Atrium Medical Center Foundation

28th Annual/2026 Estate & Tax Planning Professional Seminar

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Medicaid Law Update

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I. MEDICAID – WHAT IS IT?

Medicaid is a federal program which is administered by the states to provide for the basic health care needs of poor individuals and families. For the elderly, Medicaid benefits provide for nursing care and several types of "waiver" programs which are designed to help those who would otherwise need nursing home care stay at home or in an assisted living facility.

II. MEDICAID – NURSING CARE

A. Covered Category and Medical Need.

In order to be eligible for Medicaid benefits for long-term nursing care, an individual must have a medical need and also fall within one of the categories of covered persons. These categories are: (i) age 65 or older; (ii) blind; or (iii) disabled. The medical need is established through a "level of care" assessment which establishes that the person needs an intermediate or skilled level of nursing care. OAC §5160-3-14.

B. Income Eligibility.

1. Countable Income.

   If an individual's "countable income" is equal to or less than the monthly cost of care, the individual meets the income eligibility test. A person's "countable income" is his or her gross income less certain disregards, such as up to $60 per calendar year quarter in unearned income. OAC §5160:1-3-03.2(A).

2. Patient Liability.

   Beginning with the month in which an individual becomes eligible for Medicaid benefits, all of his or her countable income, except several allowances discussed below, must be paid to the nursing facility. This is the person's "patient liability". Only the individual's income is used to establish the patient liability; it does not include the income of his or her spouse. OAC § 5160:1-6-07.

3. Allowances.

   In calculating the individual's patient liability, several deductions are permitted:

i. Personal needs allowance of $75 (up from $50 prior to 2026) each month (only $30 for an SSI recipient). This amount is increased by $90 per month for those individuals receiving VA benefits.

ii. Monthly Income Allowance. If the Community Spouse's ("CS") income is below a certain level, which is currently a minimum of $2,705 and a maximum of $4,066.50[1] (the "Minimum Monthly Maintenance Needs Allowance" or "MMMNA"), the community spouse may retain enough of the institutionalized spouse's income to reach monthly minimum. This additional amount of income from the institutionalized spouse is called the Monthly Income Allowance ("MIA"). OAC §5160:1-6-07.

iii. Medical insurance premiums.

iv. Past Medical Expenses.

v. Family Allowance.

C. Resource Eligibility - Long-Term Nursing Care Benefits.

1. Single Individuals.

A single individual must have no more than $2,000 in countable resources to be eligible for nursing home Medicaid benefits.

2. Married Individuals.

A married person must, also, have no more than $2,000 in countable resources to be eligible for Medicaid benefits. However, where a married couple is involved, the community spouse is entitled to retain a "Community Spousal Resource Allowance", or "CSRA", which is equal to one-half of the couple's countable resources as of the first day of institutionalization, with a minimum amount of $32,532 and a maximum amount of $162,660[2]. OAC § 5160:1-6-04.

EXAMPLE

Paul and Mary, both age 75, are married. Paul entered a nursing home on August 20, 2026. As of August 20, 2026, Paul and Mary owned their own home, a 1999 Buick and have about $125,000 in countable resources. Paul will be eligible for

[1] These numbers are for 2026 and are typically changed annually.
[2] Id.

Medicaid benefits to pay for his nursing care when they have spent their countable resources down below $64,500 since Mary is entitled to retain a CSRA of $62,500 and Paul is entitled to retain up to $2,000. Please note that in determining countable resources, any income received for the month of application is ***not*** considered a countable resource.

3. Countable Resources.

"Countable resources" include all of a person's or a couple's cash, savings, brokerage accounts, stocks, annuities, IRAs which are not in payout status, the cash value of life insurance policies, real property, promissory notes, life estates which can be transferred, and any other asset which can be liquidated. OAC § 5160:1-3-05.1.

4. Exempt Resources.

Certain resources are not included in the definition of countable resources:

i. The residence, if occupied by the individual's spouse or dependent relative. OAC § 5160:1-3-05.13. The home is exempt, also, so long as the Medicaid applicant ***intends*** to return and signs a statement to that effect. OAC §5160:1-3-05.13.

ii. Life insurance with a face value less than $1,500. OAC §5160:1-3-05.12(C)(1).

iii. Irrevocable funeral arrangements for both spouses, plus burial spaces for family members. See Exhibit "A", attached hereto.

iv. One motor vehicle regardless of value if for community spouse or for medical transportation.

v. Lump sum payments, such as Social Security, SSI benefits, or insurance proceeds (on an exempt resource, for example), for the first nine months after receipt.

vi. Household goods.

vii. IRAs and qualified retirement plan accounts which are in "payout" status.

See OAC §5160:1-3-05.14 for the full and complete list of exempt resources.

D. Transfers of Assets.

Even if all other eligibility requirements have been met, a person might not be eligible for Medicaid benefits if the applicant or his or her spouse has transferred assets in an attempt to hasten Medicaid eligibility.

1. Look-Back Date.

   When applying for Medicaid, there is a 5-year look-back period for all improper transfers. The penalty period for making improper transfers starts running when the Medicaid applicant has applied, and otherwise been found eligible, for assistance. Large transfers (e.g., $1,000 +) are rebuttably presumed to have been made in order to hasten Medicaid eligibility and are, therefore, considered improper. However, since the presumption is rebuttable, if a large transfer can be shown to have been made for non-Medicaid related reasons, it should not be treated as improper and should not cause a penalty period to be imposed. OAC § 5160:1-6-06(F).

2. Calculation of Penalty Period.

   If an improper transfer has been made, a period of "restricted coverage" for Medicaid benefits is calculated. The period of restricted coverage is calculated by dividing the amount of the improper transfer by the average monthly private cost of care in a nursing facility which is currently $8,669. OAC § 5160:1-6-06. The penalty period is imposed as of the first day of the month in which the person has applied for and otherwise been found eligible for Medicaid. Rather than create a penalty period which includes a fractional month, the person's "patient liability" is simple increased the first month of eligibility. OAC § 5160:1-6-06.5.

