adequate insurance, and do not qualify for Medicaid or Medicare. For example, they may provide low-cost medications for Medicare beneficiaries and may be the only sources of medical assistance for those who have no Medicare, Medicaid or private health insurance. They can also be helpful in finding programs for clients, as they are trained to identify clients eligible for Medicaid and other major programs, to avoid use of limited local funds. Examples are the following:

Community Health Centers
Rebekah Baines Johnson Building
15 Waller Street, 5th Floor
Austin, Texas 78702
512-978-9000 http://www.communitycaretx.org/
http://communitycaretx.org/locations/
http://communitycaretx.org/about/
Indigent health care is also offered in Dallas through the Parkland HealthPLUS System: http://www.parklandhospital.com/patients_visitors/financial_services/parkland_healthplus.html.

For a wide array of public health services in Harris County (Houston), visit: http://www.hcphes.org/divisions_and_offices/disease_control_and_clinical_prevention/health_clinics/

[473] TEX. BUS. & COMM. CODE § 24.005(a).
[474] Texas Disciplinary Rules of Professional Conduct 1.02(c); 8.04(a)(3).

For a wide array of public health services in San Antonio, visit: http://www.sanantonio.gov/health/.

For a list of public health centers in Tarrant County (Arlington and Fort Worth), visit http://www.tarrantcounty.com/publichealth/cwp/browse.asp?a=3&bc=0&c=41170&publichealthNav=|.

These public health centers often offer only the basics, such as immunizations, but there are some exceptions.

Comment: Such programs vary greatly in their willingness to share eligibility information with prospective beneficiaries and their advocates. For example, representatives of the Austin-Travis County and Harris County MAP programs provided only partial and misleading information to the author in response to repeated informal requests for information. However, written requests under the Texas Open Records Act yielded their complete training and eligibility manuals. In contrast, they are reported to be generally fair and open to beneficiaries seeking their services. There may be a perception that advocates could create unsustainable demands on the very limited resources available, which in my view is a realistic concern. However, its proper resolution is in not in obscuring our clients' needs but rather in publicizing the woeful inadequacy of the assistance available, of which many politicians and members of the public apparently have little knowledge.

B. Emergency Room Assistance

Hospitals are required by Texas statute to provide emergency care to persons in need regardless of ability to pay. Although some individuals unfortunately utilize this as their sole source of medical assistance, it should be viewed as a last resort.

C. Indigent-Care Responsibilities of Hospitals

Under the federal Hill-Burton Act and other laws, hospitals are required to provide some services without compensation to indigent persons. Some such services are reimbursed indirectly under the Medicaid program's "Disproportionate Share Hospital Funds." These programs are of little use for planning purposes, as they are ordinarily utilized as payers of last resort when indigent patients have failed to respond to collection efforts.

D. Local Nonprofit Agencies

Many areas have private nonprofit agencies that assist persons with disabilities, often in situations in which they would otherwise "fall through the safety net." Although they often receive some funding from public agencies, their benefits are not usually "entitlements" in a legal sense. For a list of such agencies, contact your local Area Agency on Aging, Alzheimer's Association, Association for Retarded Citizens or similar organization serving persons with disabilities, women or other applicable group.

E. Property Tax Exemptions

Persons age 65 and over and individuals with disabilities are eligible for increased exemptions from property taxes on their homes. Homeowners age 65 and over are also entitled to a "school tax freeze." Both elderly (age 65 and over) and disabled Texans have the right to defer property taxes (at 8% interest) until after their lifetimes. More information is available at www.window.state.tx.us/taxinfo/proptax/exmptns.html and from your local tax appraisal district.

F. Unlisted Agencies & Benefits

This section is here primarily to emphasize that the benefits discussed above are not by any means all the benefits available to persons with disabilities, but only the major national programs. One of the lesser-known programs may offer just the help you or your client need, but only with diligent work and advocacy will you find it. In addition to the referral agencies named above, you may want to call the Texas Health & Human Services Commission, or one of the agencies under HHSC, Legal Aid, veterans' organizations or relevant advocacy groups.

Agencies and groups serving persons with disabilities truly form a "network." You can find almost anything available, no matter where you start, if you are persistent and diligent. And you will meet some very remarkable people on the way.

XXII. BREAST CANCER & CANCER CONTROL SERVICES AND THE TEXAS BREAST AND CERVICAL CANCER TREATMENT ACT

A. The Breast & Cervical Cancer Control Services (BCCCS)[475]

Women in need of breast and cervical cancer services may be eligible for services under this program. The program provides breast cancer services to women age 50-64, and cervical cancer services to women age 18-64 who have never or rarely been screened for cervical cancer. For both these categories of services, the income limits are at or below 200% of the federal poverty level and the women must not have any other source of payment (e.g., Medicaid or other insurance that would otherwise cover the services). There are no resource or asset restrictions.

There are, moreover, exceptions to these age limits, which can be found at 25 TAC §61.34.476 As a matter of practice, BCCCS providers limit use of the federal funds they receive to these age groups for screening purposes, but provide diagnostic services to a broader age range of women who have symptoms of cancer or questionable test results.

For further information and to locate a provider in the client's area, call (512) 458-7796 or visit: http://www.dshs.state.tx.us/bccscliniclocator.shtm .

[475] http://www.dshs.state.tx.us/bcccs/default.shtm.
[476] 25 T.A.C. § 61.34.

B. The Texas Breast and Cervical Cancer Treatment Act[477]

Some women who are diagnosed with breast or cervical cancer by the BCCCS may be eligible for Medicaid medical assistance under this Act.[478] To be eligible under the Treatment Act, a woman must: 1) be screened for breast or cervical cancer by a BCCCS provider and found to need treatment for either breast or cervical cancer; 2) not have other insurance coverage and not be otherwise eligible for Medicaid; 3) be under age 65; and 4) be a citizen or meet qualified alien status requirements.[479] (Note: Although there is a screening requirement by a BCCCS provider, these two programs are completely distinct and do not have the same eligibility requirements. As with all programs, the administering agency should be contacted for a full list of eligibility requirements and procedures.)

The application process is handled through a BCCCS provider, and there is no need for a face-to-face interview with a HHSC caseworker, even though HHSC makes the final eligibility determination. For further information and to locate a provider in the client's area, call (512) 458-7796 or visit: http://www.dshs.state.tx.us/bccscliniclocator.aspx

XXIII. TIPS FOR NEW ELDER LAW AND SPECIAL NEEDS PRACTITIONERS

A. Contact Information for Texas Health and Human Services Commission

Telephone Numbers

Benefits Information: 211

Hotline: 1 (800) 252-8263 or 1 (800) 633-4227

Fax: 1 (877) 447-2839

Long Term Care Ombudsman: 1 (800) 252-2412

Regional Legal Services:
Region 01 HHSC Legal Services: 1 (806) 783-6638
Region 03 HHSC Legal Services: 1 (972) 337-6127
Region 04 HHSC Legal Services: 1 (903) 509-5159
Region 05 HHSC Legal Services: 1 (713) 767-2371
Region 06 HHSC Legal Services: 1 (713) 767-2371
Region 08 HHSC Legal Services: 1 (210) 619-8158
Region 10 HHSC Legal Services: 1 (915) 834-7521

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477 http://www.dshs.state.tx.us/layouts/contentpage.aspx?pageid=29549&id=2361&terms=Texas+Breast+and+Cervical+Cancer+Treatment+Act, http://www.dshs.state.tx.us/bcccs/treatment.shtm.

478 1 T.A.C. Chapter 366.

479 1 T.A.C. § 366.407.

Region 11 HHSC Legal Services: 1 (956) 316-8322

Address to Submit Medicaid Application: P.O. Box 14200
Midland, Texas 79711-4200
Or send by fax to 877-447-2839 (in Midland)

For Contact information for Medicaid for the Elderly and People with Disabilities (MEPD) Management Teams by Region*:* See Appendix 7 or located online at http://www.dads.state.tx.us/handbooks/sph/appendix/III/index.htm

B. Tips for a Successful Medicaid Application

1. Frequently Asked Questions

Q. How is the Texas Health and Human Service Commission organized?
- See organizational chart in Appendix 8 or located online at http://www.hhsc.state.tx.us/about_hhsc/OrgChart/HHS_OrgChart.pdf

Q. Where do I go to get a Medicaid Application?
- Go to the Texas Health and Human Services handbook, Forms, H1200 found at http://www.dads.state.tx.us/forms/H1200/.

Q. What should I include in the application?
- Full copies of all documents (e.g. Power of Attorney, bank statements, contracts, etc.).
- Applicable MEPD sections. These sections can be found in the MEPD handbook located at http://www.dads.state.tx.us/handbooks/mepd/index.htm.
- Your own calculations of co-payments with details and supporting documentation.
- Explanations to questions you foresee being asked by a caseworker (e.g. missing paper work or discrepancies in documentations).
- A narrative of transfers made, including why a transfer was made, or if it is a transfer that is exempt from a penalty period for loss of eligibility. For other examples see Chapter I of the MEPD handbook, Transfer of Assets.

Q. Who should I contact to find out who the assigned caseworker is?
- 211.

Q. Who should I contact if I need additional help tracking down a caseworker?
- The Regional Legal Department.

Q. What should I do if I suspect co-pay was calculated incorrectly by the caseworker?
- Request the co-pay calculations used by the caseworker.

