

Medicaid and Medicare Issues in Tort and Worker Compensation Settlements

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I. Checklist Of Medicaid Issues Related to Trusts.

A. What Are The General Rules For Medicaid Eligibility?²

1. Individuals must be U.S. citizens³ or "qualified aliens"⁴ residing in the U.S. under color of law to be eligible for all Medicaid services. Virginia residence is required for Virginia Medicaid eligibility. Residence is established by demonstrating the intent to remain in Virginia permanently or for an indefinite period of time.⁵
2. Virginia offers Medicaid payment to "mandatory categorically needy," "optional categorically needy," "medically needy," and medically indigent.⁶

¹ The writer acknowledges with gratitude the contributions of his friend, Johnson Kanady, Esq., of Kanady and Quinn, P.C., in the initial version of this article for the Virginia Society of Certified Public Accountants appearing in 1998. Any errors or omissions in the present work are solely the responsibility of R. Shawn Majette.

² Virginia Medicaid Manual § M 0220.001.

³ Virginia Medicaid Manual § M 0220.100.

⁴ *Id.*

⁵ Virginia Medicaid Manual § M 0230.001 A. Distinctions exist between *sui juris* and *non compos* or incapacitated applicants with different requirements to establish residence.

⁶ Virginia Medicaid Manual § M 0210.200 Virginia Medicaid Manual § M 0310.002 has a helpful listing of the various categories Medicaid recognizes in Virginia.

- a. The "mandatory categorically needy class consists of aged (65 or over), blind, or disabled individuals who receive SSI and who meet Virginia's more restrictive Medicaid eligibility criteria, and also to the disabled person whose income is less than 80% of the federal poverty level.⁷

- b. The "optional categorically needy" category includes persons who are eligible but have not applied for SSI or an optional state supplement⁸, patients in an intermediate care facility operated in a Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services facility whose incomes are less than 300% of the SSI level,⁹ persons who receive Medicaid approved community-based personal care and whose income is less than 300% of the SSI level,¹⁰ and aged, blind, or disabled individuals receiving a benefit under the Auxiliary Grant paid to persons living in adult care residences licensed pursuant to section 63.1-175 of the Virginia Code.¹¹
 - (i) The SSI rate is \$545 per month as of January, 2002.¹²

 - (ii) The income limit for Virginia public mental health hospitals, and also for several waiver related programs (MR, CBC) is 300% of the SSI rate, or \$1,635.

- c. The "medically needy" category includes the aged, blind, or disabled person who would receive SSI or AFDC except that his or her income exceeds a certain level,¹³ and has insufficient income and resources to meet medical care needs.¹⁴ Medicaid coverage for this group is based on the so called "spend-down." The spend-down is an ongoing payment of "excess" income (i.e., income over a permissible limit) for incurred medical expenses. If possible, income should be minimized (and resources maximized) due to the low monthly income allowance Virginia permits for necessities of life *other* than medical expenses - food, shelter, and clothing.¹⁵ **The spend-down should not be confused with the exhaustion**

⁷See Virginia Medicaid Manual § M 320.210 for the "new" 80% FPL category.

⁸42 C.F.R. § 435.210 (1989).

⁹42 C.F.R. § 435.211, .236 (1991), Virginia Medicaid Manual § M 0320.203.

¹⁰Medicaid Manual, Volume XIII, Part I, Chapter A.

¹¹ Virginia Medicaid Manual § M 0320.202.

¹²See <http://www.ssa.gov/OACT/COLA/SSI.html>, accessible via <http://majette.net>.

¹³ Virginia Medicaid Manual § M 330.001.

¹⁴ Virginia Medicaid Manual § M 0330.001 A 1.

¹⁵ The amount is even less than the SSI "subsistence" value; in Virginia, *all* income of the applicant / recipient is considered available to pay for medical needs to the extent the monthly income exceeds as little

of assets that is sometimes required before an applicant is impoverished enough to qualify for Medicaid.

3. Long-term Care Coverage. Medicaid is available for aged, blind or disabled persons who are medically needy and located in medical facilities furnishing nursing facility services.¹⁶ Medicaid is available in Department of Mental Health and Mental Retardation facilities in accordance with special limitations¹⁷

B. What Are The General Financial Requirements?

1. Income Limitations. There is no strict income limit for persons receiving nursing care services in private nursing facilities. A medically needy resident's income affects the amount of "patient pay" required - i.e., the amount the individual must contribute to the cost of care.
 - a. Otherwise eligible residents in Virginia public mental facilities (i.e., generally residents of state hospitals under the age of 21 (22 in certain cases of ongoing treatment, *supra*) or over the age of 65) are eligible only if their income does not exceed 300% of the monthly SSI rate.
2. General Resource Rules. Applicants/recipients may have the following amounts in "countable" resources. A "countable resource" is any property which is not excluded from consideration by the Virginia Medicaid Plan or Virginia Medicaid Manual, and which a person owns, has the right, authority or power to convert into cash, and which the person is not legally restricted from using for support and maintenance.¹⁸
 - a. An individual may retain \$2,000.00. A couple may retain \$3,000.00 in 2002 if both apply.

as \$230.08 per month! See Majette, *Practical Elder Law Entitlements: SSI and Medicaid: 2002*, Virginia Law Foundation 11th Annual Elder Law Seminar, page I-28, for tables.

¹⁶12 VAC 30-50-60(2), (5) (medically needy); 12 VAC 35-50-20(2), (4) (categorically needy); Virginia Medicaid Manual § M 1460 (long term care generally), 1470 (patient pay for long term care) and 1480 (spousal impoverishment – when one spouse is institutionalized and the other is not).

¹⁷Virginia Medicaid Manual § M 0320.203 for medical institutions generally; Virginia residents over the age of 65 and under the age of 21 (or, in cases of ongoing care *prior* to age 21, until the 22nd birthday) are eligible for Medicaid reimbursement for their care while in an institution for treatment of mental diseases (IMD) if they: (1) receive such care and treatment in a specified medical or surgical center, intensive psychiatric center, skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded within in a Virginia public mental facility; (2) meet the resource limitations and transfer of resource policies described below, and (3) if their income does not exceed 300% of the SSI income limit. Virginia Medicaid Manual § M 0280.200. Individuals not meeting these restrictions are not eligible and their cases are closed. Virginia Medicaid Manual § M 1550.400.

¹⁸Medicaid Manual, S1110.100 (B).

- b. When one spouse is admitted to a nursing facility and the other remains in the community (defined as anywhere that is not "institutionalized"), the community spouse is entitled to retain a "community spouse resource allowance."¹⁹ The spouse in the nursing facility is still entitled to retain \$2,000.00.
- c. Eligibility based upon resources is determined for each calendar month. Resource eligibility exists for the entire calendar month if countable resources were at or below the resource limit at any time in the month.²⁰

C. Whose Assets Fund The Trust?

- 1. Property which is transferred without adequate compensation (i.e., transferred into a trust for less than what Medicaid deems fair value) is presumed to have been transferred for purposes of qualifying for benefits under Medicaid, and generally results in the disqualification of the transferor for a specified period of time dating from the month in which the transfer is made.
- 2. The disqualification period is for Medicaid long term care services.²¹
 - a. "Long term care services" includes nursing home and "waivered" home health care services under the Virginia Medicaid plan.
- 3. If the transferor is married, the transferor and the transferor's spouse are *each* made ineligible.²²
- 4. If the Medicaid applicant or recipient (or the transferor's spouse) is entitled to property which he fails to take, such as through a disclaimer,²³ he is treated as having made a transfer of such property.

¹⁹The rules for the calculation of the CSRA are inherently complex. Virginia Medicaid Manual § M 1480.000 *et seq.* They are often the subject of Medicaid appeals. *Wisconsin v. Blumer*, 122 S.Ct. 962 (2002)(states may require that institutionalized spouse's income be wholly allocated to the community spouse before allowing additional resources to be protected). Creation of a trust for a disabled child of a nursing home spouse should be considered, but only after suitable provision is made for the community (well) spouse is provided for under these rules. A good text on the subject is the Virginia Law Foundation, *Estate Planning in Virginia, 2d. Ed.*, Chapter 8 (by writer).

