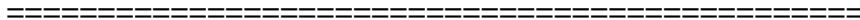


New York Medicaid Law

By Ronald A. Fatoullah, Esq. and Stacey Meshnick, Esq.



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Introduction

Medicaid is a “means tested” program enacted by Congress in 1965 to address the health care needs of individuals who are unable to afford such care. The program is jointly funded by the federal, state and local governments. In order to qualify for Medicaid coverage, an individual must be under twenty-one (21) years of age or over sixty-five (65) years of age, or disabled, blind, eligible for public assistance or a recipient of Supplemental Security Income.¹

Medicaid benefits include coverage of long-term institutional care and home care. In order to qualify for Medicaid home care and institutional care, applicants must meet certain asset requirements and submit an application that conforms to the requirements of the appropriate Department of Social Services Agency to which the application is being submitted. An application must be made on a state prescribed form.² Medicaid coverage can be retroactive for up to three months prior to the month of the application.³

Many individuals have felt compelled to deplete their available resources in order to become eligible for Medicaid benefits due to the rising cost of health care, inaccessibility of private insurance, and the increased need for care as they age. The idea that a well spouse’s resources may be depleted is a cause for concern and has created feelings of insecurity for many of our clients.

In New York State, the Medicaid program is administered by the local county Departments of Social Services and, in New York City, by the Human Resources Administration. State Medicaid statutes and regulations are subject to and must be consistent with federal law. Many significant changes in the federal law regarding Medicaid eligibility were promulgated by the Omnibus Budget Reconciliation Act of 1993 (OBRA-93), which was signed into law by President Clinton on August 10, 1993. OBRA-93 contains many changes that limit the ability of individuals to become eligible for Medicaid benefits. An administrative directive released by the New York State Commissioner of Social Services in 1996 has interpreted much of OBRA-93.⁴

The Deficit Reduction Act of 2005 (“DRA”), signed by President Bush on February 8, 2006, has further amended Section 1917 of the Social Security Act making it even more difficult to obtain Medicaid benefits. The DRA has made many changes to Medicaid eligibility rules including a change to the asset transfer rules and the look back period. The DRA mandates the disclosure of annuities; requires that the State be named as beneficiary of annuities; counts as an available resource certain entrance fees for continuing care retirement communities; makes the transfer of additional assets, such as

¹ N.Y. Soc.Serv.L. §366(1),(2),(3)

² 18 NYCRR §350.4

³ 18 NYCRR §360-2.4(c).

⁴ 96 ADM 8

funds used to purchase a promissory note, loan, mortgage or life estate, subject to the imposition of a penalty unless the purchase meets certain criteria; and amends Section 1919 of the Social Security Act to impose a home equity limitation for nursing facility services and community-based long-term care services.⁵

Medicaid eligibility rules and regulations, as well as elder law planning concepts in general, are constantly changing. As such, it is imperative that elder law practitioners be kept abreast of these changes and establish networks within which changes may be discussed, analyzed and implemented for the benefit of their clients. While not all fair hearings are published, the Western New York Law Center and the Greater Upstate Law Project have placed several thousand full text fair hearings on their website.

Medicaid Eligibility

Resources - In order to qualify for Medicaid, an individual may have non-exempt resources totaling no more than \$4,200 (in 2007). A married couple applying for Medicaid may have combined non-exempt resources of no more than \$5,400. The community spouse of a nursing home recipient may retain resources of up to \$101,640 (see below for a detailed explanation).

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.

Exempt Resources - In addition, the individual can have either an irrevocable funeral trust or a \$1,500 burial fund.⁶ There is no limit to the amount that can be placed in the irrevocable funeral trust fund, but money in the trust that is not used for funeral and burial expenses must be paid to the County in which the applicant resided.⁷ For applicants who have both a \$1,500 burial account and an irrevocable burial trust, any dollar amount not designated for burial space related items (e.g. casket, burial space) reduces the amount permitted in the \$1,500 burial account. The irrevocable funeral trust may be moved from funeral home to funeral home.

For community based Medicaid applicants, the applicant/recipient's home is considered an exempt resource, and will not affect Medicaid eligibility.⁸ Under the DRA equity in the home may not exceed \$750,000. Medicaid can *recover* against the home at the time of the recipient's death if the home is part of the recipient's probate estate. For institutionalized applicants, an applicant who holds title to a homestead with equity not exceeding \$750,000 will be eligible if there is a possibility that the individual can return home from the nursing home, or if the recipient has stated his or her intention to return

⁵ For purposes of accuracy, most of the description of post-DRA law herein is substantially derived/quoted from 06 OMM/ADM 5.

⁶ N.Y.Soc.Serv.L. §209(6)(b) and 18 NYCRR §360-4.6(b)(1) and).

⁷ N.Y.Soc.Serv.L. §141(6).

⁸ 18 NYCRR §360-4.7(a)(1)

home.⁹ However, Medicaid can place a lien on the home, which will be removed if the applicant returns home.¹⁰ In Anna W. v. Bane, the Court held that a client's *subjective* intent to return home was sufficient to determine that a homestead shall not be counted as an available resource. The Court concluded that a State's presumption that a Medicaid applicant had no expectation of returning home was a violation of federal law.