Q. Who can I contact if the caseworker is unresponsive to my questions?

- The Regional Manager's Office (the Regional Legal Services Office will be able to direct you to the appropriate office).

Q. What should I document during the application process?
- You should document all communications with the MEPD department.

Q. Who can I contact to answer any other general application questions I may have?
- 211.

C. Tips for Qualified Income Trusts (Miller Trusts)

1. Qualified Income Trust (QIT) Checklist

- Are all of the mandatory distributions (e.g. personal needs allowance, spousal allowance, medical assistance allowance, etc.) listed?

- Are there any modifications? No modifications are allowed.

- Is there a reversion clause?

- Is the document signed by both the settlor and the trustee?

- Are all sources of income listed in the body of the QIT?

- If a Power of Attorney (POA) is signing on behalf of the settlor, is the POA attached?

- If QIT is signed on behalf of the settlor, was the Power of Attorney established prior to the QIT or on the same day? It is important to have documentation that the Power of Attorney was granted before the QIT was signed.

XXIV. APPENDICES

Appendix 1: Benefit Eligibility Numbers

Medi*caid* & SSI
Dollar Amounts Effective as of January 1, 2015

	2014	2015
Medicaid Single Income/Mo.	$2,163	$2,199
Medicaid Couple Income/Mo.	$4,326	$4,398
SSI Single Income/Mo.	$721	$733
SSI Couple Income/Mo.	$1,082	$1,100
Protected Resource Amt. Min.	$23,448	$23,844
Protected Resource Amt. Max.*	$117,240	$119,220
Spousal Monthly Allowance	$2,931	$2,980.50
Gift Penalized**	$156.34/day	$156.34/day
Personal Needs Allowance	$60	$60
Maximum Residence Value (with exceptions)	$543,000	$552,000

*When combined incomes of both spouses are below the Spousal Monthly Allowance, the Community Spouse can usually keep more than the Protected Resource Amount Maximum.

**For case actions before 9/1/13, the divisor is $142.92/day; on or after 9/1/13 it is $156.34/day.

Medi*care* & Social Security & VA
Dollar Amounts Effective as of January 1, 2015*

	2014	2015
Part A Premium/Mo.[480]	$441	$426
Part B Premium/Mo.[481]	$104.90	$104.90
Skilled Nursing Facility Copayment	$152.00	$157.50
Hospital Stay (Part A) Deductible	$1,216	$1,260
Hospital Copayment, Days 61-90	$304	$315
Hospital Copayment, Days 91-150	$608	$630
Part B (Medical) Annual Deductible	$147	$147
QMB max income single (gross incl. $20 exempt amt)	$993*	$993*
QMB max income couple (gross incl. $20 exempt amt)	$1,333*	$1,333*
SLMB max income single (gross incl. $20 exempt amt)	$1,187*	$1,187*
SLMB max couple (gross incl. $20 exempt amt)	$1,593*	$1,593*
QI-1 max income single (gross incl. $20 exempt amt)	$1,333*	$1,333*
QI-1 max income couple (gross incl. $20 exempt amt)	$1,790*	$1,790*
QDWI max income single (gross incl. $20 exempt amt)	$1,965*	$1,965*
QDWI max income couple (gross incl. $20 exempt amt)	$2,642*	$2,642*
"Substantial Gainful Activity" (Non-Blind)	$1,040	$1,090
Max Earnings Taxed for SS	$117,000	$118,500
Retirement Test Earnings/Yr, Under 65	$15,480	$15,720
Retirement Test Earnings in 1st Yr of Full Retirement Age**	$40,400	$41,880
Quarterly earnings for 1 Social Security credit	$1,200	$1,220
VA Pension With "Aid & Attendance"—Married	$2, 085	$2,120
VA Pension With "Aid & Attendance"--Unmarried Vet	$1,758	$1,789
VA Pension With "Aid & Attendance"--Widow(er)	$1,130	$1,149

VA Pension that is A&A (not counted by Medicaid) in 2015: $716/mo. (or for surviving spouse, $430/mo.)

*Numbers with * effective 3/1/2014 to 2/28/2015 (dependent on Federal Poverty Guidelines)

**Full Retirement = 65 and 10 months if born in 1942 or age 66 if born in 1943-1954. Full retirement age will gradually increase to age 67 for those born in 1960 and later.

2014 Social Security & VA Cost of Living Allowance (COLA): 1.5%; 2015 COLA: 1.7%

[480] 99% of Social Security beneficiaries have sufficient Medicare covered quarters that they pay no Part A premium.

[481] The Part B premium is more for those with over $85,000 income (individual return) or $170,000 (joint return).

FEDERAL POVERTY GUIDELINES 2014-2015 Excluding Alaska & Hawaii

Family Size	100% Annual	100% Monthly	120% Monthly	133% Monthly	135% Monthly	150% Monthly	158% Monthly	185% Monthly	200% Monthly	300% Monthly
1	$11,670	$973	$1,167	$1,297	$1,313	$1,459	$1,537	$1,799	$1,945	$2,918
2	$15,730	$1,311	$1,573	$1,748	$1,770	$1,966	$2,071	$2,425	$2,622	$3,933
3	$19,790	$1,649	$1,979	$2,199	$2,226	$2,474	$2,606	$3,051	$3,298	$4,948
4	$23,850	$1,988	$2,385	$2,650	$2,683	$2,981	$3,140	$3,677	$3,975	$5,963
5	$27,910	$2,326	$2,791	$3,101	$3,140	$3,489	$3,675	$4,303	$4,652	$6,978
6	$31,970	$2,664	$3,197	$3,552	$3,597	$3,996	$4,209	$4,929	$5,328	$7,993
7	$36,030	$3,003	$3,603	$4,003	$4,053	$4,504	$4,744	$5,555	$6,005	$9,008
8	$40,090	$3,341	$4,009	$4,454	$4,510	$5,011	$5,279	$6,181	$6,682	$10,023
Each										
Add'l:	$4,060	$338	$406	$451	$457	$508	$535	$626	$677	$1,015

Programs with Poverty-Level-Related Income Limits
(*Above amounts effective 3/1/14-2/28/15*. Multiples of poverty level income are rounded in Excel. Agencies may round differently, creating a difference of $1.00 one way or the other in actual income limits.)

QMB:*	100% of poverty + $20 ($7,160 resources unmarried, $10,750 married)
SLMB:*	120% of poverty + $20 ($7,160 resources unmarried, $10,750 married)
QI-1*	135% of poverty +$20 ($7,160 resources unmarried, $10,750 married)
QDWI*	200% of poverty + $20 ($4,0000 resources unmarried, $6,000 married)
Part D Full Sub.*	135% of poverty + $20 ($8,580 resources unmarried, $13,620 married)
Part D Other*	150% of poverty + $20 ($13,300 resources unmarried, $26,580 married)
MERP Waiver	300% of poverty (up to $100,000 tax appraised residence value, for shares of low-income descendants)
CPWUnder 1**	194.25% of poverty (185% FPL plus 5% income disregard) (No resource limit effective 01/01/2014)
CPW Preg W**	194.25% of poverty (185% FPL plus 5% income disregard) (no resource limit)
CPW 1-18**	139.65% of poverty (133% FPL plus 5% income disregard) (No resource limit effective 01/01/2014)
CHIP 1-18**	210% of poverty (200% FPL plus 5% income disregard) (No resource limit effective 01/01/2014)

***The following "methodology" applies to the programs marked * above (but not to the others, which do not allow the same income "disregards" and have different "resource" definitions):**

"Income" is defined the same as under the SSI program, except for the Part D programs, for which in-kind support and maintenance (food and shelter supplied in kind) are not counted. All the SSI income "disregards" apply: $20 per month of any income, $65 per month of earned income, half of the rest of earned income, etc. Therefore, numbers in the table can safely be increased by $20 in every case; and if there is earned income, only half the amount over $65 is countable.

"Resources" (countable assets) are defined the same as for the SSI program, except as follows for the Part D programs: (a) any life insurance policy is excluded, and (b) only "liquid" assets and non-exempt real estate are counted.

***CPW = Children & Pregnant Women Medicaid**. Effective 01/01/2014, Modified Adjusted Gross Income methodology applies to CPW Medicaid and CHIP; SSI methodology applies to the other programs as discussed at * above.

Appendix 2: How to Calculate "Pro Rata Share"

HOW TO CALCULATE A "PRO RATA SHARE" OF HOUSEHOLD EXPENSES

Applicants for certain "means-tested" benefits can sometimes qualify only if they pay their "pro rata share" of household expenses. Otherwise, some of the cost of their food and shelter is treated as "income" from someone else. Examples of programs that (in some cases) require payment of a "pro rata share" are Supplemental Security Income, Community Care, Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary and "extra help" Medicare Part D (prescription medications).

Annual cost to all household members of **food**	
Annual cost to all household members of **rent or mortgage payments***	
Annual cost to all household members of **mandatory homeowner fees****	
Annual cost to all household members of **property taxes**	
Annual cost to all household members of **heating fuel, gas & electricity**	
Annual cost to all household members of **water, sewerage & garbage**	
(The Texas Application lists phone expense. That is an error, so appeal if it matters.)	

1. Total annual household expenses (total of expenses listed above)	
2. Total monthly household expenses (above total divided by 12)	
3. Number of household members	
4. Pro rata share of monthly household expenses (Divide #2. above by #3. above)	

*Home insurance is included **only** if required by a lender.
**Such fees count to the extent they include other items listed.

