

**Medicaid and Privacy for Institutionalized Persons in Virginia:¹
What People Need to Know About Medicaid After
the Deficit Reduction Act of 2005²
and March 16, 2006, HIPAA Enforcement Rule.**

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I. General Power Of Attorney Issues in the Medicaid Context.

- A. To avoid guardianship and conservatorship, it's important for a third party to be authorized to act on behalf of Medicaid applicant to secure medical information and make necessary transfers

- B. Attributes of a power of attorney / health care power of attorney.
 - 1. Alternate Agents, Health Care Decisions under Title 54.1
 - 2. Gifting and Support Authority Vested In Agent (Va. Code Ann. § 11-9.5)
 - 3. Compelled Disclosures to "Problem" Family Members & Others (Va. Code Ann. § 11-9.6)
 - 4. HIPAA confidentiality, doctors, and "springing powers" (Va. Code Ann. § 11-9.4)³
 - 5. Divorce issues and waiver agreements
 - 6. Waiver of conflict of interest rules for agency self dealing, if desired.

¹ Different income rules ("caps") are applicable to DMHRSAS facilities and the CBC waiver program. Generally, the caps are 300% of the SSI monthly allowance for an eligible individual. See *infra*.

² The Deficit Reduction Act of 2005 (herein, DRA 2005) was signed by President Bush on February 8, 2006. While subject to at least two lawsuits questioning its constitutional legitimacy, until it has been declared void, it is considered effective as to transfers occurring after February 7, 2006. The full text of the transfer of assets and related provisions regarding eligibility for citizens applying for Medicaid benefits to pay for long term care services is available at <http://majette.net> in the link captioned, "[Medicaid Cuts In Situ – 42 U.S.C. 1396p as Amended.](#)" At present (June 9, 2006), no policy or regulations have been published regarding DRA 2005.

³ See <http://majette.net> for similar outline for HIPAA information.

II. Medicaid For Institutionalized Persons: Six Tests

A. Citizenship Credentials.

1. DRA 2005, § 6036, “Improved Enforcement of Documentation Requirements,” requires proof of citizenship with application for assistance.⁴
2. Medicaid policy in Virginia provides for requirement, see, generally, M0220.000 *Citizenship & Alien Requirements*.
3. Acceptable sources of proof of citizenship under DRA 2005.
 - (a) By itself:
 - (i) A United States passport.
 - (ii) Form N-550 or N-570 (Certificate of Naturalization).
 - (iii) Form N-560 or N-561 (Certificate of United States Citizenship).
 - (iv) A *valid*⁵ state-issued driver's license or other state issued identity document described in the Immigration and Nationality Act, **if**:
 - (v) the State issuing the license or such document requires proof of United States citizenship before issuance of such license or document or obtains a social security number from the applicant and
 - (vi) verifies before certification that such number is valid and assigned to the applicant who is a citizen.
 - (b) Other documents.
 - (i) At least one of:
 - (a) (i) A certificate of birth in the United States.
 - (b) Form FS-545 or Form DS-1350 (Certification of Birth Abroad).
 - (c) Form I-97 (United States Citizen Identification Card).
 - (d) Form FS-240 (Report of Birth Abroad of a Citizen of the United States).
 - (e) Any other document the HHS Secretary may specify that provides proof of United States citizenship or nationality.
 - and**
 - (ii) At least one of these documents:
 - (a) Any identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act, which include:
 1. driver's license or similar document issued for the purpose of identification by a State, if it contains a photograph of the individual or such other personal identifying information relating to the individual as the Attorney General finds, by regulation,⁶ sufficient; or
 2. in the case of individuals under 16 years of age or in a State which does not provide for issuance of an identification document (other than a driver's license) referred to in clause (i), documentation of personal

⁴ See <http://thomas.loc.gov/cgi-bin/query/F?c109:5:./temp/~c109YDtxKk:e239331>. The provision amends 42 U.S.C. 1396b.

⁵ In Virginia, an incapacitated person's driver's license is revoked unless otherwise provided for in the order of adjudication.

⁶ Beyond the outline's scope.

identity as the Attorney General finds, by regulation, provides a reliable means of identification.⁷

- (b) Any other documentation of personal identity of such other type as the Secretary of HHS finds, by regulation, provides a reliable means of identification.

B. Age or Disability: 65 or disabled.

C. Prescreening: Activities of Daily Living / U.A.I., §M1420.⁸

1. Required for persons entering long term care or community based care, except not required for persons *in* long term care for at least 30 days at application date, §M 1420.400 (B).
2. The screening criteria are ongoing, and DMAS can rescind certification while the recipient remains in the nursing home, §M 1420.400 B 6.

