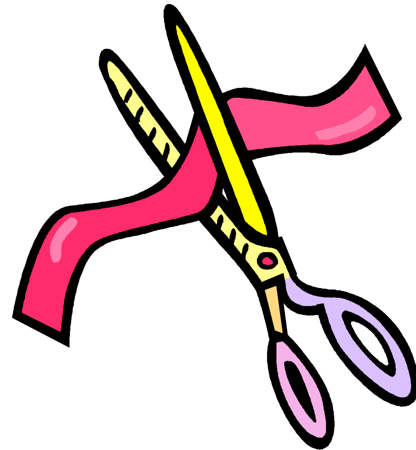
Responding to the TennCare Cuts

Statewide Meeting
District Long Term Care Ombudsmen
March 16, 2005



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Introduction to Medicaid Qualifying Income Trusts

Information compiled by Pam Wright, West Tennessee Legal Services[1]
For state-wide meeting of District Long Term Care Ombudsmen
March 16, 2005

Under Federal Medicaid law, there are three potential groups of Medicaid recipients. These include:

- the mandatory categorically needy,[2]
- the optional categorically needy,[3] and
- the medically needy.[4]

States are required to provide Medicaid to the mandatory categorically needy. States have the *option* of providing Medicaid to the optional categorically needy and the medically needy.

The most familiar category of the "mandatory categorically needy" populations is the group of recipients of Supplemental Security Income (SSI), who draw Medicaid automatically as long as they receive as little as one dollar of SSI benefits.[5]

States may choose to provide Medicaid to the "optional categorically needy" categories.[6] Recipients in these groups include individuals who are generally just as needy as the mandatory categorically needy, but who do not meet other eligibility rules. For the purpose of this presentation, the two most important of the optional categorically needy groups is the category of "institutionalized individuals" with incomes

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[1] This introduction is based extensively on materials provided by Vickie Kimbrell and +the Georgia Legal Services Program; large portions of this material were provided by Amy Turner of Kentucky Legal Aid Society. Thanks to these shared materials, this information has reference footnotes. Any mistakes in numbers and information are those made by Pam Wright in compiling the information.
[2] 42 U.S.C.§ 1396a(a)(10)(A)(i). While not an exhaustive list, typical recipients in the mandatory categorically needy population of Medicaid recipients include families and children who would have been eligible for Aid to Families with Dependent Children (AFDC) before AFDC was discontinued on July 16, 1996 pursuant to The Personal Responsibility and Work Opportunity Act of 1996 (Pub. L. No. 104-193, 110 Stat. 2105 (1996); pregnant women and children under certain federal poverty income limits, and Supplemental Security Income (SSI) recipients. 42 U.S.C.§ 1396a(a)(10)(A)(i).
[3] 42 U.S.C.§ 1396a(a)(10)(A)(ii).
[4] 42 U.S.C.§ 1396a(a)(10)(C).
[5] 42 U.S.C.§ 1396a(a)(10)(A)(i); Tenn. Comp. Rules & Reg 1240-3-.02(2)(b).
[6] 42 U.S.C.§ 1396a(a)(10)(A)(ii); 42 C.F.R. § 435.200 et seq.

less than 300 percent of the SSI benefit level (called the Federal Benefit Rate or FBR),[7] and those receiving services under home and community-based waiver programs with incomes less than 300 percent FBR.[8]

The third category of Medicaid recipients, the medically needy, includes individuals whose incomes are higher than the incomes of persons in the mandatory categorically needy group, but who are permitted to "spend down" their incomes to a certain level to become eligible for Medicaid.[9] Institutionalized persons whose incomes are above the Federal Benefit Rate can be Medicaid-eligible through the Medically-Needy "spend down" as long as they meet the other medical and non-medical criteria.[10]

As part of his proposed cuts to the TennCare program, Governor Bredesen intends to eliminate the adult Medically-Needy program in Tennessee.[11] Based on the Governor's early announcements, we expect the proposed cuts to eliminate Medicaid eligibility for about 1500 nursing home residents.[12] This paper seeks to explain the mechanism through which nursing home residents can transition into the "institutionalized" Medicaid program by using Qualified Income Trusts (QITs) which are also called "Miller Trusts." Most of the information about the use of QITs will apply to residents of ICF-MR and Home- and Community-Based programs, as well.

