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2022 CHANGES AND TRENDS AFFECTING SPECIAL NEEDS TRUSTS
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Protecting and Maximizing Public Benefits

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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.

This overview of the most significant public benefits for persons with disabilities in Texas 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.

I. OVERVIEW OF TEXAS HEALTH & HUMAN SERVICE AGENCIES

A. TEXAS AGENCIES

The Texas Health and Human Services Commission (HHSC) administers the government programs Special Needs Trust beneficiaries need the most often:

- Long-Term Care Medicaid (nursing home and home care programs)
- Medicaid for children and their caregivers
- SNAP (food stamps)
- TANF (cash assistance for families)
- Behavioral Health Services
- Intellectual Disability Services
- Women's Health Services

HHSC also licenses long-term care facilities, certifies certain nursing facilities as Medicaid providers.

Within HHSC, the Texas Department of State Health Services (DSHS) manages birth and death records, gathers and shares public health data, collects data to monitor for chronic and infectious disease, provides emergency response services for health emergencies, regulates producers of consumer health goods and service providers that pose potential danger to public health.

Other agencies that do not fall under HHSC's umbrella but are still important to know include:

- Texas Department of Family and Protective Services (DFPS) - responsible for adult and child protective services.[1]

- Texas Workforce Commission (TWC) - responsible for workforce development including providing training and employment services to people with disabilities.[2]

B. MEDICAID SERVICE DELIVERY MODELS

1. HISTORICAL BACKGROUND IN TEXAS

Medicaid is funded by federal and state government but is administered by the state. Typically, a state provides through a fee-for-service model ("traditional" Medicaid) or a pay-per-patient model ("managed care" Medicaid). In 2011, the Texas Health & Human Services Commission applied for a new Medicaid waiver program that moved away from the "traditional model" towards the "managed care" model. The U.S. Centers for Medicare & Medicaid Services (CMS) approved the new waiver program on 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.[3] This is a five-year "demonstration program," scheduled to end in September 2016 but has been extended several times and is currently approved through September 2022.

Over the last 10 years, most Medicaid programs have been integrated into the STAR managed care model including long-term care recipients, children with intellectual and developmental disabilities, children in state conservatorships, and those receiving services under 1915(c) waiver programs.[4]

A few categories of individuals remain eligible for "traditional Medicaid" benefits, as discussed below. The switch to managed care does not affect (1) long-term care programs without comprehensive medical coverage, such as non-waiver home care programs like Community Attendant Services, or (2) Medicare Savings Programs (QMB, SLMB, QI-1).

2. CHANGES SHOULD NOT ADVERSELY AFFECT CLIENTS

There is an inherit conflict when the delivery of a public benefits is entrusted to a for-profit organization that is paid a "capitated" rate per member.[5] There is an obvious financial incentive to

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[1] TEXAS DEPARTMENT OF FAMILY AND CHILD PROTECTIVE SERVICES, *About DFPS*, https://www.dfps.state.tx.us/About_DFPS/default.asp.

[2] TEXAS WORKFORCE COMMISSION, *About Texas Workforce,* https://www.twc.texas.gov/about-texas-workforce.

[3] These "demonstration program" is sometimes referred to as the "1115 Transformation Waiver" because CMS's authority derives from Social Security Act §1115, 42 U.S.C. §1315.

[4] *See* Tex. Health & Human Services Comm'n, Demonstration Extension Application Section 1115(a), Appendices A-E, (July 2021), available for download at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83231 (application pending approval as of January 11, 2022).

[5] "Capitated" managed care is required by Texas statute for acute-care Medicaid generally, unless the HHSC determines that another arrangement, including a traditional fee-for-service arrangement, would be "more cost-

minimize provision of services to reduce costs. Special Needs Trust beneficiaries often have extensive and complicated, and therefore expensive, medical needs.

In recognition of this concern, 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 (FFS) clients, unless explicitly changed by HHS through a waiver.[6] The federal rules set by CMS requires this as well:

> Each contract with an MCO, . . . 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 ….[7]

Texas incorporated this into the Star+Plus Handbook, which provides, "The STAR+PLUS program does not change Medicaid eligibility or services. It does change the way Medicaid services are delivered."[8]

HHSC still determines financial eligibility:

> The [HHSC] Program Support Unit (PSU) staff coordinate with Medicaid for the Elderly and People with Disabilities (MEPD) specialists to determine financial eligibility for individuals not eligible for Supplemental Security Income (SSI)."[9]

The process for determining financial eligibility is becoming more automated but is still determined by the state, not the MCO. Therefore, in HCBS Waiver cases, there are two eligibility determinations: HHSC determines financial eligibility and the MCO determines medical eligibility (whether the medical necessity requirement is met, if applicable, and how much service the MCO will be required to provide in the service plan).

Since an MCO can adversely affect a person's care through their definition of "medical necessity," the federal rules state 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. . . ."[10]

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effective or efficient." Tex. Gov't Code § 533.0025(b); *see also* Acts of June 28, 2011, 82nd Leg. 1st C.S., S.B. 7, § 2.01(b) ("The legislature finds that the use of certified healthcare collaboratives will increase pro-competitive effects.").

[6] 1 T.A.C. § 353.409(b). Acts of May 27, 2013, 83rd Leg., R.S., S.B. 7, § 2.21 provides more generally, "[t]he changes in law made by this article are not intended to negatively affect Medicaid recipients' access to quality health care."

[7] 42 C.F.R. § 438.210(a)(2).

[8] Tex. Health & Human Services Comm'n, Star+Plus Handbook § 1100, https://hhs.texas.gov/laws-regulations/handbooks/sph/starplus-handbook.

[9] Star+Plus Handbook § 1131; *see also id.* § 3300 (administrative procedures of the PSU).

[10] 42 C.F.R. § 438.210(a)(5)(i).

Further, both the state and federal laws permitting Medicaid managed care have provisions for consumer protection and mandatory quality assessment studies.[11] There are also due process procedures through both HHSC and the MCO. The right to appeal through the HHSC fair hearing procedure continues, even regarding the decisions of a Managed Care Organization (MCO). In addition, MCO's are required to have their own appeal procedures that a member may utilize instead of *or in addition to* an appeal to an HHSC fair hearing.

3. CHANGES IN PROGRAM NAMES

Switching to a managed care delivery model has resulted in major—and arguably unacknowledged—changes in program names and terminology.[12] With some trepidation, your authors attempt to provide a brief guide in the bullet points and table below.

- STAR stands for "State of Texas Access Reform." STAR was the initial managed care program in Texas. For some categories, this was a transitional program, and, by September 1, 2014, they moved to STAR+PLUS. STAR still includes important Medicaid programs for children and pregnant women.
- STAR+PLUS refers to all the Medicaid managed care services that moved from the STAR category, programs for those 65 and older or those with disabilities, plus some that were never in that category. Generally, this program is for those receiving Medicaid for basic medical services and long-term support services.
- STAR+PLUS WAIVER refers to services previously provided through Community Based Alternatives (CBA). These programs were integrated into STAR+PLUS and CBA was terminated as a separate program effective September 1, 2014.
- These terms are often used interchangeably. As a general rule, STAR+PLUS PROGRAM includes both STAR+PLUS and STAR+PLUS WAIVER.

Benefit Program	**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
SSI-Related (Community, Acute-Care) Medicaid; DAC, Pickle, Widow/Widower Medicaid; Medicaid Buy-In; Medicaid Buy-In For Children[13]	STAR +PLUS	Star+Plus Handbook

[11] *See, e.g.,* 42 U.S.C. § 1396u-2(c) ("the State shall develop and implement a quality assessment and improvement strategy. . . ."); Acts of May 26, 2013, 83rd Leg., R.S., S.B. 7, § 2.11 (studies due January 15, 2015 regarding the extension of managed care to nursing facilities under Tex. Gov. C. § 533.00251).

[12] The agency provides a helpful explanation of the terminology and history at its website dedicated to the transition to managed care at https://hhs.texas.gov/services/health/medicaid-chip/provider-information/expansion-managed-care. However, the clearest and most authoritative guide is the rule at 1 T.A.C. § 353.603.

[13] Enrollment is automatic (and mandatory) for those receiving SSI, TANF, Children's Medicaid, or Pregnant Women's Medicaid. 1 T.A.C. §§ 353.603(a), 353.802. Enrollment in STAR+PLUS is voluntary for children under

Benefit Program	Managed Care Name	Eligibility Handbooks
Nursing Home Medicaid	STAR+PLUS	MEPD Handbook
Community Based Alternatives	HCBS STAR+PLUS WAIVER	Star+Plus Handbook MEPD Handbook
Other "1915(c) waiver" programs: CLASS, MDCP, HCS, DBMD	STAR+PLUS	MEPD Handbook CLASS Provider Manual HCS Handbook DBMD Handbook Star+Plus Handbook 40 T.A.C. Chapters 45 and 48
Children and young adults in conservatorship of DFPS or in a DFPS foster care program[14]	STAR Health	
Non-waiver CCAD programs: community attendant services, primary home care, etc.	CCAD Participants are not eligible for STAR+PLUS unless they are eligible for regular Medicaid through another program. In general, STAR+PLUS members may not receive additional services from non-waiver CCAD programs.[15]	Star+Plus Handbook MEPD Handbook
Dual-Eligibles (eligible for both Medicare and Medicaid)	Medicare provides acute care and medications. STAR+PLUS Medicaid provides long-term support services and other services not covered by Medicare.[16]	Star+Plus Handbook
Health insurance premium payment program (HIPP)	Serves enrollees of any Medicaid Program, such as STAR+PLUS, except STAR and CHIP.[17]	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 the MSP alone.	No Handbook

HHSC published these handbooks (among others) on their website at https://hhs.texas.gov/laws-regulations/handbooks.

age 21 in the following categories: (1) receiving SSI and not in a nursing facility; (2) residing in an ICF-IID and not enrolled in Medicare; or (3) 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(b).

[14] 1 T.A.C. § 353.702.

[15] Star+Plus Handbook § 3126.1.

[16] Star+Plus Handbook § 3111.

[17] Texas Health & Human Services, Health Insurance Premium Payment (HIPP) Program, https://hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program; Star+Plus Handbook § 3127. However, the "capitated" nature of managed care may make it harder to prove that the private insurance coverage will save the state money, a HIPP requirement

Handbook	Website
STAR+PLUS Handbook	https://hhs.texas.gov/laws-regulations/handbooks/sph/starplus-handbook
Texas Works Handbook	https://hhs.texas.gov/laws-regulations/handbooks/twh/texas-works-handbook
Medicaid for the Elderly and People with Disabilities (MEPD) Handbook	https://hhs.texas.gov/laws-regulations/handbooks/mepd/medicaid-elderly-people-disabilities-handbook
STAR Kids Handbook	https://hhs.texas.gov/laws-regulations/handbooks/skh/star-kids-handbook
Community Living Assistance and Support Services (CLASS) Provider Manual	https://hhs.texas.gov/laws-regulations/handbooks/community-living-assistance-and-support-services-provider-manual
Deaf Blind with Multiple Disabilities (DBMD) Program Manual	https://hhs.texas.gov/laws-regulations/handbooks/deaf-blind-multiple-disabilities-dbmd-program-manual
Home and Community-based Services (HCS) Handbook	https://hhs.texas.gov/laws-regulations/handbooks/home-community-based-services-handbook

For more on terminology, see the Glossary of the Star+Plus Handbook. A list of acronyms can be found at Appendix VII of the Star+Plus Handbook.

4. MORE CHOICES IN SERVICE DELIVERY

For home and community-based services (HCBS), under Star+Plus MCO framework, the member gets a choice how to manage their HCBS providers.[18] There are 3 options: the Agency option (AO), consumer-directed services (CDS) option or service responsibility option (SRO) delivery models[19].

> Members who choose the AO work with the MCO to coordinate service delivery for each service in the ISP. Members who choose the CDS model can self-direct designated services, while the MCO coordinates delivery of non-member-directed designated services. In the CDS model, providers employed by the member or authorized representative (AR) must be qualified personnel to provide all authorized services when services are necessary. These personnel may be employed directly by or through personal service agreements or subcontracts with the providers. A member's services and service providers must be based on an MCO assessment of the member's individual More information is available in Appendix XXVIII, Consumer Directed Services (CDS) Training for Service Coordinators and CDS Training Manual. In the SRO model, an attendant is employed by a provider who handles business details while the member or designated representative day-to-day management of the attendants' activities.

MCO's can also distinguish themselves by expanding their coverage. Each MCO is required to provide certain "basic" benefits, presumably tracking the benefits of Traditional FFS Medicaid. In addition, they can provide various other services, varying by location and MCO. A summary is at

[18] Star+Plus Handbook § 1131

[19] *Id.*

https://hhs.texas.gov/services/health/medicaid-chip/programs/starplus/starplus-comparison-charts.

5. EXTENSION OF MANAGED CARE TO NURSING FACILITIES

a) History and Authority

With the implementation of S.B.7 and the 1115 Transformation Waiver, as of March 1, 2015, nursing facility services are provided under the Star+Plus managed care program.[20] As with other Medicaid managed care programs, nursing facility services are authorized by and subject to the Social Security Act, specifically the provisions specifically relating to Medicaid managed care.[21] The Texas Health and Human Services Commission rules published in title 1, chapter 353 of the Texas Administrative Code provide a well-organized and authoritative summary.

b) Effect on Dual-Eligible(s)

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

> 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. [22]

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.

Under Social Security Act § 1932, which authorizes Medicaid managed care programs to require beneficiaries to join a Managed Care Organization, Medicare beneficiaries are exempted. That is, states cannot require dual-eligible(s) to join an MCO as a condition of receiving Medicaid services.[23] However, HHSC attorneys distinguish the 1115 Transformational Waiver program on the basis that it is a demonstration project authorized by §1115 of the Social Security Act. As such, they contend it is not subject to the terms of § 1932—even though § 1932 is more recent, more specific, and not included in the list of sections the federal agency is authorized to waive under § 1115.[24] If the agency's attorneys are correct, then all the other safeguards in § 1932 are presumably

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[20] *See* Acts of May 26, 2013, 83rd Leg., R.S., S.B. 7, §2.02; Tex. Gov. C. §533.00251.

[21] Social Security Act §1932, 42 U.S.C. §1396u-2.

[22] 1 T.A.C. § 353.603(e)(2).

[23] Social Security Act § 1932(a)(2)(B), 42 U.S.C. § 1396u-2(a)(2)(B).

[24] Social Security Act § 1115(a)(1), 42 U.S.C. § 1315(a)(1).

trumped by the CMS waiver documents, and the latter (cited above) are the highest source of law on the 1115 Transformational Waiver. The author has not researched the case law (if any) on this potential issue.

c) Mandatory MCO Membership

In November 2014, nursing facility residents on Medicaid or their representatives were sent packets asking them to choose a Managed Care Organization (MCO) and a primary physician (in the MCO). Those who had not made that choice by mid-February 2015 were to be assigned to an MCO and a primary care provider. If the resident's attending physician is not an MCO provider, a new physician would be assigned. Although this is stated without exception in the FAQ's, there appears to 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 and related insurance 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. For example, the Texas statute requires HHSC to "ensure that a nursing facility provider authorized to provide services under Medicaid on September 1, 2013, is allowed to participate in the STAR + PLUS Medicaid managed care program through August 31, 2017."[25] Such a facility must be accepted as a provider by any MCO to which it may apply, provided only the facility agrees 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.

e) Nursing Facilities Still Report Medical Data

The nursing facility still must develop and transmit the Minimum Data Set (MDS) and Long-Term Care Medicaid Information (LTCMI) to Texas Medicaid and Healthcare Partnership (TMHP). The switch to managed care has not changed this requirement.

f) Nursing Facility Fees Determined the Same Way—Mostly

The Nursing Facility Unit Rate—the amount due to the facility—is based on the Resource Utilization Group (RUG). The Nursing Facility Unit rate is the RUG rate plus any applicable liability insurance coverage and "staff rate enhancement" reimbursements. TMHP will continue to determine the RUG. It will also determine whether or not the resident meets the Medicaid

[25] Tex. Gov. C. § 533.00251(d).

medical necessity requirement, based on the data transmitted. The determination process has not changed except:

- 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 the standard rate.
- 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 wheelchairs, 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 must continue to make reasonable efforts to collect the Medicaid copayment. After two unsuccessful attempts, the facility is required to notify the MCO. The facility's service coordinator is required to notify the resident that, if the copayment is not paid, the resident may not be able to stay at the facility.

h) MCO Service Coordination

One of the advertised benefits of managed care is that the MCO will provide another level of oversight over the quality and continuity of the nursing facility's provision of services, in addition to the annual (typically) surveys and the occasional complaint investigations by Texas Health and Human Services.

The nursing facility and MCO must have a service coordinator available to the MCO's members residing in the facility. Each nursing facility resident on Medicaid has a named MCO service coordinator. All of the MCO members residing in the same facility will generally have the same coordinator, unless another coordinator is necessary due to a high number of member-residents. The service coordinator is involved in care planning and in the monitoring of plan implementation, add-on services, value-added services and acute care services. As part of this role, the service coordinator must have a face-to-face visit with each member at least quarterly and work 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. To request a change by phone, call 1–800–964–2777.

C. EQUAL PROTECTION FOR PARTNERS IN SAME-SEX MARRIAGES

In 2013, the United States Supreme Court, in *United States v. Windsor*, the court held that the federal Defense of Marriage Act's restriction on the definition of marriage is unconstitutional but did not decide whether a state may constitutionally restrict the definition of marriage to exclude

same-sex couples.[26] On June 26, 2015, in *Obergefell v. Hodges*, the Court decided that a state may not constitutionally restrict the definition of marriage to same sex marriage.[27] This decision eliminated the complex issues involving differing state policies. The Texas Health and Human Services Commission has reduced its policy to one clear statement:

> For all programs, the policies and procedures that apply to opposite-sex marriages now apply to same-sex marriages, effective June 26, 2015.[28]

As of this writing, in the authors' experience, no major issues have yet arisen regarding the implementation of the Court's *Obergefell* decision as so construed.

II. SUPPLEMENTAL SECURITY INCOME (SSI)

Supplemental Security Income (SSI) is a federal program that provides cash to help aged, blind, and people with disabilities, who have little or no income, meet their basic needs for food, clothing, and shelter.[29] Eligibility for SSI and the benefit amount is based on income. Therefore, a person may be eligible for SSI but their benefit may be reduced.

Often, the money is less important than the other major benefit of SSI. A person who receives SSI is also eligible for Medicaid. Even if, after all reductions are applied, they only receive one dollar ($1.00) in supplemental income, they are eligible for full Medicaid benefits.

SSI is often confused with Social Security Disability Insurance (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.

To remember this important difference, notice SSI is a needs-based program (hence the name: supplemental . . . income) while SSDI is an insurance program that most workers "buy" into in case a disability renders them unable to work (hence the name: Social Security Disability Insurance). Eligibility for SSDI is based on completion of a certain work history and a qualifying determination of disability, irrespective of financial need.

A person who has a disability and the requisite work history, but a small SSDI benefit, may be eligible for both SSI and SSDI. Such individuals are entitled to both Medicaid and Medicare respectively. They are often called "Dual Eligible(s)."

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[26] *United States v. Windsor,* 570 U.S. 744, 133 S. Ct. 2675 (2013).

[27] *Obergefell v. Hodges*, 576 U.S. __ (2015).

[28] MEPD Policy Bulletin 16–01, 5, https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/mepd/09-18-15_16-_01.pdf .

[29] SOCIAL SECURITY ADMINISTRATION, *What is Supplemental Security Income?*, https://www.ssa.gov/ssi/.

SSI is also funded differently from the other Social Security benefits. Most Social Security benefits are paid for by workers through the Social Security taxes. In contrast, SSI is paid for by general funds in United States Treasury.[30]

Name	Acronym	Eligibility	Healthcare	Funded through
Supplemental Security Income	SSI	Based on income	Medicaid	General funds from the U.S. Treasury
Social Security Disability Insurance	SSDI or SSD	Based on work history and qualifying disability regardless of financial resources	Medicare	Social Security taxes

This section covers SSI. SSDI is discussed in section V.

The Social Security Handbook includes the provisions of the Social Security Act (the Act), regulations issued under the Act, and precedential case decisions (rulings).[31] It is available online at https://www.ssa.gov/OP_Home/handbook/handbook.html and further information can be found at http://www.benefits.gov/.

A. ELIGIBILITY

To get SSI, you must meet (1) categorical (disabled, blind, or at least 65 years old), (2) citizenship, (3) income, and (4) resource requirements. [32]

1. "CATEGORICAL" REQUIREMENTS: AGED, BLIND OR DISABLED

a) Disabled

An adult is disabled, for the purposes of SSI and SSDI, if he or she "is unable to engage in any substantial gainful activity because of a medically determinable physical or mental impairment that is either expected to result in death or that has lasted or can be expected to last for a continuous period of at least 12 months."[33] Presumptively, in 2022, a person who is not blind and is earning more than $1,350 per month is able to perform "substantial gainful activity," and thus is not considered "disabled." [34]

This is a very tough standard, particularly compared to the standards of most disability insurance policies and clients' expectations. For example, the SSA will not provide benefits if

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[30] SOCIAL SECURITY ADMINISTRATION, SOCIAL SECURITY HANDBOOK § 2105, http://www.ssa.gov/OP_Home/handbook/handbook.21/handbook-2105.html .

[31] SOCIAL SECURITY ADMINISTRATION, SOCIAL SECURITY HANDBOOK, preface, https://www.ssa.gov/OP_Home/handbook/handbook-preface.html.

[32] *See* SOCIAL SECURITY ADMINISTRATION, *Supplemental Security Income (SSI) Eligibility Requirements,* https://www.ssa.gov/ssi/text-eligibility-ussi.htm.

[33] 42 U.S.C. § 1382c(a)(3)(A); 20 C.F.R. § 416.905; *see* SOCIAL SECURITY ADMINISTRATION, *Supplemental Security Income (SSI) Eligibility Requirements,* https://www.ssa.gov/ssi/text-eligibility-ussi.htm.

[34] *See* SOCIAL SECURITY ADMINISTRATION, *Fact Sheet: 2022 Social Security Changes*, https://www.ssa.gov/news/press/factsheets/colafacts2022.pdf.

- the client is partially but not totally disabled.
- the client is unable to do his or her previous job (e.g., teaching or driving a truck) but is qualified for a much lower-paying job (e.g., assembly-line work)
- there is no work available locally but there is work available somewhere else in the United States.

A child under age 18 is disabled if he or she has:

> a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months.[35]

An impairment(s) causes marked and severe functional limitations if it (1) meets, (2) medically equals or (3) functionally equals the severity of a set of criteria for an impairment in the Listing of Impairments, 20 C.F.R. Part 404 Subpart P, Appendix 1.[36] A person's "impairment(s) is medically equivalent to a listed impairment . . . if it is at least equal in severity and duration to the criteria of any listed impairment.[37] Section 416.926a explains further:

> By 'functionally equal the listings,' we mean that your impairment(s) must be of listing-level severity; i.e., it must result in 'marked' limitations in two domains of functioning or an 'extreme' limitation in one domain, as explained in this section.[38]

For 2022, a person with a disability earning more than $1,350 per month is presumptively able to perform "substantial gainful activity."[39]

b) Aged

A person aged 65 or over who meets the other income and citizenship requirements is eligible for SSI. A person eligible for both SSI and SSDI is also known as a dual-eligible. While SSDI provides Medicare and an income subsidy, SSI provides Medi*caid* plus an income subsidy. While Medicare provides short-term hospital and out-patient benefits, only Medicaid provides certain benefits like long term support services.

> 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 more comprehensive than Medicare benefits as discussed below.

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[35] 20 C.F.R. § 416.906; *see* Social Security Administration, *Child Disability Starter Kit—Fact Sheet,* https://www.ssa.gov/disability/disability_starter_kits_child_factsheet.htm

[36] 20 C.F.R. 416.924. *See also* Social Security Administration, *List of Impairments—Childhood Listings (Part B),* https://www.ssa.gov/disability/professionals/bluebook/ChildhoodListings.htm .

[37] 20 C.F.R. 416.926(a).

[38] 20 C.F.R. 416.926a(a).

[39] *See* Social Security Administration, *Fact Sheet: 2022 Social Security Changes*, https://www.ssa.gov/news/press/factsheets/colafacts2022.pdf

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 visual field limitation in your better eye, such that the widest diameter of the visual field subtends an angle no greater than 20 degrees.[40] For 2022, a blind person earning more than $2,260 per month is presumptively able to perform "substantial gainful activity."[41]

2. CITIZENSHIP/IMMIGRATION/RESIDENCY STATUS

a) Residency

To qualify for SSI, a person must be a resident of one of the 50 states of the United States, the District of Columbia, or the Northern Mariana Islands. Note that Puerto Rico residents are not included.[42] Absence from the United States for 30 consecutive days disqualifies the client for SSI benefits, and the client cannot regain qualification until he or she has again resided in the United States for at least 30 days.[43]

b) Citizen or Entitled Alien

Only U.S. citizens, by birth or naturalization, are eligible for public benefits. With the exception of certain "qualified aliens," non-citizens are ineligible for federal public benefits.[44]

A "qualified alien" is a non-citizen who is any of the following:

- a permanent resident alien
- an asylee
- a refugee
- an alien paroled into the U.S. for at least a year
- an alien whose deportation is withheld under 8 U.S.C. § 1253,
- a person granted conditional entry under 8 U.S.C. § 1153(a)(7)
- a Cuban or Haitian entrant[45]

A "qualified alien" is potentially eligible for SSI, if he or she meets any of the following requirements:

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[40] *See* SOCIAL SECURITY ADMINISTRATION, *Supplemental Security Income (SSI) Eligibility Requirements,* http://www.ssa.gov/ssi/text-eligibility-ussi.htm#blind.

[41] *See* SOCIAL SECURITY ADMINISTRATION, *Fact Sheet: 2022 Social Security Changes*, https://www.ssa.gov/news/press/factsheets/colafacts2022.pdf.

[42] *See* 20 C.F.R. §§ 416.202, 416.1603. Chapter 416 of the CFR can be accessed through the Social Security Administration's website at http://www.ssa.gov/OP_Home/cfr20/416/416–0000.htm.

[43] *See* 416 C.F.R. § 416.1327.

[44] 8 U.S.C. § 1611(a).

[45] 8 U.S.C. § 1641(b)

- 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);[46]
- For the first 7 years after the non-citizen was granted one of the following statuses:
- An asylee
- A refugee
- Alien whose deportation has been withheld
- certain Cuban or a Haitian entrants
- certain Amerasian immigrants[47]
- certain Native Americans[48]
- and the non-citizen children of a battered parent;[49]
- 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);[50]
- A permanent resident who has worked 40 qualifying quarters and earned Social Security coverage, or who can be credited with such quarters due to the work of a parent or spouse under certain specified rules.[51]

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

- Legal immigrants residing in the United States 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.).[52]
- Aliens receiving SSI only because of the August 22, 1996, exceptions are not eligible for food stamps.[53] However, all aliens receiving SSI are eligible for Medicaid.[54]

See page 183 for a chart summarizing the limits on the eligibility of aliens for numerous types of public benefits.

3. INCOME

SSI is a needs-based program, meaning it is only available to those with limited income and other financial resources. The SSA reviews two financial components. One is income--or the value of

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[46] 8 U.S.C. § 1612(a)(2)(E)

[47] 8 U.S.C. § 1612(a)(2)(A)

[48] 8 U.S.C. § 1612(a)(2)(G)

[49] 8 U.S.C. § 1612(c)

[50] 8 U.S.C. § 1612(a)(2)(C)

[51] 8 U.S.C. § 1612(a)(2)(B).

[52] 8 U.S.C. § 1612(a)(2)(E), (F).

[53] 8 U.S.C. §§ 1612(a)(1) (a)(2)(E), (a)(2)(F).

[54] 8 U.S.C. § 1612(b)(2)(F).

everything a person receives during a given time period--and the other is resources--cash and property already in that person's possession before the time-period starts.[55]

Every year, the Social Security Administration increases the SSI benefit and eligibility thresholds based on the current cost of living. These cost-of-living adjustments (COLAs) are published every year. For 2022, an unmarried person must have less than $841 per month of countable income. A married couple's countable income totals must be less than $1,261 per month. Because the first $20 of income is not counted, and many SSI beneficiaries have one or more other sources of income, these numbers are sometimes expressed as $861 and $1,281, respectively.

Some states have an "SSI supplement" that gives SSI beneficiaries more than the federally mandated maximum of $841--Texas is not one of them.

a) Income, generally

"Income" generally includes any cash (or property readily convertible to cash), food or shelter an applicant receives during a particular time period.[56] "Shelter" includes any "room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection services" provided to the applicant. [57] For more specifics on the very important definition of "shelter" and a worksheet for doing calculations, see the "Pro Rata Share Worksheet" in Appendix 2 to this paper. Unlike the income tax rules, the SSI rules count even gifts as "income."[58] This general definition does have a long list of exclusions.[59]

Any income not excluded is considered "countable income." In general, countable income will reduce an SSI beneficiary's monthly benefit on a dollar-for-dollar basis. Therefore, any reductions must be carefully reviewed and calculated. As long as the SSI recipient continues to receive at least one dollar ($1.00) in SSI benefits, after all reductions are implemented, will continue to be eligible for Medicaid benefits.

> Appendix 3 contains instructions to a trustee of a Special Needs Trust for an SSI beneficiary. It incorporates these rules.

While the dollar-for-dollar reduction is the general rule, different rules may apply to different types of income.

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[55] The income rules for SSI eligibility are located in 20 C.F.R. Part 416, Subpart K.

[56] 20 C.F.R. § 416.1102.

[57] 20 C.F.R. § 416.1130.

[58] 20 C.F.R. § 416.1121.

[59] *See* 20 C.F.R. § 416.1103.

b) Earned/Unearned Income

Earned income is the gross wages of an employee (i.e. wages before deductions for taxes, insurance, etc.), and net earnings from self-employment (i.e. earnings after deduction of business expenses but also without deductions for taxes, insurance, etc.).[60]

The following are examples of the things that are excluded from countable earned income:

- 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.[61]

"Unearned" income is all income that is not "earned." This includes, among others, annuity payouts, pension payments, alimony, support, dividends, life insurance proceeds, prizes, gifts, and inheritances.[62]

The list of exclusions from unearned income is quite lengthy.[63] They include the following:

- most federal payments (for example, food stamps)
- up to $60 per month of irregular or infrequent income
- one-third of child support payments
- certain special VA payments (though VA pensions count as income).

c) In-Kind Support and Maintenance

"In-kind support and maintenance" is food and shelter that is furnished or paid for by someone other than the SSI applicant.[64] When provided free of charge, food and shelter is generally considered unearned income and reduces SSI benefits dollar-for-dollar. However, there are a few rules, if used correctly, that can improve the client's situation.

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[60] 42 U.S.C. § 1382a(a)(1); 20 C.F.R. § 416.1110.

[61] 42 U.S.C. § 1382a(b); 20 C.F.R. §§ 416.1102, 416.1112.

[62] 42 U.S.C. § 1382a(a)(2); 20 C.F.R. § 416.1120.

[63] 42 U.S.C. § 1382a(b); 20 C.F.R. § 416.1124.

[64] The SSA's regulation on support and maintenance are published at 20 C.F.R. § 416.1130–416.1148. The SSA's policies are published in the Social Security Administration Program Operations Manual or POMS, available at https://secure.ssa.gov/apps10/.

Of course, it is impossible for most people, particularly those with disabilities, to live on $841 per month without falling into conditions of squalor and ill health that shock the conscience and constitute public health hazards. Therefore, applying the following techniques is critical to the client's health and safety.

(1) 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). [65] In 2022, that amount is 1/3 X $841=$280.33[66]

(2) Presumed Maximum Value Rule

If the client is furnished *either* food or shelter, but not both, 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 2022, $280.33 + $20 = $300.33.[67] A client can rebut this presumption by showing that the actual value of what is furnished is less than $300.33. In that case, the client can have his or her income reduced by the actual value rather than the full $300.33. [68]

(3) Deemed Income 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.[69] For example, the income of a child applicant under age 18 includes any income they might receive as well the parents' income "deemed" to the child. In that case, the parents' 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.

(4) Business Arrangement (Client pays pro rata share of household expenses)

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. 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 $261. See Appendix 2 for a worksheet for pro rata share calculations.

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 $861 per month (the 2022 SSI benefit rate of $841 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

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[65] 20 C.F.R. § 416.1131; POMS SI 00835.200.A.1.

[66] *See* SOCIAL SECURITY ADMINISTRATION, *Fact Sheet: 2022 Social Security Changes*, https://www.ssa.gov/news/press/factsheets/colafacts2022.pdf .

[67] 20 C.F.R. § 416.1140(a); POMS SI 00835.300A.

[68] 20 C.F.R. § 416.1140(b); POMS SI 00835.300C.

[69] 20 C.F.R. § 416.1148; POMS SI 00835.210, 01320.150.

Security Disability Insurance income) which, when added to the $280.33 + $20 = $300.33 amount, causes total countable income to exceed $841 per month.

(5) Rent Subsidy (Client pays a maximum of 1/3 FBR + $20 to Landlord)

Under a settlement agreement, the Social Security Administration has agreed to apply the "business arrangement" rule in Texas. Under this rule, whenever the rent paid equals or exceeds the presumed maximum value ($300.33 in 2022). Therefore, even if the fair market value of the rent is $841, there will be no income attributed to a rent subsidy, so long as the client pays at least $300.33 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 only applies 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.[70]

A note of caution, the rent subsidy rule applies only to rent. To avoid a reduction of benefit because of "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.

(6) Unlimited Where Landlord is Neither Parent nor Child

If nobody in the household is related as a parent or child to the landlord, a rent subsidy will not be treated as income.[71] 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.

(7) Ownership of the residence by a trust

If the client's residence is owned by a trust and the client is a beneficiary of that trust, the client has an ownership interest in the residence. Therefore, no "income" results from the client's occupation of the residence.[72]

However, if the trust pays for household expenses--such as electricity, gas, water, sewage, and garbage collection--those payments are "income" unless fully reimbursed by the client.[73] Of course, if others 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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[70] 20 C.F.R. § 416.1130(b); POMS SI DAL00835.380, SI 00835.380C.4; *see* Settlement Agreement, *Diaz v. Chater,* C.A. No. 3:95-CV-1817-X (N.D. Tex. 1996)(unreported agreed order). This rule applies to all Medicaid programs in which Texas determines eligibility. *See* Texas Health and Human Services, Medicaid for the Elderly and People with Disabilities Handbook § E-8222.1, https://hhs.texas.gov/laws-regulations/handbooks/medicaid-elderly-people-disabilities-handbook [hereinafter MEPD Handbook]

[71] POMS SI 00835.380A.

[72] *See* POMS SI 01120.200F.2.

[73] POMS SI 01120.200F.3.c.

(8) SNT pays for food and shelter

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 $280.33 per month, under the "Presumed Maximum 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 $841.00—$280.33= $569.67 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.

This strategy works best when a beneficiary is receiving a full monthly SSI check (in 2022 $841.00 per month). Should the beneficiary receive less that the full SSI check, this strategy should be examined closely to ensure that this strategy benefits the client.

Unfortunately, some trusts expressly prohibit the provision of food, clothing or shelter. This is an unduly restrictive provision and should be avoided for beneficiaries residing in Texas and in almost all states.

Trusts with such restrictions can almost certainly be modified. A Texas trust can always be modified by a court "because of circumstances not known to or anticipated by the settlor, the order will further the purposes of the trust."[74] In 2017, the Texas Legislature also added specific language related to government benefits, "the order is necessary or appropriate to achieve the settlor's tax objectives or to qualify a distributee for governmental benefits and is not contrary to the settlor's intentions."[75]

(9) ABLE Account

Under a recent interpretation of the ABLE Act by the Social Security Administration, friends, relatives, and trustees can help SSI beneficiaries pay for food and housing, without creating "income," by running up to $16,000 per year through an ABLE Act account. For many beneficiaries, that will reduce the cost of food and shelter that must be paid from their SSI benefits and other cash income to the point they can pay their pro rata share and therefore avoid reduction of the SSI benefit. See the discussion on page 45.

d) Deeming of Income

Generally, only the SSI applicant's income is used to determine eligibility and payment amount. Under certain circumstances, the income of a relative of an SSI client is "deemed" the client's income.[76] These relationships include:

- an ineligible spouse living in the same household
- an ineligible parent, or parent's spouse, living in the same household with a client under age 18

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[74] TEX. PROP. CODE § 112.054(a)(2). Further, Texas specifically provides that courts can modify Supplemental Needs Trusts created by guardianship (probate) courts and trial courts so the ward can be eligible for public benefits. TEX. EST. CODE § 1301.101(c); TEX. PROP. CODE § 142.005(g).

[75] TEX. PROP. CODE § 112.054(a)(4).

[76] POMS SI 01320.001; For specific rules, *see* 20 C.F.R. §§ 416.1160–416.1169.

- a non-citizen client's sponsor—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.[77] 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.

e) When is a Reimbursement "Income"?

Generally, "[r]eimbursements made from the trust to a third party for funds expended on behalf of the trust beneficiary are not income."[78] For example, a reimbursement to the parent for attendant care for a minor child is not "income" to the child. However, payment of care services by a trust to the parent of a minor child (under age 18) is problematic. Parents have a duty to support their minor children. If the trust reimburses the parent for care services, that payment is likely considered income to the parent. Income of the parent is deemed the income of the minor child in the parent's household.

Further, some SSI and Medicaid programs may see a payment from the trust to the parent as a violation of the "sole benefit rule." Under the "sole benefit rule" when the trust makes a payment to a third party for goods or services, the goods or services must be for the primary benefit of the trust beneficiary. Because a parent has a duty to support a minor child, the parent benefits by not having to meet that obligation. For instance, if the trust reimburses for their purchases of shoes for the beneficiary, they are relieved of their obligation to provide shoes to the child. In reality, the needs of most children with disabilities are so far beyond what is ordinarily expected of parents that payment for care is usually permitted by guardianship and family courts.

When there is an issue, the effect can be mitigated by treating the parent-caregiver as an employee of the trust. This way the trust distributions for childcare is earned income, not unearned income. When the income is deemed to the child, the first $65 per month plus half the rest is disregarded. Make sure to deduct and report payroll taxes and file a W-2 form. In many cases that will avoid

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[77] POMS SI 01320.100B.11. See POMS SI 01320.100 for a more comprehensive list of items not included in deeming.

[78] POMS SI 01120.200E.1.d., 01120.201 I.1.g. Before a POMS change on February 8, 2013, it was common 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 may pay for attendant care for his or her minor child then is reimbursed by a Special Needs Trust. Until the POMS change, the agency justified with a POMS section that states, "Treat monies received by an agent acting on behalf of an SSI beneficiary as if the beneficiary received the monies directly." POMS SI 00810.120D.1.

"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.)." POMS SI 00810.120B.1.

Agency representatives treated parents of minors that were due reimbursements as agents. Some agency representatives went further by saying an agent was *anyone* who was due a reimbursement by the trust. In response to complaints by trustees and their attorneys, the agency changed the policy.

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.

f) Calculators to Estimate SSI Income

The deeming rules are extremely complex. They can be applied efficiently only with automated calculators like the one at https://careersourcebrevard.com/career-services/supporting-services-persons-disabilities/ticket-to-work-program-features/ssi-calculator-unearned-income.

g) Child Support

Cash child support given to the child or to another on the child's behalf counts as income for the month in which it was received. If the "child" is (1) unmarried, (2) under age 22, **and** (3) a student, only 2/3 of the actual amount counts as income.[79] Otherwise, child support is counted dollar for dollar.

When an individual reaches the age of 22 and is no longer eligible for the one-third exemption of child support,[80] there are at least 3 possible strategies to consider. This can also be used for younger children but it is critical for those approaching their 22nd birthday.

(1) "Presumed Maximum Value" strategy

The supporting parent may pay the support in the form of food or shelter, as long as the payment is not made directly to the child. For example, the supporting parent could pay rent directly to the landlord or another party (such as another parent or roommate). Instead of cash, the support payment is now food and shelter. The presumed maximum value of food and shelter is $281, so, no matter how much the payment, the value of the support payment for SSI purposes would not exceed $281.[81] Alternatively, in many cases, a reduction of SSI income can be avoided by running up to $16,000 per year through an ABLE Act account. See the discussion on page 59.

(2) "Special Needs Payments" strategy

The supporting parent could pay a special needs provider directly for the child's special needs services. For example, the parent could pay the offspring's health insurance, medical care, training, counseling, etc. "Special needs" services are not counted as income.[82] So, the amount paid to a provider for services provided to the child would not be considered income.

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[79] 42 U.S.C. §§ 1382a(a)(2)(E), (b)(1), (b)(9).

[80] POMS SI 00830.420C.

[81] *See* POMS SI 00830.420, 00835.380. 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.

[82] POMS SI 00815.050E.2.a.1. The POMS uses the terms "social services," but most of the world now knows them as "special needs":

(3) "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. As long as the trustee of such a trust distributes funds only for "special needs," the child support payment is not income and not subject to the income limits.[83]

h) Spousal Support

Spousal support received by a divorced individual is generally considered unearned income when determining SSI eligibility. However, as with child support, through well-crafted trust documents and court orders, spousal support can be paid, under court order, directly to a court-created SNT. These payments are considered irrevocable and not counted as income for SSI purposes.[84]

In the case of pooled trust accounts, spousal support payments irrevocably assigned to a pooled trust under a court order for the benefit of the disabled spouse are not counted as income.[85] However, if the payment is assigned to the pooled trust after the spouse with a disability turns 65, it is an improper transfer of assets and Social Security will impose a period of ineligibility, also known as a transfer penalty.[86]

Resources

Resources include "cash, other liquid assets, and any real or personal property that an individual (or spouse, if any) owns and could convert to cash or spouse owns and can convert to cash..." 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.[87] Unlike the income limits, which are revised annually, resource limits haven't changed since 1989.

i) Exceptions

The list of items that can be resources is very broad but there are quite a few exceptions. These are the most significant:

In-kind items (*other than food, or shelter*) provided by a nongovernmental medical or social services program (e.g., recreational equipment, magazines, toiletries) for medical or social services purposes are not income. *Id.* (emphasis added)

[83] 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. For more on this topic, see Keith Maples, *Divorce and Disability/Child Support*

[84] POMS SI 01120.200G.1.d.; SI 01120.200J.1.d.

[85] POMS SI 01120.203D.7.

[86] See Keith D. Maples, *From The Family Practitioner's Perspective: Divorce Actions and Special Needs Trusts* (Feb. 2019)(presented at the UT SNT conference February 2019.) *See also Some Potential Problems with SSA's New Trust Guide,* ELDERLAW ANSWERS, https://attorney.elderlawanswers.com/some-potential-problems-with-ssas-new-trust-guide-14693 (originally printed in CMS Threatening Transfers into Pooled Trusts By Those 65+, THE ELDER LAW REPORT, Sept. 2008.)

[87] 20 C.F.R. § 416.1205.

(1) Residence

An applicant's residence is not considered a resource. The entire value of the residence, without limit, including all contiguous acreage, if (1) the resident subjectively believes they will return to the residence, (2) the residence is not a resource (such a rental income), even if the applicant is in a nursing home care or other institution. [88]

(2) Household Goods

"Household goods" and "personal effects" are not resources.[89] Household goods are 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 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 as resources. However, items acquired or held "for their value or as an investment" are not considered "personal effects"—for example, "[g]ems, jewelry that is not worn or held for family significance, or collectibles."[90]

(3) Vehicle

One vehicle used for transportation of the individual or a member of the individual's household. [91]

j) Deeming of resources

In certain cases, resources of other household members are "deemed" the claimant's as well. For example:

- All resources of the claimant's spouse living in the same household[92]
- Resources of the claimant's parent in excess of $2,000, or parent and the parent's spouse together in excess of $3,000, if the claimant is under age 18 and living in the same household with a parent. The parent's spouse's assets are deemed, and the $3,000 limit applies, only if the spouse lives in the same household with the claimant.[93]
- Certain resources of an alien's sponsor.[94]

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[88] 20 C.F.R. § 416.1212.

[89] 20 C.F.R. § 416.1216.

[90] 20 C.F.R. § 416.1216; 70 Fed. Reg. 6340, 6342.

[91] 20 C.F.R. § 416.1218; 70 Fed. Reg. 6340, 6343.

[92] 20 C.F.R. § 416.1202(a).

[93] 20 C.F.R. § 416.1202(b).

[94] 20 C.F.R. § 416.1204.

B. BENEFITS

1. CASH BENEFITS

An eligible person with no other income receives the monthly "federal benefit rate" in 2022 of $841 (eligible single individual) or $1,261 (for a married couple with both spouses eligible).[95] However, countable income, as explained above, reduces the amount of cash benefits by the amount of countable income dollar-for-dollar. Determining the amount of countable income for benefit reduction is the same as determining the amount for eligibility.

2. MEDICAID ELIGIBILITY

In Texas, SSI beneficiaries are automatically eligible for the comprehensive medical benefits of the Medicaid program.[96] These benefits, often more important than the cash benefits, are the "Regular Medicaid" benefits discussed in Part VI.

C. TRUST RULES

A trust is a legal entity formed through a will or contract. There are three parties: (1) a grantor (settlor) who provides assets for the trust, (2) a beneficiary who gets the benefit of the trust, and (3) a trustee who manages the trust. Trusts can be formed through wills (testamentary trusts) or by transfers during the settlor's lifetime (inter vivos trusts). A common combination is an inter vivos trust established during lifetime but funded by the settlor with a nominal contribution such as $10, because the trust is to be fully funded only after the settlor's death through the settlor's will and beneficiary designations. This is sometimes called a "standby trust."

If a trust beneficiary has legal authority to revoke or terminate the trust and use the distribution to meet his or her food or shelter needs, the corpus of a trust is a resource under the SSI and Medicaid rules. Similarly, if the trust beneficiary can direct the use of the trust principal for his or her support and maintenance under the terms of the trust, the trust principal is also a resource for SSI purposes. However, inversely, if the beneficiary cannot terminate, revoke, 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.[97]

A trust can be established with assets of someone other than the beneficiary (a "Third-Party Trust") or with assets owned at any time by the beneficiary (a "Self-Settled Trust"). Determining whether a trust is a countable resource for the beneficiary also turns on whose property makes up the corpus of the trust. Unfortunately, both types of trust are commonly referred to as Supplemental Needs Trusts and Special Needs Trusts.

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[95] See Social Security Administration, Fact Sheet: 2022 Social Security Changes, https://www.ssa.gov/news/press/factsheets/colafacts2022.pdf.

[96] *See* Social Security Administration, *Supplemental Security Income (SSI) Overview,* https://www.ssa.gov/ssi/text-over-ussi.htm; *see generally* MEPD Handbook.

[97] POMS SI 01120.200D.2.

1. THIRD-PARTY SETTLED TRUSTS

If a person other than the beneficiary contributes assets to a trust, the trust is a third-party settled trust. Typically, these trusts are created by the disabled person's parents or other family members for the benefit of a person with a disability. As long as the trust does not contain contributions from the beneficiary, provisions for repaying Medicaid benefits after the beneficiary's death are not required and the age restrictions on "self-settled" trusts discussed below do not apply.[98]

a) Agent of the Beneficiary

Watch out for agency issues. Another person, acting as an agent, could provide the beneficiary legal authority to direct the use of the trust principal. "While a trustee may have the 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."[99]

b) Supplement versus Supplant

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, but it is not the policy of the Social Security Administration nor the Texas Health and Human Services Commission (Texas Medicaid). Thus, even a traditional "support" trust will not be counted as an asset of the beneficiary under the SSI program and Texas Medicaid, 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.

