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Elder Law Attorney

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of the New York State Bar Association

Message from the Chair

Bees buzzing around the hive have nothing over the Elder Law Section this year. We are indeed a very industrious bunch. The Section has many ideas and plans for the year. Fortunately, many Section members have stepped up to the plate to help implement them. Described below are just some of the recent events and projects undertaken by the Section.

Pro Bono Senior Clinic Project

I am proud to report that the Section has initiated a series of statewide *pro bono* senior clinics. I have asked **Ami S. Longstreet** to Chair this project. She is working with the Section's Delegates to set up within each District a senior clinic where older adults can seek the advice of legal counsel on Elder Law-related issues. The strategy for the clinic is to have a small cadre of Elder Law attorneys available for face-to-face individual consultations with seniors on issues that concern them. The clinics will be promoted in local newspapers and the senior will have to pre-register to participate. On the day of the clinic, Elder Law attor-

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neys will be seated at individual tables and will provide 15 to 20 minute consultations on basic issues to the pre-registered seniors. When a senior's legal problem is beyond the scope of the attorney's knowledge or is too complicated to solve within the applicable time frame, the attorney will direct the senior to additional referral sources for answers to their questions.

Many seniors have never met with an attorney. They do not know where to seek answers to very basic legal questions. The senior clinic *pro bono* project is designed to provide good counsel. The District Delegates will be seeking volunteers to provide the legal expertise for the morning clinics. The plan is to have a Fall, Winter and Spring senior clinic in each District. Public service does good and feels good, so I urge each of you to volunteer when asked.

Compact for Long Term Care

I am pleased to report that the Elder Law Section, with the help of Compact Legislation Co-Chairs, **Howard S. Krooks** and **Vincent J. Russo**, is meeting success in seeking legislative passage of the Compact for Long Term Care. The Compact, if enacted, will provide an alternative to Medicaid and would provide another option to those who require long term care. As currently proposed, the Compact provides that the person in need of long term care will pledge to pay from his or her own funds a defined amount for long term care costs. Once the pledged funds are spent, the government will pick up most of the long term care costs without requiring a further spend down of assets. Participants will have to contribute a portion of their income to defray costs and co-payments for services rendered may be required.

After much hard work on the part of the Compact Committee, the Senate passed the Compact legislation by unanimous vote this past June. This is an excellent first step and the Committee is to be congratulated.

It is heady stuff to believe that the Elder Law Section has the opportunity to promote a change in social policy. The Compact Committee continues to advocate for the Compact with the hope that in 2007 the Compact legislation will be passed by both the Senate and Assembly and then signed into law by the Governor.

Elder Law Section Summer Meeting

The Section's Summer Meeting was held in beautiful Portsmouth, New Hampshire and was a great success. Over 160 attorneys and their families attended the meeting. My thanks go to **Michael J. Amoruso** who enthusiastically served as Chair of the event. Michael put together an interactive program which, among other topics, explored the new Medicaid regime under DRA 2005 and New York's implementation of the regime. My gratitude for a job well done also goes to **Neil Rimsky** who ably served as Vice-Chair of the program. Much of the success of the program was due to the high quality of the speakers: **Louis W. Pierro**; **Sharon Kovacs Gruer**; **Vincent J. Russo**; **Bernard A. Krooks**; **Valerie J. Bogart**; **Hon. Joel K. Asarch**; **Stephen J. Silverberg**; **Cora A. Alsante**; **Marilyn S. Faust**; **Joan L. Robert**; **Ellyn S. Kravitz**; **Anthony J. Enea**; **Antonia J. Martinez**; **Judith D. Grimaldi**; and all of those attendees who interacted with the speakers bringing new perspectives and commentary to the issues at hand.

Future Elder Law Section Events

The Section has a full roster of events to look forward to this year. The Fall 2006 meeting, which will take place in White Plains, New York, has secured **Judy Schneider** as the keynote speaker. Judy, who serves as Specialist for the Government and Finance Division of the Library of Congress, will tell us what it really takes to get legislation passed in Congress. We are also fortunate to have **Deborah A. Bushnell**, who served as counsel for **Michael Schiavo** in the recent end-of-life litigation, address meeting attendees about what it is like to be a small town attorney litigating an important case in a national spotlight. The Fall meeting will also explore the nuts and bolts of dealing with DRA 2005 and the Department of Health's ADM which implements New York State's new Medicaid law. The Fall 2006 meeting is chaired by **Beth Polner Abrahams**. **T. David Stapleton** serves as the Vice-Chair of the program.

I am also excited with the plans for the Fall Elder Law Advance Institute. The Advance Institute will have a new format this year, providing participants up-to-the-minute information on current Elder Law issues via interactive dialogues between meeting participants and a panel of experts who will serve to both moderate the discussion and interject their expertise as various issues arise. The Program Co-Chairs for the Advance Institute are **Margaret Z. Reed** and **Judith B. Raskin**.

The Section's Annual Meeting once again will take place in New York City and will be chaired by **Fran Pantaleo**. **Michael Cathers** will serve as Co-Chair of the program. In the Spring, I am looking forward to bringing to the Section a new concept, the Un-Program. **Stephen J. Silverberg** and **Howard S. Krooks** serve as Co-Chairs for the program which has neither speakers nor formal agenda. Instead, substantive and practice-related topics will be suggested by the registrants. During the Un-Program, facilitators will lead topic discussions and attendees will be able to participate in

(Continued on page 93)

Editor's Message

I think it's safe to say we may have killed a small forest of trees to print and publish this edition of the *Elder Law Attorney*. Because of the sheer length and complexity of the articles herein, I want to begin by commending the Associate Editors—Joan Robert, Vincent Mancino, Brian Tully, Andrea Lowenthal, and our newest Associate Editor, Lee Hoffman—for their hard work and effort. Under difficult time constraints they have been able to help produce what I believe is truly a keepsake edition of the *Elder Law Attorney*.

In the Summer Edition, the articles contained therein focused on the "Nuts, Bolts and Impact of the DRA." In this edition it has been my goal to provide our members with an analysis of the DRA in light of the Administrative Directive Transmittal 06 OMM/ADM-5, issued on July 20, 2006. This has been accomplished in an excellent piece, authored by Louis Pierro with the assistance of Michael Amoruso, which I believe acts as the cornerstone for the other articles which follow. We have also endeavored to provide the reader with an analysis of the DRA's impact on various specific aspects of our practice (for example, the transfers of real property, Medicaid planning in guardianships, the use of private annuities, long-term care insurance and planning for home care). Additionally, I thought it would be helpful to have an analysis of an underutilized planning tool, a personal service contract. I am confident that this edition will be a referral source that you will be able to utilize over and over again as we fight our way through the maze created by the DRA.

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We, of course, have many wonderful, insightful and interesting pieces from our regular contributing authors. Fortunately, there is more to our practices than the DRA. I wish to personally thank all of the authors who contributed an article, and encourage our readers to submit an article for consideration. It is your submission which is the lifeblood of our publication.

Anthony J. Enea
Editor-in-Chief

Request for Articles

If you have written an article, or have an idea for one, please contact the new *Elder Law Attorney* Editor

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Articles should be submitted on a 3½" floppy disk, preferably in Microsoft Word or WordPerfect, along with a printed original and biographical information.

Medicaid 2006: DRA '05 and the Brave New World of Medicaid Applications

By Louis W. Pierro

I. Introduction

Which do you want first, the good news, or the bad news? The worst news is that the Medicaid eligibility changes mandated by the Deficit Reduction Act of 2005[1] ("DRA") went into effect in New York State on August 1, 2006. The New York State Department of Health published 06 OMM/ADM-5 on July 20, which interprets and implements the DRA provisions adopted by New York through budget legislation passed on June 23, 2006.[2]

The good news is that the New York State Legislature passed a budget which rejected other provisions of the Governor's appropriations bill, including the elimination of spousal refusal, the application of penalties to home care and the expansion of the definition of estate to include non-probate assets. The bad news was that the Governor vetoed the budget. The good news was that the Legislature overrode the veto. Then, things got interesting—threats, litigation and compromise (along with tax revenues that exceeded expectations) resulted in the Governor first refusing to honor the override, then settling on State changes that mirrored the DRA. Spousal refusal, home care and non-probate assets are safe—for now.

Meanwhile, the Compact for Long-Term Care gained momentum in New York State, due in large part to the efforts of the Elder Law Section. After countless meetings and phone conferences, the Senate passed S.3530-C, and according to Greg Olsen, Assembly Aging Committee director, the Assembly will be conducting hearings on the Compact in the late fall. That's very good news.

II. DRA and 06 OMM/ADM-5

Of the many changes wrought by the DRA, the most significant include the changes to the look-back period and the commencement of the penalty period due to an uncompensated transfer of assets. Given these changes, consumers and providers alike will need the guidance of experienced elder law attorneys schooled in the complex and burdensome Medicaid eligibility rules to navigate the minefield created by the DRA. This article will explore the changes to both the Medicaid look-back period and the commencement of the penalty period caused by the DRA and the recently enacted New York State enabling legislation. Administrative guidance was published by the NYS Department of Health in 06 OMM/ADM-5 on July 20, 2006, making provisions of the new law effective **August 1, 2006.** The Center for Medicare and Medicaid Services issued guidance to states on July 27, 2006 in publication SMDL #06-108 and SMDL #06-019.

It is important to note that we are in uncharted waters regarding how the DRA provisions for look-back and commencement of the penalty period will be interpreted and implemented. In fact, issues regarding the constitutionality of the DRA itself remain unresolved. Other provisions of the DRA impact annuities, home equity, the "income first" rule, promissory notes and the purchase of life estates, presenting challenges and opportunities. Nonetheless, we must define new terms and formulate interpretations as the new rules are upon us, and this article will explore the Medicaid look-back and penalty changes.

III. The Medicaid Look-Back Period

A. Pre-DRA

Prior to February 8, 2006, there were two separate look-back periods to determine whether an individual disposed of assets for less than fair market value, namely (1) thirty-six months (or three years) for direct transfers of assets and (2) sixty months (or five years) for transfers made to or from a trust.

The trigger date *for the look-back,* unaffected by the DRA, for an institutionalized individual is the first date the individual is receiving institutional services (at home or in a facility), and applies for Medicaid under a State plan.[3] For an individual requiring community Medicaid, the trigger date is the date on which the individual applies for Medicaid, or the date on which the individual disposes of assets for less than fair market value, if later.[4]

Given the disparity in the look-back period for direct transfers (3 years) and transfers involving trusts (5 years), it was possible to leverage the look-back periods to maximize asset preservation.

> ***Example 1:*** Assume that a regional rate for three years of nursing home assistance totals $314,064, and a client has $630,000 in available resources. Prior to the DRA, if the client did not require nursing home care for 3 years, the elder law attorney may have suggested a direct gift of $314,000 to the client's children and a $314,000 transfer into an irrevocable income-only trust. This strategy may have preserved $628,000 if the client did not apply for chronic care Medicaid until the expiration of 3 years because the direct transfer to the children would be outside the look-back period. While the transfer into the trust would be within the 5 year look-back, the penalty caused by the transfer would have expired in three years ($314,000/$8,724 = 35.99 months).

Under the DRA, however, as of February 8, 2006 this leveraging of the three-year look-back period is no longer a viable planning strategy.

B. Post-DRA

The DRA amended the Federal look-back statute to include the following:

> The look-back date specified in this subparagraph. . .***in the case of any other disposal of assets made on or after the date of the enactment of the Deficit Reduction Act of 2005, 60 months)***. . .[5]

Congress' intent was to change the look-back period for all post-February 8, 2006 transfers to five (5) years. Pursuant to 06 OMM/ADM-5 the change will be phased in as follows:

> Districts will continue to request resource documentation for the past 36 months (60 months for trusts) until February 1, 2009. Beginning February 1, 2009, districts will require resource documentation for the past 37 months (60 months for trusts). The look-back will increase by one-month increments until February, 2011. Effective February 1, 2011, the full 60-month look-back period will be in place for all transfers of assets.

Specifically, 42 U.S.C. § 1396p(c)(1)(B)(i) preserves the three (3)-year look-back for any transfer before February 8, 2006; for post-DRA transfers, the look-back period remains at three years until February 1, 2009, when it will increase in one-month increments.

> ***Example 2:*** Ned made a single charitable transfer to the Alzheimer's Association on February 10, 2006 and is applying for institutional Medicaid on August 1, 2006. The pre-DRA look-back period would only require a disclosure of all transfers from August 1, 2003 to July 31, 2006, and the DRA and 06 OMM/ADM-5 likewise require a disclosure of all transfers from August 1, 2003 to present.

It is not until February 1, 2011 that the look-back of five (5) years will be applicable—five (5) years from February 1, 2006.

> ***Example 3:*** Ned made a single charitable transfer to the Alzheimer's Association on February 10, 2006 and is applying for institutional Medicaid on May 1, 2009. The local Medicaid administering agency will require resource documentation for the past 3 years and 3 months.

Essentially, there will be an ascending scale for the number of years and months for which disclosure will be required until the five (5)-year threshold is reached on February 1, 2011.

C. New York State Enabling Legislation

On June 23, 2006, New York State passed enabling legislation for the DRA changes in New York,[6] which adopted the DRA's five (5)-year look-back period for all transfers *on or after* February 8, 2006.[7]

Starting on February 1, 2009, New York's seniors and disabled persons will bear the increased burden of providing financial documentation for over three (3) years with their Medicaid applications. Today, in most cases, it is difficult for clients to obtain even three (3) years of statements. In fact, certain financial institutions may not retain a customer's monthly statements (including deposit slips and cancelled checks) for more than three (3) years. This is certain to be an issue that the elder law attorney will confront after February 1, 2009, when the look-back period begins the gradual ascent to five (5) years, and clients should be advised to keep accurate records dating back three years, but increasing to five years effective February 1, 2006.

IV. Commencement of the Penalty Period

A. Pre-DRA

The purpose of the look-back is to determine if the Medicaid applicant ("A/R") divested otherwise available assets in order to qualify for Medicaid. Generally, whenever an A/R makes an uncompensated transfer of property (a gift or donation), a time period of ineligibility ("Penalty Period") for Medicaid institutional coverage (i.e., nursing home or Lombardi Program coverage) is created.[8] For transfers made ***prior to February 8, 2006, such a Penalty Period commences on the first day of the month following the month of transfer.***[9] There continues to be *no* Penalty Period for *community Medicaid* eligibility.

The Penalty Period is calculated by dividing the value of the transferred property by the average monthly cost of nursing home care in the A/R's geographic region.[10] In 2006, the rates are as follows:[11]

Region	Counties	Rate
New York City	Bronx, Kings, New York, Queens & Richmond	$9,132
Long Island	Nassau & Suffolk	$9,842
Northern Metropolitan	Westchester, Dutchess, Orange, Putnam, Rockland, Sullivan & Ulster	$8,724
Western	Alleghany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans & Wyoming	$6,540
Northeastern	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren & Washington	$6,872
Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne & Yates	$7,375
Central	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga & Tompkins	$6,232

***Example 4*:** Ned gifts real property in Albany County to his nephew Bill that has a fair market value of $150,000. Ned is ineligible for institutional Medicaid for 21.83 months ($150,000/$6,872 = 21.83).

1. Transfers to Persons Exempt from Penalty Period

Uncompensated transfers of the home (i.e., gifts) to a "qualified individual"[12] continue to be exempt from the imposition of a Penalty Period. Pursuant to 06 OMM/ADM-5, the exceptions to the transfer rules that apply under OBRA '93 continue to apply to transfers made on or after February 8, 2006 and 96 ADM-8 will continue to apply to all issues not specifically covered by the new ADM.

Specifically, a **transfer of a home** is exempt if made to an A/R's:

a. spouse;

b. child under the age of twenty-one (21);

c. child who is certified blind or certified disabled of any age;

d. sibling with an equity interest in the home and who was residing in the home for at least one year *immediately* prior to the date the A/R became institutionalized and continues to lawfully reside in the home;

e. "caretaker child" who was residing in the home for at least two years immediately prior to the date the A/R became institutionalized *and* who provided care, as defined in 18 N.Y.C.R.R. § 311.4(a)(1), to the A/R which permitted the A/R to reside at home rather than in the facility and such child continues to lawfully reside in the home.[13]

Similarly, uncompensated **transfers of all other assets** are exempt from the Penalty Period if the assets:

a. were transferred to the individual's spouse, or to another for the sole benefit of the individual's spouse;

b. were transferred from the individual's spouse to another for the sole benefit of the individual's spouse;

c. were transferred to the individual's child who is blind or disabled, or to a trust established solely for the benefit of such child; or

d. were transferred to a trust established solely for the benefit of an individual under sixty-five years of age who is disabled.[14]

In long-term care crisis planning (i.e., immediate institutional Medicaid is required), a transfer to a qualified individual is an attractive proposition in terms of Medicaid eligibility and recovery. A transfer of the home or other asset to any of the enumerated individuals or trusts will not cause a Penalty Period for Medicaid eligibility. In addition, a transfer to a qualified individual, *other* than the spouse, will protect the home or asset from Medicaid recovery. Remember, a transfer of the home or asset to a spouse may ensure Medicaid eligibility of the A/R (since there is no Penalty Period for the spousal transfer), and it will protect against the imposition of a lien if the spouse continues to reside in the home. However, if the home or other asset remains in the estate of the spouse, then it may be subject to Medicaid recovery at the spouse's death if he or she is determined to be a "responsible relative."[15]

Thus, if an exempt transfer to a spouse is utilized, it is imperative that the elder law attorney advise the spouse once Medicaid eligibility is established on asset preservation planning (referred to as "post-eligibility" planning) to remove the home or other asset from the spouse's estate, which will then be subject to the same 5-year look-back and penalty rules for the community spouse. If the transfer is made in trust solely for the benefit of the (a) spouse, (b) child, or (c) disabled person under age 65, and such person is receiving Medicaid, the home or other asset may be subject to Medicaid recovery at their death.

These qualified transfers will play an important role in asset preservation planning in a post-DRA environment.

B. Post-DRA

Clearly the most profound and devastating DRA provision for seniors and disabled persons (and their families) is the change in the Penalty Period start date. As discussed above, for transfers *prior* to February 8, 2006, the Penalty Period commences on the first day of the month following the month of transfer.[16] This statutory start date authorized Medicaid applicants to make uncompensated transfers (i.e., to children, charities, churches, temples, etc.) and qualify for Medicaid as long as the individual privately paid for care (or waited out) the resulting Penalty Period. Such a statutory system was fair and, most times, not harmful to our seniors and disabled clients when properly guided by qualified counsel. The pre-DRA Penalty Period start date rendered clients *immediately* accountable to the State for any uncompensated transfers of assets.

Under the DRA, however, the Federal government penalizes seniors when they are most frail and vulnerable—only when they are receiving institutional level care and have just $4,150 to their name. Specifically § 6011 of the DRA amends 42 U.S.C. § 1396p(c)(1)(D) as follows:

> (i) In the case of a transfer of asset made before the date of the enactment of the Deficit Reduction Act of 2005, the date specified in this subparagraph is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.
>
> (ii) In the case of a transfer of asset made on or after the date of the enactment of the Deficit Reduction Act of 2005, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, ***or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (c) based on an approved application for such care but for the application of the penalty period, whichever is later***, and which does not occur during any other period of ineligibility under this subsection.[17]

While poorly drafted, the DRA appears to mandate that the Penalty Period (for an uncompensated non-exempt transfer) will not commence until the A/R ***files*** an application for institutional Medicaid and would be eligible for such coverage except for the resulting Penalty Period.[18] This is the point in time that the A/R is receiving (a) nursing home services, (b) a level of care in any institution equivalent to nursing home services, or (c) home or community based services under a waiver program (i.e., the Lombardi Program),[19] and, is otherwise financially eligible for institutional Medicaid (i.e., non-exempt assets less than or equal to $4,150 and available monthly income less than medical expens-

es).[20] DOH's new policy directive 06 OMM/ADM-5 provides:

> **Transfers on or After February 8, 2006**
>
> For transfers made on or after February 8, 2006, the penalty period starts the first day of the month after which assets have been transferred for less than fair market value, or the first day of the month the otherwise eligible institutionalized individual is receiving nursing facility services for which Medicaid would be available but for the transfer penalty, whichever is later, and which does not occur during any other period of ineligibility.

Such harsh provisions will have a detrimental impact on the safety and well being of an individual requiring immediate nursing home care under the Medicaid program who unwittingly made an uncompensated transfer of assets within the last 5 years. It is important to remember, however, that neither the DRA nor New York's Budget Bill impose a Penalty Period for community-based Medicaid.

Examples provided in 06 OMM/ADM-5 give guidance on application of the start date:

> ***Example 1 (Institutionalized applicant not otherwise eligible):*** An applicant is determined to have made a prohibited transfer after February 8, 2006, and is also determined to have excess resources for the month nursing home coverage is requested. The penalty period for the transfer of assets would not be calculated since the individual is not otherwise eligible due to excess resources.
>
> ***Example 2 (Institutionalized applicant otherwise eligible)***: An applicant makes an uncompensated transfer of $30,534 in April, 2006. The institutionalized individual is determined to be otherwise eligible for Medicaid starting September 1, 2006. A four-month penalty period ($30,534 divided by $6,872, the Medicaid regional rate, = 4.443) is imposed from September, 2006, the first month eligibility is established, through December, 2006 with a partial month penalty calculated for January, 2007. The calculations for this specific example follow:

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

> ***Example 3 (Institutionalized recipient transfer):*** On September 18, 2006, the district discovers that an institutionalized **recipient** failed to pursue his right of election from his spouse's estate. The last date the institutionalized individual could have pursued his elective share was determined to be July 10, 2006. The district calculates a transfer penalty of four months based on the value of the recipient's elective share. The penalty for this example starts August 1, 2006, the month following the month of transfer. However, the district must send a 10-day notice prior to the reduction in coverage. If the district can notify the individual 10 days prior to October 1, 2006, coverage would be reduced for October 1, 2006 and November 2006, the third and fourth months of the penalty period. If timely notice cannot be sent 10 days in advance of October 1, 2006, coverage could not be reduced until November 1, 2006, the fourth month of the penalty period. In such cases, districts may pursue Medicaid incorrectly paid for months that should have been affected by the transfer penalty (August, September and possibly October, depending on when notification was sent).

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

> ***Example 4 (Overlapping penalties):*** An application for nursing facility services is filed September 21, 2006, and the applicant is determined to have made a prohibited transfer prior to February 8, 2006. The transfer results in a penalty period that ends with a partial penalty of $929 for November, 2006. Another $10,000 transfer was made in March, 2006. Due to the period of ineligibility from the pre-February 8, 2006 transfer, the penalty period for the March, 2006 transfer would begin in November, 2006. For November, 2006, only the amount of the March transfer that is needed to bring the penalty up to the full Medicaid regional rate would be used. Beginning December 2006, the remaining amount of the March transfer is used to calculate the remaining transfer penalty. The calculations for starting the March transfer follow:
>
> | | | |
> |---|---|---|
> | Step #1 | $ 6,872 | Medicaid regional rate |
> | | - 929 | partial month penalty 1st transfer |
> | | = $ 5,943 | amount of penalty remaining |
> | Step #2 | $10,000 | uncompensated 2nd transfer |
> | | - 5,943 | transfer amount used for November penalty |
> | | = $ 4,057 | remaining amount of transfer |
>
> Since $4,057 is less than the Medicaid regional rate of $6,872, the remaining $4,057 results in a partial penalty for December, 2006.[21]

Surprisingly, it appears that during the rush to pass the DRA certain moderate Republican U.S. Congresspersons were ill advised as to the effect gifts and charitable donations have on the Penalty Period. In a letter dated January 17, 2006 from U.S. Congresswoman Susan Kelly of New York on the impact of gifts and donations on the Penalty Period, she explicitly states:

> If a person makes an *innocent gift or donation*, the transferor CANNOT be penalized for making a gift or donation during the look-back period as long as he or she can demonstrate an exclusive purpose for the transfer other than to qualify for Medicaid. In addition, there will be no penalty when the transferor can demonstrate intent to transfer the asset for full market value or when the transferred assets are subsequently returned. (emphasis added)

For a law that narrowly passed the U.S. Senate by a tie breaking vote cast by the Vice President of the United States, and passed the U.S. House of Representatives by a mere two (2) votes, it is interesting to read that our leaders relied upon an exception that in reality has rarely been granted. Nowhere in the DRA is there a definition of an "innocent gift or donation." Most importantly, however, such a statement misses the mark because the A/R must overcome the overwhelming presumption in law that a gift was made to qualify for Medicaid, which is the very reason why the law imposes a Penalty Period for non-exempt transfers.

While the author does not know what is meant by the phrase an "innocent gift or donation," consider the language of 06 OMM/ADM-5 regarding "Undue Hardship" if the presumption applies:

> **Provision for Undue Hardship Waiver**
>
> An individual who is unable to demonstrate that a transfer was made exclusively for a purpose other than to qualify for nursing facility services, may have coverage authorized for these services if the individual meets undue hardship. For transfers made on or after February 8, 2006, undue hardship exists when:
>
> - the individual applying for nursing facility services is otherwise eligible for Medicaid; and
> - despite his or her best efforts, as determined by the social services district, the individual or the individual's spouse is unable to have the transferred asset(s) returned or to receive fair market value for the asset or to void a trust; and
> - either: the individual is unable to obtain appropriate medical care such that the individual's health or life would be endangered without the provision of Medicaid for nursing facility services; or
> - the transfer of assets penalty would deprive the individual of food, clothes, shelter, or other necessities of life.

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

PRACTICE NOTE: Consider attaching Representative Susan Kelly's letter as an exhibit to a Medicaid application where there appears to be an unintentional gifting of assets to demonstrate Congress' legislative intent not to impose a penalty for such an "innocent gift or donation."

1. Impact of the New Penalty Start Date

In addition to adopting the DRA look-back period (discussed above), New York's Budget Bill adopts the DRA's harsh Penalty Period start date. While at first blush it may appear that the Budget Bill departs from the DRA Penalty Period start date, the Penalty Period will not commence on the filing of a community Medicaid application.

PRACTICE NOTE: The most desired outcome of the DRA for the proponents of the legislation is that traditional "rule of halves" planning is eliminated. Prior to the DRA, the elder law attorney may have advised a client to transfer up to ½ of the client's assets either outright or in trust for beneficiaries and retain the remaining ½ of assets to pay for care during the Penalty Period. Such a strategy was effective because the Penalty Period, prior to the DRA, commenced the month immediately following the month of the transfer. Thus, if the client required care during the Penalty Period, the client could use the retained assets to pay for such care until the Penalty Period expired. Since the Penalty Period under the DRA does not start until the individual is receiving nursing home care and is otherwise eligible for institutional Medicaid (i.e., meets the income and resource requirements), traditional rule of halves planning serves no purpose. Remember, by retaining ½ of the assets (assuming greater than $4,150), the individual is not "otherwise eligible" for Medicaid.

The provisions of 06 OMM/ADM-5 strengthen the State's position that not only is rule of halves planning dead, but attempts to "reverse engineer" the rule with gifts back will be resisted. Consider the example on page 19 of the ADM:

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

PRACTICE NOTE: The language of the new ADM does not mirror 96 ADM-8 with regard to transfers back to an A/R, which may provide an opportunity to reduce the penalty period by paying medical expenses directly.

Perhaps the most alarming aspect of the Penalty Period is the fact that it exposes an individual who requires nursing home care to the possibility that he or she will not be admitted into a facility due to a transfer years earlier. If an individual made a transfer three (3) years prior to their immediate need for nursing home care that causes a multi-month (or multi-year) Penalty Period (beyond any potential Medicare coverage), and the individual has no assets or insurance remaining to pay for his or her care, the practical chances of that individual being offered admission into a nursing home are likely to decline. This exposure to the stark reality of the business side of a nursing home (filling beds to generate income) will place such an individual in a dire situation. On the flip side, in the event a new resident, out of sheer desperation, fails to disclose a post-DRA transfer, it will place the nursing home in the precarious position of filling a bed that fails to gener-

ate income until the expiration of the Penalty Period. These competing concerns demonstrate the potentially devastating reality of the Penalty Period to both the A/R and the care facility.

As with pre-DRA transfers, the elder law attorney should first identify whether an opportunity exists to utilize an exempt transfer before initiating the harsh Penalty Period start date under the DRA. Such transfers have proven effective in the past and will continue to be a strong tool in the elder law attorney's arsenal post-DRA.