Treatment of Trusts in the Medicaid Program

In determining eligibility for Medicaid (for long term care residents), the state will consider not just income, but "countable" and "available" assets, as well. Generally, under Medicaid law, the assets held in trust are counted as if there were no trust provisions. In OBRA '93, Congress identified specific trust arrangements that would

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[7] 42 U.S.C.§ 1396a(a)(10)(ii)(V); Tenn. Comp. Rules & Reg. 1240-3-2-.02(f). States actually have the authority to limit income eligibility more stringently than 300% FBR, but until recently all states have chosen to use the maximum of 300% FBR as the guideline for institutionalized populations. In July 2004, Mississippi announced its intention to be the first state to use a more stringent income guideline.

[8] 42 U.S.C.§1396a(a)(10)(ii)(VI); Tenn. Comp. Rules & Reg. 1240-3-2-.02(f).

[9] 42 U.S.C.§ 1396a(a)(10)(C).

[10] 42 C.F.R. § 435.800 – 435.852; Tenn. Comp. Rules & Reg. 1240-3-2-.03(2) & 1240-3-3-.06. Tennessee's state rules are found at http://www.state.tn.us/sos/rules/1240/1240-03/1240-03.htm .

[11] Transmittal Notice of Approval of State Plan Material, amendment to the Tennessee Title XIX Medicaid State Plan, Action Transmittal 2005-5, pages 24 and 26, available at http://www.state.tn.us/tenncare/New%20Updates/SPA2005.pdf (last viewed March 11, 2005).

[12] Anita Wadhwani, *Tennessean,* "Advocates say elderly in dark over TennCare drug cut plans," (March 19, 2005).

protect assets from being considered as "countable" and "available" for purposes of determining Medicaid eligibility.[13] One of the trust arrangements for which assets are not counted is the Qualifying Income Trust (QIT), also known as Miller trusts (named for a case approving these trusts).[14]

Qualifying Income Trusts or Miller trusts

Qualifying Income Trusts can only be used in states that cover the optionally categorically needy and that do not cover nursing facility services under the medically needy (spend down) program.[15] These states are often called "income cap" states.[16] Once Tennessee ends its Adult Medically-Needy program, it will become an "income cap" state. An "income cap" state does not cover nursing facility care under a medically needy program but will still assist a resident's long term care costs under the optional categorically needy Medicaid program, even if the individual's income exceeds 300 percent of the SSI benefit level, by allowing the resident to divert excess income into a Qualifying Income Trust.

To be considered a QIT, the trust must be

- irrevocable
- contain only "pension, Social Security, and other income to the individual (and accumulated income in the trust)" and contain no resources, and
- upon the individual's death, all assets in the trust (up to the total amount paid for the person's medical care) must be paid to the state.[17]
- The trust funds must be kept in a bank account separate from other funds and
- all withdrawals must comply with Medicaid law and regulations.

Eligibility determinations. At its essence, a Qualifying Income Trust allows individuals with income, which would otherwise disqualify them from receiving Medicaid, to accumulate that excess income in the trust. The state agency administering

[13] 42 U.S.C.§ 1396p(d).
[14] 42 U.S.C.§ 1396p(d)(4)(B). See Miller v. Ibarra, 746 F.Supp. 19 (D. Colo. 1990).
[15] 42 U.S.C.§ 1396p(d)(4)(B)(iii).
[16] In 2004, the "income cap" states were Alabama, Alaska, Colorado, Delaware, Idaho, Mississippi, Nevada, New Mexico, Ohio, South Dakota, and Wyoming; with Georgia joining the group later in the year. *Advising the Elderly* at p. 16-99, fn. 2.
[17] 42 U.S.C.1396p(d)(4)(B)(i) and (ii).