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

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

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[98] POMS SI 01120.200A 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 found in SI 01120.201—SI 01120.204. Use the instructions in this section to evaluate the following types of trusts: . . . Trusts established on or after 1/1/00 that contain only assets of third parties . . .

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

money or property as a result of the death of a parent or other benefactor. 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 incentive to recover and carefully use the money or property, and it can last much longer if it merely supplements the public benefits.

> 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.[100]

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. Further, if the settlor is the only beneficiary with a vested interest, such a trust will be considered revocable and therefore a resource of the beneficiary.[101]

There are two statutory exceptions to the general rule: (1) an under-65 Special Needs Trust and (2) a pooled Special Needs Trust. The assets of a self-settled trust will not count as a resource if the trust provides for repayment of Medicaid benefits after the beneficiary's death (the "payback" provision) and meets the other requirements of 42 U.S.C. §1396p(d)(4)(A), (C) (also called the Medicaid "OBRA 93" requirements).

a) Individual Under-65 Special Needs Trust

The following discussion is intended only as an introduction, not to be used as the sole source of guidance for this complex task. For more complete discussions, see the following papers presented at this conference in previous years:

> Wesley E. Wright, *Special Needs Trust Overview,* University of Texas School of Law, 2015 CHANGES AND TRENDS AFFECTING SPECIAL NEEDS TRUSTS
>
> Craig C. Reeves, *How to Make a Trust a "Special Needs Trust,",* University of Texas School of Law, 2016 CHANGES AND TRENDS AFFECTING SPECIAL NEEDS TRUSTS
>
> Craig C. Reeves, *Special Needs Trust Decision Tree Analysis,* University of Texas School of Law, 2017 CHANGES AND TRENDS AFFECTING SPECIAL NEEDS TRUSTS
>
> Craig C. Reeves, *SNT Basics and Beyond—Top Trends and Pitfalls,* University of Texas School of Law, 2018 CHANGES AND TRENDS AFFECTING SPECIAL NEEDS TRUSTS

(1) Eligible Beneficiary

The applicant must be:

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[100] *See Grillo v. Henry Cause,* No. 96–167943–96 (96th Jud. Dist. 2004).

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

- 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 be 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.[102]
- Disabled as defined in the requirements for Social Security Disability Insurance or SSI benefits.

(2) Settlor

As of December 13, 2016, individuals with the intellectual capacity to do so can establish their own special needs trusts and still avoid Medicaid counting the trust as a resource. The law has been amended to allow "*the individual*, a parent, grandparent, legal guardian, or a court" to establish such a trust.[103] This rule is prospective and does not apply to trusts established before December 13, 2016.

For trusts established before December 13, 2016, the trust must be established by a parent, grandparent, legal guardian of the client, or a court. By definition, however, self-settled trusts are funded with assets belonging to or controlled by the beneficiary.

To prevent problems during the application process, even where a parent or grandparent establishes the trust, they provide a nominal contribution (typically, a $10 bill attached to the trust instrument). That nominal contribution may be essential to creating a trust where the assets are exempt under the SSI rules. In one case, a trust created by a trust instrument signed by the parents and meeting all the other requirements was held not to protect the assets because the parents were agents of the beneficiary under her power of attorney and failed to make a nominal contribution to the trust.[104]

That suggests two safeguards to implement when establishing such trusts when the beneficiary is not able to sign the trust instrument with understanding: (1) Have the trust instrument signed, if possible, by a parent or grandparent who is not named as agent under the beneficiary's power of attorney and (2) attach that $10 bill.

(3) Source of funds

The corpus of the trust must include, in whole or in part, the assets of the individual. 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.[105] The

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

[103] 21st Century Cures Act § 5007, P.L. 114–255, amending 42 U.S.C. 1396p(d)(4)(A); SSA EM-16053 (Dec. 13, 2016).

[104] *Draper v. Colvin,* 779 F.3d 556, 563–64 (8th Cir. 2015).

[105] Clifton B. Kruse, Jr., *O.B.R.A. '93 Disability Trusts—A Status Report,* 10 NAELA QUARTERLY No. 1 (Winter 1997).

Texas Medicaid program has not adopted any such limitation on the source of funds, nor is there any provision in the federal law allowing such limits.

(4) Payback Provision

The trust documents must include a provision that each State Medicaid program involved 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, with assets distributed pro rata if there are multiple states and insufficient assets to pay all in full.

(5) Transfer Penalty

The trust must have a payback provision when it is first drafted. Fixing the problem later may result in a transfer penalty. Under legislation effective as to trusts created on or after January 1, 2000, if a trust is established with assets of the individual, the corpus will be treated as a resource of the individual. If the applicant "reforms" or creates a new irrevocable trust, the transfer is subject to a transfer penalty and may be penalized with a 36-month look-back period.[106]

(6) 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. 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.[107]

(7) Trustee

A trust created under Property Code § 142.005 (by a trial court, typically in a personal injury case) or, more frequently, under Texas Estates Code Chapter 1301 (in a guardianship proceeding 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.[108] It is not required if the trust is "established" by a parent or grandparent under 42 U.S.C. §1396p(d)(4)(A).

(8) 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.[109] Another

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[106] Some state Medicaid programs, other than Texas, require they be named as "super creditors," not remainder beneficiaries. Remainder beneficiaries are paid what is left after all other creditors—even unsecured creditors. In contrast, a "super creditor" is paid before most, if not all, general creditors.

[107] MEPD Handbook §§ D-7000 et seq.,

[108] Tex. Est. Code § 1301.057

[109] *See* Kruse, *supra* note 107.

variation is to provide for absolute discretion, with a statement of intent that the distributions be used to "supplement and not supplant" public benefits. 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.

The author is not aware of any Texas program, other than possibly the state-funded mental health and intellectual disability programs, that would fail to honor a self-settled trust unless the trustee is 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 not ordinarily 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.

Self-settled "Special" Needs Trusts discussed here are distinct from similarly named instruments funded by persons other than the client, which need not have the "remainder to Medicaid" provision.

> 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."[110] This rule 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.

b) Pooled Supplemental Needs Trusts

An individual can also put their assets into a "pooled trust" provided in-state by The Arc of Texas or by nation-wide administrators like The Center for Special Needs Trust Administration, Inc.[111] or Legacy Enhancement Trust.[112]

The Arc of Texas has developed four "pooled trusts" as authorized by 42 U.S.C. §1396p(d)(4)(C) that meet the requirements for a self-settled Medicaid trust. The Arc of Texas provides information, forms, and brochures at http://www.thearcoftexas.org/trust/index.php.

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;

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[110] MEPD Handbook § F-6610.

[111] Center for Special Needs Trust Administration, Inc., *Trust Documents,* http://www.centersweb.com/documents/trust-documents/

[112] Legacy Enhancement, https://www.legacyenhancement.org/.

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).

A pooled trust account can be funded with 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 and the Texas Health & Human Services Commission have indicated in correspondence with the Arc of Texas that they will not count assets of accounts in any of these trusts 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) Client eligibility requirements.

(a) Age

The Texas Medicaid program applies a transfer penalty to a transfer by a client age 65 or over to any self-settled trust, even if it meets the "exception trust" requirements.[113] Likewise, 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 Special Needs Trust" or a "Pooled Trust."[114] However, this restrictive interpretation of the federal statute has been challenged in several cases.[115]

(b) Disability

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

(2) Trust requirements

The trust must meet the following requirements:

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[113] MEPD Handbook § F-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. *See* 42 U.S.C. § 1396p(c)(2)(B)(iv).

[114] 42 U.S.C. § 1382b(c)(1)(C)(ii)(IV).

[115] Lewis v. Alexander, 685 F.3d 325 (3rd Cir. 2012), cert. denied, 133 S. Ct. 933 (2013); Center for Special Needs Trust Administration, Inc. v. Olson, 676 F.3d 688 (8th Cir. 2012); In re Pooled Advocate Trust, 813 N.W.2d 130 (S.D. 2012).

(a) Management/Trustee

The trust must be established and managed by a non-profit association and, according to Texas law, only banks or licensed trust companies can serve as corporate trustees. They aren't necessarily the same entity. For instance, the Arc of Texas Pooled Trust was established and is managed by the Arc of Texas, a non-profit association, while JPMorgan-Chase Bank serves as trustee.

(b) 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.

(c) Who may establish sub-accounts

Accounts are established in the pooled trust by a court, a parent of a minor child, an agent, a guardian, or by the individuals themselves. A court can order a pooled trust in a guardianship case under Texas Estates Code Chapter 1302.[116] However, the statute requires that the minor or incapacitated person be the "sole beneficiary of the trust," [117] Since a pooled trust also benefits others, they may not be considered the sole beneficiary of the trust. That said pooling is only done for investment purposes, a by designating "subaccounts" a pooled trust is the functional equivalent of a trust with a single beneficiary.

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

(e) Guardianship Court Orders

If the sub-account is established by order of a guardianship court, carefully follow the requirements of Texas Estates Code Ch.1302. The statute explicitly sets out who receives the remainder. First, the trust repays Medicaid up to the amount of Medicaid payments made for the client. After Medicaid has been repaid, the statute states that if the beneficiary is (1) living and not incapacitated, the remainder goes to the beneficiary, (2) living and incapacitated, the remainder goes to the guardian, or (3) deceased, the remainder goes to the personal representative of the beneficiary's estate.

The statute doesn't allow for the pooled trust to be a remainder beneficiary. According to the statute, The Arc of Texas Master Pooled Trust joinder agreement gives the settlor the option, but some pooled trusts require making the trust the primary beneficiary. Likewise, if a guardian is not involved, making the pooled trust the primary beneficiary cuts out any possibility of family members receiving anything out of the remainder. Unless the proposed contributor has the capacity to decide to make the pooled trust a beneficiary and does so, the interests of the beneficiaries to the estate prevail, the

[116] Property Code §142.005(b)(1).

[117] *Id.*

(f) Distributions

The federal statute does not set limits regarding 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 benefits programs, as occurs with narrowly drafted trusts and as has been required by some states (but not Texas). See the discussion above on the choices offered by the Arc Pooled Trust.

(g) Disbursements of Food, Clothing, Shelter

MEPD Handbook 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 Medicaid programs applying the full SSI methodology for counting income. However, it is incorrect with regard to nursing home Medicaid and Medicaid "waiver" home care programs, such as Star+Plus Waiver, which do not count food and shelter as income;[118] 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.

(3) Arc Pooled Trust Distribution Standards

According to their respective Master Pooled Trust Agreements establishing the trusts, the essential distribution standards of Trusts I and II are as follow:

> 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.

According to their respective Master Pooled Trust Agreements, the essential distribution standards of Trusts III and IV are as follow:

> 3.1. 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

[118] MEPD Handbook § O-3200.

> 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.

The amendment of the trust to allow payments for the support of beneficiaries, even when they would reduce or eliminate public benefits, allows for larger contributions to the trust. 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 Maximum Value Rule." With Trust III and Trust IV, such distributions are 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.

An advantage of the Arc pooled trust in the past has been that it could accept contributions from individuals aged 65 and over for their own benefit, which cannot be done in other types of self-settled trusts. However, HHSC interprets the SSI law to provide for a transfer penalty for contributions to a self-settled pooled trust by persons age 65 and over.

The Arc of Texas Master Pooled 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 .

For more information on drafting for use of pooled trusts, see Appendix 10 below.

3. JUDICIAL REFORMATION OF WILLS

Because a beneficiary has little to no control over the making of a will, often a bequest or interest is provided directly to a person who needs means-tested public benefits, such as SSI or Medicaid. This unexpected income/resource can reduce the person's benefit or disqualify them for benefits all together. To prevent this, the 2015 Texas Legislature enacted Texas Estate Code §§ 255.451-455. This allows a decedent's will can be "reformed" in order to qualify a beneficiary for

governmental benefits. Note, only the personal representative of the estate (executor or administrator) can request such an order.

If a will provides for distribution directly to an individual on Medicaid, that individual can regain eligibility by transferring the distribution to a trust with the Medicaid-payback provision and other requirements of a self-settled Special Needs Trust. However, under 1 T.A.C. § 358.336 and MEPD Handbook § F-6100, a testamentary trust (trust established in a will) does not have to name the Medicaid program as a remainder beneficiary because it is established with assets of the decedent and not with the assets of the trust's beneficiary.

The issue is whether a reformed will needs to name a remainder beneficiary. Under Texas Estates Code § 255.453, the court may direct that the reformed will have a retroactive effect. Shari Nichols confirmed at the University of Texas 2018 Galveston conference that if an order of reformation is made, HHSC will treat the trust like any other testamentary trust. The change will be effective the later of 1) the month in which the court signs the order 2) the first month of eligibility or 3) the first day of the month the individual provides the court order to HHSC. If the reformation is done prior to an application for benefits, HHSC will honor the change when checking three months prior eligibility. However, at this writing in January 2022, we do not have a statement or case in which the Social Security Administration has communicated policy on that issue.

4. SELF-SETTLED TRUSTS-KEY PROVISIONS IN 2018 POMS REVISIONS

In April 2018, the Social Security Administration issued three "transmittals" with revisions to the POMS affecting self-settled trusts. After reviewing the voluminous and important materials, the authors deem the following provisions to be the most critical.

a) The "sole benefit rule"

When evaluating a payment to a third party for goods or services, the key is to remember:

> the goods or services must be for the primary benefit of the trust beneficiary. You should not read this so strictly as to prevent any collateral benefit to anyone. e.g., if the trust buys a house for the beneficiary to live in, that does not mean that no one else can live there; if the trust buys a television, that no one else can watch it.[119]

b) Trust Payments to Third Parties

A trust is established for the benefit of the beneficiary and payments benefit the beneficiary if:

> the trustee makes payments…to another person or entity such that the individual derives some benefit from the payment….We evaluate these payments under regular income-counting rules.[120]

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[119] POMS SI 01120.201F.3.a.

[120] POMS SI 01120.201F.2.

(1) Titled goods

When a trustee purchases goods that require titling, the goods should be titled in the name of the trustee or the beneficiary unless state law does not permit it. For example, some states do not permit a minor to own a motor vehicle. In that case, the vehicle may be titled in the name of a third party as long as the trust's interest is protected by a lien on the vehicle.[121]

(2) Services performed by family members

A family member can be paid as a third-party provider, like any other provider, including for companion services. The family member doesn't need to have medical training or specialized certification:

> You should not routinely question the reasonableness of a service provider's compensation. However, if there is a reason to question the reasonableness of the compensation, you should consider the time and effort involved in providing the services as well as the prevailing rate of compensation for similar services in the geographic area."[122]

(3) Travel of the beneficiary and necessary companions

Payments to third parties for travel expenses, including transportation, lodging, and food, for the beneficiary and companions necessary due to the beneficiary's medical condition, disability, or age do not violate the sole benefit rule:

> Absent evidence to the contrary, accept a statement from the trustee that the service or assistance provided is necessary to permit the trust beneficiary to travel."
>
> Physician statements of medical necessity and evidence of a companion's medical training or certification are not necessary. The decision should be evaluated based on reasonableness. The new policy states:
>
> > Use a reasonableness test in evaluating the number of people the trust is paying to accompany the beneficiary. For example, it is reasonable for a trust to pay for other individuals, such as parents or caretakers, to accompany a disabled minor child on vacation to provide supervision and assistance. Travel without this support would not be possible. However, it would violate the sole benefit rule if the trust paid for other individuals who are not providing services or assistance necessary for the beneficiary to travel.
> >
> > In this example, the fact that the parents or caretakers cannot afford to pay for their other children's trip, or cannot leave them at home, is not a consideration relevant to the sole-benefit requirement.[123]

(4) Travel expenses to visit the beneficiary

A trust may pay for another's travel expenses to visit the beneficiary if the travel is necessary to ensure the trust beneficiary's safety or medical well-being. For example, the trust can pay for the travel of a service provider (including a family member) to oversee the beneficiary's living

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[121] POMS SI 01120.201F.3.a.

[122] POMS SI 01120.201F.3.a.

[123] POMS SI 01120.201F.3.b.

arrangements for a beneficiary living in an institution, long-term care facility, or other supported living arrangement. The trust may also pay for a trustee, trust advisor named in the trust, or successor trustee to perform their "fiduciary duties or to ensure the well-being of the beneficiary when the beneficiary does not reside in an institution."[124]

(5) Costs of Trust Administration

The trust may also pay reasonable compensation to the trustee for managing the trust and reasonable costs to providers of investment, legal and other services for the trust or the beneficiary:

> In evaluating what is reasonable compensation, consider the time and effort involved in providing the services and the prevailing rate of compensation for similar services considering the size and complexity of the trust.[125]

c) 90 days to amend

The changes to POMS are retrospective—they apply to all trusts regardless of when they were established. If a trust that was previously deemed exempt is deemed inconsistent with the current POMS, the beneficiary is entitled to notice and 90 days to amend the trust before the trust's assets can be counted as resources of the beneficiary. The 90-day period can be extended for good cause—e.g., need for additional time to obtain a court order.[126]

d) Self-settled trusts

"A trust is considered to have been established with the assets of an individual if any assets of the individual (or spouse), regardless of how little, were transferred into the trust other than by will."[127] If a beneficiary of a third-party trust puts his or her own assets into the trust, "the portion of the trust funded with the individual's assets is subject to the rules in SI 01120.201 through SI 01120.204 [self-settled trust rules]"[128]

A self-settled trust established before January 1, 2000, is governed by the same rules as a third-party trust (e.g. no Medicaid payback) regardless of the individual's filing date. Assets of the beneficiary added on or after 01/01/00 are also treated as exempt. However, the transfer rules still apply and the transfer may be subject to a transfer penalty.[129]

e) Payments assigned to a trust

For SSI purposes,

> A legally assignable payment to a trust or a trustee is income…**unless** the assignment is irrevocable.

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[124] POMS SI 01120.201F.3.c.

[125] POMS SI 01120.201F.4.

[126] POMS SI 01120.201K.

[127] POMS SI 01120.201C.2.

[128] POMS SI 01120.201C.1., C.2.c.

[129] POMS SI 01120.201C.1.

The SSA considers court-ordered child support or alimony payments to be irrevocably assigned to a trust if payment to the trust is required by the court order. Also, assignment of Survivor Benefit Plan (SBP) annuity payments is irrevocable, so assigned SBP payments are not income of the trust beneficiary.[130]

f) Trust Disbursements

Cash payments to the individual and payments to third parties for the beneficiary's support and maintenance are income. Disbursements that do not fall into those categories—like educational expenses, some travel expenses, therapy, uncovered medical services, phone bills, etc.—are not income.

When a trust makes a payment to a third party for an item that is not cash, food, or shelter, the item is not income if:

> the non-cash item would become a totally or partially excluded non-liquid resource if retained into the month after the month of receipt.[131]

One month after purchase, a computer, a household good, would be an excluded resource. Therefore, it isn't income in the month it was purchased.[132] Similarly, trust funds transferred to the beneficiary's ABLE account, an excluded resource, are not income to the trust beneficiary.[133]

g) Administrator-managed Pre-paid cards

True Link and other administrator-managed prepaid cards are a type of restricted debit card that can be customized to block the cardholder's access to cash, specific merchants, or entire categories of spending. Income and resource determinations are based on who owns the card account. If the trustee is owner of the account, it is treated as a credit card: cash to the beneficiary is unearned income, food or shelter is ISM, other purchases are not income, and any unspent balance is not a resource. If the beneficiary is owner of the account, it is treated as debit card: all distributions from the trust to the card are income and the unspent balance is a resource.[134]

h) Notice of Ineligibility Requirements

When the individual is found "ineligible due to excess resources and those resources include a trust," the individual is entitled to a manual notice.[135] The notice should explain each reason the

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[130] POMS SI 01120.201J.1.d.

[131] POMS SI 01120.201I.1.c.

[132] *Id.*

[133] *Id.*, POMS SI 01130.740.

[134] POMS SI 01120.201I.1.e. However, POMS SI 01120.201I.1.a says payments to a debit card account are unearned income, and SSA has treated True Link cards that way in cases in Florida and San Diego, California, according to a listserv post in early January 2021.

[135] POMS SI 01120.204A.

trust is not an excluded resource. [136] The notice must include the problematic section and the applicable POMS sections.[137]

5. 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).

The SSA 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."[138] 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:

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
2. All trust assets that remain must be distributed to the trust beneficiary; and
3. Someone other than the trust beneficiary holds the power to terminate the trust.[139]

This applies to pooled trusts as well as individual under-65 SNTs, except a pooled trust is exempted from the requirements above as to a provision solely allowing for the transfer of a beneficiary's assets from one qualified pooled trust to another.[140]

> 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 excepted 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

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[136] POMS SI 01120.202.A.1.g.

[137] *Id*.

[138] POMS SI 01120.199D.

[139] POMS SI 01120.199E.1.

[140] POMS SI 01120.199E.2.

within 90 days after the Administration informs the SSI recipient or representative payee of the need for amendment of the trust.[141]

> 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."[142] 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 provisions, which have been invoked to amend them to comply with this new requirement.[143]

6. 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:

1. Who should be the trustee?
2. What distribution standards are most appropriate?
3. Is a pooled trust or individual trust better?

The following factors must be considered in making these decisions:

- Is an appropriate individual trustee available?
- If so, is that person's administration preferable to administration by a pooled trust or other corporate fiduciary?
- Is the amount of the corpus sufficient to attract a corporate fiduciary other than a 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.)

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[141] POMS SI 01120.199A.

[142] TEXAS PROP. CODE §112.054(a)(2).

[143] The ARC of Texas Master Pooled Trust, http://www.thearcoftexas.org/trust/index.php#enroll_forms.

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

a) What distribution standards are most appropriate?

- Is there a likelihood of the beneficiary's moving to another state? If so, the choices may (or may not) 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 food and shelter.

b) Is a pooled trust or an individual trust better?

- 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 call for the trustee to have the discretion to supplant benefits, while the latter would call for a strict "mandatory supplemental needs" standard protecting benefits to the greatest extent possible wherever the beneficiary resides. Some of these conflicts simply must 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,[144] 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 a pooled trust.

SPECIAL NEEDS TRUST DECISION MATRIX

Issue	Pooled Trust	Individual Trust Created by the Individual, Parent, Grandparent, or Guardian	Individual Trust Created by Court
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
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; 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 complete forms required by the Pooled Trust, including an agreement establishing a subaccount, and pays a fee if applicable	Attorney drafts trust; individual, 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

[144] When considering making a trust the beneficiary of a qualified retirement plan or IRAs, the trust's individual beneficiary must qualify as the "designated beneficiary" under Treasury Reg. §1.401(a)(9)-4. Otherwise, valuable tax deferral opportunities may be lost.

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 the use of Presumed Maximum Value Rule, unlimited trustee discretion, or "spigot trust."	May provide for other standards, such as supplemental needs allowing the use of Presumed Maximum 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

7. THE SOLE BENEFIT RULE

For an Individual Under 65 trust, the trust must be "for the sole benefit" of the disabled individual. If the trust allows for disbursement that benefits others, the trust is considered a countable resource. Dubbed the "sole benefit rule," interpretations vary amongst caretakers, practitioners, corporate trustees, courts, and federal and state agencies.[145]

Read strictly, distributions that would benefit the beneficiary and benefit family and household members, even in small ways, would violate the "sole benefit" rule and be considered a resource to the beneficiary.[146].

In 2018, changes to POMS indicate that the "sole benefit" rule should not be read so strictly. For instance, the "sole benefit" rule:

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[145] *See Hobbs v. Zenderman,* 579 F.3d 1171 (10th Cir. 2009); *Lewis v. Alexander,* 685 F.3d 325 (3rd Cir. 2012). The

[146] In particular, paying family members for their caretaking services would be problematic. It would seem to require third-party home health care staffing even though parents and other members of the household may be more qualified to provide the individualized care. Further, the strict reading may have a chilling effect on the purchase of homes wherein a trust and family members would have a joint ownership agreement.

> should not read this so strictly as to prevent any collateral benefit to anyone. e.g., if the trust buys a house for the beneficiary to live in, that does not mean that no one else can live there; if the trust buys a television, that no one else can watch it.[147]

Further, a family member can be paid as a third-party provider, like any other provider, for care services, including for companion services. The family member doesn't need to have medical training or specialized certification:

> You should not routinely question the reasonableness of a service provider's compensation. However, if there is a reason to question the reasonableness of the compensation, you should consider the time and effort involved in providing the services as well as the prevailing rate of compensation for similar services in the geographic area.[148]

However, the "sole benefit rule" is still very much with us and has some practical implications. For clients who are Medicaid eligible or are seeking Medicaid coverage, all the stakeholders (Medicaid Eligibility Specialist, HHSC, court, family members, beneficiary, lawyers) should develop a plan of distribution, as a team, that will support proper care without disqualifying the recipient for public benefits.

In general, 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 may not be required for every question in every situation, addressing them will help manage all the stakeholders' expectations as early in the process as possible. This planning may also affect the trust language, but, as SSA's policy shifts, it may be prudent to document the parties' understandings in other ways.

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[147] POMS SI 01120.201F.3.a.

[148] POMS SI 01120.201F.3.a.

8. TREATMENT OF UTMA ACCOUNTS

A Uniform Transfers to Minors Act (UTMA) account allows a donor to make an irrevocable transfer of money or any kind of property, real or personal, tangible or intangible, to an account under the control of custodian until the minor turns 18. Until the minor turns 18, UTMA property, and earning on the property, are not considered income or a resource to the minor unless it is funded by with the minor's belongings.[149] If the funds belonging to a minor Medicaid recipient are placed into the minor's UTMA account, SSA considers the account a "device similar to a trust" and the rules are applied as if it were a trust.[150] Therefore, if it is self-settled and does not have a Medicaid payback provision (which no UTMA accounts do), it is a resource available to the beneficiary. If it is third-party-settled, the assets are not resources available to the beneficiary. Disbursements are subject to 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 argue that, since the funds in an UTMA account belong to the beneficiary, in the funds are, in essence, beneficiary's funds.[151] However, it may depend on the source of the funds in the UTMA account. If the UTMA account is funded by a third-party and the transfer is made before their 21st birthday, SSA may allow it

9. SSA'S SYSTEM FOR EVALUATING SSI TRUSTS

All SSI applications involving trusts are to be routed through a new Regional Trust Reviewer Team.[152] 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.[153] However, NAELA leader Thomas D. Begley, Jr. warns that the Fact Guide "probably raises more questions than it answers."[154] A section that has caused considerable suffering of persons with disabilities and has since been repudiated (but not removed from the Fact Guide) is discussed in the next section below.

Some additional insight into the thinking of the Regional Trust Reviewer Team may be drawn from a list of POMS sections they have cited when asked why they disapproved a trust:

- SI 01120.199 Early Termination Provisions and Trust

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[149] POMS SI 01120.205D.3

[150] POMS SI 01120.205E.2.; *See Begley,* supra note 161, at § 6.06[C][1][b].

[151] *See Begley,* supra note 161, at §6.06[C][1][b][2].

[152] POMS SI 01120.202B.

[153] See Fact Guide for National Trust Training, http://www.pekdadvocacy.com/wp-content/uploads/2016/07/GS4d-Fact-Guide-for-National-Trust-Training.pdf (drafted December 16, 2013)

[154] BEGLEYLAWGROUP.COM. *Fact Guide for National Trust Training: The Impact on Special Needs Trusts,* http://www.begleylawyer.com/2014/10/fact-guide-for-national-trust-training-the-impact-on-special-needs-trusts/

- SI 01120.200 Trusts–General, Including Trusts Established Prior to 1/1/00, Trusts Established with the Assets of Third Parties and Trusts Not Subject to Section 1613(e) of the Social Security Act
- SI 01120.201 Trusts established with the assets of an individual on or after 1/1/00
- SI 01120.202 Development and Documentation of Trusts Established on or after 1/1/00
- SI 01120.203 Exceptions to Counting Trusts Established on or after 1/1/00
- SI 01120.204 Notices for Trusts Established on or after 1/1/00
- SI 01120.225 Pooled Trusts Management Provisions
- SI 01120.227 Null and Void Clauses in Trust Documents

10. TEXAS IMPLEMENTS THE ABLE ACT

a) ABLE Account Requirements

The 2015 Texas Legislature passed legislation[155] to allow certain Texans with disabilities to open special accounts allowed, subject to state and agency implementation, by the federal Achieving a Better Life Experience (ABLE) Act.[156]

The funds, including earnings such as interest, in accounts meeting the federal and state requirements, are not counted as resources by the SSI and Medicaid programs. In Texas, the funds in such accounts are not counted as resources by any means-tested programs, nor are distributions counted as income.[157] Their earnings, including interest, are not taxed as long as they are used for "qualified disability purposes." The following are the major requirements:

Functional Requirement	A disability that: • meets SSI or SSDI—or their functional equivalent—requirements; AND • was diagnosed before age 26
Possible Contributors	Account holder and/or third parties
Annual Contributions	Transfer tax annual exclusion amount ($16,000 in 2022)[158]
Exclusion Limits	Varies based on the program: • SSI $100,000 • Medicaid (not linked to SSI): $370,000
Distribution Limitation	The account can only be used for "qualified disability purposes," but the list is relatively broad, including even housing, education and transportation (but not food or entertainment)

[155] Act of May 30, 2015, 84th Leg., R.S., S.B. 1664, § 2 (adding a Subchapter J to Chapter 54, Texas Education Code).

[156] Achieving a Better Life Experience (ABLE) Act of 2014, P.L. 113–295, 128 Stat. 4056 (adding §529A to the Internal Revenue Code at 26 U.S.C. §529A)

[157] TEXAS EDUC. CODE § 54.9065 (added by Act of May 30, 2015, 84th Leg., R.S., S.B. 1664, § 2).

[158] See section below on transfers for accounts funded by a donor for the purpose of qualifying the donor for Medicaid benefits.

Medicaid Payback	The account is subject to a Medicaid payback requirement at the death of the individual—even if it is funded with third-party money. The required payback is limited to the amount paid by Medicaid on behalf of the individual after the account is created
Number of Allowed Accounts	One ABLE account per person
Form of Contributions	Cash only

An individual is eligible for an ABLE account if they are receiving SSI or SSDI benefits based on a disability or blindness that occurred before age 26. Alternatively, an individual can file a disability certification that shows they meet the functional requirements although they are not receiving SSI or SSDI benefits. CMS makes clear, however, that the use of a disability certificate for an ABLE account has no effect on Medicaid eligibility.[159]

According to the federal statute, the state program must be a "qualified" ABLE program but there is no formal certification process, and the IRS proposed rules do not include a certification process. In response, CMS guidance says that state Medicaid agencies should presume all state established programs are "qualified" for the time being.[160]

b) ABLE Accounts Can Provide Food and Housing!

A distribution for housing from an ABLE account is not "income" under the in-kind support and maintenance rules:

> A distribution from an ABLE account is not income but is a conversion of a resource from one form to another. Do not count distributions from an ABLE account as income of the designated beneficiary, regardless of whether the distributions are for a QDE not related to housing, for a housing expense, or for a non-qualified expense. [161]

Therefore, it appears that all distributions from ABLE accounts are excluded from counting as income—even food and even non-qualified expenses.

Another issue related to distributions is whether they count as resources if retained beyond the beginning of the calendar month after the month of distributions. It appears that is a problem only if the purpose of the distribution was to provide "housing" or was not a Qualified Disability Expense:

> Count a distribution for a housing expense or for an expense that is not a QDE as a resource, if the designated beneficiary retains the distribution into the month following the month of receipt. [162]

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[159] CENTER FOR MEDICARE & MEDICAID SERVICES, *Re: Implications of the ABLE Act for State Medicaid Programs* (September 7, 2017), https://www.medicaid.gov/federal-policy-guidance/downloads/smd17002.pdf .

[160] *Id*.

[161] POMS SI 01130.740C.4.

[162] POMS SI 01130.740D.2

Comment: This appears to be a breakthrough event in the lives of SSI beneficiaries, their families, and their advocates. Because an ABLE Account can be funded with third-party money as well as with funds of the beneficiary, relatives and trustees can provide food and housing to the extent of $16,000 per year, without creating "income," by running the funds through an ABLE Account. Therefore, in many situations, beneficiaries will no longer be forced to choose between getting help with food and shelter and having their SSI benefit reduced by one-third. Also, as long as the funds from a distribution are used in the same calendar month as the distribution, there appears to be no restriction as to how the funds may be used. The only statutory purpose of identifying Qualified Disability Expenses is to identify uses of trust income making it non-taxable. However, these small accounts will have little or no income, and SSI beneficiaries rarely pay income tax anyway. Therefore, it would appear that except in very unusual cases, any efforts at restricting distributions to QDE's are unnecessary.

c) ABLE Account Contributions Excepted from Transfer Penalty for Parents Only

Any person may make a transfer to a trust for the "sole benefit" of a person with a disability who is under 65 years of age, without a transfer penalty in the event of the transferor's applying for Medicaid.[163] However, an ABLE Account is not a trust. Therefore, although the beneficiary is a person with a disability and may be under age 65, it is not a "sole benefit trust" to which a transfer may be made without a transfer penalty to the transferor under the "sole benefit trust" exception.[164]

However, a separate exception permits a penalty-free transfer to the transferor's *child* of any age who has a disability.[165] Since one of the requirements of an ABLE account is that the owner must have a disability beginning before age 26, there is no transfer penalty for a transfer to an ABLE account owned by the *child* of the transferor.

The result is that whether a transfer to an ABLE account by someone other than the owner may potentially be subject to a transfer penalty depends on the relationship of the transferor to the owner of the ABLE account. If it is a parent-child relation, a transfer penalty exception applies; but as with all contributions to an ABLE account, the amount contributed in any calendar year should not exceed the amount of the transfer tax annual exclusion amount ($16,000 in 2022). However, if the transferor is a grandparent, great-grandparent or any other relation other than a parent, no exception applies. Disabled Adult Child Support May Be Ordered Paid to a Special Needs Trust

Child support paid to or for the benefit of an adult child with a disability who is on SSI reduces that person's SSI benefit dollar for dollar. If the child support plus other countable income exceeds the maximum for SSI eligibility ($794 for 2022), the adult child loses both SSI income and Medicaid eligibility. However, if the child support is paid to a Special Needs Trust that pays back Medicaid upon termination of the trust, it need not affect the beneficiary's SSI and Medicaid benefits at all. Most Texas courts have been making such orders whenever the parents could agree on them, but at least one judge recently has refused to do that on the ground that it was not

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[163] 42 U.S.C. §1369p(c)(2); MEPD Handbook § I-3200.

[164] Shari L. Nichols, "The View from HHSC," University of Texas Estate Planning, Guardianship and Elder Law Conference, August 9, 2018 (in slide)

[165] MEPD Handbook § I-3200.

permitted by Texas law. The Legislature has since amended § 154.302(c) of the Texas Family Code to give courts that authority, at least in cases involving support of an adult child with a disability:[166]

> … a court that orders support under this section for an adult child with a disability may designate a special needs trust and provide that the support may be paid directly to the trust for the benefit of the adult child. The court shall order that support payable to a special needs trust under this subsection be paid directly to the trust . . . .

This provision's limitation of child support payments to SNTs for adults disabilities does not mean that courts are barred from ordering support payments for a minor child be paid directly to a Special Needs Trust. The original version of the bill amended provisions related to support for adult children with disabilities. It didn't speak to whether minor-child support could be paid directly to an SNT. The Attorney General insisted that the proposed bill be amended to make clear that it only applied to child support for adult children with disabilities and for payments that did not go through the State Disbursement Unit. The Attorney General's child support enforcement operation, as a federally funded program, is subject to a federal regulation naming who may receive child support payments for minor children. The regulation does not include Special Needs Trusts. There is no good reason that the regulation cannot be changed, but until that happens, the OAG is expected to oppose legislation inconsistent with it.

Meanwhile, though, while the law permits courts to order support payments for adult children with disabilities to an SNT, there is no law prohibiting courts from ordering payment of child support for a minor child to an SNT. By paying directly to the trust, the child will avoid having two-thirds of the child support counted as "income" and, thus reducing the SSI benefit by two-thirds of the amount paid and terminating Medicaid eligibility if the child's total countable income, including that two-thirds of child support, exceeds $794 per month.

11. CHILD SUPPORT PAID FROM SELF-SETTLED SNT IS "INCOME" TO THE SNT BENEFICIARY

There are cases in which the settlor-beneficiary of an under-65 SNT has a minor child and has been ordered by a court to pay child support for the benefit of the child. HHSC's position is that any such payments are treated as income to the SNT beneficiary, as if the beneficiary had received money then paid it as child support.[167] Therefore, if the beneficiary is on Medicaid in a nursing home and must pay virtually all her "income" to the facility, the amount paid from the trust to someone else as child support is added to the amount she must pay as copayment (and therefore subtracted from the Medicaid payment to the facility). Of course, she cannot pay it as copayment, because it is for the child's benefit. Therefore, she is subject to being discharged from the facility for failing to pay the copayment, unless the trust pays the same amount to the facility. It may be necessary to request modification of the order for child support.

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[166] Acts of May 29, 2019, 86th Leg., R.S., H.B. 558 § .

[167] Shari L. Nichols, Texas Health and Human Services Commission, *University of Texas School of Law's Changes and Trends Affecting Special Needs Trusts Conference: The View from HHSC* (Feb. 7, 2019).

12. POOLED TRUST IS NOW AN ALTERNATIVE TO A 142 TRUST

It is common for a trial court to establish a trust for the benefit of a party, under Texas Property Code Chapter 142. Typically, that occurs in a personal injury case in which a plaintiff recovers a judgment or settlement. If the proposed beneficiary has a disability and is eligible or potentially eligible for Medicaid (and typically for SSI), the trust will have a "Medicaid payback" provision enabling it to qualify as an "exception trust" whose assets do not prevent eligibility of the beneficiary for those programs.

If the funding for the trust does not exceed $50,000 or if no financial institution is willing to serve as trustee, an individual may be appointed as trustee. However, in many cases, no suitable person can be found to serve as trustee. To solve that problem, the 2019 Legislature provided for transfer of judgment or settlement funds to a pooled trust in either of two situations:

- In the alternative to establishing a 142 trust, under a new Chapter 143, a trial court may order transfer of property for a proposed beneficiary to a pooled trust subaccount.[168]
- If a 142 Trust has already been established, and the court with continuing jurisdiction over it determines that transfer of its property to a pooled trust would be in the beneficiary's best interests, that can be done by order of the court under the terms of Chapter 143.[169]

D. TRANSFER RULES

An individual may be subject to a period of ineligibility, known as a "transfer penalty," for transferring certain assets or resources prior to applying for SSI. The transfer penalty penalizes transfers of assets or resources, subject to certain exceptions made during a "look-back period.0" The "look-back period" is calculated starting at the application date or the date of transfer (whichever is later) and "looking back" a certain number of months. For SSI, the "look-back period" is 36 months prior to application, and for long-term care Medicaid it is 60 months prior to application.

When an individual applies for SSI, the agency asks if any uncompensated transfers occurred within the "look-back period".[170] If the transfers were made prior to the look-back period, there is no penalty, regardless of how much was transferred. If transfers were made during the look-back period and not otherwise excepted, it is subject to a "transfer penalty." The penalty starts on the date of transfer. The duration of ineligibility is determined by dividing the total uncompensated values of the improperly transferred resource, by the maximum monthly SSI benefit[171] effective on the date of application. Fractions are rounded down to the nearest whole month. The entire calendar month in which the transfer was made is included as a penalty month.

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[168] Acts of May 42, 2019, 86th Leg., R.S., H.B. 2245 § 8.

[169] Acts of May 42, 2019, 86th Leg., R.S., H.B. 2245 § 7.

[170] 42 U.S.C. § 1382b(c)(1)(A); Foster Care Independence Act of 1999 § 206, P.L. 106–169, 113 Stat. 1822; *see also* 20 C.F.R. § 416.1240.

[171] Including any state supplement of which there is none in Texas.

For example, if an application is filed in the year 2022, a transfer of $2,000 on January 14, 2022, will result in a penalty period of $2,000 ÷ $841 = 2.38, which is rounded down to 2 months. Ineligibility will begin January 1, 2022, and end February 28, 2022.

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, 2021, the calculation will be as follows: $4,000 ÷ $841 = 4.76, rounded to 4 months. Ineligibility will begin January 1, 2022, and end April 30, 2022.

The maximum penalty period for SSI is 36 months from the date of the transfer. In contrast, the Long-Term Care Medicaid transfer penalty for transfers on or after February 8, 2006, where the period begins sometime 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.[172] 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)[173]
- Transfers to or from a trust (including an "Under 65 Special Needs Trust" under 42 U.S.C. §1396p(d)(4) or to an ABLE Act account),[174] established solely for the benefit of the transferor's child who is blind or has a disability

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[172] 42 U.S.C. § 1382b(c)(1)(B)(ii).

[173] 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.

[174] According to Shari Nichols, attorney at HHSC, citing 42 USC 1369p(c)(2)(B)(III), transfers to an ABLE Account to a disabled child will not result in a penalty period to the donor, whereas transfers to an ABLE account to a non-disabled individual will result in a transfer penalty to the donor. For a complete discussion on ABLE accounts, see Stephen W. Dale's ABLE Act Update, presented at the 2018 Special Needs Trust Conference available at https://utcle.org/ecourses/OC7096.

- 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 the residence to the spouse of the transferor
- 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.[175]

E. APPLICATION

An eligible individual must file an application, and a person is not entitled to cash benefits until the application is filed. However, an eligible individual may be entitled to Medicaid retroactively 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[176] or call 1–800–772–1213 or TTY 1–800–325–0778. Additional information is available at the Social Security website at https://www.ssa.gov/planners/disability/.

Appeals can be filed online for denials and other adverse actions regarding SSI and other Social Security benefits. For example, Requests for Reconsideration, Requests for Hearing and

[175] 42 U.S.C. § 1382b(c)(1)(C)(iv).

[176] As of March 2021, all local hearing offices are closed to the public due to COVID-19. For the time being hearings can be done by phone or online video or they can be postponed until the offices reopen. Beginning in late 2021, SSA schedule priority in-person hearings for priority cases. For more information, go to https://www.ssa.gov/appeals/hearing_options.html.

supporting documents can be filed online. The starting point is https://www.ssa.gov/disabilityssi/appeal.html.

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
Federal agency policies and procedures	Social Security Administration's Policy Manual Program Operations Manual System (POMS) at https://policy.ssa.gov/poms.nsf.

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:

- 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 for 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)
- 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 Internet Explorer, open the Edit menu and select Find, then type in the word or phrase you want on that screen. In most browsers, if you hold down the "CTRL" key and the "f" key (the "f" is for find) at the same time, the search box will appear.

III. CHILDHOOD DISABILITY BENEFIT & DISABLED ADULT CHILD MEDICAID

There is a special Social Security benefit, for a child with a disability beginning before age 22. Their eligibility is based on their parents' earning record. If the parent has a sufficient Social Security earnings record, an adult child with a disability may qualify for a "Childhood Disability Benefit" (formerly called "Disabled Adult Child Benefit")[177] upon either parent's disability, retirement, or death (whichever comes first).

If the parent on whose record the child is claiming is retired or disabled, a qualifying adult child is entitled to a cash benefit of 50% of the "Primary Insurance Amount" (PIA). If that parent is deceased, the benefit is 75% of the parent's PIA. The PIA is a person's retirement benefit at full

[177] The Social Security Administration has changed the name of the benefit from Disabled Adult Child Benefit to Childhood Disability Benefit. However, Texas Medicaid still calls its related program Disabled Adult Child Medicaid.

retirement age. In addition to the cash benefit, the adult child will qualify for Medicare two years after they qualify for the cash benefit.

The Childhood Disability Benefit usually exceeds the SSI maximum benefit which means an individual receiving a Childhood Disability Consequently, the client is ineligible for SSI and the Medicaid that goes with it. That would be disastrous for many people; Medicaid is often more important than the cash. Fortunately, there is a special program, "Disabled Adult Child Medicaid," only for individuals in this situation. Essentially, you must prove you would have been eligible for SSI but for the Childhood Disability Benefit, in an application filed with Texas Health & Human Services Commission. A person is eligible for this program if they:

- are at least 18;
- become disabled before they are 22;
- are denied SSI benefits because of entitlement to or an increase in RSDI disabled children's benefits received on or after July 1, 1987, and any subsequent increase; and
- meet current SSI criteria, excluding the children's benefit specified above.[178]

Until recently, neither Social Security nor Medicaid provided notice of this program when SSI eligibility was terminated. However, termination of SSI eligibility due to an increase in Social Security income automatically triggers eligibility for up to two months for Disabled Adult Child Medicaid.[179] Apparently because it is to fill the gap between loss of SSI and establishment of full Disabled Adult Child Medicaid eligibility by applying for DAC Medicaid with HHSC, the entitlement is called "Gap Medicaid." Upon termination of the SSI benefits, HHSC should send a notice to the beneficiary explaining they need to apply for regular Disabled Adult Child Medicaid along with an Application for Assistance (form H1200.) If the H1200 is filed within the two-month period of eligibility for Gap Medicaid, the application receives expedited processing (required within 10 days).

For those concerned that Gap Medicaid may not be automatic, the following may help:

- Apply with Texas Health and Human Services Commission for Disabled Adult Child Medicaid (on Form H1200) at the same time that an application with Social Security for the Childhood Disability Benefit (previously called Disabled Adult Child Benefit), based on a parent's retirement, disability or death.
- When you file the application with HHSC, explain in your cover letter that you are applying at the same time for the Social Security benefit and that, in the event the Social Security application takes longer to process, the HHSC application be kept on file and not denied

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[178] MEPD Handbook § A-2310; 42 U.S.C. §1383c(b). The federal statute's statement of the requirements is clearer than the Handbooks'.

[179] MEPD Bulletin 17-9 (Sept. 18, 2017), https://hhs.texas.gov/sites/default/files//documents/laws-regulations/handbooks/mepd/bulletins/09-19-17_17-9.pdf. (changes effective on or around September 18, 2017)

until Social Security makes a decision. Ask that "Gap Medicaid" eligibility be provided as required by MEPD Bulletin 17-9.

- Immediately when you receive the notice of approval of the Social Security benefit putting the client's income over the SSI income limit, fax a copy of that notice to HHSC, with your letter asking for immediate eligibility for Gap Medicaid and that the DAC Medicaid application be acted upon as soon as possible.
- Chances are the DAC Medicaid will then take effect before the SSI-related Medicaid is terminated.
- If the HHSC application is denied while the Social Security application is pending, you can have the application re-opened without refiling, anytime within 90 days after the application was originally filed.

IV. SOCIAL SECURITY DISABILITY INSURANCE (SSDI)

A. ELIGIBILITY

A person who has paid sufficient social security and is unable to work due to a disability may be eligible Social Security Disability Insurance (SSDI). Eligible applicants receive a cash benefit and Medicare coverage.

1. WORK HISTORY

Coverage depends on 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 calendar quarters. Persons who have a 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.[180]

The 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.

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. 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.[181]

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[180] SOCIAL SECURITY ADMINISTRATION, *Social Security Disability Benefits*, https://www.ssa.gov/pubs/EN-05-10029.pdf (Jul. 2019).

