

MEDICAID FOR THE AGED, BLIND, AND  
DISABLED IN NORTH CAROLINA

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## A. Introduction

The North Carolina Medical Assistance (Medicaid) program is a cooperative federal-state program which pays for medical services for aged, blind, and disabled persons (as well as families with children) if their incomes and resources are below certain levels. Medicaid is administered in North Carolina by the Division of Medical Assistance (DMA) of the Department of Human Resources and by county departments of social services (DSS). At the federal level, Medicaid is administered by the Centers for Medicaid and Medicare Services (CMS) within the U.S. Department of Health and Human Services. Medicaid is of huge and growing importance to elderly and disabled persons of modest means. Although many have Medicare coverage, Medicare does not cover long-term nursing care and many home health services, among this population's most expensive and common health care needs. Significant numbers of the elderly and disabled (as well as families with children) are eligible for Medicaid, or could become eligible, but are not enrolled. North Carolina Medicaid eligibility significantly expanded in the 1990's but recent state budget problems have forced cutbacks in the program. The health reform law passed by Congress in 2010 requires dramatic expansion of the N.C. Medicaid program effective January 1, 2014 but those provisions are not discussed here.

The federal Medicaid statute has been referred to by the Supreme Court as "Byzantine" and "almost unintelligible to the uninitiated." While initially intimidating, the complex rules offer much room for creative advocacy. Sources of law are 42 U.S.C. § 1396 et seq., 42 C.F.R. § 430 et seq., the CMS State Medicaid Manual (available at [http://www.cms.hhs.gov/manuals/45\\_smm/pub45toc.asp](http://www.cms.hhs.gov/manuals/45_smm/pub45toc.asp)), N.C.G.S. § 108A-54 et seq., 10A N.C. Administrative Code, §§ 21A, et seq., and the North Carolina Aged, Blind, and Disabled Medicaid Eligibility Manual (hereinafter, Medicaid manual or MA). There is also a significant amount of state and federal case law. The Medicaid adult eligibility manual is a good place to start, and is available online at [info.dhhs.state.nc.us/olm/manuals/dma](http://info.dhhs.state.nc.us/olm/manuals/dma).

The rules outlined here are for North Carolina and are somewhat different in other states. North Carolina's rules apply only to North Carolina residents. Residency (which determines where the application must be filed) is generally based on county of domicile prior to entering a nursing facility or adult care home. Effective January 1, 2006, the verification requirements to prove N.C. residency were tightened by the General Assembly. See N.C.G.S. 108A-55.3; MA-2220.

Of course, the descriptions herein are general, and the law is subject to different interpretation and to modification at any time. For details or to verify the most current information, the advocate should consult the above resources or contact the county DSS or the DMA Eligibility Unit in Raleigh (919-855-4000).

## B. Application and Recertification Processes

An individual needing Medicaid or anyone acting on his behalf may apply for Medicaid at DSS. Some hospitals, rural health clinics, and public health departments have staff who can take initial applications for Medicaid, but the application must be processed by the county DSS. In addition, an application for the Medicare Part D Low Income Subsidy (LIS) through Social Security is now considered an application for full Medicaid in N.C. DMA began accepting mail-in Adult Medicaid applications (followed by telephone interviews) on October 1, 2005. MA-2302. The date of application for mail-in applications is the date that a complete, legible, signed application is received by DSS. An applicant may apply through a representative, who can be a relative, friend, or advocate. Spanish speakers are entitled to DSS interpreters and to receive DSS notices in Spanish.

A written application must be signed. An individual has the right to be interviewed and to file an application on the first day he seeks assistance at DSS. DSS must explain and offer all program categories for which the individual may qualify. DSS must offer to assist the applicant in obtaining verification of his eligibility. The applicant's statement is sufficient proof for some facts. Alternative sources of verification must be accepted if the requested proof is not available. Facts that must be verified include income, assets, citizenship, identity, residency, and age.

DSS is required to process a Medicaid application within 45 days for the aged, 90 days for the disabled. However, applications may pend up to six months to meet a deductible or for citizenship verification. There is a right to appeal and request retroactive benefits if DSS delays the application beyond the time limit, refuses to accept or discourages an application, fails to give complete information about available programs, improperly denies an application, or encourages withdrawal of an application. MA-2300-2304.

If an individual's Medicaid application is approved, her Medicaid coverage generally is effective as of the first day of the month in which she applied for Medicaid if financially eligible on that date. However, an individual also may apply for "retroactive" Medicaid coverage if she incurred coverage medical expenses during any of the three calendar months before she applied for Medicaid. For example, if an individual applied for Medicaid on July 31, her ongoing Medicaid would start July 1 and she could request retroactive Medicaid coverage for April, May, and June. However, she must have been eligible for Medicaid at the time the medical services were received. Further, she must have obtained the services from an enrolled Medicaid provider that agrees to bill Medicaid for payment. See Section G. below.

Recipients of Supplemental Security Income (SSI) automatically receive Medicaid and do not need to apply separately at DSS unless they are applying for Medicaid coverage of nursing home care. Individuals approved for Social Security disability benefits but not SSI must apply separately for Medicaid at DSS. An individual approved for SSI may apply at DSS within 60 days after SSI approval for up to three months Medicaid coverage retroactive to the date of the SSI application. However, the better practice for persons not yet approved for SSI is to immediately apply separately for Medicaid at DSS. The state application process is faster, retroactive coverage is available sooner, an earlier disability onset date may be alleged, and all

Medicaid eligibility categories will be considered. Many persons not eligible for SSI are eligible for Medicaid but they must apply at DSS. A DSS application also provides state appeal rights in addition to the SSI appeal process. See Section C.

Except for SSI recipients, eligibility is generally approved for either a six-month or a twelve-month “certification period.” SSI recipients do not have a certification period, unless they are in nursing homes. Before the end of the certification period, the recipient will receive a notice from the county DSS advising her that she must come to the county DSS office to be “recertified.” This “recertification” process is less complicated and lengthy than the original application, but it requires verification of certain eligibility factors. If a recipient is not recertified, her Medicaid coverage will terminate at the end of the certification period.

Changes affecting eligibility, such as increases in income or resources that occur during the certification period must be reported to DSS by the recipient within five days of learning of the change. For SSI recipients, changes must be reported to the Social Security Administration. An individual’s Medicaid coverage will be terminated if she no longer meets all eligibility criteria. Advance notice of a proposed termination must be sent to the recipient before her Medicaid benefits may be terminated. If SSI terminates, DSS must determine Medicaid eligibility under other categories before terminating Medicaid.

### C. Appeal Rights

A decision approving or denying an application for Medicaid will be in writing and will be mailed to the applicant or the applicant’s representative. If an individual’s application is denied, the reason for the denial will be stated in the decision and the notice of decision will explain how the applicant may appeal the decision. Such a notice is also required for a decision terminating Medicaid eligibility. N.C.G.S. 108A-79.

Any DSS decision affecting Medicaid eligibility may be appealed within sixty days by requesting a hearing from DSS. Persons terminated from Medicaid may receive continued benefits pending appeal if they appeal and request continued benefits within 10 days. Any verbal request to DSS for an appeal or hearing within the time limit is sufficient. Individuals who have missed the sixty day deadline have the following options: 1) request the appeal within ninety days and show good cause for missing the sixty day deadline; 2) reapply and request a reopening of the first application within twelve months based on new evidence or county error (Medicaid Manual, MA-2395); 3) request reopening of a Medicaid application that was denied based on disability if a subsequent Social Security appeal establishes disability and the Medicaid application was denied after the disability onset date (Medicaid Manual, MA-2395); 4) argue the sixty day deadline is unenforceable under due process or an equitable theory due to inadequate content of the notice, a mental impairment, discouragement or misinformation by DSS, or similar facts. See, 42 C.F.R. 431.200 (Medicaid notice requirements); N.C.G.S. 108A-79 (same); MA-2304 (discouragement or improper withdrawal tolls appeal deadline); Bowen v. City of New York, 106 S.Ct. 2022 (1986) (equitable tolling of time limit due to secret agency policy); Nowell

v. A & P, 250 N.C. 575 (1959) (equitable estoppel for misinformation); Culbertson v. HHS, 859 F.2d 319 (4<sup>th</sup> Cir. 1988) (due process violation to enforce time bar where mental incapacity).

Federal regulations require that the agency issue a final decision on the appeal within 90 days of the initial request for hearing. 42 C.F.R. 431.244. A consent order in a class action settled in the early 1970's, Huntley v. Morrow, requires penalty payments if hearing decisions are delayed beyond this limit in too many cases. An individual may seek intervention by the superior court in a case of unreasonable delay by the hearing officer. G.S. 150B-44; Cloninger v. N.C. DHHS, 691 S.E.2d 127 (N.C. App. 2010). The first hearing (except in disability appeals) is before an official of the county DSS. A *de novo* hearing before a state hearing officer may be requested within fifteen days of the local decision. Further review of the state hearing officer's decision may be sought from the chief hearing officer within 10 days.

Superior court review may be requested within thirty days of receipt of the final agency decision. N.C.G.S. Section 108A-79; Medicaid manual, MA-2420. Except for appeal to the chief hearing officer, administrative appeal rights must be exhausted before seeking superior court review. The county DSS may not seek judicial review. Superior court review is normally limited to determining whether there is substantial evidence in the administrative record to support the decision or an error of law. N.C.G.S. 150B-51(b). Therefore, it is important to build a complete record at the state hearing. The superior court has discretion to hear new evidence. N.C.G.S. 108A-79(k). However, the N.C. Supreme Court recently ruled that unless the superior court chooses to hold a *de novo* evidentiary hearing, that court may not make its own findings of fact. Meza v. N.C. Div. of Soc. Ser., 364 N.C. 51 (2010).

An individual denied SSI or Social Security disability also can appeal through the Social Security Administration. 20 C.F.R. Part 416, Subpart N. If an SSI appeal is successful, Medicaid coverage will automatically be provided for each month of SSI eligibility. An individual terminated from SSI based on a disability determination automatically receives Medicaid during the SSI appeal. If a Social Security appeal is successful, the Medicaid application can be reopened. See Section H.

A completely different state appeal process exists for Medicaid denials of coverage for particular medical services. See Section F.

#### D. Categories of Eligible Persons

Medicaid is available for over a dozen specific categories of low income persons with medical needs. These generally include (1) children under age 21 and their caretakers, (2) pregnant women, (3) individuals age 65 or over, and (4) individuals who are disabled or blind. A fairly new Medicaid category covers uninsured women under 65 with breast cancer regardless of income and assets if they were diagnosed as a result of a screening program through the county health department, but such applications must be filed through the Health Department, not at DSS. A new

waiver created a new Medicaid category beginning October 1, 2005 that provides Medicaid for family planning services only to women not eligible for regular Medicaid. Effective October 1, 2008, a new Medicaid category with a premium was created for disability recipients who have returned to work. See Section I. An individual is *not* eligible for Medicaid if he or she is incarcerated or a resident of a public institution (other than elderly patients in public mental hospitals).