the Medicaid program does not consider the income that is left in the trust account *for purposes of eligibility*. The trust will distribute only an amount of income that is below the income cap imposed by the state.[18]

Post-eligibility determinations. The state agency *does* consider all of the trust income in determining a recipient's "patient liability" (share of the cost of care in a nursing facility or home and community based waiver program), thus requiring recipients to "spend down" their income for the cost of their care, with Medicaid picking up the difference.[19] **A**ll income placed in a Miller trust is combined with countable income not placed in the trust for post-eligibility purposes. Here is an example from the federal Medicaid Manual,

> For example, an individual with $2,000 a month in income retains $1,338 (the maximum … permitted [in 1994] for eligibility under a special income level) and places the remaining $662 in a Miller trust. The entire $2,000 is income as defined by SSI, although only the $1,338 is counted as income for eligibility purposes. Thus, the $2,000 forms the basis for the post-eligibility computation.[20]

Payments from the resident's QIT can be made for medical needs and for spousal and dependent allowances. However, the federal Medicaid Manual states that "[w]hen payments are made for the individual's medical care [the state] must require that the payments be made at intervals specified [in your] State (e.g., every month or by the end of the month following the month the funds were placed in the trust)."[21]

Hardship exception. Finally, federal Medicaid law provides that *states must provide an exception* to the penalties imposed for failure to establish a Qualifying Income Trust where application of the rules would work an undue hardship.[22] The states have significant flexibility in determining which circumstances constitute undue hardship. However, at the least, states must provide notice of the existence of the hardship exemption, a timely process for determining whether to grant a hardship exception, and an appeals process.[23]

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[18] Dayton, et. al., *Advising the Elderly Client,* §16:154 (2004).
[19] HFCA, State Medicaid Manual § 3259.7. The State Medicaid Manual is available online at http://www.cms.hhs.gov/manuals/pub45/pub_45.asp
[20] *Id*.
[21] *Id*. At c.3.
[22] 42 U.S.C.§1396p(d)(5).
[23] HCFA, State Medicaid Manual § 3259.8.

Transferring Money to a Qualified Trust. The federal Medicaid law imposes a penalty on institutionalized individuals who transfer assets for less than fair market value.[24] The penalty (ineligibility for Medicaid) varies in length depending upon the value of the transferred assets.[25] States must impose the penalty when the transfer of assets for less than fair market value occurs during a "look back" period, which begins 36 months before the individual was institutionalized and applied for Medicaid.[26] The look back period for some transfers out of trusts is 60 months.[27]

Normally, the improper transfer of income or of the source of income will also be penalized under Medicaid's penalty provisions. However, the transfer of income into a QIT is not considered to be an improper transfer of assets for less than fair market value so long as withdrawals *from* the trust are for purposes permitted by the Medicaid Act (e.g. cost of medical care, paid to a community spouse for her sole benefit).[28] On the other hand, the improper transfer of income *that has accumulated in the trust fund is* subject to transfer penalties.

Prospective residents of long term care, and their family representatives, may want to solve the income-cap problem by taking income out of the resident's name. That may result in the application of a harsh penalty. However, there are a few transfers (such as spouse-to-spouse transfers) or other transactions that might work well in an overall financial plan that incorporates Medicaid legal issues. Given the complexity of the Medicaid rules and the severity of the Medicaid penalties, it is important that prospective residents, who have income above the cap, consult with attorneys who have demonstrated expertise in elder law.