[181] 42 U.S.C. § 405(c)(5); *see* SSR 65–42c, http://www.ssa.gov/OP_Home/rulings/oasi/33/SSR65–42-oasi-33.html.

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.[182]

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.[183]

B. BENEFITS

1. CASH BENEFITS

The monthly payment amount 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[184] or have them create an account at http://ssa.gov/myaccount.

Eligibility for, and the amount of, benefits does not depend on the 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 of great disadvantage to 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 immediately receiving their Medicaid benefits that go along with SSI, which are generally more comprehensive than the Medicare benefits—Medicare has a 2-year wait before attaching to SSDI whereas Medicaid would be available immediately, in contrast to the Medicare benefits attached to most Social Security Disability Insurance;[185]—further, Medicaid has no deductibles or copayments, and 3 prescription drugs are included.[186]

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[182] 42 U.S.C. § 423(d)(1)(A). See the SSI section above for a brief discussion of the meaning of this standard.

[183] 42 U.S.C. § 423(d)(2)(C); 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, 404.1536–404.1541.

[184] This form is available at https://www.ssa.gov/myaccount/materials/pdfs/SSA-7004.pdf or call 1–800–772–1213 to request the form.

[185] 42 U.S.C. § 1395c; 42 C.F.R. § 406.12(a); Centers for Medicare & Medicaid Services, *Medicare & You 2021* 15, https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf.

[186] TEX. HEALTH AND HUMAN SERVICES COMM'N, *Pharmacy Provider Procedures Manual: Prescription Limits* 8.3.1.1 (Nov. 2021), https://www.txvendordrug.com/about/manuals/pharmacy-provider-procedure-manual/drug-policy/3-claim-limitations/3-1-prescription

2. MEDICARE BENEFITS

A person isn't automatically eligible for Medicare when they start to receive their other SSDI benefits. Further, a person isn't entitled to SSDI benefits right away. Entitlement to benefits begins after five months from the month of onset of disability for most beneficiaries. One they are entitled to benefits, most recipients must wait another 24 months for Medicare benefits.[187]In total, most SSDI beneficiaries must wait 29 months from onset of disability for Medicare. 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 (The 3-month waiting period is waived in certain cases,)[188] and persons with Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease) are eligible immediately.[189]

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

C. APPLICATION

Filing of an application is required and the client may recover retroactive benefits up to 12 months before the date of filing the application.[190]

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

V. REGULAR MEDICAID BENEFITS

The term "Medicaid" generally applies to all benefits provided under Title XIX of the Social Security Act, codified at 42 U.S.C. § 1396 et seq. In addition to "regular Medicaid," Medicaid includes a host of programs sometimes referred to as "Long Term Care Medicaid," which are discussed at page 74 below. This part will cover only those programs that are sometimes called "regular Medicaid," which are available to all SSI beneficiaries in Texas, to beneficiaries of Children and Pregnant Women Medicaid, Medicaid Buy-In, Children's Medicaid Buy-In, beneficiaries of Long-Term Care Medicaid who are not eligible for Medicare, and some smaller programs not summarized in this paper.

A. ELIGIBILITY

Most "regular Medicaid" recipients are eligible only because they qualify for another program that includes Medicaid as a benefit, for instance:

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[187] 42 U.S.C. § 1395c; 42 C.F.R. § 406.12(a).

[188] 42 U.S.C. § 1395c; 42 C.F.R. § 406.13(c), (e)(2).

[189] 42 U.S.C. § 426(h); POMS DI 11036.001.

[190] 20 C.F.R. § 404.621.

- Supplemental Security Income (SSI)[191]
- Temporary Assistance for Needy Families (TANF)[192]
- Children's Medicaid[193]
- Pregnant Women's Medicaid[194]

It is also provided to beneficiaries of nursing home Medicaid in addition to paying for nursing home care and related services, if Medicare does not cover their acute-care needs.[195]

In addition, a Medicaid program known as "Adult Disabled Children," discussed on page 57 above, allows the adult child of a retired, deceased, or disabled worker to maintain their eligibility for Medicaid, even if the child is denied SSI because they now qualify for SSDI benefits or their benefit has increased based on the parent's earnings record.

Low-income Medicare 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), which pay some or all of the Medicare premiums, deductibles, and co-pays.[196] 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 Star+Plus Waiver, 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.[197]

B. BENEFITS

1. GENERAL SCOPE OF BENEFITS

Medicaid is a comprehensive medical assistance program. In many respects, it is broader than Medicare but, unlike Medicare, Medicaid does not require payment of premiums, deductibles, and co-payments.

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[191] 1 T.A.C. § 358.107(b)(1).

[192] 1 T.A.C. § 366.705.

[193] 1 T.A.C. § 366.507. In fact, Medicaid is the only benefit.

[194] 1 T.A.C. § 366.307. In fact, Medicaid is the only benefit.

[195] 1 T.A.C. § 358.107(c).

[196] 1 T.A.C. ch. 359.

[197] 40 T.A.C. Chapter 48 (Community Attendant Services); 40 T.A.C. Chapter 45 (CLASS).

The exact scope of benefits available to the participants in the various Medicaid programs is set out in the State Medicaid Plan prepared by the Texas Health and Human Services Commission.[198] The federal government sets some requirements in federal Medicaid legislation and rules.[199] However, the State of Texas administers the program and sets its own laws and regulations. For instance, 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.

The most comprehensive listing of regular Medicaid benefits is in the current Texas Medicaid Provider Procedures Manual,[200] 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.

In most situations, Medicaid is a payer of last resort. By law, the provider must bill private insurance, Medicare, and other Third-Party Resources (TPR) before billing Medicaid. [201]

The beneficiary is not on that last. Because Medicaid is the final available payor, a Medicaid provider cannot charge a Medicaid beneficiary for any covered service, even if it is not fully covered by the TPRs and Medicaid. For example, if the patient is covered both by Medicare and Medicaid, also known as "dual-eligible", the provider may not bill the patient for Medicare any costs of care, including copayments and deductibles. It may only bill Medicaid for any amount not covered by Medicare.[202]

2. TEXAS HEALTH STEPS (THSTEPS)

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.[203] 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."[204] It includes comprehensive checkups when eligibility is first established, regular physical exams, immunizations, lab tests, health education, and vision, dental and hearing services. Medicaid will

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198 *See* TEX. HEALTH & HUMAN SERVICES COMM'N, *State Plan,* https://hhs.texas.gov/services/health/medicaid-chip/about-medicaid-chip/state-plan

199 42 U.S.C. § 1396d(a), 42 C.F.R. § 440.1 *et seq*. .

200 TEX. MEDICAID HEALTHCARE PARTNERSHIP, *Texas Medicaid Provider Procedures Manual* (Jan. 2022), https://www.tmhp.com/resources/provider-manuals/tmppm. Section 4 of the manual provides a comprehensive list of client eligibility requirements for both regular and restricted forms of Medicaid.

201 TPRs include "health insurers, self-insured plans, group health plans…, service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service." 42 U.S.C. § 1396a(a)(25). There are exceptions to this rule for certain programs, called non-TPR programs.

202 TEX. MEDICAID HEALTHCARE PARTNERSHIP, *Texas Medicaid Provider Procedures Manual* § 4.11 (Jan. 2022).

203 42 U.S.C. § 1396d(a)(4)(B), (r). *See also* 25 T.A.C. ch. 33.

204 25 T.A.C. §§ 33.1, 33.2(4). THSteps is administered by the Texas Department of State Health Services (DSHS).

also pay for transportation. [205] The law also requires comprehensive outreach to inform recipients of the array of services available under THSteps.[206]

In addition to screening, vision, dental, and hearing services, the program to provides "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 under the State plan." [207] The following services are included within this expanded definition of "medically necessary and appropriate" coverage:

- Psychiatric hospital care
- Speech therapy
- Occupational therapy
- Augmentative Communication Devices/Systems
- Private duty nursing[208]

In determining which services are required under THSteps, one should also look to a class action settlement regarding the THSteps program, known as the *Alberto N. v. Hawkins* agreement or *Frew*.[209]

3. PRESCRIPTION MEDICATIONS

Medicaid prescription medications are distributed under the Texas Vendor Drug Program,[210] which is limited to three outpatient prescriptions per month per client,[211] except for the following:[212]

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[205] The Medical Transportation Program (MTP) provides non-emergency medical transportation services so people can receive covered health care services, such as a doctor's office, dentist's office, hospital, drug store or any place that provides covered health care services. MTP can provide transportation, or they can pay a friend, family member or neighbor for the same. In some cases, it may meals and lodging as well.

TEX. HEALTH & HUMAN SERVICES COMM'N, *Medical Transportation Program,* https://hhs.texas.gov/services/health/medicaid-chip/programs/medical-transportation-program.

[206] 42 U.S.C. § 1396a(a)(43); 25 T.A.C. §33.3.

[207] 42 U.S.C. § 1396d(r)(5).

[208] TEX. MEDICAID HEALTHCARE PARTNERSHIP, *Texas Medicaid Provider Procedures Manual: Children's Services Handbook* § 2 (Jan. 2022).

[209] Settlement Agreement, *Alberto N. v. Hawkins*, No. 6:99CV459 (E.D. Tex. May, 19, 2005), https://hhs.texas.gov/sites/default/files/documents/laws-regulations/legal-information/alberto-n-settlement-agreement.pdf.

[210] TEX. HEALTH AND HUMAN SERVICES COMM'N, *Medicaid/CHIP Vendor Drug Program: About the Program*, http://www.txvendordrug.com/about/.

[211] TEX. HEALTH AND HUMAN SERVICES COMM'N, *Pharmacy Provider Procedures Manual: Drug Policy* § 8.3.1.1 (Jan. 2022), https://www.txvendordrug.com/about/manuals/pharmacy-provider-procedure-manual/8-drug-policy.

[212] *Id*.

- Beneficiaries under age 21 (who are eligible for unlimited "medically necessary and appropriate" prescriptions through THSteps)
- Residents in skilled nursing facilities in non-Medicare beds
- Beneficiaries of the "waiver" home care programs, including CBA, HCA, MBDB, CLASS and several smaller programs
- Most managed care (e.g., STAR Program) beneficiaries

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

More information on which drugs Medicaid pays for in Texas see the Outpatient Drug Services Handbook § 7 of the Medicaid Provider Procedures Manual, and for phone numbers to call, see Appendix A of the Medicaid Provider Procedures Manual.[213]

Medicaid beneficiaries who are also Medicare beneficiaries ("dual eligibles") are no longer eligible for prescription medications through Medicaid. Instead, they may enroll in Medicare Part D with no premiums and no copayments.

C. APPLICATION

Information on applying for Medicaid may be obtained by visiting the website of the Texas Health & Human Services Commission at https://www.yourtexasbenefits.com. To contact them directly, see the information at https://hhs.texas.gov/about-hhs/find-us or contact HHSC's Area Information Centers by calling 2–1-1.

In addition to state resources, each of the co-authors has published a paper on handling long-term care Medicaid applications in Texas.[214]

Since eligibility for Medicaid for many depends on eligibility for SSI, some questions are best answered by the Social Security Administration (SSA). For information on SSI, contact the 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.

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[213] *See* TEX. MEDICAID HEALTHCARE PARTNERSHIP, *Texas Medicaid Provider Procedures Manual* (Jan. 2022), https://www.tmhp.com/resources/provider-manuals/tmppm.

[214] *See* Christina Lesher, *State Bar of Texas' CLE: Handling Your First (or Next) Medicaid Case: What to Look for in Preliminary Discussions About Medicaid Planning* (December 8, 2015); H. Clyde Farrell, *State Bar of Texas' CLE: Handling Your First (or Next) Medicaid Case: Medicaid Application* (December 8, 2015).

VI. MEDICARE

A. ELIGIBILITY

1. ELIGIBILITY AT AGE 65

Most Americans become eligible for Medicare at age 65. Because there is no "means test"—as in "means" of support—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]

2. WORK REQUIREMENTS

To be automatically eligible, an individual must work a certain number of quarters in "covered employment." For most, this is usually 40 quarters (10 years) of covered employment. Those that are not automatically eligible may become eligible by paying premiums.[217]

3. 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 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 the date of onset of disability.[219]

4. MEDICARE PREMIUMS

Persons eligible for Medicare in connection with Social Security or Railroad Retirement benefits pay no premium for Medicare Part A. Ineligible individuals who purchased Part A voluntarily pay a premium of $499 per month in 2022.[220] For those who meet the income and resource requirements, "Medicare Savings Programs" (QMB, SLMB, QI-1 and QDWI, discussed below) may pay the Medicare Part A and B premiums.

All persons eligible for Medicare Part A are also eligible for Medicare Part B. However, Part B has requirements for premiums, copays, and deductibles. The Part B premium may be as little as $170.10. It is more for those with over $91,000 income (individual return) or $182,000 (joint return). Those dollar amounts are for the year two years before the year in question, applying to

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[215] 42 U.S.C. § 1395c; 42 C.F.R. § 406.10(a).

[216] 42 C.F.R. § 406.12.

[217] 42 C.F.R. §§ 406.20–406.26.

[218] 42 U.S.C. § 1395c; 42 C.F.R. § 406.12(a).

[219] 42 U.S.C. §§ 426(h), 1395c; 42 C.F.R. § 406.13(c).

[220] Medicare.gov, *Medicare Costs at a glance,* https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance.

income tax returns for the year 2020 (the tax return filed in 2021) to determine the premiums paid in the year 2022. This premium may be paid by the QMB/SLMB/QI-1 programs for eligible beneficiaries.

5. CONTINUATION OF MEDICAL COVERAGE AFTER TOTAL DISABILITY ENDS

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, Texas has established an optional state program permitted under the Act that allows previously disabled workers to "Buy-Into" Medicaid coverage without imposing limitations on their resources and income, which is discussed more fully at XVII below. [222] The program also pays for "tickets to work" that purchase vocational counseling and other support for returning to work.

Work Incentives Planning and Assistance (WIPA) providers and their benefit counselors are helpful resources. As of this writing, there are five in Texas:

- ARCIL Inc https://arcilinc.org/
- The Coalition for Barrier Free Living, Inc. http://www.hcil.cc
- Crockett Resource Center for Independent Living http://www.crockettresourcecenter.org/
- Easter Seals of North Texas http://www.easterseals.com/northtexas/
- Imagine Enterprises http://www.imagineenterprises.org/

B. BENEFITS

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. [223]

"Part C" (also called "Medicare Advantage") is an alternative to Part B with various combinations of managed care and private-pay service delivery.[224] Medicare Advantage Plans can provide care through either a Health Maintenance Organization (HMO) or Preferred Provider Organization

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[221] 42 U.S.C. § 426(b); Ticket to Work and Work Incentives Improvement Act of 1999, § 202, Pub. L. No. 106–170, 106th Congress, 113 Stat. 1860, December 17, 1999; Social Security Administration, *Red Book* 28, https://www.ssa.gov/redbook/; Social Security Administration, *Ticket to Work Program Overview*, http://www.ssa.gov/work/overview.html; Social Security Administration, *Medicare Information,* http://www.socialsecurity.gov/disabilityresearch/wi/medicare.htm#works.

[222] 42 U.S.C. §1396a(a)(10)(A)(ii)(XIII); 15 T.A.C. Chapter 360; Texas Health & Human Services Comm'n, *Medicaid Buy-in for Adults,* https://hhs.texas.gov/services/health/medicaid-and-chip/programs/medicaid-buy-adults .

[223] MEDICARE.GOV, *Medicare & You 2021*, https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf.

[224] 42 U.S.C. § 1395w-21.

(PPO) model.[225] PPOs can be local or regional. In 2019, 34% of Medicare recipients were enrolled in a Medicare Advantage Plan, 62% of which provided through HMO, 31% through a local PPO, and 6% in a regional PPO.[226]

Medicare Part D offers all Medicare beneficiaries a variety of prescription drug plans with a variety of monthly premiums, yearly deductible, and co-pays.[227] Like Parts A and B, low-income beneficiaries with few assets are eligible for assistance with the premiums and deductibles under the "Part D Extra Help" programs.

1. HOSPITAL SERVICES

Part A covers in-patient 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.[228]

In 2022, Medicare beneficiaries must pay a deductible of $1,556 for Medicare Part A inpatient hospital services per benefit period. The beneficiary must also pay copayments of $389 per day for the 61st-90th day of hospitalization for each benefit period, and $778 per "lifetime reserve day."[229]

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.
- Admission to the nursing facility must occur within 30 days after discharge from the hospital unless it would be medically inappropriate.[230]

Even during the 100 days of nursing facility coverage under Part A, Medicare pays the full cost for only the first 20 days. For days 21 through 100, there is a co-payment of $170.10 per day in

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[225] KAISER FAMILY FOUNDATION, *Medicare Advantage* (Jun. 2019), https://www.kff.org/medicare/fact-sheet/medicare-advantage/.

[226] *Id.*

[227] For more information Medicare Advantage Part D, see Medicare's Find a Medicare Plan page at https://www.medicare.gov/plan-compare/.

[228] A "spell of illness" is a period of consecutive days that begins upon admission to a hospital or other covered facility and ends when the patient has gone 60 days without being readmitted to a hospital or other facility. 42 U.S.C. § 1395x(a).

[229] 42 U.S.C. § 1395d(a)(1); 42 C.F.R. § 409.61(a); MEDICARE.gov, *Medicare costs at a glance,* https://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html.

[230] 42 U.S.C. § 1395d(a)(2); 42 C.F.R. § 409.30.

2022.[231] 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"), a Medicare Advantage plan, or a Qualified Medicare Beneficiary program.

3. HOME HEALTH SERVICES

Medicare provides post-institutional home health services. For those only covered by Part A only and Part A and Part B, Medicare will pay for 100 visits during a home health spell of illness. For those with Part A and Part B, after an individual exhausts 100 visits of Part A, Part B finances the balance of the home health spell of illness.[232] To qualify for Medicare home health services, the individual must be:

- Confined to a home
- Under care of a doctor
- Receiving services under a plan of care established and periodically reviewed by a physician
- In need of one of the following services:
- Intermittent skilled nursing care
- Physical therapy
- Speech-language pathology services, or
- Occupational therapy.
- Services provided by or through a Medicare-certified home health agency.[233]

4. HOSPICE SERVICES

Hospice services are provided to those with a terminal illness that request comfort measures instead of pursuing treatment of the underlying illness. Medicare Part A includes fairly comprehensive services for supportive and palliative assistance for terminally ill beneficiaries who elect hospice coverage. [234] Medicare requires:

- Certification of terminal illness (life expectancy of six months or less if not treated)
- Elect to receive hospice services and waive Medicare services that related to treatment of the terminal condition

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[231] Medicare, *Skilled nursing facility (SNF) care,* https://www.medicare.gov/coverage/skilled-nursing-facility-care.html.

[232] 42 U.S.C. § 1395d(a)(3); MEDICARE.GOV, *Medicare & You 2021 42*, https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf; CENTER FOR MEDICARE & MEDICAID SERVICES, Medicare Benefit Policy Manual ch. 7 § 30l

[233] 42 U.S.C. §§ 1395f(a)(2)(C), 1395x(m); 42 C.F.R. § 409.42.

[234] 42 U.S.C. § 1395d(a)(4)-(5); 42 C.F.R. Part 418; Center for Medicare & Medicaid Services, Medicare Benefit Policy Manual ch. 9; Centers for Medicare & Medicaid Services, *Medicare & You 2021*, https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf

The beneficiary is entitled to two 90-day periods of hospice care and an unlimited number of subsequent periods of 60 days each contingent on the required recertification of terminal illness at the start of each benefit period.[235] The election for hospice care may be revoked at any time.[236]

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.[237]

In 2005, new preventive benefits were added to Medicare. These include, among other services, a one-time initial wellness physical exam, called the "Welcome to Medicare" preventative visit, within 12 months of Medicare Part B enrollment; screening blood tests for early detection of cardiovascular diseases; and diabetes screening for beneficiaries at risk.[238]

6. PART B DEDUCTIBLES AND CO-PAYS

The Part B deductible for the 2022 calendar year is $233.[239] Both the Medicare premium(s) and the deductible(s) 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 below.

After the deductible is met, Part B requires a co-payment of 20% of the Medicare-approved amount. 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 $233 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 HMOs sometimes provide non-covered items, such as limited prescription medications.

7. PRESCRIPTION DRUGS

Medicare Part D is an optional program but there is a late enrollment penalty for those who choose not to enroll when they are first eligible and don't otherwise have prescription drug coverage as

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[235] 42 C.F.R. § 418.20-.21

[236] 42 U.S.C. § 1395d(d)(2)(B); 42 C.F.R. § 418.28.

[237] 42 U.S.C. § 1395k(a); 42 C.F.R. §§ 410.10, 410.15(b), 410.29-.30.

[238] CENTERS FOR MEDICARE & MEDICAID SERVICES, *Medicare & You 2022* 53, https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf.

[239] Medicare.gov, *Costs at a glance,* https://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html.

good as or better than Part D.[240] To avoid a late enrollment penalty, contact the recipients current plan provider and ask if the plan provides drug coverage is as good as or better than Part D. If they say the plan is as good as or better than Part D request a statement in writing and keep it for your records. If they later terminate or reduce your prescription coverage, this will serve as proof that the plan was as good as Part D when you were first eligible. to avoid an increased premium as a result of delaying your application.

A person enrolling after their first enrollment period with not be subject to the late enrollment penalty, if they have prescription drug coverage through the Veteran's Administration, TRICARE, Federal Health Employee Benefit Plan, Railroad Retirement Board, PACE or Indian Health Services. If enrolled in a Medicare HMO or other "Medicare Advantage" plan with prescription drug coverage, enrolling in part D or other separate drug plan, may disenroll the recipient from their Medicare Advantage Plan and return them to original Medicare.[241]

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, Part D Extra Help recipients pay little to no premiums and deductibles and low co-pays.

The program requires an income below 150% of the Federal Poverty Income Limits, calculated using the number of people in your household., Further, countable assets—not counting your home, one vehicle and most kinds of personal property—must be below the following levels—adjusted annually for inflation:

2022 Resource Limits

	QMB, SLMB, QI-1,	Part D Partial & Full Subsidy
Single	$8,400	$14,010
Married	$12,600	$27,960

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 on page 17 apply to Part D Extra Help.

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[240] CENTERS FOR MEDICARE & MEDICAID SERVICES, *Your Guide to Medicare Prescription Drug* Coverage, https://www.medicare.gov/Pubs/pdf/11109-Your-Guide-to-Medicare-Prescrip-Drug-Cov.pdf.

In principle, dual eligibles should be automatically enrolled in a Medicare Part D plan. Center for Medicare & Medicaid Services, *Dual Eligible Beneficiaries Under Medicare & Medicaid Programs,* https://www.cms.gov/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf But there have been problems, as noted by this United States Government Accountability Office study: "Medicare Part D: Enrolling New Dual Eligible Beneficiaries in Prescription Drug Plans" from 2007 available at http://www.gao.gov/new.items/d07824t.pdf.

[241] CENTERS FOR MEDICARE & MEDICAID SERVICES, *Your Guide to Medicare Prescription Drug* Coverage, https://www.medicare.gov/Pubs/pdf/11109-Your-Guide-to-Medicare-Prescrip-Drug-Cov.pdf.

Any Medicare beneficiary enrolled in Medicaid, Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualified Individual (QI), qualifies for Part D Extra Help. It is not legally required, but recipients pay no premium or deductible for "basic plans" and co-pays will be very low.

For those without "creditable" coverage from an employer and not in any of the programs listed above, Part D is still beneficial. 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.

Enrollment is only available during the annual enrollment period between October 15 and December 7, with coverage starting January 1.[242] 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, in the case of nursing home care, Long-Term Care Medicaid.

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

- Medicare Part D Drug Plan Providers https://www.medicare.gov/find-a-plan/questions/home.aspx
- Your Guide to Medicare Prescription Drug Coverage at https://www.medicare.gov/pubs/pdf/11109-Your-Guide-to-Medicare-Prescrip-Drug-Cov.pdf.
- Call 1–800-MEDICARE (1–800–633–4227), and they can help you on the phone
- The Texas Department of Insurance—Dial "211" and ask for the Health Information Counseling & Advocacy Program [243]
- Local Health and Human Services Area Agency on Aging—call 1–800–252–9240 and ask about "Medicare prescription drug coverage."

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 isn't "improving." Skilled nursing services are provided in many settings, including skilled nursing facilities, home health, and outpatient therapy settings. Under this standard, skilled nursing care that would prevent or slow further decline would be denied. A

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[242] For exceptions to this enrollment period, *see* Center for Medicare & Medicaid Services, *Your Guide to Medicare Prescription Drug Coverage,* https://www.medicare.gov/pubs/pdf/11109-Your-Guide-to-Medicare-Prescrip-Drug-Cov.pdf. The dates indicated are for 2019 and may change in future years.

[243] Texas Department of Insurance, *Insurance Resource for Medicare Beneficiaries*, http://www.tdi.texas.gov/consumer/hicap/index.html

2013 settlement in the U.S. District Court for the District of Vermont*, Jimmo vs. Sebelius*, has abrogated this standard.[244]

The Centers for Medicare & Medicaid Services (CMS) explicitly stated that "No 'improvement standard' is to be applied in determining Medicare Coverage for maintenance claims that required skilled care." [245] 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 because the beneficiary has reached a therapeutic "plateau."[246] Services may be continued if the skilled care is necessary and reasonable. [247]

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."[248]

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.[249] 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.[250]

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.[251]

C. APPLICATION

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

- Already receiving Social Security or Railroad Retirement benefits at age 65;

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[244] *Jimmo v. Sebelius*, No. 5:11-CV-17-CR (D. Vt. 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.

[245] Center for Medicare & Medicaid Services, Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to Jimmo vs. Sebelius, https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R179BP.pdf .

[246] *See id.*

[247] *See id.*

[248] *See* Center for Medicare and Medicaid Services, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf.

[249] *See id*.

[250] *See id.*

[251] *See* CENTER FOR MEDICARE ADVOCACY, *Self Help Materials,* http://www.medicareadvocacy.org/take-action/self-help-packets-for-medicare-appeals.

- 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, a beneficiary with end-stage renal disease or a 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.

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.[252] 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.[253]

VII. "LONG- TERM CARE" MEDICAID

People who need help with basic tasks of living—bathing, dressing, personal care, housekeeping or preparing meals—are candidates for long-term care (LTC) services. A person may need long-term care because of age, disability, or health status. It can be provided at home, as part of a day program in the community, or in a residential facility. LTC services are rarely covered by any insurance plan. Without public benefits, a person typically pays for these services with their savings earned over a lifetime, though some may have purchased long-term care insurance. Even for those with savings, at an average of $4,000 per month for assisted living, $5,000-$7,000 per month for a nursing facility, or $6,500 per month for in-home skilled nursing care, a person's savings can disappear quickly. Often, obtaining LTC Medicaid coverage is beneficial, often critical, to an estate plan.

A. ELIGIBILITY

Medicaid eligibility depends on an applicant's (1) income, (2) resources/assets, (3) medical need, (4) citizenship, and (5) age, blindness, or disability.

[252] 42 C.F.R. § 405.904.

[253] CENTERS FOR MEDICARE & MEDICAID SERVICES, Original Medicare (Fee-for-service) Appeals, https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/index.html

1. INCOME

With some exceptions, all receipts of money or property are income, even gifts.[254] However, for the Medicaid nursing home and HCBS Waiver programs, countable income can be reduced through trusts so in those programs, income never has to be a disqualifying factor.[255]

The income cap is adjusted for inflation annually and is effective on January 1st.[256] For 2021 and 2022, the income caps are:

		2021	2022
Single		$2,382	$2,523
Couple		$4,764	$5,046

a) Applying Income Caps

If the applicant is single, widowed, or divorced, the single income cap applies. If both spouses apply for Medicaid and they live together (both on an HCBS Waiver program in the same household or both reside in a nursing home), the income cap is that for a couple. If one spouse is in the community (ineligible or applying for Medicaid), the single-person income cap is used, but only the applicant's income counts. Income paid to a spouse is based on whose name is "on the check" regardless of state community property rules.

b) Reduction of countable income

For nursing home Medicaid and the HCBS Waiver home care programs, if an individual or couple's income exceeds the income cap, their countable income can be reduced with a Miller Trust (also known as a Qualified Income Trust), by applying the spousal impoverishment rules, or transferring income payments to the ineligible spouse. However, the non-waiver home care programs (e.g., Community Attendant Services), SSI and the Medicare Savings Programs do not allow reduction of income with a Qualified Income Trust.

Typically, an unmarried client is eligible for Medicaid once their income is properly diverted into a Miller Trust, 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, there are two more common methods to reduce countable income. First, under the spousal impoverishment rules, income can be reduced for co-payment (as opposed to eligibility) determination. The community spouse is allowed enough of

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[254] MEPD Handbook § E-1200.

[255] In fact, most states have no "income cap;" Medicaid simply supplements the client's income to the extent necessary without requiring the "Miller Trust" procedure discussed below.

[256] These eligibility numbers are found in the Budget Reference Chart at MEPD Appendix XXXI, https://hhs.texas.gov/laws-regulations/handbooks/appendices/mepd-appendix-xxxi-budget-reference-chart. However, the appendix will not be updated until the March revision. HHSC did send a policy bulletin in December with the 2022 amounts. It can be found at https://www.hhs.texas.gov/sites/default/files/documents/21-25.pdf. Except as otherwise indicated, the "eligibility numbers" below are from these sources.

the institutionalized spouse's total income to provide the spouse with a $3,435 (in 2022) needs allowance.

Further, a client can transfer assets and income streams to his or her spouse, so the client's name is not "on the check." For example, a court can sign a Qualified Domestic Relations Order for qualified retirement benefits being paid as annuity (pension) benefits.

> Practice Note: Because of the Miller Trust and QDRO strategies, too much income is never in itself a reason not to apply for nursing home or HCBS Waiver 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.

c) Long-term care insurance benefits

Long-term care insurance benefits should be paid directly from the insurance company to the nursing home. If the insurance company pays the Medicaid beneficiary directly, the funds should be given to the nursing home, not the Texas Health and Human Services Commission, immediately upon receipt.[257] Payment to the nursing home should be made before the end of the calendar month of receipt to avoid the money's being counted as a "resource" in the next month's eligibility determination.

d) Income Tax Withholding No Longer Deductible from Copayment

Medicaid for the Elderly and People with Disabilities Handbook § E-3200 now provides: "income tax withheld from unearned income is also not a deductible expense for the co-payment calculation."

2. RESOURCES (COUNTABLE ASSETS)

a) Resources for an unmarried applicant.

An unmarried applicant's resource limit is $2,000. This amount has remained the same since 1989. Resources include all assets except a few "exempt" assets. Exempt assets include one residence located in Texas of any acreage, valued up to $636,000 (with some exceptions regarding value); one automobile used for transportation; personal and household goods; a prepaid, irrevocable funeral contract of unlimited value for the applicant; and certain other property.

> Practice Note: At the 2018 UT Galveston conference, Shari Nichols with the Texas Health and Human Services clarified that assets transferred to a revocable trust are exempt or countable the same as if they were not in the trust, with the exception of the home. Only the home loses its exempt status by being placed in a revocable trust.[258] Therefore, revocable trust

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[257] TEX. DEPT. OF AGING AND DISABILITY SERVICES, *Nursing Facilities—Claims with Other Insurance Liability*, Information Letter 15-10 (Feb. 12, 2015), https://apps.hhs.texas.gov/providers/communications/2015/letters/IL2015-10.pdf.

[258] Shari Nichols cited the definition of resources in 42 U.S.C 1396p(h)(5), located at https://www.govinfo.gov/link/uscode/42/1396p

planning is available to Medicaid applicants, provided the home is transferred to the trust, if at all, by a deed that is effective only at death—that is, a Lady Bird Deed or Transfer on Death Deed.

b) Resources for a married couple, with an ineligible spouse not "in an institutional setting"

A married couple's combined resources count towards the resource limit. If both apply for Medicaid and are in an "institutional setting" (that is, in a nursing facility or HCBS waiver program), the limit is $3,000. For an applicant with a community spouse, this limit is half the couple's combined "countable" resources, subject to a minimum "Protected Resource Amount" of $27,480 and a maximum of $137,400 in 2022.

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 an institutional setting and applying for Medicaid.

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

For a married couple, both in an institutional setting but 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."[259] 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.

d) Home Equity Limits

The Deficit Reduction Act of 2005 (DRA) 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 $636,000.[260] 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 totally disabled as defined by the Social Security Act

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[259] Regarding deeming of resources, see MEPD Handbook § F-1410; and regarding deeming of income, see MEPD Handbook § E-7200.

[260] Deficit Reductions Act of 2005, Pub. L. No. 109–171, § 6014(a) (amending 42 U.S.C. § 1396p(f)) [hereinafter DRA of 2005]; 1 T.A.C. §358.348; MEPD Handbook § F-3600, app. XXXI; MEDICAID.GOV, 2021 SSI and Spousal Impoverishment Standards, https://www.medicaid.gov/medicaid/eligibility/downloads/ssi-and-spousal-impoverishment-standards.pdf.

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.

e) 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.

However, 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.[261] 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.

f) 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:

> The Texas Health and Human Services Commission (HHSC) follows . . . 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.)

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[261] 42 U.S.C. 1396p(c)(1)(J); DRA of 2005, § 6016(d); *accord* MEPD Handbook § I-6110–6121; *see also* POMS SI 01150.122.

(2) For purposes of this subpart L, the equity value of an item is defined as:

(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."[262]

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.

g) Deferred Annuities in IRA's are Exempt

At the Annual Estate Planning, Guardianship and Elder Law Conference in February 2015, Shari Nichols, a representative of the Texas Health and Human Services Commission was asked "=if funds in an IRA are held in a Certificate of Deposit or other countable investment product and then used to purchase an annuity, are the IRA funds exempt?" Her oral answer, in a word, was "Yes."

The only place that has so far been reduced to writing was in the agency's slide at this conference in August 2015, which read as follows:

> According to 42 USC 1396p(c)(1)(G), the purchase of an annuity by an individual applying for Medicaid (or the community spouse) is not considered a transfer of assets if:
>
> - The annuity purchased is an IRA annuity [IRC 408(a), 26 USC 408(a)] or
> - The annuity was purchased with the proceeds of an IRA, or a Roth IRA [IRC 408A, 26 USC 408A]
>
> If the individual uses the funds in the IRA to purchase the IRA annuity, no transfer penalty would be imposed, and the value of the IRA annuity would not be counted in the resource calculation for that individual.
>
> The purchase of an IRA annuity is not considered a transfer of assets.
>
> According to current HHSC policy, the funds in the IRA annuity are not counted in the resource calculation for the individual.
>
> See MEPD Handbook Section F-7210 and F-7220. [263]

In her oral presentation in August 2015, Ms. Nichols commented that the annuity provision of the federal Medicaid statute is generally construed to apply only to the transfer penalty and not to

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[262] Free Online Dictionary, http://www.thefreedictionary.com/unmarketable.

[263] Shari L. Nichols, Texas Health and Human Services Commission, University of Texas School of Law's Estate Planning, Guardianship and Elder Law Conference: The View from HHSC (August 7, 2015).

create a new resource exemption for deferred annuities.[264] Therefore, the Texas Medicaid program is not required by federal law to have this exemption, and it is subject to being withdrawn at any time.

Another source of uncertainty is that the only written statements as to agency policy on retirement accounts are the PowerPoint presentations cited herein. None of these changes have been noted in the Medicaid for the Elderly and People With Disabilities Handbook, policy bulletins or rules. That is why this paper cites only those presentations and anecdotal experiences of the authors and colleagues in the Texas Chapter of the National Academy of Elder Law Attorneys. Those are the closest to "sources of law" we have at this time. Texas Health and Human Services Commission has not published a final or proposed rule regarding long-term care Medicaid eligibility (1 T.A.C. ch. 358) since November 2016.

h) IRAs With RMDs and Annuities Within IRAs Are Exempt

Exemption of assets other than deferred annuities that are held in retirement accounts is a more recent change and is logically a separate topic. Therefore, we discuss it under a separate heading. However, that issue is intertwined with deferred annuities in retirement accounts, and current policies regarding both issues are so far being withheld from public view by the agency. Therefore, this section will discuss both together, thus overlapping to some extent with section A above.

Until an oral announcement by the HHSC legal staff in August 2018, assets in tax-deferred retirement accounts were counted by the Medicaid program as "resources," unless they were invested in deferred annuities as discussed above.[265] The change in that policy was explained further in a PowerPoint presentation by the same agency representative on February 7, 2019.[266] The following summary is drawn from the latter presentation, except as indicated otherwise:

For applicants and to their community spouses who are receiving Required Minimum Distributions (RMDs), IRAs are excluded from countable resources.

> (1) Under the SECURE Act, the year in which RMDs begin was raised from age 70 1/2 to age 72, for individuals reaching that age on or after January 1, 2021 (that is, individuals born on or after July 1, 1949)
>
> (2) A member of the TXNAELA listserv recently reported that in the course of an appeal to a fair hearing, HHSC Medicaid policy officials announced that only IRAs (Individual Retirement Accounts) will be given this favored treatment, not other retirement accounts with RMDs as previously announced.

Annuities held within IRAs will continue to be treated as exempt, as discussed above. Therefore, younger owners of IRAs who do not yet have RMDs can make the accounts exempt by investing their assets in deferred annuities. For those with 401ks, TSAs and other types of retirement

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[264] 42 U.S.C. §1396p(c)(1)(G); DRA of 2005 § 6012(c).

[265] Shari L. Nichols, oral presentation at the University of Texas School of Law, *Estate Planning, Guardianship and Elder Law* (August 2018).

[266] Shari L. Nichols, University of Texas School of Law, "A View from HHSC," *Changes and Trends Affecting Special Needs Trusts* (February 2019).

accounts, exemption requires first rolling over the assets to an IRA. If there is RMD, the account then becomes exempt; or if not, it can then be made exempt by purchasing a deferred annuity within the IRA.

RMDs are counted as income for eligibility and copayment. Inherited IRAs receive the same treatment as participant accounts, "as long as the new owner is taking the RMDs according to IRS rules."

For annual RMD income, as of February 7, 2019, "…the proposed process is to divide RMD income received annually by 12 to determine countable monthly income for eligibility and copayment calculation." Statements of agency representatives since then have sometimes reflected that policy and at other times indicated that RMD is "income in the month received." However, as of this writing, the most recent reports strongly indicate the agency has adopted the policy just quoted.

Recent Texas NAELA listserv reports indicate that RMDs are averaged and counted as "non-resource-produced" monthly income also for the purpose of determining whether an enhanced Spousal Protective Resource Amount is available, regardless of when the RMDs are actually taken. One such report indicates that if RMD is not taken monthly, the IRA will be counted as a resource. Another such report says distributions from an IRA in excess of RMD are counted as income in the month received.

Gross amounts of IRA distributions are counted as income without reduction to account for income tax.[267]

3. MEDICAL NEED REQUIREMENTS

To qualify for long-term Medicaid, an applicant must have medical needs that require skilled medical care. This "medical necessity" requirement varies from program to program.

a) Nursing Home, Star+Plus Waiver, and CLASS Programs

An applicant must meet the "medical necessity" requirement for nursing home Medicaid and for the Star+Plus Waiver 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 and of itself.[268]

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[267] This would be inconsistent with previous agency policy except that in most cases, the full amounts of Medicaid copayments are deductible from taxable income, so they rarely if ever generate income tax if properly reported. 26 U.S.C. §213(d); Internal Revenue Bulletin 1997-21, Notice 97-31, at https://www.irs.gov/pub/irs-irbs/irb97-21.pdf.

[268] 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 Dept. of Health & Mental Hygiene v. Brown,*

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 the need for assistance in some activities of daily living as determined by the assessment interview.[269]

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).[270] 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 for certain categories of aliens, such as refugees, veterans, or service members.[271]

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.[272] 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 Administration's definition).[273] In practice, this requirement is never an issue with regard to nursing home care or the Star+Plus Waiver 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

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406 Md. 466, 959 A.2d 807 (Md. 2008), *aff'g and adopting per curiam,* 177 Md. App. 440, 935 A.2d 1128 (Md. Ct. Spec. App. 2007).

[269] 40 T.A.C. ch. 48.

[270] 1 T.A.C. § 358.203. For Medicaid policy on proof of citizenship and identity, see MEPD Appendix V.

[271] 8 U.S.C. § 1613.

[272] 1 T.A.C. § 358.207; 42 C.F.R. § 435.403.

[273] 1 T.A.C. § 358.211.

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

Community Care for Aged and Disabled (CCAD) is a group of services provided in a person's own home or community for aged or disabled individuals who are not self-sufficient and might otherwise be subject to premature institutionalization or to abuse, neglect or exploitation. These "Community Care" programs provide assistance with bathing, dressing, toileting, food preparation, housekeeping, etc. The number of hours per week varies according to the Medicaid worker's determination based on responses provided by the client or client's representative. These programs do not include medical benefits other than limited attendant care.

The Star+Plus Waiver program is sometimes listed with "Community Care" programs. Here, it is discussed separately because waiver eligibility requirements are different in many respects from "Community Care" programs such as Community Attendant Services, Primary Home Care, Family Care and other non- "waiver" programs.[274]

a) Eligibility

For an unmarried individual, the financial requirements are the same as for nursing home Medicaid ($2,523 gross monthly income cap in 2022), except the resource limit for individuals is $2,000 (for Community Attendant Services) or $5,000 (for Family Care). For a married couple, maximum gross monthly income cap of both spouses combined is $5,046 in 2022. However, if only one is applying, a "living allowance" ($397 in 2022) is deducted from the income of the ineligible spouse. Maximum resources for a couple, even if one spouse is ineligible, are $3,000 (for Community Attendant Services) or $6,000 (for Family Care).[275]

Achieving eligibility for a married person is often difficult, as the "spousal impoverishment" provisions do not apply.[276] Income eligibility cannot be attained by use of a "Miller Trust" (Qualified Income Trust). However, there is no transfer penalty.

b) Consumer Directed Services, Service Responsibility Option and Agency Staffing[277]

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

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[274] 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. This group of programs is separate and distinct from the Medicaid "Waiver" programs discussed below, which also provide home care but have a common origin in Social Security Act § 1915(c).

[275] See https://www.hhs.texas.gov/handbooks/medicaid-elderly-people-disabilities-handbook/appendix-xxix-special-deeming-eligibility-test-spouse-spouse.

[276] *Case Manager Community Care for the Aged and Disabled Handbook* Appendix XI, https://hhs.texas.gov/laws-regulations/handbooks/cm-ccad-appendices/cm-ccad-appendix-xi-monthly-incomeresource-limits.

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

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

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 backup plan including substitute workers in the event the employee could not or did not show up to work.

(2) Service Responsibility Option

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

(3) Agency Option

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

3. HOME AND COMMUNITY CARE UNDER THE MEDICAID "WAIVER" PROGRAMS

Medicaid "Waiver" programs are programs authorized 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. HCBS stands for Home and Community-Based Services. The "HCBS waiver program" is defined as "[a] home or community-based service authorized for use in Texas by the Centers for Medicare and Medicaid Services in accordance with . . . §1915(c) of the Social Security Act."[278] As discussed below, though, there are several distinct programs, with different eligibility requirements and different benefits, that are authorized under Social Security Act §1915(c) and therefore fit within the definition of "HCBS waiver program."

For another summary with additional detail, see https://hhs.texas.gov/sites/default/files//documents/doing-business-with-

[278] Medicaid for the Elderly and People with Disabilities Handbook Glossary

hhs/providers/resources/ltss-waivers.pdf. Some but not all that information overlaps with the summaries of the HCBS Waiver Programs immediately below.

Bear in mind that in addition to providing the long-term care services discussed below, for individuals who are not "Dual Eligibles," each of these programs provides all acute-care services. Because most older clients (and many younger ones who are Social Security Disability Insurance beneficiaries) receive their acute-care services from Medicare, this is not especially important to them. However, to the many younger clients not covered by Medicare, and to the few older ones in that category, Medicaid acute-care services (including prescription medications) can be critical.

a) Star+Plus Waiver

General Description	Provides personal care services at home or in a licensed Assisted Living Facility. However, only a few Assisted Living Facilities are Medicaid certified, as discussed in more detail below. Among the HCBS Waiver programs, this is the one almost always used by individuals over age 65.
Age Limits	Age 21 and older
Functional Eligibility	Medical necessity for nursing home care
Financial Eligibility	Unmarried: Income $2,523 (but the limit can always be raised with a Qualified Income Trust); Resources $2,000 Married: Depends on the applicant's spouse's income and living situation
Are the income and resources of the parents deemed to a child applicant?	N/A—must be at least age 21
Maximum value of annual benefits	202% of the average cost to Medicaid of the individual's nursing home care ("RUG rate")
Delivered by Star+Plus (Managed Care Organizations)?	Yes
Texas Regulations:	40 T.A.C. Chapter 48
Texas Handbook(s):	MEPD: §O-3200 STAR+PLUS Handbook https://hhs.texas.gov /laws-regulations/handbooks/starplus-handbook

Star+Plus Waiver (SPW) is the only Medicaid home care program in which the long-term care services and supports are delivered by Managed Care Organizations. That is because SPW operates under two "waivers": the HCBS Waiver Programs under Social Security Administration §1915(c), and the "1115 Transformation Waiver under Social Security Act §1115.[279] However, as indicated, some other HCBS Waiver Program beneficiaries who do not have Medicare receive their acute care benefits under the 1115 Transformation Waiver so must be members of Managed Care Organizations.

[279] The 1115 Transformation Waiver was designed to accelerate the conversion to managed care.

For help navigating the web of programs, see the Star+Plus Inquiries Chart at Star+Plus Handbook Appendix VI, available at https://hhs.texas.gov/laws-regulations/handbooks/sph-appendices/sph-appendix-vi-starplus-inquiries-chart.

b) Community Living Assistance and Support Services (CLASS)

General Description	Home care for individuals with intellectual disability or a related condition that manifested before age 22
Age Limits	All ages, but the condition must have manifested before age 22.
Functional Eligibility	Severe, chronic disability attributed to cerebral palsy, epilepsy or any other condition, other than mental illness, found to be closely related to intellectual disability, manifested before the person reaches age 22 and likely to continue indefinitely.[280] Specifically, must need ICF/IID Level of Care VIII.
Financial Eligibility	Unmarried: Income $2,522 (but the limit can always be raised with a Qualified Income Trust); Resources $2,000 Married: Depends on the applicant's spouse's income and living situation
Income and resources of parents of a minor deemed?	No
Maximum value of annual benefits	$114,736.07
Delivered by Star+Plus (Managed Care Organizations)?	No, except those age 21 and older not enrolled in Medicare must enroll in Star+Plus to receive acute care services.
Texas Regulations:	40 T.A.C. Ch. 45 & 48
Texas Handbook(s):	CLASS Provider Manual https://hhs.texas.gov/laws-regula tions/handbooks/community-living-assistance-and-support-services-provider-manual MEPD Handbook: § O-1300

c) Deaf-Blind Multiple Disabilities (DBMD)

General Description	Home care program serving individuals have both deafness and blindness and who have, in addition, one or more other disabling conditions.
Age Limits	Under 21
Functional Eligibility	Deafness and blindness and an additional disability that impairs independent functioning and qualify for ICF/IID Level of Care VIII
Financial Eligibility	Unmarried: Income $2,523(but the limit can always be raised with a Qualified Income Trust); Resources $2,000 Married: Depends on the applicant's spouse's income and living situation
Income and resources of parents of a minor deemed?	No
Maximum value of annual benefits	$114,736.07
Delivered by Star+Plus (Managed Care Organizations)?	No

[280] 40 T.A.C. § 45.201; MEPD Handbook § O-1300. "Related" conditions include, for example, muscular dystrophy, cerebral palsy and spina bifida.

