Your Florida Medicaid Information Guide

A Basic Primer on Florida Medicaid: What it is and How to Obtain it

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Chapter 8:
Solutions to the Asset Cap Dilemma

Most people believe that you need to spend down some or all of your assets in order to qualify for Medicaid. While this is a viable option, thank goodness, it is not your only option. Some, if not all your assets can be protected from the Medicaid spend down rules if done correctly prior to applying for benefits. Obviously, the sooner you begin to plan, the more options you have available.

In order to qualify for Medicaid there are techniques to protect most assets by simply changing the character or location of those assets and there are several strategies available for you to do this. However the timing of the techniques can be critical to their success. Some of the strategies that are most often used include: Spend Down by Choice, Transfer and Wait, Personal Service Contracts, Medicaid Compliant Annuities, Spousal Refusal (for married couples) and Pooled Trusts. These will all be discussed in further detail later in this chapter. There are other more sophisticated strategies available as well so make sure to consult with an Elder Law Attorney to insure that the right strategies are implemented based on your unique circumstances. And while we know the strategies that work now, please be aware that Medicaid Laws and regulations are always changing so that strategies available today may not be available a year from now.

If you call any Florida Medicaid office, you will be told that you can only apply if you have $2000 as an individual or $3000 if both you and your spouse need to apply for ICP services. You will not be told how you can legitimately reduce your assets without going BROKE. This chapter will give you points to consider when deciding if your situation is appropriate for long-term Medicaid planning. Also keep in mind that repositioning assets may have consequences beyond Medicaid, such as the imposition of income taxes on capital gains of such transferred assets.

Spend Down by Choice:

The first technique which most people erroneously think is the only way to get Medicaid is called “Spend Down by Choice”. This strategy is exactly how it sounds. One spends down assets in order to qualify for Medicaid benefits. As long as the applicant and the applicant’s spouse, if applicable, are not gifting away their funds and are not purchasing items for other individuals beside themselves, Spend Down by Choice can be a very useful tool. If you reside in your own home, you can, for instance, prepay the mortgage, make improvements to the property, i.e. purchasing new appliances, updating the interior/exterior, paint, roof and/or foundation, or possibly buying brand new furnishings for the home. In extreme cases, Medicaid applicants have sold their existing home and used the proceeds to purchase an entirely new and more expensive homestead property.

Along the same lines as buying a home, a Medicaid applicant or spouse can purchase an income producing property to reduce available assets. As long as the rental income being charged is the fair market value for similar rental properties, Medicaid will exclude that rental property as an asset. The rationale is simply that once you utilize the property for a rental income the property is not liquid and will not be sold. If the applicant owns the rental property in his/her own name, the rent produced from the property will be included as part of the applicant’s gross income. This additional income will be included in the applicant’s patient responsibility, along with social security and pension gross incomes.

Except for $35,00, all gross income attributable to the applicant is used to pay for nursing home care; when you include rental incomes, there is a strong likelihood that the applicant will now have too much income technically to qualify for Medicaid without having to create a qualified income trust..

Purchasing rental property can be an effective way to shelter assets and create more income for the non-applicant spouse. While the real estate is still an asset, once it is rented out at fair market value, the well spouse is allowed to generate

income in excess of the income cap. In that instance the value of the property is protected from the Medicaid spend-down, the spouse gets the additional rental income and the applicant still gets approved for Medicaid benefits. There must be a written rental agreement in place for Medicaid to consider that the property is now income producing. Such agreements must be submitted when Medicaid reviews eligibility.

Florida's constitution has very strong protections for your residence. Generally, creditors may not force liquidation of a person's residence (known as your "homestead") when you die provided that you leave either a spouse or lineal descendants. Thus, consider that your residence is not going to be subject to Medicaid recovery when you die so long as you are survived by a spouse or children.

If we are dealing with non-homestead real property, after the death of the applicant, the applicant's estate can be subject to a partition action forcing its sale to reimburse creditors including Florida for Medicaid benefits actually paid. However, if that same non-homestead rental property was owned (and rented out) by the spouse, the same results may not apply.

