akron bar association®

The Intersection of Guardianship & Medicaid

Kyla A. Williger, Esq.

When is a Guardianship Needed?

A guardian is a person, appointed by the Probate Court, to handle affairs and make decisions for a minor child or a person who is adjudged to be incompetent. The guardian acts as a fiduciary and makes decisions based on the best interest of the ward. A guardian may be appointed to govern the personal or financial decisions of the ward or both. The powers of the guardian may be general or limited to specific decisions.

In some cases, the need for a guardianship is clear cut and immediate, such as when an accident, stroke or other brain injury suddenly renders an individual helpless and in need of full care. A guardian must be appointed to make all decisions and manage the finances. Most cases are far more insidious. Individuals suffering from advancing senility, due to conditions such as Alzheimer's or hardening of the arteries may need a guardian at some point, but when? Those with mental illness that can be controlled with medication sometimes choose not to take the medication. The need for a guardian may be sporadic.

In determining the need for a guardianship, the court must weigh the benefits that the guardian can bring the individual against the formidable loss of freedom and autonomy that the ward will suffer. The circumstances of the ward must be examined to determine situations where the guardianship can help.

A. Ordering Medical Treatment

If an individual requires medical treatment, but lacks the capacity to give informed consent, a guardian may be needed to order (or refuse) treatment. If the condition is life threatening an emergency guardian can be appointed for up to 72 hours without hearing, and after hearing for an additional 30 days.

B. Forcing a Placement

If an individual, because of diminished capacity, is unsafe in his or her own home, but refuses to move to a safer placement, a guardian may be necessary to arrange or order the placement.

Factors that signal problems include: Inability to move about, wandering, unaddressed incontinence, not eating properly inability to clean home, reclusiveness, failure to take medication and refusal of services.

It is important to note that competent individuals may choose to live in a reclusive fashion, refuse medical treatment, and, at times, drink too much, fail to keep their

homes clean and in good repair or not take a daily bath. Lifestyle does not necessarily determine competence.

C. Preventing Exploitation

The elderly and disabled are often at risk of financial exploitation. Incompetency may cause a trusting person to be taken advantage of both in the scam and regular business transactions such as phone solicitations, contests, and charities.

Unfortunately, unscrupulous fiduciaries such as children, care givers or friends may also exploit the incapacitated person. A guardianship of the estate, only, may be sufficient in these situations, leaving the personal and medical decisions to the individual.

D. Planning for Medicaid Qualification

In addition to purchasing an irrevocable burial plan and other exempt assets, the guardian may be able to make gifts on behalf of the ward. The most common transfers would include assigning insurance policies to prepay the burial, transferring assets to a disabled or blind child and transferring the home to a spouse or caretaker child.

An Attorney can help the guardian handle the court proceedings, set up investments, handle special actions such as the sale of household goods or real estate, inventory the assets, and make reports and accounts to the Court. An Elder Law Attorney, familiar with the area and the many resources available, can assist in establishing a plan of care for nursing, housekeeping, food services, health and safety devices, long term care and other services available to help the disabled.

Sometimes a guardian is needed, but no family or friends are available or able to handle the job. I am one of a select number of attorneys in the area who is capable and willing to act as guardian myself in order to assist the disabled person.

Written by:
Williger Legal Group, LLC.
(330) 686-7777

BASIC RULES OF MEDICAID

For all practical purposes, in the United States the only "insurance" plan for long term institutional care is Medicaid. Medicare only pays for approximately 7 percent of skilled nursing care in the United States. Private insurance pays for even less. The result is that most people pay out of their own pockets for long term care until they become eligible for Medicaid. While Medicare is an entitlement program, Medicaid is a form of welfare - or at least that's how it began. So to be eligible, you must become "impoverished" under the program's guidelines.

Despite the costs, there are advantages to paying privately for nursing home care. The foremost is that by paying privately an individual is more likely to gain entrance to a better quality facility. The obvious disadvantage is the expense; in Ohio, nursing home fees average $7,000 - $8,000 a month. Without proper planning nursing home residents can lose the bulk of their savings.

