

SPECIAL NEEDS TRUSTS, STRUCTURED ANNUITIES AND MEDICARE SET-ASIDE ALLOCATIONS

WHEN AND HOW

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Patricia F. Sitchler, JD, CELA*
Schoenbaum, Curphy & Scanlan, P.C.
112 E. Pecan Street, Suite 3000
San Antonio, Texas 78205

*Certified as an Elder Law Attorney by the
National Elder Law Foundation as recognized by
the Texas Board of Legal Specialization

A Rule of Thumb for Government Need-based Benefits for the general practitioner

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The following is a very general overview of certain need-based state Medicaid benefits and federal Medicare benefits and should not be relied on as a legal opinion to be applied to specific circumstances.

When meeting with clients who may be receiving funds from a **personal injury award**, in a **divorce** or as an **inheritance**, it is always prudent to ask if the client might have government benefits so that it can be determined if the receipt of funds would cause the client to lose those benefits. Often the prime concern for people is the retention of Medicaid benefits which can be referred to as **cost-free health insurance with a prescription drug benefit**. Some benefits even pay for **housing** and **caretakers** or may include a small income from the federal or state government.

There are some consistent red flags that can alert you when special considerations need to be addressed. I suggest a series of questions be posed to individuals and families in all situations where there will be a receipt of funds. A person does not have to be homeless or totally destitute to receive need-based government assistance. If you discover that a household member has public benefits, you are in a position to assist him/her in making choices about the use of funds that might preserve eligibility for those benefits. The questions are as follows:

- 1. Do any members of the family receive a Medicaid card from the state every month?**
- 2. If someone has a Medicaid card, which family members can access medical care and prescription coverage using this card?** A few of the benefit(s) that an individual might be receiving are Temporary Aid to Needy Families (TANF), one of the Medically Needy programs, the Children's Health Insurance Program (CHIP) or medical benefits associated with nursing home care or Supplemental Security Income (SSI).
- 3. Is anyone in the household disabled and receiving assistance because of their disability?** This could be a payment of a small income and access to Medicaid benefits under the federal Supplemental Security Income program (SSI).
- 4. You could inquire about specific programs: Do you get food stamps, TANF, CHIP, SSI, Medicaid, CBA, CLASS, HCS, MDCP?**
- 5. Clients often do not know what benefit they are getting, so if someone responses that there is some benefit paid, always require either a copy of the client's award letter, identification card or at a minimum, authorization for you to contact the state and/or federal agency to verify benefits. Appendix IV is a form for an authorization for a Medicaid inquiry.**

THE MEDICAID PROGRAMS

In the state of Texas there are more than 40 different Medicaid programs, many with differing criteria for eligibility. When a program refers to a limit on "household" assets, the household includes the parents and the children (even minor children). The following is a list of the more prevalent programs. Also attached as Appendix II is a glossary of benefit programs.

TANF

This is Temporary Aid to Needy Families and is a time limited assistance program that provides a small monthly income and Medicaid benefits for the entire household. The limit for accessible resources is \$1,000 for the household. Primary VEHICLES are exempt up to \$4,650.00 of the fair market value. The excess value is counted as a resource against the \$1,000.00.

Medicaid Medically Needy family programs:

Medicaid Type Program 47 (TP 47)

Children receive Medicaid medical care without the TANF cash assistance because of income of a stepparent or grandparent. The limit for accessible resources is \$1,000.00 for the entire household (Mom, Dad, children). Primary VEHICLES are exempt up to \$4,650.00 of the fair market value. The excess value is counted as a resource against the \$1,000.00.

Medicaid Type Program 55 (TP 55)

Caretakers and/or children who meet income guidelines by spending down income on medical expenses receive Medicaid benefits on this program. The limit for accessible resources is \$1,000.00 for the entire household (Mom, Dad, children). Primary VEHICLES are exempt up to \$4,650.00 of the fair market value. The excess value is counted as a resource against the \$1,000.00. There are higher vehicle exemptions for certain TP 55 recipients.

Other Medicaid Medically Needy programs: TP 40, 42, 43, 44, 45, 48

For the most part, these medical programs cover Mom when she's pregnant and for a period of time after delivery, and the children. The children can continue on Medicaid after Mom's Medicaid stops. A second parent is not covered by the Medicaid on these programs. The household's accessible resource limit is \$2,000.00. It could rise to \$3,000.00 in households with a member who is aged or disabled. The primary VEHICLE is EXEMPT. Additional vehicles may be exempted if their use meets certain criteria.

CHIP

The Children's Health Insurance Program is for children in families with income and/or resource levels higher than the Medically Needy programs. There is no asset limit when the family's income is at or below 150% of the Federal Poverty Income Limit (FPIL; a table for the FPIL is on the last page of this paper). The CHIP asset limit is \$10,000.00 when the household income is between 150% and 200% of the FPIL. One vehicle may be exempted on use (a narrow definition which includes a vehicle modified for and used to transport a disabled household member) regardless of value. In addition, the primary VEHICLE is EXEMPT up to \$18,000.00. Additional vehicles may be exempt up to \$7,500.00. There is a premium for this insurance and the family must re-apply periodically.

FOOD STAMPS

The food stamp household resource limit is \$5,000.00. The primary/ highest value VEHICLE is exempt up to \$15,000.00 of fair market value. The amount in excess of \$15,000.00 is counted as an asset.

Medicaid Programs too Valuable to Lose

Certain Medicaid programs give disabled individuals the opportunity to live independently by providing caretakers to assist with independent living (limited, not 24 hour care) while providing cost-free health insurance and prescription drug coverage. These programs have limited funding and in some cases have a waiting list that exceeds ten years. Loss of any of these types of programs could be catastrophic. Each one of these programs limits the applicant to certain exempt resources that include \$2,000 in countable resources and one VEHICLE. The home is also an exempt resource. The following is a brief discussion of just a few valuable programs:

Community Based Alternative (CBA) This program provides in-home or assisted living caretakers, small modifications to the home, respite care along with cost-free medical care and prescription drug coverage. If application is made directly for this program, the wait is generally from two to four years.

