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From your editors

As many of you know, the Deficit Reduction Act has, for better or worse, finally come to Illinois. The official rules have been published. This Act has far-reaching effects for all elder law practitioners and most estate planners. The Elder Law Section Council is planning a CLE event to help everyone learn about the new Rules. These rules can be found at <http://ilsos.net/departments/index/register/home.html>. In this issue, we have the first part in a three-part series that goes into great depth on these new rules, and a shorter, quick reference guide to the changes. We think you will find these extremely helpful.

As editors, we are interested in what you, our readers, want to learn about in upcoming issues. Please let us know what are interested in or would find helpful in your practice. We welcome your e-mails.

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Implementation by the Illinois Department of Health and Family Services of the Federal Deficit Reduction Act of 2005

By Anthony Ferraro

I. Introduction

This is an article summarizing the implementation by the Illinois Department of Health and Family Services (Department) of the Federal Deficit Reduction Act of 2005 (DRA). Much has been written about these rules over the last several years by various members of the Elder Law Section Council and also other Section Councils. This article will deal mainly with the final rules as adopted in the State of Illinois (ILDRA).

This article will be issued in three parts, which will be found in three issues of the Section Council newsletter.

The *first part* will deal with the scope of the federal changes and five specific areas of Illinois law that have been impacted by the new Illinois rules. The *second installment* will deal with six more areas in Illinois law that have been changed. The *third and final installment* will deal with the last three areas of Illinois law that have been changed by the adoption of these new rules.

The author struggled with the choice of either making this article a short, cursory discussion of the DRA or a long version discussing the DRA and related rules in greater detail. Through discussion with the newsletter staff, we opted for the longer discussion. The reason for this decision is that a short discussion would not address the numerous issues and nuances found in the new provisions and, thus, be rather useless to a practitioner. The longer version, while more time-consuming to digest and use, will hopefully provide a way of

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***(Notice to librarians:** The following issues were published in Volume 16 of this newsletter during the fiscal year ending June 30, 2011: August, No. 1; October, No. 2; February, No. 3 June, No. 4).*

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Implementation by the Illinois Department of Health and Family Services of the Federal Deficit Reduction Act of 2005

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reading the new law that is, perhaps, slightly more convenient than reading the statue itself, while not glossing over or missing any of the nuances and issues on which our clients' cases often turn. This was our intention.

Further, it should be noted that much of this article deals with changes that were not part of the DRA. However, because the practitioner reading this article is presumably interested in the Illinois Administrative Rules dealing with long-term care cases and how they are impacted by DRA, a discussion of some of the provisions not mandated by DRA, but nevertheless inserted into this rule change by the state of Illinois, will also be discussed for a more for complete discussion that is relevant for the practitioner.

II. Scope of Federal Changes

In the federal DRA, the following 14 topical areas were addressed:

1. LOOKBACK PERIOD EXTENDED TO FIVE YEARS
2. COMMENCEMENT DATE OF PENALTY PERIOD
3. UNDUE HARDSHIP
4. DISCLOSURE AND TREATMENT OF ANNUITIES
5. INCOME–FIRST
6. HOME EQUITY CAP UNDER THE DRA
7. IMPLICATIONS OF THE CCRC PROVISIONS OF THE DRA
8. OTHER OPERATIONAL CHANGES TO THE IMPOSITION OF TRANSFER PENALTIES
9. REQUIREMENT TO IMPOSE PARTIAL MONTHS OF INELIGIBILITY
10. ACCUMULATION OF MULTIPLE TRANSFERS
11. PROMISSORY NOTES, LOANS AND MORTGAGES
12. INCLUSION OF TRANSFERS TO PURCHASE LIFE ESTATES
13. EXPANSION OF STATE LONG-TERM CARE PARTNERSHIP PROGRAM
14. EFFECTIVE DATES FOR PROVISIONS OF THE DRA

The effect of these **federal** rules has been discussed in numerous articles written by authors within the state of Illinois and nationwide. As you will recall, the Federal Deficit Reduction Act was passed and signed by President Bush on February 8, 2006. By contrast, the effective date for the implementation of the **Illinois** version of the DRA is January 1, 2012.

The author would like to point out that one cannot simply look in the Illinois Administrative Rules and find these topical areas readily available for discussion as they are listed above. Rather, the content of the above rules is weaved into the Illinois Administrative Rules sections listed below.

III. Scope of Illinois Changes

To understand the impact of the DRA on the sections of the Illinois Administrative Rules that will be affected by the implementation of the Illinois rules by HFS, see the new Illinois rules at Title 89, part 120 of the Illinois Administrative Code. Below is a list of the sections that are affected. Some of the sections are affected in small part, while some are affected in large part. Some sections have been deleted in their entirety and are noted below.