EXAMPLE

Paul applied for nursing home Medicaid benefits on August 25, 2026. On September 20, 2019, he gave his son $500,000, hoping to qualify for Medicaid as soon as possible if he needed nursing care. He entered a nursing home on March 1, 2026 and gave his son another $20,000. Paul privately paid for his care from March 1, 2026 to the end of August, 2026, when he ran out of money.

The September 20, 2019 gift was made more than 5 years before the Medicaid application was filed, and, therefore, does not fall within the look-back period. Accordingly, it is no longer treated as an improper transfer. However, the March 1, 2026 gift of $20,000 creates a penalty period of 2.3 months ($20,000 ÷ $8,669

= 2.3). The penalty period will run from August 1, 2026 to September 30, 2026. In addition, Paul will have an increase to his monthly patient liability for October, 2026 in the amount of $2,662 [the amount of the gift minus (the average monthly private pay rate for a nursing facility in Ohio times the number of whole months of ineligibility)][$20,000 – ($8,669 x 2) = $2,662].

3. Exceptions to the Improper Transfer Rule.

The following are permissible transfers:

i. Transfers of non-homestead property to a blind or disabled child.

ii. Transfer of the residence to the community spouse.

iii. Transfers to a trust established for the sole benefit of an individual under age 65 who is blind or totally disabled.

iv. Transfers of the residence to the individual's spouse, child under age 21, adult child who is blind or disabled, sibling who had an equity interest in the residence for at least one year, or adult child who lived with applicant for at least 2 years and provided care which delayed institutionalization. The documentation required to qualify for the 2-year of care rule is extensive and includes verifications of the care provided, along with a "Physician Certification" of the care necessary for the Medicaid applicant to remain at home. OAC § 5160:1-6-06(D).

4. Undue Hardship.

A person who is ineligible for Medicaid because of an improper transfer can still qualify for assistance upon a showing of undue hardship. To qualify for the undue hardship exception, the applicant must show, by clear, convincing and credible evidence, that he or she has made "a good faith attempt to recover or make the [transferred] resource available" and that an undue hardship will be created. The person (or his or her authorized representative) must first exhaust all legal remedies and appeals to the planned discharge and the facility must document that it has exhausted all legal remedies to collect or recover improperly transferred assets. OAC § 5160:1-6-06.6.

5. SPLIMPA - Transfer of Additional Resources to Community Spouse.

If a community spouse's income is below the MMMNA (after also taking the maximum MIA), he or she can opt to take an additional amount of the assets from the institutionalized spouse (over and above the CSRA) in

order to generate more income for the community spouse. The amount of additional resources which can be allocated to the community spouse is calculated based on how much additional income the additional assets would generate. OAC § 5101:6-7-02.

For instance, if the community spouse's MMMNA were $2,800 and he or she had $800 per month in income, the community spouse would be entitled to an MIA from the institutionalized spouse of $2,000. If the institutionalized spouse only had income of $1,000/month, the community spouse could take additional assets which could be used to generate an additional $1,000 in income. This is called the "SPLIMPA" option because the community spouse must obtain at least three written estimates of the cost of a "single premium lifetime immediate monthly payment annuity" to qualify for this.

In order to use the SPLIMPA option, the applicant's initial Medicaid application is denied and that denial must be appealed. An appeals officer is then presented with the annuity estimates and approves the Medicaid application.

III. TRUSTS

Because of the use, or misuse, of trusts in Medicaid planning, there are a number of rules specific to trust planning:

A. Medicaid Qualifying Trusts.

These trusts, established prior to August 11, 1993, are not treated as countable resources if there is no discretion to invade principal for the applicant.

B. Self-Settled Trusts – After August 11, 1993.

These trusts are considered countable resources to the extent income and/or principal can be used for the applicant's benefit. To the extent irrevocable transfers are made into such a trust and cannot be used for the applicant's benefit, an improper transfer has occurred.

C. Exempt Trusts.

1. Special Needs Trusts. These are established for disabled persons under age 65. Requires Medicaid payback. See OAC § 5160:1-3-05.2.

2. Qualifying income trusts ("QITs"). These trusts, also referred to as "Miller Trusts," are used to provide supplemental benefits for a Medicaid recipient if the recipient's income exceeds the Medicaid income limit.

T**hese trusts are required for any Medicaid recipient who has more than $2,,982/month in gross income.**

3. Pooled Trusts. A trust established by a non-profit entity in which all participants' assets are pooled and used for supplemental benefits. There is a Medicaid payback provision.

4. Supplemental Services Trusts. Established by a third party as a testamentary trust (parent, usually) for the benefit of a person receiving benefits through MR/DD or county board of mental health. Maximum limit of $264,000 (for 2026)(increases by $2,000/year). At least 50% of trust assets must be paid to State of Ohio at beneficiary's death. See ORC §5815.28(E).

5. Trusts established by someone else for the applicant's benefit and which are totally discretionary.

6. Trusts established by Will for the benefit of the surviving spouse.

IV. ANNUITIES

A. Eligibility Criteria for Annuities.

1. Under OAC § 5160:1-6-06.1, effective September 1, 2017, annuity purchases are required to be reviewed as an improper transfer unless: (i) the State of Ohio is the primary remainder beneficiary, up to the total amount of medical assistance furnished to the Medicaid applicant; or (ii) the State of Ohio is named as the secondary beneficiary to the surviving spouse, up to the total amount of Medicaid assistance furnished to the Medicaid applicant, and primary beneficiary if the spouse disposes of a remainder for less than fair market value.