Medicaid recipients are considered "categorically needy" if they receive or are eligible for Supplemental Security Income (SSI), Work First Family Assistance (also called TANF, formerly AFDC), or State/County Special Assistance benefits (which pays for assisted living or rest home care). Any individual receiving SSI, TANF, or Special Assistance benefits in a month automatically receives a Medicaid card for that month.

Individuals not eligible for cash benefits may still receive Medicaid, if they fall within one of the covered groups and can meet the Medicaid income and resource tests. The income and asset limits for other categories of Medicaid (e.g. for children) may be more liberal than those for the aged, blind and disabled discussed herein. DSS has a duty to explore all potential categories of eligibility when an application for Medicaid is filed.

To receive Medicaid, an individual must be a U.S. citizen or qualified alien. Medicaid Manual, Section 2504. Qualified immigrants include: (1) Lawful permanent residents, conditional entrants, parolees, and certain victims of violence who were first admitted to live in the United States before August 22, 1996; (2) Lawful permanent residents, conditional entrants, parolees, and certain victims of violence who were first admitted to live in the U.S. on or after August 22, 1996 *and* who have lived in the U.S. for at least five years; (3) Persons admitted to the U.S. as refugees, asylees, trafficking victims, Cuban-Haitian entrants, or certain Amerasian immigrants and persons whose deportation has been withheld; (4) Active duty military personnel and honorably discharged veterans and their spouses and dependents; (5) Effective July 1, 2010, pregnant women and children through age 18 are eligible without regard to the five year bar and with a more liberal definition of qualified status. See MA-3330, VIII.

Non-qualified non-citizens (including undocumented immigrants) may receive Medicaid coverage for emergency services only, if they meet all other Medicaid eligibility requirements. The N.C. Supreme Court limited the scope of emergency services that may be covered in Diaz v. Div. of Soc. Ser., 360 N.C. 384 (2006). Undocumented immigrants may also apply for eligible family members without providing Social Security Numbers for themselves.

The Deficit Reduction Act of 2005 (DRA) substantially increased documentation requirements to prove citizenship and identity effective July 1, 2006. However, DSS must assist in obtaining this verification, including requesting and paying for birth certificates if the applicant does not have one in his possession. Citizenship verification is not required for current

or former SSI recipients, Medicare recipients, or Social Security disability recipients. MA-2504. Effective January 2010, DSS verifies citizenship and identity in most cases through a match with Social Security. Also, DSS is now required to provide Medicaid for up to six months while verification of citizenship/identity is pending.

To be Medicaid eligible, applicants must be residents of North Carolina. In general, a person is a resident of North Carolina if he or she is living in the state and intends to continue living in the state. No minimum period of in-state residency is required. Homeless persons and residents of homeless shelters may be eligible for Medicaid in North Carolina.

Effective January 1, 2006, a new statute tightens proof requirements for residency at application (current recipients are exempt). See N.C.G.S. 108A-55.3; Two different documents proving N.C. residence are generally required but sworn declarations may be accepted from those without these documents (e.g. homeless). Applicants incapable of stating intent and those who are institutionalized are exempted. See MA-2220. The amount of discretion given to counties to require additional proof by this manual provision may violate the state statute as well as the federal "single state agency" regulation and Title VI of the Civil Rights Act. The N.C. Court of Appeals has ruled that non-citizens (and their citizen children) with an unexpired temporary visa may not establish intent to remain in the state. Okale v. N.C. D.H.H.S., 570 S.E.2d 741 (N.C. App. 2002).

#### E. Services Covered

In North Carolina, Medicaid covers a fairly wide range of medical services for adults, including physician treatment, inpatient and outpatient hospital care, prescriptions and some over the counter drugs, insulin, eyeglasses and optometrist care, some dental care, lab and x-ray tests, some mental health services, substance abuse treatment, chiropractors, personal care services, private duty nursing and other home health care, hospice care, durable medical equipment, orthotics and prosthetics, medical transportation, payment of Medicare premiums, co-payments and deductibles, nursing care at the skilled or intermediate levels, organ transplants, podiatry services, speech, physical and occupational therapy, and case management. Additional services are covered under home and community based waivers (see below). Care in assisted living facilities (rest homes or adult care homes) and in group homes for the developmentally disabled is covered by a different program with somewhat different eligibility requirements, State-County Special Assistance (see Section R below), although Medicaid covers some personal care services provided in assisted living facilities to Special Assistance recipients. Medicaid recipients under age 21 are required under the federal Medicaid statute (EPSDT) to receive coverage for an even broader range of services with much fewer limits and restrictions and should receive regular, complete health screenings. See the N.C. EPSDT Policy at [www.dhhs.state.nc.us/dma/epsdtprovider.htm](http://www.dhhs.state.nc.us/dma/epsdtprovider.htm).

Prior approval by DMA or one of its fiscal agents (EDS, CCME, Value Options) is

required for many services. Also, individuals enrolled in the Carolina Access managed care program generally must obtain a referral from their primary care provider before seeing a different doctor. Outpatient visits to physicians and other primary care providers are limited to thirty visits per year for adults. These limits may be waived for life-threatening illnesses.

DMA is under legislative mandate to adopt medical coverage policies based on national standards or an evidence-based, best practice standard. While DMA is exempt from APA rule-making requirements for this process, the policies are “published” for comment before they become final on DMA’s website. N.C.G.S. 108A-53. For more details about covered services, prior approval procedures, clinical coverage policies, and provider enrollment and reimbursement, visit [www.dhhs.state.nc.us/dma/prov.htm](http://www.dhhs.state.nc.us/dma/prov.htm).

Effective January 1, 2006, Medicaid no longer covers prescription drugs (except for cold medicines, prescription vitamins, barbiturates, benzodiazepines, and some non-prescription drugs) for Medicare recipients, who must obtain drugs through a Medicare Drug Plan. For non-Medicare recipients, there are limits on the number of prescription drugs (eight per month) but the pharmacist may allow up to eleven prescriptions per month if needed and may allow even more than eleven prescriptions if the recipient participates in a program called FORM to manage medication use. Prior approval is required for non-generic prescriptions (if a generic is available). An increasing number of other “non-preferred” prescriptions require prior approval.

Medicaid coverage of home health care significantly expanded in the 1990’s but coverage has been restricted in the last few years. Medicaid covers many skilled care services normally provided by a home health agency (such as physical or occupational therapy, speech-language pathology and skilled nursing services) and home health aide services (when delivered in conjunction with skilled services) if Medicare coverage is unavailable, and the care needed is part-time or intermittent (these requirements are subject to interpretation/legal challenge). 24 hour private duty skilled nursing is covered in rare cases where the need for complex 24 hour skilled nursing is prior approved. DMA working on a process to transfer adults receiving private duty nursing to a capped waiver program. In addition, Medicaid pays for personal care services, including meal preparation, personal care, medical monitoring, and home management, if related to health care needs. The limit for PCS is 60 hours per month, or 80 hours in higher need cases. Prior approval is now required for PCS and further restrictions on eligibility for the service are expected soon. The hourly limits and restrictions do not apply to recipients under age 21.

Small Medicaid co-payments (usually \$3.00) are charged for most services except for recipients under age 21, institutionalized recipients, and CAP enrollees. Providers are not permitted to refuse to provide the service for failure to pay the co-payment. MA-2905, II.D. The DRA permits the state to significantly increase recipient co-payments, premiums and other cost-sharing for certain adult recipient but N.C. thus far has not chosen this option.

When a state wishes to make home and community services (HCBS) available only to

certain distinct groups of Medicaid beneficiaries (e.g., adults who have a physical disability), it must seek federal approval of an HCBS waiver program. 42 U.S.C. §1396n(c). Under such a program various Medicaid requirements may be waived, to enable states to target services to distinct groups of Medicaid beneficiaries. The most important waiver in N.C. HCBS waivers is of the requirement to count a parent or spouse's income and assets if that financially-responsible relative lives with the Medicaid applicant. This waiver allows severely disabled persons to become financially eligible for Medicaid while living at home instead of having to live in an institution to receive Medicaid.

In addition to qualifying additional persons for Medicaid, the HCBS waivers permit the state to cover some services that the state does not choose to cover in general under its Medicaid state plan or cannot cover under federal law, except for individuals enrolled in an HCBS waiver. Eligibility for the waiver thus allows the recipient access to services not available to other Medicaid recipients, such as respite care, some medical supplies, home modifications, augmentative communication devices, certain durable medical equipment, adult day care and caregiver training. The services available and requirements for them vary according to the terms of each waiver.

North Carolina's three HCBS programs are generically referred to as Community Alternative Programs (CAP) and cover the following populations: (1) Disabled Adults (CAP-DA); (2) Mentally Retarded/Developmentally Disabled (CAP-MR/DD); (3) Children (CAP-C). Eligibility for each waiver requires a demonstration of a need for institutional care (in a nursing facility, hospital, or ICF/MR) as certified by a physician and approved by the state agency. It must also be shown the individual can be safely cared for in the community. Finally, the care needs of the individual must be managed within a budgeted sum (which varies by the CAP program).

The Community Alternatives Program for Disabled Adults (CAP-DA) may pay for more home care services for individuals receiving care at home who would otherwise need long term care in a nursing facility, if the cost of care is less at home. However, CAP-DA often has a waiting list (depending on the county) except for individuals who were residing in a nursing facility on June 1, 2002, who cannot be placed on the waiting list. There is also currently a freeze on new CAP-DA enrollment, which could be legally challenged. Enrollment in the CAP-DD program for individuals with developmental disabilities is even more difficult due to very long waiting lists. However, a new supports CAP-DD waiver which provides much more limited services has a shorter waiting list. Waiting lists for Medicaid coverage of community-based services have been the subject of lawsuits in other states, particularly for currently institutionalized recipients who wish to return home and for children who are eligible for Medicaid outside of the CAP program. Limits on community-based care have been challenged under the Medicaid Act as well as the Americans with Disabilities Act integration mandate enforced by the Supreme Court in the Olmstead decision. Other new but so far limited community care options include PACE, Money follows the Person, and self-directed waivers

(CAP Choice).

Unreasonable limits on the “amount, scope and duration” of covered services could be challenged under the comparability provisions of the federal Medicaid statute. Limits on home services have been challenged under the ADA. Service limits applied to children under age 21 are probably illegal, who are guaranteed access to many services under EPSDT provisions of the federal Medicaid law. However, the DRA significantly expands state options to limit the scope of Medicaid covered services for adult recipients.

#### F. Service Denial Appeals

Federal Medicaid regulations require the same notice and hearing rights for denials of prior approval or reductions or cessations of Medicaid coverage of services as for Medicaid eligibility determinations. Whenever prior approval of Medicaid coverage is requested, for nursing care, home health care, cancer treatment, a heart transplant, dental services, prescription drugs, or any other treatment, a written notice with appeal rights is required if coverage is denied. If a Medicaid recipient is denied prior approval for particular services, or if coverage is reduced or terminated, then the recipient has appeal rights. If the appeal involves failure to approve a timely request to continue a previously approved service, services must be reinstated by the agency pending appeal.

Service appeals often involve whether a particular treatment is medically necessary, within Medicaid coverage rules, or experimental. There is abundant case law outside of N.C. requiring deference to the treating physician’s opinion in determining medical necessity and this issue is currently pending before the N.C. Court of Appeals, along with the issue of whether the agency may reduce or terminate services it previously approved without proving medical improvement or another change in facts or law.