A lien will not be placed on the home, and the home will not be countable, even if the applicant does not intend to return home, if the home is occupied by a spouse, minor or certified blind or certified disabled child. In the case of a home that is occupied by a sibling with an equity interest in the home and who has lived in the home for at least one year prior to the applicant/recipient's ("A/R") admission to a medical facility, a lien will not be placed, but the home will be a countable resource if there is no intent to return. If the nursing home Medicaid recipient has no intention of returning home from the institution and none of the exemptions apply, the home will be treated as any other non-exempt resource, creating ineligibility.¹¹

IRAs or qualified retirement accounts of the applicant are exempt if the applicant is receiving periodic payments. An applicant who is 70½ or older with an IRA or qualified retirement account is defacto receiving periodic payments and therefore the IRA and retirement accounts are exempt. The periodic payments, however, are deemed to be income and will be budgeted by Medicaid accordingly. Medicaid's policy on IRA's changed in early 2002 when our firm presented an argument to the Human Resources Administration in New York City ("HRA") to preserve our client's IRA of approx. \$400,000. HRA eventually agreed (without litigation) that IRAs of the applicant are exempt. Nassau County followed suit shortly thereafter. Upstate New York maintained its policy that IRAs of the applicant were available for Medicaid purposes, until the decision of "In the Matter of Arnold S.," decided in the spring of 2002. The decision in Arnold S. made it clear that IRAs and any qualified retirement accounts of the applicant will not be counted as resources. IRAs and qualified retirement accounts of a non-applying spouse that are in periodic payment status are also exempt, but count towards the spouse's resource allowance.

The aggregate of all German and Austrian reparation payments made to the A/R as a result of Nazi persecution are also exempt. In these cases, the A/R should obtain a letter from Germany or Austria to prove the amount of reparation payments received by the A/R.

Additional Exempt Resources - Personal property such as clothing, furniture, personal effects and a car are exempt items. Life insurance policies with no cash surrender value are also exempt.¹²

Income - In 2007, a community-based Medicaid recipient is permitted to retain income

⁹ See Anna W. v. Bane, 863 F.Supp.125 (W.D.N.Y. 1993)

¹⁰ 18 NYCRR §360-7.11(a)(3).

¹¹ 18 NYCRR §360-4.7(a)(1)(ii)

¹² 18 NYCRR §360-4.6(b)

of \$700 each month, and an additional \$20 of the monthly household income if the Medicaid recipient is aged, blind or disabled. A couple may retain \$900 monthly. A nursing home Medicaid recipient may retain \$50 of income each month. Income exceeding the allowance must be contributed toward the individual's health care unless there is a community spouse with income under \$2,541 per month.¹³ Under such circumstances, the applicant/recipient's income may be budgeted to the community spouse, to bring her income to the \$2,541 level.

Institutional Medicaid Eligibility Pre-DRA

Transfers Of Assets For Less Than Fair Market Value - The agency to which the institutional application is made will "look back" at an individual's financial records for a period of 36 months prior to the requested "pick-up date" (the date on which the applicant requires Medicaid to begin providing benefits).¹⁴ Under OBRA-93, the look back period in the case of payments to or from certain trusts was increased to 60 months. The "look-back" period is used to determine whether income or resources have been transferred by the applicant (or spouse) for less than fair market value (i.e., gifted).

When a gift has occurred within the look-back period, Medicaid will impose a period of ineligibility, or "penalty period" on the applicant. The applicant will then be required to pay privately for his or her care during that period. New York calculates the penalty period as commencing on the first day of the month following the month in which the transfer was made.¹⁵

The penalty period is calculated by dividing the total cumulative, uncompensated value of all assets transferred during the look-back for less than fair market value by the current average monthly cost to a private-pay patient in a nursing facility within the State. New York State has exercised the federally granted option to apply community-based private-pay averages, which differentiate between the various counties in the State. The resulting number is equal to the number of months for which the applicant will be ineligible for institutional Medicaid benefits. According to the New York State Department of Health, the average cost of nursing home care for 2007 is \$9,375 in New York City (all 5 counties), \$10,123 in Nassau and Suffolk Counties, \$9,074 in the Northern Metropolitan Region; \$6,506 in the Central Region, \$7,189 in the Northeastern Region, \$8,002 in the Rochester Region and \$6,820 in the Western Region.

To apply these regulations, consider a New York City resident who has gifted the sum of \$100,000 to his daughter on January 1, 2006. To calculate the penalty period for Medicaid nursing home benefits, divide the \$100,000 gift by \$9,375 (the figure applicable for New York City applicants). The resulting penalty period is 10.67 months commencing February 1, 2006 and ending on November 30, 2006. Thus, the individual may apply for, and be eligible for institutional Medicaid benefits as of December 1, 2006, provided his or her resources do not exceed Medicaid eligibility levels.

¹³ N.Y.Soc.Serv.L. §366-c(2)(h).

¹⁴ 18 NYCRR §360-4.4(c)(2)(i)(c)

¹⁵ 96 ADM 8, p.5

Transfers made by a community spouse to any individual or entity other than the Medicaid recipient, *after* acceptance has been determined, will not affect the institutional spouse's Medicaid eligibility.¹⁶ Hence, post-acceptance transfers by a community spouse will not result in a penalty period for the institutionalized spouse.

It is important to note that OBRA-93 has eliminated the "cap" on penalty periods, which may be a trap for the unwary. For example, suppose that a Nassau County resident transferred \$500,000 to his son in January, 2006. If he applies for institutional Medicaid benefits after the pre-DRA 36-month look back period has elapsed (i.e. February 1, 2009 or thereafter), he would be eligible for institutional Medicaid benefits. However, if that same individual applied for Medicaid only 35 months after the transfer (January 1, 2009), then the Department of Social Services ("DSS") would impose a penalty period for 49.39 months (\$500,000 divided by \$10,123 = 49.39) commencing on February 1, 2006, the month following the transfer. By failing to wait the additional month to apply for Medicaid, this individual would have to pay privately for nursing home care for an additional 13 months, unless other planning measures are taken.