Community Living Assistance and Support Services (C.L.A.S.S.) CLASS services are provided to individuals of any age who were disabled prior to age 22. The individual's disability may arise from anyone or about 200 approved diagnoses, including but not limited to cerebral palsy, muscular dystrophy, spina bifida, epilepsy, head injuries or spinal injuries. Mental retardation is not included in the qualifying conditions. The wait can be in excess of ten years before a program slot is available.

Home and Community Services (HCS) "This Medicaid waiver provides various community services to persons with a diagnosis of mental retardation who would otherwise be inappropriately placed in institutional facilities. Clients may apply and have their eligibility determined while residing in an institution, but must be living in the community to begin receiving waiver services." Medicaid Eligibility Handbook § 4813. The wait can be in excess of ten years before a program slot is available.

Medically Dependent Children's Program (MDCP) Children who are under age 21 are eligible for skilled attendant care as well as adaptive aids, case management, minor home modifications, and respite care. This program, when coupled with the Comprehensive Care Program through Texas Health Steps, will provide extensive benefits for a child who is severely disabled. At age 21, MDCP kids are generally segued into the Community Based Alternative program. The MDCP program has essentially the same eligibility requirements as the CBA program requirements. There is generally a significant waiting list for MDCP.

Supplemental Security Income (SSI) (Federal Program)

A person under the age of 65 can apply for SSI but must meet both financial criteria and disability criteria. Any person who receives SSI automatically gets Medicaid (cost free health insurance and assistance with at least three medications) without a separate application. Because the disability criteria are so stringent, a person can lose SSI even if that person is partially disabled. Loss of SSI is particularly devastating because of the loss of the medical benefits. This can be compounded when the Medicaid services include special programs that have a waiting list (CBA, CLASS or HCS). Temporary loss of Medicaid eligibility may mean years of waiting for reinstatement to the same Medicaid service plan (ie. CBA). The SSI resource limit is \$2,000.00 for an individual and if both spouses are applying for SSI, \$3,000.00. Should the SSI recipient be a child, a portion of the parents' resources are 'deemed,' or counted, toward the child's \$2,000.00 limit. A vehicle of unlimited value is excluded. A second vehicle could be excluded if certain conditions exist. (Do not confuse SSI with Social Security Disability Income [SSDI] for a disabled person or Social Security Retirement benefits one receives upon retirement.) This is a highly regulated and unforgiving program. It is crucial to contact a Certified Elder Law Attorney or someone well acquainted with SSI rules and regulations if Medicaid programs such as CBA, CLASS or HCS are involved.

Beware: Receipt of funds can cause immediate loss of eligibility. This includes funds deposited into the registry of the court and funds held in the attorney's trust account.

Notice requirements. Government agencies that provide benefits based on financial need require notice of any change of circumstance along with a reconciliation of the gross amount received, less any expenses. The agency must receive copies of receipts and an attorney's letter of reconciliation. Confidentiality agreements are not recognized by government agencies and failure to provide required reconciliation could cause a loss of benefits. See *page 7* "**Client Has an Obligation to Report at Least Twice.**"

Caveat: A question that will always come up: **If receipt of funds causes ineligibility for a government benefit, "Can we just give the money away and maintain eligibility for benefits?"** In a few cases, there is no penalty for giving assets away; however, in the majority of cases, gifts will disqualify a person for benefits for a calculated period of time. **A disclaimer of an inheritance or refusing to accept a personal injury recovery is a disqualifying transfer.** Also, a person **over the age of 65 generally CANNOT fund a trust and maintain eligibility for benefits.** If that person was disabled, 64 years, 364 days old, she could fund a trust for herself to preserve eligibility for benefits; but the federal agency (CMS, formerly HCFA) has made the decision to foreclose that avenue to elderly persons.

The Small Case: Sample Strategy

If a family loses government assistance, the children may lose the needed medical attention that is so crucial to maintain their health and ability to go to school and become a productive citizen; or receipt of funds might cause an otherwise independently living adult individual to lose the government benefits and be relegated to institutional care. While there are appropriate times to transfer newly received funds to a trust, program rules and/or amount of funds may make a trust inappropriate. The following are simply examples of ways to preserve eligibility for benefits when an individual has received a small amount of money.

The family benefits: There are four members in the family, two parents and two children. One child is receiving a medical benefit (TP 45) offered under the Medicaid program. Her sibling is also receiving a medical benefit (TP 48) that is provided by the Medicaid agency. All four of the family members are receiving food stamps with previously reported gross income less than \$1510.00 per month. Each child is receiving about \$5,000 as a result of a personal injury award.

Strategies. These children are not disabled and therefore cannot divert their assets to a supplemental needs trust to preserve eligibility. Because of statutory requirements, any other trust that we draft in the attempt to preserve eligibility would generally have to be administered by a corporate trustee. Unless the assets are in excess of about \$70,000.00, it simply will not be cost-effective to have a corporate trustee manage these assets. If the parents are named the trustees, the family would lose eligibility for all benefits. If the funds were paid into the registry of the court, the family would be ineligible for benefits so long as the funds were in the registry.

Alternative I: The practical thing to do for many families is to spend the money. One example would be to use the funds to purchase a reliable car for the family. Of course, the car would be in the name of an adult parent. And the parent would have the ability to sell the car the next day after purchase and take the cash. Cash would cause the family to lose eligibility for benefits but the temptation may be too great. However, the Court could be named a lien holder on the title thus requiring the family to notify the judge if the car was to be sold. Also, to minimize fees, a document could be drafted for the parent, in advance, that could be presented to the judge in order to obtain a release of lien to sell the car. If a release were requested within a short time of purchase, the judge would probably require some funds be used for the children in another manner. However, if the car has served its purpose (5-6 years of service) then the judge may just sign the release. Under the rules, the HHSC Medically Needy programs (such as TP 44, TP 45 and TP 48) allow a family to own one vehicle, regardless of value. One other vehicle may be excluded up to about \$4,500.00 in value. The total family countable resource limit for TP 45 and TP 48 is \$2,000.00.