B. Annuity Breakthrough.

1. In recent years, many Medicaid applicants have used the annuity rules to purchase immediate annuities for the CS, trying to increase the CS' income while also spending down assets in order to qualify the IS for Medicaid. The Ohio Department of Job and Family Services ("ODJFS") has denied many of those applications on the basis that a married couple is not permitted to convert countable resources in excess of the CSRA into an income stream for the CS without a "SPLIMPA" (single premium lifetime immediate monthly annuity) hearing. Under OAC Section 5101:1-39-07, a married couple is not permitted to convert countable resources in excess of the CSRA amount into income for the CS unless the couple goes through a SPLIMPA hearing. Even if the couple goes

through the SPLIMPA process, the amount of excess assets which can be used for the CS' benefit is limited, as set forth above. This proscription against buying annuities for the CS, even when the annuities otherwise meet the very stringent requirements set for annuities to be Medicaid "compliant", is currently the source of significant litigation.

2. After much litigation on the issue, the State of Ohio Department of Medicaid issued MEPL No. 112, a copy of which is attached as Exhibit "B", which clarifies that Ohio will now respect annuity purchases so long as they comply with all regulatory requirements. This is a breakthrough for consumers, insofar as they now have clarity as to what this portion of the Medicaid regulations means.

V. IRAs AND QUALIFIED RETIREMENT ACCOUNTS.

The Ohio Department of Medicaid finally issued clear guidance with regard to the treatment of IRAs via Medicaid Eligibility Procedure Letter ("MEPL") No. 164 on May 26, 2022. MEPL No. 164 not only answers many questions with regard to the treatment of IRAs, it also expands planning opportunities with regard to the use of IRAs. See Exhibit "C".

VI. ESTATE RECOVERY

A. Probate and Non-Probate Assets Are Subject to Estate Recovery.

Ohio is required by the federal government to seek recovery for what it has paid in Medicaid benefits. Prior to July 1, 2005, Ohio sought recovery only from a decedent's probate estate, although the State had been very aggressive in asserting that any transfers which avoided a probate administration were fraudulent as to the State's claim for reimbursement. As of July 1, 2005, however, the State is authorized to seek recovery from both probate and non-probate assets that pass from a Medicaid recipient or his or her surviving spouse. See OAC § 5160:1-2-07.

B. Other Estate Recovery Requirements.

In order for the State of Ohio to be entitled to recovery, the Medicaid recipient must have lived in a nursing facility or received home and community-based services. For those receiving home and community-based services, only those benefits paid after the person reached the age of 55 are subject to recovery. OAC § 5160:1-2-07(C)(2). Recovery is sought against the "estate" (which includes non-probate assets) of the survivor of the Medicaid recipient and his or her surviving spouse. Recovery can only be sought if there is no surviving child

under age 21 or who is blind or permanently disabled. Estate recovery can also be waived upon a demonstration of undue hardship.

C. Liens.

Effective September 29, 2005, liens can be filed by the State of Ohio against real estate owned by an institutionalized individual and/or his or her spouse with certain exceptions. No lien may be imposed against the residence of the Medicaid recipient if any of the following people live there: the Medicaid recipient's spouse, children (under age 21 or blind or disabled), or sibling who had an equity interest in the property and resided there at least one year immediately before the Medicaid recipient's entrance to the nursing home.

VII. PLANNING IDEAS.

1. Gifts + Annuities.

EXAMPLE

On July 1, 2026, Bertha Bush, age 70 and in a nursing home, has life savings of about $230,000. She transfers $104,000 to her children. She still has about $126,000 in cash assets which she immediately uses to buy herself an annuity of $10,500 per month for 12 months. Her monthly cost of care in the nursing home is $12,000 and her other income is $2,000 per month. The $104,000 transfer should make her ineligible for about 12 months, just long enough for her annuity to help her pay for her care through the period of ineligibility. Her children will need to help cover any monthly shortfall at the nursing home for the 12-month penalty period. This is a small price to pay compared with the value of the $104,000 gift. **Please note that since the income is more than $2,982 per month, Bertha will need a QIT!**

2. Pooled Medicaid Payback Trust.

Money placed into Pooled Medicaid Payback Trusts will not be counted against a Medicaid applicant's $2,000 resource limit. OAC §5160:1-3-05.2. The reason? When the Medicaid recipient passes away, the money remaining in the trust will pay the state back to the extent the state has paid for his/her care via Medicaid.

So why do it? 2 reasons:

i. The trust pays the state back at the *state* nursing home Medicaid pay rate, which is almost always cheaper than the private-pay rate. Often the rate is $1,500-$3,000/month cheaper.

ii. The Medicaid recipient can draw on the trust to improve his/her quality of life. Remember, while on Medicaid, the recipient only gets to keep $75/month from his/her income. Often, that will not even cover a couple of trips to the beauty parlor. Yet, with a pooled trust in place, the recipient can draw on it each month to buy things for his or her room such as a new television or specialized chair. The Medicaid recipient can use the funds to go out to dinner or buy other supplemental needs. Best of all, the Medicaid recipient can use the funds to upgrade to a private room while remaining on Medicaid.

The risk inherent in this plan is that all of the funds in the Pooled Medicaid Payback Trust might need to be paid to the state if Bertha lives long enough.

VIII. MEDICAID – PASSPORT & ASSISTED LIVING WAIVERS

A. PASSPORT (Medicaid to pay for Home Care)

1. Process - Must be found care eligible by the Council on Aging as well as financially eligible through the Ohio Department of Job and Family Services.

2. Eligibility- To be eligible for Passport:

    a. The individual is 60 or older and agrees to participate in PASSPORT.

    b. Must have assets less than $2,000 and monthly income less than $2,982 (unless a QIT is in place).

    c. The cost of the services over a year must not exceed an annual cost cap, which is 60% of the total Medicaid cost of nursing home care (unless health declines while on PASSPORT, requiring 100% of the Medicaid cost).

    d. The needed services are not readily available through another source at the level required to allow the individual to live in the community.

e. The individual's health related needs can be safely met in a home setting as determined by the PAA.

f. Prior to PASSPORT enrollment, the attending physician must approve that the services are appropriate to meet the individual's needs.

g. The individual must be determined to meet the criteria for an intermediate or skilled level of care in accordance with rule 5101:3-3-05 or 5101:3-3-06 of the Administrative Code and, in the absence of PASSPORT, would require NF services.

h. PASSPORT has slots available.

i. The individual must not be under Medicaid or Medicare hospice at the time of enrollment.

j. If eligible, the following services may be available: adult day services; chore services; emergency response system services; home medical equipment and supplies services; homemaker services; minor home modification, maintenance and repair services; nutrition consultation services; personal care services; social work counseling; transportation services; home delivered meal services; independent living assistance services; and some non-medical transportation services.

