The Kentucky Bar Association
Elder Law Section
presents

2019 Elder Law Section
CLE Seminar

This program has been approved in Kentucky for 6.50 CLE credits including 1.00 Ethics credit
Editor's Note: The materials included in this 2019 Elder Law CLE seminar book are intended to provide current and accurate information about the subject matter covered. The program materials were compiled for you by volunteer authors. No representation or warranty is made concerning the application of the legal or other principles discussed by the instructors to any specific fact situation, nor is any prediction made concerning how any particular judge or jury will interpret or apply such principles. The proper interpretation or application of the principles discussed is a matter for the considered judgment of the individual legal practitioner. The faculty and staff of the Kentucky Bar Association disclaim liability therefor. Attorneys using these materials or information otherwise conveyed during the program, in dealing with a specific legal matter, have a duty to research original and current sources of authority.
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2019 Elder Law Section CLE Seminar  
April 12, 2019  
Lexington, Kentucky

8:00-8:30 a.m.  
Registration

8:30-9:00 a.m.  
Welcome & Non-Profit Spotlight  
Mary Ellis Patton  
*Bluegrass Elderlaw, PLLC*

Laura Dake  
*Bluegrass Care Navigators*

9:00-10:00 a.m.  
**New VA Regulations and Future Planning**  
(1.00 CLE credit)  
Victoria L. Collier, J.D., CELA  
*The Estate & Asset Protection Law Firm*

10:00-10:10 a.m.  
Break

10:10-11:10 a.m.  
**Home and Community Based Waivers**  
(1.00 CLE credit)  
Pam S. Smith, Director  
*Department for Medicaid Services*  
*Division of Community Alternatives*

11:10 a.m.-12:10 p.m.  
**Strategies Using Medicaid Compliant Annuities in Kentucky**  
(1.00 CLE credit)  
Thomas R. Krause  
*Krause Financial Services*

12:10-1:10 p.m.  
Luncheon & Section Meeting

1:10-2:40 p.m.  
**What Kentucky Elder Law Attorneys Should Know about Medicaid in Surrounding States**  
(1.50 CLE credits)  
Neil K. Aboulhosn  
*Kentucky ElderLaw, PLLC*

Ashley Shannon Burke  
*Burke & Pecquet, LLC*

Timothy L. Takacs  
*Takacs McGinnis Elder Care Law, PLLC*

2:40-2:50 p.m.  
Break
2:50-3:50 p.m.  Ombudsman Services/Complaint Process and Residents’ Rights
(1.00 CLE credit)
Denise Wells, Bluegrass District Ombudsman
Nursing Home Ombudsman Agency of the Bluegrass, Inc.

3:50-4:50 p.m.  Design Your Work Life: Developing Efficient Workflows through the Use of Smart Technology
(1.00 Ethics credit)
Brian L. Schuette
Schuette Law Group
SPEAKERS

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Victoria Collier is the founder of The Elder & Disability Law Firm of Victoria L. Collier, d/b/a The Estate & Asset Protection Law Firm, as well as Red Feather Financial, The Rainbow Family Law Group, and Collier Communications, LLC. She is a Fellow of the National Academy of Elder Law Attorneys, a Certified Elder Law Attorney by the National Elder Law Foundation, was appointed by Georgia Governor S. Purdue to the Georgia Council on Aging, and a best-selling author, to include the book 47 Secret Veterans’ Benefits for Seniors. Ms. Collier graduated from Valdosta State University with a B.A. in Psychology, and University of Nebraska-Lincoln, School of Law, subsequently being awarded as Master Alum. She is a veteran of the USAF and the Army Reserve. Ms. Collier, her wife, and boy-girl twins live in Decatur, a bedroom community of Atlanta, Georgia.

Pam S. Smith, Director
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Pam Smith is the Director of the Department for Medicaid Services Division of Community Alternatives in Frankfort. She received her Associate degree in Nursing from Kentucky State University and her B.S. in Business Management from Indiana Wesleyan University.
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Thomas R. Krause is the Vice President of Sales and Marketing at Krause Financial Services. He specializes in using annuities to accelerate eligibility for government benefits, expert testimony and litigation support when attorneys are faced with a Medicaid denial, and the valuation and sale of non-compliant annuities. Mr. Krause has a passion for teaching elder law attorneys crisis Medicaid planning strategies for their senior clients. He speaks at legal forums throughout the country and often hosts the national *KrauseCAST* webinar series, which focuses on providing the knowledge and resources needed to be successful in the industry. Mr. Krause was also recently featured in the American Bar Association’s “Voice of Experience” publication, where he discussed how a Medicaid Compliant Annuity can help seniors in need of nursing home care. Mr. Krause earned his B.S. degree in economics from the University of Wisconsin-Milwaukee in 2010 and his J.D. from California Western School of Law in 2014. He is a member of the California State Bar.

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Neil Aboulhosn assists older clients, their children, and other family members with Medicaid and VA planning and submission, asset preservation, asset distribution, mental capacity issues, probate, guardianship, and other matters. He received his B.A. from the University of Kentucky and his J.D. from the University of Louisville Louis D. Brandeis School of Law. While pursuing his law degree, he was a law clerk at Kentucky ElderLaw and was a member of the *University of Louisville Law Review*. In his time clerking at Kentucky ElderLaw, he saw firsthand the difficulties families face as their loved ones age and need care. After graduating law school, he joined Kentucky ElderLaw to assist families through this process. Mr. Aboulhosn is licensed to practice law in Kentucky and Indiana. He is a member of the Kentucky Bar Association Elder Law Section and Young Lawyers Division.
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Certified as an elder law attorney by the Ohio State Bar Association and the National Elder Law Foundation, Ms. Burke represents clients in the areas of elder law, estate planning and probate administration and is admitted to the practice of law within the State of Ohio, Commonwealth of Kentucky, and the District Court for the Southern District of Ohio. She obtained her law degree, cum laude, from the University of Cincinnati College of Law in 2009. In 2006, she earned her B.A. in sociology and criminology, summa cum laude, from The Ohio State University. Ms. Burke is vice-chair of the Cincinnati Bar Association’s Elder Law Committee, past-president and member for the Ohio Chapter of the National Academy of Elder Law Attorneys (NAELA), and vice-chair of the Elder Law and Special Needs Law Committee of the Ohio State Bar Association.

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Certified by the National Elder Law Foundation as a Certified Elder Law Attorney and by the State of Tennessee as an Elder Law Specialist, Tim Takacs was one of the first elder law attorneys in the nation to assemble an interdisciplinary team of experts to provide integrated client care. He began his legal career in 1980, right after graduating from law school. He joined three other lawyers to open a general practice in Hendersonville. In the mid-1990s, he began adding non-lawyer health care professionals to his staff, including registered nurses and a licensed master social worker, to address quality of life and care issues that the challenge of old age and disability presents to his clients. Mr. Takacs and other members of his firm have taught the fundamentals of life care planning practice to hundreds of lawyers through the U.S. He is a founding member of the Life Care Planning Law Firms Association (LCPLFA) and was the Association’s first president. He is also a founding member of the Special Needs Alliance, an organization of the nation’s leading lawyers on issues pertaining to persons with disabilities and special needs. In 2000, he incorporated Vista Points, Inc., a non-profit corporation to establish and manage the Tennessee Pooled Trust, the state’s first special needs pooled trust, and of which he is president. He has been a member of NAELA since 1991 and was a member of NAELA’s Board of Directors from 2004-2008. Mr. Takacs is a graduate of the University of Notre Dame and the Vanderbilt University School of Law. He is the author of Elder Law Practice in Tennessee (Lexis/Nexis, 1998; supplemented annually) and A Guide to Elder Law Practice (Lexis, 2007).
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Denise Wells is the Bluegrass District Ombudsman with Nursing Home Ombudsman Agency of the Bluegrass, Inc. (NHOA). She is responsible for coordinating ombudsman services for more than 5,500 long-term care residents in 17 counties. Ms. Wells received her B.A. in sociology and psychology from McKendree University. She became a Certified Ombudsman in 2014 and is a member of the National Association of Local Long-Term Care Ombudsmen.

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Brian Schuette is the lead attorney at Schuette Law Group and has been practicing law in Kentucky since 1991. He is AV-rated by Martindale Hubbell. His practice is focused on personal injury, civil litigation and legal matters for churches. He is trained as a mediator (Rule 31 listed in Tennessee) and Christian conciliator (alternative dispute resolution for churches and church members). He received his B.A. from Western Kentucky University and his J.D. from the University of Louisville Brandeis School of Law. Mr. Schuette is admitted to practice in all Kentucky and Tennessee state courts, U.S. District Court for the Eastern and Western Districts of Kentucky, U.S. District Court for the Eastern and Middle Districts of Tennessee, and the U.S. Court of Appeals for the Sixth Circuit.
On January 23, 2015, the VA issued proposed regulations, Federal Register Vol. 80, No. 15, Part IV, 38 CFR Part 3, Net Worth, Asset Transfers, and Income Exclusions for Needs-Based Benefits. Specifically, restricting the eligibility criteria to become and maintain eligible for the VA Wartime Pension (often referred to as Aid and Attendance) benefits. These benefits provide income exclusively to wartime veterans and their surviving dependents to help offset medical expenses. Because these benefits are “needs based,” Claimants must meet income and asset limitations.

On September 18, 2018, the VA finalized its proposed rules by publishing its Final Rule at Federal Register Vol. 83, No. 181, Part IV, 38 CFR Part 3. The EFFECTIVE DATE was October 18, 2018.

The changes have both positive and negative ramifications for new applicants for VA Pension benefits, and for some who are already receiving benefits. The most notable changes include:

1. **Bright-line Net Worth Limit**: 38 CFR 3.274. The VA has set an exact figure as the maximum amount of net worth a claimant may have to qualify for the VA Pension benefit. Net worth includes both gross income and countable resources. The only exempt resources are personal belongings, automobiles, and personal residence on a lot no greater than two acres. For 2019, the net worth limit is $127,061.

2. **Limit on Residential Lot Area**: 38 CFR 3.275. Until now, the personal residence was always an exempt asset, to include any reasonable lot area. Reasonable lot area was defined as the same or similar to those in the same geographic vicinity. Now, the residential lot area is restricted to two acres. The value of anything in excess of that is considered countable against the permissible net worth limit. A claimant can rebut the value if they can prove the property is unmarketable (i.e. no public access, etc.).

3. **Treatment of Trusts and Annuities**: 38 CFR 3.276. The VA acknowledges that assets in a revocable living trust are included in the net worth calculation. However, assets transferred to an irrevocable trust or used to purchase an annuity (other than as required due to retirement) are considered transfers for less than fair market value that will trigger the look back period investigation and possible penalty from qualifying for benefits. The only exception to the rule is for assets transferred to a special needs trust for the benefit of the veteran’s child who was deemed disabled prior to the age of 18 or 21 if still in school.

4. **Look Back Period**: 38 CFR 3.276. There is a three-year look back period from the date of the claim for any transfers of assets that exceed the permissible asset limit. Partial cures are permissible. All cures must be completed within 60 days of the notification from the VA regarding a transfer penalty. The maximum penalty period is five years regardless of the amount of transfer.
5. **Penalty Period**: The transfer penalty is calculated for all claimants, regardless of class of claimant (veteran, married, single, or widow) based on the current monthly Pension with Aid and Attendance rate. When there is a fractional interest, the fraction is rounded down. As an example, in 2019:

Married Veteran transfers $50,000 – penalty period is 22 months ($50,000 / $2,230 = 22.42).

Surviving Spouse transfers $50,000 – penalty period is 22 months ($50,000 / $2,230 = 22.42).

6. **Medicaid Expenses**: 38 CFR 3.278. The primary changes to this section of the regulations includes defining many terms: health care provider, activities of daily living (ADL), instrumental activities of daily living, custodial care, care facilities. The two biggest impacts are:

   a. That the VA no longer requires proof of the need for two ADLs when a person needs care due to mental or cognitive decline and just need supervision (which would be covered in the definition of custodial care); and

   b. That the VA is not concerned with the type of facility (independent living, assisted living, etc.) that a person lives in, rather, they are more concerned with the “sort of care” the person needs and is receiving. The new regulations are much more liberal than the previous regulations, to include the Fast Letter 12-23 pertaining to independent living facilities.

7. **Planning Options**:

   a. Transfer assets to another person, irrevocable trust (wherein the claimant is not the trustee or principal beneficiary) or annuity and wait at least three years and then apply for benefits.

   b. Use a three-year single premium immediate annuity to help pay for the cost of living and care during the three-year penalty period.

   c. Consider “installment sales” and the argument that annuities are comparable.

   d. Business owners distribute the assets of the business to the employees (perhaps other family members are the employees).

   e. Pre-pay for 12 months’ worth of care.

   f. Transfer assets to a SNT for the benefit of a child in need of support.

   g. Pay down encumbrances on real estate (personal residence) and any other debts.

   h. Pre-pay burial expense.
We can look at the new VA laws as a blessing or a curse. Certainly, veterans and widows who need assistance with care and would benefit by having extra funds to pay for that care, but have excess resources, will be harmed in ways claimants before the change were not harmed. It will require them to plan earlier. Possibly save less. But, if they seek the guidance of competent counsel, accredited by the VA, hopefully this will present the opportunity to do long-range, long-term care planning which they may have just waited for a crisis beforehand, spending much more money, in many cases, than necessary. The changes will permit clients with cognitive issues to get benefits whereas before they may not have because they could not meet the two ADL requirement.

With all change comes opportunity. I encourage and challenge you to find the opportunity to help veterans in your community with these new rules of eligibility.
Jack and the Beanstalk

- Jack was poor. Out of desperation and hope, he sold his family cow for magic beans.
- His mother was dismayed and threw the beans out the window.
- A big stalk reached the sky and Jack, not knowing where it would go, took the risk and climbed the stalk.
- Jack found riches, escaped a giant, and became the town hero.
- He lived richly, happily ever after.

What is the Moral?

- Taking advantage of the opportunities that life provides.
  - Who is Jack in this story?
  - Who is the stalk in this story?
  - Who is the giant?
And who am I?
Victoria L. Collier, CELA
• Co-Founder of VAGA
• Prior Chair, VA Task Force, NAELA
• USAF Veteran, Desert Storm Era
• Certified Elder Law Attorney
• Author: 47 Secret Veteran’s Benefits for Seniors
• National Expert on VA Pension Benefits

Warrior for Veterans
• Met with entire VA Pension & Fiduciary legal team in Nov 2011 to discuss inconsistencies in VA adjudication of pension claims
• Discussed transfers of assets and abuses by “pension poachers” (hearing by the Senate on 6/6/2012) following GAO Report 5/15/2012
• Discussed all the issues around the deductibility of independent living fees (which then resulted in the Fast Letter 12-23 issued October 2012)

Target on my Back
What are the VA Changes?

• Effective Date of Changes: October 18, 2018
  - Net Worth Bright Line Limit
    38 CFR 3.274
  - Limits on Residential Lot Areas
    38 CFR 3.275
  - Treatment of Trusts / Annuities
    38 CFR 3.276
  - Look-Back and Transfer Penalties
    38 CFR 3.276
  - Medical Expenses
    38 CFR 3.278
  - Custodial Care
    38 CFR 3.272

Net Worth Limit

Maximum
2019
$127,061

Assets

Income
Scenario

• Assets = $90,000
• Income = $65,000
  – Net Worth = $?

• (A) Medical Expenses = $25,000
• (B) Medical Expenses = $30,000
  – Does he meet new worth standard?

Residential Exclusion

• Residential Lot Area cannot exceed 2 Acres / 87,120 sq ft
  – UNLESS the additional acreage is not marketable.
    • -- property is only slightly more than 2 acres
    • -- the additional property is not accessible
    • -- or there are zoning limitations that prevent selling the additional property
    • “Similar in size to other residential lots in the vicinity” is no longer a requirement

Sale of Residence

If the house is sold after Pension has been established, the net proceeds will not be treated as an asset until January 1st of the following year. However, to completely exclude the asset, a new residence must be purchased by the end of the year the house was sold.
Additional Properties

- The fair market value of the property is included in net worth
  - Minus any mortgages, liens or encumbrances
  - (mortgages on primary residence do NOT reduce net worth value)

Life Estates

- A commenter inquired on how the VA would treat a life tenant's primary residence upon sale of that property and argued that the VA should adopt the IRS valuation of life estates.
  - The VA declined to respond.
- VAOPGCPREC 15-92 (1992) still holds
  - Entire value of property treated as countable because claimant possessed control over the property and could direct it to be used for his own benefit

Trusts / Annuities

- Trusts are generally not included as an asset, unless they can be entirely liquidated for the claimant’s own benefit, 38 CFR 3.276(a)(5)(i)
- Annuities and trusts that can be liquidated for the benefit of the claimant will be considered an asset in net worth
- If an annuity (or trust) cannot be liquidated, then the annuity (trust) is not considered an asset; however, distributions from the annuity (trust) count as income and the purchase of the annuity (or transfer to trust) could warrant a penalty period
  - THIS indicates that income only trusts are not assets, but could be subject to penalty
Exceptions to the Rules

• VA will NOT count as a covered asset (toward net worth) the amount transferred to an annuity if it was mandated upon retirement (38 CFR 3.276(a)(5)(ii)). Distributions from it will count as income.