Alternative II: If you believed that it was in the better interest of the children to put some cash aside for them and the family was cooperative, then a small amount may be set aside in the registry of the court. But the family would have to be willing to change to another Medicaid program. As I previously noted, TP 45 and TP 48 are medical programs. Children's Health Insurance Program (CHIP) is an insurance plan that provides some medical coverage but requires a small monthly premium. If the family opted for CHIPs and food stamps, then they could have assets totaling \$5,000.00. If their current assets total \$2,000 (because the children are on a Medically Needy program) then a total of \$3,000 could be placed in the registry of the court for the children. Of course, as interest accrues on the registry accounts, the family assets would have to be reduced to stay under the total asset limit of \$5,000. The family would have to keep up with the interest accruing.

Alternative III: If the CHIPs program was acceptable, the family decided they could live without food stamps AND the family income is at or below 150% of the FPIL, the family could put all of the assets in the registry of the court. There is no asset test for CHIP for families who have income at or below 150% of the Federal Poverty Income Limit (see an attached chart). **Effective 09-01-07** the cost of childcare may be deducted from the family's income when determining CHIP eligibility. The household asset limit increased from \$5,000 to \$10,000 for families with incomes between 150% and 200% of the FPIL.

Alternative IV: A structured annuity could be purchased for children on a Medically Needy Medicaid program that begins paying at age 18 in equal monthly payments. Such a purchase should not affect their eligibility for Medicaid benefits. If the structured annuity is purchased so that payments are paid out in lump sums over a period of years, Medicaid eligibility should not be affected; however, if the child with the structured annuity paying in lump sums ever became disabled, the existence of lump sum structure payments and/or the delay in receiving the first payment could cause him to be ineligible for Medicaid assistance for disabled persons arising under other (Title XIX) Medicaid programs.

Alternative V: If an annuity is purchased, the child will have no access or benefit of the funds until at least age 18. So an alternative to the purchase of an annuity is to spend the money now on things that the child needs.

Other alternatives: If SSI is an issue planning is more complex. If the amount recovered is a significant amount, then it may be wise to engage an attorney who has a working knowledge of SSI and/or Medicaid benefit requirements. For smaller recoveries, refer to the rule of thumb alternatives noted above.

The Medium - Big Case

Obtaining damages for a disabled person is just the beginning, not the end of your responsibility as attorney for the Plaintiff. If that disabled person is receiving Medicare or is receiving Medicaid or Supplemental Security Income and the case is more than just a small recovery, the recovery that you worked so hard to obtain may cause your client to lose those valuable government benefits. There are statutory exceptions that allow a disabled person to maintain eligibility for government benefits in light of the personal injury recovery--but like all laws, there are intricate regulations that one must follow. A device that successfully protects SSI, Medicaid and now Medicare eligibility is referred to as a Supplemental or Special Needs Trust (SNT). A SNT is a creature of statute. Generally a person cannot place their own funds aside and then apply for a welfare benefit. However, Congress allows that very act through two statutes: 42 U.S.C. sec. 1396p(d)(4)(A) and (d)(4)(C).

Generally. A supplemental needs trust is a very sophisticated estate plan with the express intent of maintaining a disabled person's eligibility for SSI and/or Medicaid, while at the same time preserving adequate funds to provide special items that he or she may need that are not otherwise provided by governmental agencies. Of course, the mere existence of the Trust alone does not and cannot assure a disabled individual's continued eligibility for public benefits because (1) no Trust can be guaranteed; (2) the laws and policies affecting the Trust will certainly change; and (3) the proper administration of the Trust, not its mere existence, is the key to maintaining eligibility for public benefits.

A SNT is generally drafted to make **broad distributions, not to be restrictive!**

The Trust is generally drafted to maximize distributions plus benefits; therefore the Trust will often allow for distributions that might cause a disabled person to lose some benefits, but not all benefits. The Trustee must be very careful about following the rules set out in the Trust and the law; thus one must take special care in choosing a Trustee. In Texas, most SNTs arise as a result of litigation. A SNT funded with an individual's personal injury recovery is most often created by a parent, grandparent, Court or Guardian. If the SNT is created through a District Court settlement, the Judge's authority to create and sign the Trust is found in Texas Property Code sec. 142.005. If the Guardian is authorized to create the Trust, such authority will arise out of Texas Probate Code sec. 867 et seq. In order to properly create a SNT via a Court or a Guardian, the Court Order must **establish the Trust**. Approval of the Trust document is not sufficient to satisfy the federal requirements for a SNT.

If a disabled person is receiving more than one type of government benefit (i.e., SSI, Medicaid, CLASS, MDCP, CBA, HUD housing, etc.) it is important to maintain eligibility for each program. The rules for Medicaid, SSI, CLASS, MDCP, CBA and any other public benefits are all different so do not assume that eligibility for one accords eligibility for another benefit. The SNT Trustee will try to make distributions so that all of the benefits are protected but some benefits such as HUD housing simply cannot be protected with a SNT.

Funding a trust with a structured settlement annuity. Part of the personal injury recovery may purchase a structured annuity and the payments from the annuity would be paid periodically into the SNT. There are four matters that must be addressed when we are funding a Supplemental Needs Trust with a structure.

1. Do not over or under fund a Structured Settlement Annuity. There should be sufficient funds in the trust to purchase the items that are needed. The Structured Settlement Annuity can be the fixed income requirement for the Trust. One method of calculating the division of assets between a Trust and a Structure is to ask the plaintiff or plaintiff's family for a "wish list." Large expenditures should be part of the Trust corpus. Monthly requirements can be funded with the structured settlement annuity.

