STATE OF MICHIGAN

WAYNE COUNTY PROBATE COURT

In the Matter of RONALD ERKMANN
a developmentally disabled person
/

Hon. Milton L. Mack, Jr.
File No. 91-859,820-DD

-MEMORANDUM OF LAW-

IN SUPPORT OF PETITION FOR PROTECTIVE ORDER TO EXECUTE JOINDER AGREEMENT TO ESTABLISH POOLED ACCOUNTS TRUST IN LIEU OF APPOINTMENT AS GUARDIAN OF THE ESTATE, TO TRANSFER ASSETS TO POOLED ACCOUNTS TRUST, DISMISSAL OF GUARDIANSHIP OF THE ESTATE AND TO APPROVE ATTORNEY FEES

Ronald Erkmann (Ronnie) is 44 years old, and has a life expectancy of another 31.5 years.[1] Ronnie suffers from severe cerebral palsy, is wheelchair bound, and is dependent upon others for assistance with all activities of daily living. He has mild mental retardation. Ronnie is "disabled," as defined by federal law, and is a person with a "developmental disability," as defined by state law. 42 USC §1382c(a)(3) LAW; MCL §330.1208. His *annual* cost of care, in a group home setting, is estimated to be $80,000 to $100,000.

Until recently, Ronnie resided with his mother, Annelise Erkmann, in her home in Detroit. Annelise Erkmann died intestate on May 16, 2002, leaving Ronnie as her sole heir. As of the date of her death, she was the Guardian of the

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Person and the Estate of Ronnie and served as his Representative Payee for purposes of receiving and handling his social security benefits (SSDI). Annelise Erkmann owned property, both real and personal, valued at approximately $500,000. About $50,000 of this will pass to Ronnie through her probate estate. The remaining $445,000 is payable directly to Ronnie through beneficiary designations.

Upon Annelise Erkmann's death, family friend and advocate,[2] Conrad Aumann, filed a Petition with this Court to succeed as Ronnie's Guardian. This Court appointed Conrad Aumann the Guardian of the Person, and conditioned his appointment as Guardian of the Estate upon the filing of a $250,000 bond.[3] Following his appointment as Guardian of the Person, Conrad Aumann, on behalf of Ronnie, filed a *Petition for Protective Order to Execute Joinder Agreement To Establish Pooled Accounts Trust In Lieu Of Appointment As Guardian Of The Estate, To Transfer Assets To Pooled Accounts Trust, Dismissal Of Guardianship Of The Estate And To Approve Attorney Fees.*

This petition sought this Honorable Court's authorization for him, as Guardian, to establish a sub-account within the *Friends of CLS, Inc. Pooled Accounts Trust dated February 10, 1999* (herein after referred to as the TRUST), an irrevocable special needs trust created under the authority of 42 USC 1396p(d)(4)(C).[4] Conrad Aumann further sought this Court's authority to transfer

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[1] See Medicaid Program Eligibility Manual, Item 405, p. 15

[2] Conrad Aumann knew Annelise Erkmann and her son, Ronnie, through his work at STEP (Services to Enhance Potential), an organization that provides vocational services to persons with disabilities.

[3] At the time Conrad Aumann filed the Petition to be appointed Ronnie's Successor Guardian, he knew of only $250,000 in assets passing to or for the benefit of Ronnie as a result of his mother's death.

[4] It should be noted that the master trust under which Ronald Erkmann seeks to establish a sub-account was drafted with terms identical to those in the first trust agreement as originally approved by the Honorable Martin T. Maher of the Wayne County Probate Court and the Guardian Ad Litem in this matter, and as amended after litigation with the Attorney General's office to satisfy the State of Michigan the that Trust Agreement fully composted with provisions of 42 USC § 1396p(d)(4)(c). See Report of Guardian Ad Litem attached as Exhibit 1.

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all property owned by Ronnie (or payable to him through beneficiary designation(s)) into the sub-account, including all property to which he is entitled through his mother's probate estate.

Petitioner's purpose in seeking to establish the TRUST and transferring Ronnie's funds into it was to allow for Ronnie's eligibility for certain government benefit programs, specifically Medicaid.[5] As noted, Ronnie's cost of care in an adult foster care setting will be $80,000 to $100,000 each year. Medicaid or normally would cover this cost for an individual who meets its financial eligibility standards.[6] In light of Ronnie's extended life expectancy, the funds left him by the death of his mother will be exhausted within 4 or 5 years, unless his funds can be set aside into one of the "special needs" trusts allowed by the Medicaid program. In this instance, and as further discussed in this Memorandum, Petitioner believes a pooled accounts trust is the most appropriate special needs trust for Ronnie. The establishment of such a sub-account and the transfer of assets are allowable by federal and state law, and are supported by public policy. See 42 USC §1396p(d)(4)(C); MCL §700.5407; and the State Medicaid Manual, Part 3 – Eligibility, HCFA Transmittal No. 64, November 1994.[7]

If this Court allows the establishment of the TRUST, then the funds left Ronnie by his mother can be preserved, marshaled, and used during the remainder of his life to pay for his needs above and beyond the basic "room and board" costs cited above. These needs include such things as providing Ronnie with transportation [a wheel-chair equipped van], travel opportunities [Ronnie, a huge

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[5] A more detailed discussion of the Medicaid program is below.
[6] Whether "housing" is a Medicaid-covered service for persons with developmental disabilities or mental illness is currently in doubt in Michigan. A recent Policy Memorandum from the Michigan Department of Community Health states it is not. However, basis of that opinion is currently being challenged in the Ingham County Circuit Court. Nonetheless, a person's social security benefits may be used to cover the shelter amount and the remaining services provided in such a setting are typically Medicaid covered services. See Policy Memorandum attached as Exhibit 2.
[7] The HCFA Transmittal is attached as Exhibit 3.

fan of country music, wants to visit "Dollywood"], adaptive housing, education suitable to his abilities, medical care by providers who do not participate in the Medicaid program, and a host of other special needs above what is provided by the bare-bones Medicaid health-care system.

It was with this as background that Petitioner sought approval of the TRUST. Upon this Court's hearing of the above petition on October 16, 2002, it, along with Ronnie's Guardian Ad Litem, asked Petitioner's counsel to submit this Memorandum of Law to address three specific concerns raised by the Court and Guardian Ad Litem. Specifically, this Memorandum will address the following:

1. The distinctions between two types of special needs trusts authorized by Title XIX of the Social Security Act[8] (specifically those described in 42 USC §1396p(d)(4)(A) and those described in 42 USC §1396p(d)(4)(C));

2. The rights of heirs to notice of a proceeding to establish a special needs trust created pursuant to 42 USC §1396p(d)(4)(C); and

3. What proofs this Court should expect when hearing and, hopefully, granting a Petition to establish a special needs trust created pursuant to 42 USC §1396p(d)(4)(C) and authorizing an irrevocable transfer of property belonging to a person with a disability.

-OVERVIEW-

SUMMARY OF THE MEDICAID PROGRAM

Medicaid, also known as the Medical Assistance Program (MA), is a federally based program that pays for necessary health services for certain groups of people [those disabled, over 65, blind or children], who have limited resources. The primary source of Medicaid law is Subchapter XIX of the Social Security Act,

[8] §1917(c) of the Act as amended by §13611 of the Omnibus Budget Reconciliation Act of 1993.

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42 USC §1396 et seq. The federal government provides broad administration of the program through the Department of Health and Human Services [DHHS], in particular through its division, Centers for Medicare and Medicaid Services [CMS]. Federal regulations are found at 42 CFR Parts 430-456.

The Medicaid program, while based on federal law, is primarily administered at the state level, through the combined efforts of the Department of Community Health and the Family Independence Agency [FIA]. The state pays for approximately 45% of the costs of Medicaid, with the federal government covering the remaining 55%. The state has issued Medicaid policy through a series of program manuals, primarily the Program Eligibility Manual [PEM], Program Administration Manual [PAM], and a number of reference manuals.

Eligibility for Medicaid services is based upon several factors. An individual must fit within certain categories, such as being blind, disabled, over 65 or a minor. An individual further follow certain procedural rules, such as applying for benefits, providing information and the like. Finally, and most importantly, the individual must be "impoverished," as defined by financial eligibility criteria relating to income and assets.

Historically, as the Medicaid program has evolved from its start in 1965, its financial eligibility criteria have become more restrictive, as this health care program's budget, like all other health care programs, have spun out of control as more individuals have begun to need more extensive, and expensive, medical services.

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OBRA '93 – A HISTORY

On August 10, 1993, President Clinton signed into law the Omnibus Budget and Reconciliation Act of 1993. Pub. L. No. 103-66, 107 Stat. 312 (1993) (hereinafter referred to as OBRA '93). This legislation significantly changed Medicaid program rules regarding the treatment of asset transfers by Medicaid applicants and recipients, and the treatment of trusts created by or for the benefit of Medicaid applicants and recipients.

The OBRA '93 legislation was aimed at preventing perceived abuses by individuals who purportedly were taking advantage of then - existing Medicaid laws regarding trusts,[9] which treated the assets held in a self-settled trusts as being "available" to the Medicaid applicant, and therefore resulting in the person being disqualified for benefits, only if, and to the extent, that the Trustee had discretion to make distributions to or for the benefit of the Medicaid applicant. 42 USC §1396a(k)(2).[10]

Further, the perception amongst many legislators and administrators was that the most serious offenders of these abuses were the children of the elderly middle class, attempting to save inheritances.[11] To address these perceived abuses and rein in the perceived offenders, OBRA '93 significantly restricted people's ability to rearrange their financial affairs in order to retain economic benefit of their assets for themselves or their heirs while at the same time benefiting from

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[9] Medicaid Qualifying Trust legislation of 1985, 42 USC §1396a(k)(2).
[10] *See*, Ira S. Weisner, *OBRA '93 and Medicaid: Asset Transfers, Trust Availability, and Estate Recovery Statutory Analysis in Context*, 19 NOVA L. Rev. 679 (1995) and Clifton B. Kruse, Jr., *Self-Settled Trusts Following OBRA 1993*, Trusts & Estates, p. 67, March 1995.
[11] A. Frank Johns, *Legal Ethics Applied to Initial Client-lawyer Engagements in Which Layers Develop Special Needs Pooled Trusts*, 29 Wm. Mitchell L. Rev. 47 (2002).

government-funded long-term care.[12] The legislation accomplished this objective in three primary ways:

(1) Imposing harsher penalties on asset transfers prior to seeking Medicaid eligibility;

(2) Eliminating, with the limited exceptions[13] discussed below that are the focus of this memo, the ability of individuals receiving or seeking Medicaid assistance to directly or indirectly benefit from assets held in trust; and

(3) Providing for enhanced state recoveries from deceased Medicaid recipients' estates.[14]

However, at the same time, the legislation also ***allowed*** for certain specifically identified groups to make use of self-funded trusts in the appropriate circumstances, a legislative determination that the needs of the people in these groups are so great that not only are they allowed, but encouraged, to make use of self-funded trusts to provide for their present and future needs.

THE LIMITED EXCEPTIONS TO THE FEDERAL PROHIBITION AGAINST SELF-SETTLED TRUSTS BENEFITING MEDICAID APPLICANTS AND RECIPIENTS

OBRA '93 allows an individual who fits within certain criteria and who is applying for or receiving Medicaid assistance benefits to transfer his or her own property or income into one of three types of special needs trusts without adversely affecting his or her eligibility. The exceptions are:

(1) The "Exception A" or "Payback Trust";

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[12] Ira S. Weisner, *OBRA '93 and Medicaid: Asset Transfers, Trust Availability, and Estate Recovery Statutory Analysis in Context*, 19 NOVA L. Rev. 679 (1995), citing Hearings on H.R. 2264 before the Subcommittee on Health and the Environment, 103d Con., 1st Sess. 6 (1993).

[13] The exceptions refer to "pay-back", 42 USC §1396p(d)(4)(A); "pay-over", 42 USC §1396p(d)(4)(C); and "Miller Trusts", 42 USC §1396p(d)(4)(B). Miller Trusts are not utilized in Michigan, as Michigan is not an income cap state.

[14] Ira S. Weisner, *OBRA '93 and Medicaid: Asset Transfers, Trust Availability, and Estate Recovery Statutory Analysis in Context*, 19 NOVA L. Rev. 679, 681 (1995).

(2) The "Miller Trust" or "Income Only Trust"; and

(3) The "Exception C" or "Pooled Accounts Trust" or "Pay-to Trust". [See 42 USC §1396p(d)(4)(A), (B) and (C).]

Since Michigan is not an Income Cap state, it is unlikely that our probate courts will be asked to rule upon Miller trusts, and so these Exception B trusts are not discussed in this memorandum. [15]

The reason that these exceptions to the OBRA '93 legislation were created is that the disability community, specifically organizations such as the ARC of the United States (f/k/a National Association for Retarded Citizens) and its state chapters, the National Academy of Elder Law Attorneys, AARP and other consumer groups and disability and elder organizations, had worked with Congress for a number of years to ensure that certain special needs trusts that "payback" to states or "pay-to" to a non-profit association at the end of the beneficiaries' lives would be exempt for purposes of Medicaid eligibility in the new legislation.[16] Obviously, their collective efforts were successful.

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[15] Michigan has no maximum cap on the amount of income a person in a nursing home can receive and still qualify for Medicaid. As long as the person's actual income is less than the cost of the nursing home, Michigan Medicaid will pay for the difference. Michigan has in the past offered a Community Waiver program, which had an income cap of three times the poverty level, or about $1,500 per month. Unless Medicaid reopens this program, and an individual with more than $1,500 in income seeks to place the excess into a Miller trust, the courts are unlikely to be requested to authorize such trusts.

[16] A. Frank Johns, *Legal Ethics Applied to Initial Client-lawyer Engagements in Which Layers Develop Special Needs Pooled Trusts*, 29 Wm. Mitchell L. Rev. 47 (2002); ARC of the United States, *Pooled Trust Policy Paper 09/19/02* (unpublished and attached as Exhibit 4).

PART 1.

- DISTINGUISHING BETWEEN THE EXCEPTION A & EXCEPTION C TRUST -

I. Defining the Exception A Trust.

The Exception A trust legislation specifically exempts a trust that: (i) contains the assets of an individual under age 65 who is disabled (as defined by §1382c(a)(3) of Title XVI of the Social Security Act); (ii) which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual, or a court; (iii) *so long as* any amounts remaining in the trust upon the death of such individual are used first to reimburse the State up to an amount equal to the total medical assistance paid on behalf of the individual through the State's Medicaid plan. 42 USC §1396p(d)(4)(A) (emphasis added).

A transfer of a disabled individual's assets (who is less than 65 years of age) to an Exception A trust will not violate the prohibitions on transfers of assets for less than fair market value contained in the transfer provisions of OBRA '93, nor will the resulting trust be counted as a "resource" to the individual for purposes of continued Medicaid eligibility. 42 USC §1396p(d)(4)(A).

II. Defining the Exception C Trust.

A. The Statutory Requirements of a Valid Exception C Trust.

The Exception C Trust legislation specifically exempts a pooled account trust containing the assets of an individual who is disabled (as defined by §1614(a)(3) of the Social Security Act) that satisfies the following conditions: (i) the trust is established and managed by a nonprofit association; (ii) a separate account is maintained for each beneficiary of the trust, but, for purposes of

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investment and management of funds, the trust pools these accounts; (iii) accounts in the trust are established solely for the benefit of individuals who are disabled by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court; and (iv) to the extent amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State's Medicaid plan. 42 USC 211396p(d)(4)(C) (emphasis added)

B. The History of the Special Needs "Pooled Accounts" Trust.

The concept and use of a "pooled accounts" trust began long before the enactment of OBRA '93. For decades, parents of children with disabilities and nonprofit organizations had been using "pooled" or "umbrella" trusts to hold assets for the benefit of their disabled children. These trusts additionally provided a mechanism for parents to detail specific instructions to the trustees concerning the care and quality of life of the children following the parents' deaths. They even served as a fund-raising device for the nonprofit organizations.[17] The inclusion of the pooled accounts trust into the OBRA '93 legislation in fact was an explicit endorsement and statement of public policy as to the continued use of such trusts.

III. Distinctions Between the Exception A Trust and the Exception C Trust.

If properly drafted and administered, both the Exception A trust and the Exception C trust are permissible vehicles to receive and hold property belonging to a disabled Medicaid recipient or applicant, even though that property otherwise would disqualify him or her from the program. As noted, these trust exceptions

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[17] A. Frank Johns, *Legal Ethics Applied to Initial Client-lawyer Engagements in Which Layers Develop Special Needs Pooled Trusts*, 29 Wm. Mitchell L. Rev. 47, 51 (2002); M. Kent Olsen, *Pooled Income Trusts Following OBRA '93*, NAELA Advanced Institute on Elder Law IV §17 (1994)

were "carved" into the restrictive provisions of OBRA '93 based on public policy, which favors protecting, providing for and maximizing the quality of life of persons with disabilities, who have financial needs beyond essential medical care[18]. Despite the overriding similarities of these two types of special needs trusts, there are several distinctions between the Exception A and the Exception C trusts.

First: A person must be under the age of 65 to transfer assets to an Exception A trust. 42 USC §1396p(d)(4)(A). This age restriction does not apply to Exception C trusts, so at least based on the federal legislation, a person who is disabled **and** over 65 years of age may transfer of his or her property to an Exception C trust and *may*[19] still be eligible for Medicaid pursuant to 42 USC §1396p(d)(4)(C).

Second: An Exception A trust may only be established for the benefit of a disabled individual by a *parent, grandparent, legal guardian or a Court.* 42 USC §1396p(d)(4)(A). The Exception A trust provisions preclude a disabled individual from establishing the trust himself or herself, in contrast to the Exception C trust provisions. *See* 42 USC §1396p(d)(4)(C)(iii).

Third: The most notable distinction between Exception A and Exception C trusts relate to the disposition of any funds remaining in either trust upon the death of the disabled beneficiary. The Exception A Trust requires the Trustee to repay any State that provided Medicaid assistance benefits to the beneficiary during his or her lifetime, up to an amount equal to the Medicaid assistance paid on his or her

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[18] Clifton B. Kruse, Jr., *OBRA '93 Disability Trusts – A Status Report*, Probate and Property, May/June 1996, citing Estate of Eubanks, King's Co., Sur., N.Y.L.J. (May 24, 1995), p. 31, col. 4; ARC of United States, *Pooled Trust Policy Paper*, 09/19/02;

[19] Although OBRA '93 specifically exempts the C trust created by an individual over the age of 65 from consideration as a resource, the transfer rules contained in the legislation only specifically reference transfers to A trusts, which by definition exclude persons over the age of 65. In practice, it should be noted that this author has not yet seen a challenge to a transfer by an individual over the age of 65, but the

behalf.[20] If, after the "payback", there are any funds remaining in the Exception A trust, expenses related to the disabled beneficiary's funeral and burial, as well as any outstanding administrative expenses, may be paid. If, after the payment of these costs, funds still remain in the trust, those funds will be distributed to the heirs [or devisees] of the disabled beneficiary.[21]

The Exception C Trust allows an alternative to the mandated payback of the A Trust. Sub-section (iv) of 42 USC §1396p(d)(4)(C) provides, "To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this title." 42 USC §1396(d)(4)(C) (emphasis added).

The clear letter and intent of the federal law authorizing Exception C trusts is to allow the trustee (which by statutory definition must be a non-profit association) of an Exception C trust to keep all, or a portion, of the funds that remain in the beneficiary's sub-account at his or her death, rather than to pay the residue back to the Medicaid program administered by the state. 42 USC

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possibility exists that such a transfer could be subject to challenge and treatment as divestment. *See* 42 USC §1396p(c)(2)(B).

[20] The payback provisions contained in this section of OBRA '93 are strictly interpreted such that any payment other than one to the State agency responsible for administering the Medicaid program violates the statute. This includes payment for funeral and burial and trust administration expenses. A departure from this strict construction has been made by the Social Security Administration which pursuant to its Program Operations Manual governing the SSI program, it allows for payment of certain administration expenses prior to the payback. The Michigan Family Independence Agency has a similar provision in PEM 401.

[21] If the beneficiary has prepared a Last Will and Testament, the trust instrument can direct that the remaining funds pass by the terms of that document. If not, any remaining funds will be distributed to his or her heirs at law. It should be noted that until recently, the Social Security Administration frowned on the use of "heirs at law" language in the remainder provisions of an Exception A trust, and condition resource eligibility for SSI for Michigan consumers (the resource rules are almost identical to those for Medicaid) on specifically naming the remainder beneficiaries. It appears that the Administration still takes this restrictive approach in the other 5 states in the Region. *See* Social Security Administration Program Circular attached as Exhibit 5.

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§1396p(d)(4)(C); State Medicaid Manual, Part 3 – Eligibility HCFA Transmittal No. 64, November 1994.

According to the *Pooled Trust Policy Paper* prepared by the ARC of the United States, the reason for allowing the trustee to retain the residue was to accommodate a common practice of pooled accounts trust in existence in 1993. First, the nonprofit association could use the retained funds to assist other pooled account trust beneficiaries who had already exhausted their own sub-accounts. Second, the nonprofit association could use the funds to help provide advocacy services to indigent people with disabilities who did not have a sub-account with the trust. *See* ARC of United States, *Pooled Trust Policy Paper*, 09/19/02.

This retention provision allows the nonprofit association-trustee to use the funds left in a beneficiary's account at his or her death to provide additional and much-needed care-giving and advocacy for those otherwise dependant upon federal and state funds and local government case management.[22] This is consistent with the public policy goal of "downsizing big government, thereby reducing the Welfare State." *See* 42 USC §1396p(d)(4)(A)(B) and (C) (2002), and implementing instructions, State Medicaid Manual, Part 3 – Eligibility, HCFA Transmittal No. 64 (1994).

Finally: The Exception A trust and the Exception C trust can be distinguished based on the considerations used in determining which trust is most appropriate in any given circumstance.

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[22] It is important to note that three of the five pooled accounts trust in Michigan (Friends of CLS, Inc; Springhill Housing Corp., Inc; P.A.L.'s, Inc) use a trustee agent, Patricia E. Kefalas Dudek, to manage trust distributions. This is done partially to address any concerns that the trustee may deny a distribution in order to assure there will be a larger remainder.