Purchasing an automobile is another way to spend down ones assets. Although it may seem silly to purchase a vehicle for an individual who may or may not have a driver's license, one automobile, regardless of value or use, is excluded as an asset. When there is more than one vehicle, the automobile with the highest equity value may be the one vehicle totally excluded, leaving the automobile with less equity value to count as an asset to the individual. However, if the automobile is over seven years old it is an excluded asset except for the following instances requiring development:

1. Luxury cars (for example, Jaguar, Mercedes Benz, Cadillac, Lincoln, Corvette);
2. Automobiles or trucks that are 25 model years or older (because they may have value as classics or antique vehicles); or

3. Customized or specially modified automobiles, except for those modified for use by a handicapped person.

The equity value of a vehicle is the average trade-in value of the vehicle minus any indebtedness. Keep in mind if you purchase a new vehicle, title must be in the applicant's (or spouse's) name alone. They cannot add on children or significant others. However, as long as title is compliant with the Medicaid rules, there is nothing that stops the children or significant other from obtaining insurance on the vehicle in their own name and using it to transport the applicant to and from appointments and for other personal reasons.

In addition to the above, Medicaid will allow the applicant and his or her spouse to purchase a burial plot, pre-need funeral arrangement and set aside burial funds.

A burial plot can be purchased for you and your spouse and will not be counted as an asset for Medicaid purposes. So long as the funeral arrangements are irrevocable it is also possible for the applicant and his/her spouse to each have a $2500 irrevocable burial savings or checking account.

One major benefit of purchasing a pre-need contract is that you are able to purchase tomorrow's funeral at today's price. Funeral costs can be quite significant, and you can enjoy considerable savings by purchasing a pre-need funeral contract. As long as the contract is made Irrevocable and the Medicaid applicant is unable to cancel the agreement or get a refund on the purchase it will not be counted as an asset by Medicaid. There is no limit to the amount of money that can be spent on ones funeral and the contract can include the cost for items such as the casket, floral arrangements, use of the chapel, transportation to and from the service to the cemetery or crematory, and other goods and services offered by the funeral home. The applicant and the applicant spouse can both have separate contracts and neither will count as an asset so long as the above criteria are met. This is a great way to ensure that your end of life arrangements are taken care of the way you

would want as well as a means to spend down a considerable amount of money for Medicaid purposes.

Aside from the Pre-Need Funeral Contract, Medicaid also recognizes that there may be additional costs that arise upon ones death that were not pre-paid for or included in the funeral contract. Because of these unforeseen expenses Medicaid will allow both the applicant and the applicant spouse to set aside up to $2500 each in a burial fund. The Burial Fund can be established through a bank account that is paid on death to a beneficiary of your choosing and CANNOT be touched during the applicant's lifetime. The only other requirement is that the funds are clearly designated as Burial Funds. You can also set this money aside in a Burial Trust account through a funeral home or designate a life insurance policy up to the $2500 as the Burial Funds as well.

Transfer and Wait:

With enough lead time, you can transfer a limited amount of assets, apply for benefits and get denied for a certain period of time because you transferred assets for less than fair market value within the five year look back period and begin the penalty period clock. Once that penalty period is up you would then be eligible for Medicaid benefits as long as all other criteria being met. You can also choose to transfer an unlimited amount of assets and wait out the entire 60 month look back period. Since the transfer occurred 60 months prior to the date of application, there will be no penalty period imposed and you can apply immediately for Medicaid benefits.

It is important to assess the health status of the individual or couple to determine whether or not to utilize this method. As mentioned earlier in the e-book, Medicaid uses a mathematical equation in order to determine the amount of time one is ineligible if they made any impermissible transfers. Consider that if you give away assets for less than fair market value within five years of applying for Medicaid, you

can be ineligible for a period of time (up to 60 months) from the date you APPLY for Medicaid coverage in the future.

Example:

John Smith has $225,000 in total countable assets. He is in an ALF which cost him $4000 a month. Every month he receives $2000 in income, leaving him with a $2000 shortage every month. If he was to transfer $173,000 to one or more of his children he would be left with $52,000 in countable assets which he could use every month toward the shortage and any other out of pocket expenses he needed. After 26 months he will have waited out the penalty period for transferring the $173,000 and since he has been using the $52,000 to help cover his income shortage ($173,000 /$6880 = 26 months disqualified). John now should be below the asset cap limit and eligible for Medicaid benefits. Remember for every $6880 transferred there is a one month penalty. Note: If John needs any additional funds above and beyond his personal needs allowance, his children can spend the money he transferred to them, provided they pay the vendor DIRECTLY.

Often there is not enough time or there is a limited amount of assets to be transferred. In such cases it is often recommended to transform an asset from a countable asset into a non-countable asset as we will discuss in the next section.

