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Elder Law Update

Presented by the Elder Law and Special Needs Practice Group in Collaboration with ProSeniors, Inc.

Thursday, May 16, 2019

Elder Law Update

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8:30 a.m.	**Registration & Continental Breakfast**	
8:55 a.m.	**Welcome & Opening Remarks**	
9 a.m.	**Social Security—With You Through Life's Journey . . .** Kelly Draggoo, *Social Security Administration*	**TAB A**
10 a.m.	**Break**	
10:15 a.m.	**Elder Abuse: Reporting Requirements** Stephanie Hull, *Adult Protective Services* Michael S. Bailes, Esq., *US Bank*	**TAB B**
11:15 a.m.	**Medicaid Update** Lindsay C. Jones, Esq., *Schraff Thomas Law LLC*	**TAB C**
12:15 p.m.	**Adjourn**	

TAB
A

Kelly Draggoo, *Social Security Administration*

Kelly Draggoo began her career with Social Security Administration in 2009 as an SSI Claims Specialist in Cincinnati. She has been cross-trained in most programs at Social Security including Retirement, Disability, Survivor and Supplemental Security Income. Kelly is a graduate of the University of Cincinnati and holds a Bachelor's degree in Psychology. She currently serves as a volunteer for the Greater Cincinnati Literacy Network tutoring adults seeking help learning to read. Kelly is a native Cincinnatian and lives on the west side of town.

Social Security:
With You Through Life's Journey…

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Produced at U.S. taxpayer expense

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Contacting Social Security

Call 1-800-772-1213
Representatives from 7 a.m. to 7 p.m., Monday through Friday. Information is provided by automated phone service 24 hours a day.

Visit a local office
Open to the public Monday, Tuesday, Thursday and Friday from 9 a.m. to 4:00 p.m. and Wednesdays from 9 a.m. to 12:00 p.m., except Federal holidays.

www.socialsecurity.gov
Apply for benefits, visit Retirement Planner, appeal a decision, get info about earnings and benefits, see popular Baby Names, and more.

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Claiming Your Benefits

3 options available to apply:

- Online @ www.ssa.gov
- By phone 1-800-772-1213
- At our office

You choose the most convenient option for you!

Note: Child and survivor claims can only be done by phone or in a field office (not online) at this time.

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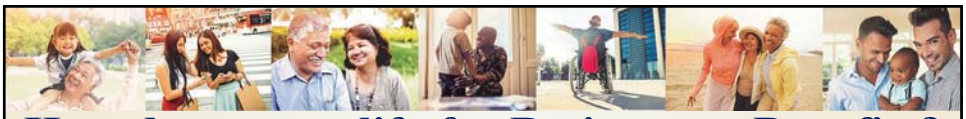

How do you qualify for Retirement Benefits?

- By earning "credits" when you work and pay Social Security payroll tax (FICA)
- FICA (Federal Insurance Contribution Act) is a US Payroll tax deducted from each paycheck (7.65%- your employer matches)
- Earn a maximum of 4 credits per year. Each $1,360 = 1 creditYou need 40 credits (10 years of at least part time work) – having more credits won't necessarily increase your benefit amount
- You must be 62 or older to claim benefits

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Retirement Benefit Election Options

- **Age 62:** You can choose to get benefits before FRA, as early as age 62, but at a reduced rate- each month prior to FRA the benefit is reduced a certain percentage. An Annual Earnings Limit applies, and entitlement to a reduced benefit will result in a limitation being placed on subsequent widow benefits.
- **At FRA:** Waiting to elect until your Full Retirement Age avoids a reduction due to age, AND the annual earnings limit no longer applies- you can work and earn as much as you want!
- **DRC's:** You can also choose to delay filing past your FRA, up to age 70, and collect Delayed Retirement Credits (DRCs) to get a higher monthly benefit amount (approx. 8% per year). Continuing to work beyond FRA could increase MBR based on averaging of highest 35 years of earnings. DRC's can also increase widow benefits.
- Or elect benefits anywhere in between age 62- 70!

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Benefit Percentages based on year of birth

Year of Birth	Full Retirement Age	% of PIA at age 62	% at age 70
1943-1954	66	75.0%	132.00%
1955	66 + 2 months	74.2%	130.67%
1956	66 + 4 months	73.3%	129.33%
1957	66 + 6 months	72.5%	128.00%
1958	66 + 8 months	71.7%	126.67%
1959	66 + 10 months	70.8%	125.33%
1960 or later	67	70.0%	124.00%

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How Much will your retirement benefit be?

- We base the payment on how much you earned during your working career-
- ***Your benefit amount replaces a percentage of your pre-retirement income***
- Social Security benefit amounts are figured with a weighted benefit formula that gives proportionately higher benefits to workers with low lifetime earnings
- Social Security benefits replace a larger share of past earnings for low earners.
- While high earners receive larger benefits, their benefits replace a smaller share of what they had been making.

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How Social Security Determines Your Benefit

- Step 1 –We adjust or "index" your actual earnings to account for changes in average wages since the year your earnings were received.
- Step 2 –Next, we calculate your average indexed monthly earnings during the 35 years in which you earned the most.
- Step 3 –Then, we apply a formula to these earnings and arrive at your basic benefit – This is a sum of three separate percentages of portions of your average indexed monthly earnings, known as the PIA (Primary Insurance Amount)

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2019 Retirement Benefit Formula
Higher Lifetime Wage Earner (40%)

If your average monthly earnings are = $5,800 ($69,600 yr)

Then your monthly benefit would be = $2,356 ($28,272 yr)

Average Monthly Earnings = $5,800

90% of First..... **$926** is **$833**

32% of Earnings over $926 through $5,583... **$4,657** is **$1,490**
($5,583-$926=$4,657)

15% of Earnings over $5,583..... **$217** is **$33**

$5,800 is **$2,356**

**Payments rounded to whole dollar amounts*

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https://www.ssa.gov/OACT/COLA/piaformula.html

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2019 Retirement Benefit Formula
Lower Lifetime Wage Earner (53%)

If your average monthly earnings are = $2,500 ($30,000 yr)

Then your monthly benefit would be = $1,356 ($16,272 yr)

Average Monthly Earnings = $2,500

90% of First..... **$926** is **$833**

32% of Earnings over $926 through $5,583... ..**$1,574** is **$503**
($2,500-$926=$1,574)

15% of Earnings over $5,583..... **$0** is **$0**

$2,500 is **$1,336**

**Payments rounded to whole dollar amounts*

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https://www.ssa.gov/OACT/COLA/piaformula.html

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Retirement Estimator

- Convenient, secure, and quick financial planning tool
- Immediate and accurate benefit estimates
- Lets you create "What if" scenarios based on different ages and earnings

socialsecurity.gov/estimator

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Windfall Elimination Provision and Government Pension Offset

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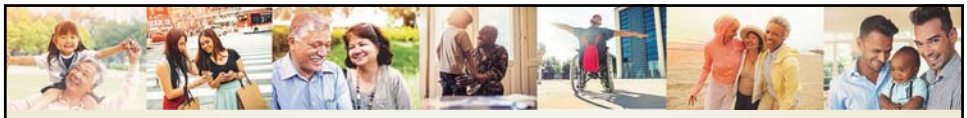

Windfall Elimination Provision (WEP)

- If any part of your pension is based on work not covered by Social Security, you may be affected by the Windfall Elimination Provision.
- As a result of the 1983 Amendments, the benefit formula is modified so that 40% is the first factor in the computation instead of 90% which prevents the worker, from receiving the advantage of the weighted benefit formula, and being paid a benefit as if they were a lower wage earner.

WEP can apply if:

- You reached 62 after 1985; or You became disabled after 1985; and You first became eligible for a monthly pension based on work where you didn't pay Social Security taxes after 1985.