First, some consideration should be given to the value of the property being transferred into the trust. The value of the property, however, is not dispositive. There is nothing in the letter or history of the OBRA '93 trust provisions suggests an Exception A or C Trust should be selected based solely on dollar value. *See* generally 42 USC §1396p.

Rather, the legislative language, the reports of the subcommittee hearings, scholarly commentary and public policy dictate that the considerations to be used in considering which type of trust (A or C) to select for an individual must focus on the *individual* and his or her needs and circumstances. The value of the assets to be transferred is only part of the consideration.[23]

For example,[24] a family or advocate may choose an Exception A trust to benefit a disabled beneficiary where the family or advocate wishes to retain control and management of the asset. Because an Exception A trust is drafted for the particular disabled beneficiary, the person creating the trust (the parent, grandparent, legal guardian or court) can select the trustee, who may or may not be a family member.

Again, since an Exception A trust is drafted for the particular disabled beneficiary, the person creating the trust (the parent, grandparent, legal guardian or court) may choose an Exception A trust to benefit a disabled beneficiary where the family or advocate has very specific wishes about the exact services to be

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[23] *See* generally, 42 USC §1396p; State Medicaid Manual, Part 3 – Eligibility, HCFA Transmittal No. 64 November 1994; Ira S. Weisner, *OBRA '93 and Medicaid: Asset Transfers, Trust Availability, and Estate Recovery Statutory Analysis in Context*, 19 NOVA L. Rev. 679 (1995), citing Hearings on H.R. 264 Before the Subcomm. on Health and the Environment, 103d Cong., 1st Sess. 6 (1993); A. Frank Johns, *Legal Ethics Applied to Initial Client-lawyer Engagements in Which Layers Develop Special Needs Pooled Trusts*, 29 Wm. Mitchell L. Rev. 47 (2002); ARC of United States, *Pooled Trust Policy Paper*, 09/19/02; Clifton B. Kruse, Jr., *OBRA '93 Disability Trusts – A Status Report*, Probate and Property, May/June 1996, et al.

[24] This section merely highlights some considerations used in selecting the appropriate self-settled special needs trust. It is not all-inclusive.

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provided, or the location at which the services will be rendered, or to establish, as an integral part of the document, the names of family members or other individuals who will provide the trustee with information about the needs of the disabled beneficiary.

The cost of preparing an Exception A trust, often $2,000 to $3,500 or more, as compared to entering into an Exception C sub-account, with its usual joinder fee of $500, will of course have an impact on which type of trust device is used. For example, if the kind and level of services the disabled beneficiary currently receives, or is likely to need in the future, is such that the trust funds will likely be used up in a short period of time, then the costs associated with drafting an Exception A trust and administering it may not be justified.

If the value of the Medicaid services that a beneficiary receives annually are high, so that after a few short years any funds remaining in the beneficiary's trust, if any, will be owed to the State as a part of a payback, then again the additional costs associated with drafting and administering an Exception A trust may not be justifiable.

Additionally, pooled accounts trusts historically were utilized by parents of children with disabilities to ensure a support-network remained for their children after the parents were gone and no longer able to provide the care and quality of life assurances they provided while living. A. Frank Johns, *Legal Ethics Applied to Initial Client-lawyer Engagements in Which Layers Develop Special Needs Pooled Trusts*, 29 Wm. Mitchell L. Rev. 47 (2002). A significant consideration of parents or grandparents, when deciding between an Exception A or C trust for the disabled child or grandchild, is whether there are people, such as other family members or friends, who would be able and willing to act as trustee and/or an advocate for the disabled child after the parent is deceased. Particularly where

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there are not other family members or friends to care for the disabled child after the death of the parent or parents, Exception C trusts are particularly appropriate. The nonprofit associations that serve as trustee for these pooled accounts trusts are the same organizations that provide advocacy and services to persons with disabilities. This is exactly the vision the parents of disabled children had in the 1970's when the use of pooled trusts to benefit persons with disabilities began.[25]

Another consideration in determining which type of trust to use in a given circumstance is whether the disabled person has any other family members with special needs. For a family with two or more individuals with special needs, the required payback in an Exception A trust for one of the disabled individuals would not allow any remaining residue in the trust at the first beneficiary's death to be used to benefit the other family member, assuming the Medicaid payback amount exceeded the value of the residue.

Even if the residue was greater than the amount of the payback, and if that remainder were to pass to the second disabled family member, it would do so by intestate succession or by devise. A separate court order likely would be needed to place these funds into an Exception A or C trust for the second disabled family member. However, the retention provisions of Exception C trusts allow family members who create sub-accounts for the benefit of one disabled family member to specify that any remaining funds after the death of the first beneficiary be used to benefit the other family member, assuming he or she is surviving.[26] Further they could direct that the person with a disability who receives the benefit of the

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[25] A. Frank Johns, *Legal Ethics Applied to Initial Client-lawyer Engagements in Which Layers Develop Special Needs Pooled Trusts*, 29 Wm. Mitchell L. Rev. 47 (2002).

[26] Patricia E. Kefalas Dudek, the drafting attorney of all five pooled accounts trusts that are currently in operation in the State of Michigan, utilizes this option for families with multiple loved ones with disabilities. Because the master trust agreements provide that funds retained by the trust are to be used to benefit other people with disabilities, the joinder agreements prepared by the family member (or the individual beneficiary) can specify that the funds be used for the benefit of the other family member(s) with the disability first.

remaining funds be affiliated with another non-profit association like JARC, Angel's Place, the Alzheimer's Association or other such organization.

PART 2.

- THE RIGHTS OF HEIRS TO NOTICE OF A PROCEEDING TO ESTABLISH A SPECIAL NEEDS TRUST CREATED PURSUANT TO 42 USC §1396P(D)(4)(C) -

The legislation establishing Exception A and C trusts does not grant heirs or devisees of the disabled beneficiary any specific "rights" to the trust property. The legislation contains no reference whatsoever to the heirs or devisees of the disabled beneficiary. 42 USC §1396p. In fact, based upon the history and policy behind the enactment of OBRA '93, the legislature considered the heirs and/or devisees of disabled individuals needing Medicaid benefits as being the primary abusers of the Medicaid program.[27] The Exception A and C trusts, as allowed by 42 USC 1396p, are intended and designed solely to provide for the person with the disability during his or lifetime. There is no provision to provide for the person's heirs or devisees upon death.

Under state law, of course, heirs may have rights to *notice* of certain court proceedings involving disabled persons. For the reasons indicated below, the presumptive heirs of a disabled beneficiary will receive notice of a *petition* before the court to establish either an Exception A or C Trust. However, it is only when

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[27] Ira S. Weisner, *OBRA '93 and Medicaid: Asset Transfers, Trust Availability, and Estate Recovery Statutory Analysis in Context*, 19 NOVA L. Rev. 679 (1995), citing Hearings on H.R. 264 Before the Subcomm. on Health and the Environment, 103d Cong., 1st Sess. 6 (1993 This article quotes a letter authored by Congressman Henry Waxman to the Boston Globe in response to a May 20, 1993 column in which he wrote, "I am offended by wealthy individuals with the aid of lawyers like Mr. Bove taking advantage of the Medicaid program for the poor to finance the transmission of wealth to their heirs at federal and state taxpayer expense."

court action is involved that they will receive such notice. Both Exception A and C trusts can be, and often are, established without court action.[28]

In Michigan, the probate court has exclusive legal and equitable jurisdiction over proceedings that concern the settlement of a trust. MCL §700.1302(b). Therefore, if a person with a disability, or someone acting on his or her behalf, seeks a court order to establish an Exception A or C trust, that authority must be sought from the probate court.[29] While federal law governs the substantive rules regarding the validity of a either an Exception A or C trust, state law (or court rule) governs the procedure for establishing such a trust, providing the state law (or court rule) does not conflict with, or serve as a barrier to, the federal law.[30] Boulhanis v. Prevo's Family Market, Inc. et al., 230 Mich App 131 (1998); Bibbo v. Dean Witter Reynolds, Inc., 151 F.3d 559 (6th Cir. 1998).

Chapter 6 of the Michigan Mental Health Code (MHC), which governs guardianship proceedings for persons with developmental disabilities, does not address proceedings involving the settlement of trusts for such persons. See, MCL §330.1600 et. seq. The only reference in Chapter 6 of the MHC to the rights of heirs of persons with developmental disabilities is their right to notice of a petition

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[28] As noted earlier, the legislation authorizes parents, grandparents, guardians, and, for C trusts, the disabled individual him or herself, to establish the trust. See 42 USC §1396p(d)(4), generally.

[29] The person with the disability (who may be a "person with a developmental disability" as defined by the Mental Health Code at MCL §330.1208, or an "incapacitated individual" as defined by the Estates and Protected Individuals Code at MCL §700.1105(a), so long as such person is "disabled" as defined by 42 USC §1382c(a)(3), may seek court authority either because he or she chooses, or because the legal representative does not have the requisite authority over the property of the individual or because an insurance company or defense attorney requires such authority as a condition precedent to paying-over a settlement to the special needs trust.

[30] Because Medicaid is a program governed exclusively by federal law, regulation and policy, any law, rule or policy of a state which conflicts with the Medicaid law, regulation or policy, including the trust exceptions contained in OBRA '93, is preempted. Boulhanis v. Prevo's Family Market, Inc. et al., 230 Mich App 131 (1998) (holding that field preemption may be found where the state law at issue regulates conduct in a field that Congress intended the federal government to occupy exclusively and that conflict preemption exists when it is impossible to comply with both state and federal law, or where the state law stands as an obstacle to the accomplishment of Congress' objectives); Bibbo v. Dean Witter Reynolds, Inc., 151 F.3d 559 (6th Cir. 1998).

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to appoint a guardian of a person with a developmental disability. MCL §330.1614.

The Estates and Protected Individuals Code (EPIC) governs proceedings regarding incapacitated individuals and protected individuals.[31] MCL §700.5401 specifically grants the probate court the authority to issue a protective order in relation to a person's affairs or estate if the court determines both that the individual is unable to manage property and business affairs effectively for such reasons as mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, confinement, detention by foreign power or disappearance and that the individual has property that will be wasted or dissipated unless proper management is provided, or money is needed for the individual's support, and that protection is necessary to obtain or provide money. MCL §700.5410(3)(a) and (b).

Although a person with a developmental disability is not specifically referenced as an individual in need of protection, the definition of "disability" found in §700.1103(o) is sufficiently broad that one may interpret that a "developmental disability" is within its scope. MCL §700.1103(o). Because the provisions of EPIC as they relate to the issuance of protective orders grant the probate court the authority to create trusts on behalf of a person with a disability (who may be developmentally disabled or "disabled" as defined by the Social Security Act), a *Petition for Protective Order* is the proper pleading to file when seeking a court order establishing a self-settled Exception A or C special needs

[31] Proceedings affecting both "incapacitated individuals" (who are defined by MCL §700.1105(a) as an individuals who are impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause, not including minority, to the extent of lacking sufficient understanding or capacity to make or communicate informed decisions) and "protected individuals" (who are defined as minors or other individuals for whom a conservator has been appointed or other protective order has been made as provided in part 4 of Article V of EPIC) are governed by Article V of EPIC, MCL §700.5101 et. seq.

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trust for the benefit of a person with a disability. MCL §700.5407(c)(v); MCL §700.5408(1) and (2).

As to giving notice to the heirs of a protected individual (or individual for whom a protective order is sought), EPIC provides that a petition for a protective order must set forth, *to the extent known*, the name and address of the nearest relative known to the petitioner. MCL §700.5404(2). Notice of the hearing on a petition for protective order is to provided to the protected individual, a conservator of the protected individual's estate, and any other person as ordered by the court or as provided by court rule. MCL §700.5405(2). The Michigan Court Rules governing probate court proceedings define "Interested Persons" for purposes of defining those who are entitled to notice of proceedings in the probate court See MCR 5.125. This rule has two provisions that describe those persons entitled to notice of a proceeding involving the creation of a trust for an individual:

MCR 5.125(C)(24) provides, "The persons interested in a petition for the appointment of a conservator or for a protective order are: (a) the individual to be protected if 14 years of age or older, (b) the presumptive heirs of the individual to be protected, (c) if known, a person named as attorney in fact under a durable power of attorney, (d) the nominated conservator, and (e) a governmental agency paying benefits to the individual to be protected or before which an application for benefits is pending."

Alternately, if the trust is being created pursuant to a settlement for the benefit of a minor or incapacitated individual (which does not necessarily include a person with a developmental disability),[32] MCR 5.125(C)(28) provides that the persons interested in the petition for the approval of the trust are "(a) the protected individual if 14 years of age or older, (b) the presumptive heirs of the protected

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individual, (c) if there is no conservator, a person named as attorney in fact under a durable power of attorney, (d) the nominated trustee, and (e) a governmental agency paying benefits to the individual to be protected or before which an application for benefits is pending."

The above two court rule subsections deal with known presumptive heirs. Both the Guardian Ad Litem in this case, and this Honorable Court, have asked what sort of notice, if any, must be given to *unknown* presumptive heirs. The answer appears to be given by MCR 5.125(A), which provides, in relevant part, "In addition to persons named in sub-rule (C) with respect to specific proceedings, the following persons must be served: (1) The Attorney General must be served if required by law or court rule. The Attorney General must be served in the specific proceedings enumerated in sub-rule (C) when the decedent is not survived by any known heirs, *or the protected person has no known presumptive heirs*." MCR 5.125(A)(1) (emphasis added).

Therefore, according to court rule (which EPIC references as guiding authority on who is considered an interested person for purposes of notice of proceedings), where there are *no* known presumptive heirs, notice should be given to the Attorney General. MCR 5.125(A)(1). Such notice, once properly given, would bind any later found presumptive heirs.

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[32] MCR 2.420 governs *Settlements and Judgments for Minors and Legally Incapacitated Individuals.*

PART 3.

- WHAT THE COURT SHOULD EXPECT BY WAY OF PROOFS IN GRANTING A PETITION TO ESTABLISH A SPECIAL NEEDS TRUST CREATED PURSUANT TO 42 USC §1396P(d)(4)(C) AND AUTHORIZING AN IRREVOCABLE TRANSFER OF PROPERTY BELONGING TO A PERSON WITH A DISABILITY -

This Honorable Court has requested that this Memorandum address what the probate court should expect in the way of proofs before granting a petition to establish an Exception C trust and authorizing the irrevocable transfer of a protected individual's property to that trust. This is essentially a three-part analysis:

First, the Court must determine that there is a basis to issue a protective order. MCL §700.5401(2). If the Court is satisfied that the would-be trust beneficiary is unable to manage his or property effectively because of a disability, and that the would-be beneficiary has property that will be wasted or dissipated unless management is provided, the first step in the analysis is complete. Generally speaking, this initial test is easily met. By definition, in order for an Exception C trust to be established, the beneficiary must be disabled. 42 USC §1396p(4)(C). Further, unless the person has property that will be dissipated due to a loss of or inability to secure government benefits, he or she is not likely seeking court authority to establish a special needs trust.

Second, the Court must determine that the establishment of a self-settled special needs trust (whether it be an Exception A or C trust) is in the person's *best interest*. MCL §700.5408 provides that the probate court may authorize, direct or ratify a trust relating to the protected individual's property if the court determines the transaction is in the individual's best interests. MCL §700.5408(2). Although this statutory provision requires the court to consider the interests of the protected

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individual's creditors and dependents, it has no reference to the individual's other presumptive heirs who may hope for an inheritance, nor does it include any mandate that the court consider the heirs when determining if establishing a trust is in a protected individual's best interest. MCL §700.5408(3).

Further, if such a mandate did exist, either by statute, court rule or developed through case law, it would violate the principles of federal preemption. It is a basic rule of preemption that where state law stands as an obstacle to the accomplishment of Congress' objectives, conflict preemption exists. Bibbo v. Dean Witter Reynolds, Inc., 151 F.3d 559 (6th Cir. 1998); Boulhanis v. Prevo's Family Market, Inc. et al., 230 Mich App 131 (1998).

As already noted, the letter and spirit of the OBRA '93 legislation regarding Exception A and C trusts focuses on the individual's needs and quality of life, not the expected needs or expected inheritance of the person's heirs. There are no references in the OBRA '93 legislation to the heirs of a person with a disability. The interests of the States providing medical assistance, and the nonprofit associations administering pooled accounts trusts, are second only to the interests of the people with disabilities who have these special needs trusts.[33] There would be nothing left for a presumptive heir until the accumulated debt to Medicaid is satisfied.[34]

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[33] *See* generally, 42 USC §1396p; State Medicaid Manual, Part 3 – Eligibility, HCFA Transmittal No. 64 November 1994; Ira S. Weisner, *OBRA '93 and Medicaid: Asset Transfers, Trust Availability, and Estate Recovery Statutory Analysis in Context*, 19 NOVA L. Rev. 679 (1995), citing Hearings on H.R. 264 Before the Subcomm. on Health and the Environment, 103d Cong., 1st Sess. 6 (1993); A. Frank Johns, *Legal Ethics Applied to Initial Client-lawyer Engagements in Which Layers Develop Special Needs Pooled Trusts*, 29 Wm. Mitchell L. Rev. 47 (2002); ARC of United States, *Pooled Trust Policy Paper*, 09/19/02; Clifton B. Kruse, Jr., *OBRA '93 Disability Trusts – A Status Report*, Probate and Property, May/June 1996, et al.

[34] In the case of an Exception C trust wherein the governing instrument provides for 100% retention of remaining funds, there will be no payback to the state providing benefits. If there is a lesser retention percentage provided in the governing instrument, the portion of the funds not retained are used for Medicaid reimbursement. 42 USC 1396p(d)(4)(C). Please note, all five pooled accounts trusts in operation in Michigan provide for a 100% retention of funds remaining after the beneficiary's death. Some of the

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In determining if establishing an Exception A or C trust is in a person's best interest, the Court should expect proofs that the person with a disability has basic medical and other support needs that can be provided through government assistance benefit programs, and that the transfer of his or her property to a self-settled special needs trust will both provide for effective management of that property and at the same time preserve a flexible source of funds to provide for special needs over and above those provided through government benefit programs.[35] This flexible source of funds will become even more essential as the extent of Medicaid services restrict.[36]

Since either an Exception A or C trust will provide for the above, the primary question for the court is not which type of special needs trust is in a person's best interest, but whether either, or any, special needs trust would be. However, the probate court should inquire into the basis for the selection of the type of trust. It should expect proofs from the petitioner that the type of trust chosen was done so with careful consideration.

For example, if the beneficiary has the capacity to make decisions regarding his or her property, the court should inquire as to the beneficiary's preference for an Exception A or C trust. The court may also inquire as to the availability and ability of family members to provide support and advocacy on behalf of the disabled beneficiary in the future. If there is no such family, or no known family with a history of providing such services, the Exception C trust may more appropriately serve the disabled beneficiary's best interest.

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non-profits are considering a different "class" of trusts which provide for a "partial retention" option, but to date, non exist in Michigan. See Exhibit 6 for a list of pooled accounts trusts in the country.

[35] Our State Constitution provides that "Institutions, programs and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally or otherwise seriously disabled shall always be fostered and supported." at MCL Const. Art. 8 §8.

[36] See Policy Memorandum from the Michigan Department of Community Health attached as Exhibit 2.

Further, the court may also inquire as to whether there is a person or entity that the petitioner feels is suitable to serve as trustee. If not, the Exception C trust may again be the more appropriate trust vehicle.

As discussed above, although the value of the property should not be the sole consideration in determining which type of trust, A or C, is the most appropriate in any given circumstance, it does play a role. The court should be advised of the extent of the property to be transferred to trust. The court might inquire into the annual cost of care for the beneficiary to discern the likelihood of any remainder upon the beneficiary's death and the required payback. This factor should be considered in conjunction with the beneficiary's familial relationships.

Finally, although there is no reference in this body of law to the court using a "substituted judgment" standard (and in fact EPIC specifically references "best interests"), the court should consider which type of trust would the person whose property it is (or was) would prefer.

Third, once the court determines that the basis for a protective order exists and that the establishment of a self-settled special needs trust created pursuant to 42 USC §1396p(d)(4) is in the disabled beneficiary's best interest, the court must have the *power* to establish such a trust. There is no doubt that the terms of the federal legislation grant 'a court' the power to establish either an Exception A or C trust. See, generally, 42 USC §1396p(d)(4)(A) and (C).

Further, there is no doubt that the probate courts in the state of Michigan have the power to establish an irrevocable trust for the benefit of individual within its jurisdiction. See MCL §700.1302(b) as it relates to jurisdiction; see MCL §700.5407(c)(v) and MCL §700.5408(1) and (2).

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Of particular concern to the Guardian Ad Litem in this matter, a concern echoed by the court, was whether the court could make an irrevocable transfer of Ronnie's property that had the effect of a testamentary disposition of that property.

It should first be noted that the federal law governing the creation and administration of Exception A and C trusts unequivocally provides that a court may establish such a trust on behalf of an individual who is disabled, and the Court may authorize and effectuate the transfer of that person's property *irrevocably* to that trust, with a remainder that may be limited only to the state which provided Medicaid assistance payments, or to a non profit association that serves as trustee. 42 USC §1396p(d)(4)(A) and (C); State Medicaid Manual, Part 3 – Eligibility, HCFA Transmittal No. 64, November 1994.

Next, state law unequivocally grants the probate courts the authority to make an irrevocable disposition of a disabled person's in trust even if the disposition extends beyond the disability or life of the person. MCL §700.5407(c)(v). There is no limit upon this Court in granting such an order.

-CONCLUSION-

The OBRA '93 legislation, which regulates transfers of property and the treatment of trusts of persons with disabilities who seek Medicaid, memorializes a trade-off: the government will allow persons with disabilities to have the benefit of a separate source of funds to supplement needs-based assistance program benefits and to provide for an enhanced quality of life. In return, the disabled beneficiary gives up control over the assets transferred to trust – both during his or her lifetime (reflected in the prohibitions against an ability to demand or direct distributions) and where the property will go after his or her death. With the

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enactment of the OBRA '93 legislation, Congress sought to both recognize the special needs of persons with disabilities and to halt perceived abuses of the Medicaid program by the heirs of elders and other persons seeking Medicaid assistance. Essentially, Congress has said "you can't have your cake and eat it, too."