In the event that the possibility of an exempt transfer does not exist, there may be hope to escape the harsh Penalty Period if the A/R can demonstrate that any transfers were made exclusively for a purpose other than to qualify for institutional Medicaid.[22] It is important to note, however, that since the Penalty Period under the DRA will not commence, in some cases, for many years later, the exclusive purpose for such a transfer, in fact, may have been for a purpose other than to qualify for Medicaid. Further, the Budget Bill provides that if a satisfactory showing is made to demonstrate that the A/R (or spouse) (a) intended to dispose of the assets at fair market value or other valuable consideration, or (b) that all assets transferred for less than fair market value have been returned to the A/R, then a Penalty Period may be avoided.[23]

> **PRACTICE NOTE:** If you identify that a non-exempt transfer was made by the A/R, explore the purpose and circumstances surrounding the transfer. Was the A/R in good health with no expectation of requiring nursing home care at the time of transfer? Was the transfer made as part of the individual's estate planning (i.e., consistent history of annual exclusion gifting while in good health)? Can the facts rise to a level that the A/R may succeed at a fair hearing or in Court?

2. Undue Hardship Provision

Interestingly, both the DRA and the Budget Bill contain a provision that may permit the A/R to obtain institutional Medicaid if application of the Penalty Period would deprive the A/R of medical care that would endanger the A/R's life or health, or deprive the A/R of food, clothing or shelter.[24] In fact, the NYS Office of Temporary and Disability Assistance ("OTDA") must inform all individuals affected by the Penalty Period in writing of the hardship waiver process.[25] The Commissioner of the OTDA must develop a hardship waiver process that is timely so that the A/R has a sufficient opportunity to appeal an adverse decision.[26] Under current regulations, an A/R in New York may establish undue hardship if (1) they are otherwise eligible for institutional Medicaid, (2) they are unable to obtain appropriate medical care without Medicaid, (3) despite best efforts are unable to have transferred assets returned or obtain fair market value for the transferred assets.[27] "Best efforts" to obtain the transferred assets or their fair market value includes cooperating with the DSS to pursue such assets or obtain their fair market value, perhaps through litigation, from the donee (i.e., children, charity, trust).[28] Unfortunately, however, hardship waivers under pre-DRA law were rarely granted in New York.[29]

One positive addition under the DRA and the Budget Bill is the fact that if the A/R is an institutionalized individual, the nursing home, with the A/R's consent, may file a request for a hardship on the A/R's behalf.[30] While this may not increase the likelihood of success, this provision does provide for a Medicaid paid bed hold for the A/R at the facility for up to thirty (30) days (if certain criteria to be promulgated by the OTDA are met).[31] Also, the A/R's case would be handled by the nursing home's attorney who may have a higher level of expertise in such matters.

V. The Challenge for the Elder Law Attorney

With the elimination of rule of halves planning, asset preservation planning is dealt a severe blow. Instead of creating a penalty and self-paying for care throughout the penalty period until the A/R is Medicaid eligible, in a post-DRA world, the A/R will have to be made *immediately* "otherwise eligible" for Medicaid to start the Penalty Period. How can an A/R accomplish the seemingly impossible?

The elder law attorney will be relied upon to recommend existing strategies, such as: caregiver agreements; exempt transfers; use of annuities and promissory notes; and litigation to overcome the presumption that a transfer was made for the purpose of obtaining Medicaid. Also, the DRA appears to sanction the purchase of a life estate interest if the A/R resides in the home for a year after such purchase,[32] and the use of the life estate in this fashion needs to be explored.

In addition, the elder law attorney may investigate the existence, viability and use of products such as short-term immediate annuities (assuming they meet stringent requirements of the DRA). Likewise, long-term care insurance will be an important tool in future asset preservation planning (assuming that a client can financially afford it and medically qualifies). Finally,

the irrevocable income-only trust may become a more attractive alternative to clients who decide, wisely, to plan well before the five (5) year look-back is an issue. The trust may offer more protection and flexibility over a direct gift and now has parity with the direct gift with regard to the look-back period.

VI. Conclusion

There can be no doubt that in a post-DRA environment, the ones who will suffer are the chronically ill and medical providers. One can only hope, for the sake of our Nation's chronically ill citizens, that either a constitutional challenge to the DRA will prevail or that reform legislation, once the impact of the DRA is truly understood, will prevail. Thanks to the tireless efforts of the New York State Bar Association, the Elder Law Section's Officers and Executive Committee, the Budget Bill includes language that provides for New York's Medicaid eligibility laws to retreat to pre-DRA rules if either event occurs.

Endnotes

1. Public Law 109-171 (2006).
2. S.8471, A.42045 (June 23, 2006).
3. 2 U.S.C. § 1396p(c)(1)(B)(ii)(I), (c)(1)(C)(i).
4. 42 U.S.C. § 1396p(c)(1)(B)(ii)(II).
5. Public Law 109-171 § 6011(a).
6. S.8471, A.42045.
7. *Id.*
8. Social Services Law § 366[5](d)(3).
9. Social Services Law § 366[5](d)(4).
10. Social Services Law § 366[5](d)(4); 18 N.Y.C.R.R. § 360-4.4(c)(2)(iv).
11. GIS 06 MA/001.
12. Social Services Law § 366[5](d)(3)(i)(A)-(D); 18 N.Y.C.R.R. § 360-4.4(c)(2)(iii)(b)(1)-(4).
13. 18 N.Y.C.R.R. § 360-4.4(c)(2)(iii)(b)(1)-(4).
14. Social Services Law § 366[5](d)(3)(ii).
15. *See In re Craig*, 82 N.Y.2d 388 at 391; *In re Tomeck*, 811 N.Y.S.2d 790.
16. Social Services Law § 366[5](d)(4).
17. Public Law 109-171 § 6011(b).
18. *Id.*
19. 42 U.S.C. § 1396p(c)(1)(C)(i).
20. Social Services Law § 366.
21. Administrative Directive 06 OMM/ADM-5.
22. S.6457-C § 50-a; Social Services Law § 366[5](e)(4)(iii)(B). *E.g., Cacchillo v. Perales*, 172 A.D.2d 98, 576 N.Y.S.2d 916 (3d Dep't 1991); *Kulikowski v. New York State Dept. of Social Services*, 166 A.D.2d 858, 563 N.Y.S.2d 536 (3d Dep't 1990).
23. S.6457-C § 50-a; Social Services Law § 366[5](e)(4)(iii)(A) & (C).
24. Public Law 109-171 § 6011(d), S.6457-C § 50-a; Social Services Law § 366[5](e)(4)(iv).
25. S.6457-C § 50-a; Social Services Law § 366[5](e)(4)(iv).
26. *Id.*
27. 18 N.Y.C.R.R. § 360-4.4(c)(1)(ii)(d)(2).
28. *Id.*
29. Vincent J. Russo and Marvin Rachlin, *New York Elder Law Practice*, § 8:35 (West 2005).
30. S.6457-C § 50-a; Social Services Law § 366[5](e)(4)(iv).
31. *Id.*
32. S.6457-C § 50-a; Social Services Law § 366[5](e)(3)(ii).

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Planning With Real Property in Light of the DRA(conian) Changes to Medicaid

By Robert J. Kurre and Michael L. Pfeifer

In light of the *Deficit Reduction Act of 2005* (DRA), practitioners will have to re-examine how we help our clients protect their real property from the ruinous costs of long-term care. The first part of this article will set forth the provisions of the DRA which affect Medicaid planning for the homestead. The second part will discuss possible planning strategies in light of these provisions.

Robert J. Kurre

I. Changes to the Law

Caps on Equity in the Home

Under prior law, the homestead was an exempt resource regardless of its value if the Medicaid recipient, among other persons, resided in the home, or if institutionalized, executed a statement of intent to return home. The DRA, for the first time, put a cap on the equity a person can have in the home and still qualify for certain Medicaid benefits. Specifically, the DRA states that an individual applying for "nursing facility services or other long-term care services" is not eligible for such services if his or her equity in the home exceeds $500,000. However, the states were given the option to increase this amount to $750,000. New York State did, in fact, increase the amount of equity an individual may have in the homestead to $750,000.[1]

If the spouse of the individual is lawfully residing in the homestead, the equity limitation does not apply and the homestead remains exempt. It also does not apply if the person's child is lawfully residing in the home and is under 21 years of age; or blind; or permanently and totally disabled.

A hardship exception is available from the home equity limitation if a legal impediment prevents the applicant from accessing his or her equity interest in the property and the denial of Medicaid coverage would deprive the applicant of medical care such that the individual's health or life would be endangered or deprive the applicant of food, clothing, shelter or other necessities of life.[2]

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The above rules are effective August 1, 2006, retroactive to January 1, 2006 for "nursing facility services" or "community-based long-term care services."[3] "Nursing Facility Services" are defined in 06 OMM/ADM-5, at page 10, to include nursing care and health-related services provided in a nursing facility; a level of care provided in a hospital which is equivalent to the care which is provided in a nursing facility; and care, services or supplies provided pursuant to a waiver under subsection (c) or (d) of Section 1915 of the Social Security Act. "Community-based long-term care services" are also defined in 06 OMM/ADM-5, at page 10, to include adult day health care (medical model); limited licensed home care; certified home health agency services; hospice in the community; hospice residence program; personal care services; personal emergency response services; private duty nursing; Consumer Directed Personal Assistance Program; Assisted Living Program; managed long-term care in the community; residential treatment facility; and non-waiver services in a home and community-based waiver program.

Change to the Look-Back Period

The look-back period will remain at thirty-six months (except for transfers to and from certain trusts which transfers have a sixty-month look-back period) until February 1, 2009, at which time it will increase to thirty-seven months for all transfers.[4] It will further increase by one month increments each month thereafter until February 1, 2011, at which time the look-back period will be sixty months for all transfers of assets.[5]

Change in the Onset of the Penalty Period

For transfers made on or after February 8, 2006, the penalty period starts the first day of the month after which assets have been transferred for less than fair

market value, or the first day of the month the otherwise eligible institutionalized individual is receiving nursing facility services for which Medicaid would be available based on an approved application for such care but for the transfer penalty, whichever is later, and which does not occur during any period of ineligibility.[6] If a transfer penalty period falls within another penalty period, the penalty does not start until after the first penalty expires, with the exception of partial month penalties. A subsequent penalty shall begin in the month in which the partial month penalty from a previous penalty period ends.[7]

Purchase of a Life Estate in Another Person's Home

Under the new law, if one purchases a life estate in another person's home and then applies for nursing facility services, the purchase of the life estate "shall be treated as the disposal of an asset for less than fair market value unless the purchaser resided in such home for a period of at least one year after the date of purchase."[8]

II. Preserving the Homestead Post-DRA

So how can we help our clients protect the homestead in light of the foregoing provisions? Due to the increase in the look-back period and the delay in the onset of the penalty period under the DRA, practitioners will have to be more creative in finding ways to minimize the adverse effects of the new law. Here are some suggestions.

Encourage Early Planning

If a client is relatively young and/or in good health and does not anticipate needing a nursing home within the look-back period, the viability of transferring title to real property to an irrevocable trust or family members (possibly subject to a life estate) remains. After the look-back period has expired (the look-back period will remain at thirty-six months, except for transfers to and from certain trusts which transfers have a sixty-month look-back period, until February 1, 2009, at which time it increases to thirty-seven months; it will further increase by one month increments each month thereafter until February 1, 2011, at which time the look-back period will be sixty months for all transfers of assets),[9] the transfer will not be subject to a penalty. In light of the incremental increase of the look-back period to sixty months for all transfers and the delay in the onset of the penalty period, it would be prudent for such planning to be done earlier than in the past to avoid exposing the client to a lengthy penalty period during which time Medicaid benefits may be needed. Crisis planning may no longer be as effective as before the DRA. As such, clients should be encouraged to engage in early planning.

Consider Availability—and Possible Creation—of Exception Transfers

The ability to transfer the homestead without penalty to certain parties has not been changed by the DRA. These parties include a spouse; a minor, disabled or blind child; a sibling with an equity interest in the home who resides in the home at least one year prior to the applicant's institutionalization; and a caretaker child who resides with the applicant for at least two years prior to institutionalization.[10] The scope of each of these exceptions is beyond the boundaries of this article but has not changed under the DRA. Any planning involving real property should continue to carefully consider the existence of such persons who, as grantees, would qualify a real property transfer as exempt. If such exceptions do not already exist, the practitioner should discuss with the client the possibility of creating such an exception transfer. For example, the practitioner may present the option of a child moving into a parent's home if the parent and child can be expected to live together for at least two years before the parent is institutionalized.

If the parent has additional, liquid assets, such assets could be used to purchase a life estate interest in the home after it has been transferred to a caretaker child (see below for a more detailed discussion concerning the purchase of a life estate in another's home). Under this scenario, both the transfer of the home to the child and the subsequent purchase of a life estate interest by the parent will be exempt, provided the parent and child live together during the two-year period immediately preceding the parent's institutionalization and the parent lives in the home at least one year after purchasing the life estate interest.

Another possibility for creating an exception transfer involves a sibling moving into the applicant's home if the sibling is expected to be able to live at least one year with the applicant. The sibling must be given an "equity interest" in the home.[11] "Equity interest" does not necessarily mean an ownership interest in the home. An "equity interest" can be shown by the submission of canceled checks or money orders for mortgage payments, a deed reflecting ownership, or other documents verifying the sibling's payment of expenses for *capital* improvements. (*See* 89 ADM-45 at page 16.) Medicaid has, in certain cases, accepted proof of the sibling's payment of ordinary household expenses as creating an "equity interest" although the authors cau-

tion that there appears to be no legal authority to support this position.

Consider Transferring Remainder Interests to an Irrevocable Trust Rather Than to Family Members

Under pre-DRA planning, transferring the homestead to the grantor's children (or other family members) subject to the grantor's retention of a life estate was perhaps the most common technique used for Medicaid planning to protect the homestead. The attractiveness of this technique has been lessened by virtue of the provisions of the DRA which will extend the look-back period on an incremental basis to sixty months. In light of these provisions of the DRA, clients would be well-advised, in many cases where the retention of a life estate is desirable,[12] to transfer the remainder interests in the homestead to an irrevocable trust rather than to family members.

Under pre-DRA planning, a primary reason that irrevocable trusts were often viewed as a less desirable planning technique than deeds with life estates was the difference in the length of the look-back period. The transfer of property into an irrevocable trust was subject to a five-year look-back period, while a transfer of the remainder interest to the grantor's children with a retained life estate was only subject to a three-year look-back period. Moreover, the penalty period for deed transfers subject to a life estate could be capped at thirty-six months with proper planning. Assuming a Medicaid application was submitted outside of the thirty-six month look-back period, the Medicaid eligibility date was thirty-seven months from the date of the last transfer regardless of the length of the penalty period. Thus, although a penalty period of greater than thirty-six months could result from a transfer, the penalty period was able to be limited to thirty-six months. Further adding to the preference towards the use of deeds with a retained life estate over the use of irrevocable trusts was the reduction in the penalty period resulting from the grantor's retention of a life estate.[13] This reduction in the penalty period often resulted in a penalty period of less than the three-year look-back period.

In light of the five-year look-back period eventually applying to all transfers as set forth in the DRA, the benefit of transferring a remainder interest to family members rather than to an irrevocable trust is generally no longer evident in many cases unless the grantor is expected to need a nursing home before the increase in the look-back period to sixty months is fully implemented (i.e., February 1, 2011). This is the case under the DRA since, in light of the five-year look-back period eventually applying to all transfers, the penalty period will no longer necessarily be able to be limited to three years by waiting to apply for Medicaid thirty-seven months after the transfer.

By virtue of the inability to limit the penalty period to no more than three years under the DRA, it would be appropriate to transfer the remainder interests to an irrevocable trust rather than family members in many cases where it is desirable for a life estate to be retained. There are still circumstances, however, where a person should be the transferee of the remainder interest. For example, if a transfer is being made to a caretaker child to qualify as an exception transfer, the remainder interest must be transferred to that individual and cannot be transferred to a trust in which the individual is a beneficiary. Additionally, if the client intends to obtain a reverse mortgage on the property, the ability to obtain the reverse mortgage can be impaired if the remainder interest was transferred to an irrevocable trust.

Due to the reduction in the penalty period resulting from the grantor's retention of a life estate, an actual penalty period of less than five years can be realized in many cases. Let's take Sue, a seventy-six-year-old widow who transfers her Long Island home valued at $750,000 to an irrevocable trust while retaining a life estate. Using this combination technique, she will have limited the penalty period to 38.10 months (38.10 months = $375,000 approximate reduced value of the gift by virtue of a seventy-six-year-old person retaining a life estate divided by the regional rate for Long Island residents of $9,842). (It is important to note, however, that the commencement of the penalty period would likely be delayed as previously explained in this article.) In addition to the reduction in the penalty period to less than the look-back period of five years, the transfer of the remainder interest to a properly drafted irrevocable trust rather than family members provides the benefit of protecting the remainder interest from claims of creditors of the family members. In addition, if the trust is drafted to qualify for grantor trust status, capital gains tax may be minimized or perhaps even completely avoided should the transferred property be sold during the grantor's lifetime. If the property had just been transferred by Sue to her children subject to her retention of a life estate, the penalty period would still be 38.10 months under the DRA once the look-back period is increased. However, the additional benefits a properly drafted trust offers of protecting the remainder interest from claims against creditors of the family members and the minimization or avoidance of capital gains tax though the full use of the IRC § 121 exclusion from capital gains tax would not have been achievable.

The full use of the IRC § 121 exclusion would be available if the trust was drafted to qualify as a grantor trust[14] and the conditions of IRC § 121 were met.

Rule of Halves Planning With the Residence

In analyzing the DRA much attention has focused on the issue of whether "rule of halves" planning will still be viable. Some commentators have suggested that, under the DRA, such planning will no longer be available. However, such planning may still be available at least with respect to planning with the homestead. The following is a basic example of how such planning may work after the implementation of the DRA.[15] Kate, age 73, owns a home worth $500,000, and a bank account totaling $4,150. She is expected to enter a nursing home in the near future. Kate deeds a one-half ownership interest in her residence to her son. She now enters a nursing home on a permanent basis and applies for Medicaid institutional benefits. She executes a statement of intent to return home to make her home an exempt asset.[16] Kate faces a penalty period resulting from the transfer of her one-half interest in her residence to her son. The penalty period, under the DRA, will only start when she enters the nursing home and is otherwise eligible for Medicaid but for the imposition of the penalty period based upon an approved application. Once the penalty period has begun to run, Kate and her son sell the residence with each receiving one-half of the net proceeds from the sale. Kate uses her one-half share of the net sale proceeds to pay the nursing home. In theory, the other half which her son received from the sale will be preserved for the son.

It is not certain whether the above technique will work. However, 06 OMM/ADM-5 seems to support the viability of this technique. The penalty period starts for Kate, the institutionalized individual, when she is "otherwise eligible" for Medicaid but for the transfer penalty. When she receives her portion of the net sale proceeds from the sale of her home, she is no longer "otherwise eligible" for Medicaid as she will have more than the Medicaid resource allowance in her name. Will the penalty period resulting from Kate's transfer of her one-half interest in her residence to her son be tolled or begin anew since she was no longer "otherwise eligible" for Medicaid after the commencement of the penalty period? 06 OMM/ADM-5 suggests that the running of the penalty period should not be affected. It states, in relevant part on page 17, as follows: "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*." (Emphasis added).[17]

Purchase of a Life Estate

42 U.S.C. § 1396p(c)(1)(J) statutorily recognizes a planning opportunity that prior to the DRA was not specifically addressed by statute and was considered by some practitioners as suspect. This provision of the DRA provides, in effect, that if a parent purchases a life estate interest in a child's home for fair market value and then lives in the home for at least one year after the purchase, such transaction will not be subject to a penalty period. Prior to the DRA, at least one court ruled that such a transaction was a sham and was not considered a transfer for fair market value.[18] Now with the passage of the DRA, there is no doubt that the purchase of a life estate interest in another's home is a legitimate planning technique.

New York's implementing legislation, Social Services Law § 366(5)(e)(3)(ii) mirrors the above-mentioned federal legislation by simply stating that the life estate purchaser must reside in the home for a period of at least one year after the purchase. There is no reference to the one-year residency period having to be continuous. 06 OMM/ADM-5, at page 23, provides that when an applicant or an applicant's spouse transfers assets to buy a life estate on or after February 8, 2006, the purchase is treated as a transfer of assets for less than fair market value unless the purchaser resides in the home for a continuous period of one year after the purchase. As an ADM is the New York State Department of Health's interpretation of the law, the condition under 06 OMM/ADM-5 that the one-year residency be continuous could be litigated in the appropriate case where this interpretation led to the denial of Medicaid benefits.

The practitioner who is faced with a situation where a parent is steadily but not precipitously declining in health may wish to counsel the family to consider this option. The parent might sell his or her house and move in with a child if it is expected that the parent will be able to live in the child's home for at least one year. Such a transaction could potentially result in a parent being able to transfer hundreds of thousands of dollars to his or her child without penalty and qualify for Medicaid nursing home benefits one year and a day later.

Traditionally, Medicaid has used the Life Estate and Remainder Interest Table set forth in 96 ADM-8 (Attachment V) to value a *retained* life estate interest. The value of a life estate could, however, vary in significant fashion if Medicaid seeks to use another table

when implementing the DRA for the purpose of valuing a life estate in the context of a purchase of a life estate. Neither the federal and state legislation nor 06 OMM/ADM-5 states how the purchase price of the life estate should be calculated.

An interesting point regarding this provision in the law is that there appears to be nothing to prevent a parent from repeating this strategy by buying a life estate interest in a second child's home one year after purchasing a life estate interest and living in the first child's home. The parent would have to move in with the second child and live with the second child for one year. If the parent has six children, could this process be repeated six times over six years?

Other open questions remain about the purchase of a life estate. For example, what exactly does a "continuous" period of one year mean, if, in fact, that is a legal requirement? What if the parent is a snowbird? What if the parent is hospitalized during a significant part of the first year after the purchase? These questions will have to be resolved.

The practitioner must also be mindful of the tax implications of such a transaction. In addition to triggering a transfer tax in connection with the parent's purchase of the life estate interest in the child's home, the subsequent sale of the home during the parent's lifetime could result in adverse capital gains tax consequences (i.e., the parent has moved out of the house after purchasing the life estate interest and does not qualify for the IRC § 121 exclusion from capital gains tax).

It is imperative that the parent sign a Durable Power of Attorney allowing the agent to gift and/or sell the life estate interest, if necessary. The child should also be forewarned that the existence of the parent's life estate interest may impede the child's ability to freely transfer the property without the parent's consent. Additionally, if the property is sold during the parent's lifetime, the portion of the sale proceeds corresponding to the life estate interest will become available and count as a resource to the parent. If the parent has already begun receiving Medicaid benefits at the time of the property's sale, such sale could cause the parent to become ineligible for Medicaid and all, or at least a portion, of the proceeds from the sale may have to be spent down on the cost of the parent's care. Thus, if the child who would sell the life estate interest to the parent does not expect to remain in the home for the balance of the parent's lifetime, the use of this technique may not be desirable.

The provisions in the law regarding the purchases of life estates apply to applications filed on or after August 1, 2006 for nursing facility services including requests for an increase in coverage for nursing facility services.[19]

Reducing Excess Equity in the Home

A Medicaid applicant may use a reverse mortgage or home equity loan to reduce the equity in the home.[20] That leads to the issue of whether the receipt and/or retention of proceeds from a reverse mortgage or home equity line of credit will cause the person to be ineligible for Medicaid. Social Services Law § 131-x provides that "to the extent permissible under federal law, regulation, or waiver" reverse mortgage proceeds shall not be counted as income or resources of the mortgagor for the purposes of public assistance. The authors have not been able to find any federal law, regulations or waiver provisions which would clarify the issue of whether the proceeds of a reverse mortgage or loan are considered resources beyond the month received. However, we have found support for the position that proceeds from bona fide loans should not be counted as income or resources regardless of how long they are held.[21] The Medicaid Reference Guide, however, provides on page 105 that proceeds from a reverse mortgage are disregarded as income and counted as a resource if retained beyond the month received.[22] In addition, 06 OMM/ADM-5, at page 25, states that "although payments received from a reverse mortgage or home equity loan are not counted in the month of receipt for eligibility purposes, if the funds are transferred during the month of receipt, the transfer is to be considered a transfer for less than fair market value." Thus, the issue of Medicaid's treatment of reverse mortgage or other loan proceeds which are retained by an applicant beyond the month of receipt appears ripe for litigation.

Long-Term Care Insurance

Last but not least, the client might consider how long-term care insurance could play an increased role in planning to preserve the home in light of the provisions of the DRA which, in many cases, can be expected to impede an individual's ability to qualify for Medicaid institutional benefits. The eventual increase in the look-back period to five years should lead to our clients considering the purchase of policies with a corresponding increase in the benefit period. Ideally, enough insurance should be purchased to carry the client past the look-back period. The problem is, of course, that the client must both qualify for the insurance (i.e., be healthy enough to purchase it) and be able to afford it. In the proper circumstance, long-term care insurance could assist in preserving the home, either alone or in conjunction with other planning techniques.

III. Conclusion

This article is only the beginning of our quest to understand how the DRA is going to impact planning with regard to real property. There is no doubt that elder law attorneys will be reviewing the law and considering various methods to properly protect our clients' interests in light of these changes. The authors look forward to participating in this ongoing process.

One thing is certain however—the provisions of the DRA, as discussed above, will have a profound effect on the elder law bar's approach to planning to protect real property.

Endnotes

1. N.Y. Social Services Law ("SSL"), § 366(2)(a)(1)(ii).
2. *See* 06 OMM/ADM-5 at page 25.
3. *See* N.Y. SSL, § 366 (2)(a)(1)(ii) and 06 OMM/ADM-5 at page 29.
4. 06 OMM/ADM-5 at page 11.
5. *Id.*
6. N.Y. SSL, § 366(5)(e)(5). *See also* 06 OMM/ADM-5 at pages 15 and 16.
7. 06 OMM/ADM-5 at page 17 (Example 3).
8. N.Y. SSL, § 366(5)(e)(3)(ii).
9. 06 OMM/ADM-5 at page 11.
10. *See* 18 N.Y.C.R.R. § 360-4.4(c)(2)(iii)(b).
11. *See* 18 N.Y.C.R.R. § 360-4.4(c)(2)(iii)(b)(3).
12. The practitioner must be mindful of the issue of whether only the remainder interest should be transferred into an irrevocable trust or whether the entire property should be put into the trust. With a life estate, if the home is sold, the Medicaid recipient is entitled to that portion of the sales proceeds that represents the fair market value of the life estate. Thus, if the Medicaid recipient is in a nursing home, all or at least part of the life tenant's portion of the sale proceeds would have to be used to pay for his or her care. Very often it is desirable for the home to be sold when the Medicaid recipient goes into the nursing home. The other choices are to leave the home vacant; have one of the children move in; or rent the home. In many, if not most cases, none of these choices will be palatable to the family. On the other hand, the poor health and/or the advanced age of the client may make the reservation of a life estate with the remainder interest passing into the trust more attractive.
13. 96 ADM-8, pages 19 and 20.
14. *See* Internal Revenue Code §§ 671-679.
15. To simplify things, factors such as the Medicaid applicant's income, insurance, etc., will be ignored in this example.
16. *See Anna W. v. Bane*, 863 F. Supp. 125 (W.D.N.Y. 1993).
17. It is important to note that Kate's son would likely not be eligible for the IRC § 121 exclusion from capital gains tax and, thus, the capital gains tax liability resulting from the transfer of a one-half interest in Kate's home to him shortly before selling the property must be considered in determining whether this approach is the best planning option.
18. *See Thompson v. Department of Children and Families*, 835 So.2d 357 (Fla. Dist. Ct. App., 5th District, 2003). It is significant to note, however, that the life estate interest was purchased after the Medicaid applicant had already entered a nursing home.
19. *See* 06 OMM/ADM-5 at page 24.
20. 06 OMM/ADM-5 at page 25.
21. 20 C.F.R. § 416.1103; N.Y. SSL, § 131-x; 18 N.Y.C.R.R. § 360-4.6 (xxv); 18 N.Y.C.R.R. § 352.22(c). (The MRG cited N.Y. SSL, §§ 366.1 and 366.2 for its position. A search on Loislaw did not find §§ 366.1 and 366.2. However, §§ 366(1) and 366(2) do not seem to support the position of the MRG.
22. Medicaid Reference Guide, p. 105.

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Use of Annuities in the Elder Law Context from OBRA 1993 to DRA 2005

By Lee A. Hoffman, Jr.