If coverage is denied after the fact for a service not requiring prior approval, the provider, but not the recipient, has appeal rights. However, regardless of whether an appeal is filed, the provider may not bill the recipient in this circumstance.

North Carolina has a separate appeal process for Medicaid services than for eligibility appeals. See N.C.G.S. 108A-70.9A and 70.9B. Appeal is through the Office of Administrative Hearings (OAH) pursuant to G.S. Section 150B, Article 3. The OAH process is a more formal procedure than the eligibility appeal process. See 10 NCAC 26I. The deadline for filing an OAH petition is thirty days from the date of the written agency denial. This deadline is jurisdictional but has been equitably tolled in rare cases. In the absence of proper notice to the recipient, the appeal deadline does not begin to run, since under both federal and state regulations it is a particular written notice to the recipient which triggers appeal rights. 42 CFR 431.200, et. seq; 10A N.C.A.C. 22H, N.C.G.S. 150B-23, 108A-70.9A.

Once an appeal is requested, the recipient may elect a telephone mediation to try to settle the appeal. ALJ hearings are by telephone or in person in Raleigh unless good cause is shown for a local in person hearing. For more information on Medicaid service appeals, visit [www.oah.state.nc.us](http://www.oah.state.nc.us). In late 2010 new procedures and notices for the N.C. Medicaid service prior approval and appeal process were agreed to by the state agency to settle a class action, D.T.M. v. Cansler. The procedures and notices agreed to in the settlement are posted at [www.ncdhhs.gov/dma/provider/URVendorInstruct.pdf](http://www.ncdhhs.gov/dma/provider/URVendorInstruct.pdf)

#### G. How Medicaid Coverage Works

Medicaid is a payer of last resort. Medicaid will not cover bills for which Medicare, private insurance, or any other third party is responsible. If Medicaid does pay a bill, the state takes assignment on any right the recipient has to third party recovery, including from a tortfeasor. N.C.G.S. 108A-59. Failure to cooperate with third party recovery may lead to denial or termination of Medicaid. Attorneys handling personal injury claims for Medicaid recipients must report to DMA any recovery that is made. N.C.G.S. 108A-57. See also, Ezell v. Grace Hospital, 360 N.C. 529 (2006) (DMA subrogation not limited).

Medicaid generally will not reimburse individuals for medical bills they have paid. However, the N.C. Court of Appeals recently ruled that the agency may be required to reimburse recipients for their out of pocket costs incurred during a successful appeal of a Medicaid denial. McCann v. N.C. DHHS, COA10-80 (1/18/11). Bills must be submitted for payment to a DMA contractor by a medical provider that participates in the Medicaid program. If Medicaid has been approved, the individual should show his Medicaid card to the provider when receiving services. If Medicaid has not been approved yet, the individual should make sure the provider will accept Medicaid, inform the provider that a Medicaid application is pending, and ask that the bill be submitted to Medicaid. If the provider insists on payment of the bill, the individual should ask the provider to refund payment and submit the bill to Medicaid after the application is approved. But some providers may refuse to do this since Medicaid pays less than the private charge.

Medical providers generally may choose not to accept Medicaid from all patients for all services. For example, a nursing home may certify only some of its beds for Medicaid patients, reserving the rest for private patients. However, hospitals and nursing homes that ever have received Hill-Burton funds from the federal government must accept Medicaid for all services and provide access to physicians that will do so. Settlement of a class action challenging the failure of the N.C. state agency to pay adequate reimbursement rates to attract enough dentists to accept Medicaid resulted in a significant increase in dentists accepting Medicaid. Antrican v. Odom, 290 F.3d 178 (4<sup>th</sup> Cir. 2002). New procedures took effect October 1, 2002 for payment of services for recipients who have both Medicare and Medicaid. 9/02 N.C. Special Provider Bulletin. However, problems can arise when Medicaid requires prior approval for a service but Medicare does not.

If a provider does agree to accept Medicaid as payment, it must accept Medicaid as full payment. The patient may not be billed for the portion of the charge not paid by Medicaid unless the charge is for (1) a service not covered by Medicaid, (2) the amount used to meet a Medicaid deductible, or (3) services rendered before the individual became eligible for Medicaid. See generally, 10 NCAC 26K.0006. Also, providers are required by the federal Medicare statute to accept assignment of Medicare claims for all services furnished to Medicaid eligibles, even if the provider doesn't accept Medicaid. 42 U.S.C. §1395w-4(g)(3). CMS has recently clarified that for dual eligibles, Medicaid providers may not balance bill the patient if Medicare has paid but Medicaid has paid nothing because the Medicare payment exceeds the Medicaid rate.

Providers must submit bills to Medicaid for payment within six months, or twelve months with good cause. An override of this requirement is available where eligibility is not determined before the time limit. A provider who does not timely submit a bill for payment may not bill the Medicaid recipient, regardless of the reason for delay, if the provider has agreed to accept Medicaid for the service and the bill would have been covered by Medicaid if timely submitted.

Many N.C. Medicaid recipients participate in a non-capitated managed care plan, Carolina Access, which places the recipient with a primary care physician. This physician, in turn, serves as a gatekeeper for referrals to specialists. In many parts of North Carolina, Carolina Access also has a care management component working with recipients to attempt to lower care costs through better preventive services. Another utilization control program, Community Care of N.C., has been expanded to better manage the use of home health services, prescriptions, and services to the elderly and disabled, including medical homes for dual eligibles and pregnancies.

#### H. Disability Determinations for Medicaid

If an individual is under age 65 and has no minor children in his care, disability must be established to obtain Medicaid. Medicaid uses the same standard used by the Social Security Administration (SSA), i.e. inability to perform substantial gainful activity which is expected to last twelve continuous months or result in death. Medicaid manual, MA-2525. While a twelve month duration test must be met, the ability to work on a sporadic basis or an unsuccessful work attempt does not preclude a finding of disability. Substantial gainful activity is roughly defined as work with gross earnings of \$1000 per month or more in 2011, after subtracting out-of-pocket impairment related expenses and any employer subsidy. 20 C.F.R. 404.1571.

If SSA has determined the applicant to be disabled, that decision is adopted by Medicaid. If SSA has denied disability within the last twelve months, that decision is adopted unless the applicant alleges a new impairment not considered in the SSA application. If a disability determination by SSA is pending, the Medicaid application may be held pending up to 90 days for adoption of the SSA decision. Otherwise, the Medicaid agency must make an independent disability determination.

No matter how disability is determined by Medicaid, a denial of disability may be appealed through the Medicaid administrative appeal procedure so long as a DSS Medicaid application was made. N.C.G.S. §108A-79. Medicaid disability appeals have advantages over the SSA appeal process, including faster decisions and generally more sympathetic decision-makers. However, if Medicaid is approved based on a state hearing officer's finding of disability, the Medicaid recipient must continue to exhaust his appeal of any subsequent Social Security/SSI disability denial or termination, or Medicaid coverage will end. MA-2525. The right to keep Medicaid while appealing an SSA denial ends when disability is denied by the SSA Appeals Council. However, there is an exception if the individual has a new impairment not considered by SSA or if the last SSA decision was more than twelve months earlier.

On the other hand, if Medicaid denies disability, but SSA later determines that the individual was disabled at the time his Medicaid application was denied, the Medicaid denial must be reopened upon request and retroactive Medicaid coverage is available. There is no time limit for such a reopening if the Medicaid disability denial was an adoption of an SSA denial. Otherwise reopening must be requested within 12 months. MA-2525.

#### I. Income Eligibility/ Deductible

An individual who does not receive TANF (formerly AFDC), SSI, or Special Assistance must meet both income and resource eligibility rules in order to qualify for Medicaid. The "categorically needy" income limit for the aged, blind and disabled is the same as the federal poverty line. Effective April 1, 2011, the maximum countable gross income will be \$907 per month for an individual and \$1,226 per month for a couple. Higher income is permitted for residents of a nursing home. See Section K. below. Social Security COLA's must be disregarded each January through March, until Medicaid income limits are increased each April. Certain deductions from countable income, including \$20 per month for most unearned income, and \$65 plus one-half of earned income are allowed.

A relatively new category of Medicaid for Workers with Disabilities allows disabled but employed applicants and recipients under age 65 to have countable income up to 150% of poverty (\$1361/mo for an individual and \$1839/mo for a couple effective April 1, 2011). This category also has a much higher resource limit. See Sections L and M. Eligibility is limited to employed persons (making substantial, reasonable work effort in competitive work environment or self-employment) who would meet all SSA disability requirements but for their work activity (or are working under SGA level but are over-income for MAD). Once approved under this category, recipients who medically improve but would be likely to be found disabled if treatment stopped can retain their coverage. Also, once approved, coverage can last up to 12 months after losing employment. See MA-2180.

The Medicaid income limits for an individual apply even if the individual lives with a spouse unless the spouse is also applying for and is otherwise eligible for Medicaid (i.e. spouse is

also aged, blind, or disabled) or unless the eligible spouse would be income-eligible as an individual but for the ineligible spouse's income. This policy of using a family size of one instead of two persons is subject to legal challenge for a disabled or elderly applicant with income who has a non-disabled, non-elderly spouse without income, based on an extension of the N.C. Court of Appeals decision in Martin v. NC DHHS, 670 S.E.2d 629 (2009). The income of an ineligible spouse (or parent for a minor) living with the applicant is counted unless the individual is enrolled in a CAP waiver to provide services at home as a less expensive alternative to institutional care.

The budgeting is more complex in cases where income is "deemed" from an ineligible spouse or parent. First, an eligible person living with an ineligible spouse must be income eligible under the income limits for an individual but for the spouse's income. If so, before an ineligible spouse's income is deemed available to a Medicaid applicant or recipient, the county DSS will first deduct a "living allowance" for any ineligible child under age 18 (21 if in school) living in the home (\$338 per child in 2011 minus the child's own income) from the ineligible spouse's gross income. If the remaining gross income of the ineligible spouse is less than \$338, no income is deemed to the eligible spouse. If the remaining gross income of the ineligible spouse is greater than \$338, the combined gross income of the couple is compared to the Categorically Needy income limit for an eligible couple (\$1226 effective 4/1/11) and all income disregards apply. MA-2100, 2250, 2260. The manual is unclear on whether the \$338 deduction is given if the ineligible spouse's income is greater than \$338 but it appears under federal law that it should be given.

Social Security recipients who formerly received SSI (or Special Assistance if in assisted living facility) benefits may be eligible for Medicaid under one of three "passalong" provisions that disregard a portion or all of their Social Security income. These provisions are particularly helpful to individuals receiving Social Security on the record of a parent or deceased spouse (widows not receiving Medicare and those receiving Adult Disabled Child's benefits) and to those who last received SSI several years ago. See MA-2110. Failure to consider passalong eligibility is a common DSS error. Individuals terminated from SSI due to earned income also may retain Medicaid eligibility under Section 1619(b) of the Social Security Act. A potential issue for litigation is DMA's failure to consider the combined effects of the 1619(b) and "passalong" disregards for former SSI recipients.