Texas Regulations:	40 T.A.C. Ch. 42
Texas Handbook(s):	Deaf Blind with Multiple Disabilities (DBMD) Handbook https://hhs.texas.gov/laws-regulations/handbooks/deaf-blind-multiple-disabilities-dbmd-program-manual MEPD Handbook: § O-1500

d) Home and Community-Based Services (HCS)

General Description	This provides home care to individuals with a diagnosis of intellectual disability. Although it has a requirement of "must be living in the community," it finances services of many small "group homes."
Age Limits	All ages
Functional Eligibility	Medical necessity for nursing home care
Financial Eligibility	Unmarried: Income $2,523 (but the limit can always be raised with a Qualified Income Trust); Resources $2,000 Married: Depends on the applicant's spouse's income and living situation
Income and resources of parents of a minor deemed?	No
Maximum value of annual benefits	$167,468 to $305,877 based on Level of Need (LON)
Delivered by Star+Plus (Managed Care Organizations)?	No, except those age 21 and older not enrolled in Medicare must enroll in Star+Plus to receive acute care services.
Texas Regulations:	40 T.A.C. §§9.151–9.192
Texas Handbook(s):	Home and Community-based Services Handbook https://hhs.t exas.gov/laws-regulations/handbooks/home-and-community-based-services-handbook (Note: Despite the name, this does not cover all the HCBS Waiver programs—just the HCS program) MEPD Handbook: § O-1600

e) STAR Kids (formerly known as Medically Dependent Children's Program (MDCP)

General Description	Home care plus regular Medicaid benefits for children under age 21. When they reach 18, most beneficiaries qualify for SSI (because parents' income and resources are no longer deemed by SSI) and are transferred to SSI-related Medicaid (which includes home care under the Primary Home Care benefit). Those who still are not on SSI at age 21, or who need more care than Primary Home Care will provide, are usually transferred to the Star+Plus Waiver Program.
Age Limits	Under 21
Functional Eligibility	Medical necessity for nursing home care
Financial Eligibility	Unmarried: Income $2,523(but the limit can always be raised with a Qualified Income Trust); Resources $2,000 Married: Depends on the applicant's spouse's income and living situation
Income and resources of parents of a minor deemed?	No
Maximum value of annual benefits	50% of the average cost to Medicaid of the individual's nursing home care ("RUG rate")
Delivered by Star+Plus (Managed Care Organizations)?	No

Texas Regulations:	40 T.A.C. Ch. 51
Texas Handbook(s):	Medically Dependent Children Program Provider Manual https://hhs.texas.gov/l aws-regulations/handbooks/medically-dependent-children-program-provider-manual MEPD Handbook: § O-1700

f) Texas Home Living (TxHmL)

General Description	Home and community services to supplement regular Medicaid services available to individuals eligible for Medicaid through SSI and other Medicaid programs who live in their own home or family home
Age Limits	Serves all ages
Functional Eligibility	Same as HCS
Financial Eligibility	Must meet financial (and all other) requirements for Medicaid eligibility through one of the following: SSI, Disabled Adult Child Medicaid, Pickle Program Medicaid, Widow(er)s Medicaid, foster parent Medicaid, TANF or Medicaid Buy-In. The "special income limit" of 3 times maximum SSI does not apply, and income limits of the programs above are much lower.
Income and resources of parents of a minor deemed?	Yes
Maximum value of annual benefits	$17,000
Delivered by Star+Plus (Managed Care Organizations)?	No, except those age 21 and older not enrolled in Medicare must enroll in Star+Plus to receive acute care services.
Texas Regulations:	40 T.A.C. Chapter 9 Subchapter N
Texas Handbook(s):	MEPD Handbook: § O-1800

C. THE HCBS WAIVER "SPOUSAL PROTECTED RESOURCE AMOUNT"

1. BOTH SPOUSES AT HOME

In the Medicaid Nursing Home program, the "Spousal Protected Resource Amount" never changes. It is based on the countable resources of both spouses as of the first day of the first month one goes into a Medicaid-certified nursing home, and it will be the same regardless of when the application is filed.

However, in the Star+Plus Waiver Program (formerly known as the Community Based Alternatives Program) and other "waiver" programs, an individual can qualify for services with a nursing home by coming up on the waiting list. When applying for a waiver program, the SPRA is based on the countable resources of both spouses as of the first day of the first month one spouse applies for assistance. If the application is denied because the couple has not yet spent down, and they reapply, then a new PRA is determined based on countable resources on the first day of the month of the new application.[281] HHSC applies this even though state and federal law say spousal

[281] MEPD Handbook §J-4310

impoverishment protections, including date PRA determination, apply to the Star+Plus Waiver Program.[282] The applicable policy, as stated in MEPD Handbook § J-4310, is:

> **Determining the Assessment Date for a Home and Community-Based Services Waiver**
>
> The SPRA is assessed as of 12:01 a.m. on the first day of the month that the application was received for the financial Medicaid eligibility component. See Chapter O, Waiver Programs, Demonstration Projects and All-Inclusive Care.
>
> - If the waiver application is certified, the SPRA assessment date does not change unless it was based on incomplete or inaccurate information.
> - If the waiver application is not certified and the individual reapplies, the SPRA assessment date is 12:01 a.m. on the first day of the re-application month.

Logically enough, some Medicaid Specialists have interpreted this to mean that nobody will ever be eligible for an HCBS Waiver Program until the spouses have spent down to the minimum PRA (currently $27,480), plus the $2,000 personal exemption. However, that is clearly not the rule. Rather, this problem can be avoided if the couple spends down very quickly, between the time the application is filed and the time it is acted upon. For example, a couple with $100,000 in countable resources can still keep $50,000 (plus the $2,000 exempt amount) by paying $48,000 on a home mortgage, home improvements, etc. before the Medicaid Specialist gets around to denying the application; or if the application is denied, presumably it can be reopened within 90 days without filing that new application that would trigger a new "snapshot date."

However, when the spouses' incomes are not too high, and neither spouse is in a nursing home, a recent change in the law provides for very favorable treatment of a request for an enhanced Spousal Protective Resource Amount. CMS sent a letter dated May 7, 2015, to State Medicaid Directors regarding the application of the spousal impoverishment protections to the HCBS Waiver Programs as required Section 2404 of the Affordable Care Act. As a result, HHSC amended the Medicaid for the Elderly and People with Disabilities Handbook, effective September 1, 2015, to allow the community spouse in an HCBS Waiver case to keep the same Minimum Monthly Maintenance Needs Allowance as if it were a nursing home Medicaid case. That is, the MMMNA in HCBS Waiver cases was increased from $3,216.50 per month in 2020, $3,259.50 in 2021, and $3,435 in 2022.

The institutionalized spouse is still allowed to keep a personal needs allowance. In nursing home cases that is $60 per month, but in HCBS Waiver cases the personal needs allowance is $2,523 per month. Therefore, in an HCBS Waiver case in which the institutionalized spouse is not in a nursing home, the income of the institutionalized spouse is "diverted" to the community spouse only to the extent it exceeds $2,523 per month.[283] In most cases, that reduces dramatically the amount treated as "available" to the community spouse. Therefore, it creates many cases in which the Spousal

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[282] Affordable Care Act §2404; 42 C.F.R. §435.217; LTC ME Bulletin 7–11 (May 31, 2007).

[283] MEPD Handbook § J-6300. See also *id.* § J-6200.

Protective Resource Amount can be enhanced, quite often allowing protection of all the couple's resources.

However, all HCBS Waiver Program cases are not created equal with regard to the application of the Affordable Care Act mandate that they apply the spousal impoverishment rules. If the institutionalized spouse in an HCBS Waiver application is in an Assisted Living Facility, the personal needs allowance is not the income cap (3X Federal Benefit Rate = $2,523 in 2022) but 1X the Federal Benefit Rate ($841 in 2022).[284] Therefore, in such cases, more couples can enhance the Spousal Protective Resource Amount with the institutionalized spouse in an Assisted Living Facility compared to nursing home cases, but far fewer than in cases in which the institutionalized spouse lives at home.

Note that the dramatic increase in potential Spousal Protective Resource Amount cannot be achieved if a person bypasses the interest list using Money Follows the Person, because then eligibility of the institutionalized spouse must first be certified under the Medicaid nursing home rules—where the only deduction from the income of the institutionalized spouse, other than incurred medical expenses, is a $60 personal needs allowance. Therefore, if the spouses' incomes are low enough to protect all assets when applying to an HCBS Waiver Program when both are at home, and if they can postpone application until the applicant spouse is released from the interest list, that can be an excellent strategy.

2. ONE SPOUSE IN A NURSING HOME

Another strategy is for the applicant spouse to establish "institutionalized spouse" status by entering a nursing home, then transfer under Money Follows the Person to an HCBS Waiver Program (usually Star+Plus Waiver). See the discussion below of Money Follows the Person. Then the Spousal Protective Resource Amount is determined as in any other case with one spouse in a nursing home and the other at home. Once the "Spousal Protected Resource Amount" has been assessed, it is permanent, even if the institutionalized spouse later leaves the facility, and even for the purpose of determining HCBS Waiver Program eligibility.[285] In addition, when there is a waiting list for an HCBS Waiver Program (which there usually is), it is necessary to establish Medicaid eligibility in the nursing home before discharge, in order to bypass the waiting list. Although a 30-day stay would be sufficient to establish a right to a "Protected Resource Amount," the institutionalized spouse can also bypass the interest list only by qualifying for an HCBS Waiver Program before discharge from the facility.[286]

D. ELIGIBILITY RULES WHEN BOTH SPOUSES APPLY

The following will serve as an introduction to the complexities involved when both spouses apply for Medicaid long-term care programs:

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[284] MEPD Handbook § J-6310.

[285] MEPD Handbook § O-1200.

[286] Star+Plus Handbook § 3510.

J-1300 Spousal Definitions

Community spouse—A person who is not living in a setting that provides medical care/services and who is married to:

- an institutionalized person, or
- a person who has been determined eligible for a Home and Community-Based Services waiver program.

Note: The community spouse of an institutionalized person may receive services under a Home and Community-Based Services waiver program, which will not affect the spousal diversion.

As noted in this definition, the "community spouse" applying for HCBS Waiver is still entitled to a spousal diversion from the income of the spouse on nursing home Medicaid.[287] However, if the spousal diversion would put income of the community spouse over the income cap, the community spouse can waive the right to whatever amount would exceed the income cap (so it would instead be paid as copayment of the institutionalized spouse). The same rule applies if the community spouse applies for a non-waiver Community Care program.[288]

Despite the label "community spouse" in J-1300 above, a spouse applying for an HCBS Waiver Program, when the other spouse is in a nursing home or on an HCBS Waiver Program (or applying for either), does not meet the definition of a community spouse and cannot be so treated for most purposes. That is because such a spouse is (or will be if an application is certified) "living in a setting that provides medical care/services." Put another way, both spouses are in an "institutional setting" (or will be if the application is certified). It follows that both meet the definition of "institutionalized spouse," so neither can be a "community spouse."[289]

When a married couple is involved, and one or both spouses apply for a Medicaid long-term care program, the income and eligibility limits depend on many factors: whether one or both spouses are applying, whether the Medicaid program applied for is "institutional" (nursing home or HCBS Waiver) or "non-institutional" (nonwaiver home care, referred to here as "Community Care"), etc. The complex "budgeting" rules are at Medicaid for the Elderly and People with Disabilities Handbook Chapter G. For the purpose of simplicity, the matrix below does not use the specialized terminology of that chapter but applies it to the examples:[290]

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[287] MEPD Handbook § J-1520.

[288] TEXAS HEALTH AND HUMAN SERVICES COMM'N, CASE WORKER COMMUNITY CARE FOR AGED AND DISABLED HANDBOOK § 3310, https://hhs.texas.gov/laws-regulations/handbooks/case-worker-community-care-aged-disabled-handbook.

[289] *See* 42 U.S.C. §1396r-5(h)(2). The term 'community spouse' means the spouse of an institutionalized spouse. *id.*;1 T.A.C. § 358.412;MEPD Handbook § J-1100.

[290] See https://www.hhs.texas.gov/handbooks/medicaid-elderly-people-disabilities-handbook/appendix-xxix-special-deeming-eligibility-test-spouse-spouse.

Situation	Income Limit	Resource Limit
Both spouses at home, both apply for Community Care	$5,046 combined incomes (QIT not available, but either spouse can have more than $2,523 if total does not exceed $5,046).	$3,000 combined
Both at home, one applies for Community Care	$5,046 (after applying deeming rules)[291].	$3,000 combined
Both in nursing home, both apply	$2,523 for each; QIT available & needed if income of either exceeds $2,523.	$3,000 combined
Both in nursing home, only one applies	$2,523 (income of non-applicant spouse not counted).	$2,000 (resources of non-applicant spouse not counted
One in nursing home, one at home not applying for any Medicaid program	$2,523 for applicant; QIT available; spousal diversion available to bring community spouse's gross monthly income to $3,435.	Spousal impoverishment rules including Spousal Protective Resource Amount determine initial eligibility; personal needs allowance in enhanced Spousal Protective Resource Amount formula is $60; $2,000 limit on institutionalized spouse resources at first annual review
One in nursing home, one at home applying for HCBS Waiver	$2,523 each spouse; QIT available to each; spouse at home can get diversion to bring his/her income up to $3,435.	$3,000 both together
Both at home, both apply for HCBS Waiver	$2,523 each spouse; QIT available to each.	$3,000 both together
Both at home, one applies for HCBS Waiver	$2,523 for applicant; QIT available; spousal diversion available to bring non-applicant's spouse's gross monthly income to $3,435.	Spousal impoverishment rules including Spousal Protective Resource Amount determine initial eligibility; personal needs allowance in enhanced Spousal Protective Resource Amount formula is $2,250; $2,000 limit on institutionalized spouse resources at first annual review
Spouses separated without intent to evade deeming of resources for Medicaid purposes (treated as if applicant spouse was	$2,523	$2,000

[291] The complex deeming rules in a "companion case" (only one spouse applying) that is not a "spousal impoverishment" case are not clearly explained in the Medicaid for the Elderly and People with Disabilities Handbook. According to one source, the best form for applying these deeming rules has been moved to the HHSC OSS website, which is not available to the public, and sometime soon will exist only in TIERS. At the moment, it may be possible with great effort to work through a case with the help of MEPD G-2311.2 and Appendix XXIX. Fortunately, this comes up rarely, because this set of deeming rule does not apply to cases involving full Medicaid benefits—essentially, then, in Elder Law practice, it applies only to Community Attendant Services applications by (1) a married applicant (2) living in the same household with his or her spouse (3) who is not also applying for Community Attendant Services.

unmarried under MEPD HB J-1410–1420)		
Spouse of applicant refuses to provide information and applicant assigns right of support (treated as if applicant spouse was unmarried under MEPD HB J-1410–1420)	$2,523	$2,000

E. THE HCBS WAIVER PROGRAM INTEREST LISTS

People who express interest in a HCBS Waiver program are added to interest list. Individuals are "released" from the interest list on a first-come, first-served basis when a program spot becomes available. Once released, HHSC determines eligibility before the person can receive benefits.

1. INTEREST LIST WAIT TIMES

The HCBS 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 the programs do not "deem" parents' assets and income, many children qualify for them who do not qualify for SSI, which has strict deeming rules. Data reported by HHS indicates that as of December 2021, it was taking approximately the following lengths of time to "come up on the interest list" for the following programs:[292]

STAR KIDS (MDCP)	3-4 years
CLASS	15-16 years
HCS	16-17 years
Star+Plus Waiver	9 months – 2 years

Under threat of intervention by the federal courts,[293] the Legislature in 2005 and 2007 provided a modest increase in funding for these programs. At this writing in early 2021, the Star+Plus Waiver interest list is unknown due to the COVID-19.

It costs nothing to join the interest lists, and you don't have to file an application. For the STAR Kids (formerly known as MDCP), CLASS, and DBMD Programs, call 1–877–438–5658 and provide the basic information requested. For the Star+Plus Waiver and HCS Programs, contact the

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[292] Statistics available at https://hhs.texas.gov/about-hhs/records-statistics/interest-list-reduction.

[293] The Arc of Texas, represented by Advocacy, Inc., represented the interests of Texans with intellectual disability in need of home care in a suit in federal district court, *McCarthy v. Hawkins*, filed in late 2002. It was brought under the landmark case *Olmstead v. L. C.,* 527 U.S. 581 (1999), which held that state agencies violate the Americans with Disabilities Act if they limit care to persons with disabilities to institutional settings, when the same persons would be appropriately served in a home or community-based setting. The case was settled in 2006 for an order requiring the Texas Health & Human Services Commission to request sufficient funding in the next three Legislatures to offset the increases in the HCS and CLASS waiting lists in the previous biennium and achieve a 5% to 10% reduction in those lists. See https://scholar.google.com/scholar_case?case=15815343414157342809.

local HHSC office, which you can find by searching at https://apps.hhs.texas.gov/contact/search.cfm

2. BYPASSING THE INTEREST LISTS WITH "MONEY FOLLOWS THE PERSON"

a) Introduction to Money Follows the Person

An alternative to the long wait on the HCBS Waiver Program interest lists is to "bypass" the lists with an admission to a nursing home. This is called "Money Follows the Person," in recognition of legislation to encourage delivery of long-term care services in the least-restrictive environment by using funds that otherwise would have been available only to residents of long-term care facilities.[294]

In the Star+Plus Waiver program, it boils down to this: if the applicant is approved for Star+Plus Waiver services before leaving the nursing home, there is no need to come up on the interest list.[295] Conversely, an applicant who is discharged from the nursing home before certification for Star+Plus Waiver services cannot bypass the interest list—even if they have already been certified eligible for nursing home Medicaid.

HCBS Waiver Programs other than Star+Plus Waiver (CLASS, STAR Kids (formerly known as MDCP), DBMD, HCS or TxHmL) are also included in Money Follows the Person, but they are distinguished from Star+Plus Waiver in two ways: (1) long-term care services are not delivered by Managed Care Organizations and (2) procedures for transitioning from nursing home to home care are different. For example, according to one recent paper, MFP bypass to CLASS usually takes 3–4 months of residence in a nursing home; bypass to HCS can take up to a year in the facility; and bypass to STAR Kids can be accomplished with only a single overnight stay if certain conditions are met, otherwise with a stay of at least 30 days.[296]

The Star+Plus Handbook provides much specificity as to procedures for implementing Money Follows the Person to bypass the interest list for the Star+Plus Waiver Program.[297] Because most clients of elder law attorneys are seeking access to the Star+Plus Waiver Program rather than the other HCBS Waiver programs, the provisions just cited in the Star+Plus Handbook will be summarized below. This discussion may be helpful to those applying for CLASS, STAR Kids, DBMD, HCS or TxHmL, but as indicated, the specifics may be different for each program.

The procedures for the MFP Bypass to access Star+Plus Waiver differ, depending on whether the applicant is already a member of a Managed Care Organization or not. Members would include those who have already qualified for Medicaid in a nursing home and want to transition to home care. Non-members would include individuals who are in a nursing home only for the purpose of

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[294] General Appropriations Act for 2004-2005, 78th Leg., Art. II, Health and Human Services Commission, Rider 28; General Appropriations Act for 2002-2003, 77th Leg., Art. II, Health and Human Services Commission, Rider 37

[295] Star+Plus Handbook § 3510.

[296] Patricia Flora Sitchler, Kathy Lynch & Christina Lesher, *And How are the Children? Planning for Children with Special Needs Trusts,* University of Texas 12th Annual Changes and Trends Affecting Special Needs Trusts (February 4–5, 2016), page 36.

[297] Star+Plus Handbook 3511–3526.

bypassing the Star+Plus Waiver interest list. The most important difference in those two groups is the following:

- If the client is already on Medicaid when the transition to Star+Plus Waiver (and discharge from the nursing home) is initiated, the first contact should be with the client's MCO Service Coordinator; but
- If the client has not yet been certified eligible for Medicaid, the first contact should be with the DADS Program Support Unit.

b) Status of Money Follows the Person

According to HHSC attorney, Shari Nichols, at the University of Texas School of Law Galveston program, there are two funding sources for Money Follows the Person: the federal program, known as the MFP Demonstration project, and the state of Texas program, known as Texas MFP/Promoting Independence project. The ACA reduced the minimum nursing home stay to qualify for the MFP Demonstration project from 6 months to 90 days. It also extended federal funding for the program through September 2016.[298] Subsequent legislation has extended the program several times. Most recently at this writing the 2021 Spending Bill extended the federal funding through May 31, 2021.[299] The Sustaining Excellence in Medicaid Act of 2019 was passed into law on August 6, 2019, and included funding for the MFP program for four and a half years.[300] Even if the federal funding ends, some funds will be available under the Texas MFP/Promoting Independence.

F. TRUST RULES

As with SSI, certain trusts can be used to prevent ineligibility. Usually, the SSI trust rules apply, but there are specific situations you need to look out for when using trusts to help a person applying for long-term Medicaid.

1. THIRD-PARTY-SETTLED TRUSTS

The SSA's rules for third-party-settled trusts in SSI eligibility determinations, discussed on page 35, also apply to Texas Long Term Care Medicaid. In addition, the Texas Long Term Care Medicaid program policy explicitly provides that the corpus of a Third-Party Trust is not a resource as long as the beneficiary isn't in control of distributions. Therefore, the distinction between a support trust and a supplemental trust is not relevant.[301]

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[298] PPACA §2403(a).

[299] NAELA Advocacy Alert (December 17, 2019).

[300] Sustaining Excellence in Medicaid Act of 2019, Pub. L. No. 116-39, 133 Stat. 1061 (2019); *see* Empowering Beneficiaries, Ensuring Access, and Strengthening Accountability Act of 2019, H.R. 3253, 116th Congress (2019).

[301] 1 T.A.C. §358.336(b); MEPD Handbook § F-6100.

2. BENEFITS OF A TESTAMENTARY TRUST FOR A SPOUSE

A trust established with property owned by the spouse of a Medicaid recipient would not seem, at first glance, subject to the self-settled trust rules because it is the property of the spouse rather than the Medicaid recipient. However, under Medicaid law, the term "assets" is defined to include assets of the spouse as well.[302] Therefore, the language "other than by will" in 42 U.S.C. §1396p(d)(2)(A) 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.

3. SELF-SETTLED TRUSTS GENERALLY

Similarly, the SSA's "Under 65" and "pooled" self-settled trust requirements for SSI eligibility, discussed on page 36, also apply to the long-term care Medicaid programs.[303] However, there are some special planning situations that tend to be important for older clients.

4. 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.[304] 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.[305]

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[302] 42 U.S.C. § 1396p(c)(1).

[303] Texas Long-Term Care Medicaid rules and policy on self-settled trusts are at 1 T.A.C. §358.339 and MEPD Handbook §§ F-6300–6610.

[304] MEPD Handbook §§ F-3210, F–3211; State Medicaid Manual §3259.6.F, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html (For these sections, download "Chapter 3—Eligibilty.zip" and extract the files. These sections are in "sm 03 3 325 to 3259.8.doc").

[305] This was confirmed by HHSC attorney Shari Nichols during her presentation at the UT Galveston Elder Law and Guardianship conference.

(2) Income. Both income and assets withdrawn from a trust are treated as "income" for Medicaid purposes.[306]

5. 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.

(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.[307]

(5) Hardship exception.[308]

> 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, Texas policy as stated in the MEPD Handbook seems to create 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."[309] 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 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.[310] An experienced Texas Elder Law attorney has published a paper advocating use of such trusts.[311] Policy-wise, it makes no sense to treat a trust

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[306] 42 U.S.C. § 1396p(d)(3); MEPD Handbook § F-6400.

[307] 42 U.S.C. § 1396p(d)(3)(B)(ii); MEPD Handbook § F-6500.

[308] 42 U.S.C. § 1396p(d)(5); State Medicaid Manual §3259.8A; MEPD Handbook § F-6900.

[309] MEPD Handbook § F-6500.

[310] State Medicaid Manual §3259.6C and in at least one letter to an Elder Law attorney.

[311] John K. Ross, IV, *Drafting an Income Only Asset Protection Trust,* 2012 NAELA Annual Conference.

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,[312] which was repealed effective September 1, 2009, and replaced by a rule incorporating the SSI trust rules.[313] The same language, though, was retained in MEPD Handbook F-6500 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.

6. EXCEPTIONS TO GENERAL RULES GOVERNING TRUSTS "ESTABLISHED BY" THE CLIENT

a) Under-65 Supplemental Needs Trusts

As discussed in the section on SSI eligibility, a self-settled trust will be treated as a resource of an SSI beneficiary unless it meets specific statutory 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 HHSC estimates the average cost of nursing home care in Texas is $213.71 per day ($6,500.30 per month), the Texas Legislature has seen fit to deny nursing home Medicaid benefits to anyone with more than $2,523 per month in gross monthly 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.[314] Such trusts are called "Miller Trusts" after the case Miller v. Ibarra,[315] 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 Star+Plus Waiver, HCS, Star Kids, 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, Qualified Individual and 1929(b) ("Community Attendant Services," "Frail Elderly").[316]

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[312] 1 T.A.C. §358.417(e)(4) (2009); 34 Tex. Reg. 3047, 3050, 3029.

[313] 1 T.A.C. §358.321.

[314] 42 U.S.C. § 1396p(d)(4)(B).

[315] 746 F. Supp. 19 (D. Colo. 1990).

[316] 1 T.A.C. §358.339(c)(4)(B).

(2) The requirements for the trust

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

- Funded only with pension, Social Security, and other income of the individual (and accumulated income in the trust)[317];
- Irrevocable;
- 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
- Require that the trustee:
- Pay to the beneficiary a monthly personal needs allowance.
- Pay to the spouse (if any) of the beneficiary a sum sufficient to provide a minimum monthly maintenance needs allowance, and
- Pay from the funds remaining the cost of medical assistance provided to the beneficiary.[318]

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."[319]

c) Pooled Supplemental Needs Trusts

See the discussion 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.[320] However, the provision that there is a transfer penalty for transfers to such a trust by persons aged 65 and over often limits their usefulness for clients needing long-term care.

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[317] 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 Handbook §§ F-6800 to F-6820 and additional agency policies are at MEPD Appendix XXXVI.

[318] 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 (published in the State Medicaid Manual §§ 3257–3259.8), 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.

[319] Unpublished 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.

[320] 42 U.S.C. § 1396p(d)(4)(C); 1 T.A.C. §358.339, MEPD Handbook §§ F-6720 to F-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.

Recently, some have reported that HHSC now requires these modifications include a "payback to Medicaid" provision. To clarify this requirement, the author conferred with an agency representative. The representative said "payback" is only required if, at the time of modification, the trust is considered 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 the 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, notice should be sent to HHSC General Counsel at 4900 North Lamar, Austin, TX 78751. The agency's general counsel prefers that the agency not be joined as a party and served with citation but rather that it simply be notified by letter with a copy of the petition.[321]

e) Availability of Self-Settled Special Needs Trusts for Persons with Physical Disabilities

Chapter 1301 of the Texas Estates Code 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.[322] Further, a physically disabled individual can petition for creation of a management trust on his or her own behalf.

As of December 13, 2016, however, it is no longer necessary for persons with disabilities to obtain a court order just to establish a self-settled Special Needs Trust. Such individuals with the intellectual capacity to do so can establish their own special needs trusts and still avoid Medicaid counting the trust as a resource. The law has been amended to allow "the individual, a parent, grandparent, legal guardian, or a court" to establish such a trust.[323] This rule is prospective and will not apply to trusts established after December 13, 2016.

7. EXEMPT ASSETS REMAIN EXEMPT IF TRANSFERRED TO REVOCABLE TRUST—EXCEPT THE HOME

The Medicaid policy handbook says regarding revocable trusts, "The corpus is an available resource."[324] Therefore, HHSC's Medicaid Specialists occasionally count exempt personal and household items (and possibly other exempt items) in a revocable trust as if they were not exempt,

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[321] "View from the HHSC," University of Texas School of Law Special Needs Trust Conference (February 8–9, 2013).

[322] Texas Est. Code § 1301.054.

[323] 21st Century Cures Act § 5007, P.L. 114–255, amending 42 U.S.C. 1396p(d)(4)(A); SSA EM-16053 (Dec. 13, 2016).

[324] MEPD Handbook § F-6400.

when they have been transferred to a revocable trust. That is incorrect, and HHSC confirmed in August 2018 that it is not agency policy.[325] The handbook language is a direct quote from the federal Medicaid statute,[326] but the statute defines "resources" as not including the whole list of "exempt" items (such as personal and household items) except if a home is transferred to a trust by an applicant and is still available to the applicant, it is no longer exempt.[327] The policy of HHSC follows the policy of the federal Centers for Medicare and Medicaid Services, which provides as follows: "…placement of an excluded asset in a trust does not change the excluded nature of that asset; it remains excluded…the only exception is the home…"[328]

This opens up some elegant planning opportunities. For example, it is common for Medicaid applicants to own a home in a revocable trust, which must be revoked at least to the extent of conveying the home back to the settlor(s). That can be frustrating to clients, who may only recently have paid an attorney several thousand dollars to establish and fund the trust. However, given the advantages of using a revocable trust to receive the home under a deed effective only at death, the optimal plan often is to *leave the trust in place and immediately convey the home back to it* by a Lady Bird Deed or Transfer on Death Deed. That supports the client's wish to avoid probate while accomplishing the additional goal of avoiding Medicaid Estate Recovery.

G. 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. To protect the integrity of the program, federal statute requires states to penalize transfers for less than fair market value. The HHSC Transfer rules are in the Medicaid Eligibility for the Elderly and People with Disabilities Handbook Chapter I, Transfer of Assets.

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 $213.71 gifted. The $213.71 amount represents HHS' estimate of the average private-pay cost of nursing home care in Texas. The amount is different in every state and is changed from time to time with inflation. For more information on calculating a penalty period, look at MEPD Handbook I-5000.

> Practice Note: Whenever gifts exceeding $16,000 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. Because there is now (as of 2021) an $11.7 million lifetime exemption on taxable gifts, the gift tax is a concern of few, if any, Medicaid applicants in Texas.

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[325] Shari L. Nichols, "The View from HHSC," University of Texas Estate Planning, Guardianship and Elder Law Conference, August 9, 2018 (in presentation).

[326] 42 U.S.C. 1396p(d)(3)(A).

[327] 42 U.S.C. 1396p(h)5, incorporating the definitions in 42 U.S.C. §1382b.

[328] State Medicaid Manual § 3259.6, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html .

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. See below. 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, the lookback period is 60 months before the beginning of the calendar month in which the Medicaid application is filed. 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.
5. Determine the number of days in the penalty period by dividing the amount of uncompensated transfer by $213.71 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:
8. Go to http://www.timeanddate.com/date/dateadd.html and enter the start date.
9. Enter the number of days in the penalty period (calculated in Step 5 above).
10. Click "Calculate New Date."

The displayed date is the date the penalty period ends.

3. TREATMENT OF MULTIPLE TRANSFERS

For most transfers, 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.[329]

[329] MEPD Handbook § I-5220. This does not apply transfers not covered by the DRA, i.e., applications filed before October 1, 2006 for transfers before February 8, 2006.

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

To have a start date, 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 . . ."[330] This process has also been used for many years when a nursing home resident's only barrier to full eligibility is the transfer penalty: they are "admitted to Mason Manor,"[331] 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 doesn't need to be in a "Medicaid bed" (nursing home capacity is measured in 'beds,' and some are dedicated to residents on Medicaid) 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 will 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).

Until April 2018, only nursing home residents could be admitted to Mason Manor and get a start date. An applicant for a "waiver" home care program (such as Star+Plus Waiver or Community Living Assistance and Support Services) or for State Supported Living Center services would not have a start date unless and until they were admitted to a nursing home then admitted to Mason Manor there. However, a letter dated April 17, 2018 from CMS directs all state Medicaid programs to apply the same rules to HCBS Waiver programs that apply to nursing home Medicaid. Under nursing home Medicaid, the penalty period will start on the date when the applicant meets all the requirements for initial eligibility, but for the transfer penalty. That is, the individual:

- Meets the financial and nonfinancial requirements for Medicaid eligibility;
- Meets the level-of-care criteria for the HCBS waiver program;

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[330] DRA of 2005 § 6011(b); *accord* 1 T.A.C. §358.401(d); MEPD Handbook § I-5200.

[331] MEPD Handbook § I-5400. 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.

- Has an approved person-centered service plan; and
- Has an approved waiver slot[332]

Whether the HCBS Waiver program will hold open a "slot" that became available only after months or years on the "interest list" is unanswered as of this writing (January 2022),

5. 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)
- All HCBS Programs (home care and Assisted Living Facility waiver programs)

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

- Family Care
- Community Attendant Services (formerly called Primary Home Care)
- Qualified Medicaid Beneficiary Program (QMB)
- Specified Low-Income Medicaid Beneficiary Program (SLMB)
- Medicare Part D Extra Help[333]

6. DISCLAIMERS AS TRANSFERS

An unexpected inheritance can be problematic. When considering federal gift tax and rights of creditors, a person can disclaim their inheritance, and the property is treated as if it had never been owned by the disclaiming party. According to the long-term care Medicaid rules, a disclaimed inheritance is an asset that was received and then immediately transferred and, therefore, subject to transfer penalties.[334]

7. WHAT IS "COMPENSATION" REDUCING A TRANSFER PENALTY

A transfer penalty can be offset or eliminated when the transferee provides "compensation" to the transferor (the client). To reduce a transfer penalty, compensation must be part of an agreement at or before time of transfer.[335] An agreement to provide something in the future to the client is not treated as any "compensation" until something of value is actually provided.

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[332] Shari L. Nichols, "The View from HHSC," University of Texas Estate Planning, Guardianship and Elder Law Conference, August 9, 2018 (in slide).

[333] MEPD Handbook § I-1200.

[334] *See* 42 U.S.C. § 1396p(h)(1); MEPD Handbook § E-3372.

[335] MEPD Handbook §§ I-4100, I-4110.

A common issue is whether a particular form of payment back from the transferee to or for the benefit of the transferor (Medicaid applicant) will reduce the transfer penalty. Compensation can be cash, real property, personal property, food, shelter, or services. Compensation may be in the form of payment or assumption of a legal debt of the client.[336] When expenses are incurred or services provided that can be treated as "compensation" under these rules, written receipts or statements are required.

a) Services

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 as a "transfer without consideration" and not "compensation." 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.[337]

b) Out of Pocket Expenses

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

c) Paying for repairs or improvements to the transferor's home

HHSC officials sometimes distinguish between repairs and improvements, saying payment for repairs—particularly to accommodate functional impairments—will reduce the transfer penalty but payment for improvements will not. Still in the gray area are repairs not related to functional impairments of the transferor and repairs made when the transferor is in a nursing home with no hope of returning to the home.

d) Paying for repairs to someone else's home

HHSC will sometimes reduce the transfer penalty for payment of repairs to a home not owned by the transferor, to the extent the transferor proves those repairs will benefit him or her. For example, a transferee may pay for disability access construction to the home of a child of the transferor with whom the transferor resides.

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[336] MEPD Handbook § I-4120.

[337] MEPD Handbook § 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.

8. CASH COMPENSATION OR RETURNS OF TRANSFERRED ASSETS

A recurring issue is whether a payment or other transfer by a transferee to a transferor should be governed by the "compensation" policy at MEPDH §§ I-4000 through I-4160, or by the "return of transferred asset" policy at MEPDH § I-5700. Often the recipient of an asset pays for the nursing home care of the transferor, either as part of a "transfer and return" strategy or with no planning at all. As of this writing (January 2021), the recent trend has been to apply the "compensation" policy.

a) Transfer back is "additional cash compensation"

As provided in MEPD Handbook § I-4150:

> If the person receives additional cash compensation that was *not a part of the transfer agreement* from the party who received the transferred asset, reduce the uncompensated value of the transferred asset by the amount of the additional compensation and as of the date the compensation is received. *Cash compensation includes direct payments to a third party to meet the person's food, shelter or medical expenses, including nursing facility bills, incurred after the date of the transfer.* [338]

That seems logical and consistent with how the agency has treated such payments in the past. However, cases have been reported from time to time in which such payments did not reduce the transfer penalty. Also, a recent HHSC presentation included a slide saying I-4150 applies only "if the payment were made pursuant to a legally binding agreement signed on or before the date of the transfer…"[339] That is very confusing because by its terms, I-4150 applies only to *additional* compensation *not* included in such an agreement. The intent may be to discourage planning strategies by requiring that the transferee pay the entire cost of the transferor's care during the transfer penalty period.

In any case, as discussed below, there are several strategies that will still allow a transferee to make only a partial return of the transfer by estimating the optimal amount to return and returning it all at once--in the form of a prepayment to the facility, an annuity, or a lump-sum partial return to the transferor after the start date of the transfer penalty.

b) Transfer back is a return of a transferred asset

The authors have it on good authority that the rules for returning a transferred asset at MEPD Handbook § I-5700 apply when the asset transferred was money and money is returned directly to the transferor/applicant. On the other hand, if the transferee "returns" the transfer by making payments to providers of goods and services to the transferor, it is treated as a "compensation" case under MEPD Handbook § I-4100 et seq.[340] However, the agency may require a "legally binding agreement signed on or before the date of the transfer," which can rarely be shown.

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[338] MEPD Handbook § I-4150 (emphasis added).

[339] Shari L. Nichols, "The View from HHSC," University of Texas Estate Planning, Guardianship and Elder Law Conference, August 9, 2018 (in slide).

[340] Shari L. Nichols, "The View from HHSC," University of Texas Estate Planning, Guardianship and Elder Law Conference, August 9, 2018 (in oral presentation).

The "return" policy presumably is followed in cases in which exactly the same real or personal property is returned, as when a home is deeded back to the transferor or title to a vehicle is returned. Such cases are not problematic as long as the transferee is able and willing to make the return. However, great difficulty may arise if a transferred home or vehicle has been sold by the transferee. That appears to be covered by I-5700, which provides, "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…" However, it appears the agency disregards that language in favor of the "compensation" rules. As discussed above, those rules would work in most cases if I-4150 were applied, as it gives credit for cash paid to the applicant or direct payments to a third party to meet the applicant's food, shelter or medical expenses. However, it does not work if there is a requirement of a "transfer agreement" entirely for purposes other than Medicaid eligibility. There rarely is such an agreement in these cases, and if there were, there would be no transfer penalty because there was no Medicaid intent.

The language of I-5700 strongly indicates an intent that it should apply whenever a transferred asset is returned, even if the asset is something other than money and even if money is returned in place of the asset. It provides that 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) that is returned, the nullification is applied retroactively to the date of the transfer. However, if it is a countable asset (such as a CD), it is treated as if the client owned it until the date it was returned. The following handbook language underscores this part of the rule:

> 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. [341]

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. Likewise, if all of an asset is returned after the penalty period has run, but before the application is certified, the applicant will lose eligibility for the entire period between transfer and return of the asset, even if it is longer than the penalty period.

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[341] MEPD Handbook § 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."

c) Techniques to Reduce Transfer Penalty

If a transfer of cash within the lookback period precludes eligibility, consider returning only part of it. The client does not have to return the entire amount to erase the transfer penalty because they have already "served" a portion of the "transfer penalty." It is even possible to do this as part of a plan, in which the optimal amount to be transferred is computed in advance.[342]Here are four options for returning part of the assets transferred.

(1) Pay Nursing Home Expenses as Incurred

The transferee pays the nursing home as expenses are incurred, 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).[343] There is also a risk that the agency will not reduce the penalty period for one of the reasons discussed above. Therefore, we do not recommend this as a planned strategy.

(2) Transfer All; Return Part

Once the client has established Mason Manor eligibility, the transferee returns, directly to the client in a lump sum, the amount of assets that, according to the calculations, 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 potentially available from Mason Manor eligibility.[344] It should be used only when the asset transferred was cash, and only cash is returned.

(3) Purchase Annuity; Transfer Rest

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 irrevocable payments and a Medicaid payback provision as required) 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 for payment of the nursing home (from the transfer of the other funds), divided by the number of months of ineligibility.

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[342] The optimal amount to transfer can be computed either by an algebraic formula or by a spreadsheet showing the cash flow. Those computations are beyond the scope of this paper.

[343] 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.

[344] 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.

(4) Pre-pay Nursing Home; Transfer Rest

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. The MEPD Handbook clearly allows this, and agency representatives have confirmed that is their interpretation.[345] However, agency representatives have made comments to the effect of "don't get greedy," which the authors interpret to mean that paying ahead to the nursing home beyond a foreseeable delay in processing the Medicaid application—perhaps three to six months—would invite adverse action by the agency.

9. TRANSFERS BY OR TO A COMMUNITY SPOUSE

At the UT Estate Planning, Guardianship & Elder Law Conferences on August 7, 2015 and August 9, 2018, HHSC attorney Shari L. Nichols answered questions regarding transfers by and to a community spouse. The following are from those presentations:

> Q: If the community spouse transfers his/her separate property after the MEPD certification, does that potentially create a transfer penalty for the institutionalized spouse?
>
> A: No, after certification, the community spouse may dispose of separate property as he/she wishes.
>
> Q: If the community spouse transfers community property after the MEPD certification, does that potentially create a transfer penalty for the institutionalized spouse?
>
> A: The community spouse may transfer only his/her community interest without causing a transfer penalty.
>
> Q: Would either of the answers to the previous questions be different if the transfer was made after the first annual review?
>
> A: No. Transfers by either the institutionalized spouse or the community spouse must be reported when the institutionalized spouse owns an interest in the property transferred.
>
> Q: If the institutionalized spouse transfers all his/her interest in the home he/she owns with the community spouse to the community spouse prior to the eligibility determination, and then after eligibility is determined, the community spouse sells the home, must the sale be reported?
>
> A: No.
>
> Q: If the institutionalized spouse transfers assets to the community spouse after eligibility is established, or after the first annual review, is there a transfer penalty?
>
> A: No. A transfer from one spouse to the other never results in a transfer penalty.

From those answers, the authors draw the following underlying principles regarding transfers from a community spouse to a third party:

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[345] MEPD Handbook § 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.

- If the transfer is to a third party, before the date on the notice certifying the eligibility of the institutionalized spouse, there is a potential for a transfer penalty, regardless of whether the asset is community property or the separate property of either spouse.
- If the transfer is to a third party after that certification date, there is a potential transfer penalty only on the value of the interest of the institutionalized spouse in transferred assets.

10. CERTAIN TRANSFERS EXCEPTED FROM PENALTY

The following transfers are not subject to transfer penalties:

1. Transfers of a home to
    a. The client's spouse; or
    b. child of the client who is (1) under age 21 or (2) blind or permanently disabled, or
    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.[346]
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 the age of the "child"), or to such a child of the client directly.[347]

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[346] To prove the adult lived in the home and cared for the client, they must provide "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 Handbook § I-3100.

[347] MEPD Handbook § I-3200 to I-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.

Comment: Taken literally, the Texas rule at 1 T.A.C. §358.401(d)(2)(B)(iv) requires that the transfer be to a trust to be within that exception. However, the federal statute requiring that rule is broader, allowing a direct transfer. It reads as follows, at 42 U.S.C. §1396p(c)(2)(B)(iii):

> An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—. . . the assets . . . were transferred to, or to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1382c(a)(3) of this title) . . . (emphasis added)

Apparently, due to a clerical error, the underlined language was omitted in the Texas rule during the rulemaking effective September 1, 2009. Several practitioners who have encountered this issue report that the agency follows the federal law on this when the issue is presented to legal or policy staff.

5. Any transfers to a trust established solely for the benefit of an individual under 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)
9. 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 another purpose at a fair hearing, the penalty period will be avoided.
10. Transfers of property that has since been returned to the client[348]
11. Imposition of a penalty would cause "undue hardship."
12. 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)
13. The client purchases an irrevocable funeral arrangement or assigns ownership of such an arrangement to a third party
14. Transfers to a Uniform Transfers to Minors Act (UTMA) account for the benefit of a person under 21 years of age (discussed above)

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[348] See discussion of "Return of Transferred Asset Rule" above.

Prepayments to a nursing home are not treated as transfers of assets, and they are not counted as resources until the first day of the calendar month after a refund is made.[349]

11. EXCEPTION: TRANSFERS SOLELY FOR NON-MEDICAID PURPOSE

As mentioned above, 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."[350]

The Medicaid law presumes that any transfer of assets for less than fair market value is for the purpose of obtaining Medicaid services.[351] 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 the date of receipt by the client) to present oral or written rebuttal of the presumption.[352]

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

- the 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;
- means of or plan for self-support after the transfer; and
- relationship to the person to whom the asset was transferred [353]

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.

12. EXCEPTION: TRANSFER PENALTY WOULD RESULT IN "UNDUE HARDSHIP"

"Undue hardship" is an affirmative defense to the transfer penalty. [354] This defense must be asserted within 10 days of the date in which the worker filled out the notification form. To

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[349] MEPD Handbook § F-1312.2

[350] MEPD Handbook § I-3200.

[351] 42 U.S.C. § 1396p(c)(2)(C); MEPD Handbook § I-4220.

[352] MEPD Handbook § I-4210.

[353] MEPD Handbook § I-4220.

[354] 1 T.A.C. §358.401(d)(2)(D); MEPD Handbook §§ I-3200, I-4300, I-4310. .

underscore its importance, the Texas rule as described in the MEPD Handbook §I-4300 states in full:

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 to 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 to 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 place to return to in the community and/or receive the care required to meet the person's needs.
- If a person claims undue hardship, HHSC must make a decision on the situation as soon as possible, but within 30 days of receipt of the request for a waiver of the penalty. The person has the right to appeal an adverse decision on undue hardship.[355]

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.

> Comment: The most difficult issue appears to be whether the recipient of the transfer is "unwilling to cooperate." Although the parenthetical (such as an APS exploitation or potential fraud case) is quoted at Medicaid Eligibility for the Elderly and People With Disabilities Handbook §I-4300 as if it were part of the rule, in fact, it is not; but since a staff member thought the quotation of the rule needed such embellishment, this may be useful evidence of an informal policy not yet fully articulated. One guess would be that opening an APS exploitation case or filing criminal charges may be a "safe harbor," outside of which one cannot predict with assurance what a Medicaid worker or hearing officer may decide. For example, will it be sufficient for Mom to testify that she asked Son to return the money and he refused? If not, how much more explanation will be required?

[355] MEPD Handbook § I-4300; 1 T.A.C. §358.401(d)(2)(D).

Put another way, the author suspects that "unwilling to cooperate" is not the standard actually applied, which if fully articulated would be something like "unable to return the amount transferred or unwilling to do so; and the person has made every reasonable effort to compel its return." In any case, it would be prudent to prepare every case to meet that standard.

13. MOTOR VEHICLE TRANSFER ON DEATH AVOIDS TRANSFER PENALTY AND MERP

Under Chapter 115 of the Texas Estates Code:

> An owner of a motor vehicle may transfer the owner's interest in the motor vehicle to a sole beneficiary effective on the owner's death by designating a beneficiary…"[356] The designation is to be made by submitting an application for title.[357]

The form is titled "Beneficiary Designation of a Motor Vehicle" (form VTR-121). It was published in May 2018 and at this writing is available at the website of the Texas Department of Motor Vehicles at http://www.txdmv.gov/forms-tac.