Personal Service Contracts:

For many individuals, home health care comes at a high price. Family and friends often provide necessary services so that an elder can remain at home. This responsibility can become so large that it can affect the caregiver's regular employment and also negatively impact the quality of the caregiver's family life. Many Baby Boomers find this balancing act to be impossible and wind up taking on more and more direct responsibility for the care of their parents.

One very effective tool to assist both the elder and the caregiver is a Personal Service Contract. A Personal Service Contract or Caregiver Agreement is a formal

written agreement between two or more parties in which one or more of those parties agrees to provide personal and/or managerial oversight in exchange for fair market value compensation paid by the party receiving those services. Since the enactment of the Deficit Reduction Act (DRA) of 2005, which lengthened the look-back period for asset transfers and changed the penalty start date, the Florida Department of Children and Families (DCF) has seen an increase in the number of Medicaid applications involving Personal Service Contracts. By the terms of the Personal Service Contract, the elderly applicant's resources are transferred, usually in the form of a lump sum payment, to a family member or close friend in exchange for services to be provided by the family member for the lifetime of the applicant. If a Medicaid applicant is married please be aware that the spouse cannot be the provider under this agreement. This planning tool is used to reduce the applicant's resources (assets) in order to qualify for Medicaid while compensating family members for the services provided.

In Florida a PSC generally serves four purposes:

1. It reduces an applicant's countable resources to an acceptable level, which entitles the applicant to receive benefits;
2. It outlines the duties and obligations of the parties;
3. It establishes the compensation that will be paid to the caregiver; and
4. It dictates the maximum amount of time needed to provide care to the elder based on the elder's actuarial life expectancy. This time period is the length of the PSC. It is determined by using the life expectancy table tool for Medicaid Planning found in ACCESS Medicaid.

In order to assess the value of these furnished services, the DCF case worker must be provided with credible documentation (e.g., a log with the dates and hours of services already provided) in addition to the contract itself. Many times DCF will also require letters from professional caregivers confirming that the reimbursement rate is fair. The contract should identify the specific services provided, including frequency that the

family member is to perform the services. Generally, these services fall in the following categories:

• General bookkeeping and bill-paying, which can include preparation of tax returns;

• Personal assistance, including shopping for necessities, helping with household chores, errand-running, and the like;

• Caregiving services that are not duplicative of Medicaid provided services (think geriatric care management).

In determining a compensation value, it's imperative to consult care providers in the local geographical area who offer similar services, in determining the compensation to be paid to the family member. The pay rate must be based on 'fair market value' for the types of services provided. Note that payments made pursuant to a personal services contract must be only for services performed *after* the contract is signed. Payments made for past services performed are subject to challenge as disqualified transfers. If an individual is not looking for immediate Medicaid and just wants to use the PSC as a preplanning tool, the contract can be drawn up so that periodic payments are made to a provider as long as those payments are fair market value and based upon the life expectancy as well.

The balance can be paid when and if ICP (Institutional Care Program) Medicaid is sought. Be aware that based on the duties performed under the typical caregiver contract, the IRS will likely consider the caregiver to be an employee of the older person. Hence, there may be income tax implications for the caregiver under a PSC. But there are ways for qualified Elder Law Attorneys to help reduce income tax consequences. Therefore before entering into such an agreement it is best to consult with both a tax advisor and Elder Law attorney to be familiar with all of your options.

Example:

John Smith is 81 years old. He life expectancy based upon the Social security actuarial tables is 7.41 years. John has $130,000.00 in assets. He and his son enter into a PSC with his son to be compensated at a rate of $75.00 an hour where his son agrees to provide services to John 5 hours a week every week for the remainder of John's life. Based upon the numbers above it is calculated:

$75.00 x 5 hours a week x 52 weeks a year x 7.41 years=$144,495.00

Since John only has 130k in assets, which is less than the fair market value as determined in the above calculation, he can transfer the full amount to his son without any penalty from Medicaid and be below his $2000 asset in order to be Medicaid eligible.

Once again remember the money is income to John's son and therefore that money will be taxable as income. John's son may use this money to help cover any additional expenses John personally may incur. However, this is not required since John's son was hired to perform a service and therefore the money is his to spend in any manner he wants. Keeping these important concepts in mind, choose your provider wisely.

Medicaid Compliant Annuity:

A "Medicaid Compliant Annuity" (aka MCA) is one of several permissible asset transfer techniques under current Federal and Florida Medicaid laws and regulations.