Institutional Medicaid Eligibility Post-DRA

The look-back period for transfers made on or after February 8, 2006, has increased from 36 to 60 months for nursing home Medicaid applications. For transfers made on or after February 8, 2006, the beginning 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. As a result, in most cases, the waiting period for nursing home Medicaid eligibility will not start until the A/R is in a nursing home, has assets of no more than \$4,200 (plus other exempt assets) and has applied for benefits.

Most of the provisions of the DRA apply to Medicaid nursing home applications filed on or after August 1, 2006. Nevertheless, social services districts will continue to require resource documentation for only the past 36 months (60 months in the case of a trust). However, commencing on February 1, 2009, districts will require resource documentation for the past 37 months. The look-back will increase by one-month increments until February 2011, when the entire 60 month look-back will be fully phased in.

In the event that the imposition of a transfer penalty would create an undue hardship for the applicant/recipient, 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, but the procedural requirements have changed pursuant to the DRA. Procedural changes are found in 06 OMM/ADM 5.

¹⁶ 96 ADM 11

Return of Assets

According to 06 OMM/ADM-5 if all or part 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, are 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, the original transfer penalty period is to be reduced by the returned assets.

Undue Hardship Waiver

If an individual is unable to demonstrate that a transfer was made exclusively for a purpose other than to qualify for nursing home benefits, the individual may nevertheless receive coverage if he can establish 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 individual's spouse is unable to have the transferred assets 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 (this provision was added by the DRA).

Annuities Post-DRA

Section 366-a of the Social Services Law is amended to require as a condition of Medicaid eligibility for nursing facility services that the applicant/recipient disclose a description of any interest that the applicant or spouse has in an annuity regardless of whether it is irrevocable or not. For annuities purchased on or after February 8, 2006, the applicant must be informed of the right of the State to be named remainder beneficiary.

Effective August 1, 2006, for annuities purchased on or after February 8, 2006, the State must be named as the first remainder beneficiary or the purchase of the annuity will be considered an uncompensated transfer of assets, resulting in a penalty period. For

applicants who have a spouse or minor or disabled child, the State must be named as the contingent (secondary) remainder beneficiary.

In addition, the annuity will be considered an uncompensated transfer of assets unless the annuity is (1) purchased with the proceeds from an individual retirement trust or account as described in Section 408 of the Internal Revenue Code of 1986 or (2) purchased with qualified money OR the annuity is irrevocable and non-assignable; is actuarially sound (the term of the annuity does not exceed the individual's life expectancy); and provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.

Treatment of Transfers to Purchase Loans, Notes and Mortgages Post-DRA

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 applicant/recipient.

Home Equity Value Post-DRA

Section 366.2(a)(1) of the Social Services Law 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. The limitation does not apply if a spouse or minor, blind or disabled child is residing in the home.

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 spend down 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.

Despite the foregoing, an otherwise eligible applicant will be provided Medicaid coverage of long-term care services if the applicant meets the criteria of undue hardship. The DRA provides for separate undue hardship criteria regarding the primary residence. Undue hardship exists when denial of Medicaid coverage would (a) deprive the applicant of medical care such that the individual's health or life would be endangered or (b)

deprive the applicant of food, clothing, shelter, or other necessities of life AND there is a legal impediment that prevents the applicant from being able to access his or her equity interest in the property.

Continuing Care Retirement Community Contracts and Life Care Community Contracts

Individuals with contracts for admission to a State licensed, registered, certified or equivalent continuing care retirement or life care community may be required to use their admission fees 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.

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.

DRA Long-Term Care Partnership Provisions

The DRA lifts the moratorium and permits all states to establish so-called "partnership programs", permitting states to amend their plans to provide for a partnership program. A qualified state long-term care insurance partnership is an approved state plan amendment "that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy" if seven requirements are met.¹⁷

Connecticut, New York, California and Indiana already had approved partnership programs well before the DRA. As long as the particular state's standards are not less stringent than the standards applicable in the state as of December 31, 2005 the seven

¹⁷ §6021 of DRA codified at 42 USC 1396p(b)(1)and(5)

requirements are deemed to have been met.

The DRA requires state partnership programs to comply with model guidelines established by the National Association of Insurance Commissioners.

DHSS must develop standards for “uniform reciprocal recognition” of partnership policies from state to state so that “benefits paid under such policies will be treated the same by all states.”

DHSS must also establish a National Clearinghouse for Long Term Care Information. The DRA sets out the requirements for the clearinghouse.

Life Estates

96 ADM 8 states that “a life estate will not be considered an available resource”. Thus, the retention of a life estate by a Medicaid applicant will not preclude eligibility. When a Medicaid applicant retains a life estate on a property, the penalty period resulting from the transfer of the property is reduced by the value of the life estate. The Health Care Financing Administration of the US Department of Health and Human Services, “HCFA” (now referred to as the Center for Medicare and Medicaid Services “CMS”) has established tables valuing life estates based on the life expectancy of life tenants.¹⁸ As an example, the HCFA tables indicate that the life estate of an 80 year old is valued at .43659. Thus, if an 80 year-old transfers a home valued at \$400,000, retaining a life estate, he has retained \$174,636 of the home’s total value, reducing the transfer to \$225,364.