Appendix 3: Sample Instructions for Trust Distributions

(Where Beneficiary is on SSI)

It is extremely important that you pay funds from the trust in such a way as to keep the beneficiary's "income" each month below the maximum for SSI eligibility. Presently, the maximum is $733 per month, and this changes every January 1. Call my office or the Social Security Administration in December every year to determine the new maximum effective January 1. Here is a summary of the principles you will need to apply:

Definition of "income": "Income" of the beneficiary includes (1) cash paid to the beneficiary, or "property easily converted to cash," and (2) payments to providers of food or shelter for the beneficiary. "Shelter" includes "room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection services." The first $65 per calendar month is excluded from *earned* income, and half of the rest of the beneficiary's earned income each month is likewise excluded.

What is *not* "income": You can make unlimited payments *directly to providers* of *anything other than food or shelter*. For example only, you can pay directly to providers for any of the following: automobile and other transportation expenses, such as insurance, gasoline and repairs; entertainment and educational expenses, such as cable TV, telephone, books and magazines, videos, etc.; personal services of all kinds, such as haircuts, therapy, etc.; and any medical expenses not paid by public benefits or insurance; and medical insurance. See below the list of distributions that would *not* be counted as "income."

Do not pay any "income" at all: Under the rules governing the SSI and nursing home Medicaid programs, any "income" the beneficiary receives, aside from certain limited deductions, reduces the amount of benefits dollar for dollar (in the case of SSI) or is supposed to be paid to the nursing home (in the case of nursing home Medicaid). Therefore, generally, there is no point in providing the beneficiary any cash, property that can be easily converted to cash, or payments for food or shelter. Remember, you can provide *anything else*, as long as you pay the provider directly.

An exception would be if you wanted to apply the Presumed Value Rule, under which you can provide unlimited food and shelter in exchange for having $264.33 per month count as "income." If that is the only countable income, the SSI monthly benefit will be reduced by $244 to $489.00 (because $20 of any income does not count).

Examples of Distributions from a Supplemental Needs Trust
Not Counted as "Income" by SSI and Medicaid

1. Dental, ophthalmic, or auditory care, diagnostic work or other medical treatment for which there are not funds available, including plastic surgery or other non-essential medical procedures.

2. Private rehabilitative training and physical therapy.

3. Supplemental nursing care and similar care that assistance programs may not otherwise provide.

4. Personal attendant care.

5. Companion care, companions for travel, reading, driving, and cultural experiences.

6. Payments to bring beneficiary's relatives or friends for visitation and to accompany beneficiary on periodic outings and vacations, and travel in the event that the trustee deems such expenditures appropriate and reasonable.

7. Therapies or supplies to provide tactile stimulation, holistic, herbal, or other alternative therapies or services.

8. Special equipment such as an electric wheelchair or other supportive device, and a specially equipped van or other vehicle for transportation.

9. Programs for training, education, and social, recreational, and entertainment opportunities.

10. Books, magazines, musical instruments, recreational equipment, games, & crafts.

11. Telephone, television, radio, & cable service.

12. Clothing

13. Advocacy and legal services.

Source: The Arc of Texas Master Pooled Trust

Appendix 4: Limits on Eligibility of Aliens for Public Benefits in Texas

See next page for definitions of alien classifications (A-D) and types of benefits (1-3)

Classification of Alien	Emergency Benefits (1)	"Resident-Alien-Only" (2)	SSI	Food Stamps	TANF	Medicaid	Soc. Svc. Block Grants (3)
I. "Qualified" (A), entered U.S. before 8/22/96, with either "SS status" (B) or "veteran status" (C)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
II. "Qualified" (A), entered U.S. before 8/22/96, with "refugee status" (D)	Yes	Yes	Yes	Benefits 5 Years Only	Benefits 5 Years, (then state option)	SSI-Linked; Otherwise, Benefits 7 Years, Then State Option	Benefits 5 Years, Then State Option
III. "Qualified" (A), entered U.S. before 8/22/96, *not* "refugee status" (D)	Yes	Yes	Yes	Only if disability, or age 65 on 8/22/96	State Option (Yes in Texas)	SSI-Linked; Otherwise, State Option (Yes in Texas)	State Option
IV. "Qualified" (A), entered U.S. on or after 8/22/96, with *either* "SS status" (B) *or* "veteran status" (C)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
V. "Qualified" (A), entered U.S. on or after 8/22/96, with "refugee status" (D)	Yes	Yes	Benefits 7 Years, (then ineligible if not citizen)	Benefits 5 Years, (then ineligible if not citizen)	Benefits 5 Years (then state option)	SSI-Linked; Otherwise, Benefits 7 Years (then state option)	Benefits 5 Years (then state option)
VI. "Qualified" (A), entered U.S. on or after 8/22/96, no special status	Yes	Yes	No	No	Ineligible 5 Yrs (then state option)	SSI-Linked; Otherwise, Ineligible 5 Yrs (then state option)	Ineligible 5 Yrs (then state option)
VII. *Not* "Qualified" (A)	Yes	No	No	No	No	No	No

Definitions Pertaining to Classifications of Aliens	Definitions Pertaining to Types of Benefits
A. "Qualified Alien": any alien who is lawfully admitted for permanent residence is a "qualified alien." The term also applies to the following classes of aliens lawfully present in the U.S.: asylees, refugees, those paroled into the U.S. for at least one year, certain aliens whose deportation is being withheld, and certain aliens granted conditional entry. 8 U.S.C. § 431. The term is somewhat misleading, because "qualified aliens" are *dis*qualified for many benefits unless additional requirements are met. **B. "SS Status":** lawfully admitted for permanent residence; and has worked 40 qualifying quarters of coverage as defined by the Social Security Act or can be credited with such coverage; and, with respect to any qualifying quarter for any period after December 31, 1996, did not receive any federal means-tested benefit. 8 U.S.C. § 1612(a)(2)(B). **C. "Veteran Status":** (a) an honorably discharged veteran who is an alien and who fulfills the active service requirements of 38 U.S.C. § 5303A(d); (b) an alien on active duty in the U.S. armed forces; or (c) the spouse, unremarried surviving spouse, or unmarried dependent child of an alien in category (a) or (b). **D. "Refugee Status":** certain aliens admitted as refugees, asylees, whose deportation is withheld, Cuban and Haitian entrants, and Amerasian immigrants. 8 U.S.C. § 1612 (a)(2)(A), §1612(b)(2)(A), § 1613(b)(1).	**1. "Emergency Benefits":** The federal law would allow Texas to provide the following: (a) Medicaid benefits for an emergency medical condition other than organ transplant, if Medicaid requirements are otherwise met, other than the requirement for SSI eligibility; (b) short-term, non-cash, in-kind emergency disaster relief; (c) public health (non-Medicaid) immunizations for communicable diseases and testing and treatment for symptoms of such diseases; (d) community-level, in-kind, non-means-tested services that are necessary for the protection of life or safety, as designated by the Attorney General; (e) certain HUD programs, to the extent the alien was receiving such benefits on 8/22/96; (f) Title II Social Security benefits to an lien lawfully present in the U.S., if the alien is entitled to the benefit under an international agreement, or under Title II if the application was filed in or before August, 1996; (g) Medicare Part A benefits payable to an alien lawfully resident in the U.S., who was authorized to be employed with respect to the wages on which benefits are based; and (h) railroad retirement benefits payable to an alien lawfully present in the U.S. or residing outside the U.S. 8 U.S.C. § 1611(b). Of the permissible benefits listed above, the author has been able to confirm that Texas offers only emergency medical treatment, limited to persons who would be eligible for Medically Needy or SSI-related Medicaid but for their alien status (discussed on page 133). **2. "Resident-Alien-Only Benefits":** (a) National School Lunch Act benefits; (b) Child Nutrition Act of 1966 benefits; (c) foster care and adoption assistance, if the foster or adoptive parent(s) is/are qualified alien(s); (d) certain programs of student assistance under the Higher Education Act of 1965; (e) Head Start benefits; (f) Job Training Partnership Act benefits. 8 U.S.C. § 1612(b)(3)(B). **3. "Soc. Svc. Block Grants":** the program of block grants to states for social services under Title XX of the Social Security Act. 8 U.S.C. § 1112(b)(3)(B).

This chart is offered as an educational overview only and is not intended as legal advice to any person. Advice regarding eligibility of particular individuals for benefits should be given only after consulting all applicable laws, including without limitation 8 U.S.C. § 1611 *et seq.*; 1 T.A.C. § 358.203; and Medicaid Eligibility for the Elderly and People with Disabilities Handbook §§ A-2000-

Appendix 5: Sources of Free and Reduced Price Prescription Medications[482]

One should begin the search for discounted prescription drugs by contacting the pharmaceutical company that makes the medication needed by the client because they often have their own free or discounted prescription programs for consumers who cannot afford them.

These websites list participating companies and eligibility criteria for assistance in getting free or steeply discounted medications:

Screener for over 240 programs: www.benefitscheckup.org
Another screener (one of the first): www.needymeds.org
Pharmaceutical Research and Manufacturers of America: www.phrma.org
Centers for Medicare and Medicaid Services: http://www.medicare.gov/Pubs/pdf/10050.pdf
Government & private programs: www.medicarerights.org

These websites give information about lower-cost drug alternatives, cost cutting measures, drug comparison shopping information, and medication substitutes if your brand has no generic equivalent:
www.rxhope.com
www.rxoutreach.com
www.togetherrxaccess.com
www.merck.com/merckhelps/
www.needymeds.org
www.themedicineprogram.com
https://aarp.benefits.catamaranrx.com/rxpublic/portal/memberMain

These websites give price and product information about online drugstores:

www.destinationrx.com
www.riteaid.com
www.walgreens.com

Look for the VIPPS (Verified Internet Pharmacy Practice Sites) seal of approval from the National Association of Boards of Pharmacy when you go to a website. Always consult with your own doctor before making any changes.