• Trusts established for Child incapable of self-support are exempt from net worth.*

Types of Annuities/Trusts

• Revocable Living Trust = Countable
• Irrevocable Income Only Trust = Not an asset; subject to penalty if covered asset and transferred within 3 year look-back
• Deferred annuity = Countable
• SPIA = Same as Irrev income only trust
• Employer mandated annuity upon retirement = not an asset, could be income

Transfers and Penalties

• 36 month look-back for all transfers of assets for less than fair market value
  – Penalty begins on the first day of the month that follows the last asset transfer
  – Maximum penalty is 5 years
  – Penalty divisor is $2,230 for 2019
  – Penalty can be cured; partial cures acceptable
    • Claimants have 60 days following the penalty period decision notice to cure or partially cure a transfer and allow 90 days following the penalty period decision notice to notify the VA of the cure

* This exemption applies to certain cases where the child is unable to support themselves due to physical or mental incapacity.
PRIOR Transfers

- Transfers PRIOR to October 18, 2018
  - VA will NOT “look back” to a time before the effective date of the final rule.
  - VA will disregard asset transfers made before that date.

Scenario One

- Claimant transfers $100,000 into an irrevocable income only trust on October 1, 2018, leaving him with $40,000. He applies for VA pension benefits on December 1, 2018.
  - Is he subject to a penalty period?
  - If so, when does it begin?
  - How long is the penalty?

Scenario Two

- Claimant transferred $100,000 on October 31, 2018, leaving him with $20,000. He applies for VA pension benefits on November 1, 2018.
  - Is he subject to a penalty period?
  - If so, when does it begin?
  - How long is the penalty?
Scenario Three

- Claimant transferred $100,000 on October 31, 2018, leaving him with $30,000. He applies for VA pension benefits on November 1, 2018.
  - Is he subject to a penalty period?
  - If so, when does it begin?
  - How long is the penalty?

Scenario Four

  - Is he subject to a penalty period?
  - If so, when does it start?
  - How long is the penalty?

Deductible Medical Expenses

- The final rule reflects numerous changes from the proposed rules
- There is currently no regulation that adequately defines medical expenses for VA purposes
  - Primary guidance was the Fast Letter 12-23 issued October 2012
**Definition: Health Care Provider**

- **Health care provider**: an individual licensed by a State or country in which the individual provides health care, as well as a nursing assistant or home health aide who is supervised by such a licensed health care provider.
  - In-home attendants are not often required to be health care providers.

**Definition: ADL**

- **ADLs (activities of daily living)**:
  - Ambulating within the home or living area*
  - Getting in/out of bed or chair
  - Bathing
  - Dressing
  - Eating
  - Toileting

**Medication Administration**

- **Medication Administration = IADL**
  - Medication administration IF performed by a health care provider, would be a health care expense
  - Medication reminders from a provider who is NOT a health care provider would NOT be a medical expense
  - UNLESS the individual needs custodial care AND the provisions of 3.278(d) apply
Definition: Custodial Care

- Custodial care is regular (i) assistance with two or more ADLs, OR (ii) supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangers incident to his or her daily environment. ***

What’s in a Name?

- Medical expense deductions should be contingent on the sort of care the disabled individual is receiving in the facility and the necessity for the individual to be there – not the name of the facility.
  - "Care facility other than nursing home"
    - A facility in which a disabled individual receives health care OR custodial care under the provisions of para (d) of this section.

Definition: Care Facilities

- Care facilities must be licensed
- A facility that is a residential facility must be staffed 24 hours per day with care providers and that the care providers do NOT have to be licensed health care providers.
Care “in” a Facility

• Care “in” a facility may be provided by
  – The facility
  – Contracted by the facility
  – Obtained by a third-party provider
  – Family*, OR
  – Friends*

In-Home Care

• No hourly rate limitation; all rates are deductible medical expenses

Verification of Need for Care

• VA form 21-2680
  – Can now be signed by
    • Physician
    • Physician’s Assistant
    • Certified Nurse Practitioners
    • Clinical Nurse Specialists
Scenario Five
- Claimant lives at home and is receiving home health care, paying $28 per hour, 12 hours a days, 7 days a week ($10,080 month). She has dementia and can do all of her ADLs on her own with cueing from the caregiver. The physician's assistant completed a 21-2680 saying she needs regular supervision for safety in her own environment due to dementia.
- How much, if any, is the HHC deductible?

Scenario Six
- Claimant lives in an independent living facility due to having a leg amputated due to diabetes and being in a wheelchair. His daughter comes over twice a week to assist with showers (for free); otherwise, claimant can do all else on his own. He has a 21-2680 that says he needs this environment for his safety.
- Are the ILF fees deductible?
- If the daughter charged, would her fees be deductible?

Scenario Seven
- Claimant lives in ALF and is blind. Claimant is able to do all ADLs, but needs help with medication administration, which the facility provides. 21-2680 states she needs to be there for safety.
- Are the ALF fees deductible?
- Are the extra fees for RX admin deductible?
Summary of Planning Options

• Over Assets
  – Transfer asset to another, or an irrevocable trust (income only or completed gift), or an annuity
  – Wait out penalty or apply after three years, whichever is shorter
  – Use a 3-year annuity to help pay during the 3-year penalty
  – Consider installment sales and how annuities could be argued to meet the standard

Summary of Planning Options

• Over Assets
  – Business owners can sell the business and distribute net proceeds to pay employees
    • Set up a business, transfer cash to it, hire children as employees, sell the business to a child, and then distribute the net proceeds to the employees of the business (probably not an “overnight” planning tool but something to ponder)

Summary of Planning Options

• Pre-pay the calendar year’s worth of ALF fees (or home health if a child is providing it) – this will reduce both income and assets for that year
  • Set up trust for children of Veterans who meet the definition of Child Incapable of Self-Support
  • Pay down encumbrances on primary residences
Summary of Planning Options

• Pay for burial contracts for self and permissible family members
• Pay off permissible debts

Questions?

• BE JACK’S HERO SO HE CAN LIVE HAPPILY EVER AFTER. PRE-ORDER MY NEW BOOK SO YOU CAN PROVIDE IT TO YOUR CLIENTS AS A GIFT ENHANCING THE VALUE YOU BRING TO THEM.

The Estate & Asset Protection Law Firm, LLC

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• www.ElderLawGeorgia.com
HOME AND COMMUNITY BASED WAIVERS
Pam S. Smith

I. MEDICAID 101 – 1915(C) WAIVER BACKGROUND

A. Medicaid History

1. From its inception in 1965, Medicaid has provided comprehensive long-term care; however, care was only provided in an institutional setting.

2. In 1981, the 1915(c) Home and Community-based Services Waiver Program was authorized by the Centers for Medicare and Medicaid Services (CMS) as an alternative to institutional care.

B. Home and Community-Based Waivers – CMS Funding

CMS defines a waiver as allowing states to waive certain Medicaid program requirements; hence the term “waiver.”

1. CMS requires a state to ensure the same level of care in the community as provided in an institutional setting.

2. States must also determine that the community services can be provided equal to or for less than the cost of the comparable institutional care.

3. States receive matching federal funds for services in the home or the community.

4. States must provide ongoing quality assurance to demonstrate that the services are being rendered per the approved waiver and regulation to continue receiving the federal match and to retain what they have been provided.

II. KENTUCKY HCBS WAIVER OVERVIEW

A. 1915(c): Home and Community-based Services Overview

The 1915(c) Home and Community-based Services (HCBS) waivers are one of many options available to states to allow the provision of long-term care services in home and community-based settings under the Medicaid program.
B. KY HCBS Waivers

<table>
<thead>
<tr>
<th>Acquired Brain Injury (ABI)</th>
<th>Adults with an acquired brain injury who meet nursing facility level of care</th>
<th>Michelle P. (MPW)</th>
<th>Individuals with intellectual or developmental disabilities and meet ICF / IID level of care or nursing facility level of care</th>
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<tr>
<td>Acquired Brain Injury-Long Term Care (ABI_LTC)</td>
<td>Adults with an acquired brain injury who meet nursing facility level of care and need long term supports</td>
<td>Model II (MIIW)</td>
<td>Individuals who are ventilator-dependent and meet nursing facility level of care</td>
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<tr>
<td>Home and Community-Based (HCB)</td>
<td>Individuals who meet nursing facility level of care and without services would be institutionalized</td>
<td>Supports for Community Living (SCL)</td>
<td>Individuals with intellectual or developmental disabilities who meet ICF / IID level of care</td>
</tr>
</tbody>
</table>

C. Acquired Brain Injury

1. Overview.

The Acquired Brain Injury (ABI) waiver program provides intensive services and support to adults with acquired brain injuries working to re-enter community life. Services are provided exclusively in community settings.

2. Services.

   a. Case management.
   b. Personal care.
   c. Companion services.
   d. Respite care.
   e. Environmental modifications.
   f. Behavior programming.
   g. Counseling and training.
   h. Structured day program.
   i. Specialized medical equipment and supplies.
   j. Prevocational services.
k. Supported employment.

l. Occupational therapy.

m. Speech and language services.

n. Community residential services.

3. Eligibility.

To qualify for services, an individual must:

a. Have an acquired brain injury;

b. Be age 18 or over;

c. Meet nursing facility level of care requirements.

d. Be expected to benefit from waiver services.

e. Be financially eligible for Medicaid services.

D. Acquired Brain Injury – Long Term Care

1. Overview.

The ABI Long Term Care (LTC) waiver program provides an alternative to institutional care for individuals that have reached a plateau in their rehabilitation level and require maintenance services to avoid institutionalization and to live safely in the community.

2. Services.

a. Case management.

b. Community living supports.

c. Respite care.

d. Adult day health care.

e. Adult day training.

f. Environmental modifications.

g. Behavior programming.

h. Counseling.

i. Group counseling.
j. Specialized medical equipment and supplies.

k. Supported employment.

l. Occupational therapy.

m. Speech therapy.

n. Nursing supports.

o. Family training.

p. Physical therapy.

q. Assessment and reassessment.

r. Supervised residential care.

3. Eligibility.

To qualify for services, an individual must:

a. Be age 18 or over;

b. Meet nursing facility level of care;

c. Have a primary diagnosis of an acquired brain injury which necessitates supervision, rehabilitative services, and long term supports;

d. Be Medicaid eligible.

E. Home and Community-based Waiver

1. Overview.

The Home and Community-based Waiver program provides services and supports to elderly people or children and adults with disabilities to help them to remain in or return to their homes.

2. Services.

a. Case management & PDS coordination.

b. Attendant care.

c. Environmental or minor home adaptation.

d. Adult day health care (Level I & II).

e. Home and community supports.
f. Personal care.
g. Respite (specialized and non specialized).
h. Goods & services.
i. Home delivered meals.

3. Eligibility.

To qualify for services, an individual must:

a. Be elderly or disabled;

b. Meet nursing facility level of care and, without services, would be admitted to a nursing facility;

c. Be financially eligible for Medicaid services.

F. Michelle P. Waiver

1. Overview.

The Michelle P. Waiver (MPW) is a home and community-based waiver program within the Kentucky Medicaid program developed as an alternative to institutional care for individuals with intellectual or developmental disabilities. MPW allows individuals to remain in their homes with services and supports.

2. Services.

a. Case management.
b. Adult day training.
c. Supported employment.
d. Community living supports.
e. Behavior supports.
f. Occupational therapy.
g. Physical therapy.
h. Speech therapy.
i. Respite.
j. Homemaker service.
k. Personal care.
l. Attendant care.
m. Environmental/minor home adaptation.
n. Adult day health care.
o. Home and community support (PDS).
q. Community day support (PDS).
r. Financial management (PDS).

3. Eligibility.

To qualify for services, an individual must:
a. Have a developmental disability or significantly sub-average intellectual functioning;
b. Require a protected environment while learning fundamental living skills, having educational experiences, self supporting activities and developing awareness of their environment;
c. Meet Medicaid financial eligibility requirements.

G. Model II Waiver

1. Overview.

Model II Waiver (MIIW) services are a community-based, in-home waiver services for an individual who is dependent on a ventilator 12 hours or greater per day, meets High Intensity nursing care services 24 hours per day, and would otherwise require nursing facility level of care in a hospital-bed nursing facility as defined by 907 KAR 1:022.

2. Services.

a. Skilled nursing.
b. Respiratory therapy.
3. **Eligibility.**

To be eligible for Model II Waiver services an individual shall:

a. Be eligible for Medicaid;

b. Require ventilator support for at least 12 hours per day;

c. Meet ventilator dependent patient status requirements established in 907 KAR 1:022.

H. **Supports for Community Living**

1. **Overview.**

Supports for Community Living (SCL) is a home and community-based waiver under the Kentucky Medicaid program developed as an alternative to institutional care for individuals with intellectual and developmental disabilities. SCL allows individuals to remain in or return to the community in the least restrictive setting.

2. **Services.**

a. Day training.

b. Positive behavior supports.

c. Case management.

d. Community access services.

e. Community transition.

f. Consultative clinical and therapeutic services.

g. Environmental accessibility adaptation.

h. Goods and services.

i. Natural supports training.

j. Person-centered coaching.

k. Personal assistance.

l. Residential support services.

m. Respite services.

n. Specialized medical equipment and supplies.
3. Eligibility.

Eligible individuals must:

a. Have an intellectual or developmental disability;

b. Meet the requirements for residence in an intermediate care facility for people with intellectual disabilities;

c. Meet Medicaid financial eligibility requirements.
### Kentucky Waiver Prescreening Criteria

<table>
<thead>
<tr>
<th>Prescreening Requirements</th>
<th>ABI</th>
<th>ABI-LTC</th>
<th>HCB</th>
<th>MPW</th>
<th>Model II</th>
<th>SCL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1) Have an ABI</td>
<td>1) Have an ABI</td>
<td>Must be physically disabled or aged (65+ years of age)</td>
<td>1) Have a developmental disability or intellectual disability</td>
<td>1) Be vent dependent for 12+ hours daily</td>
<td>Have a developmental disability or intellectual disability</td>
</tr>
<tr>
<td></td>
<td>2) Be 18 or older</td>
<td>2) Be 18 or older</td>
<td>2) Require supervision, rehabilitative services, and long term supports</td>
<td>2) Require a protected environment while learning living skills, educational experiences, awareness of their environment</td>
<td>2) Meet ventilator status established in <a href="#">907 KAR 1:022</a></td>
<td></td>
</tr>
</tbody>
</table>

Specific forms are required prior to being assigned to each waiver. All required documentation must be submitted before an individual will be routed to a waiver for review.
I. COMPANY INTRODUCTION

Krause Financial Services is a pioneering, attorney-led financial services firm that specializes in crisis Medicaid planning through the use of Medicaid Compliant Annuities and other insurance products. With over 25 years of experience, we work with elder law attorneys and their clients to accelerate eligibility for benefits and provide relief from the financial hardship of long-term care.

II. GOALS OF TODAY’S PRESENTATION

A. Provide an introduction to Kentucky Medicaid eligibility.

B. Define “Medicaid Compliant Annuity.”

C. Gain a better understanding of the strategies and considerations involved with Medicaid Compliant Annuity planning.

III. AGING DEMOGRAPHICS

A. Seventy percent of seniors will require long-term care at some point in their lifetime.¹

B. The average stay in a nursing home is 2.3 years.²

C. The average cost of a semi-private room in a nursing home in Kentucky is $6,844/month.³

D. Fifty percent of couples and 75 percent of single individuals will exhaust their life savings within one year of entering a nursing home.⁴

E. Significance: More seniors require long-term care services than ever before. With most being financially unprepared for a nursing home stay, they must turn to elder law attorneys for assistance.

¹ Centers for Medicare & Medicaid Services.

² Centers for Disease Control and Prevention.

³ Genworth Cost of Care Survey 2018.

⁴ U.S. Department of Health.
IV. THE PAYERS OF LONG-TERM CARE

A. “Other Public” – 4.4 percent

1. Medicare will cover a nursing home stay in a rehabilitative setting after a qualifying hospital stay of at least three days.

2. It will pay up to 20 days of full coverage in a skilled nursing facility and up to an additional 80 days of partial coverage (a daily benefit of $170.50 in 2019), so long as the individual continues to require skilled nursing care.

3. The non-service connected VA pension benefit can also assist in paying for care. Veterans or their surviving spouses may be eligible to receive a monthly pension of up to $2,230 to help pay for their medical expenses.

4. There are specific service, physical, and financial requirements the veteran or surviving spouse must meet.

5. The VA also recently enacted significant changes to their financial eligibility standards, which may make it more difficult for some individuals to qualify.

B. “Other Private” – 11.6 percent

1. Long-Term Care Insurance (LTCI) is the best way to fund a long-term care stay. It provides the individual with the greatest amount of flexibility and allows them to pay for care at all levels: home health care, assisted living facilities, and nursing homes.

2. The problem is most seniors wait too long to secure a policy. LTCI should be purchased while the individual is still healthy, before ever needing long-term care.

C. Out-of-Pocket – 21.9 percent

Those with a substantial net worth may be able to pay for their long-term care expenses out of pocket, but for most, the nursing home bill will deplete their life savings within one year of entering a nursing home.

D. Medicaid – 62.2 percent

Medicaid is the primary payer of long-term care in the United States. For those that haven’t planned ahead through the purchase of an LTCI policy or other “pre-planning” method, it is the best option to gain financial relief when faced with a nursing home stay.

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5 Who Pays for Long-Term Care in the U.S.? The SCAN Foundation, 2013.
V. WHAT IS MEDICAID?

A. Medicaid is a joint federal and state program that pays for a person’s custodial care in a nursing home, including room and board, pharmacy, and incidentals.

B. Each state has unique regulations; therefore, the Kentucky Medicaid program is specific to Kentucky.

C. Applicants must meet both financial and non-financial criteria in order to qualify.

VI. NON-FINANCIAL ELIGIBILITY REQUIREMENTS

A. Must be a U.S. citizen or qualified alien.

B. Must be age 65 or older, or disabled.

C. Must reside in a Medicaid-approved facility (typically a nursing home).

VII. FINANCIAL ELIGIBILITY REQUIREMENTS: INCOME

A. Institutionalized Individual

1. Income from all sources must be less than the private pay rate of the facility. This includes Social Security, pension, etc.