The first statutory recognition of the intersection of annuities and Medicaid planning was in OBRA 93 which amended § 1917(d)(6) of the Social Security Act. As amended, the section provided that the term "Trust" includes annuities. "Transmittal 64," issued by the Health Care Financing Administration (now CMS) contained reasonably comprehensive guidelines to the states on the treatment of annuities in the context of determinations for Medicaid eligibility for institutional care, which reads

> B. Annuities—Section 1917(d)(6) of the Act provides that the term "trust" includes an annuity to the extent and in such manner as the Secretary specifies. This subsection describes how annuities are treated under the trust/transfer provisions.
>
> When an individual purchases an annuity, he or she generally pays to the entity issuing the annuity (e.g., a bank or insurance company) a lump sum of money, in return for which he or she is promised regular payments of income in certain amounts. These payments may continue for a fixed period of time (for example, 10 years) or for as long as the individual (or another designated beneficiary) lives, thus creating an ongoing income stream. The annuity may or may not include a remainder clause under which, if the annuitant dies, the contracting entity converts whatever is remaining in the annuity into a lump sum and pays it to a designated beneficiary.
>
> Annuities, although usually purchased in order to provide a source of income for retirement, are occasionally used to shelter assets so that individuals purchasing them can become eligible for Medicaid. In order to avoid penalizing annuities validly purchased as part of a retirement plan, but to capture those annuities which abusively shelter assets, a determination must be made with regard to the ultimate purpose of the annuity (i.e., whether the purchase of the annuity constitutes a transfer of assets for less than fair market value). If the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the beneficiary, the annuity can be deemed actuarially sound.
>
> To make this determination, use the following life expectancy tables, compiled from information published by the Office of the Actuary of the Social Security Administration. The average number of years of expected life remaining for the individual must coincide with the life of the annuity. If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive fair market value for the annuity based on the projected return. In this case, the annuity is not actuarially sound and a transfer of assets for less than fair market value has taken place, subjecting the individual to a penalty. The penalty is assessed based on a transfer of assets for less than fair market value that is considered to have occurred at the time the annuity was purchased.
>
> For example, if a male at age 65 purchases a $10,000 annuity to be paid over the course of 10 years, his life expectancy according to the table is 14.96 years. Thus, the annuity is actuarially sound. However, if a male at age 80 purchases the same annuity for $10,000 to be paid over the course of 10 years, his life expectancy is only 6.98 years. Thus, a payout of the annuity for approximately 3 years is considered a transfer of assets for less than fair market value, and that amount is subject to penalty.

Basic Concepts

An annuity is a contract which has the following characteristics:

— an individual pays a lump sum to an entity or another individual;

— the entity or other individual agrees to pay and does pay periodic (usually monthly) payments for a period

of time, either for a specific time or for the life of the annuitant (the person receiving the payments).

If the payments were not for the life of the annuitant, the contract usually provides that any payments still due at the time the annuitant dies will be paid to a designated beneficiary.[1]

In the Medicaid context, we want the purchase of an annuity to be a transfer for fair consideration (not an uncompensated transfer) and we also want to avoid the principal remaining in the annuity from being considered an available resource. Thus, to be useful for Medicaid planning, an annuity must have additional terms:

— the annuity must be irrevocable, which means that the remaining principal can never be liquidated; and

— the annuity must be actuarially sound, i.e., the term of the annuity must be less than or equal to the life expectancy of the Medicaid applicant/recipient.

The reasons for these additional requirements should be self-evident. If the owner/annuitant can liquidate the principal, then the principal is an available resource and the owner/annuitant is not eligible for Medicaid. Transmittal 64 teaches us that if the term of the annuity is greater than the life expectancy of the annuitant, then there is an uncompensated transfer equal to the payments due after the end of the annuitant's life expectancy.

"Plain Vanilla" Use of Annuities in New York under OBRA 93

Annuities which met the requirements noted above have been used in planning for both individuals seeking Medicaid and also for community spouses. Note that the actual life expectancy (based upon medical considerations) of the annuitant is irrelevant as far as Medicaid is concerned—the only issue is the life expectancy set forth in the tables. Transmittal 64 contained a life expectancy table which was incorporated into 96ADM8, the New York State administrative directive on the interpretation of OBRA 93.

For the following examples, assume that the penalty divisor (average cost of care in nursing homes, as determined by the Department of Health) is $8,000 per month. The following situation is a typical example of the use of an annuity for an individual who wanted to apply for institutional Medicaid prior to DRA 2005:

An 82-year-old male is suffering from Parkinson's Disease and requires nursing home care. He has $240,000 in the bank. Since his life expectancy, according to the table in 96ADM8, is 6.21 years, he purchases an annuity for a term of 6 years, naming his children as beneficiaries. The annuity would pay approximately $4,000 per month for 6 years. The $4,000 per month would be paid to the nursing home for as long as the Parkinson's victim lived. If he lived 3 years, one-half of the annuity would be paid to the nursing home and the children would get the balance of the payments due. If the Parkinson's victim lived only 1½ years, then the children would get 4½ years worth of payments. If there was a reasonable probability that the Medicaid applicant would not survive for more than one-half of his life expectancy set by the tables, then use of the annuity was a preferred planning tool, as compared to the standard "half a loaf" planning.

Annuities are very useful in the institutionalized spouse/community spouse situation where the community spouse had resources above the CSRA. The following example is typical:

An 80-year-old husband is suffering from Alzheimer's Disease and needs to go into a nursing home. His 75-year-old spouse, after the transfer of all assets to her, has countable resources of $240,000 more than the CSRA. The life expectancy for the wife, again using the table in 96ADM8, is 12.05 years. Thus, the wife can purchase a $240,000 annuity for a term of 12 years. This will result in monthly income to her of approximately $2,000 per month. This will continue until she turns 87 and, if she dies before then, her named beneficiary receives the remaining payments. The payments are her income. They would act to reduce any contribution from her institutionalized husband to bring her income up to the Minimum Monthly Maintenance Needs Allowance (MMMNA). However, if she has significant income of her own, her income may be more than the MMMNA. If the annuity increased her income above the MMMNA, then Medicaid would ask for a voluntary con-

tribution of 25% of her income above the MMMNA. The theory here is that countable resources are made to disappear in exchange for an income stream.

Reaching for the Limit under OBRA 93

The basic use of annuities set forth above was tweaked by various practitioners seeking to increase the percentage of the asset which could be protected. These "tweaks" fell into three categories:

— annuities with deferred payments;

— annuities with balloon payments; and

— self-canceling installment notes (SCINs).

In a deferred payment annuity, the payments begin at some point in the future. In a balloon payment annuity, all but the last payment are artificially low, and the last payment would be a very large payment (almost the entire value of the annuity). Thus, if the Medicaid recipient did not survive until payments started or did not live out his or her full life expectancy, the beneficiaries would receive virtually the entire amount of the excess resources which had been converted into an annuity.

A SCIN is similar to an annuity contract. Usually, a SCIN is a Promissory Note which creates a contract between the Medicaid applicant and a family member. In exchange for the payment by the Medicaid applicant to the family member, the family member agrees to pay the Medicaid applicant a monthly payment for the life expectancy of the Medicaid applicant. The twist is that upon the death of the Medicaid applicant/recipient, the balance due on the Note is cancelled and the family member gets to keep the balance. Deferred annuities and balloon annuities were occasionally used in New York. SCINs were rarely used in New York.

Changes under DRA 2005

DRA 2005 contains three categories of provisions relating to annuities under which an applicant for Medicaid institutional care, or the applicant's spouse, has an interest in an annuity as an owner, annuitant or beneficiary.[2] First, there are disclosure requirements; second, there are requirements relating to the state being named as a beneficiary; and third, there are requirements relating to the terms of the annuity contract.

1. Disclosure Requirements

Section 6012(a) of DRA 2005 (42 U.S.C. 1396p(e)), which requires that any interest in an annuity of either an applicant/recipient of institutional care or that applicant/recipient's community spouse must be disclosed to the Medicaid agency, reads:

(e) (1) In order to meet the requirements of this section for purposes of section 1902(a)(18), a State shall require, as a condition for the provision of medical assistance for services described in subsection (c)(l)(C)(i) (relating to long-term care services) for an individual, the application of the individual for such assistance (including any recertification of eligibility for such assistance) shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of sum medical assistance.

(2) (A) In the case of disclosure concerning an annuity under subsection (C)(l)(F), the State shall notify the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State's remainder interest under such subsection.

(B) In the case of such an issuer receiving notice under subparagraph (A), the State may require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure described in paragraph (1). A State shall take such information into account in determining the amount of the State's obligations for medical assistance or in the individual's eligibility for such assistance.

(3) The Secretary may provide guidance to States on categories of transactions

> that may be treated as a transfer of asset for less than fair market value.
>
> (4) Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1).

Although the interest as an annuitant is probably most relevant for Medicaid purposes, an interest as an owner and a beneficiary must also be disclosed. The disclosure requirement applies to both initial applications and recertifications. Even though annuities held by retirement plans are not counted as assets (see below), any interest in an annuity held by a retirement plan in which an applicant/recipient or community spouse has an interest must also be disclosed. New York has now passed implementing legislation. Chapter 57 of the Laws of 2006, § 50-b added a new Subdivision 10 to Social Services Law 366-a, implementing the disclosure requirement of the DRA, which reads

McKinney's Social Services Law § 366-a

> (10) As a condition for the provision of medical assistance for nursing facility services, the application of an individual for such assistance, including any recertification of eligibility for such assistance, shall disclose a description of any interest the individual or community spouse has in an annuity or similar financial instrument, regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that the state of New York becomes a remainder beneficiary under such annuity or similar financial instrument by virtue of the provision of such medical assistance.

See also Department of Health GIS Memo O6 MA/016 and 06 OMM/ADM 5, the most currently available administrative directives regarding the disclosure requirement. The GIS Memo reads, in pertinent part,

> The applicant/recipient (A/R) must provide documentation of any interest the A/R or the A/R's spouse has in an annuity, regardless of whether the annuity is irrevocable or treated as an asset. For annuities purchased on or after February 8, 2006, the A/R must be informed of the right of the State to be named remainder beneficiary. In addition, if an A/R or the A/R's spouse purchased an annuity on or after February 8, 2006, and the A/R is seeking Medicaid coverage for nursing facility services, the State must be named as a remainder beneficiary or the purchase of the annuity will be considered an uncompensated transfer of assets. In addition, when an annuity is purchased by or on behalf of an A/R, the purchase will be treated as a transfer of assets for less than fair market value unless the annuity meets certain criteria (i.e., no deferral or balloon payments).

The federal statute also requires the state to advise the issuer of the annuity of its preferred remainder beneficiary status. The state may also require the issuer of an annuity to notify the state when there is a change in the amount of income or principal being withdrawn which is different from the amount disclosed on the application or most recent recertification.

2. State as Remainder Beneficiary Requirements

Section 6012(b) of DRA 2005 (42 U.S.C. 1396p(c)(1)(F)) requires that the state be named a remainder beneficiary in an amount equal to "at least" the total amount of medical assistance paid on behalf of the annuitant. It reads:

> (F) For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless:
>
> (i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant under this title; or
>
> (ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

This lien on any remainder payments due pursuant to the annuity contract after the death of the annuitant refers only to Medicaid benefits paid on behalf of the annuitant. Thus, if a community spouse is the annuitant and dies with six years of payments due on the annuity, the claim of the state only applies to Medicaid benefits received by the community spouse. If the community spouse never went on Medicaid, the state has no lien or claim against any payments due after the death of the

community spouse/annuitant. The state implementation statute is in the budget bill (8471) signed into law in June 2006 and reads:

> (i) the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless: the state is named as the beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant, or the state is named in the second position after a community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value; and the annuity meets the requirements of section 1917(c)(1)(G) of the federal social security act;

The GIS Memo and the ADM also address the remainder beneficiary issue.

If the annuitant received Medicaid benefits and there are payments due on the annuity after the death of the annuitant, then Medicaid receives any post-death payments up to the amount that Medicaid provided. After the state is paid, any balance remaining will be paid to named beneficiaries. However, the state is relegated to a subordinate position if there is a surviving spouse, minor child or disabled child who is named as a beneficiary. What happens if the spouse predeceases the annuitant, or a minor child reaches the age of majority? Because the right of the beneficiary accrues when the annuitant dies, the state's position should be determined as of the date of death of the annuitant. Once a minor child reaches the age of majority, that child should no longer have a priority position with respect to the state.

Likewise, if a spouse who is the beneficiary of a Medicaid applicant's annuity predeceases, the state steps into first position as beneficiary.

3. Annuity Contract Requirements

DRA 6012(b) also states that the purchase of an annuity is now treated as an uncompensated transfer of assets unless

- the annuity is within a retirement plan; or
- it meets certain requirements.

The statute reads:

> (G) For purposes of this paragraph, with respect to a transfer of assets, the term "assets" includes an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services under this title unless—
>
> (i) the annuity is—
>
> (I) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or
>
> (II) purchased with proceeds from—
>
> (aa) an account or trust described in subsection (a), (c), or (p) of section 408 of such Code;
>
> (bb) a simplified employee pension (within the meaning of section 408(k) of such Code); or
>
> (cc) a Roth IRA described in section 408A of such Code; or
>
> (ii) the annuity—
>
> (I) is irrevocable and nonassignable;
>
> (II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and
>
> (III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

New York's implementation statute is above and the GIS Memo is applicable.

A non-retirement plan annuity must be

- irrevocable;
- non-assignable;
- actuarially sound;
- no deferral of payments is permitted;
- no balloon payments are permitted; and
- there must be payments in equal amounts during the term of the annuity.

The determination of the "actuarially sound" requirement refers to "actuarial publications of the Office of the Chief Actuary of the Social Security Administration" to determine life expectancy. These are available at www.ssa.gov/OACT/STATS/table4c6.html. A comparison

of the life expectancy tables in 96ADM8 and the Social Security Tables (now required by statute) set forth a slightly shorter life expectancy than the tables we have used for many years. Thus, the new tables should be used to avoid any transfer penalty. Because these tables are updated frequently, they should be consulted every time an annuity is purchased.

Summary

For most of us who have used annuities as planning tools, the most significant changes imposed by DRA 2005 are the disclosure requirements and the requirement that the state be a priority remainder beneficiary

— up to the amount of Medicaid benefits provided to the annuitant; and

— unless the annuitant is survived by a spouse, minor child or disabled child.

Annuities and New Penalty Period Start Date

The change in the penalty period start date to the time an individual is institutionalized and "otherwise eligible" creates some additional opportunities using annuities. In the example below, we will assume a monthly transfer penalty of $9,000.

> An individual will be entering a nursing home permanently and will be discharged from the hospital within five days. She is a single individual with $180,000 in countable resources and would like to recognize the efforts of several neighbors who were instrumental in allowing her to remain at home.
>
> The client has other income of $1,500 per month. The Medicaid nursing home rate is $7,000 and the private-pay rate is $10,000 per month.
>
> The client transfers $90,000 ($30,000 to each neighbor) before she goes into the nursing home. She also purchases an annuity which will generate $5,400 per month. (The claimant is young enough so that the term of this annuity is less than her life expectancy. We are also assuming that any increase in the Medicaid rate for the home will be greater than the increase in Social Security income.) The annuity plus the Social Security is less than the Medicaid rate for the facility. Thus, there is absolutely no question that the individual is "otherwise eligible" for Medicaid because if she had not made the transfer, Medicaid would pay $100 a month toward the cost of her care. Because the applicant is "otherwise eligible," the penalty period starts to run. The gifting and the annuity need to be structured to ensure that the annuity pays for at least as long as the penalty period for the gift.

This approach, if properly planned and executed, results in the Medicaid applicant being able to pay privately for institutional care while the penalty period runs. In essence, this is similar to the old "half-a-loaf" planning except that the nursing home resident must pay privately when he or she is otherwise eligible for Medicaid.

The difficulty with this approach is dealing with the nursing home about payment for the difference between the Medicaid rate and the private-pay rate. This will have to be negotiated separately with the nursing home. Note that the private-pay rate for nursing homes is filed with regulatory agencies and cannot be modified on a case-by-case basis.

This article takes the conservative approach that a Medicaid applicant is not "otherwise eligible" unless he or she has income below the Medicaid rate for the facility in which he or she is a patient and that the applicant must be "otherwise eligible" for the entire penalty period. It is crystal clear that if the applicant's income exceeds the private-pay rate, then the applicant is not eligible for Medicaid. The several Departments of Social Services with whom I have spoken take the position that, if the applicant's income is above the Medicaid rate for the relevant nursing home, then the applicant is not eligible for Medicaid. There is a countervailing argument, but this will involve at least a Fair Hearing and uncertainty. Therefore, the author's recommendation is that the annuity be structured to ensure that the total income of the applicant is less than the Medicaid rate for the nursing home.

Annuities Purchased by Community Spouse to Decrease Resources in Excess of CSRA

The ability to use annuities purchased by a community spouse to decrease resources in excess of the CSRA continues to be a viable planning option. The only required changes are that the annuity purchased must be disclosed to Medicaid upon the application on behalf of the institutionalized spouse and Medicaid must be named as a beneficiary with respect to any Medicaid benefits paid to the community spouse. (See "Open Issues" section below.) Note that the GIS Memo and the ADM specifically deal with the documentation and remainder beneficiary issues, as well as the requirements that it be irrevocable, non-assignable, and immediately payable in equal payments with no deferral or balloon payments.

Open Issues

There are a number of issues which have been discussed by the Elder Law Bar concerning the new requirements relating to annuities. I will attempt to outline the differing positions and present my opinion as to the most likely outcome.

Interaction Between § F and § G of the Federal Law as Implemented in New York

My reading of § F and § G of the Federal Law is that the requirements of § F and § G are cumulative. This is made clear in the New York State implementation, in the GIS Memo, and in the ADM. My reading of § G is that it tells us what is included as a countable resource for Medicaid purposes. Basically, my reading is that an annuity is a countable resource unless it is within a pension or IRA plan of some kind, or it meets the requirements of irrevocable, non-assignable, and actuarially sound and payments in equal amounts with no deferral and no balloon payments. My reading of § F is that the purchase of an annuity is an uncompensated transfer, unless the state is named as remainder beneficiary in first or second position.

It appears that the state legislation differs from my view—the state legislation appears to say that an annuity which does not comply with both the requirements of the Federal § F and § G will be treated as an uncompensated transfer. I do not believe that the New York State statute fully complies with the Federal Law. However, I do not think there is a significant impact. The Department of Health transmittal 06 OMM/ADM-5 issued on July 20, 2006 requires that any annuity name the state as a remainder or contingent remainder beneficiary AND that it either be an annuity within a retirement plan or meet the statutory requirements.

The countervailing argument is that if the annuity meets the requirements of § G, then the State is not required to be named as a remainder beneficiary. This is a statutory construction argument—§ G says that any annuity which complies with its terms is not an asset with respect to transfer of assets. Therefore, if an annuity which complies with § G is not an asset, it cannot be subject to the requirements of § F, which say that ". . . The purpose of an annuity shall be treated as the disposal of an asset for less than fair market value . . . unless the state is named as a remainder beneficiary."

As a practical matter, this dispute will rarely come into play. If an annuity is purchased for a single institutionalized individual to pay down the penalty period, one of two things will happen—(1) the individual will outlive the term of the annuity and there will be no remainder interest to be paid to Medicaid, or (2) the individual will die before the annuity has expired and there will be no Medicaid claim against the remainder of the annuity, because the individual never received Medicaid (of course, if the individual received community Medicaid, then Medicaid would have a claim). In the case involving a community spouse, the Medicaid paid to the institutionalized spouse cannot be recouped from the annuity for which the community spouse is the annuitant.

Commercially Available Annuities

As of the writing of this article, there are no commercially available annuities which meet the statutory requirements.

Private Annuities

Annexed as Appendix A is a form of private annuity.[3] There are a number of questions which arise with respect to the use of private annuities. These include

- Will the family be able to properly administer the annuity?
- What kind of disclaimer information should the attorney furnish to the family to avoid liability if the family administers the annuity improperly?
- Should the attorney, accountant or other professional administer the funds for the annuity? If one of these individuals does administer the funds, is he or she, as the administrator, subject to any state or federal regulatory requirements? Does it make a difference whether a fee is collected for administering the annuity?
- Does a private annuity have to pay the same amount (based on anticipated interest) as a commercially available annuity? If yes, do the remainder beneficiaries understand that the actual income earned by the annuitized funds may be less than the required payout, leaving the family to additionally fund the cost of care?

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Appendix A—ANNUITY AGREEMENT

THIS AGREEMENT is made by and between , an individual currently residing at (hereafter referred to as "Obligor") and , currently residing at , (hereafter referred to as "Annuitant").

WHEREAS, Annuitant currently has assets totaling $ (hereafter referred to as the "property"); and

WHEREAS, Annuitant desires to be assured of fixed monthly payments for his or her life expectancy, as determined by actuarial publications of the Office of the Chief Actuary of the Social Security Administration; and

WHEREAS, the fixed monthly payments shall be made regardless of how the property is invested and regardless of any return earned on the investment of the property; and

WHEREAS, Obligor desires to own the property and agrees to make payments to Annuitant pursuant to the terms of this Agreement; and

WHEREAS, Obligor also agrees to pay any property remaining after the death of Annuitant in accordance with this Agreement.

NOW, THEREFORE, IN CONSIDERATION OF THE PREMISES SET FORTH ABOVE AND THE MUTUAL COVENANTS CONTAINED HEREIN, THE PARTIES AGREE AS FOLLOWS:

1. Annuitant hereby conveys the property to Obligor absolutely.

2. Obligor agrees to pay the Annuitant $ per month for months, commencing on , 200 , and ending on , 20 .

3. If at the time the Annuitant dies, the Annuitant has no spouse, has no minor children and has no blind or disabled children, any property not paid to the annuitant shall be distributed as follows:

—to the Department of Health of the State of New York (hereafter referred as "DOH") or any successor agency, or as directed by DOH, an amount not to exceed the total medical assistance paid on behalf of the Annuitant; and

—if there is any surplus remaining, to (family members, friends, charities, etc.)

4. If at the time the Annuitant dies, he or she is survived by a spouse, minor child or disabled child, any property not paid to the Annuitant shall be distributed:

(a) to surviving spouse/minor child/disabled child of annuitant, as follows

(b) any surplus to DOH, its successor, or as directed by DOH or its successor.

5. Any payments due after the death of the annuitant shall be made in one lump-sum payment to the appropriate beneficiary within six (6) months after the Annuitant's death or within two (2) months of the receipt of a demand for payment, whichever is later.

6. All payments due under this annuity shall be made by check dated and delivered no later than the tenth day of the month for which the payment is made; mailing to an address designated by the Annuitant or his or her agent shall constitute delivery.

7. Annuitant does not retain any right to require payment of the property to him or her in excess of the monthly payment set forth above.

8. Annuitant has no right to assign the income stream payable to him or her.

9. Obligor shall be personally and absolutely liable for the payments due pursuant to this Agreement. The required payments are not contingent upon Obligor's future earnings from or continued ownership of the property.

10. This Agreement is binding on the heirs, successors and assigns of the Obligor.

Endnotes

1. An annuity has an owner, an annuitant, and usually a beneficiary. In the Medicaid context, the owner and the annuitant are usually the same person and the beneficiary is usually a child or other relative.
2. "Institutional care" includes nursing home care, the equivalent of nursing home care provided in any institution and waivered home care services. In New York, the primary waivered home care service is the long-term home health care/Lombardi program.
3. The form appended is a modification of a form prepared by Vincent Russo included in the Fall 2003 Elder Law Section CLE entitled, "Document Drafting for the Elder Law Practitioner."

ATTACHMENT V

Social Security Online

Statistical Tables

Actuarial Publications

Period Life Table

Updated June 27, 2006

Period Life Table, 2002

Exact age	Male			Female		
	Death probability [a]	Number of lives [b]	Life expectancy	Death probability [a]	Number of lives [b]	Life expectancy
0	0.007644	100,000	74.21	0.006275	100,000	79.49
1	0.000528	99,236	73.78	0.000421	99,373	78.99
2	0.000357	99,183	72.82	0.000273	99,331	78.02
3	0.000268	99,148	71.85	0.000196	99,304	77.05
4	0.000232	99,121	70.87	0.000168	99,284	76.06
5	0.000202	99,098	69.88	0.000152	99,267	75.07
6	0.000186	99,078	68.90	0.000142	99,252	74.08
7	0.000171	99,060	67.91	0.000135	99,238	73.10
8	0.000151	99,043	66.92	0.000128	99,225	72.11
9	0.000127	99,028	65.93	0.000119	99,212	71.11
10	0.000110	99,015	64.94	0.000113	99,200	70.12
11	0.000119	99,004	63.95	0.000118	99,189	69.13
12	0.000177	98,993	62.96	0.000140	99,177	68.14
13	0.000297	98,975	61.97	0.000184	99,164	67.15
14	0.000460	98,946	60.98	0.000244	99,145	66.16
15	0.000640	98,900	60.01	0.000312	99,121	65.18
16	0.000810	98,837	59.05	0.000375	99,090	64.20
17	0.000964	98,757	58.10	0.000423	99,053	63.22
18	0.001090	98,662	57.15	0.000447	99,011	62.25
19	0.001189	98,554	56.22	0.000453	98,967	61.27
20	0.001290	98,437	55.28	0.000456	98,922	60.30
21	0.001386	98,310	54.35	0.000464	98,877	59.33
22	0.001443	98,174	53.43	0.000471	98,831	58.36
23	0.001450	98,032	52.50	0.000479	98,784	57.38
24	0.001421	97,890	51.58	0.000488	98,737	56.41
25	0.001379	97,751	50.65	0.000499	98,689	55.44
26	0.001345	97,616	49.72	0.000513	98,640	54.47
27	0.001325	97,485	48.79	0.000532	98,589	53.49
28	0.001330	97,356	47.85	0.000557	98,537	52.52
29	0.001355	97,226	46.91	0.000590	98,482	51.55
30	0.001389	97,094	45.98	0.000628	98,424	50.58
31	0.001428	96,959	45.04	0.000673	98,362	49.61

Exact age	Male			Female		
	Death probability [a]	Number of lives [b]	Life expectancy	Death probability [a]	Number of lives [b]	Life expectancy
32	0.001484	96,821	44.10	0.000727	98,296	48.65
33	0.001561	96,677	43.17	0.000793	98,224	47.68
34	0.001657	96,526	42.24	0.000869	98,146	46.72
35	0.001770	96,366	41.31	0.000953	98,061	45.76
36	0.001897	96,196	40.38	0.001045	97,968	44.80
37	0.002043	96,013	39.45	0.001147	97,865	43.85
38	0.002207	95,817	38.53	0.001259	97,753	42.90
39	0.002389	95,606	37.62	0.001381	97,630	41.95
40	0.002589	95,377	36.71	0.001514	97,495	41.01
41	0.002808	95,130	35.80	0.001655	97,347	40.07
42	0.003047	94,863	34.90	0.001800	97,186	39.14
43	0.003306	94,574	34.00	0.001946	97,011	38.21
44	0.003585	94,262	33.12	0.002097	96,823	37.28
45	0.003891	93,924	32.23	0.002264	96,620	36.36
46	0.004218	93,558	31.36	0.002446	96,401	35.44
47	0.004554	93,164	30.49	0.002631	96,165	34.52
48	0.004895	92,739	29.63	0.002816	95,912	33.61
49	0.005249	92,285	28.77	0.003010	95,642	32.71
50	0.005643	91,801	27.92	0.003227	95,354	31.80
51	0.006079	91,283	27.07	0.003476	95,046	30.90
52	0.006538	90,728	26.24	0.003763	94,716	30.01
53	0.007018	90,135	25.40	0.004091	94,360	29.12
54	0.007535	89,502	24.58	0.004465	93,974	28.24
55	0.008106	88,828	23.76	0.004884	93,554	27.36
56	0.008755	88,108	22.95	0.005349	93,097	26.50
57	0.009500	87,336	22.15	0.005861	92,599	25.64
58	0.010356	86,507	21.36	0.006423	92,056	24.78
59	0.011320	85,611	20.58	0.007040	91,465	23.94
60	0.012405	84,642	19.81	0.007732	90,821	23.11
61	0.013589	83,592	19.05	0.008497	90,119	22.28
62	0.014840	82,456	18.31	0.009318	89,353	21.47
63	0.016149	81,232	17.57	0.010192	88,521	20.67
64	0.017547	79,920	16.85	0.011138	87,618	19.88
65	0.019102	78,518	16.15	0.012199	86,642	19.09
66	0.020847	77,018	15.45	0.013384	85,586	18.32
67	0.022767	75,413	14.77	0.014669	84,440	17.56
68	0.024878	73,696	14.10	0.016055	83,201	16.82
69	0.027201	71,862	13.45	0.017571	81,866	16.08

Exact age	Male			Female		
	Death probability [a]	Number of lives [b]	Life expectancy	Death probability [a]	Number of lives [b]	Life expectancy
70	0.029824	69,908	12.81	0.019312	80,427	15.36
71	0.032719	67,823	12.19	0.021265	78,874	14.66
72	0.035795	65,604	11.59	0.023333	77,197	13.96
73	0.039031	63,255	11.00	0.025500	75,395	13.29
74	0.042518	60,786	10.42	0.027850	73,473	12.62
75	0.046499	58,202	9.86	0.030582	71,427	11.97
76	0.051003	55,495	9.32	0.033749	69,242	11.33
77	0.055873	52,665	8.79	0.037253	66,905	10.71
78	0.061104	49,722	8.29	0.041110	64,413	10.10
79	0.066844	46,684	7.79	0.045426	61,765	9.51
80	0.073269	43,564	7.31	0.050396	58,959	8.94
81	0.080572	40,372	6.85	0.056098	55,988	8.39
82	0.088858	37,119	6.41	0.062487	52,847	7.86
83	0.098235	33,821	5.99	0.069605	49,545	7.35
84	0.108694	30,498	5.58	0.077552	46,096	6.86
85	0.120186	27,183	5.20	0.086443	42,521	6.40
86	0.132672	23,916	4.85	0.096377	38,846	5.96
87	0.146137	20,743	4.51	0.107427	35,102	5.54
88	0.160593	17,712	4.20	0.119640	31,331	5.14
89	0.176074	14,867	3.90	0.133035	27,583	4.78
90	0.192615	12,250	3.63	0.147616	23,913	4.43
91	0.210240	9,890	3.38	0.163376	20,383	4.11
92	0.228968	7,811	3.15	0.180297	17,053	3.82
93	0.248798	6,022	2.93	0.198353	13,978	3.55
94	0.269717	4,524	2.74	0.217509	11,206	3.30
95	0.290557	3,304	2.56	0.236924	8,768	3.08
96	0.311026	2,344	2.41	0.256339	6,691	2.88
97	0.330817	1,615	2.27	0.275469	4,976	2.70
98	0.349613	1,081	2.15	0.294012	3,605	2.54
99	0.367093	703	2.04	0.311653	2,545	2.39
100	0.385448	445	1.93	0.330352	1,752	2.25
101	0.404720	273	1.82	0.350173	1,173	2.11
102	0.424956	163	1.72	0.371184	762	1.98
103	0.446204	94	1.63	0.393455	479	1.86
104	0.468514	52	1.53	0.417062	291	1.74
105	0.491940	28	1.44	0.442086	170	1.63
106	0.516537	14	1.36	0.468611	95	1.52
107	0.542364	7	1.28	0.496728	50	1.41

Exact age	Male			Female		
	Death probability [a]	Number of lives [b]	Life expectancy	Death probability [a]	Number of lives [b]	Life expectancy
108	0.569482	3	1.20	0.526531	25	1.31
109	0.597956	1	1.12	0.558123	12	1.22
110	0.627854	1	1.05	0.591610	5	1.13
111	0.659246	0	0.98	0.627107	2	1.05
112	0.692209	0	0.92	0.664733	1	0.97
113	0.726819	0	0.85	0.704617	0	0.89
114	0.763160	0	0.79	0.746894	0	0.82
115	0.801318	0	0.73	0.791708	0	0.75
116	0.841384	0	0.68	0.839210	0	0.68
117	0.883453	0	0.63	0.883453	0	0.63
118	0.927625	0	0.57	0.927625	0	0.57
119	0.974007	0	0.53	0.974007	0	0.53

[a] Probability of dying within one year.