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https://www.ssa.gov/pubs/EN-05-10045.pdf

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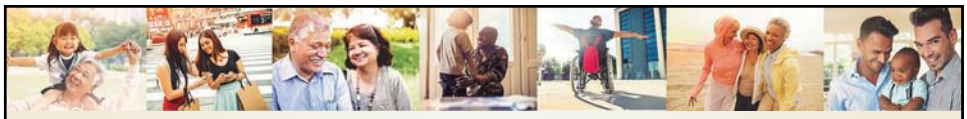

Substantial Earnings…Eliminating WEP

Year	Substantial earnings
1937–1954	$900
1955–1958	$1,050
1959–1965	$1,200
1966–1967	$1,650
1968–1971	$1,950
1972	$2,250
1973	$2,700
1974	$3,300
1975	$3,525
1976	$3,825
1977	$4,125
1978	$4,425
1979	$4,725
1980	$5,100
1981	$5,550
1982	$6,075
1983	$6,075
1984	$7,050
1985	$7,425
1986	$7,875
1987	$8,175
1988	$8,400
1989	$8,925
1990	$9,525
1991	$9,900

Year	Substantial earnings
1992	$10,350
1993	$10,725
1994	$11,250
1995	$11,325
1996	$11,625
1997	$12,150
1998	$12,675
1999	$13,425
2000	$14,175
2001	$14,925
2002	$15,750
2003	$16,125
2004	$16,275
2005	$16,725
2006	$17,475
2007	$18,150
2008	$18,975
2009–2011	$19,800
2012	$20,475
2013	$21,075
2014	$21,750
2015-2016	$22,050
2017	$23,625
2018	$23,850
2019	$24,675

Years of substantial earnings	Percentage
30 or more	90 percent
29	85 percent
28	80 percent
27	75 percent
26	70 percent
25	65 percent
24	60 percent
23	55 percent
22	50 percent
21	45 percent
20 or less	40 percent

https://mwww.ba.ssa.gov/pubs/EN-05-10045.pdf

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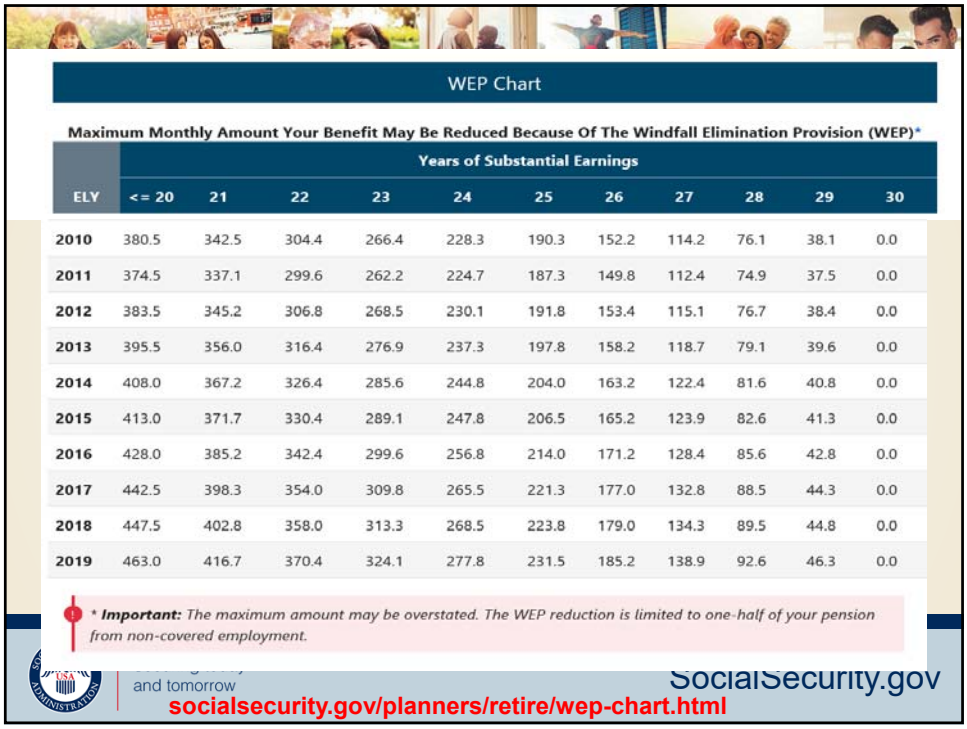

WEP Chart

Maximum Monthly Amount Your Benefit May Be Reduced Because Of The Windfall Elimination Provision (WEP)*

ELY	Years of Substantial Earnings										
	<= 20	21	22	23	24	25	26	27	28	29	30
2010	380.5	342.5	304.4	266.4	228.3	190.3	152.2	114.2	76.1	38.1	0.0
2011	374.5	337.1	299.6	262.2	224.7	187.3	149.8	112.4	74.9	37.5	0.0
2012	383.5	345.2	306.8	268.5	230.1	191.8	153.4	115.1	76.7	38.4	0.0
2013	395.5	356.0	316.4	276.9	237.3	197.8	158.2	118.7	79.1	39.6	0.0
2014	408.0	367.2	326.4	285.6	244.8	204.0	163.2	122.4	81.6	40.8	0.0
2015	413.0	371.7	330.4	289.1	247.8	206.5	165.2	123.9	82.6	41.3	0.0
2016	428.0	385.2	342.4	299.6	256.8	214.0	171.2	128.4	85.6	42.8	0.0
2017	442.5	398.3	354.0	309.8	265.5	221.3	177.0	132.8	88.5	44.3	0.0
2018	447.5	402.8	358.0	313.3	268.5	223.8	179.0	134.3	89.5	44.8	0.0
2019	463.0	416.7	370.4	324.1	277.8	231.5	185.2	138.9	92.6	46.3	0.0

* ***Important:*** *The maximum amount may be overstated. The WEP reduction is limited to one-half of your pension from non-covered employment.*

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Government Pension Offset

- *Only* affects Social Security spouse/widow(er) benefits
- Reduces Social Security spouse/widower(er) benefit by 2/3 of non-covered government pension

www.socialsecurity.gov/gpo

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Working While Receiving Benefits

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Work Before FRA is subject to the Annual Earnings Limit

- Work is wages and net earnings from self employment
- Not investments, not other pension income, annuity payments, IRA Distributions, Dividends, Capital Gains, unemployment, VA benefits
- Earnings Limit applies for benefits you receive on your own record, or as a spouse/widow(er)
- Use online **Earnings Test Calculator** to estimate how work will affect your benefits

www.ssa.gov/planners/morecalculators.htm

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Working While Receiving Benefits

If you are	You can make up to	If you earn more, some benefits will be withheld
Under Full Retirement Age	$17,640/yr.	$1 for every $2
The Year Full Retirement Age is Reached	$46,920/yr. before month of full retirement age	$1 for every $3
Month of Full Retirement Age and Above	No Limit	No Limit

Note: SSA will recalculate your benefit amount, at FRA, to leave out the months when we reduced or withheld benefits due to your excess earnings. Months withheld are credited towards the reduction factor at FRA.

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How Work Affects Your Benefits.

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Taxation of Social Security Benefits

If you:

file a federal tax return as an "individual" and your *combined income** is

- between $25,000 and $34,000, you may have to pay income tax on up to 50 percent of your benefits.
- more than $34,000, up to 85 percent of your benefits may be taxable.

file a joint return, and you and your spouse have a *combined income** that is

- between $32,000 and $44,000, you may have to pay income tax on up to 50 percent of your benefits
- more than $44,000, up to 85 percent of your benefits may be taxable.

are married and file a separate tax return, you probably will pay taxes on your benefits.

Visit IRS.gov and search for Publication 554, *Tax Guide for Seniors*, and Publication 915, *Social Security And Equivalent Railroad Retirement Benefits*

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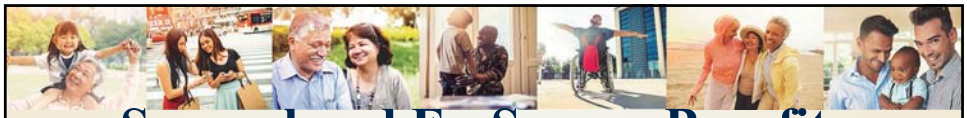

Spousal and Ex-Spouse Benefits

- A spouse who has not worked or who has low earnings can be entitled to as much as one-half of the retired workers full benefit.
- The benefit the spouse gets does not reduce payment to the retired worker
- Reduction to spouses payment for early retirement (before FRA)
- The Annual Earnings Limit Applies to spouse benefit
- If you are eligible for both your own benefit, and as a spouse, we always pay your own first. If your spouse benefits are higher, then you will get a combination of benefits equaling the higher spouse benefit.

- To qualify as an ex spouse, you must have been married for at least 10 years, been divorced at least two years, be at least 62, be currently unmarried and not be entitled to or eligible for a benefit on your own record that is more than half of your ex spouse.

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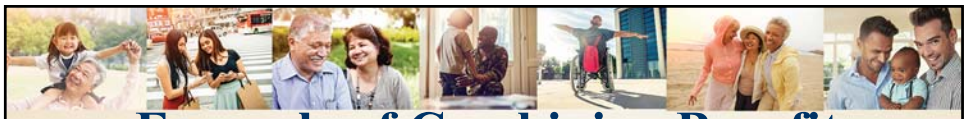

Example of Combining Benefits

- Mary qualifies for a retirement benefit of $250 and a spouse's benefit of $400.

- At her full retirement age, she will get her own $250 retirement benefit, plus we will also add $150 from her spouse's benefit, for a total of $400.

- This gives Mary benefits that equal the higher spouse benefit.

- If she takes her own retirement benefit before her full retirement age, we'll reduce both amounts.

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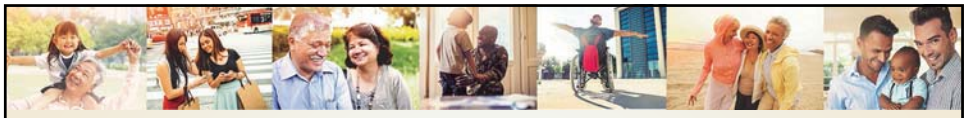

Benefits for Children

A child must have:

- A parent who's disabled or retired and entitled to Social Security benefits; or
- A parent who died after having worked long enough in a job where they paid Social Security taxes.