Ronnie Erkmann is a person with a disability. He, through his legal guardian, has sought this Honorable Court's authority to establish a sub-account within the *Friends of CLS Pooled Accounts Trust dated February 10, 1999.* His guardian believes that establishing a special needs trust for the benefit of Ronnie is in Ronnie's best interest. Ronnie is disabled as defined by federal law and, as a person with a developmental disability as defined by state law, he is eligible for medically necessary and valuable government services. His guardian, as authorized by federal law, has chosen the Exception C trust as the more appropriate self-settled special needs trust for Ronnie.

Ronnie has no known relatives nearby, and but for his guardian and the providers employed by advocacy organizations serving persons with disabilities, he has no one to provide companionship and advocacy to him. The property to which Ronnie seeks to transfer was left to him as the sole heir of his mother's estate. Ronnie's guardian, who was a part of Ronnie's life prior to his mom's demise and familiar with his mom, believes that Ronnie's mom would have chosen a pooled accounts trust as the preferred self-settled special needs trust for Ronnie because of the fact that under the terms of the particular trust at issue, all funds remaining in Ronnie's sub-account upon his death, if any, will be retained by the trust and used to benefit other persons with disabilities.

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Respectfully Submitted,

Dated: December 16, 2002 By: _____

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EXHIBIT 1

Eckmann Ex

STATE OF MICHIGAN

IN THE PROBATE COURT FOR THE COUNTY OF WAYNE

Estate of [redacted], a Developmentally Disabled Person. File No. [redacted]
_____/

REPORT OF GUARDIAN AD LITEM RE:
PETITION OF [redacted] A DEVELOPMENTALLY DISABLED PERSON, TO EXECUTE JOINDER AGREEMENT, TO TRANSFER ASSETS TO POOLED ACCOUNTS TRUST, TO APPROVE ATTORNEY FEES AND FOR CONSTRUCTION OF TRUST

AND

OBSERVATIONS AND COMMENTS IN REGARD THERETO INCLUDING CONSENT TO RELIEF REQUESTED AND WAIVER OF NOTICE OF HEARING THEREON

The undersigned, JOHN M. CHASE, JR., the duly appointed Guardian ad Litem, hereby reports to the Court that he has examined in detail the Petition of [redacted] as Partial Guardian of the Person of [redacted], a Developmentally Disabled Person, by and through its attorney, Patricia E. Kefalas Dudek, to Execute Joinder Agreement, to Transfer Assets to Pooled Accounts Trust, to Approve Attorney Fees and for Construction of Trust, which Petition is dated October 3, 1997.

Further, your Guardian ad Litem reviewed in detail the Exhibits appended to the Petition, including the Last Will and Testament of [redacted]; the First and Second Codicils to the Last Will and Testament of [redacted]

dated February 20, 1982, and October 1, 1983, respectively; and, the Report of [redacted] as Guardian ad Litem regarding the Petition for Commencement of Proceedings and Admission of the Last Will and Testament and Codicils thereto of [redacted] to Probate, which Report is dated October 19, 1984, which together are appended as Exhibit "1". The print out for the [redacted] Testamentary Trust, being File No. 0C-767567, at the Wayne County Probate Court was reviewed in detail. The Trustee for said Testamentary Trust is the [redacted] being the Petitioner herein, and its attorney is [redacted] Your Guardian ad Litem discussed with [redacted] the status of that Testamentary Trust.

The Pooled Accounts Trust of [redacted] April 21, 1997; and, the proposed Joinder Agreement, as well as the two (2) page time and billing statement of the office of Patricia E. Kefalas Dudek attached as Exhibits "2", "4" and "5" to the Petition were reviewed in detail.

Pertinent provisions of Title 42 of the United States Code relating to the establishment of Special Needs Trusts for disabled individuals if the State will receive all amounts remaining in the Trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the disabled individual under a State plan were reviewed. Your Guardian ad

Litem also read an article titled "The Omnibus Budget Reconciliation Act of 1993, Expansion of Trust Options for Persons With Disabilities" written by the attorney for the Petitioner herein, Patricia E. Kefalas Dudek, as well as Jan M. Peronis, scheduled for publication next month. Finally, your Guardian ad Litem discussed the Petition and the various aspects thereof with Patricia E. Kefalas Dudek, the attorney for the Petitioner, on two (2) occasions.

[redacted], the father of [redacted] the Developmentally Disabled Person, died in 1984. His sole heir at law and the sole beneficiary under his Last Will and Testament and the two (2) Codicils thereto was his daughter, [redacted]. Pursuant to the provisions of the Testamentary Trust established by [redacted] all of the residue of his Estate is being held in Trust "... for the use and benefit, education, well-being and support of my daughter, [redacted] The Trustee of the Testamentary Trust [redacted] the Petitioner herein, and its attorney is [redacted] advised that he is presently in the process of drafting the Tenth Annual Account of the Testamentary Trustee under the Last Will and Testament and the two (2) Codicils thereto. The closing date of the Account is December 31, 1996, and the asset balance was at that date [redacted] As set forth in the

Petition, presently the assets amount to about $45,000.00 which demonstrates the high cost of maintaining [redacted].

Assuming this Honorable Court approves the Petition and the prayers contained therein, a subsequent Petition in the Testamentary Trust proceedings, being File [redacted], will be required in order to terminate that Trust and transfer the assets to the Pooled Accounts Trust as requested in the pending Petition. The first step in the process, however, is to approve the prayers contained in the present Petition.

The thrust of the present Petition is to seek the approval by this Honorable Court of the Pooled Accounts Trust established by the Petitioner, [redacted], on April 17, 1997. After the approval of the Pooled Accounts Trust, the Court is then asked to determine that the execution of a Joinder Agreement set forth as Exhibit "4" appended to the Petition and the transfer of all of the assets of [redacted] to the Pooled Accounts Trust is in her best interest. Finally, this Court is asked to approve the attorney fees associated with the drafting of the Pooled Accounts Trust, the Joinder Agreement and the present Petition.

If this Honorable Court approves the Pooled Accounts Trust and the remaining relief requested in the Petition, an application would then be made to the Family Independence Agency for the State of Michigan for Medicaid benefits for the support and maintenance of the Developmentally Disabled Person, who presently suffers from

Downs Syndrome and Alzheimers. Prior to the application to the Family Independence Agency, your Guardian ad Litem repeats that from a procedural standpoint, a formal request must be made in the Testamentary Trust proceedings, being Wayne County Probate Court File No. 00-767567, to terminate that ongoing Trust under the Last Will and Testament and two (2) Codicils thereto of [redacted], the father of the Developmentally Disabled Person, and transfer the assets under said Testamentary Trust to the Pooled Accounts Trust. It may be that this Honorable Court will be able to short circuit proceedings in the Testamentary Trust file since all of the parties in interest in that file are identical to the parties in interest in the present proceeding, including [redacted] the Developmentally Disabled Person, and the Petitioner, [redacted] who is the designated remainder beneficiary of the aforesaid Testamentary Trust. [redacted] acting as the attorney for the Petitioner herein in the Testamentary Trust file and he had not been served with a copy of the Petitioner herein. [redacted]ices, however, support the relief requested in this Petition as described to him by your Guardian ad Litem.

The concept of a Pooled Accounts Trust is new in the State of Michigan. Insofar as is known to Patricia E. Kefalas Dudek, the attorney for the Petitioner, and your Guardian ad Litem, there has never been a Pooled Accounts Trust previously approved by a state

agency or a Federal agency for that matter. [redacted] would be the first participant in the proposed Pooled Accounts Trust if this Court approves the relief requested in the pending Petition. Thus, the concept set forth in this Petition is unique and innovative.

The propcsed Pooled Accounts Trust has been drafted in accordance with the provisions of Title 42 United States Code Section 1396 p (d) (C). Pursuant to Title 42 USC 1396 p (d), statutory provisions are established for trusts for disabled individuals which will enable the individuals to receive various governmental benefits if the State wherein the disabled person resides will receive all accounts remaining in the Trust upon the death of the disabled individual up to an amount equal to the total medical assistance paid on behalf of the disabled individual under a State plan. All of the "Special Needs" trusts which your Guardian ad Litem has seen up to this point drafted pursuant to Title 42 are individual trusts created under Section (A) of the Code wherein amounts remaining in the trust upon the death of the beneficiary must be paid to the State in an amount equal to the total amount of medical assistance paid on behalf of the beneficiary with the excess, if any, to be paid to designated remainder beneficiaries.

The within "Pooled Accounts Trust" has been created under Section (C) wherein it is provided that if the trust is established and managed by a non-profit association and a separate account is

maintained for each beneficiary of the trust but for purposes of investment and management of funds the trust pools the accounts and the trusts are established solely for the benefit of individuals who are disabled by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court, then and in that event to the extent that amounts remaining in the beneficiary's account after the death of the beneficiary are retained by the trust and used for the benefit of other trust beneficiaries or to aide or to provide persons who are indigent and disabled as defined by Title 42 of the United States Code with housing or supplement support services deemed suitable for such persons by the Trustee then and in that event, it is not necessary to pay to the State from such remaining accounts in the deceased disabled beneficiary's account amounts equal to the total amount of medical assistance paid on behalf of the deceased disabled beneficiary under a State plan.

It is noted that in Article XI titled "Termination of Trust", in Paragraph 2 thereof, the proposed "Pooled Accounts Trust" provides that "Upon the death of a Beneficiary, any amounts remaining in the Beneficiary's Trust sub-account shall be deemed to be surplus Trust property and shall be retained by the Trust and, in the Trustee's sole discretion, used (a) for the benefit of other Beneficiaries, (b) to aide persons who are indigent and disabled, as defined in 42 U.S.C. § 1382 c (a) (3), or (c) to provide persons who are indigent and disabled, as defined in 42

U.S.C. § 1382 c (a) (3), with housing or supplemental support services deemed suitable for such persons by the Trustee." Thus, the Pooled Accounts Trust as drafted does not contemplate upon termination of an individual beneficiary's Trust at said beneficiary's death that the amount in said beneficiary's account will be paid to the State of Michigan to reimburse the State for monies up to an amount equal to the total medical assistance paid on behalf of the individual beneficiary but rather, will remain in the Trust for the benefit of other disabled persons. This is a dramatic departure from the terms of a Section A Trust which requires upon death of the beneficiary, the State to receive all amounts remaining in the Trust up to an amount equal to the total medical assistance paid on behalf of the individual beneficiary.

Your Guardian ad Litem is advised that at the time of the hearing of this Petition, Ms. Dudek will propose an amendment to the termination article (Article XI) of the Pooled Accounts Trust which will provide for reimbursement to the State of all amounts remaining in the Trust account of a deceased disabled beneficiary up to an amount equal to the total medical assistance paid on behalf of the disabled beneficiary only in the event the assets of that individual beneficiary do not remain a part of the total Trust assets.

Your Guardian ad Litem enthusiastically endorses the concept of the Pooled Accounts Trust which is possible in this instance because the Trust itself has been established and will be managed

by a non-profit association, namely the [redacted] This non-profit corporation is also the Partial Guardian of the Person of the Developmentally Disabled Person, [redacted], as well as the Testamentary Trustee and residuary beneficiary of the Testamentary Trust created for her benefit by the Last Will and Testament and two (2) Codicils thereto of her late father, [redacted] The clear purpose of the Trust is to provide security and independence to persons in the category of [redacted] and will permit her to obtain Medicaid assistance for the extensive services which she requires as a result of her condition. By placing the funds in the Pooled Accounts Trust, the same can be preserved and maintained for her to provide her with additional services and comforts above and beyond those paid for by Medicaid.

In the mind of your Guardian ad Litem, the relief sought is excellent and should be granted because without the placing of the funds into the Pooled Accounts Trust, all of the funds of [redacted] as a Developmentally Disabled Person will be used in their entirety until they are exhausted to provide her with the identical services which she would receive with her funds being placed in the Trust. By placing the funds in the Trust, her funds will be preserved and can be used to supplement the services which she will receive, all of which will then be paid for by Medicaid.

While the fees requested are substantial, being [redacted] plus costs in the amount of [redacted], being a total of [redacted] the

amount of time and effort and research to draft and establish the Trust was extraordinary since we are dealing with a new concept. The charge at the rate of $150.00 per hour is very reasonable in the opinion of your Guardian ad Litem for an attorney with the special expertise that Patricia E. Kefalas Dudek possesses in matters of this nature.

Based upon the aforesaid, your Guardian ad Litem hereby reports to the Court that he believes it to be in the best interest of [redacted] the Developmentally Disabled Person; and, also all other persons interested herein who are minors, or legally or mentally incompetent to act in their own behalf; and, all persons who are or may become interested herein, although unborn, unknown, undetermined, contingent or unascertained, that for the reasons set forth in the body of this Report, the prayers contained in the Petition of [redacted] Developmentally Disabled Person, by and through its attorney, Patricia E. Kefalas Dudek, to Execute Joinder Agreement, to Transfer Assets to Pooled Accounts Trust, to Approve Attorney Fees and for Construction of Trust, be granted as prayed.

WHEREFORE, the undersigned Guardian ad Litem hereby consents to the granting of the Petition of [redacted] as Partial Guardian of the Person of [redacted] a Developmentally Disabled Person, by and through its attorney, Patricia E. Kefalas Dudek, to Execute

Joinder Agreement, to Transfer Assets to Pooled Accounts Trust, to Approve Attorney Fees and for Construction of Trust and your Guardian ad Litem waives Notice of Hearing on said Petition.

JOHN M. CHASE, JR. (P11810)
Guardian ad Litem
645 Griswold Street
Suite 3180
Detroit, Michigan 48226
(313) 963-5343

State of Michigan)
) SS
County of Wayne)

On this 25th day of November, A.D. 1997, before me, a Notary Public in and for said County, personally appeared JOHN M. CHASE, JR., to me known to be the same person described in and who executed the foregoing instrument and then acknowledged to me that he executed the same as his free and voluntary act and deed.

ANGELA LEE WORLEN, Notary Public
Wayne County, Michigan
My Commission Expires: June 12, 1999

EXHIBIT 2

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JOHN ENGLER
GOVERNOR

JAMES K. HAVEMAN, JR.
DIRECTOR

November 22, 2002

TO: Executive Directors of Michigan's Specialty Prepaid Health Plans and Community Mental Health Services Programs

FROM: Patrick Barrie, Deputy Director
Health Programs Administration

SUBJECT: Policy Hearing Authority Decision

Recently, Michigan Department of Community Health (MDCH) Director, James K. Haveman, Jr., signed the Policy Hearing Authority Decision #01-0358CMH. Policy hearing authority decisions are issued by the MDCH Director in situations where existing departmental policy appears to conflict with federal or state law or regulation. Decisions are binding on the department and its contract agents as department policies.

The Policy Hearing Authority Decision affirmed the recommended decision issued earlier by an Administrative Law Judge (ALJ), pursuant to a Medicaid fair hearing appeal. The circumstances of the particular fair hearing appeal were rather intricate, involving consideration of services available under the state Medicaid plan, the subset of state plan services included under Michigan's 1915(b) specialty services waiver, "alternative" services offered under the authority of Section 1915(a)(1)(A), and the services covered under the 1915(c) Habilitation Supports Waiver (HSW). In the course of rendering a hearing decision, the ALJ identified several instances where departmental policy appeared to deviate in some way from statute and/or promulgated regulations. The ALJ made recommendations regarding these inconsistencies, and the Director - as the Policy Hearing Authority - issued the ruling (#01-0358CMH) to resolve the discrepancies.

The Policy Hearing Authority Decision (which was sent to CMHSP Directors on July 16, 2002) covered a number of issues and considerations that are of particular importance to specialty Prepaid Health Plans (PHPs) managing services under Michigan's concurrent 1915(b)/1915(c) waivers. I am writing to provide some perspective, clarification and direction to specialty PHPs on these issues and considerations as they implement - and bring current practices into compliance with - the Policy Hearing Authority Decision.

Beneficiaries, family members, and advocacy organizations have expressed strong concern regarding the varying interpretations they have received from PHPs regarding the Policy Hearing Authority Decision, and the potential negative impact that such interpretations may have on consumers. This correspondence is intended to standardize PHP understanding and application of the decision, and hence reduce the uncertainties experienced by consumers who are served by specialty PHPs throughout the state.

The following sections provide a brief recap of the concurrent 1915(b)/(c) specialty services program and more detailed examination of three specific issues contained within the Policy Hearing Authority Decision. Those issues are:

- The status of "alternative services" and the authority/jurisdiction of the Department's Administrative Tribunal to conduct hearings regarding alternative service disputes and payment methodologies;
- The differences (and relationship) between Medicaid home and community-based waiver services (provided under the authority of section 1915(c) of Title XIX) and Medicaid state plan services;
- Room and board as a service funded by Medicaid.

BRIEF REVIEW OF THE CONCURRENT 1915(B)/(C) PROGRAM

As you know, under approval granted by the Centers for Medicare and Medicaid Services (CMS), MDCH operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver. Under this waiver, selected Medicaid state plan specialty services related to mental health and developmental disabilities, as well as outpatient substance abuse services, have been "carved out" (removed) from Medicaid primary physical health care plans and arrangements. The 1915(b) Specialty Services Waiver Program operates in conjunction with Michigan's existing 1915(c) Habilitation Supports Waiver (HSW) for persons with developmental disabilities. Under section 1915(c) of the Social Security Act, states may request a waiver of certain federal requirements in order to provide specified home and community-based services to designated enrolled participants who would otherwise require institutional services reimbursed through Medicaid.

Michigan opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) waivers to create a managed care program that would integrate the administration and provision of certain traditional state plan services, newly identified alternatives, and (for enrolled participants) existing HSW home and community-based services. Such arrangements have been designated as "concurrent 1915(b)/(c)" programs by CMS.

Some of the major objectives of the concurrent 1915(b)/(c) program were to: a) provide Medicaid beneficiaries with the opportunity to experience "person-centered" assessment and planning approaches; b) establish - under the authority of Section 1915(a)(1)(A) - certain "alternatives" to traditional state plan services, increasing service and support options; c) afford beneficiaries and PHPs greater latitude to negotiate mutually acceptable, more flexible, service and support arrangements (within the parameters of the concurrent 1915(b)/(c) program); and d) promote the exercise of greater choice and control by beneficiaries.

ALTERNATIVE SERVICES

In the approved 1915(b) waiver component of the concurrent 1915(b)/(c) program, MDCH indicated the Medicaid state plan services included in the waiver and also identified certain other services that may be offered to beneficiaries - under the authority of Section 1915(a)(1)(A) of Title XIX of the Social Security Act - as alternatives to these state plan services.

Hence - under the authority of Section 1915(a)(1)(A) - specialty PHPs **are permitted** to use Medicaid capitation payments to provide more individualized, cost-effective, medically necessary, approved supports and services - according to the beneficiary's needs - as an alternative(s) to provision of the state plan coverages (included in the waiver) for which the beneficiary qualifies.

The person-centered planning process should be used to discuss traditional state plan benefits available through the 1915(b) waiver, permissible 1915(a)(1)(A) alternatives to these state plan benefits, 1915(c) services (if applicable, for beneficiaries enrolled in the HSW waiver), and other services available under the state Medicaid plan (but not provided through the concurrent 1915(b)/(c) program) for which the beneficiary may qualify.

In addressing beneficiary requests, negotiating alternative service and support arrangements, and authorizing the provision of services and the expenditure of Medicaid capitation funds for permissible 1915(a)(1)(A) alternatives, PHPs should keep in mind several important considerations and parameters:

- Other benefits (e.g., personal care - Home Help - under the state plan for beneficiaries living independently) and resources (e.g., other insurance and third-party liability), for which the beneficiary might be eligible or qualify, have been explored, and these other primary sources of coverage and/or reimbursement have been appropriately and fully utilized;
- The state plan service - included under the 1915(b) waiver - for which the alternative is being offered (in lieu of the provision of the medically necessary state plan service) is identified in the written plan of service;
- The service/support is reasonable and necessary, is consistent with the purpose of the medically necessary state plan service for which it is a substitute, and is congruent with the approved alternative services identified in the MDCH-PHP contract; and
- A prudent purchaser principle is applied in amount, scope, and duration.

The use of permissible alternatives - in lieu of a medically necessary state plan services included in the waiver - must be agreed to by both parties (i.e., beneficiary and the PHP). Such agreement would normally be reached as part of the person-centered planning process. It is important to note, however, that the decisions and agreements reached in the person-centered planning process regarding the type, amount, scope and duration of alterative services must be properly reflected, described and documented in the written individual plan of service.

Listed below are those approved alternative services that were referenced in the MDCH **waiver submission**. This list differs slightly from the list of alternative services that will be included in the contract between MDCH and the PHP. The **contract list** of approved alternative services is more extensive and inclusive, since it breaks out - for definitional and reporting purposes - components of alternative services that were combined or aggregated in the waiver submission. For example, the contract list includes supported (or integrated) employment as an alternative service, isolating this service component from the multiple and combined aspects of an alternative service definition provided in the waiver. It is this broader and more extensive **contract list** of approved alternative services that must be available in the PHP's service area. Definitions of the contract list of alternative services will be provided in the Specialty Services and Supports Contract (Reporting Requirements Attachment).

<u>Alternative Services: Persons with Serious Mental Illness or Serious Emotional Disturbance</u>:

- Peer-Delivered or Peer-Operated Support Services
- Family Skills Development
- Respite Care
- Community Living Training and Support

- Skill Building Assistance
- Housing Assistance
- Extended Observation Beds
- Specialized Behavioral Health (Wraparound) Services for Children and Adolescents
- Prevention and Consultation Services

Alternative Services: Persons with a Developmental Disability:

- Crisis Stabilization and Response
- Support and Service Coordination
- Family Support - Family Skills Development
- Respite Care Services
- Community Living Staff
- Community Living - Environmental Modifications
- Community Living - Assistive Technology
- Housing Assistance
- Skill-Building Assistance - All Other
- Enhanced Health Care Services
- Assistance for Challenging Behaviors
- Prevention and Consultation Services

Because the "alternatives" are provided under the authority of Section 1915(a)(1)(A) of the Social Security Act, the Policy Hearing Authority Decision concluded that these services are not "Medicaid" services (although these services may be paid for from Medicaid capitation funds), and hence the Administrative Tribunal has no jurisdiction to hear matters pertaining to the provision, modification or denial of alternative services. However, consistent with previous contractual requirements (which are continued in the new agreement), beneficiaries must be provided a local dispute resolution conference for complaints and disagreements related to the provision, modification or denial of alternative services. The beneficiary retains fair hearing rights regarding any denials, reductions, suspensions, and/or terminations of state plan benefits and of home and community-based waiver services (if enrolled in the HSW).