Find Discussion of the following Sections in Installment One:

SUBPART B: ASSISTANCE STANDARDS

Section 120.10 Eligibility for Medical Assistance
Section 120.20 MANG (AABD) Income Standard
Section 120.40 *Repealed*

SUBPART C: FINANCIAL ELIGIBILITY DETERMINATION

Section 120.60 Community Cases
Section 120.61 Long Term Care
Section 120.62 *Repealed*
Section 120.63 *Repealed*
Section 120.65 *Repealed*

SUBPART H: MEDICAL ASSISTANCE–NO GRANT (MANG) ELIGIBILITY FACTORS

Section 120.308 Client Cooperation

Find Discussion of the following Sections in Installment Two:

Section 120.347 Treatment of Trusts and Annuities
Section 120.380 Resources
Section 120.379 Provisions for the Prevention of Spousal Impoverishment
Section 120.381 Exempt Resources
Section 120.382 Resource Disregard

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Section 120.384 Spenddown of Resources

Find Discussion of the following Sections in Installment Three:

Section 120.385 Factors Affecting Eligibility for Long Term Care Services

Section 120.387 Property Transfers Occurring on or After August 11, 1993 and Before January 1, 2007

Section 120.388 Property Transfers Occurring On or After January 1, 2007

SUBPART I: SPECIAL PROGRAMS

Section 120.TABLE B - Repealed

As shown above, the list of Illinois changes seem as though they are a moderate overhaul of the prior Medicaid rules. However, the devil is in the details, and the remainder of this series of articles will deal with the above Illinois Administrative Rules sections that, in many cases, are replete with massive changes to the way Medicaid will be administered for long-term care in the State of Illinois. A numerical approach will be used to trace the above listed changes.

IV. DETAILED ANALYSIS

Following is a discussion of changes in the Illinois Administrative Rules based on Illinois interpretation of the federal DRA.

Section 120.10 Eligibility for Medical Assistance. This is not part of DRA specifically, but is telling in that subsections (a)–(g) provide that financial eligibility for medical assistance for persons will be determined depending on their status for Medicaid.

This Section is careful to distinguish between persons receiving medical assistance while *living in the community*, and financial eligibility for medical assistance for purposes of persons *receiving long term care services*. The various rules are directed to certain MANG (Medical Assistance–No Grant) programs, such as AABD (Aid to Aged Blind and Disabled), and TANF (Temporary Assistance for Needy Families).

MANG means Medical Assistance – No Grant. Virtually all cases coming to elder law attorneys are of this type. These types of cases should be distinguished from MAG which is Medical Assistance – Grant. Rarely are these latter cases see by elder law attorneys, at least in the author's experience.

It should also be noted that discussion pertaining to TANF cases will also be "intentionally omitted" (IO) since the elder law attorney is not often concerned with cases of that type. Rather we will focus on AABD type cases which refers to Assistance to Aged, Blind and Disabled. The elder law attorney sees these types of cases frequently.

In subsection (a), the basic proposition is that *eligibility for medical assistance* exists when a person meets nonfinancial requirements of the program and the person's countable nonexempt income is equal to or less than the MANG standard. Also, going one step further, in AABD cases, the state requires that the person's nonexempt resources are not in excess of the applicable resource disregards found at Section 120.382, which is generally $2,000 for a person.

Financial eligibility for medical assistance for *other persons or family units living in the community* is determined according to Section 120.60, discussed hereafter.

Financial eligibility for medical assistance for *persons receiving long-term care services*, as defined in Section 120.61(a), is determined according to Section 120.61(a).

Subsection (b) of Section 120.10 provides that, for AABD cases, a person's *countable income and resources* include the person's countable income and resources and the countable income and resources of all persons included in the Medical Assistance Standard. The person's responsible relatives living with the child must be included in the standard. The person has the option to request that a dependent child under 18 in the home who is not included in the MANG unit be included in the MANG standard.

Subsection (c) provides for TANF. TANF discussion is intentionally omitted (IO) by the author for the remainder of this article.

The next two subsections address the concept of spenddown obligation in the case of both AABD and TANF-type cases.

Subsection (d) provides that, for AABD cases, if a person's countable nonexempt income is greater than the applicable MANG standard *and/or* countable nonexempt resources are over the applicable resource disregard, the person must meet the spenddown obligation determined for the applicable time period before becoming eligible to receive medical assistance.

Subsection (e) provides that, for TANF cases, (IO)

Next, subsection (f) provides that a *one-month eligibility period* is used for persons receiving long-term care services. Nonexempt income and nonexempt resources over the resource disregard, described in Section 120.382 (discussed later in this article), are applied toward the cost of care on a monthly basis, which means they must be used and contributed to the cost of care.

Subsection (g) deals with newborns and their status in TANF or a AABD cases.

Section 120.20 MANG (AABD) Income Standard. This is not part of the DRA, but this provision indicates that the *monthly countable income standard* is 100% of the Federal Poverty Level Income Guidelines.

Section 120.40 Exceptions To Use Of MANG Income Standard. This Section was *repealed*.

Section 120.60 Community Cases. This is not part of DRA, and is a very long section. This Section applies to persons or family units who reside in the community or community-based residential facilities or settings (such as Community Living Facilities, Special Home Placements, Home Individual Programs, or Community and Residential Alternatives).

The discussion of incurred medical expenses that are defined in this section apply to the initial eligibility step for long-term care cases described previously in Section 120.10.

Because this Section is so long and much of it deals with limited circumstances that will not be relevant to the practitioner on a day-to-day basis, the discussion of some of its provisions is curtailed below. The reader may always refer to the Administrative Rules for a more complete and exhaustive analysis of these provisions.