2. When should the annuity begin paying? This question is unsettled at this time. However, before deferring payment for more than 30 days from the date of purchase, the author strongly recommends contacting an attorney who has an expertise in maintaining government benefits.

3. Who gets annuity assets when the disabled person dies? In order to maintain eligibility for governmental benefits, the government benefit provider (Social Security Administration, Texas Health and Human Services Commission, Texas Department of Aging and Disability Services, Texas Department of Health Services) may ask to scrutinize the annuity contract.

The Social Security Administration will simply verify that an annuity was purchased for the disabled person. If an individual receives even \$1 of SSI payments, that person automatically, without additional qualifications, receives Texas Medicaid benefits. If however, one wanted to avoid the complexities of SSI and apply for Texas Medicaid, such as the Medically Dependent Children's Program or Community Based Alternative Medicaid program, the Texas agency would also scrutinize the annuity. And the State of Texas has more complex rules for annuities.

Texas rules require the annuity to name the State of Texas as the primary beneficiary (person taking the remaining proceeds on the disabled person's death prior to total payout) to the extent that when the disabled person's dies, the State will be reimbursed for up to all of the expenditures made on his or her behalf.

4. Can the disabled person change his or her mind and receive the annuity payments directly? This will only occur if the disabled person is no longer disabled and the Trust is judicially terminated.

Subrogation and Liens. Prior to funding the trust, all Medicare, Medicaid liens (there could be two Medicaid liens arising from the Texas Department of Health and Human Services and the Texas Medicaid and Healthcare Partnership) or any other liens that arose as a result of this injury must be satisfied and released. (See Obligation to Report - just before Appendix I)

Obtaining payments from the Trust. Technically, how would the disabled person or agent or legal guardian ask for a payment? Consider this example: The disabled person or agent or legal guardian decides that the disabled person needs a new computer with high speed internet access. The disabled person or agent or legal guardian would obtain a written cost estimate from the retail store and the cable supplier, forward a request for purchase of the specific computer (i.e., from Best Buy) and cable contract to the Trustee. The Trustee would consider the request and then, if there is enough money in the account, the Trustee would send a check payable to the retail store (i.e., Best Buy) for the cost of the computer and would send a check payable to the cable provider for the cost of the high speed internet access.

Parent's duty to support. A disabled child's parents should understand that Texas Family law requires a parent to support his/her child. Under Texas law, a child's money cannot be used for those basic necessities that a parent should provide. However, if the parent has no means to provide, for example, necessary medical treatments, and if Medicaid does not pay for the procedure, then most likely the Trust would. As mentioned earlier, some payments (such as indirect assistance with food and shelter costs) could affect a food stamp allocation for the family.

Who gets the money in the Trust when the Trust terminates? If the Trust terminates because the disabled person dies or because the disabled person is no longer disabled, the law requires that any money remaining in the Trust be used to reimburse the State for Medicaid payments the State has made for the disabled person. Keep in mind that the State of Texas has negotiated a significant discount for all goods and services and there is no interest on the repayment of the expenditures. This is a reimbursement provision and not a windfall. Therefore, any remaining funds will be paid to the disabled person if alive, or to the disabled person's estate if he or she is deceased.

Examples of Distributions. The following are examples of possible payments that the Trustee might make for a disabled person. The possible payments are examples only and could change, but should give some indication of how the Trustee might respond to requests for payments.

- A. Basic items that can generally be purchased:
 - 1. A pre-paid funeral;
 - 2. A burial plot.
 - 3. Home
 - 4. Car (van with handilift)
- B. Furnishings:
 - 1. Prepayment of cable TV if paid directly to the provider;
 - 2. Payment directly to the provider for hair care;
 - 3. Extra pair(s) of glasses;
 - 4. Television, DVD player, Improved remote TV's (extra remotes), radio, VCR (for watching tapes of family events, if any, or nostalgic movies), tape recorder and books on audio tapes;
 - 5. Furnishings for a disabled person's room or home.
 - 6. Club or hobby memberships and magazines.
- C. Services:
 - 1. Massage therapists;
 - 2. Psychologists, psychiatrists, counselors, therapists and dental care not provided by Medicare or Medicaid;
 - 3. Skilled care such as occupational, speech, music or physical therapists that are not covered by Medicare or Medicaid;
 - 4. Alternative medical care--acupuncture, hypnosis, and relaxation therapies.
- D. Limitations: The following list of items may be restricted based on the government benefit and the flexibility of the Trust.
 - 1. Cash.
 - 2. House payment, utilities, insurance, house taxes, garbage fees and condo fees;
 - 3. Food bill.
 - 4. Parents' obligations of support.

It may be malpractice to fail to consider using a SNT to protect SSI and/or Medicaid current or future eligibility. The case law is scant, probably because the attorney (1) has malpractice insurance and (2) doesn't want to go before a jury on damages. But there are a couple of cases of actual or potential malpractice - all out of Texas.

The Grillo (Tarrant County district court) cases (1991) arose from a personal injury law suit that settled in 1984. The attorneys for the plaintiff (an incompetent person) and the Guardian Ad Litem directed the settlement amount into the registry of the court and directed the guardian of the plaintiff to ask the Court for a 142 trust and suggested that the Guardian could purchase annuities if she wanted to. However, the attorneys did not offer the opportunity to create a SNT to preserve SSI/Medicaid eligibility nor did they discuss the possibility and tax advantages of purchasing a structured settlement annuity. The Plaintiff's attorney and the Guardian ad Litem ultimately settled the malpractice lawsuit for \$4.1 million.

The French case (filed by Harry Bates of San Antonio) alleged that the attorney failed to create a SNT for the client and placed the funds in the attorney's trust account subjecting the client to a potential loss of Medicaid eligibility. The defendant attorneys prevailed; however the opinion was overruled by a subsequent Texas Supreme Court case.