The Policy Hearing Authority Decision on alternative services also addressed "housing assistance" and "room and board". These items will be dealt with below in a separate, specifically labeled, section.

STATE PLAN BENEFITS AND MEDICAID HOME AND COMMUNITY-BASED WAIVER SERVICES: ISSUES REGARDING THE PROVISION OF "PERSONAL CARE"

Under Title XIX, states may make available a range of personal care or assistance services to persons with disabilities and/or chronic conditions to enable them to accomplish tasks that they would normally do for themselves if they did not have certain impairments and functional constraints. Under the state Medicaid plan, there are three varieties of personal care coverage available (depending upon particular circumstances) for beneficiaries with a serious mental illness, serious emotional disturbance or a developmental disability, who need assistance with activities of daily living. In addition, there are other differentiated forms of personal assistance

and support - the Community Living Support (CLS) benefit under the 1915(c) HSW program (for enrolled participants) and the various forms of CLS allowed as alternatives under the provisions of Section 1915(a)(1)(A) within the 1915(b) program - that further facilitate independence, community living and participation.

The Policy Hearing Authority Decision called attention to the federal requirement of "**nonduplication**"; that is, the state may not provide the exact same service under a 1915(c) waiver (or, presumably, as an "alternative" under a 1915(b) waiver program) that it offers under the regular state Medicaid plan. The logic behind "nonduplication" (especially in the context of the 1915(c) waiver) is straightforward: the beneficiary is already eligible for the service under the state plan. While a service under the 1915(c) waiver (or an alternative under the 1915(a)(1)(A) provisions) cannot duplicate a state plan coverage, it can "**complement**" the state plan coverage by offering additional (differentiated) or extended services that go beyond the basic assistance provided through the state plan.

In order to avoid duplication of the state plan service - and to properly apply and provide complementary additional services (as a covered service in the HSW or as alternative services under the 1915(a)(1)(A) provisions within 1915(b) program) - the PHP must appreciate what is covered through (and under what circumstances) the three state plan "varieties" of personal care services:

1. Personal Care in Licensed and Certified Specialized Residential Settings is a Medicaid state plan service - and part of the PHP's state plan service responsibilities under the 1915(b) waiver - available for beneficiaries who live in those settings when ordered by a physician or Medicaid-designated case manager. It covers activities such as assistance with eating, toileting, bathing, grooming, dressing, transferring, ambulation, self-administered medication, and assistance with food preparation, clothing, laundry, and housekeeping beyond the level required by foster care licensure.

2. Personal Care in Non-Specialized "Regular" Licensed AFC Settings is a Medicaid state plan service available to beneficiaries who live in those settings when ordered by a physician or Medicaid-designated case manager. It covers activities such as assistance with eating, toileting, bathing, grooming, dressing, transferring, ambulation, self-administered medication, and assistance with food preparation, clothing, laundry, and housekeeping beyond the level required by foster care licensure.

3. Home Help Program is a Medicaid state plan service that provides assistance to beneficiaries who live in unlicensed non-foster care settings (e.g., own home/apartment, or with family). The eligibility and extent of coverage are determined through a functional assessment by the Family Independence Agency (FIA), which also administers the program. Covered activities include assistance with: meal preparation, laundry, housework, shopping, eating, toileting, bathing, grooming, dressing, transferring, mobility and taking medication. The Home Help program authorizes additional assistance and increased rates (Expanded Home Help) depending upon the severity of the beneficiary's needs.

The Policy Hearing Authority Decision indicated that basic personal care for beneficiaries needing assistance with activities of daily living must be furnished through one of these three

state plan varieties of personal care coverage. The applicable state plan coverage depends upon the circumstances of the beneficiary, as noted above. PHPs must be knowledgeable regarding Home Help Program requirements (see FIA Adult Service Manual 363, accessed through the web at http://www.mfia.state.mi.us/olmweb/ex/asm/asm.pdf), including procedures for requesting expanded home help services (EHHS) and/or for soliciting an exemption to the home help service rate.

Case managers or supports coordinators working for the PHP, for a CMHSP affiliate of the PHP, or for a contracted network provider, should assist the beneficiary in applying for Home Help services, when it appears that the beneficiary is eligible for and in need of this personal care coverage. The case manager or supports coordinator should also advocate for and assist the beneficiary to appeal (if the beneficiary wishes to appeal) decisions regarding eligibility for or the amount of Home Help or Expanded Home Help, if it appears that these determinations do not adequately address (within the allowable parameters of the Home Help benefit) the documented needs of the beneficiary.

As noted above, CLS is a covered benefit (for enrolled participants) under the Habilitation Supports Waiver, and (in various forms) is an allowable alternative service - under the authority of 1915(a)(1)(A) - through the 1915(b) specialty services and supports waiver. The definitions of CLS under the 1915(c) waiver, and the descriptions of CLS as an alternative under the 1915(b) waiver, incorporate a variety of supports, service enhancements and assistance which facilitate personal independence and community integration. Specifically, in regard to personal care, these CLS definitions and descriptions identify service augmentations that either complement - but do not supplant - the basic state plan personal care benefits listed above, or afford distinctly different forms of personal assistance than those provided through the Home Help program. For example, Home Help doesn't cover supervising, monitoring, reminding, guiding or encouraging the performance of activities of daily living, while CLS (complement) does, and CLS (additional) broadens personal assistance, support, and training to include money management, monitoring of medications, non-medical care, socialization and relationship building, transportation (see below), leisure choice and participation in community activities, and attendance at medical appointments.

During the person-centered planning process and in the subsequent development of the written individual plan of service, PHPs must be attentive to these coverage distinctions and properly apply and harmonize these benefits, services and alternatives to meet the needs of the beneficiary.

Clarification Regarding Transportation

Transportation (with limited exceptions described below) for the purpose of obtaining medically necessary Medicaid covered services is available through state plan transportation services administered by FIA or by the beneficiary's health plan. The PHP must assure that beneficiaries who need such medical transportation use the transportation services arranged through FIA or by the beneficiary's health plan. Information on medical transportation is presented in FIA Program Administration Manual 825 (accessible via the internet at http://www.mfia.state.mi.us/olmweb/ex/html/). PHP staff should advise the beneficiary regarding how to access medical transportation services through FIA or a health plan, and should provide guidance on appeal mechanisms in circumstances of transportation denials.

Transportation is a federally-approved part of the HSW's community living supports, out-of-home habilitation, pre-vocational, and supported employment services. Transportation is also covered by the state plan - and is part of the PHP state plan service responsibilities under the 1915(b) waiver - when provided as a round trip from the beneficiary's residence to access services through an MDCH-approved day program (location where covered services may be provided) or to attend a psychosocial rehabilitation program (clubhouse).

Housing Assistance

Of all of the issues addressed in the Policy Hearing Authority Decision, none has sparked as much confusion and controversy as the discussion regarding housing assistance and the ruling on "room and board" as an allowable "alternative" service. Housing assistance is identified - under the authority of 1915(a)(1)(A) - as an allowable "alternative" service within the 1915(b) waiver program for both persons with mental illness and persons with developmental disabilities, although it is defined somewhat differently for each of these populations.

Housing assistance, as an 1915(a)(1)(A) alternative service, has a number of dimensions and parameters. Unfortunately, the definitions of housing assistance - both in the waiver submission and in MSA Bulletin 98-09 (Chapter III for Managed Care, effective 10/01/98) - are not particularly detailed regarding these dimensions and parameters, nor are there clear indications regarding the circumstances under which housing assistance as an alternative service should or could be provided.

To correctly apply the Policy Hearing Authority Decision on this issue; it is important to clarify the various components and constraints related to housing assistance, and to differentiate those elements of housing assistance that were affected (excluded) by the Policy Hearing Authority Decision from those that were not proscribed and which hence remain allowable.

The waiver and bulletin (98-09) definitions of housing assistance either indicate or imply that housing assistance includes: a) one-time assistance with certain "start-up" expenses (e.g., security deposits, furnishings, utility set-up fees, moving costs, etc.) which pose a barrier to successful transition to home ownership or to leasing/renting a dwelling, or for particular home repair or appliance replacement expenses, to avert or remedy situations in which a beneficiary might be forced to leave the dwelling for health and safety reasons; b) limited term or temporary assistance with living expenses for beneficiaries transitioning from restrictive settings into more independent, integrated living arrangements, with the expectation that other benefits (e.g. SSI) or public programs (e.g., governmental rental assistance and/or home ownership programs) will become available to assume these obligations and provide needed assistance; c) ongoing assistance with certain expenses that are "..in excess of resources available to the client for room and board" (mental health definition), or which "...exceed the capacity of their other sources of funding for room and board" (developmental disabilities definition).

It is this last component or dimension of housing assistance - ongoing assistance with room and board expenses - that was overturned (and is now excluded) by the Policy Hearing Authority Decision. The Policy Hearing Authority ruled - as a conclusion of law - that such ongoing assistance with room and board is prohibited. "Room" is defined in the State Medicaid Manual (SMM) as "...hotel or shelter type expenses including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services" and "board" is defined as "...three meals a day or any other full nutritional regimen" (SMM 4442.3).

Generally - as the Policy Hearing Authority Decision points out - federal financial participation (FFP) for room and board is only allowable in specific situations, such as inpatient hospitals, nursing homes and ICF/MR facilities. Moreover, there are some specific statutory and regulatory citations - section 1915(c)(1) of the Social Security Act and 42 CFR 441.310 (both of which pertain to Home and Community-Based Waivers) - that explicitly prohibit Medicaid payment for "room and board".

It is worth noting that, historically, in developing various non-institutional state plan coverages to address the needs of beneficiaries with developmental disabilities (e.g., HSW) and mental illness (e.g., intensive crisis residential services), the state has always applied methods to separate and break-out service costs from ongoing room and board costs, when services were provided in residential settings or living arrangements (e.g., requiring an amount equal to the SSI personal care level daily rate to be deducted in calculating service or support costs).

In summary, the elements or dimensions of housing assistance as an alternative service that relate to one-time or limited-term assistance (defined above) are permissible, but Medicaid funds may not be used to pay ongoing, open-ended room and board costs. Housing assistance is not intended to provide long-term funding for ongoing housing costs.

THE IMPORTANCE OF THE WRITTEN PLAN OF SERVICE

The individual plan of service is developed through the person-centered planning process. For Medicaid beneficiaries, the individual plan of service must document the state plan services to which the beneficiary is entitled based upon medical necessity. The individual plan of service must also document that alternative service options were discussed and offered to the beneficiary. **The agreed upon individual plan of services and supports must specify the amount, duration, and scope of each state plan and/or alternative service(s) and support(s)**. Any changes to the individual plan of service must be made in writing and the beneficiary must be provided a copy.

MDCH is keenly aware of beneficiary, family and advocacy concerns that the concept of "medical necessity" might be formulated, used and applied in a manner that may unduly limit or restrict the provision of services and supports. The department intends to address these concerns in the waiver renewal process, and to provide more guidance to PHPs regarding the definition and application of medical necessity criteria and coverage determination decisions.

FINAL THOUGHTS

As elements of the Policy Hearing Authority Decision are phased in over time, it is the intent of MDCH to work with PHPs to minimize service disruptions and complications generated by the decision. In particular, the department is absolutely committed to assuring the continued availability of alternative services - within the framework provided by the Policy Hearing Authority Decision and under the authority of Section 1915(a)(1)(A) - within the 1915(b) component of the concurrent 1915(b)/(c) program. MDCH intends to work with stakeholders to develop a department-level complaint mechanism regarding the provision, modification and/or denial of alternative services when local mechanisms do not provide resolution to disputes between consumers and the PHPs regarding alternative services.

I encourage PHPs and CMHSPs to use this communication to improve how decisions are made regarding the provision of alternative services, personal care, transportation and housing assistance. I would also urge you to proceed with care as you adjust any existing service and support arrangements in response to the Policy Hearing Authority Decision. Such modifications

should be done through the person-centered planning process, with a thorough discussion of service/support options, an explanation of applicable appeal, grievance and dispute resolution processes, and the development of a revised written individual plan of service. Sweeping and indiscriminate alterations in service and support arrangements - lacking consideration of individual circumstances and circumventing the person-centered planning process – must be avoided.

cc: James K. Haveman
Carol Isaacs
Irene Kazieczko
Judy Webb
Interested Parties

EXHIBIT 3

Appendix C

State Medicaid Manual, Part 3—Eligibility, HCFA Transmittal No. 64, November 1994

New Implementing Instructions—Effective Date: 12/13/94

This instruction applies to all transfers made or trusts established on or after August 10, 1993.

Section 3258, Transfers of Assets for Less Than Fair Market Value, was added to interpret § 1917(c) of the Act, as amended by § 13611 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), on the treatment of transfers of assets for less than fair market value. This section discusses actions which result in the denial of coverage for certain medical services to otherwise eligible institutionalized or noninstitutionalized individuals who transfer assets for less than fair market value.

Section 3259, Treatment of Trusts, was added to interpret the new § 1917(d) of the Act, as created by § 13611 of OBRA 1993 on the treatment of trusts. This section sets forth the rules under which a trust must be considered in determining eligibility for Medicaid. The provisions apply to any individual who establishes a trust and who is an applicant for or recipient of Medicaid. The instructions discuss both revocable and irrevocable trusts for both institutionalized or noninstitutionalized individuals, in addition to various exemptions for certain types of trusts.

GENERAL AND CATEGORICAL ELIGIBILITY REQUIREMENTS

3257. Transfers of Assets and Treatment of Trusts

A. *General.* Section 13611 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) amended § 1917 of the Act by incorporating in § 1917(c) and (d) new requirements for treatment of transfers of assets for less than fair market value and for treatment of trusts. The following instructions apply only to transfers made and trusts established after the effective date explained in § 3258.2. For transfers made and trusts established before that effective date, the old policies regarding treatment of trusts and transfers apply. See §§ 3215 and 3250 for instructions on the treatment of trusts established and transfers made before August 11, 1993.

B. *Definitions.* The following definitions apply, as appropriate, to both transfers of assets and trusts:

1. *Individual.* As used in this instruction, the term "individual" includes the individual himself or herself, as well as:

- The individual's spouse, where the spouse is acting in the place of or on behalf of the individual;

- A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; and
- Any person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

2. *Spouse.* This is a person who is considered legally married to an individual under the laws of the State in which the individual is applying for or receiving Medicaid.

3. *Assets.* For purposes of this section, assets include all income and resources of the individual and of the individual's spouse. This includes income or resources which the individual or the individual's spouse is entitled to but does not receive because of any action by:

- The individual or the individual's spouse;
- A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or
- Any person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse. For purposes of this section, the term "assets an individual or spouse is entitled to" includes assets to which the individual is entitled or would be entitled if action had not been taken to avoid receiving the assets.

The following are examples of actions which would cause income or resources not to be received:

- Irrevocably waiving pension income;
- Waiving the right to receive an inheritance;
- Not accepting or accessing injury settlements;
- Tort settlements which are diverted by the defendant into a trust or similar device to be held for the benefit of an individual who is a plaintiff; and
- Refusal to take legal action to obtain a court ordered payment that is not being paid, such as child support or alimony.

However, failure to cause assets to be received does not entail a transfer of assets for less than fair market value in all instances. For example, the individual may not be able to afford to take the necessary action to obtain the assets. Or, the cost of obtaining the assets may be greater than the assets are worth, thus effectively rendering the assets worthless to the individual. Examine the specific circumstances of each case before making a decision whether an uncompensated asset transfer occurred.

4. *Resources.* For purposes of this section, the definition of resources is the same definition used by the Supplemental Security Income (SSI) program, except that the home is not excluded for institutionalized individuals. In determining whether a transfer of assets or a trust involves an SSI-accountable resource, use those resource exclusions and disregards used by the SSI program, except for the exclusion of the home for institutionalized individuals.

In determining whether resources have been transferred for less than fair market value, you may not apply more liberal definitions of resources which you may be using under § 1902(r)(2) of the Act. For transfer of assets purposes, if you are a 209(b) State, you cannot use more restrictive definitions of resources that you may have in your State plan.

However, in determining whether and how a trust is counted in determining eligibility, you may apply more liberal methodologies for resources which you may be using under § 1902(r)(2) of the Act. For trust purposes, if you are a 209(b) State, you may use more restrictive definitions of

resources that you may have in your State plan.

For noninstitutionalized individuals, the home remains an exempt resource.

5. *Income.* For purposes of this section, the definition of income is the same definition used by the SSI program. In determining whether a transfer of assets involves SSI-countable income, take into account those income exclusions and disregards used by the SSI program.

You may not, for transfer of assets purposes, apply more liberal definitions of income that you may be using under § 1902(r)(2) of the Act. If you are a 209(b) State, you cannot use more restrictive definitions of income that you may have in your State plan.

However, in determining whether and how a trust is counted in determining eligibility, you may apply more liberal methodologies for income which you may be using under § 1902(r)(2) of the Act. Also, for trust purposes, if you are a 209(b) State, you may use more restrictive definitions of income that you may have in your State plan.

6. *For the Sole Benefit of.* A transfer is considered to be for the sole benefit of a spouse, blind or disabled child, or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

Similarly, a trust is considered to be established for the sole benefit of a spouse, blind or disabled child, or disabled individual if the trust benefits no one but that individual, whether at the time the trust is established or any time in the future. However, the trust may provide for reasonable compensation, as defined by the State, for a trustee or trustees to manage the trust, as well as for reasonable costs associated with investing or otherwise managing the funds or property in the trust. In defining what is reasonable compensation, consider the amount of time and effort involved in managing a trust of the size involved, as well as the prevailing rate of compensation, if any, for managing a trust of similar size and complexity.

A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not the spouse, blind or disabled child, or disabled individual is not considered to be established for the sole benefit of one of these individuals. In order for a transfer or trust to be considered to be for the sole benefit of one of these individuals, the instrument or document must provide for the spending of the funds involved for the benefit of the individual on a basis that is actuarially sound based on the life expectancy of the individual involved. When the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void.

An exception to this requirement exists for trusts discussed in § 3259.7. Under these exceptions, the trust instrument must provide that any funds remaining in the trust upon the death of the individual must go to the State, up to the amount of Medicaid benefits paid on the individual's behalf. When these exceptions require that the trust be for the sole benefit of an individual, the restriction discussed in the previous paragraph does not apply when the trust instrument designates the State as the recipient of funds from the trust. Also, the trust may provide for disbursal of funds to other beneficiaries, provided the trust does not permit such disbursals until the State's claim is satisfied. Finally, "pooled" trusts may provide that the trust can retain a certain percentage of the funds in the trust account upon the death of the beneficiary.

3258. Transfers of Assets for Less Than Fair Market Value

3258. *General.* Under the transfer of assets provisions in § 1917(c) of the Act, as amended by OBRA 1993, you must deny coverage of certain Medicaid services to otherwise eligible institutionalized individuals who transfer (or whose spouses transfer) assets for less than fair market value. You may also choose to deny coverage for certain other services for noninstitutionalized individuals who transfer (or whose spouses transfer) assets for less than fair market value. The following instructions explain the specific circumstances and rules under which you must deny Medicaid services.

The provisions explained in these instructions apply to all States, including those using more restrictive eligibility criteria than are used by the SSI program, under § 1902(f) of the Act. Thus, 209(b) States cannot apply periods of ineligibility due to a transfer of resources for less than fair market value except in accordance with these instructions.

A. *Definitions.* The following definitions apply to transfers of assets.

1. *Fair Market Value.* Fair market value is an estimate of the value of an asset, if sold at the prevailing price at the time it was actually transferred. Value is based on criteria you use in appraising the value of assets for the purpose of determining Medicaid eligibility.

Note: For an asset to be considered transferred for fair market value or to be considered to be transferred for valuable consideration, the compensation received for the asset must be in a tangible form with intrinsic value. A transfer for love and consideration, for example, is not considered a transfer for fair market value. Also, while relatives and family members legitimately can be paid for care they provide to the individual, HCFA presumes that services provided for free at the time were intended to be provided without compensation. Thus, a transfer to a relative for care provided for free in the past is a transfer of assets for less than fair market value. However, an individual can rebut this presumption with tangible evidence that is acceptable to the State. For example, you may require that a payback arrangement had been agreed to in writing at the time services were provided.

2. *Valuable Consideration.* Valuable consideration means that an individual receives in exchange for his or her right or interest in an asset some act, object, service, or other benefit which has a tangible and/or intrinsic value to the individual that is roughly equivalent to or greater than the value of the transferred asset.

3. *Uncompensated Value.* The uncompensated value is the difference between the fair market value at the time of transfer (less any outstanding loans, mortgages, or other encumbrances on the asset) and the amount received for the asset.

4. *Institutionalized Individual.* An institutionalized individual is an individual who is:

- An inpatient in a nursing facility;
- An inpatient in a medical institution for whom payment is based on a level of care provided in a nursing facility; or
- A home and community-based services recipient described in § 1902(a)(10)(A)(ii)(VI) of the Act. For purposes of this section, a medical institution includes an intermediate care facility for the mentally retarded (ICF/MR). (See 42 CFR 435.1009.)

5. *Noninstitutionalized Individual.* A noninstitutionalized individual is an individual receiving any of the services described in § 3258.8.

6. *Nursing Facility Services.* Nursing facility services are services as described in the State Medicaid Plan as nursing facility services.

3258.2 *Effective Date.* This section applies to all transfers which are made on or after August 11, 1993. Transfers made before August 11, 1993, are treated under the rules in § 3250. While this section applies to transfers made on or after August 11, 1993, penalties for transfers for less than fair market value, as described in § 3258.8, cannot be applied to services provided before October 1, 1993. Instead, for the period prior to October 1, 1993, apply pre-OBRA 1993 rules regarding transfers of assets to transfers made on or after August 11, 1993, and before October 1, 1993.