The transfer of a home with a retained life estate can be a valuable tool for Medicaid planning. A life estate is the retention of the right to the possession, use and control of the home during the transferor’s lifetime. The value of the remainder interest is the amount of the gift and determines the period of ineligibility for institutional care.

The office of Ronald Fatoullah & Associates assisted a client with transferring several properties and retaining life estates on all of them. The City of New York Human Resources Administration attempted to assert that the administrative directive regarding life estates is intended to apply only to a homestead (primary residence) and denied the A/R’s application. Our firm prevailed on this issue at a fair hearing. We received a letter from the New York State Department of Health, verifying that the section of the ADM regarding life estates “was not intended to imply that social services districts should disregard only one life estate per applicant/recipient”.

Purchase of a Life Estate Post-DRA

For applications filed on or after August 1, 2006, for nursing facility services, the purchase of a life estate interest in another individual’s home on or after February 8, 2006

¹⁸ Dept. of Health & Human Services Health Care Finance Administration State Medicaid Manual Transmittal No. 64.

is treated as an uncompensated transfer of assets unless the purchaser resided in the home for a continuous period of at least one year *after* the date of purchase. For example, a 76 year-old A/R can use \$200,000 of this assets to purchase a life estate on his daughter's home valued at \$400,000. The purchase would not be considered a gift and would not incur a penalty period as long as the A/R lived in his daughter's home for a continuous period of one year after the purchase.

Options Regarding The Homestead

As discussed above, an A/R may transfer his or her homestead and retain a life estate. The life estate is valued according to Medicaid tables, which are based on an individual's age. The value of the remainder interest would be the amount of the gift and would determine the period of ineligibility for institutional Medicaid. Depending upon when nursing home care is required, an elder law attorney can craft a plan to further reduce the gift of the remainder interest, thereby reducing the penalty period during which the A/R would have to privately pay for care.

If the grantor retains a life estate and the home is not sold during the grantor's lifetime, then the home will be in the grantor's taxable estate and his/her heirs will receive the home with a basis "step-up". This means that the tax basis of the home for capital gains tax purposes will be "stepped up" to the market value on the date of the grantor's death (or alternate valuation date). This will reduce capital gains taxes that may be due upon the sale of the home by the beneficiaries of the transferor.

On the other hand, if the grantee sells the home on which the A/R has retained a life estate while the A/R is alive, the A/R is entitled to the present value of the life estate pursuant to Medicaid's charts, which would disqualify the him/her from benefits at that time.

If the A/R transfers the home without retaining a life estate, whether to individuals or to a trust, the gift, and therefore the waiting period, is based on the entire fair market value of the home. Consequently, the waiting period is longer for transfers without life estates. In addition, for transfers directly to individuals (not to trusts) or transfers with no retention of a life estate, there will be a carry over basis and the grantee will receive the grantor's tax basis, and will likely have to pay capital gains upon sale of the home (unless he or she occupies the home and is entitled to the \$250K exemption).

A fourth option is to simply put the house up for sale immediately, allowing the A/R to receive the \$250K capital gains exemption. When the house is sold, the A/R can gift some or all of the proceeds. The gift will create a waiting period pursuant to the provisions of the DRA as outlined above.

If the A/R needs nursing home care immediately, the A/R could also sign a letter of "intent to return home", apply for Medicaid and begin receiving benefits right away (assuming he/she is otherwise eligible and the equity in the home is \$750,000 or less). Medicaid will likely put a lien on the home if it determines that it is not reasonably expected that the A/R can return home. Once the A/R begins receiving Medicaid benefits,

the A/R can then sell the home. Upon the sale, the A/R will have to pay back Medicaid for what they expended on his or her care (this rate is often in the area of 30% less than the private rate). In addition, there is a way to preserve a portion of the net proceeds received from the sale of the home. The A/R's attorney may be able to negotiate an escrow agreement with DSS, allowing the A/R to stay on Medicaid and pay to Medicaid the sum that would be paid privately during the waiting period.

Subsequent to signing a letter of intent to return home, the A/R can transfer the home into a revocable trust, leaving the possibility that Medicaid may not recover upon the A/R's death (as discussed below, Medicaid only recovers from the probate estate of individuals 55 and older). However, if Medicaid puts a lien on the home, it will likely recover from the proceeds upon the sale of the home, whether or not the home is a probate asset.

If the A/R does not wish to transfer the home to an individual, he or she may transfer the home into an irrevocable trust, whereby the A/R retains the right to use the home and to receive income generated from the trust for the A/R's lifetime. The transfer into the trust rather to an individual can entitle the grantor A/R to retain the \$250,000 exemption from capital gains upon sale provided the trust is drafted properly. If the home is sold after the waiting period, Medicaid will not disqualify the A/R, and the \$250,000 capital gains exclusion will be preserved. A basis step-up can also be preserved if the home is held by a properly drafted irrevocable trust.

Finally, one of the most commonly used options is for the A/R to transfer the remainder interest into an irrevocable trust and retain a life estate. This reduces the period of ineligibility while maintaining the capital gains exemption and avoiding problems that may result from the death, incapacity or financial problems of a grantee. However, if the home were sold during the Grantor's lifetime, the net proceeds received from the value of the life estate would be deemed an asset of the Grantor A/R for Medicaid purposes.