Certain types of income are excluded in determining Medicaid eligibility. Excluded income sources include SSI (unless in a nursing home), Work First Family Assistance, Food Stamps, assistance from other agencies, some veteran's benefits (aid and attendance, unusual medical expense reimbursement, and aid to the homebound), income of a minor child not needing Medicaid, a portion of a student's earned income, impairment related work expenses for the disabled and blind, irregular income, interest and dividends, earned income tax credits and other tax refunds, loans, lump sum payments from Social Security and SSI, and in-kind contributions other than food or shelter. Another useful income exclusion for disabled persons is income used to fund a Plan to Achieve Self Support. See 20 C.F.R. §416.1180. Income assigned to a (d)(4) special needs trust is also excluded. See Section O. below.

Because in-kind income or vendor payments (other than for food and shelter) are excluded for Medicaid (and SSI), one Medicaid planning device is to covert alimony payments or cash contributions from relatives to direct payments to creditors such as car payments, insurance premiums, and phone bills. Because in-kind support for food and shelter are counted, it is important that a Medicaid applicant living at home pay his pro rata share of household expenses for rent and utilities. Another possible but problematic option for disabled applicants under 65 who are over the Categorically Needy income limit may be to assign income to a special needs trust. See Section O below.

Applicants living at home with countable income above the poverty line must meet a deductible, i.e. "spend down" to the much lower "medically needy" income limit: \$242.00 per month for an individual and \$317.00 per month for a couple. The same income exclusions and deductions generally apply here. A deductible for prospective Medicaid coverage is computed based on a six month certification period. The amount by which countable income exceeds the medically needy income level is multiplied by six to determine the deductible. For retroactive coverage, excess countable income per month must be spent down for as many of the three months prior to the month of application for which the individual needs Medicaid.

Example: Mr. Smith lives at home. His Social Security check (before any deductions) is \$1000 per month Social Security benefits. He never received SSI benefits. He applies in November for Medicaid coverage of an October hospital bill as well as ongoing Medicaid. After the \$20 disregard, his countable income is \$980, over the categorically needy limit of \$907 per month, so he must spend down to the medically needy limit of \$242. His deductible for retroactive coverage for January is \$738 (\$980 minus \$242). His ongoing deductible for February through July is \$4428 (\$738 x 6 months).

The deductible is met by incurring (whether or not paid) medical expenses equal to the amount of deductible. Medicaid will not pay the bills used to meet the deductible. Any tax deductible medical expense can be used, whether or not Medicaid covers the service provided (e.g. over the counter medicine). Bills that are eligible for payment by Medicare or private health insurance can be used to meet the Medicaid deductible only to the extent the other coverage leaves the bill unpaid and the patient liable for payment. To meet a deductible, an individual can submit (1) paid or unpaid medical expenses incurred during the months for which Medicaid is requested; (2) "old bills" to the extent still unpaid (and not written off by provider) if they were incurred within the previous two years or if any payment was made on the bill within the last two years; (3) medical expenses of a spouse (or parent of a minor Medicaid applicant) whether or not the spouse is eligible for Medicaid and even if deceased, within the same limits in (1) and (2). MA-2360. Old bills should still be allowable in the full amount still owed even if the bill has been sold to a collection agency.

Once the deductible is met, Medicaid will pay the cost of covered medical services provided to the individual from the date the deductible is met until the end of the individual's current Medicaid certification period. In the example described above, the individual would have to incur \$4,428 in medical expenses before Medicaid would pay for his remaining medical expenses during that six month certification period. Medicaid will not pay the medical expenses that were used to meet the deductible.

Individuals not receiving Medicare automatically meet a six month ongoing Medicaid deductible by being admitted as a hospital inpatient. Medicaid is authorized as of the date of admission, regardless of length of stay, amount of deductible, or third party liability. Medicaid manual, MA-2360. This provision allows more individuals to qualify for Medicaid or to qualify earlier in their certification period. However, the hospital may bill the individual for the amount of his deductible, so this strategy may be unwise if the applicant is not judgment-proof. A second option which reduces the amount of the deductible is to wait to apply for retroactive Medicaid coverage until the month after hospitalization. But this option will not provide ongoing Medicaid coverage for other medical needs.

#### J. Medicare-Aid

Since 1989 Congress has provided a limited Medicaid benefit for Medicare recipients living at home with more liberal income and resource rules than regular Medicaid benefits. Unlike regular Medicaid benefits, Medicare-Aid does not cover any services not covered by Medicare. Medicare Aid covers Medicare Part B premiums. For those with incomes under the poverty line who do not qualify for full Medicaid due to excess resources, Medicare-Aid also covers Medicare deductibles and co-payments. All Medicare Aid recipients (like full Medicaid recipients) are automatically enrolled in the Low Income Subsidy (LIS) or Extra Help, which pays their Medicare Part D (prescription drug) premiums, co-payments, and deductibles. MA-2310, 2311. Those with incomes less than 150% of the poverty line and modest assets also may apply for LIS through DSS or SSA.

The resource limit for Medicare-Aid effective January 1, 2011 is \$6,680 for an individual and \$10,020 for a couple. (More on resources in Section L below). LIS resource limits are even higher, \$8180 for an individual and \$13,020 for a couple. Medicaid manual, § 2130, 2140. Income limits are also higher for these programs than full Medicaid. Effective April 1, 2011, a Medicare recipient with countable monthly income of \$1224 or less (\$1655 per month for a couple) is eligible for Medicare Aid. A written application for Medicare Aid must be filed at DSS, unless a regular Medicaid application has been filed. Many eligible Medicare recipients do not receive this benefit. In Martin v. N.C. DHHS, 670 S.E.2d 629 (2009), the N.C. Court of Appeals ruled that DMA must use the income limit for a couple when one spouse with Medicare applies for Medicare Aid with another spouse who is not Medicare eligible and has no income.

#### K. Income Eligibility for Nursing Home Care

Income eligibility for Medicaid is determined differently for individuals who need long term nursing care. Long term care budgeting (including the spousal income and resource allowances discussed below) applies to individuals who have been in a nursing facility for longer than one month.

Under long term care budgeting, only \$30 of countable income is excluded to be used for personal needs. A deduction from income is also made for medical needs not covered by Medicaid, if regularly reported to DSS. An additional deduction of \$242 per month is permitted if there is no spouse at home and the individual is expected to return home within six months. The remainder of the individual's income must be paid each month toward the current month's nursing home bill. This is called the monthly patient liability. Medicaid will pay the amount by which the Medicaid rate of payment for that level of care exceeds the patient liability.

Example: Ann, a widow, is in a long term nursing facility. Her income is \$1200 per month in Social Security. She has prescriptions not covered by Medicare of \$70 per month. Her patient liability is \$1100 (1200-30-70) and that amount must be paid by her to the nursing facility each month. Medicaid pays the remainder of the cost of her care and other medical bills.

A little known provision in the Medicaid manual permits an additional deduction from the monthly patient liability for payments made to the nursing home for charges from past months in which the individual was not Medicaid eligible. The deduction can include expenses incurred when the individual was over the Medicaid resource limit or otherwise ineligible. However, DMA has changed this policy to exclude ineligibility due to a transfer of assets sanction. The effect of this deduction is to permit the advocate to arrange a repayment plan by which the individual's monthly income is applied to past bills, leaving Medicaid to pay the entire current bill. This arrangement avoids eviction from the facility for unpaid bills, benefiting both the nursing home and the patient. Medicaid manual, MA-2270, VIII.F.

Example (continued): Ann owes the nursing facility \$10,000 for charges incurred before she became resource eligible for Medicaid. If she agrees to repay the charges at \$1100 per month, her patient liability for current charges is reduced to zero until the debt is repaid.

Deductions or exclusions from the income of a nursing home resident with no spouse at home are very limited. For example, Medicaid does not deduct alimony payments made by the nursing home resident to a divorced spouse or to a spouse separated for more than twelve months before institutionalization. This policy, which can create a choice between violating a court order and nursing home eviction, has generally been upheld by the courts. A deduction from patient liability is permitted for guardianship fees, but only up to \$25.00 per month. The limitation on this deduction is subject to challenge because it is inconsistent with SSI methodologies for individuals with income other than Social Security.

An important exception to normal nursing home budgeting applies if the patient's countable income exceeds the monthly Medicaid rate for that level of care but is less than the rate charged by the nursing home to private patients. Individuals in this "twilight zone" were once ineligible for Medicaid. But since the mid-1980's DMA has permitted additional deductions to allow the individual to become Medicaid eligible and thus pay the facility only the Medicaid rate and receive coverage for other bills. Medicaid Manual, MA-2270, V.B.3.

If an individual needing nursing home care has a spouse at home (living together or separated less than 12 months at time of entering facility), federal law provides an additional income exclusion in order to prevent "spousal impoverishment." This allowance applies only to income of the institutionalized spouse which is actually given to the "community spouse" (i.e. the spouse still living at home) and only if the institutionalized spouse's income is less than the nursing home's private rate. Effective July 2010, the first \$1,822 per month of the couple's income is allocated to the community spouse. The allowance is then increased by the amount by which utility bills, rent, insurance, taxes and other expenses for the home exceed \$547 per month (in 2010-11). Utility costs are based on a standard allowance (\$277/mo for one person in the home in 2010-11). As of this writing, the maximum protected amount is \$2,739 per month, but a higher amount may be permitted on administrative appeal based on a showing of "exceptional circumstances" and "significant financial hardship," or based on a court order (e.g. alimony, guardianship) which requires the community spouse to receive more income than the maximum allowance. Medicaid manual, Section 2270, IV. On appeal the hearing officer also may increase the minimum spousal allowance based on hardship (e.g. the community spouse's medical expenses) even if there are not excess shelter costs.

The community spouse's own income is subtracted from the allowance in determining the protected amount. Conversely, none of the community spouse's income is counted in determining the monthly patient liability if the community spouse's income exceeds the spousal allowance. (This rule may provide an incentive in some cases to transfer title to income producing property to the community spouse.)

Example: Bob is in a nursing home. His wife Judy lives at home. Bob has income of \$2,000 per month in social security and pension benefits. His wife has an income of \$600 per month social security. The mortgage, taxes, utilities and insurance on the home are \$1,250 per month. The private rate for Bob's nursing home care is \$4,000 per month. Is Bob income eligible for Medicaid. How much of his income is protected for Judy?

Answer: Bob is income eligible. His income (not counting Judy's income) is less than the private rate. Judy is entitled to income protection of \$2525 because \$1,822 plus her excess shelter costs (\$1,250 minus \$547) equals that amount, which is less than the maximum of \$2,739.

Her own income of \$600 is subtracted from the protected amount, leaving \$1925, which can be protected from Bob's income as long as he actually makes that income available to Judy. This leaves a patient liability of \$45 for Bob (\$2000 minus \$1925 minus the \$30 personal allowance). Medicaid will pay the remainder of the nursing home's charges at the Medicaid rate, plus other covered medical expenses.

N.C. DMA defines "community spouse" as separated less than 12 months at the time of institutionalization. MA 2270 VI.A. Thus, community spouse income protections are denied to a spouse who lives in the community if the couple was separated more than 12 months before the other spouse went into the nursing home. Nothing in 42 USC 1396r-5 or SMM 3260 supports this limitation on definition of community spouse if the couple is still married. Also, DMA provides no community spouse income allowance for applicants for the Community Alternative Program (CAP). MA-2270.