A Medicaid Compliant Annuity is a traditional single premium annuity with certain restrictions imposed by Federal and Florida Medicaid related laws and regulations. A single premium annuity is a contract between a person (Annuitant) and an insurance company. The Annuitant agrees to transfer a lump sum of money to the insurance company in exchange for a guarantee from the insurance company to pay a fixed monthly payment for a specific number of years or for the lifetime of the Annuitant. Because these are bona fide investment vehicles, the sum of money

transferred to the insurance company is not considered an impermissible asset transfer under most state Medicaid laws, including Florida. Because the annuity contract is irrevocable, the funds transferred into the annuity are no longer construed as a countable asset. Rather the monthly income from the annuity is included as the income of the applicant/annuitant for Medicaid purposes and may throw an individual over the income cap. But as we discussed earlier, there is a cure for this particular problem as well.

Generally speaking, the Deficit Reduction Act '05 (DRA) rules now require that if an annuity is to be deemed "Medicaid compliant" the annuity must:

- be irrevocable and non-assignable
- be actuarially sound: In most states, the term "actuarially sound" means that the owner of an annuity must receive his or her investment back within his or her Medicaid life expectancy, as determined by that state's respective life expectancy table, or the life expectancy table published by the Chief Actuary of the Social Security Administration. In other words, the annuity can almost always be shorter than the owner's Medicaid life expectancy, but never longer.
- provide for payments in equal amounts, with no deferral and no balloon payments; and
- name the state Medicaid program as the primary beneficiary to the extent that medical assistance benefits were provided to the institutionalized individual (certain exceptions may apply)

Because the income is paid out monthly it is considered income to the applicant who has purchased a MCA; it will be subject to payback after the applicant passes. It also becomes part of the individual's patient responsibility if he is residing in a Nursing Facility. We often recommend using MCA's when there is a community spouse. We purchase the annuity with the community spouse as owner. The community spouse receives the monthly income. Note that the income to the community spouse can be higher than the income cap.

People often are leery about establishing a Medicaid annuity since the State is the beneficiary upon the death of the applicant. When an individual becomes a “Medicaid” patient, the long term care facility is reimbursed at the Medicaid rate both by the applicant and by the Medicaid program which is significantly lower than the private pay rate for care. If there are any remaining benefits due from the annuity, the state will claim those benefits up to the amount the state has paid. If there is a balance after the state is reimbursed, the ultimate beneficiary (spouse, etc.) will receive the balance. If not for the purchase of the annuity, the patient would have paid the higher private pay rate until “impoverished” and unable to preserve any assets for his or her family. Thus, while there is a potential downside, using MCAs strategically can be one way to protect and preserve overall family wealth.

Example:

John Smith is 85 years old. Based upon the social security actuarial life tables his life expectancy is 5.65 years. If John was to invest $100,000 at a fixed income rate for five years the total monthly payment he would receive each month would be approximately $1,667 in additional income. (This is just an estimate and an insurance broker would have to determine the actual amounts based upon interest rates, fees etc.) Since the $100,000 has been converted into a monthly income stream that money is no longer viewed by Medicaid as an asset to John. He is now below the $2000 Medicaid asset limit and could possibly qualify for benefits, assuming income levels and level of necessary care are met.

Spousal Refusal (Married Couples Only)

Spousal refusal, in the context of Medicaid, refers to a spouse's refusal to pay for the long-term care expenses of the other spouse. In Florida, married people do not have a legal obligation to pay for the healthcare costs incurred by their spouse if their spouse is admitted into a nursing home. If your spouse has been admitted to a nursing home, by stating that you refuse to pay for your spouse's care, you may be able to retain more

resources than you normally would be able to. We start this process by shifting excess assets into the name of the community spouse alone. He or she then signs a document which the Elder Law attorney prepares and files it with the Florida Department of Children and Families indicating that they refuse to contribute their income and assets to the care of the ill spouse since they need those income and assets for their own care and well-being. Once the community spouse invokes their right to refuse to contribute and all of the other myriad of requirements of the Medicaid application are met, the state Medicaid program will pay for the care of the institutionalized spouse without mandating the community spouse to have assets under $113,000 (2012). This strategy is only viable if the ill spouse is not residing under the same roof as the community spouse. Thus, if you are first accessing Medicaid under one of the Waiver/Diversion programs for HOME HEALTH CARE assistance the Spousal Refusal technique is NOT available.