Appendix 6: Selected Bibliography

[482] This is presented as a list of resources for evaluation by the reader. In particular, the reader should be alert to false or deceptive representations, issues of quality of products and legality of sales and marketing. The author has not personally evaluated the sites, their sponsors nor their products and makes no endorsement nor representation as to their quality, suitability or veracity.

The author has found the following resources particularly helpful for finding information on public benefits. Numerous other secondary resources are available, as are many other ways of finding the applicable statutes and regulations. Although the treatises focus on Elder Law, virtually all the same benefits are available to non-elderly persons with disabilities.

Treatises

Abshire, Farrell, Sitchler & Wright, TEXAS ELDER LAW (in West's Texas Practice Series).

Clifton B. Kruse, Jr., THIRD-PARTY AND SELF-CREATED TRUSTS, 3rd ed. (American Bar Association 2003). The most thorough and authoritative treatise on the law of supplemental needs trusts.

Harry S. Margolis, THE ELDERLAW PORTFOLIO SERIES (looseleaf, updated annually).

Judith A. Stein & Alfred J. Chiplin, Jr., MEDICARE HANDBOOK (updated annually).

Leslie Ann Barnett, et al., SPECIAL NEEDS TRUSTS: PLANNING, DRAFTING, AND ADMINISTRATION, Continuing Education of the Bar (California) (looseleaf, updated annually)

Matthew Bender, SOCIAL SECURITY PRACTICE GUIDE

Mezzulo & Woolpert, ADVISING THE ELDERLY CLIENT (Clark, Boardman Callahan, Looseleaf)

Regan, Morgan & English, TAX, ESTATE & FINANCIAL PLANNING FOR THE ELDERLY (Matthew Bender, Looseleaf).

Regan & Gilfix, Tax, ESTATE & FINANCIAL PLANNING FOR THE ELDERLY: FORMS & PRACTICE (Matthew Bender, Looseleaf).

THOMAS D. BEGLEY, JR. & JO-ANNE HERINA JEFFREYS, REPRESENTING THE ELDERLY CLIENT (Aspen Publishers, looseleaf). Comprehensive Elder Law treatise with both forms and text.

Thomas D. Begley, Jr. & Angela E. Canellos, SPECIAL NEEDS TRUSTS HANDBOOK (Aspen Publishers, looseleaf).

Thomas E. Bush, SOCIAL SECURITY DISABILITY PRACTICE (looseleaf, updated annually).
WEST GROUP, ESTATE & ELDER LAW ADVISOR (CD product with most state and federal statutes and rules, optionally included on the disk ADVISING THE ELDERLY CLIENT)

Internet Resources

Benefits finders & counseling services	www.govbenefits.gov www.benefitscheckup.org/ Automated benefit identification http://www.arcil.com/index.php/services/ (ARCIL Benefits Planning) http://www.dads.state.tx.us/services/listofservices.html (Texas Department of Aging and Disability Services) (Note: Certain services provided by DADS and the Area Agencies on Aging that relate to Medicare and other health insurance counseling must be provided to all Medicare beneficiaries regardless of age by virtue of federal funding. https://www.yourtexasbenefits.com/wps/portal
Children's Health Insurance Program	http://www.chipmedicaid.org/
Disability resources, federal	www.ssa.gov/disability/professionals/bluebook/ (SSD Evaluation)
Elder Law as a profession	www.naela.org
Elder Law information and links	www.elderlawanswers.com www.keln.org
Government agencies	www.hhsc.state.tx.us/ **(**Texas Health & Human Services Commission: Medicaid & other programs) http://www.dads.state.tx.us/news_info/publications/handbooks/index.html (publications, including Medicaid Eligibility Handbook) www.dads.state.tx.us (Texas Dept. of Aging and Disability Services) http://www.hhs.state.tx.us/ (Texas Dept. of Health and Human Services) www.dshs.state.tx.us (Texas Dept. of State Health Services) www.dars.state.tx.us (Texas Dept. of Assistive and Rehabilitative Services) www.dfps.state.tx.us (Texas Dept. of Family and Protective Services) www.seniors.gov (U.S. government websites for seniors) www.nih.gov/nia/ (National Institute on Aging) www.aoa.gov/ (U.S. Administration on Aging) http://www.hud.gov/groups/seniors.cfm (U.S. Dept. of HUD) www.hacanet.org/ (Housing Authority of the City of Austin) www.va.gov (Veterans Administration)
Health-related information generally	www.cdc.gov (including AIDS information) www.healthfinder.gov
Insurance, health	http://www.tdi.texas.gov/consumer/index.html (Texas Dept of Insurance consumer information) http://www.chipmedicaid.org/. (Children's Medicaid and the

	Children's Health Insurance Program) www.txhealthpool.com/benefits.html (Texas Health Insurance Risk Pool)
Law, Federal	http://www.loc.gov/law/help/statutes.php (federal statutes) www.gpoaccess.gov/cfr/index.html (federal regulations)
Law, Texas	http://info.sos.state.tx.us/pls/pub/readtac$ext.viewtac(Texas regulations) www.legis.state.tx.us/ (Texas statutes)
Legal resources, generally	www.texasbar.com(State Bar) www.tlsc.org (Texas Legal Services Center)
Medicaid and Medicare information	http://cms.hhs.gov (Medicare & Medicaid) www.medicare.gov (Medicare) www.dads.state.tx.us/handbooks/mepd/ (Medicaid Eligibility for the Elderly and People with Disabilities Handbook)
Organizations-Private	www.alz.org (Alzheimer's Association) www.aarp.org (American Assoc. of Retired Persons) www.caremanager.org (National Assn of Professional Geriatric Care Mgrs) www.arcil.com (ARCIL-disability assistance in Travis Co. area) www.thearcoftexas.org/ (The Arc of Texas-MR & DD) www.texashousingcounselor.org/ (Texas Housing Counselor) www.disabilityrightstx.org (Disability Rights Texas, formerly Advocacy, Inc. in Austin)
Probate	www.texasprobate.com
Social Security	www.ssa.gov/

Agency Manuals

The following agency manuals are just the most important of the many available at the DADS website at http://www.dads.state.tx.us/news_info/publications/handbooks/index.html#handbooks:

Medicaid Eligibility for the Elderly and People with Disabilities Handbook
Case Manager Community Based Alternatives Handbook
Community Care for Aged and Disabled Handbook
Nursing Facility Requirements for Licensure and Medicaid Certification Handbook
Fair and Fraud Hearings Handbook
Texas Works Handbook
Star Plus Handbook

Appendix 7: Medicaid for the Elderly and People with Disabilities (MEPD) Managers and Supervisors

HHSC-MEPD Management Team Contact Information by Region

Region/County Area of Responsibility	Medicaid for the Elderly and People with Disabilities Management Team		Administrative Assistant
Region 01 High Plains: Armstrong, Bailey, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Crosby, Dallam, Deaf Smith, Dickens, Donley, Floyd, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher, Terry, Wheeler, Yoakum **Region 02 Northwest Texas**: Archer, Baylor, Brown, Callahan, Clay, Coleman, Comanche, Cottle, Eastland, Fisher, Foard, Hardeman, Haskell, Jack, Jones, Kent, Knox, Mitchell, Montague, Nolan, Runnels, Scurry, Shackelford, Stonewall, Stephens, Taylor, Throckmorton, Wichita, Wilbarger, Young **Region 09 West Texas**: Andrews, Borden, Coke, Concho, Crane, Crockett, Dawson, Ector, Gaines, Glasscock, Howard, Irion, Kimble, Loving, Martin, Mason, McCulloch, Menard, Midland, Pecos, Reagan, Reeves, Schleicher, Sterling, Sutton, Terrell, Tom Green, Upton, Ward, Winkler	Stephen Moseley 622 S. Oakes St., Suite E1 San Angelo 76903	Phone: 325-659-7908 Fax: 325-659-7939 Cell: 325-232-1221 Mail Code: 277-7	Ida Perez 325-659-7919
Region 03 Metroplex: Collin, Cooke, Dallas, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, Wise	Daphne Shaw 801 West Freeway #810 Grand Prairie 75051	Phone: 972-647-3011 Fax: 972-337-6303 Cell: 214-729-8216 Mail Code: 012-5	Tamara Beck 972-647-3009
Region 04 Upper East Texas: Anderson, Bowie, Camp, Cass, Cherokee, Delta, Franklin, Gregg, Harrison, Henderson, Hopkins, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Upshur, Van Zandt, Wood **Region 05 Southeast Texas**: Angelina, Hardin, Houston, Jasper, Jefferson, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity, Tyler	Carolyn Deauman 111 NW Loop 304 Crockett 75835	Phone: 936-544-2123, x235 Fax: 936-544-5295 Cell: 936-577-4640 Mail Code: 081-8	Kathy Henderson 936-544-2123, x236
Region 06 Gulf Coast: Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Harris, Liberty, Matagorda, Montgomery, Walker, Waller, Wharton	Diane Hall 5425 Polk St., Suite 210 Houston 77023	Phone: 713-767-2454 Fax: 713-767-2477 Cell: 713-305-1946 Mail Code: 173-8	Martina Mendiola 713-767-2266
Region 07 Central Texas: Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Coryell, Falls, Fayette, Freestone, Grimes, Hamilton, Hays, Hill, Lampasas, Lee, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Travis, Washington, Williamson	Charlene Sparks 3000 E. Villa Maria Bryan 77803	Phone: 979-776-7478 Fax: 979-776-7445 Cell: 512-963-7236 Mail Code: 733-1	John Grizzaffi 979-776-7420