Subsection (a) provides for the determination of when the eligibility period shall begin for community cases. The *eligibility period shall begin* with:

1. the first day of the month of application;
2. the first day of any month, prior to the month of application, in which the person meets the financial and non-financial eligibility requirements for up to three months prior to the month of application; OR
3. the first day of a month, after the month of application, in which the person meets the non-financial eligibility requirements.

Subsection (b) provides for eligibility *without spenddown* for MANG cases, and breaks down the cases between AABD cases and TANF cases.

1. For an AABD case, if the person's countable income during the eligibility period is equal to or below the applicable AABD

income standard *and* nonexempt resources are not in excess of the applicable resource disregard (see Section 120.382), the person is eligible for medical assistance from the first day of the eligibility period. The Department will pay for covered services during the entire eligibility period.

2. For a TANF case, IO.
3. This paragraph indicates that the person is responsible for reporting any changes that occur during the eligibility period that might affect eligibility for medical assistance. If changes occur, appropriate action shall be taken by the Department, including termination of eligibility for medical assistance. If changes in income, resources or family composition occur that would make the person a spenddown case, then a spenddown obligation will be determined and subsection (c) of Section 120.60 will apply.
4. A redetermination of eligibility will be made at least every 12 months.

Subsection (c) addresses eligibility *with spenddown* for MANG cases, both AABD and TANF. This is a long section that has 9 parts. We will discuss only those provisions that seem most relevant to the practitioner on a daily basis and just briefly discuss those other provisions that do not seem to have as much day-to-day relevance for most practitioners.

1. For AABD community cases, if the person's countable nonexempt income available during the applicable eligibility period is greater than the applicable AABD income standard *and/or* nonexempt resources are over the applicable resource disregard, the person must meet the spenddown obligation determined for the eligibility period before becoming eligible to receive medical assistance. The spenddown obligation is the amount by which the person's countable income exceeds the MANG AABD income standard and/or the amount of nonexempt resources in excess of the applicable resource disregard (see Section 120.384).
2. For TANF cases, IO.
3. A person meets the spenddown obligation by incurring or paying for medical expenses in an amount equal to the spenddown obligation. Persons also have the *option* of meeting their income or resource spenddown by paying or having a third party pay the amount of the spenddown obligation to the Department.
   A. Incurred expenses are expenses for medical or remedial services:
      i. recognized under state law;
      ii. rendered to the person, the person's family or a financially responsible relative;
      iii. for which the person *is* liable in the current month for which eligibility is being sought or *was* liable in any of the 3-month retroactive eligibility period described in subsection (a) of this Section; and
      iv. for which no third party is liable in whole or in part unless the third party is a State program.
   B. Incurred medical expenses shall be applied to the spenddown obligation in the following order:
      i. Expenses for necessary medical or remedial services, as funded by DHS or the Department on Aging from sources other than federal funds. The expenses shall be based on the service provider's usual and customary charges to the public. The expenses shall not be based on any nominal amount the provider may assess the person. These charges are considered incurred the first day of the month, regardless of the day the services are actually provided.
      ii. Payments made for medical expenses within the previous six months. Payments are considered incurred the first day of the month of payment.
      iii. Unpaid medical expenses. These are considered as of the date of service and are applied in chronological order.
   C. If multiple medical expenses are incurred on the same day, the expenses are applied in the following order:
      i. Health insurance deductibles (including Medicare and other co-insurance charges).
      ii. All copayment charges incurred or paid on spenddown met day.
      iii. Expenses for medical services and/or items not covered by the Department's Medical Assistance Program.
      iv. Cost share amounts incurred for in-home care services by individuals receiving services through the Department on Aging.
      v. Expenses incurred for in-home care services by individuals receiving or purchasing services from private providers.
      vi. Expenses incurred for medical services or items covered by the Department's Medical Assistance Program. If more than one covered service is received on the day, the charges will be considered in the order of amount. The bill for the smallest amount will be considered first.
   D. If a service is provided during the eligibility period but payment may be made by a third party, such as an insurance company, the medical expense will not be considered towards spenddown until the bill is adjudicated. When adjudicated, that part determined to be the responsibility of the person shall be considered as incurred on the date of service.
   E. AABD MANG spenddown persons may choose to pay or to have a third-party pay the amount of their spenddown obligation to the Department to meet spenddown. The following rules will govern when persons or third parties choose to pay the spenddown:
      i. Payments to the Department will be applied to the spenddown obligation after all other medical expenses have been applied per subsections (c)(3)(A), (B) and (C) of this Section.
      ii. Excess payments will be credited forward to meet the spenddown obligation of a subsequent month for which the person chooses to meet spenddown.
      iii. The spenddown obligation may be met using a combination of medical expenses and amounts paid.
4. This subsection provides for an additional eligibility determination for applications for medical assistance in cases eligible with a spenddown obligation that do not have a QMB (qualified Medicare ben-

eficiary) or MANG(P) member. This discussion is intentionally abbreviated by the author.