Payment of Administrative and Conservatorship Fees

Many long term care residents will not have the mental capacity to handle their finances. For residents who do not have a legal representative in place, a conservatorship may have to be established in order to authorize someone to act on the resident's behalf. As Georgia moved to become an "income cap" state, limited

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[24] 42 U.S.C.§ 1396a(a)(18), 1396p(c).
[25] 42 U.S.C.§ 1396p(c)(1)(E).
[26] 42 U.S.C.§ 1396p(c)(1)(B).
[27] 42 U.S.C.§ 1396p(c)(1)(B), 1396p(d)(3).
[28] See 42 U.S.C.§ 1396p(c)(2)(B).

conservatorships were filed for residents who needed a legal representative to establish a QIT. Obviously, the costs of establishing a conservatorship will be a serious barrier to obtaining services for some residents.

Some states allow the Medicaid recipient to deduct the cost of maintaining the trust account from their patient liability.[29] Oregon allows up to $50 per month in "administrative fees" which include the cost of maintaining the account, as well as conservator fees. If Tennessee's policy (as ultimately developed) allows the trust fund to make payments for "administrative fees" and/or allows the payment of the fees from patient liability funds, residents may be able to arrange for payment of costs on an installment basis.

In the event that such a policy is not available, advocates may be able to get assistance for these residents through the courts. In *Rudow v. Commissioner*, 707 N.E.2d 339, 429 Mass. 218 (1999), the Supreme Judicial Court of Massachusetts ordered the Division of Medical Assistance (which administers the Medicaid program) to provide funds to pay for guardianship services furnished to Medicaid eligible nursing home residents.[30] As a result of the decision, Massachusetts promulgated regulations which allows the payment of costs of such services to come out of the patient liability in the same way as "item D" deductions.[31] In *Rudow*, the court determined that the resident could deduct from her monthly income judicially approved guardianship expenses (attorney's fees and costs) as an allowance for "necessary . . . medical or remedial care recognized under state law." See , 42 U.S.C. § 1396a(r)(1)(A)(i) (1994); 42 C.F.R. § 435.725(c)(4)(ii). The deductions were allowed because "the physician-certified guardianship proceeding [was] a prerequisite to the Massachusetts resident gaining access to the long-term care facility suitable to provide the medical and related care services she needed, and to implementing an appropriate physician-approved treatment plan for her." *Rudow* at 218.

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[29] See, e. g., Alabama rules at *http://www.medicaid.state.al.us/ABOUT/Form262%20QITpacket%20.pdf* ; Oregon rules at *http://www.dhs.state.or.us/spd/tools/program/osip/incap.pdf* .
[30] This decision is available on the internet at http://oldsite.socialaw.com/sjcslip/March99.html
[31] See, Massachusetts Bar Association,"The ABCs of a Rudow Guardianship" by John J. Ford <available at **Error! Main Document Only.**http://www.massbar.org/article.php?c_id=758&vt=2> (last visited March 9, 2005).

The Georgia Experience

In 2004, Georgia Governor Sonny Perdue announced his intention to eliminate Georgia's Medically Needy program effective July 1, as part of a move to cut costs in that state's Medicaid program. It was estimated that 1,800 residents would be affected.[32] Advocates quickly pointed out that the "likely harm is compounded by Georgia's failure to notify these medically needy beneficiaries that there is an option, creation of a Miller Trust, that could permit the residents to continue to participate in the Medicaid program."[33]

Eventually, in September 2004, a class action lawsuit was brought on behalf of nursing home residents who were losing their Medically-Needy Medicaid.[34] The plaintiffs alleged that their severe disabilities prevent them from accomplishing the complicated task of establishing a Qualified Income Trust (QIT), and that the state's failure to provide a reasonable accommodation to them violated the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act. They also asserted that the state had failed to issue proper notice; and that Georgia had failed to follow federal law requiring the state to provide individuals who are not able to create a Miller Trust the opportunity to establish that denial of Medicaid coverage would constitute an undue hardship, 42 U.S.C. §1396p(d)(5). The plaintiffs were successful in getting a preliminary injunction from the district court. Georgia Legal Services Program, Inc., Atlanta Legal Aid Society, Inc. and Bondurant, Mixson & Elmore, LLP, represented the plaintiffs.[35] Eventually, a consent decree was entered allowing residents of nursing facilities more time to establish QITs so that they could maintain Medicaid eligibility.