#### L. Resource Limit

A common barrier to Medicaid eligibility for the elderly and disabled is excess property or assets. Generally an individual can own only \$2000 of countable assets; a married couple living together can own up to \$3000 (even if one spouse is Medicaid ineligible). Additional property may be owned where Medicaid is sought for nursing home care and there is a spouse at home (see below). In addition, Medicaid for Workers with Disabilities (MA-2180) permits resources up to the same limit as the allowance for spouses of a nursing home resident. See Section M. Countable resources are assets that a Medicaid applicant or recipient (or, in most cases, her spouse) owns and are available for her support. Countable assets include bank accounts, investments, real property, personal property, cars, boats, life insurance, revocable trust funds, certain continuing care community entrance fees, and certain irrevocable trusts and annuities (see Section O below). Resources the individual may retain and still qualify for Medicaid are sometimes called the person's reserve.

The Medicaid resource limit for an individual (\$2000) applies if the applicant or recipient is not married, is married but separated from his or her spouse, is married and living with a spouse who receives SSI or Work First assistance, is a nursing home patient whose spouse lives in the community, is a nursing home patient whose spouse lives in another nursing home or in another room in the same nursing home, is a nursing home patient who lives in the same room as her spouse but the spouse does not request Medicaid, or she and her spouse live together but one or both of them are applying for or receiving assistance under the Community Alternatives Program waiver (CAP). Otherwise, the Medicaid resource limit for a couple (\$3000) applies if the applicant or recipient is married and is living with a spouse.

The countable assets of a financially responsible person generally are deemed to be available to the applicant. The resources owned by a spouse are counted if they live together or if the applicant is institutionalized (e.g. in a nursing home care) and the couple has been separated less than twelve months on the date of institutionalization. MA-2230 III. Also deemed available are the

resources of a parent for a minor disabled child who lives at home (unless enrolled in a CAP waiver). MA- 2230 III, MA-2260 III.

Some assets are not counted in determining Medicaid eligibility. Exempt assets include the home and all real property contiguous to the home site. However, for applications filed on or after November 1, 2007, Medicaid coverage for nursing services (institutional or CAP) is denied to those with equity in the home exceeding \$500,000 (increased to \$506,000 effective 1/01/11) unless a spouse, child under 21, or disabled child lives in the home. MA-2242. Reverse mortgages and home equity loans may be used to reduce the equity value of the home but cash from the loan or income from the reverse mortgage are countable. This provision does not apply to individuals continuously receiving Medicaid LTC services since before November 1, 2007. The excess home equity rule will be waived for demonstrated hardship. However, the request for waiver must be made within 12 days of notice of the right to do so. The standard for waiver in the manual is that the applicant has no other person able to take care of him if discharged and has no other assets. MA-2242. A denial of a request for demonstrated hardship is appealable under G.S. 108A-79.

Assuming the excess home equity rule is met, the home site remains exempt for nursing home residents in North Carolina if (1) a spouse or a minor or disabled child is living in the home; OR (2) a “dependent” (financially, medically, or for housing) relative (adult child, stepchild, grandchild, parent, stepparent, grandparent, aunt, uncle, sibling, stepsibling, half-sibling, cousin or in law) lives in the home; OR (3) the nursing home resident subjectively intends to return home someday (regardless of medical or other objective evidence of possibility of doing so). If the individual is incapable of stating intent, the representative may do so. There is no time limit on this exclusion. Also excluded is property contiguous to the applicant’s or recipient’s home if the applicant or recipient doesn’t own the home and the tax or fair market value of the contiguous property is less than \$12,000. However, these exemptions provide no protection from estate recovery which can attach if the home site is part of the Medicaid beneficiary’s estate at death. See Section P below.

DMA also excludes from countable resources real or personal property which is being rented if the property has an equity value of less than \$6000 AND produces an annual net income equal to 6% of its equity value, OR up to \$6000 in property used to produce goods or services for the home. MA-2230. Also exempt as an asset is real or personal property or even a bank account used in a trade or business (including a family farm), regardless of the value of the assets or amount of profit, so long as the a/r or spouse is actively involved in day to day operations and it is a legitimate business under IRS rules. MA-2230 VII. Unlike SSI and Special Assistance rules, N.C. Medicaid rules do not exclude real property which the applicant is making a good faith effort to sell. This omission is subject to possible legal challenge. Estate of Greer v. Chen, CCH Medicare/Medicaid Guide, ¶43162 (D.Ariz. 1995).

Medicaid rules also exclude from countable assets tenancy in common interests in real property, life estates, remainder interests if more than one remainder holder (other than spouse),

personal belongings, household goods, one licensed motor vehicle per household (but only up to a fair market value of \$4500 effective July 1, 2006), if used for transportation of the applicant/recipient, the cash value of life insurance when the total face value is no more than \$10,000, retirement accounts that cannot be withdrawn as lump sums, awards of retroactive Social Security and SSI benefits for a period of nine months following receipt, Earned Income tax credit and child tax credit refunds for 9 months after receipt (even if commingled with other funds), cash or other resources received for repair or replacement of lost, stolen, or damaged excluded resources for a period of nine months after receipt, educational grants and scholarships for 9 months after receipt, funds held under a Program to Achieve Self Support (PASS) approved by SSA, and burial plots for family members. Also for burial, the Medicaid manual exempts one of the following: 1) irrevocable pre-need burial contracts of any reasonable value for the individual and spouse, or 2) up to \$1,500 each for the applicant and spouse of the cash value of life insurance or a bank account if designated for burial. Medicaid Manual, Section 2230.

Only assets that are "available" to the applicant (i.e. may be converted to cash to pay for medical care) are counted. An asset may be considered available if there is no legal impediment to accessing it even if the recipient or his attorney in fact is not aware of the existence of the asset. Cloninger v. N.C. DHHS, 691 S.E.2d 127 (N.C. App. 2010). Proof that a resource is not legally or "actually available" excludes the property entirely until it becomes available. Haynes v. Dept of Human Resources, 470 S.E.2d 56 (N.C.App. 1996). The presumption of availability may be rebutted, for example, by evidence that the individual does not have equitable title to the property because of a parol or resulting trust. Medicaid manual, Section 2230, V.

Similarly, DMA presumes the availability of all funds in a joint bank account held by the Medicaid applicant with another person unless both persons must sign for a withdrawal of funds. This presumption may be rebutted by evidence that the Medicaid applicant's name is on the account as an agent for the owner of the funds or that the applicant has ownership of only one half of the funds. MA-2230 V; O'Brien v. Reece, 263 S.E.2d 817 (N.C. App. 1986).

Availability also may be rebutted by evidence of mental incompetence. DMA regulations provide that resources belonging to a mentally incompetent person are not considered to be available to him for purposes of Medicaid eligibility until necessary legal action has been taken to enable the resources to be converted to cash. MA 2230, VI. This provision means that in the absence of a valid power of attorney (recorded, durable, with power over assets), the incompetent individual will be eligible for Medicaid regardless of the fair market value of resources he owns until a guardian is appointed and (for real property) until the court issues a final order approving the sale of the property. The written opinion of incompetence to last at least 30 days (or end in death before then) from a doctor, psychologist, nurse, or social worker is sufficient to establish incompetence. DSS is required to file the incompetency/guardianship proceeding if no family member does so. Once a guardian is appointed, the best interest of the ward may be served by requesting the court to approve the purchase of (or conversion to) assets considered exempt by

Medicaid. Argue such a disposition preserves the ward's estate while obtaining Medicaid eligibility.

Resources generally are valued by DSS at their "equity value," subtracting mortgages, liens, and other encumbrances from the tax value of the property. However, an applicant has the right to rebut the value assigned by DSS to a resource by submitting evidence that the property is not actually worth its tax value. DSS values a second automobile based on its book value, but this may be rebutted by a statement from a dealer that the vehicle is worth less. In addition, liens against property are sometimes not known to DSS, including judgments and tax liens. MA-2230.

The Medicaid manual provides that if a Medicaid applicant has countable resources in excess of the resource limit at the time a medical bill is incurred, Medicaid coverage must be denied for that bill. Thus, for example, an individual with no spouse who owns assets worth \$2,100 when he incurs a \$50,000 hospital bill is not eligible for Medicaid coverage for any of that bill. This is the case even if he spends his assets down under the \$2000 limit the day after he leaves the hospital. The N.C. Courts have upheld this provision, but also held that federal law would permit a "resource spend down" provision if the state chose to adopt it. Elliot v. N.C. Dept of Human Resources, 115 N.C. App. 613, 446 S.E.2d 809 (1994), aff'd per curiam, 341 N.C. 191, 459 S.E.2d 273 (1995).

Although the general rule is that resource eligibility must exist before the medical bill is incurred, an exception exists for the designation of funds in a bank account or life insurance for burial purposes. Such a designation may be made within thirty days after the date of the Medicaid application and still have retroactive effect up to three months before the month of application. Surgeon v. Division of Social Services, 357 S.E.2d 388 (N.C. App. 1987); Medicaid manual, Section 2230. A possible subject of future litigation is whether the Surgeon retroactive effect of a resource exemption applies to the purchase of irrevocable pre-need burial contracts in excess of \$1500. However, the decision in Elliot may make expansion of Surgeon difficult.

Another exception to this rule is that if the individual is under the resource limit on the first day of the month, eligibility exists for the entire month even if resources are acquired during the month. Conversely, if resources are spent down under the limit during the month, eligibility begins on the day the individual is under the limit.

#### M. Resource Protection for Nursing Home Patients with a Spouse at Home

Except for individuals institutionalized continuously since September 30, 1989, assets belonging to the community spouse are deemed to be available to the spouse in the nursing home. The community spouse's resources are excluded only if the couple was continuously separated for one year prior to entering the facility, or if the community spouse cannot be located. Refusal of the community spouse to cooperate, prenuptial agreements, and separation agreements

are not grounds for excluding the community spouse's assets.

If the community spouse refuses to provide his assets to the institutionalized spouse, federal law permits the nursing home resident to become Medicaid eligible by assigning to the state her rights to support. 42 U.S.C. Section 1396r-5(c)(3)(A); Morenz v. Wilson-Coker, 415 F.3d 230 (2nd Cir. 2005); State Medicaid Manual Section 3262.2D. This provision is absent from the N. C. Medicaid manual despite two N.C. statutes which arguably give DMA the authority to accept such an assignment or seek spousal support. See N.C.G.S. 108A-59; 108A-70(b). Federal law also requires the state to allow an undue hardship exception to spousal deeming for institutionalized persons. 42 U.S.C. 1396r-5(c)(3)(C); SMM 3262.2D. This provision is also absent from the N.C. Medicaid Manual.