D. Income: Va. Medicaid Manual § M 1480.410

1. **ONLY** income of institutionalized adult is counted.
 - (a) When an institutionalized person is married to a spouse who is not institutionalized, the institutionalized spouse is an “institutionalized spouse” (the “IS”) under special rules.
 - (b) The non-institutionalized spouse, is referred to as the community spouse (the “CS”).
 - (c) **The income of the CS is not considered in determining Medicaid eligibility for the IS.**
 - (i) *After* eligibility of the institutionalized spouse is conferred, income of the IS may be paid to the CS under the rules below.
 - (ii) If the community spouse has monthly income of more than \$1,900, a claim may be made for “expected” support, see §M 0260.401 C., and below.
 - (a) The claim has no effect on the institutionalized spouse’s eligibility.
 - (b) The claim can only be enforced through a court proceeding.
2. Income of IS under \$1,809 (in 2006), automatic eligibility; otherwise, daily, retroactive counting required.⁹
3. Supplementing the CS by “Minimum Monthly Maintenance Needs Allowance,” §M 1480.410.
 - (a) Minimum: July 1, 2005 until July 1, 2006: \$1,603.75
 - (b) Maximum Monthly Excess Shelter Allowance (January 1, 2006 until January 1, 2007): \$884.75 (The maximum monthly income the CS can receive equals \$2,488.50, calculated thus: \$1,603.75 + [(monthly mortgage (PITI), homeowner

⁷ Beyond the outline’s scope.

⁸ All cites to “§M” or “§S” are current citations to the Virginia Medicaid Manual, which may be accessed via <http://majette.net>.

⁹ 12/22/05: §M 0810.002 (Internet: http://www.dss.virginia.gov/files/division/bp/me_famis/policy/manual/s08.pdf Adobe p. 5 of 253)).

association dues, and utility allowance (\$253 or \$317¹⁰) - \$481.13 (which is 30% of C.3.a.)). §M 1480.410.¹¹

- (c) Family Dependent Amount, July 1, 2005 until July 1, 2006 : \$520.00 (maximum). §M1480.430 E.2.¹²
4. **Post-eligibility** court support orders are recognized to allocate additional income to CS. §M1480.
 5. Medicaid expects a contribution from the CS when income exceeds \$1,900 per month, but does not impute it to the IS unless paid. §M1480.310 B.3., §M1480 Appendix 6.

E. Resources: Exempt, Countable, and Married Person Rules.

1. Exempt and countable resources.
 - (a) A resource is any property which a person owns; has the right, authority, or power to convert to cash (if not already cash); and is not legally restricted from using for his/her support and maintenance.¹³
 - (b) All resources are countable unless specifically exempted.
2. Exempt Resources: §S 1130¹⁴ and §M 1480.210.
 - (a) Home
 - (i) Six months after institutionalization, or
 - (ii) Longer when certain persons¹⁵ reside there (all applicants);
 - (b) Home and all real estate contiguous to it, married persons, when community spouse residing in the home.
 - (c) Motor vehicle of any value.
 - (d) Burial arrangements.
 - (i) Cash set aside for expenses.
 - (a) Single person: \$3,500 burial account
 - (b) Married person: \$1,500 burial account
 - (ii) Burial life insurance policies, not limited.
 - (iii) Tangible personal property for the grave.
3. Personal resource allowance of the institutionalized person is limited to \$2,000.
4. Lump sum for protection of the community spouse.
 - (a) The Community Spouse Resource Allowance ("CSRA") or the Community Spouse Protected Resource Amount ("CSPRA") is the value of countable resources which can be protected for the community spouse while the institutionalized spouse receives Medicaid.
 - (i) 50% of resources in names of both spouses existing on the institutionalization snapshot date.

¹⁰ The higher utility allowance applies to households in which more than three persons reside.

¹¹ (Internet: <http://www.dss.state.va.us/policymanual/medicaid/m14.pdf> (Adobe p.343 of 384)).

¹² (Internet: <http://www.dss.state.va.us/policymanual/medicaid/m14.pdf> (Adobe p. 351 of 384)).

¹³ Va. Medicaid Manual § S 1110.100 (B). (Internet:

http://www.dss.virginia.gov/files/division/bp/me_famis/policy/manual/s11.pdf (Adobe p. 6 of 222)).

¹⁴ (Internet: http://www.dss.virginia.gov/files/division/bp/me_famis/policy/manual/s11.pdf (Adobe p. 55 of 222)).

¹⁵ Spouse, minor or disabled children, etc. See Medicaid Manual § M 1130.100.