B. Assisted Living Waiver (Medicaid to pay for Assisted Living)

1. Process: Similar to Passport**.** Must be found care eligible by the Council on Aging as well as financially eligible through the Ohio Department of Job and Family Services.

2. Eligibility. To be eligible:

i. The applicant must be 21 or older.

ii. Must have assets less than $2,000 and monthly income less than $2,982, unless a QIT is used.

iii. The individual must have an intermediate or skilled level of care (needs help with at least 2 activities of daily living).

iv. If the individual requires skilled nursing care beyond supervision of special diets, application of dressings, or administration of medication, it must only be required on a part-time, intermittent

basis for not more than a total of one hundred twenty days in any twelve-month period. A part-time, intermittent basis means that skilled nursing care is needed for les less than eight hours a day or less than forty hours a week.

v. The individual must be: (i) a nursing facility resident who is seeking to move to a residential care facility and would remain in the nursing facility for long term care if not for the assisted living waiver; or (ii) participates in another waiver program (like PASSPORT or regular Medicaid) and would move to a NH if not for the wavier; or (iii) has resided in a residential care facility and privately paid for 6 months.

vi. The cost of the services over a year must not exceed an annual cost cap, which is 60% of the total Medicaid cost of nursing home care.

vii. The individual must have the ability to make room and board payments at the current supplemental security income (SSI) federal benefit level minus fifty dollars.

viii. The individual is age twenty-one or older at the time of enrollment.

ix. There are Assisted Living Slots Available.

x. The individual's health related needs, as determined by the PASSPORT administrative agency, can be safely met in a residential care facility.

xi. The individual may not already be enrolled in hospice.

IX. MEDICAID – TOP 10 REASONS TO FILE AN APPEAL

1. No 10-day letter.

2. No period of restricted coverage calculated where there is an improper transfer and/or no credit given for returned gifts.

3. Payments to child were for services and were not a gift.

4. Countable real property was listed for sale at an amount which was not *exactly* at the county auditor's value.

5. Deposit at a retirement community is treated as a life lease or a countable resource.

6. Medicaid caseworker does not process case in a timely fashion.

7. Caseworker treated income as a countable resource in month it was received.

8. Property contiguous to exempt house is treated as a countable resource.

9. Medicaid office fails to properly comply with a State Hearing or Administrative Appeal Decision.

10. County treats a transfer as improper even where it has been rebutted by clear and convincing evidence.

X. Additional Resources.

A. Immediateannuities.com. This website provides good estimates of how much an annuity might cost or how much of a monthly annuity can be produced with a given single premium payment. The estimates available on the website are useful in counseling clients as to what the approximate cost of an annuity might be.

B. Medicaidannuity.com. This is the website for Krause Financial Services. Not only does Krause Financial Services sell annuities as short as three months in length, its website can be a good resource for both attorneys and their clients to help them determine whether an annuity can be helpful as a part of a Medicaid plan.

C. **http://www.odjfs.state.oh.us/HearingsAppeals/**. This is the web address to search for the Ohio Department of Job and Family Service's state hearing and administrative appeal decisions. Cases can be searched by topic and is an invaluable resource to better understand the Medicaid regulations.

D. https://www.proseniors.org/pamphlets-resources/medicaid-eligibility/.
ProSeniors updates all of the financial eligibility standards for Ohio Medicaid on its website. It is a fantastic resource to make sure that you know exactly what the current numbers are.

Exhibit "A"

5160:1-3-05.7 Medicaid: burial spaces.

(A) This rule describes the treatment of burial spaces for the purposes of determining eligibility for medical assistance.

(B) Definitions.

(1) "Agreement," for the purpose of this rule, means a contract with a burial provider for a burial space held for the individual or a member of the individual's immediate family.

(2) "Burial space," means a burial plot, gravesite, crypt, mausoleum, casket, urn, niche, or other repository customarily and traditionally used for the deceased's bodily remains. The term also includes a contract for care and maintenance of the gravesite, sometimes referred to as an endowment or perpetual care and necessary and reasonable improvements or additions to such spaces, including but not limited to vaults, headstones, markers, or plaques, burial containers (e.g., for caskets) and arrangements for the opening and closing of the gravesite.

(3) "Immediate family" includes the individual's:

(a) Parents, including adoptive parents;

(b) Minor or adult children, including adoptive and stepchildren;

(c) Siblings, including adoptive and stepsiblings; or

(d) Spouses of immediate family if the marriage is in effect at the time of determination or renewal of eligibility for medical assistance.

(C) A burial space or burial space contract, described in rule 5160:1-3-05.6 of the Administrative Code which represents the purchase of a burial space held for the burial of the individual, the individual's spouse, or any other member of the individual's immediate family is an excluded resource, regardless of value.

(D) A burial space is held for an individual when someone currently has:

(1) Title to and/or possesses a burial space intended for the individual's use (e.g., has title to a burial plot or owns a burial urn stored for his own use); or

(2) A contract with a funeral service company for specified burial spaces for the individual's burial (i.e., an agreement which represents the individual's current right to the use of the items at the amount shown).

(E) Until the purchase price is paid in full, a burial space is not held for an individual under an installment sales contract or similar device and the installment payments shall be considered burial funds in accordance with rule 5160:1-3-05.6 of the Administrative Code.