²⁰Medicaid Manual, M1100.001 (B)(1).

²¹ 42 U.S.C. § 1396p(e)(1); 12 VAC 30-40-300(E); Medicaid Manual § M1450.500 *et seq.*

²²12 VAC 30-40-300 (E)(2) provides that "[a]n institutionalized individual who disposes of, or whose spouse[0] disposes of, assets for less than fair market value on or after the look-back date specified in subdivision 2.b. shall be ineligible for nursing facility services, a level of care in any institution equivalent to that of nursing facility services and for home or community-based services furnished under a waiver granted under subsection (c) of §1915 of the Social Security Act."

²³*Id.* (E)(1), definition of "Asset" for purposes of transfers of assets..

D. Who Is The Medicaid Applicant Or Recipient?

1. If the transferor into the trust is not the Medicaid applicant or recipient, or his surrogate, the anti-transfer rules will not apply to the transferor.
 - a. Surrogates for purposes of asset transfers under 42 USC 1396p / 12 VAC 30-40-300 (E) are:
 - (i) the individual's spouse,
 - (ii) any 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
 - (iii) any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.²⁴
 - b. Obviously, the attorney for the injured party or the insurance company which funds the trust will be considered a surrogate.
 - c. *Crummey* withdrawal power *caveat*.
 - (i) A *Crummey* power should not be included in a special needs trust established pursuant to 42 U.S.C. § 1396p.
 - (A) A *Crummey* power is the right given to A to take property which B places in a trust.
 - (B) The power is required in order to meet the "present interest" element of a gift for B's annual gift tax exclusion (presently \$11,000 per person per donee).
 - (C) When the holder of the power fails to exercise it, a gift is nevertheless imputed to the holder, and the donor of the property to the trust qualifies for the annual exclusion equal to the value of the property over which the power is given.
 - (D) The power should not be included when the holder is a beneficiary of the trust and a Medicaid applicant / recipient because:
 - (1) In *any* such trust, failure to take available property from a trust pursuant to a *Crummey* power is construed as a transfer of

²⁴42 USC 1396p (e) (1), definition of "Asset," and 12 VAC 30-40-300 (E)(1), definition of "Asset" for purposes of transfers of assets.

assets by the holder of the power for Medicaid purposes.²⁵

(2) In a special needs trust under 42 U.S.C. § 1396p (d)(4)(A), the trust must be for the sole benefit of the disabled person under 65, and the power to withdraw vested in any third party could be construed for the benefit of a person *other* than the Medicaid recipient.

2. If the transferor into the trust, or the spouse of the transferor, is or may become a Medicaid applicant or recipient, the anti-transfer rules will be applied to the transferor upon the creation of *any* irrevocable trust.

E. When Does The Transferor Apply For Medicaid?

1. The "look-back date" is the first date of a period during which Medicaid may scrutinize the transfers of assets made by a Medicaid applicant or recipient.²⁶
2. Transfers to anyone other than a trust sets a 36 month look-back.
3. Transfer to an irrevocable trust sets a 60 month look-back.

F. Who Can Be Made Medicaid Ineligible By *Establishment* Of The Trust?

1. The *transferor* can be rendered ineligible if assets are transferred to a non-exempted trust is by reason of the *act* of transferring assets into the trust.
2. The *spouse of the transferor* can be rendered ineligible if the trust is not exempted under the Virginia Medicaid plan by reason of the *act* of transferring assets into the trust.²⁷

G. Who Can Be Made Medicaid Ineligible By Reason Of The *Existence* Of The Trust?

²⁵ 12 VAC 30-40-300 (E)(1), definition of "Asset" for purposes of the regulation; Virginia Medicaid Manual § M 1450.003 (B)(assets not claimed may be deemed transferred for less than value).

²⁶ Virginia Medicaid Manual § M 1450.500.

²⁷ *Id.* Once Medicaid has been established for the institutionalized spouse of a community spouse, Virginia appears to insist that it may disqualify the institutionalized spouse from Medicaid by reason of a (post-eligibility) transfer of assets by the community spouse. This is contrary to the stated position of HCFA (predecessor to the present Center for Medicare and Medicaid Services (CMS)): "[A]fter the month in which an institutionalized spouse is deemed eligible for Medicaid, any resources belonging to the community spouse are solely the property of that spouse. That is, the community spouse can do whatever he or she wants to do with them." Ronald Preston, Associate Regional Administrator, HCFA, April 5, 2000; posted at <http://majette.net>.

1. The *beneficiary* (who is not also the transferor) can be rendered ineligible based upon the *availability* of the trust assets to him. This can be avoided by providing the trustee with total discretion in the administration of the trust and a specific instruction to consider public benefits as a resource to be protected by the trustee in the exercise of such discretion.²⁸
2. See *Crummey* discussion above with respect to powers over an otherwise exempt trust.

H. How Does The Transfer Of Assets Into A Trust Affect The Medicaid Applicant?

1. Federal law requires that property of the applicant / spouse transferred into a trust for sixty months before (and at any time after) an institutionalized person files an application for Medicaid be reviewed by DMAS to determine whether the transfer renders the transferor, or the transferor's spouse, disqualified for Medicaid payment of long term care services for a certain period of time.
2. The period of time for which the applicant must disclose transfers is referred to as the "look-back" period.²⁹
3. At least for civil purposes, a "transfer" is considered to be made by any action that reduces or eliminates the applicant's ownership or control of an asset. Included are gratuitous transfers, sales, disclaimers, transfers of income, etc. Transfers may be made by the applicant, and, depending upon the date of the transfers, will be deemed to have been made by the applicant even if made by the applicant's spouse, a joint owner of an asset, a court or administrative body with legal authority to act in place of the applicant, or any other person acting at the direction of, or upon the request of, the applicant or his spouse.³⁰
4. In analyzing the transfer DMAS presumes that a transfer of a resource for less than the fair market value was for the purpose of establishing Medicaid eligibility. To rebut the presumption, the applicant must demonstrate by

²⁸Trust assets in a completely discretionary trust are exempt as resources to the beneficiary because they are not considered resources to him under the definition provided in Virginia Medicaid Manual § M 1120.010: the trust beneficiary has no ownership interest, no legal right to access the trust corpus or income, and no legal ability to use, or compel the use, of the same for his support. More specifically, when "an individual ... has legal authority to revoke the trust and then use the funds to meet his food, clothing or shelter needs, or if the individual can direct the use of the trust principal for his/her support and maintenance under the terms of the trust, the trust principal is resource for Medicaid purposes[,]” Virginia Medicaid Manual § M 1120.200 D 1, but when he “does not have the legal authority to revoke the trust or direct the use of the trust assets for his/her own support and maintenance, the trust principal is not the individual’s resource.” *Id.* D 2.

²⁹42 U.S.C. § 1396p; 12 VAC 30-40-300; Medicaid Manual § M1450.500 et seq.

³⁰42 U.S.C. § 1396p(e)(1); 12 VAC 30-40-300; Medicaid Manual § M1450.500 et seq.

"convincing evidence" that the purpose of the transfer was wholly one other than qualifying for Medicaid. In practice, this is very difficult to do.

I. Can An Attorney Be Prosecuted For A Criminal Act In The Creation Of The Trust Under The Health Insurance Portability And Accountability Act Of 1996 And The Balanced Budget Act Of 1997?

