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**MEDICAID PROVISIONS IN THE
DEFICIT REDUCTION ACT OF 2005**

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CAUTION: This document is not intended to be legal advice or advice for any particular factual situation. This law is new and very complex, and uses terms that are not fully defined. Knowledgeable professionals disagree over what the law means. This document represents the authors' best understanding of the law as of the date it is written. Revisions of this document will be posted at http://onlineresources.wnyc.net/healthcare/health_care.asp under the heading **MEDICAID - 2006 Federal and State Medicaid Changes**. Please check there for updates.

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MEDICAID PROVISIONS IN THE DEFICIT REDUCTION ACT OF 2005

INTRODUCTION: On February 8, 2006, President Bush signed into law the Deficit Reduction Act of 2005,¹ which inflicts harsh cuts in Medicaid. At the same time, New York State came close to enacting a 2006 state budget that would have (1) ENDED spousal/parental refusal and (2) imposed transfer penalties on community-based home care. These two cuts were DEFEATED again this year. Therefore, spousal/parental refusal are still permitted, and there are NO penalties on transferring assets when one is seeking only home care and community-based care other than Lombardi and other waiver services.

REFERENCES: The NYS Department of Health administrative directive implementing the DRA was issued on July 20, 2006 (the "ADM" or the "new ADM").² The DRA went into effect on August 1, 2006 in New York State. An earlier 1996 directive, 96-ADM-8, is referenced in this outline as well.³ The federal agency responsible for Medicaid, CMS, issued guidance on the DRA on July 27, 2006.⁴

In general, the DRA made these big changes:

- Transfer of assets:
 - Lengthens lookback period from 36 months to 60 months (gradually)
 - Delays the commencement of the penalty period
- Caps the value of the homestead at \$750,000 (in NYS), with exceptions
- Adds new requirements for annuities, promissory notes, and life estates;
- Requires more extensive documentation of citizenship or naturalization, and identity (Not covered in this outline) See <http://onlineresources.wnyc.net/healthcare/docs/Summary%20of%20New%20Citizenship%20Regs.pdf>.

NOTE TO social workers and other non-lawyers: Information on "life estates," "annuities," and other complex concepts is included here to help alert you to legal strategies, for which your client should consult an elder law attorney.

¹ The Deficit Reduction Act can be found online at <http://thomas.loc.gov/>. In the box "Search bill text" select search by "Bill Number." Enter S.1932.ENR. However, it is now incorporated in the Medicaid Act at 42 U.S.C. 1396p (transfers of assets) and other sections.

² 06 OMM/ADM-5, dated July 20, 2006 entitled, "Deficit Reduction Act of 2005 - Long Term Care Medicaid Eligibility Changes." See, http://www.health.state.ny.us/health_care/medicaid/publications/pub2006adm.htm

³ http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/96adm8.pdf

⁴ <http://www.cms.hhs.gov/SMDL/SMDL/list.asp#TopOfPage> - scroll down to Transfer of Assets.

I. TRANSFERS OF ASSETS – THE PENALTY OR INELIGIBILITY PERIOD FOR NURSING HOME, LOMBARDI AND OTHER WAIVER CARE

A. WHAT IS THE “LOOKBACK PERIOD” and WHEN WILL IT INCREASE to 60 MONTHS?

1. When an individual applies for Medicaid for nursing home or Lombardi home care, they must document their assets for a specified period *before* the date they applied for Medicaid. This is the “lookback period.” It is a disclosure period. An applicant must provide all bank statements, brokerage statements, etc. for the lookback period. The purpose of the lookback period is for Medicaid staff to identify transfers of assets. If they find transfers, and it is not an “exempt” transfer, they then calculate a “penalty.” The DRA increases the length of the lookback period.
2. Before the DRA, the lookback was 36 months for all transfers, except that transfers into a trust had a 60- month lookback.
3. After the DRA, the lookback for all transfers is 60 months. However, the 60-month lookback will be phased in gradually:

Date of Application	Lookback Period	
	All transfers except into trusts	Transfers into Trusts
1993 until Jan. 30, 2009	36 months	60 months
February 1, 2009	36 + 1 = 37 months	60 months
March 1, 2009	36 + 2 = 38 months	60 months
Every month through Feb. 1, 2011	Lookback grows by one additional month, for example:	60 months
February 1, 2010	36 + 13 = 49 months	60 months
February 1, 2011	60 months for all transfers	

RECORD KEEPING TIP: Help clients start a system for saving their bank statements and other financial records now, if they do not do so already, in case they need to go into a nursing home in the future. It will be very burdensome to gather 5 years of records. And 5 years of records will be necessary even for the poorest individuals, who have to prove that they have *not* transferred any assets.

B. WHICH MEDICAID SERVICES HAVE A LOOK-BACK AND A TRANSFER PENALTY?

The definition of "institutionalized individual" for purposes of the look-back and transfer penalty⁵ includes anyone who is in a:

1. NURSING HOME ⁶-- including an intermediate care facility for the mentally retarded (ICF-MR), or
2. HOSPITAL but is on "alternate level of care" or ALOC - hospital care provided after the patient is ready for discharge, but stays in the hospital.

C. WHAT SERVICES WILL NOT HAVE A TRANSFER PENALTY?

The federal law has long given an option to states to impose a transfer penalty for community-based Medicaid too. 42 U.S.C. 1396p(c)(1)(C)(ii). NYS has never exercised this option before, and in 2006 this proposal was once again defeated.⁷ The DRA and implementing state law do not specifically define these services. By implication, those not defined as received by an "institutional individual" are not subject to the transfer penalty. The 2006 state ADM gives a definition.

1. "Community-based Long Term Care Services" -- The ADM at p. 10 defines these services, which are not subject to the transfer penalty, as the following.
 - a) Medical model adult day care
 - b) Medicaid Assisted Living Program (ALP)⁸
 - c) Medicaid home care --
 - (1) Personal Care services - ("home attendant" in NYC) 18 NYCRR 505.14
 - (2) Certified home health agency services ("CHHA") - 18 NYCRR 505.23 (includes part time and intermittent "visiting nurse" services, home health aide up to 24 hours/day, in-home physical, speech or occupational therapy)

⁵ SSL § 366.5(e)(1)(vii).

⁶ Technically defined as a nursing facility under Public Health L. § 2801

⁷ The final budget is Chapter 29 L. 2006. Chapter 57 of the Laws of 2006 -- A9957 (Article 7 bill) <http://publications.budget.state.ny.us/fy0607artVIIbills/HMH.HTM> and Chapter 54 of the Laws of 2006 -- A 9554 (Appropriations bill) - . <http://publications.budget.state.ny.us/fy0607appropbills/HE.pdf> .

⁸ For a list of ALPS in NYS see <http://www.health.state.ny.us/nysdoh/acf/map.htm>. Other information on ALP admission requirements, etc. is posted at http://www.health.state.ny.us/facilities/assisted_living/.

- (3) Private Duty Nursing services. SSL § 365-a, subd. 2(a), 18 NYCRR 505.8
- (4) Consumer Directed Personal Assistance Program (CDPAP), SSL § 365-f
- (5) Managed Long-Term Care in the community (VNS Choice, Guildnet, Independence Care Systems, etc.)⁹

- d) Hospice -- in the community AND hospice residence program;
- e) Personal emergency response system (PERS);
- f) Residential treatment facility (drug or alcoholism treatment)
- g) NOT IN ADM BUT SHOULD NOT BE SUBJECT TO TRANSFER PENALTY - -"Short-term rehabilitation"-- one nursing home admission up to a maximum of 29 *consecutive* days in a twelve-month period.¹⁰ This benefit, created by state law in 2002, allows up to 29 days of Medicaid nursing home care within the *community* Medicaid benefit -- without having to file the 36-60 month application that would trigger the transfer penalty.¹¹ Discussed more later.

2. WAIVER PROGRAM (Home and Community Based Waiver) --

- a) In NYS these include¹² the Lombardi program, the Traumatic Brain Injury (TBI) Waiver Program, OMRDD Home and Community-Based Services

⁹ Information about and statewide listing of these programs is at http://www.health.state.ny.us/health_care/managed_care/mltc/pdf/mltc_cons_guide.pdf

¹⁰ SSL § 366-a(2)(enacted 2002), 18 NYCRR 360-2.3(c)(3) (eff. 2/25/05), 04 OMM/ ADM-6, GIS 05 MA 004 , 05 OMM-INF-2 June 8, 2005.

¹¹ SSL § 366-a(2)(enacted 2002), 18 NYCRR 360-2.3(c)(3) (eff. 2/25/05), 04 OMM/ ADM-6, [ADM # 04 OMM/ADM-6](#), GIS 05 MA 004 , 05 OMM-INF-2 June 8, 2005. (Q & A).