For most individuals, the object of long term care planning is to protect savings (by avoiding paying them to a nursing home) while simultaneously qualifying for nursing home Medicaid benefits. This can be done within the following rules of Medicaid eligibility.

THE ASSET RULE

In Ohio, Medicaid is administered by the Department of Job and Family Services (DJFS). However, in order to qualify for federal reimbursement, the state program must comply with applicable federal statutes and regulations. So the following explanation includes both Ohio and federal law as applicable.

The basic rule of nursing home Medicaid eligibility is that an applicant, whether single or married, may have no more than $2,000 in "countable" assets in his or her name. "Countable" assets generally include all belongings except for (1) personal possessions, such as clothing, furniture, and jewelry, (2) one motor vehicle, (3) the applicant's principal residence (if it is in Ohio), and (4) assets that are considered inaccessible for one reason or another.

THE HOME

The home, if valued under $572,000 (2018), will not be considered a countable asset and, therefore, will not be counted against the asset limits for Medicaid eligibility purposes for the first thirteen months of nursing home care as long as the nursing home resident intends to return home or his or her spouse or other qualified dependent relatives live there. It does not matter if it does not appear likely that the nursing home resident will ever be able to return home; the intent to return home by itself preserves the property's character as the person's principal place of residence and thus as a non-countable resource. As a result, for all practical purposes nursing home residents do not initially have to sell their homes in order to qualify for Medicaid. After thirteen months of nursing care it is presumed the resident is not returning home and the house

must be sold to maintain Medicaid eligibility. Any equity interest over $572,000 is considered a countable asset.

THE TRANSFER PENALTY

The other major rule of Medicaid eligibility is the penalty for transferring assets. If an applicant (or his or her spouse) transfers assets, he or she will be ineligible for Medicaid for a period of time beginning at the time he or she is otherwise qualified for Medicaid. The actual number of months of ineligibility is determined by dividing the amount transferred by $6,570. For instance, if an applicant made gifts totaling $124,830, he or she would be ineligible for Medicaid for 19 months ($124,830 divided by $6,570 = 19). Another way to look at this is that for every $6,570 transferred, the applicant will be ineligible for nursing home Medicaid benefits for one month.

The maximum period of ineligibility, no matter the size of the transfer or transfers, is 60 months. However, there is a trap for the unwary in the way the rules are written. The DJFS may only consider transfers made during the 60 month period preceding an application for Medicaid, the "look back" period. Thus, if a person transfers $591,300 to his children and applies for Medicaid only 50 months after signing the deed, he will be ineligible for 95 months ($591,300 divided by $6,570 = 90) following the transfer. If, instead, he waits 61 months to apply for Medicaid, the DJFS may not take the transfer into account. A penalty period may be eliminated by returning all of the transferred funds.

Exceptions to the Transfer Penalty

Transferring assets to certain recipients will not trigger a period of Medicaid ineligibility. These exempt recipients include:

(1) A spouse (or anyone else for the spouse's benefit);
(2) A blind or disabled child;
(3) A trust for the benefit of a blind or disabled child; or
(4) A trust for the benefit of a disabled individual under age 65 (even for the benefit of the applicant under certain circumstances.)

Special rules apply with respect to the transfer of a home. In addition to being able to make the transfers without a penalty to one's spouse or blind or disabled child, or into trust for other disabled beneficiaries, the applicant may freely transfer his or her home to:

(1) A child under age 21;

(2) A sibling who has lived in the home during the year preceding the applicant's institutionalization and who already holds an equity interest in the home; or

(3) A "caretaker child," who is defined as a child of the applicant who lived in the house for at least 2 years prior to the applicant's institutionalization and who during that period provided such care that the applicant did not need to move to a nursing home.

ESTATE RECOVERY

The state has the right to recover whatever benefits it paid for the care of the Medicaid recipient from his or her estate. Given the rules for Medicaid eligibility, the only property of substantial value that the Medicaid recipient is likely to own at death is his or her home. Under current law, the state may make a claim against the decedent's probate or non- probate estate. Property that is jointly owned, in a life estate, or in a trust is included in the estate and thus is subject to recovery.