Because Georgia has a state-wide "senior hotline," it was decided to use that phone number on flyers.[36] For the majority of affected residents, the District Long Term Care Ombudsmen were the first contacts and sources of assistance. The Georgia Senior Hotline became the clearinghouse where residents were matched with legal resources and follow-up was done to make sure that the transition tasks were being completed.

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[32] "Georgia Moves to Eliminate Medically Needy Program; Fails to Advise Beneficiaries of Options," *NSCLC Washington Weekly,* June 18, 2004.
[33] *Id*.
[34] *Smith v. Burgess*, U.S.D.C., No. Ga. 4:04-CV-207-HLM, filed Sept. 1, 2004.
[35] *"Georgia Elderly and Disabled File Suit Against Medicaid Cutbacks,"* Washington Weekly*, September 10, 2004.* http://www.nsclc.org/news/04/sept/georgiamedicaidcase.htm.
[36] Conversation with Cheri Tipton, Director of Georgia Senior Hotline, Jan. 1, 2005.

Referrals to the hotline were taken by phone and hard copy, resulting in some duplication. Eventually, the state sent the hotline a list of persons being terminated so that they could be matched against the hotline's list. That allowed the hotline, working with the Ombudsmen, to contact the residents who had not yet requested assistance. The hotline staff hired two temporary workers to help with these clearinghouse functions.

In Georgia, the first step in assisting the residents was to file an appeal of the Medicaid termination so that coverage would remain in place while the appeal was pending and the trust was being established.[37] Initially, there were problems with the appeals because the Administrative Law Judges were not aware that almost 1,800 appeals were being dumped into their system. Eventually, when the ALJs were informed of the situation, they assisted the appellants by "slow-walking" the cases, giving the appellants more time to establish the trusts; and, when necessary, getting limited conservators to assist.[38]

It is my understand that the state wouldn't agree to work out a form for the trust in advance,[39] and that an attorney in Atlanta submitted a vanilla trust and a "certificate of compliance" that the Department of Community Health approved at the first fair hearing. Eventually, two trust forms were approved this way. If an applicant submitted a trust that deviated from the standard form, it was sent to General Counsel's office for approval. The state bar association and this attorney provided training, with materials and approved forms to attorneys. Everyone who practices in elder law area wanted the standard form and agreed to come to training, accepting the requirement that they take a minimum of five pro bono cases. Two or three of the larger firms, and at least one Certified Elder Law Attorney, volunteered to take on the larger numbers.[40] Some private attorneys took cases for reduced fee in appropriate situations.

Some banks were willing to set up the trust accounts and waive fees for their services. Apparently, unlike some other states, Georgia is not allowing the cost of maintaining the bank account to be deducted from the resident's "patient liability."

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[37] This strategy may not work in Tennessee, since the Medically Needy population will be moved into TennCare Standard (taking them out of the Medicaid appeals process) and the Governor's plans state that there will be no appeals about the elimination of coverage categories.

[38] *Id*.

[39] Some other states have done so and a few even make the forms available on-line. See page 14.

[40] *Id*.

The Kentucky Experience

In July 2003, as part of a larger package of cost containment measures, the Kentucky Secretary for Health Services informed the Kentucky General Assembly that the state would remove nursing facility care and certain waiver programs from the State's medically needy program and establish a Miller Trust Program. Shortly before the Labor Day weekend, the Cabinet for Health Services sent letters to Medicaid recipients in long-term care facilities and home and community based waiver programs whose income exceeded three times the SSI benefit amount.[41]

