DEFRA of 2005:
Impact on Medicaid, One Year Later

This training will cover changes under the Federal Deficit Reduction Act (DRA) of 2005, such as asset transfer rules and citizenship documentation requirements. The session includes lecture with slide presentation, allowing for group discussion, as well as time allotted for questions and answers.

I. Long-Term Care Medicaid Eligibility Changes

The DRA amends Section 1917 of the Social Security Act (the Act) to change asset transfer rules, require the disclosure of annuities and count as an available resource certain entrance fees for continuing care retirement communities and life care community admission contracts. The DRA also amends Section 1919 of the Act to impose a home equity limit for applicants of nursing facility services and community-based long-term care services.

II. Background and Overview of DRA 2005 — 30 Minutes

A. Changes in Long-Term Care Eligibility Required by OBRA 93

B. Changes in Long-Term Care Eligibility Required by DRA 2005

1. Lengthened Look-Back & Change in Begin Date for a Transfer Penalty Period
2. Disclosure & Treatment of Annuities
3. Application of Income First Rule
4. Disqualification for Long-Term Care for Individuals with Substantial Home Equity
5. Enforceability of Continuing Care Retirement Communities (CCRC) & Life Care Community Admission Contracts
6. Accumulate Multiple Transfers
7. Purchase of Certain Notes, Loans & Mortgages
8. Purchase of Life Estate Interest

III. Specific Provisions – A Closer Look — 60 Minutes

A. Asset Transfers

1. Transfer Effective Dates
    a. February 8, 2006
    b. August 1, 2006
2. Look-Back Period
    a. Increase to 60 months for all asset transfers made on or after February 8, 2006

b. Increase by one-month increments beginning March 1, 2009
c. February 1, 2011, full 60-month look-back

3. Eligibility/Transfer of Assets
    a. Application for nursing facility services – request 36 months resource documentation
    b. Excess income/resources – ineligible, penalty period does not begin
4. Financial Eligibility Example
5. Post Eligibility Example
6. Otherwise Eligible
7. Penalty Period
    a. Not imposed
    b. Is imposed
8. Annuities
    a. Purchased on or after February 8, 2006
    b. Certain transactions made on or after February 8, 2006
    c. Remainder beneficiary
    d. Tax Relief & Health Care Act of 2006
    e. Change in insurance law
    f. Annuities/retirement related
    g. Annuities owned by the applicant
9. Promissory Notes
    a. Treated as a transfer unless certain criteria is met
    b. Negotiable or non-negotiable

B. Substantial Home Equity Limit

C. Annuities – Income/Resource

BREAK **15 Minutes**

IV. Post DRA Loopholes **30 Minutes**

1. Non-negotiable promissory note
2. Short-term payout example
3. Annuities, short-term, unsecured
4. Personal Care Service contracts

Questions and Answers **15 Minutes**

V. Citizenship and Identity Documentation **30 Minutes**

1. Background

2. New York's Successes prior to DRA
3. What has changed?
4. General Information Systems Messages
    a. 06 GIS MA/015
    b. 06 GIS MA/021 & Attachment (desk aid)
    c. 06 GIS MA/024
    d. 07 GIS MA/004
5. Proof of Primary Documentation
6. Proof of Secondary Documentation
7. Proof of Identity
8. Federal Exemptions
9. Special Consideration
10. Failure to Cooperate

Questions and Answers

DEFRA 2005

Impact on Medicaid, One Year Later

New York State
Department of Health

March 21, 2007

Deficit Reduction Act of 2005

- Transfers - Lengthened Look-Back & Change in Begin Date for Penalty Period
- Disclosure & Treatment of Annuities
- Application of Income First Rule

Deficit Reduction Act of 2005

- Disqualification for Long-Term Care for Individuals with Substantial Home Equity
- Enforceability of Continuing Care Retirement Communities (CCRC) & Life Care Community Admission Contracts

Additional Reforms of Medicaid Asset Transfer Rules

- Accumulate Multiple Transfers
- Purchase of Certain Notes, Loans & Mortgages
- Purchase of Life Estate Interest

Transfer Effective Dates

- **February 8, 2006**
- State Implementation:
  Applies to Applications Filed on or After
  August 1, 2006

Look-Back Period

- Increases to 60 months for all asset transfers made on/after February 8, 2006
- Increase by one month increments beginning March 1, 2009 (37 months)
- February 1, 2011, full 60-month look-back

Eligibility/Transfer of Assets

- Application for nursing facility services – request 36 months resource documentation
- If excess income/resources - ineligible, penalty period does not begin
  - Must be institutionalized
  - No notice available if not institutionalized

Financial Eligibility

STEP ONE:

(Budget Type 04 / Case Count = 1)

IS's Income
- $20 Inc. Disregard
- MA Level for 1
Net vs. Medical Bills

Spousal Impoverishment Treatment of Resources

Post Eligibility

STEP TWO:

(Budget Type 07 Singles)
(Budget Type 08, 09, 10 Spousal)

IS's Income
- Personal Needs Allowance
- CSMIA
Net Available Monthly Income

Eligibility

- Otherwise eligible - third party insurance may be paying, if no excess income to offset with medical bills
- Otherwise eligible – Excess/NAMI may be greater than MA Rate

PENALTY PERIOD

NOT Imposed When:

- Pending placement in a nursing facility
- Pending participation in a waiver program
- If applied to an application filed prior to 8/1/06, at reapplication no penalty for same transfer

Penalty Period

Is Imposed When:

- Institutionalized and otherwise eligible
- If temporary placement, then more than 29 days of short-term rehab. required, transfer penalty starts
- Once penalty period starts, continues to run

ANNUITIES

- Purchased on or after February 8, 2006 by A/R or spouse treated as a transfer unless:
  - State is named remainder beneficiary – first position
  - State is named remainder beneficiary in second position after spouse, minor or disabled child

ANNUITIES

- Applies to "transactions" made on or after February 8, 2006 which affect the course of payment or the principal of the annuity owned by the A/R or the spouse

ANNUITIES

- Remainder beneficiary:
  - NYS Dept. of Health/Medicaid
  - LDSS reports amount on Schedule E

ANNUITIES

Tax Relief &
Health Care Act of 2006

- Amends Section 6012(b) of the DRA by striking `annuitant' and inserting "institutionalized individual".
- Remainder Interest of spouse's annuity – recovered for IS's care

ANNUITIES

- Meeting with NYS Dept. of Insurance
  - Change in insurance law needed to require annuity issuer to inform the state of annuity transactions

ANNUITIES

- Owned by A/R are a transfer unless:
  - Retirement annuity; or

  Purchased with proceeds from:

  - Individual retirement account,
  - Simplified employee pension plan; or
  - Roth individual retirement account; or

ANNUITIES

- The annuity is:
  - Irrevocable and non-assignable;
  - Actuarially sound; and
  - Provides for equal payments during the term with no deferral and no balloon payments.

ANNUITIES

- Annuitized - payment counted as income. Principal not a resource.
- Not annuitized – Principal is a resource.

Promissory Notes

- The purchase is treated as an uncompensated transfer unless:
  - Repayment term is actuarially sound;
  - Equal payments with no deferral & no balloon payments; and
  - Cancellation of balance upon death of lender is prohibited

Treatment of Promissory Notes, Loans & Mortgages

- If negotiable (can be sold) = resource
  Interest on Payments = income
- If non negotiable – Not a resource
  Full amount of payment = income

POST DRA LOOPHOLES

- Non negotiable promissory notes
  - Unsecured, no secondary market
  - Used to pay for care during transfer penalty period

Promissory Note Income

Transferred Asset(s)	**Promissory Note**
$100,000 Transfer 9/06	$50,000 Purchase
-$50,000 Uncompensated	@ 5%
÷ $6872 Regional Rate	8 Month Payout
= 7.2 Month Penalty	$6367.76 Monthly

POST DRA LOOPHOLE

- Annuities with larger periodic payments
- Payout over a short term
- Use of private annuities – unsecured, no secondary market

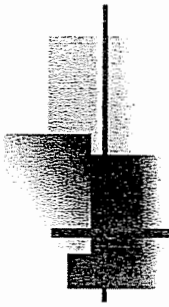
POST DRA LOOPHOLES

Personal Care Contracts

- Evaluate on a case by case basis
- FMV for Care/Service
- No large payments for future care services

Substantial Home Equity

- NYS limit - $750,000
- Limit applies to applications for long-term care services
- Does not apply when spouse, minor or disabled child resides in home



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New York State
Department of Health

March 21, 2007

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THE DEFICIT REDUCTION ACT OF 2005

CITIZENSHIP AND IDENTITY DOCUMENTATION

New York State Department of Health
March 21, 2007

Interim Final Rules were Implemented on **July 1, 2006**

- Background
- New York's successes Prior to DRA
  - Flexibility
    "a common sense, problem solving approach"
  - Application assistance
  - Electronic matching

What has changed?

- U.S. citizens are now required to **document** satisfactory documentary evidence of U.S. Citizenship.
- Documents must be originals or certified copies from the issuing agency.
- Copies or notarized copies are not acceptable.

General Information Systems Messages

The Department has issued:

- 06 GIS MA/015
- 06 GIS MA/021 & Attachment (desk aid)
- 06 GIS MA/024
- 07 GIS MA/004

Proof of Citizenship Documentation
Primary*

- **U.S. passport**
- **Certification of Naturalization** (N-550 or N-570)
- **Certificate of U.S. Citizenship** *(N-560 or N-561)*

*Proves U.S. citizenship and identity. No other document is required.

Proof of Citizenship Documentation
Secondary*

- U.S. Birth Certificate
- Official Military Record of Service
- Final Adoption records
- Official Hospital/Clinic/Doctor Record
- Federal or State Census Record
- Written Affidavit

*Also requires an identity document

Proof of Identity

- Driver's License (issued by State or territory with photograph)
- Identification card issued by Federal, State or local government (with the same information included on driver's license)
- U.S. Military card or draft record
- Military dependent identification card

Proof of Identity continued

- U.S. Coast Guard Merchant Mariner card
- Native American Tribal document
- Certificate of Indian Blood/or other U.S. American Indian/Alaska native tribal document
- School Identification card with photograph

Proof of Identity continued

- For children under 16:
  - School records may include nursery or daycare records.
  - Affidavit may be used if no other documents are available.
  - Affidavit is only acceptable if signed under penalty of perjury by a parent or guardian.
  - Affidavit must state date and place of birth of the child and cannot be used if an affidavit for citizenship was provided.

Federal Exemptions

- A/Rs enrolled in Medicare;
- Receiving Supplemental Security Income (SSI);
- Receiving Social Security Disability Income (SSDI);
- Child under Title IV-B (on the basis of being a child in foster care); or
- Adoption/foster care assistance under Title IV-E.

Special Consideration

- "Reasonable opportunity period"
- "Good faith effort"
- Our most "vulnerable" population

Failure to Cooperate

- Medicaid may be denied or terminated
- Notices
- Appeal Rights

BIOGRAPHIES OF PANELISTS

Wendy Butz, Medical Assistance Specialist III
Office of Health Insurance Programs
New York State Department of Health

Ms. Butz has more than 18 years' experience in the Medicaid program working primarily with the aged, blind, disabled and chronic care populations. She has overseen the implementation of numerous federal and State legislative and regulatory initiatives. Most recently, Ms. Butz and her staff implemented the long term care eligibility provisions of the federal Deficit Reduction Act of 2005.

Shirley Race, Medical Assistance Specialist II
Office of Health Insurance Programs - Medicaid Services
New York State Department of Health

Shirley is a registered nurse with 30 plus years of nursing experience including Medicaid Utilization Review, Medicaid Managed Care Case Management.

Over the past 6 years, Shirley has worked with the Office of Health Insurance staff, the Children's Defense Fund and New York Immigration Coalition and other advocacy groups in developing various training curriculum on Citizenship and Immigration Eligibility for Medicaid.

Enclosure

Section 6013

Application of the Spousal Impoverishment "Income-First" Rule Under the Deficit Reduction Act of 2005

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations

July 27, 2006

Enclosure Highlights—Section 6013

I. Background
II. New Provision

III. Effective Date

I. Background

Section 6013 of the Deficit Reduction Act of 2005 (DRA); P.L. 105-171 amends section 1924 of the Social Security Act (the Act) to require all States to follow the "income-first" method in calculating revisions to the community spouse resource allowance (CSRA) under section 1924(d).

Section 1924(d) of the Act requires States to set a monthly maintenance needs allowance (MMNA) for community spouses of institutionalized individuals applying for Medicaid. If the community spouse's own income is less than the MMNA, income of the institutionalized spouse may be paid to the community spouse to make up the difference or "shortfall." The State must also protect (i.e., not count in determining the institutionalized spouse's resource eligibility) for the community spouse a certain amount of the couple's resources, known as the community spouse resource allowance (CSRA). Protecting resources as part of the CSRA makes them available for transfer to the community spouse without counting as resources in determining the institutionalized spouse's initial Medicaid eligibility.

In calculating the community spouse's income, any interest, dividend, or other income generated by resources that are part of the CSRA, is included to the extent made available to the community spouse (see section 1924(d)(1)(B) of the Act). However, under section 1924(e)(2)(C) of the Act, the CSRA may be increased if an increase is necessary to raise the community spouse's income to the MMNA.

Prior to enactment of the DRA, generally States could use one of two methods in determining whether to increase the CSRA in order to increase the community spouse's income. States using an "income-first" method assume that all income of the institutionalized spouse that could be made available to the community spouse to bring the spouse up to the MMNA will be made available. Only if there would still be a remaining income "shortfall" would the CSRA be increased to the amount necessary to make up for the "shortfall" in income. In other States, using a "resources first" method, the increased CSRA is calculated based on comparing the community spouse's income to the MMNA without assuming that any allocation of income from the institutionalized spouse will be made.

II. New Provision

The DRA makes use of the "income first" method mandatory for all States. Thus, all States are required to attribute or allocate the maximum available income of the institutionalized spouse to the community spouse before granting an increase in the CSRA under section 1924(e)(2)(C) of the Act.

In cases where a community spouse is seeking an increased CSRA on the basis that additional resources are needed to generate the monthly maintenance needs allowance (MMNA), States may now follow the following steps:

1. Determine the MMNA for the community spouse in the same manner that you currently use pursuant to sections 1924(d)(3), (4), and (5) of the Act;

2. Determine the community spouse's total gross monthly income, including income from income-producing assets retained by the community spouse;

3. Subtract the community spouse's total monthly gross income from the MMNA. If there is a deficit, this is the amount of the income "shortfall" for the community spouse;

4. Determine the institutionalized spouse's total gross monthly income. Deduct the personal needs allowance. Allocate sufficient income from the remainder of the institutionalized spouse's income to meet the "shortfall" amount for the community spouse.