At first glance, this may seem duplicative of the previous procedure by which a right of survivorship may be created.[358] There is a critical difference, however. Signing a right of survivorship form transfers a legal interest in the vehicle. The Medicaid program considers this a "transfer" that may result in a Medicaid transfer penalty. Further, on the theory that designating a beneficiary makes the vehicle unmarketable, HHSC values the amount transferred as the entire fair market value of the vehicle.

Apparently to avoid this result, the new transfer on death law provides that such a beneficiary designation "does not create a legal or equitable interest in favor of the designated beneficiary in the motor vehicle that is the subject of the designation."[359] Also, it "does not affect an owner's or the designated beneficiary's eligibility for any form of public assistance, subject to applicable federal law."[360] Therefore, HHSC does not assess a transfer penalty for signing the new form.[361]

This is an important issue to Elder Law attorneys primarily because using the new transfer on death beneficiary designation (form VTR-121) appears to be a way of keeping vehicles out of the probate estates of their owners and therefore not subject to the Medicaid Estate Recovery Program. However, it has the disadvantage that according to information on the back of the form, it must be submitted with an Application for Texas Vehicle Title and/or Registration (Form 131-U) and fees to a county tax-assessor before the owner's death. Therefore, if the client is not concerned about Medicaid estate recovery, they will be much happier using form VTR-122, the Rights of

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[356] Tex. Est. Code § 115.002; Acts of May 24, 2017, 85th Leg., R.S., S.B. 869.

[357] Tex. Est. Code § 115.002; Tex. Trans. Code § 501.0315(a); Acts of May 24, 2017, 85th Leg., R.S., S.B. 869.

[358] Form VTR-121 at http://www.txdmv.gov/forms-tac .

[359] Tex.as Est. Code §115.004(2).

[360] Tex. Est. Code §115.004(4).

[361] Shari L. Nichols, Texas Health and Human Services Commission, University of Texas School of Law's Estate Planning, Guardianship and Elder Law Conference: The View from HHSC (Aug. 4, 2017).

Survivorship form, which requires no other paperwork and no visit to the county tax-assessor during the owner's lifetime.

14. GIFTING BY GUARDIANS

A guardian can gift and transfer a ward's assets so they qualify 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" but only "on a showing that the ward will probably remain incapacitated during the ward's lifetime. . . ."[362]

This amendment opened a door that allows guardians and legal counsel to assist wards in qualifying 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 the 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 the capacity to express such a desire.

This change signals a 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 a 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 drafters of the bill has stated the latter, broader interpretation was intended.[363]

15. 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:

- The guardian's compensation may not exceed $250 per month;

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[362] Tex. Est. Code § 1162.001. In 2011, the Texas Legislature amended § 865 of the Texas Probate Code, recodified in 2013 as Texas Estates Code §§ 1162.001- 1162.008. Prior to the 2011 amendment, 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.

[363] 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.

- Fees for the ad litem 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 limited to $1,000 during any three-year period. [364]

An amendment effective September 1, 2011, provides 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.[365] Moreover, there can be no deduction for services provided "before the effective date of the deduction. . . ."[366] In most cases, this will be before the date of the order authorizing compensation for the services.

This amendment seems to create a logical impossibility by requiring a court to approve fees at the initial establishment of the guardianship when the court has not 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.[367]

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

H. APPLICATION

The Texas Health & Human Services Commission handles the application process. Information is available at https://www.yourtexasbenefits.com

I. 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. A client contacted Ms. Lesher about filing an application for Medicaid benefits. Upon previous inquiry, the nursing facility told the family that in order to have their loved one placed in a Medicaid-certified bed, they were required to engage the legal services of a particular attorney with whom the facility had an agreement. The nursing home provided the family with an information packet produced by the attorney's office, notably with incorrect and incomplete legal advice. Because of the pre-existing relationship, the client chose to contact Ms. Lesher's office for assistance.

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. This type of agreement is problematic for a few reasons. First, the Texas Business and Commerce Code

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[364] Tex. Est. Code §1155.202(a).

[365] Tex. Est. Code §1155.202(c)(1).

[366] Tex. Est. Code §1155.202(c)(2).

[367] 1 T.A.C. §358.439.

provides guidance on the issue: "every contract, combination, or conspiracy in restraint of trade or commerce is unlawful."[368]

When a nursing facility requires a family to engage 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. By requiring a family to hire a specific attorney to access a Medicaid-certified bed, 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 nursing home regulations, which provide: 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. . . ."[369]

If the attorney of the family's choice and the nursing facility happen to lie in different states, this restraint of trade or commerce crosses state lines and is prohibited by Federal law.[370]

J. MEDICAID ESTATE RECOVERY PROGRAM

The Medicaid Estate Recovery Program (MERP) allows Medicaid to force the 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 the certification of eligibility. There are some important exemptions and waiver provisions. For a summary, answers to frequently asked questions, rules and statutes, and forms, go to https://hhs.texas.gov/services/aging/long-term-care/your-guide-medicaid-estate-recovery-program.

K. LADY BIRD DEED

The "Enhanced Life Estate" or "Lady Bird" Deed adds to the reservation of a life estate, the reservation of the power to take away from the remainder owner(s) the rights given them in the deed and give those rights to someone else, as well as the right to sell without liability to the remainder beneficiary.[371]

> At common law, an estate in remainder, expectant on the death of the grantor, could not be created, but in this state, by virtue of a special statutory provision, an estate in land may be created by deed to commence in the future. The grantor's death may be designated as the time when the estate is to fall into possession. Upon such death, a complete title, in the sense of a

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[368] Tex. Bus. & Comm. Code § 15.05(a).

[369] 40 T.A.C. 19.406(c)(1).

[370] 15 U.S.C. § 1.

[371] For a more comprehensive discussion of the Enhanced Life Estate Deed and other real estate issues affecting Medicaid eligibility, see Kristen Quinney Porter & Patricia A. Sitchler, *Where Real Estate and Estate Planning Collide*, State Bar of Texas 2014 Advanced Elder Law Course.

> right of present enjoyment, becomes vested in the grantee, unless the right to make other disposition of the property has been reserved by the grantor.[372]

The statute in question is Texas Property Code §5.041: "A person may make an inter vivos conveyance of an estate of freehold or inheritance that commences in the future, in the same manner as by a will."

The validity of the reservation of the right to revoke the grant of such a future interest was affirmed recently, when the grantee of such a deed argued that a later conveyance by the grantor to a Limited Liability Company was ineffective. The Texarkana Court of Appeals rejected that argument, holding that the grantor "reserved her rights in the Property (including the right to convey it) thereby eviscerating any rights or interests [the grantee] may have had in the Property prior to that time."[373]

Practice Tip: Title companies sometimes require that grantees of an Enhanced Life Estate Deed join in any sale by the grantor. However, that may be resolved by negotiation or by finding another title company without that requirement; and the Turner *case will be helpful in that effort.*

Another basis for affirming the validity of interests passing under an Enhanced Life Estate Deed is Estates Code §111.052(a) (formerly in Probate Code §450), which provides, "This code does not invalidate…(1) any…conveyance of property…effective as a contract, gift, conveyance or trust, stating that:… (A) money or other benefits under the instrument due to or controlled by a decedent shall be paid after the decedent's death, *or property that is the subject of the instrument shall pass, to a person designated by the decedent in the instrument…(b) A provision described by Subsection (a)(1) is considered non-testamentary*." (emphasis added) Thus, cases invalidating conveyances passing at death as "testamentary" and ineffective because the instrument did not include two witnesses and other requirements of a will are inapplicable.

An Enhanced Life Estate Deed has the following benefits in addition to the benefits of reserving a life estate:

- If a remainder owner displeases the grantor, his or her interest can be taken away.
- Other family members may be rewarded for helping the client by a change of estate plan implemented simply by signing and recording a new Enhanced Life Estate Deed
- Likewise, if someone in the family falls on hard times and needs extra help, the estate plan can be changed with a new deed. As discussed below, if disability is involved, the grantee probably should be a trust, to protect potential Medicaid and other means-tested benefits and/or to provide for management of the property.
- The grantor reserves the right to sell or mortgage the property without consent of the grantee.

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[372] *Davis v. Zeanon,* 111 S.W.2d 772, 773 (Tex. Civ. App.-Waco 1937, writ refused); *see York v. Boatman,* 487 S.W.3d 635, 641 (Tex. App.-Texarkana 2016, no pet.)

[373] *In re Estate of Turner,* No. 06-17-00071 (Tex. App.—Texarkana 2017, pet. denied).

- If creditors of a remainder owner threaten action affecting the property, the grantor can protect his or her interests by appointing the remainder to someone else. This would not be a fraudulent transfer if the life tenants are not "debtors" as to the creditors.[374]
- Of most interest to this discussion, under the policy cited next below, the conveyance creates no Medicaid transfer penalty; and at the death of the grantor, title will pass under such a deed outside the grantor's probate estate and will therefore not be subject to Texas estate recovery under the current state law.

The Medicaid for the Elderly and People with Disabilities Handbook provides as follows:[375]

> Transfer of the person's home does not result in a penalty when the title is transferred to the person's…children, siblings, etc., if the deed is an enhanced life estate [sic] and has been approved by the regional attorney…

The following definition is important:

> **Enhanced Life Estate Deeds** — A legal document (sometimes known as a Lady Bird Deed) in which one transfers property to their heirs while at the same time retaining a life estate with powers including the right to sell the property in their lifetime.
>
> Since the life estate holder retains the power to sell the property, its value as a resource is its full equity value. If you see a document that appears to transfer property to heirs while retaining a life estate with powers, contact the regional attorney to determine the value of any transfer. The full value of the asset is treated as a countable resource to the individual, unless it is a resource that is otherwise excluded, such as a home to which the individual intends to return.
>
> All Enhanced Life Estate Deeds must be reviewed by the regional attorney. [376]

Notice that under the Handbook definition above, unless the property conveyed by an Enhanced Life Estate Deed is exempt, its full value is treated as a resource of the Medicaid applicant, because he or she retains the power to sell it and convert it to cash.

> Author's Comment: Therefore, it is clear that you cannot use a Lady Bird Deed to make property exempt. Its only function with regard to Medicaid is to protect the property from estate recovery. For example, it will not make a farm or ranch exempt if the property cannot be exempted either as a residence or as "business property." Likewise, if the owner's equity in a residence is more than $595,000, conveying it by Enhanced Life Estate Deed will not solve the problem that (subject to certain exceptions, including occupation by the Medicaid applicant's spouse) the owner's equity over $595,000 counts as a resource.

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[374] Tex. Bus. & Comm. Code §24.005.

[375] MEPD Handbook § I-3100. See also State Medicaid Manual §3258.9A. The mention of particular family relationships in the Handbook is apparently to give examples only, as nothing in the law requires that the grantee have any particular relationship to the Medicaid applicant. In fact, as discussed below, the grantee often should be a trustee.

[376] MEPD Handbook Glossary.

However, the following could interfere with the "ideal" operation of this strategy:

- Some title companies are not comfortable with insuring a title based solely on such a deed. If such an objection is encountered, it may be necessary to change title companies or ask the title company representative to change insurance carriers. In some communities, there is only one title company, but that one title company will generally insure through several different insurance carriers. Alternatively, it is usually possible to do "cleanup work" such as probating a will or developing a family settlement agreement.
- It may be difficult or impossible to refinance a mortgage or take out a reverse mortgage. An attorney has reported that a reverse mortgage application was denied on the basis that the grantee of the Enhanced Life Estate Deed was under 62 years of age, so a reverse mortgage would violate federal rules pertaining to such loans.
- The Medicaid program could seek to change its rules so as to make this device no longer effective.
- The Texas Legislature could adopt "expanded estate recovery," thus possibly bringing property so held within the scope of estate recovery, as has happened in many states.[377]

In any case, the issue most pertinent to this discussion is whether, in some cases, the same functions may be performed more reliably by a Transfer on Death Deed under the new statute creating that instrument.

L. TRANSFER ON DEATH DEED: THE NEW LADY BIRD DEED?

1. FEATURES OF THE TRANSFER ON DEATH DEED

The 2015 Legislature added a new Chapter 114 to the Texas Estates Code to provide for a Transfer on Death Deed.[378] The 2019 Legislature repealed Subchapter D, which previously provided for a statutory form. However, that made no substantive change in the law, as the statutory form was never mandatory to any extent.[379] Such a deed has the following features:

- A deed is governed by Chapter 114 only if it is "authorized under this chapter," and that description "does not refer to any other deed that transfers an interest in real property on the death of an individual."[380]

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[377] *Bonta v. Burke,* 98 Cal.App.4th788, 120 Cal.Rptr.2d 72 (2002) (holding that property conveyed by this type of deed is subject to estate recovery in California, which has an expanded definition of estate recovery that includes non-probate assets.)

[378] S.B. 462, 84th Leg., R.S. (2015).

[379] H.B. 2782 §47(2), 86th Leg., R.S. (2019); H.B. 2782 §48 provides, "The repeal of Subchapter D, Chapter 114, Estates Code, by this Act does not affect the validity of a transfer on death deed or a cancellation of a transfer on death deed executed before, on, or after the effective date of this Act."

[380] Tex. Est. Code § 114.002(a)(6).

- It must be "executed and acknowledged on or after September 1, 2015, by a transferor who dies on or after September 1, 2015."[381]
- The new statute "does not affect any method of transferring real property otherwise permitted under the laws of this state."[382]
- A "beneficiary" of the deed may be any "person."[383] "Person" includes corporation, organization, government or governmental subdivision or agency, business trust, estate, trust, partnership, association, and any other legal entity.
- It is revocable.[384] Revocation may be effected by a subsequent inconsistent Transfer on Death Deed or by an instrument expressly revoking it. The subsequent deed or revocation must be acknowledged by the transferor after the acknowledgment of the deed being revoked and recorded in the county where the deed being revoked is recorded.[385] However, a will may not revoke or supersede it.[386] A judgment of divorce between transferor and beneficiary revokes it automatically if notice of the judgment is recorded before the transferor's death in the county where the deed is recorded.
- It is "a non-testamentary instrument."[387] That is, although it performs a function similar to a will, it is not subject to the requirements as to formalities of execution of a will.
- It may not be created through use of a power of attorney.[388]
- During the transferor's life, the transferor retains all rights in the property, including the right to transfer or encumber it, homestead rights and property tax exemptions.[389]
- It does not "affect the transferor's or designated beneficiary's eligibility for any form of public assistance, subject to applicable federal law."[390]
- The beneficiary's interest lapses if the beneficiary fails to survive the transferor by 120 hours, unless the "anti-lapse" provision applies.[391]

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[381] Tex. Est. Code § 114.003.

[382] Tex. Est. Code § 114.004.

[383] Tex. Est. Code §§ 114.002(a)(1), (a)(4), 114.051; Gov't Code § 311.005.

[384] Tex. Est. Code § 114.052.

[385] Tex. Est. Code § 114.057(a)

[386] Tex. Est. Code § 114.057(b)

[387] Tex. Est. Code § 114.053.

[388] Tex. Est. Code § 114.054(b).

[389] Tex. Est. Code § 114.101(1). The right to a school tax freeze is not mentioned expressly but may be construed to be included with property tax "exemptions."

[390] Tex. Est. Code § 114.101(4).

[391] Texas Estates Code §114.103(a).

- Concurrent interests are transferred in equal and undivided shares with no right of survivorship; but the unless the document provides otherwise, the share of any beneficiary who predeceases the transferor passes as if the deed were a devise made in a will.[392]

  Authors' Comment: The statute was amended by the 2017 Legislature to make the anti-lapse provision apply to any beneficiary who fails to survive the transferor by at least 120 hours if the predeceased beneficiary is a descendant of the owner or of the owner's parent.[393] *Previously that provision applied only to a beneficiary of a concurrent interest (two or more beneficiaries of the same property). The amendment provides that the interest of a predeceased beneficiary "lapses…and is subject to and passes in accordance with Subchapter D, Chapter 255, as if the transfer on death deed were a devise made in a will…" That is, if the predeceased beneficiary is a descendant of the owner or of the owner's parent, that beneficiary's interest goes to his or her descendants if any.*

  So what if Mom transfers Blackacre to Son 1, with Son 2 as alternate beneficiary, and Son 1 predeceases Mom, survived by descendants? Under the original statute of 2015, the default in the form deed was for Blackacre to go to Son 2. Under the 2017 amendment, the property goes to the descendants of Son 1. As with a will, you have to ask "If Son 1 dies before you leaving descendants who survive you, do you want Blackacre to go to the descendants of Son 1 or to Son 2?"

- A Transfer on Death Deed transfers real property without covenant of warranty of title even if the deed contains a contrary provision."[394]

- In general, with regard to creditors of the transferor, the property is treated in probate as if it had passed under a will,[395] except it is liable for claims against the estate only to the extent the estate is insufficient to satisfy them and the interest of a divorced spouse is not cut off automatically.[396]

- However, the property transferred is "not considered property of the probate estate for any purpose, including for the purposes of Section 531.077, Government Code.[397] That section authorizes the Medicaid Estate Recovery Program, and its exclusion was added to the legislation in a committee substitute bill to ensure that it would not be construed to extend the scope of estate recovery beyond the probate estate. Section 114.106 includes other rights of creditors not included in this summary.

The following states the policy of Stewart Title regarding Transfer on Death Deeds:[398]

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[392] Texas Estates Code §114.103(a)(2).

[393] S.B. 2150 § 1, 85th Leg., R.S. (2017)(amending Estates Code §114.103(a), incorporating by reference the anti-lapse provisions in Estates Code Ch. 255 Subch. D.) See especially § 255.153 on devisees who predecease the testator.

[394] Texas Estates Code §114.103((d).

[395] Texas Estates Code §114.104.

[396] Texas Estates Code §114.106(a).

[397] Tex. Est. Code §114.106(b).

[398] Stewart Title Virtual Underwriter at http://www.vuwriter.com/en/bulletins/2015-7/tx2015003.html

> Stewart will accept a TODD as a vesting instrument so long as it substantially conforms to the statutory form as provided in Estates Code Sec. 114.151. If you receive a non-statutory form that appears to not contain the elements required above, seek Texas underwriter approval.
>
> If the real property is non-homestead and less than two (2) years have passed since the transferor's death, you should add the following exception:
>
> *Loss, cost or expense resulting from any claim that the assets of the estate of _____ (insert name of deceased) are insufficient to satisfy any estate claim against the estate or expense of the administration.*
>
> As with any deceased owner, you must also examine a balance sheet of the estate and obtain an indemnity from the beneficiaries as required in P-11b. (9). Please note that the beneficiaries must prove their solvency to the Stewart underwriter's sole satisfaction.

As noted above, the provision for the statutory form was repealed by the 2019 Legislature, effective September 1, 2019. That leaves drafters with the following options:

- Use the form in the statute as passed by the 2015 Legislature, which is clear enough but does not give notice of the effect of the anti-lapse provisions. That leaves open the possibility of disputes between descendants entitled under the anti-lapse provisions and other beneficiaries claiming those shares under the plain language of the deed—just the sort of thing title companies seek to avoid.
- Use the form in the statute as passed by the 2017 Legislature, whose complexity may be warranted in those cases in which the anti-lapse provisions actually apply.
- Use the form in the State Bar's *Texas Real Estate Forms Manual*.
- Use the form developed by Legal Services programs in Texas[399] or
- Develop your own form.

2. COMPARISON OF TODD AND LBD

a) Effect on Medicaid Eligibility

With both types of deeds, the interest transferred is properly considered unmarketable by HHSC, so there is no transfer penalty; and it passes outside the probate estate, so it is not subject to the Medicaid Estate Recovery Program. Therefore, "For MEPD [Medicaid eligibility] purposes, the Transfer on Death Deed will be treated like an Enhanced Life Estate Deed [Lady Bird Deed]."[400]

b) Will a TODD Preserve Title Insurance Protection?

As indicated above, the Transfer on Death Deed statute expressly provides that such a deed is not a warranty deed—even if it purports to be. On the surface, that seems favorable to the estate of the

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[399] TexasLawHelp.org, *I want to pass on my house or land without a will.,* https://texaslawhelp.org/toolkit/i-want-pass-my-house-or-land-without-will?ref=Od10y. **Caution,** the author has not reviewed that form in detail so cannot evaluate it at this time.

[400] HHSC attorney Shari Nichols, "The View from HHSC," University of Texas School of Law Estate Planning, Guardianship and Elder Law Course (August 7, 2015).

transferor because it precludes liability of the estate to a beneficiary or an owner later in the chain of title if a title problem arises.

However, it may cut off title policy protection the owner paid for and probably wants for the beneficiary. That is because it is not clear whether the beneficiary of this new type of deed—unforeseen by the drafters of title policy forms and the statutes that govern them--is within the definition of "insured" under the policy or is otherwise entitled to the policy's protection.[401] It is clear that the purchaser of the policy is entitled to its protection in the event the purchaser is found liable on a warranty of title. This is why well-informed attorneys ordinarily use a warranty deed when conveying property to a revocable trust, limited partnership or family member—so if a title problem later develops, the grantee can assert a claim against the grantor, and *that claim will be covered by the title insurance*. That would not be the case if conveyance were by a quitclaim deed, a deed without warranty or (as to claims arising before the owner took title) a special warranty deed.[402] The same problem may arise when a Transfer on Death Deed is used.

c) Will a LBD Give Better Protection from Creditors?

The Transfer on Death Deed statute provides as follows:[403]

> Sec. 114.106. LIABILITY FOR CREDITOR CLAIMS; ALLOWANCES IN LIEU OF EXEMPT PROPERTY AND FAMILY ALLOWANCES. (a) To the extent the transferor's estate is insufficient to satisfy a claim against the estate, expenses of administration, any estate tax owed by the estate, or an allowance in lieu of exempt property or family allowance to a surviving spouse, minor children, or incapacitated adult children, the personal representative may enforce that liability against real property transferred at the transferor's death by a transfer on death deed to the same extent the personal representative could enforce that liability if the real property were part of the probate estate.
>
> (b) Notwithstanding Subsection (a), real property transferred at the transferor's death by a transfer on death deed is not considered property of the probate estate for any purpose, including for purposes of Section 531.077, Government Code.
>
> (c) If a personal representative does not commence a proceeding to enforce a liability under Subsection (a) on or before the 90th day after the date the representative receives a demand for payment, a proceeding to enforce the liability may be brought by a creditor, a distributee of the estate, a surviving spouse of the decedent, a guardian or other appropriate person on behalf of a minor child or adult incapacitated child of the decedent, or any taxing authority.
>
> (d) If more than one real property interest is transferred by one or more transfer on death deeds or if there are other non-probate assets of the transferor that may be liable for the claims,

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[401] For a scholarly discussion of this issue, see Michael J. Lucksinger, "Transfer on Death Deed, Lady Bird Deed, Survivorship Agreements," State Bar of Texas Advanced Real Estate Law Course (2016). He concludes that the policy forms do purport to extend protection to beneficiaries of Transfer on Death Deeds but that they may be unenforceable because they exceed the scope permitted by the statute under which the forms are promulgated.

[402] For a thorough discussion of this issue, see D'Ana H. Mikeska and Michael A. Wren, *Conveyancing Techniques to Preserve Title Insurance in Real Estate Transactions*, State Bar of Texas 22nd Annual Advanced Real Estate Drafting Course (2011).

[403] Tex. Est. Code §114.106

> expenses, and other payments specified in Subsection (a), the liability for those claims, expenses, and other payments may be apportioned among those real property interests and other assets in proportion to their net values at the transferor's death.
>
> (e) **A proceeding to enforce liability under this section must be commenced not later than the second anniversary of the transferor's death**, except for any rights arising under Section 114.104(d).
>
> (f) In connection with any proceeding brought under this section, a court may award costs and reasonable and necessary attorney's fees in amounts the court considers equitable and just.

Apparently based on that provision, at least some title companies have declined to insure title involving a sale by a beneficiary of a Transfer on Death Deed until two years after the transfer's date of death. That is sometimes cited as a potential benefit of a Lady Bird Deed over a Transfer on Death Deed.

The passage in question provides for liability against the property only "…to the same extent the personal representative could enforce that liability if the real property were part of the probate estate." That is, if the property is in the hands of the beneficiary, the personal representative can sell it and use the proceeds to pay claims against the estate. But what if the beneficiary sells the property to a bona fide purchaser for value? The statute does not purport to affect the rights of such a purchaser. Rather, if the beneficiary makes such a sale, the remedy of the personal representative or of a creditor would be to pursue the proceeds of the sale in the hands of the beneficiary. There is no lien and therefore no right of *anyone* to take the property from a bona fide purchaser for value, regardless of whether a personal representative has been appointed.

Title Companies approach this issue from a different perspective. They are risk averse. Their fees are set by law, so they earn no more to insure a safe case than a risky one; and the cost of defense more than offsets the profit even if the defense is successful.[404] Therefore, they may reason that the mere existence of a statute seeming on its face to allow forced sale of the property by creditors (other than Medicaid estate recovery) may increase the likelihood that a creditor will file suit or threaten to do so--even if there is no lien and the insured owner is a bona fide purchaser for value. Hence it appears that at this moment in time, use of a Lady Bird Deed may make title to property more insurable, and therefore more marketable, in the hands of its grantee after death of the grantor than would a Transfer on Death Deed.

However, that is just one factor. Independent title agent and attorney Michael Lucksinger comments that even with title companies with a stated guideline for declining coverage in such cases, "that has never proved to be a hard and fast rule. In the real world there are ways to work around it, e.g. by thorough investigation of the decedent's affairs with the beneficiaries and obtaining proper affidavits and indemnity agreements. The result is not a perfect world for the underwriter but one that they understand they must operate in to be competitive with their

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[404] Charles Edmund Kramer, "Real Estate Transaction and Probate: What's Legal v. What's Insurable," State Bar of Texas Advanced Elder Law Course (April 4, 2019), page 1.

peers."[405] For the same reason, it is not uncommon for coverage to be declined by one title company but offered by another regarding the same transaction.

Taking the prediction, a step further into the future, we may ask what will happen if the use of Lady Bird Deeds becomes so common that substantially less real property goes through probate and creditors' claims are routinely avoided. Presumably, financial institutions will seek redress in the form of legislation giving creditors and personal representatives the same rights regardless of the form of the deed accomplishing the transfer at death. Still another step could involve widespread use of such deeds by insolvent individuals and entities to avoid their creditors, which could lead to limitations on use of the bona fide purchaser doctrine in this context. As suggested above, this is another reason that regardless of whether a Transfer on Death Deed or Lady Bird Deed is used, it should be backed up by a valid will with exactly the same disposition for the property, so if the deed fails, the estate plan can still be "cleaned up" with probate (hopefully coupled with some other defense against estate recovery).

d) Effect of Divorce

A final judgment dissolving a marriage has the effect of revoking a Transfer on Death Deed from one spouse to the other—but only if the judgment is recorded before the transferor's death in the deed records of the county where the deed is recorded.[406]

e) Which Type Deed to Use?

It appears that both a Lady Bird Deed and a Transfer on Death Deed will pass the transferor's title to the transferee and will protect real property from the Medicaid Estate Recovery Program. The Lady Bird Deed has the advantage, for the moment, of being more familiar both to Medicaid program personnel and to title companies. In addition, a Lady Bird Deed allows for the creation of a general warranty of title for protection of the beneficiary, in case a title problem later arises. That might take the form, for example, of drilling equipment arriving under a lease signed by a previously unknown owner of mineral rights, or a claim by an heir whose right was not extinguished earlier in the chain of title.

At this writing, property passing under a Transfer on Death Deed may be harder to sell after the death, because title companies may decline to insure title for two years after the date of death. Therefore, if an earlier sale is anticipated, that argues for use of a Lady Bird Deed.

Regardless of the type deed selected, clients should be advised to back up the deed with a valid will drafted by an attorney and providing for exactly the same plan of disposition. Then if title companies will not insure, probate of the will and administration of the estate will solve the problem. That would also reduce the risk of attack on the deed based on incapacity, fraud, or undue influence, due to the greater formality of will execution and availability of an attorney to testify to its validity. However, if the decedent was on Medicaid, probate of the will may require the executor

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[405] Michael J. Lucksinger, in email correspondence with the author June 24, 2019.

[406] Tex. Est. Code §114.057(c).

to deal with a claim by the Medicaid Estate Recovery Program. Such claims can sometimes--but not always--be avoided or reduced with exemptions, waivers or other defenses.

A Transfer on Death Deed has statutory authority to name contingent ("alternate") beneficiaries (grantees). Moreover, it even has a default anti-lapse provision under which the share of a deceased beneficiary passes as if the deed were a will—that is, if the deceased beneficiary is a descendant of the transferor or of one or both of the transferor's parents, the interest passes to the descendants of the deceased beneficiary if any.[407] In any case, though, a provision in the Transfer on Death Deed providing for different contingent beneficiaries will prevail.[408]

> Author's Comment: This statutory invitation to naming contingent beneficiaries is somewhat unsettling, since title companies generally frown on contingent beneficiary provisions in deeds, making the best practice generally to use a will or trust rather than a gift deed if such a provision is important.
>
> It remains to be seen whether title companies will insure titles when one link in the chain is through a contingent beneficiary of a Transfer on Death Deed, especially if the gift is to a class such as "descendants" of a named person.[409] However, one title examiner has pointed out that they do insure titles involving affidavits of heirship requiring a title company to ascertain the identities of descendants and other heirs.
>
> He suggested that when contingent beneficiaries/grantees are involved, they may be more inclined to insure under a Transfer on Death Deed than under a Lady Bird Deed, because the Transfer on Death Deed statute provides for "alternate" beneficiaries and also has the anti-lapse provisions.

Whether a Transfer on Death Deed or an Enhanced Life Estate Deed is preferable in a given transaction can be determined only on a case-by-case basis, involving at least the following considerations:

- Must the deed be signed by a power of attorney agent? If so, only a Lady Bird Deed will do, as a Transfer on Death Deed signed by an agent would not be effective. However, the gifting power of the power of attorney must be broad enough to include the transfer. Most gifting powers are not, as they are typically restricted to the gift tax annual exclusion amount (currently $16,000 per person per year).
- Is there title insurance now? If so, a Lady Bird Deed drafted as a General Warranty Deed may be preferable to avoid possible loss of title insurance protection.
- Will the grantees/beneficiaries likely want to sell the property within two years after death of the current owner? If so, that argues for use of a Lady Bird Deed, which title companies are more likely to insure because of the statutory two-year period for creditors' claims in the Transfer on Death Deed statute.

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[407] S.B. 2150 § 1, 85th Leg., R.S. (2017)(amending Texas Estates Code §114.103(a)(2),(4).)

[408] Tex. Est. Code §114.103(a).

[409] Michael J. Lucksinger, "Transfer on Death Deed, Lady Bird Deed, Survivorship Agreements," State Bar of Texas Advanced Real Estate Law Course (2016).

- Is there a mortgage? If so, a Transfer on Death Deed has the advantage of a statutory assurance that its execution will not trigger a due on sale clause in the deed of trust.
- Does the client want to provide for one or more contingent beneficiaries—for example, title passing to the grantee or beneficiary's descendants if the grantee or beneficiary predeceases the grantor/owner? If so, that argues for using a Transfer on Death Deed, which carries the statutory seal of approval for creating such interests. However, designating either named beneficiaries or a trust as beneficiary provides more certainty as to title company approval; and in any case, the deed should always be backed up with a will providing for the same disposition of the property as the deed.

Caution: Don't use a Joint Tenants with Right of Survivorship Deed for a client with a known likelihood of applying for Medicaid, unless it is a deed between spouses.

We used those when the Medicaid Estate Recovery Program was first established, and the Texas Health and Human Services Commission responded by treating the deed as a transfer without consideration, even if the deed transferred a present interest in only a tiny percentage of the property.

The agency's theory is that by giving up the right to decide unilaterally the terms of a sale, the owner parts with the entire value of the property. There is no need to litigate that, because the agency has no objection to use of a Lady Bird Deed or Transfer on Death Deed, and those instruments provide quite sufficient protection from estate recovery while effectively conveying the owner's interest at death.

This problem does not arise with a Community Property Survivorship Agreement,[410] because such a transfer between spouses is exempt from the transfer penalty.

Practice Tip: Regardless of what type deed you use, be sure to ask for the client's will. If the proposed deed is inconsistent with the current will or if there is no current will, offer to draft a new will that is consistent. Title companies sometimes object if the will is inconsistent with the deed, even if the will is not offered for probate and even though the law is clear that either type of deed will trump an inconsistent will. And will beneficiaries (or heirs at law in absence of a will) who get less or nothing because of the deed are more likely to attack the deed (and the attorney who drafted it) if it is inconsistent with the owner's previous estate plan. Yes, a person of any age has a right to change their estate plan, but you can serve the client better if you know that is happening so as to document and defend the change as well as possible. And if the person you are dealing with is proposing to act as an agent to change the principal's estate plan with a deed, you absolutely must find that out and advise them against it.

M. ACA Extends Spousal Impoverishment Protections to HCBS Waiver Programs

In May 2015, CMS notified the State Medicaid Directors that the Affordable Care Act required spousal impoverishment protections be applied to HCBS waiver programs as required Section 2404 of the Affordable Care Act. However, at this writing that ACA provision has expired and has

[410] HHSC attorney Shari L. Nichols has recently announced that contrary to previous policy, the agency will not penalize a transfer from an institutionalized spouse to a community spouse at any time, even if it is after the first annual review. Hence this change in the text from the August 2018 version.

continued in effect only due to short extensions. Most recently it was extended for five months after its latest expiration date of December 31, 2019 in the 2021 Spending Bill.[411] An HHSC Bulletin describes this requirement and notes it has an expiration date but states that staff should continue to apply the policy "until notified otherwise."[412]

Based on the ACA provision cited above, HHSC published a bulletin and amended the Medicaid for the Elderly and People with Disabilities Handbook to provide the following when an expanded Spousal Protective Resource Amount is computed in a Star+Plus Waiver case:[413]

- The minimum monthly maintenance needs allowance for the "community spouse" is the same as in nursing home cases, currently $3,216.50 per month; and
- The Star+Plus Waiver personal needs allowance ($2,523.00 per month) is subtracted from the income of the institutionalized spouse to determine the amount of income of the institutionalized spouse that must be considered in the formula

Previously, the community spouse was given a minimum monthly maintenance needs allowance of only $783 per month. Under the new rule, the spouses together can qualify for an expanded Spousal Protective Resource Amount at much higher levels of income.

For example, if each spouse has $2,500 per month income, the amount diverted from the institutionalized spouse will be only $2,500 (applicant's income)—$2,523 (the monthly personal needs allowance for HCBS- which is the current the monthly income cap) = $118.

That gives the community spouse only $2,500 + $118 ($118 shifted from the applicant spouse's income to the community spouse) = $2,618 in the formula.

The amount to make up from income on resources is then $3,435 (the current monthly spousal needs allowance) —$2, 618 (the community spouse's income of $2,500 + $118 shifted from the applicant spouse's income) = $817.00 per month.

At a one-year CD rate of 1.0%, that allows the couple to expand the Spousal Protective Resource Amount to ($817.00 X 12) ÷ .01 = $980,400.

The policy is less generous to couples in which the institutionalized spouse applies for waiver care in an Assisted Living Facility or Adult Foster Care. In that case, the personal needs allowance subtracted from the income of the institutionalized spouse is only the maximum SSI federal benefit rate ($794 in 2022).

Also, it is now clear that the spouse of a Medicaid beneficiary in a nursing home can be a waiver program beneficiary without losing her or his right to a diversion of income as a community spouse:

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[411] NAELA Advocacy Alert (December 17, 2019).

[412] MEPD Handbook & Texas Works Bulletin 19-06 (May 30, 2019).

[413] MEPD Handbook §§ J-6300 to J-6310; MEPD Bulletin #16–01 (Sept. 18, 2015).

> HHSC allows spousal diversions to a community spouse who is receiving services under a Home and Community-Based Services waiver program. Count the diversion as income to the community spouse in the waiver budget. [414]

Unfortunately, there has been no change in spousal impoverishment policy to give an HCBS Waiver applicant a snapshot date if the application is denied.[415] Therefore, such applicants are still treated differently from applicants for nursing home Medicaid.

N. 1915(C) IS NOW HCBS

References to 1915(c) are changed throughout the handbook to Home and Community-Based Services (HCBS). The Glossary now provides, "Home and Community-Based Services waiver program—A home or community-based service authorized for use in Texas by the Centers for Medicare and Medicaid Services in accordance with . . . §1915(c) of the Social Security Act."

O. EFFECT OF COURT ORDERS TRANSFERRING ASSETS AND INCOME BETWEEN SPOUSES

The authors have distilled policies in the MEPD Handbook and statements by HHSC's lead Medicaid eligibility attorney to arrive, tentatively, at the following conclusions. However, the written record as to HHSC policies is quite thin, and we have not seen these conclusions tested in cases.

- Alimony and spousal support payments received by a Medicaid applicant under a divorce decree are treated as unearned income to the applicant.
- When the same payments are made *by* a Medicaid applicant, a court order entered in the original divorce case is disregarded entirely. Although income is paid directly to the former spouse under court order, HHSC still considers it countable unearned income of the applicant.
- If a QDRO for spousal support is modified post-divorce to divert income from the Medicaid applicant, the payments are no longer treated as income of the applicant. They are treated as having been transferred by the applicant to the former spouse and a transfer penalty may be assessed.
- The foregoing policies do not apply to *property* divisions in divorce cases nor to orders of spousal support when a divorce is not involved. In cases involving either type of order, the court order is honored, and the payments are treated as income only of the person receiving them, with no transfer penalty applied.[416]

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[414] MEPD Handbook § J-1520.

[415] MEPD Handbook § J-4310 .

[416] MEPD Handbook §§ E-3320, E-1410.

HHSC may treat spousal support orders in cases not involving a divorce more favorably in order to maintain compliance of the Texas Medicaid program with the following federal requirement:

> If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.[417]

The policy treating a court order as a "transfer" should be read in the light of a common defense to the transfer penalty—that the transfer was motivated entirely by purposes other than Medicaid eligibility. Therefore, alimony orders entered before the payer had a known condition likely to lead to long-term care should not be subject to a transfer penalty. Likewise, such orders entered more than five years before the month in which the Medicaid application is filed should not be penalized.

The policy of treating alimony as if it were received by a Medicaid applicant when in fact it is not may be intended to maintain consistency with the general rule that income being garnished by a creditor or withheld by a payer (such as Social Security income being recouped to cover an overpayment) is still treated as income of the Medicaid applicant. As long as the garnishment or recoupment is in place, that puts the applicant in an impossible position, as the amount being withheld is subtracted from the Medicaid payment to the nursing home as if it were being paid as copayment. In fact, it cannot be paid as copayment, because it is never under the control of the Medicaid beneficiary. To avoid discharge for failure to pay, the only avenue open to the Medicaid beneficiary is to have the order of garnishment or recoupment revoked. That would appear to be the same situation here—the Medicaid applicant will have to move for modification of the order for alimony and persuade the Court to revoke it entirely.

P. NON-WAIVER COMMUNITY-BASED LTC MEDICAID PROGRAMS

1. COMMUNITY FIRST CHOICE

Effective June 1, 2015, Texas became one of five states to implement the "Community First Choice" under the Affordable Care Act.[418] That Medicaid state option provides for somewhat expanded services to certain individuals eligible for Medicaid under existing programs. It will be financed at least in part by a 6% increase in the federal share of Medicaid expenses for services provided under the new option.

Eligibility for these expanded home care services has the following requirements:[419]

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[417] 42 U.S.C. §1396r-5(d)(5).

[418] Affordable Care Act §2401, Social Security Act §1915(k), 42 U.S.C. §1396n(k). An HHSC summary is at https://hhs.texas.gov/services/health/medicaid-chip/programs/community-first-choice.

[419] These requirements are drawn, rather loosely, from the federal statute cited above, the Texas rules at 1 T.A.C. §354.1362, and the federal rules at 42 C.F.R. §441.510. The author has revised and summarized quite liberally, in the interest of extracting meaning from the incomprehensible.

- Eligibility for a Medicaid program that provides general medical care including institutional care (not including, for example, home-care-only programs such as Community Attendant Services, or Medicare Savings Programs)
- Residence in a home setting (not in an institutional setting—that is, not in a nursing home, ICF-ID facility, group home or in-patient mental health facility)
- In need of care in an institutional setting (but willing to forego such care in favor of home care)

Community First Choice is sometimes referred to as an "entitlement," because the state is required by the federal statute to provide all the required services to all eligible individuals. However, it does not establish a new eligibility group. It only enhances Medicaid home care services for certain individuals already eligible for Medicaid home care services.[420] Therefore, for example, it will not help anyone avoid the interest list for the Star+Plus Waiver Program, although it may enhance services available to those who have achieved eligibility.[421]

> Comment: To anyone looking for an access point to Medicaid home care, Community First Choice offers less than meets the eye. Everything written about it, other than the CMS explanation in the Federal Register, fails to note that it does not create one new eligibility slot. In fact, there is no such thing as applying for Community First Choice, because it merely expands services for individuals eligible for Medicaid under another program.

However, it is likely to be very helpful to SSI beneficiaries who are eligible for Medicaid but generally receive only a modest level of home care until they come up on the interest list for a waiver program. Unlike the home care they previously received, it has no absolute limit in terms of cost or hours of service.

2. "TEXAS DUAL ELIGIBLE INTEGRATED CARE PROJECT" AFFECTS 6 COUNTIES

In 2015, Texas began a demonstration program to better coordinate care for those eligible for both Medicare and Medicaid. Dual eligible members in the six demonstration counties were passively enrolled into a Medicare-Medicaid plan. The six counties are Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant.[422] The cost of the program will be paid in monthly premiums shared by the state and federal governments. Approximately 160,000 Texans are eligible to participate. As February 2021, there are 40,646 clients enrolled in the program.

Participants must meet all the following requirements:

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[420] A slide show by Texas Health and Human Services Commission states, "Due to a federal limitation, STAR+PLUS HCBS waiver members whose financial eligibility is established as Medical Assistance Only are excluded from CFC.") However, the author has found no such limitation in the federal statute nor in the federal or state rules.

[421] The comments and responses in the federal rulemaking procedure are replete with the confusion created by the appearance that this is a new path to home care. CMS makes clear that it is not. 77 Federal Register 26828, 26839 (May 7, 2012).

[422] Texas Health and Human Services, Texas Dual Eligible Integrated Care Project. https://hhs.texas.gov/services/health/medicaid-chip/programs/texas-dual-eligible-integrated-care-project.

- Age 21 or older
- Receiving Medicare Parts A, B and D and full Medicaid
- Enrolled in the Medicaid STAR+PLUS program for at least 30 days
- Individuals residing in ICF-ID facilities and those with developmental disabilities receiving services through CLASS, DBMD, HCS, or TxHml waiver programs.

In November 2021, CMS, HHSC, and the participating MCOs agreed to extend the demonstration to December 31, 2021, with the option of extending through 2023.[423]

VIII. CHILDREN'S MEDICAID

Most of the programs discussed so far require some sort of disability to receive benefits. Certain low-income children and others are eligible for Regular Medicaid benefits without regard to disability or eligibility for TANF.[424]

A. ELIGIBILITY

1. RESIDENCE AND CITIZENSHIP

Texas residence is required, but there is no minimum time limit.[425] Applicants must also be U. S. citizens or aliens meeting certain specific requirements.[426]

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.[427]

There is a separate program for young people 18—20 years of age (to age 21), called Medicaid for Transitioning Foster Care Youth.[428] 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.[429] However, the Texas Health and Human Services Commission still

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[423] CENTERS FOR MEDICARE & MEDICAID SERVICES, *Texas Capitated Financial Alignment Model Demonstration (Texas Dual Eligible Integrated Care Demonstration Project),* https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Texas.

[424] 1 T.A.C. Chapter 366, Subchapter E.

[425] 1 T.A.C. §366.517; 42 C.F.R. § 435.403.

[426] 1 T.A.C. §366.513, See Appendix 4 to this paper for more information regarding alien eligibility for Medicaid generally

[427] 1 T.A.C. §366.507.

[428] 1 T.A.C. §366.601–637.

[429] 42 U.S.C. §1396a(e)(14); 1 T.A.C. §§ 366.505, 366.507 (Medicaid); 1 T.A.C. §370.809 (CHIP).

has the power to collect information on assets and resources, such as vehicles and bank accounts, when determining eligibility.[430]

4. INCOME

The Affordable Care Act made the following changes in income limits of Children's Medicaid:[431]

- Income is defined according to what is included in Modified Adjusted Gross Income under the federal income tax law, with certain exclusions. For example, the 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.[432]
- 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. The income limit for children ages 1–5 is now 144% FPL (plus 5% of FPL for that size household as discussed next).
- 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. In Texas that is done by adding 5% of the Federal Poverty Level for the household size to the dollar amount that household size would otherwise have.[433] For example, in a household of 2 with an infant under age 1, the Children's Medicaid income limit is 198% of FPIL for a household of 2 plus 5% of FPIL for a household of 2: $2,791 + $70.50 = $2,861.50. The formula is *not* 105% of 198% of FPIL for a household of 2, which would be $2,930.55.

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, SSI, or 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.

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[430] 1 T.A.C. §366.1109.

[431] 42 U.S.C. §1396a(e)(14); 1 T.A.C. §§366.507, 366.523, Subchapter K.

[432] Texas Works Handbook § A-1341 sets out the steps for determining who is in the "household," and MAGI income is determined. Texas Works Handbook C-131.1 shows the income limits for the various Children's Medicaid programs using only Federal Poverty Level, and Texas Works Handbook C-131.4 shows how much is added to each size household (5% of FPL for that size household).

[433] Texas Works Handbook C-131.4. Note that the same dollar amount (5% of the household's Federal Poverty Level) is added to the household's income limit, even when the income limit is more or less than FPL.

Children's Medicaid Income Limits Effective July 1, 2019

(Including the 5% of FPL MAGI Income Disregard)

Family Size	Under Age 1	Ages 1–5	Ages 6–18
1	$2,113.05	$1,551.05	$1,437.05
2	$2,861.50	$2,100.50	$1,945.50
3	$3,608.90	$2,648.90	$2,453.90
4	$4,356.30	$3,197.30	$2,961.30
5	$5,104.75	$3,746.75	$3,469.75
6	$5,852.15	$4,295.15	$3,978.15
7	$6,599.55	$4,844.55	$4,486.55
8	$7,347.00	$5,393.00	$4,995.00

B. BENEFITS

Benefits provided to children and pregnant women are the same as for Regular Medicaid, described above. They are provided through managed care organizations under the STAR program, as discussed above.

C. TRUST AND TRANSFER RULES

Because there is no longer a resource limit, trust and transfer rules are not relevant.

IX. 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.[434] This program is available to all U. S. citizens and some legal aliens who meet certain specific requirements.[435]

2. RESOURCES

Pregnant Women's Medicaid has no resource limit.[436]

[434] 1 T.A.C. §366.317.

[435] 1 T.A.C. §366.313; and see Appendix 4 regarding alien eligibility for Medicaid generally.

[436] 1 T.A.C. §§ 366.307, 366.321.

3. INCOME

The Pregnant Women's Medicaid income limit under the Texas rules is 198% of the federal poverty level. As indicated in the table below, when the 5% of Federal Poverty Level amount is added, the income limit is the same as for Children's Medicaid when the child is under age 1.