The child must also be:

- Unmarried;
- Younger than age 18;
- 18-19 years old and a full-time student (no higher than grade 12); or
- 18 or older and disabled. (The disability must have started before age 22.)

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How much will my survivor receive?

- We base the amount on the earnings of the person who died- We use the deceased worker's basic benefit amount to calculate the percentage the survivor can get- depends on age and relationship to the worker
- At FRA, a widow or widower generally gets 100 % of the worker's basic benefit amount- plus DRC's if the deceased earned any
- A widow or widower, age 60 or older, but still under FRA, gets between 71.5% - 99% of the workers basic benefit amount
- A widow or widower, any age, with a child younger than 16, gets 75% of the worker's benefit amount
- A child gets 75% of the worker's benefit amount
- The Annual Earnings Limit applies

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Understanding Medicare A/B Enrollment

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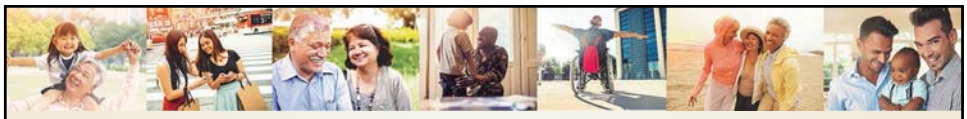

What is Medicare and When am I eligible?

- A federal health insurance program administered by the Centers for Medicare & Medicaid Services (CMS) for people who are age 65+, people receiving SSDI after 24 months, those diagnosed with permanent kidney failure requiring dialysis or transplant or those receiving SSDI because of ALS (no 24 month waiting period).
- You are eligible with 40 Social Security credits for both retirement and Medicare
- A worker's uninsured spouse (65 or older) may apply for Medicare on the record of the insured worker who is at least 62

Visit Medicare.gov for details

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4 Parts to Medicare
1. Part A = Hospital Insurance (HI)
• Enroll with Social Security
2. Part B = Supplemental Medical Insurance (SMI)
• Enroll with Social Security
3. Part C = Medicare Advantage Plans
• Enroll with Private Insurance Companies
4. Part D = Medicare Prescription Drug Plans
• Enroll with Private Insurance Companies
Medicare.gov
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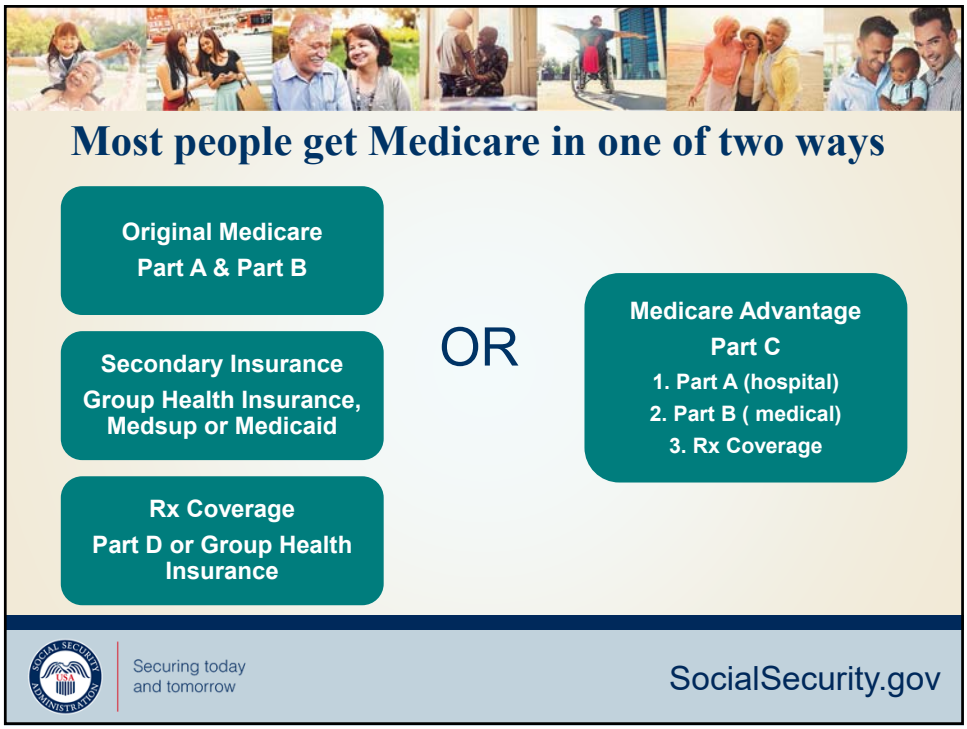
Most people get Medicare in one of two ways
Original Medicare
Part A & Part B
Secondary Insurance
Group Health Insurance, Medsup or Medicaid
Rx Coverage
Part D or Group Health Insurance
OR
Medicare Advantage
Part C
1. Part A (hospital)
2. Part B (medical)
3. Rx Coverage
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Original Medicare

Part A Hospital Insurance

- Covers most inpatient hospital expenses, skilled nursing care, hospice care
- Most people do not pay a monthly premium, but those who have to buy Part A, pay up to $437/mo

Part B Medical Insurance

- Helps cover doctor bills and other outpatient medical expenses, Home Health Care, Durable Medical equipment, some preventative services
- Copayments generally 20% of Medicare Approved Amount
- 2019 Monthly Premium is $135.50 for most- *income based so some pay more*

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Medicare Enrollment Periods

Automatic Enrollment

Anyone receiving a Social Security benefit prior to age 65 is automatically enrolled in Medicare A & B at age 65.

Or if getting SSDI, after 24 months

General Enrollment Period

January 1 – March 31

Coverage begins July 1

Late Enrollment Penalties may apply

Initial Enrollment Period

Begins 3 months before your 65th birthday and ends 3 months after that birthday

Enroll during the 3 months prior to age 65 for Medicare coverage to begin your birthday month

Special Enrollment Period

If you delayed Medicare at 65 and are covered under a group health plan based on your – or your spouse's – current work, you can use the SEP (month you leave work + 8 months) to enroll after your IEP.

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Medicare Part B Coverage

If you enroll in this month of your initial enrollment period:	Then your Part B Medicare coverage starts:
One to three months before you reach age 65	The month you reach age 65
The month you reach age 65	One month after the month you reach age 65
One month after you reach age 65	Two months after the month of enrollment
Two or three months after you reach age 65	Three months after the month of enrollment

Note: If IEP and SEP months ever overlap, the IEP chart will determine when Medicare coverage begins.

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How to take advantage of your Special Enrollment Period (SEP)

- If you enrolled in Part A when you turned 65, but chose to delay Part B, you do not need to file a new application to enroll in Part B…
- Call 1-800-772-1213 or download the Special Enrollment forms from www.ssa.gov (under FORMS).
  - Give CMS-L564 to employer to complete.
  - Complete CMS 40B showing month you want Part B to begin.
  - Submit the forms to SSA before your insurance ends
- If you did NOT enroll in Part A at 65, and now need both Parts A and B you'll need to file an application AND submit the SEP forms.

Download PDF forms at www.ssa.gov/forms

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Enrolling in Medicare when you have an HSA

- You cannot have an HSA and have any insurance other than a HDHP
- You should delay Social Security benefits AND decline Part A if you wish to continue contributing funds to your HSA.
- You may continue to withdraw money from the HSA after you enroll in Medicare to help pay for medical expenses such as deductibles, premiums, copayments and coinsurances.
- If you decide to delay enrolling in Medicare beyond 65, be sure to stop contributing to your HSA at least six months before you plan to enroll in Medicare. When you do enroll, you will receive up to six months of retroactive coverage, not going back farther than your initial month of eligibility. If you fail to do so, you may incur a tax penalty.