Remember, most SNTs are created pursuant to the powers of Texas Property Code 142 so they are 142 Trusts with a few added requirements for the Trustee. I believe that there is a perception that a SNT is very restrictive and it can be restrictive. However, if properly drafted it can be as broad as any 142 Trust but it allows the Trustee to stretch the trust dollars by (1) relying on government benefits to pay for some goods and services and (2) utilizing the State's huge negotiating power so that when the State is reimbursed, it is reimbursed at the State's discounted rate for goods and services - not the private pay rate.

Medicare Set-Aside Trust Considerations in light of the Medicare Secondary Payer statute

If your client is receiving a **personal injury recovery and also receives Medicare benefits**, or anticipates receiving Medicare benefits within 30 months of receipt of the personal injury funds, then it is imperative to investigate the effect that a personal injury recovery may have on the client's continued eligibility for injury related Medicare coverage.

In 1980, Congress passed the Medicare Secondary Payer Act (MSP Act) found in 42 U.S.C. §§ 1302, 1395w-101 through 1395w-152, 1395hh with regulations found at 42 C.F.R. § 411.40. The MSP Act mandated that Medicare would be the payer of last resort if there was any other source for medical payments. The primary means of paying for future medicals was through Workers Compensation benefits and so the only MSP interpretative comments issued by CMS only involved reference to Workers Compensation recoveries. However, for a number of years CMS has assured attorneys that the MSP Act applied not only to Workers Compensation but also to Liability Insurance (including self-insurance) and No-Fault Insurance as described in the Statute.

If there is no guidance regarding recoveries outside of Workers Compensation, what is a Litigator to do? The following are excerpts taken from a presentation at the University of Texas School of

Law, Special Needs Trust Conference, February 19-20, 2009, Austin Texas, by Sally Stalcup, MSP
Regional Coordinator, CMS, Region 5, Dallas, Texas:

Section 1862(b)(2)(A)(ii) of the Social Security Act precludes Medicare payment for services to the extent that payment has been made or can reasonable be expected to be made promptly under liability insurance.

Anytime a settlement, judgment or award provides funds for future medical services, it can reasonably be expected that those funds are available to pay for Medicare covered future services **related to what was claimed and/or released in the settlement, judgment or award**. Thus, Medicare should not be billed for future services until those funds are exhausted by payments to providers for services that would otherwise be covered by Medicare.

The fact that a settlement/judgment/award does not specify payment for future medical services does not mean that they are not funded. The fact that the agreement designates the entire amount for pain and suffering does not mean that future medicals are not funded.

While it is Medicare's position that counsel should know whether or not their recovery provides for future medicals, simply recovers policy limits, etc., we are frequently asked how one would 'know'. Consider the following examples as a guide for determining whether or not settlement funds must be used to protect Medicare's interest on any other Medicare covered, case related future medical services. Does the case involve a catastrophic injury or illness? Is there a Life Care Plan or similar document? Does the case involve any aspect of Workers' Compensation? This list is by no means all-inclusive.

At this time, CMS is not soliciting cases solely because of the language provided in the general release. CMS does not review or sign off on counsel's determination of the amount to be held to protect the Trust Fund in most cases. We do however, urge counsel to consider this issue when settling a case and recommend that their determination as to whether or not their case provided recovery funds for future medicals be documented in their records. Should they determine that future services are funded those dollars must be used to pay for future otherwise Medicare covered case related services. There is no formal CMS review process in the liability arena as there is for WC, however Regional Offices do review most submitted set-aside proposals. On occasion, when the recovery is large enough or other unusual facts exist within the case, this [Dallas] CMS Regional Office will review the settlement and help make a determination on the amount to be available for future services.

Attorney's Obligation Regarding Medicare: Once you/your firm is retained, it is your capacity as an officer of the court and under CMS regulations to see that Medicare's interests are protected.

Finally, when pointedly asked why CMS has not pursued liability cases that included Medicare allowable injury related recoveries, Ms. Stalcup noted that such cases have, up to now, been difficult if not impossible to track. However, she noted, with the Medicare, Medicaid and SCHIP Extension Act of 2007, CMS will now have the ability to track personal injury recoveries. Under the SCHIP amendment to the MSP Act, effective July 1, 2009, insurers will have the obligation to report certain information regarding every insurance liability payment including the name, address and phone number of the Plaintiff and the Plaintiff's Attorney along with the amount of the recovery.

Solution: Scrutinize the recovery. Are there injury related future medicals anticipated and is your client eligible for Medicare (or will he be eligible within 30 months of receipt of funds)? If so, take steps to protect your client and yourself. There are organizations that will (1) calculate a set-aside amount based on existing Workers Compensation Rules (2) negotiate with CMS on your behalf (3) and even administer the funds to assure that the funds are paid only for Medicare allowable expenses so that when the funds are exhausted Medicare will again pay. **The costs for the calculation and administration of a set aside fund should be part of any Settlement negotiation.**

What do you do when the Defendant wants to pay but you have 8 weeks to 18 months needed to negotiate with CMS? The funds might be held in the Attorney's Trust account provided that there is no need-based benefit (medicaid or SSI) considerations or the need for a Structured Settlement Annuity. Or one might consider receiving the funds into a 468B Qualified Settlement Fund.

What is the penalty for failing to protect Medicare's Secondary Payer status? CMS can recover erroneous payments by bringing an action 'against any entity' including a beneficiary, supplier, provider, physician, attorney or private insurer who has received any part of the third-party payment, directly or even indirectly. 42 U.S.C. sec. 1395y(b)(2)(ii). The Statute allows for *double damages plus interest* when collected from the primary payer (insurance company). Or, Medicare could refuse to pay injury related medicals to the full extent of the recovery.