¹² Lombardi program, SSL §§ 367-c, 366(6), 10 NYCRR § 505.21, 85 ADM-27

Traumatic Brain Injury (TBI) Waiver Program, N.Y. Pub Health § 2740 et seq, 95 LCM-70, 96 INF-21

Nursing Home Transition and Diversion Waiver - SSL § 366(6-a)(enacted 2004, waiver application pending with CMS - NOT yet implemented)

OMRDD Home and Community-Based Services (HCBS) Waiver, SSL 366(7), 92 INF-33, 92 LCM-170, 94 LCM-24, and 94 LCM-147

AIDS Home Care Program: NY SSL §367-e; 18 NYCRR § 505.21(a)(2).

(HCBS) Waiver, the AIDS Home Care Program, and the not-yet-implemented Nursing Home Transition and Diversion Waiver.

- b) NOTE: Originally, the transfer penalties DID apply to waived services – before the DRA as well as in the DRA.¹³ The 2006 State ADM stated that “waivered” services¹⁴ provided in a waiver program are subject to the transfer penalty, implying that “non-waivered” services¹⁵ were subject to the penalty. As a practical matter, there was no way for an individual to receive waiver services at all unless Medicaid paid for it. If there was a transfer penalty, Medicaid would not pay for it, creating a catch-22.
- c) **NEW – UNDER A NEW DOH DIRECTIVE dated 9/24/07, the look back and penalty do NOT apply to Waiver Services** (including Lombardi, TBI Waiver, OMRDD HCBS, AIDS Home Care Program, etc.) GIS 07 MA/018 http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/07ma018.pdf

¹³ 42 U.S.C. 1396p(c)(1)(C) provides, “The services described in this subparagraph [regarding transfers of assets] with respect to an institutionalized individual are the following:

(I) Nursing facility services.

(II) A level of care in any institution equivalent to that of nursing facility services.

(III) Home or community-based services furnished under a waiver granted under subsection (c) or (d) of section 1915 [[42 USCS § 1396n\(c\)](#) or (d)].”

¹⁴ Under the DOH Long Term Home Health Care Program [LTHHCP] Manual (June 2006) Ch. 3 http://www.health.state.ny.us/health_care/medicaid/reference/lthhcp/lthhcpmanual.pdf, these include:

- a) Medical Social Services, Nutrition counseling/ Educational services
- b) Respiratory therapy
- c) Home-delivered and congregate meals,
- d) Home maintenance tasks, housing improvements, and moving assistance,
- e) Personal Emergency Response System (PERS),
- f) Respite care, *Social* adult day care and day care transportation.

¹⁵ “Non-waivered services” as defined in the DOH LTHHCP manual, are those that are normally provided by Medicaid, not solely through a waiver. *Id.* These include:

- a) Personal care
- b) Skilled nursing visits, physical and speech therapy
- c) Social work counseling
- d) Medical transportation
- e) Medication, durable medical equipment, and supplies,
- f) *Medical* model adult day care

3. All other Medicaid services are not institutional long term care services, so are not subject to transfer penalty. These include acute inpatient hospital care, all outpatient services, all physician's services, lab tests and x-rays, prescription drugs, outpatient rehabilitation, all other treatment and care in the community.

D. WHAT IS THE "PENALTY PERIOD?"

1. DEFINITION: If a transfer is identified during the look-back period, and no exception applies, then a "Penalty Period" is calculated. The penalty is a waiting period that can be days, months, or years during which the individual is not eligible for Medicaid to pay for long term care, because of transfers of assets that were made during the "lookback period."
2. LENGTH OF PENALTY or WAITING PERIOD - The DRA did NOT change how long the penalty period is. The length of the penalty depends on the amount transferred. To calculate the penalty period, divide the total value of assets transferred by the regional average monthly cost of private nursing facility services, which is \$9,375 in NYC in 2007.¹⁶
 - a) EXAMPLE: Judy transferred \$30,000 before she applied for Medicaid nursing home care. The penalty is just over 3 months: $\$30,000 \div \$9375 = 3.2$ months. If she transferred \$300,000 instead, the penalty would be 32 months.
3. WHEN THE PENALTY PERIOD COMMENCES -- The DRA made a very significant change in WHEN the penalty period commences or "starts running."
 - a) PRE-DRA -- The penalty period began to run the month after the date of the transfer.
 - (1) THIS RULE STILL APPLIES TO TRANSFERS MADE BEFORE FEBRUARY 8, 2006.
 - (2) EXAMPLE: Betty transferred \$ 27,000 on February 1, 2005 to her daughter, who does not live with her. Her remaining assets are within the asset limits -- \$4150 for a single person, a \$1500 burial fund and an irrevocable burial agreement that cost \$5000. She applied for Medicaid Home Care in March 2005. She was fully eligible for Medicaid Home Care because there is no "transfer penalty" for Medicaid in the community. She receives home care until November 2006, when she has a stroke. No longer able to climb the stairs to her apartment, on Nov. 9,

¹⁶ Penalty amounts change yearly and vary throughout the state. 2007 rates are in GIS 07/MA 001. http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/07ma001.pdf . Long Island is \$ 10,123. Westchester and surrounding counties is \$9074. Central \$6505 Northeastern \$7189 Rochester \$8002 Western \$6820

2006, she goes into a nursing home and applies for Medicaid. Medicaid “looks back” three years to see what assets she transferred. The \$27,000 she transferred in February 2005 is revealed in that “lookback.” Since the transfer was BEFORE the new law was enacted, the penalty period began in March 2005, the month after she made the \$27,000 transfer. The penalty was just under three months (the penalty rate in 2007 in NYC is \$9,375 and expired as of June 1, 2005).

When she is admitted to the nursing home in November 2006, the transfer penalty had long ago expired, and she is fully eligible for Medicaid to pay for her nursing home care.

b) POST-DRA -- DELAYED PENALTY PERIOD

- (1) **THE NEW RULE:** The penalty begins “running” on the later of:
 - (a) the date the assets are transferred *or*
 - (b) the “date on which the individual is eligible for [Medicaid] ...and would otherwise be receiving institutional level care ...based on an *approved application* for such care but for the application of the penalty period....”¹⁷
- (2) The (b) alternative is what will apply in most situations.¹⁸ This means that the penalty won’t start running until the individual has already been admitted to a nursing home (or has applied for Lombardi or other waiver care - discussed later) AND has applied for Medicaid AND is financially eligible for Medicaid, except for the transferred assets. It is best understood by example.
- (3) **EXAMPLE -- Betty’s case above UNDER THE NEW LAW --** If Betty’s transfer was on February 9, 2006 -- after the DRA went into effect:
 - (a) Home care -- Betty would still be eligible for Medicaid home care after the transfer, the same as before. The new federal law does not change the current rules for community-based care.
 - (b) When Betty enters a nursing home and applies for Medicaid in November 2006:

¹⁷ 42 U.S.C. 1396p(c)(1)(D)(ii), as added by Sec. 6011 of the Deficit Reduction Act.

¹⁸ The only time that (a) would apply is when the client is already in a nursing home and on Medicaid, and inherits money or settles a lawsuit, and transfers that money. In that case, the penalty would start running on the date the assets were transferred.

(i) LOOKBACK -- Is still 3 years, because it is before Feb. 2009.
This transfer made in Feb. 2005 will be revealed in the lookback.

(ii) The three-month penalty period that was caused by this transfer will first begin to "run" in November 2006 -- This is the first month in which she is:

in a nursing home,

has applied for Medicaid, and

is eligible to receive Medicaid, except for the transfer.

Betty's application will be denied because of the transfers. The penalty period will run for 3 months from November 2006 - January 2007. In those 3 months, Medicaid will not pay for her nursing home care. Her daughter or someone else must pay for it out of the transferred assets or other funds. In February 2007 she must re-apply for Medicaid and will be eligible.

(4) The new rule applies to all transfers made on or after February 8, 2006.

Transfers made *before* February 8, 2006 will be assessed under the old rules. The penalty on these transfers started running the month after the transfer. Thus two different rules will be applied when Medicaid evaluates different transfers made in a Medicaid application.

(a) **EXAMPLE:** Mary applies for Medicaid for nursing home care in February 2007. She made 2 transfers in the 3-year "lookback period," which began February 1, 2004. One transfer in January 2006 will be evaluated under the OLD rules -- the penalty will start "running" in the month after the transfer was made. The other transfer in March 2006 will be evaluated under the NEW rules -- the penalty will start "running" as explained above, once she applies for nursing home or Lombardi care.

(b) **EXCEPTION -- APPLICATIONS FILED BEFORE AUGUST 1, 2006** were processed under the OLD RULES, even for transfers made on or after Feb. 8, 2006. New ADM, page 5. However, there is no guarantee that any post-Feb. 8, 2006 transfers in those applications will not be re-evaluated later, at a recertification/renewal, and the new delayed penalties imposed. This could mean temporary termination of Medicaid coverage in the nursing home. As of November 2007, DOH has not announced any such retroactive application.

c) **After August 1, 2006, CASAs and other Medicaid offices may no longer process applications for “full” Medicaid coverage -- including nursing home and waived services -- for people not currently in a nursing home or applying for a waived program.** Clients in the community will no longer have the option of doing a 36-month (or 60 month) lookback so that eligibility can be determined for nursing home/ waiver services that may be needed in the future. One can apply for nursing home/waiver services only when actually in need of those services. New ADM p. 11.