5. Cases with a spenddown obligation that do not have a QMB, a MANG(P) member or person on a waiting list or who would be on a waiting list to receive a transplant if he or she had a source of payment, will be reviewed beginning in the sixth month of enrollment. There are several other rules applying to these limited circumstances. This discussion is intentionally omitted by the author.
6. This subsection provides that the person is responsible for *reporting any changes* that occur during the enrollment period that might affect eligibility for medical assistance. If changes occur, appropriate action shall be taken by the Department, including termination of eligibility for medical assistance.
7. For MANG AABD cases, if *changes* in income, resources or family composition occur, appropriate adjustments to the spenddown obligation and date of eligibility for medical assistance shall be made by the Department. Notification requirements are set out as well.
   A. If income decreases, or resources fall below the applicable resource disregard and, as a result, the person has already met the new spenddown obligation, eligibility for medical assistance shall be backdated to the appropriate date.
   B. If income or resources increase and, as a result, the person has not produced proof of incurred medical expenses equal to the new spenddown obligation, the written notification of the new spenddown amount will also inform the person that eligibility for medical assistance will be interrupted until proof of medical expenses equal to the new spenddown obligation is produced.
8. For TANF cases, IO.
9. Reconciliation of Amounts Paid-in to Meet Spenddown.
   A. The Department will reconcile payments received to meet an income spenddown obligation for a given month against the amount of claims paid for services received in that month and refund any excess spenddown paid to the person. Excess amounts paid for a calendar month will be determined and refunded to the person six calendar quarters later. Refund payments will be made once per quarter.
   B. The Department will reconcile payments received to meet a resource spenddown obligation against the amount of all claims paid during the individual's period of enrollment for medical assistance. Excess amounts paid will be determined and refunded to the individual six calendar quarters after the individual's enrollment for medical assistance ends.
   C. When payments are received to meet both a resource and income spenddown obligation, the Department will first reconcile the amount of claims paid to amounts paid toward the resource spenddown. If the total amount of claims paid have not met or exceeded the amount paid to meet the resource spenddown by the time the individual's enrollment ends, the excess resource payments shall be handled per subsection (c)(3)(C) of this Section. Once the amount of claims paid equals or exceeds the amount paid toward the resource spenddown, the remaining amount of claims paid will be compared against the amount paid to meet the income spenddown per subsection (c)(3)(B) of this Section.
10. The Department will refund payment amounts received for any months in which the person is no longer in spenddown status and the payment cannot be used to meet a spenddown obligation. The payment amounts shall not be subject to reconciliation under subsection (c)(9) this Section. Refunds shall be processed within six months after the case status changed.

Again, the author would like to reiterate that there are numerous other new parts in this Section, but because they do not deal with DRA directly, they can be read at the reader's convenience.

Section 120.61 Long Term Care. While this Section is not part of the DRA, the purpose of it is to provide, in long term care cases, for initial eligibility steps and post-eligibility steps. Because this Section deals with long term care cases, we will go into more detail, as it seems to be relevant for most practitioners handling long term care cases in the practice of elder law.

Subsection (a) defines "long term care facility." It provides that a long term care facility is:

1. an institution (or a distinct part of an institution) that meets the definition of a "nursing facility", as that term is defined in 42 USC 1396r.
2. licensed Intermediate Care Facilities (ICF and ICF/DD), licensed Skilled Nursing Facilities (SNF and SNF/PED) and licensed hospital-based long term care facilities; and
3. Supportive Living Facilities (SLF) and Community Integrated Living Facilities (CILA). Note that the Department has added CILAs to this definition.

Subsection (b) states that the *eligibility period shall begin* with:

1. the first day of the month of application;
2. up to three months prior to the month of application for any month in which the person meets *both* financial and non-financial eligibility requirements. Eligibility will be effective the first day of a retroactive month if the person meets eligibility requirements at any time during that month; OR
3. the first day of a month, after the month of application, in which the person meets non-financial and financial eligibility requirements.

The most controversial part of this subsection is that in order to obtain eligibility for any of the prior three months prior to the submission of the application, the state will require that persons meet the financial eligibility requirements *in any or all of the three prior months* if eligibility is sought for any or all of the three months prior to the month of application. While this is not specifically required by DRA, the Department is requesting this. This will affect residents who need to pay for expenses during the application process.

Subsection (c) addresses eligibility *without spenddown*.

1. This subsection indicates that a one-month eligibility will be used. If a person's

nonexempt income available during the eligibility period is equal to or below the applicable income standard AND nonexempt resources are not excess of the applicable resource disregard (described in Section 120.382), the person is eligible for medical assistance from the first day of the eligibility period *without a spenddown*.

2. This subsection goes on to say that if, during the eligibility period, there is any change from the initial calculations made, this *must be reported* to the Department. Specifically, if changes in income, resources or family composition occur that would make the person a spenddown case, a spenddown obligation will be determined and subsection (d) of this Section will apply.

Subsection (d) addresses eligibility *with spenddown*.

1. If countable income available during the eligibility period exceeds the applicable income standard *and/or* nonexempt resources exceed the applicable asset resource disregard, *a person has a spenddown obligation* that must be met before financial eligibility for medical assistance can be established. The spenddown obligation is the amount by which the person's countable income exceeds the income standard *or* the nonexempt resources exceed the applicable resource disregard.
2. A person meets the spenddown obligation by incurring or paying for *medical expenses* in an amount equal to the spenddown obligation. Medical expenses shall be applied to the spenddown obligation as provided in Section 120.60(c) of this Part. See prior discussion of Section 120.60(c).
3. Projected expenses for services provided by a long term care facility that have not yet been incurred, but are reasonably expected to be, *may also be used* to meet a spenddown obligation. The amount of the projected expenses is based on the private pay rate of the long term care facility at which the person resides or is seeking admission.
4. A person who has both an income spenddown *and* a resource spenddown cannot apply the same incurred medical benefits to both. Incurred medical expenses are *first applied* to an income spenddown.