Pregnant Women's Medicaid Income Limits—Effective July 1, 2019

(Including the 5% of FPL MAGI Income Disregard)

Family Size	Income Limit
1	$2,113.05
2	$2,861.50
3	$3,608.90
4	$4,356.30
5	$5,104.75
6	$5,852.15
7	$6,599.55
8	$7,347.00

B. BENEFITS

Benefits provided to children and pregnant women are the same as for Regular Medicaid, described at page [insert page]. Virtually all are provided through managed care organizations under the STAR+PLUS program.

C. TRUST AND TRANSFER RULES

Because there are no resource limits for a pregnant woman, there are no trust or transfer rules.

X. 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).[437] 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

Parents and Caretaker Relatives Medicaid requires that the applicant be a "caretaker or second parent of a dependent child who receives Medicaid."[438] A "dependent child" is one who meets both the following requirements:[439]

- Either under age 18
- 18 and a full-time student; or
- "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 and who meets the relationship requirements. . . ."[440]

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.[441]

2. RESOURCES

Under the Affordable Care Act, effective January 1, 2014, Parents and Caretaker Relatives Medicaid has no resource limit.[442]

3. INCOME

The applicable Texas rule provides, "To be eligible for the Medicaid for Parents and Caretaker Relatives Program, an applicant or recipient must have household income for the applicable household size that is equal to or less than the amount determined by HHSC and listed in the *Texas Works Handbook.*[443] The

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[437] Rules are at 1 T.A.C. Chapter 366, Subchapter G.

[438] 1 T.A.C. § 366.707.

[439] 1 T.A.C. § 366.703(5).

[440] 1 T.A.C. § 366.703(3).

[441] 1 T.A.C. § 366.719(c).

[442] 42 U.S.C. § 1396a(e)(14).

[443] 1 T.A.C. §366.723(b).

table below shows the dollar amounts that apparently refers to, although they appear not to have changed since 2015:[444]

PARENTS AND CARETAKER RELATIVES MEDICAID INCOME LIMITS

(Including the 5% of FPL MAGI Income Disregard)

	One - Parent	Two - Parent
MAGI Household Size	MAGI-Converted Limits	MAGI-Converted Limits
1	$103	N/A
2	$196	$161
3	$230	$251
4	$281	$285
5	$310	$332
6	$356	$367
7	$389	$412
8	$441	$447

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 above. Virtually all are provided through managed care organizations under the STAR program.

D. TRUST AND TRANSFER RULES

Because there is no longer a resource limit, trust and transfer rules are not relevant.

E. APPLICATION

Application for Parents and Caretaker Relatives Medicaid is to the Texas Health and Human Services Commission by paper application, online at http://www.yourtexasbenefits.com, by telephone, or in person at an HHSC office. It can be made by any "person acting responsibly" for the applicant.[445]

[444] Texas Works Handbook C-131.2.

[445] 1 T.A.C. § 366.709(a).

XI. MEDICALLY NEEDY PROGRAM

The income requirements for Children's Medicaid, Pregnant Women's Medicaid, and Parent & Caretaker Medicaid can be very draconian. For those who don't qualify due to income but have high medical bills, the Medically Needy Program for a family to meet the income eligibility requirements by "spending down" the excess income on certain medical expenses.[446]

A. ELIGIBILITY

1. AGE & GENDER

The Medically Needy Program is limited (1) children under age 19 and (2) pregnant women without any TANF-eligible children.[447]

2. INCOME

There is no limit on total income to qualify for the program. However, benefits do not begin until all income above the "Medically Needy Income Limit" has been "spent down" to pay medical expenses.

To determine how much income an individual must spend down in order to qualify, subtract the monthly Medically Needy Income Limits (MNIL) from the applicant's monthly net income as determined under the MAGI rules. The difference is generally referred to as the "spend down amount."

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, *without* adjustment under the MAGI methodology.[448]

Medically Needy Income Limit

Family Size	Income Limit
1	$104
2	$216
3	$275
4	$308
5	$357
6	$392
7	$440

[446] 1 T.A.C. § 366.823; 42 C.F.R. § 435.831(d).

[447] 1 T.A.C. Chapter 366, Subchapter H.

[448] 1 T.A.C. §§ 366.823; Texas Works Handbook § C-131.2 (TP 32).

Family Size	Income Limit
8	$475
Each added person	+$57 (usually)

If, for example, a family of 3 applying for a 7-year-old child has a monthly net income of $1,408, the calculation would be: $1,408—$275 = $1,133, and the family would thus have to pay and provide proof of medical expenses totaling at least $1,133 each month.

Income methodology is the same as for Children's Medicaid and CHIP, discussed above ("modified adjusted gross income").

3. RESOURCES

Under the Affordable Care Act, there is no resource limit for the Medically Needy Program.[449]

B. BENEFITS

Medically Needy benefits are the same as for Regular Medicaid, described above, 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 begins on the first day of the month of the 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.[450]

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.[451]

E. APPLICATION

Information on who is eligible and how to apply is available by calling 211.

XII. THE TEXAS CHILDREN'S HEALTH INSURANCE (CHIP) PROGRAM

The Children's Health Insurance Program, more commonly referred to as CHIP, is administered by HHSC.[452] HHSC CHIP eligibility and administers enrollment in the plans that deliver services. Managed

[449] 1 T.A.C. §§ 366.805, 366.807.

[450] 1 T.A.C. §366.827.

[451] 1 T.A.C. §366.843(e).

[452] The CHIP regulations are at 1 T.A.C. Ch. 370.

Care Organizations in urban areas and CHIP provider networks in rural areas provide health care to CHIP recipients.

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.[453]

2. RESIDENCE/CITIZENSHIP

The applicant-child must be a U. S. citizen or a non-citizen qualified alien as well as a resident of Texas. The applicant must include the child's citizenship, immigration status and Texas residency on the application. The applicant is required to provide documentation to prove citizenship or qualified alien status. However, the citizenship and immigration status of the parents does not affect the child's eligibility and is not reported on the application form.[454]

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.[455] There are, however, some important exceptions to this rule.[456] 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.[457] 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 sources in the last two footnotes.

4. INCOME

The CHIP income limit under the Texas rules is 200% of the federal poverty level, determined under MAGI methodology. [458] As with other MAGI methodology, an amount of income equal to 5% of the Federal Poverty Level for the household size is disregarded.[459]

CHILDREN'S HEALTH INSURANCE PROGRAM INCOME LIMITS—2020

(Including the 5% of FPL MAGI Income Disregard)

Family Size	Income Limit
1	$2,138

[453] 1 T.A.C. § 370.42.

[454] 1 T.A.C. § 370.43.

[455] 1 T.A.C. § 370.46.

[456] 1 T.A.C. § 370.46(c)-(d).

[457] 1 T.A.C. § 370.46(c)(1)(D); Your Texas Benefits, *CHIP and Children's Medicaid,* https://yourtexasbenefits.hhsc.texas.gov/programs/health/child/childrens-medicaid.

[458] 1 T.A.C. § 370.805. See also Texas Works Handbook § C-131.1 .

[459] 1 T.A.C. § 370.815.

Family Size	Income Limit
2	$2,888
3	$3,639
4	$4,389
5	$5,139
6	$5,890
7	$6,640
8	$7,420.00

5. RESOURCES

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.[460]

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;[461] or
- Covered by other "adequate" health insurance.[462]

B. BENEFITS AND COSTS

Children who qualify for CHIP receive health insurance coverage comparable to that available to state employees and their families.[463] 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.[464] All families must pay co-pays, but most of these range from only $3 to $35 depending on the family's income and the type of service received. [465]

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.

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[460] 1 T.A.C. § 370.809.

[461] 1 T.A.C. § 370.45(c).

[462] Adequacy is determined by the Health and Human Services Commission. TEX. HEALTH & SAFETY CODE § 62.101(a)(3).

[463] 42 U.S.C. § 1396u-7(b)(1).

[464] 1 T.A.C. §§370.321, 370.325. MEPD Handbook § N-7410.

[465] MEPD Handbook § N-7410.

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 from HHSC in any of the following ways:

- Calling the toll-free number: 1–877–543–7669 (877-KIDS-NOW). Callers who are deaf or hard-of-hearing can use Texas Relay by calling 1–800–735–2988; *or*
- Completing an application online at https://www.yourtexasbenefits.com/Learn/Home *or*
- Downloading an application from https://www.yourtexasbenefits.com/Learn/GetPaperForm.

Enrollment is for a continuous 12-month period, with some exceptions, after which the recipient's eligibility must be re-determined.[466]

XIII. THE AFFORDABLE CARE ACT

A. INTRODUCTION

Congress passed the two bills known jointly as the Affordable Care Act in March 2010.[467] They are also known as "Health Care Reform" and "Obamacare."[468]

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. In addition, virtually every program discussed in this paper was affected in some way by the Affordable Care Act.

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.[469] However, on December 18, 2019, a panel of the Fifth Circuit Court of Appeals upheld a decision of the Northern District of Texas in *Texas v. United States* that the requirement of purchasing health insurance is unconstitutional. Most importantly, it remanded to the District Court the question of whether the individual mandate is inseverable from the rest of the Act so as to make the entire Act unconstitutional. Final disposition of the

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[466] 1 T.A.C. §370.307.

[467] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111–148, 124 Stat. 119 (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), https://www.govinfo.gov/link/plaw/111/public/148.

[468] 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.

[469] *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012), http://www.supremecourt.gov/opinions/11pdf/11–393c3a2.pdf.

case is not expected before the 2021 presidential election. Therefore, we will not discuss it further other than to say if the District Court again determines the entire Affordable Care Act is unconstitutional, and that is upheld by the Supreme Court, virtually every page of this paper will have to be revised.

B. CHANGES PUT INTO EFFECT BEFORE 2013

1. THE "FEDERAL RISK POOL"

This pool, known as the Pre-Existing Condition Insurance Plan (PCIP), was available through 2014 when other provisions of the ACA went into effect making PCIP no longer be needed.

2. "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 extended federal funding for the program through September 2016.[470] Subsequent legislation has extended the program several times. It was extended for five months after its latest expiration date of December 31, 2019 in the 2021 Spending Bill.[471] The Sustaining Excellence in Medicaid Act of 2019 was passed into law on August 6, 2019 and included funding for the MFP program for four and a half years.[472]

3. COVERAGE FOR CHILDREN WITH PRE-EXISTING CONDITIONS

Minor children must be offered coverage under their parents' health insurance policies regardless of pre-existing conditions.[473] This became effective 6 months after passage of the ACA, although the elimination of pre-existing condition exclusions in other circumstances were not effective until January 1, 2014.[474]

4. 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.[475]

5. MEDICARE PART D "DONUT HOLE" REDUCTION

The Medicare Part D "donut hole" is to be reduced gradually with various supplements beginning in 2011.

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[470] PPACA §2403(a).

[471] NAELA Advocacy Alert (December 17, 2019).

[472] Sustaining Excellence in Medicaid Act of 2019, Pub. L. No. 116-39, 133 Stat. 1061 (2019); *see* Empowering Beneficiaries, Ensuring Access, and Strengthening Accountability Act of 2019, H.R. 3253, 116th Congress (2019).

[473] PPACA § 2714.

[474] *Id.*

[475] *Id.*

6. 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 co-payments.[476] Therefore, they will no longer be subject to the dreaded "donut hole." That affords them equal treatment to nursing home residents on Medicaid.

7. 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.[477]

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.[478] 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.[479] To illustrate, based on 2015 poverty levels[480], maximum premiums for lower-income persons look like this:

% FPL[481]	Monthly Income in 2015	% of Income Paid	Premium/Month
100%-133%	$1,308	2.0%	$26.16
150%	$1,471	4.0%	$58.84
200%	$1,962	6.3%	$123.61
250%	$2,452	8.05%	$197.39

[476] PPACA § 3309.

[477] PPACA §§ 6101–6107, 6121, 6201.

[478] PPACA § 2704.

[479] PPACA §1412.

[480] For current federal poverty levels, see Appendix 1. There is no asset test for this indirect subsidy.

[481] The chart above shows only the breakpoints. The actual premiums change continuously between the breakpoints of 133% FPL, 150% FPL, etc.

% FPL[481]	Monthly Income in 2015	% of Income Paid	Premium/Month
300%	$2,943	9.5%	$279.59
400%	$3,924	9.5%	$372.78

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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" (MAGI), which is adjusted gross income (as reported on page 1 of Income Tax Form 1040) to which is added untaxed foreign income, interest from tax-free securities, and all Social Security income not already included in adjusted gross income. "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.[482]

> Comment: In the state of Texas and other states without a Medicaid program coordinating with the ACA, meeting the MAGI poverty level income test can be a life-or-death matter. It is an effort best started early in the calendar year, to build an above-poverty-level income record sufficient to qualify for ACA coverage at open enrollment the next fall. The following is a summary of the author's findings when trying to develop that record at open enrollment time:

- To be eligible for premium credits and low copayments, [Client, with a single-person household] must have at least $11,770 adjusted gross income in 2016. That is 100% of the federal poverty level. (Many online summaries say 133%, but that is incorrect.)
- There is no requirement of having made that much in 2015. All the law requires is a good-faith estimate for 2016. However, when you purchase the policy, you have to estimate your 2015 income as well as your estimated 2016 income. If the "exchange" is not satisfied that you will make at least $11,770 in 2016, you don't get the coverage.
- The only penalty for estimating incorrectly, if you get the coverage anyway, is a tax of a little over $250. If you have no other income tax, that is all you pay.

The mechanism for applying the subsidy is a tax credit. However, it is applied when health insurance premiums are determined, so is 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.[483] 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

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[482] PPACA §1401(a), as amended by HCER §1004(a)(1)(A), codified at Internal Revenue Code §36B(d)(2)(A).

[483] PPACA §1402.

the ACA, those shares will change to an average of 28% and 72%, respectively.[484] 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 for that benefit:

% FPL	Monthly Unmarried Amt. in 2015	% Benefits Paid by Insurance Company	% Benefits Paid by Insured
100%-150%	$1,471	94%	6%
150–200%	$1,962	87%	13%
200–250%	$2,452	73%	27%
250–400%	$3,924	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 before the ACA was that it was 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) did not exceed the SSI federal benefit rate ($794 per month in 2022).[485]

The ACA requires that the spousal impoverishment rules also apply to the HCBS Waiver programs.[486] Therefore, based on a letter from CMS, Texas Medicaid now allows the use of the same formula as in nursing home Medicaid for calculating an enhanced PRA for the waiver programs. Because the personal needs allowance of $2,523 is not included in income of the institutionalized spouse in this calculation, it is now very common for an institutionalized spouse to qualify for an HCBS Waiver program with an enhanced Spousal Protective Resource Amount. However, the ACA provision requiring that has expired and has continued in effect only due to short extensions. It was extended for five months after its latest expiration date of December 31, 2019 in the 2021 Spending Bill.[487]

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.

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.

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[484] "Money's Essential Guide to the Health Care Law," *Money Magazine* (September 2012).

[485] MEPD Handbook § J-6300.

[486] PPACA § 2404, amending 42 U.S.C. §1396r-5(h)(1)(A).

[487] NAELA Advocacy Alert (December 17, 2019).

The concern is that if the decision of Texas officials not to implement this program 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 healthcare 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, their clients are no 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 newsletter article presented the comments of five advanced practitioners of Special Needs Trust law on their practices.[488] 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 the reduction of premiums and cost sharing.
>
> 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

[488] "The Health Care Ruling's Effect on Practices: Five Commentaries," *The Elder Law Report* (September 2012).

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."

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.[489] 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:[490]

> 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

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[489] The regulations for this program are at 1 T.A.C. Chapter 366, Subchapter I. For the general eligibility requirements, see § 366.903(b). This program is required by the federal Medicaid statute. 42 U.S.C. § 1396b(v); 42 C.F.R. § 435.139.

[490] 42 U.S.C. § 1396b(v)(3); 1 T.A.C. §366.903(b)(B)(3) (incorporating by reference 42 C.F.R. §440.255(c)).

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 Medicare Savings programs, State Medicaid programs pay for all or some of the Medicare premiums, deductibles, and co-payments of Medicare beneficiaries who meet certain income and resource limits.[491] Because Medicaid pays these Medicare benefits, they are known by a variety of names, including: "Medicare Savings Programs," "Medicare Cost-Sharing Programs," or "Dual Eligible Programs."

The current income and resource limits for the Medicare Savings Programs are available at https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html.

> 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) save eligible individuals the monthly Medicare Part B premium, which is for most individuals $144.60 per month in 2021.[492] 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. Because $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. In that calculation, the income of the ineligible spouse is reduced by a "program-specific living 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).[493]

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.

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[491] 1 T.A.C. Ch. 359; 42 U.S.C. §1396a(a)(10)(E); MEPD Handbook ch. Q; Medicare.gov, *Medicare Savings Programs,* https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html .

[492] QMB income and asset limits for 2022 were not released as of the date of this paper.

[493] MEPD Handbook § Q-1000.

The monthly income limit for 2021 is $1,061 per month for an individual and $1,430 per month for a couple. These amounts include the $20 per month that is "exempt." The resource (asset) limit is $7,860 for an unmarried person, $11,800 for a married couple.[494]

2. SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES (SLMB)

The SLMB program requires states to pay the Medicare Part B premiums (maximum of $144.60 per month in 2021) of Medicare beneficiaries who meet the resource requirements for QMB and whose monthly incomes are higher than the QMB (poverty level) limits but under $1,269 for an individual, and under $1,711 for a couple, in 2021. (These amounts are equal to 120% of the federal poverty limits + the $20 disregard.) The resource (asset) limit is $9,060 for an unmarried person, $14,340 for a married couple.[495]

3. QUALIFYING INDIVIDUALS (QI)

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 in 2021 to individuals with monthly incomes greater than $1,269 and not more than $1,426, and couples with monthly incomes greater than $1,711 and not more than $1,923. Those amounts include the $20 per month that is "exempt." The resource (asset) limit is $9,060 for an unmarried person, $14,340 for a married couple.[496] The reader is cautioned that there has been 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 ($458 per month in 2021) 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 2021 are $2,102 for an individual, and $2,839 for a couple.[497] These numbers represent 200% of the FPL + the $20 disregard. Note, if all the income is earned income, then the real limit is twice as much plus $85, 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.[498]

5. INCOME & RESOURCE METHODOLOGY

Income: Income methodology of all those programs is same as for SSI, except for the Low-Income Subsidy (LIS) Programs, in-kind support and maintenance does not count as income. Therefore, the methodology takes into account the $20 per month disregard of any income, $65 per month disregard for earned income

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[494] MEPD Handbook § Q-2500. At this writing, the numbers in the cited handbook section are lower because they are one year out of date.

[495] MEPD Handbook § Q-3200; Medicare, *Medicare Savings Programs,* https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html.

[496] MEPD Handbook § Q-5200;.

[497] MEPD Handbook § Q-6200.

[498] MEPD Handbook § Q-6000.

plus disregard of half the rest of earned income, and all other SSI exemptions and exclusions. 42 U.S.C. 1395w-114(a)(3)(C), incorporating for the LIS the QMB methodology at 42 U.S.C. 1396d(p)(1)(B), which incorporates the SSI methodology at 42 U.S.C. 1382a (except states may not use less restrictive methodology than SSI as permitted for the SSI program under 42 U.S.C. 1396a©(2), and except ISM is excluded). CMS rules at 42 C.F.R. 423.772, pertaining only to LIS, define "income" the same way and state that income of a spouse living in the same household as the applicant is counted, regardless of whether the spouse is also an applicant. Note that the Low-Income Subsidy (Part D Extra Help) methodology is less restrictive than that of QMB, SLMB and QI-1 in that it does not count in-kind support and maintenance as income. Therefore, some clients denied for the latter programs can nevertheless qualify for Part D Extra Help only, with an application to the Social Security Administration at https://secure.ssa.gov/i1020/start.

Resources: Resource methodology is same as for SSI, except for the LIS only, any life insurance policy is excluded. 42 U.S.C. 1395w-114(a)(3)(D), referencing the SSI resource definition at 42 U.S.C. 1382b. As to LIS only, CMS rules at 42 C.F.R. 423.772 provide as follows: "Resources means liquid resources of the applicant (and, if married, his or her spouse who is living in the same household) such as checking and savings accounts, stocks, bonds and other resources that can be readily converted to cash within 20 days, that are not excluded from resources in section 1613 of the Act [42 U.S.C. 1382b], and real estate that is not the applicant's primary residence or the land on which the primary residence is located. It exempts the value of any life insurance policy."

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 that disqualifies him or her for these programs.

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 Star+Plus Waiver Programs) and SSI.[499]

C. Application

An application can be submitted through <http://www.yourtexasbenefits.com>, or a paper form can be downloaded from https://www.yourtexasbenefits.com/Learn/GetPaperForm.

XVI. MEDICAID BUY-IN PROGRAM

The Medicaid Buy-In Program allows individuals with disabilities 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.

[499] 1 T.A.C. § 358.402(a).

A. ELIGIBILITY

1. DISABILITY

The applicable rule provides as follows:[500]

> 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.

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 $1,260 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."[501]

This may resolve the apparent paradox that one can be engaging in substantial gainful activity (making over $1,260 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 $5,000 per month earned income.

2. INCOME

Currently, the MEPD Handbook provides as follows:

> To be eligible, a person must be working and earning income. The person must provide proof of employment. Consider any of the following as proof of employment:
>
> Tax payment verification under the Federal Insurance Contribution Act (FICA); or Tax payment verification under the Self-Employment Contribution Act (SECA); or A written explanation that substantiates the person is in an employed status. [502]Comment: Until the October 2010 change, it appeared that the standard of at least the minimum income for a Qualifying Quarter 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

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[500] 1 T.A.C. § 360.107; *accord* MEPD Handbook § M-3200.

[501] 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.* The author does not practice in the 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.

[502] MEPD Handbook § M-5100. Until October 2010, the MEPD Handbook required that earned income be at least enough to be a Qualifying Quarter, according to the Social Security Administration (SSA). For 2022 this amount is $1,510 per quarter. However, that standard was changed effective October 26, 2010, to the "working and earning income" standard. MEPD Bulletin 11–06. *See also* MEPD Policy Bulletins 09–09 and 09–10.

remove the minimum income requirement entirely. However, it is clear that there must be some employment (or self-employment) with some income that can be documented.

A person's countable earned income must be less than 250% of the Federal Poverty Income Level (FPIL), which is $2,603 per month for 2019-20.[503] Income limits change annually, usually on March 1. Certain types of income are excluded:

- Spouse's income
- 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 are not considered, either in determination of eligibility or in determination of premium.[504]

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). Resources of the applicant's spouse don't count.[505] 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).[506]

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, ($783 per month in 2021). All participants whose net pay (gross income, minus mandatory payroll deductions) exceeds 150% of the

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[503] *Id.; id.* app. XXXI.

[504] 1 T.A.C. §360.115.

[505] MEPD Handbook § M-4000.

[506] MEPD Handbook §§ M-4100 to M-4130.

federal poverty income limit (FPIL) are required to pay a small additional amount ($20-$40) based on their earned income.[507] However, the maximum premium, in any case, is $500 per month.[508]

B. BENEFITS

The individual will have access to the same Medicaid services available to Medicaid recipients generally, 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. Under a change effective November 1, 2011, a person may participate in the Medicaid Buy-In program and receive long-term care waiver services at the same time.[509]

C. APPLICATION

Application is to the Texas Health & Human Services Commission on Form H1200-MBI (or if through www.yourtexasbenefits.com, the same as an application for long-term care Medicaid).

XVII. MEDICAID BUY-IN FOR CHILDREN PROGRAM

In October 2010 the Texas Health and Human Services Commission released the rules for implementation of the new Medicaid Buy-In Program for Children effective January 1, 2011. These rules are now incorporated into the MEPD HANDBOOK Section N.[510]

A. PROGRAM DESCRIPTION

The program is designed to provide regular Medicaid coverage for children with disabilities who do not qualify for SSI for reasons other than disability—usually, because parents' income and/or assets exceed SSI requirements.[511] A child does not need to apply for SSI to meet eligibility requirements for MBIC.[512] MBIC is an optional Medicaid program (permitted but not required by the federal Medicaid statute).[513] The Medicaid eligibility under MBIC and Medicaid eligibility under 1915(c) Waiver services are separate programs with separate and distinct eligibility determinations.[514]

Institutional care is covered for up to 90 days.[515] A separate determination of eligibility using nursing home criteria is conducted for benefits beyond 90 days.[516]

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[507] MEPD Handbook app. XXXI.

[508] MEPD Handbook § M-7100.

[509] MEPD Handbook § M-1310; Star+Plus Handbook § 3114 (because TP 87 is MBI.)

[510] MEPD HANDBOOK at ch. N.

[511] 1 T.A.C. § 361.101(b).

[512] *Id.*

[513] 42 U.S.C. § 1396a(cc); Texas Government Code § 531.02444.

[514] 42 U.S.C. § 1396n; MEPD HANDBOOK at § N-1320. Section 1915(c) waiver services include MDCP, YES, HCS, and CLASS.

[515] MEPD HANDBOOK at § N-1310.

[516] *Id.*

B. ENABLING STATUES

The MBIC program is optional under the Federal Deficit Reduction Act of 2005. In Texas, it was authorized by the 81st Legislature through SB 187 and enacted under Texas Government Code §531.02444.[517]

C. ELIGIBILITY REQUIREMENTS

The MBIC program eligibility requirements include financial and non-financial criteria as do other Medicaid programs. Parents are required to apply for and enroll in Employer Sponsored Health Insurance (ESI) whenever the employer pays 50% or more of the premium. There is assistance with the payment of the parent's portion of the premium under the Health Insurance Premium Payment (HIPP) program.[518]

1. FINANCIAL REQUIREMENTS

According to the MEPD HANDBOOK, § N-4200, income is the primary financial test when determining eligibility. Because there are no asset limits, there are no trust or transfer rules for the MBIC.[519] While there is no resource test for MBIC, the income generated by a resource (interest, profits, etc.) *is* counted. Support and maintenance are not considered income. Further, the child's parents' income is not "deemed" to the child.[520] Nevertheless, the incomes of parents and certain other household members are taken into account in determining eligibility.[521]

2. NON-FINANCIAL REQUIREMENTS

MBIC has the following nonfinancial requirements for eligibility:

Citizenship/Immigration Status/Residency	The requirements are the same as for Texas Medicaid programs in general.
Disability	This requirement is the same as for SSI, discussed above. 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
Living arrangement	Must not reside in a "public institution, including a jail, prison, reformatory, or other correctional or holding facility, as defined in 42 C.F.R § 435.1009 and § 435.1010." This type of 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.522

[517] Tex. Gov't Code §531.02444(2); Acts of May 1, 2009, 81st Leg., R.S., ch. 24, § 1.

[518] MEPD HANDBOOK at § N–7000.

[519] *See id.* at § N-4100.

[520] *See id.* at § N-4200. Lack of parental deeming of income and resources will only be in effect as long as the Affordable Care Act (ACA) is not repealed. If the ACA is repealed, then the parents' income and assets will be counted.

[521] MEPD Handbook § N-6350.

[522] 1 T.A.C. § 361.107.

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.523

Premiums, or "monthly payments," may be a condition of eligibility. In accordance with the MEPD HANDBOOK §N-700, the premium amounts are based on a sliding scale, dependent upon family income and whether the applicant/recipient is covered under a parent's ESI plan. If a parent's insurance qualifies, the Health Insurance Premium Payment Program (HIPP) can reimburse the family for the ESI premium. HIPP eligibility is also a determining factor in the MBIC premium amount.

D. MBIC PREMIUM AMOUNTS

1. NO ESI

Family Income	Premium Amount[524]	
	Family of 1 or 2	Family of 3+
150% FPIL	$0	$0
151–200% FPIL	$90	$115
201–300% FPIL	$180	$230

2. ESI WITH STATE-PAID HIPP

Family Income	Premium Amount [525]	
	Family of 1 or 2	Family of 3+
At or below 150% FPIL	$0	$0
151–200% FPIL	$25	$35
201–300% FPIL	$50	$70

3. ESI AND NO STATE-PAID HIPP

No premiums are required for families with ESI who are not eligible for HIPP. These families are paying their full share of the premium for ESI and are not expected to also pay a premium for MBIC.

E. EXEMPTIONS AND WAIVERS

Specific groups may be exempt from premiums. For example, certain American Indians and Alaska Natives are exempt from premiums. In other cases, premiums for 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;

523 1 T.A.C. § 361.113.

524 These amounts are subject to change when Federal Poverty Income Limits (FPIL) change.

525 These amounts are subject to change when Federal Poverty Income Limits (FPIL) change.

- involuntary reduction in work hours;
- a parent's leaving the household because of divorce or separation;
- or parent's death.

Only one such waiver may be granted every 12 months.[526]

XVIII. HELP WITH INSURANCE PREMIUMS—THE HIPP PROGRAM

The HIPP (Health Insurance Premium Payment)[527] program is a Medicaid program that reimburses the cost of insurance premiums for employer-provided medical insurance of a 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.[528] 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).

The application is made by telephone to 1–800–440–0493 or by filling out a form available at https://hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program.

STAR members are not eligible for HIPP. STAR+PLUS members can get HIPP, but they will have to pay copayments and deductibles for (1) services not covered by Medicaid & (2) any services by a provider who is not Medicaid-certified.[529]

> 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

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[526] 1 T.A.C. §361.115(e).

[527] TEXAS HEALTH AND HUMAN SERVICES, *Health Insurance Premium Payment (HIPP) Program,* https://hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program. 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.

[528] TEXAS MEDICAL ASSOCIATION, *The Health Insurance Premium Payment (HIPP)*, http://www.texmed.org/Template.aspx?id=2619.

[529] TEXAS COUNCIL FOR DEVELOPMENT DISABILITIES, *Get HIPP with STAR+PLUS,* http://www.tcdd.texas.gov/hipp_with_star_plus/ .

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.

Cost-sharing is the amount a person pays out-of-pocket for health care, including MBIC premiums.[530] These premiums and medical costs are tracked for the 12 months beginning with the case disposition month.[531] During this 12-month period, once a person reaches a cost-share limit, premiums are discontinued.[532] This limit is based on the family's gross countable gross annual income.[533] For families with an income below 200% FPIL, their cost-share limit is 5% of their gross annual income.[534] For families with an income between 201% and 300% FPIL, their cost-share limit is 7.5% of their gross annual income.[535]

XIX. FOOD STAMPS (SNAP)[536]

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.[537] Therefore, for 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

Maximum allowable resources for a household is $5,000 [538]

Resources that are countable include the 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[539]

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[530] MEPD HANDBOOK at § N-7900.

[531] *Id.* at § N-7920.

[532] *Id.* at § N-7910.

[533] *Id.*

[534] *Id.*

[535] *Id.*

[536] 1 T.A.C. ch. 372; TEXAS HUMAN & HEALTH SERVICES, *SNAP Food Benefits,* http://yourtexasbenefits.hhsc.texas.gov/programs/snap ; USDA FOOD AND NUTRITION SERVICE, *Supplemental Nutrition Assistance Program (SNAP)*, https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap .

[537] 1 T.A.C. § 372.153, incorporating 7 C.F.R. § 273.2(j)(2)(D),(E).

[538] Texas Works Handbook § 1220; 1 T.A.C. § 372.355(a) (states HHSC follows 7 C.F.R. § 273.8 to define SNAP resource limits). The amount in the Handbook at this writing is higher than the rules would indicate, but agency employees generally follow the handbook.

[539] 7 C.F.R. § 273.8(e)(1).

- 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[540]
- 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.[541] Excesses over any of these FMVs is counted toward the combined resource limit.
- Income-producing property as determined by specified standards[542]
- Property in irrevocable trusts meeting certain requirements[543]

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.[544]

2. TRUST RULES[545]

Trust rules for food stamps are the same as for Temporary Assistance for Needy Families, as follows:[546]

A—1237 Trust Funds

TANF, SNAP, Children on TP 32 and Children on TP 56

Trust funds are exempt if all of the following conditions are met:

- The trust arrangement is unlikely to end during the certification period.
- No household member can revoke the trust agreement or change the name of the beneficiary during the certification period.
- The trustee of the fund is either a:court, institution, corporation, or organization not under the direction or ownership of a household member; orcourt-appointed person who has court-imposed limitations placed on the use of the funds; and
- The trust investments do not directly involve or help any business or corporation under the control, direction, or influence of a household member.

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[540] 7 C.F.R. § 273.8(e)(2).

[541] 1 T.A.C. §327.355; 7 C.F.R. § 273.8(e)(3); Texas Works Handbook § A-1238.

[542] 7 C.F.R. § 273.8(e)(4).

[543] 7 C.F.R. § 273.8(e)(8).

[544] TEXAS HUMAN & HEALTH SERVICES, SNAP *Food Benefits,* http://yourtexasbenefits.hhsc.texas.gov/programs/snap .

[545] 7 C.F.R. § 273.8(h).

[546] Texas Works Handbook § A-1237, based on 1 T.A.C. §372.354(c)(6)(B), incorporating by reference the SNAP rule at 7 CFR §273.8(e)(8).

- Trusts established from the household's own funds are exempt if the trustee uses the funds:
    - only to make investments on behalf of the trust; or
    - to pay the education or medical expenses of the beneficiary.

Comment: Remember that SSI and TANF beneficiaries are "categorically" eligible for SNAP. Therefore, even if they are beneficiaries of a trust not meeting the SNAP requirements, they are still eligible for SNAP.

3. TRANSFER RULES[547]

A transfer of resources for the purpose of qualifying or attempting to qualify for food stamps is penalized by the 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.[548]

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.[549]

4. INCOME

Both eligibility for and the amount of benefits (food stamp "allotments") depends upon household income. The methodology for determining eligibility and amount of benefit is quite complex.[550]

In-kind income is exempt. Therefore, trust distributions do not affect food stamp eligibility as long as the trust pays directly to the provider of goods and services for the beneficiary.[551]

5. CITIZENSHIP/IMMIGRATION STATUS

Only U. S. citizens and aliens lawfully admitted for permanent or temporary residence can be eligible for food stamps.[552]

Moreover, even permanent resident aliens are excluded from the food stamp program unless they fall into one of the following categories:

- asylee
- refugee
- person whose deportation is withheld
- Cuban, entrant

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[547] 7 C.F.R. § 273.8(h).

[548] 7 C.F.R. § 273.8(h)(4).

[549] 7 C.F.R. § 273.8(h)(1).

[550] 7 C.F.R. § 273.9; Texas Works Handbook §§ C-121, C-122, C-1431, C-1432.

[551] Texas Works Handbook § A-1326.5.

[552] 7 C.F.R. § 273.4(a); 1 T.A.C. § 372.203.

- Haitian, entrant
- Amerasian
- certain Native Americans from Canada
- non-citizen children of a battered parent. Active duty troops and honorably discharged veterans meeting the minimum service requirement (generally, 24 months active duty).as well as their spouses, their un-remarried surviving spouses, unmarried dependent children,

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.[553]

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.[554] 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.[555] Moreover, all aliens receiving SSI are eligible for Medicaid.[556]

6. 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.[557] 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[558]

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.)[559]

C. APPLICATION

Information about where and how to apply is available at https://www.yourtexasbenefits.com/Learn/Home.

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[553] 8 U.S.C. § 1612 (limitations for certain "qualified aliens"), § 1641 (defining "qualified aliens").

[554] 8 U.S.C. § 1612(a)(2)(E).

[555] P.L. 105–185 (effective November 1, 1998).

[556] 8 U.S.C. § 1612(b)(2)(F).

[557] 7 C.F.R. § 273.24(b).

[558] 7 U.S.C. § 2015(o)(3); 7 C.F.R. § 273.24(c).

[559] TEXAS HEALTH AND HUMAN SERVICES, *Lone Star FAQs*, https://hhs.texas.gov/services/financial/lone-star-card/lone-star-faqs.

XX. Texas Mental Health & Intellectual Disability Programs

Mental health services and intellectual disability services that were once provided by the Texas Department of Mental Health and Mental Retardation (TXMHMR) are now administered by the Texas Health & Human Services Commission.

At the community level, however, local centers still administer programs for both mental health services and intellectual disability services. Local MHMR centers that were once overseen by TXMHMR now may be called Local Mental Health Authorities (LMHAs)[560] or Local Intellectual and Developmental Disability Authorities (LIDDAs).[561] There are many differences between the centers as to programs offered, locations, contact information, and names. For example, the following are names of several of the centers:

- Emergence Health Network[562] (El Paso),
- Denton Country MHMR[563],
- LifePath Systems[564] (Collin County),
- Access[565] (Jacksonville, Anderson and Cherokee County),
- Metrocare[566] (Dallas),
- Integral Care[567] (Austin, Travis County),
- Spindletop Center[568] (Beaumont),
- MHMR of Tarrant County[569]

Texas statutes and rules often refer to persons provided with mental health services as "patients" and to the facilities as "state hospitals" or "outpatient facilities." Individuals receiving services for intellectual disabilities at state-operated facilities are often referred to as "residents" and the facilities as "state supported living centers." Persons utilizing local outpatient facilities are referred to as "clients" and the outpatient facilities are still frequently referred to as "community MHMR centers" or simply "community centers."[570]

The terminology is dynamic; there are relatively frequent and significant changes in terminology and programs—along with vast differences throughout the state—that makes the determination of available

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[560] See TEXAS HEALTH AND HUMAN SERVICES, *Find Your Local Mental Health or Behavioral Health Authority*, https://www.dshs.texas.gov/mhsa/lmha-list

[561] See TEXAS HEALTH AND HUMAN SERVICES, *Contact HHS: Local Intellectual and Developmental Disability Authorities Directory,* https://apps.hhs.texas.gov/contact/la.cfm

[562] See EMERGENCE HEALTH NETWORK, Homepage, https://emergencehealthnetwork.org/

[563] See DENTON COUNTY MHMR CENTER, Homepage, https://www.dentonmhmr.org/

[564] See LIFEPATH SYSTEMS, Homepage, https://www.lifepathsystems.org/

[565] See ACCESS MHMR, Homepage, http://www.accessmhmr.org/

[566] See METROCARE, Homepage, https://www.metrocareservices.org/

[567] See INTEGRAL CARE, Homepage, https://integralcare.org/en/home/

[568] See SPINDLETOP CENTER, Homepage, https://integralcare.org/en/home/

[569] See MHMR TARRANT, Homepage, https://integralcare.org/en/home/

[570] *See* TEXAS COUNCIL OF COMMUNITY CENTERS, INC, Texas Council Homepage, http://txcouncil.com.

services challenging. However, there are multiple ways to access local centers by starting online or by calling "211," and many of the services offered are extensive, once accessed.

A. ELIGIBILITY

1. MEDICAID-FUNDED SERVICES

Medicaid does not generally cover services for patients aged 21 through 64 in an "institution for mental diseases" or "IMD."[571] The lack of Medicaid coverage in this age group may be referred to as the "IMD exclusion." Many state hospital services fall under this archaic definition, although some Medicaid-funded services may be available for specific programs and individuals aged 65 or older.[572] Many DSHS services, particularly in the mental health area, are not funded by Medicaid and therefore are governed only by state laws. State supported living centers and may have both Medicaid-funded services and state-funded services, with different cost coverage rules.

Thus, important categories of services are covered by Medicaid and therefore involve the Medicaid financial eligibility rules, even though DSHS or DADS 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 Facilities for Individuals with Intellectual Disabilities (ICF-IID) program for residential care, which is available to all ages because it does not involve an IMD. 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, the determination 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 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 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

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

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[571] 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).

[572] 25 T.A.C. § 419.374.

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.[573]

While with many Medicaid-funded services one's resources will be a factor in determining eligibility for services, with state-funded mental health and intellectual disability services, financial liability may be determined later.

A "patient" is defined by the Texas Health & Safety Code as an individual who is receiving voluntary or involuntary mental health services in a facility that provides inpatient care and treatment for persons with "mental illness." "Mental illness" is defined as "an illness, disease or condition, other than epilepsy, dementia, substance abuse, or intellectual disability, 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." [574] 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."

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 physician or psychologist licensed in Texas or certified by DADS "to have sub-average general intellectual functioning with deficits in adaptive behavior."[575]

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.[576] Those determinations are "guided" by rules of DADS at 40 T.A.C. Chapter 7, Subchapter J** (for residential facilities) and 40 T.A.C. Chapter 2, Subchapter C (for community-based services)[577] 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).[578]

A person responsible for payment may appeal the payment determinations made by either DSHS or DADS. The appeals processes and where to appeal depends on whether the charges are for services in a state hospital, state supported living center, community center, or other facility.[579]

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[573] Tex. Health & Safety Code 552.013.

[574] Tex. Health & Safety Code § 571.003(14).

[575] TEX. HEALTH & SAFETY CODE § 591.003(7-a). *See also id.* §§ 591.003(13), (16); *id.* § 593.005.

[576] Tex. Health & Safety Code §§ 552.012–552.019; Tex. Health & Safety Code §§ 593.072–593.081.

[577] 25 T.A.C. Chapter 419, Subchapter J; 40 T.A.C. Chapter 2, Subchapter C.

[578] 25 T.A.C. Chapter 417, Subchapter C; 25 T.A.C. Chapter 412, Subchapter C.

[579] 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).

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.[580]

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.[581]

B. BENEFITS

1. MENTAL HEALTH FACILITIES

There are "state hospitals" in Austin, Big Spring, El Paso, Kerrville, North Texas State Hospital (at Vernon or Wichita Falls), Rusk, San Antonio, Terrell, Waco (ages 13–17).[582] They provide a broad range of in-patient and out-patient mental health services.

2. INTELLECTUAL DISABILITY SERVICES

State law requires HHSC to make "all reasonable efforts consistent with available resources" to:

- assure that each person with an 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 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 intellectual and developmental disabilities, including treatment and care, education and training, sheltered workshop programs, counseling and guidance, and development of community residential facilities (including group homes, halfway houses and day-care facilities).[583]

The "state supported living centers" for persons with intellectual and developmental disabilities are located in Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, Rio Grande, San Angelo, and San Antonio.[584] DADS also funds and provides administrative and support services to numerous group homes, halfway houses, other residential facilities, and day-care facilities throughout the state.

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[580] Tex. Health & Safety Code § 552.019(a), (f).

[581] Tex. Health & Safety Code § 533.004.

[582] TEXAS DEP'T OF HEALTH & HUMAN SERVICES, *State Hospitals*, https://hhs.texas.gov/services/mental-health-substance-use/state-hospitals.

[583] Tex. Health & Safety Code § 591.011.

[584] TEXAS DEPARTMENT OF HEALTH & HUMAN SERVICES, *About State Supported Living Centers*, https://hhs.texas.gov/services/disability/intellectual-or-developmental-disabilities/state-supported-living-centers-sslcs.

3. COMMUNITY SERVICES

HHSC approves and to some extent supervises community MHMR centers. Such organizations are for most purposes local governmental entities, although they may have substantial funding from non-governmental sources.[585]

The local centers are intended to provide a continuum of services to Texans who have mental illness or intellectual disabilities and may provide services to persons with chemical dependency.[586] 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 collecting fees for treating patients and clients that . . . [HHSC has] by law," and the county or district attorney of the center's county is to represent the center in collecting fees.[587]

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
- medication-related services, including medication clinics, laboratory monitoring, medication education, mental health maintenance education, and the provision of medication
- psychosocial rehabilitation programs, including social support activities, independent living skills, and vocational training
- appropriate community-based services for each person discharged from a department facility who is in need of care to the extent resources are available,

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.[588]

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[585] Tex. Health & Safety Code § 534.001.

[586] Tex. Health & Safety Code § 534.0015.

[587] Tex. Health & Safety Code § 534.017.

[588] Tex. Health & Safety Code § 534.053.

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 20,000 or more 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.

4. GROUP HOMES

Group homes include Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID facilities),[589] 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.[590] 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 2022, the income limit for an individual is $2,523).[591]

In addition, the client must have been determined to have a disability by the Social Security Administration, 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.[592]

Under the statutes just cited, the following are not considered "trusts" and are not entitled to the exemption:

- a guardianship established under the former Texas Probate Code or under the Estates 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 §551.003the 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

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[589] TEX. HEALTH & SAFETY CODE ch. 252; 26 T.A.C. ch. 551.

[590] HCS group home information is at https://hhs.texas.gov/services/disability/intellectual-or-developmental-disabilities-idd-long-term-care.

[591] 40 T.A.C. § 9.236.

[592] TEX. HEALTH & SAFETY CODE § 534.0175(a) ("clients" served by community centers), § 552.018(a) ("patients" in state hospitals), and § 593.081 ("residents" of a state supported living center for persons with intellectual disabilities). 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 case apparently cited most frequently for the State's authority to proceed against trusts is *State v. Rubion*, 308 S.W.2d 4, 6 (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. Texas statutes now include Health & Safety Code provisions addressing trusts, which are cited to in the previous footnote.

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 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.

- If the trust includes a statement of intent to avoid disqualification of the beneficiary for public benefits, the State may be less likely to seek recovery against the trust.

- The State has in some cases taken the position that discretionary trusts are subject to reimbursement but may consider 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.

- 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 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 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, and whether the determination is different when the trust is exempt under Medicaid rules. The "142 trust," created by a trial court under Texas Property Code § 142.005, may be drafted to be an exempt asset under Medicaid rules,[593] yet such trusts, along with guardianship estates, are expressly excluded from favorable treatment in the statute.[594] 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.

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[593] 42 U.S.C. § 1396pd/(4).

[594] 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.

Moreover, public policy as expressed by the Medicaid laws and 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 may not provide protection from state claims for mental health and intellectual disability services provided by state-funded programs.

If the benefit being sought is "Long Term Care Medicaid" in a facility, and only Medicaid funds are involved, 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."

D. TRANSFER RULES

The statutes and rules governing state hospitals, state supported living centers, and community MHMR 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 (for example, 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 state-funded mental health of intellectual disability services or has an outstanding bill for such services, the agency is highly likely to treat the transfer as a fraudulent conveyance.

In short, advice regarding transfers for the purpose of avoiding financial responsibility for 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.[595] Moreover, it is unethical for an attorney to assist or counsel a client to engage in conduct the attorney knows is fraudulent.[596]

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.

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[595] Tex. Bus. & Comm. Code § 24.005(a).

[596] Texas Disciplinary Rules of Professional Conduct Rule 1.02(c), 8.04(a)(3).

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 the use of limited local funds. Examples are the following:

Travis County (Austin)	Central Health http://www.cheligibility.net/ 512–978–8130
Dallas County	Parkland Financial Assistance (for care at Parkland Health & Hospital Systems) http://www.parklandhospital.com/phhs/parkland-financial-assistance.aspx 214.590.4900

In some cases, a client may find help at a public health center. These public health centers often offer only the basics, such as immunizations, but there are some exceptions. The following are a few public health centers:

Harris County (Houston)	Harris County Public Health	http://publichealth.harriscountytx.gov/Services-Programs/Services/HWC
San Antonio	Metropolitan Health District	http://www.sanantonio.gov/Health
Tarrant County (Arlington and Fort Worth)	Tarrant County Public Health	http://access.tarrantcounty.com/en/public-health.html

> 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 another applicable group.

E. PROPERTY TAX EXEMPTIONS

Persons aged 65 and over and individuals with disabilities are eligible for increased exemptions from property taxes on their homes and to a "school tax freeze." Both elderly (age 65 and over) and disabled Texans have the right to defer property taxes (at 5% interest) until after their lifetimes. More information is available at https://www.comptroller.texas.gov/taxes/property-tax/exemptions/index.php 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 along the way.