2. If the individual has monthly income in excess of the income cap, a Qualified Income Trust (QIT or “Miller Trust”) is required.\(^6\)

   a. The income cap, or “special income standard,” is 300 percent of the SSI Federal Benefit Rate (FBR).

   b. This figure is $2,313 in 2019.

3. A QIT is an irrevocable trust meant to hold the income of a Medicaid recipient. Funds from a QIT can only be used for:

   a. Valid medical expenses.

   b. A community spouse’s Monthly Maintenance Needs Allowance (see below).

4. The Kentucky Cabinet for Health and Family Services Department of Medicaid Services (DMS) must be named primary beneficiary of the QIT up to the amount paid on the recipient’s behalf.

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\(^6\) Division of Family Support Operation Manual Volume IVA §MS 3505, “Qualifying Income Trust.”
B. Community Spouse

1. There are no limits on the income of the community spouse.

2. If the community spouse’s income is below the Monthly Maintenance Needs Allowance (MMNA), they are entitled to some or all of the institutionalized spouse’s income.

C. Monthly Maintenance Needs Allowance (MMNA)

1. Kentucky employs a minimum and a maximum MMNA.

2. This means the community spouse is always entitled to at least the minimum MMNA (currently $2,058) but may be entitled a larger MMNA, not to exceed the maximum (currently $3,161).

3. The MMNA will increase if the community spouse has shelter expenses in excess of the Shelter Standard (currently $618).

VIII. FINANCIAL ELIGIBILITY REQUIREMENTS: ASSETS

A. Exempt assets are those that do not count toward one’s resource allowance. Examples include:

1. Primary residence.

2. One vehicle.

3. Personal property.

4. Irrevocable Funeral Expense Trust.

5. IRAs/retirement accounts.

B. Countable assets are assets that count toward one’s resource allowance. Too many countable assets will result in ineligibility for benefits. Examples include:

1. Checking, savings, or money market accounts.

2. Cash.

3. Life insurance cash value (if above $1,500).

4. Tax-deferred annuities.

5. Second vehicles or property.

C. The institutionalized individual is allowed to keep $2,000 in countable assets.
D. The community spouse is allowed to keep a separate amount known as the Community Spouse Resource Allowance (CSRA).

E. Community Spouse Resource Allowance (CSRA)
   1. Similar to the MMNA, Kentucky has a minimum CSRA (currently $25,284) and a maximum CSRA (currently $126,420).
   2. The community spouse is allowed to retain one-half of the countable assets as of the snapshot date, not to exceed the maximum and not to fall below the minimum.
   3. The snapshot date is the date in which the institutionalized individual first entered care on a continuous basis.

IX. DIVESTING ASSETS

A. An applicant cannot give away their assets without incurring consequences.

B. The Deficit Reduction Act of 2005 (DRA) changed the way gifts are treated. The DRA:
   1. Imposed a 60-month lookback period. When an applicant applies for Medicaid, the caseworker will “look back” over the previous 60 months to see if any gifts have been made. Gifts include:
      a. A transfer of assets for no compensation.
      b. A transfer of assets for less than fair market value.
   2. Determined the penalty period doesn’t begin until the applicant is “otherwise eligible” for Medicaid benefits (i.e., an applicant must be physically and financially eligible for Medicaid before the penalty period can begin).
      a. The penalty period is a period of Medicaid ineligibility the applicant will incur if gifts have been made during the lookback period.
      b. The penalty period is determined by dividing the gift amount by the Divestment Penalty Divisor (currently $199.46/day).7
   3. Created the aggregate gift rule – all gifts within the lookback period will be considered at the time of application.

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7 Division of Family Support Operation Manual Volume IVA §MS 2080, “Consideration of Transferred Resources.”
X. HOW CAN ONE QUALIFY FOR MEDICAID?

A. Those that do not automatically qualify must turn to an elder law attorney to gain financial relief from the nursing home.

B. Many attorneys recommend applicants try to “spend down” their assets by purchasing or improving exempt assets and paying off debts.

C. However, many will still have excess countable assets that must be eliminated before they can qualify.

D. A Medicaid Compliant Annuity can help.

XI. WHAT IS A MEDICAID COMPLIANT ANNUITY?

A. A Medicaid Compliant Annuity (MCA) is a Single Premium Immediate Annuity (SPIA) with added restrictions to meet the requirements of the DRA.

B. It is used as a “spend-down tool” in crisis Medicaid planning, meaning it helps an individual with excess countable assets eliminate those assets and accelerate their eligibility for benefits.

C. When using an MCA, it converts those assets into an irrevocable income stream with zero cash value.

XII. REQUIREMENTS OF AN MCA

A. Irrevocable

The contract cannot be revoked or altered.

B. Non-Assignable

The contract cannot be assigned or sold to another party.

C. Actuarially Sound

The term of the annuity cannot exceed an individual’s Medicaid life expectancy as determined by the actuarial tables published by the Social Security Administration. https://www.ssa.gov/OACT/STATS/table4c6.html

D. Equal, Monthly Payments

The contract must provide equal, monthly payments with no deferral or balloon payments.
E. DMS as Beneficiary

1. In most cases, DMS must be named primary death beneficiary for the amount of benefits paid on behalf of the institutionalized individual.

   a. DMS regulations previously stated the primary beneficiary of the annuity must be DMS for the amount of benefits paid on behalf of the annuitant.

   b. This language was problematic in cases where the community spouse was the owner/annuitant of the contract. Should that individual predecease the annuity, DMS would be unable to recover any funds in that they did not pay any benefits on behalf of the community spouse.

   c. A recent case, Singleton v. Commonwealth of Kentucky, 843 F.3d 238 (6th Cir. 2016), examined this issue and declared the “annuitant” language to be an oversight during the adoption of the DRA. The intention is to recover funds on behalf of the institutionalized individual.

   d. The Kentucky Administrative Regulations were recently updated to now require DMS be named beneficiary on behalf of the institutionalized individual.

2. Certain exceptions exist to naming DMS primary beneficiary.

   a. If the owner of the annuity has a minor or disabled child, DMS may be named contingent beneficiary.

   b. If the owner is an institutionalized spouse with a community spouse at home, DMS may be named contingent beneficiary.

F. Kentucky’s requirements for a Medicaid Compliant Annuity can be found in 907 KAR 20:030, “Trust and transferred resource requirements for Medicaid other than Modified Adjusted Gross Income (MAGI) standards or for former foster care individuals.”

XIII. WHEN IS USING AN MCA APPROPRIATE?

An MCA may be appropriate for your client if he/she...

A. Is a resident of a Medicaid-approved facility;

B. Is expected to remain at the facility indefinitely;

C. Has exhausted all of his or her LTCI or Medicare benefits;

D. Is paying out-of-pocket; and

E. Has excess countable assets.
XIV. STRATEGIES USING AN MCA

A. Married Couple

1. Using an MCA is a quick and easy way to spend-down the excess countable assets of a married couple.

2. The most common strategy is to fund assets in excess of the CSRA into an MCA for the benefit of the community spouse – they are the owner and payee.

3. DMS is typically named primary beneficiary, per the requirements previously noted.

4. The term of the annuity can be long or short, depending on the goals of the client.

5. Using a long-term MCA (not to exceed their Medicaid life expectancy) may be appropriate if:
   a. The community spouse is in good health and has a family history of longevity.
   b. The couple wants to minimize the monthly income produced by the MCA in order to maximize a shift in income from the institutionalized spouse to the community spouse under the MMNA rules.

6. Using a shorter MCA may be appropriate if:
   a. The community spouse is in questionable health and fears predeceasing the annuity term or entering a long-term care facility before the annuity has paid out and wants to reduce the risk of estate recovery by DMS on the annuity.
   b. The couple would not otherwise be eligible for a shift under the MMNA rules.
   c. The community spouse has large monthly shelter expenses that would not be covered under the MMNA alone.

7. Because DMS could recover some or all of the remaining annuity funds if the community spouse predeceases the term, factoring in their health and longevity is key to producing the best economic results.

B. Single Person

1. The most common strategy for a single person is the “Gift/MCA Plan.”
a. This involves the applicant using the divestment penalty rules to their advantage.

b. They divest approximately half of their excess countable assets to a loved one or irrevocable trust and use the other half to purchase an MCA in their name.

c. The purpose of the MCA is to provide them income that helps them pay for their care during the penalty period of ineligibility caused by the divestment.

d. The MCA term is structured to be congruent with the penalty period.

e. This plan creates a guaranteed, immediate wealth transfer to the applicant’s intended heirs while also accelerating their Medicaid eligibility.

2. If the applicant is in poor health, they can consider using the “Standalone MCA Plan.”

a. Rather than create a divestment and purchase an annuity, the applicant can fund their entire spend-down amount into an annuity.

b. The excess countable assets are quickly eliminated, and the applicant gains immediate Medicaid eligibility. The MCA income becomes part of their Medicaid co-pay.

c. Once eligible, DMS will pay the nursing home its Medicaid Reimbursement Rate, which is typically significantly less than the private pay rate of the facility.

d. Upon the individual's passing, DMS will recover its claim, and any remaining funds will be distributed to the contingent beneficiary – typically the individual's children or a trust.

e. The economic benefit comes in the individual’s estate paying the Medicaid Reimbursement Rate versus the private pay rate.

f. The longer the individual lives, the less residual benefits are available to the contingent beneficiary; therefore, the success of this strategy can never be guaranteed.

To see detailed case studies of these strategies, go online to www.medicaidannuity.com.

Note: Medicaid planning figures referenced in this presentation can be found in the Division of Family Support Operation Manual Volume IVA §MS 1750.
I. MEDICAID – DIFFERENCES BETWEEN KENTUCKY AND INDIANA

A. The biggest difference between the two Medicaid programs is that Indiana Medicaid will cover Assisted Living care through its Aged and Disabled waiver program.

B. Assisted Living – Care in licensed residential care facilities is covered. Waiver covers assistance beyond room and board. Facility does have to be licensed to accept recipients under this program.
   • You do not have to be in a Medicaid certified bed just in a facility that is licensed to accept recipients under this program.

II. AGED AND DISABLED WAIVER

A. To apply for waiver services, you do not apply through the state like you would for long term care Medicaid. Instead, you apply through the local area aging agency.

B. You also have to apply for Medicaid after the waiver is approved.

C. There is no waiting list. The only wait time is the time needed for the local area aging agency to conduct their assessment and obtain waiver approval (normally about two to three weeks in our experience).

D. Unlike with traditional long term care Medicaid, Medicaid benefits will not apply retroactively for the waiver. They can only go back to the date the waiver was approved.

E. Under this waiver, the Medicaid recipient pays $771/month to the facility unless their income is less than $771/month or greater than $2,313/month. (If it's greater, it is increased by the amount over $2,313; if it's less than $771 then it's the lesser amount).
   • This can result in a significant spend down each month if you have a client who has high income as they still have to stay under $2,000 in countable resources.

G. Asset and income requirements are the same as long term care Medicaid.

H. Penalty period divisor is the same.

I. Due to the much lower cost of assisted living, can save much more for a single applicant as opposed to long term care Medicaid.
III. MEDICAID – DIFFERENCES FOR SINGLE APPLICANT

A. Biggest difference until very recently was that IRAs and other qualified accounts were not exempt under Indiana Medicaid except for CS.

B. However, this was changed within the last six months or so. Now qualified retirement accounts are exempt if applicant has been taking regular periodic payments.

C. Unlike in Kentucky, one vehicle of any value is exempt. You do not need a doctor’s note.

D. However, transfer of exempt assets is not explicitly allowed. Some attorneys do it and have been successful at fair hearing level using federal rules, but the majority do not advise it and stay away from it.

E. Penalty divisor is higher for Indiana. It is $6,527/month.

F. Personal needs allowance is also slightly higher at $52/month.

G. No exception for hospice transfers like in Kentucky.

H. Home is not automatically exempt for the first six months like it is in Kentucky. Home must be listed for sale to be considered exempt. Intent to return home is also allowed but Division of Family Resources (“DFR”) can require verification from the applicant’s doctor that return to the home is a possibility.

I. Income Producing and Other Exempt Real Estate

1. Real estate is exempt if it produces income greater than the expenses of ownership.

2. Real estate which is used to produce food for home consumption is exempt.

J. Indiana also has approved Partnership policies. For every dollar of benefits paid out under an individual’s long term care policy for Medicaid eligible services, that person’s asset limit increases by the same amount.

IV. MEDICAID – DIFFERENCES FOR MARRIED APPLICANT

A. Biggest difference is how the CSRA is determined.

B. CSRA is determined at the “Snapshot Date.”

C. Amount CS can keep depends on the amount of assets the couple has on first day of institutionalization for the IS.

D. This is known as the “Snapshot Date.”
E. Snapshot is only taken for the IS’s first institutionalization of at least 30 days.

F. If the IS has a snapshot date from a long time ago and financial records are not readily available, it can be very difficult to determine the couple’s assets from that time.

G. If records are not available, DFR should accept the applicant’s statement as the value of the couple’s resources on the snapshot date.

H. Determining the snapshot date for waiver recipients can be difficult if the applicant has not already had a prior stay of at least 30 days in a nursing home or hospital.

I. If the applicant has not had a prior stay of at least 30 days then the snapshot date is determined at the time of the Medicaid application.

J. Exempt Assets for Married Applicants

1. Biggest difference in terms of exempt assets for Indiana as opposed to Kentucky is that real estate owned solely by the community spouse is not counted.

2. Huge planning tool is to place non-exempt real estate in just the name of the community spouse prior to the Medicaid application. This causes the real estate to be exempt.

3. Another planning tool is to use some of the excess countable resources to purchase real estate in just the community spouse’s name.

K. Planning Tools for Married Applicants

1. Planning strategies for married applicants in Indiana are very similar to Kentucky.

2. Primary differences are the types of exempt assets that can be purchased as part of the spend down.

3. Similar to Kentucky, you want assets to be as high as possible at the snapshot date. However, you cannot control the snapshot date like you can in Kentucky. We can still convert resources that were countable at the snapshot date to exempt resources. For example, if you have jointly owned non-home real estate, it is countable. However, if we place it in just the community spouse’s name, it becomes exempt.

4. Promissory notes are used frequently as non-negotiable promissory notes are not counted as a resource.

5. This is similar to how Kentucky Medicaid treats promissory notes.
6. However, there is one big difference – Promissory note repayments are not considered income under Indiana Medicaid like they are in Kentucky. Only the interest is considered income for Indiana.

7. This means that the community spouse can often keep a portion of the institutionalized spouse’s income even if there is a promissory note paying money back to the community spouse.

L. Preplanning methods are the same for Indiana as in Kentucky.

M. Estate recovery is also very similar in regard to the type of assets Indiana Medicaid will recover against.
## I. OHIO MEDICAID WAIVERS

<table>
<thead>
<tr>
<th>Waiver Name</th>
<th>Eligibility Requirements</th>
<th>Available Services</th>
<th>Who Administers</th>
</tr>
</thead>
<tbody>
<tr>
<td>MyCare Ohio</td>
<td>Dually eligible for Medicare and Medicaid; Age 18 and older; enrolled in MyCare Demonstration; Meet Intermediate or Skilled Level of Care; require at least one waiver service monthly</td>
<td>Adult day health; chores; community transition; emergency response; home care attendant; homemaker services; nutritional consultation; out-of-home respite; personal care aide; social work counseling; waiver nursing; waiver transportation.</td>
<td>Ohio Dept. of Medicaid administers the waiver, but contracts with Managed Care Plans.</td>
</tr>
<tr>
<td>Ohio Home Care Waiver</td>
<td>Meet Nursing Facility Level of Care; Meet Medicaid Financial Criteria; be 59 or younger</td>
<td>Adult day health; emergency response; home care attendant; home delivered meals; home modifications; out-of-home respite; personal care aide; supplemental adaptive and assistive devices; supplemental transportation; and waiver nursing</td>
<td>Ohio Dept. of Medicaid</td>
</tr>
<tr>
<td>PASSPORT</td>
<td>Meet Nursing Facility Level of Care; Meet Medicaid Financial Criteria; be 60 or older</td>
<td>Adult day health; alternative meal service; choice home care attendant; chores; community transition; home care attendant; home delivered meals; homemaker services; home medical equipment and supplies; independent living assistance; minor home modification, maintenance, and repair; non-medical transportation; nutritional consultation; out of home respite; personal care; pest control; social work and counseling; transportation; and waiver nursing</td>
<td>Ohio Dept. of Aging operates based on an interagency agreement with Ohio Dept. of Medicaid</td>
</tr>
<tr>
<td>Waiver Type</td>
<td>Eligibility Criteria</td>
<td>Services Provided</td>
<td>Agency Operations</td>
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<tr>
<td>---------------------</td>
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<tr>
<td>Assisted Living</td>
<td>Meet Nursing Facility Level of Care; Meet Medicaid Financial Criteria; be 21 or older</td>
<td>Assisted Living Services; Community Transition but only for nursing home residents</td>
<td>Ohio Dept. of Aging operates based on an interagency agreement with Ohio Dept. of Medicaid</td>
</tr>
<tr>
<td>Individual Options</td>
<td>Meet ICF/IID Level of Care; Meet Medicaid Financial Criteria; All ages</td>
<td>Adaptive and assistive equipment; Adult day support; Career planning; environmental accessibility adaptations, group employment supports; homemaker/personal care; home delivered meals; individual employment support; interpreter; money management; non-medical transportation; nutrition, participant-directed homemaker/personal care; remote monitoring and equipment; respite (residential and community); shared living; social work, transportation; vocational habilitation; waiver nursing delegation; waiver nursing</td>
<td>Ohio Dept. of Developmental Disabilities operates based on an interagency agreement with Ohio Dept. of Medicaid</td>
</tr>
<tr>
<td>Level One Waiver</td>
<td>Meet ICF/IID Level of Care; Meet Medicaid Financial Criteria; All ages</td>
<td>Adult day support; Career planning; environmental accessibility adaptations, group employment supports; homemaker/personal care; home delivered meals; individual employment support; informal respite; money management; non-medical transportation; participant-directed homemaker/personal care; remote monitoring and equipment; respite (residential and community); specialized medical equipment and supplies; transportation; vocational habilitation; waiver nursing delegation</td>
<td>Ohio Dept. of Developmental Disabilities operates based on an interagency agreement with Ohio Dept. of Medicaid</td>
</tr>
<tr>
<td>S.E.L.F.</td>
<td>Meet ICF/IID Level of Care; Meet Medicaid Financial Criteria; All ages. This is a participant-directed model and there are cost limitations: $25,000 a year for children under the age of 22 and $40,000 year for adults.</td>
<td>Adult day support; Career planning; Clinical and Therapeutic intervention; Functional behavioral assessment; group employment support; Individual employment support; non-medical transportation; participant-directed homemaker/personal care; Participant/family stability assistance; remote monitoring and equipment; respite (residential and community); support brokerage; transportation; vocational habilitation; waiver nursing delegation</td>
<td>Ohio Dept. of Developmental Disabilities operates based on an interagency agreement with Ohio Dept. of Medicaid</td>
</tr>
</tbody>
</table>

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**Basic Medicaid Eligibility for Long Term Care Services**

The Ohio Department of Medicaid (ODM) operates the Medicaid program in Ohio. The County Departments of Job and Family Services process Medicaid applications and make initial eligibility decisions. Ohio has 13 Area Agencies on Aging that contract with ODM to operate the PASSPORT and Assisted Living Waiver programs and to complete Level of Care Assessments.