EXAMPLE: An individual who applies for Medicaid transfers an asset on September 1, 1993. The transfer is found to have been made for less than fair market value. As such, a penalty, as described in § 3258.8, is assessed. Because of transfer occurred after August 11, 1993, the transfer is assessed under the new rules set forth in this section. However, because a penalty under OBRA 1993 rules cannot apply before October 1, 1993, the penalty assessed under OBRA 1993 in this case begins on October 1, 1993. Pre-OBRA 1993 rules are used to determine whether a penalty is assessed for the period between September 1 and October 1. On October 1, begin using the OBRA 1993 rules for the transfer described in this example.

3258.3 *Individuals to Whom Transfer of Assets Provisions Apply.* You must apply these provisions when an institutionalized individual or the individual's spouse disposes of assets for less than fair market value on or after the look-back date explained in § 3258.4. You also have the option of applying this provision to noninstitutionalized individuals when those individuals or their spouses dispose of assets for less than fair market value.

See § 3258 for definitions of institutionalized and noninstitutionalized individuals.

For purposes of this section, assets transferred by a parent, guardian, court or administrative body, or anyone acting in place of or on behalf of or at the request or direction of the individual or spouse, are considered to be transferred by the individual or spouse.

For noninstitutionalized individuals, you have the option of applying these provisions. If you wish to apply these provisions to noninstitutionalized individuals, you have the further option of choosing the groups to which the provisions apply. You may apply them to all noninstitutionalized individuals, or to specific categorical groups. However, if you choose to apply these provisions only to some groups, the groups you choose must be recognized groups as listed in § 1905(a) of the Act.

3258.4 *Look-Back Date and Look-Back Period.* The look-back *date* is the earliest date on which a penalty for transferring assets for less than fair market value can be assessed. Penalties can be assessed for transfers which take place on or after the look-back date. Penalties cannot be assessed for transfers which take place prior to the look-back date. The look-back date varies for individuals transferring assets, depending on whether they are institutionalized, and there are special rules for some trusts, as described in subsection E.

A. *Institutionalized Individual.* For an individual in an institution, the look-back date is 36 months prior to the baseline date. The baseline date is the first date as of which the individual was:

- Institutionalized; *and*
- Applied for medical assistance under the State plan.

When an individual is already a Medicaid recipient and becomes institutionalized, the baseline date is the date upon which both of the above conditions are met, that is, the first day of institutionalization.

B. *Noninstitutionalized Individual.* For a noninstitutionalized individual, the look-back date is 36 months prior to the baseline date, which is the date the individual:

- Applies for medical assistance under the State plan; *or,* if later,
- The date on which the individual disposes of assets for less than fair market value.

C. *Multiple Periods of Institutionalization and Multiple Applications.* When an individual has multiple periods of institutionalization or has made multiple applications for Medicaid (whether or not they are successful), the look-back date is based on a baseline date that is the *first* date upon which the individual has both applied for Medicaid and is institutionalized. Similarly, if a noninstitutionalized individual has applied for Medicaid more than once and has made more than one transfer of assets, the baseline date is that date on which the individual has first applied for Medicaid or, if later, made the first transfer of assets for less than fair market value after applying. Thus, each individual has only one look-back date, regardless of the number of periods of institutionalization, applications for Medicaid, periods of eligibility, or transfers of assets.

D. *Look-Back Period.* The look-back *period* is the period that begins with the look-back date and ends with the baseline date. This can be 36 or 60 months, depending on whether certain kinds of trusts are involved. (See subsection E for look-back periods involving trusts.) The look-back period is the period of time prior to the baseline date during which a previous transfer of assets for less than fair market value can be penalized. However, it is important to note that transfers which occur after the baseline date are also subject to penalty if they are made for less than fair market value.

NOTE: The 36 month look-back periods described above do not become fully effective until August 11, 1996. Prior to that date, a 36 month look-back period actually begins at some time before the date transfers are covered by these rules. While the 36 month look-back period is effective for transfers made on or after August 11, 1993, any transfers actually made before that date are treated under the rules described in § 3250. Thus, the look-back period is phased in over the 36-month period ending August 11, 1996.

EXAMPLE 1: Institutionalized Individual

An individual is institutionalized on February 13, 1997. He/she applies for Medicaid on April 7, 1997. The look-back date is the date 36 months prior to the baseline date, when both initiating requirements are met, i.e., institutionalization *and* application for Medicaid. That date is April 7, 1997. Thus the look-back date is April 7, 1994. The look-back period is from April 7, 1994, through April 7, 1997.

EXAMPLE 2: Institutionalized Individual

An individual is institutionalized on February 13, 1995. He/she applies for Medicaid on April 7, 1995. The look-back date is 36 months prior to April 7, 1995, or April 7, 1992. However, because the transfer provisions of OBRA 1993 apply only to transfers made on or after August 11, 1993, any transfers made prior to August 11, 1993, are treated under the rules in § 3250.

EXAMPLE 3: Noninstitutionalized Individual

An individual applies for Medicaid on February 13, 1997. On April 7, 1997, he/she transfers an asset for less than fair market value. The look-back date in this case is

April 7, 1994, 36 months prior to the baseline date on which he/she transferred the asset. If the asset had been transferred before February 13, 1997 (the date of application for Medicaid), the baseline date would have been February 13, 1997 (the date of application). The look-back period would begin February 13, 1994, and extend to February 13, 1997.

E. *Look-Back Period for Transfers of Assets Involving Trusts.* When an individual establishes a revocable trust, a portion of which is disbursed to someone other than the grantor or for the benefit of the grantor, that portion is treated as a transfer of assets for less than fair market value. When an individual establishes an irrevocable trust in which all or a portion of the trust cannot be disbursed to or on behalf of the individual, that portion is treated as a transfer of assets for less than fair market value. When a portion of a trust is treated as a transfer, the look-back period discussed in subsection D is extended to 60 months from:

- The date the individual applied for Medicaid *and* was institutionalized; or,
- For a noninstitutionalized individual, the date the individual applied for Medicaid or, if later, the date the transfer was made.

When a trust is irrevocable but some or all of the trust can be disbursed to or for the benefit of the individual, the look-back period applying to disbursements which could be made to or for the individual but are made to another person or persons is 36 months.

When the trust is revocable, the transfer is considered to take place on the date upon which the payment to someone other than the grantor was made. If the trust is irrevocable, the transfer is considered to have been made as of the date the trust was established or, if later, the date upon which payment to the grantor was foreclosed.

When an individual places assets into an irrevocable trust and can still benefit from those assets, the amount transferred is any of those assets which have been paid out for a purpose other than to or for the benefit of the individual. When an individual places assets in an irrevocable trust and can no longer benefit from some or all of those assets, that unavailable portion of the trust is considered as transferred for less than fair market value. The value of these assets is not reduced by any payments from the trust which may be made from these unavailable assets at a later date.

See §§ 3259ff for a discussion of treatment of trusts in determining eligibility for Medicaid.

See § 3259.6 for rules which apply when assets which may involve a transfer of assets for less than fair market value are placed in a trust.

3258.5 *Penalty Periods.* When an individual (or spouse) makes a transfer of assets for less than fair market value, payment for certain services received by the individual is denied for a specified period of time. However, the individual remains eligible for Medicaid and can have payment made for services not subject to penalty. (See § 3258.8.) For example, an institutionalized individual who transfers assets for less than fair market value must be denied reimbursement for nursing facility services. However, he or she may still be eligible for reimbursement for physician's services, provided such services are not provided as part of the individual's nursing home care.

A. *Penalty Date.* The penalty date is the beginning date of each penalty period that is imposed for an uncompensated transfer. The penalty date for all individuals who transfer assets for less than fair market value is the first day of the month in which the asset was transferred (or, at State option, the first day of the month following the month of transfer), provided that date does not

occur during an existing penalty period. If an asset was transferred prior to the look-back date discussed in § 3258.4, no penalty can be imposed for that transfer.

B. *Penalty Period—General.* The penalty period is the period of time during which payment for specified services is denied. Unlike the penalty period under the rules discussed in § 3250, which was limited to 30 months, the penalty period under the OBRA 1993 rules has no statutory limit. Rather, the length of the penalty period is based solely on the value of the assets transferred and the cost of nursing facility care.

C. *Transfer of Assets Takes Place During Existing Penalty Period.* When a transfer for less than fair market value takes place during an existing penalty period, whether imposed under the pre-OBRA 1993 or post-OBRA 1993 rules, a new penalty period cannot begin until the existing penalty period has expired.

EXAMPLE: An individual transferred an asset in May 1993 for which a penalty of 12 months was imposed. The individual transfers another asset in October 1993 to which another 12 month penalty applies. Because the second transfer took place within the first 12 month penalty period, the second penalty period cannot begin until the first expires, on April 30, 1994. Thus, the first penalty period runs from May 1, 1993, through April 30, 1994, and the second runs from May 1, 1994, through April 30, 1995.

D. *Restricted Coverage—Institutionalized Individual.* The penalty for an institutionalized individual consists of ineligibility for certain services for a period or periods of ineligibility that equal the number of months calculated by taking the total, cumulative uncompensated value of all assets transferred by the individual or spouse on or after the look-back date discussed in § 3258.4, divided by the average monthly cost to a private patient of nursing facility services in the State at the time of application. As an alternative, the State may use the average monthly cost in the community in which the individual is institutionalized.

When the amount of the transfer is less than the monthly cost of nursing facility care, you have the option of not imposing a penalty or imposing a penalty for less than a full month. Under the latter option, the actual length of the penalty is based on the proportion of the State's private nursing facility rate that was transferred. If you choose to impose penalties for less than a full month, you must impose such penalties in all cases where a partial month penalty applies.

When an individual makes a series of transfers, each of which is less than the private nursing facility rate for a month, you have the option of imposing no penalty or imposing a series of penalties, each for less than a full month.

E. *Restricted Coverage—Noninstitutionalized Individual.* The penalty period for a noninstitutionalized individual is calculated using the same method that is used for an institutionalized individual, including use of the average monthly cost of nursing facility services. The penalty for a noninstitutionalized individual cannot exceed the number of months calculated using this method. However, you may impose shorter penalty periods if you wish to do so. Obtain HCFA approval for any shorter penalty period you choose to impose, including approval of the methodology you use to calculate the shorter penalty period. See subsection D for transfers which are less than the private monthly rate for nursing facility care.

F. *Individual Has Penalty Period Both as Institutionalized and Noninstitutionalized Individual.* When an individual incurs separate penalty periods as both institutionalized and noninstitutionalized for the same transfer, the total penalty period cannot exceed the penalty period that is applicable under only one category. In other words, a penalty imposed during a period of

institutionalization reduces a penalty imposed for the same transfer or transfers made during the period of noninstitutionalization and vice versa.

EXAMPLE: An institutionalized individual transfers assets for less than fair market value, thereby incurring a transfer penalty of 24 months. After 12 months have elapsed, the individual leaves the institution and returns home. Because the State imposes penalties on noninstitutionalized individuals for transfers for less than fair market value, the same 24 month penalty applies to the individual, even though he/she left the institution. However, because of the limits on total penalty described above, the individual incurs only the 12 month penalty remaining from the transfer which occurred while he/she was institutionalized.

G. *Multiple Transfers—General.* OBRA 1993 provides that the number of months of restricted coverage discussed in subsections C and D is based on the total, cumulative uncompensated value of the assets transferred. When a single asset is transferred or a number of assets are transferred during the same month, the penalty period is calculated using the total value of the asset(s) divided by the average monthly cost of nursing facility care. When assets are transferred at different times, use the following methods for calculating the penalty periods.

H. *Transfers Made So That Penalty Periods Overlap.* When assets have been transferred in amounts and/or frequency that make the calculated penalty periods overlap, add together the value of all assets transferred, and divide by the cost of nursing facility care. This produces a single penalty period which begins on the first day of the month in which the first transfer was made.

EXAMPLE: An individual transfers $10,000 in January, $10,000 in February, and $10,000 in March, all of which are uncompensated. Calculated individually, based on a nursing facility cost of $2,500 a month, the penalty for the first transfer is from January through April, the second is from February through May, and the third is from March through June. Because these periods overlap, calculate the penalty period by adding the transfers together (a total of $30,000) and dividing by the nursing home cost ($2,500). This yields a penalty period of 12 months, which runs from January 1 through December 31 of that year.

As an alternative, calculate the initial penalty periods, as above, and impose them sequentially. Thus, the penalty for the first transfer extends from January through April, the second extends from May through August, and the third extends from September through December. In this example, the result is the same regardless of the method used.

I. *Transfers Made So That Penalty Periods Do Not Overlap.* When multiple transfers are made in such a way that the penalty periods for each do not overlap, treat each transfer as a separate event with its own penalty period.

EXAMPLE: An individual transfers $5,000 in January, $5,000 in May, and $5,000 in October, all of which are uncompensated. Assuming a State private nursing facility cost of $2,500 a month, the penalty periods for transfers are, respectively, January through February, May through June, and October through November.

If you wish to use other methodologies for determining penalty periods, you may do so, provided you obtain HCFA approval for those methods. However, any alternative method must adhere to the basic principles that:

- The total, cumulative uncompensated value of the asset or assets transferred is used to determine the length of the penalty period or periods;
- Penalty periods do not overlap, nor in any way run concurrently; and
- No penalty period can begin while a previous penalty period is in effect.

J. *Transfer by a Spouse That Results in Penalty Period for the Individual.* When a spouse transfers an asset that results in a penalty for the individual, the penalty period must, in certain instances, be apportioned between the spouses. You must apportion the penalty when:

- The spouse is eligible for Medicaid;
- A penalty could, under normal circumstances, be assessed against the spouse, i.e., the spouse is institutionalized, or the State has elected to impose penalties on noninstitutionalized individuals; and
- Some portion of the penalty against the individual remains at the time the above conditions are met.

When these conditions are met, you must apportion any existing penalty period between the spouses. You may use any reasonable methodology you wish to determine how the penalty is apportioned. However, the methodology you use must provide that the total penalty imposed on both spouses does not exceed the length of the penalty originally imposed on the individual.

EXAMPLE: Mr. Able enters a nursing facility and applies for Medicaid. Mrs. Able transfers an asset that results in a 36 month penalty against Mr. Able. Twelve months into the penalty period, Mrs. Able enters a nursing facility and becomes eligible for Medicaid. The penalty period against Mr. Able still has 24 months to run. Because Mrs. Able is now in a nursing facility, and a portion of the original penalty period remains, you must apportion the remaining 24 months of penalty between Mr. and Mrs. Able. You may apportion the remaining penalty period in any way you wish, provided that the total remaining penalty period assessed against both spouses does not exceed 24 months.

When, for some reason, one spouse is no longer subject to a penalty (e.g., the spouse no longer receives nursing facility services, or the spouse dies), the remaining penalty period applicable to both spouses must be served by the remaining spouse.

In the above example, assume the 24 month penalty period was apportioned equally between Mr. and Mrs. Able. After six months, Mr. Able leaves the nursing facility, but Mrs. Able remains. Because Mr. Able is no longer subject to the penalty, the remaining total penalty (12 months) must be imposed on Mrs. Able. If Mr. Able returns to the nursing facility before the end of the 12 month period, the remaining penalty is again apportioned between the two spouses.

K. *Penalty Period When Individual Leaves Institution.* A penalty period imposed for a transfer of assets runs continuously from the first date of the penalty period (the penalty date), regardless of whether the individual remains in or leaves the institution (or waiver program). Thus, if the individual leaves the nursing facility, the penalty period nevertheless continues until the end of the calculated period.

3258.6 *Treatment of Income as Asset.* Under OBRA 1993, income, in addition to resources, is considered to be an asset for transfer (and trust) purposes. Thus, when an individual's income is given or assigned in some manner to another person, such a gift or assignment can be considered a transfer of assets for less than fair market value.

In determining whether income has been transferred, do not attempt to ascertain in detail the individual's spending habits during the 36 or 60 month look-back period. Absent some reason to believe otherwise, assume that ordinary household income was legitimately spent on the normal costs of daily living.

However, you should attempt to determine whether the individual has transferred lump sum payments actually received in a month. Such payments, while counted as income in the month received for eligibility purposes, are counted as resources in the following month if they were retained. Disposal of such lump sum payments before they can be counted as resources could constitute an uncompensated transfer of assets. Also attempt to determine whether amounts of regularly scheduled income or lump sum payments, which the individual would otherwise have received, have been transferred. Normally, such a transfer takes the form of a transfer of the right to receive income. For example, a private pension may be diverted to a trust and no longer be paid to the individual. You may raise questions on whether lump sums of income or the right to income have been transferred based on information given on the Medicaid application or through active questioning of the individual concerning sources of income, income levels in the past versus the present, direct questions about giving income to others, etc.

When you find that income or the right to income has been transferred, a penalty for that transfer *must* be imposed for institutionalized individuals (if no exceptions apply). In determining the length of the penalty period, you may use several methods of treating the income involved.

When a single lump sum is transferred (e.g., a stock dividend check is given to another person in the month in which it is received by the individual), the penalty period is calculated on the basis of the value of the lump sum payment. When the amount of the payment is small enough that a full month's penalty does not result, you have the option of not imposing a penalty or, if you choose, applying the penalty for only part of the month.

EXAMPLE: A lump sum amount of $1,000 is transferred, but the State's private nursing facility rate is $2,000. You can either impose no penalty or apply a penalty for half of the month.

When a stream of income (i.e., income received on a regular basis, such as a pension) or the right to a stream of income is transferred, you can calculate the penalty period as you would for a single lump sum. Using this method, a penalty period is imposed for each income payment. When the transfer involves a right to income (as opposed to periodic transfers of income the individual owns) you can, as an alternative, make a determination of the total amount of income expected to be transferred during the individual's life, based on an actuarial projection of the individual's life expectancy, and calculate the penalty on the basis of the projected total income.

You may choose to use alternative methods for determining the length of the penalty period where income is transferred. However, you must obtain approval from HCFA for use of alternative methods.

3258.7 *Treatment of Jointly Owned Assets.* When an asset is held by an individual in common with another person or persons via joint tenancy, tenancy in common, joint ownership, or a similar arrangement, the asset (or affected portion of the asset) is considered to be transferred by the individual when any action is taken, either by the individual or any other person, that reduces or eliminates the individual's ownership or control of the asset.

Under this provision, merely placing another person's name on an account or asset as a joint owner might not constitute a transfer of assets subject, of course, to the specific circumstances of

the situation. In such a situation, the individual may still possess ownership rights to the account or asset and thus have the right to withdraw all of the funds in the account or possess the asset at any time. Thus, the account or asset is still considered to belong to the individual. However, actual withdrawal of funds from the account or removal of the asset by the other person removes the funds or property from the control of the individual and so constitutes a transfer of assets. Also, if placing another person's name on the account or asset actually limits the individual's right to sell or otherwise dispose of the asset (e.g., the addition of another person's name requires that the person agree to the sale or disposal of the asset where no such agreement was necessary before), such placement constitutes a transfer of assets.

Use regular Medicaid rules to determine what portion of a jointly held asset is presumed to belong to an applicant or recipient. This portion is subject to a transfer penalty if it is withdrawn by a joint owner. However, you must also provide an opportunity for the owners to rebut the presumption of ownership. If either the applicant/recipient or the other person can establish to your satisfaction that the funds withdrawn were, in fact, the sole property of and contributed to the account by the other person, and thus did not belong to the applicant/recipient, withdrawal of those funds should not result in the imposition of a penalty.

3258.8 *Penalties for Transfers of Assets for Less Than Fair Market Value.* When you find that assets have been transferred for less than fair market value, OBRA 1993 provides for specific penalties. These penalties involve the denial of reimbursement for certain services received by the individual. The specific services for which reimbursement must be withheld depend on the individual's situation.

A. *Penalties for Institutionalized Individuals.* For institutionalized individuals, the services for which payment must be withheld are:

- Nursing facility services, as defined in the State Medicaid Plan;
- A level of care in any institution equivalent to that of nursing facility services; and
- Home and community-based services provided under a waiver for individuals eligible for such services under § 1915(c) or (d) of the Act.

B. *Penalties for Noninstitutionalized Individuals.* For a noninstitutionalized individual, the services for which payment must be withheld are the following, not including those services described above:

- Home health services, as described in § 1905(a)(7) of the Act;
- Home and community care (to the extent allowed and as defined in § 1929 of the Act) for functionally disabled elderly adults (see § 1905(a)(22) of the Act); and
- Personal care services furnished to individuals who are not inpatients in certain medical institutions. (See § 1905(a)(24) of the Act.)

At the option of the State, you may also withhold reimbursement for services provided to noninstitutionalized individuals for other long term care services for which medical assistance is otherwise available under the State plan to individuals requiring long term care. Such services might include, for example, private duty nursing. However, the specific services involved depend on your own State plan.

3258.9 *Treatment of Certain Kinds of Transfers for Less Than Fair Market Value.* Certain financial transactions or purchases may constitute a transfer of assets for less than fair market value. Treat the following as described.

A. *Life Estates.* Under a life estate, an individual who owns property transfers ownership of that property to another individual while retaining, for the rest of his or her life (or the life of another person), certain rights to that property. Generally, a life estate entitles the owner of the life estate (the grantor) to possess, use, and obtain profits from the property as long as he or she lives. However, actual ownership of the property has passed to another individual.

In a transaction involving a life estate, a transfer of assets is involved. This transfer is for less than fair market value whenever the value of the transferred asset is greater than the value of the rights conferred by the life estate.

In determining whether a penalty is assessed because of a life estate and how long that penalty should be, compute the value of the asset transferred and the value of the life estate, and calculate the difference between the two.

The value of the asset transferred is computed by using the regular Medicaid rules for determining the value of assets. To calculate the value of the life estate, use the life estate table below (from POMS SI 01140.120). Determine the value of the life estate by multiplying the current market value of the property by the life estate factor that corresponds to the grantor's age. The value of the life estate is then subtracted from the value of the asset transferred to determine the portion of the asset that was transferred for less than fair market value. Or, if only the value of the transferred portion is needed, multiply the current market value of the asset by the remainder factor.

EXAMPLE: Mrs. Able, age 65, owns a house with a small farm attached to it, worth $100,000 in total. She deeds the house and farm to her son but retains a life estate in the property. Under the terms of the life estate, Mrs. Able is entitled to live in the house for the rest of her life and to any produce, income, etc. generated by the farm. To determine the value of Mrs. Able's life estate, the current market value of the property ($100,000) is multiplied by a life estate factor corresponding to Mrs. Able's age in the table (.67970), resulting in a life estate worth $67,970. The penalty is assessed for the difference between the value of the asset transferred ($100,000) and the value of the life estate ($67,790), or a penalty based on $32,030 of assets transferred for less than fair market value.