Region 08 Upper South Texas: Atascosa, Bandera, Bexar, Calhoun, Comal, Dewitt, Dimmit, Edwards, Frio, Gillespie, Goliad, Gonzales, Guadalupe	Philip V. Jones 11307 Roszell San Antonio 78217	Phone: 210-619-8043 Fax: 210-871-6432 Cell: 512-484-6394 Mail Code: 279-4	Asonja Thomas 210-619-8042
Region 10 Upper Rio Grande: Brewster, Culberson, El Paso, Hudspeth, Jeff Davis, Presidio	Isela Ortiz 5150 El Paso Dr. El Paso 79905	Phone: 915-775-4520 Fax: 915-775-4446 Cell: 903-780-0890 Mail Code: 111-7	Patricia Chavira 915-775-4477
Region 11 Lower South Texas: Aransas, Bee, Brooks, Cameron, Duval, Hidalgo, Jim Hogg, Jim Wells, Kennedy, Kleberg, Live Oak, McMullen, Nueces, Refugio, San Patricio, Starr, Webb, Willacy, Zapata	Steven Esteban Covarrubia 2520 N. Closner Edinburg 78539	Phone: 956-316-8471 Fax: 956-316-8561 Cell: 956-286-0115 Mail Code: 108-6	Irma Gonzalez 956-316-8470
Tiers and CCC Statewide	Brenda Hellie 4105 Victory Dr. Marshall 75672	Phone: 903-927-0233 Fax: 903-927-0249 Cell: 903-472-2750 Mail Code: 227-1	Teresa Grubbs 903-927-0283
Lead Program Manager: **Oversight for Regions 01, 02, 06, 07, 08 and 09**	David Pfleeger 1545 W. Mockingbird Lane, Suite 2000 Dallas 75235	Phone: 214-819-6773 Fax: 214-819-6724 Cell: 214-563-3669 Mail Code: 088-9	Lisa Harris 214-819-6787
Lead Program Manager: **Oversight for Regions 03, 04, 05, 10, 11, Tiers and CCC**	Gloria Robinson 330 E. Spring St., Suite D Palestine 75801	Phone: 903-661-6176 Fax: 903-723-1169 Cell: 903-269-7872 Mail Code: 254-1	Bonnie Oliva 903-661-6170
Regional Director Statewide	Janis Ambs – Regional Director 801 West Freeway, Suite 240 Grand Prairie 75051	Phone: 972-337-6193 Fax: 972-647-3013 Cell: 817-879-1589 Mail Code: 012-5	Marty Stalewski 972-337-6166

REGION	UNIT	MEPD SUPERVISORS		CLERK IV / WORKER III
1	10	Cheryl Meinzer 5806 34th Street Lubbock 79407	Phone 806-791-7513 Fax 806-791-7537 Mail Code 217-3	Stephanie Reed 806-791-7527 Priscilla Ross 806-791-7520 Ruby Mendez 806-791-7514
1	11	Becky Lacy 28 Western Plaza Drive Amarillo 79109	Phone 806-457-5301 Fax 806-457-5235 Mail Code 005-2	Shonda Ledbetter 806-457-5316 Jovita Hernandez 806-457-5302 Paula Chavez 806-647-4904
2/9	19	Melinda (Mindy) Wright 3016 Kermit Highway Odessa 79764	Phone 432-334-5179 Fax 432-334-5604 Mail Code 250-3	Selena Rodriguez 432-334-5173 Christina Lopez 432-686-2248
2/9	20	Judi Beagle 622 South Oakes Suite E-1 San Angelo 76903	Phone 325-659-7947 Fax 325-659-7939 Cell 325-262-2206 Mail Code 277-7	Vacant 325-659-7936 Tammye Cloyd 325-643-7017
2/9	25	Jana Norville 115 West Morris Street P.O. Box 792 Seymour 76380	Phone 940-888-8014 Fax 940-888-3364 Cell 940-704-1542 Mail Code 296-1	Sara Parker Decker 940-888-8013 Carrie Oakley 940-720-8489 Jennifer Henricks 940-888-8014
3	6 OWP	Lori Beck 801 South State Highway 161 Suite 810 Grand Prairie 75051	Phone 972-337-6134 Fax 972-647-5428 Mail Code 012-5	Patsy Chandler 972-337-6180 Shellie Palmore-Guedry 972-337-6306
3	7 OWP	QuaShauna Conner (Acting Supervisor) 801 South State Highway 161 Suite 810 Grand Prairie 75051	Phone 972-337-6255 Fax 972-647-5428 Mail Code 012-5	Michelle Clemons 972-647-3009 QuaShauna Conner 972-337-6255
3	11	Mary Farris 1501 Circle Drive Suite 110 Fort Worth 76119	Phone 817-321-8119 Fax 817-321-8900 Mail Code 128-9	Laura Dean 817-321-8020 Jenice Foucher 817-321-8120 Deana Griffin 940-320-5725
3	12	Yolanda Ramirez 1540 New York Avenue Arlington 76010	Phone 817-462-3975 Fax 817-462-3929 Mail Code 012-6	Vacant 817-462-3944 Doris Glover 817-462-3941
3	13	Ramona Short 2220 Mall Circle Fort Worth 76116	Phone 817-740-6270 Fax 817-624-7306 Mail Code 128-3	Carol Gray 817-740-6233 Yvonne Rosalez 817-740-6307
3	20	Claudia Ray 204 Kimberly Drive Cleburne 76031	Phone 817-648-7938 Fax 817-648-7909 Mail Code 063-3	Tina Pierce 817-648-7944 Kimberly Knieper 817-648-7937

REGION	UNIT	MEPD SUPERVISORS		CLERK IV / WORKER III
3	22	Justin Reeves 5455 Blair Road Dallas 75231	Phone 214-239-6262 Fax 214-750-1939 Mail Code 088-2	Karen Sneed 214-239-6260 Walter Hadnot 214-239-6261 Jinu Joseph 214-239-6247
3	26	Marcella Spohn 2001 Loy Lake Road Suite D Sherman 75090	Phone 903-892-7853 Fax 903-870-5302 Mail Code 298-7	Jennifer Manry 903-892-7846 Angela Hightower 903-892-7857
3	28 OWP	Teresa Hamilton 801 South State Highway 161 Suite 810 Grand Prairie 75051	Phone 972-337-6144 Fax 972-647-5428 Mail Code 012-5	Lekia Carson 972-337-6354 Calantha Cyrus 972-795-6506
3	29	Stephanie Lee 1545 West Mockingbird Lane Suite 2000 Dallas 75235	Phone 214-819-6779 Fax 214-819-6730 Mail Code 088-9	Bernadette Hunter 214-819-6752 Janet McClain 214-819-6765 Cassandra Thompson 214-302-4237
4	12	Rickie Humphrey 101 West Baker Street Athens 75751	Phone 903-677-9215 Fax 903-677-9248 Mail Code 014-1	Kim Jaeger 903-677-9247 Lou Ann Sanders 903-677-9207
4	13	Michelle Davis 1400 College Street Sulphur Springs 75482	Phone 903-439-9224 Fax 903-439-9216 Mail Code 305-3	Frieda Meadows 903-439-9212 Deana Parks 903-439-9222
4	14	Shawna Franklin 502 East Pine Jacksonville 75766	Phone 903-589-2223 Fax 903-589-2246 Mail Code 185-1	Delia Torres 903-589-2203 Sandra Allen 903-655-6235
4	15	Charlotte Key-Jackson 3303 Mineola Highway Tyler 75702	Phone 903-533-4499 Fax 903-533-4310 Mail Code 313-7	Melissa McCann 903-533-4326 Yvonne Ray 903-533-4421
5	10	Dee Hall 3105 Executive Boulevard Beaumont 77705	Phone 409-730-1784 Fax 409-730-1872 Mail Code 029-1	Cheryl Culbreath 409-730-1781 Jackie Weatherspoon 409-383-5532
5	11	Felicia Stanfield 2614 Northwest Stallings Drive Nacogdoches 75963	Phone 936-569-4975 Fax 936-569-4997 Mail Code 244-1	Vacant 936-569-4928 Patty Gondron-Groover 936-569-4967
6 Hackett	10	Shelia Howard-Carter 220 Meadowfern Suite 158 Houston 77067	Phone 281-775-7985 Fax 281-775-7971 Mail Code 176-6	Deborah Green 281-775-7983 Ruthia Moss 281-775-7986
6 Ikpeme	12	Ruth Sherman 117 Lane Drive Suite 50 Rosenberg 77471	Phone 281-344-3433 Fax 281-344-3507 Mail Code 270-7	Mabel DeLeon 281-344-3447 Debbie Nemec 979-282-6511
6 Hackett	15	Prescilla Alexander 1425 East 40th Street Houston 77022	Phone 713-699-6038 Fax 713-696-7178 Mail Code 173-2	Ellen Balthazar 713-696-8024 Vance Miller-Louis 713-696-3614