### II. INCOME ELIGIBILITY

In August 2016, Ohio changed from a 209(b) state to a 1634 state under the Social Security Act. This has made Ohio an income cap state. In an income cap state, an individual must have income less than the special income limit of $2,313 (2019). If an individual has income above the special income limit the Medicaid rules allow for the use of a Qualified Income Trust, also known as a Miller Trust, to assist with making an individual income eligible. However, only individuals applying for Long Term Care Services or a Home and Community Based Waiver Service (HCBS) can use a Qualified Income Trust to become income eligible. Individuals applying for non-HCBS Medicaid, such as MAGI Medicaid, cannot use a Qualified Income Trust. Qualified Income Trusts are authorized under 42 U.S.C. §1396p(d)(4)(B), O.A.C. 5160:1-3-05.2 and O.A.C. 5160:1-6-03.2.¹ Once a Qualified Income Trust has been created, the individual will transfer the amount of income that is over $2,313 into the Trust. This will make the individual income-eligible. The income held by a Qualified Income Trust is still used in all post eligibility calculations.

### III. RESOURCES

The Ohio Medicaid resource standard for an individual is $2,000. Prior to the switch to a 1634 state, Ohio’s resource standard for an individual was only $1,500. The individual must have a legal interest in the property, and the property must be

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¹ More information about QITs can be found at ODM’s website [http://medicaid.ohio.gov/](http://medicaid.ohio.gov/).
available to the individual for use and disposition for the resource to be countable. “Resources” are everything left after the income is taken out for the month.

A. Ohio Medicaid excludes the value of:

1. The home and the land associated with it, occupied by:

   a. The individual or if the individual is institutionalized then the individual has signed an intent to return home;

   b. The individual’s spouse;

   c. A dependent relative,

   d. The individual’s child who is under the age of 21 or is permanently blind or disabled;

   e. It is occupied by the individual’s child who is age 65 or older and is verifiably financially dependent upon the individual for housing,

   f. The individual’s brother or sister who owns an equity interest in the home and who has lived in the home for at least one year before the individual’s admission to the nursing home;

   OR

   g. It has been transferred to a son or daughter who has been living in the home and has been providing care that delayed the parent’s need for nursing home care for at least two years prior to admission.

When Ohio switched to a 1634 state the rules regarding valuing real estate changed. Fair market value used to be defined as the county auditor’s value or the average of two certified appraisals. Now the rule is more broad, and fair market value is defined as the going price, for which real or personal property can reasonably be expected to sell on the open market, in the particular geographic area involved. See O.A.C. 5160:1-3-05.13. Real property also used to be unavailable if it was listed for sale. That rule was also rescinded in the 1634 switch. Now even if the property is listed for sale, some counties will find the property to be an available resource.

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2 See OAC 51601:1-3-05.13.

3 See OAC 51601:1-6-06.
2. Life insurance with a face value equal to or less than $1,500; if face value is over $1,500, then all of the cash value is counted. O.A.C. 5160:1-3-05.12.

3. Irrevocable burial contracts for individual or spouse, and burial space for individual, spouse, family members. O.A.C. 5160:1-3-05.14(C)(2)(g) and 5160:1-3-05.7.

4. One motor vehicle, regardless of value. O.A.C. 5160:1-3-05.11.

5. Income producing property used to meet basic living needs. Equity is excluded up to $6,000, only if income produced exceeds 6 percent of equity. O.A.C. 5160:1-3-05.19.

6. Property that produces goods or services to provide for basic living needs, up to a maximum of $6,000 in equity. O.A.C. 5160:1-3-05.19.

7. Receipt of certain lump sums, such as retroactive benefits, Social Security/SSI, for the first six months after receipt. O.A.C. 5160:1-3-05.8.

8. Household goods and personal effects. O.A.C. 5160:1-3-05.10.

9. ABLE accounts, also known as a STABLE accounts in Ohio: This account is similar to a 529 account in the fact that it is a savings account that is administered by the state. This account can be created for any person diagnosed with a disability of which the onset of the disability was prior to age 26 and can hold funds up to $100,000 before interference with benefits; however, only $15,000 a year can be placed into these accounts.

10. Any resource which is not otherwise available for use by the individual: does the individual have the legal right and ability to use and dispose of the property? If the property cannot be sold, it should not be available. Examples: life estates with no value, property held in ownership with another when the co-owner refuses to liquidate the property. O.A.C. 5160:1-3-05.17.

RETIREMENT AND INCOME SUPPLEMENTING ACCOUNTS (RISA)

O.A.C. 5160:1-3-03.10. A retirement fund such as an IRA and a 401(k) will be considered a resource to the full extent of the legal ability to convert the fund to cash, minus any penalty associated with its surrender if the community spouse and institutional spouse are not living together. If access to the principal is foreclosed and monthly or periodic income is paid, the income will be considered under the unearned income rules and the principal will not be a

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4 See page 45 Re: Resources.
countable resource. The applicant must take steps to access all income sources and must attempt to maximize available income. Consequently, the applicant is required to verify that an attempt has been made to get the community spouse to waive his or her rights under the plan. O.A.C. 5160:1-3-03.10. If the applicant has a disabled child, the applicant can opt for a smaller monthly payment, leaving a portion of the fund for the child.

A RISA is not a resource if the individual must terminate employment for access.

B. Resource Calculation where there is no Community Spouse

Add all countable available resources and compare to the resource standard of $2,000. If under that standard, the individual meets the resource test.

C. Community Spouse Resource Allowance (CSRA)

Add countable available resources based on the value as of the first continuous date of institutionalization (30 days or more) – the “snapshot” date, then apply the total to the following formula:

Community Spouse receives a RESOURCE ALLOWANCE of THE GREATER OF:

$25,284 (2019),

OR

one-half of remaining countable available resources not to exceed $126,420 (2019).\(^5\)

Institutionalized spouse receives a “resource allowance” of $2,000 and is resource-eligible when total countable resources are at or below amount allocated per above formula. 42 U.S.C. §1396r-5(c)&(e); O.A.C. 5160:1-6-04.

D. Annuity Planning for a Married Couple

A planning technique for married couples in Ohio is the purchase of an annuity, where the community spouse exchanges spend-down funds for a stream of income, and provided the annuity complies with Medicaid annuity rule found at 42 U.S.C. §1396p(c)(1)(F) and (G), the purchase is a proper use of spend-down funds. Annuities were authorized as a Medicaid

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\(^5\) A community spouse maybe entitled to a greater amount if established at fair hearing the community spouse needs resource above the maximum allowed CSRA to generate income so that he or she receives the minimum income allowed under the Monthly Income Allowance Rules, see O.A.C. 5101:6-7-02.
planning technique in the Deficit Reduction Act (DRA) of 2006. However, Ohio challenged the use of annuities for married couples until 2016.

The annuity needs to be immediately payable, irrevocable, non-assignable, actuarially sound, does not have balloon payment or deferral, and the State is named as the remainder beneficiary in the first position. O.A.C. 5160:1-6-06.1.

Since IRAs are considered countable assets for Medicaid purposes in Ohio, rather than liquidate an IRA and risk facing large tax consequences, the client may be able to rollover or transfer his or her IRA into a Medicaid Compliant Annuity. The IRA will be eliminated as a countable asset, and immediate tax consequences are avoided. The income from the Medicaid Compliant Annuity is taxable in the year of receipt, allowing the owner to spread any tax consequences out over the term of the annuity.

In cases that involve married couples, if the Community Spouse has an IRA, the account can be transferred to Medicaid Compliant Annuity for his or her benefit. If the Institutionalized Spouse has the IRA, the couple could consider using the “Name on the Check Rule” in which the Institutionalized Spouse’s IRA is transferred to a Medicaid Compliant Annuity for the benefit of the Community Spouse. This is risky because if the State finds it to be income to the Institutionalized Spouse, not Community Spouse, most if not all of the monthly income will go to the nursing home as patient liability and you have lost a major resource for the Community Spouse. Some practitioners in Ohio have used the “Name on the Check Rule” but very few do due to the risk.

IV. TRANSFER OF ASSETS IN OHIO

The Medicaid transfer of assets rules can be found at 42 U.S.C. §1396p(c) & (e), Ohio Revised Code §5111.011, and O.A.C. 5160:1-6-06.

The Ohio Medicaid transfer penalty rules currently apply only to nursing facility services or services provided through a home and community-based waiver (such as PASSPORT and the Home Care Waiver program). The individual under a Medicaid transfer penalty remains potentially eligible for Medicaid to pay for all other medical services, such as pharmaceutical drugs and home health benefits. The Medicaid penalty is a “restricted period of coverage.”

A. Certain Transfers are Permitted

1. Transfers between spouses or to another for the sole benefit of the spouse.

2. The transfer of any asset to a disabled child. “Disabled child” means disabled by the definition of the Social Security Administration.

3. Transfers for fair value.

4. Transfers of an exempt resource other than the home.
5. Transfers into a special needs trust or a Medicaid pooled trust.

6. Transfers made exclusively for a reason other than qualifying for Medicaid.

B. Ohio’s Home Transfer Medicaid Rule

Transfers of an otherwise exempt home are considered improper if made for less than fair market value during the 60 months prior to Medicaid application, or any time after, unless the home was transferred to one of the following individuals:

1. The individual’s spouse, provided the spouse does not subsequently transfer the home to a third party.

2. The individual’s child under the age of 21.

3. The individual’s child over the age of 21 who is blind or permanently disabled (meets the disability criteria for Social Security benefits).

4. The individual’s child over the age of 21, who was living in the home for the two-year period before the individual is placed into the nursing facility, and who, during this two-year period, provided care to the individual that prevented the individual from entering the facility. This “Adult Caretaker Child” exception to the home transfer rule requires that the child provide evidence of the parent’s level of care – the parent must have needed care at the intermediate or skilled level for the entire two-year period, as certified by the parent’s physician.

5. The individual’s sibling who has lived in the home for the year before the individual enters the nursing facility and who has an equity interest in the home.

C. The Penalty Period

The length of time during which the penalty applies is determined by the following formula:

\[
\text{Number of months} = \frac{\text{Amount of transferred asset}}{\text{Average private pay rate of a nursing facility in Ohio}}
\]

The penalty begins the month the applicant is “otherwise eligible” and carries forward until the number of months is satisfied or all of the assets have been reconveyed. \(^6\)

There is no cap on the length of the penalty period.

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\(^6\) As of 1/1/2016, partial returns are no longer allowed to reduce a penalty period. O.A.C. 5160:1-6-06.5(F). The only way to reduce a penalty is to return all of the transferred assets.
V. GIFTING

It is hard for many individuals to see their assets dwindle and for family members to see their loved ones not have the proper funds to pay for quality of life items. For many of our single clients we will “gift” or transfer assets in an effort to preserve some of the assets.

Gifting using partial returns is no longer allowed. Gifting can only be accomplished in Ohio by doing pre-planning and waiting five years, using an annuity, or in certain circumstances a Pooled Medicaid Payback Trust.

VI. TRUSTS

Medicaid treats trusts differently depending on the grantor, beneficiary, reason for the trust, and how the trust is funded. A brief description of the Medicaid trust rules follows; however, this outline is not intended to address this particular aspect of the Medicaid rules in great detail. The reader is cautioned to research further before drafting a “Medicaid-friendly” trust.

Third Party Trusts: Trusts created after August 10, 1993 are available if established by the applicant or spouse, for his or her benefit, or established by a court, administrative body, or other entity or person for the individual’s behalf, regardless of the purpose for the trust, if the trustee has the ability to invade the principal through an ascertainable standard (health, maintenance, and support) for the benefit of the Medicaid recipient. These types of trusts are considered available to the extent of any income paid to the individual, and to the amount of the principal which the trustee has discretion to distribute. Placing assets into trusts may also be considered to be a transfer of a resource, subject to the period of restricted coverage. Any income paid to third parties is considered a transfer and will be subject to a period of restricted coverage. O.A.C. 5160:1-3-05.2(C)(2) and (4).

Trusts created for certain individuals are exempt if for supplemental services or special needs, see R.C. §1339.51 and R.C. §5111.151. The following are examples of trusts that are exempt for Medicaid.

A. Special Needs Trust

This type of trust can be established for a disabled individual by a court, parent, grandparent or guardian and can hold the assets of only the individual if established prior to the age of 65. It can be used for supplemental services, provided that upon death of beneficiary the corpus is paid to Medicaid to the extent of what Medicaid paid for that individual - 42 U.S.C. §1396p(d)(4)(A), often called “(d)(4)(A) trusts, O.A.C. 5160:1-3-05.2(C)(3)(a).

B. Medicaid Pooled Trust

A trust set up by a non-profit for a disabled individual, in which the assets of all such individuals are pooled, used for supplemental services, and from which the remainder is either paid to Medicaid to the extent of Medicaid payments made for that individual and then to heirs, or to the non-profit
upon the individual’s death. In Ohio, an individual over the age of 65 can establish a Medicaid Pooled Trust. Therefore, this type of trust is commonly used as a planning technique for Medicaid Applicants. 42 U.S.C. §1396p(d)(4)(C), O.A.C. 5160:1-3-05.2(C)(3)(c), R.C. § 5111.151.

C. Supplemental Services Trust

A supplemental services trust established through a third party (usually a parent) for the benefit of an individual eligible to receive services from the state or county boards of developmental disabilities or mental health, not to exceed the maximum allowed by law ($248,000 in 2018 to increase $2,000 each year), provided that upon the death of the beneficiary, at least 50 percent of the assets in the trust are paid to organizations who benefit individuals with DD or mental illness. The trusts can be inter vivos or testamentary. R.C. §1339.51; O.A.C. 5160:1-3-05.2(C)(3)(d), R.C. §5111.151.

D. Wholly Discretionary Trust

These trusts are funded with assets that never belonged to the beneficiary and are typically set up by a parent or grandparent. They must be irrevocable and distributions from the trust may only be made at the trustees’ discretion. There can be no support standard. See R.C. 5801.01(y).

VII. POST ELIGIBILITY TREATMENT OF INCOME

Patient Liability: Once an individual is approved for Medicaid, a determination is made of the amount of income that is to be paid to the nursing facility. This is called the “patient liability” and is calculated as follows:

1. Calculate applicant’s gross monthly income.
3. Subtract $15 for the QIT only if bank charges administration fee.
4. Subtract any amount necessary for remedial medical expenses not covered by Medicaid.
5. Subtract amounts for health insurance and Medicare Part B premium.
6. Subtract amount for Maintenance Needs Allowance for the Community Spouse or Family Allowance.
7. Subtract past unpaid medical expenses not covered by Medicaid.
8. Remainder is the amount owed to nursing facility.

O.A.C. 5160:1-6-07.
VIII. ESTATE RECOVERY IN OHIO

The Ohio Department of Job and Family Services may recover Medicaid benefits paid from the estate of a permanently institutionalized individual of any age and from the estate of an individual 55 years of age and older who is not permanently institutionalized, only after the surviving spouse has died and the individual has no dependent, disabled, or blind children, and only against the estate of the individual who was on Medicaid. “Estate” includes recovery from non-probate assets. The Department may grant an undue hardship or defer recovery—see O.A.C. 5160:1-2-07; 42 U.S.C. §1396p(b)(1); O.A.C. 5160:1-2-07.

IX. PROCEDURAL PROCESS IN OHIO

A. Applications

The Medicaid Application is filed with the County Department of Job and Family Services in the county in which the individual lives, or in the county in which the individual is placed in the nursing facility. The Department of Job and Family Services must determine eligibility within 45 days of application, absent extenuating circumstances. An authorized representative may apply for the individual and his or her acts bind the applicant in most situations.