Exempt Transfers

The following transfers (gifts) are exempt from Medicaid transfer penalty rules:

1. assets transferred to the individual's spouse, or to another for the sole benefit of the individual's spouse;
2. the outright transfer of assets to an applicant/recipient's blind or disabled child;
3. transfers for fair market value or for other valuable consideration;
4. transfers of assets exclusively for a purpose other than to qualify for medical assistance (Medicaid);
5. transfers for less than fair market value that have been returned to the Medicaid applicant/recipient and/or spouse;

Transfers involving spouses - Transfers between spouses are exempt from Medicaid

ineligibility rules.¹⁹ The purpose is to protect against the impoverishment of a community or well spouse. The following transfers are also exempt:

1. transfers to an individual other than an applicant/recipient's spouse for the sole benefit of the individual's spouse; and
2. transfers from an applicant/recipient's spouse or another for the sole benefit of the individual's spouse.

The regulations permit transfers between spouses to be completed within 90 days after a determination of eligibility, if the community spouse's assets do not exceed the Community Spouse Resource Allowance (see below for discussion of the CSRA).²⁰ However, completing all transfers to a spouse prior to submission of the Medicaid application often simplifies the application process.

Transfers to blind or disabled children - Transfers made to or solely for the benefit of an A/R's disabled child of an age are exempt. However, it may be ill advised to transfer assets directly to a disabled child who may be receiving governmental benefits. Rather, the transfer to a trust for the sole benefit of the disabled child is often advised. It must be noted that in order for the transfer to be exempt from transfer penalties, the estate of the spouse or disabled child must be the beneficiary of the trust upon death. If not, the transfer may be construed as a transfer to someone other than the spouse or disabled child. Often a cost benefit analysis must be computed to evaluate whether a direct transfer to a disabled child, and the resulting loss of governmental entitlements received by the child, if any, is advisable.

Transfers to certain trusts - The following transfers by an A/R and his or her spouse are also exempt for purposes of Medicaid eligibility:

1. the transfer of assets to a trust established solely for the benefit of the applicant/recipient's blind or disabled child; and
2. the transfer of assets to a trust established solely for the benefit of an individual under 65 years of age who is disabled.

Transfer of a homestead – If title of the homestead (primary residence of the A/R) is transferred to one of the following persons, no penalty period will be imposed:

1. a spouse;
2. a child under the age of 21, or a blind or disabled child;
3. a sibling of the applicant/ recipient who has an equity interest in the home and who was residing in the home for a period of at least one year immediately prior to the date the applicant/recipient became institutionalized; and
4. an adult child who resided in the home for a period of at least two years before the date the applicant/recipient became institutionalized and who "provided care" to such individual which permitted such individual to reside at home

¹⁹ 18 N.Y. Soc.Serv.L. §366(5)(d)(3)

²⁰ 18 N.Y. Soc.Serv.L. §360-4.10(c)(6).

rather than in an institution.²¹

Institutionalized Applicants With Spouses

In 1988, Congress enacted the Medicare Catastrophic Coverage Act (MCCA).²² MCCA was created to remedy the impoverishment of community spouses who were left without the means to support themselves upon institutionalization of their ill spouses. The federal government permitted states to establish income and resources levels for the community spouse, with a maximum level.

With regard to the income maximum, a community spouse's income of up to \$2,541 per month (for 2007), including interest, is not considered available to pay for the institutionalized spouse's care. This total may include the total income of both spouses, regardless of who earned this money and regardless of the name in which the income is received. As such, if the individual income of the community spouse is less than \$2,541 per month, the community spouse will be entitled to keep the amount of the institutionalized spouse's income necessary to bring her income up to \$2,541. In the event a community spouse's income is greater than \$2,541, Medicaid will request that the community spouse contribute 25% of the excess over \$2,541 towards the care of the institutionalized spouse.²³

If a community spouse's monthly income is below \$2,541, Medicaid will look first to the income of the institutionalized spouse to bring the community spouse's income up to the allowable level. In Golf v. New York State Dept. of Social Services²⁴, the Court held that the county Department of Social Services should use an "income first" method, allocating first the income of the institutionalized spouse rather than allowing for the community spouse to have more resources than the Community Spouse Resource Allowance (see below) in order to generate a higher monthly income. However, in Robbins v. DeBuono²⁵, the Court held that the deeming of Mr. Robbins' Social Security benefits to his wife is an "alienation" in violation of the Social Security Act. In other words, after Robbins, the income first rule no longer applied to Social Security benefits.²⁶ In such cases, the elder law attorney had the opportunity to advocate for an enhanced Community Spouse Resource Allowance rather than deeming the institutionalized spouse's Social Security benefits as available to the community spouse. However, Robbins was undermined by subsequent cases, Washington State Dep't of Social & Health Services v. Guardianship Estate of Keffler²⁷ and Ruck v. Novello²⁸. As a result the State issued a memorandum informing districts that the Department rescinded GIS 00 MA/027.²⁹ After the release of the GIS, the Department of Health no longer treated

²¹ N.Y.Soc.Serv.L. §366(5)(d)(3)(i).

²² Medicare Catastrophic Coverage Act of 1988, 42 U.S.C.A. §1396p

²³ N.Y. Soc.Serv. L. §360-4.10(b)(5).

²⁴ 674 N.Y.S.2d 600 (N.Y., 1998).

²⁵ 218 F.3d 197

²⁶ GIS 00 MA/027

²⁷ 537 U.S. 371

²⁸ 295 F.Supp.2d 258

²⁹ GIS 05 MA/002

institutionalized spouses with Social Security income differently than other institutionalized spouses. However, the Appellate Division Third Department decided Matter of the Estate of Margaret M. Tomeck on March 9, 2006.³⁰ The Court disagreed with the holding in *Keffler* and affirmed *Robbins*.