- (ii) Minimum (as of 1/1/2006 until 1/1/2007): \$19,908. § M 1480.231.
 - (iii) Maximum¹⁶ (as of 1/1/2006 until 1/1/2007): \$99,540.¹⁷ § M 1480.231.
5. Resource valuation date.
- (a) For unmarried institutionalized applicant, valued at any time in the month (the “any day in month” rule).¹⁸
 - (b) For IS with CS.
 - (i) Assets (of both spouses) valued on “snapshot date.”
 - (ii) Snapshot date is 1st day of month IS in which IS becomes “institutionalized.”¹⁹
 - (a) Snapshot date is generally first day of month IS admitted to nursing home and expected to be there for at least 30 consecutive days.²⁰
 - (b) Snapshot can be based on any institutionalization, in a nursing home or otherwise.²¹
 - (iii) A couple with “excess resources” (i.e., above \$22,908) cannot become resource eligible in the month of institutionalization.²²
6. **Post-eligibility** increases in CS’ resources immaterial to IS’ eligibility. M1480.240 C, C.2.²³

F. Transfer of Resources: 12 VAC 30-40-300; §M 1450 *et seq.*

- 1. Granny I and II "criminal" exposure: 42 U.S.C. 1320a-7b; held unconstitutional, *New York State Bar Association v. Reno*, 999 F. Supp. 710; 1998 U.S. Dist. Lexis 4796 (1998) ("pending final judgment, the United States, its agents, servants, employees, attorneys, and all persons in active concert and participation with Defendant are enjoined from commencing, maintaining, or otherwise taking action to enforce 42 U.S.C. § 1320a-7b(a)(6).")

¹⁶ See III B below regarding limited revisions (institutionalization before DRA 2005).

¹⁷ (Internet: http://www.dss.virginia.gov/files/division/bp/me_famis/policy/manual/m14.pdf (Adobe p. 294 of 384)).

¹⁸ Medicaid Manual § M 1110.600 (A) (1) (“We make all resource determinations per calendar month. Resource eligibility exists for the full month if countable resources were at or below the resource standard for any part of the month.”)

¹⁹ Medicaid Manual § M 1480.200 (A) (“A resource assessment is strictly a: compilation of a couple's reported resources that exist(ed) at the first moment of the first day of the month in which the first continuous period of institutionalization began on or after September 30, 1989”)

²⁰ Medicaid Manual § M 1480.010 B (15) (“Institutionalized Spouse means an individual who: is in a medical institution, or who is receiving Medicaid waiver services, or who has elected hospice services; is likely to remain in the facility, or to receive waiver or hospice services for at least 30 consecutive days; and who is married to a spouse who is NOT in a medical institution or nursing facility.”)

²¹ “Institutionalization means receipt of 30 consecutive days of care in a medical institution (such as a nursing facility), or waiver services (such as community-based care); or a combination of the two.” Medicaid Manual § M 1410.010 B 1; § M 1480 B 5 (married persons).

²² Medicaid Manual § M 1480.250 (D) (“An institutionalized spouse **cannot** establish resource eligibility by reducing resources within the month. The institutionalized spouse may become eligible for Medicaid payment of LTC services when the institutionalized spouse's resources are equal to or below the \$2,000 CNNMP/MN resource limit as of the first moment of the first day of a calendar month.”)

²³ (Internet: http://www.dss.virginia.gov/files/division/bp/me_famis/policy/manual/m14.pdf (Adobe p. 305 of 384)).

2. Transfers by *either* spouse will affect *both spouses* for initial eligibility of the institutionalized spouse, but post transfer of assets by the community spouse have no effect upon eligibility of the institutionalized spouse. §M1450.500 A.²⁴
3. Exempt Transfers:
 - (a) Exempt transferees.
 - (i) Spouse to spouse.
 - (ii) Children who are under 21 or disabled Children
 - (iii) Special needs trusts for Disabled Persons under 65 (all classes)
 - (iv) Special needs “pooled” trust for disabled persons over the age of 65, with limitations.
 - (v) Home to adult child taking care of parent for 2 years.
 - (b) Exempt property tangible property, business property, §M 1450.501, -.502.²⁵
4. Ineligibility is for long term care services, including nursing facility services and home or community based care services under the Virginia waiver.²⁶
5. The look-back, 42 USC 1396p.
 - (a) The look-back is the period of time in which Medicaid may consider gifts and under-valued sales (“uncompensated transfers”) to disqualify an applicant / spouse from certain Medicaid services.
 - (b) The look-back for uncompensated transfers made **before** the effective date of DRA 2005.
 - (i) To a trust or similar legal instrument, sixty months.
 - (ii) To all others, thirty six months. 42 USC 1396p(c); §M 1450.500 B.²⁷
 - (c) The look-back for uncompensated transfers made **after** effective date of DRA 2005 is sixty months, regardless of the transferee.
6. Ineligibility By Reason of Uncompensated Transfers Within The Look-Back, 42 USC 1396p.
 - (a) “Uncompensated” transfers **before** effective date of DRA 2005.

²⁴ (Internet: <http://www.dss.state.va.us/policymanual/medicaid/m14.pdf> (Adobe p. 103 of 384).

²⁵ <http://majette.net> or <http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-40-300>. **Caveat:** DRA 2005 impact unknown.

²⁶ 42 USC 1396p (c) (i) (institutionalized persons), (ii) (non-institutionalized persons).

²⁷ (Internet: <http://www.dss.state.va.us/policymanual/medicaid/m14.pdf> (Adobe p. 104 of 384). See http://www.geocities.com/hana+zushi/prac_el.pdf for details and calculator.