B. Notices/Hearing Rights

Applicants/recipient must receive written notice of any determination affecting the scope of coverage and benefits. The individual has a right to appeal any determination (except for mass changes) to a state hearing. The appeal must be requested within 90 days of the mailing date of the decision. Further appeal and judicial review are available. If benefits are being terminated, the individual has a right to continue to receive those benefits provided he or she requests a state hearing within 15 days after the termination notice has been mailed.
I. AN OVERVIEW

A. Federal-State

Tennessee participates in the Medicaid program through the Tennessee Medical Assistance Program, which (among other things) pays for certain long-term services and supports provided to persons who meet its technical, medical, and financial eligibility criteria. The Department of Health is designated as the single state agency to administer Tennessee’s Medical Assistance program. In the event of any conflict with the single state agency requirements of Title XIX, however, the Department of Finance and Administration shall become the single State agency.

B. TennCare II Demonstration

For the purpose of demonstrating alternative approaches to service delivery, Section 1115(a) of the Social Security Act vests the Secretary of Health and Human Services with broad authority to grant states waivers of certain federal Medicaid requirements and to provide federal matching funds for expenditures that are not otherwise allowable. HHS, through the U.S. Centers for Medicare & Medicaid Services (CMS), may authorize experimental, pilot, or demonstration projects which, in the judgment of the Secretary, are likely to assist in promoting the objectives of the Medicaid statute – especially the delivery of Medicaid benefits by managed care contractors. This is the most significant trend in the delivery of services under Medicaid. Upon application by a state for a “Section 1115

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3 Tenn. Code Ann. §71-5-104.


5 42 U.S.C. §1315(a); 42 C.F.R. pt. 431, subch. G.

demonstration waiver,” CMS may waive any of the requirements in Section 1396a of the Social Security Act (among others) and offer state residents who would otherwise qualify for traditional Medicaid benefits some form of managed care.

Authorized by the General Assembly in 1993,7 the TennCare program began operation on January 1, 1994. Tennessee was among the first of the states to apply for and receive approval for a Section 1115 Medicaid waiver demonstration. Under the original Section 1115 waiver, TennCare administered health services for Medicaid recipients and uninsurable state residents using managed care organizations (MCOs).

Long-term services and supports were not included in the original TennCare section 1115 waiver, however. Authorized under section 1915(c) of the Social Security Act,8 Tennessee had one approved 1915(c) waiver for older people, the Statewide Elderly and Disabled (E&D) HCBS waiver, which is the primary means by which states provide home- and community-based services (HCBS) for Medicaid beneficiaries. This waiver ended in 2010 when the TennCare Section 1115 waiver, adding TennCare CHOICES in Long-Term Services and Supports, was fully implemented statewide.9

A fuller history of the TennCare program is beyond the scope of this presentation.10 In 2015, TennCare posted this summary description of the TennCare waiver:11

TennCare is a Medicaid demonstration program that has operated under waivers of certain provisions of federal law since 1994. The principle being “demonstrated” by TennCare is that a state can organize its Medicaid program under a managed care model without spending more than the Medicaid program would have spent in the absence of


10 See Elder Law Practice in Tennessee §4.12(a).

the demonstration program and without compromising quality of care.

A variety of resources are available on or from the TennCare website. Introductory materials that summarize key concepts and principles related to the Demonstration include:

- **TennCare Overview** (rev. April 2018): [https://www.tn.gov/content/dam/tn/tenncare/documents/TennCareOnePager.pdf](https://www.tn.gov/content/dam/tn/tenncare/documents/TennCareOnePager.pdf), accessed from [https://www.tn.gov/tenncare/information-statistics/tenncare-overview.html](https://www.tn.gov/tenncare/information-statistics/tenncare-overview.html);


- **TennCare CHOICES**, [https://www.tn.gov/tenncare/long-term-services-supports/choices.html](https://www.tn.gov/tenncare/long-term-services-supports/choices.html);


- **Operational Protocol** (a more comprehensive and detailed description of the TennCare II Demonstration, currently under revision): [https://www.tn.gov/tenncare/policy-guidelines/operational-protocol.html](https://www.tn.gov/tenncare/policy-guidelines/operational-protocol.html);

- **TennCare II Medicaid Section 1115 Demonstration** (waiver agreement between TennCare and the U.S. Centers for Medicare and Medicaid Services), defining the terms and conditions under which the Demonstration may operate (Oct. 23, 2018): [https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn-tenncare-ii-ca.pdf](https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn-tenncare-ii-ca.pdf); and


Other documents that portray the TennCare program at various points in time – and, therefore, relate directly to the progress of the Demonstration – include:

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12 All URLs cited in this presentation were accessed Feb. 26, 2019.

13 [42 CFR §431.424(e)](https://www.cfr.gov/cfr/plain.html?node=42:431-434.424) requires that states with Section 1115 demonstration programs publish their evaluation designs on their websites. TennCare’s evaluation design was approved by CMS on March 31, 2008, but the performance measures contained within that design have been updated several times in subsequent years.

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• **Timeline** summarizing key events in the Demonstration’s history from January 1994 to August 10, 2018: https://www.tn.gov/tenncare/information-statistics/tenncare-timeline.html;

• **Synopsis of the TennCare Demonstration** (updated Nov. 1, 2018): https://www.tn.gov/content/dam/tn/tenncare/documents2/DemonstrationSynopsis.pdf;

• **Annual reports**: https://www.tn.gov/tenncare/information-statistics/annual-reports.html;

• **Budget presentations**: https://www.tn.gov/tenncare/information-statistics/budget.html;


TennCare publishes information for consumers and providers\(^{14}\) on its website. For consumers, the **TennCare Quick Guide**\(^{15}\) provides a fast and easy way for people to identify what services, products, and supplies are covered and not-covered by TennCare. The alphabetical listing includes citations to TennCare Rules & Regulations and TennCare Policy Statements.

For providers, TennCare’s website includes resources such as the **HCBS Assessment Manual**\(^{16}\), the **TennCare II Operational Protocol**\(^{17}\), TennCare **Guide to Pre Admission Evaluation Applications**\(^{18}\) and numerous forms

\(^{14}\) For example, under the topic TennCare, Long-Term Services & Supports, Partners-Program Updates, https://www.tn.gov/tenncare/long-term-services-supports/partners-program-updates.html (accessed Feb. 26, 2019).


\(^{17}\) TennCare II Operational Protocol (TennCare Feb. 2015; under revision & nla), accessible from TennCare, Policy & Guidelines, Operational Protocol, https://www.tn.gov/tenncare/topic/operational-protocol.

specific to CHOICES in LTSS\(^9\) and to the TennCare Medicaid and TennCare Standard programs.\(^{20}\)

Legal forms and information such as HIPAA forms\(^{21}\) and links for court orders in cases in which TennCare is a defendant are also accessible.\(^{22}\)

Also accessible from TennCare’s website are official reports, such as the Annual Report to the U.S. Centers for Medicare and Medicaid Services (CMS). The report summarizes important achievements and developments in the operation of the TennCare program for the preceding state fiscal year. The report is required both by federal regulation and by the terms of TennCare’s Demonstration agreement with CMS.\(^{23}\)

Pertinent information may also be found in the TennCare Managed Care Organizations’ Contractor Risk Agreements (MCO CRAs)\(^{24}\) and TennCare policy statements.

TennCare rules are posted on the website of the Tennessee Secretary of State.\(^{25}\)

Policy is contained in three manuals: TennCare Standard is contained in the *Families and Children* manual; TennCare Medicaid and TennCare CHOICES in the *Aged, Blind and Disabled* manual; and applications and appeals and the like in the *General Administrative* manual. The manuals are not issued under TennCare’s rulemaking authority and so do not have

\(^{19}\) The forms specific to CHOICES in LTSS are accessible from TennCare, *Long-Term Services & Supports, Partner-Program Updates, LTSS Forms*, [https://www.tn.gov/tenncare/long-term-services-supports/partners-program-updates/ltss-forms.html](https://www.tn.gov/tenncare/long-term-services-supports/partners-program-updates/ltss-forms.html).

\(^{20}\) These forms are accessible from TennCare, *Providers*, [https://www.tn.gov/tenncare/section/providers](https://www.tn.gov/tenncare/section/providers).


\(^{24}\) For the contractual obligations imposed on MCOs, see TennCare, *Providers, Managed Care Organizations*, “Contract Between the State of Tennessee, Department of Finance and Administration[,] Division of Health Care Finance and Administration[,] Division of TennCare and [Contractor Name], Statewide Contract with Amendment 8-July 1, 2018,” [https://www.tn.gov/content/dam/tn/tenncare/documents/MCOSstatewideContract.pdf](https://www.tn.gov/content/dam/tn/tenncare/documents/MCOSstatewideContract.pdf); and Amerigroup Corp., *Provider Manual Supplement: TennCare CHOICES: Amerigroup Community Care* (July 2018), [https://providers.amerigroup.com/ProviderDocuments/TNTN_CHO_Prov_Man_Supp.pdf](https://providers.amerigroup.com/ProviderDocuments/TNTN_CHO_Prov_Man_Supp.pdf).

the force of law but instead contain state agency interpretations of Medicaid and TennCare statutes and rules.

1. **FAMILIES AND CHILDREN (FC):** Section Nos. 005.005 to 025.005. Sections 005.005 to 005.045 address *Non-Financial Eligibility Requirements*. Sections 010.005 to 010.070 address *Financial Eligibility Requirements*. Sections 015.005 to 015.055 address *Categories of Eligibility*. Sections 015.060 and 017.005 address *TennCare Standard*. Section 019.005 addresses *Hospital Presumptive Eligibility*. Section 020.005 addresses *Emergency Medical Services*. Section 025.005 addresses *CoverKids*.

2. **AGED, BLIND AND DISABLED (ABD):** Section Nos. 100.005 to 130.005. Sections 100.005 to 100.030 address *Non-Financial Eligibility Requirements*. Sections 110.005 to 110.060 address *Financial Eligibility Requirements*. Sections 115.005 to 115.030 address *Categories of Eligibility*. Sections 120.005 to 120.025 address *Medicare Savings Programs*. Sections 125.005 to 125.025 address *Institutional Medicaid*. Section 130.005 addresses *Choices*.

3. **GENERAL ADMINISTRATIVE PROCEDURES AND COMPLIANCE (GA):** Section Nos. 200.005 to 200.112. These sections address, *inter alia*, The Application Process, Eligibility Determination, and Appeals.

Each manual is divided into sections, under which are chapters, numbered paragraphs, and lowercase-lettered subparagraphs. Chapter revisions bear the revision date; thus, for example:

**Manual: AGED, BLIND AND DISABLED**  
Section: 125 Institutional Medicaid  
Chapter: .015 Resource Assessment  
Paragraph: 6. Resource Transfer as a Result of Assessment  
Subparagraph: b. Transfer Refusal  
(Revised February 1, 2018)

*Division of TennCare Eligibility Policy Consolidated* consolidates the three manuals into one volume.26

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26 Division of TennCare Eligibility Policy Consolidated (TennCare Nov. 1, 2018),  
https://www.tn.gov/content/dam/tn/tenncare/documents/HCFAEligibilityPolicyConsolidated.pdf,  
accessible from TennCare, Policy & Guidelines, Eligibility Policy,  
https://www.tn.gov/tenncare/policy-guidelines/eligibility-policy.html. The consolidated eligibility policy manual was formerly called *HCFA Eligibility Policy Consolidated*. By January 2018 the title had become Division of TennCare Eligibility Policy Consolidated.
II. TENNCARE BENEFIT PACKAGES

The initial June 15, 2012, TennCare II waiver approved 12 benefit packages for individuals enrolled in TennCare.\textsuperscript{27} Enrollees receive a card from the Managed Care Organization that bears a letter, A-M, which denotes the benefit package provided to the card holder. The letter is called a Benefit Indicator. The packages are described in detail in a chart of the “TennCare Benefit Packages.”\textsuperscript{28}

CHOICES Group 1 (NF) pays for individuals who need daily nursing care services in a nursing facility that participates in the CHOICES program.

CHOICES Group 2 (HCBS) services may have limits and co-payments, including the number of hours provided. The MCO will assist in determining what services will meet the enrollee’s needs.

Home-based services covered by Group 2:

- Personal care visits: Short visits of no more than four hours when someone will help with transferring, bathing, dressing, eating and preparing meals, and toileting.
- Attendant care: The same kinds of help provided with personal care visits, but for longer periods of time.
- Home-delivered meals.
- Personal Emergency Response System.
- Adult day care.
- In-home respite care.
- In-patient respite care.
- Assistive technology.
- Minor home modifications: grab bars, wheelchair ramps, and similar items to promote safe and secure living at home.
- Pest control.

\textsuperscript{27} TennCare Approval Letters (dated June 15, 2012; June 7, 2013; July 16, 2013; Dec. 16, 2016). The December 2016 waiver approval extended the TennCare II Section 1115(f) demonstration period through June 30, 2021.

\textsuperscript{28} TennCare, Members/Applicants, Covered Services, “Benefit Packages,” \url{https://www.tn.gov/content/dam/tn/tenncare/documents/benefitpackages.pdf} (updated March 20, 2018). For a listing and description of the benefits provided in Benefit Packages J-M (the CHOICES Packages), see TennCare CHOICES Program; Benefits in the TennCare CHOICES Program, Tenn. Comp. R. & Regs. 1200-13-01-.05(8).
Community-Based Residential Alternatives are places to live that offer care and support for someone who can no longer live alone that include the following:

- **Assisted-Care Living Facility** [the statutory term for “Assisted-Living Facility”]: TennCare pays for the enrollee’s personal care needs, homemaker services, and medication management in an ALF that participates in the CHOICES program. The recipient pays for room and board.

- **Community Living Supports**: A shared home or apartment where no more than four persons reside. The level of support provided depends on the enrollee’s needs and can include hands-on assistance, supervision, transportation and other supports needed to remain in the community.

- **Community Living Supports – Family Model**: A shared home or apartment where no more than four persons reside with a trained host family. The level of support provided depends on the enrollee’s needs and can include hands-on assistance, supervision, transportation and other supports needed to remain in the community.

- **Critical Adult Care Home**: A home where no more than five persons reside with a health care professional that takes care of special health and long-term care needs. Under state law, this is available only for people who are ventilator dependent or who have traumatic brain injury. The TennCare enrollee must pay for his or her room and board.

- **Companion Care**: Someone the enrollee hires who lives in the enrollee’s home to help with personal care or homemaker services as needed. Companion Care is available only for enrollees in Consumer Direction who need care throughout the day and night that cannot be provided by unpaid caregivers and whose cost would not exceed that of other kinds of home care that would meet the enrollee’s needs.

Some of these services can be provided through Consumer Direction, which offers enrollee’s more choice and control over who provides home care and how care is given than for those enrollees receiving CHOICES services and not consumer directing. In Consumer Direction, the enrollee is the employer, not the agency. As a consequence, the enrollee must be able to do the things that an employer would do, such as hire, train, and schedule employees.

Enrollees can hire a family member, friend, neighbor, or other person to provide care in Consumer Direction, but with some limitations.

### III. TENNCARE ELIGIBILITY

TennCare CHOICES in Long-Term Services and Supports (or CHOICES for short) is for adults with a physical disability and seniors. Tennessee’s CHOICES program includes nursing facility services (NF) and home- and community-based services (HCBS).
There are three CHOICES groups:

1. CHOICES Group 1 is for people of all ages who receive NF care.

2. CHOICES Group 2 is for adults age 21 and older with a physical disability and seniors age 65 and older who qualify to receive NF care, but choose to receive HCBS instead. CHOICES Group 2 offers HCBS services to help a person live in his or her own home or in the community. These services can be provided in the home, on the job, or in the community to assist with activities of daily living.

3. CHOICES Group 3 is for adults age 21 and older with a disability and seniors age 65 and older who don’t qualify for NF care, but need a more moderate package of home care services to delay or prevent the need for NF care. As of July 1, 2015, Group 3 is closed to new enrollees except for those who are SSI eligible.

To qualify for and remain in CHOICES Group 3, the applicant/enrollee must:

- Be “at risk” of needing the level of care provided in a NF unless the individual receives home care; and
- Be receiving SSI (Supplemental Security Income).

To enroll in CHOICES and receive home care services:

- The applicant’s TennCare health plan (or MCO) must be able to meet the applicant’s needs safely at home; and
- If the applicant qualifies for NF care, the cost of the home care cannot exceed the cost of NF care. The cost of home care includes any home health or private duty nursing care that is needed. If the applicant does not qualify for NF care, but is “at risk” of needing NF level of care, the cost of CHOICES HCBS cannot exceed $15,000 per year. That amount does not include the cost of any minor home modifications that may be needed.

A. Technical Eligibility

This criterion for eligibility pertains to status as aged or disabled, citizenship and residency, and length of institutionalization.

B. Medical Eligibility

To attain medical eligibility, the applicant must meet the Level of Care (LOC) criteria necessary to receive covered services as a member of a CHOICES Group (1, 2, or 3) or a PACE organization.29

PASRR. A PASRR (PreAdmission Screening and Resident Review) enables the Tennessee Department of Health to determine whether an

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29 Level of Care (LOC), Definitions, Tenn. Comp. R. & Regs. 1200-13-01-.02(118).
individual who seeks admission to a Medicaid-certified nursing facility has, or is suspected of having, mental illness or mental retardation, and, if so, whether the individual requires specialized services and is appropriate for nursing facility placement. All PASRR screenings must be completed on all individuals prior to admission to a NF or to a HCBS program.

Level of Care. Every applicant for TennCare CHOICES must be screened for two components of level of care (LOC) eligibility requirements.

The first component is medical necessity, which definition depends on the applicant’s care setting:

For a NF: Ordered by the applicant’s physician and expected to be ongoing, NF care is expected to improve the applicant’s physical or mental condition.

For HCBS: Care is expected to prevent deterioration in health status or to delay progression of disease. HCBS is not necessarily ordered by a physician but it is ongoing. The goal is to live safely in the community and delay admission to a NF.

The second component is the need for inpatient NF care. Whether CHOICES Group 1 or 2, to qualify the applicant’s physical or mental condition as a practical matter requires daily inpatient NF care.