5. If, after Step 4 above, there is still some "shortfall" remaining for the community spouse, determine the amount of increased resources needed to generate that amount of income for the community spouse. In making this calculation, States may use any reasonable method for determining the amount of resources necessary to generate adequate income, including adjusting the CSRA to the amount a person would have to invest in a single premium annuity to generate the needed income, attributing a rate of return based on a presumed available rate of interest, or other methods.

The above steps are offered for illustrative purposes, and do not preclude States from applying the income-first methodology in a different manner or sequence.

III. Effective Date

The effective date of this change is the date of enactment of DRA, February 8, 2006. However, this provision applies only to determinations of the CSRA made on or after the effective date, and only when the institutionalized spouse became institutionalized on or after the effective date. Couples who have had increased CSRAs calculated under a resources first methodology prior to the enactment of DRA will not be affected.

Attachment II

LDSS NAME
LETTERHEAD

Date _____

Long-Term Care Documentation Requirement Checklist

Case Name: _____ Representative Name: _____
Address: _____ Due Date: _____
_____ Case Number: _____

On _____, you requested Medical Assistance coverage of long-term care services. In order for us to determine your eligibility for long-term care services, including up to three months prior to the month of your request, your worker must receive the following information checked below no later than the above due date. Failure to submit the information may result in the denial of Medical Assistance coverage for long-term care services. If you cannot obtain these items by the above due date, you must contact your worker to request a brief extension. Verification of your attempt to obtain these documents may be required prior to granting an extension.

☐ You are requesting we (re)determine your eligibility for undue hardship for Medical Assistance coverage of nursing facility services. Undue hardship exists when you meet all other eligibility requirements, and are not able to obtain appropriate medical care such that your health or life is in danger or the application of the transfer penalty period would deprive you of food, clothing, shelter or other necessities of life. You must provide proof of how you meet undue hardship.

☐ Complete, sign and return the enclosed "Long-Term Care Change In Need Resource Checklist." You must provide proof of the value of each resource checked "Yes" for the period _____ to_____.

☐ Document all checks and withdrawals over $ _____ .

☐ Copies of your last three years income tax returns (including 1099s and all schedules and forms).

☐ Additional documentation: _____

_____

_____ _____
Social Welfare Examiner Phone Number

TO: Local District Commissioners, Medicaid Directors

FROM: Brian J. Wing, Deputy Commissioner
Office of Medicaid Management

SUBJECT: Citizenship Documentation Requirements of The Deficit Reduction Act of 2005

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Support Unit
Upstate (518) 474-8887 NYC (212) 417-4500

Effective July 1, 2006, the Deficit Reduction Act of 2005 (DRA) amends federal Medicaid statute to require that all United States citizens applying for or renewing Medicaid coverage provide "satisfactory documentary evidence" of their citizenship. Documentation of United States citizenship or satisfactory immigration status has long been a requirement for Medicaid eligibility in New York State; therefore, changes in New York are minimal at this time.

These new provisions do not affect immigrants. Individuals with satisfactory immigration status can continue to receive Medicaid in New York as described in OMM 04 ADM-07.

The DRA requires all states to obtain documentary evidence from citizen applicants/recipients (A/Rs) and maintain this documentation in their case files, or risk losing federal matching funds. The federal government has stated that a passport or a certificate of naturalization or certificate of citizenship issued by the United States Department of Homeland Security is considered a "primary" document. However, if an individual says they do not have one of these documents, **LDSS may and should continue to accept birth certificates and other documents listed in OMM 04 ADM-07.**

Documents presented by A/Rs must be originals. Districts may copy or scan the documents for the LDSS files; naturalization papers cannot be copied, but may be recorded. For individuals who present other than primary documents, including birth certificates, LDSS must obtain additional proof of identity, such as a driver's license or photo ID. If no other identity document is available for a child under age 16, a parent or guardian may certify to the child's identity.

New Applicants

Districts must begin following these guidelines for applications filed on or after July 1, 2006. Pregnant women continue to be eligible for prenatal and postpartum care in New York without regard to citizenship or immigration status. However, minors who are applying for the Family Planning Benefit Program may no longer attest to citizenship. There must be a document in the case record showing citizenship or satisfactory immigration status for FPBP participants, as well as identity documentation when other than primary documentation of citizenship is relied upon.

Individuals who cannot provide "satisfactory documentary evidence" of citizenship, but who are making a good faith effort to obtain the documentation must not be denied. LDSS must assist applicants in obtaining such documentary evidence when requested.

Renewal Recipients

The local district need not re-document citizenship unless the case record lacks "satisfactory documentary evidence" of citizenship. Cases affected may include minors in receipt of FPBP benefits if they attested to citizenship. Current recipients remain eligible as long as they are undertaking a good faith effort to provide acceptable citizenship documentation to the local district.

As additional information becomes available, the Office of Medicaid Management will provide further guidance to LDSS.

If you cannot access this GIS from the e-mail or through the Intranet, please contact Chris Larsen at (518) 486-9054.

TO: Local District Commissioners, Medicaid Directors

FROM: Linda LeClair, Director
Bureau of Medicaid Eligibility, Operations and Family Health Plus

SUBJECT: Citizenship Documentation and Identity Requirements of The Deficit Reduction Act of 2005

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Support Unit
Upstate (518) 474-8887 NYC (212) 417-4500

This Message supplements GIS 06 MA/015, and provides further clarification of recently issued federal citizenship documentation requirements.

Federal exemptions: In the Interim Final Rules on Citizenship Documentation for Medicaid Eligibility issued by the Centers for Medicare and Medicaid Services (CMS) on July 6, 2006, CMS announced that the following individuals who state they are U.S. citizens are exempt from the citizenship documentation requirements established under the DRA:

- Individuals who are receiving Supplemental Security Income (SSI-cash) in New York State.
- Applicants/Recipients enrolled in Medicare who are able to present their Medicare card. Under State law, such individuals must continue to provide proof of identity.

Identity: Districts are reminded that birth certificate can no longer be accepted as proof of both citizenship and identity. If the birth certificate is presented as proof of citizenship, the eligibility worker must obtain another form of identity document from the Identity Documentation checklist, such as a driver's license.

For children under 16 years of age, school records may be used as an identity document when available; these include nursery or daycare records. If no other form of identity listed in the charts is available, an affidavit from the parent or guardian is acceptable if it is signed under penalty of perjury by the parent or guardian and states the date and place of birth of the child. For Medicaid purposes the parent or guardian's signature on the Medicaid application should suffice in fulfilling the affidavit requirement.

Foster care: Foster care children, who are categorically eligible for Medicaid, are considered **recipients**; therefore, Medicaid for foster care children who are citizens shall be authorized pending documentation of citizenship.

Case records: Although eligibility workers/facilitated enrollers are required to see original documents or documents certified by the issuing agency, copies may be made for the case record. The worker should make photocopies of any original documents and annotate on the copy that they saw the original or a document certified by the issuing agency.

Please note: A Certificate of Naturalization may not be copied. The worker should record in the case file:

- The type of certificate;
- The certificate number;
- The alien number (do not data enter the alien #);
- Date Naturalization was granted; and
- Sign their initials and enter the date the document was reviewed.

Types of documents: Please refer to the attached document entitled "Documents Establishing U.S. Citizenship and Identity". These charts contain a description of the types of documentation that establish evidence of U.S. citizenship and an explanation of documents that establish identity.

NOTE: Please be reminded that pregnant women continue to be eligible for prenatal and postpartum care in New York without regard to citizenship or immigration status. Further, the new DRA provisions do not affect immigrants. Individuals with satisfactory immigration status can continue to receive Medicaid in New York as described in 04 OMM/ADM-07.

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DOCUMENTS ESTABLISHING U.S. CITIZENSHIP AND IDENTITY

PRIMARY CITIZENSHIP DOCUMENTS

Primary Documents	Explanation ***Highest reliability; proves U.S. citizenship and identity. No other document required.***
United States passport	The Department of State issues this document. A U.S. passport does not have to be currently valid to be accepted as evidence of U.S. citizenship. Note: Spouses and children were sometimes included on one passport through 1980. U.S. passports issued after 1980 show only one person. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented.
Certificate of Naturalization (DHS Forms N-550 or N-570)	Department of Homeland Security (DHS) issues for naturalization.
Certificate of Citizenship (DHS Forms N-560 or N-561)	Department of Homeland Security (DHS) issues certificates of citizenship to individuals who derive citizenship through a parent.

SECONDARY CITIZENSHIP DOCUMENTS (In order of reliability)

(Districts should attempt to obtain the most reliable document available.)

Secondary Documents	Explanation ***Satisfactory reliability when a primary document not available; also requires an identity document.***
A U.S. public birth certificate showing birth in: • **One of the 50 U.S. States;** • **District of Columbia;** • **American Samoa;** • **Swain's Island;** • ***Puerto Rico (if born on or after January 13, 1941);** • ***Virgin Islands of the U.S. (on or after January 17, 1917);** • ***Northern Mariana Islands (after November 4, 1986 (NMI local time)); or** • **Guam (on or after April 10, 1899)**	The birth record document may be issued by the State, Commonwealth, territory or local jurisdiction. It must have been issued before the person was five years of age. Note: If the document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the United States, the individual may be a collectively naturalized citizen. Collective naturalization occurred on certain dates listed for each of the territories. * See additional requirements for Collective Naturalization, on page 5.
Certification of Report of Birth (DS-1350)	The Department of State issues a DS-1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth, based on the information shown on the FS-240. When the birth was recorded as a Consular Report of Birth (FS-240), certified copies of the Certification of Report of Birth Abroad (DS-1350) can be issued by the Department of State in Washington, D.C. The DS-1350 contains the same information as that on the current version of Consular Report of Birth FS-240. The DS-1350 is not issued outside the U.S.
A Report of Birth Abroad of a U.S. Citizen (FS-240)	The Department of State consular office prepares and issues this document. A Consular Report of Birth can be prepared only at an American consular office overseas while the child is under the age of 18. Children born outside the U.S. to U.S. military personnel usually have one of these.

SECONDARY CITIZENSHIP DOCUMENTS (In order of reliability)

Secondary Documents	Explanation *Satisfactory reliability when a primary document not available; also requires an identity document.*
Certification of Birth issued by Department of State (Forms FS-545 or DS-1350) **(No longer issued, however, still acceptable documentation)**	Before November 1, 1990, Department of State consulates also issued Form FS-545 along with the prior version of the FS-240. In 1990, U.S. consulates ceased to issue Form-545. Treat an FS-545 the same as the DS-1350.
United States Citizenship Identification Card (I-197) or prior version I-179 **(No longer issued, however, still acceptable documentation)**	The former Immigration and Nationality Services (INS) issued the I-179 from 1960 until 1973. It revised the form and renumbered it as Form I-197. INS issued the I-197 from 1973 until April 7, 1983. INS issued Form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.
American Indian Card (I-872)	DHS issues this card to identify a member of the Texas Band of Kickapoos living near the U.S./Mexican border. A classification code "KIC" and a statement on the back denote U.S. citizenship.
Northern Mariana Card (I-873) **(No longer issued, however, still acceptable documentation)**	The former INS issued the I-873 to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 4, 1986. The card is no longer issued, but those previously issued are still valid.
Evidence of civil service employment by the U.S. government	The document must show employment by the U.S. government before June 1, 1976.
Official Military record of service	The document must show a U.S. place of birth (for example a DD-214 or similar official document showing a U.S. place of birth).
Final adoption decree	The adoption decree must show the child's name and U.S. place of birth. In situations where an adoption is not finalized **and** the State in which the child was born will not release a birth certificate prior to final adoption, a statement from a State approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the birth information is an original birth certificate.
Extract of hospital record on hospital letterhead established at the time of the person's birth that was created at least 5 years before the initial application date and that indicates a U.S. place of birth.	**DO NOT ACCEPT** a souvenir "birth certificate" issued by the hospital. *Note: For children under 16 the document must have been created near the time of birth or 5 years before the date of application.*
Life or health or other insurance record showing a U.S. place of birth that was created at least 5 years before the initial application date.	Life or health insurance records may show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.
Federal or State census record showing U.S. citizenship or a U.S. place of birth (Generally for persons born 1900 through 1950).	The census record must also show the applicant's age. *Note: Census records from 1900 through 1950 contain certain citizenship information. To secure this information the applicant, recipient or social services district should complete a Form BC-600 Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested." Also add that the purpose is for Medicaid eligibility. This form also requires a fee.*

SECONDARY CITIZENSHIP DOCUMENTS (In order of reliability)

Secondary Documents	Explanation ***Satisfactory reliability when a primary document not available; also requires an identity document.***
Institutional admission papers from a nursing facility, skilled care facility or other institution that was created at least 5 years before the initial application date and indicates a U.S. place of birth.	Admission records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.
Other document as listed in the explanation column that was created at least 5 years before the application for Medicaid.	This document must be one of the following and show a U.S. place of birth: • Seneca Indian tribal census record; • Bureau of Indian affairs tribal census records of the Navajo Indians; • U.S. State Vital Statistics official notification of birth registration; • An amended U.S. public birth record that is amended more than 5 years after the person's birth; or Statement signed by the physician or midwife who was in attendance at the time of birth.
Medical (clinic, doctor, or hospital) record that was created at least 5 years before the initial application date and that indicates a U.S. place of birth.	Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. ***Note:*** *An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.* ***Note:*** *For children under 16 the document must have been created near the time of birth or 5 years before the date of application.*
Written Affidavit	**Affidavits should ONLY be used in rare circumstances.** The affidavit must contain the following information under the following circumstances: • There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship. • The two affidavits can be combined in a joint affidavit. • At least one of the individuals making the affidavit **cannot** be related to the either of the two individuals. • The person(s) making the affidavit **must** be able to provide proof of his or her own citizenship and identity for the affidavit to be accepted. • If the affiant has information which explains why documentary evidence establishing the applicant's or recipient's claim of citizenship does not exist or cannot be readily obtained, the affidavit should contain this information as well. • The affidavit **must** also be signed **under penalty of perjury** by the person making the affidavit. • A separate affidavit from the applicant/recipient or other knowledgeable individual (guardian or representative) explaining why documentary evidence does not exist or cannot be readily obtained **must** also be obtained.

When primary evidence of citizenship is not available, a document from the list of Secondary Documents may be presented and must be accompanied by an identity document below.