[b] Number of survivors out of 100,000 born alive.

Note: The period life expectancy at a given age for 2002 represents the average number of years of life remaining if a group of persons at that age were to experience the mortality rates for 2002 over the course of their remaining life.

Planning for Home Care After the Deficit Reduction Act of 2005—and the NYS Budget 2006

By Valerie J. Bogart

Since the DRA will tremendously restrict Medicaid payment for nursing home care, use of Medicaid long term care services in the community will be more important than ever. Fortunately, attempts in the NYS Budget to END spousal refusal and impose transfer penalties on community-based home care were DEFEATED again this year. As a result, options remain for accessing Medicaid for community-based care.

1. Which Medicaid services will have a transfer penalty?

The definition of "institutionalized individual" for purposes of the transfer penalty, at N.Y. Social Services Law (SSL) § 366.5(d)(1)(vii), means any individual who is:

A. an in-patient in a nursing facility (defined as a nursing home under N.Y. Public Health Law (PHL) § 2801), including an intermediate care facility for the mentally retarded; or

B. an in-patient in a medical facility and is receiving a level of care provided in a nursing facility. (NOTE: This is known as "alternate level of care" or ALOC); or

C. receiving care, services or supplies pursuant to a waiver granted pursuant to subsection (c) of § 1915 of the federal Social Security Act. Waivered services include:

i. Lombardi program, SSL §§ 367-c, 366(6); 10 N.Y.C.R.R. § 505.21;[1] 85 ADM-27

It is not yet known how the DRA penalty will run for Lombardi or other waiver services. A person who transferred assets applies for Medicaid and for the Lombardi program, and is denied because of transfer of assets. It is unclear what they have to do to trigger running of the transfer penalty—if they have to pay for Lombardi services privately during the penalty period in order to "receive" them, there is no mechanism to privately pay for these services.[2] If, after the Medicaid Lombardi application is denied, the client instead receives Medicaid personal care (home attendant) which has no transfer penalty, or pays for private grey market services, will the penalty still run on the Lombardi care?

ii. Traumatic Brain Injury (TBI) Waiver Program, PHL § 2740 *et seq.*, 95 LCM-70, 96 INF-21

iii. Nursing Home Transition and Diversion Waiver, SSL § 366(6-a) (enacted 2004, waiver application pending with CMS)

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

v. AIDS Home Care Program, N.Y. SSL § 367-e; 18 N.Y.C.R.R. § 505.21(a)(2)

2. What services will not have a transfer penalty?

A. Personal care services ("home attendant" in NYC), 18 N.Y.C.R.R. § 505.14

B. Certified home health agency services ("CHHA"), 18 N.Y.C.R.R. § 505.23

(These include part-time and intermittent or "visiting nurse" services, home health aide services up to 24 hours/day, in-home physical, speech or occupational therapy.)

C. Private duty nursing services, SSL § 365-a, subd. 2(a); 18 N.Y.C.R.R. § 505.8

D. Medicaid Assisted Living Programs (ALP)—NYS Medicaid Reference Guide p. 354 says that during a transfer penalty period an applicant will not be eligible for "nursing facility services including home and community-based services [waiver]," and refers to p. 303.9 for a list of "nursing facility services." This list at 303.9 lists ALPs under Community-Based Long Term Care programs, and not as Nursing Facility services. In the community-based category, there is no look-back period. MRG 303.4–303.9.

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

E. Acute inpatient hospital care, all outpatient services, all physician's services, lab tests and x-rays, out-

patient rehabilitation, all other treatment and care in the community

F. "Short-term rehabilitation" in a rehabilitation facility—This benefit is one short-term nursing home admission, up to a maximum of 29 *consecutive* days in a 12-month period. This benefit is very limited, and is discussed further below. SSL § 366-a(2)(enacted 2002); 18 N.Y.C.R.R. § 360-2.3(c)(3) (effective February 25, 2005); 04 OMM/ADM-6; GIS 05 MA 004; 05OMM-INF-2 June 8, 2005.

3. Strategy One: Minimize the transfer penalty even if goal is to stay home with home care.

A. Someone who transferred assets after Feb. 8, 2006 may wait out five years after the transfer by staying home with home care or in a Medicaid ALP.

B. However, since no one has a crystal ball and cannot know whether they will need nursing home care in the 5 years, it is important to plan to minimize the penalty period even if the client's preference is to remain home with home care.

Make sure any available exceptions to the transfer penalty are used even though even a non-exempt transfer will not prevent eligibility for home care. In the past, if the transfer was a modest amount of money, and nursing home care could reasonably be avoided within the penalty period, we did not have to pay such close attention to using these exceptions.

For example, if a client was transferring $30,000, she did not risk any disqualification from Medicaid as long as she didn't go to a nursing home within the 3+ months after the transfer. This was a risk that could reasonably be taken. Now, the same transfer will disqualify her from 3 months of nursing home care even 4 and one-half years down the road. It would be a shame in 4 and one-half years to learn that the client could have transferred the $30,000 to her husband, but instead transferred it to her daughter because she was "just" applying for home care.

C. The exceptions are:

i. For transfer of assets *other than the home*:[3]

a. The assets were transferred to the applicant's spouse or on behalf of the spouse.

(1) In the community, the spouse who receives the money may still do a spousal refusal under SSL § 366.3(a) to contribute these assets, though he or she risks being sued by the local district for support.

(2) If there is a spouse, assets should be transferred to the spouse first who does a spousal refusal. After Medicaid application is accepted, then the non-applying spouse may transfer the assets without affecting the Medicaid recipient's immediate home care eligibility. Caution that the eligibility of *both* spouses for nursing home care in the next 5 years will be affected by that post-eligibility transfer.

b. The assets were transferred to a **Supplemental Needs Trust** established either:

(1) for the individual's **disabled adult child** OR

(2) for **an individual under 65 years of age who is disabled** (does not have to be related to the person setting up the trust) OR

(3) **for himself/herself**, but only if the client is **under age 65**.

c. 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.

d. The client can show that the assets were transferred exclusively for a purpose other than to qualify for medical assistance.

Example: Assets transferred to achieve estate and gift tax savings. Or if client's gift was consistent with a *past pattern* of financially helping family—paying for a wedding, education, etc.—or assets were transferred before an unexpected onset of a serious medical condition—this would be harder to show for someone of very advanced age.

e. ***All assets* have been returned to the individual**. Because the law says "all assets," it may not be possible for the family member to return PART of the assets to reduce the amount transferred, and reduce the penalty.[4] An interpretation of "all" could be that with respect to a particular penalty period, "all" of the assets have been returned.

A 1996 state directive implementing the old law says that if the family member or other "transferee" directly pays for the nursing home care with part of the transferred assets, this would reduce the transfer penalty.[5] It is unclear if the penalty would be similarly reduced if the transferred assets were used to make in-kind payments for the client's rent or other bills, or for home care. The state directive says that the transferred assets must be returned in cash or "an equivalent amount of cash or other liquid assets." *Id*.

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.

ii. Home

a. *One may still* transfer the home with no penalty to:[6]

(1) a spouse;

(2) a child under 21, *or* who is an adult and blind or disabled;

(3) a son or daughter if he or she lived in the home for 2 years immediately before the date the individual becomes an institutionalized individual and cared for client; or

(4) a sibling with equity interest who lived in home for 1 year immediately before the date the individual was institutionalized.

b. Even though one may transfer the home to anyone and still qualify for Medicaid for care in the community, regardless of whether an exception is met, it is better to transfer the home using the nursing home Medicaid and tax planning techniques before the Medicaid application is filed in the community. A non-exempt transfer made after Medicaid is already activated may be considered a fraudulent conveyance in avoidance of a potential creditor.

c. $750,000 equity limit—The DRA and implementing state law disqualifies applicants whose equity interest in the home exceeds $750,000 for "nursing facility services and other long-term care services." DRA 6014(a); SSL § 366, subd. 2 (1)(a). "Other long-term care services" is not expressly defined anywhere, but it is clear that the equity limit does not apply to community Medicaid alone, with no home care.[7] 42 U.S.C. § 1396p(f)(1)(A).

(1) The new limit expressly applies to all applications filed after January 1, 2006.[8] There is, thankfully, no provision that it be applied at recertification to individuals who are already receiving Medicaid.

(2) This cap would not apply to homes in which the individual's **spouse** or **minor or disabled child** are living. 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. If the home is worth more than the limit, all or part of the home could also be transferred without penalty to these exempt individuals, as well as to a non-disabled son or daughter if he or she 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.

CAUTION: Transfers of a home always have tax consequences because of the appreciation in the value.

(3) The new restriction will apply to "applications filed after Jan. 1, 2006." SSL § 366, subd. 2 (1)(a). The law does not say it will apply to recertifications of existing cases.

(4) **"**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 under the limit.

(5) The law requires CMS to establish a process to request a waiver of this rule for a "demonstrated hardship." We have no idea what the standards will be.

d. Holocaust reparations and other exempt assets other than the home—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.

e. Minimize the "transfer" by pre-paying for expenses with part of the money.

i. Prepayment of rent and other expenses—Mrs. S's rent is $1,000 per month. Her income is $1,200 per month. She has $30,000 in assets. She had planned to transfer the amount over the $4,150 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.

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." We have no experience drafting these yet, so cannot say what would pass review.

ii. Purchase pre-paid burial arrangements.

iii. Pay off mortgage. 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 show her intent to return home once she enters the nursing home. Need to see a private lawyer for the home.

f. Buy a life estate in another person's home.[9]

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 client resides in the home for a period of at least one year after the date of purchase**. Client may apply for and receive Medicaid home care services during the period she is living in the daughter's home.[10] Since transfer penalties do not apply to community-based care, she is eligible for home care until she needs to go into a nursing home or dies, even if these events occur before the one-year minimum period is over. Admission to a nursing home before she has lived in the home for a full year will apparently make the purchase of the life estate subject to a transfer penalty. We do not know whether the penalty will be pro-rated—e.g., cut the penalty by 25 percent if she stays in the home nine months.

CAUTION: There are tax consequences with this strategy.

4. Damage Control—After you've minimized the transfer penalty, steps to take to minimize the harm later if nursing home care is needed.

A. Save evidence of HARDSHIP for later—HARDSHIP WAIVER—DRA 6011(d)—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 in case of nursing home care, begin saving evidence that may constitute proof of "hardship."

The definition of "hardship" will probably be further elaborated in federal and/or state regulations. Current state regulations require the individual to show she has made best efforts to have the assets returned or sold for fair market value, but the family/friend refused.[11] These regulations are based on the old law and may be changed.

B. Save evidence to show transferred funds are used for vital expenses. Under current rules, if family members (or whomever the assets were transferred to) use part of the transferred funds to pay for nursing home care, this would reduce the penalty. See above I.D.4(a)(v) above pp. 4–5. It is not known whether the penalty will be reduced if these funds are used to pay for home care, rather than nursing home care. What if the family uses the funds to pay the client's rent, or other expenses because of a shortfall in the client's own income? We do not yet know how these expenditures will be treated, but since they may be treated favorably, keep evidence of them.

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. Recordkeeping—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 are necessary even for the poorest individuals, who must still prove that they have not transferred any assets.

Advise them about keeping receipts of expenses, payments over $1,000.

5. What happens to the NYSARC Supplemental Needs Trust for reducing spend-down?

A. Since a fair hearing decision in early 2004, Medicaid recipients who are disabled have been placing their "excess income" into the NYSARC or other pooled trusts to reduce or eliminate their Medicaid spend-down to qualify for community-based care. As long as they remain in the community, these "transfers" of monthly income do not affect their Medicaid eligibility.

i. People under age 65 may place assets into an SNT without any penalty even for nursing home care. People age 65 and over, however, are subject to a penalty for transfers. Because transfers will not be penalized for community-based care, thanks to the last minute deal struck in Albany, transfers into the NYSARC trust should not affect eligibility for community-based care for people over as well as under age 65.

ii. Many people don't realize that the nursing home transfer rules penalize not only transfers of *assets* but also transfers of *income*. Under the DRA, if a person over age 65 who had been using the NYSARC trust while in the community later enters a nursing home, *past* transfers of excess income into the trust on or after Feb. 8, 2006 may be treated as a TRANSFER that has a PENALTY. Since the penalty period first starts at the time of nursing home placement, this may disqualify seniors from Medicaid for nursing home care for an extended period of time in the future.

Example: Ben places $1,000 into the NYSARC trust on the 5th of each month beginning June 2005. He enters a nursing home in June 2007. The $9,000 he put into the trust before February 8, 2006 doesn't count. But he transferred $16,000 in monthly payments beginning March 2006. He may potentially be disqualified from Medicaid paying for nursing home care for almost two months ($16,000 divided by $9,000).

B. DOH has given conflicting information about what their policy will be with respect to income transferred into the trust by people age 65+. If DOH policy will be to penalize these transfers for nursing home eligibility, this policy could be challenged. Section 3259.7(1) of the CMS State Medicaid Manual provides that the treatment of income placed into Self-Settled Supplemental Needs Trusts and Pooled Trusts is controlled by the section discussing the treatment of income placed into Miller Trusts (subsection C). CMS State Medicaid Manual §§ 3259.7(1) and (1)(C)(3) at p. 3-3-109.36 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.[12]

For information on SNTs, including training outlines, NYSARC enrollment documents, list of pooled trusts, and requirements for people over age 65 to prove that they are disabled, see http://online resources.wnylc.net/healthcare/SNT_Materials.htm.

6. What if client receiving Medicaid Home Care needs short-term rehabilitation in a nursing home?

A. The penalty period for a transfer made since February 8, 2006 will begin on 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. . . ."[13] The law does not distinguish between a permanent placement for nursing home care or a temporary one. Even a short-term placement will trigger imposition of the transfer penalty. It is not yet clear what will happen if the client leaves the nursing home after a short-term stay, when there is still time left to run on the penalty. Since the State budget deal was struck, we know that the penalty will not affect resumption of Medicaid home care in the community after the rehab stay. But will the rest of the penalty be put on hold until the next nursing home stay?

B. There will be a strategy decision to make on whether or not to apply for institutional Medicaid with the look-back period during a short-term nursing home stay.

One factor will be the unknown question above—if the client leaves the nursing home before the penalty is used up, but the penalty keeps running when they go home, then that will be a big incentive to APPLY for Medicaid and start the penalty running, then leave the nursing home while it is still running.

C. The new "Short-Term Rehabilitation Benefit" may provide some Medicaid coverage of limited days of rehab within the community Medicaid benefit—without having to file the 36–60-month application that would trigger the transfer penalty. This benefit is one short-term nursing home admission, up to a maximum of 29 *consecutive* days in a 12-month period. This benefit is very limited, and is discussed further below. SSL § 366-a(2) (enacted 2002); 18 N.Y.C.R.R. 360-2.3(c)(3) (effective February 25, 2005); 04 OMM/ADM-6; GIS 05 MA 004; 05 OMM-INF-2 June 8, 2005. (Q & A).

i. **The 29 days must be *consecutive*.** Client cannot spread it over two or more rehab stays in a year. **Example:** Client was in a nursing home rehab program, 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 first stay, of the 29-day maximum, are lost and cannot be carried over to her second 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.

ii. **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 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).

Note: If Susan was not in receipt of Medicaid upon admission and applied for Medicaid coverage to begin December 1 (not retroactive to November), November 8 would still count as Day One of the short-term rehabilitation.

Exception: If an individual does not apply for Medicaid coverage for a nursing home admission, that commencement/admission is **not counted** toward the one commencement/admission limit per 12-month

period. In the above example, 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.

iii. **TIP:** Before client applies for Medicaid for nursing home care using the 29-day short-term Medicaid benefit, consider

a. Whether Medicare and Medigap are expected to pay for most of the stay.

(1) If so, don't apply and waste the 29-day benefit.

(2) If Medicare won't pay full stay, and/or client doesn't have Medigap nursing home co-insurance, need to predict how long a stay might be to decide if it is worth applying for Medicaid for that stay.

iv. It is early or late in the year, and how likely it is that client will have a second nursing home admission this year for which she'll need Medicaid. Use your crystal ball!

Example of Beating the Odds: Mrs. S applies for Medicaid coverage for a six-week nursing home stay which began on September 4, 2004. 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, 2004, even if Medicare covers the first 20 days in full.

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

v. Spend down cases—One only needs to meet a one-month spend-down requirement 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. ADM p. 10 and 05OMM-INF-2 June 8, 2005.

7. Buy long-term care insurance (LTC)

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 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. More info at http://www.nyspltc.org.[14]

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- to 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

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.

C. The new law will encourage other states to adopt these Partnership policies.[15] 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 to 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. Partnership Policies sold in NYS must have 5 percent interest compounded annually.

8. Stricter Documentation Requirements for Citizens and Nationals—DRA § 6036

A. All Medicaid applications filed on or after July 1, 2006, and redeterminations made after that date must establish that the applicants are U.S. citizens or nationals, or the state will not receive federal matching funds for their Medicaid services. In regulations amending 42 C.F.R. Part 435 and 436, published July 12, 2006,[16] these requirements will NOT apply to:

i. Medicare beneficiaries (dual eligibles and Medicare Savings Program) and

ii. SSI recipients

The regulations and June 2006 CMS directive are posted at http://www.cms.hhs.gov/MedicaidEligibility/05_ProofofCitizenship.asp.

The NYS DOH GIS 06-MA-015 on citizenship from June 2006 is http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/06ma015.pdf.

This outline summarizes the new regulations. It does not list every document in the regulations, just the broader categories. For the many specified naturalization documents, documents for people born in the U.S. territories, etc., see the regulations.

B. Proof must be either:

i. PROVE IDENTITY AND CITIZENSHIP with one document

- OR -

ii. PROVE IDENTITY *and* CITIZENSHIP separately

C. **Primary Evidence** of Citizenship AND Identity:

ii. U.S. passport (does not have to be currently valid to be accepted, as long as it was originally issued without a limitation; if it has a limitation, it may be used as proof of identity only, not citizenship).[17] Passports issued before 1980 may have included both spouses and children, and may be used to prove citizenship for all listed.

iii. Certificate of citizenship (N-560, -561) or naturalization, or other CMS-approved document.

iv. A *driver's license* is not acceptable, unless the state requires proof of citizenship to issue the license, which NYS does not; or if NYS verified that the driver's social security number is valid and assigned to the applicant who is a citizen, which NYS does not. In fact no state requires this proof for a driver's license.

D. Evidence of Citizenship—Need one of the following plus one from (C)—Evidence of Identity.

ii. **Secondary evidence** of citizenship. If primary evidence unavailable,

a. U.S. Public birth certificate showing birth in a state, DC, and territories after the dates they became U.S. territories. (Dates listed in regulation—if born before those dates, may be a "collectively naturalized citizen.") State has option of cross matching a vital statistics agency to document birth.

(1) Document must have been issued before the person was age 5. If it was amended after age 5, it is "fourth-level" document.

(2) Certification of Report of Birth or Report of Birth Abroad of a U.S. Citizen issued by Department of State for citizens born outside U.S.

(3) U.S. Citizen ID card issued by INS until the 1980s (I-97 or I-179 or I-197), certain ID cards for Mariana Islands, American Indians, final adoption decree showing U.S. birth

(4) Evidence of U.S. Civil Service employment before June 1, 1976.

(5) U.S. Military record showing U.S. birth.

iii. **Third-level evidence** of citizenship may be used only when primary evidence cannot be obtained within the state's reasonable opportunity period, secondary evidence does not exist, or cannot be obtained, and applicant alleges being born in the U.S.

(1) Hospital record extract on hospital letterhead established at the time of birth and created 5 years before the INITIAL application for Medicaid ("Do not accept a 'souvenir' birth certificate."). For children under 16, the document must have been created near the time of birth or 5 years before the date of application.

(2) Life, health, or other insurance record created at least 5 years before INITIAL Medicaid application date and indicating a U.S. place of birth.

iv. **Fourth-level evidence** of Citizenship, lowest reliability, "should only be used in the rarest of circumstances." When primary evidence is unavailable, both secondary and third-level evidence do not exist or cannot be obtained within the state's reasonable opportunity period, and applicant alleges being born in the U.S.

(1) Census record, federal or state, showing U.S. citizenship or birth, generally if born before 1950. To secure, complete form BC-600—Application for Search of

Census Records for Proof of Age, and add in remarks portion "U.S. Citizenship data requested." Add that purpose is for Medicaid eligibility. FEE REQUIRED.

(2) The following documents created at least 5 years before Medicaid application if they show a U.S. place of birth:

(a) Indian tribal census records;

(b) U.S. State Vital Statistics official notification of birth registration;

(c) U.S. public birth certificate amended more than 5 years after birth;

(d) Statement signed by MD or midwife who was present at birth;

(3) Institutional admission papers from a nursing home or other institution if it shows U.S. place of birth. It does not say it must be from a certain number of years before the Medicaid application; it may be contemporaneous.

(4) Medical record *other than an immunization record* created at least 5 years before the initial application date indicating U.S. birthplace. For children under 16, the document must have been created near the time of birth or 5 years before the date of application.

(5) Written sworn affidavits are used only in rarest circumstances. Must have TWO affidavits by 2 people other than the applicant with personal knowledge of events establishing citizenship. At least ONE of the 2 people cannot be related to the applicant. Both persons must be able to document their own citizenship and identity. Must also submit a separate affidavit from the applicant or other knowledgeable individual (guardian) explaining why evidence does not exist or cannot be obtained.

E. Evidence of Identity

i. Driver's license issued by state or territory with picture OR other identifying information—sex, race, height, eye color

ii. School ID with photo

iii. U.S. Military card or draft record or military dependent's ID card, U.S. Coast Guard Merchant Mariner card

iv. ID issued by U.S., state, or local government with same info included on driver's license

v. Native American Tribal documents, various (see regulation)

vi. *NOT* voter's registration or Canadian driver's license

vii. States may use a cross match with a government data system with agencies that may include law enforcement, public assistance, child support, motor vehicles, corrections, if that agency certifies true identity.

viii. Children under 16 (special rules) may include nursery or day care records. If no other documents available, may use a sworn affidavit by parent or guardian stating date and place of birth. Cannot use affidavit to prove BOTH citizenship and identity.

F. Special populations needing assistance—States may assist individuals to secure documentation of citizenship if because of incapacity they would be unable to do so and lack a representative to assist.

G. Rules about documents

i. ORIGINALS—Must be originals or copies certified by issuing agency. Copies, even if notarized, are not acceptable. 435.406(h).

ii. States may permit applicants to submit original documents without appearing in person, by mail or by representative.

iii. ONE-TIME documentation—Once citizenship is documented, subsequent changes in eligibility should not require repeating. State should maintain in data base. States must maintain for 3 years after person stops receiving Medicaid.

iv. States must conduct computer matches of names and SS numbers to check against fraud. When automated capabilities are available, states will be required to match files for those who use third- or fourth-tier documents.

v. Reasonable opportunity to present satisfactory evidence—States must give a reasonable opportunity to submit satisfactory evidence of citizenship before taking action affecting eligibility for Medicaid. States must give the same time to submit documentation of citizenship as for other eligibility requirements.

H. Federal Financial Participation (FFP)—FFP will not be given for individuals unless satisfactory documentation is obtained, unless person has Medicare or SSI. § 435.1008.

I. Litigation—*Bell v. Leavitt* (N.D. Ill.) a class action lawsuit was filed in federal court in Chicago on June 18, 2006. Just when the preliminary injunction motions

were about to be argued, CMS issued the interim regulations described above, which made some improvements on the guidance issued earlier in June 2006. For example, the exemption of Medicare and SSI recipients from the requirements was new. However, key problems continue with the implementation:

i. CMS continues to treat the provision of documentation as an eligibility requirement, even though the statute provides otherwise. As a result, CMS says that states are still forbidden to provide Medicaid to applicants until they have provided all the required documentation.

ii. The regulations do not exempt children receiving foster care services under Title IV-E of the SSA, even though the statute by its terms does not apply to this group.

iii. CMS is still requiring a hierarchy of documentation, and the regulations remain unclear about exactly how, or how rigidly, that hierarchy should be observed.

iv. The regulations say nothing about ongoing outreach to affected individuals, continuing CMS' approach of all but ignoring this statutory mandate. In the June 9, 2006 Guidance, CMS sought to "meet" its obligation here by foisting responsibility for it off on the states.

v. Though the preamble to the regulations says that individuals who are already eligible and who show "a good faith effort" to present satisfactory evidence will remain eligible as long as they continuously show this effort, this is not so clear in the regulations themselves.

vi. This provision will particularly affect elderly people born in the South and elsewhere, in poor communities and small towns or rural places where official birth documents were not always issued or maintained. The Center for Budget & Policy Priorities wrote an excellent report on the effects of this new requirement. *Survey Indicates Deficit Reduction Act Jeopardizes Medicaid Coverage for 3 to 5 Million U.S. Citizens*, Feb. 17, 2006, http://www.cbpp.org/1-26-06health.htm.

J. It is possible that just as New York state was forced, through litigation, to provide state-funded Medicaid for certain immigrants who would not be covered under federal law alone, New York state may be forced to provide state-funded Medicaid for residents who lack this documentation. See information posted at http://www.empirejustice.org/MasterFile/IssueAreas/ImmigRights/AccessMed.htm.

Endnotes

1. The state said it is waiting for guidance from CMS on this issue. Description of program on VNS website on their Lombardi program at http://www.vnsny.org/s_longterm.html.
2. Perhaps client can apply for Lombardi, which submits approval for a plan of care that includes a "waivered" service. When this application is denied because of a transfer penalty, the penalty period should start running. It is unknown whether the same Lombardi program may provide "non-waivered" services only during the penalty period, and receive Medicaid payment since these are not subject to the transfer penalty.
3. 42 U.S.C. § 1396p(c)(2)(B).
4. 42 U.S.C. § 1396p(c)(2)(C).
5. NYS Administrative Directive 96 ADM-8, pp. 22–23 http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/96adm8.pdf.
6. 42 U.S.C. § 1396p(c)(2)(A); SSL (5)(d)(3)(i)(B).
7. The old law defines "institutional services" as nursing facility services and home and community based waiver services (Lombardi, TBI waiver, etc). 42 U.S.C. § 1396p(3)(3). This definition is still in effect, but the new law uses the term "long term care services" which is not defined. It presumably will include all home care services—CHHA, personal care, nursing.
8. DRA § 6014(b); SSL 366, subd. 2 (a)(1).
9. DRA § 6016(D), amending 42 U.S.C. § 1396p(c)(1).
10. 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.
11. 18 N.Y.C.R.R. §§ 360- 4.10(a)(11), -4.4(c)(2)(ii). See also 96 ADM-8, pp. 23–24 http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/96adm8.pdf.
12. Thanks to NYSBA Member Aytan Bellin, Esq. for this research. The State Medicaid Manual is posted at http://www.cms.hhs.gov/Manuals/PBM/list.asp.
13. 42 U.S.C. § 1396p(1)(D)(ii), as added by Sec. 6011 of the Deficit Reduction Act.
14. SSL § 367-f; 11 N.Y.C.R.R. § 39.
15. Section 6021 of Deficit Reduction Act.
16. Federal Register: July 12, 2006 (Volume 71, Number 133, pp. 39214-39229) posted at http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/06-6033.htm.
17. 42 C.F.R. § 435.407(a)(1).