Some States allow life estates with powers, wherein the owner of the property creates a life estate for himself or herself, retaining the power to sell the property, with a remainder interest to someone else, e.g., a child. Since the life estate holder retains the power to sell the property, its value as a resource is its full equity value. In this situation, the individual has not transferred anything of value, because he or she can terminate the life estate at any time and restore full ownership to himself or herself. Instead, the full value of the asset in question is treated as a countable resource to the individual (assuming, of course, that it is not an otherwise excluded resource).

Life Estate and Remainder Interest Table

(See 26 C.F.R. § 20.2031-7 and 49 F.R. Vol. 49 No. 93/5-11-84.)

Age	*Life Estate*	*Remainder*	*Age*	*Life Estate*	*Remainder*	*Age*	*Life Estate*	*Remainder*
0	.97188	.02812	40	.91571	.08429	80	.43659	.56341
1	.98988	.01012	41	.91030	.08970	81	.41967	.58033
2	.99017	.00983	42	.90457	.09543	82	.40295	.59705
3	.99008	.00992	43	.89855	.10145	83	.38642	.61358
4	.98981	.01019	44	.89221	.10779	84	.36998	.63002
5	.98938	.01062	45	.88558	.11442	85	.35359	.64641
6	.98884	.01116	46	.87863	.12137	86	.33764	.66236
7	.98822	.01178	47	.87137	.12863	87	.32262	.67738
8	.98748	.01252	48	.86374	.13626	88	.30859	.69141
9	.98663	.01337	49	.85578	.14422	89	.29526	.70474
10	.98565	.01435	50	.84743	.15257	90	.28221	.71779
11	.98453	.01547	51	.83674	.16126	91	.26955	.73045
12	.98329	.01671	52	.82969	.17031	92	.25771	.74229
13	.98198	.01802	53	.82028	.17972	93	.24692	.75308
14	.98066	.01934	54	.81054	.18946	94	.23728	.76272
15	.97937	.02063	55	.80046	.19954	95	.22887	.77113
16	.97815	.02185	56	.79006	.20994	96	.22181	.77819
17	.97700	.02300	57	.77931	.22069	97	.21550	.78450
18	.97590	.02410	58	.76822	.23178	98	.21000	.79000
19	.97480	.02520	59	.75675	.24325	99	.20486	.79514
20	.97365	.02635	60	.74491	.25509	100	.19975	.80025
21	.97245	.02755	61	.73267	.26733	101	.19532	.80468
22	.97120	.02880	62	.72002	.27998	102	.19054	.80946
23	.96986	.03014	63	.70696	.29304	103	.18437	.81563
24	.96841	.03159	64	.69352	.30648	104	.17856	.82144
25	.96678	.03322	65	.67970	.32030	105	.16962	.83038
26	.96495	.03505	66	.66551	.33449	106	.15488	.84512
27	.96290	.03710	67	.65098	.34902	107	.13409	.86591
28	.96062	.03938	68	.63610	.36390	108	.10068	.89932
29	.95813	.04187	69	.62086	.37914	109	.04545	.95455
30	.95543	.04457	70	.60522	.39478			
31	.95254	.04746	71	.58914	.41086			
32	.94942	.05058	72	.57261	.42739			
33	.94608	.05392	73	.55571	.44429			
34	.94250	.05750	74	.53862	.46138			
35	.93868	.06132	75	.52149	.47851			
36	.93460	.06540	76	.50441	.49559			
37	.93026	.06974	77	.48742	.51258			
38	.92567	.07433	78	.47049	.52951			
39	.92083	.07917	79	.45357	.54643			

B. *Annuities.* Section 1917(d)(6) of the Act provides that the term "trust" includes an annuity to the extent and in such a manner as the Secretary specifies. This subsection describes how annuities are treated under the trust/transfer provisions.

When an individual purchases an annuity, he or she generally pays to the entity issuing the annuity (e.g., a bank or insurance company) a lump sum of money, in return for which he or she is promised regular payments of income in certain amounts. These payments may continue for a fixed period of time (for example, 10 years) or for as long as the individual (or another designated beneficiary) lives, thus creating an ongoing income stream. The annuity may or may not include a remainder clause under which, if the annuitant dies, the contracting entity converts whatever is remaining in the annuity into a lump sum and pays it to a designated beneficiary.

Annuities, although usually purchased in order to provide a source of income for retirement, are occasionally used to shelter assets so that individuals purchasing them can become eligible for Medicaid. In order to avoid penalizing annuities validly purchased as part of a retirement plan but to capture those annuities which abusively shelter assets, a determination must be made with regard to the ultimate purpose of the annuity (i.e., whether the purchase of the annuity constitutes a transfer of assets for less than fair market value). If the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the beneficiary, the annuity can be deemed actuarially sound.

To make this determination, use the following life expectancy tables, compiled from information published by the Office of the Actuary of the Social Security Administration. The average number of years of expected life remaining for the individual must coincide with the life of the annuity. If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive fair market value for the annuity based on the projected return. In this case, the annuity is not actuarially sound and a transfer of assets for less than fair market value has taken place, subjecting the individual to a penalty. The penalty is assessed based on a transfer of assets for less than fair market value that is considered to have occurred at the time the annuity was purchased.

For example, if a male at age 65 purchases a $10,000 annuity to be paid over the course of 10 years, his life expectancy according to the table is 14.96 years. Thus, the annuity is actuarially sound. However, if a male at age 80 purchases the same annuity for $10,000 to be paid over the course of 10 years, his life expectancy is only 6.98 years. Thus, a payout of the annuity for approximately 3 years is considered a transfer of assets for less than fair market value and that amount is subject to penalty.

Life Expectancy Table—Males

Age	*Life Expectancy*	*Age*	*Life Expectancy*	*Age*	*Life Expectancy*
0	71.80	40	35.05	80	6.98
1	71.53	41	34.15	81	6.59
2	70.58	42	33.26	82	6.21
3	69.62	43	32.37	83	5.85
4	68.65	44	31.49	84	5.51
5	67.67	45	30.61	85	5.19
6	66.69	46	29.74	86	4.89
7	65.71	47	28.88	87	4.61
8	64.73	48	28.02	88	4.34
9	63.74	49	27.17	89	4.09
10	62.75	50	26.32	90	3.86
11	61.76	51	25.48	91	3.64
12	60.78	52	24.65	92	3.43
13	59.79	53	23.82	93	3.24
14	58.82	54	23.01	94	3.06
15	57.85	55	22.21	95	2.90
16	56.91	56	21.43	96	2.74
17	55.97	57	20.66	97	2.60
18	55.05	58	19.90	98	2.47
19	54.13	59	19.15	99	2.34
20	53.21	60	18.42	100	2.22
21	52.29	61	17.70	101	2.11
22	51.38	62	16.99	102	1.99
23	50.46	63	16.30	103	1.89
24	49.55	64	15.62	104	1.78
25	48.63	65	14.96	105	1.68
26	47.72	66	14.32	106	1.59
27	46.80	67	13.70	107	1.50
28	45.88	68	13.09	108	1.41
29	44.97	69	12.50	109	1.33
30	44.06	70	11.92	110	1.25
31	43.15	71	11.35	111	1.17
32	42.24	72	10.80	112	1.10
33	41.33	73	10.27	113	1.02
34	40.23	74	9.27	114	0.96
35	39.52	75	9.24	115	0.89
36	38.62	76	8.76	116	0.83
37	37.73	77	8.29	117	0.77
38	36.83	78	7.83	118	0.71
39	35.94	79	7.40	119	0.66

Life Expectancy Table—Females

Age	*Life Expectancy*	*Age*	*Life Expectancy*	*Age*	*Life Expectancy*
0	78.79	40	40.61	80	9.11
1	78.42	41	39.66	81	8.58
2	77.48	42	38.72	82	8.06
3	76.51	43	37.78	83	7.56
4	75.54	44	36.85	84	7.08
5	74.56	45	35.92	85	6.63
6	73.57	46	35.00	86	6.20
7	72.59	47	34.08	87	5.79
8	71.60	48	33.17	88	5.41
9	70.61	49	32.27	89	5.05
10	69.62	50	31.37	90	4.71
11	68.63	51	30.48	91	4.40
12	67.64	52	29.60	92	4.11
13	66.65	53	28.72	93	3.84
14	65.67	54	27.86	94	3.59
15	64.68	55	27.00	95	3.36
16	63.71	56	26.15	96	3.16
17	62.74	57	25.31	97	2.97
18	61.77	58	24.48	98	2.80
19	60.80	59	23.67	99	2.64
20	59.83	60	22.86	100	2.48
21	58.86	61	22.06	101	2.34
22	57.89	62	21.27	102	2.20
23	56.92	63	20.49	103	2.06
24	55.95	64	19.72	104	1.93
25	54.98	65	18.96	105	1.81
26	54.02	66	18.21	106	1.69
27	53.05	67	17.48	107	1.58
28	52.08	68	16.76	108	1.48
29	51.12	69	16.04	109	1.38
30	50.15	70	15.35	110	1.28
31	49.19	71	14.66	111	1.19
32	48.23	72	13.99	112	1.10
33	47.27	73	13.33	113	1.02
34	46.31	74	12.68	114	0.96
35	45.35	75	12.05	115	0.89
36	44.40	76	11.43	116	0.83
37	43.45	77	10.83	117	0.77
38	42.50	78	10.24	118	0.71
39	41.55	79	9.67	119	0.66

3258.10 *Exceptions to Application of Transfer of Assets Penalties.* There are a number of instances where, even if an asset is transferred for less than fair market value, the penalties discussed above do not apply. These exceptions are:

A. The asset transferred is the individual's home, and title to the home is transferred to:
- The spouse of the individual;
- A child of the individual who is under age 21;
- A child who is blind or permanently and totally disabled as defined by a State program established under title XVI in States eligible to participate in such programs or blind or disabled as defined by the SSI program in all other States;
- The sibling of the individual who has an equity interest in the home and who has been residing in the home for a period of at least one year immediately before the date the individual becomes institutionalized; or
- A son or daughter of the individual (other than a child as described above) who was residing in the home for at least two years immediately before the date the individual becomes institutionalized, and who (as determined by the State) provided care to the individual which permitted the individual to reside at home, rather than in an institution or facility.

B. The assets were:
- Transferred to the individual's spouse or to another for the sole benefit of the individual's spouse;
- Transferred from the individual's spouse to another for the sole benefit of the individual's spouse;
- Transferred to the individual's child, or to a trust (including a trust described in § 3259.7) established solely for the benefit of the individual's child (The child must be blind or permanently and totally disabled, as defined by a State program established under title XVI, in States eligible to participate in such programs or blind or disabled as defined under SSI in all other States); or
- Transferred to a trust (including a trust as discussed in § 3259.7) established for the sole benefit of an individual under 65 years of age who is disabled as defined under SSI.

1. *For the Sole Benefit of.* See § 3257 for a definition of the term "for the sole benefit of." In determining whether an asset was transferred for the sole benefit of a spouse, child, or disabled individual, ensure that the transfer was accomplished via a written instrument of transfer (e.g., a trust document) which legally binds the parties to a specified course of action and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer. A transfer without such a document cannot be said to have been made for the sole benefit of the spouse, child, or disabled individual since there is no way to establish, without a document, that only the specified individuals will benefit from the transfer.

2. *Blind or Disabled as Defined Under SSI Program.* When it is alleged that an asset was transferred to or for the benefit of an individual who is blind or totally and permanently disabled, you must determine that the individual in fact meets the definitions of blindness or disability used by the SSI program (which are currently the same definitions as under the title II program) or under the State plan programs established under title XVI or under the title II program. If the individual is receiving SSI benefits or is eligible for Medicaid as a result of blindness or disability,

you can accept the determination of blindness or disability as valid evidence. However, if the individual is not receiving SSI and/or Medicaid, you must make a separate determination of blindness or disability. When such a determination is necessary, follow the procedures usually used in your State when an individual applies for Medicaid on the basis of blindness or disability. However, if you use more restrictive criteria under § 1902(f) of the Act, you may not use a more restrictive definition of blindness or disability. Instead, you must use the definitions used by the SSI program.

C. In addition to the above, a penalty for transferring an asset for less than fair market value is not assessed if a satisfactory showing is made to the State that:

- The individual intended to dispose of the assets either at fair market value or for other valuable consideration;
- The assets were transferred exclusively for a purpose other than to qualify for Medicaid;
- All of the assets transferred for less than fair market value have been returned to the individual; or
- Imposition of a penalty would work an undue hardship.

Pending publication of regulations on transfers of assets that will provide guidelines on what is meant by the term "satisfactory showing," you must determine what constitutes a satisfactory showing in your State.

1. *Intent to Dispose of Assets for Fair Market Value or for Other Valuable Consideration.* See § 3258.1 for a definition of the term "valuable consideration." In determining whether an individual intended to dispose of an asset for fair market value or for other valuable consideration you should require that the individual establish, to your satisfaction, the circumstances which caused him or her to transfer the asset for less than fair market value. Verbal statements alone generally are not sufficient. Instead, require the individual to provide written evidence of attempts to dispose of the asset for fair market value, as well as evidence to support the value (if any) at which the asset was disposed.

2. *Transfers Exclusively for a Purpose Other Than to Qualify for Medicaid.* Require the individual to establish, to your satisfaction, that the asset was transferred for a purpose other than to qualify for Medicaid. Verbal assurances that the individual was not considering Medicaid when the asset was disposed of are not sufficient. Rather, convincing evidence must be presented as to the specific purpose for which the asset was transferred.

In some instances, the individual may argue that the asset was not transferred to obtain Medicaid because the individual is already eligible for Medicaid. This may, in fact, be a valid argument. However, the validity of the argument must be determined on a case-by-case basis, based on the individual's specific circumstances. For example, while the individual may now be eligible for Medicaid, the asset in question (e.g., a home) might be counted as a resource in the future, thus compromising the individual's future eligibility. In such a situation, the argument that the individual was already eligible for Medicaid does not suffice.

3. *All Assets Transferred for Less Than Fair Market Value Are Returned to the Individual.* When all assets transferred are returned to the individual, no penalty for transferring assets can be assessed. In this situation, you must ensure that any benefits due on behalf of the individual are, in fact, paid. When a penalty has been assessed and payment for services denied, a return of the assets requires a retroactive adjustment, including erasure of the penalty back to the beginning of the penalty period.

However, such an adjustment does not necessarily mean that benefits must be paid on behalf of the individual. Return of the assets in question to the individual leaves the individual with assets which must be counted in determining eligibility during the retroactive period. Counting those assets as available may result in the individual being ineligible for Medicaid for some or all of the retroactive period (because of excess income/resources) as well as for a period of time after the assets are returned.

It is important to note that, to void imposition of a penalty, *all* of the assets in question or their fair market equivalent must be returned. If, for example, the asset was sold by the individual who received it, the full market value of the asset must be returned to the transferor, either in cash or another form acceptable to the State.

When only part of an asset or its equivalent value is returned, a penalty period can be modified but not eliminated. For example, if only half the value of the asset is returned, the penalty period can be reduced by one-half.

4. *Imposition of Penalty Would Work Undue Hardship.* When application of the transfer of assets provisions discussed in these sections would work an undue hardship, those provisions do not apply. Unlike the policies applying to transfers made on or before August 10, 1993, which only required that you acknowledge that the statute included an undue hardship provision, under OBRA 1993 you must implement an undue hardship procedure for transfers of assets. Further, that procedure must be described in your Medicaid State Plan. You have considerable flexibility in implementing an undue hardship provision. However, your undue hardship procedure must meet the requirements discussed in subsection 5.

5. *Undue Hardship Defined.* Undue hardship exists when application of the transfer of assets provisions would deprive the individual of medical care such that his/her health or his/her life would be endangered. Undue hardship also exists when application of the transfer of assets provisions would deprive the individual of food, clothing, shelter, or other necessities of life.

Undue hardship does not exist when application of the transfer of assets provisions merely causes the individual inconvenience or when such application might restrict his or her lifestyle but would not put him/her at risk of serious deprivation.

You have considerable flexibility in deciding the circumstances under which you will not impose penalties under the transfer of assets provisions because of undue hardship. For example, you can specify the criteria to be used in determining whether the individual's life or health would be endangered and whether application of a penalty would deprive the individual of food, clothing, or shelter. You can also specify the extent to which an individual must make an effort to recover assets transferred for less than fair market value. As a general rule, you have the flexibility to establish whatever criteria you believe are appropriate, as long as you adhere to the basic definition of undue hardship described above.

However, your undue hardship procedure must, at a minimum, provide for and discuss the following administrative requirements:

- Notice to recipients that an undue hardship exception exists;
- A timely process for determining whether an undue hardship waiver will be granted; and
- A process under which an adverse determination can be appealed.

3258.11 *Transfers of Assets and Spousal Impoverishment Provisions.* Under § 1917(c)(2)(B) of the Act, certain transfers of assets for less than fair market value are exempt from penalty. (See § 3258.10 for a complete discussion of those exemptions.) Among those exemptions are transfers from an individual to a spouse, transfers from an individual to a third party for the sole benefit of a spouse, and transfers from a spouse to a third party for the sole benefit of the spouse.

Section 1924 of the Act sets forth the requirements for treatment of income and resources where there is an individual in a medical institution with a spouse still living in the community. This section of the Act provides for apportioning income and resources between the institutional spouse and the community spouse so that the community spouse does not become impoverished because the individual is in a medical institution. (See § 3260 for a complete discussion of the spousal impoverishment provisions.)

The exceptions to the transfer of assets penalties regarding interspousal transfers and transfers to a third party for the sole benefit of a spouse apply even under the spousal impoverishment provisions. Thus, the institutional spouse can transfer unlimited assets to the community spouse or to a third party for the sole benefit of the community spouse.

When transfers between spouses are involved, the unlimited transfer exception should have little effect on the eligibility determination, primarily because resources belonging to both spouses are combined in determining eligibility for the institutionalized spouse. Thus, resources transferred to a community spouse are still to be considered available to the institutionalized spouse for eligibility purposes.

The exception for transfers to a third party for the sole benefit of the spouse may have greater impact on eligibility because resources may potentially be placed beyond the reach of either spouse and thus not be counted for eligibility purposes. However, for the exception to be applicable, the definition of what is for the sole benefit of the spouse (see § 3257) must be fully met. This definition is fairly restrictive, in that it requires that any funds transferred be spent for the benefit of the spouse within a time-frame actuarially commensurate with the spouse's life expectancy. If this requirement is not met, the exemption is void, and a transfer to a third party may then be subject to a transfer penalty.

3259. Treatment of Trusts

3259.1 *General.* Under the trust provisions in § 1917(d) of the Act, you must consider whether and to what extent a trust is counted in determining eligibility for Medicaid. The following instructions explain the rules under which trusts are considered. These instructions apply to eligibility determinations for all individuals, including cash assistance recipients and others who are otherwise automatically eligible and whose income and resources are not ordinarily measured against an independent Medicaid eligibility standard. Also, these instructions apply to post-eligibility determinations as well as eligibility determinations.

A. *Definitions.* The following definitions apply to trusts.

1. *Trust.* For purposes of this section, a trust is any arrangement in which a grantor transfers property to a trustee or trustees with the intention that it be held, managed, or administered by the trustee(s) for the benefit of the grantor or certain designated individuals (beneficiaries). The trust must be valid under State law and manifested by a valid trust instrument or agreement. A trustee holds a fiduciary responsibility to hold or manage the trust's corpus and income for the

benefit of the beneficiaries. The term "trust" also includes any legal instrument or device that is similar to a trust. It does not cover trusts established by will. Such trusts must be dealt with using applicable cash assistance program policies.

2. *Legal Instrument or Device Similar to Trust.* This is any legal instrument, device, or arrangement which may not be called a trust under State law but which is similar to a trust. That is, it involves a grantor who transfers property to an individual or entity with fiduciary obligations (considered a trustee for purposes of this section). The grantor makes the transfer with the intention that it be held, managed, or administered by the individual or entity for the benefit of the grantor or others. This can include (but is not limited to) escrow accounts, investment accounts, pension funds, and other similar devices managed by an individual or entity with fiduciary obligations.

3. *Trustee.* A trustee is any individual, individuals, or entity (such as an insurance company or bank) that manages a trust or similar device and has fiduciary responsibilities.

4. *Grantor.* A grantor is any individual who creates a trust. For purposes of this section, the term "grantor" includes:

- The individual;
- The individual's spouse;
- A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; and
- A person, including a court or administrative body, acting at the direction or upon the request of the individual, or the individual's spouse.

5. *Revocable Trust.* A revocable trust is a trust which can under State law be revoked by the grantor. A trust which provides that the trust can only be modified or terminated by a court is considered to be a revocable trust, since the grantor (or his/her representative) can petition the court to terminate the trust. Also, a trust which is called irrevocable but which terminates if some action is taken by the grantor is a revocable trust for purposes of this instruction. For example, a trust may require a trustee to terminate a trust and disburse the funds to the grantor if the grantor leaves a nursing facility and returns home. Such a trust is considered to be revocable.

6. *Irrevocable Trust.* An irrevocable trust is a trust which cannot, in any way, be revoked by the grantor.

7. *Beneficiary.* A beneficiary is any individual or individuals designated in the trust instrument as benefiting in some way from the trust, excluding the trustee or any other individual whose benefit consists only of reasonable fees or payments for managing or administering the trust. The beneficiary can be the grantor himself, another individual or individuals, or a combination of any of these parties.

8. *Payment.* For purposes of this section a payment from a trust is any disbursal from the corpus of the trust or from income generated by the trust which benefits the party receiving it. A payment may include actual cash, as well as noncash or property disbursements, such as the right to use and occupy real property.

9. *Annuity.* An annuity is a right to receive fixed, periodic payments, either for life or a term of years. See § 3258.9.B for a discussion of how to treat annuities.