Unfortunately, the letter sent to Medicaid recipients gave them only until September 17, 2003 to submit a trust to their Medicaid worker. Moreover, the letter described a Qualifying Income Trust as "[a] legal written agreement (contact your attorney)." Those of us in the legal services community dubbed this the "Dear Hazel" letter. Fortunately, all the legal aid programs in the state were scheduled to have the annual statewide conference at the end of August and used the opportunity to work together to confront the crisis. Eventually, they were able to negotiate an extended deadline (October 22, 2003) with the state. Also, the state modified their position to allow a resident's Medicaid to remain uninterrupted if that resident submitted a "letter of intent" stating his or her intention to establish a Miller Trust before the deadline.[42]

According to the state website, Kentucky did not adopt a template for the Miller trust but, rather, referred residents, in their FAQs, to the state bar association and the legal services programs in their areas.[43] The form suggested by Kentucky Legal Aid Programs is in the appendix at p. 15 and is posted at http://www.kylawhelp.org/Data/DocumentLibrary/Documents/1064850138.15/QIT%20interactive.pdf

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[41] At the time of the initial announcement of the program, letters were sent to individuals whose income was more than $1,656.00 per month. As of January 2004, that figure is now $1,692.00.

[42] Kentucky Cabinet for Health and Family Services, Department of Medicaid Services, Qualifying Income Trusts Frequently Asked Questions,
< http://chfs.ky.gov/NR/rdonlyres/09B96C4A-B67C-4540-BF56-06D6ABE6DC96/0/qitfaqs2.pdf > (last viewed March 11, 2005).

[43] *Id.*, *also*, at <http://chfs.ky.gov/NR/rdonlyres/BE0F311D-2B14-44E7-9763-369E3A857EAF/0/qitfaqs.pdf > (last viewed March 11, 2005).

Trust Requirements (in Kentucky)

- The trust must be irrevocable.[44]
- Money deposited to the trust must be maintained in a separate account opened for this purpose.[45]
- Only pension, Social Security and other income is to be placed in the trust. The amount of income put into the trust must be at least three times the federal SSI income standard ($1,737 as of January 2005). At the option of the Medicaid applicant/recipient, their entire income can be placed in the trust. The trust consists only of this income and accumulated interest, if any; no resource of any kind (such as money from a savings account of the beneficiary) can be put in the trust without incurring a transfer of resource penalty.[46]
- The income placed in the trust is not considered available income for determining Medicaid eligibility. It is, however, considered income available for paying toward the individual's medical care.[47]
- The trust must provide that, at the death of the beneficiary, the trustee will pay the state of Kentucky any funds remaining up to the amount of un-reimbursed medical assistance provided to the beneficiary during the beneficiary's lifetime. Any money left over after the state has been reimbursed will go to the beneficiary's estate.[48]
- The only allowable expenditures from the trust are for the beneficiary's personal needs allowance, community spouse or family support, health insurance premiums, and the patient liability amount to the nursing home or medical facility. All other expenditures must be pre-approved by the caseworker.[49]

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[44] 907 KAR § 1:650, Section 3(5)(a)(4).
[45] 907 KAR § 1:650, Section 3(5)(b)(1).
[46] Field Services Operation Manual, OM Pol. Upd. 03-30, MS 99639.
[47] 907 KAR § 1:650, Section 3(5)(c).
[48] 907 KAR § 1:650, Section 3(5)(a)(3).
[49] 907 KAR § 1:650, Section 3(5)(d).

- Expenditures are to be made monthly, or by the end of the month after the month in which the funds were placed in the trust.[50]

Although the Kentucky regulation explicitly provides that "All expenditures from a qualifying income trust shall require verification by the department that they are allowable expenditures"[51] this provision is not expected to require pre-approval in every event, as long as an expenditure fits within the categories described in the trust, which will have been approved by the Department at the trust's inception.