These two components together make up the underlying premise of increased LOC acuity for inpatient NF care. TennCare utilizes a weighted PAE (Pre-Admission Evaluation) assessment tool. A PAE score of 9 (of a total of 26) or greater is required.

Applicants who have elected Medicare hospice automatically meet CHOICES’ medical eligibility requirement.

Applicants whose PAE score is 7 or 8 may request a Safety Determination.

The Safety Determination Request Form is 10 pages and has 13 different reasons that justify a Safety Determination Review. The applicant must have at least one but should check all that apply. The form also identifies what other documentation needs to be submitted: a Comprehensive Needs Assessment, Plan of Care developed by the MCO, NF or PACE, and a Safety Explanation.

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30 Tenn. Comp. R. & Regs. 1200-13-01-.10(2)(i) and “Nursing Home Preadmission Screenings for Mental Illness and Mental Retardation,” 1200-13-01-.23.

31 PreAdmission Screening/Resident Review (PASRR), Definitions, Tenn. Comp. R. & Regs. 1200-13-01-.02(166); 1200-13-01-.23(2).

TennCare will review the PAE, the Safety Determination Request Form, and other documentation and decide whether the applicant meets the criteria for NF LOC. If not, TennCare will decide whether the applicant meets the "at risk" LOC. If yes, TennCare will make a determination that Group 3 is or is not appropriate based on safety.

C. Financial Eligibility

To qualify for CHOICES: (1) The applicant’s monthly income cannot exceed $2,313 (three times the SSI federal benefit rate). If so, the applicant may establish a Medicaid Qualifying Income Trust (QIT). (2) Countable resources may not exceed $2,000. The homestead is an exempt resource, with an equity cap of $585,000 for an unmarried applicant. (3) TennCare applies the usual transfer-of-asset rules.

As of this writing (March 1, 2019), TennCare does not penalize asset transfers made by an applicant over age 65 to a special needs pooled trust established and maintained under 42 U.S.C. §1396p(d)(4)(C).

For married couples, the community spouse resource allowance (referred to by TennCare as the “community spouse resource maintenance allowance” or CSRMA) is one-half of the total countable assets, but not more than the maximum CSRA unless a higher amount is set by court order or by a hearing office to generate enough income to the raise the couple’s total monthly income up to the state minimum monthly maintenance needs allowance. An IRA or qualified retirement plan titled to the community spouse is not counted as a resource as long as the community spouse is receiving required minimum distributions or if the community spouse must leave employment to begin receiving distributions.

D. Conditional Assistance

Conditional assistance may be available to an otherwise-eligible CHOICES applicant who has excess non-liquid resources. Conditional assistance is a contractual agreement allowing CHOICES eligibility based on the applicant’s agreement to make reasonable efforts to sell excess non-liquid resources at current market value. The applicant must also agree to repay TennCare for Medicaid costs during the conditional assistance period from the proceeds of the sale of the excess non-liquid resources. An individual is allowed to receive one period of conditional assistance during a period of eligibility.34

33 Pursuant to Beach v. Tenn. Dept. of Human Servs., No. 092120-III (Davidson County Ch. Sept. 8, 2010). TennCare proposed a rule change in September 2018, however, that if effective penalizes transfers made to pooled trusts by individuals age 65 and over.

34 ABD Conditional Assistance, TennCare Elig. Policy 110.052 (Nov. 1, 2016).
Conditional assistance is based upon a comparable SSI rule of eligibility and is deemed to be a no more restrictive methodology applied by the State to SSI recipients.\(^{35}\)

IV. TENNCARE ENROLLMENT AND START DATE

Eligibility for benefits is determined beginning with the date of the CHOICES application or date determined otherwise eligible (that is, the Medicaid Qualified Income Trust (QIT or "Miller Trust") date, PAE approval date, or the date that the HCBS MCO determines an individual is likely to need HCBS services), \textit{whichever is later}. Elimination of retroactive coverage means that even if the individual has met all technical, medical, and financial criteria on an earlier date, the start date for benefits will not begin until the date the application is filed.

For a nursing facility resident who meets the technical, medical, and financial criteria at the time of admission and seeks CHOICES Group 1 coverage from date of admission, an application must be filed on or before the date of admission, and an approvable PAE must be filed within 30 days after the date of admission.\(^{36}\) The earliest date of TennCare-reimbursed care provided in a nursing facility is the date that all of the following criteria are met:

1. Completion of the PASRR process;
2. The effective date of level of care (LOC) eligibility as reflected by the PAE Approval Date;
3. The effective date of Medicaid eligibility (known as the Medicaid-Only Payer Date (MOPD): This is the date that the facility certifies that Medicaid reimbursement for NF services will begin. The person has in fact been admitted to the facility and all other sources of reimbursement (including Medicare and private pay) have been exhausted);
4. The date of admission to the nursing facility; and
5. The effective date of enrollment into CHOICES Group 1.\(^{37}\)

Individuals in a nursing facility may be eligible, as of the application date, once 30 days of continuous confinement and all other eligibility requirements are met.

A. Example

Mr. Jones enters the nursing facility on June 1, 2015, and applies for CHOICES Group 1 on June 1, 2015. The facility files an approvable PAE


\(^{36}\) General Eligibility Criteria, TennCare CHOICES in Long-Term Services and Supports, TennCare Elig. Policy 130.005.3 (Dec. 1, 2016).

on June 15, 2015. He meets continuous confinement on June 30, 2015. He met all other eligibility requirements beginning June 1, 2015. His application will be approved effective June 1, 2015.

B. Example

Mr. Jones enters the nursing facility on June 1, 2015. The nursing home files an approvable PAE on June 15, 2015. He applies for CHOICES Group 1 on August 3, 2015. Beginning July 10, 2015, he met all other eligibility requirements. His application will be approved effective August 3, 2015.

Because of the potential for risk for loss of payment, many nursing facilities will submit a CHOICES application on the day the resident is admitted. The decision on eligibility must be made within 45 days of the date of the application, except in unusual circumstances, such as where an examining physician fails or delays to take action, the delay is caused by the applicant, or there is an emergency beyond the control of TennCare.\textsuperscript{36}

V. APPLYING FOR TENNCARE CHOICES GROUP 2 (HCBS)\textsuperscript{39}

Mr. Jones is residing in his own home, with the assistance of his daughter Jane, who prepares his meals, sets up his medications, does housework, bathes and dresses him, and puts him to bed at night. Jane lives in her father’s home during the weekdays and returns to her own home on weekends when her other sister Betty brings Mr. Jones to Betty’s home.

Seeking a “CHOICES referral,” Jane calls her local Area Agency on Aging and Disability (AAAD). Jane explains that her father is a U.S. citizen and a lifelong resident of Tennessee, owns his own home and has less than $2,000 in countable resources. The AAAD intake counselor transfers the call to the AAAD care manager to schedule a comprehensive needs assessment in the home of Mr. Jones, with Jane present.

At the assessment visit, during the in-home face-to-face visit, the AAAD care manager delivers and reviews with Mr. Jones and Jane \textit{CHOICES Education Materials} provided by TennCare. These materials include all subjects – an explanation of the CHOICES program, who qualifies for CHOICES, limits on enrollment (\textit{i.e.}, enrollment targets), and the Estate Recovery Program – addressed by the intake counselor at the initial screening. Mr. Jones and Jane have an opportunity to ask questions regarding the information provided.

In addition to general education about CHOICES, the information Mr. Jones receives at the assessment includes:

- Explanation of the three Groups in TennCare CHOICES;

\textsuperscript{36} 42 C.F.R. §435.911; CHOICES Application Process, TennCare CHOICES in Long-Term Services and Supports, TennCare Elig. Policy 130.005.4 (Dec. 1, 2016).

\textsuperscript{39} Example from \textit{Elder Law Practice in Tennessee} §5.05(b)(3).
• The AAAD is facilitating a CHOICES application, but the State will determine if an applicant satisfies categorical and financial requirements for CHOICES eligibility and to receive LTSS and if the applicant meets nursing facility level of care or is at risk for nursing facility placement;

• If the applicant qualifies for CHOICES, TennCare will determine in which CHOICES group(s) the applicant is eligible for enrollment;

• Upon enrollment into CHOICES, a care coordinator from the applicant’s MCO will complete an assessment, explain the specific benefits that are available for the member and determine what CHOICES services will be needed to meet the member’s needs;

• Mr. Jones may seek Consumer Direction, using the Consumer Direction Interest Form developed by TennCare.

Mr. Jones would be interested in Consumer Direction, Jane says. The AAAD care manager informs them that, in order to participate in Consumer Direction, Mr. Jones’ plan of care must contain one or more of the eligible HCBS (that is, attendant care, personal care, and in-home respite). If he needs one or more of the services available through Consumer Direction, he can ask to participate in Consumer Direction at any time.

Mr. Jones consents to go forward with the process of enrollment. The AAAD care manager obtains Jane’s signature as his attorney-in-fact and Representative on the Patient Liability Acknowledgement Form. Jane, on behalf of Mr. Jones, completes and signs the Freedom of Choice Form, in which he elects to receive care at home (HCBS) instead of a nursing home. The AAAD care manager also assists Jane in completing Mr. Jones’ TennCare CHOICES LTSS application.

In addition, the AAAD care manager completes, signs, and obtain Jane’s signature (as his representative) on the AAAD-LTSS Facilitated Enrollment Addendum. (If Mr. Jones opts to select an MCO at this time, he can do so on this form. Otherwise, TennCare will choose one for him. Regardless, he has 45 days after enrollment to change his MCO assignment.) AAAD will assist Mr. Jones and Jane in gathering documentation specified on the Checklist of Requirements for LTSS Enrollment that will be required for an eligibility determination.

Within five business days of the intake visit, utilizing the TennCare PreAdmission Evaluation System (TPAES), the AAAD submits the information gathered at the intake visit for determination of Mr. Jones’ LOC determination. The AAAD recommends Immediate Eligibility for him by completing the IE form, and attaches the form along with a copy of the TennCare CHOICES application packet to the PAE in TPAES. Mr. Jones’ Total Acuity Score is 11, thereby entitling him to enroll.

40 Tenn. Comp. R. & Regs. 1200-13-01-.05(8)(n).

in CHOICES Group 1 or Group 2. TennCare approves Mr. Jones for Immediate Eligibility, which entitles him to 45 days of limited HCBS (Personal Care Visits, Attendant Care, Home-Delivered Meals, PERS, and Adult Day Care).42

Mr. Jones is assigned a Managed Care Organization,43 which schedules a visit to him from one of its care coordinators to complete the assessment. Mr. Jones designates Jane as his Representative.44 The MCO determines that Mr. Jones can be served safely and appropriately in the community and within his individual cost-neutrality cap. TennCare approves Mr. Jones for enrollment in CHOICES Group 2.45 The MCO Care Coordinator, Mr. Jones, and Jane begin developing a Plan of Care that includes Consumer Direction.

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43 For the contractual obligations imposed on MCOs, see TennCare’s, “[] Statewide Contract with Amendment 8-July 1, 2018,” supra; and Amerigroup Corp.’s Provider Manual Supplement: TennCare CHOICES, supra.

44 Consumer-Direction (CD), Enrollment in CD, Representative, TennCare CHOICES Programs, Tenn. Comp. R. & Regs. 1200-13-01-.05(9)(d)(5). A Representative cannot receive payment for serving in that capacity and cannot serve as a member’s worker for any consumer-directed service.

KENTUCKY STATE LONG-TERM CARE OMBUDSMAN PROGRAM
Denise Wells, Bluegrass District Ombudsman

I. WHAT IS AN OMBUDSMAN?

Ombudsman is a Swedish word for advocate. A long-term care ombudsman (LTCO) is an advocate for individuals and their families that need the services of a long-term care facility. They are trained to impartially investigate and resolve resident’s concerns. They also provide information and refer residents to additional community resources when appropriate.

The Kentucky State Long-Term Care Ombudsman Program serves more than 35,000 nursing home, personal care home, and family care home residents and their families (as well as other interested consumers) in Kentucky. Its primary objectives are to:

- Protect the rights of long-term care residents;
- Identify, investigate and work to resolve residents’ concerns;
- Empower residents to make informed choices;
- Monitor and work to enact laws protecting older Kentuckians;
- Be a regular friendly visitor to residents.

The LTCO is an advocate ombudsman. The LTCO is impartial in investigation, determining the facts pertinent to a case. Ombudsmen must gather sufficient information to gain an accurate understanding of the problem in order to develop a resolution plan. Then the LTCO becomes an advocate, seeking a resolution the resident wants. Long-Term Care Ombudsmen represent residents and resident concerns by seeking resolution for both individual issues and systemic issues.

II. AUTHORITY OF THE LONG-TERM CARE OMBUDSMAN PROGRAM

The long-term care ombudsman program is a federally mandated program authorized through the Older Americans Act (OAA). In Kentucky, ombudsmen are authorized to advocate for residents in nursing homes, personal care homes, and family care homes.

The OAA contains:

- Guidance for access to resident records.
- Provisions regarding confidentiality of information identifying a resident.
- Prohibitions against individuals serving as representatives of the LTCOP until they have been trained and approved by the SLTCO.
- Requirements that the disclosure of LTCOP files and records is subject to approval by the SLTCO and certain types of disclosure are prohibited.
- Prohibitions and sanctions for willful interference with ombudsman duties are required to be established by the state.
- Conflicts of interest for the Office of the SLTCO, entities, and individuals participating in the LTCOP are prohibited.
III. UNIQUE ELEMENTS OF THE LTCO

The long-term care ombudsman program is unique in many aspects of its complaint investigations and resolutions.

A. Jurisdiction

The jurisdiction of the LTCO is the interest of the resident.

B. Resolution Standard

At the end of the investigation and resolution process, the key question for a long-term care ombudsman is, “has the complaint been resolved to the satisfaction of the resident?”

C. Standards of Evidence

The LTCO gathers enough evidence to understand the real issue in order to resolve it as the resident desires. Other agencies use different, and possibly higher, evidentiary standards. The LTCO is not bound to regulations or legal standards of evidence and may pursue resolution in complaints without regulatory violations.

D. Confidentiality

The OAA stipulates strict parameters for protecting the confidentiality of the identity of complainants. There are also very specific provisions for the release of LTCOP information. Virtually all human services agencies have confidentiality provisions. The LTCOP's distinction is the narrow limits the OAA puts on sharing of resident specific information even with other agencies or departments. Ombudsmen are federally exempt from state mandatory reporting laws.

IV. COMPLAINT INVESTIGATION AND RESOLUTION

Ombudsmen investigate individual complaints with the consent of the resident involved.

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<tr>
<th>Stage 1</th>
<th>Intake &amp; Investigation</th>
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</thead>
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<tr>
<td>Receive the complaint</td>
<td>Receive problems, complaints, or concerns directly from the resident or from family, friends, or even the facility staff.</td>
</tr>
<tr>
<td>Gather information</td>
<td>Collect information from interviews, records, and observations.</td>
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<tr>
<td>Verify the problem</td>
<td>Review information gathered and assess what seems to be the root of the problem.</td>
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### Stage 2
#### Analysis & Planning

<table>
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<th>Analyze the situation</th>
<th>Consider possible causes of the problem.</th>
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<tr>
<td>Consider solutions</td>
<td>Generate multiple solutions or approaches. Consider who should be involved and how and when solutions could be implemented.</td>
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<tr>
<td>Identify obstacles</td>
<td>Anticipate obstacles to help select the most appropriate response</td>
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### Stage 3
#### Resolution & Follow Up

<table>
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<th>Choose an approach</th>
<th>Choose the most efficient way to proceed but identify alternative strategies.</th>
</tr>
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<tbody>
<tr>
<td>Act</td>
<td>Proceed with the selected plan.</td>
</tr>
<tr>
<td>Evaluate outcome</td>
<td>Check back with the residents or complainants involved to evaluate the outcomes. Evaluate whether the problem is resolved or partially resolved. If a problem remains, act on alternative strategies or start the problem-solving process again.</td>
</tr>
</tbody>
</table>

### V. PROTECTING RESIDENTS’ RIGHTS

State and federal regulations outline additional rights for individuals living in long-term care settings. A key role of the ombudsman is to educate residents, families, long-term care employees, and the public of these rights.

### VI. FEDERAL RESIDENTS’ RIGHTS

Nursing homes which participate in the Medicare and Medicaid reimbursement programs must adhere to the federal Nursing Home Reform Law. The law requires nursing homes to “promote and protect the rights of each resident” and stresses individual dignity and self-determination. These regulations address **quality of life** and **quality of care**. The full regulations may be found on the CMS website.

The Nursing Home Reform Act requires each nursing home to care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident. This statement highlights an emphasis on dignity, choice, and self-determination for nursing home residents.

Each nursing home is required to provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care which is initially prepared with participation (to the extent practicable) of the resident, the resident’s family, or legal representative. This means that a resident should not decline as a direct result of the nursing facility’s care.

All residents have the following rights:
A. The Right to Be Fully Informed, including...

1. The right to be informed of all services available as well as the charge for each service.

2. The right to have a copy of the nursing home's rules and regulations, including a written copy of their rights.

3. The right to be informed of the address and telephone number of the State Ombudsman, State licensure office, and other advocacy groups.