(F) Administrative agency responsibilities. The administrative agency shall:

(1) Determine whether the burial space is held for the individual or member of the individual's immediate family if the agreement shows the purchase of a specified burial space at a specified price.

(2) Of items that serve the same purpose, exclude only one per person. For example, exclude a cemetery lot and a casket for the same person, but not a casket and an urn.

(3) If the agreement calls for installment payments, determine whether the value of the burial space must be treated as burial funds in accordance with rule 5160:1-3-05.6 of the Administrative Code.

Replaces: 5160:1-3- 05.7 **Cite as Ohio Admin. Code 5160:1-3-05.7** Effective: 8/1/2016

Exhibit "B"

Ohio Department of Medicaid
John R. Kasich, Governor
John B. McCarthy, Director

Medicaid Eligibility Procedure Letter No. 112

Effective Date:	**February 26, 2016**
OAC Rules:	**5160: 1-3-05.3 and 5160:1-3-07.2(G)**
To:	**All Medicaid Eligibility Manual Holders**
From:	**John B. McCarthy, Director**
Subject:	**Treatment of Annuities**

Reason for Change: The Ohio Department of Medicaid (ODM) is revising its policy about how to treat the purchase of an annuity by an individual or the individual's spouse after the date of institutionalization, but before the eligibility determination date, in an amount that is above the Community Spouse Resource Allowance (CSRA).

Prior Policy: Currently, caseworkers are required to treat the purchase of the annuity by an individual or the individual's spouse after the date of institutionalization, but before the eligibility determination date, as an improper transfer if the purchase price is above the CSRA.

New Policy: Effective immediately, the purchase of annuity by an individual or the individual's spouse after the date of institutionalization, but before the eligibility determination date, in an amount above the CSRA shall not be determined improper if the purchase of the annuity meets the requirements listed in Ohio Administrative Code 5160:1-3-05.3. Those requirements include, that the State of Ohio be named as a remainder beneficiary in the correct position.

Action Required: Effective immediately, when determining eligibility for long-term care services, caseworkers must determine whether the purchase of an annuity meets the requirements listed in Ohio Administrative Code 5160:1-3-05.3. One of those requirements is that the State of Ohio must be named as the primary remainder beneficiary (or as the second remainder beneficiary after a community spouse or minor or disabled child) for at least the value of the Medicaid assistance provided. If the annuity does not name the State of Ohio as a remainder beneficiary in the correct position, the annuity must be treated as an improper transfer. The full purchase price of the annuity is the amount that is subject to penalty. If any of the other applicable requirements listed in Ohio Administrative Code 5160:1-3-05.3 are not met, the purchase of the annuity must be treated as an improper transfer. The full purchase price of the annuity is the amount that is subject to penalty.

Please contact ODM Eligibility Technical Assistance at Medicaid_Eligibility_TA@Medicaid.Ohio.gov for further assistance or clarification regarding the processing of specific cases. If additional assistance is needed, please contact the CRISE Help Desk at CRISE_HELPDESK@jfs.ohio.gov.

This information is also available on the Internet. The information may be accessed on the ODM website under the header "Medicaid Policy" and found under Behavioral Health, Eligibility, & CHIP - Medicaid Eligibility Procedure Letter (MEPL):
http://www.medicaid.ohio.gov/RESOURCES/Publications/ODMGuidance.aspx#1535541medicaid-policy

Medicaid Eligibility Procedure Letter (MEPL) No. 164

Effective Date: **May 26, 2022**

Issue Date: **May 26, 2022**

OAC Rules: **5160:1-3-03.10, 5160:1-3-05.3**

To: **All Medicaid Eligibility Manual Holders**

From: **Maureen M. Corcoran, Director**

Subject: **Treatment of Individual Retirement Accounts (IRAs) for Medicaid Eligibility Purposes**

Reason for Change: The Ohio Department of Medicaid is clarifying its policy with regard to the treatment of funds received from IRAs for the purpose of determining eligibility for medical assistance.

Policy: Ohio Administrative Code (OAC) rule 5160:1-3-03.10 states that a retirement fund in which an individual has the legal ability to receive regular guaranteed lifetime payments will be treated as unearned income rather than as a resource. OAC 5160:1-3-03.10 further states that an individual is required to obtain the maximum available amount of payment from his/her retirement plan and that a retirement fund shall be evaluated as a potential resource only after it is determined to not be income. The Social Security Administration's (SSA's) Program Operations Manual System (POMS) SI 01120.210(E)(1) states, in reference to retirement accounts, that if an individual is eligible for either periodic payments or a lump-sum, the individual must choose to receive periodic payments.

Action Required: County Job and Family Services (JFS) offices must evaluate IRAs consistent with responses to the following frequently asked questions (FAQs):

1. What qualifies as an Individual Retirement Account (IRA)?

IRA is an umbrella term used to describe a personal retirement savings plan that provides the owner tax advantages for setting aside money for retirement. The IRA itself is not an

investment, but rather a holding account for investments. An IRA holds investment products like stocks, bonds, annuities, and mutual funds (among others). IRAs are considered "tax-favored" retirement plans.

2. What are required minimum distributions (RMDs)?

The IRS requires an IRA owner to take mandatory withdrawals from his/her IRA account (also known as RMDs) when the individual reaches a certain age (regardless of whether he/she needs or wants the income). RMDs are regular, periodic payments that are calculated from the Life Expectancy Tables published by the Internal Revenue Service (IRS). The age requirement for taking RMDs was adjusted when the Setting Every Community Up for Retirement Enhancement (SECURE) Act of 2019 became law on December 20, 2019. The SECURE Act increased the age at which individuals must begin taking RMDs. Prior to the SECURE Act, an individual born on or before June 30, 1949, was required to start taking RMDs for the year he/she reached the age of 70½. Under the SECURE Act, if an individual's 70th birthday is July 1, 2019, or later, the individual is not required to take his/her first RMD until the year he/she reaches age 72. An individual who attained age 70½ prior to July 1, 2019, would fall under the old rules (before the SECURE Act) and would be required to receive RMDs for the year he/she reached age 70½. The deadline for an individual to take his/her first RMD is April 1 of the year following the year he/she turns age 72 (or 70½ depending on the individual's date of birth).