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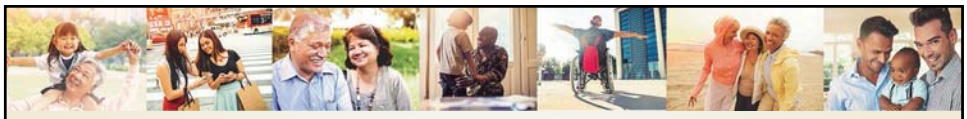

Medicare Premiums: Rules for higher-income beneficiaries

- If you have higher income, the law requires an adjustment to your monthly Medicare Part B and Medicare prescription drug coverage premiums. Called IRMAA
- Affects less than five percent of people with Medicare
- For most beneficiaries, the government pays about 75% of the Part B Premium and the beneficiary pays the remaining 25%.
- Higher income beneficiaries pay a larger percentage of the total cost of Part B based on the income reported to the IRS.
- Based on most recent tax return the IRS provides to SSA
- Request a reduction if you have a life changing event (marriage/divorce/death of spouse/work stoppage/reduction) - Form SSA-44

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Medicare standard Part B premium for 2019

If you're single and file an individual tax return, or married and file a joint tax return:

Modified Adjusted Gross Income (MAGI)	Part B monthly premium amount	Prescription drug coverage monthly premium amount
Individuals with a MAGI of $85,000 or less Married couples with a MAGI of $170,000 or less	2019 standard premium $135.50	Your plan premium
Individuals with a MAGI above $85,000 up to $107,000 Married couples with a MAGI above $170,000 up to $214,000	Standard premium + $54.10	Your plan premium + $12.40
Individuals with a MAGI above $107,000 up to $133,500 Married couples with a MAGI above $214,000 up to $267,000	Standard premium + $135.40	Your plan premium + $31.90
Individuals with a MAGI above $133,500 up to $160,000 Married couples with a MAGI above $267,000 up to $320,000	Standard premium + $216.70	Your plan premium + $51.40
Individuals with a MAGI above $160,000 up to $500,000 Married couples with a MAGI above $320,000 up to $750,000	Standard premium + $297.90	Your plan premium + $70.90
Individuals with a MAGI equal to or greater than $500,000 Married couples with a MAGI equal to or greater than $750,000	Standard premium +$325.00	Your plan premium + $77.40

Medicare Resources

www.insurance.ohio.gov

MyMedicare.gov

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Disability Programs

Title II

SSDI
Social
Security
Disability
Insurance

Medicare

Title XVI

SSI
Supplemental
Security
Income

Medicaid

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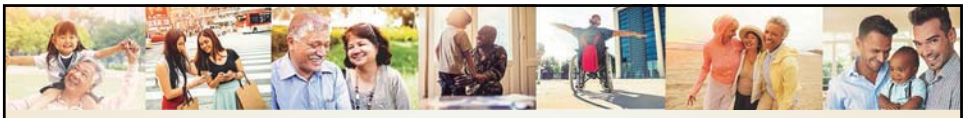

Definition of Disability - Adult

The Social Security Act defines disability as:

- a person who cannot work due to a severe medical condition that has lasted, or is expected to last, at least one year or result in death; or
- the person's medical condition must prevent him or her from doing substantial gainful employment ($1,220 mo) – work that he or she did in the past, and it must prevent the person from adjusting to other work.

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SSDI vs. SSI: A Summary

Social Security Disability Insurance	Supplemental Security Income
Payments come from the Social Security trust funds and are based on a person's earnings.	Payments come from the general treasury fund, NOT the Social Security trust funds. SSI payments are not based on a person's earnings.
An insurance that workers earn by paying Social Security taxes on their wages.	A needs-based public assistance program that does not require a person to have work history.
Pays benefits to disabled individuals who are unable to work, regardless of their income and resources.	Pays disabled individuals who are unable to work AND have limited income and resources.
Benefits for workers and for adults disabled since childhood. Must meet insured status requirements. Qualifies for Medicare after 24 months	Benefits for children and adults in financial need. Must have limited income and limited resources. Qualifies for Medicaid

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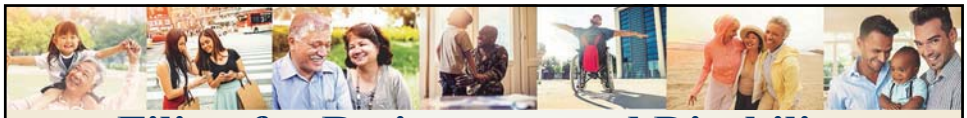

Filing for Retirement and Disability Simultaneously

- You can file for disability benefits up to your full retirement age
- If you can't work, or have reduced your work, because of a disability expected to last at least one year or result in death, you may be eligible to claim your early retirement benefit and file for disability benefits at the same time.
- Disability benefits are not reduced based on age like retirement benefits are

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Month of Entitlement (MOE) Scenarios for Retirement and Widow Insurance

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MOE Comparison 1- Break Even Point

EXAMPLE 1 : RECEIVING RETIREMENT AGE 62 VS. FULL RETIREMENT AGE (FRA) 66 YEARS 6 MONTHS

STARTING RETIREMENT AT AGE 62 THE REDUCED PAYMENT IS $1458.00 PER MONTH. THIS OPTION PAYS 53 MONTHS BEFORE FRA. 53 MONTHS X $1458.00 = $77,274.00 TOTAL PAYMENTS BEFORE FRA.

STARTING RETIREMENT AT FRA THE FULL PAYMENT IS $2000.00 AT FRA. THE DIFFERENCE IN THE MONTHLY PAYMENT IS $542.00.

TO CALCULATE HOW LONG IT TAKES TO RECOVER BENEFITS THAT COULD HAVE BEEN PAID FROM AGE 62 TO FRA, DIVIDE THE DIFFERENCE $542.00 INTO THE TOTAL PAYMENTS THAT WOULD HAVE BEEN PAID $77,274.00.

IT TAKES 142.6 MONTHS (11.9 YEARS) TO RECOVER THE PAYMENTS THAT COULD HAVE BEEN PAID PRIOR TO FRA.

THE "BREAK EVEN" POINT IS FOUND BY ADDING THE 11.9 RECOVERY YEARS ONTO FRA AGE (66 AND 6 MONTHS). THE BREAK EVEN AGE IS ABOUT 78 YEARS OLD.

IF THE PERSON DIES ANY TIME BEFORE AGE 78, THEY NEVER RECOVER THE MONEY THAT COULD HAVE BEEN PAID EARLY.

CALCULATION SUMMARY

AGE 62 PAYMENT = $1458.00

AGE 66 AND 6 MONTHS PAYMENT = $2000.00

DIFFERENCE = $542.00

TOTAL BENEFITS PAID BEFORE FRA = $77274.00

DIVIDE $77274.00 BY $542.00 = 142.5 (11.9 YEARS) TO RECOVER BENEFITS NOT PAID BEFORE FRA.

ADD 11.9 RECOVERY YEARS TO 66 AND 6 MONTHS = APPROXIMATELY AGE 78 TO RECOVERY UNPAID EARLY BENEFITS.

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MOE Comparison 2- Break Even Point

EXAMPLE 2 : RECEIVING RETIREMENT AT FULL RETIREMENT AGE (FRA) 66 AND 6 MONTHS VS. AGE 70.

STARTING RETIREMENT AT AGE 66 AND 6 MONTHS THE FULL PAYMENT IS $2000.00 PER MONTH. THIS OPTION PAYS 42 MONTHS BEFORE AGE 70. 42 MONTHS X $2000.00 = $84,000.00 TOTAL PAYMENTS BEFORE AGE 70.

STARTING RETIREMENT PAYMENTS AT AGE 70 THE FULL DELAYED RETIREMENT PAYMENT IS $2560.00. THE DIFFERENCE BETWEEN THE MONTHLY PAYMENTS IS $560.00.

TO CALCULATE HOW LONG IT TAKES TO RECOVER BENEFITS THAT COULD HAVE BEEN PAID BEFORE AGE 70, DIVIDE THE DIFFERENCE $560.00 INTO THE TOTAL PAYMENTS THAT WOULD HAVE BEEN PAID $84,000.00.

IT TAKES 150 MONTHS (12.5 YEARS) TO RECOVER THE PAYMENTS THAT COULD HAVE BEEN PAID PRIOR TO AGE 70.

THE "BREAK EVEN" POINT IS FOUND BY ADDING THE 12.5 RECOVERY YEARS ONTO AGE 70. THE BREAK EVEN AGE IS ABOUT AGE 82.5 YEARS OLD.

IF THE PERSON DIES ANY TIME BEFORE AGE 82.5, THEY NEVER RECOVER THE MONEY THAT COULD HAVE BEEN PAID EARLY.

CALCULATION SUMMARY

AGE 66 AND 6 MONTHS PAYMENT = $2000.00

AGE 70 PAYMENT = $2560.00

DIFFERENCE = $560.00

DIVIDE $84,000.00 BY $560.00 = 150 MONTHS (12.5 YEARS) TO RECOVER BENEFITS NOT PAID BEFORE AGE 70.

ADD 12.5 RECOVERY YEARS TO AGE 70 = APPROXIMATELY AGE 82.5 TO RECOVER UNPAID EARLY BENEFITS.

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Widow(er) Filing Options

A fully insured widow(er) has several filing options such as:

- Filing for Widow Insurance Benefits (WIB) as early as age 60, then switching to their own Retirement Insurance Benefit (RIB) as early as 62; or
- Waiting until FRA to begin WIB benefit instead of their own RIB benefit so that their own RIB benefit can increase with Delayed Retirement Credits (DRC's), and the annual earnings limit no longer applies; or
- Continue drawing a WIB benefit past FRA, up to age 70, then switching to their own RIB to collect maximum DRC's; or

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MOE Comparison- Break Even Point

EXAMPLE 3 : RECEIVING WIDOW PAYMENTS FIRST AND WAITING FOR THE HIGHEST RETIREMENT PAYMENT AT AGE 70

A PERSON FILING FOR A FULL WIDOW PAYMENT AT AGE 66 AND 2 MONTHS WOULD RECEIVE $2000.00 PER MONTH.