The next two subsections discuss post-eligibility income and deductions.

Subsection (e) provides that, if non-financial and financial eligibility is established, a person's total income, including income exempt and disregarded in determining eligibility, must be applied to the cost of the person's care, minus applicable deductions provided under subsection (f) of this Section.

Subsection (f) describes various deductions that can be used to reduce post-eligibility income. The effect of the deductions is that they increase the amount which the Department will pay for residential services on behalf of the person, up to the Department's payment rate for the facility (approximately $3,500 per month). The deductions that are contemplated are:

1. certain SSI benefits;
2. a personal needs allowance (usually $30 per month);
3. the community spouse income allowance ($2,739 in 2011);
4. a family allowance;
5. an amount to meet the needs of qualifying children under age 21 who do not reside with either parent, who do not have enough income to meet their needs and whose resources do not exceed the resource limits;
6. amounts incurred for certain Medicare and health insurance costs not subject to payment by a third party;
7. certain expenses not subject to third party payment for "necessary medical care" recognized under state law, but not a covered service under the Medical Assistance Program. The term "necessary medical care" has the meaning described in 215 ILCS 105/2 and must be proved as such by a prescription, referral or statement from the patient's doctor or dentist. The following are allowable deductions from a person's post-eligibility income for medically necessary services:
   A. expenses incurred within the six months prior to the month of an application, provided those expenses remain a current liability to the person and were not used to meet a spenddown. (The author understands that there may be some controversy in limiting medical expenses to those incurred within the six-month period prior to the month of application. It will remain to be seen how this will be resolved.) Medical expenses incurred during a period of ineligibility resulting from a penalty imposed under Section 120.387 or 120.388 of this Part are not an allowable deduction;
   B. expenses incurred for necessary medical services from a medical provider, so long as the provider was not terminated, barred or suspended from participation in the Medical Assistance Program at the time the medical services were provided; and
   C. expenses for long term care services, subject to the limitations of this subsection (f)(7) and provided that the services were not provided by a facility to a person admitted during a time the facility was subject to the sanction of non-payment for new admissions.
8. Certain expenses to maintain a residence in the community for up to six months, when the person does not have a spouse and/or dependent child, and the physician has certified that the stay in the facility is temporary and the individual is expected to return home within six months. The amount of the deduction must be based on the rent or property expense allowed under the AABD MANG standard if the person was at home and the utility expenses that would be allowed under the AABD MANG standard if the person was at home.

Sections 120.62, 63, and 65. These Sections were repealed. With regard to Section 120.65, it should be noted that, before this rule was repealed, persons living in Community Integrated Living Arrangements (CILAs) were treated as living in the community. With this Section being repealed by this rule change, those persons will now be treated as long term care cases and provisions dealing with asset transfers and resource limitations will now apply to this group.

SUBPART H: MEDICAL ASSISTANCE – NO GRANT (MANG) ELIGIBILITY FACTORS

Section 120.308 Client Cooperation.

This section is not part of the DRA, but it should be discussed. The thrust of this Section in subparagraphs (a)-(h) is to set out the terms of cooperation that an applicant is required to demonstrate and what coopera-

tion is expected by HFS.

Subsection (a) provides that cooperation by applicants is required in the determination of eligibility, including the acquisition and verification of information upon which eligibility may depend, and applying for all financial benefits for which they may qualify and to avail themselves of those benefits at the earliest possible date.

Subsection (b) provides that clients are to avail themselves of all potential income and resources and to take appropriate steps to access and receive these resources, including those steps to be taken by the person's spouse as later set out in Section 120.388(d)(2).

Subsection (c) states that, when eligibility cannot be conclusively determined because the individual is unwilling or fails to provide essential information or to consent to verification, the client shall be ineligible.

Subsection (d) requires that, at screening, applicants shall be informed, in writing, of any information they are to provide at the eligibility interview.

Subsection (e) provides that, at the eligibility interview, or at any time during the application process, when the applicant is requested to provide information in his or her possession, the Department will allow 10 days for the return of information requested by the Department. There are specific rules that describe the beginning and ending of the 10 day period. There are also rules for returning information to the Department when requested.

Subsection (f) states that, at the eligibility interview or at any time during the application process, when the applicant is requested to provide third party information, the Department shall allow 10 calendar days for the return of the requested information or for verification that the third party information has been requested. If the applicant does not provide the information or verification that the information was requested by the date on the information request form, the application shall be denied on the following work day.

1. Third party information is defined as information that must be provided by someone other than the applicant.
2. The Department shall advise clients of the need to provide written verification of third party information requests and the consequences of failing to provide that verification.
3. If the applicant requests an extension either verbally or in writing in order to obtain third party information and provides written verification of the request for the third party information, an extension of 45 days from the date of application shall be granted.
4. If an applicant's attempt to obtain third party information is unsuccessful, upon the applicant's request, the Department will assist in securing evidence to support the client's eligibility for assistance.