TREATMENT OF INCOME

When a nursing home resident becomes eligible for Medicaid, all of his or her income, less certain deductions, must be paid to the nursing home. The deductions include a $50 per month personal needs allowance, a deduction for any uncovered medical costs (including medical insurance premiums), and, in the case of a married applicant, an allowance he or she must pay to the spouse that continues to live at home. Qualified Veterans or their widows may be able to keep an additional $90.

SPOUSAL PROTECTIONS

Assets

Medicaid law provides for special protections for the spouse of a nursing home resident, known in the law as the "community" spouse. Under the general rule, the spouse of a married applicant is permitted to keep one-half of the couple's combined assets (as of the date of institutionalization) up to $123,600 (2018). There is a minimum resource allowance for the community spouse of $24,720 (2018).

So, for example, if a couple owns $90,000 in countable assets on the date the applicant enters the hospital, he or she will be eligible for Medicaid once their assets have been reduced to a combined figure of $2,000 for the applicant and $45,000 (one-half of $90,000) for the community spouse. If the couple owned $250,000 in assets, the spouse in need of care would not become eligible until their savings were reduced to $125,600 ($2,000 for the nursing home spouse plus a maximum of $123,600 (2018) for the community spouse).

The determination of the level of the couple's assets is made as the date of institutionalization of the nursing home spouse. That date is the day on which he or she enters either a hospital or a long term care facility in which he or she then stays for at least 30 days. It is advantageous for the couple to try to have as much money as possible in their names on that date, up to $247,200, so that the amount the community spouse is allowed to keep will be as high as possible.

Income

In all circumstances, the income of the community spouse will continue undisturbed; he or she will not have to use his or her income to support the nursing home spouse receiving Medicaid benefits. In some cases, the community spouse is also entitled to share in all or a portion of the monthly income of the nursing home spouse. The DJFS determines an income floor for the community spouse, known as the minimum monthly maintenance needs allowance, or MMMNA, which, under a complicated formula, is calculated for each community spouse based on his or her housing costs. (Where the community spouse can show hardship, the DJFS may award a larger MMMNA, but only after an appeal to a fair hearing). The MMMNA may range from a low of $2,057.50 (2018) to a high of $3,090 (2018) a month. If the community spouse's own income falls below his or her MMMNA, the shortfall can be made up from the nursing home spouse's income.

Increased Resource Allowance

When the income of both the institutional spouse and the community spouse is less than the MMMNA, they may petition the DJFS for an increase in the standard resource allowance so that these additional funds may be invested in order to generate income to make up shortfall. This sometimes can permit the community spouse to retain a substantial level of savings. Unfortunately, the DJFS may not award an increased resource allowance described above and the applicant must appeal the determination to a fair hearing.

THE MEDICAID APPLICATION

Applying for Medicaid is cumbersome and tedious. Every fact asserted in the application must be verified by documentation. The application process can drag on for several months as the DJFS demands more and more verification regarding such issues as the amount of assets and dates of transfer. If the applicant does not comply with these requests and deadlines on a timely basis, the DJFS will deny the application. In addition, after Medicaid eligibility is achieved, it must be determined every year.

Prepared by:
Williger Legal Group, LLC.
(330) 686-7777

Updated 11/2017

Pooled Trusts & Medicaid Planning

A powerful tool for Medicaid planning that we are seeing more use from is a Pooled Trust. A Pooled Trust (sometimes referred to as a (d)(4)(C) trust) is a very specific type of trust used to help disabled individuals qualify for the government benefits they need while maintaining some funds set aside for things they may want to preserve the quality of life they are used to. A pooled trust is one of many tools an elder law attorney can use to help a person qualify for Medicaid. There are many different types of trust, and it is important to make sure you have the right trust for your situation. If used in the wrong way, a trust can actually cause more harm than good.

Basics of Medicaid

Medicaid is a needs-based governmental program to help people who cannot afford to pay for their medical care. In order to qualify for Medicaid, one must have less than $2,000 in assets. Once qualified for Medicaid, a person gets to keep $50 per month for personal spending. The rest of their income goes to pay the initial cost of the nursing home. Medicaid then picks up the tab for whatever that income does not cover that month. With the average monthly nursing home cost ranging between $7,000 - $8,000 a month, Medicaid is often the only choice for senior citizens in need of care.