IDENTITY DOCUMENTS

Documents to Establish Identity	Explanation
Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska native tribal document.	Acceptable if the document carries a photograph of the applicant or recipient, or has other personal identifying information relating to the individual.
Any identity document described in Section 274A(b)(1)(D) of the Immigration and Nationality Act (INA).	Use **8 CFR 274a.2(b)(1)(v)(B)(1).** This section includes the following acceptable documents for Medicaid purposes: • A valid driver's license issued by State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color; • School identification card with a photograph of the individual; • U.S. military card or draft record; • Identification card issued by Federal, State, or local government with the same information included on driver's license; • Military dependent's identification card; • Native American Tribal document; or • U.S. Coast Guard Merchant Mariner card. **NOTE**: For children under 16, school records may include nursery or daycare records. If none of the above documents in the preceding charts are available, an affidavit may be used. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of birth of the child and cannot be used if an affidavit for citizenship was provided. **Exception:** Do not accept a voter's registration card or Canadian driver's license as listed in 8 CFR 274a.2 (b)(1)(v)(B)(1).

COLLECTIVE NATURALIZATION

Evidence that establishes U.S. citizenship for collectively naturalized individuals:	Explanation
***Puerto Rico**	• Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the U.S. possession or Puerto Rico on January 13, 1941; or • Evidence that the applicant/recipient was a Puerto Rican citizen and the applicant's/recipient's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.
***U.S. Virgin Islands**	• Evidence of birth in the U.S. Virgin Islands, and the applicant/recipient's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927; • The applicant/recipient's statement indicating resident in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 citizen and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; or • Evidence of birth in the U.S. Virgin Islands and the applicant/recipient's statement indicating residence in the U.S., a U.S. (possession or territory or the Canal Zone on June 28, 1932).
***Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Island (TTPI))**	• Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. territory or possession on November 3, 1986 (NMI local time) and the applicant/recipient's statement that he or she did owe allegiance to a foreign state on November 4, 1986 (NMI local time); • Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant/recipient's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or • Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant/recipient's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time). **NOTE:** If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

TO: Local District Commissioners, Medicaid Directors

FROM: Brian J. Wing, Deputy Commissioner
Office of Medicaid Management

SUBJECT: Citizenship Documentation and Identity Requirements of the Deficit Reduction Act of 2005

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Support Unit
Upstate (518) 474-8887 NYC (212) 417-4500

The purpose of this GIS message is to clarify and to update local districts regarding recent policy changes relating to citizenship and identity documentation under the Deficit Reduction Act of 2005 (DRA).

Clarification of Federal exemptions: The Centers for Medicare and Medicaid Services (CMS) has clarified that applicants/recipients who are enrolled in Medicare or are receiving Supplemental Security Income (SSI) are exempt from documenting both citizenship and identity. These individuals have already established their citizenship and identity to the Social Security Administration. This supersedes previous instructions issued in GIS message 06 MA/021.

Clarification on photocopies: GIS message MA/021 also instructed the worker not to photocopy a Certificate of Naturalization. This rule no longer applies. **A Certificate of Naturalization and a Certificate of U.S. Citizenship may be photocopied by a worker or facilitated enroller for use in a Medicaid case record.** Workers are reminded they should make photocopies of any original documents and annotate on the copy that they saw the original or a document certified by the issuing agency.

The worker should sign their initials, record the date the document was reviewed and place the copy in the case file. The alien number on the certificates should **not** be data entered.

As additional information becomes available, the Office of Medicaid Management will provide further guidance to LDSS.

TO: Local District Commissioners, Medicaid Directors, Services Directors

FROM: Deborah Bachrach, Deputy Commissioner
Office of Health Insurance Programs

SUBJECT: Technical Amendments To Deficit Reduction Act Of 2005

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Support Unit
Upstate (518) 474-8887 NYC (212) 417-4500

The recently passed "Tax Relief and Health Care Act of 2006 (Public Law 109-432)" contains several technical amendments to the Deficit Reduction Act of 2005 (DRA) related to citizenship and identity verification.

Previously, The Centers for Medicare and Medicaid Services (CMS) clarified that applicants/recipients who are enrolled in Medicare or are receiving Supplemental Security Income (SSI) are exempt from documenting both citizenship and identity. These individuals have already established their citizenship and identity to the Social Security Administration.

Additionally, a Medicaid applicant/recipient declaring to be a citizen or national of the United States is also exempt from the citizenship/identity documentation requirements required by the DRA if he or she meets one of the following criteria:

- is entitled to or enrolled for Medicare benefits under any part of Title XVIII; or
- is receiving either
  - (1) Social Security benefits under Title II on the basis of a disability (SSDI); or
  - (2) Supplemental Security Income (SSI) benefits under Title XVI; or
- with respect to whom:
  - (1) child welfare services are made available under Title IV-B on the basis of being a child in foster care; or
  - (2) adoption or foster care assistance is made available under Title IV-E."

Please Note:
These technical amendments require the State foster care agency, which is the NYS Office of Children and Family Services, to have in effect procedures for Verifying the citizenship or immigration status of children in foster care under the responsibility of the State under Title IV-E or IV-B of the Social Security Act. This requirement is effective six months from the date of enactment which is June 20, 2007.

Should you have further questions regarding Title IV-E or child welfare services available under Title IV-B on the basis of being a foster care child, please contact:

Nancy White Martinez, Director
Office of Strategic Planning & Policy Development
New York State Office of Children & Family Services
Phone number: 518 473-1776
E-mail: nancy.martinez@ocfs.state.ny.usprograms

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid & State Operations

FEB 22 2007

SMDL #07-002

Dear State Medicaid Director:

We are writing to inform you of recent legislative changes made to section 1903(x) of the Social Security Act (the Act), which establishes new requirements related to documentation of citizenship by Medicaid applicants or recipients who declare they are citizens or nationals of the United States. Guidance on the implementation of section 1903(x) of the Act was provided through a State Medicaid Director's letter on June 9, 2006, and the publication of an Interim Final Rule with comment period on July 12, 2006. Section 405(c)(1) of the Tax Relief and Health Care Act of 2006 (TRHCA), P.L. 109-432, which amends section 1903(x), was enacted on December 20, 2006.

The TRHCA amends section 1903(x) by replacing the word "alien" in 1903(x)(2) with the phrase "individual declaring to be a citizen or national of the United States." This change corrects in statute the scrivener's error as described in the Interim Final Rule with comment period. This correction does not affect the policy as described in the Interim Final Rule.

The TRHCA also amended section 1903(x)(2) to exempt two additional groups of individuals from the provisions requiring presentation of satisfactory documentary evidence of citizenship or nationality. These groups are:

- Individuals receiving disability insurance benefits under section 223 of the Act or monthly benefits under section 202 of the Act, based on such individual's disability (as defined in section 223(d) of the Act); and
- Individuals with respect to whom child welfare services are made available under part B of title IV on the basis of being a child in foster care, or adoption or foster care assistance is made available under part E of title IV of the Act.

It should be noted that policy outlined in this letter, as provided for by TRHCA, Division B, Section 405(c)(1)(A) supersedes the policy outlined in the Interim Final Rule published on July 12, 2006, regarding these groups.

These amendments made to 1903(x) by TRHCA are effective as if included in section 6036 of the Deficit Reduction Act of 2005.

In addition, important amendments were made to the title IV-E program, and the Children's Bureau will be issuing guidance on those provisions.

The Centers for Medicare & Medicaid Services' contact for this new legislation is Jean Sheil, Director, Family and Children's Health Program Group, who may be reached at 410-786-5647.

Sincerely,

Dennis G. Smith

Dennis G. Smith
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators,
Division of Medicaid and Children's Health

Martha Roherty
Director, Health Policy Unit
American Public Human Services Administration

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Jacalyn Bryan Garden
Director of Policy and Programs
Association of State and Territorial Health Officials

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Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 06 OMM/ADM-5

TO: Commissioners of Social Services

DIVISION: Office of Medicaid Management

DATE: July 20, 2006

SUBJECT: Deficit Reduction Act of 2005 - Long-Term Care Medicaid Eligibility Changes

SUGGESTED DISTRIBUTION:	Medicaid Staff Fair Hearing Staff Legal Staff Audit Staff Staff Development Coordinators
CONTACT PERSON:	Local District Liaison Upstate: (518) 474-8887 New York City: (212) 417-4500
ATTACHMENTS:	See Appendix I for Listing of Attachments

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
06 OMM/ADM-2 04 OMM/ADM-6 96 OMM/ADM-8		360-2.3 360-4.4 360-4.6	SSL 366-a(2), 366 & 366-c SSA 1917 & 1919 Ch. 109 of Laws of 2006 Sec. 6011, 6012, 6014, 6015 & 6016 of DRA 2005	MRG pp. 353-363	

TABLE OF CONTENTS

I. PURPOSE

This Administrative Directive (OMM/ADM) advises social services districts of the long-term care Medicaid eligibility provisions of the Deficit Reduction Act (DRA) of 2005. The DRA amends Section 1917 of the Social Security Act (the Act) to change asset transfer rules, require the disclosure of annuities and count as an available resource certain entrance fees for continuing care retirement communities. The DRA also amends Section 1919 of the Act to impose a home equity limitation for nursing facility services and community-based long-term care services.

II. BACKGROUND

A. ASSET TRANSFER CHANGES AND ANNUITIES

In 1993, the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) amended Section 1917(c) of the Act to require that a transfer penalty be imposed for individuals who transfer assets for less than fair market value. Specifically, the rules require a period of ineligibility for nursing facility services when a Medicaid applicant/recipient (A/R), or the A/R's spouse, transfers assets for less than fair market value on or after a "look-back date." The "look-back date" is 36 months prior to application for Medicaid coverage of nursing facility services, and 60 months in the case of certain transfers to or from trusts.

Ineligibility for Medicaid coverage is limited to only certain long-term care services, not all services covered under the program. The services for which the penalty applies include nursing facility care, services provided in an institution in which the level of care is equivalent to that provided by a nursing facility, and home and community-based waiver services provided for under Section 1915(c) or (d) of the Act. The period of ineligibility, or penalty period, begins on the first day of the first month after which assets have been transferred and which does not occur in any other period of ineligibility. There is no limit to the length of the penalty period.

Under these OBRA '93 transfer provisions, penalties imposed for A/Rs who made uncompensated transfers within the look-back period could expire before the date of Medicaid application for nursing facility services. For example, an uncompensated transfer of $100,000 made two years prior to application could result in a 20-month penalty period ($100,000 divided by the average private pay rate for nursing home care in the region of $5,000). Since the individual does not apply for Medicaid until two years, or 24 months, after having made the transfer, the penalty expired before the individual applies for Medicaid.

To address this eligibility loophole, the DRA amended Section 1917(c) of the Act to lengthen the look-back date for all transfers of assets made on or after February 8, 2006, to five years, or 60 months, and change the begin date for the penalty period to the month after which assets have been transferred for less than fair market value, or the date the institutionalized individual is otherwise eligible for and receiving nursing facility services, whichever is later.

The DRA also addresses the growing use of annuities to shelter resources in excess of the allowable Medicaid resource limit. The purchase of an annuity was effectively used by individuals to convert excess resources into an income stream. The annuity was required to be actuarially sound, meaning the anticipated return on the annuity's principal and interest must not exceed the annuitant's life expectancy. Upon the death of the annuitant, any remaining monies in the annuity pass to the named beneficiary rather than to the individual's estate. The DRA requires, as a condition of eligibility for nursing facility services, that the State be named the remainder beneficiary of an A/R's and community spouse's annuity. The DRA also made several amendments to Section 1917(c) of the Act to address the issue of annuities as a potential transfer of assets for less than fair market value. These changes include imposing a transfer penalty unless an annuity meets certain criteria as further explained in this directive.

Additional changes to the Medicaid asset transfer rules include making additional assets subject to the look-back period and imposition of a penalty if established or transferred for less than fair market value. These assets include funds used to purchase a promissory note, loan, mortgage or life estate interest unless the purchase meets certain criteria.

B. HOME EQUITY AND CONTINUING CARE RETIREMENT COMMUNITY CONTRACTS

To further help combat the rapidly increasing costs of Medicaid long-term care, the DRA amends Section 1919 of the Act to exclude individuals from qualifying for Medicaid coverage of nursing facility services and community-based long-term care services if the individual's equity interest in his or her home exceeds a certain value, barring certain exceptions.

The DRA also amends Section 1917 of the Act to treat certain entrance fees for continuing care retirement communities and life care communities as countable resources to the applicant for purposes of determining Medicaid eligibility.

III. PROGRAM IMPLICATIONS

As a result of the enactment of the Deficit Reduction Act of 2005 and corresponding changes to State statute (Chapter 109 of the Laws of 2006), a number of changes are being made to the Medicaid rules concerning asset transfers and the treatment of other resources for individuals applying for long-term care services. Unless otherwise stated in this directive, the policies contained in 96 ADM-8, "OBRA '93 Transfer and Trust Provisions," continue to apply.

A. TRANSFER OF ASSETS PROVISIONS

The following changes apply to individuals who apply for Medicaid coverage of nursing facility services on or after August 1, 2006.

1. Change in Look-Back and Penalty Period Begin Date

The look-back period for transfers made on or after February 8, 2006, is increased from 36 to 60 months for individuals applying for Medicaid coverage of nursing facility services. Previously, only trust related transfers were subject to a 60-month look-back date. For transfers made on or after February 8, 2006, the look-back period is 60 months for all transfers.

In the case of a transfer of assets made on or after February 8, 2006, the begin date of the period of ineligibility is the first day of the month after which assets have been transferred for less than fair market value, or the date on which the otherwise eligible individual is receiving nursing facility services for which Medicaid coverage would be available but for the imposition of a transfer penalty, **whichever is later,** and which does not occur during any other penalty period.

Multiple transfers made during the look-back period, including transfers that would otherwise result in a fractional penalty, are accumulated into one total amount to determine the penalty period. In the event that the imposition of a transfer penalty would create an undue hardship for the A/R, an exception may be made to the application of the penalty. There are no substantive changes to the definition of undue hardship as described in 96 ADM-8; however, the procedural requirements for undue hardship, as required by the DRA, have changed and are described in the Required Action Section of this directive.

The exceptions to the transfer rules that apply under the OBRA '93 transfer provisions continue to apply to transfers made on or after February 8, 2006, in accordance with the DRA.