1. Section 217 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) amended 42 U.S.C. § 1320a-7b, "Criminal penalties for acts involving Medicare or State health care programs," to make the "knowing and willful dispos[itions] of assets in order for an individual to become eligible for medical assistance" a criminal act **only when and "if** disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c)." Under Section 218 of HIPAA, the criminal provision became effective on January 1, 1997.
2. In August, 1997, Section 4734 of the Balanced Budget Act of 1997 repealed the criminal penalty applied to persons *making* the transfer of assets and ***imposed*** it upon any person who, "for a fee knowingly and willfully *counsels or assists* an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under title XIX [Medicaid], **if disposing of the assets results in the imposition of a period of ineligibility for such assistance** under section 1917 (C). Section 4734 became effective on August 5, 1997.
 - a. The statute permits the *act* of transferring assets to obtain eligibility for Medicaid while
 - b. it purports to criminalize *communication for a fee* of counsel or assistance that the law permits such transfers.
3. Constitutional concerns were raised early in connection with the criminalization of the transmission of legal and accounting advice, and the generally ambiguous language of the statute.³¹
 - a. A DHHS Inspector General Advisory Opinion (Opinion No. 97-3) support the conclusion that paid counsel and assistance in the transfer of assets coupled with advice and assistance in waiting until the "period of ineligibility" which could be imposed has expired will not violate the

³¹See *Peebler v Reno*, 965 F. Supp 28 (Dist. Ore. 1997) (dismissed on standing grounds, but containing position by the United States Attorney General to the effect that transfers made within the "look-back" period but beyond the date of calculated ineligibility do not trigger the statute); *Appointment Of A Guardian Of Betty Gersten*, 661 N.Y.S.2d 943 (Sup.Ct. 1997) (criticizing over reliance on *Peebler* but permitting transfer of assets by guardian regardless of HIPAA).

statute.³²

- b. In March, 1998, Attorney General Reno opined that the statute was unconstitutional and informed Congressional leadership in both chambers that she would not defend the same.³³

³² Opinion No. 97-2 is available at http://www.complianceland.com/ao/html/ao97_3.html.

³³Text of March 11, 1998 Letter from Attorney General Janet Reno to then Speaker of the House of Representatives Newt Gingrich:

Dear Mr. Speaker:

I am writing to you regarding Section 1128B(a)(6) of the Social Security Act, as amended by Section 4734 of the Balanced Budget Act of 1997, which was signed into law on August 5, 1997. As amended by Section 4734, Section 1128B(a)(6) of the Social Security Act, to be codified at 42 U.S.C. Sec. 1320a-7b(a)(6), provides that whoever: for a fee knowingly and willfully counsels or assists an individual to dispose of assets in order for the individual to become eligible for medical assistance under a State plan under Title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c), shall ... (ii) in the case of such a ... provision of counsel or assistance by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year or both. Pub. L. No. 105-33, 11 Stat. 522-23. Section 1128B(a)(6) is the subject of constitutional challenges in *New York State Bar Association v. Reno*, 97-CV-1768-TJM-DRE in the District Court for the Northern District of New York, and *Magee v. United States*, 98-CA-073, in the District Court for the District of Rhode Island.

This is to respectfully inform you that, after close and careful scrutiny of the matter, the Department of Justice will not defend the constitutionality of Section 1128B(a)(6) because the counseling prohibition in that provision is plainly unconstitutional under the First Amendment and because the assistance prohibition is not severable from the counseling prohibition.

Notably, Section 4734 of the Balanced Budget Act of 1997 repealed the prior Section 1128B(a)(6) of the Social Security Act, which had been added by Section 217 of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 2008, and which was codified at 42 U.S.C. Sec. 320a-7(a)(6) (Supp. II 1996). The prior Section 1128B(a)(6) of the Social Security Act made it unlawful for any person to "knowingly and willfully dispose[] of assets (including by any transfer in trust) in order for an individual to become eligible for medical assistance under a State Plan under Title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under Section 1317(c).

Because Section 4734 repealed the provision just quoted, the new Section 1128B(a)(6) of the Social Security Act would prohibit attorneys and other professional advisors from "counsel[ing]" their clients to engage in an estate-planning strategy that itself is lawful. Under these unique circumstances, and in light of the fact that, pursuant to this provision, professional advisors such as attorneys would be prohibited from providing truthful, non-misleading advice to their clients about lawful behavior, we are unable to identify a governmental interest that would justify this restriction on protected speech. Accordingly, we believe that the "counseling" prohibition in Section 1128B(a)(6) of the Social Security Act plainly is unconstitutional under First Amendment, and cannot survive judicial scrutiny.

The amended Section 1128B(a)(6) of the Social Security Act also would prohibit attorneys and other professionals from "assist[ing]" an individual "to dispose of assets in order for the individual to become eligible for medical assistance", if disposing of the assets results in the imposition of a period of ineligibility for Medicaid nursing home benefits under Section 1917(c). Congress may enjoy greater authority under the Constitution to restrict professional "assist[ance]" that is distinct

- c. On April 7, 1998, in *New York State Bar Association v. Reno*, case number 97-CV-1760, the United States District Court for the Northern District of New York issued a preliminary injunction preventing the United States, its agents, servants, employees, attorneys, and all persons in active concert and participation with Attorney General Reno, from commencing, maintaining, or otherwise taking action to enforce 42 U.S.C. § 1320a-7b(a) (6).
 - d. On September 14, 1998, in *New York State Bar Association v. Reno*, the District Court ruled the statute unconstitutional and issued a permanent injunction from its enforcement.³⁴
4. Apart from the constitutional issues, under the statute itself, only persons who receive a fee for counsel or assistance in effecting a transfer that "result[s] in the imposition of a period of ineligibility for such [Medicaid] assistance" violate the statute. **Transfers which do not result in the imposition of ineligibility were never intended to be sanctioned,³⁵ as reflected in the 1999 (and thus *post*-Granny) amendment to 42 USC 1382b, which imposes a period of ineligibility when assets are transferred, but subject**

from "counsel[ing]," since such assistance need not necessarily take the form of protected speech. However, we do not believe that Congress would have intended to impose an assistance prohibition in the absence of a concomitant prohibition either on the underlying conduct (the disposal of assets itself) or on the counseling to engage in such conduct. Accordingly, we have concluded that the assistance prohibition is not severable from the counseling prohibition.

Therefore, in accordance with the practice of the Department, I am hereby informing the Congress that the Department of Justice will not defend the constitutionality of the counseling prohibition in Section 1128B(a)(6) of the Social Security Act. Consistent with my determination on the constitutional and severability questions, I also am hereby informing the Congress that the Department of Justice will not bring any criminal prosecutions under the current version of that Section.

Finally, I would like to stress that the Department of Justice is available to assist Congress, if it so desires, in attempting to draft new legislation that would address the concerns of Congress in a manner that comports with contemporary First Amendment jurisprudence and that meets other policy objectives of the Congress and the Executive Branch.

Sincerely,
Janet Reno"

³⁴ See transcript of proceedings at <http://www.seniorlaw.com/mcavoy.htm>.

³⁵ 42 U.S.C. § 1396p(c)(4) provides that "[a] State (including a State that has elected treatment under section 1902(f) [42 U.S.C. § 1396a(f)]) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection."

Dispositions that cause (and do not cause) imposition of periods of ineligibility are defined in the state plan (see State Plan for Medical Assistance Relating to Transfer of Assets and Treatment of Certain Assets, 12 VAC 30-40-300), and generally in 42 U.S.C. § 1396p, "Liens, adjustments and recoveries, and transfers of assets." In addition, Virginia, in accordance with other provisions of the federal law, has a detailed list of assets that may be disposed of for purposes other than to qualify for medical assistance, found in the Medicaid Manual M1450.501.

to the identical exclusions for transfers of assets and trusts under 42 USC 1396p.

5. Several transfers which accelerate Medicaid eligibility do not cause a period of ineligibility.
 - a. Dispositions occurring *before* the "look-back" date (42 U.S.C. § 1396p(c)(1)(A)), as defined in 42 U.S.C. § 1396p(c)(1)(B)(i), (ii), cannot be the basis for a period of ineligibility.
 - (i) The "look-back date" is 36 months prior to the month in which the Medicaid application is made, unless the disposition is in favor of a nonexempt trust (see below).
 - (ii) In the case of a disposition in favor of a nonexempt trust, the look-back date is 60 months.³⁶
 - b. Dispositions occurring *within* the "look-back" period which are expressly exempted by the state's Medicaid plan³⁷ and the federal statute cannot cause a period of ineligibility. 42 U.S.C. § 1396p(C) (2) and the applicable portion of the Virginia Medicaid Plan³⁸ provides that an "individual shall not be ineligible for medical assistance by reason o paragraph (1) (i.e., transfers made after the look-back date) to the extent that:
 - (i) the assets transferred were a **home** and title to the home was transferred to -
 - (A) the spouse of such individual;

³⁶A critical issue in the interpretation of the criminal statute is whether legal advice to apply within the "look-back" period but beyond the calculated period of ineligibility (see below) subjects the paid counselor to criminal liability. See *Peebler and Matter of Gersten, supra*. The issue is directly answered in a *non-binding* but persuasive opinion issued by the Office of the Inspector General pursuant to 42 C.F.R. Part 1008.41 in 1997. D. McCarty Thornton, Chief Counsel to the Inspector General, opined in OIG Advisory Opinion 97-3 that an attorney counseling a recipient to make a series of transfers which resulted in a period of ineligibility under the Oregon Medicaid plan did not breach the criminal statute when the transfers caused a period of disqualification, but no period of ineligibility was imposed because the Medicaid application was filed *after* the date ineligibility would lapsed.