Subsection (g) requires that any information or verifications requested under this Section must be returned to the Department or its agent's office in the manner indicated on the information request form. Information mailed or otherwise delivered to an address not indicated on the form will not toll the timeframes for providing information under this Section.

Subsection (h) provides that failure to cooperate in the determination of eligibility under this Section, including failure to provide requested information or verifications, is a basis for the denial of an application for benefits. The Department goes on to provide somewhat of a safe harbor by indicating that the Department shall not deny an application:

- when the delay is beyond the control of the person following a timely request to the third party, or
- for failure to timely provide information in the applicant's possession if the person has made a good faith attempt to retrieve the information and is unable to do so due to incapacity, illness, family emergency or other just cause. ■

Editor's Note: This has been the first part of a three-part article on the new Illinois DRA regulations. The final two installments will be published in future editions of this newsletter.

Summary of DRA changes that will affect your clients and how you process their Medicaid applications

By Kerry R. Peck, Esq. and Diana M. Law, Esq.

It's been more than 18 months since we first met with the Department of Healthcare and Family Services to discuss the "new rules" that were coming to Illinois. Of course, as Medicaid planners and elder law attorneys, we knew the "new rules" meant implementation of the long-dreaded Deficit Reduction Act of 2005 (DRA). Due to the harsh nature of the proposed rules, we created and co-chaired the Task Force for Senior Fairness, a group of 25 elder law attorneys and other people knowledgeable in the area of Medicaid, to fight for Illinois Seniors and fair rules for Medicaid eligibility. The Task Force worked closely with the Illinois State Bar Association's Elder Law Section Council's Heather McPherson and their extremely competent lobbyists, Jim Covington and Lynne Davis.

After 18 months, countless hours of research, 60 pages of our written commentary on the proposed regulations, numerous meetings with the Department, lobbying the 12 Senators and Representatives serving on the Joint Committee on Administrative Rules (JCAR) and other legislators, eight trips to Springfield, two official hearings and several intense week-ends of eleventh hour negotiations has resulted in a very different set of rules that will become law on January 1, 2012.

The new rules are compliant with the DRA but also go beyond just DRA rules. The new regulations are harsher than current rules and require the practitioner to be aware of how this impacts your clients and the future of your elder law practice. Here is a summary of the major changes beginning in the New Year:

1. **Disclosure:** The "Look-back" period will increase from 36 months to 60 months;
2. **Asset Limit**: The applicant that applies with more than $2,000 in total assets will be put in a spend-down. However, any penalty will not begin until the spend-down has been met and the applicant is down to just $2,000 in assets;
3. **Non-allowable transfer and penalty periods**: All non-allowable transfers will be accumulated and brought forward. The penalty period will not begin until the applicant is "otherwise eligible" which is defined as "institutionalized and would be otherwise eligible for Medicaid";
4. **Penalty Period**: The penalty period begins with the LATER of:
   a. the first day of the month during which a transfer for less than fair market value is made; or
   b. the date on which the person is eligible for medical assistance and would otherwise be receiving long term care services were it not for the imposition of the penalty period and the spenddown has been met;
5. **There will be no "round down" for penalties**: The penalty period will be determined by dividing the total assets transferred by the average monthly cost of the facility where the applicant resides at the time of application. The new rules allow the penalty period to be calculated to the half of a day. For example, if $65,000 was transferred and the cost of care is $4,000, the penalty would be 16.25 or 16 months and 7.5;
6. **Multiple transfers are accumulated and treated as a single transfer**: Multiple, non-allowable transfers are cumulated and treated as a single transfer. One period of ineligibility will be calculated to determine the length of the penalty period. Once the penalty has been determined by the Department, it continues to run without regard to whether or not the applicant continues to receive long-term care services;
7. **Retroactivity and Hardship Waivers**: The new rules will be retro-active, meaning future applicants who made transfers prior to January 1, 2012 will be judged not according to the rules that were in place at the time they made the transfer but according to the new, harsher rules. However, any applicant who signs an affidavit stating that they relied on the rules that were in place at the time of the transfer will be granted an undue hardship waiver for transfers made prior to November 1, 2011.
8. **Hardship Waivers**: The rules require that the Department shall waive penalty period (or a portion thereof) if the applicant will have an undue hardship due to the penalty period. An undue hardship exists when the applicant would be deprived of the following:
   a. medical care that would endanger their life or health; or
   b. food, clothing, shelter, or other necessities of life.