2. Annuities

Section 366-a of the SSL is amended to require as a condition of Medicaid eligibility for nursing facility services, that the A/R disclose a description of any interest the A/R or the A/R's spouse has in an annuity regardless of whether the annuity is irrevocable or treated as an asset. For annuities purchased on or after February 8, 2006, the A/R must be informed of the right of the State to be named remainder beneficiary by virtue of the provision of Medicaid.

In addition, effective August 1, 2006, if an A/R or the A/R's spouse purchased an annuity on or after February 8, 2006, and the A/R is seeking Medicaid coverage for nursing facility services, the State must be named as a remainder beneficiary in the first position or the purchase of the annuity will be considered an uncompensated transfer of assets. In cases where there is a community spouse or minor or disabled child, the State must be named the remainder beneficiary in the second position, and named in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value. The Medicaid application is being revised to inform applicants with annuities that the State becomes the remainder beneficiary under an annuity by virtue of the provision of Medicaid.

If the A/R or the A/R's spouse fails or refuses to name the State as the remainder beneficiary of an annuity purchased on or after February 8, 2006, the purchase will be considered a transfer of assets for less than fair market value. In addition, if an annuity is purchased by or on behalf of an A/R, the purchase will be treated as a transfer of assets for less than fair market value unless the annuity is:

- an annuity described in subsection (b) or (q) of Section 408 of the Internal Revenue Code of 1986; or

- purchased with the proceeds from an account described in subsection (a),(c),(p) of Section 408 of such Code; a simplified employee pension (within the meaning of Section 408(k) of such Code); or a Roth IRA described in Section 408A of such Code; or

the annuity is:

- irrevocable and non-assignable;

- is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

- provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.

The annuity provisions apply to transactions, including purchases, which occur on or after February 8, 2006. Transactions subject to these provisions include any action by the individual that changes the course of payment from the annuity or that changes the treatment of the income or principal of the annuity. These transactions include additions of principal, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract and similar actions.

3. Treatment of Transfers to Purchase Loans, Notes, Mortgages and Life Estate Interest

In accordance with the DRA, the transfer of assets provisions in Section 1917(c) of the Act are amended to require that funds used to purchase a promissory note, loan or mortgage on or after February 8, 2006, will be treated as an uncompensated transfer of assets unless the note, loan or mortgage meets the following criteria:

- has a repayment term that is actuarially sound;
- provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and
- prohibits the cancellation of the balance upon the death of the A/R.

The purchase of a life estate interest in another individual's home is treated as an uncompensated transfer of assets unless the purchaser resided in the home for a period of at least one year after the date of purchase.

B. HOME EQUITY VALUE

Section 366.2(a)(1) of the SSL is amended to require that for applications for nursing facility services and community-based long-term care services made on or after January 1, 2006, an individual will not be eligible for such care and services if the individual's equity interest in his or her home exceeds $750,000. This is the maximum amount allowed under the DRA. Individuals cannot spend down excess equity with the use of medical bills. The home equity limitation does not apply if one or more of the following persons are lawfully residing in the individual's home:

- the spouse of the individual; or
- the individual's child who is under age 21, or certified blind or certified disabled.

An otherwise eligible A/R will be provided Medicaid coverage of long-term care services if the A/R meets an undue hardship. Undue hardship exists when the denial of Medicaid coverage would:

- deprive the A/R of medical care such that the individual's health or life would be endangered; or
- deprive the A/R of food, clothing, shelter, or other necessities of life;

and there is a legal impediment that prevents the A/R from being able to access his or her equity interest in the property.

C. CONTINUING CARE RETIREMENT COMMUNITY CONTRACTS AND LIFE CARE COMMUNITY ADMISSION CONTRACTS

Continuing Care Retirement Communities (CCRCs) offer a range of housing and health care services to serve older individuals as they age and as their health care needs change over time. CCRCs generally offer independent living units, assisted living, and nursing facility care for individuals who can afford to pay entrance fees and who often reside in such CCRCs throughout their older years. The services generally offered include meals, transportation, emergency response systems, and on-site nursing and physician services. Many also offer home care, housekeeping, and laundry services.

Individuals with contracts for admission to a State licensed, registered, certified or equivalent continuing care retirement or life care community may be required to spend on their care resources declared for purposes of admission before applying for Medicaid. Under certain circumstances an individual's paid entrance fee to a CCRC or life care community will be considered a resource when determining Medicaid eligibility.

IV. REQUIRED ACTION

A. DEFINITIONS

1. Assets

"Assets" means all income and resources of an individual and of the individual's spouse, including income or resources to which the individual or the individual's spouse is entitled but which are not received because of action by: the individual or the individual's spouse; a person with legal authority to act in place of or on behalf of the individual or the individual's spouse; a person acting at the direction or upon the request of the individual or the individual's spouse; or by a court or administrative body with legal authority to act in place of or on behalf of the individual or the individual's spouse or at the direction or upon the request of the individual or the individual's spouse.

2. Blind

"Blind" has the same definition given to such term in Section 1614(a)(2) of the Social Security Act.

3. Disabled

"Disabled" has the same meaning given to such term in Section 1614(a)(3) of the Social Security Act, which states that an individual shall be considered to be disabled if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months.

4. **Fair Market Value**

"Fair market value" (FMV) means the estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred. Fair market value of real property or other assets may be established by means of an appraisal by a real estate broker or other qualified dealer or appraiser.

5. **Income**

"Income" has the same meaning given to such term in Section 1612 of the Social Security Act, and includes both earned and unearned income, with certain exceptions, as defined in such section.

6. **Resources**

"Resources" has the same meaning given to such term in Section 1613 of the Social Security Act, without regard, in the case of an institutionalized individual, to the homestead exclusion provided for in subsection (a)(1) of such Section.

7. **Look-Back Period**

For transfers made on or after February 8, 2006, the "look-back period" means the sixty-month period immediately preceding the date that an institutionalized individual is both institutionalized and has applied for Medicaid.

8. **Institutionalized Individual**

"Institutionalized individual" means any individual who is an in-patient in a nursing facility, including an intermediate care facility for the mentally retarded, or who is an in-patient in a medical facility and is receiving a level of care provided in a nursing facility, or who is receiving care, services or supplies pursuant to a waiver under subsection (c) or (d) of Section 1915 of the Social Security Act.

9. **Intermediate Care Facility for the Mentally Retarded**

"Intermediate care facility for the mentally retarded" means a facility certified under Article Sixteen of the Mental Hygiene Law and which has a valid agreement with the Department for providing intermediate care facility services and receiving payment therefore under Title XIX of the Social Security Act.

10. **Nursing Facility**

"Nursing facility" means a nursing home as defined by Section 2801 of the Public Health Law and an intermediate care facility for the mentally retarded.

11. **Nursing Facility Services**

"Nursing facility services" means nursing care and health related services provided in a nursing facility; a level of care provided in a hospital which is equivalent to the care which is provided in a nursing facility; and care, services or supplies provided pursuant to a waiver under subsection (c) or (d) of Section 1915 of the Social Security Act.

12. **Uncompensated Value**

"Uncompensated value" means the difference between the fair market value at the time of transfer (less any outstanding loans, mortgages, or other encumbrances on the asset) and the amount received for the asset. If the client's resources are below the appropriate Medicaid resource level, the amount by which the Medicaid resource level exceeds the client's resources must be deducted from the uncompensated value of the transfer. Likewise, amounts specified in Department regulations for burial funds, but not for burial space items, also must be deducted.

13. **Non-Assignable**

"Non-assignable" is a term that applies to a plan, annuity, or other arrangement (whether qualified or not qualified under Part I of Subchapter D of Chapter 1 of Subtitle A of the Internal Revenue Code) that qualifies for the marital deduction but for Section 2056(d)(1)(A), and that does not allow the policyholder to assign or transfer the policy to a third party.

14. **Community-Based Long-Term Care Services**

Community-based long-term care services include: adult day health care (medical model); limited licensed home care; certified home health agency services; hospice in the community; hospice residence program; personal care services; personal emergency response services; private duty nursing; Consumer Directed Personal Assistance Program; Assisted Living Program; managed long-term care in the community; residential treatment facility; and non-waiver services in a home and community-based waiver program.

B. **TRANSFER OF ASSETS**

1. **Asset Transfer Changes**

a. **New Cases**

For applications filed on or after August 1, 2006 for Medicaid coverage of nursing facility services, social services districts must require resource documentation for the A/R and the A/R's spouse, for the past 36-month period (60 months for transfers to or from a trust). Resource documentation for the past 36 months is also required for recipients who request an increase in

coverage for nursing facility services on or after August 1, 2006. The 36-month period is determined from the date that an institutionalized individual is both institutionalized and requesting coverage to be established for nursing facility services. Districts will continue to request resource documentation for the past 36 months (60 months for trusts) until February 1, 2009. Beginning February 1, 2009, districts will require resource documentation for the past 37 months (60 months for trusts). The look-back will increase by one-month increments until February, 2011. Effective February 1, 2011, the full 60-month look-back period will be in place for all transfers of assets.

Effective for applications filed on or after August 1, 2006, individuals will no longer have eligibility determined for nursing facility services unless the applicant is in need of such services. Applicants who are in need of nursing facility services must complete the LDSS-2921, "Application for Public Assistance/Medical Assistance/Food Stamps/Services." If a recipient requests an increase in coverage for nursing facility services and is in need of such services, the district must send the recipient the revised DOH-4319 (Rev. 8/06): "Long-Term Care Change In Need Resource Checklist" (Attachment I) with the revised cover letter (Attachment II). The attachments have been revised to request documentation for undue hardship due to a transfer penalty and to address the new home equity limitation for long term care services.

Note: Attachments I and II must also be used when a recipient requests an increase in coverage for community-based long-term care services due to the new home equity limitation.

b. Undercare Cases

Individuals who have been determined eligible for full coverage, including nursing facility services prior to requiring such care and services, should continue to receive Medicaid coverage for all covered care and services if resource documentation is provided at each renewal. No new cases will be allowed this option but undercare cases may continue. Pregnant women and children, who have no resource test, may also continue to be authorized with full Medicaid coverage, if otherwise eligible.

2. **Financial Eligibility**

The first step, after receiving an application for Medicaid coverage of nursing facility services, or a request for an increase in coverage, along with the requested documentation, is to determine the individual's financial eligibility for Medicaid. Eligibility for institutionalized individuals is to be calculated as follows:

a. **Resource Eligibility**

For single individuals, after applying any applicable resource disregards based on community budgeting rules and the individual's category of assistance, the remaining countable resources are compared to the Medicaid resource level for one. For institutionalized spouses, the resources are to be calculated in accordance with the spousal impoverishment provisions; subtract from the couple's total countable resources, the maximum community spouse resource allowance and the Medicaid resource level for one for the institutionalized spouse. If there are resources in excess of the Medicaid resource level for one, social services districts must determine whether the institutionalized individual has medical expenses, not covered by a third party, that offset the amount of the excess resources for the month coverage is sought. Bills incurred for nursing facility services may be used to offset excess resources. Individuals may also spend excess resources on an irrevocable pre-need funeral agreement.

If the institutionalized individual has medical bills that offset the amount of the individual's excess resources, the individual is resource eligible. The next step is for the district to determine the individual's income eligibility for the month coverage is sought.

If the individual does not have medical bills to offset excess resources, the individual is not resource eligible and the district must review the individual's income eligibility for client notice purposes.

b. **Income Eligibility**

For single individuals and couples where there is an institutionalized spouse, to calculate income eligibility, the following deductions are to be applied

to the institutionalized individual's gross monthly income (after deducting any categorical disregards such as interest income):

- From the individual's gross monthly income, deduct the applicable income disregards under community budgeting rules based on the individual's category of assistance (e.g., for SSI-related A/Rs, deduct the $20 income disregard and any health insurance premiums).

- Deduct from the remaining net income, the Medicaid income level for one.

- Compare the remaining income to the amount of the individual's unpaid medical bills that are not subject to payment by a third party other than a public program of the State or any of its political subdivisions. Any portion of unpaid bills, including bills incurred for nursing facility services, not used to offset any excess resources, may be used to establish income eligibility.

- If the individual has medical bills that equal or exceed the individual's net monthly income, the individual is income eligible. If the individual does not have medical bills that at least equal the amount of the individual's net monthly income, the individual is not income eligible.

Note: A community spouse's income is not counted when determining an institutionalized spouse's financial eligibility for nursing facility services.

The required income calculation can be made using Budget Type 04 (SSI-related) or 01 (ADC-related), as applicable. Social services districts should only enter the income of the institutionalized individual.

c. Eligibility Outcome

(1) Financially Ineligible

A notice of denial/discontinuance must be sent to institutionalized individuals who are determined to be ineligible for Medicaid due to excess income and/or excess resources. A review of potential transfers during the look-back period is not required for individuals who are not otherwise eligible for Medicaid. Ineligible individuals include applicants who do not have medical bills to offset any excess income or resources. Upon reapplication at a later date, the district may need to review the resource documentation that was submitted. Until that event occurs, the district should maintain the resource documentation in a case folder.

(2) Financially Eligible

For institutionalized individuals who are financially eligible for Medicaid, social services districts must review resource documentation for the past 36-month look-back period (or 60 months for trusts) immediately preceding the date the individual requests Medicaid coverage to begin. As noted on page 10 of this directive, the 36-month look-back period will increase to 60 months in one month increments starting February 1, 2009.

If an A/R who needs nursing facility services does not provide documentation of his/her resources for the look-back period, but does document or attests to the amount of his/her current resources and is otherwise eligible, the district must deny the request for Medicaid coverage of all covered care and services and authorize Community Coverage Without Long-Term Care or Community Coverage With Community-Based Long-Term Care, as applicable (see Attachments V and VI to 04 OMM/ADM-06, Resource Documentation Requirements for Applicants/Recipients [Attestation of Resources]).

A person with a spouse who does not qualify for Medicaid coverage of a waiver service due to the A/R's failure or refusal to provide adequate resource documentation is not entitled to spousal impoverishment budgeting since there is no expectation that the individual will be in receipt of a waiver service for at least 30 days. Regular community budgeting rules apply. If a community spouse fails or refuses to provide documentation about his/her resources, and the institutionalized spouse executes an assignment of his/her right to pursue support from the community spouse in favor of the social services district and this department, or is unable to execute such an assignment due to physical or mental impairment; or the denial of eligibility for nursing facility services would result in undue hardship, Medicaid must be authorized.

Districts should note that the eligibility calculations discussed in 04 OMM/ADM-6, for institutionalized individuals who do not provide the necessary resource documentation for coverage of all care and services, are revised with the issuance of this directive. The budgeting, as described in the Income Eligibility section, does not provide for a deduction from the institutionalized spouse's income for a community spouse monthly income allowance.