Referring to the "key" portion of 42 U.S.C. § 1320a-7b(a)(6), "the last phrase, if disposing of the assets results in the imposition of a period of ineligibility for such assistance[.]" the Office of the Inspector General concluded that the transferor and the attorney "will not be subject to sanction under 42 U.S.C. § 1320a-7b(a)(6), because no period of ineligibility will be imposed because of Mrs. P's disposition of assets."

³⁷See 12 VAC 30-40-300.

³⁸*Id.*, (E.) (3), (3)(g).

(B) a child of such individual who is under age 21, or (with respect to States eligible to participate in the State Program established under title XVI [42 U.S.C. § 1381 et seq.]) [a child who] is blind or permanently and totally disabled, or (with respect to States that are not eligible to participate in such program) is blind or disabled as defined in Section 1614 [42 U.S.C. § 1382c]

(ii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

(iii) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date the individual becomes and institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

c. **the assets [including but not limited to a home]**

(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse;

(ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse;

(iii) **were transferred to, or to a trust (including a trust described in subsection (d)(4)) established solely for the benefit of, the individual's child described in subparagraph (A)(ii)(II), or**

(iv) **were transferred to a trust (including a trust described in subsection (d)(4)) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1614 (a)(3)) [42 U.S.C. § 1382c(a)(3)].**

II. Medicaid Beneficiary Funded Special Needs Trusts Under 42 USC 1396p(d)(4)(A) or (d)(4)(C).

A. Generally.

1. Available for any person who is disabled and under the age of 65.
2. Lawful transfer of the disabled person's tort (or Worker Compensation) proceeds to the trustee of a trust which is exempt under 42 USC 1396p(d)(4)

will not cause a period of Medicaid ineligibility.

3. Resources in and income earned by an exempt trust under 42 USC 1396p(d)(4) are not attributable to the beneficiary except to the extent the same are distributed to the beneficiary.
4. Funds in the Medicaid trust can be used to provide for the special needs of the injured person in the provision of housing, transportation, loans, etc., and will supplement the medical care which is provided by Medicaid.

B. The Medicaid Lien on Personal Injury Settlements.

1. Statute: Va. Code Ann. § 8.01-66.9.
 - a. Claim of the Commonwealth applies only to “claim for personal injury,” not to worker compensation claims.
 - b. Claim applies only with respect to payments actually made up to the time of settlement.
 - c. In contrast to Medicare subrogation / “super claim,” costs of procurement – attorney’s fees, costs, and expenses are not specifically given priority over the claim of the government.
 - d. Lien may be adjusted by the Court only when there has been an unsuccessful, good faith negotiation between the Plaintiff and the Commonwealth.
 - e. Requires the Court to consider the “equities of the case”
2. Cases.
 - a. *Commonwealth v. Huynh*, 262 Va. 165, 546 S.E.2d 677 (Va.S.Ct. 2001) (Mr. Majette associated as counsel in trial court) (holding that because the statute uses the word "apportion," and the trial court placed **all** of the settlement funds in the special needs trust approved by the trial court while refusing to reduce the attorneys' fee claim: "the trial court erred in failing to award some portion of the recovery to the Commonwealth while providing Huynh's attorneys the full amount of their contractual fee. ***This is particularly true in light of the fact that both the Commonwealth and Huynh's attorneys concede that the portion of the recovery afforded to Huynh under the trial court's apportionment provided her with less than complete relief, and was inadequate to meet her expected future needs. Indeed, the trial court's use of a "Special Needs" trust to preserve Huynh's share of the recovery was predicated on the inescapable conclusion that her future medical expenses would rapidly exhaust the***

*money awarded to her if it were not sheltered in a manner that would allow her to continue receiving assistance from the Commonwealth.*³⁹

Accordingly, we will reverse the judgment of the trial court on this issue and remand this case to the trial court to make an appropriate apportionment."

- b. *University of Virginia v. Harris*, 239 Va. 119, 387 S.E.2d 772 (Va.S.Ct. 1990).
 - c. *Commonwealth v. Lee*, 239 Va. 114, 387 S.E.2d 770 (Va.S.Ct. 1990).
 - d. *Commonwealth v. Smith*, 239 Va. 108, 387 S.E.2d 767 (Va.S.Ct. 1990).
 - e. *Terry v. Harris*, 13 Cir. LM17814 (Richmond Circuit Court 2001) (reducing lien by 25%, the same amount that counsel for the Plaintiff reduced fee)(citing *Huynh*).
 - f. *Diaz v. Arlington Anesthesia, Inc.*, 17 Cir. CL97662 (Arlington County Circuit Court 2001) (reducing plaintiff attorney's contingent fee from forty percent to thirty three and one third percent, reducing Commonwealth's lien from 866,000 to \$85,000; disallowing certain "office overhead" related expenses of counsel for Plaintiff)(citing *Huynh* and *Barreca v. Tillery, infra*).
 - g. *Motley v. Mobley*, 13 Cir. LC24404 (Richmond Circuit Court 1999)(expressly referring to the equities of the case, Judge Johnson permitted no reduction when Plaintiff bankrupted third party creditors (her lawyer's expenses, her health care providers *other* than the Commonwealth), and she would nevertheless recover \$78,000 without any lien reduction).
 - h. *In Re: Wood*, 13 Cir. LE26674 (Richmond Circuit Court 1999) (refusing to reduce lien of the Commonwealth but limiting liens of private entities to statutory maximums).
 - i. *Emery v. Fletcher*, 23 Cir. CL9348 (Roanoke Circuit Court, 1995) (Medicaid lien reduced by approximately 75%, balance held in trust for child).
 - j. *Barreca v. Tillery*, 13 Cir. LW202B (Richmond Circuit Court 1994).
3. Attorney General of Virginia Lien Compromise Negotiation Guidelines.
- a. The Attorney General requests that inquiries for reductions or waivers be addressed to Ms. Jocelyn G. Maxim, Legal Assistant for Debt Collection Section, at 804-786-6576, fax number 804-786-4839.
 - b. Content of lien reduction / waiver request (which should form the basis for the good faith lien negotiation):

³⁹ Emphasis added.

- (i) A brief description of the injured person's injuries or illness and reason for compromise
 - (ii) Prognosis for the injured person Injured person's disability
 - (iii) temporary, permanent) and degree (or percentage) of disability
 - (iv) Future medical treatments expected to be required
 - (v) Brief description of accident and litigation risks bearing on recovery prospects (contributory negligence, assumption of risk, likely trial outcome)
 - (vi) Post accident work history of the injured person
 - (vii) Amount of settlement offer
 - (viii) Medical payments made by automobile liability carriers, if any
 - (ix) Attorneys' fees, including any proposed reduction
 - (x) Attorneys' costs and expenses
 - (xi) Names of other entities asserting liens against the settlement, and "their compromised amounts."
- c. While not the customary practice, nothing in the statute or the suggested guidelines set forth above would prevent the Commonwealth and the injured party from agreeing *at the outset of the matter* regarding compromise of the lien in relation to a special needs trust, the attorney's fee and costs, etc. Especially when, as in many of the reported cases above, there is already a huge Medicaid lien for services provided which exceeds the insurance limits, an agreement would avoid uncertainty for the Plaintiff as to fees, costs, and benefit to the Plaintiff while assuring the taxpayers that the sheer magnitude of the expense they have already borne will not chill an attempt at recovery by a motivated Plaintiff and personal injury attorney.