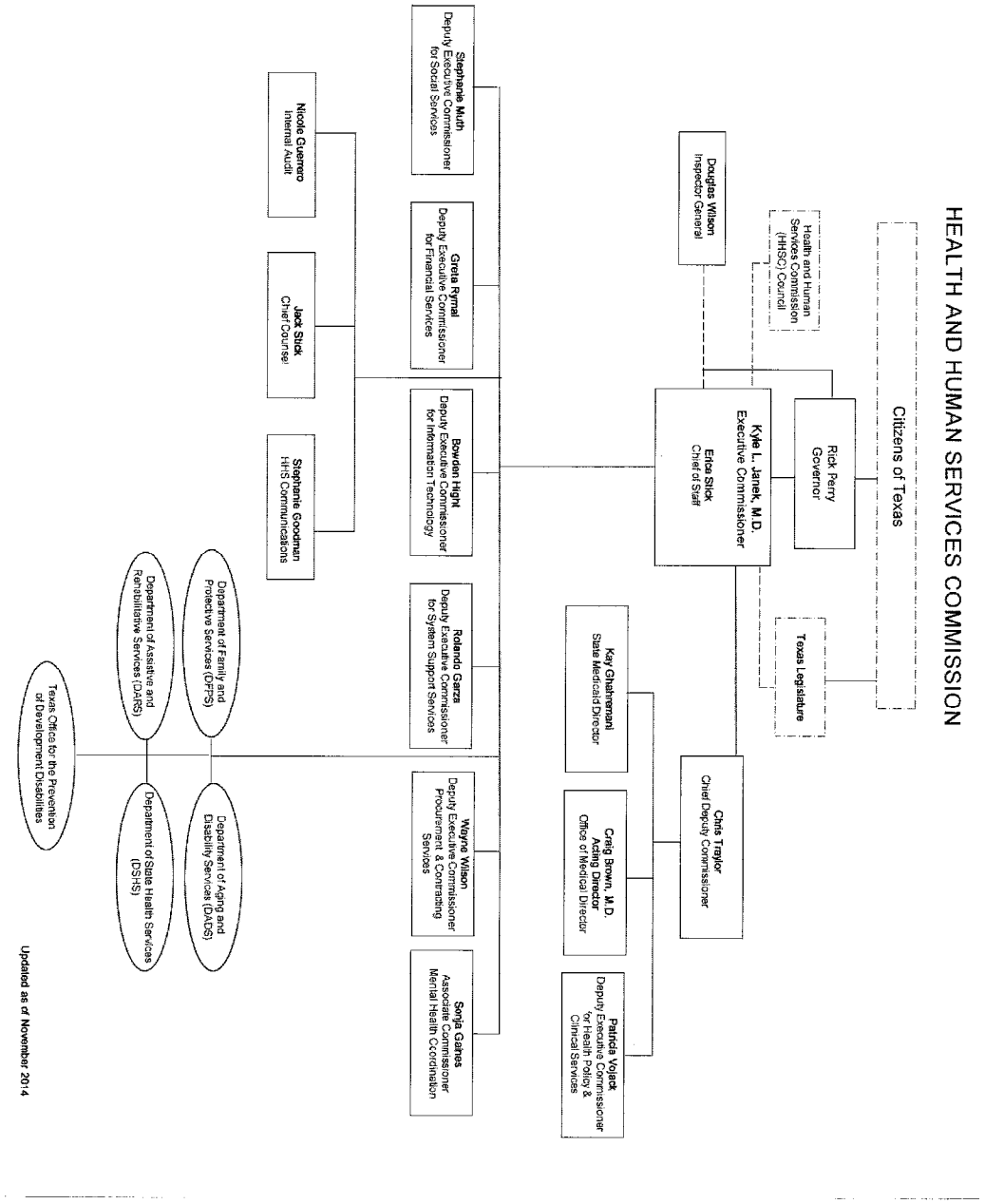
REGION	UNIT	MEPD SUPERVISORS		CLERK IV / WORKER III
6 Hackett	16	Nessia Hall 10202 I-10 East Freeway Houston 77029	Phone 713-671-8889 Fax 713-671-8836 Mail Code 173-6	Blanca Sanchez 713-671-8894 Evette Gardner 713-671-8862
6 Nieuwenhuis	17	Dan Gonzalez 608 North Loop 336 East Conroe 77301	Phone 936-760-4811 Fax 936-760-4707 Cell 936-828-1861 Mail Code 071-1	Valerie Braxton 936-336-4812 Kim Rogers 936-336-4809
6 Ikpeme	18	Mary Grear 489 This Way Lake Jackson 77566	Phone 979-266-3542 Fax 979-266-3551 Cell 979-583-8098 Mail Code 133-1	Elaine Kemp 979-266-3541 Phyllis Petrosky 979-241-3138
6 Hackett	26	Evelyn Durden 1425 East 40th Street Houston 77022	Phone 713-696-7182 Fax 713-696-7178 Mail Code 173-2	Verlisia Harris 713-696-7180 Tanya Coleman 713-696-7104
6 Ikpeme	11 OWP	Karen Mayfield 1425 East 40th Street Houston 77022	Phone 713-696-7129 Fax 713-696-7198 Mail Code 173-2	Monique Benjamin 713-696-3620 Amy Jones 713-735-8962
7	21 OWP	Rhonda Webb 4501 South General Bruce Drive Suite 25 Temple 76502	Phone 254-770-2632 Fax 254-770-2697 Cell 512-968-1759 Mail Code 928-1	Mayra Ayala 254-770-2694 Amanda Luning 254-770-2646
7	22	Rheana Jennings 939 Industrial Boulevard Mexia 76667	Phone 254-562-4229 Fax 254-562-4292 Mail Code 234-1 Cell 512-788-0974	Katie Eason 254-435-6761 Phyllis Landers 254-562-4237
7 includes Bellville Columbus Hempstead	23	Amanda Hart 228 North Main LaGrange 78945	Phone 979-968-4657 Fax 979-968-8968 Cell 254-247-6892 Mail Code 199-1	Darlene Jenke 979-968-4658 Meredith Wehring 979-865-7214
7	24	Kristi Hoida 801 Austin Avenue Suite 520 Waco 76701	Phone 254-750-9242 Fax 254-750-9381 Cell 254-495-6845 Mail Code 942-1	Christina Wafer 254-750-9650 Laurie Taylor 254-750-9394
7	25	Caron Kuo 4501 South General Bruce Drive Suite 25 Temple 76502	Phone 254-770-2679 Fax 254-770-2697 CELL 512-540-2937 Mail Code 733-1	Cassie Borgardts 254-770-2628 Wrenda Mankowski 512-556-4322
7	26	Marie Almaraz 1600 Sara DeWitt Street Suite 200 Gonzales 78629	Phone 830-672-8435 Fax 830-672-9247 Cell 512-983-3047 Mail Code 152-1	Monica Arredondo 830-672-8457 Vacant
7	27	Janice Becker P.O. Box 479 Giddings 78942	Phone 979-540-3662 Fax 979-540-3649 Cell 979-540-9228 Mail Code 146-4	Lynnette Wiederhold 979-540-3668 Debbie Russell 979-731-0125
7	28	Bridgette McEntire 10205 North Lamar Suite 2007 Austin 78753	Phone 512-908-8223 Fax 512-908-8100 Mail Code 209-4	Shirley Toungate 512-908-8206 Richard “Brett” Scott 512-753-2262

REGION	UNIT	MEPD SUPERVISORS		CLERK IV / WORKER III
8	3	Sonya Barrera-Medrano 410 Carter Hondo 78861	Phone 830-426-7558 Fax 830-426-7590 Mail Code 170-1	Jeannie Jasso 830-426-7555 Esmeralda Sulaica 830-374-1011
8	50	Margaret (Christine) Cervera 2534 Castroville Road San Antonio 78237	Phone 210-431-2352 Fax 210-431-2364 Cell 210-289-8099 Mail Code 281-1	Monica Brinegar 210-431-2300 Joe C. Nieto 361-574-7440
8	51	Dan (Scott) Carter 109 Windy Meadows Drive Schertz 78154	Phone 210-945-1550 Fax 210-945-1589 Mail Code 237-1	Gloria Ray 210-945-1560 Veronica Martinez 210-945-1551
8	52	Martha Valdez 3411 Horal San Antonio 78227	Phone 210-475-4579 Fax 210-475-4510 Cell 210-279-9420 Mail Code 905-1	Yolanda Montez 210-475-4587 Aurora (Dora) Hernandez 210-475-4553
8	54	Charles (Rob) Hill 109 Windy Meadows Drive Schertz 78154	Phone 210-945-1561 Fax 210-945-1588 Mail Code 237-1	Jerry Sue Perez 210-945-1570 Amber Satzer 210-945-1562
8	81	Helen Maldonado 2534 Castroville Road San Antonio 78237	Phone 210-431-2353 Fax 210-431-2364 Cell 210-414-7372 Mail Code 281-1	Dorothy Wilson 210-431-8778 Haydee Ramirez 210-431-2339
10	14	Paula Roberts 5150 El Paso Drive El Paso 79905	Phone 915-775-4412 Fax 915-775-4446 Mail Code 111-7	Gloria Sanchez 915-775-4529 Johnny Rodriguez 915-775-4439
10	16	Stephanie Badillo 5150 El Paso Drive El Paso 79905	Phone 915-775-4419 Fax 915-775-4446 Mail Code 111-7	Jennifer Carr 915-775-4465 Tony Licon 915-775-4503
10	18	Yolanda Enriquez 5150 El Paso Drive El Paso 79905	Phone 915-775-4470 Fax 915-775-4482 Mail Code 111-7	Rosa Montelongo 915-775-4472 Theresa Sierra-Reveles 915-775-4570
10	19	Lourdes Guerra 5150 El Paso Drive El Paso 79905	Phone 915-775-4581 Fax 915-775-4446 Mail Code 111-7	Denise Bernal-Partida 915-775-4456 Isabel Chavez 915-775-4417
11 Scheffer	7	Yvonne Paul 5155 Flynn Parkway Corpus Christi 78411	Phone 361-878-3301 Fax 361-878-3397 Mail Code 073-4	Beverly Gearin 361-878-3340 Richard Varnell 361-878-3305 Eliza Saenz 361-878-3302
11 Scheffer	14	Lucy Montero-Perez 202 West 2nd Street Mercedes 78570	Phone 956-565-7333 Fax 956-565-7330 Mail Code 232-1	Arlena Salazar 956-565-7354 Norma Fuentes 956-565-7334
11 Scheffer	15	Grace Garza 408 North Flournoy Road Alice 78332	Phone 361-660-2218 Fax 361-660-2294 Mail Code 004-1	Connie Farias 361-660-2217 Lydia Cadena 361-660-2248