The Kentucky regulation requires that the Beneficiary's personal needs allowance ($40/month); the allowance for the community spouse, if there is one; medical expenses of the Beneficiary which are not covered by Medicaid; and the Patient Liability amount, which is the Beneficiary's share of the nursing home cost of care. If the Trustee wants to spend money on something other than these specific needs, they must get written approval from Medicaid. [52]

In Tennessee, when a long term care resident is approved for Medicaid, a budget sheet is generated that is copied to the financial office of the resident's long term care facility. That copy should be filed in the resident's file in the financial, or book-keeping, office. By checking that budget page, a resident or her representative can ascertain if she has medically-needy Medicaid or categorically-needy Medicaid (with income below the income cap). The following two pages have examples of these budget sheets.

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[50] 907 KAR § 1:650, Section 3(5)(f).
[51] 907 KAR § 1:650, Section 3(5)(e).
[52] Legal Aid Network of Kentucky, Qualifying Income Trust Questions and Answers, <http://www.kylawhelp.org/Home/PublicWeb/docs/qitquestions.htm> (last viewed March 11, 2005).

This is an example of a budget sheet for a Medicaid recipient in a nursing facility who has Medicaid as a "**Categorically Needy**" or "institutionalized" recipient. Note that the top of the document says "MEDICAID INSTITUTIONALIZED CN." In the lower left-hand corner, the amount of the Medicaid Income Cap is listed and there is a statement that this resident (AG means Assistance Group; or, in this case, the resident) passed the Categorically Needy Budget. In other words, the amount of income, $322.00, is below the Medicaid Income Cap.

MAR.16.2005 2:08PM MAPLEWOOD HEALTHCARE NO.681 P.1/1

Page: 1 Document Name: untitled

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EBML              MEDICAID INSTUTIONALIZED CN/              12/08/04 16:33
                    PATIENT LIABILITY BUDGET                DEC55EH  S MINTON
COUNTY: 55   CASE: 0018105641   CAT: MA A   SEQ: 1
AGNAME:                         WORKER: DEC55EH
BEGIN: 01/01/05   END:                STATUS:      OPEN,PASS

        PATIENT NAME                   SSN         LONG TERM CARE FACILITY
                                    408509647      MAPLEWOOD HEALTH CARE

   TOTAL EARNED INCOME:        .00 |                  TOTAL INCOME:      322.00
 TOTAL UNEARNED INCOME: +   322.00 |      PERSONAL NEED ALLOWANCE: -     40.00
          TOTAL INCOME: =   322.00 | SPOUSAL/DEPENDENT ALLOCATION: -       .00
                                   |    MEDICAL INSURANCE PREMIUMS: -       .00
MEDICAID INCOME CAP STD:   1737.00 |      ITEM D/RECURRING MED EXP: -       .00
AG PASSED CATEGORICALLY NEEDY BUDGET     PAT LIABILITY OVERCHARGE: -       .00
                                   |                    VA A & A: +       .00
                                   |          PATIENT LIABILITY   =    282.00

NEXT TRAN: ________ PARMS: ____________________________________ MORE...
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ID 00947823663

mco - TLC

Date: 12/8/04 Time: 4:34:02 PM

This is an example of a budget sheet for a Medicaid recipient in a nursing facility who has Medicaid as a "**Medically Needy**" recipient. Note the designation at the top of the sheet that says "Institutionalized MN Budget." At the bottom of the right-hand columns, you see part of the spend-down calculations.

MISSION CONVALESCENT 731 424 7915 TO:4232600 P:3/3

Document Name: untitled

EBIN MEDICAID INSTITUTIONALIZED MN BUDGET 02/05/04 11:12
COUNTY: 55 CASE: 28537701 CAT: MA A SEQ: 1 DEC55EH S MINTON
AG NAME:
WORKER: DEC55EH
BEGIN: 03/01/04 END: STATUS: OPEN, PASS