(1) **“Grandfathered” applications** -- BUT if someone who applied in the community was already determined eligible for “full” Medicaid, including nursing home/waivered services, before August 1, 2006, they will NOT have to go through the new process once they do enter a nursing home or waiver program. These are called “Undercare” cases. ADM p. 11. This benefit will only help those who made transfers on or after Feb. 8, 2006 and have already been determined eligible, since transfers made before that date are evaluated under the old rules anyway.

Summary of Transfer Penalty Rules⁽¹⁾

Application Date	Look-Back Period ⁽²⁾	Transfer Date	Rule
Before 2/8/06	3 years	Before 2/8/06	<i>Old rule</i> - Penalty runs from date of transfer
2/8/06 – 8/1/06	3 years	Before 2/8/06	<i>Old rule</i> - Penalty runs from date of transfer
		After 2/8/06	<i>Old rule</i> - Penalty runs from date of transfer (special grace period for these transfers, since technically they should be under <i>New rule</i> - hopefully, Medicaid will not come back and re-assess these transfers at a later date) ⁽³⁾
8/1/06 – 2/8/09	3 years	Before 2/8/06	<i>Old rule</i> - Penalty runs from date of transfer
		After 2/8/06	<i>New rule</i> - Penalty runs from date that applicant is receiving institutional care, has applied for Medicaid, and is otherwise eligible but for the transfer
2/8/09 – 2/8/11	Phase in period to 5 years	Before 2/8/06	<i>Old rule</i> -Penalty runs from date of transfer
		After 2/7/06	<i>New rule</i> -Penalty runs from date that applicant is receiving institutional care, has applied for Medicaid, and is otherwise eligible but for the transfer

After 2/8/11	5 years	After 2/7/06	<i>New rule</i> - Penalty runs from date that applicant is receiving institutional care, has applied for Medicaid, and is otherwise eligible but for the transfer
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- (1) Note that for any particular application submitted between August 1, 2006 and February 8, 2011, some transfers will be evaluated under the old rule and some under the new rule, depending upon the date of the transfer. Thus, a *pre-2/8/06* transfer penalty may be over by the time of application, but a *post-2/8/06* penalty may only begin running at the time of application.
- (2) Except for transfers to trusts, for which look-back period is always 5 years.
- (3) See paragraph (b) on page 8. See also NYS Dep't of Health, Administrative Directive 06 OMM/ADM-5 at 5,10, 29 (July 20, 2006), available at http://onlineresources.wnylc.net/pb/docs/06adm-5deficit_reduction.pdf

E. MORE ABOUT THE NEW PENALTY AFTER THE DRA

1. TWO MEDICAID APPLICATIONS FOR EVERY CASE.

The penalty begins only when an application for nursing home/waiver Medicaid has been filed. So the client has to apply for Medicaid in the nursing home TWICE.

- a) First application -- Filed when admitted to a nursing home or waiver program and is "otherwise eligible" for Medicaid, meaning she has resources that are now under the Medicaid limits. This application will be denied if she transferred assets after 2/7/06, no matter how small the amount -- even if the penalty period would have run out under the old rules. *She must apply to get the penalty period to start running and to determine how long the penalty period is. This is a **big change from the past**, where the client just waited until after the transfer penalty has run out to apply for Medicaid.*

The ADM describes a 2-step process within this application.

- (1) STEP ONE - Determining if the applicant is "otherwise eligible." Before they even look at the 36-60 months of bank records, they will first see if the applicant is NOW eligible, with respect to both income and resources. If she's not, they will not even do the lookback. This is because if she's not "otherwise eligible" now, even if there were no transfers in the lookback period, she's not eligible for Medicaid. If she is "otherwise eligible" now, then the penalty on past transfers within the lookback period will start running. More on this step below
- (2) STEP TWO -- If she is "otherwise eligible," they do the lookback review of asset transfers. If there were no transfers in the lookback period, the application is accepted. If there were transfers, the application is denied but the penalty starts running.

- b) Second application -- Once the penalty period expires, she must reapply. She should be eligible if there were no further transfers.

2. THE PENALTY PERIOD CONTINUES TO RUN IF CLIENT LEAVES THE NURSING HOME AFTER MEDICAID APPLICATION IS DENIED BECAUSE OF A PENALTY -- Some good news:

- a) "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." ADM at 17. This means that one may enter a nursing home, apply for Medicaid, and have application rejected because of the transfer penalty. Once the application is rejected, you may then LEAVE the nursing home program, and the penalty period will run. While the penalty is running, there is no requirement that the client pay for or even receive any services, or that she be on Medicaid.
- b) Thus the penalty period will run even if the client leaves the nursing home and receives Medicaid home care - personal care, CHHA, Consumer-Directed -- or goes into a Medicaid assisted living program, or privately pays for home care, while running out the penalty period.
- c) After the penalty expires, if she needs and applies for nursing home care again, then she is eligible with no penalty (unless she's made subsequent transfers). If the penalty has not yet expired when she later enters a nursing home, then she is not eligible for those services until the remainder of the penalty has expired.

3. MULTIPLE TRANSFERS

All transfers made *after* Feb. 7, 2006 and within the look-back period will be added together. The length of the penalty will be based on the combined total amount.

- a) EXAMPLE: Sadie transfers \$80,000 to her daughter in March 2006 (8.76 month penalty). In September 2006, she inherits from her deceased sister \$40,000 which she transfers that month to her daughter (4.38 month penalty). Sadie enters a nursing home January 2007 and is at the Medicaid income and resource levels. Her 13.14 (8.76 + 4.38 = 13.14) month period of ineligibility start January 2007 and ends early February 2008 .¹⁹

¹⁹ Thanks to Sara Meyers, Brookdale Center on Aging of Hunter College for this example.

- b) If Sadie's first transfer of \$80,000 was on February 1, 2006 - before the DRA -- the penalty would have begun running in March 2006 and would have expired in mid-November 2006, before she entered the nursing home. This transfer would not be added to the later one in Sept. 2006.
- c) Under the old rule, transfers that did not overlap were not added together to arrive at a penalty period. Now, even if they do not overlap, they are added together. This change and the delayed penalty make the new rule harsher. In Sadie's case, the two transfers overlap, so even under the old rule they would be added together -- and the penalty would have expired in May 2007 (13.14 months beginning April 2006), instead of February 2008.

F. EXCEPTIONS TO THE TRANSFER PENALTY

1. The pre-DRA **exceptions** to the transfer penalty still apply. They are now more important than ever. **Before**, if we were counseling a client seeking Medicaid home care about transferring assets, we had to counsel them that they risked being denied Medicaid if they needed nursing home care before the penalty expired. But if the penalty was relatively short, even as much as a year, and home care was a viable option now, we could help them assess the risk of whether they'd need nursing home care within the year-long penalty period. **NOW**, someone transferring assets in October 2006 has to know that she risks being denied Medicaid for nursing home care for the *next five years*. Even a small transfer of \$27,000 will disqualify her from 3 months of nursing home care in five years.
2. For this reason, it is important that those who counsel clients seeking COMMUNITY-BASED CARE help them utilize any EXCEPTIONS to the penalty that may apply, to protect the client from this risk down the road.
3. **For transfer of assets *other than the home*:**²⁰ the exceptions are:
 - a) Transfers to the **spouse**. For nursing home or waiver eligibility, the community spouse may keep the higher of \$74,820 in assets or half the couple's assets up to \$99,540. In the community, the spouse who receives the money may do a spousal refusal to contribute these assets -- though s/he risks being sued by the local district for support.

Example. Mary is applying for Medicaid home care. She lives with her husband, Ben. Mary and Ben have \$30,000 in assets and want to transfer them to their daughter. She should instead transfer them to Ben because transfers to a spouse are exempt which would become relevant should she

²⁰ 42 U.S.C. 1396p(c)(2)(B)

subsequently enter a nursing home. Because he now has all of their assets in his name, he will need to sign a “spousal refusal” form and submit it with her application.

<http://onlineresources.wnyc.net/pb/docs/SpousalRefusaForm.pdf>.