3. Do all IRAs require RMDs upon reaching the age threshold?

The Roth IRA is the only type of IRA that does not have an IRS requirement for the owner to take RMDs; however, the individual must take regular, periodic payments from a Roth IRA in order for the IRA to be treated as income rather than as a resource for Medicaid purposes. Although an individual cannot take RMDs from a Roth IRA, he/she can elect to take regular, periodic payments. When an individual elects to receive regular, periodic payments from a Roth IRA, the funds must be counted as unearned income for Medicaid purposes (regardless of the amount of the payments). When an individual elects to not take regular, periodic payments, the entire value of the Roth IRA must be counted as a resource.

4. What constitutes regular, periodic payments?

Per IRS Publication 575, Pension and Annuity Income, regular, periodic payments are amounts paid at regular intervals (such as weekly, monthly, or yearly) for a period of time greater than one year. Regular, periodic payments are not based on the amount of the payment, but rather the frequency of the payment.

5. Can distributions from an IRA be considered both income and a resource at the same time?

A single distribution from an IRA would never count as both income and a resource at the same time. Payments from an IRA must always be evaluated as income first; only if an IRA is found to not be income would an IRA be treated as a resource. Payments from an IRA are considered unearned income when the IRA is in "payout status," meaning the individual is taking regular, periodic payments from the account as described in OAC 5160:1-3-3.10(C). OAC 5160:1-3-03.10(D) explains how an IRA is treated when it is determined to be a resource. Each

distribution must be reviewed separately, as an individual could be receiving regular, periodic payments but also take an irregular lump-sum withdrawal. Each distinct distribution must be reviewed individually.

6. What if an individual (applicant or his/her spouse) is not old enough to qualify for RMDs or is not required to take RMDs? Is the individual still required to take regular, periodic payments from his/her IRA for Medicaid purposes?

Yes, regardless of the individual's age or the type of IRA, an individual must take regular, periodic payments from his/her IRA in order for the funds to be considered income rather than a resource. An Individual who is not old enough to take RMDs or an individual who has a Roth IRA and is not required to take RMDs must place his/her IRA in payout status and take regular, periodic payments for Medicaid purposes (regardless of any penalties or fees that may be imposed for an early withdrawal). When an individual elects to not take regular, periodic payments from his/her IRA because of an early withdrawal penalty, the IRA is a countable resource to the extent of the funds available minus any penalties and fees.

An individual who is not yet required to take RMDs is not mandated to take a specific periodic payment amount, but he/she *may* elect to take payments based on the SSA's Life Expectancy Tables. When an individual needs guidance regarding how to compute a withdrawal based on the SSA's Life Expectancy Tables, he/she should consult a tax professional or the individual's Plan Administrator. Until an individual is mandated to take RMDs by age or when an individual is not required to take RMDs with a Roth IRA, regular, periodic payments of any amount will suffice for the IRA to be counted as income and not as a resource.

7. Do RMDs (or regular, periodic payments for those individuals who are not old enough or not required to take RMDs) satisfy the requirement at OAC 5160:1-3-03.10(C)(2) that states an individual must obtain the "maximum available amount of payment from the plan?"

For Medicaid purposes, the payment of RMDs from an IRA are considered the *maximum* benefit available to the individual over his/her lifetime, thus satisfying the requirement at OAC 5160:1-3-03.10(C)(2). For an individual who is not qualified for or not required to take RMDs, any regular, periodic payments (regardless of the amount) will satisfy the requirement at OAC 5160:1-3-03.10(C)(2).

8. How are non-periodic distributions or irregular withdrawals from IRAs treated for Medicaid?

Non-periodic distributions or irregular withdrawals from an IRA are always considered a resource. When an individual takes the required RMDs/periodic payments (counted as income), but then also takes out an additional irregular withdrawal, the irregular withdrawal is considered a resource and treated like a lump-sum payment, while the regular, periodic payments are considered income.

9. Do RMDs or regular, periodic payments, need to be taken monthly for Medicaid purposes?

No, RMDs or regular, periodic payments can be taken monthly, quarterly, or annually. The individual does not need to elect monthly RMDs for Medicaid purposes, as long as the total required RMD amount is satisfied by the end of the calendar year. When an individual has elected annual RMDs, the annual amount is prorated to monthly by dividing by twelve. When an individual has elected quarterly RMDs, the quarterly amount is prorated to monthly by dividing by three. Once an individual is receiving RMDs or regular, periodic payments, the distributions are counted as unearned income on a monthly basis (regardless of the actual frequency of the payment). When the total required RMD is taken annually, the investment is considered "actuarially sound," regardless of the payout schedule. The term actuarially sound means the individual will receive his/her investment back within his/her life expectancy period as determined by the Social Security Administration actuarial charts or the Life Expectancy Tables published by the IRS.

10. How would a county JFS worker identify the frequency of regular, periodic payments or RMDs?

An individual should be able to provide the county JFS office with the most recent plan statement showing the frequency and type of payments coming from his/her IRA. Many plans require a form to document distributions, such as the "IRA Distribution Request Form" or "Periodic Distribution Request Form," so a copy of one of those forms could also be provided to the county JFS office to document the payout schedule. The individual could also provide a letter from the IRA Plan Administrator to verify his/her payout schedule.

11. What if an individual elects to liquidate his/her entire IRA (taking one lump-sum payment) rather than taking regular, periodic payments?