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This outline is from Ms. Bogart's presentation at the NYSBA Elder Law Section Summer Meeting in Portsmouth, NH.

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Significant Items in 06 OMM/ADM-5 Deficit Reduction Act of 2005—Long Term Care Medicaid Eligibility Changes and CMS Guidance dated July 27, 2006

By Valerie J. Bogart

This memo does not explain the changes made by the DRA, since this has been done previously. See, e.g., http://onlineresources.wnylc.net/healthcare/docs/OutlineDRA.pdf. This memo identifies policies or procedures in the ADM issued July 20, 2006 [referred to as "the ADM" or the "new ADM"] that fill gaps in the DRA or which raise questions. The memo also cites the new CMS "Transfer of Assets" Guidance issued on July 27, 2006, posted at http://www.cms.hhs.gov/smdl/smd/list.asp (scroll to Transfer of Assets Guidance dated July 27, 2006).

CAUTION: The analyses in this document are opinions of the author based on an initial review of the state and federal directives discussed herein. Many policies, including those discussed here, still have to be clarified by the federal and state government.

Thanks to David Goldfarb and Ira Salzman for contributing Points 9–12 and to them, Michael Cathers, and Andrew Koski (Home Care Association) for comments on the draft.

1. What services are subject to new transfer penalty?

We already knew the transfer penalty will apply to an "institutionalized individual" who receives "nursing facility services," which include nursing home care, "alternate level of care" in hospitals, and a person "who is receiving care, services or supplies pursuant to a waiver granted pursuant to subsection (c) of section 1915 of the federal Social Security Act." SSL § 366.5(e)(1)(vii), ADM p. 10. These waivers are the Lombardi program, TBI and OMRDD waivers, and other home and community-based waiver programs.

The new clarification in the ADM is the definition of "Community-based Long Term Care Services," which are services that are *not* subject to the transfer penalty. ADM p. 10.

A. As expected, "Community-based Long Term Care Services" include:

a. Medical model adult day care

b. Medicaid home care—

(1) Personal care services—("home attendant" in NYC)

(2) Certified home health agency services ("CHHA")

(3) Private duty nursing services

(4) Consumer Directed Personal Assistance Program (CDPAP)

(5) Managed long term care in the community

c. Hospice in the community AND Hospice residence program;

d. Personal Emergency Response System (PERS);

e. Residential treatment facility (Note: This is presumably for alcoholism and drug treatment.)

f. Medicaid Assisted Living Programs (ALP)—NYS Medicaid Reference Guide p. 354 says that during a transfer penalty period an applicant will not be eligible for "nursing facility services including home and community-based services [waiver]," and refers to p. 303.9 for a list of "nursing facility services." This list at 303.9 lists ALPs under Community-Based Long Term Care programs, and not as nursing facility services. In the community-based category, there is no look-back period. MRG 303.4–303.9.

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

g. Non-waivered services provided within a home and community-based waiver program

(1) The ADM does not specify which services are "non-waivered," but they are services normally covered by Medicaid, so they are not extra non-medical services provided solely as part of the waiver:[1]

(a) Personal care

(b) Skilled nursing visits

(c) Physical and speech therapy

(d) Social work counseling

(e) Medical transportation

(f) Medication and supplies

As services now defined as community-based, the above services should not be subject to the transfer penalty even when provided by a Lombardi or other waiver program (though they are subject to the homestead equity limit). Therefore, someone denied waiver services because of a transfer penalty should be able to receive the above non-waiver services from the same Lombardi or other waiver provider . . . and thereby trigger running of the transfer penalty(!)

(2) During the penalty period, they could not receive waivered services such as the following:

(a) Medical social services,

(b) Nutrition counseling/Educational services,

(c) Respiratory therapy,

(d) Home-delivered and congregate meals,

(e) Home maintenance tasks and Housing improvements,

(f) Moving assistance,

(g) Personal Emergency Response System (PERS),

(h) Respite care,

(i) Social adult day care and day care transportation.

(3) Note that the definition of "institutionalized individual," however, includes "those receiving care, services and supplies pursuant to a . . ." 1915(c) or (d) waiver, without limiting that definition to "waivered" services. These definitions are inconsistent in this regard. This definition implies that no services may be provided to a waiver recipient who has a transfer penalty.

h. The list omits one service which should be included as exempt from the transfer penalty: "Short-term rehabilitation" in a rehabilitation facility. This benefit is one short-term nursing home admission, up to a maximum of 29 *consecutive* days in a 12-month period. This benefit is very limited, and is discussed in more detail below. It appears this omission is an inadvertent error, as the ADM at p. 18 references this benefit in a way that implies it is not subject to the transfer penalty.

i. All other Medicaid services are not "community-based long term care services," so they are not subject to transfer penalty AND not subject to homestead equity limit: acute inpatient hospital care, all outpatient services, all physician's services, lab tests and x-rays, outpatient rehabilitation, and all other treatment and care in the community.

2. Which services are subject to the homestead equity limit of $750,000?

A. The list of community-based long term care services in the ADM set forth above purports to specify services subject to the equity limit. However, after the ADM was issued, the CMS Guidance dated July 27, 2006 was issued. This Guidance defines "other long term care services" subject to the homestead equity limit as including:

i. "A level of care in an institution equivalent to nursing facility services" COMMENT: This essentially means inpatient hospital "alternate level of care"

ii. Home and community-based services under a waiver under § 1915(c) or (d) (Lombardi and other waivers), and

iii. Services for a non-institutionalized individual that are described in § 1905(a) of the Act [42 U.S.C. § 1396d] paragraphs:

¶ (7) home health care services (CHHA),

¶ (22) home and community care (to the extent allowed and as defined in section 1929 [42 USCS § 1396t] for functionally disabled elderly individuals; NOTE: NYS does not have this type of waiver,

and

¶ (24) personal care services (home attendant in NYC).

iv. 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 § 1917(c) [42 U.S.C. § 1396p]. *Since New York does not penalize transfers for other services, this section does not apply*.

B. Because of this more limited definition in the CMS guidance, the following services that the ADM lists as "long term care services" should NOT be subject to the home equity limit:

i. Medical model adult day care

ii. Private duty nursing

iii. Consumer Directed Personal Assistance Program (CDPAP)

iv. Hospice

v. Personal Emergency Response System (PERS)

vi. Managed long term care program

vii. Assisted Living Program (ALP). NOTE: While theoretically it is true that this service should not be subject to the home equity limit for the above reason, in practice, the homestead of an ALP resident will be a countable asset, not exempt, because she does not live in the home. If the ALP resident has a spouse, minor or disabled child living in the couple's home, the home is exempt from the equity limit anyway.

3. No more applications for "full" Medicaid coverage—including nursing home and waivered services for people not currently in need of those services

After Aug. 1, 2006, applications for a determination of eligibility for nursing home/waiver services, with the 36-month (or 60-month) look-back will no longer be accepted unless the applicant is actually in need of those services. ADM p. 11. Before, someone applying in the community, whether at a CASA or regular Medicaid office in NYC, had the option of doing the full 36-month look-back even though they currently sought only community-based care, such as home care. They might have done it just to get it over with, knowing they may be going into a nursing home soon. This will no longer be permitted, but people who did that before get an extra bonus.

If someone who applied in the community was already determined eligible for "full" Medicaid, including nursing home/waivered services, 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. The ADM does not give a date, but presumably they must have been determined eligible for full Medicaid as of Aug. 1, 2006. This benefit will only help those who made transfers after Feb. 8, 2006 and have already been determined eligible, since transfers made before that date are evaluated under the old rules anyway.

4. Penalty period continues to run if leave nursing home, or if denied waiver services because of penalty

Some good news: "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 p. 17. This means that one may enter a nursing home program, apply and have application rejected because of the transfer penalty, then LEAVE the nursing home program, and the penalty period will run. While the penalty is running, there is no requirement that client pay for or even receive any services. Thus the penalty period will run even if client leaves nursing home and receives Medicaid home care—personal care, CHHA, Consumer-Directed—or goes into a Medicaid assisted living program, or privately pays for care while running out the penalty period.

A. Application of this policy to Lombardi or other waiver services. This policy applies to waiver services, since they are part of "nursing facility services." If client is denied "waivered" services because of a transfer, she should be able to receive:

1. Medicaid home care services since they have no penalty, and while receiving them, the penalty should run.

2. Non-waiver services from the Lombardi or other waiver provider while she is running out the penalty period. This is because "non-waiver" services have been defined as community-based long term care services not subject to a penalty. See discussion at Point 1.A.g. above of the definition at ADM p. 10. We do not yet know whether or how these programs will authorize a service plan with only non-waiver services.

3. Private pay services from any provider—need not be a CHHA or Lombardi/waiver provider.

B. Under the ADM policy, the penalty may run and expire while the person denied nursing home or waiver services is receiving these "community-based" services. After the penalty expires, if she needs and applies for nursing home or waiver 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 or waiver program, then she is not eligible for those services until the remainder of the penalty has expired.

5. Partial return of transferred Assets

The ADM at p. 18 confirms that the policy stated in 96 ADM-8[2] regarding return of *part* of the transferred assets will continue. *Return of part of the assets will reduce the penalty period proportionally to the amount returned*. However, the ADM gives an example to point out that this policy does not allow a "rule of halves" transfer. In the example, half of the transferred assets are returned to the applicant at the time he applies for Medicaid in the nursing home. While the partial return of the assets does reduce the transfer penalty by half, the application will be denied because she is not

"otherwise eligible" when she is in possession of the returned assets. The penalty on the assets that were *not* returned will *not* start running. When the returned assets are spent down, she must reapply. At that time she will be "otherwise eligible" and the penalty on the half of the assets that were not returned will start running. If the transferred assets are still not available to pay the nursing home, she either has to resist the nursing home's attempts to discharge her for failure to pay through the penalty period OR return to the community and access Medicaid for home care, assisted living, and/or other community-based services to ride out the penalty period.

6. Definition of "Undue Hardship" for transfer of asset penalty

DRA 6011(d) requires each state to provide a process for granting a waiver if denying Medicaid would constitute an "undue hardship."

A. Definition of "Undue Hardship" in DRA—Denying Medicaid because of transfer penalty would deprive the individual of:

1. Medical care such that her health or life would be endangered if nursing home care is denied;

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 in the DRA, 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,[3] and the new ADM state that undue hardship cannot be claimed:

1. If best efforts have not 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.[4] 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 N.Y.C.R.R. §§ 360-4.4(d)(2)(iii); new ADM p. 20; 96 ADM-8 at 23.

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.

3. "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.

a. COMMENT: The harsh limitations in (2) and (3) are only in the ADMs, not in state regulation. Though they have been state policy since at least 1996, the onerousness of these limitations may only be apparent now—with the delayed transfer penalties. The limitation in (2), especially, may violate the new criteria for hardship in the DRA.

b. A "hardship waiver" has always been very difficult to obtain, and cannot be counted on.

4. 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 and Disability Assistance, rather than the Department 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 bed holds, 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.

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 p. 21

7. Steps in determining eligibility and asset penalty for applicants in nursing homes or waiver programs

A. The new ADM at pp. 12–16 details the steps in determining financial eligibility and assessing the penalty.

B. Application One—Step One—Application for Medicaid filed for coverage of nursing home or waiver services. Note that this may only be filed when person has already been admitted to nursing home, or is in need of waiver services. This step determines whether the individual is "otherwise eligible" for Medicaid for nursing home or waiver care.

1. Resource eligibility—Does the institutionalized individual have resources that exceed the individual resource limit ($4,150 for 2006), after disregards have been applied, after the community spouse resource allowance has been deducted for married couples, and after given an opportunity to establish an irrevocable pre-need funeral agreement? If she still has excess resources and has medical bills that offset the excess amount, she is resource-eligible, and you go on to evaluate income eligibility. If unpaid medical bills are less than the amount of her excess resources, stop here.

NOTE: Since client is not on Medicaid yet, the unpaid nursing home bill is at the higher private rate, not the Medicaid rate. This higher unpaid medical bill may help her get past this threshold.

2. Income eligibility—For this initial eligibility determination, community, not "chronic care," budgeting is used. This is consistent with current practice for initial budgeting before the person is in "permanent absence" status. See Medicaid Reference Guide p. 230. This means that the community-budgeting SSI-related income disregards are used, and the excess income is the amount over the community income level for one ($692 for 2006). The community spouse's income is not counted in this budget, and no community spouse income allowance is allotted at this stage. New ADM p. 13. The spousal income allowance is calculated only at "step three" below.

If the unpaid medical bills (those not used to offset the excess resources and not paid by Medicare or another third party) exceed the excess income, the individual is income-eligible. If the excess income is enough to pay the unpaid bills, including the nursing home bill, then the individual is not "otherwise eligible" for Medicaid.

3. Possible eligibility outcomes of Step One

a. If Financially Ineligible—Application for nursing home/waiver services is denied with notice. NO review is done of transfers in the look-back period. Even if there were no disqualifying transfers, the person is simply not eligible anyway. If there *were* disqualifying transfers, the penalty could not begin running because the person is not currently "otherwise eligible."

b. If Financially Eligible (p. 14), district does look-back (Step Two).

C. Application One—Step Two—Look-back review of assets and determination of transfer penalty. ADM p. 14

1. As predicted, the look-back will continue to be 36 months (and 60 months for transfers into trusts) until February 1, 2009, when it will begin to increase to 60 months in one-month increments. ADM p. 14

2. The ADM gives examples of calculation of the penalty period. The only one that illustrates a point not obvious in the DRA is Example 3 on pp. 16–17, which shows that in some cases *advance 10-day notice* must be provided before a penalty is imposed. This example is of a transfer made *after* the date of institutionalization and application for Medicaid. The way this occurs in the example is that the institutionalized individual, already on Medicaid while in a nursing home, made a transfer by declining his right of election of his spouse's estate.[5] This situation could also occur if the nursing home resident settles a lawsuit or receives an inheritance.

The penalty should begin the month following the month of the transfer, since this is later than 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. . . ."[6]

The ADM makes the point that *advance 10-day notice* is required of the determination of the penalty period and of the date that the penalty period would begin. Since this notice may not be retroactive, the penalty period may have to begin running later than it otherwise would. In the example, if the transfer was in July 2006, the penalty should theoretically begin running in August 2006. However, if the district first learns about this transfer in September 2006, it must give notice 10 days before October 1, 2006 in order to begin the penalty period on that date.

3. If non-exempt transfers are identified in the look-back period, the application for nursing home care will be denied. The notice is called "Notice of Limited Coverage," and approves coverage for community Medicaid, while denying nursing home coverage and giving notice of the transfer penalty. See Attachments III and IV of new ADM.

a. Attachment III is for people who did not receive any form of Medicaid before, and approves "limited coverage," indicating the amount of the spend-down, if any.

b. Attachment IV is for someone who had community Medicaid and is now given "limited coverage" in that the request for nursing home/waiver Medicaid is denied. This notice is confusing.

c. These notices specify the amount of the transfer and the number of months in the penalty. Though the notices do not specify the date on which the penalty begins, they do have a space for the end date of the penalty. It is not clear whether this blank must be filled in, or is optional.

d. Attachment V is the notice of decision on request for Undue Hardship.

4. Once the notices have been issued determining the transfer penalty, the penalty begins to run. As stated in Point 4 above, the penalty will continue to run even if the individual leaves the nursing home. For waiver applicants denied because of a transfer, they may wait out the penalty period by receiving "non-waiver" services from the waiver provider, or by receiving other community-based Medicaid home care services, or if they receive no Medicaid services at all. See above, Point 1.A.g.

D. Application One—Step Three—If there is no penalty because no transfers were made in the look-back period, or because the transfers were exempt, or if undue hardship was found, the next step is to determine the budget. The ADM does not describe Step Three, since this step has not changed from before the DRA. In this step, chronic care budgeting would be used. ADM p. 15 (top of page). For married couples, the spousal impoverishment income and resource allowances would be determined.

NOTE: While not a change from current rules, the State's emphasis on the use of "chronic care/post-eligibility budgeting" reflects a recent bad trend. The distinction between post-eligibility budgeting and the community budgeting used in "Step One" to determine "eligibility" in a nursing home has recently been used by the State to deny persons under age 65, who are in nursing homes or waiver programs, the right to place their excess income into a Supplemental Needs Trust to eliminate their contribution to the cost of care. *In re J.S.,* FH No. 4457519H, dated July 21, 2006 (Aytan Bellin, counsel for Appellant). The rationale is that in post-eligibility budgeting, income excluded in step one "eligibility" budgeting—such as income placed into an SNT—is not excluded in post-eligibility budgeting.

E. Application Two—If the first application was denied after Step Two because of a transfer penalty, once the transfer penalty runs out, the same person must file a second application for nursing home or waiver care if she still needs it. In the meantime, during the penalty period, she could have had someone pay for her care, left the nursing home and received Medicaid or private home care or assisted living services, or received "non-waiver" services in a waiver program.

8. "Short Term Rehabilitation Benefit"

This benefit was created by statute in 2002, and allows limited days of Medicaid coverage of rehabilitation in a nursing home within the *community* Medicaid benefit—without having to file the 36- to 60-month application that would trigger the transfer penalty. This benefit is one short-term nursing home admission, up to a maximum of 29 *consecutive* days in a 12-month period.[7]

i. Though the new DRA 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 p. 18. If the initial days of a nursing home stay were covered under this benefit, the look-back period would be the period immediately preceding the month the short-term rehab service began. The transfer penalty for an "otherwise eligible" individual (which anyone receiving the short-term rehab benefit must be) would begin in the first month the short-term rehab service began. While the ADM does not say so, presumably the penalty does not bar coverage of the rehab benefit, but begins when it expires.

ii. NOTICE—ADM p. 18 provides that if, when someone receiving the short-term rehab benefit then applies for "full" Medicaid nursing home coverage, and a transfer penalty is imposed, since this is a reduction in benefits, the district must give 10-day advance notice before imposing the penalty. However, if the 29-day rehab benefit has already ended, the 10-day notice requirement does not apply.

As a practical matter, it is doubtful that anyone would ever be entitled to the 10-day notice. The full nursing home application with the look-back and penalty determination will never be completed within the 29-day benefit.

More information about the 29-day benefit—unaffected by the DRA—is below.

iii. The 29 days must be *consecutive*. Client cannot spread it over two or more rehab stays in a year. **Example:** Client was in a nursing home rehab program, where she applied for and used part of the Medicaid rehab benefit. After only 15 days, she was sent back to the hospital for one week, and then went back to the nursing home for more rehab. The 14 remaining days from her first stay, of the 29-day maximum, are lost and cannot be carried over to her second 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.

iv. 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 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).

Note: If Susan was not in receipt of Medicaid upon admission and applied for Medicaid coverage to begin December 1 (not retroactive to November), November 8 would still count as Day One of the short-term rehabilitation.

Exception: If an individual does not apply for Medicaid coverage for a nursing home admission, that commencement/admission is **not counted** toward the one commencement/admission limit per 12-month period. In the above example, 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.

iv. **TIP:** Before client applies for Medicaid for nursing home care using the 29-day short-term Medicaid benefit, consider:

a. Whether Medicare and Medigap are expected to pay for most of the stay.

(1) If so, don't apply and waste the 29-day benefit.

(2) If Medicare won't pay for the full stay, and/or client doesn't have Medigap nursing home co-insurance, need to predict how long a stay might be to decide if it is worth applying for Medicaid for that stay.

b. Likelihood that client will have a second nursing home admission in the same year for which she'll need Medicaid—If so, then may not want to use up the benefit now, and wait to apply for it later. If it is very late in the year, so that it is less likely she will be admitted a second time, it is worth it to use this benefit, OR if for other reasons the risk of a second nursing home stay in the same year is unlikely.

Example of Beating the Odds: Mrs. S applies for Medicaid coverage for a six-week nursing home stay which began on September 4, 2004. 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, 2004, even if Medicare covers the first 20 days in full.

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

c. Considerations under DRA—Now that we know that the transfer penalty will start running even if client leaves the nursing home:

(1) If client has a transfer penalty, she may want to apply for Medicaid to have the penalty be 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. The downside of this is that client is liable for the cost of care during the short-term stay, to the extent that Medicare, Medigap, and the 29-day Medicaid rehab benefit were exhausted.

Practical consideration: Medicaid applications take months to process. If client leaves nursing home while Medicaid application is still pending, for Medicaid to cover the closed period of her admission, will the penalty still run in the same way while she is at home, once the notice of the penalty is issued retroactively?

(2) Conversely, if client does NOT want to trigger the transfer penalty, perhaps because she is near the

end of the 3- to 5-year look-back period for 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.

v. **Spend-down cases**—One only needs to meet a one-month spend-down requirement 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.

9. Home Equity Limit—Prohibition of Transfer of Proceeds of Reverse Mortgage

The ADM at p. 25 states that if an individual takes out a reverse mortgage or home equity loan to reduce the equity in their home, the payments are not counted in the month of receipt for eligibility purposes. This is consistent with State Medicaid Reference Guide [MRG] p. 105 and Real Property Law § 131-x. However, the ADM states, "if the funds are transferred during the month of receipt, the transfer is to be considered a transfer for less than fair market value." The State Medicaid Reference Guide [MRG] has long stated that the loan is exempt as income in the month received but counts as a resource if retained into the next month. MRG p. 105. The new policy appears to be based on this interpretation, since if the loan counts as a resource if retained in the following month, then transfer of a countable resource incurs a penalty. However, the new ADM would penalize a transfer of the loan *during* the month of receipt, when it is exempt income. Moreover, both the MRG and the new ADM policy may be inconsistent with Real Property Law § 131-x, which provides, "the proceeds of a reverse mortgage loan made in conformity with the requirements of Real Property Law 280 or 280a or exempted therefrom . . . shall not be considered as income or resources of the mortgagor for any purpose under any law relating to . . . medical assistance. . . ."

10. Date of transfer for failure to exercise right of election

Example 3 on p. 16 of the ADM involves a transfer penalty imposed on the failure to exercise a right of election. The ADM states that the date of transfer is "[t]he last date the institutionalized individual could have pursued his elective share. . . ." This differs from policy in previous case law, which uses the date of death as the date of transfer. *Estate of Dionisio v. Westchester County Department of Social Services*, 224 A.D.2d 483, 665 N.Y.S.2d 904 (2d Dep't 1997) (The date of transfer was considered to be the decedent's date of death.). Since under the DRA, a penalty now runs from the date one applies for and is eligible for Medicaid in a nursing home or waiver program, not from the date of transfer, the impact of this policy change is unclear. If the death was before February 8, 2006 or, if later, more than 5 years before the Medicaid application was filed, it could be significant.

11. Purchase of life estate in another's home

The DRA provides that a "purchase of a life estate interest in another individual's home" is not a transfer of assets if the purchaser resides in the home for at least one year after the date of purchase. 42 U.S.C. § 1396p(C)(1)(J). The implementing state law tracks this language. SSL, subd. 5 (e)(3)(ii). 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 limiting it to a "home" of another individual. Since such broad language would be inconsistent with both the federal and state law, it is presumably an error in drafting.

12. 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 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.

CMS Guidance, P. 4, No. 5 <http://www.cms.hhs.gov/smdl/smd/list.asp> (scroll to Transfer of Assets Guidance dated July 27, 2006).

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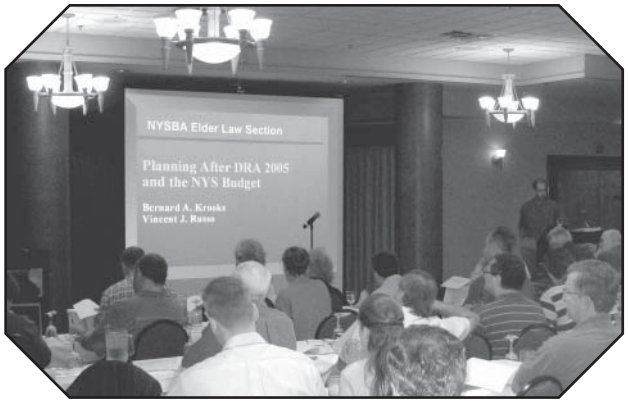
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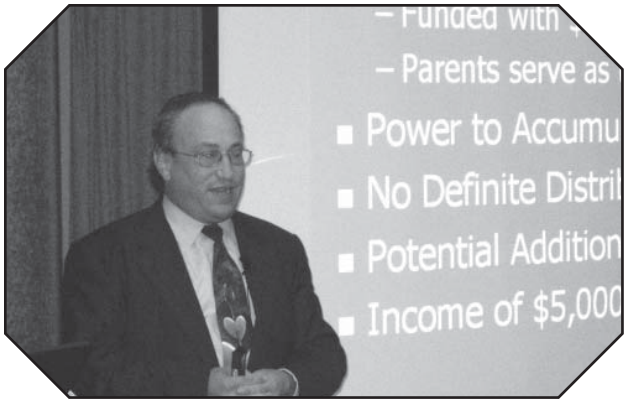
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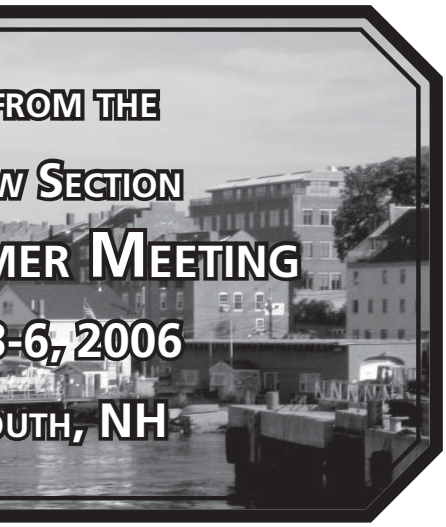
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The problem with this procedure is that an annuity returns principal as well as income. Unless they are planning to split out the income portion of the annuity payment in some way, by using this method they are essentially counting resources as both 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. *Berg v. Novello et al.* (No. 1681/0) (Supreme Ct., Sullivan Co., Sackett, J., March 1, 2006); *see also Parks v. Moon* (No. 122885) (Supreme Ct., Sullivan Co. February 14, 2006). 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.

Endnotes

1. NYS Dept. of Health Long Term Home Health Care Program Reference Manual (June 2006) Ch. 3 <http://www.health.state.ny.us/health_care/medicaid/reference/lthhcp/lthhcpmanual.pdf.
2. ADM # 96 OMM/ADM-8 OBRA '93 Transfer and Trust Provisions.
3. ADM # 96 OMM/ADM-8 OBRA '93 Transfer and Trust Provisions.
4. 18 N.Y.C.R.R. §§ 360- 4.10(a)(11), -4.4(c)(2)(ii). *See also* 96 ADM-8, pp. 23–24. http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/96adm8.pdf , new ADM p. 20.
5. This example shows another change in state policy regarding determination of the date of transfer for a failure to exercise a right of election. See Point below.
6. 42 U.S.C. § 1396p(1)(D)(ii), as added by § 6011 of the Deficit Reduction Act.
7. SSL § 366-a(2) (enacted 2002); 18 N.Y.C.R.R. 360-2.3(c)(3) (effective February 25, 2005); 04 OMM/ ADM-6; ADM # 04; OMM/ADM-6; GIS 05 MA 004; 05 OMM-INF-2 June 8, 2005. (Q & A).

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Medicaid Planning in Guardianships Post DRA

By Joan Lensky Robert

I. Introduction

Elder law practitioners often plan for asset preservations of their clients in light of health care needs. With the cost of nursing home care in the New York City metropolitan area averaging $120,000/year, only the wealthy can pay indefinitely for care without impoverishment. Absent sufficient funds to pay privately, and absent private long term care insurance, the community often looks to the Medicaid program to pay for the costs of long term health care.