On July 7, 2006 *Wojchowski v. Novello*, in which the court held that *Robbins* is no longer good law (affirming *Keffler* and *Robbins*) was decided.³¹

All resources held by either spouse or by both spouses will be considered available to the institutionalized/applicant spouse. The community spouse is entitled to retain a Community Spouse Resource Allowance (“CSRA”), currently \$74,820, or ½ of the couple’s total resources, up to a maximum of \$101,640. The CSRA as well as the homestead in which the spouse resides are not considered available to pay for the institutionalized spouse’s care. The community spouse may retain more than the CSRA if her income (including interest from her assets) is below \$2,541, or if she requires a greater amount for her support as determined by a fair hearing or court order. For a more in-depth discussion of spousal support, see *Gomprecht v. Gomprecht*,³² in which the Court of Appeals held that payments to a spouse remaining in the community after her husband was institutionalized could be increased above the minimum monthly maintenance needs allowance only upon a finding of “exceptional circumstances.” Also see *Jenkins v. Fields*,³³ in which the court found that in adopting the exceptional circumstances standard the judges in *Gomprecht* were not in violation of the basic congressional intent of the applicable statute. Thus, the court found that the spouse had shown no probability of success on the merits and denied her motion for a preliminary injunction.

In assisting married clients with a nursing home Medicaid application, extensive advocacy may be required where an argument can be made for an enhanced CSRA. An enhanced CSRA is established by a court order or fair hearing. Ronald Fatoullah & Associates has successfully represented community spouses that received court orders fixing the income level well above the Minimum Monthly Maintenance Needs Allowance (“MMMNA”), currently \$2,541, despite the exceptional circumstance requirement set forth in the *Gomprecht* matter.

Spousal Refusal - If a community spouse has assets and/or income in excess of the CSRA and/or MMMNA, such assets and income will be considered available to pay for the institutionalized spouse’s care. However, under current New York law, Medicaid benefits will not be denied to the institutional spouse if the community spouse refuses to contribute any of his or her excess assets and or income by signing a “Spousal Refusal” letter.³⁴

In addition, when a community spouse refuses to contribute to the institutional

³⁰ 2006 N.Y. Slip Op. 01683

³¹ U.S. Dist. LEXIS 46108 (WDNY July 7, 2006)

³² 86 N.Y.S.2d (1995)

³³ 1996 U.S. Dist. LEXIS 5852

³⁴ N.Y.Soc.Serv.L. §366(3)(a); 18 NYCRR §360-4.3(f)(1)(i)

spouse's care, the Medicaid applicant/recipient must execute an assignment of support rights against the community spouse and in favor of the Department of Social Services.³⁵ A formal assignment of support will not be required if the applicant is unable to execute the assignment because of a mental or physical impairment, or if the denial of assistance would create an undue hardship.³⁶ In such circumstances, the assignment of support rights from the institutionalized spouse to the Department of Social Services will be implied.

In cases involving spousal refusal, Medicaid has the right to commence an action on behalf of the recipient against the community spouse, in order to compel support and for reimbursement of expenses incurred on behalf of the institutional spouse.³⁷ Further, Medicaid has the right to recover from the community spouse for benefits paid on behalf of the institutionalized spouse. See *supra* for a discussion of recovery.

There have been sporadic surges of attempts by Medicaid in various districts to recover from community spouses for benefits paid. Practitioners must be aware of these attempts at recovery and advise their clients accordingly. It is always best to seek the advice of an elder law practitioner and subsequently implement a plan *prior* to submission of the Medicaid application in an attempt to eliminate or reduce the chance of a spousal suit. Such plans typically involve purchase of an annuity or a promissory note that meets the criteria set forth in the DRA and subsequent NYS policy, thereby turning the community spouse's excess assets into an income stream.

Community-Based Medicaid Eligibility

Medicaid rules regarding transfer of asset penalty periods currently apply only to persons seeking or receiving coverage for nursing home services. Therefore, if a person needs medical assistance to pay for a home health aide or for a hospital visit, there is *no* period of ineligibility, even if that individual has transferred assets for less than fair market value. For example, if a client is seeking community-based Medicaid in July, 2007, the client may transfer his or her assets in June, 2007. The client may then apply for and be eligible for community-based Medicaid beginning July 1, 2007 as long as his or her assets are below the allowable resource level. The same resource levels for the applicant/recipient apply for both community based and institutional Medicaid. It must be noted that there are no statutory protections of resources and income of well spouses of community-based Medicaid recipients. Thus, a spousal refusal is submitted for virtually all home care Medicaid applications in which the well spouse has assets. The homestead, as well as the surrounding land, is an exempt resource for applicants applying for community based Medicaid, but keep in mind the home equity restriction of \$750,000 discussed earlier.

³⁵ 18 N.Y. Soc.Serv.L. §366-c(5)(b).

³⁶ 18 N.Y.Soc.Serv.L. §360-4.10(a)(12)(iv)(b).

³⁷ See *Commissioner of the Dept. of Social Services v. Spellman*, 661 N.Y.2d 895 (Sup.Ct. New York County, 1997), affirmed 672 N.Y.S.2d 298 (1st Dep't 1998).

Under OBRA-93, states have the option to impose a penalty period for community based Medicaid, which penalty period can be no greater than that for nursing home services. Although it has been proposed many times, New York State not as yet imposed any such penalty period.