- (1) **WARNING:** Ben must not re-transfer the assets to their daughter or to anyone else, however, even after Mary is accepted for community Medicaid. If she needs to go to a nursing home in the next 5 years, Ben’s transfer to their daughter will still be counted against her (Transfers by the applicant’s spouse are penalized as well as transfers by the applicant). Therefore, he must hold on to the money and do the spousal refusal. They should consult a private elder law attorney for future planning needs for both of them.
- b) Transfers to the individual’s **child who is certified blind or disabled** - whether directly to the child or to a supplemental needs trust established for the benefit of the blind or disabled child.
- c) Transfers to a **supplemental needs trust** established for the benefit of either:
 - (1) Himself/herself, but only if s/he **is under age 65** (people age 65+ would have a transfer penalty)
 - (2) for the individual’s **disabled or blind adult child** OR
 - (3) for an **individual under 65 years of age who is disabled** -- (does not have to be related to the person setting up the trust).²¹
- d) The client can show that she didn’t intend the assets to be a “gift” but to sell them at **fair market value**, or for other valuable consideration.
- e) The assets were transferred **exclusively for a purpose other than to qualify for medical assistance for nursing facility services**.
 - (1) This exception has existed for many years and has been interpreted in earlier directives. A 1996 state directive, 96-ADM-8 , states, “...Factual circumstances supporting a contention that assets were transferred for a purpose other than to qualify for MA include, but are not limited to...:
 - (a) the sudden, unexpected onset of a serious medical condition after the transfer ;

²¹ For more information on Supplemental Needs Trusts, see http://onlineresources.wnyc.net/healthcare/SNT_Materials.htm

- (b) the *unexpected* loss, after the transfer, of income or resources which would have been sufficient to pay for nursing facility services; or
- (c) a court order specifically requires transfer of a certain amount of assets."

This ADM requires Medicaid offices to advise applicants in writing that they may make this showing, before denying Medicaid because of a transfer. (The notice is Attachment III of that ADM). The ADM further states, "All of the circumstances of the transfer will be considered as well as factors such as your **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 ineligibility."

- (2) Examples of circumstances that *may* satisfy this test, depending on the facts shown, are:
 - (a) gifts that are consistent with a *past pattern* of giving, such as by paying for a family member's wedding, education, etc.,
 - (b) consistent donations to one's church, synagogue, or charity, or
 - (c) consistent history of estate and gift tax planning by giving annual gifts in annual exclusion amount (now \$12,000);
 - (d) In one 1989 hearing, the applicant showed that she intended to give the assets as a gift earlier, well before the lookback period, but had mistakenly kept the assets in her own name, in an account "in trust for" the family member who was the intended recipient of the gift. The hearing decision found that the later transfer to the same family member was only meant to correct this error, and was not for the purpose of qualifying for Medicaid. (While the law on transfers was somewhat different at that time, the same exception from the penalty existed). (FH No. 1399855N, dated 12/13/1989).
- f) HOLOCAUST REPARATIONS, life insurance policies with cash value under \$1500, and other exempt assets -- Transfer of these exempt assets does NOT trigger a transfer penalty. If client is transferring these funds, even if only applying for home care, document the fact that they are reparations, using the tools posted at http://www.claimscon.org/forms/selfhelp_claimscon.pdf and http://www.claimscon.org/ReparationWorksheet_Web.htm. Before, it was sometimes easier just to transfer these funds before applying for home care, rather than documenting the amount of reparations received over many decades. Now, since these clients may need nursing home care in the next 5 years, it is essential to assemble this documentation.

g) **RECORD KEEPING TIP:** Save evidence NOW that an exception applies to the transfer penalty, and make sure it is well marked and available for the next 5 years should the client need nursing home care. For social workers, this also means keeping copies in your files for 5 years.

4. **TRANSFER OF THE HOME** has no penalty if transferred to:²²

- a) a spouse,
- b) a child under 21, or who is an adult and blind or disabled,
- c) a son or daughter if s/he lived in the home for 2 years immediately before the date the individual becomes an institutionalized individual and cared for client, and
- d) a sibling with equity interest who lived in home for 1 year immediately before the date the individual was institutionalized.
- e) **CAUTION.** If Betty owned her home and transferred it to her daughter who does not live with her on or after February 8, 2006, and before applying for Medicaid home care, it would be fine for community-based care. Individuals often transfer the home before applying for community Medicaid to avoid estate recovery upon their deaths. But if she goes into a nursing home within the next 5 years, the value of the home at the time of the transfer would be counted as a transfer. Since she does not live with her daughter, it is not an exempt transfer. The penalty would be the market value of the home at the time of transfer (minus outstanding mortgages) divided by the transfer penalty - \$9375 in 2007 (NYC - see fn 16 for other rates). If it was worth \$360,000 it would disqualify her from having Medicaid pay for her nursing home care for about 40 months beginning in February 2008, when she enters the nursing home.

Tax Warning: There are **tax consequences** from any transfer of a home, because of the appreciation in the value. An elder lawyer should be consulted for any transfer of a home.

G. WHAT HAPPENS TO THE PENALTY IF ALL OR PART OF THE TRANSFERRED ASSETS ARE RETURNED or HAVE BEEN SPENT?

- 1. If *all assets have been returned to the individual, this cancels out the transfer penalty.* According to the ADM, a return of assets causes them to be treated as if they had never been transferred, eliminating any penalty. However, this

²² 42 U.S.C. 1396p(c)(2)(A); SSL(5)(d)(3)(i)(B).

means that they will be treated as available resources as of the time of the original transfer. Once the transferor has these resources back in her possession, she is not “otherwise eligible” for Medicaid, so the transfer penalty will not start running.

2. **Return of PART of the assets.** The federal DRA says that “all assets” must be returned in order to cancel out the transfer penalty.²³ However, this rule was the same under the old law, and under the old law, the State in 96 ADM-8 said, “Return of part of the assets will reduce the penalty period proportionally to the amount returned.” The new State ADM confirms that this 1996 policy will continue: 2006 ADM, p. 18. However, it has not yet been tested.
 - a) **RULE OF HALVES BEFORE THE DRA** -- Before the DRA, the “rule of halves” allowed a Medicaid applicant to preserve half of his or her assets by transferring half of the assets, and spending down the remaining half on nursing home care. For example, Sam has \$90,000 over the asset limit. Upon admission to the nursing home, Sam transfers half of his assets to his daughter, which would trigger a penalty of about 5 months (\$45,000 divided by \$9000 = 5 months). Sam spends the other \$45,000 down by privately paying for his care during the penalty period. The penalty period on the transferred half would run out at around the same time that he spent down the other half of his money. Medicaid would start paying after 5 months, and half his assets are now in his daughter’s name, with no further penalty.
 - b) **After the DRA** -- the Rule of Halves does not work. When Sam keeps half the money (\$45,000) and spends it down over the next 5 months, he is not “otherwise eligible” for Medicaid -- because he has these assets. Therefore, he cannot apply for Medicaid and start the penalty clock ticking on the half that he transferred to his daughter. The same result happens if Sam’s daughter returns half the money to him, to spend down on his care. These returned assets now prevent him from being “otherwise eligible” for Medicaid, so he cannot apply for Medicaid and start the penalty clock ticking. The new ADM makes clear in an example at page 19 that a “rule of halves” transfer is not allowed. The bottom line is that the return of assets will technically reduce the penalty period but will not help make him eligible for Medicaid earlier.
3. What if the family member uses part of the transferred money to pay for the nursing home, home care, or other expenses?
 - a) **Using Transferred Money To Pay For NURSING HOME CARE** -- The 1996 ADM-8 implementing the old law says that if the family member or other

²³ 42 U.S.C. § 1396p(c)(2)(C)

“transferee” directly pays for the nursing facility services (which includes waived home care) with part of the transferred assets, this would reduce the transfer penalty. 96-ADM-8, pp. 22-23. This may be a way of protecting part of the transferred money. It is tricky, however -- when the family member is paying for the nursing home, if they pay the entire bill for any month, the client is not “otherwise eligible” in that month, so cannot apply for Medicaid to start the penalty clock ticking on the transferred amount.

- b) **Using Transferred Money to Pay for Home Care, Rent, or other Client Expenses** -- The 1996 state directive says that the transferred assets must be returned in cash or “an equivalent amount of cash or other liquid assets,” in order to reduce the penalty by the amount returned. *Id.* It is unclear if the Medicaid program will reduce the penalty if the family showed that they spent the money on home care, rent, or other expenses for the client. Is this return of “an equivalent amount of cash?” The new ADM is silent on this issue.

Recordkeeping TIP: Family members who use the transferred assets to pay the client’s bills must be advised of the risk that the penalty will *not* be reduced by the amount of the payments they have made. If they want or need to take that risk, they should **keep receipts** of all payments made on behalf of the client.

TAX TIP: If the family member paying for private home care is providing more than half of the client’s financial support, that family member may deduct the nursing home payments as a medical deduction on his or her taxes.

- c) **What if the transferred assets are not available to pay the nursing home at all?-** If all the assets were spent by the person who received them, in some cases, the client may qualify for a hardship waiver, described below, if she uses her best efforts to seek return of the assets. But that waiver is limited to very low income people.. see below. Alternatively, if client is able to return to the community with Medicaid home care, assisted living, and/or other community-based services, she can ride out the penalty period at home, since the penalty, once determined, continues to run at home.