If an institutionalized individual has not made a prohibited transfer and is financially eligible for Medicaid, the district must determine the individual's liability toward the cost of care using chronic care/post-eligibility budgeting (Budget Type 07, 08, 09 or 10, as applicable).

3. **Penalty Period Begin Date for Otherwise Eligible Individuals**

For individuals who are determined to have made an uncompensated transfer within the look-back period, the treatment of multiple transfers and the begin date for a transfer penalty period depend on when the transfer was made. Districts will continue to calculate the penalty period for uncompensated transfers using the Medicaid regional nursing home rates that are established annually.

a. **Transfers Prior to February 8, 2006**

For institutionalized individuals, if an uncompensated transfer of assets has occurred during the look-back period and prior to February 8, 2006, the penalty period begins on the first day of the month following the month in which the transfer occurred. Social services districts should continue to follow the policies outlined in 96 ADM-8 in cases where multiple transfers have been made within the look-back period but prior to February 8, 2006.

If an applicant is determined to be subject to a transfer penalty, Attachment III, LDSS-4144(Rev.8/06), "Notice of Decision on Your Medical Assistance Application - Limited Coverage (Transfer of Assets Penalty)", must be used to inform the individual of his/her limited coverage. For recipients who request an increase in coverage and are determined to be subject to a transfer penalty, Attachment IV, LDSS-4145(Rev.8/06), "Notice of Decision on Your Request for Coverage of Nursing Facility Services - Limited Coverage (Transfer of Assets Penalty)", must be used.

Note: Social services districts must reproduce these notices until further notice.

For institutionalized A/Rs, Coverage Code 10 (All Services Except Nursing Facility Services) or Coverage Code 23 (Outpatient Coverage with no Nursing Facility Services) must be used.

b. **Transfers on or After February 8, 2006**

For transfers made on or after February 8, 2006, the penalty period starts the first day of the month after which assets have been transferred for less than fair market value, or the first day of the month the otherwise eligible institutionalized individual is receiving nursing facility services for which Medicaid

would be available but for the transfer penalty, whichever is later, and which does not occur during any other period of ineligibility.

For institutionalized A/Rs, Attachment III or IV must be used, as applicable, to inform the A/R of his/her limited coverage depending on whether the individual is an applicant requesting coverage or a recipient requiring an increase in coverage.

For institutionalized A/Rs, Coverage Code 10 (All Services Except Nursing Facility Services) or Coverage Code 23 (Outpatient Coverage with no Nursing Facility Services) must be used.

The following examples demonstrate the new transfer provisions:

Example 1 (Institutionalized applicant not otherwise eligible): An applicant is determined to have made a prohibited transfer after February 8, 2006, and is also determined to have excess resources for the month nursing home coverage is requested. The penalty period for the transfer of assets would not be calculated since the individual is not otherwise eligible due to excess resources.

Example 2 (Institutionalized applicant otherwise eligible): An applicant makes an uncompensated transfer of $30,534 in April, 2006. The institutionalized individual is determined to be otherwise eligible for Medicaid starting September 1, 2006. A four-month penalty period ($30,534 divided by $6,872, the Medicaid regional rate, = 4.443) is imposed from September, 2006, the first month eligibility is established, through December, 2006 with a partial month penalty calculated for January, 2007. The calculations for this specific example follow:

Step #1	$30,534	uncompensated transfer amount
	÷ $6,872	Medicaid regional rate
	= 4.443	number of months for penalty period
Step #2	$6,872	Medicaid regional rate
	X 4	four-month penalty period
	$27,488	penalty amount for four full months
Step #3	$30,534	uncompensated transfer amount
	-$27,488	penalty amount for four full months
	$3,046	partial month penalty amount

Example 3 (Institutionalized recipient transfer): On September 18, 2006, the district discovers that an institutionalized recipient failed to pursue his right of election from his spouse's estate. The last date the institutionalized individual could have pursued his elective share was determined to be July 10, 2006. The district calculates a transfer penalty of four months based on the value of the recipient's elective share.

The penalty for this example starts August 1, 2006, the month following the month of transfer. However, the district must send a 10-day notice prior to the reduction in coverage. If the district can notify the individual 10 days prior to October 1, 2006, coverage would be reduced for October 1, 2006 and November 2006, the third and fourth month of the penalty period. If timely notice cannot be sent 10 days in advance of October 1, 2006, coverage could not be reduced until November 1, 2006, the fourth month of the penalty period. In such cases, districts may pursue Medicaid incorrectly paid for months that should have been affected by the transfer penalty (August, September and possibly October, depending on when notification was sent).

If a transfer penalty period falls within another penalty period, the penalty does not start until after the first penalty expires, with the exception of partial month penalties. Districts are to begin a subsequent penalty in the month in which the partial month penalty from a previous penalty period ends.

Example 4 (Overlapping penalties): An application for nursing facility services is filed September 21, 2006, and the applicant is determined to have made a prohibited transfer prior to February 8, 2006. The transfer results in a penalty period that ends with a partial penalty of $929 for November, 2006. Another $10,000 transfer was made in March, 2006. Due to the period of ineligibility from the pre-February 8, 2006 transfer, the penalty period for the March, 2006 transfer would begin in November, 2006. For November, 2006, only the amount of the March transfer that is needed to bring the penalty up to the full Medicaid regional rate would be used. Beginning December 2006, the remaining amount of the March transfer is used to calculate the remaining transfer penalty. The calculations for starting the March transfer follow:

Step #1	$6,872	Medicaid regional rate
	- $929	partial month penalty 1st transfer
	= $5,943	amount of penalty remaining
Step #2	$10,000	uncompensated transfer 2nd transfer
	$5,943	transfer amount used for November penalty
	=$4,057	remaining amount of transfer

Since $4,057 is less than the Medicaid regional rate of $6,872, the remaining $4,057 results in a partial penalty for December, 2006.

Once a penalty period has been established for an otherwise eligible individual, the penalty period continues to run regardless of whether the individual continues to receive nursing facility services or remains eligible for Medicaid. Upon reapplication for Medicaid coverage of nursing facility services, any uncompensated transfer that still falls within the new

look-back period which has already resulted in an expired penalty period, would not again be assessed a penalty. Only subsequent transfers can result in a transfer penalty period.

(i) **Short-Term Rehabilitation**

In cases where the initial days of nursing facility care were covered as short-term rehabilitation under Community Coverage Without Long-Term Care or Community Coverage With Community-Based Long-Term Care, the look-back period is the period immediately preceding the month the individual started to receive the short-term rehabilitation service. Any transfer penalty for an **otherwise eligible** individual would also start the first month the individual started to receive the short-term rehabilitation service. However, districts are reminded that if a determination to impose a transfer penalty is made during the 29 days of short-term rehabilitation, a transfer penalty cannot be imposed until a 10-day notice has been provided. The 10-day notice requirement does not apply to coverage beyond the 29 days of short-term rehabilitation services.

(ii) **Treatment of Multiple Transfers**

Multiple transfers of assets for less than fair market value made on or after February 8, 2006, must be accumulated and treated as one transfer. Districts will accumulate all uncompensated transfers of assets whether the transfers add up to the regional rate used to determine a period of ineligibility, or total less than the regional rate. The total will be used to determine the period of ineligibility for nursing facility services.

(iii) **Exceptions for Transfers**

The exceptions to the application of transfer of asset penalties that apply to transfers made on or after August 11, 1993, continue to apply to transfers made on or after February 8, 2006 (see 96 ADM-8). The following clarification should be noted with respect to assets that are returned to the individual.

For active Medicaid cases, if all or parts of the transferred assets are returned after the Medicaid eligibility determination, the assets must be counted in recalculating the individual's eligibility as though the returned assets were never transferred, and the length of the penalty period must be adjusted accordingly. The recalculated penalty period, if any, will begin when the individual is receiving nursing facility services for which Medicaid coverage would be

available but for the imposition of the transfer penalty. Therefore, the recalculated penalty period cannot begin before the assets retained by the individual at the time of transfer, combined with the assets transferred and subsequently returned to the individual, have been spent down to the applicable Medicaid resource level.

If an application is denied or a case discontinued where a transfer penalty has been imposed, the individual must file a new application. If upon reapplication, the transferred assets have been returned to the applicant, for purposes of determining eligibility, including coverage for the three-month retroactive period, the original transfer penalty period is to be reduced by the returned assets.

For example: A transfer of $100,000 was made in June just prior to filing an August, 2006 application. The institutionalized individual is otherwise eligible in August. The transfer results in a 14.5 month penalty that starts August 1, 2006, and runs through September, 2007 with a partial penalty for October, 2007. Seven months later, $50,000 of the transferred assets is returned to the recipient. In calculating a reduction of the penalty period, eligibility is redetermined for August, 2006 counting the $50,000. The individual does not have medical bills to offset the amount of the excess resources until March, 2007 ($50,000 ÷ $7,000 actual monthly nursing home costs = 7.1 months). The adjusted 7.2 month penalty for the remaining $50,000 transfer ($50,000 ÷ $6,872 = 7.2) would start in March, 2007 and run through September, 2007 with a partial month penalty for October, 2007.

(iv) Provision for Undue Hardship Waiver

An individual who is unable to demonstrate that a transfer was made exclusively for a purpose other than to qualify for nursing facility services, may have coverage authorized for these services if the individual meets undue hardship. For transfers made on or after February 8, 2006, undue hardship exists when:

- the individual applying for nursing facility services is otherwise eligible for Medicaid; and

- despite his/her best efforts, as determined by the social services district, the individual or the individual's spouse is unable to have the transferred asset(s) returned or to receive fair market value for the asset or to void a trust; and

- either: the individual is unable to obtain appropriate medical care such that the individual's health or life would be endangered without the provision of Medicaid for nursing facility services; or

- the transfer of assets penalty would deprive the individual of food, clothing, shelter, or other necessities of life.

Note: The only change to the definition of undue hardship required by the DRA is the added provision regarding the individual being deprived of food, clothing, shelter or other necessities of life.

Undue hardship cannot be claimed:

- if the applicant failed to fully cooperate, to the best of his/her ability, as determined by the social services district, in having all of the transferred assets returned or the trust declared void. Cooperation may include, but is not limited to, assisting in providing all legal records pertaining to the transfer or creation of the trust, assisting the district, wherever possible, in providing information regarding the transfer amount, to whom it was transferred, any documents to support the transfer or any other information related to the circumstances of the transfer; or

- if after payment of medical expenses, the individual's or couple's income and/or resources are at or above the allowable Medicaid exemption standard for a household of the same size; or

- if the only undue hardship that would result is the individual's or the individual's spouse's inability to maintain a pre-existing life style.

At application for Medicaid coverage of nursing facility services, the individual, individual's spouse, representative and/or nursing facility, with consent from the institutionalized individual, individual's spouse or individual's representative, may apply for an undue hardship waiver. If Medicaid coverage is approved based on a determination that the individual meets undue hardship, a notice must be sent informing the individual that undue hardship has been met. To meet this notice requirement, a new notice has been developed (Attachment V). As stated in Attachment V, the notice must be sent with a second notice of decision that informs the individual of his or her Medicaid eligibility. If

an individual who claimed undue hardship is determined not to meet the undue hardship criteria, Attachment V must be used to inform the individual that he/she was determined not to meet undue hardship. Undue hardship determinations are to be made within the same time period that districts have to determine eligibility. Additional time for providing documentation to determine undue hardship may be approved by the district. If an individual disagrees with the district's determination of undue hardship, the recipient's notice will inform the individual of his/her right to request a fair hearing.

Recipients of limited coverage may request a consideration of undue hardship in order to obtain Medicaid coverage of nursing facility services at any time during a transfer penalty period. The (re)determination may include up to three months prior to the month in which the request for review of undue hardship is made. The individual, individual's spouse, representative, or nursing facility, with the consent of the individual or individual's representative, may request a (re)determination of undue hardship. Social services districts may use Attachment II to inform the requestor that proof of undue hardship is required and that the (re)determination may be made for up to three months prior to the month in which the request is made.

(v) Explanation of the Effect of Transfer of Assets on Medical Assistance Eligibility

To inform individuals of the changes to the transfer of assets provisions required by the DRA, the LDSS-4294 (Rev. 8/06) "Explanation of the Effect of Transfer of Assets on Medical Assistance Eligibility" (Attachment VI) has been revised. The Department will distribute this revised notice to all medical institutions, nursing facilities and long-term care providers. Social services districts are required to make the notice available to all persons requesting such information, and are required to include the notice with all Medicaid applications involving an institutionalized individual applying for nursing facility services. A copy of this notice must also be sent when an A/R's (re)application is denied or discontinued due to a prohibited transfer. The explanation must be included with the appropriate mandated notice. The notice is mandated, and must be reproduced by the district without modification until such time that it becomes available from this Department.

4. Disclosure of Annuities Purchased on or After February 8, 2006

Effective for applications filed on or after August 1, 2006 for Medicaid coverage of nursing facility services, including requests for an increase in coverage for nursing facility services, A/Rs are required to disclose a description of any interest the A/R or the A/R's spouse has in an annuity, regardless of whether the annuity is irrevocable or treated as an asset.

In order to inform A/Rs of their obligation to disclose information concerning annuities purchased on or after February 8, 2006, and the requirement for Medicaid coverage of nursing facility services that the State be named the remainder beneficiary of the A/R's or the spouse's annuity, the LDSS-2921 "Application for Public Assistance/Medical Assistance/Food Stamps/Services" is being revised. Until the revised form is available, districts must include a copy of Attachment VII with all applications for nursing facility services. The attachment must also be given to individuals who request an increase in Medicaid coverage for nursing facility services.

For annuities purchased by the A/R or the A/R's spouse on or after February 8, 2006, the purchase of the annuity shall be treated as a transfer of assets for less than fair market value unless:

- the State is named as the remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of the annuitant; or

- the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child, or in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value.

The social services district must require a copy of the annuity contract owned by the A/R or A/R's spouse in order to verify that the State has been named the remainder beneficiary. If the A/R or the A/R's spouse fails or refuses to provide the necessary documentation, the district must treat the purchase of the annuity as a transfer of assets for less than fair market value.