"Spousal impoverishment" provisions in federal law for nursing home patients with spouses at home include a resource allowance for the community spouse which can protect a large amount of assets. MA-2231. These resources protections (but not the community spouse income allowance) also apply to an individual living with a spouse but seeking services under the Community Alternatives Program (CAP). MA-2230 III. At this writing, the allowance protects for use by the community spouse all of the couple's non-exempt assets up to \$21,912 OR one-half of their otherwise countable assets, whichever is greater, up to a maximum of \$109,560. A hearing officer may protect even more of their assets based on special circumstances or a court order, as discussed above with regard to the spousal income allowance. Assets protected by the spousal allowance must be transferred to the community spouse within a reasonable time.

Both rules just discussed -- the availability of the community spouse's assets and the spousal resource allowance -- apply only to assets that the couple owned at the time the Medicaid applicant first entered the nursing facility (even if institutionalization is later interrupted). If assets of the nursing home resident increase while he is there, those assets are countable in full. However, any increase in the community spouse's assets after Medicaid is approved is disregarded. Upon request, DSS will perform an assessment at the time of entry into the facility to determine the amount of protected resources. Obtaining an assessment is strongly advised for private patients with community spouses who may later need Medicaid in order to assure there is proof of the value of assets at the relevant time. An assessment also may include DSS advice about how Medicaid eligibility may be established without exhausting all assets paying for nursing care.

Example: Bob and Judy own the following assets at the time he enters a nursing home: their home, \$50,000 in a bank account, two cars valued at \$5,000 and \$2,000, household goods, jewelry worth \$1,000 and a painting worth \$5,000. Since Bob entered the nursing home, the bank account has dropped to \$35,000 but the other assets remain the same. How can Bob qualify for Medicaid? What assets are protected for Judy?

Answer: The home is exempt so long as Judy lives there. The more valuable car is exempt if used for Bob's transportation. Household goods, including the painting, are exempt as long as Judy is living in the home. Jewelry, regardless of value, is exempt as a personal effect. This leaves the bank account and \$2,000 car (\$37,000). Because the countable assets were worth \$52,000 at the point of institutionalization, one half of that amount (\$26,000) is protected for Judy. \$37,000 minus \$26,000 minus the resource limit of \$2000, leaves \$9,000 in Bob's excess resources. To become resource eligible, Bob must spend that \$9000 on his care (or other bills) or convert Bob's countable assets (\$9000) to exempt assets. For example, he can purchase an irrevocable burial contract for each of them. He also can prepay household bills and debts such as the home mortgage, make home repairs and improvements, and purchase additional furnishings, appliances, and personal effects. Or Bob and Judy can take out a home equity loan before he enters the facility, which increases the one-half share protected for Judy, then repay the loan out of Bob's half of countable assets after he enters the facility.

#### N. Transfers of Assets

Federal law mandates a strict transfer of assets penalty for Medicaid eligibility for certain services. The law includes a disqualification period for transfers of property without receiving fair consideration that occur within a "look back" period or anytime after becoming Medicaid eligible for those services. A penalized transfer can include any action to change ownership, waive or renounce assets or income, or change the names on or make withdrawals from a bank account. The transfer of asset rules have been significantly changed beginning with transfers made on or after November 1, 2007.

A transfer disqualification does not result in denial of Medicaid eligibility, but rather denial of coverage for specified services: skilled or intermediate nursing care in a facility, services under a community-based waiver (CAP), and hospital care if the individual has a medical need only for nursing care (i.e. is awaiting placement).

OBRA 93 gave states the option to extend transfer penalties to home health care services for non-institutionalized persons. North Carolina elected to exercise this option effective February 1, 2003. Thus, effective with transfers occurring on or after February 1, 2003, N.C. DMA, pursuant to a directive from the 2002 General Assembly, expanded the services which were denied to recipients under a transfer of assets disqualification. The expansion included all home health services provided outside CAP (except for private duty nursing), personal care services, durable medical equipment, home infusion therapy, and home health supplies. Sanctioned recipients could still receive coverage for all other Medicaid covered services such as prescription drugs, doctor visits, hospitalization, and dental care. However, effective with transfers occurring on or after November 1, 2007, the transfer of assets penalty for home health services (other than CAP) can occur only if a portion of the sanction period remains after first

being applied to institutionalization or a request for CAP services. MA-2240. The sanction period runs continuously once it begins. The penalty can still begin with in-home services for transfers prior to November 1, 2007.

The transfer of assets penalty applies only to uncompensated transfers made on or after the beginning of the “look back” period. Any non-exempt, uncompensated transfer after the look back date is subject to penalty. The trigger date or ending date of the look back period is called the “starting point.” For applications filed on or after November 1, 2007, the “starting point” is the date the person is both admitted to the nursing home (or has requested CAP services) and has applied for Medicaid to pay the cost of nursing home care (or CAP services). For applications made before November 1, 2007, the “starting point” is the date she first applies for Medicaid for home health services.

Under OBRA 93, the "look back" period for imposing the penalty applied to any transfer made within 36 months prior to a Medicaid application by an institutionalized person, except that the look back period was 60 months for transfers made to a trust or annuity. However, DRA 2005 gradually increases the look back period to sixty months for all transfers. If the “starting point” is before November 1, 2010, the look back period is 36 months (except for transfers to a trust or annuity). If the “starting point” is between November 1, 2010 and November 1, 2012, the look back period is always back to November 1, 2007. After November 1, 2012, the look back period is always sixty months. Once established, the look back date never changes. The look back period for one spouse controls for the other spouse, even if the second spouse has not applied for Medicaid.

For transfers made before November 1, 2007, the sanction period begins with the first day of the month in which the property is transferred. However, under the DRA, the beginning of the sanction period is postponed until the individual applies for and is “otherwise eligible” for Medicaid payment for long term care. DMA and CMS have interpreted this provision to require that the individual actually be receiving long term care in a facility or at home before the penalty can begin. MA-2240. This interpretation can create a never-ending “Catch 22” penalty if the nursing home won’t admit the individual until she becomes Medicaid eligible. A legal challenge to this interpretation of DRA is possible. This provision applies to all uncompensated transfers made on or after November 1, 2007.

The number of months of disqualification is determined by dividing the uncompensated value (the fair market value of the asset minus any liens and minus the compensation received) by the average private monthly rate for nursing home care, rounded down to the nearest whole number. However, rounding down is no longer permitted under the DRA for transfers made after November 1, 2007. This means that fractional portions of a month are now included in computing the penalty period. The current figure for the denominator in this calculation (the average monthly cost of private nursing care) is \$5500. Future increases in this figure can be expected because federal law requires that this figure reflect the average statewide private cost of nursing care at the time of application. There is no outside limit on the length of the sanction for any transfer made within the look back period. MA-2240. For transfers of property worth less than \$5500 made before

November 2007, the transfers are accumulated until they exceeded that amount; then the sanction began. MA- 2240, XII.C. Disqualification periods for multiple transfers run consecutively. Transfers in the month after a sanction period ends must be added to the prior transfer. The same accumulation principle applies to transfers of income.

The transfer of assets penalty applies to transfers made by the applicant or recipient, the applicant's or recipient's spouse, or any person acting on behalf of the applicant or recipient or on behalf of the applicant's or recipient's spouse (for example, a court-appointed guardian). A transfer of or relinquishing the right to receive a lump sum payment (e.g. renouncing inheritance or right to personal injury award) is subject to the transfer penalty. Also penalized are transfers of income sources (e.g. of right to receive pension).

For transfers made on or after November 1, 2007, the transfer of assets penalty applies to the transfer of any countable or non-countable resource or income (including the applicant's or recipient's home, tenancy-in-common interests in real property, life estates, exempt automobiles, household goods, jewelry, etc.). MA-2240, IV.D. and V.C. For transfers made before November 1, 2007, transfers of most exempt assets other than the home are not penalized. This expansion of the rule to transfers of exempt assets could be challenged as inconsistent with the N.C. Administrative Procedures Act because no rulemaking process was followed. The policy also appears to conflict with the language of the N.C. transfer of assets statute, G.S. 108A-58.1, which does not authorize penalizing transfer of any exempt assets except for tenancies in common, income producing property, and life estates. See also, CMS State Medicaid Manual, Section 3257B4.

Even for transfers made before November 1, 2007, transfer of property exempt as a former home site OR as non-business income producing property OR as a tenancy in common interest is penalized. Transfer of an ownership interest in the home site has always been penalized even though the home is excluded as an exempt asset. The home site is defined very broadly: property which *at any time within the look back period* was used as the principal place of residence by a/r or a spouse or a dependent relative or to which a/r intended to return. MA-2240, VI.B

For annuities purchased by the applicant or spouse on or after November 1, 2007, the state of N.C. must be named the remainder beneficiary. The application of this provision of the DRA to annuities purchased by the spouse could be the subject of legal challenge. See 42 U.S.C. 1396p(c)(1)(G). Copies of annuity contracts must be provided to DSS. Failure to meet these requirements is treated as a transfer of assets. For annuities purchased before or after November 1, 2007, the purchase is considered a transfer of assets where the principal is currently unavailable to the Medicaid applicant and the annuity was established within the 60 month look back period for trusts. MA-2240. The purchase of a single premium pure endowment policy is treated as an uncompensated transfer.

An annuity purchase before November 1, 2007 was an allowable transfer if the beneficiary is the applicant (or a spouse, blind or disabled child, or unrelated disabled person under age 65) and the beneficiary is expected to live long enough (based on actuarial tables) to receive an amount

equal to or greater than the amount of the purchase. However, even before November 1, 2007, purchase of an annuity with minimal payments and a balloon payment was penalized as a transfer of assets. MA-2240.

The purchase of a promissory note, loan, or mortgage on or after November 1, 2007 also may be treated as a transfer of assets unless the repayment terms meet certain criteria. DRA penalizes the purchase of a promissory note if the note provides for cancellation on death, deferral of payments, unequal payments, or a balloon payment. However, DMA appears to have removed the requirement that the note be negotiable for notes purchased after 11/1/07. MA-2240 IX.B. The purchase after 11/1/07 of a life estate in the home of another also may be penalized if certain requirements are not met, including that the purchaser live in the home for one year after purchase. MA-2240 IX.C.

Withdrawals of assets from joint accounts also create a transfer of assets penalty, even if the action was not taken by the applicant. OBRA 93 clarified that assets held in joint tenancy will be considered transferred "when any action is taken, either by such individual or by any other person that reduces or eliminates such individual's ownership or control of such asset." Such action may include establishing a joint account with the applicant's funds, adding the other person's name to an existing account, removing the applicant's name from the account, or withdrawal of funds by the other person. This provision can cause serious problems for applicants who have joint accounts with adult children and others but have not kept detailed records regarding ownership of funds and consideration received.

The follow transfers are exempt from the penalty provision: (1) transfer of any property to or legally restricted for the benefit of a child in the home who is under age 21, blind, or disabled; (2) transfer of the home to an adult child who cared for the institutionalized individual, permitting him to remain at home rather than in a facility for at least two years immediately before his institutionalization; (3) transfer of the home site to a sibling who has an ownership interest in the home and lived there for at least one year immediately prior to the institutionalization; (5) transfer of any property to the community spouse or to another for the sole benefit of the community spouse (but transfers to the spouse after Medicaid has been approved are limited to an amount equal to the resource allowance for the community spouse, transfers by the community spouse prior to establishing Medicaid eligibility are subject to the transfer of assets penalty, and transfers of the home by the spouse are still penalized even after Medicaid is approved); (6) the property was transferred by a person other than the Medicaid applicant to a (d)(4) special needs trust for a disabled individual under age 65. See Section O below.