REGION	UNIT	MEPD SUPERVISORS		CLERK IV / WORKER III
11 Scheffer	16	Mary Gorena 4501 West Business Highway 83 McAllen 78501	Phone 956-971-1226 Fax 956-971-1297 Mail Code 222-2	Melva Kretchmer 956-971-1352 Juan F. Garza 956-971-1308
11 Vasquez	18	Adriana Gonzalez 8511 McPherson Laredo 78045	Phone 956-764-5270 Fax 956-764-5275 Mail Code 181-4	Edith Larralde 956-764-5251 Melinda Serna 956-764-5273
11 Scheffer	45	Blanca Guajardo 2520 North Closner Boulevard Edinburg 78541	Phone 956-316-8511 Fax 956-316-8476 Mail Code 108-6	Pearl Vega 956-316-8568 George Almanza 956-316-8494
11 Vasquez	46	Susie Zavala 801 North 13th Street, Suite 19 Harlingen 78550	Phone 956-412-4652 Fax 956-412-4680 Mail Code 160-4	Velma Osejo 956-412-4689 Arnold Deleon 956-412-4676 Martha Cruz 956-504-4303
11 Scheffer	47	Lionila (Liony) Villarreal 4410 Dillon Lane Suite 28 Corpus Christi 78411	Phone 361-878-7778 Fax 361-878-7645 Mail Code 028-1	Rose Valdez 361-878-7774 Irma Lerma 361-878-7770
11 Vasquez	48	Ana Castillo 8511 McPherson Road Laredo 78045	Phone 956-764-5260 Fax 956-764-5275 Mail Code 181-4	Edith Larralde 956-764-5251 Ivana Chaires 956-764-5259
11 Vasquez	49	Diana Cantu 3505 Boca Chica Boulevard Suite 300 Brownsville 78521	Phone 956-983-7641 Fax 956-983-7650 Mail Code 113-7	Christina Clinch 956-983-7625 Mary Trevino 956-983-7622
11 Vasquez	65	Sylvia Rodriguez 3505 Boca Chica Boulevard Suite 300 Brownsville 78521	Phone 956-983-7640 Fax 956-983-7628 Mail Code 113-7	Christina Clinch 956-983-7625 Lourdes Luna 956-983-7644
MBI MBIC	29	Julia Davis 3105 Executive Boulevard Beaumont 77705	Phone 409-730-1785 Fax 409-730-1873 Cell 409-504-8709 Mail Code 029-1	Linicia Humphrey 903-677-9206
MCCU		Deborah Elaine Mitchell 3105 Executive Boulevard Beaumont 77705	Phone 409-730-1783 Fax 409-730-1873 Mail Code 029-1	Traci Lafoy 254-562-4238 Rhonda Terry 903-581-9254

Revised 12/2/14

Appendix 8: Health and Human Services Commission Organizational Chart



HOT TOPICS IN MEDICAID 2015

Marilyn G. Miller
Christina Lesher
Lori Leu
Monica A. Benson
***based on a paper by**
H. Clyde Farrell & Christina Lesher

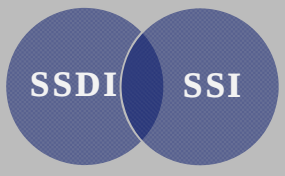
The Basics: SSDI & SSI

Social Security Disability Insurance (SSDI)

- Monthly cash benefit and Medicare
- Not Means Tested
- SSDI pages 62-64

Supplemental Security Income (SSI)

- Monthly cash benefit and Medicaid
- Means Tested
- SSI pages 20-57



Can be eligible for both

3

REGULAR ("COMMUNITY") MEDICAID"--ELIGIBILITY

- Now known as STAR + PLUS
- Medicaid linked to SSI & TANF
- Medicaid for children & pregnant women
- "Medically needy" Medicaid

- Pages 58-62

4

SOCIAL SECURITY DISABILITY

- Eligibility
  - Work history--usually 10 years
  - Disability--Permanent and total
  - NOT MEANS-TESTED
- Benefits
  - Monthly payments--amount depends on contributions while working
  - Medicare--usually 2 years 5 months after onset of disability

•Trusts & Transfers--Not Applicable
•Dual eligible SSI/SSDI
•Pages 62-64

5

MEDICARE ELIGIBILITY

- **At age 65:** Social Security Retirement & Railroad Retirement beneficiaries
- **Disabled:** SS & RRR *Disability* beneficiaries, usually after 24 months of income entitlement
- **Age 65 + Premium:** If not eligible for SS or RRB-- $407/mo. Part A + $104.90 Part B
- **Age 65+ w/QMB, SLMB, QI:** no premiums
- Page 64-71

6

COMMUNITY CARE (MEDICAID HOME CARE)

Benefits: attendant services at home, up to about 40 hours/week (depending on need)-usually much less

Eligibility:

- Income: $2,199/month, cannot use QIT if over income cap
- Resources: $2,000 single, $3,000 couple
- No transfer penalty
- Can bridge gap until client is on CBA.
- Not eligible for STAR + PLUS
- Page 77

7

Community Based Alternatives

- Now known as HCBS STAR + PLUS WAIVER
  - (aka Star+Plus Waiver, aka SPW)
  - Statewide as of 9/1/14
- Pays up to twice cost of nursing home care, for home care
- Same eligibility requirements as nursing home Medicaid
- Can use Miller Trust to reduce countable income
- Wait list can be up to 2 years
- Married couples: Spousal impoverishment provisions apply
- Single person: $2,000 in countable assets
- Can by-pass wait list by qualifying for nursing home Medicaid
- See also other "Waiver" programs in paper
- Page 80

8

"LONG TERM CARE" MEDICAID --FINANCIAL ELIGIBILITY

- Income: $2,199 individual, $4,398 couple (if both eligible)
- Resources:
  - $2,000 individual, $3,000 couple (both eligible)
  - Spouse at home can keep 1/2 assets, with $23,448 minimum & $117,240 maximum; or (usually) all assets if combined incomes under $2,931/month
  - Exemptions: Generally same as SSI
- STAR + PLUS (eff. 3/1/15)
- Pages 72-113

9

"LONG TERM CARE"/ STAR + PLUS MEDICAID --NON-FINANCIAL ELIGIBILITY

- "Medical Necessity"-- for Nursing Home & Community Based Alternatives
- Disability + Help with Activities of Daily Living--for Community Care
- Alien exclusion: Citizens & aliens entering before 8/22/96 OK
- Pages 75-77

10

"LONG TERM CARE" MEDICAID --BENEFITS

- Nursing facility care/ STAR + PLUS
- "Community Care" home care
- "Community Based Alternatives" home & Assisted Living Facility care
  - HCBS STAR + PLUS WAIVER
- Home care under the CLASS program--cerebral palsy & similar conditions manifested before age 22
- Other "waiver" programs
- Pages 77-81

11

Medicaid and MCOs

- 2011 Texas legislature applied for Medicaid Waiver
- At this writing in January 2015, managed care affects individuals receiving long-term care Medicaid only to the extent they are in the Community Based Alternatives (CBA) Medicaid "waiver" home care program,
  - who effective September 1, 2014 are all now in the "Star+Plus Waiver" managed care program.
- However, effective March 1, 2015, *nursing facility* services will be added to the "array of services" of the Star+Plus managed care program.
- Pages 13-20

12

Medicaid and MCOs continued…

- Changes should not adversely affect eligibility, benefits or appeal rights
- Changes in program names
- Extension of managed care to nursing facilities
- Nursing facility contracts with MCO's
- Pages 13-20

13

Medicaid Managed Care in Nursing Homes

- Effective March 1, 2015—
- Medicaid will pay nursing homes only through a Managed Care Organization (MCO)
- Medicaid beneficiaries get NH care only if they are members of an MCO
- If you don't join by 2/15/15, you are assigned to an MCO
- If the nursing home does not have a contract with your MCO, it gets paid 5% less
- TMHP still determines medical necessity