For any individual who is applying for a non-MAGI eligibility category, including an individual who is seeking long-term care (LTC) services, liquidating an IRA by taking one lump-sum payment will result in the IRA being counted as unearned income in the month of receipt and as a countable resource in the month following the month of receipt. A lump-sum payment received and then disposed of must be evaluated to determine whether fair market value (FMV) was received in exchange for the asset. When FMV is not received for an asset, a penalty period, also known as a restricted Medicaid coverage period (RMCP), must be calculated and applied per OAC 5160:1-6-06.5. During an RMCP, Medicaid will not pay for LTC services for the individual.

12. What if an individual who is qualified to take RMDs elects to not take RMDs?

When an individual who is qualified to take RMDs fails to do so or when an individual is not reasonably expected to live longer than the guarantee period of his/her IRA, the individual is not receiving fair market value (FMV) for the IRA. When an individual is not receiving FMV, the entire amount of the IRA must be counted as a resource. This should be uncommon, as the IRS penalty for not taking RMDs is very high. For every RMD dollar not withdrawn, the IRS charges a 50% penalty, known as the excise tax, to the individual. When an individual is still working and cannot access the funds while employed, the IRA is not considered an available resource as long

as the individual remains employed. An IRA is not a countable resource if an individual must terminate employment in order to obtain payments.

13. What happens if an individual has more than one IRA? How are RMDs or regular, periodic payments handled from multiple IRAs?

When an individual has multiple IRAs, an RMD or regular, periodic payment must be calculated *separately* for each IRA account annually. An individual with multiple IRAs can elect to "aggregate" his/her separate RMD amounts into one consolidated RMD, withdrawing the combined total of all RMD amounts from only one IRA. It does not matter which IRA account the individual takes the RMD from, as long as he/she withdraws enough to satisfy the total annual RMD of all IRAs combined. As long as the combined total of all required RMDs/payments for the year are satisfied, the distributions must be counted as income and not as a resource. For example, if an individual calculates that he/she needs to take $15,000 in RMDs/payments from one IRA and $10,000 from another, the IRS does not require that the individual take these dollar amounts out of the corresponding IRA accounts. As long as the individual takes a total of $25,000 in RMDs/payments out of one or both IRAs during the calendar year, he/she has met the IRS's requirement for taking RMDs.

14. How are RMDs calculated? For an individual who is not qualified for or not required to take RMDs, how should his/her regular, periodic payments be calculated?

RMDs are calculated by dividing the year-end value of the IRA (monetary value of the IRA at the end of the previous calendar year) by the expected distribution period (life expectancy) that corresponds to the owner's age on the "Uniform Lifetime Table" found in Appendix B of IRS Publication 590-B, Distributions from Individual Retirement Arrangements. RMD amounts must be rounded to the nearest whole dollar to follow Internal Revenue Service (IRS) rounding guidelines. Rounding to the nearest whole dollar is achieved by rounding any amounts *under* fifty cents to zero and by increasing any amounts from fifty cents to ninety-nine cents to the next highest dollar. For example, if an individual had $500,000 in a traditional IRA at the end of 2020, and he/she is 75 years old, the Uniform Lifetime Table expects that the individual will live another 22.9 years. Dividing the value of the IRA at the end of the previous calendar year ($500,000) by the expected distribution period for age 75 (22.9 years), results in a 2021 RMD of $21,834.06 before rounding. After rounding to the nearest whole dollar, the appropriate RMD amount is $21,834.00. The RMD amount can be taken monthly, quarterly, or annually, as long as the total RMD of $21,834 has been taken by the end of the 2021 calendar year.

Most Plan Administrators will calculate RMDs for the individual. An individual can also calculate his/her own RMDs by using IRS Publication 590-B. For an individual who is not qualified for or not required to take RMDs, payments can be calculated by using the Social Security Administration actuarial charts in place of the IRS Uniform Lifetime Table; however, for an individual who is not qualified to take RMDs or an individual who has an IRA that does not require RMDs, the use of these tables is **not** required. Any regular, periodic payments from an IRA for an individual who is not qualified for or not required to take RMDs will meet the requirement of OAC 5160:1-3-03.10(C)(2).

15. How are regular, periodic distributions from an IRA that are paid annually or quarterly treated when calculating an institutionalized individual's post-eligibility treatment of income (PETI)/patient liability for an individual who is receiving LTC services?

Regardless of frequency (annually or quarterly), unless the individual already elected monthly payments, regular, periodic payments from an IRA must be converted to a monthly amount to complete a proper monthly PETI/patient liability calculation. Distributions received annually must be divided by twelve and quarterly payments must be divided by three to calculate monthly PETI/patient liability. When an individual is receiving regular, periodic distributions from an IRA, the payments are treated as unearned income on a monthly basis, regardless of the actual frequency of the payment.

16. How are previous lump-sum withdrawals from an IRA treated (before the individual applied for LTC, but during his/her lookback period)?

Any withdrawal meeting the definition of a lump-sum payment in accordance with OAC 5160:1-3-05.8 is considered unearned income in the month of receipt and as a countable resource in the month following the month of receipt. When a lump-sum withdrawal is received and then disposed of prior to the time of application but during an individual's lookback period, the payment must be evaluated to determine whether fair market value (FMV) was received in exchange for the asset. When FMV is not received for an asset, a penalty period, also known as a restricted Medicaid coverage period (RMCP), must be calculated and applied per OAC 5160:1-6-06.5. During an RMCP, Medicaid will not pay for long-term care services for the individual. When an individual retained funds from a lump-sum withdrawal that was received during his/her lookback period, the remaining funds (as of the date of the application) must be compared to the Medicaid resource limit.

17. How are a community spouse's IRAs treated in the community spouse resource allowance (CSRA) calculation?

The county JFS office should review the snapshot value, the age of the community spouse (CS), and the IRA payout status early in the determination process. When a CS is receiving regular, periodic payments or RMDs from his/her IRA, the funds are not countable in the CSRA calculation because the payments are considered unearned income. When the CS fails to take RMDs or regular, periodic payments from his/her IRA, the IRA is a countable resource in the CSRA calculation. The countable value of the IRA for the CSRA calculation is the total amount the CS can withdraw from the IRA minus any penalties and fees.