C. Related SSI Implications.

As this outline is written, there are several unresolved issues concerning the establishment of trusts under the anti-transfer and anti-trust provisions of 42 USC 1382b, which became effective on January 1, 2000.

1. Federal Statute.

- a. 42 USC 1382b, Resources, specifies exempt resources and, as of January 1, 2000, disqualification procedure for persons who, within three years of apply for SSI, transfer assets.
- b. 42 USC 1382b (c) (1) (C) (ii) incorporates Medicaid exceptions to the period of disqualification for SSI (and thus categorical eligibility for Medicaid) for transfer of any asset to certain beneficiaries (spouses,

disabled children, etc.) and to the trusts described in this part of the outline:

“(C) An individual shall not be ineligible for benefits under this subchapter by reason of the application of this paragraph to a disposal of resources by the individual or the spouse of the individual, to the extent that -

....

the resources -

(I) were transferred to the transferor's spouse or to another for the sole benefit of the transferor's spouse;

(II) were transferred from the transferor's spouse to another for the sole benefit of the transferor's spouse;

(III) were transferred to, or to a trust (including a trust described in section 1396p(d)(4) of this title) established solely for the benefit of, the transferor's child who is blind or disabled; or

(IV) were transferred to a trust (including a trust described in section 1396p(d)(4) of this title) established solely for the benefit of an individual who has not attained 65 years of age and who is disabled.⁴⁰

c. The Medicaid exceptions for trusts funded with the assets of the Medicaid applicant / recipient set forth in 42 USC 1396p (d) are also specifically incorporated for *SSI purposes* at 42 USC 1382b.

(i) 42 USC 1382b (e)(1) provides, “[i]n determining the resources of an individual, paragraph (3) shall apply to a trust (other than a trust described in paragraph (5)) established by the individual.)

(ii) 42 USC 1382b (e)(3) provides:

“(A) In the case of a revocable trust established by an individual, the corpus of the trust shall be considered a resource available to the individual.

(B) In the case of an irrevocable trust established by an individual, if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual (or of the individual's spouse), the portion of the corpus from which payment to or for the benefit of the individual (or of the individual's spouse) could be made

⁴⁰Emphasis added.

shall be considered a resource available to the individual.”

- d. 42 USC 1382b (e)(5) states that “[t]his subsection shall not apply to a trust described in subparagraph (A) or (C) of section 1396p(d)(4) of this title.”

2. Federal SSI Policy – The POMS.

- a. POMS SI 01120.203 (E), *Exceptions to Counting Trusts Established on or after 1/1/00*,⁴¹ contrary to federal statute and without any underpinning in any known regulation or case law (and expressly contrary to the established judicial practice in Virginia⁴² and elsewhere), states:

“e. Who Established the Trust

To qualify for the special-needs trust exception, the trust must have been established by the disabled individual's:

- parent(s);
- grandparent(s);
- legal guardian(s); or
- a court.

The special-needs trust exception **does not apply** to a trust established by the individual himself/herself.

The person establishing the trust must have legal authority to act with regard to the assets of the individual. An attempt to establish a trust by an individual without the legal right or authority to act with respect to the assets of the individual may result in an invalid trust.

NOTE: This requirement refers to the individual who physically took action to establish the trust even though the trust was established with the assets of the SSI claimant/recipient.”

- b. **Interpretation of Federal POMS in the W. Case.**

Reproduction of Social Security Administration Supplemental Security Income Notice of Reconsideration.

Notice of Reconsideration

⁴¹Available at <http://majette.net> or by direct link to the Social Security Administration website here: <http://policy.ssa.gov/poms.nsf/517e83681a5eb8b28525688d0058721c/a77a5f8f0a02abf985256a5f000b5b79?OpenDocument>

⁴²See *Commonwealth of Virginia, Department of Medical Assistance Services v. Huynh*, 262 Va. 165 (2001) (writer’s case).

September 17, 2002
Claim Number: 123-45-5679
Reconsideration Filed: 06/10/2002

Social Security has determined REDACTEDNAME's Trust of 2002 to be countable for Supplemental Security Income purposes. Based on information shared with Mandy Ballasy, our Systems Support Specialist, we found that REDACTEDNAME'S father, Mr. REDACTEDNAME FATHER, Sr., had no legal authority to act in reference to his adult son's assets. If the legal authority to establish the trust is under the provision of 6.1-125.15:1 (Duties of parties to joint bank accounts), then this appears to be based on the father being considered an agent or attorney-in-fact. As such, the actions of the parent to establish the trust are within the scope of that authorization and, under law, it is as though the actions have been taken by the adult child. This means that although the trust was validly established by the parent, it would not meet the Medicaid exception due to the fact that it was actually established by the adult child (through an agent, the parent). Assuming this trust was validly established, we look to the Medicaid exceptions under 1917 (d) (4) (A) and (C) [42 USC 1396 (d) (4) (A) and (C)]. The provisions of 42 USC 1382 (c) is in reference to the transfer of assets. This is applied to any claimant that transfers an asset to become eligible for Supplemental Security Income (SSI). There is an exception for any claimant who transfers the assets to a 1396p (d) (4) trust for that claimant's child who is blind or disabled. This would only apply to this trust if REDACTEDNAME FATHER (SSI claimant) established a trust for his son or daughter which is not the case in this particular situation. Therefore, Social Security concludes that the REDACTEDNAME Trust of 2002 is hereby determined invalid and consequently, countable as a resource for Supplemental Security Income (SSI) purposes.

D. Virginia Medicaid Implications.

While Congress obviously limited the use of trusts to qualify or retain eligibility for Medicaid in 1993, it simultaneously incorporated into statutory law the

judicial gloss that had developed to help disabled Medicaid beneficiaries.⁴³

Two of the OBRA'93 trusts are important in Virginia practice.⁴⁴

1. Trust For Disabled Persons Under Age 65.⁴⁵

- a. These trusts are not deemed to be a resource of the beneficiary.⁴⁶
- b. Transfers to such a trust are not considered disqualifying transfers of assets.⁴⁷
- c. The only persons who may establish these trusts are the disabled person's parent, grandparent, or legal guardian, or a court on behalf of the disabled person.⁴⁸
 - (i) While the disabled person cannot *establish* the trust, assets of the disabled person, or of any other person, may be transferred to the trust without incurring a period of Medicaid disqualification .
- d. The trust must be for the sole benefit of an individual under 65 who is disabled for Social Security purposes (i.e., "disabled as defined in [42 U.S.C. § 1382c(a)(3)]").
- e. The trust must provide that 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 beneficiary under a the Medicaid plan.

⁴³42 USC 1396p(d),(e); 12 VAC 30-40-300 (E)(1), effectively eliminating by statute and regulation the pre-OBRA law basis for these trusts, see *Miller v. Ibarra*, 746 F.Supp. 19 (D.Colo. 1990); *Navarro v. Sullivan*, 751 F. Supp 349 (E.D.N.Y. 1990); *Trust Company of Oklahoma v. State of Oklahoma*, 825 P.2d 1295 (Ok. Sup. Ct. 1991), cert den., 121 S.E.2d 224 (1992) (court established trust); *Kegel v. State*, 830 P.2d 563 (N.M. App. 1992); *Hughes v. Physicians Hospital*, 566 N.Y.S.2d 496 (Sup. 1991) (settlement paid directly to special needs trust without intervention of guardian, under court order).

⁴⁴The third trust is for use in "income-cap" states, which include the State of Florida.

Income-cap states do not cover the optional medically needy category. Such states impose a strict limit on income as a condition to Medicaid eligibility. The unavailability of Medicaid in these states was the original basis for *Miller v. Ibarra*, 746 F.Supp. 19 (D.Colo. 1990), the seminal case for the judicial gloss.

When the settlor / transferor is likely to reside in an income cap state, counsel should review 42 U.S.C. § 1396p (d) (4)(B) for the specific requirements for these "income" trusts and consult local counsel for drafting nuances of the particular jurisdiction.

⁴⁵42 U.S.C. § 1396p (d)(4)(A); 12 VAC 30-40-300(E)(3)(g)(1); *Medicaid Manual*, M1120.202.