- (i) Calculate period of ineligibility thus for gifts *in each separate month* during look-back: (Gift \$) / \$4,060 (\$5,403 in Northern Virginia) = months ineligible (rounded down).
- (a) Example: Applicant's \$4,000 gift on December 22, 2005 / \$4,060 = 0.97, rounded to 0 months of ineligibility.
- (b) Example: Applicant's \$10,000 gift on October 1, 2005²⁸ / \$4,060 = 2.46, 2 or 2.46 months of ineligibility. Applicant's second gift of \$10,000 on December 22, 2005 / \$4,060 = 2.46, 2 or 2.46 months of ineligibility.
- (ii) Commence ineligibility period from the date of the transfer. In the second example above, first month of ineligibility is December, 2005, and the last day is the last day of January, 2006.
- (b) "Uncompensated" transfers **after** effective date of DRA 2005.
- (i) Calculate period of ineligibility for uncompensated transfers *in all 60 months*²⁹ preceding application date:
- (a) Single gift within look-back.
1. Divide value of gift by average monthly cost of private nursing home payment (\$4,060 (\$5,403 in Northern Virginia as of December, 2005).
 2. Quotient is the ineligibility period, which is the number of months of ineligibility for long term care services.
 3. Ineligibility period must include partial months (quotient not rounded down).³⁰
 4. Example: Applicant's \$10,000 gift on February 9, 2006.³¹
 - a. $\$10,000 / \$4,060 = 2.46$
 - b. Ineligibility period = 2 months, 14 days.
- (b) Multiple gifts in different months of look-back.³²
1. Add the total, cumulative value of all assets transferred.
 2. Divide total by average monthly cost of private nursing home payment (\$4,060 (\$5,403 in Northern Virginia).
 3. Quotient is the ineligibility period, which is the number of months (& partial months, see below) of ineligibility for long term care services.
 4. Ineligibility period must include partial months (quotient not rounded down).³³

²⁸ Assumes 2005 Deficit Reduction Act is effective.

²⁹ DRA 2005 provides explicit state authority to accumulate multiple transfers into one penalty period. DRA 2005 § 6016 (b). The provision appears unnecessary because the statute, with DRA 2005 amendments to the commencement date of the penalty, will cause the same result. 42 USC 1396p (c) (1) (E) (i) (I) [requiring consideration of "the total, cumulative uncompensated value of all assets ... on or after the look-back date", for institutionalized persons], and 42 USC 1396p (c) (1) (E) (ii) (I) [same, for non-institutionalized persons].

³⁰ DRA 2005 § 6016 (a).

³¹ Assumes 2005 Deficit Reduction Act is effective.

³² *Caveat*: ambiguity in DRA 2005.

5. Example: Applicant's \$10,000 gift on February 9, 2006, and of \$10,000 on March 5, 2006.
 - a. $\$20,000 / \$4,060 = 4.93$
 - b. Ineligibility period = 4 months, 28 days.

(ii) Commence calculated ineligibility period from the *latter* of these dates:³⁴

- (a) First day of month during or after which³⁵ assets have been transferred for less than fair market value, or
- (b) the date on which the individual is eligible for Medicaid and would otherwise be receiving nursing home level care but for the application of the penalty period.

(c) Example:

1. \$5,000 tuition paid for 19 year old grandchild, May 6, 2006, and \$10,000 for medical bills of daughter.
2. Donor (or spouse) enters nursing home in April, 2008.
3. Assets spent on nursing home care and exhausted to \$2,000, and application for benefits otherwise granted, in Richmond, Virginia, in September, 2009.
4. Donor ineligible for Medicaid for 111 days, commencing September 1, 2009.³⁶

III. Planning Considerations: Initial Eligibility And Survivor Eligibility

Example: H and W own a home and have non-working farm land which is contiguous to the home; combined real estate value is \$200,000 with no mortgage. They have \$200,000 in cash or stocks. She has Social Security Administration benefits of \$500 per month. He has Social Security Administration benefits of \$1,100 and a private pension of \$350. **H goes into the nursing home on January 3, 2006. No gifts of any kind (including Christmas, birthdays, etc.) made in preceding five years.** Powers of attorney with gifting authority in place.³⁷

³³ DRA 2005 Conference Report § 6016 (a).

³⁴ DRA 2005 Conference Report § 6011 (b).

³⁵ Presumably it will be "during" the month for an applicant and "after" a month for a recipient.

³⁶ $\$15,000 / 4060 = 3.6946$ months; 3.6946×30 (days) = 110.8374 days. The penalty does not commence until September because that is the first day of the month in which the applicant is institutionalized and otherwise eligible for nursing home care based upon an approved application. A complete analysis of the policy is found at "Virginia Medicaid and Public Entitlement Tables (3/6/06)," <http://mysite.verizon.net/vze3mmd7/documents/Medtab06.pdf>.