HIS/HER RETIREMENT PAYMENT AT THE SAME POINT WOULD BE SLIGHTLY LESS $1955.00 PER MONTH. CLEARLY IT IS NOT ADVANTAGEOUS TO START THE RETIREMENT PAYMENT FIRST.

IF THE WIDOW WAITS UNTIL AGE 70 TO SWITCH OVER TO THE HIGHEST POSSIBLE RETIREMENT PAYMENT AT 70 THE PAYMENT WILL BE $2560.00 PER MONTH.

QUESTION? WHEN THE WIDOW AND RETIREMENT PAYMENTS ARE SIMILAR, IS IT ADVANTAGEOUS TO SWITCH OVER TO THE RETIREMENT PAYMENT BEFORE AGE 70?

IF THE WIDOW STARTS THE RETIREMENT PAYMENTS 16 MONTH BEFORE AGE 70 THE PAYMENT WILL BE $2346.00 PER MONTH. BUT IT WILL ONLY TAKE 2 YEARS 6 MONTHS TO RECOVER THESE EARLY RETIREMENT PAYMENTS IF HE/SHE CONTINUES TO WAIT FOR THE HIGHEST PAYMENT AT AGE 70.

SUMMARY : WHEN THE RETIREMENT AND WIDOW PAYMENT ARE SIMILAR, IT IS GENERALLY CONSIDERED ADVANTAGEOUS TO RECEIVE THE WIDOW PAYMENT FIRST AND WAIT FOR THE HIGHEST POSSIBLE RETIREMENT PAYMENT AT AGE 70.

BECAUSE THE WIDOW IS ALREADY RECEIVING A SIMILAR PAYMENT, THE RECOVERY PERIOD IS VERY SHORT-USUALLY ONLY A FEW YEARS.

HOWEVER, THERE ARE MANY CONSIDERATIONS THAT MAY CAUSE A WIDOW TO SWITCH TO HIGHER RETIREMENT PAYMENTS BEFORE AGE 70. DIRE FINANCIAL NEED OR HEALTH PROBLEMS THAT MAKE THE WIDOW DOUBT LIVING TO RECOVER EARLY PAYMENTS, MAY CAUSE A WIDOW TO SWITCH TO RETIREMENT BEFORE AGE 70.

ALERT: WHEN THE WIDOW PAYMENT IS SIGNIFIGANTLY LESS THAN THE RETIREMENT PAYMENT, THE LONG RECOVERY YEARS MAY CAUSE A WIDOW TO FILE FOR RETIREMENT PAYMENTS AND NEVER BOTHER FILING AS A WIDOW AT ALL.

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Q&A session

Presenters:

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TAB
B

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CREDENTIALS

B.A.,Binghamton University, Binghamton, New York

J.D., Boston University School of Law, Boston, Massachusetts

As a Wealth Trust Advisor Managing Director, Michael leads a regional team that is responsible for understanding client's wealth planning, estate planning and wealth transfer needs. Michael and the team also research and recommend fiduciary strategies and opportunities. He has an extensive background in complex estate administration, trust asset allocation and private foundation management.

Michael began his career in the banking and financial services industry in 1993. Prior to joining U.S. Bank Private Wealth Management, Michael worked for a local regional and a super regional bank, where he held various management positions.

Michael has always been active in the Cincinnati community, serving on a variety of boards throughout his career. He is currently on the board and Executive Committee with the Cincinnati Ballet. Michael recently joined the board for the Jewish National Fund and he is president of the Cincinnati Bar Association Foundation.

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Stephanie Hull

Stephanie Hull has worked at Hamilton Co Job & Family Services for 23 years. Ms. Hull has served as a Manager of Adult Protective Services at Hamilton Co Job & Family Services for 15 years. Ms. Hull completed her MSW from the University of Kentucky in 1998.

Elder Abuse & Financial Exploitation

Stephanie Hull
Adult Protective Services

Michael Bailes
US Bank – Private Wealth Management

May 16, 2019

1

Statistics

- Nearly 1/5 seniors report falling victim to financial exploitation.
- Only 1/44 cases of elder financial exploitation are ever reported.
- 90% of perpetrators are family members or trusted others.
- Nearly one million seniors are currently skipping meals as a result of financial exploitation. The True Link Report on Elder Financial Abuse 2015, reports it is estimated that 954,000 seniors are currently skipping meals as a result of financial abuse.

2

The Scope of Adult Protective Services Hamilton County Job and Family Services:

- APS investigates allegations of elder abuse, neglect, self neglect and exploitation of those individuals 60 and over in Hamilton County.
- The elderly person has to be living in an independent living environment, and has to meet the criteria of the law, as defined by the ORC (Ohio Revised Code).

3

Highlights of the Law:

- Definition:
  - Elder Financial Exploitation is the illegal, unauthorized, or improper use of an older person's property or financial assets. An older person refers to someone 60 years old or older. Perpetrators who target older persons typically include, but are not limited to family members, caregivers, scam artists, financial advisers, home repair contractors, and fiduciaries (agents under a power of attorney and guardians of property).
  - Older persons are usually targeted because they typically have accumulated assets and equity in their homes in addition to a regular source of income and may be susceptible to exploitation due to isolation, cognitive decline, physical disability, health problems, or the recent loss of a partner, family member, or friend.

APS receives referrals from other professionals (often mandated reporters), neighbors, friends, relatives, etc…

APS receives referrals by phone, fax, mail or in person.

APS investigates allegations of elder: abuse, neglect, exploitation, and self neglect.

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The Consumer Financial Protection Bureau (CFPB) Offers This

"When seniors fall prey to a scam by a stranger or to theft by a family member, they may be too embarrassed or too frail to report it. Banks and credit unions are uniquely positioned to look out for older Americans and take action to protect them."

5

Additional New Financial Mandated Reporters 5101.63

- CPAs
- Ohio-licensed real estate agents of brokers
- Notary Public commissioned in Ohio
- Bank/S&L/Credit Union Employees
- Investment Advisors
- Financial Planners

6

Duty to Report

- Any mandatory reporter who has reasonable cause to believe
  - That an adult is being abused, neglected or exploited; or
  - Is in a condition which is the result of abuse, neglect or exploitation
  - Not reporter's responsibility to determine if abuse, neglect or exploitation is occurring. Only suspicion is required.
  - Shall immediately report to the Cunty Department of Jobs and Family Services or its designee.
- Any person with reasonable cause to believe an adult is suffering abuse, neglect, or exploitation who makes a report, testifies or acts responsibly in the discharge of their official duties:
  - Shall be immune from civil/criminal lability unless the person acted in bad faith or with malicious purpose.

7

If Exploitation Goes Unreported

- Ohio statute fine not more than $500 or potential misdemeanor;
- Other consequences:
  - For the Victim:
    - ✓Significant financial losses
    - ✓Loss of trust
    - ✓Inability to provide long term care needs
    - ✓Depression and feelings of guilt and shame
    - ✓Death
  - For the organization or employee:
    - ✓Regulatory fines and penalties / Reputational damages / Litigation / Financial Losses

8

Senior Safe Act – Congress Enacted May 24, 2018

- Financial exploitation or otherwise illegal, unauthorized, or improper actions by a caregiver, fiduciary, or other individual in which the resources of an older person are used by another for personal profit or gain.
- Some additional protection against lawsuits if financial service firms raise the concern of suspicious activity in their elder clients' accounts.

9

Forms of Neglect:

- Active neglect

Behavior that is willful- This is, the caregiver intentionally withholds care or necessities.

Neglect may be motivated by financial gain (e.g. the caregiver stands to inherit) or reflect interpersonal conflicts.

- Passive neglect

Situations in which the caregiver is unable to fulfill his or her care giving responsibilities as a result of illness, disability, stress, ignorance, lack of maturity, or lack of resources.

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Examples of Neglect and Self Neglect:

- Both neglect and self neglect include the withholding of medical treatment, medication, food, personal care, and in some cases, shelter and safe living conditions.
- Self neglect is the largest form of abuse that is reported.

Physical indicators of neglect and self neglect

- Obvious malnutrition or dehydration
- Physically unclean and unkempt, (dirty, ragged clothing)
- Decubiti (bedsores)
- Excessive fatigue and listlessness
- Unmet medical or dental needs

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Physical Indicators of Neglect and Self Neglect:

- Exacerbation of chronic diseases despite a care plan
- Worsening dementia
- Home in state of filth or dangerous disrepair
- Absence of necessities including food water, heat
- Animal or insect infestations

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Additional Forms of Elder Abuse:

- Emotional Abuse
- Sexual Assault
- Abandonment / Desertion
- Violation of Rights

Signs/ Symptoms; low self esteem, witnessing someone talking down to client, client withdrawn, yelling, screaming, demeaning, or threatening. Client visibly scared of a particular person.

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Elder Abuse:

- Exploitation

  Means the unlawful or improper act of a caretaker using an adult or his resources for monetary or personal benefit, profit or gain.
- Signs of Exploitation
  - Client receiving calls or letters from the bank regarding overdraft fees when they shouldn't be overdrawn.
  - Missing large amounts of money
  - Fees to facility not being paid by family members.
  - Client telling staff members that they are concerned about their family taking their money.
  - Client depressed or withdrawn surrounding financial issues.