Basics of Pooled Trusts

One thing all trusts have in common is that there are at least three parties to a trust; the Settlor, the Trustee, and the Beneficiary. The Settlor is the person who funds the trust. The Trustee is the person who manages the trust. The Beneficiary is the person who benefits from the trust. Often there is a primary beneficiary and then contingent beneficiaries named for after the primary has passed away.

The purpose of a Pooled Trust is to pay for items or services not provided by Medicaid. These items and services are not meant to replace SSI or Medicaid benefits but rather enhance the life of the beneficiary by supplementing them.

Pooled Trusts must be irrevocable, which means once they are set up and funded, there is no way a person can demand their money back. If they could, the trust would not qualify for Medicaid purposes.

Who can be the Settlor?

Pooled Trusts are unique in that the trust itself is already set up. An individual opts to join into an already established trust. Pooled Trusts get their name from fact that the funds in the trust are "pooled" with funds of other disabled individuals into one main trust and each individual gets their own account when they opt in. The account must be set up solely for one disabled individual's benefit and must be funded with the individual's assets. The person who sets up the account can be the disabled individual herself, or her power of attorney, parent, grandparent, legal guardian, or the court.

Who can be the Trustee?

The trust must be managed by a nonprofit organization. Currently in Ohio there are three companies that specialize in pooled trusts to choose from:

- The Community Fund Management Foundation (CFMF) in Cleveland
- The Disability Foundation in Dayton
- The Ohio McGivney Pooled Special Needs Trust in Columbus

Separate from the trustee, who manages the funds, is the Designated Advocate, often a spouse or power of attorney, who represents the beneficiary and submits requests for money on behalf of the beneficiary.

Who can be the Beneficiary?

The primary beneficiary must be the disabled individual. "Disabled" is defined in rules adopted by ODJFS. There is currently no age limit in the state of Ohio on who can be a beneficiary. There can be no other primary beneficiaries named on the account, including the spouse or children.

Once the primary beneficiary has died, the pooled trust must contain an express provision for reimbursement to the state of Ohio for Medicaid services provided. If there are still excess funds remaining in the account once Medicaid has been paid back, those remaining funds may go to the spouse or other named remainder beneficiaries.

Funding the Pooled Trust

The trust is funded exclusively with the individual's assets. The trust cannot receive funds from people other than the individual. A pooled trust is funded exclusively with cash. You would not put a house or personal property in a pooled trust. Assets that would otherwise be countable for Medicaid can be transferred into

the pooled trust penalty free. Excess funds can later be added as they become available such as an inheritance or a lawsuit settlement. The individual can fund the trust with assets or irrevocably assign his or her income to the pooled trust. Generally there is a required minimum initial deposit of at least $5,000 to set up a pooled trust, however there is a method to fund pooled trusts with less.

Getting Money out of the Pooled Trust

Once the trust is set up and the Beneficiary is on Medicaid, the Designated Advocate represents the Beneficiary and submits forms (including receipts) to the pooled trust to request money from the trust account for the Beneficiary's supplemental services. Once a request is approved, the Trustee releases the money from the trust account for payment to the vendor, service provider, or Designated Advocate. Cash can never be distributed directly to the Beneficiary.

Distribution requests can be submitted at any time and there is no limit on the number of distribution requests that can be submitted. The entire process may take three to four weeks from the date the request is issued. If there is an emergency, an emergency distribution request can be made at any time, but there is a fee. Reoccurring payments can be set up if the amount of the item or service remains the same, for example, a distribution request can be made for cable TV or other such common expenditure each month.

Money distributed from a trust account must be used for supplemental services for the sole benefit of the Beneficiary. The trust cannot provide for other people in the beneficiary's life, such as for example, tuition for a child. A request may be denied if the Trustee feels it would interfere with the beneficiary's governmental benefits, if they do not have proper documents and receipts, or if they feel the request is unreasonable.