4. The right to see the State survey reports of the nursing home and the home's plan of correction.

5. The right to be notified in advance of any plans to change their room or roommate.

6. The right to daily communication in their language.

7. The right to assistance if they have a sensory impairment.

B. The Right to Participate in Their Own Care, including...

1. The right to receive adequate or appropriate care.

2. The right to be informed of any changes in their medical condition.

3. The right to participate in planning their treatment, care, and discharge.

4. The right to refuse medication and treatment.

5. The right to refuse chemical and physical restraints.

6. The right to review their medical record.

C. The Right to Make Independent Choices, including...

1. The right to make independent personal decisions, such as what to wear and how to spend free time.

2. The right to reasonable accommodation of their needs and preferences by the nursing home.

3. The right to choose their own physician.

4. The right to participate in community activities, both inside and outside the nursing home.

5. The right to organize and participate in a Resident Council.
D. The Right to Privacy and Confidentiality, including…

1. The right to private and unrestricted communication with any person of their choice.

2. The right to privacy in treatment and in the care of their personal needs.

3. The right to confidentiality regarding their medical, personal, or financial affairs.

E. The Right to Dignity, Respect, and Freedom, including…

1. The right to be treated with the fullest measure of consideration, respect, and dignity.

2. The right to be free from mental and physical abuse, corporal punishment, involuntary seclusion, and physical and chemical restraints.

3. The right to self-determination.

F. The Right to Security of Possessions, including…

1. The right to manage their own financial affairs.

2. The right to file a complaint with the State survey and certification agency for abuse, neglect, or misappropriation of their property if the nursing home is handling their financial affairs.

3. The right to be free from charge for services covered by Medicaid or Medicare.

G. Rights during Transfers and Discharges, including…

1. The right to remain in the nursing facility unless a transfer or discharge…

   a. Is necessary to meet the resident's welfare.

   b. Is appropriate because the resident's health has improved and the resident no longer requires nursing home care.

   c. Is needed to protect the health and safety of other residents or staff.

   d. Is required because the resident has failed, after reasonable notice, to pay the facility charge for an item or service provided at the resident's request.
2. The right to a 30-day notice.
   
a. The notice must include the reason for transfer or discharge, the effective date, the location to which the resident is transferred or discharged, a statement of the right to appeal, and the name, address, and telephone number of the state long-term care ombudsman.
   
b. The right to a safe transfer or discharge through sufficient preparation by the nursing home.

H. The Right to Complain, including….

1. The right to present grievances to the staff of the nursing home, or to any other person, without fear of reprisal.

2. The right to prompt efforts by the nursing home to resolve grievances.

I. The Right to Visits, including…

1. The right to immediate access by a resident's personal physician and representatives from the health department and ombudsman programs.

2. The right to immediate access by their relatives and for others subject to reasonable restriction with the resident's permission.

3. The right to reasonable visits by organizations or individuals providing health, social, legal, or other services.

VII. STATE RESIDENTS' RIGHTS

Whereas the federal residents' rights only apply in nursing homes which accept Medicare and Medicaid dollars, Kentucky’s state residents' rights apply to all long-term care residents. These include nursing homes, personal care homes, and family care homes. Assisted living regulations in Kentucky do not include additional rights.

KRS 216.515 Long-Term Care Residents’ Rights:

A. Before admission to a long-term-care facility, the resident and the responsible party or his responsible family member or his guardian shall be fully informed in writing, as evidenced by the resident's written acknowledgment and that of the responsible party or his responsible family member or his guardian, of all services available at the long-term-care facility. Every long-term-care facility shall keep the original document of each written acknowledgment in the resident's personal file.

B. Before admission to a long-term-care facility, the resident and the responsible party or his responsible family member or his guardian shall be
fully informed in writing, as evidenced by the resident's written acknowledgment and that of the responsible party or his responsible family member or his guardian, of all resident's responsibilities and rights as defined in this section and KRS 216.520 to 216.530. Every long-term-care facility shall keep the original document of each written acknowledgment in the resident's personal file.

C. The resident and the responsible party or his responsible family member or his guardian shall be fully informed in writing, as evidenced by the resident's written acknowledgment and that of the responsible party or his responsible family member, or his guardian, prior to or at the time of admission and quarterly during the resident's stay at the facility, of all service charges for which the resident or his responsible family member or his guardian is responsible for paying. The resident and the responsible party or his responsible family member or his guardian shall have the right to file complaints concerning charges which they deem unjustified to appropriate local and state consumer protection agencies. Every long-term-care facility shall keep the original document of each written acknowledgment in the resident's personal file.

D. The resident shall be transferred or discharged only for medical reasons, or his own welfare, or that of the other residents, or for nonpayment, except where prohibited by law or administrative regulation. Reasonable notice of such action shall be given to the resident and the responsible party or his responsible family member or his guardian.

E. All residents shall be encouraged and assisted throughout their periods of stay in long-term care facilities to exercise their rights as a resident and a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and to outside representatives of their choice, free from restraint, interference, coercion, discrimination, or reprisal.

F. All residents shall be free from mental and physical abuse, and free from chemical and physical restraints except in emergencies or except as thoroughly justified in writing by a physician for a specified and limited period of time and documented in the resident's medical record.

G. All residents shall have confidential treatment of their medical and personal records. Each resident or his responsible family member or his guardian shall approve or refuse the release of such records to any individuals outside the facility, except as otherwise specified by statute or administrative regulation.

H. Each resident may manage the use of his personal funds. If the facility accepts the responsibility for managing the resident's personal funds as evidenced by the facility's written acknowledgment, proper accounting and monitoring of such funds shall be made. This shall include each facility giving quarterly itemized statements to the resident and the responsible party or his responsible family member or his guardian which detail the status of the resident's personal funds and any transactions in which such
funds have been received or disbursed. The facility shall return to the resident his valuables, personal possessions, and any unused balance of moneys from his account at the time of his transfer or discharge from the facility. In case of death or for valid reasons when he is transferred or discharged the resident's valuables, personal possessions, and funds that the facility is not liable for shall be promptly returned to the resident's responsible party or family member, or his guardian, or his executor.

I. If a resident is married, privacy shall be assured for the spouse's visits and if they are both residents in the facility, they may share the same room unless they are in different levels of care or unless medically contraindicated and documented by a physician in the resident's medical record.

J. Residents shall not be required to perform services for the facility that are not included for therapeutic purposes in their plan of care.

K. Residents may associate and communicate privately with persons of their choice and send and receive personal mail unopened.

L. Residents may retain the use of their personal clothing unless it would infringe upon the rights of others.

M. No responsible resident shall be detained against his will. Residents shall be permitted and encouraged to go outdoors and leave the premises as they wish unless a legitimate reason can be shown and documented for refusing such activity.

N. Residents shall be permitted to participate in activities of social, religious, and community groups at their discretion.

O. Residents shall be assured of at least visual privacy in multibed rooms and in tub, shower, and toilet rooms.

P. The resident and the responsible party or his responsible family member or his guardian shall be permitted the choice of a physician.

Q. If the resident is adjudicated mentally disabled in accordance with state law, the resident's guardian shall act on the resident's behalf in order that his rights be implemented.

R. Each resident shall be treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs.

S. Every resident and the responsible party or his responsible family member or his guardian has the right to be fully informed of the resident's medical condition unless medically contraindicated and documented by a physician in the resident's medical record.
T. Residents have the right to be suitably dressed at all times and given assistance when needed in maintaining body hygiene and good grooming.

U. Residents shall have access to a telephone at a convenient location within the facility for making and receiving telephone calls.

V. The resident's responsible party or family member or his guardian shall be notified immediately of any accident, sudden illness, disease, unexplained absence, or anything unusual involving the resident.

W. Residents have the right to have private meetings with the appropriate long-term care facility inspectors from the Cabinet for Health and Family Services.

X. Each resident and the responsible party or his responsible family member or his guardian has the right to have access to all inspection reports on the facility.

Y. The above-stated rights shall apply in all cases unless medically contraindicated and documented by a physician in writing in the resident's medical record.

Z. Any resident whose rights as specified in this section are deprived or infringed upon shall have a cause of action against any facility responsible for the violation. The action may be brought by the resident or his guardian. The action may be brought in any court of competent jurisdiction to enforce such rights and to recover actual and punitive damages for any deprivation or infringement on the rights of a resident. Any plaintiff who prevails in such action against the facility may be entitled to recover reasonable attorney's fees, costs of the action, and damages, unless the court finds the plaintiff has acted in bad faith, with malicious purpose, or that there was a complete absence of justifiable issue of either law or fact. Prevailing defendants may be entitled to recover reasonable attorney's fees. The remedies provided in this section are in addition to and cumulative with other legal and administrative remedies available to a resident and to the cabinet.

VIII. PERSONAL AND FAMILY CARE HOMES

Personal care homes and family care homes are categorized as "boarding homes" in Kentucky regulation. In addition to the rights above, residents of boarding homes have the following rights.

**KRS 216B.303:**

A. Before entering a boarding home, the resident or the resident's guardian, if any, shall be fully informed in writing, as evidenced by the resident's written acknowledgment or that of the resident's guardian, of all services provided by the boarding home and all applicable charges.

B. Before entering a boarding home, the resident or the resident's guardian shall be fully informed in writing, as evidenced by the resident's written
acknowledgment or that of the resident's guardian, of all the resident's rights as defined in this section, and a list of any rules established by the boarding home.

C. All residents shall be allowed to exercise their rights as a resident and a citizen, and may voice grievances and recommend changes in policies and services to the boarding home operator and to outside representatives of their choice, free from restraint, interference, coercion, discrimination, or reprisal.

D. All residents shall be free from mental and physical abuse.

E. Each resident may manage the use of his personal funds. The boarding home operator shall not require a resident to designate the operator as payee for any benefits received by the resident. However, if the operator accepts the responsibility for managing the resident's personal funds as evidenced by the operator's written acknowledgment, proper accounting and monitoring of such funds shall be made. This shall include the operator giving quarterly itemized statements to the resident or the resident's guardian which detail the status of the resident's personal funds and any transactions in which such funds have been received or disbursed. The operator shall return to the resident his valuables, personal possessions, and any unused balance of moneys from his account at the time the resident leaves the boarding home.

F. Residents shall not be required to perform services for the boarding home.

G. Residents may associate and communicate privately with persons of their choice, within reasonable hours established by the boarding home, and send and receive personal mail unopened.

H. No resident shall be detained against the resident's will. Residents shall be permitted and encouraged to go outdoors and leave the premises as they wish.

I. Residents shall be permitted to participate in activities of social, religious, and community groups at their discretion.

J. Residents shall be assured of at least visual privacy in multibed rooms and in bathrooms.

K. If the resident has been adjudicated wholly mentally disabled in both financial and personal affairs in accordance with KRS 387.590, the resident's guardian shall not place the ward in a boarding home.

L. Each resident shall be treated with consideration, respect, and full recognition of his dignity and individuality.

M. Residents shall have access to a telephone at a convenient location within the boarding home for making and receiving telephone calls subject to reasonable rules established by the boarding home.
N. Residents have the right to have private meetings with inspectors representing the Cabinet for Health and Family Services.

O. Each resident and his guardian have the right to have access to all inspection reports on the boarding home.

IX. **OMBUDSMAN OFFICES IN KENTUCKY**

The Kentucky State Long-Term Care Ombudsman Program operates out of the Nursing Home Ombudsman Agency of the Bluegrass in Lexington. To contact the State Ombudsman, call 800-372-2991 or email nhoa@ombuddy.org. To contact a District Ombudsman, review the list below.

**Barren River**
1-800-355-7580
Allen, Barren, Butler, Edmonson, Hart, Logan, Metcalfe, Monroe, Simpson, and Warren counties

**Big Sandy**
1-800-737-2723
Floyd, Johnson, Magoffin, Martin, and Pike counties

**Bluegrass**
1-877-787-0077
Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jessamine, Lincoln, Madison, Mercer, Nicholas, Powell, Scott, and Woodford counties

**Buffalo Trace**
1-800-998-4347
Bracken, Fleming, Lewis, Mason, and Robertson counties

**Cumberland Valley**
1-800-795-7654
Bell, Clay, Harlan, Jackson, Knox, Laurel, Rockcastle, and Whitley counties

**FIVCO**
1-800-274-5863
Boyd, Carter, Elliott, Greenup and Lawrence counties

**Gateway**
1-800-274-5863
Bath, Menifee, Montgomery, Morgan, and Rowan counties

**Green River**
1-800-928-9094
Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster counties

**Kentucky River**
1-800-928-5723
Breathitt, Knott, Lee, Leslie, Letcher, Owsley, Perry, and Wolfe counties

**Kentuckiana Regional Planning & Development Agency (KIPDA)**
1-800-854-3233
Bullitt, Henry, Jefferson, Oldham, Shelby, Spencer, andTrimble counties

**Lake Cumberland**
1-800-264-7093
Adair, Casey, Clinton, Cumberland, Green, McCreary, Pulaski, Russell, Taylor, and Wayne counties

**Lincoln Trail**
1-800-264-0393
Breckinridge, Grayson, Hardin, Larue, Marion, Meade, Nelson, and Washington counties

**Northern Kentucky**
1-800-255-7265
Boone, Campbell, Carroll, Gallatin, Grant, Kenton, Owen, and Pendleton counties

**Pennyrile**
1-800-928-7233
Caldwell, Christian, Crittenden, Hopkins, Livingston, Lyon, Muhlenberg, Todd, and Trigg counties

**Purchase**
1-877-352-5183
Ballard, Carlisle, Fulton, Hickman, Graves, Marshall, and McCracken counties
I. INTRODUCTORY OBSERVATIONS ABOUT THE PRACTICE OF LAW

The practice of law is often romanticized in movies, on television and in the shows that we stream. We read books about lawyers who overcome tremendous obstacles to deliver justice. The good guys usually prevail – with soaring orchestral scores to emphasize the moment of triumph. There is a grain of truth in these depictions. But fiction is fiction and reality is reality. The differences between the two are much more prominent than the similarities.

We revel in helping people solve legal problems large and small, but the satisfaction of being the rescuer comes at a price – sometimes, a heavy price. Most of us spend a great deal of time trying to relieve the anxiety of people caught up in a legal matter. They are frightened and angry. Sometimes they even lash out at us.

So, there is no escaping the reality that the day-to-day work of a practicing attorney, while often deeply satisfying, is just often a grind that wears us down. More often than not, it is simply hard work that requires us to work long hours, interact with difficult people and contend with deadline after deadline. Most of us have those moments when we live in mortal fear of making a mistake that will harm our clients, damage our reputations, and bring financial ruin.

These circumstances contribute to our subjective sense of well-being or occasional lack thereof. Our sense of well-being impacts how effectively we practice law. A sense of well-being significantly affects productivity, career longevity (i.e. ability to avoid burnout), and the ability to have a positive impact on the morale of others.¹

It is against the backdrop of these observations that we view some very sobering statistics concerning lawyers as a group.

II. SOME DISTURBING STATISTICS

According to an oft-cited 1990 study by Johns Hopkins University, lawyers are nearly four times more likely to suffer from depression than the average person.² As many as 25 percent suffer from "psychological distress, including anxiety, social alienation, isolation, and depression."³ Substance abuse among lawyers is nearly

² Id.
twice the rate of the general population. Divorce rates also appear to be higher for attorneys than members of other professions. Most disturbingly, suicide rates among lawyers are significantly higher than the general population, a fact with which Kentucky lawyers are all too familiar.

A recent study by two Florida State University law school professors delves deeply into the question of what makes lawyers happy. One observation worth noting is that there is a well-established connection between performance and well-being. Stated differently, the better we are at what we do, the more satisfied we will be. That sense of doing well is an important part of what sustains us as we push through the difficult times.

So, how can we improve when we are already doing all that we can do? The first step is to identify what impedes performance. The second is to proactively, deliberately address what was identified.

III. IDENTIFYING STRESSORS THAT WE CAN DO SOMETHING ABOUT

On the most basic level, the problem that most of us face in law practice is the sense of being overwhelmed by the demands on our time and attention. In a way, we become victims of our own successes and expectations. We want to help everyone. There is so much to do and simply not enough time in which to do it. One week, we may feel as though we are about to be crushed by our caseload. The next, the pendulum has swung to the opposite extreme so that we feel like our business is drying up. The idea of balance just seems like a theoretical point that we pass through on the way to one extreme or the other. For most of us, the more persistent condition is feeling overwhelmed.

Most simply stated, here are the things that chase us the hardest:

- We feel like we are always playing defense and never playing offense.
- We feel like we are spending more time on the logistics of law practice than on the actual practice of law.

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5 Id. at p. 877-78.

6 Id. at p. 879-80.


• We find it difficult to return phone calls or respond to emails as promptly as we should.

• We sit up in bed in the middle of the night and exclaim, "Oh, snap!" because we just realized that we failed to complete a particular task.

These concerns are not entirely unreasonable because they can sometimes have disciplinary ramifications. The Kentucky Supreme Court's Rules of Professional Conduct, SCR 3.130, set high standards for how we are to practice law.

Our duties include:

• The duty to demonstrate competence in the practice of law.\(^9\)

• The duty to act with diligence and promptness in representing our clients.\(^10\)

• The duty to keep our clients informed about the status of their cases and to comply with their requests for information.\(^11\)

• The duty to expedite litigation.\(^12\)

• The duty to supervise the lawyers whose work you oversee and to attend to the business of your firm.\(^13\)

• The duty to supervise non-lawyer assistants to assure that their actions are consistent with the Rules of Professional Conduct.\(^14\)

When you put it all together, it is no surprise that being an attorney is really difficult at times. So, what can we do about it? Actually, a part of the solution is literally at your fingertips. That brings us to the Big Idea of this presentation.

IV. **THE BIG IDEA**

*Through the smart use of technology, you can make your work life better.*

Our work lives are intertwined with our lives as a whole. Given the amount of time that most of us devote to law practice, it is easy to see how improving our

\(^9\) SCR 3.130(1.1) Competence.

\(^10\) SCR 3.130(1.3) Diligence.

\(^11\) SCR 3.130(1.4) Communication.

\(^12\) SCR 3.130(3.2) Expediting litigation.

\(^13\) SCR 3.130(5.1) Responsibilities of partners, managers and supervisory lawyers.