Most Medicaid districts in New York have implemented a simplified application procedure for community based Medicaid. Under this procedure, the applicant need only provide information about income and resources for a three-month (rather than thirty-six month or sixty month) period prior to the requested Medicaid pick-up date.

Trusts

Trusts Established by the Medicaid Applicant

OBRA 93 (which applies to all trusts created on or after August 11, 1993) changed the rules regarding trust funds, imposing restrictions on Medicaid eligibility. Irrevocable income-only trusts are often used as a tool to protect assets of a Medicaid applicant. These trusts typically provide that while income is distributed to the grantor, the trust principal cannot, under any circumstances, be distributed to the grantor. HCFA (now "CMS") interpreted OBRA 93 to mean that in such cases the income and not the principal will be deemed available to the applicant. If a trust provides that principal can be paid to the grantor, even if only for a limited purpose, or even at the sole discretion of the trustee, then the entire principal of the trust will be deemed available to the grantor because there is a circumstance under which some principal could be paid, even if it is a remote one. In such a case, Medicaid eligibility will be denied to the grantor for excess resources.

As previously mentioned, if an applicant has transferred assets to or from certain trusts, including asset transfers to an irrevocable income only trust, the look back period will be sixty (60) months, even for transfers prior to February 8, 2006, the date that the DRA was signed by President Bush.

Of course, assets in a revocable trust with the Medicaid applicant as grantor will be considered available. As such, revocable trusts are often not used as Medicaid planning tools, but rather for other purposes, including avoiding probate and continuing management of assets if the grantor becomes unable to do so. However, the revocable trust can be used to avoid probate of assets held by the A/R, thereby eliminating Medicaid recovery. There is a distinction between liens and recovery and Medicaid can still pursue a lien placed on the A/R's home during his lifetime. Finally, transfers from a revocable trust, even if made prior to February 8, 2006, will result in a 60 month look-back period.

Exempt Trusts

Under OBRA-93, there are certain types of trusts that are exempt from the Medicaid transfer rules and from the 60 month look back period. Under these trusts,

neither the creation nor the funding affects Medicaid eligibility of the settlor or the beneficiary.

“Under 65” Special Needs “Payback” Trusts - This self-settled Special Needs Trust is available only to individuals who are under sixty-five years of age and disabled.³⁸ Self-settled means that the applicant/recipient must use his/her own money to fund the trust. The Special Needs Trust must be created for the individual’s benefit by a parent, grandparent, legal guardian, or by a court.³⁹

The Trust will remain exempt if the individual lives beyond sixty-five years of age. However, assets that are added to the trust after the beneficiary reaches sixty-five, will be subject to Medicaid transfer penalty rules.

While exempt from Medicaid transfer rules, the Special Needs Trust is still subject to some restrictions. The Trust must contain a provision that upon the death of the individual, all remaining balances left in the Trust must be paid to the Department of Social Services in an amount not to exceed the Medicaid benefits paid on behalf of the individual.⁴⁰ If any balance remains, it may be distributed to the beneficiaries as provided for in the Trust agreement.

Pooled Trusts – In a “Pooled Trust”, the assets of many disabled persons are held in a single trust with separate accounts for each person.⁴¹ Similar to the Under 65 Special Needs Trust, the Pooled Trust is limited to individuals who are disabled.⁴² However, unlike the Special Needs Trust, there is no requirement that the beneficiary be under the age of sixty-five. However, the funding of the trust is exempt from Medicaid penalty periods only if the individual is under age sixty-five at the time of the funding.

A Pooled Trust must be established and managed by a non-profit organization. A separate account for each disabled person must be maintained. The trust must be funded by the disabled person, his parents, his grandparents, his legal guardian, or a court. The trust must contain language indicating that payments will not replace or reduce Medicaid benefits of the disabled individual.

Similar to the Special Needs Trust, there must be a provision that provides that when the disabled person dies, Medicaid must be paid back from the balance in his account, up to the amount paid on his behalf. This payback provision can be avoided if the disabled person chooses to leave the remaining funds in the Trust after his death. The statute does not address how the remaining funds of the individual will be distributed.

As a result of a September 23, 1997 Addendum to 96 ADM 8, community Medicaid recipients are often advised to transfer their monthly surplus income into a

³⁸ EPTL § 7-1.12.

³⁹ *Id.*

⁴⁰ 42 U.S.C.A. §1396p(d)(4)(A)

⁴¹ 42 U.S.C.A. §1396p(d)(4)(C)

⁴² *Id.*

pooled trust. As it is usually impossible for an A/R in New York to meet expenses at home on an income of only \$720 per month, the use of a pooled trust helps the individual to remain in the community rather than being forced to enter a nursing home. The Department of Health has issued an informational letter instructing districts how to handle disability determinations.⁴³

Estate Recovery

Prior to OBRA 93, Medicaid was entitled to recover from the estates of a recipient who received Medicaid benefits after age 65. OBRA-93 extended the right of recovery against the estates of individuals who received benefits after age 55.⁴⁴ The law permits recovery for benefits paid within ten years of death.

OBRA-93 defines the term "estate" to include all real and personal property and other assets included within an individual's estate, as defined for purposes of the respective state's probate law.⁴⁵ This includes assets that may be administered if the individual had no will. OBRA-93 permits the optional expansion of the definition of "estate" to include jointly held assets, life estates and assets held in trust for recovery purposes.⁴⁶

As of the present date, the definition of "estate" has not been expanded for purposes of Medicaid recovery in New York State. Thus, in New York Medicaid may only recover from the probate or administered estate of the A/R.