Medicaid is a joint federal-state Social Security program established by federal law in 1965.[1] The laws governing Medicaid vary depending upon whether the applicant is single or married, receiving services in the community or in a nursing home, and under or over the age of 65. Disabled individuals of any age and individuals over the age of 65 are eligible for Medicaid so long as they meet the financial criteria.[2] As qualifying for Medicaid may require the gifting of assets, individuals without capacity are often the subject of Mental Hygiene Law Article 81 proceedings in which Petitioners ask the courts to apply substituted judgment and to authorize financial transactions in order to accelerate and/or establish eligibility for Medicaid benefits either in the community or in a skilled nursing facility.[3]

On February 8, 2006, President Bush signed into law the Deficit Reduction Act of 2005 (DRA), which contained changes in the manner in which one qualifies for certain Medicaid programs. The first part of these materials details the exempt transfers which have not been altered by the DRA. The second part discusses standard elder law planning for transfers made prior to February 8, 2006. All transfers since that date are subject to the new Medicaid transfer rules as established in the DRA 2005. The last part of this article details the planning opportunities that Guardians may request the courts to authorize since the enactment of the DRA.

II. Exempt Transfers

A. Overview of Medicaid Eligibility

Medicaid is a means-tested program. In order to be eligible for Medicaid, the Medicaid recipient may have no more than $4,150 in countable resources and the waiting period, if any, caused by the transfer of assets must have ended. When an applicant gifts assets to those not protected by statute, the federal government mandates that a penalty period be imposed for institutionalized individuals—and for those receiving a level of care similar to institutionalized individuals—before Medicaid will cover the cost of care.[4] A level of care similar to institutionalized individuals includes services provided under a Medicaid waiver, such as the Lombardi Program/Long Term Home Health Care Program for seniors,[5] and any waivered Medicaid services for those with disabilities under the age of 65.

B. The Home

The home is treated differently from other assets owned by a Medicaid applicant/recipient. The home may be transferred from the Medicaid applicant to certain individuals without incurring any waiting period for Medicaid for the Medicaid applicant. Specifically, the transfer of the home to a spouse[6] or a sibling with an equity interest in the home and who has been residing in the home for at least 1 year immediately before the Medicaid applicant became institutionalized;[7] or to a care-giving child who has resided in the home for at least 2 years immediately before the Medicaid applicant became institutionalized and who provided care to him or her so that he or she did not require institutionalization;[8] or to a child who is blind or disabled;[9] or to a child who is under the age of 21[10] will not incur transfer penalties for Medicaid eligibility.

C. Other Exempt Transfers

When the donees are certain individuals protected by statute, all assets, not only the home, may be gifted to those individuals without penalty. All assets transferred to a spouse,[11] or to a disabled child or to a trust for the sole benefit of a disabled child,[12] or to a trust for the sole benefit of any disabled individual under the age of 65,[13] incur no ineligibility period for Medicaid benefits. In addition, if the individual shows the state that he or she intended to dispose of the assets for fair market value but could not,[14] or that the assets were

transferred exclusively for a purpose other than qualifying for Medicaid,[15] there will be no ineligibility period for Medicaid. Moreover, if all assets transferred for less than fair market value have been returned to the Medicaid applicant,[16] Medicaid will be granted. Lastly, if the State determines that denial of eligibility would cause an undue hardship, endangering the health or life of the Medicaid applicant by denying food, clothing, shelter or other necessities of life, Medicaid also will be granted.[17]

D. Community Medicaid

Those residing in the community who do not require institutional level of care will be eligible for the Community Medicaid program without incurring any waiting period caused by the transfer of assets.[18] Once an individual has no more than $4,150 in countable assets he or she will be eligible for community Medicaid services that include prescription drugs, home health care attendants and hospitalizations for up to 30 continuous days.[19]

III. "Prudent Medicaid Planning" Prior to the Deficit Reduction Act of 2005

A. Individuals—Nursing Home Care

To be eligible for Medicaid in a nursing home, an applicant must have retained resources no greater than $4,150. He or she may also have a prepaid funeral. Prior to the enactment of the DRA, those with capacity were able to gift assets and, after any applicable waiting period had passed, would be eligible for Medicaid services.

1. The Ineligibility Period

was calculated by dividing the amount of assets transferred by the average cost of a nursing home in the county in which the applicant resided. For New York City, the average cost of a nursing home is $9,132 in 2006. For Nassau and Suffolk Counties, the average cost of a nursing home is $9,842. Thus, if $100,000 were gifted by the applicant, there would be a waiting period of 10 or 11 months, beginning the month after the transfer of the assets. If $100,000 were transferred in January 2005, a Medicaid application would properly be placed in December 2005 for Nassau-Suffolk, or January 2006 for New York City, so long as he or she had no more than $4,150 in countable resources at that time.

2. Look-back

Upon application, the government was entitled to "look back" at all financial transactions made by the applicant within the 36 months prior to application,[20] or 60 months for transactions involving trusts.[21] If transfers were made more than 36 months before applying for nursing home care (or 60 months for transfers to a trust), they were beyond the scrutiny period and the gifted funds no longer created any ineligibility for Medicaid and would not be considered available to pay for the cost of health care so long as no application had been filed during the look-back period.

3. Article 81 of the Mental Hygiene Law and Substituted Judgment

The doctrine of substituted judgment requires a guardian to be guided by the decision the Incapacitated Person (IP) would have made if competent to make the decision for him or herself.[22] After the enactment of Article 81 of the Mental Hygiene Law, with its codification of the doctrine of substituted judgment,[23] and the explicit authority for Guardians to make gifts,[24] Petitioners often requested that Guardians be authorized to implement prudent Medicaid planning. Cases authorized transfers of assets between spouses,[25] and transfers of assets that extended beyond the 3-year look-back period.[26]

4. "Rule of Halves"

Prior to the enactment of DRA, an individual did not have to divest him or herself of all assets prior to entering a nursing home in order to safeguard some funds. Individuals who were about to enter a nursing home or who are already in a nursing home could transfer approximately one-half of his or her assets, resulting in a waiting period for Medicaid benefits. Using the remaining one-half of the funds to pay privately during that waiting period was a standard elder law planning technique. Thus, if an elder law client entered a nursing home with $200,000, and if he or she had income from Social Security of $1,000/month, and if the nursing home cost $10,000/month, the rule of halves was applied as follows: A gift of $100,000 to the children incurred a waiting period of 11 months for Medicaid benefits ($100,000 divided by $9,842 = 10 months, beginning the month after the transfer). During the 11-month ineligibility period, the private pay rate for the facility would be $10,000/month x 11 months, or $110,000. The $100,000 retained, plus the $1,000/month income received x 11 months, or $11,000, would be sufficient to pay privately during the 11 months. At the end of 11 months, the money retained would have been exhausted, and the ineligibility period caused by the gifting of assets would have lapsed. A Medicaid application was properly brought at that time.

5. Article 81 and the "Rule of Halves"

When a nursing home resident no longer had capacity to make these transfers, and if he or she had no alternative available resources, such as a Durable Power of Attorney giving authority to make these gifts, Guardians often sought permission from the courts to apply the "Rule of Halves." The courts found that the transfers of assets to others did not violate public policy, and that incapacitated persons should have the same options with respect to transfers of property that are available to individuals who have capacity. The courts considered what a competent, reasonable person in the same circumstance as the IP would likely do.[27]

As set forth in N.Y. Mental Hygiene Law § 81.21, the court was to consider whether the Incapacitated Person could consent to the gift at this time.[28] If not, the Petitioner must show that the needs of the incapacitated person and any dependents will be met from the assets that will remain after the gifts.[29] The court also must consider whether the proposed donees are the natural objects of the individual's bounty,[30] and whether or not the IP had ever indicated an intent contrary to the proposed transfer,[31] or whether the gift is consistent with a known testamentary or *inter vivos* plan of gifting.[32] By applying these factors, courts often allowed Guardians to transfer assets and to accelerate eligibility for Medicaid.

B. Long Term Home Health Care Program, a/k/a "Nursing Home Without Walls" or "Lombardi"

A home care program is considered a "waivered service" if the normal federal requirements have been waived.[33] As such, eligibility is determined as in nursing home programs and therefore non-exempt transfers of assets will incur a waiting period. Many adult day programs are Lombardi programs. Certain skilled home care services are provided under this program as well.

IV. Provisions Contained in the Deficit Reduction Act of 2005

On February 8, 2006, President Bush signed into law the Deficit Reduction Act of 2005. This legislation changes Medicaid transfer rules for institutional care, i.e., nursing home and waivered community-based programs, and applies to transfers of assets made on or after February 8, 2006.

A. Increase the Look-Back Period to 5 years for all transfers

If a Medicaid applicant applies for nursing home or waivered home care, he or she must now reveal to the government all financial records and documentation involving gifts made on or after February 8, 2006 for 5 years rather than 3 years, whether or not these are transfers to a trust.[34] The difference caused by the new look-back period between the pre-DRA and post-DRA transfers may be seen in the following illustration. If a Medicaid applicant enters a nursing home in March 2009, and made a non-trust transfer of $500,000 in January 2006, a Medicaid application may be brought in March 2009, as the transfer made was more than 36 months before the application will be beyond the look-back, or scrutiny, period of the government. If the transfer is made on or after February 8, 2006, however, the March 2009 application will be denied, as the February 2006 gift is within the new 5-year transfer period and still on the "radar screen." That transfer will remain subject to government scrutiny for five years until February 2011.

B. The Date the Transfer Penalty will Begin

The greatest change in determining Medicaid eligibility involves the commencement of the penalty period for Medicaid caused by the transfer of assets. For transfers made within the look-back period, the transfer penalty period will commence on the LATER of: the month following the month in which the transfer is made (as is the existing law) OR the date on which an individual is BOTH receiving institutional level care (nursing home or waivered home care services) AND who has no excess resources ($4,150) and who has had an application for Medicaid approved but for the transfer penalty. So, if a transfer of $100,000 is made within the 5-year look-back period, the penalty will begin to run at the time the individual first receives institutional level of care AND has no more than $4,150 in available resources. At that time, he or she will file a Medicaid application that will be denied due to the penalty period and the approximate one-year ineligibility period for Medicaid will begin at that time.[35]

C. Calculating the Ineligibility Period

The number of months of ineligibility caused by an uncompensated transfer is still determined by dividing the assets transferred by the average cost of a nursing home in the community.[36]

D. Equity Interest in Medicaid Applicant/ Recipient's Home

If the Medicaid applicant for nursing facility services and other long term care services has more than $750,000 equity in his or her home, then that home will render the applicant ineligible for Medicaid, unless a spouse OR child under 21 OR disabled child is residing in the home.[37] An individual MAY use a reverse mortgage or home equity loan to reduce the equity interest in the home.

E. Planning Opportunities Explicitly Authorized by DRA

1. Annuities: The Medicaid applicant may purchase an annuity that is irrevocable, unassignable, actuarially sound, and that has no deferred or balloon payments, without incurring an ineligibility period for his or her Medicaid benefits so long as the State is named as the remainder beneficiary after a community spouse or minor or disabled child.[38]

2. Promissory Notes, Loans and Mortgages: Funds used to purchase a promissory note, loan or mortgage will not be considered available to pay for an applicant's medical care so long as the note, loan or mortgage is actuarially sound,[39] provides for equal payments during the loan[40] and the term of the note is not self-canceling.[41]

3. Purchase of a Life Estate in Another's House: The DRA explicitly considers the purchase of a life estate in another's house as a transaction for fair market value and not a transfer of assets so long as the Medicaid recipient/applicant resides in the home for at least one year after the date of the purchase of the life estate.[42]

V. "Prudent Medicaid Planning" Post-DRA

A. Asset Preservation Still Possible

Despite the enactment of DRA, the Medicaid transfer rules still present planning opportunities to preserve assets for those in need of long term health care. Transfers of assets to spouses and those with disabilities are still free of transfer penalties as is the transfer of the family home to a caregiving child or a sibling with an equity interest in the home. A senior who will reside in another person's home for at least one year may purchase a life estate in that home without incurring an ineligibility period for Medicaid. Moreover, transfers for community Medicaid and those that are made more than 5 years before one applies for institutional level of Medicaid services will also not affect Medicaid eligibility.

Planning opportunities exist even for those whose circumstances do not allow for exempt transfers. As the government does not impose a transfer penalty when the IP receives full value for funds expended, individuals may enter into care contracts to pay for services rendered by adult children/friends/neighbors who serve as de facto geriatric care managers and caregivers. So long as the contract terms are detailed and the cost of services calculated, the lump sum payment for ongoing and future care should not be considered a transfer of assets that will disqualify an applicant for Medicaid even if the contract was entered into within 5 years of an application for Medicaid.

Even the "rule of halves," though altered, will still be possible. If one has entered a nursing home with, for example, $200,000, and gifts $100,000 to an adult child, post-DRA, the 11-month penalty period will not begin until the senior is "otherwise eligible" for Medicaid, has applied for Medicaid and has an application approved but for the transfer penalty. By creating an income stream with the remaining $100,000, either through a promissory note or annuity that will provide payments at least during the penalty period, the nursing home resident will be eligible for Medicaid *but for* the transfer of the $100,000 to the adult child based upon an application for Medicaid that will approve Medicaid benefits after the 11-month penalty period has passed and then Medicaid will begin to pay for the nursing home.

B. Applications that Guardians May Bring to Preserve Assets Post-DRA

It is anticipated that Guardians will bring applications pursuant to Article 81 of the Mental Hygiene Law to engage in prudent Medicaid planning under the DRA. The following are possible Petitions that the courts will adjudicate:

1. Application to appoint Special Guardian to make exempt transfer of assets to spouse.[43]
2. Application for Appointment of Special Guardian to transfer home to care-giving child or sibling with equity interest upon AIP's entry to nursing home.
3. Application to transfer parent IP's assets to a trust for the sole benefit of disabled child or to a trust for the sole benefit of a disabled friend/ relative under the age of 65.
4. Application to purchase life estate in son/ daughter/niece's home in which IP will reside.[44]
5. Application to transfer all assets of IP to obtain Medicaid home care.[45]

6. Application to transfer one-half of the assets and purchase an annuity or enter into a promissory note with the remaining one-half of the assets for institutionalized IP.[46]

7. Application to transfer assets of IP in the community to obtain Medicaid eligibility for institutional or long term care services after 5 years.[47]

8. Application to enter into a care contract with son/daughter/niece/friend who will provide services for IP during IP's lifetime.

9. Application to enter into contract to obtain reverse mortgage or home equity loan.

VI. Conclusion

In 1988, Congress enacted legislation to prevent the impoverishment of husbands and wives whose spouses required institutionalization for long term health care needs.[48] Congress also enacted legislation at that time that expanded the Medicare program to cover skilled care in skilled nursing homes with benefits renewable annually.[49] This legislation was repealed in 1989, and the problem of paying for long term care persists. In the 21st century, the cost of long term care continues to soar.

The Deficit Reduction Act of 2005 renders asset preservation for those in need of chronic long term care more difficult for all but the wealthy. Planning options still exist, but require transfers of assets at least 5 years prior to the entry to a nursing home; planning through the use of annuities or loans or paying privately during the remaining portion of a 5-year wait if the entire look-back period has not ended prior to needing a nursing home. It is anticipated that Guardians will ask courts to authorize these transactions by continuing the application of the doctrine of substituted judgment codified by the New York State legislature in 1993 when it enacted Article 81 of the Mental Hygiene Law.

Endnotes

1. 42 U.S.C. § 1396 *et seq.*, N.Y. Soc. Serv. L. § 366.
2. N.Y. Soc. Serv. L. § 366.
3. *See, e.g., In re Shah*, 95 N.Y.2d 148, 711 N.Y.S.2d 824 (2000).
4. 42 U.S.C. § 366(5)(d) and the newly enacted N.Y. Soc. Serv. L. § 366(5)(e).
5. N.Y. Soc. Serv. L. § 367-c.
6. 42 U.S.C. § 1396p(c)(2)(A)(i); N.Y. Soc. Serv. L. § 366(5)(e)(4)(i)(A).
7. 42 U.S.C. § 1396p(c)(2)(A)(iii); N.Y. Soc. Serv. L. § 366(5)(e)(4)(i)(C).
8. 42 U.S.C. § 1396p(c)(2)(A)(iv); N.Y. Soc. Serv. L. § 366(5)(e)(4)(i)(D).
9. 42 U.S.C. § 1396p(c)(2)(A)(ii)(II); N.Y. Soc. Serv. L. § 366(5)(e)(4)(i)(B).
10. 42 U.S.C. § 1396p(c)(2)(A)(ii)(I); N.Y. Soc. Serv. L. § 366(5)(e)(4)(i)(B).
11. 42 U.S.C. § 1396p(c)(2)(B)(i),(ii); N.Y. Soc. Serv. L. § 366(5)(e)(4)(ii)(A), (B).
12. 42 U.S.C. § 1396p(c)(2)(B)(iii); N.Y. Soc. Serv. L. § 366(5)(e)(4)(ii)(C).
13. 42 U.S.C. § 1396p(c)(2)(B)(iii); N.Y. Soc. Serv. L. § 366(5)(e)(4)(ii)(C).
14. 42 U.S.C. § 1396p(c)(2)(C)(i); N.Y. Soc. Serv. L. § 366(5)(e)(4)(iii)(A).
15. 42 U.S.C. § 1396p(c)(2)(C)(ii); N.Y. Soc. Serv. L. § 366(5)(e)(4)(iii)(B).
16. 42 U.S.C. § 1396p(c)(2)(C)(iii); N.Y. Soc. Serv. L. § 366(5)(e)(4)(ii)(C).
17. 42 U.S.C. § 1396p(c)(2)(D); N.Y. Soc. Serv. L. § 366(5)(e)(4)(iv).
18. *See* N.Y. Soc. Serv. L. § 366(5)(e)(1)(vi), assessing a look-back period, or scrutiny, only to institutionalized individuals or those receiving institutional level of care.
19. N.Y. Soc. Serv. L. § 366.
20. N.Y. Soc. Serv. L. § 366(5)(d)(vi).
21. *Id*.
22. *See, e.g., In re Florence*, 140 Misc.2d 393, 593 N.Y.S.2d 981 (Surr. Ct., Nassau Co. 1989).
23. N.Y. Ment. Hyg. L. § 81.21.
24. N.Y. Ment. Hyg. L. § 81.21(a)(1).
25. *See, e.g., In re Shah*, 95 N.Y.2d 148, 711 N.Y.S.2d 824 (2000).
26. *In re XX (John)*, 226 A.D.2d 79 (3 Dep't 1998).
27. *See, e.g., In re Daniels*, 162 Misc. 2d 840, 618 N.Y.S.2d 499 (Sup. Ct., Suffolk Co. 1994).
28. N.Y. Ment. Hyg. L. § 81.21(d)(1).
29. *Id.* at (d)(3).
30. *Id.* at (d)(4).
31. *Id*. at (e)(3).
32. *Id*. at (b)(6).
33. 42 U.S.C. § 1396n; 10 N.Y.C.R.R. § 505.21.
34. 42 U.S.C. § 1396p(c)(i)(B)(i); N.Y. Soc. Serv. L. § 366(5)(e)(1)(v).
35. 42 U.S.C. § 1396p(c)(1)(D); N.Y. Soc. Serv. L. § 366(5)(e)(5).
36. 42 U.S.C. § 1396p(c)(1)(E); N.Y. Soc. Serv. L. § 366(5)(e)(5).
37. 42 U.S.C. § 1396p(f); N.Y. Soc. Serv. L. § 366(a)(1)(ii).
38. 42 U.S.C. § 1396p(c)(1)(F),(G); N.Y. Soc. Serv. L. § 366(5)(e)(3)(i).
39. 42 U.S.C. § 1396p(c)(1)(I)(i).
40. *Id*. at (ii).
41. *Id*. at (iii); N.Y. Soc. Serv. L. § 366(5)(e)(3)(iii).
42. 42 U.S.C. § 1396p(c)(1)(J); N.Y. Soc. Serv. L. § 366(5)(e)(3)(ii).

43. An application may contain the following language:

SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF

In the Matter of the Application of X For the Appointment of Special Guardian for Property Management of AIP An Alleged Incapacitated Person	**PETITION TO APPOINT SPECIAL GUARDIAN TO TRANSFER ASSETS TO COMMUNITY SPOUSE** Index No.:

Petitioner, the Community Spouse of AIP, seeks the authorization of the following single transaction pursuant to § 81.16(b):

1. to transfer the home, jointly owned by Petitioner and AIP, solely to Petitioner as well as brokerage accounts solely in the name of AIP valued at $300,000.00 to X, the community spouse of AIP, as an exempt spousal transfer for Medicaid purposes. *See In re Shah*, 95 N.Y.2d 148, 711 N.Y.S.2d 824 (N.Y. 2000). *See also* 18 N.Y.C.R.R. 360-4.10(c)(5), concerning the transfer of assets between spouses.

B. This court should grant the proposed transfer by application of the doctrine of substituted judgment, pursuant to N.Y. Ment. Hyg. L. § 81.21 as follows:

1. N.Y. Ment. Hyg. L. § 81.21(a)(1) authorizes a Guardian to make gifts;

2. As a Medicaid recipient in a skilled nursing facility all of AIP's basic needs will be met. X maintained AIP at home as long as possible, but the combination of his physical needs and mental impairments made it impossible for her to provide sufficient care. In order for AIP to apply for Medicaid, X must execute a spousal refusal.

3. A reasonable person in the situation of AIP would want his devoted wife to own the couple's funds so that he may apply for the Medicaid program.

5. Petitioner believes that AIP does not have the capacity to consent to the proposed transfer.

6. AIP executed a Will which is annexed to the Court's papers and to the Court Evaluator's papers. The terms of this Will are consistent with the proposal to have this court authorize a single transaction to compromise the action to transfer funds to X.

7. AIP provided for his wife and 9 children. AIP and X shared all expenses and decision-making as a happy, unified husband and wife.

44. An application to purchase a life estate may contain the following language:

In the Matter of the Application of X For the Appointment of a Special Guardian for Property Management of AIP An Alleged Incapacitated Person.	**PETITION TO APPOINT SPECIAL GUARDIAN FOR PROPERTY MANAGEMENT AND TO ENTER INTO CONTRACT TO PURCHASE A LIFE ESTATE IN PETITIONER'S HOME**

Implement the Plan to have AIP reside with Petitioner and to purchase a life estate in the home of X:

1. To enter into contract to purchase for AIP with her share of the proceeds of the estate of JOHN DOE a life estate in the real property of X, located at _____. Petitioner intends to have AIP reside with her and her family and to avoid having her aunt placed in a skilled nursing home. This plan is set forth more fully herein below in Paragraph TENTH, *infra*.

TENTH: The plan is to have AIP purchase a life estate in the real property of X, located at _____. This home is appraised at $500,000. Appraisal annexed hereto as Exhibit D. AIP will reside with your Petitioner at the house in _____. AIP is 87-years-old, and her life estate is valued at 32% of the home's value as set forth on a chart utilized by the Medicaid agencies, annexed hereto as Exhibit E.

Pursuant to the Deficit Reduction Act of 2005, the purchase of a life estate is not a transfer of assets for less than fair market value for Medicaid purposes if AIP resides in the home for at least one year after purchasing the life estate. AIP will no longer be a Medicaid recipient upon the sale of the home and receiving its proceeds. X will secure private live-in care for her aunt to retain her aunt in Petitioner's home as long as she can be maintained there safely.

45. An application to transfer assets for home care may contain the following language:

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF

In the Matter of the Application of X For the Appointment of a Guardian for Property Management of AIP An Alleged Incapacitated Person.	**PETITION TO APPOINT GUARDIAN AND TO ENGAGE IN MEDICAID PLANNING BY GIFTING THE HOME TO THE CARETAKING CHILD AND TO GIFT ASSETS FOR COMMUNITY MEDICAID AND TO AUTHORIZE PENSION TO BE PLACED INTO NYSARC COMMUNITY TRUST II FINANCIAL RESOURCES OF AIP**

FIFTH: The assets of the AIP include: the real property located at _____(of which she was Co-Owner), and accounts totaling approximately $126,000. Deed and Financial Statements annexed hereto as Exhibit A. AIP receives Social Security of $705/month and a Pension of $687/month. She worked for the New York City Department of Social Services.

PRUDENT MEDICAID PLANNING

SIXTH: The Community Medicaid Program imposes a penalty period only for institutional waivered Medicaid benefits. Petitioner intends to retain his mother in her home as he has done for the past ten (10) years. He has resided in this home continuously for the past ten (10) years and returned home in order to care for both his mother and his father. Petitioner thus seeks to transfer the liquid assets, approximately $126,000 to the two living children of AIP, as consistent with the Last Will and Testament of AIP, annexed hereto as Exhibit B. AIP explicitly did not provide for the issue of her predeceased

son nor for her predeceased son after his demise. He died on January 1, 2000 and the Will was executed on January 1, 2001.

Petitioner will maintain AIP at home but needs additional assistance in caring for her. Hence, the application to transfer the liquid assets to preserve them and to access the Medicaid program.

Petitioner asks that the home be transferred to him as the care giving child. Should AIP require nursing home care then the transfer of the home to the care giving child also would not preclude Medicaid eligibility for AIP in a skilled nursing facility. Consent of sibling of X, annexed hereto as Exhibit C.

In order for AIP not to have a monthly income spend-down, petitioner seeks to place AIP's pension income monthly into NYSARC Community Trust II. There is no ineligibility for Medicaid unless the AIP becomes institutionalized. As petitioner will not have AIP enter a skilled nursing facility and will continue to care for her as he has for the past several years, the proposed placing of the monthly income into the NYSARC Community Trust II, with the Trustee to pay bills of the AIP in order to maintain her in the community, is in the best interest of the AIP.

46. An application to use a promissory note or annuity with one-half of the assets not gifted may contain the following language:

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF

In the Matter of the Appointment of X and XX as Co-Guardians for Property Management and Personal Needs of IP	**PETITION TO EXPAND POWERS TO ENGAGE PRUDENT MEDICAID PLANNING BY ENTERING INTO PROMISSORY NOTE & RULE OF HALVES** Index No.:

REQUEST TO ENGAGE IN PRUDENT MEDICAID PLANNING

NINTH: In order to PRESERVE ASSETS AND ENGAGE IN PRUDENT Medicaid planning, petitioner seeks the authority to gift one-half (1/2) of assets of the IP held in the Guardianship account, or $250,000, to be divided equally between the Co-Guardians. The Petitioners then propose to begin the ineligibility period for Medicaid by borrowing the remaining one-half (1/2) of the assets at four percent (4%) annually at a term not to exceed the life expectancy of IP. Based on the IRS table, the IP, 82 years of age, has a life expectancy of 4.5 years. The proposed promissory note will pay for 3.25 years. The number of months of ineligibility for Medicaid in a skilled nursing facility caused by the transfer of assets is calculated by dividing the assets gifted, $250,000 by the average cost of a nursing home in Nassau County ($9,842), resulting in a twenty-five (25)-month wait for Medicaid beginning the month after the transfer. The private rate at NH is $11,000 per month. The Medicaid reimbursement rate is $9,000 per month.

Pursuant to the Deficit Reduction Act of 2005, the penalty period for Medicaid eligibility will begin when an institutionalized individual is otherwise eligible for Medicaid and has made an application for Medicaid that is accepted but for the penalty period. An individual is otherwise eligible for Medicaid when he or she has available assets below $4,150 and income below the Medicaid reimbursement rate. A loan agreement is not an available resource so long as it will issue payments in an actuarially sound manner.

By entering into a promissory note that will return $250,000 at four percent (4%) annually, or $282,500 over 39 months, or $7,243.59/month, the ineligibility period caused by gifting $250,000 will have begun.

TENTH: Although IP does not have the capacity to make this proposed transfer, due to her lack of capacity, the proposed transfer is in accordance with the intent of IP to provide for her heirs. IP has two (2) children. They are her heirs-at-law and are the named beneficiaries of her Will.

A competent person in the position of IP would wish to preserve assets to the extent possible. The funds that are the subject of the instant application come from an inheritance payable to the IP. The proposed disposition of the assets to the natural objects of her bounty and the accompanying promissory note will preserve assets for the IP's heirs. The IP's nursing home care during the 25 months of ineligibility for Medicaid will be paid by the monthly income of the promissory note as well as a voluntary contribution from X and XX to subsidize the difference between the Medicaid reimbursement rate and the private rate at the NH. As the promissory note will pay $7,243.59/month, and as IP's Social Security is $1,000/month, X and XX will pay, voluntarily, $2,857/month until IP is eligible for Medicaid in 25 months.

47. An application to transfer assets and leave sufficient funds to pay privately for the full look-back period may contain the following language:

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF

In the Matter of the Application of

X For the Appointment of a Special Guardian for Property Management AIP An Alleged Incapacitated Person	**PETITION TO APPOINT SPECIAL GUARDIAN AND TO ENGAGE IN PRUDENT MEDICAID PLANNING BY TRANSFERRING BEYOND LOOK-BACK**

PLAN FOR AIP

A. PRUDENT MEDICAID PLANNING

NINTH: The funds of the AIP, $1,250,000, are the elective share that she received upon the death of her spouse. AIP resides at NH as she needs ongoing assistance and full-time assistance. In order to qualify AIP for the Medicaid program, petitioner seeks the authority to gift $750,000 to AIP's five children and to use the remaining assets to pay privately at _____ Skilled Nursing Facility for the full five (5)-year look-back period.