³⁷ A power of attorney without gifting authority can be construed to permit it, see Va. Code Ann. § 11-9.5. In the absence of any power of attorney a conservatorship can accomplish the same result, Va. Code Ann. § 37.2-1024.

A. Initial eligibility:

1. Home is exempt as well as all contiguous real estate.³⁸
2. CSRA for W: \$99,540 (1/2 of \$200,000, not exceeding \$99,540).
3. MMNA for W: \$1,603.75 - \$500 (Soc. Sec. For Wife) = \$1,103.75.
4. **Excess resources, \$98,460** (\$200,000 - [\$99,540 + \$2,000]).
5. First possible eligibility date is February 1, 2006.

B. A Dozen Excess Resource Dispositions.

1. Payment for long term care of IS and living expenses of CS.
2. Enhanced home, car, contiguous property to home.
3. Purchase of home for CS and creation of HECM reverse mortgage.
 - (a) Purchase of home is exempt.
 - (b) Loan proceeds are excluded from income calculations.
4. Long term care insurance for CS.
5. Enhanced CSRA when sum of CS and IS income less than MMNA via fair hearing for institutionalizations occurring before February 8, 2006,³⁹ limited court order.⁴⁰
6. Annuity for CS or single person.
 - (a) Federal provisions under DRA 2005, § 6012.
 - (i) Disclosure requirements (new 42 USC 1396p (e)(1)).
 - (ii) State required remainder-person for annuitant's Medicaid (new 42 USC 1396p (c) (1) (F)).
 - (iii) Purchase as transfer of assets (new 42 USC 1396p (c) (1) (G)).
 - (a) Purchase of annuity an uncompensated transfer of assets unless annuity:
 1. Purchased as, or with proceeds of, an Individual Retirement Account (IRA), Simplified Employee Pension, or Roth IRA, or
 2. The annuity is:
 - a. Irrevocable and non-assignable
 - b. Actuarially sound under Social Security Administration guidelines; and
 - c. Provides with payments in equal amounts during the term of the annuity, with no deferral and no balloon payments.
 - (iv) Applicable to transfers after DRA 2005 effective date.
 - (b) State Law provisions under §S0830.160A, §M1140.260.⁴¹
 - (i) An annuity with a balloon payment is an available resource.
 - (ii) An annuity that names revocable beneficiaries is considered to be an available resource because it can be surrendered, cashed in, assigned, transferred or have

³⁸ Only \$5,000 in surrounding property exempt were H single.

³⁹ 12VAC 30-110-856; §M 1480.232 F (1,3); and federal rule 42 CFR 431.260 (conferring authority to make "resources first" a state option) and *Wis. Dep't of Health and Family Servs. v. Blumer*, 543 U.S. 473 (2002).

⁴⁰ Va. Code Ann. § 20-88.02:1

⁴¹ Effective for applications filed after November 30, 2004. As written, the policy imposes the new requirements enumerate above. They are a trap for the unwary. The Commonwealth must be made the remainder beneficiary as to Medicaid payments made for the "individual." The Writer has been informed that the "individual" is the annuitant. §M 1140.260 requires the term to "equal" the life expectancy of the annuitant; this conflicts with policy § M 1450.602, and has been corrected in the proposed amendment creating new subsection 12 VAC 30-40-300 E 3 H.

the beneficiary changed. Annuities are presumed to be revocable when the annuity contract does not state that it is irrevocable.

- (iii) A non-employment related annuity purchased by or for an individual using that individual's assets will be considered an available resource unless the annuity meets all of the following criteria:
 - (a) it is irrevocable;
 - (b) it pays out principal and interest in equal monthly installments (no balloon payment) to the individual over the total number of months equal to or less than the actuarial life expectancy of the annuitant;⁴²
 - (c) it names the Commonwealth of Virginia as the residual beneficiary of funds remaining in the annuity not to exceed the amount of any Medicaid funds expended on the individual during his lifetime; and
- (iv) is issued by an insurance company, bank, or other registered or licensed entity approved to do business in the jurisdiction in which the annuity is established. Payments from the annuity to the Commonwealth of Virginia cannot exceed the total amount of funds for long-term care services expended on behalf of the individual.
- (v) Annuities issued prior to 12-01-04⁴³ which do not: (a) provide for the payout of principal and interest in equal monthly installments and (b) for which documentation is received from the issuing company that the payout arrangements cannot be changed will be considered to meet the above requirements once amended to name the Commonwealth of Virginia as the primary beneficiary of funds remaining in the annuity, not to exceed the amount of any Medicaid funds expended on the individual during his lifetime.

(c) §M 1450.602.