H. HARDSHIP WAIVER

DRA 6011(d), 42 USC 1396p(e)(2)

1. Each state must provide a process for granting a waiver if denying Medicaid because of a transfer penalty would constitute an “undue hardship.”
 - a) Definition of “Undue Hardship” in DRA -- Denying Medicaid because of the transfer penalty would deprive the individual of:

- (1) Medical care such that her health or life would be endangered; OR
 - (2) Food, clothing, shelter or other necessities of life
- b) In the federal CMS guidance issued July 27, 2006, CMS does not further define the criteria, but says that states have “considerable flexibility in deciding the circumstances...” that would constitute undue hardship.”
- c) State definition -- Existing state regulations, 96-ADM-8, and the new ADM state that undue hardship cannot be claimed:
- (1) UNLESS BEST EFFORTS HAVE BEEN MADE TO HAVE ASSETS RETURNED -- The individual must show she has made best efforts to have the assets returned or sold for fair market value.²⁴ The applicant must cooperate to the best of her ability, as determined by the local district, in having the assets returned. Cooperation is defined as providing all legal records and other information about the transfer. 18 NYCRR §§ 360- 4.4(d)(2)(iii); New ADM p. 20; 96-ADM-8 at 23, AND
 - (2) 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.” 96-ADM-8 p. 23, new ADM p. 20. This language does not specify whether, for a couple, the community income or resource limits are used or the spousal impoverishment levels. The Medicaid exemption standard in the community is \$692 singles, \$900 couples -- very low. This will exclude many people.
 - (3) The state directives say hardship will not be found “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.” 96-ADM-8 p. 23, new ADM p. 20.
 - (4) COMMENT: These harsh limitations are only in the ADM, not in state or federal regulation. Though they have been state policy since at least 1996, the onerous nature of these limitations may only be obvious now with the delayed onset of the transfer penalties.
- d) A “hardship waiver” has always been very difficult to obtain, and cannot be counted on. There will likely be fair hearings and litigation on this issue.

²⁴ 18 NYCRR §§ 360- 4.10(a)(11), -4.4(c)(2)(ii). See also 96-ADM-8, pp. 23-24 , new ADM p. 20.

2. PROCEDURE -- The DRA requires the state to establish a procedure for requesting a waiver, with the right to a hearing if it is denied. Strangely, the new state law designates the Office of Temporary & Disability Assistance, rather than the Dept of Health, to give notice of the procedure for requesting a waiver to new applicants. SSL 366, subd. 5(e)(4)(iv).
 - a) A "nursing facility," may request a waiver on the resident's behalf. This right should extend to waiver programs.
Bed hold payments -- New York State has exercised the option in the DRA for a nursing facility to qualify for payment for 30 days of care to hold the bed while a waiver request is pending. SSL 366, subd. 5(e)(4)(iv). The DRA directs CMS to develop criteria for bedholds, which the state law references. Unfortunately, the CMS guidance issued July 27, 2006 has no such criteria.
 - b) State procedure - The new ADM at pp. 20-21 says that the individual, spouse, representative or nursing facility may apply for a waiver *at the time of application*, with consent. The determination must be made in the same time that the application is processed, and notice of denial may be appealed at a hearing. This requires client and her representative to include all the documentation of hardship at the same time as assembling the 36- 60 months of bank records, etc.
 3. Recipients of "limited coverage" -- apparently meaning Medicaid for home care but not for nursing home care -- may request consideration of hardship to obtain nursing facility services at any time during the penalty period. The hardship determination may be retroactive back to 3 months prior to the month in which the request for review of hardship is made. ADM at p. 21
 4. **RECORD KEEPING TIP -- Save evidence of HARDSHIP for later --** During the 5 year period in which the person receives Medicaid home care or ALP services, if it is anticipated that the transferred assets will not be available later for nursing home care, begin saving evidence that may constitute proof of "hardship."
- I. Do Deposits of the Spend-down in the NYSARC Supplemental Needs Trust Have an Effect on Transfer Penalties?**
1. People over age 65 have been placing their "excess income" into pooled trusts such as NYSARC's to reduce their Medicaid spend down for community-based care. As long as they remain in the community, these "transfers" of monthly income do not affect their Medicaid eligibility. However, nursing home transfer rules penalize not only transfers of *assets* but also transfers of *income*. Since the penalty on a transfer is now delayed, and since all transfers are added together, someone age 65+ who transferred \$1000 of income into the NYSARC trust every

month from March, 2006 - March, 2008 *could* have a cumulative penalty of \$24,000 or almost 3 months of nursing home care.²⁵ (Deposits into the NYSARC trust before February 8, 2006 have no consequence on later nursing home applications).

2. On January 23, 2007, counsel for State DOH orally stated at a meeting of the NYS Bar Association Elder Law Section that they *will not penalize* transfers into a pooled trust, as long as the client can show that the money put into the trust was then used for her own benefit. In October 2007, the State again stated verbally that this should be the policy, but has not yet put it in writing. This should be the rule under the federal State Medicaid Manual, which states that deposits into pooled trusts should be “exempt transfers” as long as the deposited funds were used to pay the client’s expenses.²⁶

II. STRATEGIES FOR PEOPLE APPLYING FOR MEDICAID - DAMAGE CONTROL

A. USE any EXCEPTIONS to the transfer penalties.

- B. **Make it through the 5-year penalty period.** Of course, this could cost a bundle. Use Medicaid community-based services during this period, which have no transfer penalty. This includes Medicaid Assisted Living Program. If there are none, and if the client cannot wait five years to apply for nursing home or waiver care, and if the transferred money is no longer available to pay for nursing home care, which would reduce the penalty. See 96 ADM 8 at p. 23, here are some strategies.

1. **Buy Long Term Care Insurance (LTCI).** The asset changes were pushed through by a strong lobby from the long term care insurance industry. Certainly one way to get through the new penalty period would be to use a long term care insurance policy. Unfortunately, these policies are generally unaffordable to most of our clients. Also, many of our clients would be denied coverage because of pre-existing medical conditions.

- a) New York State is one of four states that have long term care insurance “Partnership” policies under a demonstration program. These policies allow someone who uses the insurance to cover three years worth of nursing home

²⁵ For people under age 65 are receiving community-based Medicaid, transfers of the spend-down into a Supplemental Needs Trust are exempt from any transfer penalties. They, do not risk being penalized on these transfers should they enter a nursing home in the next 5 years.

²⁶ CMS State Medicaid Manual Section 3259.7(1) and (1)(C)(3) at page 3-3-109.36, which provides that to the extent the income is actually paid out by the Trust for the benefit of the individual, the individual will be considered to have received fair market value for the assets placed in the trust and no transfer of asset penalties will apply. Thanks to Aytan Bellin, Esq. for this research.

care, or 6 years of home care, or a combination of the two, to become eligible for Medicaid for nursing home care after the three years, regardless of the amount of their assets. Their income must still be contributed to the cost of care, as is now the case. More info at <http://www.nyspltc.org>.²⁷

- b) A new “Dollar for Dollar” Partnership policy option is for people who do not have enough money to purchase LTC insurance for the full 3 - 6 year period described above, or who only want to protect a certain amount of assets. *Id.* They may buy coverage for period as short as 1.5 years for nursing home, or 3 years for home care, or more if they prefer. After that period is over, they qualify for Medicaid even though they have excess assets.
<http://www.nyspltc.org/expansion.html>
- c) EXAMPLE: Bob has \$180,000 in assets, which would pay for about 18 months of care privately. He purchases LTC insurance to cover 18 months of care. When he needs nursing home care in 3 years, he has paid total premiums of \$30,000 (this is not a real number, just for illustration). His insurance pays for 18 months of nursing home care, after he has paid \$20,000 for the first 2 months privately during the “elimination period’ under his policy. After that, he still has \$130,000 left which he is allowed to keep. Medicaid will begin paying after the 18 months. He will still have to contribute his income to the cost of his care.
- d) Partnership Policies sold in NYS must have 5% interest compounded annually.²⁸

C. Minimize the “transfer” by **pre-paying for expenses** with part of the money.

- 1. Prepayment of rent and other expenses -- Mrs. S’ rent is \$1000 per month. Her income is \$1200 per month. She has \$30,000 in assets. She had planned to transfer the amount over the \$4150 asset limit to her daughter, and then apply for home care. The daughter was planning to use the transferred part of the money to pay all or part of her rent. If her housing situation is stable, consider pre-paying rent or maintenance for a year or some other period of time, or pre-paying cable TV, telephone, Medigap policy, etc. Since these payments are for market value, they are not transfers.

²⁷ Social Services Law § 367-f, 11 NYCRR § 39

²⁸ The new law will encourage other states to adopt these Partnership policies.²⁸ However, the law allows insurance companies to give very meager inflation protection. For people under age 61, the policy must provide “compound annual inflation protection,” which is essential. However, from age 61 - 75, only “some level of inflation protection” (presumably this means simple inflation) must be provided, and at age 76 and above, inflation protection is completely optional. New York has stronger protection.

a) A pre-payment of rent must be carefully done. It should have a written agreement with the landlord or co-op management, that acknowledges what time period the payment is for, and has a contingency plan for the client's death or nursing home placement before the period is over. This must be carefully drafted, to avoid looking like a "transfer." Also, it cannot be "revocable" or Medicaid will view it as the client's assets. We have no experience drafting these yet, so cannot say what would pass review.