   The applicant has the burden of proof that the actual, not just possible, hardship exists and the Department may require written evidence to substantiate that the transfers which created the penalty were not done on the applicant's own accord. (i.e., you can't get a waiver if you created the hardship). The following criteria may be considered by the Department: whether legal action has been taken to recover the assets and the medical condition, mental capacity and financial ability of the applicant at the time the assets were transferred. Other evidence that may help the applicant is if they will be forced to move if denied eligibility for Medicaid and/or if they would be prohibited from joining their spouse in a facility or living in close proximity to their family;
9. **Transfers and the Community Spouse**: If a transfer made by the community spouse creates a penalty period for the institutionalized spouse and the community spouse subsequently becomes institutionalized and is otherwise eligible for medical assistance, the penalty will be split equally between the spouses. However, if one spouse predeceases during the penalty period, the remaining penalty will be added to the surviving spouse's penalty;
10. **Home Equity Limit**: The limit for the applicant's equity interest in his or her home is limited to $750,000. Any lien or mortgage can offset the equity value of the home. Farmland is exempt if the land is being farmed and producing an income;
11. **Life Estate**: Under old rules, an applicant could buy a life estate in someone else's property and this was a purchase for fair market value, even if the life es-

tate owner never lived in that property. Under the new rules, such a purchase would be a non-allowable transfer **unless** the person resided in the property for one full year. This does not mean that an applicant can buy the life estate, live in the property for one year and then be free and clear. It simply means that the transfer is for fair market value and will not be included in the non-allowable transfers category.

12. **Care-taker child exemption**: The criteria for an exempt transfer of homestead property to the caretaker child has increased. The caretaker child still needs to care for their parent at least two years prior to the date the parent became institutionalized but they also need to provide evidence that:
    a. The applicant needed care that would otherwise required an institutional level of care. This proof can be met with a physician's statement or other medical professional. Interestingly enough, the rules allow a diagnosis of Alzheimer's or other dementia related illness to be prima facie evidence that the applicant required an institutionalized level of care; AND,
    b. Proof of the child resided with the person for two years immediately prior to the applicant's institutionalization (such as tax returns, driver's license, cancelled checks, etc.); AND
    c. Proof that the care provided by the child prevented the institutionalization of the parent. This may be met with a sworn affidavit or statement signed by the caretaker child.
13. **Personal Care Agreements**. Under the new rules, there will be heightened scrutiny when an applicant has paid a friend or family member for care. The rules have a presumption that services, care or accommodations are, "gratuitous and without expectation of compensation." An applicant will not only be penalized for paying for any past care without a written agreement. Furthermore, if care was provided for a loved one for "free" in the past and there was a change which led the applicant to begin to pay for that same care, it will be considered a transfer for less than fair market value without credible documentary evidence that pre-exists the delivery of care. Again, this is one area that is remains hyper-technical and an impossible hurdle to overcome - how would an applicant have credible documentary evidence that pre-exists the delivery of care?
14. **Pre-Paid Burial Contracts**: are limited to a $10,000 limit for goods and services. Note: although the HFS rules have been approved by JCAR, the funeral home industry continues to strongly lobby against this limit. This may be changed by rulemaking in the near future;
15. **3-month Backdating:** The Department will take a separate snapshot of the assets in each of the backdated months. Only medical costs, burial contract and up to $10,000 of attorney fees will be allowed to reduce the amount of assets in the backdated months. For example, if applicant has $12,000 in January, purchases a burial plan for $8,000 and pays legal fees in the amount of $2,000 prior to applying for Medicaid in April, this applicant should be eligible to receive Medicaid for the three months prior to April despite having more than $2,000 of assets;
16. **Non-homestead real property:** Non-homestead real property, which includes the homestead if it is no longer exempt, is considered available. Farmland which produces income is exempt under the new rules. If the homestead is listed for sale, it is exempt (but will be liened). If the homestead is being rented, it must be producing annual income that is not less than 6% of the person's equity interest. For example, a house worth $150,000 must be bringing in annual rent of $9,000 in order to be considered unavailable for Medicaid purposes;
17. **Return of Assets to the Applicant**: There will be **no credit** under the new rules for partial returns. As discussed above, if there was a partial return that was done in reliance upon current rules prior to November 1, 2011, there is the possibility of obtaining a hardship waiver to shorten the penalty. However, going forward under the new rules, the applicant will not receive credit for a partial return, they will only receive credit for a full return of gifted assets;
18. **Medicaid Qualifying Annuities (MQA)**: MQAs must still meet all of the current requirements such as no cash value, non-assignable, equal monthly payments and must not be for longer than the annuitant's life expectancy. But now, the State must be named as a remainder beneficiary after the community spouse or adult disabled child, if any;
19. **Promissory Notes**: Promissory Notes will be allowed within certain criteria, but providing required proof of applicant's tangible, verifiable record of consistent, timely payments could be problematic;
20. **Transfers of Income**: Transfers of income in the month it is received will no longer be an exempt transfer;
21. **Refusal to Disclose**: If the community spouse refuses to disclose his or her assets, the institutionalized spouse must assign to the State any right of support from the community spouse. The State may pursue any legal means in order to determine the community spouse's Administrative Support Obligation. While some practitioners read the new rules to create no change from the current rules regarding this issue, we believe we will have to "wait and see" what the changes in the refusal to disclose regulations bring, practically speaking, from the Department. ■

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Upcoming CLE programs

To register, go to www.isba.org/cle or call the ISBA registrar at 800-252-8908 or 217-525-1760.

January

Thursday, 1/5/12- Teleseminar—Estate Planning in 2012: Now That the Federal Tax is a Dead Letter, Part 1. Presented by the Illinois State Bar Association. 12-1.

Friday, 1/6/12- Teleseminar—Estate Planning in 2012: Now That the Federal Tax is a Dead Letter, Part 2. Presented by the Illinois State Bar Association. 12-1.