18. What happens if a community spouse (CS) fails to take RMDs from his/her IRA as of the snapshot date (regardless of the CS's age or the category of his/her IRA), but then starts taking RMDs at or before the time of the institutionalized spouse's application for Medicaid?

When a CS fails to take RMDs or regular, periodic payments from his/her IRA as of the snapshot date, the funds are considered a countable resource to the CS and the total value of the IRA (less any penalties and fees) must be counted in the community spouse resource allowance (CSRA) calculation and used to determine the institutionalized spouse's Medicaid eligibility. When the CS is receiving regular, periodic payments from his/her IRA as of the snapshot date,

the account must not be counted in the CSRA calculation and must not be used to determine the institutionalized spouse's Medicaid eligibility; the IRA payments must be considered unearned income to the CS only. If a CS had failed to take RMDs as of the snapshot date but then started taking (or applied to take) RMDs/mandatory withdrawals at or before the time of the institutionalized spouse's application for Medicaid, the IRA must no longer be counted as a resource, but rather considered unearned income to the community spouse.

Example:
Jeffrey had a stroke on March 9, 2020 and was admitted to the hospital. While in the hospital, Jeffrey's condition slowly deteriorated, and his 65-year-old wife Linda realized she would not be able to care for him at home. The decision was made on May 5, 2020 to transfer Jeffrey to a nursing facility. Jeffrey will need to apply for Medicaid to pay for his continued care. On June 1, 2020, a Medicaid application was submitted for Jeffrey. The snapshot date was Jeffrey's original hospitalization date of March 9, 2020. As of the snapshot date, Jeffrey's wife in the community, Linda, had an IRA with an available balance of $130,000. The IRA was NOT in a payout status. Linda, the CS, advised she was not taking RMDs because she is under age 70½ and she does not want to pay a penalty. When an individual elects to not take regular, periodic payments, even if the reason is fear of an imposed penalty, the IRA is considered an available resource to the extent of the funds available minus any penalties and fees. Regardless of age, a CS must elect to take periodic payments or RMDs from his/her IRA if the CS does not want the entire IRA balance to be considered a resource. Because the CS Linda was not receiving periodic payments from her available retirement fund as of the snapshot date, the fund was considered a countable resource (minus any penalties and fees) for the purposes of determining the CSRA and IS Jeffrey's Medicaid eligibility. If Linda decided to start taking periodic payments as of Jeffrey's application date, the funds would then be considered unearned income to Linda only.

19. How is an IRA converted to an annuity handled?
IRA funds converted to an annuity are considered under annuity rules, but IRA funds converted to an annuity are handled differently than annuities purchased through other types of funds. Retirement funds converted to an annuity for an individual who is not seeking or receiving long-term care services are considered in accordance with OAC 5160:1-3-05.3 because a retirement-related annuity is not subject to the additional requirements in OAC 5160:1-3-03.10. An annuity that's considered either an individual retirement annuity under section 408(b) of the Internal Revenue Code (IRC) or is deemed an Individual Retirement Account under a qualified employer plan under section 408(q) of the IRC, <u>will not be considered</u> a transfer for less than fair market value and <u>will not be subject</u> to the irrevocability, actuarially sound, and equal monthly payments requirements. When an individual who previously did not receive long-term care services transitions to long-term care, his/her annuity must be further examined using OAC 5160:1-6-06.1.

20. What is the "Name on the Check Rule" and how does it relate to IRAs?
The "Name on the Check Rule" describes a practice whereby an institutionalized spouse makes his/her community spouse the sole recipient of his/her IRA annuity payments. The CS's name being the only name on the check (solely receiving the RMDs/periodic payments from the fund) allows the IS to avoid increasing his/her income so the payments do not become part of the IS's patient liability. When RMDs or regular, periodic payments from an IRA annuity are only paid to the CS (even when the IRA annuity is in the IS's name), the payments must be considered unearned income to the CS only. Per 42 U.S.C. §1396r-5(b)(2)(A)(i), "if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse."

21. What happens when IRA income makes an individual ineligible for Medicaid?
An individual receiving or requesting long-term care (LTC) services may choose to establish a Qualified Income Trust (QIT), also known as a Miller Trust, when his/her countable income exceeds the special income level (SIL).

22. Under the CARES Act, can an individual waive his/her RMDs for 2020?
Changes to required minimum distributions occurred in 2020 due to the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Setting Every Community Up for Retirement Enhancement (SECURE) Act. Section 2203(a) of the CARES Act added a new subsection I to Section 401(a)(9) of the Internal Revenue Code, allowing the suspension of required minimum distributions (RMDs) during 2020; however, the CARES Act did not change the treatment of retirement accounts for Medicaid. When an individual is eligible to receive periodic payments, those payments are unearned income to the individual and per POMS SI 01120.210, when the individual is eligible for either periodic payments or a lump-sum, the individual must choose to receive periodic payments. When the individual was receiving periodic payments and chose to not receive those payments in 2020 based on the CARES Act legislation, the value of the retirement account would then count as a resource to the individual.

23. How does an individual verify the payout status of his/her IRA for Medicaid purposes?
To verify the status of an IRA, an individual can provide documents including, but not limited to:

- A letter from the Plan Administrator that includes details of the IRA
- A current IRA statement
- A transaction history that includes withdrawals/RMDs from the IRA in prior year(s)
- IRS data (e.g., Form 1099-R, Form 5498)
- An IRA award letter
- An IRA denial letter (or IRA termination letter)
- A severance letter from the individual's employer that includes IRA amounts
- A current IRA payment stub
- A copy of the IRA distribution request form received by the plan

This information is also available on the Ohio Department of Medicaid website and may be accessed at:
Resources for Providers > Policies & Guidelines > Medicaid Eligibility Procedure Letters (MEPLs)
https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/policies-guidelines/medicaid-eligibility-procedure-letters/medicaid-eligibility-procedure-letters