⁴⁶42 U.S.C. § 1396p (d)(4)(A); 12 VAC 30-40-300 (E)(3)(g); Va. Medicaid Manual, § M1120.202(B).

⁴⁷42 U.S.C. § 1396p (c)(2)(B)(iv); 12 VAC 30-40-300 (E)(3)(g); Va. Medicaid Manual, § M1450.502 (C).

⁴⁸42 U.S.C. § 1396p (d)(4)(A); 12 VAC 30-40-300 (E)(3)(g); Va. Medicaid Manual, § M1120.202(B).

- (i) Since it is impossible to predict how Medicaid may mutate or whether it will even survive, payment should be qualified by language limiting the requirement to the minimum necessary to secure the exemption.
 - (ii) If the reimbursement requirement is later eliminated, a naked direction to reimburse could require trust assets to be paid the state that otherwise could have passed to the settlor's more likely remainder persons.
- f. Section 3259.7 of HCFA Trans. 64 (11/94) states that the trust exemption continues even after the beneficiary reaches age 65. However, HCFA then states that the trust "cannot be added to or otherwise augmented after the individual reaches age 65. Any such addition ... after age 65 involves assets that were not the assets of an individual under age 65. Thus those assets are not be [sic] subject to the exemption discussed in this section."⁴⁹
- g. Grantor / Beneficiary Income Tax Implications.

To preserve the grantor trust tax status of the income generated on the trust (i.e., to have the income taxed at the same rate as the disabled beneficiary), one or more administrative incidents of control over the trust should probably be retained.⁵⁰

- h. Grantor / Beneficiary Gift and Estate Tax Implications.

To preserve a step-up for the remainder-persons as to any residue in the trust which is not paid to the state to reimburse the Medicaid claim, in the beneficiary (and considerably more flexibility in the disposition of the assets at the death of the beneficiary), a special power of appointment may

⁴⁹Virginia has not published a position in *Medicaid Manual* § 1450.502 or M1120.202, both of which merely require that the trust be established for a disabled person under the age of 65.

The cited HCFA policy also requires that when the trust beneficiary has resided in more than one state, the states in which he has resided shall receive a proportionate reimbursement share upon the beneficiary's death.

⁵⁰For tax purposes, the grantor of the trust can be the transferor of funds *into* the trust, even though another person is the nominal settlor of the trust. *Blackman v. United States*, 30 A.F.T.R. 846 (Ct. Cl. 1943); Priv. Ltr. Rul. 90--4-007. While IRC § 674 provides grantor tax status to a trust when the grantor (here, the beneficiary) retains the unrestricted right to remove, substitute, or add trustees, and to designate any person, including the beneficiary/grantor as the replacement, see Treas.Reg. §1.674(d)-2, this power could easily be deemed to require the beneficiary to appoint the property to himself, thus destroying the exempt status of the trust for Medicaid purposes. A better retained power is found by reference to IRC §675(4), which taxes the grantor on the trust income if the grantor retains possession of a power to reacquire the trust property by substituting property of equal value for the same. See also Rev. Rul. 83-25, 1983-C.B. 116; Priv. Ltr. Ruls. 95-02-019, 95-02-020, 95-02-024, 95-02-029, and 95-02-031.

be reserved to the beneficiary.⁵¹

2. Non-Profit Pooled Trust For Disabled Persons Of Any Age.

The second trust available in Virginia practice is the nonprofit pooled trust for disabled persons of any age.⁵² These trusts are exempt from the general OBRA trust rules. Assets in the trust are not deemed available resources to the beneficiary of the trust or to the grantor of the trust

a. **Because DMAS regulations do not provide a clear exemption for transfers into these trusts, and the federal statute does not expressly exempt transfers into these trusts, it is possible that paid counsel or assistance in funding these trusts could accordingly result in a violation of the criminal statute described above.**

(i) 12 VAC 30-40-300 (E)(3)(g)⁵³, "Exceptions," states that "[t]his section [emphasis supplied] shall not apply to any of the following trust(s)," and then describes the (d)(4)(C) trust.

(ii) To exactly what does "this section" refer? Is it the entire regulation, and thus the transfer of assets provision? Or is its reference only to the *countability* of the assets *in the trust under sub-section (3)*?

(iii) The first result is preferred under the rule of statutory construction, since the agency promulgating the regulation could have used "sub-section" if that is what "this section" intended.

(iv) However, until August, 1994, the *Medicaid Manual* provided that "transfer(s) of assets into these trusts will not affect eligibility."⁵⁴ The replacement policy, *Medicaid Manual*, M1120.202, is silent on the point.⁵⁵

(v) While removal of the express transfer exemption from the Va. Medicaid Manual indicates that the Department of Social Services would view transfers into the trust as disqualifying, a series of 1999 letters from the Virginia Department of Social Services, culminating in

⁵¹Treas.Reg. §25.2511-2(c); Priv. Ltr. Rul. 94-37-034. Note that it is not relevant that the beneficiary is actually incapable of exercising the retained power of appointment, *Boeving v. United States*, 493 F.Supp. 665 (D. Mo. 1980), *rev'd*, 650 F.2d 493 (8th Cir. 1981), the mere existence of the retained power of appointment appears to avoid any completed gift for this purpose. *Estate of Alperstein v. Commissioner of IRS*, 613 F.2d 1213 (2d Cir. 1979); Rev. Rul. 55-518, 1955 12 C.B. 384; the

⁵²42 U.S.C. § 1396p (d)(4)(C); 12 VAC 30-40-300(E)(3)(g)(2); *Medicaid Manual*, M1120.202.

⁵³Available at <http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-40-300>.

⁵⁴*Medicaid Manual*, Volume XIII, Part II, Chapter D, page 26e (Trans. #93-4, 10/93).

⁵⁵Va. Medicaid Manual, § M1120.202 (B)(2).

a December 20, 1999 letter to counsel for a Virginia d4C trust, opine:

- (A) assets in d4C a pooled-income trust will not be deemed the resources of the disabled beneficiaries of the trust, and
- (B) “[t]ransfers of the disabled individual’s assets or the assets of the disabled individual’s parents [into a (d)(4)(C) pooled income trust] are exempted transfers and would not impact Medicaid eligibility of the beneficiary or the grantor. for Medicaid eligibility purposes. Transfer of assets of anyone else would not be exempt and could impact the grantor’s Medicaid eligibility.”

(vi) It is not clear whether and how the POMS policy discussed above⁵⁶ will affect transfers of assets into a (d)(4)(C) pooled income trust.

- b. Only nonprofit associations may establish and manage these trusts. The disabled beneficiary's parent, grandparent, legal guardian, court, or the disabled person himself may establish an account in such trust.
- c. Separate accounts must be maintained for each beneficiary, but the trust may pool the funds for investment and management purposes. All accounts in the trust must be for the sole benefit of individuals who are disabled for Social Security purposes. The *Medicaid Manual* also requires the individual to have "been found to be disabled" by Social Security.
- d. The trust must allow Medicaid to recoup its expenditures when the beneficiary dies, but only to the extent that the residue is not retained by the trust. The donor into the trust (including the Medicaid recipient) can direct the residue of the sub-account be retained by the non-profit association instead of distributing the balance to Medicaid at the beneficiary's death.⁵⁷

E. Structured Settlement Issues.

- 1. Recurrent structure payments should NEVER be made to the plaintiff because income is always considered available to the Medicaid recipient in the month of receipt and subjected to the spenddown in the medically needy category.

⁵⁶ See II A 2 a, *supra*.

⁵⁷The right to direct the residue can provide strong incentives to caring for the disabled beneficiary, who (or whose guardian, child, spouse, etc.) could be provided a power to appoint and apportion the residue between Medicaid and the non-profit sponsor.

2. Guaranteed payments (following the death of the beneficiary during the guaranteed payments period) should not be diverted from the Trust unless the donee is himself or itself an exempt transferee.
 - a. Any diversion to a third party (other than an exempt transferee) will be considered to be for the benefit of the third party and can result in Medicaid ineligibility or disqualification of the special needs trust.
 - b. A right to assign the recurrent income to the takers at death, *subject to the rights of the Medicaid agency for reimbursement*, has not been challenged in the writer's trusts.