(d) Do not use "CS annuity trust."⁴⁴

- 7. Burial Planning for H & W? §M 1130.400 *et seq.*; §M1450.601 B.1. (Burial insurance).
- 8. Trust for disabled child or other person < 65? §M 1450.502 C, Va. Medicaid Manual § S 1120.202 A.
- 9. "Pooled" Disability Trust for disabled person of any age pursuant to 42 U.S.C. 1396p (d)(4)(C)?
 - (a) Trust is recognized as an exempt trust in Virginia Medicaid policy,⁴⁵ but
 - (b) No specific Virginia Medicaid exemption from transfer of assets penalties for such trust.
- 10. Split interest (life/remainder estate planning)?
 - (a) Life estates are not countable resources.
 - (b) Acquisition of a new home for value with a child in which the parent acquires the entire interest, but sells a remainder to the child, provides:

⁴² See correction in 12 VAC 30-40-300 E 3 H, *op cit.*, and policy at 1140.260 B (Trans. 80 7/05).

⁴³ See correction, *op cit.* The correct date will be June 20, 2005.

⁴⁴ *Johnson*, at 166 F.Supp.2d 42 (2001) (an annuity in the form of a trust was a countable resource). See also *Estate of Gross v. NDDHS* (ND S.Ct., 10/12/04, <http://www.court.stave.ned.us/court/opinions/200040071.htm>)(non-assignable annuity countable resource). Based on these and other reports of "abusive" annuities, *e.g.*, National Association of State Medicaid Directors Report (http://www.nasmd.org/Annuities%20Workgroup%20Product_October%202003.pdf), DRA 2005 addressed the issues in 42 U.S.C. 1396p.

⁴⁵ Va. Medicaid Manual § S 1120.202 (B)(2)

- (i) safe harbor for the parent should he be able to return to the community;
 - (ii) a common tenancy as to the child for the lifetime of the parent; and
 - (iii) a remainder interest that passes free of estate recovery.
- (c) Life estate / Remainder in home of child / parent? §1140.110
- (d) Parent purchases partial life estate in extant home of child or child purchases a remainder interest in the home of the parent.
- (i) *Caveat*: causes loss of tax exclusion under IRC §121.
 - (ii) *DRA 2005 Caveat*: Purchase of life estate after DRA 2005 in another individual's home is an uncompensated transfer of assets unless the purchaser resides in the home at least one year after purchase. DRA 2005 Conference Report § 6016 (D).
11. Contract for services rendered by family member for CS? §M 1450.003 D, G.
- (a) Services provided by the child to either the IS or CS may be compensated.
 - (b) *Caveat* income tax consequences.
12. Divorce *following* transfer of assets to CS?
- (a) Transfers between spouses are exempt.
 - (b) Divorce following transfers of assets from institutionalized spouse to community spouse severs the conduit (marriage) which imputes resources of the (former) community spouse to the institutionalized spouse.
 - (c) *Caveat*: MMNA (II.C.3,4) income support rules no longer applicable to the *former* community spouse.
 - (i) Consider QDROS by which ownership of the income producing asset (pension) is itself transferred to the community spouse in the divorce decree itself.
13. Purchase of United States EE or I Bonds post-institutionalization (\$30k / \$15k limit per spouse, 6-12 month holding period)?⁴⁶

C. Survivor Eligibility Issues:

1. When a benefactor (such as a spouse, parent, or other significant other in the life of a Medicaid or potential Medicaid recipient) dies and leaves to the Medicaid recipient, the assets will trigger disqualification and fund a source of Medicaid estate recovery.
2. Advise likely benefactors (e.g., parents, unmarried siblings, adult children) to bypass spouse(s) or create special needs trust for spouse(s) in benefactor's estate plan.

⁴⁶ §S 1140.240 (A). See <ftp://ftp.publicdebt.treas.gov/sbibond.pdf> and <ftp://ftp.publicdebt.treas.gov/sbeebond.pdf>

3. In addition to the loss of eligibility, Virginia will recoup its Medicaid expenditures for benefits paid after the recipient's 55th birthday from whatever remains in the estate of the Medicaid beneficiary after death.⁴⁷
 - (a) Example: Great uncle leaves niece, 65, \$50,000 in his will. She has been on Medicaid for 9 years. She loses eligibility, but dies 5 days after Uncle. Medicaid is entitled to recover its claim for 9 years of payments from the gift Uncle made.
4. Benefactors other than spouses.
 - (a) Any trust (either one created by will or during lifetime of the benefactor) in which the benefactor retains the use during life but creates a spendthrift, purely discretionary trust effective to supplement assets of the Medicaid beneficiary during life.
 - (b) At death of Medicaid beneficiary, residue in trust will avoid estate recovery and pay to third parties (grandchildren, charities, etc.).
5. Spouse benefactors.
 - (a) Because of the elective share rules applicable to spouses,⁴⁸ beware of *both* resource and transfer of assets issues.
 - (b) **DO NOT USE** living trusts when one spouse is Medicaid eligible, or expected to be.⁴⁹
 - (c) Marital agreements waiving elective share, Va. Code Ann. § 64.1-13 *et seq.*⁵⁰
 - (d) Possible testamentary dispositions:
 - (i) Testamentary⁵¹ special needs trust with mandatory income interest for survivor spouse in entire estate.
 - (ii) Testamentary special needs trust with 34% in trust for survivor spouse.