A pooled trust can be used only to pay for supplemental services. It cannot be used for food and shelter. Supplemental services are those items or services that will not be paid for by insurance or a government program, but supplement and can enhance the quality of life of an individual with a disability. Examples include:

- Dental Care
- Plastic, cosmetic surgery or non-necessary medical procedures
- Psychological support services
- Recreation and transportation
- Differentials in cost between housing and shelter

- Supplemental nursing care and similar care which public assistance programs may not otherwise provide, including payments to those providing services in the home
- Telephone and television services
- Electric wheelchair and other mobility aids
- Mechanical bed
- Periodic outings and vacations, including costs incurred by caretaker companions
- Hair and nail care
- Stamps and writing supplies
- More sophisticated medical, dental or diagnostic treatment, including experimental treatment, for which there are not funds otherwise available
- Private rehabilitative training
- Payments to bring in family and friends for visitation if the trustee deems that appropriate and reasonable
- Private case management to assist the primary beneficiary, or to aid the trustee in the trustee's duties
- Medication or drugs prescribed by a physician
- Drug and/or alcohol treatment
- Prepay funeral and burial expenses
- Companions for reading, driving and cultural experiences

A Pooled Trust is one of many tools that can help a person qualify for Medicaid while maintaining some funds that enhance the beneficiary's life. It can be a powerful tool in your long term care plan. Because all types of trusts are complex, consult your attorney if you feel a Pooled Trust would be advantageous to you or someone you love.

Prepared By:
Williger Legal Group, LLC.
(330) 686-7777

Medicaid Qualifying Income Trusts

Medicaid Waiver Programs such as PASSPORT and ALF Waiver have income caps. Applicants with countable monthly income in excess of the cap ($2,250 in 2018) do not qualify for the programs regardless of their needs. A Qualifying Income Trust (QIT) described under the Ohio Medicaid statutes may help high income individuals qualify for these programs.

The QIT is a relatively simple trust established to divert some of the applicant's monthly income into the hands of the Trustee (usually a family member). The diverted income is not counted in determining the individual's eligibility for Medical Assistance allowing him to qualify for the Medicaid Waiver Program. Once the individual qualifies for the program, however, the income diverted to the QIT as well as interest generated by the QIT assets are considered in establishing patient liability or spenddown. Assets that have accumulated in the trust in the months prior to Medicaid qualification, however, are considered exempt resources.

QIT Rules:

- The trust can be funded only with the individual's pension, social security, and/or other income including interest earned by the trust in the month the income is earned.
- No resources may be used to establish or add to the trust.
- The individual cannot assign or transfer his right to receive income to the trust.
- The income cannot be paid directly to the trust. The individual must first receive the income and then transfer it to the QIT.

Uses of The QIT:

The main purpose of the QIT is to qualify the high income applicant for a Medicaid Waiver program that has an income cap. This can be done in the month that qualification is desired. If used in this way, the trust is often of little use after Medicaid qualification. It can be abandoned after qualification since diverted income will then be counted in patient liability and spenddown calculations.

With advance planning, however, the QIT can be used to protect funds for the applicant's future needs. If the QIT is established in advance of the Medicaid application, income can be deposited into the QIT while the applicant's resources are being spent down. At the end of each month "income" that is not spent becomes

"resources." Resources that accumulate in the QIT are considered exempt for Medicaid purposes.

Example: John qualifies medically for PASSPORT, the home Waiver program, but his income of $2,700 monthly and his resources of $50,000 are both too high to qualify. John needs to spend his resources down to $2,000 to qualify. He does this by paying for household repairs and home health care services for 6 months. During those 6 months, he deposits $2,000 of his monthly income into a QIT. When he applies for PASSPORT in month 7, the income for that month will be excluded for qualification purposes, but included in calculating his monthly spend down amount. The $12,000 that has accumulated in the QIT over the prior 6 months will be considered exempt resources.

Definitions:

- **Income:** assets received on a regular basis such as earned income, interest and dividend, pensions, Social Security and other benefits.
- **Resources**: assets accumulated by the applicant such as savings, real estate, and investments
- **Spenddown/Patient Liability**: amounts the Medicaid recipient is required to pay toward his medical expenses monthly.

The QIT is one of many strategies that can be used to qualify for Medicaid. If you or a loved one are concerned about how to pay for long term care or need a QIT to qualify for a waiver program, consult a knowledgeable Elder Law attorney.

Prepared by:
Williger Legal Group
(330) 686-7777