3259.2 *Effective Date.* This section applies to all trusts established on or after August 11, 1993. However, the provisions in this instruction are effective December 13, 1994. For the period

prior to this date, you may use any reasonable interpretations of the statute in dealing with trusts. Trusts established before August 11, 1993, are treated under the rules in § 3215. Also, trusts established before August 11, 1993 but added to or otherwise augmented on or after that date are treated under the rules in § 3215. (However, additions to an established trust on or after August 11, 1993, may be considered transfers of assets for less than fair market value under §§ 3258ff.) While this section applies to trusts established on or after August 11, 1993, you cannot deny eligibility for Medicaid or apply the rules under this section based on an individual creating a trust until October 1, 1993. For a trust established on or after August 11, 1993, but prior to October 1, 1993, apply pre-OBRA 1993 rules until October 1. On October 1, begin using the OBRA 1993 rules for treating trusts.

When the Secretary determines that your State requires enabling legislation (other than legislation to appropriate funds) to implement the trust provisions in §§ 3259ff, you may delay complying with the effective date of the statute (October 1, 1993). The compliance date can be delayed until after the close of the first regular legislative session that begins after August 10, 1993. It can be delayed until the first day of the first calendar quarter beginning after this session closes. In the case of a 2-year legislative session, each year is considered a separate regular session.

The statutory effective date of October 1, 1993, remains in effect even if a State is granted a delayed compliance date. However, no compliance action will be taken against a State which requires legislation to enact the trust provisions. Once enabling legislation is enacted, a State can choose whether to enforce the trust provisions retroactively.

To obtain a delayed compliance date, submit a written request to your HCFA regional office with an opinion from the State's Attorney General concerning the necessity of passing enabling legislation.

3259.3 *Individuals to Whom Trust Provisions Apply.* This section applies to any individual who establishes a trust and who is an applicant for or recipient of Medicaid. An individual is considered to have established a trust if his or her assets (regardless of how little) were used to form part or all of the corpus of the trust and if any of the parties described as a grantor in § 3259.1 established the trust, other than by will. (See also § 3257 for a definition of individual as it is used in this section.)

3259.4 *Individual's Assets Form Only Part of Trust.* When a trust corpus includes assets of another person or persons as well as assets of the individual, the rules in §§ 3259ff apply only to the portion of the trust attributable to the assets of the individual. Thus, in determining countable income and resources in the trust for eligibility and post-eligibility purposes, you must prorate any amounts of income and resources, based on the proportion of the individual's assets in the trust to those of other persons.

3259.5 *Application of Trust Provisions.* The rules set forth in this section apply to trusts without regard to:

- The purpose for which the trust is established;
- Whether the trustee(s) has or exercises any discretion under the trust;
- Any restrictions on when or whether distributions can be made from the trust; or
- Any restrictions on the use of distributions from the trust.

This means that any trust which meets the basic definition of a trust can be counted in determining eligibility for Medicaid. No clause or requirement in the trust, no matter how specifically it applies to Medicaid or other Federal or State programs (i.e., an exculpatory clause), precludes a trust from being considered under the rules in §§ 3259ff.

NOTE: While exculpatory clauses, use clauses, trustee discretion, and restrictions on distributions, etc., do not affect a trust's countability, they do have an impact on how the various components of specific trusts are treated. (See § 3259.6 for a detailed discussion of how various types of trusts are treated.)

3259.6 *Treatment of Trusts.* How a specific trust is counted for eligibility purposes depends on the characteristics of the trust. The following are the rules for counting various kinds of trusts.

A. *Revocable Trust.* In the case of a revocable trust:

- The entire corpus of the trust is counted as an available resource to the individual;
- Any payments from the trust made to or for the benefit of the individual are counted as income to the individual (see § 3257 for the definition of income);
- Any payments from the trust which are not made to or for the benefit of the individual are considered assets disposed of for less than fair market value. (See §§ 3258ff. for the treatment of transfers of assets for less than fair market value.)

When a portion of a revocable trust is treated as a transfer of assets for less than fair market value, the look-back period described in § 3258.4 is extended from the usual 36 months to 60 months. (See § 3258.4 for how to determine the look-back period for transfers of assets for less than fair market value.)

EXAMPLE: Mr. Baker establishes a revocable trust with a corpus of $100,000 on March 1, 1994, enters a nursing facility on November 15, 1997, and applies for Medicaid on February 15, 1998. Under the terms of the trust, the trustee has complete discretion in disbursing funds from the trust. Each month, the trustee disburses $100 as an allowance to Mr. Baker and $500 to a property management firm for the upkeep of Mr. Baker's home. On June 15, 1994, the trustee gives $50,000 from the corpus to Mr. Baker's brother.

In this example, the $100 personal allowance and the $500 upkeep of the house counts as income each month to Mr. Baker. Because the trust is revocable, the entire value of the corpus is considered a resource to Mr. Baker. Originally this was $100,000. However, in June 1994, the trustee gave away $50,000. Thus, only the remaining $50,000 is countable as a resource to Mr. Baker.

However, the giveaway is treated as a transfer of assets for less than fair market value. When a trust is revocable, the look-back period for such transfers is 60 months rather than the usual 36 months. The look-back period in this case starts on February 15, 1993 (60 months prior to February 15, 1998, the date Mr. Baker was both in an institution and applied for Medicaid). Because the transfer occurred in June 1994, it falls within the look-back period. Thus, a penalty under the transfer of assets provisions is imposed, beginning June 1, 1994 (the beginning of the month in which the transfer occurred). This penalty, which is denial of payment for Mr. Baker's nursing home care, is based on the amount of the transfer ($50,000), divided by the State's average monthly cost of private nursing facility care. (See § 3258ff. for the transfer of assets rules.)

B. *Irrevocable Trust—Payment Can Be Made to Individual Under Terms of Trust.* In the case of an irrevocable trust, where there are any circumstances under which payment can be made to or for the benefit of the individual from all or a portion of the trust, the following rules apply to that portion:

- Payments from income or from the corpus made to or for the benefit of the individual are treated as income to the individual;
- Income on the corpus of the trust which could be paid to or for the benefit of the individual is treated as a resource available to the individual;
- The portion of the corpus that could be paid to or for the benefit of the individual is treated as a resource available to the individual; and
- Payments from income or from the corpus that are made but not to or for the benefit of the individual are treated as a transfer of assets for less than fair market value. (See §§ 3258ff. for treatment of transfers for less than fair market value.)

EXAMPLE: Use the same facts that were used in the previous example, but treat the trust as an irrevocable trust. The trustee has discretion to disburse the entire corpus of the trust and all income from the trust to anyone, including the grantor. The $100 personal allowance and $500 for home upkeep are income to Mr. Baker. The $50,000 left after the gift to Mr. Baker's brother is a countable resource to Mr. Baker, since there are circumstances under which payment of this amount could be made to Mr. Baker. The $50,000 gift to Mr. Baker's brother is treated as a transfer of assets for less than fair market value. However, the look-back period for this type of trust is only 36 months. (See § 3258.4 for transfer look-back periods as they apply to trusts.) The transfer occurred outside of the look-back period. Thus, no penalty for transferring an asset for less than fair market value can be imposed.

C. *Irrevocable Trust—Payments From All or Portion of Trust Cannot, Under Any Circumstances, Be Made to or for the Benefit of the Individual.* When all or a portion of the corpus or income on the corpus of a trust cannot be paid to the individual treat all or any such portion or income as a transfer of assets for less than fair market value, per instructions in §§ 3258ff.

In treating these portions as a transfer of assets, the date of the transfer is considered to be:

- The date the trust was established; *or*,
- If later, the date on which payment to the individual was foreclosed.

In determining for transfer of assets purposes the value of the portion of the trust which cannot be paid to the individual, do not subtract from the value of the trust any payments made, for whatever purpose, after the date the trust was established or, if later, the date payment to the individual was foreclosed. If the trustee or the grantor adds funds to that portion of the trust after these dates, the addition of those funds is considered to be a new transfer of assets, effective on the date the funds are added to that portion of the trust.

Thus, in treating portions of a trust which cannot be paid to an individual, the value of the transferred amount is no less than its value on the date the trust is established or payment is foreclosed. When additional funds are added to this portion of the trust, those funds are treated as a new transfer of assets for less than fair market value.

When that portion of a trust which cannot be paid to an individual is treated as a transfer of assets for less than fair market value, the usual 36 month look-back period is extended to 60

months. (See § 3258.4 for the look-back period for transfers of assets for less than fair market value.)

EXAMPLE: Use the same facts that are used in the examples in subsections A and B, *except* that the trustee is precluded by the trust from disbursing any of the corpus of the trust to or for the benefit of Mr. Baker. Again, the $100 and $500 (which come from income to the trust) count as income to Mr. Baker. Because none of the corpus can be disbursed to Mr. Baker, the entire value of the corpus at the time the trust was created ($100,000 in March 1994) is treated as a transfer of assets for less than fair market value.

As with the revocable trust in subsection A, the date of transfer is within the 60 month look-back period that applies to portions of trusts that cannot be disbursed to or for the individual. Thus, a transfer of assets is considered to have occurred as of March 1, 1994. The fact that $50,000 was actually transferred out of the trust to Mr. Baker's brother does not alter the amount of the transfer upon which the penalty is based. That amount remains $100,000, even after the gift to Mr. Baker's brother.

If, at some point after establishing the trust, Mr. Baker places an additional $50,000 in the trust, none of which can be disbursed to him, that $50,000 is treated as an additional transfer of assets. The penalty period that applies to that $50,000 starts when those funds are placed in the trust, *provided* no penalty period from the previous transfer of $100,000 is still running. If a previous penalty period is still in effect, the new penalty period cannot begin until the previous penalty period has expired. (See §§ 3258ff. for transfers of assets for less than fair market value.)

Amounts are considered transferred as of the time the trust is first established or, if later, payment to the individual is foreclosed. Each time the individual places a new amount into the trust, payment to the individual from this new portion is foreclosed. It is this later date that determines when a transfer has occurred.

D. *Payments Made From Revocable or Irrevocable Trusts to or on Behalf of Individual.* Payments are considered to be made to the individual when any amount from the trust, including an amount from the corpus or income produced by the corpus, is paid directly to the individual or to someone acting on his/her behalf, e.g., a guardian or legal representative.

Payments made for the benefit of the individual are payments of any sort, including an amount from the corpus or income produced by the corpus, paid to another person or entity such that the individual derives some benefit from the payment. For example, such payments could include purchase of clothing or other items, such as a radio or television, for the individual. Also, such payments could include payment for services the individual may require, or care, whether medical or personal, that the individual may need. Payments to maintain a home are also payments for the benefit of the individual.

NOTE: A payment to or for the benefit of the individual is counted under this provision only if such a payment is ordinarily counted as income under the SSI program. For example, payments made on behalf of an individual for medical care are not counted in determining income eligibility under the SSI program. Thus, such payments are not counted as income under the trust provision.

E. *Circumstances Under Which Payments Can or Cannot Be Made.* In determining whether payments can or cannot be made from a trust to or for an individual, take into account any restric-

tions on payments, such as use restrictions, exculpatory clauses, or limits on trustee discretion that may be included in the trust.

For example, if an irrevocable trust provides that the trustee can disburse only $1,000 to or for the individual out of a $20,000 trust, only the $1,000 is treated as a payment that could be made under the rules in subsection B. The remaining $19,000 is treated as an amount which cannot, under any circumstances, be paid to or for the benefit of the individual. On the other hand, if a trust contains $50,000 that the trustee can pay to the grantor only in the event that the grantor needs, for example, a heart transplant, this full amount is considered as payment that could be made under *some* circumstances, even though the likelihood of payment is remote. Similarly, if a payment cannot be made until some point in the distant future, it is still payment that can be made under some circumstances.

F. *Placement of Excluded Assets in Trust.* Section 1917(e) of the Act provides that, for trust and transfer purposes, assets include both income and resources. Section 1917(e) of the Act further provides that income has the meaning given the term in § 1612 of the Act and resources has the meaning given that term in § 1613 of the Act. The only exception is that for institutionalized individuals, the home is not an excluded resource.

Thus, transferring an excluded asset (either income or a resource, with the exception of the home of an institutionalized individual) for less than fair market value does not result in a penalty under the transfer provisions because the excluded asset is not an asset for transfer purposes. Similarly, placement of an excluded asset in a trust does not change the excluded nature of that asset; it remains excluded. As noted in the previous paragraph, the only exception is the home of an institutionalized individual. Because § 1917(e) of the Act provides that the home is not an excluded resource for institutionalized individuals, placement of the home of an institutionalized individual in a trust results in the home becoming a countable resource.

G. *Use of Trust vs. Transfer Rules for Assets Placed in Trust.* When a nonexcluded asset is placed in a trust, a transfer of assets for less than fair market value generally takes place. An individual placing an asset in a trust generally gives up ownership of the asset to the trust. If the individual does not receive fair compensation in return, you can impose a penalty under the transfer of assets provisions.

However, the trust provisions contain specific requirements for treatment of assets placed in trusts. As discussed in subsections A through C, these requirements deal with counting assets placed in trusts as available income, available resources, and/or a transfer of assets for less than fair market value, depending on the circumstances of the particular trust. Application of the trust provisions, along with imposition of a penalty for the transfer of the assets into the trust, could result in the individual being penalized twice for actions involving the same asset.

To avoid such a double penalty, application of one provision must take precedence over application of the other provision. Because the trust provisions are more specific and detailed in their requirements for dealing with funds placed in a trust, the trust provisions are given precedence in dealing with assets placed in trusts. Deal with assets placed in trusts exclusively under the trust provisions (which, in some instances, require that trust assets be treated as a transfer of assets for less than fair market value).

3259.7 *Exceptions to Treatment of Trusts Under Trust Provisions.* The rules concerning treatment of trusts set forth in § 3259.6 do not apply to any of the following trusts, i.e., the trusts

discussed below are treated differently in determining eligibility for Medicaid. Funds entering and leaving these trusts are generally treated according to the rules of the cash assistance programs, the State's more restrictive rules under § 1902(f) of the Act, or more liberal rules under § 1902(r)(2) of the Act, as appropriate.

As is noted in each exception below, one common feature of all of the excepted trusts is a requirement that the trust provide that upon the death of the individual, funds remaining in the trust go to the State agency, up to the amount paid in Medicaid benefits on the individual's behalf. When an individual has resided in more than one State, the trust must provide that the funds remaining in the trust are distributed to each State in which the individual received Medicaid, based on the State's proportionate share of the total amount of Medicaid benefits paid by all of the States on the individual's behalf. For example, if an individual received $20,000 in Medicaid benefits in one State and $10,000 in benefits in another State, the first State receives two-thirds of the amount remaining in the trust, and the second State receives one-third, up to the amount each State actually paid in Medicaid benefits.

A. *Special Needs Trusts.* A trust containing the assets of an individual under age 65 who is disabled (as defined by the SSI program in § 1614(a)(3) of the Act) and which is established for the sole benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court is often referred to as a special needs trust. To qualify for an exception to the rules in this section, the trust must contain a provision stating that, upon the death of the individual, the State receives all amounts remaining in the trust, up to an amount equal to the total amount of medical assistance paid on behalf of the individual under your State Medicaid plan. In addition to the assets of the individual, the trust may also contain the assets of individuals other than the disabled individual.

When a trust is established for a disabled individual under age 65, the exception for the trust discussed above continues even after the individual becomes age 65. However, such a trust cannot be added to or otherwise augmented after the individual reaches age 65. Any such addition or augmentation after age 65 involves assets that were not the assets of an individual under age 65. Thus, those assets are not subject to the exemption discussed in this section.

To qualify for this exception, the trust must be established for a disabled individual, as defined in § 1614(a)(3) of the Act. When the individual in question is receiving either title II or SSI benefits as a disabled individual, accept the disability determination made for those programs. If the individual is not receiving those benefits, you must make a determination concerning the individual's disability. In making this determination, follow the normal procedures used in your State to make disability determinations for Medicaid purposes. If you are a 209(b) State, you must use the disability criteria of the SSI program, rather than any more restrictive criteria you may use under your State plan. The only exception to this requirement is if you had a more restrictive trust policy in general in 1972 than the policy described in §§ 3259ff. If so, you may use any more restrictive definition of disability which applied to that 1972 policy. If not, you must use the disability criteria of the SSI program.

NOTE: Establishment of a trust as described above does not constitute a transfer of assets for less than fair market value if the transfer is made into a trust established solely for the benefit of a disabled individual under age 65. However, if the trust is not solely for the benefit of the disabled person or if the disabled person is over age 65 transfer penalties may apply. (See § 3258.10 for the exceptions to imposing penalties for certain transfers of assets.)

B. *Pooled Trusts.* A pooled trust is a trust containing the assets of a disabled individual as defined by the SSI program in § 1614(a)(3) of the Act, that meets the following conditions:

- The trust is established and managed by a non-profit association;
- A separate account is maintained for each beneficiary of the trust but for purposes of investment and management of funds the trust pools the funds in these accounts;
- Accounts in the trust are established solely for the benefit of disabled individuals by the individual, by the parent, grandparent, legal guardian of the individual, or by a court (see § 3257 for a definition of the term "solely for the benefit of"); and
- To the extent that any amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State the amount remaining in the account up to an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under your State Medicaid plan. To meet this requirement, the trust must include a provision specifically providing for such payment.

To qualify as an excepted trust, the trust account must be established for a disabled individual, as defined in § 1614(a)(3) of the Act. When the individual in question is receiving either title II or SSI benefits as a disabled individual, accept the disability determination made for those programs. If the individual is not receiving those benefits, you must make a determination concerning the individual's disability. In making this determination, follow the normal procedures used in your State to make disability determinations for Medicaid purposes. If you are a 209(b) State, you must use the disability criteria of the SSI program. The only exception to this requirement is if you had a more restrictive trust policy in general in 1972 than the policy described in this instruction. If so, you may use any more restrictive definition of disability which applied to that 1972 policy. If not, you must use the disability criteria of the SSI program.

NOTE: Establishing an account in the kind of trust described above may or may not constitute a transfer of assets for less than fair market value. For example, the transfer provisions exempt from a penalty trusts established solely for disabled individuals who are under age 65 or for an individual's disabled child. As a result, a special needs trust established for a disabled individual who is age 66 could be subject to a transfer penalty. (See § 3258.10 for the exceptions to imposing penalties for certain transfers of assets.)

While trusts for the disabled (as well as *Miller* trusts described in subsection C) are exempt from treatment under the trust rules described in § 3259.6, funds entering and leaving them are not necessarily exempt from treatment under the rules of the appropriate cash assistance program. The following are rules applicable to funds entering and leaving both kinds of exempt trusts for the disabled.

1. *Trusts Established with Income.* While most trusts for the disabled are created using the individual's resources, some may be created using the individual's income, either solely or in conjunction with resources. When an exempt trust for a disabled individual is established using the individual's income (i.e., income considered to be received by the individual under the rules of the SSI program), the policies set forth in subsection C for treatment of income used to create *Miller* trusts apply.

NOTE: The following policies assume that the income placed in the trust is the individual's own income, placed in the trust after he or she receives it. When the right to income placed in the trust actually belongs to the trust and not the individual the income does not count under SSI

rules as income received by the individual.

The policies pertaining to treatment of income belonging to the individual include:

- Not counting for eligibility purposes income before it is placed in the trust;
- Application of transfer of assets rules (where a transfer into trust for a disabled individual is not exempt from penalty under the exceptions to the transfer of assets rules explained in § 3258.10);
- Application of post-eligibility treatment of income rules to income placed in the trust;
- Counting as income, per cash assistance rules, funds paid out of the trust to or for the benefit of the individual (This rule applies to any payment from an exempt trust, regardless of whether the trust is established using income, resources, or both.); and
- Spousal impoverishment provisions as they apply to exempt trusts.

For a detailed discussion of how these policies apply to income placed in an exempt trust for a disabled individual, see subsection C.

2. *Trusts Established with Resources.* When an exempt trust is established for a disabled individual using resources either in whole or in part, those resources are treated as follows.

Resources placed in an exempt irrevocable trust for a disabled individual may or may not count as resources to the individual in determining eligibility, depending on the circumstances. Resources are counted as resources only during those months in which they are in the possession of the individual, up to but not including the month in which the resources are placed in the trust. Beginning with the month the resources are placed in the trust, they are exempt from being counted as resources to the individual.

Resources placed in an exempt trust for a disabled individual are subject to imposition of a penalty under the transfer of assets provisions *unless* the transfer is specifically exempt from penalty as explained in § 3258.10 or unless the resources placed in the trust are used to benefit the individual, and the trust purchases items and services for the individual at fair market value. See subsection C for the rules concerning application of the transfer of assets provisions to assets placed in an exempt trust. These rules apply to both income and resources placed in the exempt trusts discussed in this section.

C. Miller-*Type or Qualifying Income Trusts (QIT).* This type of trust, established for the benefit of an individual, meets the following requirements:

- The trust is composed only of pension, Social Security, and other income to the individual, including accumulated interest in the trust; and
- Upon the death of the individual, the State receives all amounts remaining in the trust, up to an amount equal to the total medical assistance paid on behalf of the individual under your State Medicaid plan. To qualify for this exception, the trust must include a provision to this effect.

NOTE: HCFA has interpreted § 1917(d)(4)(B) of the Act as explained below to avoid reading it as a nullity. This interpretation applies to those situations in which an individual first receives income and then places it into a *Miller* trust. It does not apply to situations in which an individual has irrevocably transferred his or her right to receive income to the trust. Under SSI rules, this income is no longer considered to be the individual's income. As a result, a trust established with income the right to which has been transferred to the trust does not meet the requirements for exemption under this section, since the statute requires that a *Miller* trust be established using the income of the individual.

This type of trust is applicable in your State only if your State Medicaid plan provides Medicaid to individuals eligible under a special income level, as described in § 1902(a)(10)(A)(ii)(V) of the Act but does not provide Medicaid for nursing facility services to the medically needy, who are described in § 1902(a)(10)(c) of the Act.

To qualify for this exception, the trust must be composed only of income to the individual, from whatever source. The trust may contain accumulated income, i.e., income that has not been paid out of the trust. However, no resources, as defined by SSI, may be used to establish or augment the trust. Inclusion of resources voids this exception.

While *Miller* trusts (as well as the trusts for the disabled described in subsections A and B) are exempt from treatment under the trust rules described in § 3259.6, funds entering and leaving them are not necessarily exempt from treatment under the rules of the appropriate cash assistance program. The following are rules applicable to funds entering and leaving *Miller* trusts.