IV. HIPAA SAFE HARBORS: ANSWERS TO QUESTIONS UNDER THE NEW PRIVACY PROTECTION RULE⁵²

A. Final rule citation.⁵³

⁴⁷ Estate recovery for Medicaid recipient, 12 VAC 30-20-140 for *past* benefits paid (after age 55). See <http://majette.net> or <http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-20-140>.

⁴⁸ Va. Code § 64.1-13 *et seq.*. See <http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+64.1-13>. The share is 1/3 if there are surviving descendants of the decedent, 1/2 if not. Va. Code § 64.1-16 (<http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+64.1-16>).

⁴⁹ The short reason is that each spouse is a creator of the trust (§M 1140.404 B 1a) and to the extent the corpus cannot be paid to the individual, the trust corpus is considered a transfer of assets, *Id.* b. See *Bezzini*, at 715 A.2d 791 (Conn.App., Jul 21, 1998). The analog – that a testamentary trust *is* not a transfer of assets by a spouse, and thus preferable in the planning process for the community spouse's estate – is discussed (and approved) in *Skindzier*, *infra*.

⁵⁰ See 9/25/02 Roanoke Department of Social Services disqualification based upon failure to claim elective share at <http://www.geocities.com/hana+zushi/roanoke.pdf>, linked at <http://majette.net>.

⁵¹ *Skindzier*, at 784 A.2d 323 (Conn. 2001) (testamentary trust not disqualifying asset transfer).

⁵² No copyright protection is claimed as to these reproductions from the United States HHS Office for Civil Rights – HIPAA Privacy Policy website, <http://www.hhs.gov/ocr/hipaa/>.

⁵³ 45 CFR Parts 160 and 164, HIPAA Administrative Simplification: **Enforcement; Final Rule. Federal Register** / Vol. 71, No. 32 / Thursday, February 16, 2006. http://www.cms.hhs.gov/Enforcement/04_GeneralEnforcementInformation.asp#TopOfPage

B. May a health plan disclose protected health information to a person who calls on the beneficiary's behalf?

Answer ID 1067
Category Privacy of Health Information/HIPAA Disclosures to Family and Friends
Date Created 03/14/2006 02:08 PM
Last Updated 03/14/2006 02:34 PM

May a health plan disclose protected health information to a person who calls on the beneficiary's behalf?

Question

May a health plan disclose protected health information to a person who calls the plan on the beneficiary's behalf?

Answer

Yes, subject to the conditions set forth in 45 CFR 164.510(b) of the HIPAA Privacy Rule. The Privacy Rule at 45 CFR 164.510(b) permits a health plan (or other covered entity) to disclose to a family member, relative, or close personal friend of the individual, the protected health information (PHI) directly relevant to that person's involvement with the individual's care or payment for care. A covered entity also may make these disclosures to persons who are not family members, relatives, or close personal friends of the individual, provided the covered entity has reasonable assurance that the person has been identified by the individual as being involved in his or her care or payment.

A covered entity only may disclose the relevant PHI to these persons if the individual does not object or the covered entity can reasonably infer from the circumstances that the individual does not object to the disclosure; however, when the individual is not present or is incapacitated, the covered entity can make the disclosure if, in the exercise of professional judgment, it believes the disclosure is in the best interests of the individual.

For example:

- A health plan may disclose relevant PHI to a beneficiary's daughter who has called to assist her hospitalized, elderly mother in resolving a claims or other payment issue.
- A health plan may disclose relevant PHI to a human resources representative who has called the plan with the beneficiary also on the line, or who could turn the phone over to the beneficiary, who could then confirm for the plan that the representative calling is assisting the beneficiary.
- A health plan may disclose relevant PHI to a Congressional office or staffer that has faxed to the plan a

letter or e-mail it received from the beneficiary requesting intervention with respect to a health care claim, which assures the plan that the beneficiary has requested the Congressional office's assistance.

- A Medicare Part D plan may disclose relevant PHI to a staff person with the Centers for Medicare and Medicaid Services (CMS) who contacts the plan to assist an individual regarding the Part D benefit, if the information offered by the CMS staff person about the individual and the individual's concerns is sufficient to reasonably satisfy the plan that the individual has requested the CMS staff person's assistance.

C. Is an individual's required to use or disclose Protected Health Information to an interpreter?

Answer ID 760
Category Privacy of Health Information/HIPAA Business Associates Disclosures to Family and Friends Treatment/Payment/Health Care Operations
Date Created 02/28/2005 03:05 PM
Last Updated 08/08/2005 11:14 AM

Is an individual's authorization required to use or disclose PHI to an interpreter?

Question

Must a covered health care provider obtain an individual's authorization to use or disclose protected health information to an interpreter?