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Potential Signs of Financial Exploitation

- Changes in bank account or banking practices
- Inclusion of additional names on signature card
- Unauthorized withdrawal
- Changes in estate planning and other financial documents
- Missing property
- Substandard care or unpaid bills despite adequate financial resources
- Forged signatures
- Appearance of uninvolved relatives
- Unexplained sudden transfer of assets
- Missing or redirected mail
- Unnecessary services being provided

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Financial Exploitation by Perpetrator Type

- Familiar Perpetrator
  - Most common
  - Theft of case or other valuables / withdrawals or credit card use / deed transfer / misuse of POA / identity theft
- Stranger Perpetrator
  - Lottery, mail, telephone or internet scams / door to door home repair scams / identity theft
- Professional Perpetrator
  - In positions of trust or authority
  - Fraudulent investments / sale of financial products or services unsuitable

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Facts and Prevalence of Elder Abuse:

- Estimates of the frequency of elder abuse range from 2-10% based on various sampling, survey methods and case definitions.
- Data suggest that 1 in 14 incidents, excluding self neglect, come to the attention of authorities.
- Current estimates of financial exploitation suggest that 1 in 25 cases are reported.
- It is estimated that for every one case of elder abuse, neglect, exploitation or self neglect reported to authorities, about five more go unreported.

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Principles of APS:

- Adults have the right to be safe.
- Adults retain all their civil and constitutional rights unless some of these rights have been restricted by court action.
- Adults have the right to make decisions that do not conform with societal norms as long as these decisions do not harm others.
- Adults are presumed to have decision-making capacity unless a court adjudicates otherwise.
- Adults have the right to accept or refuse services.

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Tools to Combat Financial Elder Abuse

- Employee of the bank prepares an IRF – Investigative Referral Form
- Temporary Restraining Order (Access or Provision of Services)
- (Emergency) Protective Services Order
- Ex-Parte Emergency Order

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Elder Estate Planning Considerations

- Advanced Care Planning process
  - Values, Goals and Priorities – Important Discussions
  - Trust Arrangements
  - Palliative, Hospice and Home Care
  - Sharing, Coordination & Proxies
  - Durable or Springing Power of Attorney
  - Exercise of Financial Powers of Attorney
  - Living Will and Durable Power of Attorney for Health Care and Organ Donation
  - Consent to medical treatment
  - HIPPA access
  - Digital Assets

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APS How to Make a Referral:

- Our 24 hour hot line number is 421-life (5433). APS calls are taken by the social workers who also handle the 241-kids hot line.
- The social workers answering the phone ask a lot of detailed questions to determine if the situation meets the criteria of the law.
- If a case is taken: APS has three working days to attempt initial contact with the client. APS involvement is short term. Our mandate is to investigate the allegation, and make referrals, recommendations, etc. We involve other authorities in our cases when needed.

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APS Involvement:

- The law requires that APS completes an investigation within 30-45 days from date of receipt.
- On one end of spectrum APS may investigate and not take any action. On the other end of the spectrum APS may facilitate the guardianship process for placement in a nursing facility.
- In the middle, or in a typical case, APS works closely with many other organizations including; the health department, building department, police, sheriff's, mobile crisis, etc., depending on the circumstances involved with the case.

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Clinical Indications for Closure:

- APS cases are closed when;
- Client requests closure or refuses to meet with APS and there isn't justification to pursue court intervention.
- Investigation is complete, client is referred to outside services.
- Guardianship is awarded through probate court and client placed in nursing home.
- APS has completed assessment, and made recommendations. If client is competent they have the right to self determination

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Resources

- Ohio APS law (ORC 5101.60-5101.73)
- Ohio Administrate Code Rules governing Ohio's APS program emanuals.jfs.ohio.gov/FamChild/FCASM/SocialServices
- Ohio Adult Protective Services Program jfs.ohio.gov/APS_FactSheet.pdf
- https://www.com.ohio.gov/documents/ElderAbuse_FinExploitation.pdf
- Elder Justice Roadmap justice.gov/elderjustice/financial-exploitation
- Money Smart for Older Adults Resource Guide
- Advanced Directives Counseling Guide for Lawyers - ABA

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TAB
C

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Lindsay practices law with *Schraff Thomas Law, LLC*. Her practice is focused on Estate planning, Senior planning, Medicaid Planning and other Elder Law Issues. Lindsay graduated from Law School at the University of Akron College of Law and completed her undergraduate degree in English at Kent State University. Lindsay is a Member of the Board for the Long-Term Care Ombudsman (LTCO) and NAELA.

2019 Medicaid Updates

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1

Failure to Provide Verifications

Resource Verifications Unavailable

- State Hearing: 3294221 (4/2018)
  - The Agency denied the application for failure to provide income and resource verifications, as requested.
  - The Hearing Officer determined that, given the circumstances involved (a spouse who works, an applicant with dementia, the amount of records requested), that it was reasonable for the Agency deadlines to not be met.
  - The Agency was instructed to assist in obtaining verifications.
  - Note also: OAC 5160:1-2-01(K), which states that the Agency shall not terminate, deny, or suspend benefits until appropriate steps have been taken to verify the relevant information, in accordance with 42 CFR 435.952(d). That provision points to 435.952(c), which includes the stipulation that the "agency must provide the individual a reasonable period to furnish any additional information required under paragraph (c) of this section." 435.912(g) supplements that, by stipulating that the Agency must not use *time standards* as the reason to deny eligibility. ie, the reason for delay can be documented by the County; reasonable delays should never be the sole reason for a denial.

2

Incompetent Applicant
Lack of Access

- Administrative Appeal: 3272640 (3/2018)
  - A Medicaid applicant was evaluated to be incompetent. Prior to that, an Authorized Representative form was completed; there was no Agent under POA. The AR authorized the Agency to directly request records. Countable resources totaling more than $40,000.00 were known to the Agency.
  - The applicant's resources were ultimately determined to *not* be available, due to lack of access. The Agency was directed to determine eligibility without considering resources until Guardianship was established.
    - The underlying fact pattern was relatively extreme. No family members were available to assist, and the local volunteer Guardian program would not assist (with the Estate, presumably).
    - The ultimate focus was that there was no method to *legally access* the resources. The Agency was directed to assist in obtaining a legal representative or guardian. This is in line with OAC 5160:1-2-01(F)(4) & (5).

3

Incompetent Applicant
Guardianship Established

- Administrative Appeal: 3337019 (8/2018)
  - At the time of application, the Applicant was residing in a nursing facility and had no intention to return. A guardian had been appointed. The Guardian had entered into a purchase agreement to sell the property.
  - As there was legal access, and no intent to return, the Applicant's residence was considered to be an available resource, causing ineligibility, until closing occurred. (At which point, title was transferred.)

4

"For Sale" Insufficient (A)

- Administrative Appeal: 3340517 (9/2018)
  - The Applicant's home had been listed for sale for 6 months prior to application. The Authorized Representative indicated that Applicant did not intend to return home.
  - The home was considered a countable resource, causing ineligibility.
- The rules regarding the Applicant's home have changed:
  - The 13 month rule is gone.
  - Real property is *not* exempt simply because it is listed for sale at the AMV.
    - For non-homestead property, consider arguments to establish a low/zero value or document it as a legally unavailable resource.
  - A purchase offer within 90% of the AMV no longer *has* to be accepted. (Good and bad points.)
  - OAC 5160:1-3-05.13 includes specific exemptions if a spouse or dependent relative (including a stepchild, grandchild, sibling, or in-law) is living in the home, or if undue hardship would be involved.

5

"For Sale" Insufficient (B)

- The home is exempt, *so long as* the Applicant intends to return.
  - See OAC 5160:1-3-05.13(B)(2). The statement should be in writing, to ensure it is part of the record.
- Real property should be sold at Fair Market Value.
  - FMV is defined at OAC 5160:1-3-05.1(B)(4) 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. This essentially defaults to AMV.
  - Be prepared to document FMV. Alternatively, be prepared to rebut the presumption of an improper transfer (ie, the difference between gross sale value and the AMV), under OAC 5160:1-6-06(F). Supporting documentation should include a written explanation of why the asset's FMV is lower than AMV, or why it was transferred for less than AMV, and disclose if it was transferred to a relative.
  - Supporting documentation can include realtor agreements, sworn statements, and third party statements (such as Broker Opinion Letters or a Certified Appraisal).
  - Many Counties will still accept 90% of AMV as being an appropriate sale value, but this is not guaranteed. Supporting documentation is suggested.