TOTAL INCOME	:	2296.00
PERSONAL NEED ALLOWANCE	:-	30.00
SPOUSAL/DEPENDENT ALLOC	:-	655.00
MEDICAL INSURANCE PREMIUMS	:-	186.93
PAT LIABILITY OVERCHARGE	:-	.00
COUNTABLE INCOME	:=	1424.07
LTC RATE	:	3150.00
VA A & A	:-	.00
ADJ LTC RATE	:=	3150.00
AG PASSED EXCEPTIONALLY MN BUDGET		
COUNTABLE INCOME	:	1424.07
ITEM D/RECURRING MED EXP	:-	.00
VA A & A	:+	.00
PATIENT LIABILITY	:=	1424.07

COUNTABLE INCOME	:	1424.07
MEDICAL INSURANCE PREMIUMS	:-	.00
MEDICAL EXPENSES	:-	.00
ONGOING INCOME	:=	.00
ADJ LTC RATE	:-	3150.00
DELAYED SPEND-DOWN LIAB	:=	.00
AG ONGOING SPEND-DOWN MED BUDGET		
MEDICAID COVERED MEDICAL EXP	:-	.00
REMAIN SPEND-DOWN LIAB	:=	.00
AG DELAYED SPEND-DOWN MED BUDGET		

NEXT TRAN: PARMS: MORE...

Date: 2/5/04 Time: 11:13:22 AM

Information from Other States

"Income cap" states include Alabama, Alaska, Colorado, Delaware, Georgia, Idaho, Kentucky, Mississippi, Nevada, New Mexico, Ohio, South Dakota and Wyoming.

Alabama:
http://www.medicaid.state.al.us/ABOUT/Form262%20QITpacket%20.pdf
Form: http://www.medicaid.state.al.us/forms/form204205.pdf
http://www.medicaid.state.al.us/ABOUT/longtermcare.htm (waivers)

Alaska:

Colorado's state web site has consumer information and forms on-line:
http://www.dora.state.co.us/insurance/senior/stern7.pdf

Delaware:
http://www.state.de.us/research/AdminCode/title16/5000/5100/20000/20000%20%20Long%20Term%20Care%20Introduction-15.shtml

Georgia:
http://www.odis.dhr.state.ga.us/3000_fam/3480_medicaid/MANUALS/2407.DOC

Kentucky: http://chfs.ky.gov/dms/sept.htm
http://lrc.ky.gov/kar/907/001/650.htm
Suggested form from Legal Services:
http://www.kylawhelp.org/Data/DocumentLibrary/Documents/1064850138.15/QIT%20interactive.pdf

Mississippi:
http://www.dom.state.ms.us/Eligibility_and_Services/NH_Elig_Guide/body_nh_elig_guide.html

Florida: Income trust state; Here is on-line manual:
http://www.dcf.state.fl.us/publications/esspolicymanual/a_22.pdf

Check out this handy calculator (based on Florida law)
http://www.elderlaw.tv/articles.asp?Key=177

Texas on-line information:
http://www.dads.state.tx.us/services/dads_help/paying_for_care/qit_factsheet.html

Oregon on-line information:
http://www.dhs.state.or.us/spd/tools/program/osip/wg5.htm

Oregon form: http://www.dhs.state.or.us/spd/tools/program/osip/incap.pdf
The states have Adult Medically Needy Medicaid:

These continguous states appear to still have Adult Medically Needy:

Virginia: M1480.330 MEDICALLY NEEDY INCOME & SPENDDOWN
http://www.dss.state.va.us/benefit/medicaid_manual.html

Arkansas: http://www.state.ar.us/dhs/dco/Medicaid%20Eligibility.PDF

Missouri and North Carolina: Have Medically Needy programs according to www.statehealthfacts.kff.org

Appendix

Information posted on the website for the Kentucky Legal Aid Network

at http://www.kylawhelp.org/Home/PublicWeb/Search

- **Sample Irrevocable Qualifying Income Trust**
- **Qualifying Income Trusts: Questions and Answers**
- **Preparing a Qualifying Income Trust (QIT) in Kentucky**
- **Instructions for QIT Trustees**