MSA embedded in a SNT: The establishment of a MSA will disqualify your client for SSI and or Medicaid. However, a MSA can be embedded within a SNT thus protecting Medicare, SSI and/or Medicaid benefits. See your local SNT Attorney to assist you in providing the highest quality of representation to your client. You can locate an Attorney who maintains an expertise in this area by contacting the Special Needs Alliance - www.specialneedsalliance.com

**CLIENT HAS AN OBLIGATION TO REPORT AT LEAST TWICE
FIRST REPORT
UPON DETERMINATION OF A POTENTIAL RIGHT OF RECOVERY**

The obligation for a client to report is described in Section 32.033 of the Texas Human Resources Code. It requires a person who is receiving government assistance through the Medicaid program to give notice within 60 days of a right to recover from an insurance company or tortfeasor. The statute states, in part:

“An applicant or a recipient shall inform the department as required by this subsection within 60 days of the date the person learns of his or her insurance coverage, tort claim, or potential cause of action. An applicant or a recipient who knowingly and intentionally fails to disclose the information required by this subsection commits a Class C misdemeanor.”

“A claim for damages for personal injury does not constitute grounds for denying or discontinuing assistance under this chapter.”

“A separate and distinct cause of action in favor of the state is hereby created, and the department may, without written consent, take direct civil action in any court of competent jurisdiction. A suit brought under this section need not be ancillary to or dependent upon any other action.”

“The department’s right of recovery is limited to the amount of the cost of medical care services paid by the department. Other subrogation rights granted under this section are limited to the cost of the services provided.”

“The commissioner may waive the department’s right of recovery in whole or in part when the commissioner finds that enforcement would tend to defeat the purpose of public assistance.”

The report for the potential recovery is made to two agencies, the Texas Health and Human Services Commission’s:

Texas Medicaid Healthcare Partnership

TPL/Tort Department
P.O. Box 202948
Austin, TX 78720-2948
512-506-7546

and

Department of Aging and Disability Services

Provider Claims Services Recovery Unit (E-400)
P.O. Box 149081
Austin, TX 78714-9081
512-438-2219

**CLIENT HAS AN OBLIGATION TO REPORT
SECOND REPORT
AT THE DISPOSITION OF THE PERSONAL INJURY RECOVERY**

Upon funding the Trust, the Client or the Client’s legal representative must give notice to all governmental entities providing benefits (at the numbers noted above) and pay any subrogation amounts. Medicare can be contacted at:

Trailblazer Health Enterprises
Medicare Secondary Liability
P.O. Box 9020
Denison, TX 75021-9020
(903) 463-0641 (8:00 a.m. - noon, M-F)
(903) 463-0642 fax

Confidentiality Agreements: It is common to enter into a confidentiality agreement in the settlement of a personal injury suit. However, I must point out that when a person on government benefits receives any funds the governmental agency must be informed of the gross recovery, the amount of any payments out of the recovery and the net proceeds that went into the trust. Governmental agencies are not supposed to release the information to anyone but the principal or the principal's agent (or any person noted under the patriot act) however, without this release of information benefits, will cease.

Any subrogation amounts must be paid prior to funding a Supplemental Needs Trust or risk loss of Medicaid eligibility. In negotiating the payoff amount with the State, keep in mind the recent *Ahlborn* case. *Arkansas Dept. of Human Servs v. Ahlborn*, 547 U.S. 268, 126 S.Ct. 1752, 164 L.Ed.2d 459 held that the Arkansas "statute automatically imposing lien in favor of ADHS on tort settlement proceeds was not authorized by federal **Medicaid** law, to extent that statute allowed encumbrance or attachment of proceeds meant to compensate recipient for damages distinct from medical costs, and (2) anti-lien provision of federal Medicaid law precluded Arkansas statute's encumbrance or attachment of proceeds related to damages other than medical costs" "The federal third-party liability provisions *require* an assignment of no more than the right to recover that portion of a settlement that represents payments for medical care. They did not mandate the enactment of the Arkansas scheme..." p. 1762. Ultimately, the *Arkansas* Supreme Court opinion limited the state to reimbursement for medicals as set out in litigation.

Medicaid Estate Recovery Program (MERP) Finally, if you are suing on behalf of a deceased person, keep in mind that the State of Texas has the right to recover some Medicaid expenditures from the Estate of the deceased medicaid recipient. Inquiries should be directed to: Texas Department of Aging and Disability Services, Estate Recovery (MERP), 1-800-458-9858, merp@dads.state.tx.us.

Appendix I
2009 Federal Poverty Guidelines for the 48 Contiguous States
and the District of Columbia

Family Size	Gross Yearly Income	Gross Monthly Income
1	\$10,830	\$ 902.50
2	\$14,570	\$1,214.17
3	\$18,310	\$1,525.83
4	\$22,050	\$1,837.50
5	\$25,790	\$2,149.17
6	\$29,530	\$2,460.83
7	\$33,270	\$2,772.50
8	\$37,010	\$3,091.75
Over 8 add per child	+\$3,740	+\$311.67

APPENDIX II
GLOSSARY OF BENEFIT PROGRAMS

Not an exclusive list but a general overview of the most common governmental programs and associated financial limitations

HUD Housing: Based on FINANCIAL NEED. Subsidized housing for needy families.

Medicaid based on FINANCIAL NEED. There are approximately 40 programs in Texas. The following are selective programs for two specific client bases: those who are 65 or disabled (Title XIX) and those who are poor (Title XXI):

Medicaid Title XIX: Based on FINANCIAL NEED & must be age 65 or have a diagnosis of DISABILITY

Long term nursing home care that includes cost-free health and drug coverage

Community Based Alternative (CBA) to nursing home care; provides for limited in-home caretaker, minor adaptive renovations to home, and cost-free health and drug coverage (waiting list for this benefit)

Primary Home Care (Community Attendant Services /1929b) provides minimal (1-3 hours/day) caretaker in the home

Community Living Assistance and Support Services (CLASS), for persons who are disabled prior to the age of 22, the program provides for limited in-home caretaker, minor adaptive renovations to home, and cost-free health and drug coverage. (waiting list for this benefit)

Home and Community Services (HCS), similar to CLASS but for persons who have a diagnosis of mental retardation. (waiting list for this benefit).