6

Asset Verification System (AVS)

Direct Access for County

- The Agency is federally required to obtain financial records from financial institutions to determine eligibility. Per OAC 5160:1-1-05, the Agency *shall*, where authorized, electronically verify assets through AVS to determine eligibility. This can assist with efficiency, both for the Agency and for the Applicant. However, privacy concerns and appropriate notice/consent are also considerations. The applicant/recipient has a responsibility to provide such authorization if records are required (and otherwise unavailable).
- To access AVS (re: bank accounts and balances, etc), permission must be granted by the applicant/recipient; such permission can be expressly revoked, in a written notification to the Agency.
- So long as due notification is provided, IRS information from the Federal Data Hub does not require special permission and (effectively) cannot be revoked.
- MEPL No. 136 (9/2018) clarified the above policies.
- Authorization to use *both* systems is essentially a default, unless application is made via paper (Form 7200 or 7216) or via an eGateway application. Full access is also considered a default for *all* methods of renewal (paper, phone, and online).

7

Incompetent Applicant

Agent under HC POA Insufficient

- Administrative Appeal: 3382939 (11/2018)
  - Here, a State Hearing was requested and denied, on the grounds that the request was not made by a proper authorized representative.
  - Essentially, it was determined that a Health Care Power of Attorney document does not contain sufficient powers for the Agent to represent the Applicant on legal and financial matters.
- Administrative Appeal: 3454613 (5/2019)
  - Applicant's sister requested a State Hearing, and attached a Health Care Power of Attorney to the request. It was determined that the Health Care Power of Attorney document did not provide sufficient powers to permit the sister to represent the Applicant at a hearing.

8

Qualified Income Trusts (QIT)

OAC 5160:1-6-03.2

- State Hearing: 3263709 (2/2018)
  - If applicant's total gross income is above SIL ($2,313.00 for 2019), a QIT is required. *All income* can be transferred to the QIT.
    - This is directly supported by OAC 5160:1-6-06(D)(7), which states that the transfer of the IS's income to a QIT is not an improper transfer.
    - That said, only the amount of income in excess of SIL *must* be transferred.
- Administrative Appeal: 3365898 (10/2018)
  - A Medicaid recipient completed Patient Liability payments, but failed to properly fund the QIT in particular months. The Hearing Officer determined that she was not eligible to receive Medicaid benefits in those months, ultimately resulting in an erroneous payment (overpayment) by Medicaid.
    - OAC 5160:1-2-04
    - Note: Unpaid Past Medical Expense request. OAC 5160:1-3-04.1(C)(8) & (14)

9

Sole Benefit Requirement (A)

- Administrative Appeal: 3289345 (3/2018)
  - Applicant gifted funds, via personal check, to their disabled child. Agency required Applicant to establish that the transfer was for the child's "sole benefit," under OAC 5160:1-6-06(D).
- Per the 9/2017 update to OAC 5160:1-6-06, the "sole benefit" requirement:
  - Continues to *not* apply to transfer of title to the home to disabled child.
  - Now applies to other assets, if directly transferred to disabled child.
  - Continues to apply to transfers to a trust, established for a disabled child's benefit.
- Also applies to transfers to a trust for the benefit of a disabled individual under the age of 65, and transfers "to another" for the benefit of the CS.

10

Sole Benefit Requirement (B)

- "Sole benefit" is not well defined by statute or by federal regulation.
- POMS SI 01120.201, updated on 4/30/2018, states the SSA's explanation of the "sole benefit" rule:
  - A trust is for the "sole benefit" of an individual, so long it only benefits that individual at the time it is established, or for the remainder of the individual's life.
  - This is further clarified in .201F.3.a, which states that payments to 3rd parties for goods and services must be for the "*primary benefit*" of the trust beneficiary. This takes into account the reality of collateral benefit.
  - Further, it includes notes stating that persons or entities, other than the beneficiary, may be listed on a title to purchased goods (in certain circumstances), so long as the goods are used for the sole benefit of the trust beneficiary.
- In *Hughes v. McCarthy*, 734 F.3d 473, the 6th Circuit noted that the designation of contingent beneficiaries does not necessarily violate the "sole benefit" rule, and that it was difficult to conceive of what type of financial arrangement *could* meet the definition urged by the Ohio agency.
- OAC 5160:1-6-06(E) states that, to be for an individual's "sole benefit," the instrument or document must provide for the spending of the funds on a basis that is *actuarially sound* based on the individual's life expectancy.

11

Start Date for AL Waiver

OAC 5160-3-14 &173-38-03

- State Hearing: 3373495 (3/2019)
  - Receipt of form 3697, *signed and dated by the doctor*, completed the LOC assessment. Completion of the LOC then established the start date for Waiver.
    - 12/29/2017: Application made.
    - 12/27/2017: Area Agency on Aging's LOC assessment was completed.
    - 1/23/2018: A doctor's letter was received by Area Agency, confirming LOC. This was thus the date that Applicant met all eligibility requirements for Medicaid LOC.
      - A Physician's signature on the JFS Form 03697, or alternative form, must be obtained within thirty calendar days, unless health and welfare is at risk, per OAC 5160-3-14(B)(3).
    - 7/3/2018: A second LOC assessment was completed. (There was a delay in the County's financial determination; presumably the second LOC assessment was to conform with the 30 day requirement.)
      - *7/2018*: Initial start date for Waiver services, as determined by the County.
      - *1/23/2018*: Actual start date (agreed to by all parties at Hearing).

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Start Date for Waiver: RMCP (A)

- Identifying the start date for a RMCP can be problematic. Effectively, the start date is when the applicant is "otherwise eligible" "but for" the RMCP.
- *Does this require an applicant to reside in a Medicaid bed… even though they will be privately paying during the anticipated RMCP?*
- Several Area Agency representatives have indicated that residing in an ODA-certified facility/unit/bed is not required to complete the LOC assessment, which (arguably) would provide an appropriate start date for the RMCP, as a doctor's letter could be completed. However, please note the following:
- CMS SMD Letter #18-004, dated 4/17/2018
  - This indicates that, to be "otherwise eligible," the individual must meet the criteria listed in OAC 5160-33-03, which requires *all* non-financial requirements to be met (including residing in an ODA-certified facility/unit/bed, and having an available waiver slot).
- Administrative Appeal: 3273243 (3/2018)
  - Applicant applied for Assisted Living Waiver. She did not live in an ODA-certified facility. It was determined that the Agency was correct to deny the application, and that the RMCP could not begin (as the Applicant was not "otherwise eligible.")

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Start Date for Waiver: RMCP (B)

- See also *Raymond Hein v. ODJFS*, CV-17-875068 (Cuyahoga County, 3/2018).
  - If the CDJFS does not determine financial eligibility in a timely manner (45 days), RMCP could be retroactive to the date that all non-financial requirements were met (presuming, of course, that verifications are provided in a timely manner, and that the applicant is ultimately determined to be "otherwise eligible" on a financial basis, but for the improper transfer). Presumably, this would be retroactive to the date the doctor's letter is received by Area Agency on Aging. This particular case dealt with a PACE application.
- As a final note, OAC 5160-31-03 was revised effective 1/1/2019, and now explicitly provides that, in order to enroll in PASSPORT services, the applicant cannot reside in a residential care facility (ie, an Assisted Living facility).
  - This means that an applicant cannot reside in a private pay AL and apply for PASSPORT (in order to receive services, or to begin RMCP).

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Start Date for LTC: RMCP

- Administrative Appeal: 3356241 (10/2018)
  - Applicant filed for LTC Medicaid in 2/2018. The nursing facility indicated to the County that it had been paid in full through 6/2018. The application was determined and approved in 6/2018. The Agency began the RMCP period as of 7/1/2018.
  - The Hearing Officer looked to OAC 5160:1-6-06.5(C)(2), and determined that July 1st was the appropriate date on which Applicant would otherwise be receiving LTC services, paid for by the Medicaid program, as the facility had already received full private payment up to that point.
  - This result indicates that, even when a RMCP is expected, *full* payment should not be made to the facility each month – at least, not until the application has been determined.

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New RMCP Calculation

OAC 5160:1-6-06.5 (1/25/2019)

- This rule revision provides for two main updates: (1) there is now an *initial* pro-rated period of restricted coverage; and (2) different rules apply to transfers completed by a Medicaid *recipient* (vs. a new applicant).
- For Applicants, RMCP no longer defaults to being the first day of the month. Rather, it is effective as of the actual calendar day on which the applicant is eligible for Medicaid *and* would otherwise be receiving Medicaid payment of LTC services.
  - This is expected to impact Applicants who have Medicare days that end mid-month, or who become institutionalized mid-month.
- For Recipients, RMCP will be effective on the first day of the month following the expiration of the required notice period under OAC 5101:6-2-04 (ie, notice to be provided at least 15 days prior to the effective date of the proposed adverse action).
  - If there is an existing RMCP, the new RMCP shall be applied consecutively.
- MEPL No. 138 (10/2018) addressed this policy change (and includes examples). Note that the actual rule update has an effective date of 1/25/2019.
  - Administrative Appeal 3420967 (5/2019) specifies that the current version of the rule is effective as of 1/25/2019.