2. Purchase pre-paid burial arrangements

3. Pay off mortgage or other debt. Of course if client owns the co-op or home, this will have to be transferred to qualify for nursing home coverage, unless client can express her intent to return home once she enters the nursing home, or unless a spouse or disabled or minor child lives there. Need to see a private lawyer for the home.

D. Enter into a **caregiver agreement**. Enter into an agreement with an individual to provide care – the care might be hands-on personal care or care management, such as arranging medical care, financial management, etc. The caregiver is treated as an "employee" rather than as an "independent contractor" which means it will be necessary to pay and withhold FICA taxes and to file appropriate documents. This strategy may only be used prospectively; one cannot enter into an agreement to reimburse a daughter for care previously given. The amount paid will likely be scrutinized to see whether the client received Fair Market Value for the resources transferred to the caregiver.

Use of such agreements has been limited by a 2007 directive of the State DOH. GIS 07 MA/019, http://www.health.state.ny.us/health_care/medicaid/publications/index.htm - 9/24/07. This directive makes it almost impossible to use such agreements when the individual is in a nursing home, since "no credit is allowed for services that are provided as part of the Medicaid nursing home rate." Even where the individual remains in the community, so that the caregiver may be providing myriad services, a contract "that does not provide for the return of any prepaid monies if the caregiver becomes unable to fulfill his/her duties under the contract, or the [client] dies before his/her calculated life expectancy..." Contracts with services to be provided on an "as needed" basis are not acceptable. Elder law attorneys question the legality of this directive, and a challenge is possible.

E. **Buy a Life Estate in another person's home**²⁹

1. Client may purchase a "life estate" in her daughter's home, and the money paid to the daughter for this purchase will not be counted as a transfer, **as long as**

²⁹ DRA Sec. 6016(D), amending 42 U.S.C. § 1396p(c)(1)

client resides in the home for a continuous period of at least one year after the date of purchase. ADM p. 23.

2. A life estate is the right to live in a home for the rest of one's life. Someone else, usually the client's daughter, owns the "remainder" interest, which means the home is owned solely by the daughter when the client dies.³⁰
 3. The ADM at pp.23-24 speaks more broadly, arguably permitting purchase of a life estate interest in any "property" owned by another individual, rather than limited to a "home" of another individual. Since such broad language would be inconsistent with both the federal and state law, it is presumably a drafting error.
 4. **CAUTION:** There are tax consequences with this strategy. An experienced elder lawyer must be consulted.
- F. **ANNUITIES --** An annuity is a contract by which one receives fixed payments on an investment for a lifetime, or for a specified number of years. One purchases an annuity with all or part of their assets. Purchasing an annuity is not a "transfer of assets" so has no penalty period. This is because one receives back payments of principal and interest that have the same "fair market value" as the assets with which the annuity was purchased.
1. **Requirements for Annuities --** Even before the DRA, annuities were becoming a more common tool for doing Medicaid planning. They had to follow certain rules to avoid being counted as an "asset" for Medicaid, or to avoid a transfer penalty. These same rules continue, but now there are added requirements, which are indicated as "new" in the list below³¹
 - a) Annuity must be **irrevocable**. Client can't change their mind later and get their assets back, after they purchase the annuity.
 - b) The fixed payments that the annuity pays in return must be in amounts that are "**actuarially sound**," according to designated life expectancy tables. This means if the client's life expectancy under the table is 12 years, then the annual payments she receives must be about one-twelfth (1/12) of the original assets plus interest. In other words, the annuity is meant to be used up by the time the client dies.

³⁰ Life expectancy tables are used to determine the value of a life estate. It is not clear which table will be used - Attachment V of state directive 96-ADM-8 at http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/96adm8.pdf or tables of the SSA Chief Actuary at <http://www.ssa.gov/OACT/STATS/table4c6.html>.

³¹ Section 6012 of the Deficit Reduction Act, amending 42 U.S.C. 1396p, new ADM at pp. 5-7.

- (1) NEW -- The life expectancy tables are now those used by the Chief Actuary of the Social Security Administration rather than those found in HCFA transmittal 64. See <http://www.ssa.gov/OACT/STATS/table4c6.html>.
- c) Payments must be **“immediate”** - start soon after the annuity is purchased, and not be **“deferred”** to a later time, such as in a “balloon” annuity.
2. **Where annuity obtained** --An annuity could be purchased from an annuity company OR from a family member or friend, in a contract carefully drawn up to meet all the requirements above. This could be a way to transfer assets without a penalty. The client would purchase the annuity with a large payment of assets to the family member, who would be required to make annual payments back to the client under the rules above. There may be different tax ramifications based on whether the annuity is issued by an insurance company or a family member; a tax advisor should be consulted on this issue.
3. The **payments** from the annuity count as “income” by Medicaid, increasing the client’s spend-down. But since there is no transfer, there is no penalty delaying eligibility. Also, if the client is in the community, the income could be placed in a pooled Supplemental Needs Trust, to avoid increasing the spend-down.
4. NEW -- effective with respect to transactions occurring on or after February 8, 2006 -- **Medicaid payback** -- Unless the beneficiary is the spouse or a minor or disabled child, the **State must be the primary beneficiary** so that any benefits Medicaid paid over the client’s life would have to be paid back to Medicaid upon the client’s death. Even where there is a spouse or minor or disabled child, the State must be named secondary beneficiary.
 - a) If client does have a spouse or minor or disabled child, there is no real benefit to purchasing an annuity, even though the State need not be named as a beneficiary. This is because client may transfer assets to the spouse or disabled child without a penalty anyway.
5. NEW -- States must require the annuity company to notify the State if the amounts withdrawn from the annuity increase. Such withdrawals may cause the client to lose Medicaid if the withdrawals are not “actuarially sound,” or at the least, may increase the client’s spend-down.
6. **RETIREMENT ANNUITIES EXEMPT** -- If retirement funds such as an IRA, a Simplified Employee Pension Plan (SEP), and certain other retirement accounts established by employers, are used to purchase an annuity, it will not be counted as a transfer of assets. However, this shouldn’t be necessary, since retirement

funds have already been exempt as an asset, as long as distributions are being taken from the fund in amounts that are “actuarially sound.”³²

7. **EXAMPLE:** Sadie is 65 years old and has a life expectancy of 19.09 years under the table at the above link. She purchases a \$100,000 annuity with a 19 year term. This is a private annuity in which she paid the \$100,000 to her daughter. The annuity contract provides that the daughter agrees to pay her back the \$100,000 in equal annual payments over the 19 year term. (An interest rate is calculated into the payments). The State must be named beneficiary of the annuity. If Sadie dies at age 75, the balance left of the annuity is paid to the State, which takes back the amount it spent on Medicaid for her during her entire life. If there is anything left, a person she named as secondary beneficiary, such as her daughter, would get it. The purchase is actuarially sound and is not considered a transfer of assets. If Sadie lives to age 100, the whole annuity will have been paid out, and there will be nothing left for the State to claim as beneficiary when she dies.
- G. **Promissory notes** could also be used in a similar way as an annuity. They must meet all the requirements for annuities described above, *except* that the state does not have to be named as beneficiary of the remainder. See, new ADM at p. 7. This distinction, and their flexibility, makes them more popular among elder law attorneys. If the loan does not meet the following requirements, it will count as a gift and trigger a transfer penalty.³³
1. Loans and notes may be more flexible than annuities, allowing payment over a time period that is individualized – such as 17 months -- not a standard time period, such as a fixed number of years.
 2. Like an annuity, payments must start *immediately* (not a deferred “balloon”), payments must be actuarially sound and in *equal amounts* over the course of the loan.
 3. It must be *non-negotiable*. Recent fair hearing decisions approving promissory notes, although noting the fact that the notes were not negotiable, turned on the economic argument that a note executed between family members had no value in the market place and hence had no value. This argument was supported by the testimony of an individual described as an actuary and economist. See discussion, next page.

³² *Matter of Arnold S*, Fair Hearing No. 3701203H (May 28, 2002)(available on www.wnylc.net in fair hearing database).

³³ Sec. 6016(C) of the Deficit Reduction Act.

4. Though the State does not have to be named as a beneficiary for a note, as is true for an annuity, *the note cannot say that the balance is canceled upon the death of the lender*. This means that the balance due on the death of the lender would be due to the Estate, which would be subject to a Medicaid lien.
5. While there is no specific requirement to include *interest*, this is recommended to make a bona fide note and rebut any appearance that it is a gift. A recent fair hearing decision found 5 percent interest to be market rate, noting that bank CDs paid a similar rate of interest or less. See discussion below.