In addition to naming the State as a remainder beneficiary on an annuity, the purchase of an annuity by or on behalf of an A/R is to be treated as a transfer of assets for less than fair market value unless:

- the annuity is an individual retirement annuity contract or endowment issued by an insurance company that is not transferable, has fixed premiums and the entire interest is non-forfeitable by the owner; **or**

- the annuity is a voluntary employee funded account that is established under, but is separate from a qualified employer plan; **or**

- the annuity is:

  - purchased with the proceeds from an individual retirement trust or account as described in subsection (a), (c) or (p) of Section 408 of the Internal Revenue Code;

  - a simplified employee pension plan. A simplified employee pension plan is an individual retirement annuity as described in Section 408(k) of the Internal Revenue Code; or

  - a Roth IRA. A Roth IRA is an individual retirement plan described in Sect ion 408A of the Internal Revenue Code; **or**

- the annuity is:

  - irrevocable and non-assignable;

  - actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration (see Attachment VIII life expectancy table); and

  - provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments.

The annuity provisions apply to transactions, including purchases, which occur on or after February 8, 2006. Transactions subject to these provisions include any action by the individual that changes the course of payment from the annuity or that changes the treatment of the income or principal of the annuity. These transactions include additions of principal, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract and similar actions.

5. <u>Assets Transferred to Purchase Life Estate Interest</u>

A life estate is a limited interest in real property. A life estate holder does not have full title to the property, but has the use of the property for his or her lifetime, or for a specified period. Generally, life estates are in the form of a life lease on property that the person is using, or has used, for a homestead.

When an A/R or the A/R's spouse transfers assets to purchase a life estate interest in property owned by another individual on or after February 8, 2006, the purchase is to be treated as a transfer of assets for less than fair market value unless the purchaser resides in the home for at least a continuous period of one year after the

date of purchase. If the purchaser has not resided in the home for at least one year after the date of purchase, the amount used to purchase the life estate interest is to be treated as the uncompensated transfer of assets amount in the eligibility determination. This provision applies to applications filed on or after August 1, 2006 for nursing facility services, including requests for an increase in coverage for nursing facility services.

Districts should note that this provision does not apply to A/Rs or their spouses who transfer property and retain life use. It only applies to the purchase of life use interest in property not previously owned by the A/R.

6. **Assets Transferred to Purchase Loans, Promissory Notes and Mortgages**

Effective for applications filed on or after August 1, 2006, for nursing facility services, including requests for an increase in coverage for nursing facility services, if an A/R or the A/R's spouse purchases a loan, promissory note or mortgage, the funds used are to be treated as a transfer for less than fair market value unless the note, loan or mortgage:

- has a repayment term that is actuarially sound;
- provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and
- prohibits the cancellation of the balance upon the death of the lender.

The amount of the transfer is the outstanding balance due as of the date of the individual's application for nursing facility services.

C. **TREATMENT OF SUBSTANTIAL HOME EQUITY**

Effective immediately, districts must review the equity value of an A/R's home if the A/R requires Medicaid coverage for nursing facility services or community-based long-term care services. Individuals applying for nursing facility services or community-based long-term care services on or after January 1, 2006, are to be denied Medicaid coverage for such services if the equity interest in the individual's home exceeds $750,000. The equity value is derived by subtracting any legal encumbrances (liens, mortgages, etc.) from the fair market value. If the home is owned jointly with one or more individuals, each owner is presumed to have an equal interest in the property, absent any evidence to the contrary. Individuals cannot spenddown excess equity with the use of medical bills to obtain eligibility. Individuals whose equity interest in the home exceeds $750,000 continue to be eligible for Medicaid coverage of Community Coverage Without Long-Term Care.

The home equity limitation does not apply if the individual's spouse, minor child or certified blind or certified disabled child lawfully resides in the home.

Individuals may use a reverse mortgage or home equity loan to reduce the individual's equity interest in the home. Social services districts should note that although payments received from a reverse mortgage or home equity loan are not counted in the month of receipt for eligibility purposes, if the funds are transferred during the month of receipt, the transfer is to be considered a transfer for less than fair market value.

Individuals who are subject to the home equity limitation may claim undue hardship. Undue hardship exists if the denial of Medicaid coverage would:

- deprive the A/R of medical care such that the individual's health or life would be endangered; or

- deprive the A/R of food, clothing, shelter, or other necessities of life;

and there is a legal impediment that prevents the A/R from being able to access his or her equity interest in the property.

If an otherwise eligible individual is determined not to meet the undue hardship criteria, Attachment IX informs the individual that he/she is being authorized for Community Coverage Without Long-Term Care due to substantial home equity interest. Undue hardship determinations are to be made within the same time period that districts have to determine eligibility. Additional time for providing documentation to determine undue hardship may be approved by the district. If an individual disagrees with the district's determination of undue hardship, the recipient's notice will inform the individual of his/her right to request a conference and/or fair hearing.

Individuals who are not eligible for nursing facility services and community-based long-term care services due to substantial home equity must be authorized with RVI Code 3/Coverage Code 20 or RVI Code 3/Coverage Code 22 (Outpatient Coverage Without Long-Term Care, as applicable. Districts should not authorize short-term rehabilitative nursing home care and the recipient is not eligible for certified home health care (CHHA) services.

The home equity limitation applies to applications for long-term care services and to requests for an increase in coverage for long-term care services filed on or after January 1, 2006. For individuals who applied on or after January 1, 2006, and were determined eligible for and in receipt of long-term care services, the home equity limitation is to apply at next client contact or recertification, whichever occurs first. The home equity limitation does not apply to individuals who applied and were determined eligible for and in receipt of long-term care services before January 1, 2006 and have no break in eligibility for long-term care services after January 1, 2006.

D. TREATMENT OF CONTINUING CARE RETIREMENT COMMUNITY CONTRACTS

CCRCs are paid primarily with private funds, but a number also accept Medicaid payment for nursing facility services. Sections 1919(c)(5)(A)(i)(II) and (B)(v) of the Social Security Act are amended so that State licensed, registered, certified or equivalent CCRCs, or life care communities (including nursing facility services provided as part of that community) which are certified to accept Medicaid and/or Medicare payment may require in their admissions contracts that residents spend their resources declared for the purposes of admission on their care, before they apply for Medicaid.

Effective for Medicaid applications filed on or after August 1, 2006, an individual's entrance fee in a continuing care retirement community or life care community shall be considered a resource to the extent that:

- the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;

- the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

- the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

For applicants with a community spouse, only that part of the entrance fee that is not protected by the community spouse's resource allowance would be considered in the computation of the share available to Medicaid.

V. NOTICE REQUIREMENTS

The following manual notices are to be used for applications filed on or after August 1, 2006. The attached manual notices are to be reproduced by the social services district until further notice.

1. LDSS-4144 (Rev. 8/06): Notice of Decision on Your Medical Assistance Application - Limited Coverage (Transfer of Assets Penalty):

This revised notice (Attachment III) must be used to inform an institutionalized applicant that his/her Medicaid application for nursing facility services has been accepted with limited coverage due to a transfer of assets. In addition, if the applicant is required to meet a spenddown requirement, a LDSS-4038, "Explanation of the Excess Income Program" must be sent.

2. LDSS-4145 (Rev. 8/06): Notice of Decision on Your Request For Coverage of Nursing Facility Services - Limited Coverage (Transfer of Assets Penalty):

This revised undercare notice (Attachment IV) is used to inform a recipient that his/her request for an increase in coverage for nursing facility services is accepted with limited coverage due to a transfer of assets. In addition, if the individual is required to meet a spenddown requirement, a LDSS-4038, "Explanation of the Excess Income Program" must be sent.

3. Notice of Decision on Your Request for Undue Hardship (Transfer of Assets Penalty):

This notice (Attachment V) must be used to inform an institutionalized individual that a determination has been made regarding undue hardship. The notice must be used to accept or deny an individual's Medicaid coverage for nursing facility services based on an evaluation of the individual's circumstances and the undue hardship criteria.

Accept Undue Hardship - For acceptance situations, the notice must be accompanied with the appropriate Medical Assistance acceptance notice.

Deny Undue Hardship - In denial situations, the notice must be sent with the "Notice of Decision on Your Medical Assistance Application - Limited Coverage (Transfer of Assets)".

4. LDSS-4294 (Rev. 8/06): Explanation of the Effect of Transfer of Asset(s) on Medical Assistance Eligibility:

The revised explanation notice (Attachment VI) must be made available to all individuals who apply for Medicaid coverage of nursing facility services. A copy must also be sent when an A/R's application for nursing facility services is denied/discontinued or limited due to a prohibited transfer.

5. Notice of Decision On Your Medical Assistance Application - Long-Term Care Services (Substantial Home Equity):

This notice (Attachment IX) must be used to inform individuals applying for nursing facility services or community-based long-term care services that they are not eligible for these services due the value of their home equity interest. The notice is used to accept the individual for Community Coverage Without Long-Term Care. The notice describes the home equity limit and the circumstances when undue hardship may exist.

VI. SYSTEMS IMPLICATIONS

A. UPSTATE WMS IMPLICATIONS

There are no systems implications.

B. CNS UPSTATE

The following CNS notices have been created to assist districts in implementing the requirements contained in this directive. The WMS/CNS Coordinator Letter associated with this directive will advise districts of the Reason Codes associated with the below notices.

1. New Notices

a. Accept CC Without LTC, Home Equity Interest Exceeds Limit, No Undue Hardship, No SD

This notice must be used to accept an individual without a spenddown requirement for Community Coverage Without Long-Term Care due to substantial home equity and no undue hardship. This notice informs the applicant of his/her ineligibility for long-term care services.

b. Accept CC Without LTC, Home Equity Interest Exceeds Limit, No Undue Hardship, 6-Mo Exc Inc and Res SD Met

This notice is used to accept an individual who has met a 6-month excess income and resource spenddown with Community Coverage Without Long-Term Care due to substantial home equity and no undue hardship. This notice informs the applicant of his/her ineligibility for long-term care services.

c. Continue MA Unchanged, Individual Home Equity Interest Exceeds Limit, No Undue Hardship, No SD

This undercare notice must be used to continue unchanged a recipient's coverage of Community Coverage Without Long-Term Care due to substantial home equity and no undue hardship. The individual does not have a spenddown requirement. This reason code informs the applicant of his/her ineligibility for long-term care services.

d. Continue MA Unchanged, Individual Home Equity Interest Exceeds Limit, No Undue Hardship, 6-Mo Exc Inc and/or Res SD Met

This undercare notice must be used to continue unchanged recipient's coverage of Community Coverage Without Long-Term Care due to substantial home equity and no undue hardship. The recipient has met a 6-month excess income and/or resource spenddown. This reason code informs the applicant of their ineligibility for long-term care services.

e. Accept CC Without LTC, Home Equity Interest Exceeds Limit, No Undue Hardship, Exc Inc SD Met

This undercare notice must be used to accept an individual who has met an excess income spenddown with Community Coverage Without Long-Term Care due to substantial home equity and no undue hardship. This notice informs the applicant of his/her ineligibility for long-term care services.

Note: In cases where an individual with substantial home equity **does** meet undue hardship, districts should use the appropriate acceptance or change notice to authorize coverage for long-term care services.

2. **Revised Notices**

Explanation of the Effect of Transfer of Assets on Medical Assistance Eligibility

This explanation notice has been revised to include information concerning prohibited transfers made on or after February 8, 2006.

C. **NYC WMS IMPLICATIONS**

NYC WMS instruction will be provided under separate cover.

VII. EFFECTIVE DATE

The transfer provisions, including the treatment of annuities, apply to applications for nursing facility services filed on or after August 1, 2006, including requests for an increase in coverage of nursing facility services made on or after August 1, 2006. The home equity provisions are effective August 1, 2006 retroactive to January 1, 2006 for applications filed on or after January 1, 2006 for nursing facility services or community-based long-term care services. The provisions for certain entrance fees for CCRCs are effective for applications filed on or after August 1, 2006.

Brian J. Wing, Deputy Commissioner
Office of Medicaid Management

LISTING OF ATTACHMENTS

Attachment I:	DOH-4319 (Rev. 8/06), Long-Term Care Change In Need Resource Checklist (available on-line)
Attachment II:	Cover Letter Resource Checklist (available on-line)
Attachment III:	LDSS-4144 (Rev. 8/06), Notice of Decision on Your Medical Assistance Application - Limited Coverage (Transfer of Assets Penalty) (available on-line)
Attachment IV:	LDSS-4145 (Rev. 8/06), Notice of Decision on Your Request for Coverage of Nursing Facility Services - Limited Coverage (Transfer of Assets Penalty) (available on-line)
Attachment V:	Notice of Decision on Your Request Undue Hardship (Transfer of Assets Penalty) (available on-line)
Attachment VI:	LDSS-4294 (Rev. 8/06),Explanation of the Effect of Transfer of Asset(s) on Medical Assistance Eligibility (available on-line)
Attachment VII:	Disclosure of Annuities (available on-line)
Attachment VIII:	Life Expectancy Table (available on-line)
Attachment IX:	Notice of Decision on Your Medical Assistance Application - Long-term Care Services (Substantial Home Equity) (available on-line)

Long-Term Care Change In Need Resource Checklist

Resources	No	Yes	Amount	
Checking account?				Copy of Bank/Credit Union Statements
Savings account?				Copy of Bank/Credit Union Statements
Retirement accounts (Deferred Compensation, IRA and/or Keogh)?				Copy of Financial Statement
Life insurance policies?				Copy of Policy and current Statement identifying Face Value and current Cash Value
Stocks, bonds or certificates of deposits (CDs)?				Copy of Stocks, Bonds, Certificates **OR** Copy of financial statement
Mutual funds?				Copy of Bonds
Homestead?				Verification of equity interest if no spouse, minor child or certified bind or certified disabled child residing in the
Other Real Property, including income producing and non-income producing property?				Copy of Deed and proof of current Fair Market Value
Annuities?				Copy of Annuity Contract/Agreement
"In trust" accounts?				Copy of Financial Statement
Safe Deposit Box?				Copy of Bank Record
Resources other than those listed above?				

Have you or your spouse given away any cash, income or resources, or sold/transferred any real or personal property within the past 36 months? If yes, when _____.

Have you or your spouse created a trust since your last recertification or transferred any assets to or from a trust or become a beneficiary of a trust? If yes, when _____.

If you own your home and no spouse, minor child or certified blind or disabled child is residing in the home, is there a legal impediment that prevents you from being able to access your equity interest in the property? If yes, what is the legal impediment _____.

I swear and/or affirm under penalties of perjury that the information I have given or will give regarding my determination for Medicaid coverage for all care and services is correct.