Although the number of months of ineligibility for Medicaid in a skilled nursing facility caused by the transfer of assets is calculated by dividing the assets gifted ($750,000) by the average cost of a nursing home in _____County ($9,842), for Suffolk, resulting in a 75-month ineligibility for Medicaid, the government looks only at transactions that have occurred within 60 months of applying for benefits. Thus, the

ineligibility period for Medicaid caused by the gifting of assets needs be no more than 60 months in the case of AIP.

During the 60 months of private pay at NH, at a cost of approximately $12,000/month, AIP will spend $720,000 for her care. She has $4,000/month in income, or $240,000. When added to $550,000 that will remain available to pay for the care, the funds retained will be more than sufficient to pay for the private rate at NH until she has Medicaid eligibility.

B. DOCTRINE OF SUBSTITUTED JUDGMENT

Although AIP does not now have the capacity to make the proposed gift, the proposed gift is in accordance with her testamentary intent to provide for her children equally. A competent person in the position of AIP would wish to preserve assets to the extent possible for her loving family. The funds that are the subject of the instant application come from the family savings after the death of her husband and the sale of her home. The proposed disposition of the assets is to her heirs-at-law, the natural objects of her bounty, as consistent with her Last Will and Testament. AIP was a loving mother who provided for her family. Although AIP did not routinely gift large sums to her family, the proposed gift as a means of asset preservation when facing the cost of long term care accomplishes the longtime goal of AIP, set forth in her Last Will and Testament, to provide for her family to the extent allowed by law. AIP never showed a contrary intent than the proposed transfer.

48. 42 U.S.C. § 1396p(c).
49. 42 U.S.C. § 1395(d).

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The Impact of the Deficit Reduction Act of 2005 on Long-Term Care Insurance and the New York State Partnership for Long-Term Care

By Charles J. Newman CLU

The Deficit Reduction Act of 2005 (DRA) dramatically expands the current Partnership insurance programs (heretofore limited to four states: California, Connecticut, Indiana, and New York) by allowing Partnership programs to be enacted in every state. Specific provisions must be in place for the new Partnership policies per the National Association of Insurance Commissioners Model Act and Model Regulations which were adopted in October 2000. Partnership policies must include federal tax qualification, consumer protections, and benefit inflation provisions.

The long-term care insurance (LTCI) partnership program was developed to encourage people who might otherwise turn to Medicaid to finance their long-term care to purchase LTCI. If people who purchase qualifying Partnership policies deplete their insurance benefits, they may then retain a specified amount of assets (or an unlimited amount in the case of The New York State Partnership for Long-Term Care's Total Asset program) and qualify for Medicaid Extended Coverage.

Post-DRA, and the corresponding widening of the Partnership programs, the government's message is clear: *Don't count on being able to obtain Medicaid in order to finance your long-term care needs unless you first take care of your long term health care with private insurance.*

In making Partnership policies more widely available and in increasing Partnership insurance policy flexibility, the DRA should stimulate sales of LTCI and may in the long run eliminate the rationale for purchasing "non-Partnership" policies. However, non-Partnership policies still can play a role. One strategy involving non-Partnership policies has the policyholder obtaining *at least* a **5-year** benefit period policy in order to cover the look-back period. If the policyholder needs long-term care during the look-back period, the policy is available to pay benefits. After 5 years have passed, the client may or may not wish to continue to hold the LTCI policy. One reason to purchase the non-Partnership policy: potential lower premium cost since inflation coverage is not mandated (as it is in Partnership coverage).

According to the "The National Underwriter" (May 29, 2006) 16 states have passed legislation permitting the new Partnership programs. Three others are currently studying such legislation. Insurance companies will be slow to introduce the new DRA-style Partnership policies, however, as they are awaiting guidelines from the U.S. Department of Health and Human Services' Centers for Medicare & Medicaid Services.

Common Partnership Policy Features per the DRA

The new Partnership policies will share the following basic features per Public Law §§ 109–171 dated February 8, 2006:

1. **Dollar-for-Dollar Asset Protection**—If a participant has a daily benefit amount of $250/day and a benefit period of 1,095 days, their *initial* (prior to any inflation increases) basis for asset protection would be $273,750 ($250 x 1,095).

   (Sec. 6021(a)(1)(iii) "Qualified State long-term care insurance partnership means an approved State plan amendment under this title 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…")

2. **Inflation Protection**—Ages 0 to 60 must have "compound annual inflation protection." Ages 61 to 75 must have "some level" of inflation protection. Ages 76 and above "may but are not required to" provide some level of inflation protection.

   (Sec. 6021(a)(1)(iii)(IV)(aa,bb,cc)

3. **Agent Training—**Certification requirements for agents to sell partnership policies will be determined by each state.

   (Sec. 6021(a)(1)(iii)(V) "The State Medicaid agency under section 1902(a)(5) provides information and technical assistance to the State insurance

department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.")

4. **Uniformity with Non-Partnership Policies in State:** Partnership policies are to be the same as tax-qualified policies in any given state. National Association of Insurance Commissioners (NAIC) model regulation compliance is required. This means that (among other criteria) the policies must be guaranteed renewable or non-cancelable, there can be no post-claims underwriting, they must be suitable for the purchaser, etc.

   (Sec. 6021(a)(1)(iii)(VI)(vi))

Reciprocity

The DRA also calls upon the Department of Health and Human Services to establish reciprocity standards by "not later than January 1, 2007."

The objective of such reciprocity is to have "uniform reciprocal recognition of such policies among States with qualified State long-term care insurance partnerships under which (1) benefits paid under such policies will be treated the same by all such States; and (2) States with such partnerships shall be subject to such standards unless the Secretary of State in writing for said state advises of the State's election to be exempt from such standards"

Information Clearinghouse

One of the goals in Partnership expansion is increased consumer education and awareness. As part of the new law, a National Clearinghouse for Long-Term Care Information is being created to educate consumers about long-term care under Medicaid and to "provide contact information for obtaining State-specific information on long-term care coverage, including eligibility and estate recovery requirements under State Medicaid programs." Three million dollars has been appropriated on an annual basis (until 2010) for this purpose.

Another goal of the Clearinghouse is to provide potential buyers of LTCI with "objective information to assist consumers with the decision making process for determining whether to purchase long-term care insurance or to pursue other private market alternatives for purchasing long term care and provide contact information for additional objective resources on planning for long term care needs."

The Clearinghouse is also charged with maintaining a list of states with long-term care partnerships that "provide reciprocal recognition of long-term care insurance policies issued under such partnerships."

Undoubtedly, the Clearinghouse's information-sharing efforts will be heavily augmented by the LTCI insurers own advertising and marketing efforts. Prior to DRA, the public may have shied away from purchasing LTCI due to the perception that Medicaid would be available to them for long-term care needs.

According to the April 2004 Congressional Budget Office Report (www.cbo.gov), "The more people save or the more insurance they purchase, the less likely they are ever to qualify for Medicaid benefits. Thus, people who buy insurance pay more than just the premiums; they also give up the value of future Medicaid benefits for which they might have been eligible." The CBO went on to say that "As people's expectations about federal assistance changed, they might purchase private LTC insurance or set aside additional savings to prepare for the possibility of future long-term care needs."

By promoting Partnership LTCI programs, the DRA addresses the "give up" issue cited in the CBO report. Now, by proactively purchasing Partnership LTCI for a future long term care need, consumers will be opening a gateway to Medicaid benefits and at the same time protecting a significant portion of their assets. Government (via the Clearinghouse) and insurance industry efforts to provide information about Medicaid eligibility under DRA will undoubtedly drive LTCI sales as "expectations of federal assistance" are changed.

Per CBO, private insurance payments for LTC services rose from about $700 million in 1995 (0.8 percent of all such expenditures) to "about $6 billion" in 2004 (about 4 percent of total expenditures (see Table 1-2)). LTCI policies written on an annual basis rose from approximately 300,000 in 1988 to more than 700,000 by 2001. America's Health Insurance Plans (formerly the Health Insurance Association of America) notes that about 8.3 million policies were sold from 1987 through 2001; with a persistent (still in force) percentage of about 70 percent (see Figure 1-2).

Table 1-2

Long-Term Care Expenditures for the Elderly, by Source of Payment, 2004

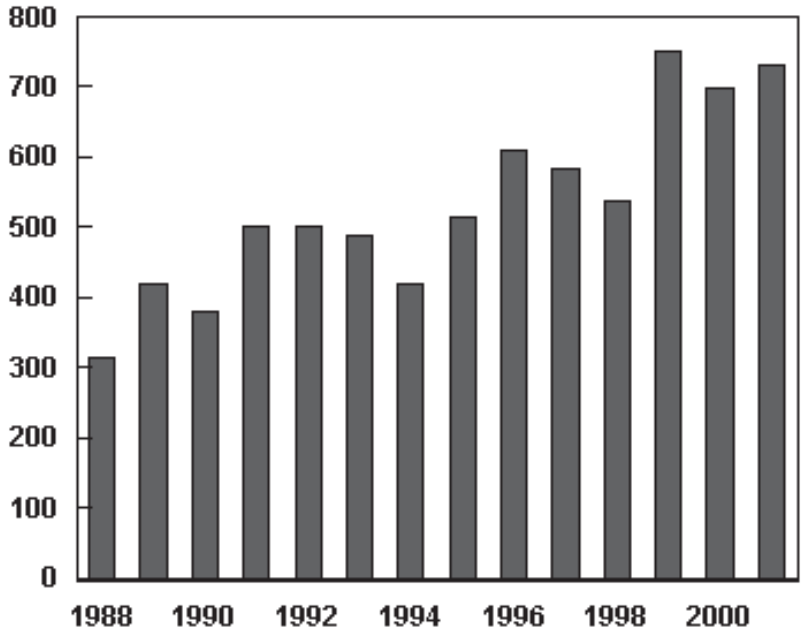
(Billions of dollars) Payment Source	Institutional Care	Home Care	Total
Medicaid	36.5	10.8	47.3
Medicare	15.9	17.7	33.6
Private Insurance	2.4	3.3	5.6
Out of Pocket	35.7	8.3	44.0
Other	2.0	2.5	4.4
Total	92.4	42.5	134.9

Source: Congressional Budget Office.

Figure 1-2

Long-Term Care Insurance Policies Sold, 1988 to 2001

(Thousands)



Source: Congressional Budget Office based on data from America's Health Insurance Plans (formerly the Health Insurance Association of America)

Post-DRA changes in New York State Partnership for Long-Term Care

The New York State Partnership for Long-Term Care (www.nyspltc.org) has made it possible for participating Partnership insurers to offer both the new "Dollar-for-Dollar Asset Protection" policies called for by the DRA as well as "Total Asset Protection" policies which allow New York consumers unlimited asset protection when applying for Medicaid Extended Coverage.

Per the "Consumer Participation Agreement" for the New York State Partnership for Long-Term Care's Total Asset Plan (Section B.3, p. 3): "Because resources are not counted in determining eligibility for Medicaid Extended Coverage, Participating Consumers are free to use their resources in any way, including making gifts or otherwise transferring away ownership of resources. This is true even if the resource generates income which otherwise would be counted in determining eligibility for Medicaid Extended Coverage."

In essence, even if the look-back period is now 5 years, a Total Asset Plan under the New York State Partnership (which by definition has a 3-year benefit for nursing home care and up to 6-year benefit for home care) *a Participating Consumer who has claimed on their policy and exhausted policy benefits can now move assets out of their name if they wish without triggering a period of ineligibility.* This is a huge impetus for the use of Partnership policies in planning for long-term care needs.

NYS Partnership Policy Comparison (Accessed via www.nyspltc.org July 14, 2006)

Core benefits

These benefits must be offered by **all** participating insurers as part of **all** plans.

- Nursing home care
- Home care
- Home health care
- Personal care
- Assisted living care
- Skilled nursing care
- Adult day care
- Respite care (14 nursing home equivalent days per year)
- Care management (2 days of long-term care planning services by a professional)
- Alternate level of care
- Nursing home bed reservation (20 days per year)
- Hospice care
- Inflation protection equal to 5% compounded annually

Optional benefits

These benefits may be in addition to the core benefits and may increase the premium costs.

- Waiver of premium
- Combined home care benefit
- Independent provider benefit
- Non-licensed/non-certified provider benefit (not offered as part of the Dollar-for-Dollar 50 and Total Asset 50 policies)

Planning Options in a Post DRA World

	Minimum Policy Duration	Maximum Policy Duration	Minimum Daily Benefit Allowances (2006)	Home Care Benefit	Maximum Elimination Period
Total Asset 50 **3/6/50**	3 years Nursing Home Care or 6 years of Home Care	Unlimited	NH = $189 HC = $95	Home care DBA is 50% of the Nursing Home Care DBA (daily benefit allowance)	100 days
Total Asset 100 **4/4/100**	4 years Nursing Home Care or 4 years Home Care	Unlimited	NH = $189 HC = $189	Home care DBA is equal to the Nursing Home DBA (daily benefit allowance)	100 days
Dollar-for-Dollar 50 **1.5/3/50**	1.5 years Nursing Home Care or 3 years Home Care	2.5 years Nursing Home or 5 years Home Care	NH = $189 HC = $95	Home care DBA is 50% of the Nursing Home Care DBA (daily benefit allowance)	60 days
Dollar-for-Dollar 100 **2/2/100**	2 years Nursing Home Care or 2 years Home Care	2.5 years Nursing Home Care or 2.5 years Home Care	NH = $189 HC = $189	Home Care DBA is equal to the Nursing Home DBA (daily benefit allowance)	60 days

Dollar-for-dollar plans with benefits for as few as 1.5 years of nursing home care and 3 years of home care, or 2 years of either nursing home care or home care will have lower premiums than the current Total Asset plans (which have either 3, 4, 5 or 7 year nursing home benefits). In reducing the benefit year requirement, the new Partnership plans will allow consumers to purchase private insurance that can eventually allow them to obtain Medicaid Extended Coverage benefits.

In reducing and reshaping the Partnership minimum coverage requirements and in allowing for the corresponding reduction of Partnership LTCI premiums, more consumers will find Partnership LTCI affordable. The consumers who purchase Partnership LTCI will also find a new way to avail themselves of Medicaid without concern for look-back periods and asset levels.

New flexibility in Partnership LTCI plan design, for instance the lack of a requirement for built-in compound inflation over age 60, will allow for Partnership LTCI policies to be purchased with dramatically lower premiums than the Partnership policies which have been available to date. Consumers will now be able to purchase Partnership LTCI policies with limited benefits (and lower premiums) as an alternative to the purchase of non-Partnership policies.

As more insurance agents become familiar with the new policy choices being offered through New York State Partnership for Long-Term Care participating insurers, sales of Partnership LTCI will grow and may even supplant those of non-Partnership policies. When Partnership policies with equivalent benefits and premiums to non-Partnership policies are available, and when they have the added bonus of allowing the consumer to participate in Medicaid Extended Coverage after policy benefits have been exhausted, the rationale for the purchase of many non-Partnership policies will be eliminated. (As noted on p. 1, some seniors may employ the strategy of purchasing at least a 5-year benefit period, non-Partnership policy with no inflation protection in order to lower premiums and cover asset transfers during the look-back period.)

Since assets can be moved and even changed into non-income producing assets under the Total Asset New York State Partnership Plan, consumers would be well advised to consider this coverage as part of an overall asset protection strategy.

Charles J. Newman CLU, Principal of The Charles J. Newman Co., LLC, Hawthorne, N.Y., is an independent insurance agent maintaining agent and brokerage relationships with more than four dozen insurance companies. He provides a full range of individual insurance plans (Life, Disability, Long-Term Care, Annuities) to his clients as well as Employee Benefit programs.

Personal Service Contracts: An Underutilized Tool

By Antonia J. Martinez

Introduction

In light of the significant changes brought about by the Deficit Reduction Act of 2005 (DRA),[1] every client receiving services from family members should know about a Personal Service Contract. Personal Service Contracts have been used by elder law practitioners in the states of Florida and Washington since 1996.[2]

Their broader use is overdue. Practitioners ought to consider drafting Personal Service Contracts whenever a relative is providing care to an elderly loved one and where the goal is to transfer assets. Many families provide extensive services for their elders with personal care, financial management, and healthcare management. These services are often provided free of charge, even though they can be labor intensive and time consuming. Personal Service Contracts can reduce an elder's assets while compensating family members who provide those services.

What Is a Personal Service Contract?

A Personal Service Contract is a written agreement between two or more parties in which one or more of those parties promise to provide personal and/or managerial services in exchange for market rate compensation paid by the party receiving those services. A Personal Service Contract is similar to an employment contract in that future services are to be rendered in exchange for an agreed-upon sum.

For families caring for their elderly loved ones, providing such services for consideration and without a contract is not recommended. Without a formal agreement, the law presumes the caretaker to perform the services for love and affection without compensation. Absent tangible evidence, asset transfers from the elder to the caregiver will likely result in the denial of a Medicaid application.[3] The only way to avoid this presumption is for a caregiver and an elder to formalize that relationship by entering into an arm's-length contract.

Medicaid Eligibility

All asset transfers for less than fair market value within the "look-back period" will render the Medicaid applicant ineligible to receive Medicaid nursing home benefits. The "look-back period" for any transfer made on or after DRA enactment on February 8, 2006 is 60 months.[4] The "look-back period" for assets transferred before the enactment of the DRA is 36 months generally, and for transfers to a trust, 60 months.[5]

Gifts or uncompensated transfers made by a Medicaid applicant result in a period of ineligibility, during which time the Medicaid applicant is ineligible to receive benefits. But a "transfer" during the "look-back" period is proper when made for fair market value or other valuable consideration. Thus, a Medicaid applicant who enters into a Personal Service Contract and pays fair market value for services will not be rendered ineligible for doing so.

Planning Benefits

1. Medicaid

For a Personal Service Contract to withstand Medicaid scrutiny, it should not only be in writing, but should spell out clearly the duties, responsibilities and compensation for all parties. With a properly drafted contract, money transfers from the elder to the caregiver are not a gift, and no ineligibility period results from making such a transfer.

2. Estate Planning

The Personal Service Contract can be an effective gift and estate tax savings mechanism. When an elder desires to transfer funds exceeding the annual exclusion amount[6] to a caregiver, the Personal Service Contract can do so without incurring any gift tax liability. Similarly, a Personal Service Contract can reduce an elder's estate tax liability. Entering into such a contract accomplishes these goals, and passes assets to an elder's intended heirs, avoids probate, and increases his or her ability to obtain governmental benefits. Payments made pursuant to a Personal Service Contract are not gifts and are not includable in an estate for estate tax purposes.

Drafting Tips

1. Specificity of Services and Responsibilities

To obtain Medicaid eligibility, the contract must spell out in detail the duties and responsibilities of each party, including the services to be performed. These duties and responsibilities can include healthcare management, personal needs assessment (recreation, social, hygiene and personal care), financial management, lodging (meals, laundry), and personal errands.

2. Term

To qualify for Medicaid, the term of a Personal Service Contract should be for the statistical life expectancy of the elder. To determine the life expectancy, use the actuarial publications of the Office of the Chief Actuary of the Social Security Administration. These tables are available at www.ssa.gov/OACT/STATS/table4c6.html.

If qualification for Medicaid in the near term is not a primary goal, a limited term contract is an alternative. Note that any retained assets adversely affect eligibility for nursing home Medicaid.

3. Arrive at Contract's Fair Market Value

To determine the contract's value, first determine the caregiver's annual salary. To do so, use the following calculation:

Estimated Hours Per Week
x 52 Weeks
x Hourly Market Value of Services Provided
= Annual Salary

Determine the value of the contract by multiplying the annual salary by the years of the contract's term, usually the elder's life expectancy.

The following examples illustrate how changing the hourly rate or the number of hours a caregiver provides can significantly change the contract's value. In each case the elder is an eighty (80)-year-old male whose life expectancy is 7.31 years.[7] But each example results in very different contract values because of 1) the hourly rate charged and 2) the number of hours provided.

Example A: Caregiver works full time and assists the elder on a part-time basis. The caregiver provides four (4) hours per week of financial and healthcare management at the rate of $25 per hour, and ten (10) hours per week of personal care at the rate of $15. In this example, the caregiver earns $100 per week or $5,200 annually for managerial services, and $150 per week or $7,800 per year for personal care services. For the estimated 7.31 years of the contract, $38,012 represents the value of the contract's managerial component and $57,018 represents the value of the contract's personal service component. The entire contract is valued at $95,030.

Example B: The caregiver agrees to care for the elder in his home for a three-year period and on a full-time basis. It is anticipated that the elder will reside in an assisted living facility or nursing home in three years but the caregiver will continue to provide managerial services even after elder leaves caregiver's home. The caregiver provides four (4) hours per week of financial and healthcare management at the rate of $60 per hour, and twenty-four (24) hours per day (less the four (4) hours of financial and health care management) or one hundred and sixty-four (164) hours per week of personal care at the rate of $15.

In this example, the caregiver earns $240 per week or $12,480 annually for managerial services, and $127,920 per year for personal care services. For the 7.31 year period of the *managerial* component, $91,228 represents the contract's value; and $383,760 represents the *personal service* component. The entire contract is valued at $474,988. In this example, if the elder applies for Nursing Home Medicaid benefits within five (5) years of the payment for the services, the applicant would be required to show that 24-hour care was necessary for the three-year period.

4. Assigning a Value to a Particular Service

The contract should assign a value no greater than market rate compensation. To determine the market rate of personal care services, contact several health care agencies in the area where the elder resides and ascertain their hourly rate for personal services. If, for example, the fee for personal services charged by a local agency ranges between $18 and $24 per hour, any figure between those two figures is an appropriate market rate. Similarly, to determine the value of managerial services, contact several geriatric care managers who service the elder's area of residence and ascertain their fees. Assigning below market rates to a Personal Service Contract will result in greater value to the elder.

The contract should also distinguish between managerial services (such as managing the elder's healthcare and finances) and personal services (such as feeding, providing ambulatory assistance, shopping, and similar services). The compensation should be attributed to, and appropriate to, the service provided. For example, the compensation for laundering, a personal service, should not be the same as healthcare management, a managerial service.

Other Considerations

1. Payroll Taxes and Employee Coverages

Compensation received by the caregiver constitutes income, must be reported by the caregiver, and is subject to income tax. This can result in negative tax consequences to the caregiver when payment is made in a lump sum, particularly if the caregiver is in a high tax bracket. Unemployment taxes should be paid. In addition, the caregiver must be provided Workers' Compensation and New York State Disability coverage.

2. Payment Options

a. A *lump sum* payment is the preferred option for the elder, because doing so results in an immediate asset transfer without penalty, and the amount transferred is no longer an available asset to the elder for Medicaid eligibility. For estate tax purposes, monies transferred also reduce the elder's taxable estate. Any claim by Medicaid that there should be a discount for advance payment can be countered by the fact that there is no increase in the hourly rate over the term of the contract.

b. *Multiple payments* may be considered when the caregiver does not want a lump sum payment. Even then, consider doing so in two payments: one before December 31; one after January 1.

c. *Real estate* may be used as a form of payment, so long as the value transferred corresponds to the fair market value of the services provided. To make such a transfer, the elder must obtain an appraisal of the fair market value of the property being transferred pursuant to the Personal Service Contract. The appraisal should be as of, or as close to, the date of contract execution. Because the value of real estate owned by the elder will usually substantially exceed the value of the personal services contract, consideration should be given to a Note and Mortgage reflecting the payment for the contract. Any such Mortgage should be immediately recorded. Note that any such mortgage will also serve to reduce the equity if the value of the elder's home exceeds $750,000.

d. Make payment to an *escrow agent*. An escrow agent is a third party who holds the elder's transferred assets and pays a fixed sum on a regular basis to the caregiver. This is a good option if there are doubts as to the caregiver's integrity or willingness to provide services for elder's lifetime. It is also a good option for the caregiver who doesn't wish to take a lump sum payment, but where the elder may need to apply for Medicaid benefits in the near future, and the elder's assets disqualify him or her from eligibility. A lump sum transfer from the elder to the escrow agent pursuant to the contract will legitimately reduce the elder's assets and will not result in a penalty period.

3. Multiple Caregivers

If more than one family member is providing care or managerial services for an elder, draft a contract that takes each caregiver's work into account. If only one family member has been doing all the work, other family members (in consultation with the elder) may perform tasks included in the contract. This may avoid inter-family resentment.

In addition, the contract should provide for a substitute caregiver if the primary caretaker is unavailable to perform his or her duties because of vacation, illness, death, or disability. When drafting the contract, decide who will be responsible for paying the substitute caregiver. If you know at the outset, for example, that caregiver will take two weeks annual vacation, set aside the sum representing the amount of annual leave, and transfer those funds to an escrow agent. Alternately, an elder who wishes to further reduce assets may want to provide the caregiver with a paid two week vacation, and set aside additional funds to pay a substitute caregiver.

Practical Considerations

1. Written Log Kept by Caregiver

The caregiver providing services should keep a detailed log of services rendered. Those records should show what services have been performed, by whom, and when. Details of services provided are properly the subject of examination at a Fair Hearing.

2. Family Meeting

When only one party is assigned as caregiver, family members may become resentful. A good practice is to have a family meeting and explain why a particular caregiver was selected. As noted above, such family members can be given an opportunity to contribute and receive compensation.

3. Power of Attorney

Problem: The agent named in a Durable Power of Attorney may also be the closest and most trusted member of the elder's family, and overseeing the elder's day-to-day activities. If so, such an agent may also be the best candidate to serve as a caregiver in a Personal Service Contract. However, when the named agent in a Durable Power of Attorney seeks to enter into a contract with himself or herself, a conflict of in-

terest can arise, including determining an appropriate salary for such personal services.

Solution: Each Durable Power of Attorney should include a paragraph authorizing the agent to also enter into a Personal Service Contract with himself or herself. For example:

This DURABLE POWER OF ATTORNEY also includes the power to enter into a personal services agreement on my behalf with any person, including the attorney-in-fact;

Similarly, the Durable Power of Attorney form should also provide for the agent to be paid for services rendered. For example:

This DURABLE POWER OF ATTORNEY also includes the power to compensate attorney(s)-in-fact for services performed by such agent(s) at the rate of $ (insert amount) per hour;

4. Advocacy in Medicaid Applications

There is a likelihood that when submitting a Medicaid application, the assigned caseworker will be unfamiliar with Personal Service Contracts. You must summarize the law for the caseworker, including a summary of the leading New York case addressing Personal Service Contracts, *In re the Appeal of Jerome Carolla*.[8]

Reported Cases

1. New York

In *Carolla*, the elder entered into a Personal Service Contract with son and daughter for $150,000, and one year later entered a nursing home. The contract specified a charge of $15 per hour for personal care services 24 hours per day and $20 per hour for financial management services. The contract also charged the elder for monthly room and board.

The decision held that while services provided by family members to an elder are presumed to be uncompensated, a Personal Service Contract rebuts that presumption and is tangible proof of legitimate compensation for services, reversing a contrary determination by the Department of Social Services. The case was remanded to determine whether the Medicaid applicant truly required 24-hour care during the period in question and to ascertain the services actually provided by the caregivers. This case also illustrates the importance of keeping detailed records by the caregiver.

A Personal Service Contract rebuts a presumption that personal care services are uncompensated. Thus, a transfer of assets for fair market value shows the intent of the parties and that compensation is in exchange for the services provided. A contract which is in proper form and delineates specific services, rights and duties of the parties will be upheld.

2. Florida

Even those elders who reside in a healthcare facility may have their lives enhanced by contracting a family member's intervention and assistance. In *Thomas v. Florida Department of Children and Families*,[9] a Personal Service Contract was upheld even though elder resided in a nursing home. The State of Florida argued that the services provided pursuant to the contract were duplicative in nature since shortly after entering into the contract, elder resided in a nursing home. There the Florida appellate court found "both federal law and the Department's own regulations provide that a transfer of assets shall not render a Medicaid applicant ineligible for benefits, if he or she can establish that 'the individual intended to dispose of the assets either at fair market value, or for other valuable consideration.'" 42 U.S.C. § 1396p(c)(2)(C)(I).

Conclusion

Every client receiving services from family members should know about a Personal Service Contract. When properly structured, it is an effective means to obtain Medicaid eligibility, transfer money to loved ones, and reduce a client's taxable estate.

SAMPLE PERSONAL SERVICE AGREEMENT

This AGREEMENT is made this day of , 2006, by and between

(MOTHER) and (DAUGHTER).

RECITALS

A. Mother currently resides at 2000 East Main Street, Peekskill, New York 10566. At this time Mother lacks transportation access and needs personal support and maintenance services for her care, safety, advocacy and comfort for the duration of her lifetime.

B. Mother needs assistance while residing in a skilled nursing facility.

C. Mother needs someone to oversee her care at Westledge Health Care Facility on a weekly basis to ensure that she is receiving adequate care.

D. Without provision of such services Mother will lack necessary and essential care, aid, advocacy, comfort and support.

E. As of the date of this contract, Mother is seventy-five (75) years of age and her life expectancy, pursuant to the Social Security Actuarial Tables, is 11.97 years.