Medically Dependant Children's Program (MDCP), similar to CLASS and has a shorter wait list

SSI related Medicaid pays for hospital and doctor costs and up to three medications per month

Medicaid based on FINANCIAL NEED only. include, but are not limited to:

Childrens Health Insurance Program (CHIP) a low-cost health insurance for children who are not necessarily disabled

Food Stamps are distributed to low income families. Notice must be given for any occurrence that would cause ineligibility (such as receipt of funds). Upon notice that something has occurred to create ineligibility the matter will automatically be referred to criminal fraud for investigation.

Temporary Aid to Needy Families (TANF) based on FINANCIAL NEED; a time limited assistance program that provides a small monthly income and Medicaid benefits for the entire household.

Medically Needy programs (TP 40,42,43,44,45,47, 48,55) Cost-free medical coverage for needy children & some mothers.

Medicare is NOT based on financial need. Eligibility is based on age or disability. Medicare is health insurance that pays for major medical costs, doctor bills, lab tests, rehabilitation, hospice and drug costs. Just like any health insurance, there are co-payments and deductibles. There is a limited window of opportunity to apply for this coverage. See attached Exhibit for co-payments and deductibles.

Part A generally covers hospital, skilled nursing facility rehabilitation, home therapy and hospice.

Part B generally covers doctor bills and some therapy

Part C or Medicare Advantage is the Medicare HMO and replaces Part A and B

Part D is the drug program

Mental Health benefits through the Texas Department of State Health Services (San Antonio is Center for Health Care Services, State School and San Antonio State Hospital) Cost will be borne by the consumer unless there is FINANCIAL NEED. By statute, there is a \$250,000 limitation on any trust for the benefit of a person accessing benefits.

Social Security Retirement Benefits (RSDI) NOT based on financial need. Persons who pay into the Social Security program a required amount for a required number of years will be able to receive monthly payments upon retirement as early as age 62.

Social Security Disabled Adult Child's benefit (DAC) is NOT based on financial need. If a child is disabled prior to age 22, that child may receive payments beginning at age 18 based on a parent's contributions to the Social Security system. The parent must be either retired or deceased for these benefits to begin paying to the adult disabled child. After receiving the equivalent of 24 months of DAC, one is eligible for Medicare health insurance.

Social Security Disability Insurance (SSDI) is NOT based on financial need. By paying into the Social Security system, a person is purchasing disability insurance. If one is disabled, it pays until the person reaches full retirement age - approximately 65 ½ for 2006. After receiving the equivalent of 24 months of SSDI, one is eligible for Medicare health insurance.

Supplemental Security Income (SSI) is based on FINANCIAL NEED. If a person, age 65 or totally disabled has never worked or paid into the Social Security system but has income less than \$637.00 per month (2008), the person can apply for a small income paid by the Social Security administration. The maximum income that a person will receive from SSI is \$623.00 for 2007 and 637.00 in 2008. Eligibility for even \$1 of SSI carries with it, at a minimum, MAO Medicaid. Do not presume that the Medicaid benefit associated with SSI is limited to basic doctor, hospital and medication coverage. One might be receiving more enhanced Medicaid benefits along with SSI.

Supplemental (Special) Needs Trust (SNT) can be used to protect a Plaintiff's continued eligibility for SSI and/or Medicaid benefits. Federal law found in 42 U.S.C. sec. 1396p(d)(4) allows a disabled individual to protect eligibility for SSI and/or Medicaid by having personal injury funds diverted to a Trust. The Trust must be established by a parent, grandparent, Court or Guardian for an individual **under age 65** and provide that upon the death of the beneficiary, the State will be reimbursed for Medicaid expenditures. It is notable that Medicaid reimbursement will often be significantly less than the private pay rate.

Medicare Set-Aside Allocation (MSA) is an amount carved out of a personal injury recovery that represents Medicare allowable future medical costs.

APPENDIX III
MEDICAID REFERENCE AMOUNTS FOR 2008-2009

MEDICAID BENEFIT	2008	2009
Income Cap	\$1,911.00	\$2,022.00
Income Cap for husband & wife applicants	\$3,822.00	\$4,044.00
Supplemental Security Income (single) (note that the income cap is calculated by multiplying the SSI amount X 3 = \$2,022) The first \$20.00 of non-SSI income is disregarded.	\$637 / \$657	\$674 / \$694
Supplemental Security Income (couple) The first \$20.00 of non-SSI income is disregarded	\$956 / \$976	\$1,011/ \$1,031
Spousal Protected Resource Amount (“PRA”), minimum	\$20,880	\$21,912
Spousal PRA, maximum	\$104,400	\$109,560
Minimum Monthly Maintenance Needs Allowance for Spouse (“MMMNA”)	\$2,610.00	\$2,739.00
Qualified Medicare Beneficiaries’ income limit (QMB) (single) The first \$20.00 of income is disregarded, effectively raising the limit	\$867.00/\$887.00 March 1, 2008 to March 31, 2009	\$867.00/\$887.00 March 1, 2008 to March 31, 2009
Specified Low-Income Medicare Beneficiaries (SLMB) (single) The first \$20.00 of income is disregarded, effectively raising the limit	\$1,040/\$1,060 March 1, 2008 to March 31, 2009	\$1,040/\$1,060 March 1, 2008 to March 31, 2009
Qualifying Individuals (QI) (single). The first \$20.00 of income is disregarded, effectively raising the limit.	\$1,170/\$1,190 March 1, 2008 to March 31, 2009	\$1,170/\$1,190 March 1, 2008 to March 31, 2009
Average cost of nursing home care in Texas (divide \$3,675 into the value of gift(s) in order to estimate the number of months of ineligibility. Fractional remainders are converted to additional days of ineligibility beginning December 1, 2005)	\$3,675 monthly/ \$122.50 daily beginning September 1, 2007, ending August 31, 2009	\$3,675 monthly/ \$122.50 daily beginning September 1, 2007, ending August 31, 2009