III. Medicare Secondary Payor Program and the Medicare Set-Aside Arrangements (Medical Expense Trusts).⁵⁸

A. Generally.

1. Medicare, like Medicaid, pays covered medical expenses for covered beneficiaries. Unlike Medicaid, Medicare is not “means-tested.” The resources and income of the beneficiary are irrelevant to eligibility because Medicaid has been earned through employment history.
2. Unlike Medicaid, Medicare has a “right” of recovery (a claim) with respect to payments it has “conditionally” made for a beneficiary. Medicaid has a statutory *lien* for benefits paid on a personal injury claim.
 - a. As seen in the statute, Medicare has “super creditor” status in the recovery of benefits paid when there is a third party which is liable for the medical care of the Medicare beneficiary (or, as seen below in the context of a worker compensation settlement, *future* Medicare beneficiary).
 - b. While there is some debate whether the attorney who represents the Plaintiff is liable to Medicare, at least where the funds in the attorney's hands have already been disbursed to the client,⁵⁹ there is no question that

⁵⁸ The writer gratefully acknowledges the intensive use of the resources compiled by his friend Susan G. Haines, Esq., at her excellent web site, www.haineselderlaw.com.

⁵⁹ Intermediaries clearly assert the right to bring such claims against the attorney: “Failure to protect the Medicare program: In the event that reimbursement is not made to Medicare as required by 42 USC 1395y(b)(2)(B)(I), action may be brought against any entity responsible for payment (and may collect double damages from insurance companies), or any entity that has received a third-party settlement. Under 42 CFR 411.24(g), this includes attorneys whose fees are paid from settlement proceeds. Please refer to *U.S. v. Sosnowski* [822 F. Supp. 570, 574 (W.D. Wis. 1993)] where judgement was entered against a beneficiary and his attorney for failing to reimburse Medicare after receiving settlement proceeds on a personal injury case.” This intermediary further asserts that “CMS has a direct right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, *attorney*, State agency, or a private insurer that has received a third party payment, 42 CFR 411.24.”

the liability or worker compensation carrier should be certain that any Medicare payments have been considered in the settlement.

3. In the settlement of a *personal injury action*, the Medicaid lien for medical expenses is through the date of settlement; there is no further claim which the Department of Medical Assistance Services can make with respect to these proceeds.⁶⁰ Similarly, once the Medicare claim has been determined (and, if applicable, “waived” by Medicare based upon a beneficiary’s “financial hardship”⁶¹ or facts which make full enforcement “against equity and good conscience”), there is no bar in a *personal injury action* to *future* coverage of the medical expenses related to the beneficiary’s illness or accident.
4. In the settlement of a worker compensation claim, Medicare’s position is very different; *it will not pay for future medical expenses when another insurer (worker compensation) is “primary” as to these expenses, regardless of any attempt by the parties to shift the liability to Medicare.*
 - a. 42 CFR 411.6 states that “if a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump sum

“Attorney Information,” published by the Georgia Medicare Part A Intermediary Service, <http://www.georgiamedicare.com/attorney.cfm>.

See also, *The Medicare "Super Lien" Revisited*, by Glenn E. Bradford, Esq., and Melinda M. Ward, <http://www.mobar.org/journal/2000/janfeb/bradford.htm>, in which the authors conclude that the “the *Super Lien* is not a true lien after all,” and that “theoretically Medicare would have what might amount to *lien* rights only as to personal injury recovery monies actually in the hands of the attorney, but no such rights after funds are actually disbursed to the client. In stating this conclusion, we would qualify it by reminding the reader that the case of *United States v. Sosnowski* may provide some precedent for allowing a claim against an attorney for previously disbursed judgment proceeds.” Commenting that *Sosnowski* “is an extremely weak precedent,” and reporting that no case is known to hold that “Medicare can recover against an attorney who has already paid out the client's portion of settlement proceeds,” the authors state that “an attorney arguably has no duty to contact Medicare to advise of a possible pending recovery in which Medicare might have an interest.”

⁶⁰ However, if these proceeds are not lawfully sheltered, converted into exempt resources or transferred (to one or more exempt transferee(s)), the proceeds in the hands of the beneficiary be considered a disqualifying resource which renders the recipient ineligible for *ongoing* Medicaid benefits as of the month following receipt of the same.

⁶¹ See 42 U.S.C. § 1370gg (c) for specific statutory authority and conditions. More information regarding the waiver process (which is conducted through the local intermediary) is available at the site of the intermediary which serves Virginia, Virginia United Government Services LLC site, <http://www.ugsmedicare.com/MedicareSecondaryPayer/MSPAttorneys.asp>. The Medicare Hardship / Good Conscience Waiver Request (CMS/SSA Form SSA-632-BK) is available at the writer’s web site, <http://majette.net>, and <http://www.georgiamedicare.com/HardShipForm.PDF>.

payment.”

b. Pitfalls:

- (i) Medicare has a right of subrogation for payment of conditionally made payments (i.e., payments which were made on a Medicare beneficiary’s behalf when there was no other source for prompt payment of the injured party). This right may be asserted against every party⁶² involved under the provisions of 42 CFR 411.26.
- (ii) Where the interest of Medicare has not been appropriately considered, Medicare eligibility can be terminated, denied, or delayed at a time when the injured worker has no other means of obtaining health insurance (other than Medicaid, when assets and income allow). In the denial notice from CMS, the worker will be informed that the state worker compensation agency may re-open the case for cause, which may give rise to malpractice liability on the part of the attorney, settlement broker and consultant if the Medicare issues were not properly discussed *ab initio*.
- (iii) In practice, unless there is an agreement at the time of the settlement (commutation), **none of the parties can be certain that there is finality in the arrangement.**

- c. Perhaps the best guidance as to safe harbors in a complex area such as this is from the CMS itself. Fortunately, a July, 2001, memorandum to all Regional Offices of the Centers for Medicare and Medicaid Services (CMS) entitled, “Workers Compensation: Commutation of Future Benefits,” Parashar B. Patel, Deputy Director (herein, “CMS Commutation Memorandum”) addressed several administrative issues in the settlement of worker compensation cases and specifically addressed the use of set-aside arrangements, “sometimes referred to by attorneys as Medicare Set-Aside Trusts.”⁶³

(i) **When is a set-aside arrangement used?**

Only in “commutation cases,” not in “compromise cases.”

“Set-aside arrangements are used in WC commutation cases, where an injured individual is disabled by the event for which WC is making payment, but the individual will not become entitled to Medicare until some time after the WC settlement is made. Medicare learns of the

⁶² But see *The Medicare "Super Lien" Revisited*, fn.58, *supra*.

⁶³ CMS Commutation Memorandum, p.1.

existence of a primary payer (WC) as soon as possible when Medicare reviews a proposed set-aside arrangement at or about the time of WC settlement. In such cases, Medicare greatly increases the likelihood that no Medicare payment is made until the set-aside arrangement's funds are depleted. These set-aside arrangements provide both Medicare and its beneficiaries security with regard to the amount that is to be used to pay for an individual's disability related expenses. It is important to note that set-aside arrangements are **only** used in WC cases that possess a commutation aspect; they are not used in WC cases that are strictly or solely compromise cases.”⁶⁴

(ii) **How are “commutation” and “compromise” cases distinguished?**

“Lump sum compromise settlements”⁶⁵ represent an agreement between the WC carrier and the injured individual to accept less than the injured individual would have received if he or she had received full reimbursement for lost wages and life long medical treatment for the injury or illness. In a typical lump sum compromise case between a WC carrier and an injured individual, the WC carrier strongly disputes liability and usually will not have voluntarily paid for all the medical bills relating to the accident. Generally, settlement offers in these cases are relatively low and allocations for income replacement and medical costs may not be disaggregated. Such agreements, rather than being based on a purely mathematical computation, are based on other factors. These may include whether there was a preexisting condition, whether the accident was really work related, or whether the individual was acting as an employee, or performing work-related duties at the time the accident occurred.

...