The November 1, 2007 policy change requires the county DSS to request bank statements and other financial documentation for the entire look back period from applicants for CAP or Medicaid coverage of nursing home care to verify that an illegal transfer has not taken place. DSS must assist in obtaining this information and must accept alternative documentation that provides a reasonable picture of the look back period.

Proof that the applicant received fair compensation for the transfer can eliminate or at least reduce the uncompensated value, and thus the penalty. The applicant can rebut both the value of the transferred asset and the value of the consideration received. MA-2240, XIII.B. However, DMA has imposed some restrictions on the definition of “good and valuable consideration received” for the transfer which appear to conflict with N.C. contract law, N.C.G.S. 108A-58.1(f)(2), the N.C. Administrative Procedures Act, and federal law. For example, the manual states that personal service contracts are compensation only if a written contract existed prior to services being rendered and only if the recipient is not in a nursing facility. MA-2240, IX.H. In contrast, N.C. contract law does not require a personal services contract to be in writing and does allow a person who is institutionalized to enter into a valid personal services contract. In addition, settlement of a past debt or claim, regardless of its validity, made honestly and in good faith, provides valuable consideration for the transfer according to N.C. law. Holt v. Holt, 304 N.C. 137 (1981). The manual also appears to penalize transfers prior to November 1, 2007 even under a written personal services contract. MA-2240, IX.H. This is despite a CMS interpretation to the contrary. See, e.g., Thomas v. Fla. DHS, 707 So.2d 954 (Fla. Ct. of App. 1998) (lifetime contract by daughter to supervise health care and provide other personal services to her mother in the future was valid consideration for transfer of over \$67,000.)

The transfer of assets penalty also can be rebutted or reduced by evidence that (1) the Medicaid applicant intended to obtain fair market value or "other valuable consideration" (documentary evidence of two attempts to dispose of asset for fair market value); or (2) the property was transferred exclusively for a purpose other than obtaining Medicaid eligibility (greater weight of oral or written evidence is sufficient to overcome presumption); or (3) the Medicaid applicant has been defrauded according to DSS adult protective services or other evidence; or (4) the Medicaid applicant has been a victim of exploitation or abuse or threatened abuse. MA-2240, XIII.C.

The manual lists factors to be considered that will make it difficult for some to show the grantor’s intent was not for the purpose of qualifying for Medicaid, including whether recipient consulted with an attorney before making the gift and whether a person providing evidence of intent benefited from the gift. MA-2240 XIII.C. A related concern raised by the DRA is that small gifts to church or charity or family members (e.g. birthday gifts) within the last five years will cause a penalty (that is then postponed) unless the presumed purpose of each transfer is rebutted or undue hardship is established. DMA has stated in the manual that a “pattern of giving” to a church or family member may establish that the purpose was not to obtain Medicaid. MA-2240 VI., XIII.C.

A new manual provision was added November 1, 2007 based on changes in state and federal law allowing a waiver of the transfer of assets disqualification in the case of "undue hardship." MA-2245. This provision applies to transfers both before and after November 1, 2007. The DRA and N.C.G.S. 108A-58.2 have adopted the following definition of undue hardship: when application of the transfer provisions would deprive the individual of medical care such that his life

would be endangered OR he would be deprived of other necessities of life. However, DMA's manual provision has added further restrictions and particular documentation requirements beyond what is authorized by either the state or federal statute and without promulgating these additional requirements as rules. See, MA-2245 IV. DSS must notify applicants of the right to claim undue hardship. The individual must request an undue hardship exception within 12 days of notice of the sanction. An additional 12 day period is given to provide evidence of the hardship. A denial of undue hardship, like the transfer sanction itself, is appealable for a local and then a state hearing. Problems with the content of DMA's transfer of asset decision notices could be used as an argument for extending the time period for appeal. See MA-2240 XIV. and Section C. above.

Once imposed, a sanction period may be lifted under the following circumstances: (1) the resource is transferred back to the transferor; (2) compensation equal to or greater than the uncompensated value of the transferred resource is paid to or on behalf of the Medicaid applicant. MA-2240. VIII. The sanction period is thus lifted or erased retroactively if the asset is returned to the applicant or if an amount equal to the uncompensated value is spent for the benefit of the applicant/recipient. However, under a November 2007 manual change, the returned asset or funds are counted as assets for the entire period they were not in the name of the applicant, which is likely to result in Medicaid ineligibility for the entire period. If a portion of the uncompensated value is returned, similar but more complex rules apply. MA-2240, XII.E. This provision applies even to transfers made before November 1, 2007. This provision could be challenged as inconsistent with the CMS State Medicaid Manual, Section 3258.10C.3, both as to money spent for the benefit of the Medicaid applicant and as to returns of a portion of the asset or equivalent value, particularly if the portion returned is an exempt asset (e.g. life estate).

#### O. Treatment of Trusts and Annuities

OBRA 93 significantly changed the law concerning Medicaid treatment of trusts (and annuities). Unlike the rules governing transfers of assets and estate recovery, the trust rules described below apply to all Medicaid services, not only nursing care. The OBRA 93 trust provisions were to be effective for trusts established after August 10, 1993, but North Carolina DMA delayed the effective date until April 1, 1994. DRA did not make material changes to these rules, except as described in Section N above.

The 1993 provisions clarified that Medicaid will consider as a countable asset the entire corpus of a revocable trust, regardless of its terms. Any payments from a revocable trust to the recipient are countable income; distributions to anyone else are evaluated as a transfer of assets if within the 60 month look back period. Changing a trust from revocable to irrevocable also may be a transfer of assets.

Also considered available under the 1993 rules are the corpus and income of an irrevocable trust if the trust was established after April 1, 1994 in whole or in part with the income or resources of the individual seeking Medicaid or his spouse and if there are any

circumstances under which payment from the trust could be made to benefit that grantor. Under the 1993 law, it does not matter whether the trust is established by the individual, a spouse, or another person or court with legal authority to act for the individual or spouse or acting at their direction. It is sufficient if the assets of the individual or his spouse were used to fund all or part of the trust. The rules also apply to a trust established by a third party in order to settle a claim by the Medicaid applicant. The 1993 rules apply regardless of the purpose of the trust, discretion of trustee, or any limitation on distributions or use of distributions from the trust.

OBRA 93 also clarified that any portion of the irrevocable trust established with assets of the Medicaid applicant from which no payments can be made benefiting the individual is considered a transferred asset as of the date on which payment to the individual is foreclosed (if within the 60 month look back period mentioned above). This applies to trusts created after April 1, 1994 and to additions to existing trusts after that date. This transfer penalty also applies to the uncompensated value of any payments made to other persons after April 1, 1994 from irrevocable trusts in existence on that date that were created with the assets of the Medicaid applicant. Annuities are treated as trusts under the 1993 law if the expected return on the annuity is not commensurate with the life expectancy of the beneficiary (based on life expectancy tables). MA-2230, MA-2240.

OBRA 93 exempts from these rules irrevocable testamentary trusts created on the death of a third party, including trusts established at the death of the Medicaid applicant's spouse. MA-2230, XI.J. In addition, living trusts established with the assets of another person not financially responsible for the Medicaid applicant are considered available to the Medicaid applicant only to the extent provided by the trust instrument. If the trust grants discretion to the trustee not to make distributions and the trustee refuses to do so, the trust is not an available asset. These rules mean that third party supplemental needs trusts can still be used to provide for needs of the Medicaid recipient. However, if the trust is used for food or shelter, this may be counted as income by SSI and Medicaid. See Section I above.

Also exempt are "(d)(4)(A) special needs trusts" to benefit disabled persons under age 65, established by a parent, grandparent, legal guardian, or court, if the state is to receive all funds remaining on the death of the disabled individual up to the amount of medical assistance provided. These trusts are exempt from Medicaid and SSI trust rules and from Medicaid and SSI transfer of asset rules even though established with the assets of the individual seeking Medicaid. Such trusts are popular and can be very beneficial in paying for services not covered by Medicaid for younger permanently disabled individuals who are to receive a personal injury settlement or other assets. These trusts cannot be established by the Medicaid applicant himself, but can be established with his assets by a parent, grandparent, legal guardian, or court. The person or court establishing the trust must have authority to do so.

Pooled special needs trusts under section (d)(4)(C) are an option for individuals with smaller amounts of assets and can be established by the individual himself, but there are

administrative expenses involved in such a pooled trust. Importantly, (d)(4)(C) trusts can be used for individuals over age 65. However, the manual penalizes as a transfer of assets funds put in a d4 trust after age 65. This rule has been challenged in some other states. The leftover funds at death can be retained by the nonprofit which administers the pooled trust. For more information on pooled trusts, I recommend Life Plan Trust, 1-888-301-0799. Once a special needs trust is established, DSS may monitor it to make sure that funds actually are used only for the benefit of the disabled individual. Another issue to address before establishing such a trust with a personal injury settlement is the state's lien on a portion of the settlement proceeds if Medicaid has paid for medical care for the injury.

Another important point about the (d)(4) trust is that the trust can be funded with income belonging to the Medicaid applicant, for example from installment payments under a structured personal injury settlement. See 42 U.S.C. 1396p(e)(1). An assignment of income to a (d)(4) trust is not penalized under SSI and Medicaid transfer of asset rules. Two limitations on such a strategy involve whether the payer of the income will agree to the assignment and whether the person establishing the trust has the authority to make the assignment. For example, some pension plans by their terms do not permit the beneficiary to be changed in this way. The third issue in such cases is whether the assignment operates to exclude the assigned income from countable income for Medicaid purposes. If it does, a (d)(4) trust could be used to qualify for Medicaid individual who would otherwise be over the Medicaid income limit. Even Social Security benefits have been assigned to be paid to a trust under a court order establishing a (d)(4) trust. However, a dispute with the state agency is likely to arise regarding whether such diverted income will be excluded under Medicaid rules, particularly for long term care budgeting. But see, *Matter of Kennedy*, 779 N.Y.S.2d 346 (2004).

A waiver of Medicaid disqualification due to an irrevocable trust is required by federal law in the case of "undue hardship." HCFA has developed the following definition of undue hardship: when application of the trust provisions would deprive the individual of medical care such that his life would be endangered or he would be deprived of other necessities of life. HCFA Transmittal No. 64, Section 3259.8 (Nov. 1994). However, DMA has not adopted any rule or manual language to implement this provision. This issue could be litigated and has been successfully raised in administrative appeals.

#### P. Estate Recovery

OBRA 93 required the state Medicaid agency to recover from the individual's estate the cost of Medicaid that was provided to persons age 55 and older for services in a nursing facility, home health care (including CAP), and related hospital and prescription coverage. Recovery is also mandated for recipients of any age in long term care who are "permanently institutionalized", i.e. cannot reasonably be expected to return home. North Carolina's estate recovery statute is at N.C.G.S. Section 108A-70.5. Significant changes to these provisions, including creating pre-death liens, that were scheduled to take effect on July 1, 2007, were

repealed by the General Assembly in 2007. Also in 2007, G.S. 108A-70.5(b) was amended to remove some Medicaid services from the list subject to estate recovery. For example, prescription drugs, Medicare premiums, physician services, and home health services are not subject to estate recovery. DMA's rules to implement the statute appear at 10 NCAC 50D .0101, et seq.