XXII. BREAST CANCER & CANCER CONTROL SERVICES AND MEDICAID

A. THE BREAST & CERVICAL CANCER CONTROL SERVICES (BCCCS)

Women in need of breast and cervical cancer services may be eligible for services under this program. [597] The program provides breast cancer screening and diagnostic services to women 40 or older, breast cancer diagnostic screenings only to women under 40, cervical cancer screenings services to woman ages 21 to 64, and cervical cancer diagnostic services for woman ages 18 to 64. To be eligible for these services, the

[597] TEXAS HEALTH AND HUMAN SERVICES, *Breast & Cervical Cancer Services*, https://www.healthytexaswomen.org/bccs-program.

person's income must be 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**.

As a matter of practice, BCCCS providers limit the 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) 776–7796 or visit https://healthytexaswomen.org/find-a-doctor.

B. MEDICAID FOR BREAST AND CERVICAL CANCER

Some women who are diagnosed with breast or cervical cancer by the BCCCS are eligible for Medicaid medical assistance.[598] To be eligible, a woman must meet the following requirements:[599]

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;
4) be a citizen or meet qualified alien status requirements; and
5) be a resident of Texas.
6) have income at or below **200% of the federal poverty level**, always treating the applicant as a **"household of one"** without counting anyone else's income

BCCC Medicaid has no resource limit.[600]

The BCCC Medicaid application process is handled through a BCCCS provider, and there is no need for a face-to-face interview with an HHSC Medicaid Eligibility Specialist, even though HHSC makes the final eligibility determination. For further information and to locate a provider in the client's area, call (512) 776–7796 or visit https://healthytexaswomen.org/find-a-doctor>

XXIII. TIPS FOR NEW ELDER LAW & 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

[598] 1 T.A.C. ch. 366, subch. D.

[599] 1 T.A.C. §§ 366.407, 366.409; Texas Works Handbook §§ X-110, 120, 210, 1410.

[600] Texas Works Handbook § X-1310

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
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 3 (located online at https://hhs.texas.gov/node/47321)

B. TIPS FOR A SUCCESSFUL MEDICAID APPLICATION - FREQUENTLY ASKED QUESTIONS

Q. How is the Texas Health and Human Service Commission organized?

See organizational chart in Appendix 8 or located online at https://hhs.texas.gov/sites/hhs/files//documents/about-hhs/leadership/hhsc-org-chart.pdf.

Q. Where do I go to get a Medicaid Application?

Go to https://www.yourtexasbenefits.com to fill out an electronic application or download the form found at https://www.yourtexasbenefits.com/Learn/GetPaperForm and print, then follow the instructions on the form.

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 https://hhs.texas.gov/laws-regulations/handbooks/medicaid-elderly-and-people-disabilities-handbook.
- Your own calculations of co-payments with details and supporting documentation.
- Explanations to questions you foresee being asked by a Medicaid Eligibility Specialist (e.g., missing paperwork or discrepancies in documentation).
- 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. What should I do if I suspect co-pay was calculated incorrectly by the Medicaid Eligibility Specialist?

Request the co-pay calculations used by the Medicaid Eligibility Specialist.

Q. Who do I contact if the Medicaid Eligibility Specialist is unresponsive, cannot be identified, or makes a mistake and cannot be persuaded to change it?

When an application is unreasonably delayed or a mistake is made that may be corrected without an appeal, contact the Service Improvement Manager in the Office of Eligibility Services (OES). In the past, the Regional Manager's Office has provided similar assistance. However, as of this writing, the Office of Eligibility Services appears to be the first place to contact. Within OES, there is a unit dedicated to facilitating attorney requests regarding Medicaid applications, at OESMEPDIC@hhsc.state.tx.us.

Note, this email address is all-purpose. Therefore, clearly identify your message as a request from an attorney's office. Without a conspicuous declaration, the request could be delayed or overlooked entirely. For best results, indicate in the subject line that this is an attorney request. For example:

ATTORNEY REQUEST—[insert the last name of Applicant]

Within the body of the request, include as much information as you can, such as:

- Applicant's name
- Applicant's social security number
- Medicaid case number
- Date application was filed
- Any attempts to contact or resolve the issue with the Medicaid Eligibility Specialist

You may need to provide additional information, depending on the type of request.

In cases of unreasonable delay, first, contact the Service Improvement Manager to request the Medicaid Eligibility Specialist's name and contact information. Try to identify the issue by speaking directly to the Medicaid Eligibility Specialist. If the application is not processed soon after contacting the Medicaid Eligibility Specialist, submit another request to the Service Improvement Manager. Explain the situation, including the attempt to resolve the issue with the Medicaid Eligibility Specialist, and request that they review the file and issue a determination as soon as possible.

If a mistake has been made, such as an incorrectly calculated co-payment, or if the case has been denied in error, contact the Service Improvement Manager and request they review the application and reissue the correct determination. In the request, describe the error, give them the correct information, and provide an in-depth explanation. For instance, for a miscalculated co-payment, state the co-payment is wrong, give the correct co-payment calculation, and explain why your calculation is the correct one. Of course, if you are already in contact with the Medicaid Eligibility Specialist, you will want to try to work it out with him or her first.

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. In theory. But getting anything from 211 is, at best, time-consuming and frequently impossible.

C. QUALIFIED INCOME TRUST (QIT) CHECKLIST (MILLER TRUSTS)

- Are all 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.COVID-19-RELATED LEGISLATION

In response to the COVID public health emergency, Congress passed two major pieces of legislation: the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act.[601] The following is a summary of key provisions related to Medicaid and Medicare.

A. FISCAL RELIEF

In order to increase immediate cash flow to all "providers of services and suppliers impacted" by COVID-19, Section 3719 expands Medicare's accelerated payment program (APP) during the COVID-19 emergency. They also increased Medicare in-patient add-on payments for treating COVID-19 patients.[602]

The FFCRA includes a temporary increase in the federal Medicaid matching rate (FMAP) by 6.2 percentage points for all states and the territories. The 6.2 percentage point increase is retroactive to January 1, 2020 and will continue until the end of the public health emergency. To receive the 6.2 percentage point increase states are prohibited from:

implementing any eligibility standards, methodologies, or procedures that are more restrictive than those in effect on January 1, 2020; imposing new or increased premiums on beneficiaries that exceed the amount in effect as of January 1, 2020; disenrolling anyone who is enrolled as of March 18 or who newly enrolls during the public health emergency period *for any reason* (unless the individual no longer resides in the state or voluntarily disenrolls); and denying coverage or imposing cost-sharing on testing services and treatment for COVID-19. The Centers for Medicare and Medicaid Services (CMS) has issued guidance that states the Families First FMAP increase also applies to Children's **Health** Insurance Program (CHIP).

The CARES Act amends the FFCRA to provide that States may qualify for the 6.2 percent increase in FMAP for 30 days after the enactment of the CARES Act, even if the state had increased premiums beyond those set as of January 1, 2020 — so long as those premiums were in effect before the CARES Act was passed and premiums have since been reduce premiums to the levels set as of January 1, 2020.

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[601] Families First Coronavirus Response Act (FFCRA), Pub .L. No. 116-127, 134 Stat. 177 (Mar. 18, 2020); Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. No. 116–136, 134 Stat. 281 (Mar. 27, 2020)

[602] CARES Act § 3710

In addition, the CARES Act provides for state fiscal relief through a $150 billion fund for states, localities, and tribes to cover unbudgeted costs incurred due to the COVID-19 public health emergency between March 1 and December 30 of this year.

Section 2104(h) makes clear that the $600 additional weekly Unemployment Insurance payments authorized by the Act are to be disregarded in determining income for purposes of Medicaid or CHIP eligibility.

B. EXPANDED COVERAGE FOR COVID TESTING

The FFCRA states that State Medicaid (including CHIP and Pregnant Women's Medicaid) must cover, without cost-sharing:

- laboratory tests for the detection of the coronavirus (SARS-CoV-2) or the diagnosis of the virus that causes COVID-19 disease
- cost administering of the tests
- testing-related services.

The CARES Act further expanded this by eliminating the requirement that the COVID-19 tests be "approved, cleared, or authorized" by the FDA in order for Medicaid payment to be made.[603]

The CARES Act adds "COVID-19 vaccine[s] and [their] administration" to the definition of "medical and other health services" covered under Part B and provides that such a vaccine shall be covered without any cost-sharing.[604]

In addition to those otherwise eligible for Medicaid, under FFCRA, states can create an optional eligibility group for uninsured individuals. The coverage is limited to COVID-19 tests and testing related services. It does not cover costs related to COVID-19 treatment or non-COVID care. The CARES Act clarifies that individuals in some optional Medicaid eligibility groups qualify as "uninsured individuals" if it doesn't provide minimum essential coverage.[605]

C. INCREASED CARE SETTING FLEXIBILITY

In order to free up resources needed for COVID-19 patients, the CARES act provides acute care hospitals the flexibility to transfer patients out of their facilities and into alternative care settings. To do so, it increases access to post-acute care, allows HCBS services to be provided in acute care settings, expands the types of health care professionals authorized to certify the need for home health services, and encourages the use of telehealth by expanding coverage of telehealth services.[606] It also allows Part D enrollees to obtain up to a 90-day supply for prescription medications in a single fill or refill.[607]

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[603] CARES Act § 3717

[604] CARES Act § 3713

[605] CARES Act § 3716

[606] CARES Act §§ 3704-3707, 3711, 3715.

[607] CARES Act § 3714

D. MEDICAID DEMONSTRATION PROGRAM EXTENSION

The CARES extends the following programs:

- Money Follows the Person Rebalancing Demonstrations
- Spousal impoverishment
- Community Mental Health Services Demonstration[608]

XXV. COVID-19-RELATED MEDICAID POLICIES

A. MEDICAID COVERAGE MAY NOT BE TERMINATED

Federal law provides that states will lose a 6.2% increase in the Federal Medical Assistance if they fail to prohibit termination of coverage for programs under the State Medicaid Plan for individuals who were covered as of March 18, 2021. This provision is in effect until the end of the calendar month in which the [COVID-19] public health emergency ends.[609] Therefore, Texas Medicaid policy provides as follows:[610]

In response, HHSC issued bulletins prohibited an agency from denying coverage to person receiving Medicaid as of March 18, 2021 unless the person:

- Voluntarily withdraws;
- Dies; or
- Moves out of state***

Note: The requirement to maintain Medicaid coverage does not apply to CHIP, Medically Needy with Spenddown or Emergency Medicaid types of assistance.

A person is not required to take any action to maintain Medicaid coverage during the public health emergency.

B. MEDICAID ANNUAL RECERTIFICATIONS INVOLVE UNCERTAINTY

Early in the pandemic, HHSC announced it was suspending annual recertifications. However, Texas Works Bulletin 20-21 (9/30/20) provides as follows:[611]

> Although H.R. 6201 (Families First Coronavirus Response Act), requires HHSC to maintain Medicaid coverage through the end of the public health emergency, the federal requirement to conduct a Medicaid eligibility determination once every 12 months has not been waived. Staff must resume processing renewals for Medicaid. As a reminder, Medicaid eligibility can only be terminated during the public health emergency period at renewal if the person has died, voluntarily withdrawn from Medicaid, or moved out of state. EDGs that are terminated for any other reason at renewal must be maintained until the end of public health emergency

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608 CARES Act §§ 3811-3814

609 Families First Coronavirus Response Act, P.L. 116-127, Sec. 6008(b)(3), at https://www.congress.gov/bill/116th-congress/house-bill/6201/text

610 MEPD and Texas Works Bulletin 20-06, page 2.

611 https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/twh/bulletin2021/20-21-revised.pdf

period. TIERS will renew the following EDGs for a six-month period instead of 12-months to ensure eligibility remains active during the public health emergency period:

- EDGs determined ineligible when processing a renewal;
- EDGs in renewal status but a renewal packet is not returned; and
- EDGs renewed with unverified eligibility criteria (i.e. the household fails to provide missing information).

Note: TIERS will extend the certification period for one additional month if the renewal was initiated before cut-off but not completed at cut-off. The extra month MEPD and Texas Works Bulletin 20-21 Page 3 ensures individuals do not lose their Medicaid eligibility while staff complete the renewal process. Staff must attempt to complete all renewals timely.

This appears to indicate that if you fail to meet the requirements for renewing eligibility at the annual recertification, the worst that can happen is that another review will be required in six months rather than 12 months. Also, if your 12 months or 6 months ends just before the emergency period ends, you will be given enough additional days so you have at least 30 days to meet the requirements.

Two somewhat mysterious agency practices emerged in late 2021 regarding annual (or 6-month) reviews:

- Many clients received notices of annual review requirements at odd times, sometimes months before their annual review would normally occur; and when they responded, their submissions were ignored. Agency representatives explain this involves an Information Technology problem. Therefore, the best practice at this writing in January 2022 is to contact the Office of Eligibility Services at OESMEPDIC@hhsc.state.tx.us whenever an annual review packet is received, with a request for the actual "deadline" for submission.
- HHSC notices responding to annual review applications have been routinely including the following warning: "You are getting this notice because a review of your most recent information indicates you will not be eligible for Medicaid coverage when the public health emergency ends." Upon an author's notice of intent to appeal every action in which that notice was sent, a representative of the Office of Eligibility Services said it was sent in error and could be safely disregarded.

C. STIMULUS PAYMENTS USUALLY DO NOT AFFECT BENEFITS

Also, in compliance with federal law,[612] Economic Impact Payments ("stimulus" payments) are excluded as income of Medicaid beneficiaries, both for the purpose of determining eligibility and for determining Medicaid copayments. Those payments are also excluded as resources for 12 months after the month of receipt. Specifically, the policy bulletin provides as follows:[613]

> Excluded funds may be commingled with other funds but must be separately identifiable. If the funds are commingled, staff must use bank statements to identify any remaining excluded

[612] Coronavirus Aid, Relief and Economic Security Act (CARES Act), H.R. 748.

[613] MEPD and Texas Works Bulletin 20-08, page 2.

> funds. When withdrawals are made from a commingled account, assume the non-excluded funds are withdrawn first.

D. "BEST AVAILABLE" INCOME VERIFICATION IS SOMETIMES GOOD ENOUGH

Another Policy Bulletin provides as follows:

> Accept an applicant's statement as verification of income when all attempts to verify the income have been unsuccessful because the person or the organization providing the income is not able to cooperate because of impacts related to COVID-19. Determine the budget amount based on the best available information.[614]

E. SOURCES OF INFORMATION ON COVID-19 MEDICAID POLICY

As indicated, most of the policies summarized above are Policy Bulletins, which are published from time to time in connection with the Medicaid for the Elderly and People with Disabilities Handbook at https://hhs.texas.gov/laws-regulations/handbooks/mepd/policy-bulletins.

Policy changes affecting Medicaid beneficiaries are also published on the HHSC website at https://hhs.texas.gov/services/health/coronavirus-covid-19/coronavirus-covid-19-information-people-receiving-services.

COVID-19 policy information is available from HHSC by email at Medicaid_COVID_Quetions@hhsc.state.tx.us.

[614] MEPD and Texas Works Bulletin 20-04, page 6.

PROPOSED Build Back Better Act

In November 2021, the United States of House of Representatives passed the Build Back Better Act to provide funding, establishes programs, and otherwise modifies provisions relating to a broad array of areas, including education, labor, childcare, health care, taxes, immigration, and the environment. The politics of getting it passed is beyond the scope of this paper but a summary of provisions effecting public benefits provides information on the general direction of policy. As of the date of this paper (January 31, 2022), the Senate has not passed the Act.

F. MEDICARE

Drug costs can be crippling for many of those receiving public benefits. The Build Back Better Act attacks this issue in multiple ways. First, the act would allow Medicare to negotiate prescription drug prices for a limited number of high-cost, single-source, brand-name drugs that have been on the market for 9-10 years. Insulin products will also be subject to negotiations.[615]

Second, to curb raising drug prices, the Act would require drug manufacturers to pay a rebate to the federal government if their prices for single-source drugs and biologicals covered under Medicare Part B and nearly all covered drugs under Part D increase faster than the rate of inflation.[616]

Third, addressing the high cost of insulin, insurers, including Medicare Part D plans and private group or individual health plans, would not be able to charge a deductible and cost-sharing would be capped at $35 for insulin products.[617]

Further, if passed, adult vaccines covered under Medicare Part D that are recommended by the Advisory Committee on Immunization Practices (ACIP), such as for shingles, be covered at no cost.[618]

The act also changes the Medicare Part D benefit program to reduce out-of-pocket spending. Currently, the bill has the cap set at $2,000 in 2024, increasing each year based on the rate of increase in Part D costs.[619]

If passed, the Act would add hearing services to Medicare Part B coverage beginning in 2023. Coverage for hearing care would include hearing rehabilitation and treatment services by qualified audiologists, and hearing aids. Hearing aids would be available once per ear, every 5 years, to individuals diagnosed with moderately severe, severe, or profound hearing loss.[620]

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[615] Build Back Better Act §§ 139001-03.

[616] Build Back Better Act §§ 139101-02.

[617] Build Back Better Act §§ 27001, 30604, 137308, 139401

[618] Build Back Better Act § 139402

[619] Build Back Better Act §§ 139201-02.

[620] Build Back Better Act § 30901

G. MEDICAID

In states that have expanded Medicaid under the ACA, all adults above FPIL are eligible for subsidized healthcare and all those that make less than 138% of FPIL are eligible for Medicaid. In effect, making all coverage available to all adults. For adults in non-expansion states, those below the FPIL and above the state's Medicaid income limits are stuck in a coverage gap. The Build Back Better Act would eliminate income restrictions on subsidized coverage thereby eliminating the coverage gap for 2022 through 2025. For certain low-income families, the federal government would fully subsidize the premium for certain plans. People would also be eligible for cost sharing subsidies that would reduce their out-of-pocket costs.[621]

The Build Back Better Act would also restrict non-expansion states use of uncompensated care (UCC) pools and disproportionate share hospital (DSH) payments. Build Back Better Act § 30608. The act also increase the federal match rate for states that have adopted the ACA Medicaid expansion from 90% to 93% from 2023 through 2025.[622]

Children on Medicaid and CHIP States must complete re-evaluations to ensure continued eligibility. The re-evaluations must be completed at least annually but states are allowed to re-evaluate more often. These re-evaluations could result in eligibility for different programs and therefore different coverage and providers. The child may even temporarily lose coverage all together. To improve continuity of care, the Build Back Better Act would require states to extend 12-month continuous coverage for children on Medicaid and CHIP.[623]

CHIP is still a temporary program and funding must be re-authorized periodically. Currently, it is only reauthorized through September 30, 2027. To ensure continued funding, the act would permanently extend the CHIP program.[624]

The Build Back Better Act would require CHIP and Medicaid to cover vaccinations for adults.[625]

Build Back Better would create a new program that would give states a 6-point percentage increase in their Medicaid matching rate on the condition that States not reduce their current level of funding, reduce provider reimbursement, or further restrict eligibility. In addition, they need to implement a federally approved plan to expand access.[626]

The act would make ACA HCBS spousal impoverishment protections and the Money Follows the Person (MFP) program permanent.[627]

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[621] Build Back Better Act § 137304.

[622] Build Back Better Act § 30609.

[623] Build Back Better Act § 30741

[624] Build Back Better Act § 30801.

[625] Build Back Better Act § 139405.

[626] Build Back Better Act §§ 30711-13

[627] Build Back Better Act §§ 30715-16.

APPENDIX 1: 2022 Benefit Eligibility Numbers

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Medi*caid* & SSI

Dollar Amounts Effective as of January 1, 2022

	2021	2022
Medicaid Single Income/Mo.	$2,382	$2,523
Medicaid Couple Income/Mo. (if both eligible)	$4,764	$5,046
SSI Single Income/Mo.	$794	$841
SSI Couple Income/Mo.	$1,191	$1,261
Protected Resource Amt. Min.	$26,076	$27,480
Protected Resource Amt. Max.*	$130,380	$137,400
Spousal Monthly Needs Allowance	$3,259.50	$3,435
Gift Penalized**	$213.71/day	$237.93/day
Personal Needs Allowance-Nursing Home	$60	$60
Maximum Residence Value (with exceptions)	$603,000	$636,000

*When combined incomes of both spouses are below the Spousal Monthly Needs Allowance, the Community Spouse can usually keep more than the Protected Resource Amount Maximum.

****For case actions before 9/1/21, the divisor is $213.71/day; on or after 9/1/21 it is $237.93/day.**

Medi*care* & Social Security & VA

Dollar Amounts Effective as of January 1, 2022*

	2021	2022
Part A Premium/Mo.628	$471	$499
Part B Premium/Mo.629	$148.50	$170.10
Skilled Nursing Facility Copayment	$185.50	$194.50
Hospital Stay (Part A) Deductible	$1,484	$1,556
Hospital Copayment, Days 61-90	$371	$389
Hospital Copayment, Days 91-150	$742	$778
Part B (Medical) Annual Deductible	$203	$233
QMB max income single (gross incl. $20 exempt amt)	$1,094	$1,153*
QMB max income couple (gross incl. $20 exempt amt)	$1,472	$1,546*
SLMB max income single (gross incl. $20 exempt amt)	$1,308	$1,379*
SLMB max couple (gross incl. $20 exempt amt)	$1,762	$1,851*
QI-1 max income single (gross incl. $20 exempt amt)	$1,469	$1,549*
QI-1 max income couple (gross incl. $20 exempt amt)	$1,980	$2,080*
QDWI max income single (gross incl. $20 exempt amt)	$2,147	$2,285*
QDWI max income couple (gross incl. $20 exempt amt)	$2,924	$3,072*
"Substantial Gainful Activity" (Non-Blind)	$1,310	$1,350
"Substantial Gainful Activity" (Blind)	$2,190	$2,260
Max Earnings Taxed for SS	$142,800	$147,000
Retirement Test Earnings/Yr, Under 65	$18,960	$19,560
Retirement Test Earnings in 1st Yr of Full Retirement Age**	$50,520	$51,960
Quarterly earnings for 1 Social Security credit	$1,470	$1,510
VA Pension With "Aid & Attendance"—Married	$2,296	$2,431
VA Pension With "Aid & Attendance"--Unmarried Vet	$1,936	$2,051
VA Pension With "Aid & Attendance"--Widow(er)	$1,244	$1,318

VA Pension that is A&A (not counted by Medicaid) in 2022: $822/mo. (or for surviving spouse, $493/mo.)
VA Pension maximum net worth: $138,489 in 2022.
*Numbers with * effective 3/1/2022 to 2/28/2023 (dependent on Federal Poverty Guidelines)
**Full Retirement = age 66 if born in 1943-1954. For those born 1955-1960, retirement age gradually increases until it reaches age 67 for those born in 1960 and later years.
2022 Social Security & VA Cost of Living Allowance (COLA): 5.9%; 2021 COLA: 1.3%

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628 99% of Social Security beneficiaries have sufficient Medicare covered quarters that they pay no Part A premium. Part A and Part B premiums are paid in full for QMB beneficiaries; SLMB pays Part B premiums only (for requirements, see next page)

629 The Part B premium in 2022 is more than $170.10 for those with more than $91,000 modified adjusted gross income (individual return) or $182,000 (joint return) for the year 2 years before the year of the premium being calculated. (For almost all individuals, modified adjusted gross income for this purpose is adjusted gross income plus tax-exempt income.)

FEDERAL POVERTY GUIDELINES **2022-2023** **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	19%
1	$13,590	$1,133	$1,359	$1,510	$1,529	$1,699	$1,789	$2,095	$2,265	$3,398	$215
2	$18,310	$1,526	$1,831	$2,034	$2,060	$2,289	$2,411	$2,823	$3,052	$4,578	$290
3	$23,030	$1,919	$2,303	$2,559	$2,591	$2,879	$3,032	$3,550	$3,838	$5,758	$365
4	$27,750	$2,313	$2,775	$3,083	$3,122	$3,469	$3,654	$4,278	$4,625	$6,938	$439
5	$32,470	$2,706	$3,247	$3,608	$3,653	$4,059	$4,275	$5,006	$5,412	$8,118	$514
6	$37,190	$3,099	$3,719	$4,132	$4,184	$4,649	$4,897	$5,733	$6,198	$9,298	$589
7	$41,910	$3,493	$4,191	$4,657	$4,715	$5,239	$5,518	$6,461	$6,985	$10,478	$664
8	$46,630	$3,886	$4,663	$5,181	$5,246	$5,829	$6,140	$7,189	$7,772	$11,658	$738
Each Add'l:	$4,720	$393	$472	$524	$531	$590	$621	$728	$787	$1,180	$75

Programs with Poverty-Level-Related Income Limits

Above amounts effective 3/1/22-2/28/23. 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. ***Resource*** limits below are effective January 1, 2022.

QMB:*	100% of poverty + $20 ($8,400 resources unmarried, $12,600 married)
SLMB:*	120% of poverty + $20 ($8,400 resources unmarried, $12,600 married)
QI-1*	135% of poverty +$20 ($8,400 resources unmarried, $12,600 married)
QDWI*	200% of poverty + $20 ($4,000 resources unmarried, $6,000 married)
Part D Full Subsidy*	135% of poverty + $20 ($8,400 resources unmarried, $12,600 married))
Part D Other*	150% of poverty + $20 ($14,790 resources unmarried, $27,950 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)
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)
CHIP 1-18**	210% of poverty (200% FPL plus 5% income disregard) (no resource limit)
CAS	300% of SSI Max ($2,000 unmarried, $3,000 married)

***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.
- **Transfer Penalty:** None (but transfers may affect other benefits such as SSI and long-term care Medicaid)

****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" OF HOUSEHOLD EXPENSES

Applicants for certain "means-tested" benefits can sometimes only qualify 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.

Note: Under a recent interpretation of the ABLE Act by the Social Security Administration, it appears that friends, relatives, and trustees can help SSI beneficiaries pay for food and housing, without creating "income," by running up to $16,000 per year through an ABLE Act account. For many beneficiaries, that will reduce the cost of food and shelter that must be paid from =\9ARURDFtheir SSI benefits and other cash income to the point they can pay their pro rata share and therefore avoid reduction of the SSI benefit. See the discussion on page <<xref>>.

APPENDIX 3: Trust Distributions Where Beneficiary Is On SSI - Sample Instructions

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. In 2021, the maximum is $783 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, 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 Maximum Value Rule, under which you can provide unlimited food and shelter in exchange for having $281 per month count as "income." If that is the only countable income, the SSI monthly benefit will be reduced by $261 to $522 (because $20 of any income does not count).

Examples of Distributions from a Supplemental Needs Trust Not Counted as "Income" by SSI and Medicaid:

- Health and dental treatment and equipment for which there are not funds otherwise available
- Rehabilitative and occupational therapy services
- Medical procedures, even though not medically necessary or lifesaving
- Medical insurance premiums
- Supplemental nursing care
- Supplemental dietary needs
- Eyeglasses
- Travel
- Entertainment
- Companionship
- Private case management
- Cultural experiences

- Vacations
- Movies
- Telephone service
- Television and cable equipment and services
- Radios
- Stereos
- Training and education programs
- Reading and educational materials

Source: The Arc of Texas Master Pooled Trust, Providing for Supplemental Needs, https://www.thearcoftexas.org/trust/#about_supplemental_needs

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. § 1641. The term is somewhat misleading, because "qualified aliens" are disqualified 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). 8 U.S.C. § 1612(a)(2)(C). 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 **Error! Bookmark not defined.**). 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. § 1613(c). 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. §1612(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 §§ D-810—D-8940.0.

APPENDIX 5: SOURCES OF FREE AND REDUCED PRICE PRESCRIPTION MEDICATIONS[630]

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:

- National Council on Aging (screener for over 240 programs): www.benefitscheckup.org
- NeedyMeds (one of the first screeners): www.needymeds.org
- Partnership for Prescription Assistance (sponsored by the Pharmaceutical Research and Manufacturers of America): https://www.pparx.org/
- Medicare: https://www.medicare.gov/part-d/index.html
- Medicare Rights Center (consumer service organization): 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.drx.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.

[630] 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.

APPENDIX 6: SELECTED BIBLIOGRAPHY

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 & Forms

Abshire, Farrell, Sitchler & Wright, Texas Elder Law (in West's Texas Practice Series).

Harry S. Margolis, The ElderLaw Portfolio Series (loose-leaf, 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)

Internet Resources

BENEFIT INFORMATION & COUNSELING SERVICES	
	www.benefits.gov
	www.benefitscheckup.org (automated benefit identification)
	https://www.yourtexasbenefits.com
ARCIL Benefits Planning	http://www.arcil.com/index.php/services/
Texas Department of Aging and Disability Services	http://www.dads.state.tx.us/services/listofservices.html 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.

DISABILITY RESOURCES, FEDERAL	
SSD Evaluation	www.ssa.gov/disability/professionals/bluebook/
Social Security	www.ssa.gov/
MEDICAID AND MEDICARE INFORMATION	
Medicare & Medicaid	http://www.cms.gov
Medicare	www.medicare.gov
ORGANIZATIONS-PRIVATE	
Alzheimer's Association	www.alz.org
American Assoc. of Retired Persons	www.aarp.org
Aging Life Care Ass'n formerly National Assn of Professional Geriatric Care Mgrs	www.aginglifecare.org
ARCIL-disability assistance in Travis Co. area	www.arcil.com
The Arc of Texas-MR & DD	www.thearcoftexas.org/
Texas Housing Counselor	www.texashousingcounselor.org/
Disability Rights Texas, formerly Advocacy, Inc. in Austin	www.disabilityrightstx.org
GOVERNMENT AGENCIES	
Texas Health & Human Services	https://hhs.texas.gov/
Texas Dept. of Aging and Disability Services	www.dads.state.tx.us
Texas Dept. of State Health Services	www.dshs.state.tx.us
Texas Dept. of Assistive and Rehabilitative Services	www.dars.state.tx.us (defunct—programs transferred to TWC and HHSC)
Texas Dept. of Family and Protective Services	www.dfps.state.tx.us
National Institute on Aging	www.nia.nih.gov

U.S Department of Health and Human Services—Administration on Aging	www.aoa.gov
U.S. Dept. of HUD	http://portal.hud.gov/hudportal/HUD?src=/topics/information_for_senior_citizens
Housing Authority of the City of Austin	www.hacanet.org
Veterans Administration	www.va.gov
HEALTH INFORMATION, GENERAL	
	www.cdc.gov (including AIDS information)
	www.healthfinder.gov
INSURANCE, HEALTH	
Texas Dept of Insurance (consumer information)	http://www.tdi.texas.gov/consumer/index.html
Children's Medicaid and the Children's Health Insurance Program	http://www.chipmedicaid.org/
Texas Health Insurance Risk Pool	www.txhealthpool.com/benefits.html
LAW, FEDERAL	
Federal statutes	http://www.loc.gov/law/help/statutes.php
Federal regulations	http://www.ecfr.gov/
LAW, TEXAS	
Texas regulations	http://texreg.sos.state.tx.us/public/readtac$ext.viewtac
Texas Legislation	www.legis.state.tx.us/
Texas Statutes	http://www.statutes.legis.state.tx.us/
LEGAL RESOURCES, ELDER LAW	
Elder Law as a profession	www.naela.org
Elder Law information and links	www.elderlawanswers.com
Probate	www.texasprobate.com
LEGAL RESOURCES, GENERALLY	
State Bar	www.texasbar.com
Texas Legal Services Center	www.tlsc.org

Agency Manuals

HHSC publishes these handbooks (among others) on their website at https://hhs.texas.gov/laws-regulations/handbooks.

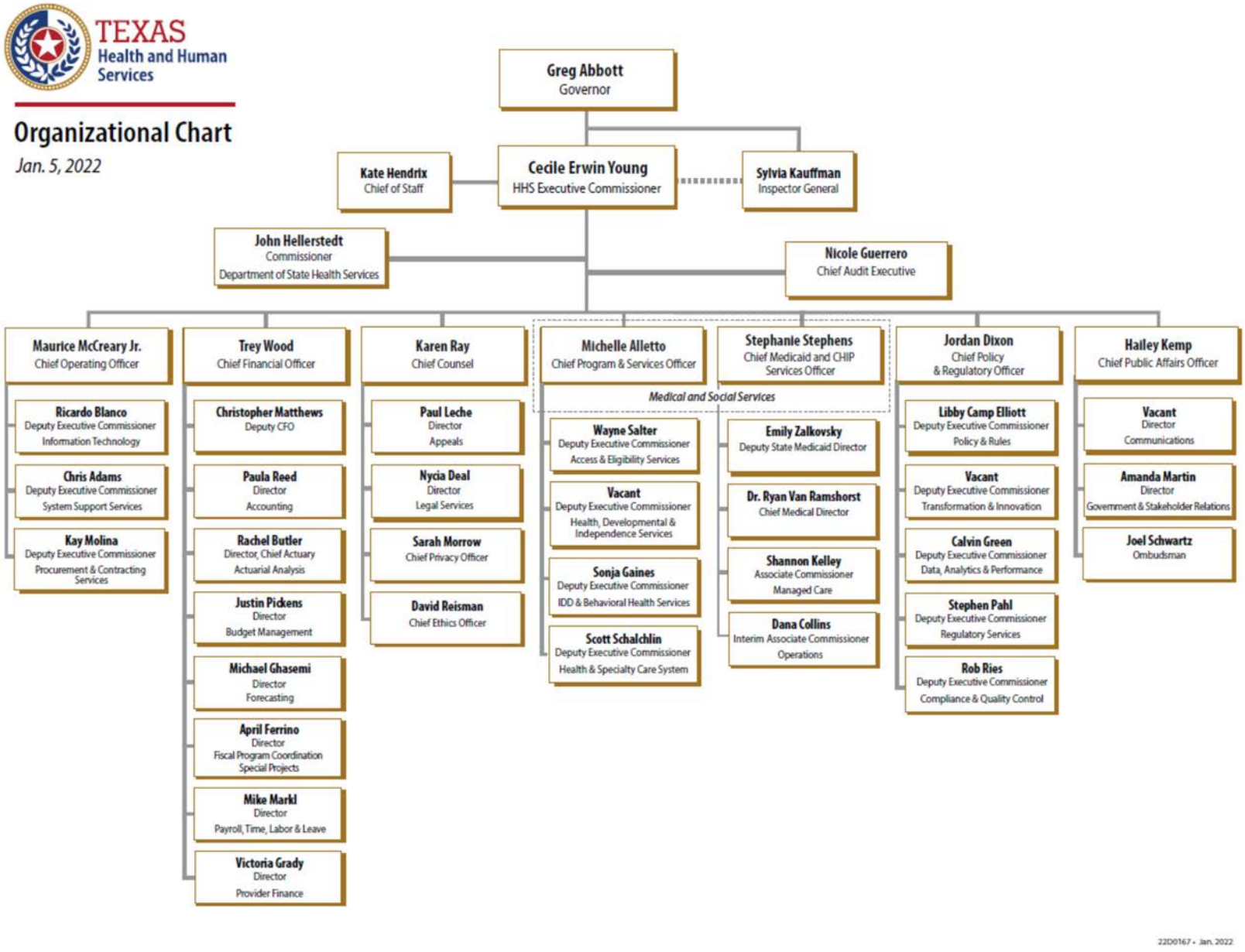
HANDBOOK	WEBSITE
STAR+PLUS Handbook	https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook
Texas Works Handbook	https://hhs.texas.gov/laws-regulations/handbooks/texas-works-handbook
Medicaid for the Elderly and People with Disabilities (MEPD) Handbook	https://hhs.texas.gov/laws-regulations/handbooks/medicaid-elderly-and-people-disabilities-handbook
Case Manager Medically Dependent (MDC) Children Program Handbook	https://hhs.texas.gov/laws-regulations/handbooks/case-manager-medically-dependent-children-program-handbook
Community Living Assistance and Support Services (CLASS) Provider Manual	https://hhs.texas.gov/laws-regulations/handbooks/community-living-assistance-and-support-services-provider-manual
Deaf Blind with Multiple Disabilities (DBMD) Program Manual	https://hhs.texas.gov/laws-regulations/handbooks/deaf-blind-multiple-disabilities-dbmd-program-manual
Home and Community-based Services (HCS) Handbook	https://hhs.texas.gov/laws-regulations/handbooks/home-and-community-based-services-handbook
Community Care for Aged and Disabled Handbook	https://hhs.texas.gov/laws-regulations/handbooks/case-manager-community-care-aged-and-disabled-handbook
Fair and Fraud Hearings Handbook	https://hhs.texas.gov/laws-regulations/handbooks/fair-and-fraud-hearings-handbook
Nursing Facility Requirements for Licensure and Medicaid Certification Handbook	https://hhs.texas.gov/laws-regulations/handbooks/nursing-facility-requirements-licensure-and-medicaid-certification-handbook

APPENDIX 7: HHSC Regional Directors

Region	Regional Director			Administrative Assistant
01	Beth Miller	Office:	1-806-783-6637	
LUBBOCK	6302 Iola Avenue	FAX:	1-806-783-6630	1-806-783-6632
	Lubbock, TX 79424	Mail-Code:	217-1	
	Amarillo: 1-806-356-3151	Toll-Free:	1-877-541-7905	
02/09	Sandra McKinney	Office:	1-325-795-5526	
ABILENE	4601 South First Street	FAX:	1-325-795-5523	1-325-795-5522
	Abilene, TX 79604	Mail-Code:	001-1	
	PO Box 521 Abilene, TX 79604	Toll-Free:	211 1-877-541-7905	
03	Tracy Hays	Office:	1-972-337-6171	
GRAND PRAIRIE	801 South State Hwy 161	FAX:	1-972-337-6298	1-972-337-6166
	Grand Prairie, TX 75051	Mail-Code:	012-5	
	PO Box 532089 Grand Prairie, TX 75053-2089	Toll-Free:	211 1-877-541-7905	
04	Fay Booker	Office:	1-903-509-5142	
TYLER	302 East Rieck Road	FAX:	1-903-509-5133	1-903-509-5125
	Tyler, TX 75703	Mail-Code:	313-5	
		Toll-Free:	211 1-877-541-7905	
05	Stephanie Semien	Office:	1-409-951-3425	
BEAUMONT	350 Pine Street, 9th Floor	FAX:	1-409-951-3449	1-409-730-4027
	Beaumont, TX 77701	Mail-Code:	028-1	
		Toll-Free:	211 1-877-541-7905	
06	Gracie Perez	Office:	1-713-767-2417	
HOUSTON	5425 Polk Street, Suite 230	FAX:	1-713-767-2323	1-713-767-3177
	Houston, TX 77023	Mail-Code:	178-7	
	PO Box 16017 Houston, TX 77222-6017	Toll-Free:	211 1-877-541-7905	
07	Sandra Dillett	Office:	1-512-832-7617	
AUSTIN	4616-1 West Howard Lane, Suite 120	FAX:	1-512-832-7665	1-512-832-7692
	Austin, TX 78728	Mail-Code:	016-1	
		Toll-Free:	211 1-877-541-7905	
08	Teriann Lyons	Office:	1-210-619-8226	
SAN ANTONIO	11307 Roszell	FAX:	1-210-619-8293	1-210-619-8019
	San Antonio, TX 78217	Mail-Code:	279-4	
	PO Box 23990 San Antonio, TX 78223	Toll-Free:	211 1-877-541-7905	
10	Kate Hill	Office:	1-915-834-7580	
EL PASO	401 East Franklin	FAX:	1-915-834-7582	1-915-834-7581

	El Paso, TX 79901	Mail-Code:	111-1	
	PO Box 981017 El Paso, TX 79998-1017	Toll-Free:	211 1-877-541-7905	
11 **EDINBURG**	Cynthia Pena	Office:	1-956-316-8272	
	2520 South Veterans Road	FAX:	1-956-316-8175	1-956-316-8277
	Edinburg, TX 78539	Mail-Code:	108-1	
	PO Box 960 Edinburg, TX 78540-0960	Toll-Free:	211 1-877-541-7905	1-956-316-8361
ART & CUSTOMER CARE CENTER	Debra Gault	Office:	1-713-696-2380	
	1457 E 40th St	FAX:	1-956-316-8175	1-979-282-6519
	Houston, TX 77022	Mail-Code:	945-1	
MEPD	Rachel Patton	Office:	1-512-908-9431	
	1601 Rutherford Lane	FAX:		1-903-927-0280
	Austin, TX 78754	Mail-Code:	227-1	

APPENDIX 8: HHSC Organizational Chart



APPENDIX 9: CHECKLIST FOR TERMINATION OF SPECIAL NEEDS TRUST WITH MEDICAID PAYBACK PROVISION

These instructions apply only to termination of a trust requiring payment to the Medicaid program when the trust is terminated, which is usually at the death of the beneficiary. They should not be used for the purpose of making distributions from any other kind of trust or from the estate of a decedent.

Follow these instructions in the order indicated:

1. Pay the following: (a) taxes due from the trust to a state or federal government due to the death of the beneficiary; and (b) reasonable fees of the trustee and professionals (for example, attorney and accountant) for administration of the trust estate, such as accounting of the trust to a court, completion and filing of documents, or other related actions associated with termination and wrapping up of the trust.
2. Generally, debts incurred by the trustee for the administration of the trust or for the benefit of the beneficiary may be paid—for example, medical and personal care expenses and other types of support of the beneficiary provided at the trustee's request. However, debts incurred by the beneficiary personally should not be paid from the trust unless and until the Medicaid claim has been fully paid.
3. In some cases, Medicaid programs have raised an issue as to whether long-delayed payments should have been made. For example, in one case, the parents of the beneficiary had provided 24-hour care to him over a long period of time and were paid only after his death, leaving almost nothing to be paid to Medicaid.[631] The Medicaid program objected on the ground that the parents provided the care out of love for their child, not intending to be paid. However, the court found the parents had intended to be paid and left the money in the trust just in case it was needed later. However, in a similar case, another court held for the Medicaid program.[632]

Payment of the following expenses is not permitted before repaying Medicaid:

- Taxes due from the estate of the beneficiary other than those arising from inclusion of the trust assets in the estate for tax purposes;
- Inheritance taxes due for residual beneficiaries;
- Payment of debts owed to third parties;
- Funeral and related expenses; or
- Payments to remainder beneficiaries.

4. Pay all Medicaid claims. It is no longer necessary to obtain Medicaid claims from all three possible Texas payers (TMHP, HHSC, MCOs). Instead, send a written request with subject line "Letter of Representation re trustee for [Beneficiary Name], SSN *, Date of Death */*/*" by postal mail or fax to Texas Medicaid & Healthcare Partnership (TMHP), TPL/Tort Division, P. O. Box 202948, Austin, TX 78720–2948. Other contact information: Phone: 512–506–7546 or 800- 846–7307 Option 3, Fax 512–514–4225. If you are seeking Medicaid claim information on behalf of a living person, also send Form 6700, Use and Release of Health Information, at https://hhs.texas.gov/laws-regulations/forms/6000-6999/form-6700-use-release-health-information-authorization .

[631] State v. Hammans, 870 N.E.2d 1071 (Ind. Ct. App. 2007).

[632] Shelf v. Wachovia Bank, No. COA 10–1510 (N.C. Ct. App. June 21, 2011).

Note: The same payment instructions apply not only to Special Needs Trusts but to all other reimbursements to Texas Medicaid, including MERP, QITs and annuities naming the Medicaid program as a beneficiary.

5. When Medicaid claims (or statements saying there is no claim) have been obtained from all 3 payers, pay each one that asserts a claim. If there are two or three claims and not sufficient funds to pay all, pay them pro rata—that is, the percent of total funds paid to each claimant is equal to the ratio of that claimant's claim to the total claims.

6. If funds remain after paying Medicaid, pay all debts of the beneficiary other than Medicaid: funeral expenses, medical, credit cards, unsecured loans, etc. If there are not sufficient funds to pay all, pay them according to priorities of claims in probate as advised by your attorney. Be sure assets of the decedent outside the trust are applied to such debts, as well as assets of the trust if any remain.

   If any assets remain, pay remainder beneficiaries as provided in the trust.

APPENDIX 10: DRAFTING FOR USE OF POOLED TRUSTS

TRUST INSTRUMENT—POOLED TRUST AS SUCCESSOR TRUST

The trustee may direct the corpus of this trust, or whatever portion of the corpus of this trust as the trustee deems appropriate, into a pooled trust managed by a non-profit organization, should the trustee, in the trustee's sole discretion, believe that such arrangement is in the best interests of BENEFICIARY. In such case, the trustee may establish an account to benefit BENEFICIARY, funded or partially funded with part of or all the corpus of this trust, designating the same remainder beneficiaries as this trust. The trustee is authorized but not required to select Trust III of the Arc of Texas Master Pooled Trust established December 2, 2000 for this purpose.

TRUST INSTRUMENT—POOLED TRUST AS SUBSTITUTE TRUST

If CADENCE TRUST declines to accept trusteeship of the BENEFICIARY TRUST, BENEFICIARY's share shall be paid to a pooled trust managed by a non-profit organization to be selected by my executor. My executor is authorized but not required to select Trust III of the Arc of Texas Master Pooled Trust established December 2, 2000 for this purpose. Remainder beneficiaries of the joinder agreement shall be the same as those designated in the trust instrument establishing the BENEFICIARY TRUST.

WILL OR REVOCABLE TRUST—POOLED TRUST AS FIRST CHOICE, SUBACCOUNT ALREADY ESTABLISHED

Provided, the share of BENEFICIARY shall not be distributed to him directly but rather shall be reduced to cash and the cash distributed to the subaccount I am establishing in Trust III of the Arc of Texas Master Pooled Trust, dated December 2, 2000, by the Joinder Agreement I have signed the same date as this will for that purpose; or if I sign a new or amended Joinder Agreement for BENEFICIARY's benefit after the date of this will, this gift shall go into the account governed by the most recent such Joinder Agreement as of the time of my death. If a pooled trust sub-account so established is terminated at a future time due to discontinuation of the pooled trust or for any other reason, the assets in the sub-account that were originally directed from this trust shall be distributed to a different pooled trust or to a new individual trust with provisions as to distributions substantially similar to this trust and with the same representatives and remainder beneficiaries as the pooled-trust subaccount. If for any reason I have not established a pooled trust subaccount for the benefit of BENEFICIARY at the time of my death that can be used for this purpose, my executor shall establish one and fund it as provided in this paragraph. In that case, remainder beneficiaries identified in the joinder agreement shall be the same persons and entities who would take the share of BENEFICIARY under this will if he died before me.

WILL OR REVOCABLE TRUST—POOLED TRUST AS FIRST CHOICE, SUBACCOUNT TO BE ESTABLISHED LATER

Provided, BENEFICIARY's share shall not be distributed to him directly but rather to an account for his benefit in a pooled trust managed by a non-profit organization to be selected by my executor. If I establish such an account for BENEFICIARY's benefit, it shall be used for that purpose. Otherwise, my executor is authorized but not required to select Trust III of the Arc of Texas Master Pooled Trust established December 2, 2000 for this purpose. Remainder beneficiaries of the joinder agreement shall be the same persons and entities who would take the share of BENEFICIARY under this will if he died before me. If a pooled trust sub-account so established is terminated at a future time due to discontinuation of the pooled trust or for any other reason, the assets in the sub-account that were originally directed from this trust shall be distributed to a different pooled trust or to a new individual trust with provisions as to distributions substantially similar to this trust and with the same representatives and remainder beneficiaries as the pooled-trust subaccount.