WC commutation cases⁶⁶ are settlement awards intended to compensate individuals for **future** medical expenses required because of a work-related injury or disease. In contrast, WC compromise cases are settlement awards for an individual’s current or past medical expenses that were incurred because of a work-related injury or disease. **Therefore, settlement awards or agreements that intend to compensate an individual for any medical expenses after the date of settlement (i.e., future medical expenses) are commutation cases.**⁶⁷

⁶⁴ Compromise and Release Agreement, p.2.

⁶⁵ Emphasis added by writer.

⁶⁶ Emphasis added by writer.

⁶⁷ Emphasis added by writer.

(iii) Typically, set-aside arrangements are used when there is a relatively young claimant with a severe, disabling impairment.

“Set-aside arrangements are most often used in those cases in which the beneficiary is comparatively young and has an impairment that seriously restricts his or her daily living activity. These set-aside arrangements are typically not created until the individual’s condition has stabilized so that it can be determined, based on past experience, what the future medical expenses may be.”⁶⁸

5. After generally discussing the definitions for various settlements the CMS Commutation Memorandum addresses a series of twelve questions posed by attorneys relating to the Medicare settlement process, and especially applicable to approval of commutation agreements and set-aside arrangements. In the interest of brevity and solely for the purpose of illustrating the serious and complex issues which a worker compensation settlement raises in the context of Medicare qualification, only the questions (excepting question 5, which provides the criteria which Medicare employs to determine whether its interests have been properly considered in a settlement) can be presented in this forum:⁶⁹

Question 1:

- (a) Does the Medicare program have a claim against a lump sum WC payment before an individual’s Medicare entitlement?
- (b) If not, can the Medicare program give a written opinion on the sufficiency of a set-aside arrangement even if the individual is not as yet entitled to Medicare?
- (c) In WC cases involving injured individuals who are not yet Medicare beneficiaries, when must Medicare's interests be considered before the parties can settle the case?

Question 2:

Should a “system of records” be established for the documentation that the RO [Regional Office] and contractors receive/collect concerning these set-aside arrangements?

⁶⁸ Compromise and Release Agreement, p. 3.

⁶⁹ The Memorandum is available at the writer’s website, <http://majette.net>, in Adobe Acrobat format, and at <http://www.haineselderlaw.com/wp-cms-mem-article.htm>, .rtf format. Note that the pagination in the Adobe format is slightly skewed from the original .rtf posting.

Question 3:

Once the set-aside arrangement has been approved by the RO (with consultation from the Regional OGC [Office of General Counsel], if necessary), what is the subsequent role of the ROs and contractors?

Question 4:

What types of measures should the RO and the contractors take to ensure that Medicare makes no payments related to the illness or accident until the set-aside arrangement has been depleted?

Question 5:

What are the criteria that Medicare uses to determine whether the amount of a lump sum or structured settlement has sufficiently taken its interests into account?

Answer:

The following criteria should be used in evaluating the amount of a proposed settlement to determine whether there has been an attempt to shift liability for the cost of a work-related injury or illness to Medicare. Specifically, is the amount allocated for future medical expenses reasonable? If Medicare has already made conditional payments their repayment also has to be taken into account.

1. Date of entitlement to Medicare.
2. Basis for Medicare entitlement (disability, ESRD or age)-- If the beneficiary has entitlement based on disability and would also be eligible on the basis of ESRD, this should be noted since the medical expenses would be higher. This would also be true for beneficiaries who are over 65 but had been entitled prior to attaining that age.
3. Type and severity of injury or illness-- Obtain diagnosis codes so injury or illness related expenses can be identified. Is full or partial recovery expected? What is the projected time frame if partial or full recovery is anticipated? As a result of the accident is the individual an amputee, paraplegic or quadriplegic? Is the beneficiary's condition stable or is there a possibility of medical deterioration?
4. Age of beneficiary-- Acquire an evaluation of whether his/her condition would shorten the life span.

5. WC classification of beneficiary (e.g., permanent partial, permanent total disability, or a combination of both).
6. Prior medical expenses paid by WC due to the injury or illness in the 1 or 2 year period after the condition has stabilized-- If Medicare has paid any amounts, they must be recovered. Also, this would indicate that the case may not purely be a commutation case, but may also entail some compromise aspects, e.g., the WC carrier or agency may have taken the position that the services were not covered by WC.
7. Amount of lump sum or amount of structured settlement-- Obtain as much information as possible regarding the allocation between income replacement, loss of limb or function, and medical benefits.
8. Is the commutation for the beneficiary's lifetime or for a specific time period? If not for lifetime, what is the basis?-- Medicare must insist that there is a reasonable relationship between the respective allocation for services covered by Medicare and services not covered by Medicare. For example, is it reasonable for the settlement agreement's allocation for services not covered by Medicare to be based on the beneficiary's life time while the agreement's allocation for services covered by Medicare is based on a lesser time period? What is the State law regarding how long WC is obligated to cover the items or services related to the accident or illness?
9. Is the beneficiary living at home, in a nursing home, or receiving assisted living care, etc.?-- If the beneficiary is living in a nursing home, or receiving assisted living care, it should be determined who is expected to pay for such care, e.g., WC (for life time or a specified period) from the medical benefits allocation of lump sum settlement, Medicaid, etc.
10. Are the expected expenses for Medicare covered items and services appropriate in light of the beneficiary's condition?-- Estimated medical expenses should include an amount for hospital and/or SNF care during the time period for the commutation of the WC benefit. (Just one hospital stay that is related to the accident could cost \$20,000.) For example, a quadriplegic may develop decubitus ulcers requiring possible surgery, urinary tract infections, kidney stones, pneumonia and/or thrombophlebitis. Although each case must be evaluated on its own merits, it may be helpful to ascertain for comparison purposes the average annual amounts of Part A and Part B spending for a disabled person in the appropriate State of residence. Keep in mind that these Fee-for-Service amounts are for all Medicare covered services, while our focus here only deals with services related to the WC accident or illness. Therefore, the RO should use appropriate judgment and seek

input from a medical consultant when determining whether the amount of the lump sum or structured settlement has sufficiently taken Medicare's interests into account.

The attorney for the individual for whom the arrangement is set-up should be advised that Medicare applies a set of criteria to any WC settlement on a case-by-case basis in order to determine whether Medicare has an obligation for services provided after the settlement that originally were the responsibility of WC. **[Emphasis in original.]**

Question 6:

Some attorneys have indicated that a set-aside arrangement should only contemplate three to five years of estimated Medicare covered items or services. Would this be reasonable?

Question 7:

What other issues should be considered ?

Question 8:

Is it permissible for Medicare to accept an up-front cash settlement instead of a set-aside arrangement?

Question 9:

How do providers and suppliers obtain payment for the services covered by the set-aside arrangement?

Question 10:

Are there documentation requirements that must be satisfied before the RO can provide a written opinion on the sufficiency of a set-aside arrangement?

Question 11:

How does the RO determine whether or not the administrative fees and expenses charged to the arrangement are reasonable?

Question 12:

What impact will arrangements have on Medicare payment systems and procedures?

B. Statute.⁷⁰

Sec. 1395y - Exclusions from coverage and Medicare as secondary payer

....

(b) Medicare as secondary payer

(2) Medicare secondary payer

(A) In general

Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that -

- (i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1),⁷¹ or
- (ii) payment has been made, or can reasonably be expected to be made promptly (as determined in accordance with regulations) under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.**

In this subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies.

(B) Conditional payment

(i) Repayment required

Any payment under this subchapter with respect to any item or service to which subparagraph (A) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this subchapter when notice or other information is received that payment for such item or service has been or could be made under such

⁷⁰ The associated official regulations are found at 42 CFR 411.1 *et seq.*, available at <http://majette.net>. CMS policy interpretations, which have the virtual force of law, are found in the Medicare Fiscal Intermediary Manual, Part 2, and the Medicare Carrier's Manual, Part 2.

⁷¹ Group health plans as defined in the statute.

subparagraph. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date such notice or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

(ii) Action by United States

In order to recover payment under this subchapter for such an item or service, the United States may bring an action against any entity which is required or responsible (directly, as a third-party administrator, or otherwise) to make payment with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph (3)(A) collect double damages against that entity), or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

(iii) Subrogation rights

The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(iv) Waiver of rights

The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this subchapter.

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