Pages 15-16

14

Changes in Program Names

STAR: Pregnant Women's, Children's, "Parents & Caretaker Relatives" Medicaid

STAR HEALTH: Children/young adults in DFPS conservatorship or foster care program

STAR+PLUS: SSI-Linked, Pickle, Widow/Widower, Buy-In Medicaid; and as of 3/1/15, Nursing Home Medicaid

STAR+PLUS WAIVER: The program formerly known as Community Based Alternatives (CBA)

Pages 12-13

15

Texas Dual Eligible Integrated Care

- Proposed new way to serve people Medicare/Medicaid
- AKA "Dual eligible"
- 3 party agreement Medicaid, Medicaid, and CMS
- Testing "innovative payment and service delivery model to improve coordination of services for dual eligibles, enhance quality of care and reduce costs for both the state and the federal government.
- Scheduled to begin March 1, 2015.
- http://www.hhsc.state.tx.us/medicaid/managed-care/dual-eligible/

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Texas Dual Eligible Integrated Care

- Demonstration cover 6 counties
- Clients must
  - Age 21 and older
  - Be on Medicare A, B, and D and be on dull Medicaid
  - Be in Medicaid STAR + PLUS program
- Counties:
  - Bexar
  - Dallas
  - El Paso
  - Harris
  - Hildago
  - Tarrant
- Clients can choose to opt out of the project

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ABLE Act Accounts

- Similar to 529 accounts
- Passed December 2014
- Use contingent on state passing enabling legislation
- No language addressing transfer penalty
- Page 57

18

ABLE Act continued

- Beneficiary must be:
  - Individuals with blindness
  - Or a disability that occurred before the age of 26
- Beneficiary is owner of account, can direct distributions
- Contributions can be made by beneficiary or third party
- Only cash contributions can be made, capped at $14K annually total gift
- Account cannot exceed $100,000 or will be considered an asset
  - If sole reason for disqualification, still get Medicaid, loose SSI
- Pages 57-58

19

Steward V. Perry

- As institutions for persons with psychiatric and intellectual disabilities were phase out, nursing homes became the homes
- A settlement b/w plaintiffs & state of Texas to expand community services for people with intellectual disabilities
- Aimed at people living unnecessarily in nursing homes
- Assessment of NH residents with intellectual disabilities
- Transition to community

* not in paper

20

Ethical Issues

- Agreements of Exclusivity Between Attorneys and Skilled Nursing homes
  - Denial of a Medicaid bed & Medicaid pending status unless a "certain attorney is used"
  - "Every contract, combination, or conspiracy in restraint of trade or commerce is unlawful."
  - 2 TEX. BUS. & COMM. CODE § 15.05(a).
- Unauthorized Practice of Law
  - Medicaid planning by non-attorneys
  - Texas Human Resources Code Section 12.001
  - Civil damages
- Florida case
- Texas NAELA efforts

21

MERP Recovery Strategies

- The Lady Bird Deed
  - May allow for protection home
  - Enhanced life estate deed because owner retains full rights
  - Allows owner to retain life estate and transfer title to a Revocable Living Trust (RLT)or specified individual(s)
- RLT
  - Vessel to avoid probate
  - Items must be retitled into the RLT
  - Can retitle vehicle into RLT
- Pages 95-96

22

HIPP- in general

- Texas Health Insurance Premium Payment Program
- Help pay your health insurance payments
- One family member on Medicaid
- Health insurance through family employer
- Application is online, response in about 7-10 days
- To join HIPP, private insurance plan must:
- Have a lifetime maximum of $500,000 or more.
- Pay at least 60 percent of the costs for:
  - Doctor's visits.
  - Medication.
  - Care out of the hospital.
  - Have lab tests or X-rays.
  - Are in the hospital.
- http://www.gethipptexas.com

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HIPP & Managed Care- Update To Paper on Page 144

- Health Insurance Premium Payment Program (HIPP) pays premiums for employer-provided health insurance for the whole family, if one family member has Medicaid.
- STAR members *cannot* get HIPP
- STAR+PLUS members *can* get HIPP *but* they will have to pay copayments & deductibles for (1)services not covered by Medicaid & (2) any services by a provider who is not Medicaid certified.

Pages 143-4
http://www.hhsc.state.tx.us/medicaid/hipp/

24

Return of Asset/ Partial Cures

- TRANSFER OF ASSETS QUESTION:

When an individual makes an uncompensated transfer, does the agency treat payments made by the transferee to the nursing facility as partial returns of the transferred asset?

- ANSWER:

Yes, the payments will be considered partial returns of the asset, and the penalty recalculated based on the remaining amount of uncompensated transfer. The penalty period will be for a shorter length of time. See MEPD Handbook Section I-5700.

- QUESTION:

When an individual makes an uncompensated transfer, does the agency treat payments made by the transferee for improvements to the individual's homestead as partial returns of the transferred asset?

- ANSWER:

Yes, the money spent on improvements to the homestead will be considered partial returns of the asset, and the penalty recalculated based on the remaining amount of uncompensated transfer. The penalty period will be for a shorter length of time. See MEPD Handbook Section I-5700

IRAs and Annuities

- **General Rule** is that the purchase of an annuity is a transfer of assets unless it meets certain conditions.

MEPD Handbook Section F-7230

- **Exception for employment and retirement-related annuities**

- Governing Federal Law

42 USC 1936p(c)(1)(G)

Purchase of an annuity by an individual applying for Medicaid (or for the community spouse) is **not** considered a transfer of assets if the annuity purchased is an IRA annuity or the annuity was purchased with the proceeds of an IRA

IRAs and Annuities (cont'd)

- Guidance is found in MEPD handbook F-7210 and F-7220
- The purchase of an IRA annuity is not considered a transfer of assets.
- The funds in the IRA annuity are not counted in the resource calculations.
- Moreover, the State of Texas/Medicaid Agency does not need to be named as the beneficiary.
- Query whether it needs to meet any of the other terms and conditions.

27

Windsor

- United States v. Windsor, 2013 the United States Supreme Court declared certain parts of the Defense of Marriage Act unconstitutional.
- CMS continues to announce policy regarding the implications on Medicare and Medicaid.
- Medicare: Applies the law of the state of celebration in all aspects of the Medicare law.
- Medicaid: Each state has the option of defining marriage for the purpose of qualifying for benefits.
- Civil unions and domestic partnerships are not recognized at the federal level.

(pp 18-20)

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Windsor (cont'd)

- CMS has proposed revisions to regulations to provide uniformity. (p.20)
- Cases are still pending on the matter in Texas. (p.19)
- Travis County Probate Case:
  - February 17, 2015 Judge Guy Herman holds that ban on gay marriage is unconstitutional
  - Attorney General responded

29

Medicaid and Trusts

- Types of Trusts
- When are trusts and Medicaid compatible?
- What choices does my client have?
- How do I know if a trust is Texas Medicaid compliant?

30

Medicaid and Trusts

- There are several types of Trusts that can be used with Texas Medicaid programs
  - Third Party settled Supplemental Needs Trust
  - First Party settled Supplemental Needs Trust
  - Master Pooled Trust
  - Qualified Income Trusts
  - Revocable Trusts

31

Supplemental Needs Trust

- A Supplemental or Special Needs Trust (SNT) is a specific type of Trust
  - Assets are not counted as a resource for beneficiary
  - Beneficiary cannot have access or control over corpus
  - Therefore, beneficiary can receive/ continue to receive public benefits
  - The type of Trust depends on how it is funded

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Third Party Settled SNT

- Contains assets which beneficiary has never owned or controlled, and that the beneficiary does not contribute to the Trust
- Beneficiary cannot have any access or control to corpus of Trust
  - No right to distribution
  - "Sole discretion" distribution standard
- No payback provision required
- No age restrictions

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First Party Settled Trust

- First Party SNTs are created by the beneficiary, parent, grandparent, or by a court on their behalf
  - Funds received through inheritance, personal injury settlement, benefits back payment
  - Funds have at some point belonged to beneficiary
- MUST contain a Medicaid payback provision
- Only available where beneficiary is under age 65

34

First Party Settled Trust

- Can be a trust for an individual, or make use of Master Pooled Trusts
- Individual Trusts are managed by a private person or Trustee
  - State law requires that a court created Trust worth more than $150,000 have a corporate Trustee
  - If principal is under $150,000, or can demonstrate no corporate Trustee will accept Trust, court can appoint individual Trustee

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Master Pooled Trust

- Combined Trust managed by Arc of Texas
- Each beneficiary has a sub-account
- Accepts both self settled and third party managed trusts
  - Can be a good option where private professional management is not feasible
  - Initial set up fee, yearly management fee
- Age restrictions apply, as do payback provisions for self settled trusts

36

Qualified Income Trusts

- Very limited use: Use only where client's gross income exceeds allowed monthly amount
  - Currently $2,199 (gross)
- Do not use QIT to hold title to assets
- Nothing should be placed in QIT other than income

Revocable Trusts

- Revocable Trusts were, and continue to be, a popular estate planning tool
- Assets in a Revocable Trust, including a residence, will be counted as an available resource
- Must approach with caution when Medicaid is a possibility

The End- Thank you!

- Tips, tools, and tricks for Medicaid/ Elder Law practice:

- Marilyn Miller
- Lori Leu
- Monica A. Benson
- Christina Lesher