SUGGESTED ATTACHMENT TO JOINDER AGREEMENT

Continuation of item K.2. (Third Party Subaccount in Arc of Texas Master Pooled Trust - Trust III):

If it becomes impossible or impracticable to fulfill the conditions of the Trust with regard to the Beneficiary for reasons other than the death of the Beneficiary, the Trustee shall take these actions in the following order of preference:

- Transfer the funds into a subaccount in another pooled trust with provisions as to distributions substantially similar to this trust and with the same representatives and remainder beneficiaries as the pooled-trust subaccount; or
- Transfer the funds to an individual trust for the Beneficiary established by one of the persons named herein as potential representatives with provisions as to distributions substantially similar to the pooled trust and with the same representatives and remainder beneficiaries as the pooled-trust subaccount; or
- Seek and follow the counsel of Family Eldercare, Inc. as to the best way of managing the funds for the benefit of the Beneficiary; or
- Transfer the funds to the Beneficiary or for his benefit, preferably to a trustee, guardian, power of attorney agent or other fiduciary, under an arrangement determined by The Arc of Texas to be in the Beneficiary's best interests.

APPENDIX 11: LIST OF MEANS-TESTED PUBLIC BENEFIT PROGRAMS IN TEXAS

Source of this list: Texas Works Handbook C-1150 at https://hhs.texas.gov/laws-regulations/handbooks/twh/part-c-appendix/section-1100-othermiscellaneous#C1150. Some long descriptions have been replaced or supplemented. The Sources of Law & Policy column is added by the authors.

Codes: TA means Type Assistance, TP means Type Program. Knowing program codes can be important because information like income limits in HHS handbooks sometimes identifies programs only by their codes.

Sources of Law & Policy: These are organized according to the priority the authors think agency employees generally set: agency handbooks (mostly policy, not law) then Texas rules then federal rules then federal statutes. That is the opposite of the priority judges place on sources of law. Therefore, one of the tools of advocacy is to start with the agency's policy and if it is adverse to the client's interests, determine whether it is contrary to the law and therefore subject to legal challenge.

Abbreviations:

MEPD HB: Medicaid for the Elderly and People with Disabilities Handbook (the primary source of policy for long-term care Medicaid programs) at https://hhs.texas.gov/laws-regulations/handbooks/mepd/medicaid-elderly-people-disabilities-handbook
TWH: Texas Works Handbook (the primary source of policy most programs listed other than long-term care Medicaid), at https://hhs.texas.gov/laws-regulations/handbooks/twh/texas-works-handbook
TAC: Texas Administrative Code (Texas rules) at https://texreg.sos.state.tx.us/public/readtac$ext.viewtac
CFR: Code of Federal Regulations (federal rules) at https://www.govinfo.gov/app/collection/cfr/
SNAP: Supplemental Nutrition Assistance Program (aka Food Stamps)
TANF: Temporary Assistance for Needy Families (tiny cash payments, formerly called AFDC or "welfare")

Explanation of some mysterious references in this list:

"Emergency" programs: The term "emergency Medicaid" is commonly misunderstood to mean that anyone needing emergency medical care can get Medicaid. There is no such program. TP 08 allows a parent or caretaker relative to qualify earlier than they ordinarily would (at date of birth instead of beginning of month of application) when a birth is involved. Likewise, the other "emergency" programs not involving aliens require that all resource, income and medical need requirements be met for *some* Medicaid program and simply allow earlier eligibility than if no emergency was involved—that is, eligibility is retroactive to time of birth or other emergency rather than at application month. Those programs are believed to have been developed so that aliens eligible for Medicaid under TP 30 due to an emergency (typically child birth) would not enjoy earlier eligibility than citizens and qualified aliens. And aliens also must meet the requirements for some Medicaid program (such as SSI-linked or pregnant woman Medicaid) to qualify for TP 30.

"Presumptive" eligibility: Presumptive eligibility is a Medicaid option that allows states to enroll applicants in Medicaid for a limited period of time before a full citizenship or legal immigrant eligibility determination is complete. Thus, an applicant may start in TA 66 and move to TA 67 when citizen or qualified alien status has been confirmed. "Presumptive" eligibility is determined by providers. "Short-term" just means the "presumptive" label is removed when the applicant's status as a citizen or qualified alien is documented by the agency.

"Manual" programs: For example, "Manual SSI Waivers" identifies HCBS waiver programs in which SSI eligibility is one of several other programs required for eligibility for the waiver program. There are some situations in which the SSI eligibility does not show up in the usual way on the automated system so must be confirmed "manually" in other ways.[633]

Tool for Advocacy
Knowing that some SSI beneficiaries are not in the online system may help advocates know what to say when a client says she is eligible for SSI but a Medicaid worker cannot confirm it: "Try the manual certification procedure."

"Spend-down": Attorneys are usually referring to reduction of *resources* (countable assets) when they speak of "spending down." However, in the "medically needy" program descriptions below, that term refers to *income.* Those programs have very low income limits, but a person or family with higher income by any other definition can meet the "medically needy" income requirement by paying monthly on their medical expenses. That is because the amount paid on medical debt is subtracted from total income for the purpose of meeting the "medically needy" income requirement.

"Rider 51": Rider 51 to the General Appropriations Act of the 2017 Legislature establishes a Community Integration Measures project designed to gather data to assess the STAR+PLUS HCBS and STAR Kids MDCP program compliance with federal HCBS rules concerning community integration. Programs to implement it provide no benefits to individuals.

***Identification of authorship*:** Text in *italics* in the table below was added to the HHSC handbook text by the authors of this paper.

SNAP, TANF and Medical Programs/Assistance[634]

SNAP *(Supplemental Nutrition Assistance Program, aka Food Stamps)*

Code	Description	Long Description	*Sources of Law & Policy*
TA 51	SNAP-CAP/FS-CAP	Supplemental Nutrition Assistance Program Combined Application Project	*Texas Works Handbook Sec. C-120-123, C-1341, C-1431; 7 C.F.R. §§ 273.8, 273.9*
TA 52	SNAP-SSI/FS-SSI	Supplemental Nutrition Assistance Program Supplemental Security Income	
TP 06	SNAP (PA)/FS-PA	Supplemental Nutrition Assistance Program Public Assistance	
TP 09	SNAP/FS-NPA	Supplemental Nutrition Assistance Program	*See Above*

TANF

Code	Description	Long Description	*Sources of Law & Policy*
TP 01	TANF Basic	Cash assistance for caretakers and deprived children with income below TANF recognizable needs	*Texas Works Handbook Sec. C-110-112.1, C-1150; 1 TAC Chapter 372*
TP 60	TANF Grandparent Payment	One-time payment for grandparent who is caretaker of their TANF-certified grandchild	

[633] MEPD Handbook H-6210 at https://www.hhs.texas.gov/book/export/html/4454 .

[634] Texas Works Handbook C-1150 at https://hhs.texas.gov/laws-regulations/handbooks/twh/part-c-appendix/section-1100-othermiscellaneous#C1150.

Code	Description	Long Description	*Sources of Law & Policy*
TP 61	TANF State Program	Cash assistance for two-parent household with income below TANF recognizable needs	
TP 71	OTTANF – 1 Adult	One-Time TANF (OTTANF) payment for households with one parent	
TP 72	OTTANF – 2 Parents	OTTANF payment for households with two parents	

Medical Programs/Assistance — Texas Works

Code	Description	Long Description	*Sources of Law & Policy*
TA 31	MA – Parents and Caretaker Relatives – Emergency	***PARENT & CARETAKER RELATIVES MEDICAID:*** Medicaid for an emergency condition for parents and caretaker relatives who do not meet alien status requirements and are caring for a dependent child who receives Medicaid *Eligibility may be child's date of birth even if it is earlier than month of application, if the applicant would have been eligible for Medicaid as a pregnant woman from the first day of her infant's birth month.*	*Texas Works Handbook Sec. A-820 (what "emergency" means), C-131.2(income limits), citing definition of "emergency" in TWH Glossary*
TA 41	Health Care – Healthy Texas Women	***HEALTHY TEXAS WOMEN'S MEDICAID:*** for women age 15–44 with income at or below the applicable income limit *(200% of Federal Poverty Level)*. Purposes: avert unintended pregnancies; positively affect the outcome of future pregnancies; and positively impact the health and wellbeing of women and their families—without elective abortions.	*Texas Works Handbook Part W; 1 TAC Chapter 382 Subchapter A; Texas Human Resources Code §32.024(c-1) (funded only by the State so no federal statute involved but subject to provisions of the U. S. Constitution regarding the right to elective abortion)*
TA 66 **TA 67**	MA – MBCC – Presumptive MA – MBCC	***MEDICAID FOR BREAST AND CERVICAL CANCER*** *There is no resource (asset) limit for either Medicaid for Breast and Cervical Cancer program.*[635]	*Breast and Cervical Cancer Services Policy and Procedure Manual at https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/Breast-and-Cervical-Cancer-Services-Policy-and-Procedure-Manual.pdf.; Texas Works Handbook Part X; 1 TAC Ch. 366 Subch D*

[635] Texas Works Handbook X-1310 at https://www.hhs.texas.gov/laws-regulations/handbooks/twh/part-x-medicaid-breast-cervical-cancer-mbcc/section-1300-resources

Code	Description	Long Description	*Sources of Law & Policy*
TA 74	MA – Children Under 1 Presumptive	***CHILDREN'S MEDICAID:*** Short-term Medicaid for children under age 1 with income at or below the applicable income limit	*1 TAC Ch. 366 Subch E, §366.507* *Texas Works Handbook § A-1341 sets out the steps for determining who is in the "household," and MAGI income is determined. Texas Works Handbook C-131.1 shows the income limits for the various Children's Medicaid programs using only Federal Poverty Level, and Texas Works Handbook C-131.4 shows how much is added to each size household (5% of FPL for that size household). Children's Medicaid has no resource limit.*
TA 75	MA – Children 1–5 Presumptive	***CHILDREN'S MEDICAID:*** Short-term Medicaid for children ages 1–5 with income at or below the applicable income limit	
TA 76	MA – Children 6–18 Presumptive	***CHILDREN'S MEDICAID:*** Short-term Medicaid for children ages 6–18 with income at or below the applicable income limit	
TA 77	Health Care – FFCHE	***FORMER FOSTER CARE IN HIGHER EDUCATION MEDICAID:*** Health Care for Former Foster Care in Higher Education with income at or below the applicable income limit	*Texas Works Handbook Part F*
TA 82	MA – Former Foster Care Children	***FORMER FOSTER CARE MEDICAID:*** Medicaid for former foster care children ages 18–25	*1 TAC Ch. 366 Subch. J; 42 U.S.C. §1396a(a)(10)(A)(i)(IX)*
TA 83	MA – FFCC Presumptive		
TA 84	CI – CHIP	***CHILDREN'S HEALTH INSURANCE PROGRAM***: The Children's Health Insurance Program (CHIP) is health care coverage for children under age 19 who are ineligible for Medicaid due to income and who have income at or below the applicable income limit. *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.*[636] *The CHIP income limit under the Texas rules is 200% of the federal poverty level, determined under MAGI methodology.* [637] *Children who qualify for CHIP receive health insurance coverage comparable to*	*Texas Works Handbook Part D; 1 TAC Chapter 370; Texas Health and Safety Code, Chapters 62 and 63; 42 U.S.C. §§1397aa, et seq.*

[636] 1 T.A.C. § 370.809.

[637] 1 T.A.C. § 370.805. See also Texas Works Handbook § C-131.1 .

Code	Description	Long Description	*Sources of Law & Policy*
		that available to state employees and their families.[638] *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.*[639] *All families must pay co-pays, but most of these range from only $3 to $35 depending on the family's income and the type of service received.* [640]	
TA 85	CI – CHIP perinatal	***CHILDREN'S HEALTH INSURANCE PROGRAM*:** CHIP perinatal is health care coverage for unborn children whose mother is ineligible for Medicaid or CHIP due to income and/or immigration status and whose income is at or below the applicable income limit	*Texas Works Handbook Part D; 1 TAC 370.401*
TA 86	MA – Parents and Caretaker Relatives Presumptive	***PARENT & CARETAKER RELATIVES MEDICAID:*** Short-term Medicaid for parents and caretaker relatives caring for a dependent child	*Texas Works Handbook Sec. A-221, A-820, C-111, C-131.2*
TP 07	MA – Earnings Transitional	***EARNINGS TRANSITIONAL MEDICAID:*** Twelve months of transitional Medicaid resulting from an increase in earnings	*Texas Works Handbook Sec. A-840*
TP 08	MA – Parents and Caretaker Relatives	***PARENT & CARETAKER RELATIVES MEDICAID:*** Medicaid for parents and caretaker relatives caring for a dependent child with income at or below the applicable income limit	*Texas Works Handbook Sec. A-221, A-820, C-111, C-131.2*
TP 20	MA Alimony/Spousal Support Transitional	***ALIMONY/CHILD SUPPORT TRANSITIONAL MEDICAID:*** Up to four months of post Medicaid resulting from an increase in alimony/spousal support. *Individuals denied TP 08 because of new or increased alimony or spousal support can keep their Medicaid for up to four months longer.*	*Texas Works Handbook Sec. A-851*

638 42 U.S.C. § 1396u-7(b)(1).

639 1 T.A.C. §§370.321, 370.325. Tex. Health & Human Services, CHIP and Children's Medicaid http://www.chipmedicaid.org/.

640 Tex. Health & Human Services, CHIP and Children's Medicaid, http://www.chipmedicaid.org/en/Costs.

Code	Description	Long Description	*Sources of Law & Policy*
TP 32	MA – MN-Medically Needy w/Spend Down – Emergency	***MEDICALLY NEEDY MEDICAID:*** Medicaid for an emergency condition for children or pregnant women who do not meet alien status requirements and who are ineligible for any other type of Medicaid, but who have medical expenses that spend down their income to below the Medically Needy Income Limit (MNIL) *This allows for a family to meet the income eligibility requirements by "spending down" the excess income on certain medical expenses. Under the Affordable Care Act, there is no resource limit.*	*Texas Works Handbook Sec. A-820, C-131.2, citing definition of "emergency" in TWH Glossary; 1 T.A.C. Chapter 366, Subch. H; 42 C.F.R. § 435.831(d).*
TP 33	MA – Children 1–5 – Emergency	***CHILDREN'S MEDICAID:*** Medicaid for an emergency condition for children age 1–5 who do not meet alien status requirements and who have income at or below the applicable income limit	*1 TAC Ch. 366 Subch E, §366.507 Texas Works Handbook § A-1341 sets out the steps for determining who is in the "household," and MAGI income is determined. Texas Works Handbook C-131.1 shows the income limits for the various Children's Medicaid programs using only Federal Poverty Level, and Texas Works Handbook C-131.4 shows how much is added to each size household (5% of FPL for that size household). Children's Medicaid has no resource limit..*
TP 34	MA – Children 6–18 – Emergency	***CHILDREN'S MEDICAID:*** Medicaid for an emergency condition for children age 6–18 who do not meet alien status requirements and who have income at or below the applicable income limit	
TP 35	MA – Children Under 1 – Emergency	***CHILDREN'S MEDICAID:*** Medicaid for an emergency condition for children under age 1 who do not meet alien status requirements and who have income at or below the applicable income limit	
TP 36	MA – Pregnant Women – Emergency	***PREGNANT WOMEN'S MEDICAID:*** Medicaid for an emergency condition for pregnant women who do not meet alien status requirements and who have income at or below the applicable income limit	*1 TAC CH. 366 Subch B, C*
TP 40	MA – Pregnant Women	***PREGNANT WOMEN'S MEDICAID:*** Medicaid for pregnant woman with income at or below the applicable income limit. *There is no resource limit.*	
TP 42	MA – Pregnant Women Presumptive	***PREGNANT WOMEN'S MEDICAID:*** Short-term Medicaid for pregnant women with income at or below the applicable income limit. *There is no resource limit.*	
TP 43	MA – Children Under 1	***CHILDREN'S MEDICAID:*** Medicaid for children under age 1 with income at or below the applicable income limit. *There is no resource limit.*	*1 TAC Ch. 366 Subch E, §366.507*

Code	Description	Long Description	*Sources of Law & Policy*
TP 44	MA – Children 6–18	***CHILDREN'S MEDICAID:*** Medicaid for children age 6–18 with income at or below the applicable income limit. *There is no resource limit.*	
TP 45	MA – Newborn Children	***CHILDREN'S MEDICAID:*** Medicaid for children through age 1 who are born to a Medicaid-eligible mother. *There is no resource limit.*	
TP 48	MA – Children 1–5	***CHILDREN'S MEDICAID:*** Medicaid for children age 1–5 with income at or below the applicable income limit. *There is no resource limit.*	
TP 56	MA – MN w/Spend Down	***MEDICALLY NEEDY MEDICAID:*** Medicaid for children or pregnant women who are ineligible for any other type of Medicaid, but who have medical expenses that spend down their income to below the MNIL *(Medically Needy Income Limit)*	*Texas Works Handbook Sec. A-820, C-131.2; 1 T.A.C. Chapter 366, Subch. H*
TP 70	Medicaid for the Transitioning Foster Care Youth	***TRANSITIONING FOSTER CARE MEDICAID:*** Medicaid for Transitioning Foster Care-Ages 18-20 with income at or below the applicable income limit *The "transition" referenced is the movement when a child in foster care reaches age 18 from Medicaid eligibility connected to the foster care to termination of that eligibility.*	*1 TAC Ch. 366 Subch. F*
TPAL	MA – Historical FMA – Emergency	N/A	*(Not found)*
TPDE	MA – Deceased Prior Medical	***DECEASED PRIOR MEDICAID:*** Medicaid for a deceased person *for medical services during lifetime*	*Texas Works Handbook 831.2*
TPPM	MA/ME – Historical Prior Medical	***THREE MONTHS PRIOR MEDICAID:*** Three months of prior Medicaid – not currently eligible	*Texas Works Handbook 831.2*

Medical Programs/Assistance — Texas Department of Family and Protective Services

Code	Description	Long Description	*Sources of Law & Policy*
TP 52	MA – State Foster Care – A	***FOSTER CARE MEDICAID***	*1 TAC Ch 366 Subch F; Texas Human Resources Code §32.0247; 2 U.S.C. §1396d(w); 42 U.S.C. §1396a(10)(A)(ii)(XVII); 42 U.S.C. §677)*
TP 53	MA – State Foster Care – B		
TP 54	MA – State Foster Care – 32		
TP 57	MA – State Foster Care – D		
TP 58	MA – State Foster Care – JPC		
TA 78	PCA Medicaid – Federal Match – No Cash		

TA 79	PCA Medicaid – No Federal Match – No Cash	***PERMANENCY CARE MEDICAID***	*Child Protective Services Handbook Parts 1600-1700. "Permanency care assistance is provided to persons who assume managing conservatorship of a child who was previously in the temporary or permanent managing conservatorship of DFPS."*[641]
TA 80	PCA Medicaid – Federal Match – With Cash		
TA 81	PCA Medicaid – No Federal Match – With Cash		
TP 88	MA – Non-AFDC Foster Care – JPC		
TP 90	MA – State Foster Care		
TP 91	Adoption Assistance – Federal Match – No Cash		
TP 92	Adoption Assistance – Federal Match – With Cash		
TP 93	Foster Care – Federal Match – No Cash		
TP 94	Foster Care – Federal Match – With Cash		
TP 95	Adoption Assistance – No Federal Match – No Cash		
TP 96	Adoption Assistance – No Federal Match – With Cash		
TP 97	Foster Care – No Federal Match – No Cash		
TP 98	Foster Care – No Federal Match – With Cash		
TP 99	MA – Non-AFDC Foster Care		
TPAS	MA – Historical Adoption Subsidy		

Medical Programs/Assistance — Medicaid for the Elderly and People with Disabilities

Code	Description	Long Description	*Sources of Law & Policy*
TA 01	ME – Interim SSI Denied Child	Medicaid (processed by SSA)	*1 TAC 358.107(b)(8)--Obsolete*
TA 02	ME – SSI Waivers	SSI Recipient Waivers	*(Not found—"SSI Waiver" appears nowhere else in any Texas Medicaid-related handbook. We presume this is obsolete.*
TA 03	ME – Manual SSI Waivers	Manual SSI Waivers	
TA 04	ME – Manual SSI State Group Home	***GROUP HOME MEDICAID:*** Manual SSI Recipient State Community-based Group Homes	*40 TAC Part 1 Chapter 9 Subchapter D*

641 https://www.dfps.state.tx.us/handbooks/CPS/default.asp

Code	Description	Long Description	*Sources of Law & Policy*
TA 05	ME – Manual SSI Non-State Group Home	***GROUP HOME MEDICAID*** Manual SSI Recipient Non-State Community-based Group Homes	*Group homes include Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID facilities),[642] 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.[643] 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 HHS, 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 2021, the income limit for an individual is $2,382).[644]* *In addition, the client must have been determined to have a disability by the Social Security Administration, as well as a determination of intellectual disability or a related condition.*
TA 06	ME – Manual SSI Nursing Facility	**NURSING FACILITY** **MEDICAID:** Medicaid for Nursing Facility Resident *This is often referred to as "Special Income Limit," i.e. 3 times SSI maximum rate*	*MEPD HB A-1300.* *The "Special Income Limit" can be avoided for nursing facility residents with a Qualified Income Trust under MEPD HB E-3315*

[642] TEX. HEALTH & SAFETY CODE Ch. 252; 26 T.A.C. Ch. 551.

[643] HCS group home information is at https://hhs.texas.gov/services/disability/intellectual-or-developmental-disabilities-idd-long-term-care .

[644] 40 T.A.C. § 9.236.

Code	Description	Long Description	*Sources of Law & Policy*
TA 07	ME – Manual SSI State Hospital	**STATE HOSPITAL MEDICAID:** Medicaid for State Hospital Resident[645]	*MEPD HB A-1100; 1 TAC 358.107(c)(1)); 42 CFR §435.211; 42 CFR §435.230*
TA 08	ME – SSI State Group Home	***GROUP HOME MEDICAID:*** SSI Recipient State Community Based Group Home	*Home & Community-Based Services Handbook at https://hhs.texas.gov/laws-regulations/handbooks/home-community-based-services-handbook; 40 TAC Part 1 Chapter 9 Subchapter D*
TA 09	ME – Manual SSI State Supported Living Center	***STATE SUPPORTED LIVING CENTER MEDICAID:*** Medicaid for State Supported Living Center Resident	*MEPD HB A-1100; 1 TAC 358.107(c)(1)); 42 CFR §435.211; 42 CFR §435.230*
TA 10	ME – Waivers-Listed below:	§1915(c) Medicaid waiver programs. Cover a person who would be eligible for Medicaid if institutionalized, but is living in the community and receiving services under a §1915(c) waiver program.	*MEPD HB A-1100; 1 TAC 358.107(c)(3)); 42 CFR §435.217; Social Security Act §1915(c)*
	Community Living Assistance Program (CLASS)	***CLASS WAIVER MEDICAID:*** Home care for individuals with intellectual disability or a related condition that manifested before age 22	*MEPD HB A-3310, O-1300; CLASS Provider Manual, https://hhs.texas.gov/laws-regulations/handbooks/classpm/community-living-assistance-support-services-provider-manual*
	Deaf, Blind with Multiple Disabilities Program (DBMD)	***DBMD WAIVER MEDICAID:*** Home care program serving individuals have both deafness and blindness and who have, in addition, one or more other disabling conditions.	*MEPD HB A-3320, O-1500; DBMD Program Manual at https://hhs.texas.gov/laws-regulations/handbooks/deaf-blind-multiple-disabilities-dbmd-program-manual*

[645] https://hhs.texas.gov/services/mental-health-substance-use/state-hospitals.

Code	Description	Long Description	*Sources of Law & Policy*
	Home and Community Services (HCS)	***HCS WAIVER MEDICAID***: Provides home care to individuals with a diagnosis of intellectual disability. Although it has a requirement of "must be living in the community," it also finances services of many small "group homes."	*MEPD HB A-3330, O-1600; HCS Handbook https://hhs.texas.gov/laws-regulations/handbooks/home-community-based-services-handbook*
	Youth Empowerment Services (YES)	***YOUTH EMPLOYMENT SERVICES MEDICAID:*** Intensive community-based services and supports for children with serious emotional disturbances and their families.	*MEPD HB A-3340, O-1400*
	Medically Dependent Children Program (MDCP)	***MDCP WAIVER MEDICAID***: Home care plus regular Medicaid benefits for children under age 21. When they reach 18, most beneficiaries qualify for SSI (because parents' income and resources are no longer deemed by SSI) and are transferred to SSI-related Medicaid (which includes home care under the Primary Home Care benefit). Those who still are not on SSI at age 21, or who need more care than Primary Home Care will provide, are usually transferred to the Star+Plus Waiver Program.	*MEPD HB A-3350, O-1700; Star Kids Handbook at https://hhs.texas.gov/laws-regulations/handbooks/skh/star-kids-handbook; Star Kids Program Support Unit Operational Support Handbook at https://hhs.texas.gov/laws-regulations/handbooks/skoph/star-kids-program-support-unit-operational-procedures-handbook*
	Texas Home Living (TxHmL)	***TEXAS HOME LIVING:*** Home and community services to supplement regular Medicaid services available to individuals eligible for Medicaid through SSI and other Medicaid programs who live in their own home or family home	*MEPD HB A-3370, O-1800; TxHmL Handbook at https://hhs.texas.gov/laws-regulations/handbooks/texas-home-living-txhml-program*

Code	Description	Long Description	*Sources of Law & Policy*
	Star+Plus Waiver (SPW) (formerly Community Based Alternatives)	***STAR+PLUS WAIVER MEDICAID***: Provides personal care services at home or in a licensed Assisted Living Facility. However, only a few Assisted Living Facilities are Medicaid certified, as discussed in more detail below. Among the HCBS waiver programs, this is the one almost always utilized by individuals over age 65.	*MEPD HB A-3380; Star+Plus Handbook Section 3000 (re SPW) at https://hhs.texas.gov/laws-regulations/handbooks/sph/starplus-handbook; and Star+Plus Program Support Unit Operational Procedures Handbook at https://hhs.texas.gov/laws-regulations/handbooks/spoph/starplus-program-support-unit-operational-procedures-handbook*
TA 12	ME – State Group Home	***ICF/IID FACILITY MEDICAID***: Medicaid for ICF/IID Residents	*MEPD HB A-1100; 1 TAC 358.107(c)(1)); 42 CFR §435.211; 42 CFR §435.230*
TA 15	ME – Rider 51 – Non-State Group Home	Medicaid for ICF/IID Residents	*Rider 51 to the General Appropriations Act of the 2017 Legislature establishes a Community Integration Measures project designed to gather data to assess the STAR+PLUS HCBS and STAR Kids MDCP program compliance with federal HCBS rules concerning community integration. Programs to implement it provide no benefits to individuals.*
TA 16	ME – Rider 51 – State Supported Living Center	Medicaid for State Supported Living Center Resident	*See Rider 51 summary above*
TA 17	ME – Rider 51 – Nursing Facility	Medicaid for Nursing Facility Resident	*See Rider 51 summary above*
TA 18	ME – Grandfathered LTC	N/A	
TA 21	ME – SSI Chest Hospital	***CHEST HOSPITAL MEDICAID***: Medicaid for Chest Hospital Patient	*MEPD HB A-1100; 1 TAC 358.107(c)(1)); 42 CFR §435.211; 42 CFR §435.230*
TA 22	ME – Manual SSI	***SSI-LINKED MEDICAID***: Manually certified SSI — processed by SSA	*MEPD HB A-2100; 1 T.A.C. 358.107(b)(1); 42 U.S.C. §1396a(a)(10)(A)(i)(I)*
TA 24	ME – Rider 51 – State Group Home		*See Rider 51 summary above*
TA 25	ME – Rider 51 – State Hospital		*See Rider 51 summary above*
TA 26	ME – SSI Non-State Group Home	***GROUP HOME MEDICAID:*** SSI Non-State Community-based Group Homes	*MEPD HB A-1100; 1 TAC 358.107(c)(1)); 42 CFR §435.211; 42 CFR §435.230*

Code	Description	Long Description	*Sources of Law & Policy*
TA 27	ME – Prior Medicaid Institutional/Waiver	***THREE MONTHS PRIOR MEDICAID*:** Prior Medicaid for person applying for Institutional or Waiver Medicaid; covers a person who would be eligible for SSI, if the person were not in an institutional setting.	*MEPD HB A-1100; 1 TAC 358.107(c)(1)); 42 CFR §435.211; 42 CFR §435.230* *MEPD HB Appendix XXX, Medical Effective Dates: MED is potentially the first day of any of the three months prior to the application file date. Use the **SSI income limit** for income eligibility purposes if the individual was **not** in the facility any part of the month*
TP 87	Medicaid Buy-In	***MEDICAID BUY-IN:*** Medicaid for a person with a disability who is working and earning income	*MEPD HB Chapter M; 1 TAC Chapter 360; 42 U.S.C. §1396a(a)(10)(A)(ii)(XIII)*
TA 88	ME – Medicaid Buy-In for Children	***MEDICAID BUY-IN FOR CHILDREN***: Medicaid benefits to eligible children with disabilities who are not eligible for Supplemental Security Income (SSI) for reasons other than disability. Individuals must pay a share of the Medicaid premium	*MEPD HB Chapter N; 1 TAC Chapter 361; 42 U.S.C. §1396a(cc)*
TP 03	ME – Pickle	***PICKLE PEOPLE MEDICAID***: "Pickle People"--denied SSI for any reason since April 1977; and meets current SSI eligibility criteria, if you don't count any Social Security COLA increases received after the person last received both SSI and Social Security benefits in the same month.	*MEPD HB A-1100, A-2330; 1 TAC 358.107(b)(5); 42 CFR §435.135(a) - (b)*
TP 10	ME – State Supported Living Center	***STATE SUPPORTED LIVING CENTER MEDICAID***: Medicaid for State Supported Living Center Residents	*MEPD HB A-1100; 1 TAC 358.107(c)(2); 42 CFR §435.236, §358.433*
TP 11	ME – SSI Prior	***THREE MONTHS PRIOR MEDICAID***: SSI, two or three months prior, as appropriate	*MEPD HB Appendix XXX*
TP 12	ME – Temp Manual SSI	***SSI-LINKED MEDICAID***: Manually certified SSI (processed by SSA)	*MEPD HB A-2100; 1 T.A.C. 358.107(b)(1); 42 U.S.C. §1396a(a)(10)(A)(i)(I)*

Code	Description	Long Description	*Sources of Law & Policy*
TP 13	ME – SSI	***SSI-LINKED MEDICAID:*** Supplemental Security Income (SSI) eligible-Medicaid automatic when SSA awards SSI	*MEPD HB A-2100; 1 T.A.C. 358.107(b)(1); 42 U.S.C. §1396a(a)(10)(A)(i)(I)*
TP 14	ME – Community Attendant	***COMMUNITY ATTENDANT SERVICES***: Community Attendant Services (also known as Primary Care)	*Case Worker Community Care for the Aged and Disabled Handbook, https://hhs.texas.gov/laws-regulations/handbooks/case-worker-community-care-aged-disabled-handbook; MEPD HB A-1100; 1 TAC 358.107(d)(1); Social Security Act §1929(b)(2)(B); 42 U.S.C. §1396t(b)(2)(B)*
TP 15	ME – Non-State Group Home	***GROUP HOME MEDICAID***: Medicaid for ICF/IID Resident	*MEPD HB A-1100; 1 TAC 358.107(c)(2); 42 CFR §435.236, §358.433*
TP 16	ME – State Hospital	***STATE HOSPITAL MEDICAID***: Medicaid for State Hospital Resident	*MEPD HB A-1100; 1 TAC 358.107(c)(2); 42 CFR §435.236, §358.433*
TP 17	ME – Nursing Facility	***NURSING FACILITY MEDICAID***: Medicaid for Nursing Facility Resident at least 30 consecutive days, with income under the Special Income Limit (3X SSI maximum)-unless uses Qualified Income Trust.	*MEPD HB A-1100; 1 TAC 358.107(c)(2); 42 CFR §435.236, §358.433*
TP 18	ME – Disabled Adult Child	***DISABLED ADULT CHILD MEDICAID***: Adult children (at least age 18) who have a disability and who were denied SSI due to an entitlement to or an increase in their RSDI Disabled Adult Child (DAC) benefits and who are eligible for Medicaid to ensure continued coverage	*MEPD HB A-1100, A-2310; 1 TAC 358.107(b)(3); 42 U.S.C. §1383c*

Code	Description	Long Description	*Sources of Law & Policy*
TP 21	ME – Disabled Widow(er)	***DISABLED WIDOW(ER) MEDICAID***: Widows, widowers or surviving divorced spouses age 50 and less than 60 who have a disability and who are ineligible for Medicare and were denied SSI due to Social Security widow/widower benefits. They are eligible for Medicaid under TP 21 until they reach age 60 or become eligible for Medicare, whichever occurs first	*MEPD HB A-1100, A-2340; 1 TAC 358.107(b)(6);*
TP 22	ME – Early Aged Widow(er)	***EARLY AGE WIDOW(ER) MEDICAID:*** Early age widows, widowers or surviving divorced spouses age 50–65 who are ineligible for Medicare and who were denied SSI due to an increase in their RSDI widow/widower benefits. They are eligible for Medicaid under TP 22 until they reach age 65 or become eligible for Medicare, whichever occurs first	*MEPD HB A-1100; 1 TAC 358.107(b)()7); 42 CFR §435.138*
TP 23	MC – SLMB	***SPECIFIED LOW-INCOME MEDICARE BENEFICIARY***: Medicare Savings Program — Specified Low-Income Medicare Benefits *Pays Medicare Part B premiums*	*MEPD HB Chapter Q-3000; 42 U.S.C. §1396a(a)(10)(E)*
TP 24	MC – QMB	***QUALIFIED MEDICARE BENEFICIARY***: Medicare Savings Program — Qualified Medicare Beneficiary *Pays Medicare Part A & B premiums, copayments & deductibles*	*4 MEPD HB Chapter Q-2000; 2 U.S.C. §1396a(a)(10)(E)*

Code	Description	Long Description	*Sources of Law & Policy*
TP 25	MC – QDWI	***QUALIFIED DISABLED AND WORKING INDIVIDUALS*** — A special Medicare savings program that pays Part A Medicare premiums for certain working people under age 65 who have a disability and are no longer eligible for free Medicare Part A because of earnings	*MEPD HB Chapter Q-6000; 42 U.S.C. §1396a(a)(10)(E)*
TP 26	MC – QI 1	***QUALIFIED INDIVIDUAL-1:*** Medicare savings program — Qualified people *Pays Medicare Part B premium*	*MEPD HB Chapter Q-5000; 42 U.S.C. §1396a(a)(10)(E)*
TP 27	MC – QI 2	***QUALIFIED INDIVIDUAL-2:*** Medicare savings program — Qualified people (not an active program)	*MEPD HB Chapter Q-5000; 42 U.S.C. §1396a(a)(10)(E)*
TP 30	ME – A and D Emergency	***EMERGENCY MEDICAID FOR ALIENS***: Emergency Medicaid for person who would be eligible for Medicaid but for alien (noncitizen, not a qualified alien) status	*1 T.A.C. Chapter 366, Subchapter I. For the general eligibility requirements, see § 366.903(b). This program is required by the federal Medicaid statute and rules. 42 U.S.C. § 1396b(v); 42 C.F.R. § 435.139; 42 CFR §435.139, an alien, as defined in 42 CFR §435.406, is provided services necessary for the treatment of an emergency medical condition, as defined in 42 CFR §440.255.*
TP 38	ME – SSI Nursing Facility	***NURSING FACILITY MEDICAID***: Medicaid for Nursing Facility Resident on SSI	*1 TAC 358.107(b)(1); 42 CFR Part 435, Subpart B*
TP 39	ME – SSI State Hospital	***STATE HOSPITAL MEDICAID***: Medicaid for State Hospital Resident on SSI	*MEPD HB A-1100; 1 TAC 358.107(c)(2); 42 CFR §435.236, §358.433*
TP 41	ME – Skilled Nursing Care	***NURSING FACILITY MEDICAID:*** Skilled Nursing Facility Co-payments	*MEPD HB A-1100; 1 TAC 358.107(c)(2); 42 CFR §435.236, §358.433*
TP 46	ME – SSI State Supported Living Center	***STATE SUPPORTED LIVING CENTER MEDICAID***: Medicaid for State Supported Living Center Residents	*MEPD HB A-1100; 1 TAC 358.107(c)(2); 42 CFR §435.236, §358.433*

Code	Description	Long Description	*Sources of Law & Policy*
P 50	ME – Rider 51J	Medicaid for Nursing Facility Resident	*SB 1, 2017 Legislature—required HHSC to develop measures of community integration outcomes*
TP 51	ME – Rider 51J Waivers	Medicaid	*Same as above*
TP 87	ME – Medicaid Buy In (*This description repeats the one above for TP 87*)	***MEDICAID BUY-IN:*** Working people with disabilities who pay a share of the Medicaid premium to be eligible for Medicaid	*MEPD HB Part M; 1 TAC Chapter 360*
	PACE	***PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY*** (PACE).	*MEPD HB A-1100; 1 TAC 358.107(d)(2); 42 CFR Part 460*

APPENDIX 12: Social Security Claim Number Suffixes

Purpose: Identifying Social Security programs for which a client is eligible from the claim number on notices from SSA

Source: Texas Works Handbook C-1420 Revision 13-3; Effective July 1, 2013

A	
B	
B1	Primary beneficiary
B2	Aged wife (1st claimant)
B3	Husband (1st claimant)
B4	Young wife (1st claimant)
B5	Aged wife (2nd claimant)
B6	Husband (2nd claimant)
B7	Young wife (2nd claimant)
B8	Divorced wife (1st claimant)
B9	Young wife (3rd claimant)
BA	Aged wife (3rd claimant)
BD	Divorced wife (2nd claimant)
BG	Aged wife (4th claimant)
BH	Aged wife (5th claimant)
BJ	Husband (3rd claimant)
BK	Husband (4th claimant)
BL	Husband (5th claimant)
BN	Young wife (4th claimant)
BP	Young wife (5th claimant)
BQ	Divorced wife (3rd claimant)
BR	Divorced wife (4th claimant)
BT	Divorced wife (5th claimant)
BY	Divorced husband (1st claimant)
BW	Divorced husband (2nd claimant)
C1, 2 etc.1	Young husband (1st claimant)
D	Young husband (2nd claimant)
D1	Child (including disabled or student child)
D2	Aged widow (1st claimant)
D3	Widower (1st claimant)
D4	Aged widow (2nd claimant)
D5	Widower (2nd claimant)
D6	Widow (remarried after attaining age 60)
D7	Widower (remarried after attaining age 62)
DB	Surviving divorced wife (1st claimant)
D9	Surviving divorced wife (2nd claimant)
DA	Aged widow (3rd claimant)
DC	Remarried aged widow (2nd claimant)
DD	Remarried aged widow (3rd claimant)
DG	Surviving divorced husband (1st claimant)
DH	Aged widow (4th claimant)
DJ	Aged widow (5th claimant)
DK	Aged widower (3rd claimant)
DL	Aged widower (4th claimant)
DM	Aged widower (5th claimant)
DN	Remarried aged widow (4th claimant)
DP	Surviving divorced husband (2nd claimant)
DQ	Remarried aged widow (5th claimant)
DR	Remarried aged widower (2nd claimant)
DS	Remarried aged widower (3rd claimant)
DT	Remarried aged widower (4th claimant)
DV	Surviving divorced husband (3rd claimant)
DW	Remarried aged widower (5th claimant)
DX	Surviving divorced wife (3rd claimant)
DY	Surviving divorced wife (4th claimant)
DZ	Surviving divorced husband (4th claimant)
E	Surviving divorced wife (5th claimant)
E1	Surviving divorced husband (5th claimant)
E2	Mother (widow) (1st claimant)

APPENDIX 13: Sources of Law

Here is our guide to sources of Medicaid law and policy, showing those sources in the order of precedence. That is, if an issue would be decided differently under two sources of law or policy, the one higher on our list should prevail.

Source of Law or Policy	Description	How to Find It
United States Constitution	Due Process Clause of the 14th Amendment guides Medicaid requirement of notice and a hearing; Supremacy Clause says federal law preempts inconsistent state law	Agency rules and policies sometimes refer to the leading procedural due process case: Goldberg v. Kelly, 397 U.S. 254 (1970).[646]
Federal SSI and Medicaid Statutes	Passed by Congress in 1966 to provide medical care for persons unable to afford it. Because most people cannot afford a long period of long-term care, often needed by middle-income Americans	Social Security Act, 42 U.S.C. §1381 et seq. (Title 16, Social Security Act (SSI))[647] and 42 U.S.C. §1396 et seq. (Title 19, Social Security Act (Medicaid)).[648] One resource summarizes the Medicaid sections of the Social Security Act and the rules under them.[649] Another shows U.S.C. sections corresponding to sections of the Social Security Act.[650] See the third column of the List of Means-Tested Public Benefits Programs in Texas below for the federal statutes on which each is based.
Federal SSI rules	As discussed above, the federal Medicaid statute requires that Medicaid methodology for counting assets and income must be "no more restrictive" than SSI	20 C.F.R. Part 416[651]
Federal SSI policy	Social Security Administration, Program Operations Manual System (POMS), thousands of pages of policy used by Social Security employees as their primary source of direction	SSI POMS[652]

646 https://caselaw.findlaw.com/us-supreme-court/397/254.html

647 http://uscode.house.gov/view.xhtml?path=/prelim@title42/chapter7/subchapter16&edition=prelim

648 http://uscode.house.gov/view.xhtml?path=/prelim@title42/chapter7/subchapter19&edition=prelim

649 https://www.macpac.gov/reference-materials/reference-guide-to-federal-medicaid-statute-and-regulations/

650 http://uscode.house.gov/table3/1935_531.htm

651 https://www.ssa.gov/OP_Home/cfr20/416/416-0000.htm

652 https://secure.ssa.gov/apps10/poms.nsf/chapterlist!openview&restricttocategory=05

CMS State Medicaid Manual	Guidance to state Medicaid programs by the Centers for Medicare and Medicaid Policy (i.e., federal agency policy but not law)	State Medicaid Manual [653]
Other CMS "Guidance"	State Medicaid Director and State Health Official Letters from the federal Medicaid agency (currently CMS)	Federal Policy Guidance[654]
Texas Medicaid State Plan	Options available in the federal law are elected in the State Medicaid Plan by the State Medicaid Agency, which in Texas is the Texas Health and Human Services Commission	Texas Medicaid State Plan [655]
Texas Medicaid Waivers	Another way HHS elects options under the federal Medicaid law is by "waiver" applications proposing policy changes that will be effective if approved by CMS	Waiver Applications Approved[656]
Texas Constitution	The only provision in the Texas Constitution specifically applying to Medicaid guarantees that proceeds of reverse mortgages will not count as "income" and credit available will not count as "resources."	Texas Constitution Art. 16 §50(o) (referring to Medicaid as "Medical Assistance")[657]
Texas Statutes	Medical Assistance Program (Medicaid) Health and Human Services Commission Medicaid Estate Recovery in Texas Medicaid Managed Care Program System Redesign for Delivery of Acute Care Services and Long-Term Care Services and Supports Medicaid and the Child Health Plan Program	Texas Human Resources Code Chapter 32[658] Texas Government Code Chapter 531[659] Texas Government Code §531.077[660] Texas Government Code Chapter 533[661]

[653] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927

[654] https://www.medicaid.gov/federal-policy-guidance/index.html

[655] https://www.hhs.texas.gov/services/health/medicaid-chip/about-medicaid-chip/state-plan

[656] https://www.hhs.texas.gov/laws-regulations/policies-rules/waivers

[657] https://statutes.capitol.texas.gov/Docs/CN/htm/CN.16/CN.16.50.htm

[658] https://statutes.capitol.texas.gov/Docs/HR/htm/HR.32.htm

[659] https://statutes.capitol.texas.gov/Docs/GV/htm/GV.531.htm

[660] https://statutes.capitol.texas.gov/Docs/GV/htm/GV.531.htm

[661] https://statutes.capitol.texas.gov/Docs/GV/htm/GV.533.htm

	Medicaid Reform Waiver [direction for HHSC to apply for a waiver] Medicaid Quality Improvement Program for Clinical Initiatives	Texas Government Code Chapter 534[662] Texas Government Code Chapter 536[663] Texas Government Code Chapter 537[664] Texas Government Code Chapter 538[665]
Texas Rules	The rules are voluminous and constitute an important source of Medicaid law	1 Texas Administrative Code Chapters 351-396[666]
Texas Medicaid Policy Note: Dozens of law and policy resources are linked at the first resource listed, then the ones of most interest to Elder Law attorneys are also listed separately here.	HHS handbooks, forms, legal information, policies, rules, reports & presentations Handbook that is the primary means HHS uses to communicate policy to its employees Handbook for non-managed care home care programs Handbook for managed care programs	Links to the numerous resources listed[667] Link to Handbooks[668] Medicaid for the Elderly and People with Disabilities Handbook (MEPD HB)[669]

662 https://statutes.capitol.texas.gov/Docs/GV/htm/GV.534.htm

663 https://statutes.capitol.texas.gov/Docs/GV/htm/GV.536.htm

664 https://statutes.capitol.texas.gov/Docs/GV/htm/GV.537.htm

665 https://statutes.capitol.texas.gov/Docs/GV/htm/GV.538.htm

666 https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=3&ti=1&pt=15

667 https://www.hhs.texas.gov/laws-regulations

668 https://www.hhs.texas.gov/laws-regulations/handbooks

669 https://www.hhs.texas.gov/laws-regulations/handbooks/mepd/medicaid-elderly-people-disabilities-handbook

	Policy Bulletins Forms for Long-term Care Medicaid programs	Community Care Services Eligibility Handbook[670] citing sources of law[671] Star+Plus Handbook[672] citing sources of law[673] MEPD and TW Policy Bulletins (appendix to MEPD HB)[674] Forms Appendix to MEPD HB[675]
Internal Texas Medicaid Policy	Policy excluding some (but not all) tax-deferred retirement accounts from counting as "resources" has been written only in the form of slides for CLE presentations; and within the last year, the agency has discontinued the practice of disclosing such policies even in that form. At this writing, the agency's current policy is undisclosed in any form outside the agency until it is applied in case actions, which are confidential.	Most recent HHS CLE presentation slides (February 13, 2020),676 which are reproduced in the "Medicaid Update" paper for this course, by Marilyn G. Miller

[670] https://www.hhs.texas.gov/laws-regulations/handbooks/ccse/community-care-services-eligibility-handbook

[671] https://www.hhs.texas.gov/laws-regulations/handbooks/ccse/appendices/appendix-xxiv-legal-basis-community-care-programs

[672] https://www.hhs.texas.gov/laws-regulations/handbooks/sph/starplus-handbook

[673] https://www.hhs.texas.gov/laws-regulations/handbooks/sph/section-1000-state-texas-access-reform-plus-starplus-managed-care#1110

[674] https://www.hhs.texas.gov/laws-regulations/handbooks/mepd/policy-bulletins

[675] https://www.hhs.texas.gov/laws-regulations/handbooks/mepd/forms

[676] Slides presented by Shari Nichols, HHS attorney and Administrative Law Judge, at the University of Texas School of Law, 16th Annual Changes and Trends Affecting Special Needs Trusts (February 13, 2020). It was produced by HHS in response to a Public Information Request by the Texas Chapter of the National Academy of Elder Law Attorneys on January 13, 2021 for documents "related to Medicaid eligibility and IRA assets."