1. Miller *Trust Meets All Requirements for Exemption Under § 1917(d)(4)(B) of the Act.* When a trust meets all requirements for exemption, *and* is irrevocable, the corpus of the trust is exempt from being counted as available to the individual. A revocable trust is exempt under the *Miller* trust provisions. However, a revocable trust is counted under SSI rules as an available resource to the individual.

2. *Income Placed in* Miller *Trust.* Income placed in a trust that meets all of the requirements for exemption as a *Miller* trust meets the SSI definition of income but is not counted in determining the individual's eligibility for Medicaid. Thus, any income, including Social Security benefits, VA pensions, private pensions, etc., can be placed directly into a *Miller* trust by the recipient of those funds, without those funds adversely affecting the individual's eligibility for Medicaid. Also, income generated by the trust which remains in the trust is not income to the individual.

3. *Application of Transfer of Assets Provisions of OBRA 1993.* The transfer of assets provisions described in §§ 3258ff. apply to funds placed in a *Miller* trust. Under the transfer of assets provisions, income is considered to be an asset. In placing income in an irrevocable trust, including a *Miller* trust, an individual gives up direct access to and control over that income. Thus, placement of funds, including income, in a trust can be a transfer of assets for less than fair market value. As such, placing funds in a *Miller* trust normally subjects the individual to the penalties provided for under the transfer of assets provisions.

However, transfer of assets penalties do not apply to income placed in a *Miller* trust to the extent that the trust instrument provides that the income placed in the trust will, in turn, be paid out of the trust for medical care provided to the individual, including nursing home care and care under a home and community-based waiver. When such payments are made, the individual is considered to have received fair market value for the income placed in the trust, up to the amount actually paid for medical care provided to the individual and to the extent that the payments purchased are at fair market value.

Because of certain exemptions from the transfer of assets penalties, funds placed in a *Miller* trust can be transferred for the sole benefit of a spouse without incurring such penalties. This can include, among other things, payments by the trust for medical care for the community spouse. Section 1917(c)(2)(B) of the Act provides that transfer penalties do not apply to assets transferred to a spouse or to a third party for the sole benefit of the spouse. A trust could be considered a third party for purposes of this transfer exemption. For an individual to avoid the transfer penalty that results from a transfer of property to a trust, the trust must be drafted to require that this particular

property can be used only for the benefit of the individual's spouse while the trust exists and that the trust cannot be terminated and distributed to any other individuals or entities for any other purpose.

When payments are made for the individual's medical care you must require that the payments be made at intervals specified by your State (e.g., every month or by the end of the month following the month the funds were placed in the trust). An individual cannot be considered to have received fair market value for funds placed in a trust until payments for some item or service are actually made. Thus, funds cannot be allowed to accumulate indefinitely in a *Miller* trust and still avoid transfer of assets penalties.

The individual is considered to have received fair market value for funds placed in a *Miller* trust for any other payments made from the trust which are for the benefit of the individual and which reflect fair payments for any items or services which were purchased. For example, funds placed in the trust can be used to pay the administrative fees of the trust, income tax owed by the trust, attorney's fees which the trust is obligated to pay (in proportion to whatever part of the trust benefits the individual), food or clothing for the individual, or mortgage payments for the individual's home.

When income placed in the trust exceeds the amount paid out of the trust for medical services or other items or services which benefit the individual, the excess income is subject to penalties under the transfer of assets provisions.

It is important to note that, although an individual may not be subject to a transfer penalty if funds he or she transferred to a trust are used by the trustee to make payments that provide fair market value to the individual, these payments from the trust may still count as income to the individual, as explained in subsection 4.

4. *Treatment of Payments Made from Trust.* While *Miller* trusts are exempt from treatment under the trust provisions described in § 3259.6, payments made from these trusts are still subject to the usual rules under the State Medicaid plan. In most States, these are the SSI rules. Any payments made from a *Miller* trust directly to the individual are counted as income to the individual, provided the individual could use the payments for food, clothing, or shelter for himself or herself. This rule applies whether or not the payments actually are used for these purposes, as long as there are no legal impediments which prevent the individual from using the payments this way.

Any payments made by the trustee to purchase something in kind for the individual also can count as income to the individual. In kind income includes actual food, clothing, or shelter, or something the individual can use to obtain one of these. For example, if the trustee makes a mortgage payment for the individual, that payment is a shelter expense and counts as income.

However, as another example, assume that the trust provides that $500 is paid each month toward the cost of the individual's nursing facility care. Under SSI policy, medical expenses paid on behalf of an individual are not counted as income to the individual. Thus, the $500 in this instance is not considered income.

5. *Post-Eligibility Treatment of Income.* All of the post-eligibility treatment of income rules in 42 CFR 435.725, 733, 735, and 832, as well as § 1924 of the Act, apply in cases involving *Miller* trusts, as follows.

a. *Income Not Placed in a* Miller *Trust.* Income retained by the individual (i.e., not placed in a *Miller* trust) is income to the individual, according to SSI policy. Thus, such income is subject to the post-eligibility rules.

b. *Income Placed in a* Miller *Trust.* Income placed in a *Miller* trust is income for SSI purposes although it is not counted as available in determining Medicaid eligibility. Thus, such income is also subject to the post-eligibility rules.

Because income placed in a *Miller* trust is income as defined by SSI (although it is not counted for Medicaid eligibility purposes), all income placed in a *Miller* trust is combined with countable income not placed in the trust for post-eligibility purposes. For example, an individual with $2,000 a month in income retains $1,338 (the maximum currently permitted for eligibility under a special income level) and places the remaining $662 in a *Miller* trust. The entire $2,000 is income as defined by SSI, although only the $1,338 is counted as income for eligibility purposes. Thus, the $2,000 forms the basis for the post-eligibility computation.

Using the $2,000 as the individual's total income for post-eligibility purposes, the State deducts, as applicable:

- A personal needs allowance;
- Family maintenance allowances, including the spousal and family allowances provided for in § 1924 of the Act;
- An allowance for maintenance of a home, if such allowance is included in the State plan; and
- Medical expenses not subject to third party payment.

The remainder is the amount by which the State reduces its payment to the medical institution or for home and community-based waiver services.

c. *Payments Made from* Miller *Trust.* Payments made from *Miller* trust to the individual may count for eligibility purposes as income to the individual under SSI rules. However, such payments are not subject to treatment under the post-eligibility rules. Post-eligibility has already been applied to all income entering the trust. Thus, there is no need to consider, for purposes of post-eligibility, payments made from the trust.

6. Miller *Trust and Spousal Impoverishment.* As explained in subsection 5, funds placed in a *Miller* trust are subject to the post-eligibility treatment of income rules, including those applicable to spousal impoverishment in § 1924 of the Act.

3259.8 *Application of Trust Provisions Would Work Undue Hardship.* When application of the trust provisions discussed in §§ 3259ff would work an undue hardship those provisions do not apply. Unlike the policies applying to trusts established on or before August 10, 1993, which only required that you acknowledge that the statute included an undue hardship provision, under OBRA 1993 you must implement an undue hardship provision for trusts. Further, that policy must be described in your Medicaid State Plan. You have considerable flexibility in implementing an undue hardship provision. However, your undue hardship provision must meet the requirements discussed below.

A. *Undue Hardship Defined.* Undue hardship exists when application of the trust provisions would deprive the individual of medical care such that his/her health or his/her life would be endangered. Undue hardship also exists when application of the trust provisions would deprive the individual of food, clothing, shelter, or other necessities of life.

Undue hardship does not exist when application of the trust provisions merely causes the individual inconvenience or when such application might restrict his/her lifestyle but would not put him/her at risk of serious deprivation.

B. *Burial Trusts and Undue Hardship.* A burial trust is a trust established by an individual for the purpose of paying, at some point in the future, for the various expenses associated with the individual's funeral and burial. At your option, you may exempt a burial trust from treatment as a trust under the State's undue hardship policies provided the total value of the trust does not exceed an amount specified by the State. For example, you may choose to exempt from being counted as a trust under your undue hardship policies any burial trust that does not exceed $5,000 in value.

C. *State Flexibility.* You have considerable flexibility in deciding the circumstances under which you will not count funds in trusts under the trust provisions because of undue hardship. For example, you may specify the criteria to be used in determining whether the individual's life or health would be endangered, and whether application of a penalty would deprive the individual of food, clothing, or shelter. You may also specify the extent to which an individual must make an effort to recover assets placed in a trust. As a general rule, you have the flexibility to establish whatever criteria you believe are appropriate, as long as you adhere to the basic definition of undue hardship described above.

However, your undue hardship provision must, at a minimum, provide for:

- Notice to recipients that an undue hardship exception exists;
- A timely process for determining whether an undue hardship waiver will be granted;
- A process under which an adverse determination can be appealed.

Your undue hardship provision must discuss how you will meet these requirements.

EXHIBIT 4

Pooled Trust Policy

RECOMMENDED POLICY FOR POOLED TRUSTS ADMINISTERED BY CHAPTERS OF The Arc

Many chapters of The Arc, as well as other organizations, have undertaken to serve people with cognitive, intellectual and developmental disabilities and their families through establishing pooled trust programs. These trust programs pool separate trust accounts of participating individuals for purposes of financial management and investment of funds and attribute a proportional share of the growth of the pooled trust to each separate account. In some cases, The Arc chapter administers the pooled trust program as part of its overall corporate structure. In other cases, The Arc chapter has created a separate corporation to administer a pooled trust, possibly in partnership with other organizations sharing a similar interest.

Under Federal law, when people with disabilities properly establish accounts within the pooled trusts, they may remain eligible for the federal/state Medicaid program and the Supplemental Security Income (SSI) program so long as the trusts adhere to certain Medicaid and SSI program criteria. In addition, expenditures from the trust accounts must also comply with Medicaid and SSI program rules to ensure that the trust beneficiary does not lose eligibility for those vital federal and state support programs. The policy recommendations below apply to those pooled trusts known as "(d)(4)(C)" trusts, administered by non-profit organizations, for people with disabilities who have transferred their own funds into an account in the pooled trust, as allowed under Section 1917(d)(4)(C) of the Social Security Act. Where the policy recommendation applies to all trusts, it will be marked with an asterisk (*).

The trusts allowed under federal law are narrow exceptions to very strict prohibitions on the transfer of assets and use of trusts to assist people in qualifying for Medicaid services. Failure to adhere to both the letter and the spirit of these important exceptions could result in loss of political support for and, ultimately, repeal of the exceptions. The exceptions allow individuals, families, and others to supplement the services that an individual with disabilities, as defined in the Social Security Act, will receive over a lifetime from the SSI and Medicaid programs. This policy paper is intended to assist chapters of The Arc in avoiding practices that might jeopardize the important provisions in federal law which make it possible to use trusts to supplement SSI and Medicaid over the lifetime of an individual with severe disabilities.

HISTORY AND BACKGROUND

Prior to 1993, Medicaid law allowed certain transfers of assets and establishment of trusts for people who became Medicaid eligible. Other practices were prohibited. In

response to perceived exploitation of the policy gaps by people over 65 and their financial planners, Congress acted in 1993 to eliminate the possibility that people over 65 could plan and time their asset transfers so that they could leave assets to heirs while making themselves qualified for Medicaid long term care services.

The disability community, specifically those representing people with mental retardation and mental illness, worked with Congress to ensure that the harsher new rules did not harm families' attempts to plan for the future of their children with severe disabilities. Advocates made the case that families had been engaging in planning to supplement SSI and Medicaid benefits because these benefit programs are unable to cover all of an individual's needs over a lifetime. Such supplementation is possible while a parent or other family member is living; families engaged in trust planning to enable such supplementation to continue beyond their own deaths.

As a result, Congress included several provisions in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). Harsh new financial penalties were established for people over 65 who engaged in certain transfers of assets prior to application for Medicaid benefits. To address the concerns of people with disabilities, several provisions were included as exceptions to the general prohibitions on transfers of assets and trusts. The exceptions are:

- The prohibition on transfers of assets does not apply to people who transfer assets, including a home, to a person with a disability under 65 or to a trust to benefit a person with a disability under 65. While there is no statutory limit on who is protected in making this transfer, it generally works to protect a parent or other family member who transfers funds to a person with a disability and who then needs Medicaid long term care services for him/herself. (Although important to members of The Arc, these transfers and trusts are not the subject of this policy statement.)

- An individual with a disability under age 65 is exempted from the prohibition on transfers of assets and trusts if he/she transfers his/her own funds into a trust that meets certain criteria.

    - If the trust is an individual trust (known as "(d)(4)(A)" trusts), the state Medicaid agency must be designated to receive the funds remaining in the trust at the beneficiary's death before any other remainder beneficiaries will receive funds.

    - If the trust is established as an account in a qualifying pooled trust (known as "(d)(4)(C)" trusts), the pooled trust may retain a percentage of the funds remaining in the individual's account at the beneficiary's death and the state Medicaid agency must be designated to receive remainder funds.

In both cases, other remainder beneficiaries are not entitled to receive funds unless the accumulated debt to Medicaid has been satisfied.

- The law also establishes another allowable trust, known as a Miller trust or a "(d)(4)(B)" trust, which is useful in only a limited number of states for qualifying for nursing home coverage. For the most part, the "(d)(4)(B)" trust does not affect people with mental retardation or developmental disabilities and is not addressed in this recommended policy for pooled trusts.

The Medicaid pay-back provision, as it is known, was established in lieu of an upper limit on the amount of funds that could be placed in a trust by an individual with disabilities for him/herself. In short, the Medicaid pay-back serves to satisfy policy-makers that the funds in the account are truly designed to supplement the needs of the beneficiary. This is especially important for those policy-makers who were concerned about the Medicaid program serving only those people who have low incomes and resources. After the death of the beneficiary, Medicaid programs are "paid-back" any remaining funds up to the value of the services Medicaid has provided to the individual during life.

The law also allows a percentage of the funds to remain in a pooled trust ((d)(4)(C) trust) before the Medicaid pay-back is calculated. The purpose of this provision was to acknowledge and accommodate a common practice of the pooled trusts in existence in 1993. At the time, pooled trusts often required from 10 to 50 percent of the amount remaining at the beneficiary's death to remain with the pooled trust. The pooled trusts used these funds for two purposes: to assist in providing services to other pooled trust beneficiaries who outlived their actuarial life expectancy and to allow provision of advocacy services to people who were "indigent" or did not have funds in the pooled trust. These were the circumstances presented to Congress in 1993 which led to the language allowing payment to the pooled trust.

In 1999, Congress acted again to require that where beneficiaries of SSI have their own funds in trust, the trusts must meet the requirements of Medicaid law.

In current practice, many chapters of The Arc have established pooled trusts. Some beneficiaries use SSI and Medicaid and the pooled trusts are designed to follow the requirements of SSI and Medicaid law.

It is critical that chapters managing pooled trusts remain up-to-date on federal and state law, regulations, and guidance regarding SSI and Medicaid law, as well as laws addressing trust management and appropriate investments.

The Arc has established the principles below as goals to guide chapters in developing quality trust programs. Adherence to these principles should also assist in protecting the integrity of the SSI and Medicaid law regarding trusts and avoiding

negative public perception of the implementation of those laws which could lead to significant limitation or repeal.

POLICY RECOMMENDATIONS

The Arc of the United States believes that in order to follow both the spirit and letter of federal law regarding trusts, chapters administering or establishing pooled trusts must follow the principles outlined below. Those chapters with pooled trusts that do not meet the principles should work toward achieving compliance with these principles.

Avoiding Conflict of Interest

Chapters of The Arc and/or the pooled trust must avoid all apparent and actual conflicts of interest. *

The purpose of and marketing of pooled trusts should be for the provision of services to the beneficiary, not for fund-raising for the chapter.
Percentages of funds remaining with the pooled trust after the beneficiary's death should not exceed 50 percent.

Percentages remaining with the pooled trust after the death of the beneficiary should not go to the general operating funds of any chapter of The Arc. Such amounts should only be available to the pooled trusts for paying for services for beneficiaries or others with disabilities or for operating expenses of the pooled trust.

Unless specifically allowed under the trust agreement for remainders left with the trust in a charitable fund, a beneficiary's funds may not be used for another individual.

The spirit and letter of the federal law (OBRA '93 and the 1999 changes to SSI law) must be observed, with no attempts to circumvent the required pay-back to state Medicaid.

Pooled trust services may not be limited only to members of The Arc.

Trust administrators must establish a separate budget for the operating account for the pooled trust.

Beneficiaries' accounts may not be invaded for operating expenses except as established in the trust agreement creating the beneficiary's account. *

The goal of chapters of The Arc should be to establish the pooled trust as a separate organization or, in the alternative, to create firewalls to ensure no linkage between The Arc general operating funds and the remainder funds left in the trust upon the death of beneficiaries.

When making referrals, The Arc chapter should not work exclusively with any particular attorney or financial planner, but should offer names of two or more attorneys or planners available to assist consumers. *

Due to the level of expertise required, The Arc should work only with attorneys or financial planners who have extensive training or expertise in this area. *

Trust administrators should communicate the established fee structure prior to the establishment of each new account.

Quality Assurance

The pooled trust should acquire a corporate and fidelity bond to protect trust assets.

The Arc should guarantee a minimum commitment of assets at start-up, until such time as the pooled trust is able to function independently financially.

The pooled trust's management must establish a monitoring system to ensure that distributions are appropriate. All unusual requests for distribution (whether for an unusual expenditure or an unusual amount for an expenditure) must be subjected to a special review process.

There must be periodic contact with the beneficiary and/or key person.

The trust administrator must provide the beneficiary and/or key person with a periodic written update, annually at a minimum. The beneficiary and/or key person should be provided written updates upon request at any time.

The trust administrators must keep records (such as receipts, purchase orders, fees for staff time, etc.) and make reports as required by SSI and state Medicaid authorities.

Trust administrators must make good faith efforts to educate family members and key persons about the allowable expenditures under SSI and Medicaid.

Trust administrators must remain up-to-date in their knowledge regarding the appropriate handling of funds for people using SSI and/or Medicaid.

Trust administrators must comply with all applicable state and federal laws, including those regarding trust management, suitability of investments, and allowable disbursements under SSI and Medicaid rules.

Trust administrators must monitor changes in state and federal law and modify the trust as necessary.

Trust administrators should follow a written investment policy adopted by its Board of Directors.

Individual Planning

Goods and services purchased by the trust should be based on a plan of care/services that reasonably reflects the amount of funds available, estimated growth of the funds, and life expectancy of the individual.

Pooled trusts should be available only for people disabled prior to age 65.

Trusts administrators must ensure that any required child support payments owed by the beneficiary are properly handled and structured to conform with state law and to ensure the integrity of the trust.

* Policy recommendation applies to all trusts administered by chapters of The Arc.

9/19/02

EXHIBIT 5

REGIONAL

S S A P R O G R A M C I R C U L A R

Supplemental Security Income

No. 01-15 **Chicago Region** **Date: 11/8/01**

Law Change Regarding Michigan Trusts

Background:

Regional Program Circular 01-06 dated April 5, 2001 provided detailed instructions on evaluating trusts for SSI resource purposes. A general rule of trust law, and one that is followed by all Region V states, is that any trust can be revoked with the mutual consent of the grantor and all beneficiaries. If the grantor and the beneficiary are the same person and there are no other beneficiaries, the trust is revocable.

If there are residual beneficiaries, the trust may be irrevocable. In addition, if the trust names other beneficiaries who may benefit from the trust during the SSI claimant's lifetime, this also may make the trust irrevocable. However, in that, case, even if the trust is not a resource, we need to consider whether there has been a transfer for less than fair market value. [This rule is true even if it is stated in the body of the trust that the trust is irrevocable.]

Definition of a Residual Beneficiary (SI 01120.200):

A residual beneficiary (also referred to as a contingent beneficiary) is not a current beneficiary of a trust, but is someone or some entity that will receive the residual benefit of the trust upon the occurrence of a specific event, e.g., the death of the primary beneficiary.

In the April 5, 2001 circular, we discussed the language in a trust that creates residual beneficiaries. A specific individual who is named to receive the trust qualifies as a residual beneficiary. However, the residual/contingent beneficiary does not always have to be a specifically named individual, and can be identified by category (e.g. "decedents", "children" or "issue").

A reference to the beneficiary's "estate" or "executor" does not create a residual beneficiary (i.e. would not make the trust irrevocable). Additionally, where the only language regarding other beneficiaries refers to the grantor-beneficiary's "heirs at law," "next of kin", "survivors", or persons entitled to inherit "on his/her death intestate" or under the "statute of descent and distribution", such language creates an inference that the grantor does not intend to create any trust interest in the person who may become his heirs or next of kin. For five of six states in the Chicago Region, we do not consider a trust with this language to have residual beneficiaries.

Distribution: All FOs/TSCs/ADOs/in the Chicago Region
Retention Date: 11/08/02

The Exception for Michigan Law:

Effective April 1, 2000, for the state of Michigan, any trust that indicates that upon the beneficiary's death, assets will be paid to "heirs at law", or "heir(s)", "next of kin", "relatives", or "family", "distributees", or similar language is considered to have residual beneficiaries. This applies to trusts created, before April 1, 2000, as well (i.e., a trust created prior to April 1, 2000, could be considered irrevocable if the requirements for this exception are met).

Note: If the trust was created on or after January 1, 2002, the language regarding the state being paid first as reimbursement for Medicaid expenditures must still be included in the trust in order for the trust not to be counted as a resource. (SI 01120.203)

Please inform the RO if you are aware of a case that was denied because of excess resources based on a finding that, under Michigan law, the trust was revocable because the grantor was the only beneficiary, and where the trust named as residual beneficiaries the claimant's "heirs" or "heirs at law," or similar language. Cases should be mailed to:

Social Security Administration
Michigan Trust
SSI Team, 10th Floor
600 W. Madison St
Chicago, IL 60661

We will evaluate and advise you of the policy application for the specific case.

Conclusion:

For states in the Region, other than Michigan, language such as "heirs at law", "heirs" survivors", "relatives", "next of kin", "family", "distributees", or similar language does not create a residual beneficiary. Such language creates an inference that the grantor does not intend to create a trust interest in the persons who may become his/her heirs or next of kin. Such trusts should be viewed as revocable.

Any questions regarding this program circular should be referred to Kay Rosen, at (312) 575-4128.