APPENDIX III-B

MEDICARE REFERENCE AMOUNTS FOR 2008 - 2009

Table 1

MEDICARE BENEFIT	2008	2009
Part B Premium (2008 figure for those with annual income below \$82,000. The 2009 income threshold is \$85,000.00.)	\$ 96.40	\$ 96.40 (no change)
Part A Premium	\$244.00 for 30-39 quarters of employment; \$443.00 for less than 30 quarters of employment	\$244.00 for 30-39 quarters of employment; \$443.00 for less than 30 quarters of employment
Part D basic (Benchmark Premium for Texas)		\$ 25.36
Part B Deductible	\$ 135.00	\$ 135.00 (no change)
Part B Co-Payment	20% of Medicare approved amount	
Skilled Nursing Facility (“SNF”) co-insurance payment (amount that individual must pay, per day, before Medicare pays; co-insurance begins on day 21 in a SNF)	\$ 128.00	\$ 133.50
Hospital Deductible per spell of illness	\$ 1,024.00	\$ 1,068.00
Hospital co-insurance payment for days 61-90	\$ 256.00	\$ 267.00
Hospital co-insurance payment for days 91-150 (“Lifetime Reserve Days”)	\$ 512.00	\$ 534.00

APPENDIX III-B

Table 2

Under recent Medicare law, higher income beneficiaries pay higher Part B premiums . The 2009 amounts are shown below.		
Unmarried individuals with annual incomes between	\$85,000 and \$107,000 will pay	\$134.90
Married couples with annual incomes between	\$170,000 and \$214,000 will pay	\$134.90
Unmarried individuals with annual incomes between	\$107,000 and \$160,000 will pay	\$192.70
Married couples with annual incomes between	\$214,000 and \$320,000 will pay	\$192.70
Unmarried individuals with annual incomes between	\$160,000 and \$213,000 will pay	\$250.50
Married couples with annual incomes between	\$320,000 and \$426,000 will pay	\$250.50
Unmarried individuals with annual incomes of	\$213,000 or more will pay	\$308.30
Married couples with incomes of	\$426,000 or more will pay	\$308.50
Rates for Married Beneficiaries Filing Separate Tax Returns from Spouse		
Individuals with income of	\$85,000 or less	\$96.40
Spouse with income between	\$85,000 and \$128,000 will pay	\$250.50
Spouse with income greater than	\$128,000 will pay	\$308.30

AUTHORIZATION FOR RELEASE OF RECORDS
(Signed by Personal Representative)

- TO: THE TEXAS HEALTH AND HUMAN SERVICES COMMISSION
- TO: THE TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES
- TO: THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES

I hereby authorize the above noted agencies to communicate with (including during a face-to-face interview) and the release of any and all records on _____ [client's name] (including records concerning all benefits and amounts of benefits that I have received in the form of Medicaid benefits, etc.) in the possession of the Texas Health and Human Services Commission, the Texas Department of Aging and Disability Services and/or the Texas Department of State Health Services to _____, personal representative and agent of _____ [client's name], through attorney, _____. This authorization shall also allow the attorney to act on behalf of _____, personal representative and agent of _____ [client's name], in a face to face meeting or any other meeting with the Texas Health and Human Services Commission, the Texas Department of Aging and Disability Services and/or the Texas Department of State Health Services. This authorization should be considered valid for six (6) months, and a copy of this authorization should be considered as valid as the original.

SIGNED this ___ day of _____, 2008.

By: _____
(signed by personal representative/agent)

Medicaid client's medicaid # _____
or
Social security # _____

How many persons are in the household? _____

Are other household members receiving government benefits? _____

If yes, please provide the following information for each benefit recipient:

- Name:
- medicaid or SS#
- type of benefit that is received:

PATRICIA F. SITCHLER, CELA*
Schoenbaum, Curphy & Scanlan, P.C.
112 E. Pecan Street, Suite 3000
San Antonio, Texas 78205
(210) 224-4491
(210) 224-7983 (fax)
www.scs-law.com

PATRICIA (“PATTY”) FLORA SITCHLER is a shareholder in the law firm of Schoenbaum, Curphy & Scanlan, P.C. A native of San Antonio, Patty is certified as an Elder Law Attorney by the National Elder Law Foundation (as recognized by the Texas Board of Legal Specialization). She earned a B.A. in mathematics from Trinity University and a J.D. with high honors from St. Mary's University School of Law. She serves as an adjunct professor at St. Mary's University School of Law since 1998, and she is a frequent author and lecturer on elder law, estate planning, trust and estate administration issues, and legal ethics at programs such as the National Academy of Elder Law Attorneys Symposium, the University of Texas Elder Law Courses and State Bar of Texas Elder Law Seminars and San Antonio Young Lawyer's Docket Call in Probate Court. She is a member of the San Antonio Bar Association, Texas Bar Association, American Bar Association, College of the State Bar of Texas and the National Academy of Elder Law Attorneys where she is Past President (2005-2006). Her practice includes Elder Law, Estate Planning and Administration and Litigation Support. Patty is a member of the Special Needs Alliance and a Fellow of the American College of Trust and Estate Counsel (ACTEC) and is the first attorney in the State of Texas to be both Certified as an Elder Law Attorney and be a Fellow in ACTEC. She is A-V rated by Martindale Hubbell, is listed in *The Best Lawyers in America* (2007, 2008), in the *Scene In SA Monthly* as one of San Antonio's Best Lawyers in the field of Trust & Estate Law and in *Texas Monthly's Super Lawyers* 2004 - 2008 under the category of Elder Law. Patty is co-author of two books: *Save My Home! Saving Your Home, Farm or Ranch from Medicaid Estate Recovery in Texas*, Elder Law Trio Press, Houston, 2005 and the newest publication of the Texas Practice Series entitled *Elder Law* published by Thomson-Reuters formerly West Publishing (2008).