Some Exceptions to Estate Recovery

No recovery may be made during the lifetime of the Medicaid recipient's surviving spouse or at a time when the recipient has a surviving child who is under 21 years of age or who is certified blind or certified disabled.⁴⁷

No lien will be imposed against the home of an institutionalized recipient if any of the following individuals is lawfully residing in the home: a spouse, minor child, certified blind or certified disabled child or a sibling with equity interest in the home who was residing in the home for at least one year prior to institutionalization.⁴⁸

In the case of a lien on a recipient's home, no recovery of correctly paid Medicaid may be made if the following individuals reside in the home: (1) a sibling of the A/R who resided in the home for at least one year prior to institutionalization and has lawfully resided in the home on a continuous basis from the date of admission to the facility to the present or (2) a child of the recipient who resided in the home for at least two years

⁴³ 05 OMM/ INF-1

⁴⁴ 42 U.S.C.A. §1396p(b)(1)(B)

⁴⁵ 42 USCA 1396p(b)(4)(A)

⁴⁶ 42 USCA 1396p(b)(4)(B)

⁴⁷ 02 OMM/ADM 3

⁴⁸ Id.

immediately prior to institutionalization and who has lawfully resided in the home from the date of admission to the facility to the present and who provided care which permitted the recipient to reside at home rather than in an institution. The lien will remain on the home even if the individual no longer resides in the home, and will typically be satisfied when the property is sold.⁴⁹

Recovery From Community Spouses

Medicaid may seek recovery from a well spouse for benefits paid on behalf of a sick spouse. This ability to seek recovery was confirmed in Commissioner of the Department of Social Services. V. Spellman, in which the court found that both state and local social services agencies have the authority to bring an enforcement action against a community spouse who has signed a spousal refusal, to seek an order directing the community spouse to contribute toward the care of an institutionalized spouse.⁵⁰

The elder law attorney must provide options to the well spouse in an effort to avoid recovery. One option is the transfer of the community spouse's assets after the sick spouse begins receiving Medicaid benefits. In such cases, Medicaid may attempt to argue that although the community spouse does not have in excess of the CSRA at the time they are seeking recovery, the spouse did in fact have the assets on as of the Medicaid pick-up date.

Annuities Pre-DRA – Prior to the DRA, another option to protect assets of the community spouse was to purchase an *irrevocable* annuity that complies with HCFA Transmittal No. 64, in that its term is no longer than the life expectancy of the spouse and is therefore actuarially sound. The annuity also had to be irrevocable and non-assignable. Medicaid did not consider the annuity as an available resource nor did they consider the purchase of such an annuity to be a transfer of assets.

Annuities Post-DRA – Section 366-a of the Social Services Law is amended to require as a condition of Medicaid eligibility for nursing facility services that the applicant or spouse disclose a description of an interest in an annuity regardless of whether it is irrevocable or not. For annuities purchased on or after February 8, 2006, the applicant must be informed of the right of the State to be named remainder beneficiary.

Effective August 1, 2006, for annuities purchased on or after February 8, 2006 by applicants seeking Medicaid nursing home coverage, the State must be named as the first remainder beneficiary or the purchase of the annuity will be considered an uncompensated transfer of assets, resulting in a penalty period. For applicants who have a spouse or minor or disabled child, the State must be named as the contingent remainder beneficiary.

The annuity will be considered an uncompensated transfer of assets unless the annuity is (1) that described in subsection (b) or (q) of Section 408 of the Internal

⁴⁹ Id.

⁵⁰ 661 N.Y.S.2d 895 (N.Y.Sup. Ct., 1997).

Revenue Code of 1986 or (2) purchased with qualified money OR the annuity is irrevocable and non-assignable; is actuarially sound; and provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.

Conclusion

Medicaid continues to be the only way for most seniors in the United States to pay for the high cost of long-term health care needs. Any practitioner that is called upon to counsel and assist clients regarding eligibility and rights under the Medicaid system must be thoroughly familiar with all applicable laws, regulations and procedures. In addition, Medicaid laws, rules, regulations and policy are constantly changing and evolving, and not all the provisions of the DRA have been satisfactorily interpreted by New York State and/or local departments of social services. It is imperative that the elder law practitioner constantly stay abreast of these changes.

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INCOME AND RESOURCE ALLOWANCES

The 2007 income and resource allowances have been increased as follows:

	<u>2007</u>
Individual Resource Allowance.....	\$ 4,200
Individual Monthly Income Allowance.....	\$ 700*
Community Spouse Resource Allowance.....	\$ 74,820**
Community Spouse Monthly Income Allowance.....	\$ 2,541

* An additional \$20 of monthly income per household will not be counted for Medicaid applicants who are aged, blind or disabled.

**or one-half (1/2) of the married couple's resources as of the first continuous period of institutionalization, up to a maximum of \$101,640, whichever is greater.

MONTHLY REGIONAL NURSING HOME RATES

	<u>As of January 1, 2007</u>
New York City (All boroughs).....	\$ 9,375
Long Island including all of Nassau & Suffolk Counties.....	\$10,123
Northern Metropolitan Area including Westchester, Putnam, Rockland, Orange, Dutchess, Sullivan, and Ulster Counties	\$ 9,074
Central Region.....	\$ 6,506
Northeastern Region.....	\$ 7,189
Rochester Region.....	\$ 8,002
Western Region.....	\$ 6,820