6. **EXAMPLE OF USING PROMISSORY NOTE TO PRESERVE HALF OF**

ASSETS. Sam is age 85 has \$100,000 in assets and needs to enter a nursing home immediately. He has no spouse or disabled children. While he lives with his daughter Sarah who has taken care of him for 2 years, he has liquid assets rather than a home, so cannot transfer any assets to her without a penalty.

On September 15th, he is admitted to the nursing home and gifts \$50,000 to his adult daughter Sarah. The transfer penalty on that amount is about 5.3 months. On the same day, he transfers another \$50,000 to Sarah, who signs a promissory note in which she promises to repay her father \$10,000/month for five months plus 5% interest, beginning October 1st. The period of five months is actuarially sound because his life expectancy is 5.29 years under the table at the link above, bottom of p. 23. While he could stretch the payments out over 5.29 years, he may choose a shorter period. He wants to choose the shortest possible period, so that he will receive income from the note only for the period he is not on Medicaid.

Medicare paid for the care in September, so he cannot apply for Medicaid in that month. He applies for Medicaid on October 1st, when Medicare stopped paying. His only remaining assets are \$4250 in the bank and a pre-paid burial arrangement. He is otherwise eligible for Medicaid. He will pay the nursing home bill for October and the next 4 months using the \$10,000 plus interest in payments on the note he receives from his daughter, plus his own income of \$3000/month. The penalty period on the gifted \$50,000 starts running in October and will expire after 5.3 months. After that time, he can reapply and will be eligible for Medicaid. The gifted \$50,000 has been preserved.

7. **Three August 29, 2007 Albany County fair hearing decisions** (numbered 4733471N, 4733466Z and 4733465H) approved well-drafted promissory notes under the DRA.³⁴ Timothy Casserly of the Albany law firm of Burke & Casserly, PC represented the appellants in each matter. In each case, the Albany County Department of Social Services (“DSS”) had denied Medicaid because the

³⁴ The decisions are posted on the www.wnyc.net fair hearing database.

applicant had transferred a sum of money to a family member in exchange for a non-negotiable promissory note payable to the applicant. The amounts of the notes ranged from \$40,000 to \$49,000. Two of the notes had a six-month term; the other a five-month term. Each note had an interest rate of 5%. The decisions reversed the DSS' denials of Medicaid and held that the payment of funds by the applicant in return for the promissory note was not an uncompensated transfer of assets which would engender a penalty period; and the promissory note was not an available resource in the hands of the applicant.

- a) The decisions held the actuarial soundness requirement was satisfied even though the term of the loans were well under the life expectancy of the applicant. The 5% interest rate to be paid under the notes was found to be a market rate – see above. The decision held the notes satisfied the other DRA requirements discussed above, and that the notes were not “available resources” because they had no value. See above re negotiability.
 - b) **Warning:** Don't try this at home! An experienced elder lawyer needs to make these calculations, which involve determining the length of the payback period using actuarial tables, calculating interest, taking into account income, payments by Medicare and Medigap insurance, if any, setting up pre-paid burial arrangements, etc. The calculation could work out very differently depending on these variables. However, this example is given to you so that you know it is worth referring a client for legal help even after the DRA.
8. Strategic factors in using annuities and loans – one gamble is whether the client lives longer than her life expectancy, or longer than her spouse or disabled child if they were a primary beneficiary on an annuity. If client lives this long, for an annuity, Medicaid won't have any claim as the beneficiary to any remainder. For a note, the concern is the same - if the client dies before expected under life expectancy tables, the balance due on the note would be due to her Estate, subject to a Medicaid lien.
 9. Also, the decision to use an annuity or note is different depending on whether the client is seeking home care or nursing home care.
 - a) In the home care situation, the income stream paid by the annuity will increase the spend-down. That income could be placed into a pooled Supplemental Needs Trust, but for people over age 65, that has a risk too of being penalized as a “transfer.” See section on Supplemental Needs Trusts above.
 - b) If client is entering a nursing home, purchasing an annuity may make sense, at least with part of the assets. The other part of the assets might be gifted, and would trigger a transfer penalty. The income back from the annuity

might be sufficient, with the client's other income, to pay for the nursing home care during the transfer period. (The transfer penalty will only "run," though, if the client is eligible for Medicaid during that period, so the annuity payments plus client's other income must be *lower* than the rate paid by Medicaid to the nursing home). This depends on many factors - client's age, amount of money involved, etc. In the past, clients with modest amounts of assets did not have to consider these options, but now they do.

H. What if You Need Short-Term In-patient Rehab During the 5-year Period?

1. People who transferred assets may need nursing home care in the next 5 years, Whether for a temporary stay such as for rehab, or for a permanent move, they must decide whether and when to apply for Medicaid.
2. If client has a transfer penalty, she may *want* to apply for Medicaid to have the penalty period determined and to have it start running, if she intends to return home after a short rehab stay. Once the transfer penalty is determined, and client goes home, penalty will *continue to run* while at home. Of course, client is liable for the cost of care during the short term stay, to the extent that Medicare, any private Medigap supplemental policy, and the 29-day Medicaid rehab benefit (described below) were exhausted.
 - a) **WARNING: Medigap insurance Types C – J, that cover SNF coinsurance, can hurt!** Nancy has a Medicare supplemental policy that covers skilled nursing facility coinsurance. Medicare and her supplemental policy cover the maximum 100 days of care. If she transferred assets after 2/7/06 and applies for Medicaid during the 100 days while the Medicare/ Medigap coverage is paying in full, the penalty will not begin to run because she is not "otherwise eligible" for Medicaid. If there is no unpaid medical bill, she is not "otherwise eligible" for Medicaid.
 - (1) TIP -- People who transferred assets after 2/7/06 may consider switching their Medigap to a plan that does NOT cover the skilled nursing coinsurance. Since they would owe the Medicare coinsurance beginning on day 21 of a rehab stay, they could apply for Medicaid and be "otherwise eligible." The penalty would start running while they are in the nursing home and continue when they go home.
 - (a) Warning #2 - This can only work for people with incomes that are lower than the cost of the coinsurance for that month, so that there is a due bill for Medicaid to pay Assuming a full 30-day month, \$119/day coinsurance x 30 = \$3570. If client's income is more than that, or if it is only a partial month with a smaller amount due, this strategy won't work.

- (2) Even if the Medicare and Medigap coverage expired, or there is no Medigap coverage, and client applies for Medicaid in the nursing home, Medicaid applications take months to process. If client leaves nursing home while Medicaid application is still pending, it is unclear whether the penalty still start running “retroactively” while she is at home, once the notice of the penalty is issued.
3. Client may NOT want to trigger the transfer penalty -- such as if she is near the end of the 3 – 5 year period after a particular transfer, she will not want to apply for Medicaid during a short-term stay, and would *want* to rely on Medicare, Medigap, and private pay.
4. **Using the 29-DAY MEDICAID REHAB BENEFIT** -- Since 2002, NYS law allows Medicaid to pay for up to 29 days of inpatient rehab care in a nursing home as part of *community* Medicaid. This means that someone with community Medicaid only, without submitting 36-60 months of bank records, and despite any transfers, can receive *some* inpatient rehab. Though the new ADM does not list this benefit as one of the “community based long term care services” that is not subject to the transfer penalty, it implicitly acknowledges that this benefit is not subject to the penalty. ADM at 18.
 - a) This benefit is VERY limited. The complete rules and cites are complicated. See fact sheet.³⁵ **The 29 days must be *consecutive* and are available only once a year.** Client cannot spread it over two or more rehab stays in a year.
 - (1) EXAMPLE: Susan was in a nursing home rehab, where she applied for and used part of the Medicaid rehab benefit. After only 15 days, she was sent back to the hospital for a week, and then went back to the nursing home for more rehab. The 14 remaining days from her 1st stay, of the 29-day maximum, are lost and cannot be carried over to her 2nd rehab stay. She would not qualify until the next year. She would have to do 36-month (60 month in 2009) resource documentation to receive more nursing home care after the hospital stay.
 - (2) **Days Paid by Medicare Count Toward the 29-Day Limit** --The 29-day short-term rehabilitation begins on the first day the applicant/recipient is admitted to a nursing home on *other than a permanent basis*, regardless of

³⁵ <http://onlineresources.wnyc.net/pb/docs/UpdateResourceAttestation.pdf> (Has not been revised yet re new lookback periods, etc., but explanation of 29-day benefit is current). One only needs to meet a one-month spend-down for Medicaid payment for each month during a 29-day period of short-term rehab. If the period spans 2 calendar months, one must meet the spend down for each of the 2 months. Note that the 6-month spend-down requirement for hospital care does not apply. 04 OMM/ ADM-6 p. 10 and 05 OMM-INF-2 June 8, 2005.

whether the client has Medicare or other insurance to pay for the early part of the stay, *IF the client applies for Medicaid during that stay* **Example:** Susan is admitted to a nursing home for rehabilitation on November 8, 2004. Medicare covers November 8 through 27 (20 days) in full. Medicaid coverage for short-term rehabilitation is available starting November 28 through December 6 (the remaining 9 days of the short-term rehabilitation allowance).