_____ _____ _____ _____

Recipient/Representative Signature **Date Signed** **Spouse/Representative Signature** **Date Signed**

DOH-4319 (Rev. 8/06)

LDSS-4144 (Rev. 8/06) Attachment III

NOTICE OF DECISION ON YOUR MEDICAL ASSISTANCE APPLICATION
LIMITED COVERAGE
(Transfer of Assets Penalty)

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (and C/O Name if Present)AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____
		OR Agency Conference _____
		Fair Hearing Information and Assistance _____
		Record Access _____
		Legal Assistance Information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

We have accepted your application dated _____ for Medical Assistance with limited coverage effective _____.

We have determined that on (date) _____ you/your spouse transferred (item(s))_____valued at $_____. The difference between this value and the amount actually received ($_____) is $_____. This amount is considered to be the uncompensated value.

Because you/your spouse transferred this asset(s) for less than fair market value, you are **not** eligible for the following types of care and services:

- services provided in skilled nursing facilities, including hospice and managed long-term care, health-related facilities, or intermediate care facilities;
- nursing facility services provided in a hospital; and
- home and community-based services provided pursuant to a waiver under Section 1915(c) or (d) of the Social Security Act.

You are **not** eligible for the above noted care and services for a period of _____ month(s) or until (date) _____. This is based on the following calculation:

Uncompensated value of transferred asset(s) (less MA exemption, if applicable) $_____

Monthly regional rate $_____

Period of limited coverage: _____ month(s)

You will also have an additional $_____ that you will have to contribute toward your cost of care for the month of _____. This is the partial month portion of the penalty period. This is in addition to any income contribution that must be contributed toward your cost of care for the month.

Although you are not eligible for certain types of care and services because of the above-referenced transfer, you may be eligible for coverage of other care and services, (*e.g., eyeglasses, hearing aids, dentures and acute hospital care*). In order for you to be eligible for this coverage: (1) your income must be no greater than the allowable MA income standard; or (2) if your income exceeds the allowable MA income standard, you must meet certain excess income requirements. You will have to meet an excess income requirement for these services if there is an ☒ in the box below.

☐ **EXCESS INCOME**

Your total gross monthly income is $_____. Your total monthly deductions are $_____. The difference between these is your net monthly income. This is $_____. The allowance income standard for a family household your size is $_____. The difference between your net monthly income amount and this standard ($_____) is your monthly spenddown or excess income amount. Your excess income for six months is $_____. Please see the enclosed Form LDSS-4038, which explains how you can meet the excess income requirements and become eligible for coverage under the EXCESS INCOME PROGRAM.

Note: If there are other factors which affect your Medical Assistance coverage, a separate notice is enclosed.

READ THE ENCLOSED NOTICE (Effect of Transfer of Asset(s) on Medical Assistance Eligibility) FOR IMPORTANT INFORMATION CONCERNING TRANFER OF ASSETS.

The Laws and/or Regulations which allow us to do this are: Social Services Law 366.5 and 18 NYCRR 360-4.4, 360-4.5, 360-4.7 and 360-4.8.

We have enclosed a budget worksheet(s) so that you can see how we determined eligibility for benefits.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the front page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1) **Telephone:** You may call the state wide toll free number: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL); **OR**

2) **Fax:** Send a copy of this notice to fax no. (518) 473-6735; **OR**

3) **On-Line:** Complete and send the online request form at: http://www.otda.state.ny.us/oah/forms.asp; **OR**

4) **Write:** Send a copy of this notice **completed**, to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:_____

_____

_____

Print Name: _____ Case Number: _____

Address: _____ Telephone: _____

Signature of Client: _____ Date: _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the front of this notice.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of the front of this notice or write us at the address printed at the top of the front of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of the front of this notice or write to us at the address printed at the top of the front of this notice.

ATTENTION: Children under 19 years of age who are not eligible for Child Health Plus A or other health insurance may be eligible for the Child Health Plus B Insurance Plan (Child Health Plus B). The plan provides health care insurance for children. Call 1-800-522-5006 for information.

NOTICE OF DECISION ON YOUR REQUEST FOR COVERAGE OF NURSING FACILITY SERVICES
LIMITED COVERAGE
(Transfer of Assets Penalty)

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (and C/O Name if Present)AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____ OR Agency Conference _____ Fair Hearing Information and Assistance _____ Record Access _____ Legal Assistance Information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

We will change your Medical Assistance coverage from Community Coverage to limited coverage effective _____.

This is because you requested an increase in Medical Assistance coverage for nursing facility services, but we have determined that on (date) _____ you/your spouse transferred (item(s)) _____ valued at $_____. The difference between this value and the amount actually received ($_____) is $_____. This amount is considered to be the uncompensated value.

Because you/your spouse transferred this asset(s) for less than fair market value, you are not eligible for the following types of care and services:

- services provided in skilled nursing facilities, including hospice and managed long-term care, health-related facilities, or intermediate care facilities;
- nursing facility services provided in a hospital; and
- home and community-based services provided pursuant to a waiver under Section 1915(c) or (d) of the Social Security Act.

You are **not** eligible for the above noted care and services for a period of _____ month(s) or until (date) _____. This is based on the following calculation:

Uncompensated value of transferred asset(s) $_____
(less MA exemption, if applicable)

÷

Monthly regional rate $_____

Period of limited coverage: _____ month(s)

You will also have an additional $_____ that you will have to contribute toward your cost of care for the month of _____. This is the partial month portion of the penalty period. This is in addition to any income contribution that must be contributed toward your cost of care for the month.

Although you are not eligible for certain types of care and services because of the above-referenced transfer, you may be eligible for coverage of other care and services, (*e.g., eyeglasses, hearing aids, dentures and acute hospital care*). In order for you to be eligible for this coverage: (1) your income must be no greater than the allowable MA income standard; or (2) if your income exceeds the allowable MA income standard you must meet certain excess income requirements. You will have to meet an excess income requirement for these services if there is an ☒ in the box below.

☐ **EXCESS INCOME**
Your total gross monthly income is $_____. Your total monthly deductions are $_____. The difference between these is your net monthly income. This is $_____. The allowance income standard for a family household your size is $_____. The difference between your net monthly income amount and this standard ($_____) is your monthly spenddown or excess income amount. Your excess income for six months is $_____. Please see the enclosed Form LDSS-4038, which explains how you can meet the excess income requirements and become eligible for coverage under the EXCESS INCOME PROGRAM.

Note: If there are other factors which affect your Medical Assistance coverage, a separate notice is enclosed.

READ THE ENCLOSED NOTICE (Effect of Transfer of Asset(s) on Medical Assistance Eligibility) FOR IMPORTANT INFORMATION CONCERNING TRANFER OF ASSETS.

The Laws and/or Regulations which allow us to do this are: Social Services Law 366.5 and 18 NYCRR 360-4.4, 360-4.5, 360-4.7 and 360-4.8.

We have enclosed a budget worksheet(s) so that you can see how we determine eligibility for benefits.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

LDSS-4145 (Rev. 8/06) REVERSE

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1) **Telephone:** You may call the state wide toll free number: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL); **OR**

2) **Fax:** Send a copy of this notice to fax no. (518) 473-6735; **OR**

3) **On-Line:** Complete and send the online request form at: http://www.otda.state.ny.us/oah/forms.asp; **OR**

4) **Write:** Send a copy of this notice **completed**, to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because: _____

_____

_____

_____

Print Name: _____ Case Number_____

Address: _____Telephone: _____

Signature of Client: _____ Date: _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any Medical Assistance benefits that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

☐ I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file, which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of page 1 of this notice or write us at the address printed at the top of page 1 of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of page 1 of this notice or write to us at the address printed at the top of page 1 of this notice.

ATTENTION: Children under 19 years of age who are not eligible for Child Health Plus A or other health insurance may be eligible for the Child Health Plus B Insurance Plan (Child Health Plus B). The plan provides health care insurance for children. Call 1-800-522-5006 for information.

NOTICE OF DECISION ON YOUR REQUEST FOR UNDUE HARDSHIP
(Transfer of Assets Penalty)

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (and C/O Name if Present)AND ADDRESS		
		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____
		OR Agency Conference _____
		Fair Hearing Information and Assistance _____
		Record Access _____
		Legal Assistance Information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

We have made a decision on your request for undue hardship for Medical Assistance coverage of nursing facility services.

We have determined that on (date) _____ you/your spouse transferred (item(s)) _____ valued at $_____. The difference between this value and the amount actually received ($_____) is $_____. This amount is considered to be the uncompensated value.

Because you/your spouse transferred this asset(s) for less than it was worth, you are not eligible for nursing facility services unless you meet undue hardship criteria. Undue hardship exists if:

- you meet all other eligibility requirements, and
- you are unable to obtain appropriate medical care without receiving Medical Assistance; **or**
- the application of a transfer penalty period would deprive you of food, clothing, shelter or other necessities of life.

Based on the above criteria, we will

☐ **ACCEPT** your request for undue hardship dated _____ for Medical Assistance coverage of nursing facility services because: _____
_____
_____.

☐ **DENY** your request for undue hardship for Medical Assistance coverage of nursing facility services because: _____
_____
_____.

NOTE: If there are other factors, which affect your Medical Assistance coverage, a separate notice is enclosed.

THE LAW AND REGULATIONS which allow us to do this are Social Services Law 366.5 and 18 NYCRR 360-4.4.

READ THE ENCLOSED NOTICE (Effect of Transfer of Asset(s) on Medical Assistance Eligibility) FOR IMPORTANT INFORMATION CONCERNING TRANFER OF ASSETS.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the front page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1) **Telephone:** You may call the state wide toll free number: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL); **OR**

2) **Fax:** Send a copy of this notice to fax no. (518) 473-6735; **OR**

3) **On-Line:** Complete and send the online request form at: http://www.otda.state.ny.us/oah/forms.asp; **OR**

4) **Write:** Send a copy of this notice **completed**, to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:_____

_____

_____

Print Name: _____ Case Number: _____

Address: _____ Telephone: _____

Signature of Client: _____ Date: _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the front of this notice.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of the front of this notice or write us at the address printed at the top of the front of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of the front of this notice or write to us at the address printed at the top of the front of this notice.

ATTENTION: Children under 19 years of age who are not eligible for Child Health Plus A or other health insurance may be eligible for the Child Health Plus B Insurance Plan (Child Health Plus B). The plan provides health care insurance for children. Call 1-800-522-5006 for information.

3. The asset(s) was transferred to your child of any age who is certified blind, or certified disabled, or to a trust established solely for the benefit of that child; or
4. The asset(s) was transferred to a trust established solely for the benefit of an individual less than 65 years of age who is certified disabled; or
5. The asset(s) transferred was your homestead (for example: a house or an apartment that you own), and the homestead was transferred to:
    a. Your spouse; or
    b. Your minor child under age 21, or your child of any age who is certified blind or certified permanently and totally disabled; or
    c. Your brother or sister who also has an equity interest in the home and who lived in the home for at least one year immediately before you became institutionalized; or
    d. Your child (other than a child who is under 21 or who is certified blind/disabled) who was living in your home for at least two years immediately before you became institutionalized and who provided care which permitted you to reside at home rather than in an institution or nursing facility.

NOTE: Although the Department does not treat a life estate possessed by you as a countable resource for purposes of determining your Medical Assistance eligibility, a life estate has value and you may be subject to a transfer penalty if you transfer your life estate interest to another person.

What other transfers do not affect your eligibility for Medical Assistance?

If you or your spouse transferred assets for less than fair market value, you can still get Medical Assistance coverage of nursing facility services if you can prove that:

1. You or your spouse intended to dispose of the asset(s) at fair market value or to receive other valuable consideration in exchange for the asset(s); or
2. The asset(s) was transferred exclusively for a purpose other than to qualify for Medicaid coverage of nursing care and related services as described on the front page; or
3. All of the transferred assets have been returned.

In the absence of the evidence described in 1 or 2 above, we will not limit your Medical Assistance coverage if we determine that despite your best efforts, as determined by the social services district, you are unable to have the transferred asset(s) returned or to receive fair market value for the asset. We will also not limit your Medical Assistance coverage if we determine that such limitation will result in undue hardship for you. We will consider undue hardship to exist if you: (a) meet all other eligibility requirements, and (b) are unable to obtain appropriate medical care without which your health or life would be in danger, or (c) the application of the transfer penalty would deprive you of food, clothing, shelter or other necessities of life. You may request a consideration of undue hardship at any time during a period of limited coverage due to a transfer penalty. The (re)determination may include up to three months prior to your request for a review of undue hardship. You, your spouse, representative or the nursing facility, with your consent or the consent of your representative, may request a (re)determination of undue hardship.

How can you prove the transfer was not made to qualify for these medical services?

We will presume that any prohibited transfer of assets made within the applicable look-back period was made for the purpose of qualifying for Medical Assistance. If you disagree with this presumption, you should present evidence to your Medical Assistance eligibility examiner which proves the transfer was made for some other purpose. Some factors which may establish that a transfer was made for a purpose other than to obtain Medical Assistance eligibility are:

1. Sudden, unexpected onset of a serious illness or disability after the transfer occurred; or
2. Unexpected loss of other resources or income which would have made you ineligible for Medical Assistance, after the transfer occurred.

These are examples only. All of the circumstances of the transfer will be considered as well as factors such as age, health, and financial situation at the time the transfer was made. It is important to note that you have the burden of providing this agency with complete information regarding all assets and any other relevant factors which may affect your eligibility.

What appeal rights do you have?

You will receive a written notice if we determine that your Medical Assistance coverage is to be limited based on a transfer of assets for less than fair market value. If you are in a nursing facility or require the services listed under the "limited coverage" section at the time we make our decision, the notice will tell you how long you will have limited coverage. This period will be based on the amount of assets you or your spouse has transferred for less than fair market value, and the average rate for nursing facility services in the region in which you reside.

You have the right to appeal our decision to limit your coverage. Our written notice will provide you with information on how to request a conference with us to review our actions. Our notice will also provide you with information on your rights to a State Fair Hearing if you believe our action is wrong.

IF YOU HAVE ANY QUESTIONS, CONTACT YOUR MEDICAL ASSISTANCE ELIGIBILITY EXAMINER.

3. The asset(s) was transferred to your child of any age who is certified blind, or certified disabled, or to a trust established solely for the benefit of that child; or
4. The asset(s) was transferred to a trust established solely for the benefit of an individual less than 65 years of age who is certified disabled; or
5. The asset(s) transferred was your homestead (for example: a house or an apartment that you own), and the homestead was transferred to:
    a. Your spouse; or
    b. Your minor child under age 21, or your child of any age who is certified blind or certified permanently and totally disabled; or
    c. Your brother or sister who also has an equity interest in the home and who lived in the home for at least one year immediately before you became institutionalized; or
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1. You or your spouse intended to dispose of the asset(s) at fair market value or to receive other valuable consideration in exchange for the asset(s); or
2. The asset(s) was transferred exclusively for a purpose other than to qualify for Medicaid coverage of nursing care and related services as described on the front page; or
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1. Sudden, unexpected onset of a serious illness or disability after the transfer occurred; or
2. Unexpected loss of other resources or income which would have made you ineligible for Medical Assistance, after the transfer occurred.