Answer

No, when a covered health care provider uses an interpreter to communicate with an individual, the individual's authorization is not required when the provider meets the conditions below. Covered entities may use and disclose protected health information for treatment, payment and health care operations without an individual's authorization, 45 CFR 164.506(c). A covered health care provider might use interpreter services to communicate with patients who speak a language other than English or who are deaf or hard of hearing, and provision of interpreter services usually will be a health care operations function of the covered entity as defined at 45 CFR 164.501.

When using interpreter services, a covered entity may use and disclose protected health information regarding an individual without an individual's authorization as a health care operation, in accordance with the Privacy Rule, in the following ways:

- When the interpreter is a member of the covered entity's workforce (i.e., a bilingual employee, a

contract interpreter on staff, or a volunteer) as defined at 45 CFR 160.103;

- When a covered entity engages the services of a person or entity, who is not a workforce member, to perform interpreter services on its behalf, as a business associate, as defined at 45 CFR 160.103. A covered entity may disclose protected health information as necessary for the business associate to provide interpreter services on the covered entity's behalf, subject to certain written satisfactory assurances set forth in 45 CFR 164.504(e). For instance, many providers -- including those that are recipients of federal financial assistance and are required under Title VI of the Civil Rights Act of 1964 to take reasonable steps to provide meaningful access to persons with limited English proficiency -- will have contractual arrangements with private commercial companies, community-based organizations, or telephone interpreter service lines to provide such language services. If a covered entity has an ongoing contractual relationship with an interpreter service, that service arrangement should comply with the Privacy Rule business associate agreement requirements.

In addition, a covered health care provider may, without the individual's authorization, use or disclose protected health information to the patient's family member, close friend, or any other person identified by the individual as his or her interpreter for a particular healthcare encounter. In these situations, that interpreter is not a business associate of the health care provider. As with other disclosures to family members, friends or other persons identified by an individual as involved in his or her care, when the individual is present, the covered entity may obtain the individual's agreement or reasonably infer, based on the exercise of professional judgment, that the individual does not object to the disclosure of protected health information to the interpreter. 45 CFR 164.510(b)(2). For example, if a covered health care provider encounters a patient who speaks a language for which the provider has no employee, volunteer member of the workforce or contractor who can competently interpret, but then is able to identify a telephone interpreter service to communicate with the patient, the provider may contact the telephone interpreter service and identify the language used by the patient, so that the interpreter may explain to the patient that the interpreter is available to assist the patient in communicating with the provider. If the provider reasonably concludes that the patient has chosen to be assisted by the interpreter, and, by the

patient's willingness to continue the health care encounter using the interpreter, reasonably infers that the individual does not object to the disclosure, protected health information may be disclosed in accordance with 45 CFR 164.510(b) without a business associate contract.

Organizations that are subject to both HIPAA and Title VI must comply with the requirements of both laws, though not all HIPAA covered entities are recipients of federal financial assistance and thus, required to comply with Title VI; and not all recipients of federal financial assistance are also HIPAA covered entities, subject to the Privacy Rule. For information about the obligation of recipients of federal financial assistance to take reasonable steps to provide meaningful access to persons who are limited English proficient, see Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons available at <http://www.hhs.gov/ocr/lep/>. This guidance includes information for recipients of federal financial assistance about important considerations for determining the competency of interpreters, such as their understanding of applicable confidentiality requirements, that should be taken into account when using interpreters arranged by the provider or when individuals elect to use friends, family or others as interpreters.

HIPAA covered entities may also be required to comply with the Americans with Disabilities Act and/or Section 504 of the Rehabilitation Act of 1973, both of which have requirements for the provision of sign language and oral interpreters for people who are deaf or hard of hearing. The use of communications assistants as part of a Telecommunications Relay Service (TRS) was the subject of a previous FAQ available at <http://www.hhs.gov/ocr/hipaa> (click on Your Frequently Asked Questions About Privacy, and then search on "TRS").

D. May health care providers leave messages at patient's homes or mail reminders to their homes?

Answer ID
198

Category
Privacy of Health Information/HIPAA
Disclosures to Family and Friends
Incidental Uses and Disclosures
Safeguards

May health care providers leave messages at patients' homes or mail reminders to their homes?

Question

May physician's offices or pharmacists leave messages for patients at their homes, either on an answering machine or with

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a family member, to remind them of appointments or to inform them that a prescription is ready? May providers continue to mail appointment or prescription refill reminders to patients' homes?

Answer

Yes. The HIPAA Privacy Rule permits health care providers to communicate with patients regarding their health care. This includes communicating with patients at their homes, whether through the mail or by phone or in some other manner. In addition, the Rule does not prohibit covered entities from leaving messages for patients on their answering machines. However, to reasonably safeguard the individual's privacy, covered entities should take care to limit the amount of information disclosed on the answering machine. For example, a covered entity might want to consider leaving only its name and number and other information necessary to confirm an appointment, or ask the individual to call back.