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Snapshot Date for LTC (not HCBS)

- There has been recent clarification (and ODM Policy confirmation) regarding the Snapshot Date, used to calculate a CSRA for the Long Term Care Program.
- Federally, Snapshot should be "the beginning of the first continuous period of institutionalization (beginning on or after 9/30/1989) of the institutionalized spouse." See 42 U.S. Code 1396r-5(c). There is leeway for state interpretation.
- OAC 5160:1-6-01.1(A)(10) and 5160:1-6-04(E)(5), updated in 9/2017, clarify that the State of Ohio interprets this as literally being the first day *of the month* in which the first continuous period began.
  - Example: A previously healthy, married individual was admitted to a SNF on January 20th, 2019. He did not return home, and a LTC Medicaid application was made on March 28th, 2019. The snapshot date would be January 1st, 2019.
  - In some areas of Ohio, the date of January 20th would have been used, based on prior policy. Please note that ODM is completing training on this issue.

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CSRA & Improper Transfers

- Administrative Appeal: 3369109 (11/2018)
  - IS applied for Medicaid on 8/2017. The fact pattern is not well identified. However, the CSRA was effectively between $69k and $120k. CS transferred $150k to an Irrevocable Trust on 11/2017. The outcome indicates that the Agency imposed RMCP for the *entire* transfer to Trust ($150k).
  - The argument was made was that part of the $150k was the CSRA, and that that portion should not be considered an improper transfer. The following policy was stated:
    - "The decision determined there was no provision to apply the the (sic) CSRA to an improper transfer. Appellant's transfer to the irrevocable trust does not meet an any exemption and no rebuttal was established."
    - This argument focuses on OAC 5160:1-6-06, as the transfer was made "on or after the look-back date." See also CMS Letter SMDL #14-001.
  - Comparison point: AA 3064363, which supports the "separate assets" argument under OAC 5160:1-6-04; ie, that imposing RMCP based on a post-eligibility transfer (completed by the CS) would constructively treat the CS's assets as being "available" to the IS, and would therefore be impermissible.

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County of Residence & Application

OAC 5160:1-2-01 & 5160:1-3-05.13

- MEPL No. 135 (9/2018)
  - Essentially, "Intent to Return" to the Applicant's home establishes the home as their Principal Place of Residence. In turn, that establishes their County of Residence as being the County in which the home is located. Application should be made, and determined, in the County of Residence – not in the County where the Applicant's SNF is located.
  - There is an established intercounty transfer process identified, in MEPL No. 135 and in OAC 5160:1-2-01.
  - When applying for LTC for an individual who holds title to their residence, ensure that the following is identified for County intake:
    - Location of Applicant's home, and confirmation of County of Residence
      - Include a Statement of Intent to Return (if applicable)
    - Location and contact information for the Applicant's Skilled Nursing Facility or other institution
    - Mailing address for both the Applicant and the Authorized Representative

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Entrance Fees

Assisted & Independent Living

- Administrative Appeal: 3291847 (4/2018)
  - IS and CS moved into an independent living facility and paid an entrance fee; contractually, the entrance fee could be refunded, and was expected to be used to pay for certain future expenses, including assisted living or skilled nursing care. As a portion of the entrance fee remained at the time of application, the remainder was considered to be an available resource.
  - See OAC 5160:1-6-02.3(D).

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Life Insurance
Consider Dividends

- Administrative Appeal: 3366557 (10/2018)
  - Applicant had a life insurance policy with a Face Value of $1,000.00. However, there were also accumulated dividends of approximately $5,000.00. The accumulated dividends were determined to be countable under OAC 5160:1-3-05.12(F)(3)(b).
  - Such accumulations can be accessed by the policy owner without penalty and without affecting the policy's FV or CSV, and are a countable resource.
  - Dividend additions and paid-up additions are different. These additions serve to increase a policy's death benefit and CSV. If the policy is exempt, such additions are also exempt.
- Note: Dividends can also impact total gross income.
  - FV under $1,500.00? Ongoing dividends will count as income.
  - Countable policy? Dividends are excluded as income.

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Nursing Facilities & Surviving Spouses

- Embassy Healthcare v. Bell (slip opinion at 2018-Ohio-4912)
  - This originated in Warren County. The healthy spouse signed the admission agreement as the "Responsible Party;" however, the agreement stated that the Responsible Party was not personally liable. No estate was initially opened. Six months and three days after the ill spouse's death, the facility sent notice to the surviving spouse that it was seeking payment from the decedent's estate.
  - The Supreme Court of Ohio determined that a creditor must first present its claim for unpaid necessaries to the decedent's estate under R.C. 2117.06(C), *before* it can pursue a claim individually against the surviving spouse under R.C. 3103.03. Effectively, the decedent spouse (and their estate) retains primary liability for the unpaid debt.
  - ie, if the nursing facility does not properly present a claim within the six-month statute of limitations, it cannot later take action against the surviving spouse under Ohio's necessaries statute.

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Spousal Impoverishment Protections
Extended to September 2019 for HCBS

- Without SIR, the combined assets and income of both the IS and the CS are attributed to the IS, as part of determining eligibility.
- SIR has been required for Medicaid's LTC Program since 1988. However, for HCBS, it was merely optional (and actually unavailable to some groups). This changed when Section 2404 of the Patient Protection and Affordable Care Act of 2010 took effect in 2014. This (temporarily) required states to apply SIR to HCBS waiver programs.
- The Medicaid Services Investment and Accountability Act of 2019 became Public Law No. 116-16 on 4/18/2019, and served to extend these required protections until 9/30/2019.
- Without further extensions, this will revert to being optional, and would require States to follow the steps outlined in the 11/9/2018 CMCS Informational Bulletin "CIB HCBS Sunset." States will effectively be required to apply for a section 1115 demonstration project, or amend an existing 1115, in order to continue applying SIR to HCBS on a broad basis.

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Managed Care Plan Appeals

- <u>Administrative Appeal: 3453270 (5/2019)</u>
  - An individual requested a State Hearing. The Hearing request was denied, as the appeal resolution process through the Managed Care Plan must be completed before a State Hearing can be requested.
  - The Managed Care program reported to the State Hearing Bureau that the individual had not yet exhausted the appeal resolution process through them.
  - See: OAC 5101:6-3-01(B)(10) and 5160-26-08.4(D).
  - Effectively, if the MCP appeal resolution process is *not* wholly resolved in the individual's favor, the written notice of the same must include information as to how to request a State Hearing. Note also that if the MCP's adverse benefit determination is upheld at the state hearing, the individual "may be liable for the cost of any continued benefit."

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SHARE: State Hearing Bureau

- State Hearing Access to Records Electronically (SHARE) is now available at: https://hearings.jfs.ohio.gov/SHARE/
- This portal requires an Ohio Benefits username and password.
- The state pamphlet is JFS 08039, which was revised 3/2019 and is not readily available. The website is up and running.
- This portal offers the ability to request a state hearing, withdraw a state hearing request, find out the status of a hearing, upload documents, and access hearing documents.
- OAC 5101:6-3-02, revised 1/1/2018, specifies that Authorized Representatives may request State Hearings via email, fax, or mail (not via phone), and requires a copy of the written authorization to be attached. At this time, I am unaware as to the exact restrictions for an AR's use of the SHARE portal.

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Medicaid Estate Recovery

- Joe McCandlish has transitioned into Bob Byrne's position.
  - joseph.mccandlish@ohioattorneygeneral.gov
    - Ohio Attorney General, Collections Enforcement Section
    - 614-466-8459
    - No Claim Requests: 614-779-0105

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Form Updates

- Form JFS 07200: Application for Cash, Food, or Medical Assistance, updated 10/2018.
  - Page 1, Section 2, *must* be completed to indicate which programs are being applied for. If "Medical Assistance" is not marked, it will not be considered an application for LTC Medicaid (etc).
- Form ODM 02399: Request for HCBS Waiver, updated 8/2018.
  - Submit together with Form JFS 07200.
- Form ODM 07408: Notice to MER regarding transfer under TOD, updated 7/2018.
  - This form is now mailed directly to MER (and is not provided to, or kept on record by, the County Recorder's Office). Note that future title transfers may require verification that this notice was submitted.

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Specialized Recovery Services

SRS Program

- This program was created in 8/2016, to assist with coverage concerns for Severe Persistent Mental Illness (SPMI) and End-Stage Renal Disease (ESRD), following Ohio's transition to a 1634 State. The program remains in flux; effectively, however, it offers access to service coordination and community support activities (covered by Medicaid).
- Non-financial eligibility evaluations are completed by CareStar, the Council on Aging of Southwest Ohio, and CareSource. Financial eligibility is determined by the County.
- Effective 7/1/2018, OAC 5160:1-5-07 was amended to remove the requirement for an individual to be *in receipt* of Social Security Disability Insurance (SSDI) benefits or Supplemental Security Income (SSI) benefits, to be eligible for the SRS program.
- The rule was also amended to clarify that diagnosed chronic conditions individuals over age sixty-five, and those with ESRD, do not require an actual disability determination.

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2019 Medicaid Updates

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