\(^14\) SCR 3.130(5.3) Responsibilities regarding nonlawyer assistants.
satisfaction at work will improve our contentment overall. We are not the sum of our work lives, but that is a big part of the equation.

Here are some of the benefits we can derive through the smart use of technology:

- You can play offense instead of defense.
- You can spend more time doing lawyer things and less time performing tasks that can be delegated to support staff.
- You can improve the timeliness of your communications with clients.
- You can reduce the number of "Oh, snap!" moments.

The tools that we need to make these transitions are readily available and less expensive than ever. We're talking about technology and that is the focus of this presentation.

V. BASIC HARDWARE TECHNOLOGY REQUIREMENTS AND RECOMMENDATIONS

Some people like to vacation at the beach, while others prefer the mountains. Selecting computer hardware offers a similar personal choice. The two basic choices are Mac and PC. My firm uses Mac computers and other Apple products from smartphones to tablets to Apple TV. Our bias for these products will be obvious from our presentation, but everything we are going to share applies equally to Apple products and PCs.

A. Preliminary Thoughts on Hardware

1. Buy the very best and most up-to-date hardware you can afford. We have spent so many years making our time valuable that it doesn't make sense to settle for tools that slow us down.

2. The most important technological development in recent years has been the degree of connectivity that we have between devices. We can create a document on our laptop, edit it on our tablet, and send it to someone for review from our smartphone. Choose hardware that integrates as seamlessly as possible because there is a huge benefit if you do.

3. Consult with someone who understands how you will be using the technology to configure your hardware. Sit with them while they do it. You'll be surprised how much you learn. For a more detailed discussion on selecting the right computer hardware, go to www.designyourworklife.com.
B. Recommended Device List


Half of the foundation of your system is your computer. Aside from the notion that you should buy the best you can afford, the first decision you will have to make is whether to buy a desktop or a laptop. Generally speaking, a desktop computer will offer greater performance for the dollar than a laptop. The obvious downside is that a desktop is not portable. For most attorneys, a laptop is a better choice, even though it costs more.

Our strong preference is a MacBook Pro laptop with the fastest processor available, as well as plenty of hard drive (or equivalent) storage and as much RAM (working memory) as you can get. The obvious benefit of a laptop is its portability. The good thing is that there really is no downside when it comes to using your laptop in your office. You can connect it to a separate monitor, mouse and keyboard and it becomes indistinguishable from a desktop. Even better, it is now possible to use a 4k flat screen television as your monitor. It is relatively economical to have the same setup at your home office. A MacBook Pro with these peripherals really does allow you to enjoy the best of both worlds – performance and portability.

Another benefit of using a laptop with a desktop adaptation is that at the end of the day, you can pack your laptop up and take it with you, eliminating the risk of someone stealing your computer from your office. For more information about selecting the right hardware and configuring it for use in a law office, go to: www.designyourworklife.com.

2. Tablet option and accessories.

The other half of the foundation of your system is your tablet. This is another place where our biases are with a particular brand. We prefer the iPad Pro to other tablets we reviewed. With the right apps, you can perform about 90 percent of the tasks you once did on a computer on a tablet. As far as accessories are concerned, we like the Poetic brand iPad case, the Apple Smart Keyboard (which is designed specifically for the iPad Pro) and the Apple Pencil. We will talk more about these later.

To complement your computer and your tablet, we suggest that you have the latest or near-latest iPhone. Aside from serving as the primary telephone for many of us, an iPhone allows us to communicate in a number of other ways that can exponentially increase our ability to meet our ethical obligations under RPC 1.4, Communication.
To round out your hardware package, we recommend getting an Apple TV device and connecting that to a flat screen TV on a stand so that it is portable. The Apple TV allows you to connect any of your Apple devices wirelessly and display your screen (from your MacBook, iPad or iPhone) onto the TV. This is a great way to collaborate with colleagues, review documents with clients or use your device as a whiteboard for drawing diagrams. Just to illustrate the point, the co-authors of this outline co-wrote the materials and almost all of their collaboration was done using this method.

Best of all, clients of all ages are impressed when we use technology well. In fact it only takes a moment for the technology to fade into the background and improve our focus on the substance of the matter at hand. They understand their cases better, and, most importantly, it makes us look really cool. Need we say more?

3. High-speed scanners.

The last item to add to your list is a high-speed scanner. You will want one that has a sheet-feeder so that you can drop a stack of documents in it and simply push a button. We have experimented with a few different brands and have had the best experience with the FUJITSU Document Scanner ScanSnap iX500. For more information, go to http://www.fujitsu.com. There are also models that are smaller and more portable in the ScanSnap line, and we have had a good experience with those as well.

We should probably say a word about multi-function machines. Printers that are also scanners, fax machines and copiers have been around for a while. For very small jobs, a multi-function machine is useful. But for jobs of any considerable size, you will find yourself counting ceiling tiles while you wait for a document to scan. It is definitely preferable to have a dedicated scanner that is designed solely for that purpose.

Lastly, many photocopiers have a scanning function. Typically, the speed and quality is very good, but copiers are really expensive by comparison to the other hardware we have been discussing. One benefit of moving to a paperless office is that you will do a small fraction of the copying that you did even five years ago. We are still using a copier that we bought in 2009 and hope to continue using it for a few more years. It would be an overstatement to say that copiers have become obsolete, but they are certainly less central to document processing than they once were.

VI. BASIC SOFTWARE/APP REQUIREMENTS AND RECOMMENDATIONS

Having laid the hardware foundation of your system, it's time to add your software applications. Most of these are apps so well known that they don't require elaboration.
A. Microsoft Office Suite

B. PDF Apps

C. Notetaking App (for tablet)
2. Others (Go to Apple App Store or Google Play).

D. Cloud Storage
5. App-specific cloud storage.

VII. ADOPTING PAPERLESS WORKFLOWS

Once you have assembled your hardware and installed your apps, it is time to put it all to work. The heart and soul of the Design Your Worklife approach is implementing an entirely paperless approach to practicing law. This idea is not new. However, recent advances have made the technology so user-friendly that you don’t have to hire an IT person or become a tech nerd to utilize it. That’s the real game-changer.

A. Move toward a Paperless Office

The move to a paperless office is based in large part on working with electronic media. Increasingly, documents are received in PDF format. For example, almost all pleadings and orders in federal courts are filed and disseminated electronically. Similarly, Kentucky state courts have moved toward an electronic filing system that is surprisingly easy to use. Serving
copies of court filings via email is becoming the norm. Our postage machine is looking more like a buggy whip each day.

1. All the progress toward electronic documents notwithstanding, we still find ourselves having to deal with a significant volume of paper. That requires us to convert paper documents to PDF format through scanning. This is an area that has changed a great deal in the past 10 years.

2. Scanners have been around for a while, but reliable, high-speed scanners used to be very expensive. Today, you can buy a high-quality scanner for around $500, which is roughly 10 percent of what an equivalent scanner cost 10 years ago.

B. Achieving Paperlessness

If you’re still dealing with a lot of paper, it is probably time to implement a plan to achieve paperlessness. Here’s how we suggest you approach this.

1. Start with new cases or matters. This is a natural step to take as you adopt a paperless approach. Once you have a process in place for your new matters, you should move to existing active matters. Depending on the size of your files, this can take some time, but once you see the benefits of a paperless office, you will want everything you have to be that way. It will seem like a lot of work on the front end and, in some ways, it is. But once you have implemented a paperless approach, you will find it comparatively easy to maintain. This will remind you of the last couple of semesters of law school – a bit of a grind. Ultimately, you made it through and that will be the case with this process as well.

2. Once all of your active files are converted, you can then move to the final and most daunting task: closed files. Bear in mind that converting closed files will become a more manageable task because when a file starts in electronic format, closing it is as simple as dragging and dropping a folder from your active files location to your closed files location.

Converting closed files should be treated as a non-urgent task. Eventually, you will complete the process of converting old closed files, and by this time, you will have gone so far into paperless mode that it will be hard to remember what it is like to handle a complete paper file.

Once you have achieved paperlessness, it is time to take advantage of the opportunities it provides.

VIII. PRACTICAL APPLICATION

Now, it is time to get practical. We now turn our attention to the imperative of imposing order on your files.
A. Imposing Order

A high degree of structure and organization is now possible with a fraction of the time, energy, and effort necessary to operate in a paper-filled environment. Compared to the amount of time necessary to organize paper filing systems, this task will be relatively simple. The platform on which your files will be organized is your cloud drive.

B. Cloud Drive Storage

In terms of technical innovations, it is difficult to overstate the importance of cloud storage. Just a few years ago, storing files in a central location that could be accessed by multiple people was expensive and difficult. Anyone who has had a file server can attest to that. The cloud makes it possible to say goodbye to your server (preferably with a hammer or a 3 Iron). You can tell your tech guy that you won't be seeing as much of him unless he knows how to work in the cloud.

Of all the tasks associated with converting to a paperless office, setting up a cloud drive is the one for which you are most likely to need assistance. And please find someone knowledgeable to help you with this step – initial configuration is important and will save you a lot of headaches down the road. Let your nephew wreck someone else’s office.

The most important feature of cloud technology is the ability to synchronize files across multiple computers and devices. The cloud allows you to share files, store files and collaborate on files. For those of us who remember 5” floppy discs, it really is quite amazing.

Once your cloud drive is securely set up so that everyone who needs access has it, it is time to drill down a bit deeper to implement an organizational scheme for your files.

C. Folder Structure

Your cloud drive will be organized just like the directory on your old server or the hard drive on your computer. We recommend organizing your files by practice area. Of course, the utility of this approach depends on the nature of your practice. Below are three possible approaches.

1. By practice area.
   a. Churches.
   b. Consumer matters.
   c. Corporations.
   d. Criminal.
   e. Domestic.
f. Estate Planning.
g. Guardian/WOA.
h. Litigation.
i. Miscellaneous.
j. PI-Med mal.
k. PI-MVA.
l. PI-other.
m. Probate.
o. Real estate.

2. By active vs. closed.
   a. Active client matters (with client folders organized by last name of client).
   b. Closed client matters (with client folders organized by last name of client).

3. Variations on the theme.
   a. Folder for each attorney with:
      i. Active client matters (with client folders organized by last name of client).
      ii. Closed client matters (with client folders organized by last name of client).
   b. Folder for each attorney with:
      i. Churches.
      ii. Consumer matters.
      iii. Corporations.
      iv. Criminal.
      v. Domestic.
      vi. Estate planning.
      vii. Guardian/WOA.
viii. Litigation.
ix. Miscellaneous.
x. PI-Med mal.
xi. PI-MVA.
xii. PI-other.
xiii. Probate.
xiv. Real estate.

4. Internal organization of specific client folders.

a. Pleadings.
b. Notices.
c. Orders.
d. Discovery.
e. Pretrial.
f. Correspondence.
g. Medical.
   i. Records.
   ii. Bills.
   iii. Timeline.
h. Client.
   i. Engagement letter.
   ii. Billings.
   iii. Expenses.
   iv. Liens.
   v. Authorizations.
i. Notes.
j. Miscellaneous.
5. File-naming regime.
   a. This is the most important aspect of the whole system in terms of ease and speed of access.
   b. We recommend naming every file according to this format: [4-digit year]-[2 digit month]-[2 digit day], followed by brief description.
   c. Examples:
      i. 2017-12-09 ltr to Jones.
      ii. 2017-12-10 eml to Jones.
      iii. 2017-12-31 note o-c Martin.
      iv. 2018-01-03 Motion to Set.
      v. 2018-01-04 Notice of Depo (Smith).
      vi. 2018-02-03 Bills (GJC).
      vii. 2018-02-03 Med Rec (Jewish).
   d. Here’s why the file-naming regime is so important: Your files will automatically sort in chronological order. This is especially important for cases that take a long time to resolve. It is also important when you are taking over a case from another attorney because you can easily access documents that you did not draft.

IX. THE PAYOFF
A. No Need to Carry Paper Files
   1. To office conferences;
   2. To out-of-office meetings;
   3. To court;
   4. For take-home work; or
   5. On the road.
B. Rapid Access to Your Files from Your Laptop, Tablet or Smartphone
   1. For your own reference;
   2. To share with opposing counsel;
3. To share with clients;

4. To share with fellow members of your firm; and

5. To share with judges.

X. HOW TO PREPARE FOR A PAPERLESS HEARING ON YOUR TABLET

A. In your cloud drive, make all potentially necessary documents available offline by creating a local copy.

B. Using your Noteshelf 2 app, import all of the necessary or potentially useful documents into a dedicated folder for that case.

C. If the documents are voluminous, color code them by type or time of filing, or both.

D. Practice navigating from document to document so that there is no undue delay in accessing what you need, when you need it.

E. Breeze through the hearing and bask in finally being one of the cool kids.

F. For evidentiary hearings or trials, you will still create hardcopies of exhibits, for which you should either create a trial binder or print and place in manila folders within an accordion file; you have greatly minimized what you need to carry with you.

G. There are portable printers that are pretty inexpensive if you truly need to create a hardcopy document on the spot, but don't give in to this temptation until you have tried getting signatures with an Apple Pencil on a document created on your iPad, which you immediately distribute to the intended recipients, including the court through e-filing or email if your judge has only made it as far as 2005.

XI. PAPERLESS WORKFLOW TIPS

A. Email whenever possible.

B. Maintain regular contact with your clients through email, text messaging or videoconferencing (and save an incredible amount of time in the process).

C. Organize your emails into practice-area-specific or client-specific folders to keep your email inbox from overflowing.

D. If you believe that it is necessary to generate a piece of correspondence on letterhead, then do that in Word, save it as a PDF, and send it to the recipient as an attachment to your email.

E. Always e-file court documents.
F. Send service copies of pleadings to opposing counsel – they will almost always agree to receive them this way. If you are nervous, file a stipulation or an agreed order that service by email will be accepted in lieu of regular mail.

G. For discovery, you can either place voluminous documents on a USB drive, a CD or DVD, or upload them to a folder on your cloud drive and share a link with the intended recipient.

H. Keep a local copy of frequently used forms (e.g. engagement letters, medical authorization, employment authorizations, etc.) on your tablet and obtain signatures using your Apple Pencil or similar stylus.

XII. STUFF YOU WON'T BE DOING ANYMORE

A. Spending chunks of your day bogged down in logistics that are outdated, inefficient and downright unnecessary.

B. Searching for hardcopy documents in every nook and cranny of your office, car, etc.

C. Addressing envelopes (at least not as often).

D. Spending as much on postage.

E. Spending a bunch of money on letterhead, envelopes and fancy paper for pleadings.

F. Dropping hundreds of dollars per year on toner cartridges for your printer.

G. Replacing your copier as often.

H. Suffering painful papercuts.

I. Sending hard copies of documents to clients.

J. Sending multiple hard copies to counsel of record in a case.

K. Spending time organizing or indexing paper files.

L. Looking for space to keep your ever-growing hardcopy files.

M. Sending your runner out to deliver copies of pleadings or discovery being sent out close to the deadline.

N. Wondering if a document got sent out and having to wait to speak with your assistant to find out.

O. Forgetting to send something to a client because you can do it right now on your tablet or smartphone.
P. Fielding angry calls from your clients because they haven't heard from you recently.

Q. Handling paper documents multiple times.

R. Forgetting what your desk looks like from being buried in paper.

S. Apologizing to clients because your office is such a mess.

T. Having a "malpractice" stack on your desk.

U. Looking too busy to take a case because your office looks like you are inundated with work that will keep you from serving the prospective client.

V. Constantly asking support staff to retrieve a file or document for you.

W. Sorting through documents that have been marinated in cigarette smoke.

X. Loading a briefcase (especially one with a retractable handle and wheels) and dragging it into court.

Y. Suffering spinal misalignment from carrying a heavy briefcase.

Z. Running and falling down in front of your colleagues because you don't want to get your heavy trial case wet.

XIII. LAST STEP

We started out by looking at some of the difficulties that we face as lawyers. One conclusion that we drew was that being better at what we do gives us an enhanced sense of well-being. And feeling better about our professional selves enables us to better handle the more stressful aspects of law practice. We then decided that we can use technology to improve our efficiency and our effectiveness. Hopefully, all of this comes together to make it easier for us to create balance in our work lives and perhaps helps us to avoid becoming a statistic.

So, with all of these things in mind, we encourage you to:

A. Be Adventurous

B. Be Persistent

C. Be Optimistic

D. Be Willing to Envision Being Better at What You Do

E. Be Happy

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**ASK ABBY VAUGHN**

**How do I plan for a future I’m not in?**

**HI ABBY:** It’s been a few years since my parents passed away, but I feel like I’m still working through issues related to their estate, which is painful on several levels. I wanted to do right by them, but I didn’t have a lot of direction. It’s important to me that my own children have a smoother experience. After all it’s hard enough to deal with the loss, let alone the finances. Do you have any suggestions?

—LOST LINDA

**HI LINDA:** First let me just say how sorry I am for your loss. We are never fully prepared to lose a loved one, but we are often less prepared for the challenges and decisions that come after in regard to finances, real estate, taxes, etc.

I think it’s very wise of you to start thinking about this now. The reality is that many of those challenges can be overcome by having a detailed plan addressing financial decisions that may need to be made in the later stages of life (special needs, guardianship, long-term care, etc.) and thereafter.

While some may feel it’s an uncomfortable topic to address, at our firm, we believe it’s important to prudently plan for the future, in this case the future of your family, heirs or charitable causes. Estate plans can be complex and multiple resources (attorney, CPA, insurance agent, etc.) are often needed. We help coordinate these efforts for our clients and then continue to review and analyze the plan to make sure it meets the evolving needs of you and your loved ones.

After all, you will spend your entire life building your legacy—it’s important to make sure your goals are met, maybe even for generations to come!

—ABBY V.
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