The estate subject to recovery is defined the same as under G.S. 28A-15-1, so that real property held by spouses as tenancy by entirety and assets conveyed through joint tenancy, remainder interests, life insurance and living trusts are exempt from estate recovery. G.S. 108A-70.5(b)(2). Estate recovery may be waived if the amount of Medicaid services provided to the deceased recipient did not exceed \$3,000 or if the value of the decedent's estate is less than \$5,000.

The state cannot collect at all from the estate if there is a surviving spouse, minor child, or adult disabled child. Current N.C. published rules improperly limit the exemption for disabled adult children to those who live on the property and who became disabled before age 21. Under federal law estate recovery is flatly prohibited if there is an adult disabled child. DMA has corrected some estate recovery notices to make this exemption clearer. However, the definition of "disability" and how disability is determined are still unanswered by DMA rules.

DMA has defined "cannot reasonably be expected to return home" to include all institutionalized recipients under age 55 not expected to come home within six months of admission even if the individual has in fact returned home. This expansion of the definition of "permanently institutionalized" appears to be inconsistent with both state and federal law.

Estate recovery may be waived or postponed upon a showing of undue hardship. The definition of undue hardship has been somewhat changed under a Medicaid State Plan amendment effective July 1, 2007. The new definition exempts an estate from a Medicaid claim if property in the estate is the sole source of income for an heir (and if that and all related persons living with him have a combined income below 200% of poverty OR if recovery would force the sale of the residence of an heir who lived there at least 12 months prior to the Medicaid recipient's death and who (along with family members living with him) has income below 200% of poverty and assets of less than \$12,000 (not including the home).

A request for an undue hardship waiver must be made within 30 days of notice of estate recovery. It is unclear under the rules and N.C.G.S. 28A who must receive the notice or how specific the notice must be to trigger the 30 day deadline, particularly when no estate administrator has been appointed. A denial of an undue hardship waiver can be appealed within 60 days to the Office of Administrative Hearings for a de novo hearing.

#### Q. Medicaid Planning

Recent changes in Medicaid rules significantly limit the ability of individuals to divest themselves of countable income and assets to qualify for Medicaid eligibility. As of this writing, it is still permissible to transfer large amounts of assets, if the individual then waits 60 months to apply for Medicaid. Some individuals may give away a portion of their assets, and use the remainder to pay for care during this waiting period.

While such transfers are only effective if they occur well ahead of time, individuals in some cases may instead wish to convert countable assets to exempt property after entering the nursing home. This is because half of the countable assets at the time of entering the nursing home are protected for the community spouse, up to the maximum discussed above. This exclusion is maximized by having more countable assets at admission. See Section M. above.

On the other hand, resource conversions/transfers need to be made before receiving services for which Medicaid coverage is needed. Examples of still allowable strategies discussed in more detail above include: (1) purchase burial plots and irrevocable pre-need burial contracts for applicant, spouse, other family members (plots only); (2) purchase items that will be excluded as household goods or personal effects (e.g. paintings, jewelry, furniture), but these items no longer may be given away without penalty; (3) purchase a motor vehicle (or trade in for a more expensive vehicle but only up to \$4500), but this item no longer may be given away without penalty; (4) purchase services which have no continuing value as resources (e.g. home repairs); (5) pay off a mortgage on an exempt home and other debts; (6) purchase a personal services contract if the new requirements of the manual are met; (7) establish a special needs trust for disabled individuals under age 65. Asset planning must take into account the likelihood of estate recovery at death, particularly if assets remain in the name of a Medicaid recipient without a spouse.

Planning to reduce countable income is another important issue, since otherwise reducing countable assets may be of little or no benefit. Strategies include transferring title to income producing property to the community spouse, converting income producing assets to assets which don't produce income, changing the income beneficiary of an annuity or other income source to the community spouse or to a (d)(4) special needs trust (but see Section O above), appealing the amount of income protected for the community spouse based on hardship, exploring passalong eligibility, and converting countable cash contributions from relatives or a divorced spouse to excluded vendor payments.

Prior to undertaking Medicaid planning for a client, an attorney needs to be very familiar with the applicable law, which changes frequently. The above description of the rules is general and applies only in North Carolina.

The client should always be advised of the risks and disadvantages of Medicaid planning. For example, if the community spouse herself needs nursing care in the future, transfer of income and assets to the spouse may only postpone the problem. An attorney considering Medicaid

planning should carefully consider and discuss with the client the following questions:

1. Who do I represent? A conflict of interest obviously may exist between an adult child or spouse who is to receive assets and the institutionalized individual who is to lose his assets and rely on Medicaid. Being aware of a potential conflict is particularly important where the individual needing long term care has limited mental capacity or may be subject to undue influence or duress by another relative. If a power of attorney or guardianship exists, self-dealing should be avoided (unless explicitly authorized by the power of attorney) or the action taken may be voided later. A power of attorney must explicitly include the power to give away real property. Whitford v. Gaskill, 460 S.E.2d 346 (N.C. App. 1995).

2. Is Medicaid the best source of funding for long term care in this case? Although the law prohibits discrimination in the quality of nursing home services between Medicaid and private pay patients, such discrimination does exist. The best nursing homes may not accept Medicaid. It is often difficult to find a nursing home placement in a Medicaid bed unless the patient goes in as a private pay patient and has significant liquid assets at the time of entry. Duration of stay contracts (where the patient agrees to remain private pay for a certain period of time) and third party liability contracts (where a relative guarantees payment) are no longer legal or enforceable but some nursing homes still try to require them. A private health insurance policy for long term care is an affordable alternative to Medicaid for many individuals, especially if purchased while the individual is still relatively young and healthy. Another alternative is a life care facility, which may guarantee lifetime care at increasing levels of care for an up-front fee and a fixed monthly charge. However, be aware of DRA rules concerning continuing care communities.

3. Are you certain this person will need long term nursing home care? Medicaid coverage for long term care depends on the physician's certification at regular intervals, accepted by the state, that skilled or intermediate nursing care is medically necessary. If assisted living care is determined by the state to be sufficient, the state will only pay for assisted living care and will do so only if different, more strict eligibility rules are met. See section R below. This problem could arise any time the individual's medical condition changes.

In addition, home health care is sometimes a viable and healthier alternative to living in a facility, if there are family members who are willing and able to provide care on a regular basis. Medicare and private insurance coverage, which do not require divestiture of assets, are more likely to be available to help pay for skilled nursing care at home (but not personal care and not indefinitely) or hospice care (Medicare coverage available for up to six months including prescription drugs) than for care in a nursing facility. Medicaid also may provide limited personal care services at home (or more through a CAP waiver).

4. What tax consequences will result from these transactions? Often Medicaid planning has an adverse effect on the basis of property (unless a life estate is preserved). Reselling a home within two years can create capital gains tax liability. Federal gift tax liability is unlikely due to

tax law changes, but a return must be filed for gifts exceeding the annual exemption.

5. If the individual impoverishes himself, how will his needs which are not covered by Medicaid be funded? Is the individual willing to rely on promises of contributions from relatives that cannot be enforced? The psychological effect of a loss of independence and control associated with divestiture of assets also should be considered. On the other hand, Medicaid planning by transfer of assets can provide a source of funds in the name of a relative to pay for needs not covered by Medicaid.

#### R. Adult Care Homes: State-County Special Assistance

Because the rules are similar but vary in important ways, a brief description is included here of the State-County Special Assistance program, which assists in paying for care in an assisted living facility (also sometimes called adult care homes or rest homes) in North Carolina. The Special Assistance manual is available at <http://info.dhhs.state.nc.us./olm/manuals/da>. As with Medicaid, a written application must be filed at the county DSS and financial eligibility is generally based on SSI rules. The appeal process for Special Assistance denials is the same as for Medicaid eligibility. See Section C. The income limit for the program effective October 2010 is \$1182 per month (after subtracting a \$46.00/mo personal needs allowance). The income limit is \$1515 for residents of Special Care Units, again after subtracting \$46/mo. Also, \$20/month of unearned income is disregarded (unless the income is VA benefits or SSI plus other income). For example, if a person has an Social Security check of \$1200 per month, \$1,182 (Maximum Rate) + \$46.00 (Personal Needs Allowance) = \$1,228.00 (Total Needs/ Maintenance Amount) - \$1180 (Countable Income less the \$20.00 General Income Exclusion) = \$48.00 SA Payment to facility. The applicant must live in North Carolina for 90 days before entering the facility or have a close relative who has been in the state for 180 days.

The resource limit is \$2000 for an individual. Some important differences from Medicaid in resource eligibility rules for S/C Special Assistance include: (1) There are no spousal impoverishment allowances for income or resources, but income and assets in the name of the community spouse are not counted. (2) Unlike Medicaid, there are no additional deductions permitted for an individual whose countable income exceeds the income limit but is less than the facility's private rate, unless he or she entered the facility before October 1, 1995, although many facilities that accept Special Assistance will accept the state's rate in such cases. There is also no deductible or spend down in such cases. (3) Tenancy in common interests and life estate interests are counted as resources. (4) Property is excluded during a reasonable attempt to sell the property. (5) The transfer of assets penalty is calculated differently (divide uncompensated value by \$2000, up to maximum sanction of 36 months). The transfer rules mirror the transfer of assets penalty for SSI benefits. Transfer of the home site is penalized. Transfer of other exempt assets is not penalized. The look back period is 36 months. The sanction period begins in the month of transfer and is not delayed until receiving assisted living care. (6) Irrevocable trusts where the trustee will not make the funds available to pay for care are exempt assets for Special Assistance

if the trust was not created with the SA applicant's funds or was created before January 1, 2000. For trusts created January 1, 2000 or later with funds of the SA applicant, irrevocable trusts are counted in full if any amount could ever be made available to the SA applicant, as per SSI rules.

These and other differences in rules can cause careful eligibility planning to backfire if an individual moves from the assisted living level of care to nursing care or vice versa. Therefore, where possible, planning should try to meet the requirements of both programs for individuals with income under the Special Assistance income limit. However, be aware that many assisted living facilities do not accept Special Assistance because of the low reimbursement rates.

Special Assistance In Home is a new program providing financial support to persons who need assisted living level of care but are being cared for by family at home. This program has a capped number of slots and may have a waiting list. Also, not all counties participate. Unlike regular Special Assistance, this program requires the individual to be otherwise eligible for Medicaid. Thus the income limit is 100% of poverty (\$907/month for an individual effective April 1, 2010). Also unlike Special Assistance for care in a facility, the spouse's income and assets are counted. The maximum monthly SA/IH payment is 75% of the amount the a/r would receive if he/she lived in an adult care home and qualified for SA.

For more information about Special Assistance eligibility, see the online eligibility manual at <http://info.dhhs.state.nc.us/olm/manuals/doa> and 10 NCAC 47A and B, or telephone the state's eligibility policy contact person for Special Assistance at (919) 733-3818.