These are examples only. All of the circumstances of the transfer will be considered as well as factors such as age, health, and financial situation at the time the transfer was made. It is important to note that you have the burden of providing this agency with complete information regarding all assets and any other relevant factors which may affect your eligibility.

What appeal rights do you have?

You will receive a written notice if we determine that your Medical Assistance coverage is to be limited based on a transfer of assets for less than fair market value. If you are in a nursing facility or require the services listed under the "limited coverage" section at the time we make our decision, the notice will tell you how long you will have limited coverage. This period will be based on the amount of assets you or your spouse has transferred for less than fair market value, and the average rate for nursing facility services in the region in which you reside.

You have the right to appeal our decision to limit your coverage. Our written notice will provide you with information on how to request a conference with us to review our actions. Our notice will also provide you with information on your rights to a State Fair Hearing if you believe our action is wrong.

IF YOU HAVE ANY QUESTIONS, CONTACT YOUR MEDICAL ASSISTANCE ELIGIBILITY EXAMINER.

NOTICE OF DECISION ON YOUR REQUEST FOR UNDUE HARDSHIP
(Transfer of Assets Penalty)

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (and C/O Name if Present)AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____ OR Agency Conference _____ Fair Hearing Information and Assistance _____ Record Access _____ Legal Assistance Information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

We have made a decision on your request for undue hardship for Medical Assistance coverage of nursing facility services.

We have determined that on (date) _____ you/your spouse transferred (item(s)) _____ valued at $_____. The difference between this value and the amount actually received ($_____) is $_____. This amount is considered to be the uncompensated value.

Because you/your spouse transferred this asset(s) for less than it was worth, you are not eligible for nursing facility services unless you meet undue hardship criteria. Undue hardship exists if:

- you meet all other eligibility requirements, and
- you are unable to obtain appropriate medical care without receiving Medical Assistance; **or**
- the application of a transfer penalty period would deprive you of food, clothing, shelter or other necessities of life.

Based on the above criteria, we will

☐ **ACCEPT** your request for undue hardship dated _____ for Medical Assistance coverage of nursing facility services because: _____
_____
_____.

☐ **DENY** your request for undue hardship for Medical Assistance coverage of nursing facility services because: _____
_____
_____.

NOTE: If there are other factors, which affect your Medical Assistance coverage, a separate notice is enclosed.

THE LAW AND REGULATIONS which allow us to do this are Social Services Law 366.5 and 18 NYCRR 360-4.4.

READ THE ENCLOSED NOTICE (Effect of Transfer of Asset(s) on Medical Assistance Eligibility) FOR IMPORTANT INFORMATION CONCERNING TRANFER OF ASSETS.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

EXPLANATION OF THE EFFECT OF TRANSFER OF ASSET(S) ON MEDICAL ASSISTANCE ELIGIBILITY

This explains how a transfer of assets may affect your eligibility for Medical Assistance. Assets include all of your and your spouse's income and resources, including any income or resources which you or your spouse are entitled to receive but do not receive because of any action or inaction by you or your spouse. A transfer is when property or assets are given or sold from one person to another. For Medical Assistance purposes, a prohibited transfer is the voluntary giving or sale of your property or assets to another person without receiving something of equal value in return, in order to qualify for:

- Services provided in skilled nursing facilities, including hospice and managed long-term care, health-related facilities, or intermediate care facilities;
- Nursing facility services provided in a hospital; or
- Care, services or supplies furnished pursuant to a waiver under section 1915 (c) or (d) of the Social Security Act, including: the Long Term Care Program, the OMRDD Home and Community Based Waiver, the Traumatic Brain Injury Waiver or the Care at Home Program.

The Medical Assistance Program will not pay for any of the services listed below if a prohibited transfer of countable assets (the total value of property, income, and resources that are in excess of the allowable Medical Assistance resource standard) for less than fair market value is made within the 36 months before your application for Medical Assistance coverage of nursing facility services, or at any time after you apply for Medical Assistance to pay for the nursing facility services listed in the "limited coverage" section below. In the case of trusts, we will look back for a period of 60 months.

For transfers made on or after February 8, 2006, if the transfer is made within the 60 months before your application for Medical Assistance coverage of nursing facility services, or at any time after you apply for Medical Assistance to pay for nursing facility services, and you meet all other eligibility requirements, your Medical Assistance coverage may be limited for a period of time.

What does limited coverage mean?

Limited coverage means that for a period of time you will not be able to receive Medical Assistance coverage for the following types of care and services:

- Services provided in skilled nursing facilities, including hospice and managed long-term care, health-related facilities, or intermediate care facilities;
- Nursing facility services provided in a hospital; or
- Care, services, or supplies furnished pursuant to a waiver under section 1915 (c) or (d) of the Social Security Act, including: the Long Term Care Program, the OMRDD Home and Community Based Waiver, the Traumatic Brain Injury Waiver or the Care at Home Program. Examples of these services are:

  - ✓ Congregate/home delivered meals
  - ✓ Home maintenance tasks
  - ✓ Housing improvement
  - ✓ Social transportation
  - ✓ Respite care
  - ✓ Social day care
  - ✓ Personal emergency response services
  - ✓ Moving assistance
  - ✓ Medical social services
  - ✓ Respiratory therapy
  - ✓ Nutritional counseling/education services

How is the limited coverage period determined?

When you or your spouse make a transfer of assets for less than they are worth, you cannot get Medical Assistance for the services listed above for a period of time, depending upon the amount of transferred assets. We determine the number of months you are ineligible for these services by dividing the uncompensated value of the assets transferred by the average monthly rate for nursing facility services in the region where you live. **For transfers made prior to February 8, 2006**, the penalty period would begin on the first day of the month following the month in which the transfer was made. **For transfers made on or after February 8, 2006**, the penalty period would begin on the first day of the month following the month in which assets have been transferred, or the month in which you are institutionalized and would otherwise be eligible for Medicaid payment of institutional level care, whichever is later, and which does not occur during any other period of ineligibility.

How do we determine the uncompensated value of the transferred asset(s)?

We take the fair market value of the asset at the time it was transferred. We deduct any outstanding loans, mortgages or other legal encumbrances on the asset and the amount of compensation received in exchange for the asset. In addition, certain resource or income disregards may be deducted, if applicable.

What transfers do not affect your eligibility for Medical Assistance?

There are exceptions to the transfer rules. Your Medical Assistance coverage is not limited when a transfer has been made if:

1. The asset(s) was transferred to (or to another for the sole benefit of) your spouse, or from your spouse to you; or
2. The asset(s) was transferred from your spouse to another person for the sole benefit of your spouse; or

Continued on reverse

DISCLOSURE OF ANNUITIES

MEDICAL ASSISTANCE COVERAGE FOR NURSING FACILITY SERVICES

The federal Deficit Reduction Act of 2005 (DRA) makes certain changes to the Medicaid eligibility rules for Medicaid coverage of nursing facility services. Nursing facility services include the following:

- Services provided in skilled nursing facilities (other than short-term rehabilitation), including hospice and managed long-term care, health-related facilities, or intermediate care facilities;

- Nursing facility services provided in a hospital; and

- Home and community-based services provided pursuant to a waiver under Section 1915(c) or (d) of the Social Security Act.

Individuals who are seeking Medicaid coverage of nursing facility services must disclose any interest the individual or his/her spouse has in an annuity.

Beginning with Medicaid applications filed on or after August 1, 2006 for Medicaid coverage of nursing facility services, including requests for an increase in Medicaid coverage of nursing facility services, applicants are required, as a condition for the provision of Medical Assistance, to disclose a description of any interest the individual or the individual's spouse has in an annuity. The disclosure of interest in an annuity is required regardless of whether the annuity is irrevocable or treated as an asset.

In addition, for annuities purchased by the applicant or the applicant's spouse on or after February 8, 2006:

- the State must be named the remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of the annuitant; or

- the State must be named in the second position after a community spouse or minor or disabled child, or in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value.

You must send in a copy of the annuity contract owned by you or your spouse in order for us to verify that the State has been named the remainder beneficiary. Failure or refusal to send in the required documentation will result in us considering the purchase of the annuity to be a transfer of assets for less than fair market value.

Age	Male Life Expectancy	Female Life Expectancy	Age	Male Life Expectancy	Female Life Expectancy
60.	19.72	23.06	90	3.70	4.47
61	18.96	22.24	91	3.45	4.15
62	18.21	21.43	92	3.22	3.86
63	17.48	20.63	93	3.01	3.59
64	16.76	19.84	94	2.82	3.35
65	16.05	19.06	95	2.64	3.13
66	15.36	18.30	96	2.49	2.93
67	14.68	17.54	97	2.35	2.75
68	14.02	16.80	98	2.22	2.58
69	13.38	16.07	99	2.11	2.43
70	12.75	15.35	100	2.00	2.29
71	12.13	14.65	101	1.89	2.15
72	11.53	13.96	102	1.79	2.02
73	10.95	13.28	103	1.69	1.89
74	10.38	12.62	104	1.59	1.77
75	9.83	11.97	105	1.50	1.66
76	9.29	11.33	106	1.41	1.55
77	8.77	10.71	107	1.33	1.44
78	8.27	10.11	108	1.25	1.34
79	7.78	9.52	109	1.17	1.25
80	7.31	8.95	110	1.10	1.16
81	6.85	8.40	111	1.03	1.07
82	6.42	7.87	112	0.96	0.99
83	6.00	7.36	113	0.89	0.91
84	5.61	6.88	114	0.83	0.84
85	5.24	6.42	115	0.77	0.77
86	4.89	5.98	116	0.71	0.71
87	4.56	5.56	117	0.66	0.66
88	4.25	5.17	118	0.61	0.61
89	3.97	4.81	119	0.56	0.56

Life Expectancy Table

Age	Male Life Expectancy	Female Life Expectancy	Age	Male Life Expectancy	Female Life Expectancy
0	74.14	79.45	30	45.90	50.53
1	73.70	78.94	31	44.96	49.56
2	72.74	77.97	32	44.03	48.60
3	71.77	77.00	33	43.09	47.63
4	70.79	76.01	34	42.16	46.67
5	69.81	75.03	35	41.23	45.71
6	68.82	74.04	36	40.30	44.76
7	67.83	73.05	37	39.38	43.80
8	66.84	72.06	38	38.46	42.86
9	65.85	71.07	39	37.55	41.91
10	64.86	70.08	40	36.64	40.97
11	63.87	69.09	41	35.73	40.03
12	62.88	68.09	42	34.83	39.09
13	61.89	67.10	43	33.94	38.16
14	60.91	66.11	44	33.05	37.23
15	59.93	65.13	45	32.16	36.31
16	58.97	64.15	46	31.29	35.39
17	58.02	63.17	47	30.42	34.47
18	57.07	62.20	48	29.56	33.56
19	56.14	61.22	49	28.70	32.65
20	55.20	60.25	50	27.85	31.75
21	54.27	59.28	51	27.00	30.85
22	53.35	58.30	52	26.16	29.95
23	52.42	57.33	53	25.32	29.07
24	51.50	56.36	54	24.50	28.18
25	50.57	55.39	55	23.68	27.31
26	49.64	54.41	56	22.86	26.44
27	48.71	53.44	57	22.06	25.58
28	47.77	52.47	58	21.27	24.73
29	46.84	51.50	59	20.49	23.89

NOTICE OF DECISION ON YOUR MEDICAL ASSISTANCE APPLICATION
LONG-TERM CARE SERVICES
(Substantial Home Equity)

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (and C/O Name if Present)AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____ OR Agency Conference _____ Fair Hearing Information and Assistance _____ Record Access _____ Legal Assistance Information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

We have accepted your Medical Assistance application dated _____ with Community Coverage without Long-Term Care effective _____.

You are not eligible for Medical Assistance coverage of the following long-term care services:

- services provided in skilled nursing facilities, including hospice and managed long-term care, health-related facilities, or intermediate care facilities;
- nursing facility services provided in a hospital; or
- home and community-based services provided pursuant to a waiver under Section 1915 (c) or (d) of the Social Security Act; and
- community-based long-term care services.

You are not eligible for Medical Assistance coverage of these services because we have determined that your home equity interest exceeds the home equity limit of $750,000 and we have decided that an undue hardship does not exist.

Undue hardship exists when you meet all other eligibility requirements and the denial of Medical Assistance would deprive you:

- of medical care such that your health or life would be endangered; or
- of food, clothing, shelter, or other necessities of life;

and there is a legal impediment that prevents you from being able to access your equity interest in the property.

Although you are not eligible for long-term care services due to the value of your home equity interest, you may be eligible for coverage of other care and services, (*e.g., eyeglasses, hearing aids, dentures and acute hospital care).* In order for you to be eligible for this coverage, either: (1) your income must be no greater than the allowable MA income standards; or (2) if your income exceeds the allowable MA income standards, you must meet certain excess income requirements. You will have to meet an excess income requirement for these services if there is an ☒ in the box below.

☐ **EXCESS INCOME**
Your total gross monthly income is $_____. Your total monthly deductions are $_____. The difference between these is your net monthly income. This is $_____. The allowance income standard for a family household your size is $_____. The difference between your net monthly amount and this standard ($_____). Please see the enclosed form LDSS-4038, which explains how you can meet the excess income requirements and become eligible for coverage under the EXCESS INCOME PROGRAM.

NOTE: If there are other factors that affect your Medical Assistance coverage, a separate notice is enclosed.

The Laws and/or Regulations which allow us to do this are: Section 366.2(a)(1) of Social Services Law.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the front page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1) **Telephone:** You may call the state wide toll free number: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL); **OR**

2) **Fax:** Send a copy of this notice to fax no. (518) 473-6735; **OR**

3) **On-Line:** Complete and send the online request form at: http://www.otda.state.ny.us/oah/forms.asp; **OR**

4) **Write:** Send a copy of this notice **completed**, to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:_____

_____

_____

Print Name: _____ Case Number: _____

Address: _____ Telephone: _____

Signature of Client: _____ Date: _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

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ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of the front of this notice or write us at the address printed at the top of the front of this notice.

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INFORMATION: If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of the front of this notice or write to us at the address printed at the top of the front of this notice.

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