- (a) Note: If Susan did not have Medicaid upon admission and applied for Medicaid coverage to begin December 1 (not retroactive to November), November 8th would still count as Day One of the short-term rehabilitation.
- (b) If Susan had been in rehab in May of the same year, but did not apply for Medicaid during that stay, the full 29 days for that year would still be available for the current stay in November. The first admission would not be counted toward the one admission limit per 12-month period because she did not apply for Medicaid.
- (c) This rule requires people to guess the odds of whether they will need a second rehab admission in the same year --one must consider how late in the year the admission occurs, the client's health condition, etc. If a second admission is unlikely because it is already December, then one might as well use the 29-day rehab benefit.
 - (i) **Example of Beating the Odds:** Mrs. S applies for Medicaid coverage for a six-week nursing home stay which began on September 4, 2006. Six months ago she had a short-term nursing home stay but did not apply for Medicaid, expecting it to be less than 20 days and fully covered by Medicare. Medicaid coverage for short-term rehabilitation is available starting September 4, 2006- -- if Medicare covers the first 20 days in full, Medicaid will cover the next 9 days if not paid by Medigap.
 - (ii) **Example of Losing the Gamble:** The same Mrs. S had the same short-term stay six months ago. She applied for Medicaid for that stay, just in case she'd stay more than 20 days. She has no Medigap insurance so was concerned about the \$119/day co-insurance (2006). She left on Day 22, so Medicaid paid the coinsurance for 2 days using the short-term rehab benefit. For the 6-week nursing home stay beginning on Sept. 4, 2004, she has NO short-term Medicaid rehab coverage, even though she only used 2 days in the last stay. The days must be consecutive. She will have to do the full 36- to 60-month lookback to qualify for

Medicaid to supplement the Medicare coverage. Next year she will have a new 29-day benefit.

- (3) **Considerations under DRA re the 29-day Benefit** -- Now that we know that the transfer penalty will start running even if client leaves the nursing home, clients can apply for nursing home Medicaid after the 29-day benefit expires, and start the penalty clock ticking . . . and go home and have the penalty continue running. If the rehab stay is totally covered by Medicare and Medigap, they *cannot* use this strategy, however, because there is no bill to pay and they are not “otherwise eligible” for Medicaid.

III. PRIMARY RESIDENCE -- NEW CAP ON EQUITY VALUE OF HOME

A. Individuals with more than \$750,000 in home equity are not eligible for Medicaid coverage of “nursing facility services or other long-term care services.”³⁶ New York’s \$750,000 limit applies statewide and to all groups, declining an option by CMS to set different equity limits in different parts of the state, or for different eligibility groups. Guidance p. 3.

1. WHICH SERVICES ARE UNDER THE EQUITY LIMIT? It is clear from the law and the July 2006 CMS guidance that these services are subject to the \$750,000 limit: Nursing home, Home and community based waiver services (Lombardi, etc.), home health care (CHHA), personal care services (home attendant), and Alternate Level of Care (ALOC) services in a hospital.³⁷ It is also clear that regular community Medicaid - hospital, outpatient clinic, dental, lab tests, etc. are not subject to the home equity limit.
 - a) The NYS ADM, however, lists more services as subject to the home equity limit than are listed by CMS. Since the state issued this ADM before the CMS Guidance was issued, we hope that the State will revise its list. Meantime,

³⁶ States may use an equity limit of \$500,000, but New York State exercised the option to increase this to \$750,000. SSL 366, subd. 2(a)(1). See, new ADM at pp. 24-25. The amounts would be indexed to inflation beginning in 2011, but the increases for inflation are minimal. Section 6014 of the Deficit Reduction Act, by adding a new subsection 42 U.S.C. 1396p(f)(1)(A).

³⁷ The CMS Guidance says that the home equity limit applies to “services for a non-institutionalized individual that are described in paragraphs (7), (22), and (24) of section 1905(a) of the Act [42 U.S.C. § 1396d], which are home health care, personal care, and a program that does not exist in New York -- home and community care for functionally disabled elderly individuals (to the extent allowed and as defined in section 1929 [42 USCS § 1396t]) The home equity limit also applies to other long term care services for which Medicaid is otherwise available, but only if a state has elected to apply the transfer of asset penalties to these services under section 1917(c) [42 USC 1396p]. Since New York does not penalize transfers for other services, the home equity limit should not apply.

clients denied the following “Community-based Long Term Care Services” because of the home equity limit may be able to challenge it:

- (1) Medical model adult day care
- (2) Private duty nursing
- (3) Consumer-directed personal assistance program (CDPAP)
- (4) Hospice (in-patient or home hospice)
- (5) Personal Emergency Response System (PERS)
- (6) Managed long term care program,
- (7) Assisted Living Program (ALP)(though as a practical matter, one living in an ALP would not own a home)

- B. **EXCEPTIONS** -- This cap on home equity would not apply to homes in which the individual's **spouse or minor or disabled child** are living.
1. Transfer of the home to a spouse or to a minor or disabled child would be permitted anyway, since these transfers are an exception to the transfer of asset penalty. See pp. 14-15 above.
 2. If the home is worth more than the limit, all or part of the home could also be transferred without penalty to a son or daughter if s/he lived in the home for 2 years and cared for client, or to a sibling with equity interest who lived in home for 1 year. See pp. 14-15 above.
 3. **CAUTION:** Transfers of a home always have tax consequences because of the likely appreciation in the value of the home. Consultation with an elder law attorney is essential when dealing with transfer of a home.
- C. **“Home Equity”** is the market value of the home minus any mortgage owed. One may take out a reverse mortgage or home equity loan to reduce the equity to get under the limit.
- D. The law requires CMS to establish a process to request a waiver of the equity limit for a “demonstrated hardship.” The new ADM (p. 7) states that an undue hardship exists when the denial of Medicaid coverage would:
1. Deprive the applicant/recipient of medical care such that the individual’s health or life would be endangered; OR
 2. Deprive the applicant/recipient [A/R] of food, clothing, shelter, or other necessities of life,

AND

3. There is a legal impediment that prevents the A/R from being able to access the equity interest in the property.

COMMENT: Since CMS has not issued guidance or regulations defining hardship, it seems DOH has made up these hardship criteria. While the requirement that one meet (1) or (2) above seems legitimate, since this is the same hardship criteria the DRA uses for the transfer penalty, the third requirement -- that there be a legal impediment to accessing the equity interest -- is questionable, though arguably reasonable

4. EFFECTIVE DATE: The new limit expressly applies to all applications filed on or after January 1, 2006.³⁸ See, new ADM at p. 24. There is, thankfully, no provision that it be applied at recertification to individuals who are already receiving Medicaid. DOH has said verbally that it will NOT apply to nursing home residents who lived in the nursing home before Jan. 1, 2006, regardless of when they applied for Medicaid, but this is not clear in the ADM.

IV. CMS GUIDANCE ON SPOUSAL IMPOVERISHMENT "INCOME FIRST" RULE

The CMS guidance concerning section 6013 of the DRA, called "Application of the Spousal Impoverishment 'Income First' Rule," implements the DRA requirement that makes the "income first" method mandatory for all States. States must allocate the maximum available income from the institutionalized spouse to the community spouse before granting an increase in the Community Spouse Resource Allowance ("CSRA"). The Guidance provides steps States "*may*" use where an increase in the CSRA is requested on the basis that additional resources are needed to generate the monthly maintenance needs allowance. If, after counting income generated by the community spouse's own assets and income from the institutionalized spouse, there is still a shortfall in the community spouse's income, the State is to determine the amount of increased resources needed to generate income to meet the shortfall.

"... 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..."³⁹

The problem with this procedure is that an annuity returns principal as well as income. Unless they are planning to split out the income portion of the annuity payment in some

³⁸ DRA Sec. 6014(b)

³⁹ CMS Guidance, Page 4, No. 5 <<http://www.cms.hhs.gov/smdl/smdl/list.asp>> (scroll to Transfer of Assets Guidance dated July 27, 2006 ; <http://www.cms.hhs.gov/smdl/downloads/TOAEnclosure.pdf>, pp 18 et seq.

way, by using this method they are essentially counting resources as both resources and income. In fact, a state court recently held that the state and local Medicaid programs lack authority to limit the amount of an enhanced CSRA to the amount required to purchase a single premium life annuity which generates a monthly payment sufficient to raise the community spouse's income to the MMMNA.⁴⁰ While the Guidance states that methods like the annuity calculation are offered for “illustrative purposes” only, and “do not preclude States from applying the income-first methodology in a different manner or sequence,” the CMS stamp of approval on this method may be harmful.

⁴⁰ *Berg v Novello et al* (No. 1681/0)(Supreme Ct. Sullivan Co., Sackett, J. March 1, 2006); see also *Parks vs. Moon* (No.122885) (Supreme Ct. Sullivan Co., Feb. 14, 2006)