Under specific circumstances the Medicaid unit does have the right to seek reimbursement from the community spouse who is not in the nursing home at the Medicaid spouse's death but such lawsuits are very, very rare. "Spousal refusal" is only allowable in a handful of states and is often a topic of debate at yearly legislative meetings where law makers are constantly trying to have this strategy eradicated. Florida case law however is clear on this point, that is, married couples are not legally responsible for the medical bills of the other. Clearly, Medicaid payments are medical in nature.

Pooled Trust

A federal law established in 1993 allows elderly and disabled people to put their monthly income and/or assets — above the amounts Medicaid allows them to keep — into a special type of trust know as a pooled trust. Pooled trust programs are set up as or administered by a non-profit organization; they are irrevocable and must be solely for the benefit of the elderly or disabled person. They provide a convenient and economical way to have trust funds administered for elders and people with disabilities that will supplement the benefits offered by entitlement programs. These programs normally implement a discretionary, irrevocable trust for supplemental needs. The individual's

assets are placed in the trust. These assets may be from the individual or others. The funds belonging to the individual are allocated into a separate sub-account. The assets from all sub-accounts are pooled together to invest and manage as one larger amount. Records are maintained for each person's trust and the amount spent for that individual. The Medicaid applicant can then tap into those funds for their own uses and benefit while still gaining eligibility for Medicaid. Some examples of how funds may be used are:

- Medical procedures not provided through governmental assistance.
- Assistive technology for persons with disabilities, not otherwise available through Medicaid
- Motorized wheelchairs, specially equipped vans, enhanced hearing and
- vision devices, and similar equipment to improve the quality of life of beneficiaries.
- Support coordinator services.
- Guardian fees.
- Attorney fees.
- Supplemental nursing care.
- Differentials in housing costs between shared and private rooms.
- Travel expenses.
- Entertainment expenses.
- Any other expense not provided by government benefit programs.

Pooled trust programs usually must charge fees for their services. Programs vary in their fees, and when and how they charge for them. The frequency and amount may depend on the type of trust plus the trust fund amount. The trust may also charge a sliding scale fee based on the amount in a particular trust sub account. Most trusts tend to have an enrollment fee which is paid when you sign a Joinder Agreement (that is a, legal document that enrolls you in the trust) or activate the trust. They may also have a periodic maintenance fee (usually annual) to provide ongoing management. Certain fees may change due to inflation or as the trust's principal decreases with distributions.

Upon the death of the elderly or disabled beneficiary the funds remaining in the beneficiary's account can either be retained in the pooled trust for the benefit of other disabled trust beneficiaries and to pay administrative costs of the non-profit charity or the funds can be used to reimburse the state's Medicaid program for assistance paid on behalf of the beneficiary and then any leftover proceeds paid to the beneficiary's designated inheritors. Note: Repayment would be at the discounted Medicaid amount, not the private pay amount.

As mentioned above there are several other options available to a Medicaid applicant in order to shelter funds and still gain eligibility. Even if you think you understand how they work, it is imperative that you consult with an experienced Elder Law Attorney to make sure these more advanced techniques are carried out correctly to comply with Florida rules governing Medicaid. In addition, each strategy is not a stand-alone one, meaning you can choose to use several options at once to best customize a plan for your specific situation.

No matter what strategy is used in order to gain eligibility, according to federal and state law, the money that the Florida Medicaid program pays on behalf of a Medicaid recipient is a debt owed back to the state. Upon the death of the Medicaid recipient, the Medicaid program files a claim against the decedent's estate in order to seek reimbursement for the amount owed. The debt includes all payments made by Medicaid for services or goods when the recipient was age 55 years or over. Not all estates are subject to recovery, though. If you are a Florida Medicaid recipient and you pass away leaving behind a spouse, a minor child, or a child who is blind or totally and permanently disabled – or if you pass away before reaching age 55 – then the Medicaid program will not file a claim against your estate. Also, if you own a home that passes to lineal descendants, usually your home is determined to be a homestead property that is protected from your creditors. Then your home would not need to be sold to pay back your Medicaid claim no matter what your age.

Under Florida probate law, some estate assets may be exempt or protected from creditors who have filed claims against the estate. The probate laws make the determination about what is exempt. In general, if the Medicaid recipient owned a home and it is his/her primary place of residence, when that home passes to the spouse or lineal descendants, a judge would likely declare it to be "homestead protected from creditors." Then Medicaid, like any other creditor, cannot force its sale. If however, any real property is not "homestead protected," it may need to be sold to pay Medicaid. Most Elder Law Attorneys will know how to properly title property to avoid probate or alternatively know how to insure that one's homestead ultimately gets transferred to the appropriate family member after the Medicaid recipient has died.