Tuesday, 1/10/12- Teleseminar—Dangers of Using "Units" in LLC Planning. Presented by the Illinois State Bar Association. 12-1.

Friday, 1/13/12- Teleseminar—Bridging the Valuation Gap: "Earnouts" and Other Techniques. Presented by the Illinois State Bar Association. 12-1.

Tuesday, 1/17/12- Teleseminar—Real Estate Finance in A World With Tight Credit and Less Leverage. Presented by the Illinois State Bar Association. 12-1.

Wednesday, 1/18/12- Live Studio Webcast—Step-by-Step Appeals in Child Custody. Presented by the ISBA Child Law Section; co-sponsored by the ISBA Family Law Section. 11-1.

Thursday, 1/19/12- Teleseminar—Ethics, Technology and Solo and Small Firm Practitioners. Presented by the Illinois State Bar Association. 12-1.

Friday, 1/20/12- Teleseminar—Rescission in Business Transactions: Techniques for Fixing Transactions Gone Awry. Presented by the Illinois State Bar Association. 12-1.

Friday, 1/20/12- Chicago, ISBA Chicago Regional Office—Practical Professional Responsibility for Health Care, Life Sciences and Corporate Attorneys and their Outside Counsel. Presented by the ISBA Health Care Section. 1-4:15.

Friday, 1/20/12- Collinsville, Gateway Center—Motion Practice. Presented by the ISBA Tort Law Section. 9-12. Max 66.

Tuesday, 1/24/12- Teleseminar—Incentive Trusts: Approaches and Limits to Encouraging "Good" Behavior in Beneficiaries. Presented by the Illinois State Bar Association. 12-1.

Thursday, 1/26/12- Chicago, Union League Club—Making the Record on Appeal and Ethics and Civility in the Court Room. Presented by the Illinois State Bar Association, the Illinois Judges Association and the Women's Bar Association of Illinois. 1:30-4:55 CLE; 5-6:30 Reception.

Friday, 1/27/12- Collinsville, Gateway Center—Motion Practice. Presented by the ISBA Tort Law Section. 9-12. Max 75.

Friday, 1/27/12- Teleseminar—Drafting Effective and Enforceable Promissory Notes. Presented by the Illinois State Bar Association. 12-1.

Tuesday, 1/31/11- Teleseminar—Choice of Entity for Service Businesses, Including Law Firms. Presented by the Illinois State Bar Association. 12-1.

February

Thursday, 2/2/12- Teleseminar—2012 Ethics Update, Part 1. Presented by the Illinois State Bar Association. 12-1.

Friday, 2/3/12- Bloomington, Holiday Inn & Suites—Hot Topics in Agricultural Law 2012. Presented by the ISBA Agricultural Law Section. 9-4:45. Max 150.

Friday, 2/3/12- Teleseminar—2012 Ethics Update, Part 2. Presented by the Illinois State Bar Association. 12-1.

Tuesday, 2/7/12- Teleseminar—Estate Planning for the Elderly, Part 1. Presented by the Illinois State Bar Association. 12-1.

Wednesday, 2/8/12- Teleseminar—Estate Planning for the Elderly, Part 2. Presented by the Illinois State Bar Association. 12-1.

Thursday, 2/9/12- Chicago, ISBA Chicago Regional Office—Nuts and Bolts of Starting Your Own Practice: A Primer for Ethically Creating Your Own Law Firm. Presented by the ISBA young Lawyers Division. 12:30-5:00.

Friday, 2/10/12- Chicago, ISBA Chicago Regional Office—Limited Representation: The Ethical, Legal and Practice Issues Exposed. Presented by the ISBA Law Office Management and Economics Committee and the ISBA General Practice Solo and Small Firm Section. 8:30-12:45.

Tuesday, 2/14/12- Teleseminar—Compensation & Other Techniques for Getting Money Out of a Closely Held Business. Presented by the Illinois State Bar Association. 12-1.

Thursday, 2/16/12- Teleseminar—Ethics Issues for Lawyers Supervising Other Lawyers and Paralegals. Presented by the Illinois State Bar Association. 12-1.

Monday, 2/20/12- Chicago, ISBA Chicago Regional Office—Advanced Worker's Compensation- Spring 2012. Presented by the ISBA Worker's Compensation Law Section. 8:30-4:00.

Monday, 2/20/12- Fairview Heights, Four Points Sheraton—Advanced Worker's Compensation- Spring 2012. Presented by the ISBA Worker's Compensation Law Section. 8:30-4:00.

Tuesday, 2/21/12- Teleseminar—Negotiating and Drafting the Purchase of Bank-Owned Commercial Real Estate. Presented by the Illinois State Bar Association. 12-1.

Thursday, 2/23/11- Chicago, ISBA Chicago Regional Office—Family Law- Rookie Camp 2012. Presented by the ISBA Family Law Section. 8-5.

Saturday, 2/25/12- Oakbrook, Doubletree Chicago—DUI, Traffic, and Secretary of State Related Issues- 2012. Presented by the ISBA Traffic Laws and Courts Section. 9-4:30. Max: 175.

March

Thursday, 3/1/12- Chicago, ISBA Chicago Regional Office—eTechnology in the Courthouse: Present and Future. Presented by the ISBA Bench and Bar Section. 1:30-4:45 ■

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