F. Mother wishes to have Daughter provide services under this contract including management, review and supervision of Mother's medical care, nursing services, physical and occupational therapy, pharmaceutical necessities, and anything related to Mother's health care and well-being; financial management; errands; and companionship.

G. Mother knows that Daughter does not have to perform these services and that hiring these services on the open market would be costly.

H. Both parties recognize that the services performed by Daughter are not rendered gratuitously and therefore wish to manage this relationship in a business-like fashion.

NOW THEREFORE, in consideration of the promises, the mutual covenants and the payments to be made and accepted by Daughter ($61,454), the value and sufficiency of which the parties acknowledge to be good and valuable, commensurate with the services to be performed and fair market value, **THE PARTIES AGREE AS FOLLOWS:**

I. PURPOSE

The purpose of this Agreement is to set forth the terms and conditions under which Daughter will provide services to Mother.

II. TERM OF AGREEMENT

Services To Be Rendered

Except as provided in this Agreement, the term of this Agreement will commence on the _____ day of January, 200__, and will continue in full force and effect until the death of Mother.

Any services provided prior to the date of the Personal Service Contract are presumed to have been rendered gratuitously. Thus, a Personal Service Contract should not include payment for services already rendered.

III. SERVICES TO BE PERFORMED BY DAUGHTER

This agreement is for services only. There is no obligation of Daughter to be financially responsible for Mother or to pay for any costs of Mother's care or support. Mother contracts to receive and Daughter agrees to furnish Mother with the services and incidentals specified below over the lifetime of Mother, on an "as needed basis," provided that Mother performs the obligations imposed upon her under this contract.

A. Supervision of Personal Care

Daughter will arrange and manage Mother's ongoing personal care according to Mother's needs. That includes:

a) Daughter will monitor Mother's health status, physical and mental condition and well-being on a regular basis.

b) Daughter will ensure that Mother's personal care needs are attended to satisfactorily, including but not limited to bathing, dressing, hair care, eating, care of clothing.

c) Daughter will arrange or make necessary changes to Mother's personal care plan in the event Mother's personal care needs are not being met to the satisfaction of Mother or Daughter.

B. Supervision of Medical Care

Daughter will arrange and manage Mother's ongoing medical care according to her needs. That includes:

a) Daughter will monitor Mother's health status, physical and mental condition and well-being on a regular basis.

b) Daughter will ensure that Mother's medical needs are tended to satisfactorily including but not limited to medical care, dental care, podiatry, ophthalmology, chiropractic, physical therapy, occupational therapy, skilled long-term nursing care, pharmaceutical care.

c) Daughter shall attempt to secure qualified health care professionals, including doctors, nurses, nurse's aides, therapists, and any other health care professionals to aid in diagnosis and treatment of Mother's health, physical and emotional status as may be deemed necessary due to illness, discomfiture or mental health as found to exist from time to time.

d) Daughter will arrange necessary changes to Mother's medical care plan in the event Mother's medical care needs are not being met to the satisfaction of Mother or Daughter.

e) Daughter will monitor Mother's living arrangements. She will recommend and properly place Mother in nursing homes or other environments

necessary for Mother to receive a necessary continuum of care. Daughter will monitor the care provided at the facilities, and if necessary, seek to relocate Mother to a facility that can better meet the needs of Mother.

f) Daughter will be in constant contact with personnel and administration of the nursing home where Mother will be a resident to maintain quality of care, services and resident rights. Daughter will, as appropriate, attend care plan meetings at the facility at which Mother resides.

C. Financial Management

Daughter will oversee Mother's bank accounts and assets to the extent Mother will make such information available to Daughter. Daughter will monitor Mother's accounts and finances. Daughter will assist with payment of periodic bills and expenses, balancing her checkbook, all banking transactions, filing medical insurance claims, application for medical benefits, and similar matters. Daughter will provide necessary assistance to the attorney or other person submitting any application for Medicaid Benefits, including furnishing or obtaining any necessary documents and other information requisite to the application process.

D. Intermittent Personal Care

1. Daughter agrees to accompany Mother out to lunch twice monthly as long as Mother is able to do so.

2. Additionally, Daughter agrees to take Mother to her home once a year to stay overnight as long as Mother's physical condition permits her to do so. For each such visit, Daughter agrees to:

a) provide Mother with three (3) nutritionally balanced meals per day. Special diets will be provided if ordered by a licensed physician;

b) arrange any necessary personal assistance for Mother including but not limited to bathing, dressing, and eating, walking and transferring;

c) assist Mother in carrying out physicians' instructions and reminding Mother to take prescribed medications.

3. Daughter agrees to accompany Mother to receive necessary medical care, dental care, podiatry, ophthalmology, chiropractic, physical therapy, occupational therapy, pharmaceutical care, and any other type of care required by Mother.

E. Amenities

Daughter will provide Mother with entertainment, hobby, recreational, social and physical activity commensurate with Mother's ability to pay for same and her needs, capabilities and wishes, including but not limited to radio, audio tapes, books-on-tape, telephone and visitations by family and friends.

F. Support and Maintenance

Daughter will generally provide support and maintenance services as detailed above and in general for Mother as and when needed, utilizing Mother's funds made available therefore. Should Mother have no funds or should Mother run out of funds, Daughter is under no obligation to pay for same.

G. General Support

In addition to the above, Daughter will arrange for family outings and gifts if possible.

IV. OBLIGATIONS OF MOTHER

A. Reimbursement for Expenses

Mother will reimburse Daughter for purchases and disbursements made by Daughter on behalf of Mother while performing errands, shopping, transportation to or from doctors' appointments, and similar matters.

B. Compensation of Daughter

Mother will compensate Daughter as provided in this agreement.

V. INCOMPETENCE OF MOTHER

It is expressly understood and agreed by both Mother and Daughter that Mother desires that Daughter perform these services. In case of Mother's incompetence, this contract will remain in full force and effect.

VI. COMPENSATION AND RECORD KEEPING

A. Hourly Rate

Mother and Daughter agree that Daughter will be compensated for her services and all services performed under the authority of this contract, whether or not specified in any particular clause of this document. Mother and Daughter agree that Guardians appointed by a Court for an incompetent ward who perform the services noted above receive compensation. The parties further agree that: Geriatric Care Managers who perform such services on a contractual basis normally receive between $95 and $125 per hour for their professional services; and accountants who provide financial management and bookkeeping services receive be-

tween $65 and $200 per hour for their professional services. Mother and Daughter agree that the minimum value of Daughter's services, if Mother were required to purchase similar services from a service provider as of the date of this contract under paragraphs III. a., III. b. and III. c., ranges from $65 to $200 per hour. It is stipulated that Daughter shall receive $25 per hour under paragraphs III. a., III. b. and III. c. Mother and Daughter agree further that the minimum value of Daughter's services, if Mother were required to purchase similar services from a service provider as of the date of this contract under paragraph III. d., ranges from $10 to $20 per hour. It is stipulated that Daughter shall receive $15 per hour under paragraph III. d.

B. Amount of Hours

The services to be performed by Daughter are to be furnished on an "as needed" basis over the lifetime of Mother. Therefore, the hours that Daughter will in fact spend in performance of her duties will vary from time to time over such lifetime. At times it may be necessary for Daughter to perform in excess of sixteen (16) or more hours per month and at times less than that. Regardless, the parties stipulate that over the lifetime of Mother, it is expected that the average time which Daughter will spend will be at least sixteen (16) hours per month.

C. Payment

Accordingly, Mother agrees to pay Daughter a lump sum of $60,328 at the time of signing this contract ($300 per month or $3,600 per year as reasonable compensation for services rendered under III. a., III. b., and III. c; $1,080 per year for services provided under paragraph III. d, and $360 per year for services provided under paragraph VI (iv)).

1. Life Expectancy

11.97 years is the life expectancy of Mother, born on April 15, 1928, 75 years of age as of the date of this contract, based on the Social Security Actuarial Tables. This contract and the services to be performed is for the lifetime of Mother, which could be more, the same or less than the life expectancy stated above of 11.97 years.

2. Financial Management and Health Care Management

$ 3,600 per year is payment for services related to financial management and healthcare management, including supervision of health and personal care services derived from the following formula:

Hourly Rate: $25

Expected weekly hours: 3

Expected number of hours per month: *12[10]

Expected number of hours per year: 144

$25 X 12 = $300 X 12 = $3,600

$3,600 X 12.05 years = $43,380

3. Personal Care Services

$1,080 per year is payment for services related to personal care services according to the following formula:

Hourly Rate: $15

Expected monthly hours: *4

Months in the year: 12

$15 X 4 = $60 X 12 = $720

$720 X 12.05 years = $8,676

4. Annual Twenty-Four Hour Visit

Once annually, Mother will visit the home of Daughter for a twenty-four hour period.

Hourly Rate: $15

Hours in a year: 24

$15 X 24 = $360

$360 X 11.97 years = $4,338

D. Changes in Monthly Care Fees

Daughter and Mother may by mutual agreement adjust the monthly fees specified in Section VI. Any adjustments shall be based on projected costs, prior year costs and economic indicators.

E. Records

Daughter will keep records of her services and will keep an accounting of all payments made by Mother for these services. Mother may request that accounting at any time from Daughter.

VII. Independent Contract

By this Agreement, Daughter will act only as an independent contractor. Daughter is not to be considered an agent or employee of Mother for any purpose. Daughter will be responsible for reporting all state, federal, and local taxes, including estimated taxes and employment reporting for Daughter. Daughter shall be responsible for providing Workers' Compensation and New York State Disability Insurance coverage for all services with respect to this contract.

VIII. Vacation/Time Away

Daughter will receive a minimum of two weeks relief from her duties under this Agreement. Daughter will arrange for another person to cover any periods when she will be absent for more than one week.

IX. Government Benefits

Nothing in this Agreement will prohibit Mother from applying for and obtaining any and all applicable federal, state, county or local benefits, including but not limited to Medicare, Medicaid, SSI, etc.

X. Construction of Agreement

Section headings are for convenience and reference only and are not to be used in construing this contract. If any part of this contract is found to be void or voidable for any reason, that section will be considered severable and struck from this Agreement and the remainder of the Agreement will continue in full force and effect.

XI. TERMS OF AGREEMENT

This Agreement will be in effect and the parties will be bound to the terms of this Agreement upon payment to Daughter as stated above and will continue in full force and effect until the death of Mother. In that event, no refund of any kind will be due and owing to Mother's estate regardless of when Mother dies. Daughter will retain the full amount of any and all payments made to her by Mother up to the time of her death.

XII. Applicable Law

This agreement shall be governed by and construed according to the laws of the State of New York.

DECLARED AND AGREED to on this _____ day of , 2006.

_____ _____

Mother Daughter

NEW YORK UNIFORM ACKNOWLEDGMENTS

STATE OF NEW YORK)

: ss.:

COUNTY OF WESTCHESTER)

On the _____ day in _____ of the year 2006 before me, the undersigned, a Notary Public in and for said State, personally appeared _____ and _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose names are subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

_____

Notary

VARIATION PERSONAL SERVICE AGREEMENT

The contract below provides a variation for the elder's intermittent personal care, payment to the caregiver in two payments rather than a lump sum, and provides payment for services rendered exceeding normally scheduled hours of care due to special circumstances.

d. Intermittent Personal Care

1. Niece agrees to accompany Aunt out of her residence to visit family for five or six hours every other week, as long as Aunt's physical condition permits her to do so. For each such visit, Niece agrees to:

a) provide Aunt with two (2) nutritionally balanced meals per day. Special diets will be provided if ordered by a licensed physician;

b) arrange any necessary personal assistance for Aunt including but not limited to bathing, dressing, eating, walking and transferring;

c) assist Aunt in carrying out physicians' instructions and reminding Aunt to take prescribed medications.

2. Niece agrees to accompany Aunt to receive necessary medical care, dental care, podiatry, ophthalmology, chiropractic, physical therapy, occupational therapy, pharmaceutical care, and any other type of care required by Aunt.

VI. Compensation and Record Keeping

a. Cash Compensation

Aunt and Niece agree that Niece will be compensated for her services and all services performed under the authority of this contract, whether or not specified in any particular clause of this document. Aunt and Niece agree that the minimum value of Niece's services under paragraph III. a., III. b. and III. c., if purchased in the open market, would range from $85 to $125 per hour as of the date of this contract .

Aunt and Niece agree further that the minimum value of Niece's services under paragraph III. d., if pur-

chased on the open market, would range from $10 to $20 per hour as of the date of this contract.

i. Financial Management and Health Care Management

Aunt will pay Niece $7,200 per year (or $600 per month) as payment for services related to financial management and health care management, including supervision of health and personal care services under III. a., III. b., and III. c. derived from the following formula: 14.66 years is the life expectancy of Aunt, born on November 21, 1932, 71 years of age as of the date of this contract, based on the Social Security Actuarial Tables.

Hourly Rate: $25

Expected weekly hours: 6

Expected number of hours per month: *24

Expected number of hours per year: 288

$25 x 288 = $7,200 per year

$7,200 x 14.66 years = $105,552

ii. Personal Care Services/Visits Outside of Aunt's Home

Aunt will pay Niece $1,980 per year (or $165.00 per month) for services related to personal care services provided under paragraph III. d. according to the following formula:

Hourly Rate: $15

Expected monthly hours: 11

Months in the year: 12

$15 x 132 = $1,980 per year

$1,980 x 14.66 years = $29,026.80

iii. Payment Schedule

Aunt and Niece agree that a lump sum payment in the amount of $____ will be made at the time of signing this contract. The balance owed under this contract will be due on December 2006. (Please remember to structure the payments so that the December 2006 payment does not cover any services provided before the payment date.)

b. Changes in Monthly Care Fees

Niece and Aunt may by mutual agreement adjust the monthly fees specified in Section VI. Any adjustments will be based on projected costs, prior year costs and economic indicators.

c. Records

Niece will keep records of her services and will keep an accounting of all payments made by Aunt for these services. Aunt may request that accounting, at any time, from Niece.

Endnotes

1. Public Law 109-171 (2006).
2. See Scott M. Solkoff, *Personal Service Contracts for the Elderly Revisited*, ( ) pages 18–21 for a discussion of cases in the states of Florida and Washington.
3. 96 ADM-8, p. 12.
4. Public Law 109-171, § 6011(a).
5. Social Services Law § 366.5 (d)(1)(vi).
6. $12,000 in 2006.
7. Social Security Administration Actuarial Tables. The DRA requires the use of these tables in lieu of the tables in HCFA Transmittal 64 and 96 ADM-8.
8. Fair Hearing No. 3565848H, Feb. 20, 2002.
9. 707 So.2d 954, 955 (4th Dist. Ct. of Appeals 1998).
10. *For Medicaid budgeting purposes, there are $4^{1}/_{3}$ weeks per month. For simplicity of math, we have used 4 weeks per month in this example.

Antonia J. Martinez, Esq., devotes substantially all her professional time to Trusts & Estates and Elder Law matters. Ms. Martinez has been active in the Westchester County Bar Association, serving as both Co-Chair and Vice-Chair of the Elder Law Committee. She is a member of the Executive Committee of the New York State Bar Association Elder Law Section and member of its subcommittee on Power of Attorney Legislation, a member of the National Academy of Elder Law Attorneys, and speaker at CLE programs. Her article, "The 529 Plan: A Well-Kept Secret," was published in Volume 34, Number 3 of the Fall 2001 publication of the *Trusts and Estates Law Section Newsletter* and the *Elder Law Attorney* of the New York State Bar Association, Fall 2001 issue. Antonia J. Martinez is a 1982 graduate of Harvard Law School.

New York Case News

By Judith B. Raskin

Medicaid

Appellant, an income beneficiary of an irrevocable trust, argued that her Medicaid application should not be denied because she transferred only a remainder interest which shortened her penalty period. Appeal denied. *Luscomb v. NYS Dept. of Health*, 2006 slip op. 2426; 813 N.Y.S.2d 239; 2006 N.Y. App. Div. LEXIS 3801 (App Div. 3d Dep't March 30, 2006).

Helen Luscomb's application for Medicaid institutional benefits was denied because she transferred $140,000 to an irrevocable trust which made her ineligible for 23 months. She unsuccessfully appealed the decision in a fair hearing and then lost an article 78 proceeding. She had argued that because she kept an interest income in the trust assets she only transferred a remainder interest, which had a value considerably less than $140,000. She then appealed to the Appellate Division.

The Appellate Division affirmed. The decision below was a reasonable interpretation of federal guidelines and therefore cannot be overturned. The transfer to the trust created an equitable life estate which is different from a legal life estate. A legal life estate vests title in someone during life and title passes to another on death. Here the title was given to the trustee and the petitioner did not have ownership but rather a beneficial interest. To decide otherwise would eliminate the difference between a trust and a life estate.

Claimant DSS brought an action to recover against a refusing spouse who transferred assets after his wife's Medicaid application was approved. DSS then moved to amend its complaint to include allegations of fraudulent transfers. Motion to amend complaint granted. *Sherman v. Wontrobski*, 2006 slip op. 50801U; 11 Misc. 3d 1090A; 2006 N.Y. Misc. LEXIS 1058 (Sup. Ct., Nassau County May 4, 2006).

The Department of Social Services ("DSS") brought an action against Mr. Wontrobski for contribution to his wife's nursing home care. Mr. Wontrobski had submitted a statement of spousal refusal at the time of his wife's application for Medicaid and approximately two years later transferred substantial assets to his children and to an irrevocable trust. DSS claimed that the defendant made these transfers to avoid his obligation to satisfy the claim made by DSS for contribution.

This decision was on a motion by DSS to, inter alia, add Mr. Wontrobski's children as defendants and amend its complaint to include two additional causes of action and supporting information including details of alleged fraudulent transactions and cites to relevant sections of the Debtor-Creditor Law.

The Court granted the requested amendments. Leave to amend should be liberally granted if "the amendment is not palpably insufficient, does not prejudice or surprise the opposing party, and is not patently devoid of merit."

Article 81

Respondents in an article 81 proceeding moved for a copy of the Petition. Granted. *In re Stuart G. and Paul G.*, 2006 N.Y. slip op. 26094; 2006 N.Y. Misc. LEXIS 483 (Sup. Ct., Nassau County March 8, 2006).

Petitioners are two sons of the alleged incapacitated person seeking the appointment of a guardian for their father. The respondents are the AIPs' ex-wife and another son. Pursuant to the recent amendment to article 81, the complete set of pleadings is to be served only upon the AIP, the Court Evaluator and the Attorney for the AIP. Respondents are to receive only a copy of the Order to Show Cause and Notice of Proceeding with a summary of the allegations in the Petition, the object of the proceeding and the relief requested.

The Respondents moved for a copy of the Petition. They argued that the Petition contained allegations and requested relief that affected their personal and property rights which entitles them to "full and specific" notice to prepare a response.

The Court ordered that the plaintiff serve a copy of the Petition on the respondent's attorney. While the statute was amended to protect the privacy of the AIP, there are a few situations that warrant an exception. In this case, the respondent ex-wife had previously initiated a proceeding to appoint a guardian for the AIP but withdrew her petition. That petition contained personal and financial information that the ex-wife was already privy to. Therefore, the information in the instant Petition will not cause "undue humiliation

and embarrassment" to the AIP. The court denied the request for sanctions against the Petitioner's attorneys as they were complying with the statute and it was appropriate to require court approval. The court said service of the Petition on respondents will be granted on a case-by-case basis.

The Alleged Incapacitated Person appealed from a decision appointing her sons as her co-guardians based upon the court's admission of her treating physician's testimony. Denied. *In re Bess Z.*, 2006 slip op. 1809; 813 N.Y.S.2d 140; 2006 N.Y. App. Div. LEXIS 2858 (App. Div. 2d Dep't March 14, 2006).

The Supreme Court appointed a guardian for Bess Z. upon petitioner's presentation of clear and convincing evidence that a guardian was necessary pursuant to the requirements of article 81. Bess Z. appealed based upon the admission of the testimony of her treating physician which she contended was a violation of the doctor-patient privilege. The petitioners argue that Bess Z. put her medical condition in issue.

The Appellate Division affirmed. Bess Z. did not waive her doctor-patient privilege by putting her medical condition in issue. However, the Court heard sufficient testimony to establish Bess Z.s' inability to care for her personal and financial needs.

Article 81 guardian petitioned for an order *nunc pro tunc* to make gifts. *Nunc pro tunc* order denied, gifting authorized in reduced amount. *In re Sandra*, 2006 slip op. 26263; 2006 N.Y. Misc. LEXIS 1712 (Sup. Ct., Tompkins County June 22, 2006).

Sandra, an article 81 guardian, petitioned for an order to make gifts of her uncle Rolland's assets *nunc pro tunc* to September 2005 to his two surviving sisters who were the beneficiaries under his will and his distributees. Rolland's living expenses were estimated at $60,000 per year and he had assets of $352,000 and $558 monthly Social Security.

The Court authorized gifting in the amount of $30,000 to each sister. The Court noted the new Medicaid 5 year look-back period and determined that Rolland would not have sufficient funds to pay his expenses for 5 years if the full $60,000 were gifted to each sister. In addressing the *nunc pro tunc* request, the court can only sign an order *nunc pro tunc* to correct ministerial errors. The court distinguished the cases cited by petitioner where gifts were authorized *nunc pro tunc*. Those cases were only contested by DSS, whereas in this case the attorney for Rolland opposed the petition and the petitioners in those cases did not seek to avoid the consequences of a change in the law.

The subject of an Article 17A proceeding moved to dismiss claiming violation of physician-patient privilege. Physician-patient privilege affirmed, motion for dismissal denied. *In re Derek*, 2006 N.Y. slip op. 26248; 2006 N.Y. Misc. LEXIS 1598 (Surr. Ct., Broome County June 27, 2006).

Derek's parents petitioned to be his Article 17A guardians. Derek, 22 years old, suffered severe injuries from an assault in 2003. Derek's attorney moved to dismiss the petition because Derek's treating physician and the supervising psychiatrist at the hospital where Derek was a patient submitted affirmations and relied upon his hospital records. Derek's attorney argued that this violated his physician-patient privilege. The court noted that the application of physician-patient privilege in an Article 17A proceeding was a matter of first impression in New York.

The Court held that the physician-patient privilege does apply in Article 17A guardianship proceedings and the physician's affirmations were stricken. The right of equal protection applies. There is no reason why the privilege should be protected in Article 81 proceedings but not Article 17A proceedings.

However the Court denied the motion to dismiss. Reports of non-treating physicians and other evidence, including testimony regarding Derek's behavior, may provide sufficient evidence to support the need for an Article 17A guardian.

Power of Attorney

Beneficiary under will sought return of funds transferred under a power of attorney with expanded gifting provision. Granted. *In re Ferrara*, 2006 N.Y. LEXIS 1759; 2006 N.Y. slip op. 5156 (Ct. of Appeals, June 29, 2006).

George Ferrara lived in Florida, never married and had no children. He executed a will leaving his estate to the Salvation Army. When he became ill he signed a Florida durable power of attorney appointing his brother and his nephew, both living in New York, as his agents. When George Ferrara was in a very weakened condition he came to New York. His brother and nephew brought him a new durable power of attorney with an added authority to "make gifts without limitation in amount to John Ferrara and/or Dominick Ferrara." George Ferrara died one month after executing the last power of attorney with the expanded gifting provision. Prior to George Ferrara's death, Dominick Ferrara transferred over $1.1 million to himself. The Salvation Army learned of the above events and commenced

a proceeding in Surrogate's Court for discovery and turnover of the funds.

The Surrogate's Court dismissed the petition, finding that because the power of attorney was executed post 1997 the presumption of impropriety no longer existed and the Salvation Army did not show that the transfers were invalid. The Court noted that gifts by agents under a power of attorney for less than $10,000 must be made in the best interest of the principal and the court suggested that the legislature require the same standard for larger gifts. The Appellate Division affirmed, saying that while the presumption of impropriety does still exist, Dominick Ferrara had overcome it with evidence that the gifts were the wish of the decedent as stated in the power of attorney.

The Court of Appeals reversed. The best interest standard for gifts under paragraph M (under $10,000) applies as well to gifts under an additional paragraph expanding paragraph M. Such added provisions with increased gifting amounts are merely a supplement to the basic form and are not an opportunity to avoid the protections of the statute. Dominick Ferrara made gifts to himself that in no way benefited his uncle and in fact contradicted his estate plan.

Judith B. Raskin is a member of the law firm of Raskin & Makofsky. She is a Certified Elder Law Attorney (CELA); and maintains memberships in the National Academy of Elder Law Attorneys, Inc., the Estate Planning Council of Nassau County, Inc., and NYS and Nassau County Bar Associations. She is the current chair of the Legal Advisory Committee of the Alzheimer's Association, Long Island Chapter.

MOVING?
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Notify OCA and NYSBA of any changes to your address or other record information as soon as possible!

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Advance Directive News

The Tale of Two Terrys

By Ellen G. Makofsky

They are both named Terry: pronounced the same but spelled differently. They share similar stories with different outcomes and implications for health care decision-makers.

Terri Schiavo was 26 years old when she suffered a heart attack as a result of a potassium imbalance. The heart attack and ensuing loss of oxygen resulted in brain damage so severe that she never regained consciousness and was unable to care for herself. Among other things, she was unable to eat or swallow and was kept alive by means of a feeding tube. She was diagnosed as being in a persistent vegetative state with no hope of recovery.[1] Terri Schiavo lived in various nursing homes and required constant care from the date of the original heart attack in 1990, until her death on March 31, 2005.

Michael Schiavo, Terri's husband, and Terri's parents, the Schindlers, had differing views about her condition. Michael Schiavo believed that there was no hope that Terri would emerge from the persistent vegetative state. Pursuant to that belief, Michael Schiavo petitioned the guardianship court in Florida to authorize the discontinuance of artificial life support in 1998. Terri's parents did not accept the diagnosis of a persistent vegetative state and took the position that if Terri were afforded intense therapy she would recover. Consequently, the Schindlers opposed the withdrawal of the artificial nutrition and hydration. A torrent of litigation ensued between Michael Schiavo and the Schindler family. Michael Schiavo advocated for his position believing Terri would never recover and the Schindlers promoted their position denying that Terri was indeed in a persistent vegetative state. The acrimonious disagreement between Terri's husband and her parents received national exposure and spawned a bitter lawsuit, attempted an end run around the courts with legislation passed by the Florida legislature, and received the attention of the President of the United States. There was heartache on all sides. One could both understand the position of Michael Schiavo and empathize with the Schindler family who did not want to let go of their daughter.

But there is another Terry story which is part of this tale. According to *The New York Times*,[2] Terry Wallis was 19 years old when the pickup truck he was riding in slid off a bridge and landed upside down in a dry river bed. The accident, which occurred in 1984, left Terry Wallis alive but unresponsive and unable to move. Initially, the doctors advised that he had no chance of recovery and described Terry as a person in a persistent vegetative state. Some months later, however, doctors adjusted their initial conclusion about Terry and he was diagnosed as a person in a minimally conscious state. A minimally conscious state is a diagnosis given to those who are severely brain damaged but who are occasionally responsive. Sporadically, a person in a minimally conscious state is responsive to the extent that he can use his eyes to track objects, and can blink or make small movements in response to commands.

After the initial hospitalization following the accident, Terry spent the next 19 years in a nursing home. Family members visited and felt that Terry exhibited a sense of awareness of his surroundings and his visitors. Family members felt that he seemed to brighten when they entered the room. His face seemed expressive depending on the situation.

No one, however, expected what happened next. After an unresponsive 19 years, Terry Wallis uttered the word "Mom" at the sight of his mother. Ever so gradually he was able to speak in simple sentences, although he remained immobile and was barely able to move. Terry remained disabled but he resumed his own persona and became recognizable as Terry Wallis. With the return of Terry's ability to speak and formulate simple thoughts, Terry was transferred from the nursing home to his parents' home where he receives home care around the clock.[3]

Dr. Nicholas Schiff, a neuroscientist at Weill Cornell Medical College, has studied a series of scans of Terry's brain as part of a research project he is conducting. Dr. Schiff's investigation showed new growth in various parts of Terry's brain which correspond to some of the skills he has regained.[4]

The research of Dr. Schiff and his team raises the possibility that in time, doctors will have the ability to determine whether patients with severe brain damage have an actual chance to recover. Medical technology may soon make the job of the surrogate health care decision-maker easier in that the health care decision could be made in the context of knowing with some

certainty what the medical outcome would be. Such knowledge would go very far in helping settle disputes in cases like the *Schiavo* case.

Endnotes

1. The *New England Journal of Medicine* defines a persistent vegetative state as "a clinical condition of complete unawareness of the self and the environment, accompanied by sleep-wake cycles, with either complete or partial preservation of hypothalamic and brain-stem autonomic functions." New Eng. J. Med. 1994 May 26; 330(21):1499-508.
2. Benedict Carey, "Long Sleep Over, He Helps Reveal Brain's Mysteries," *The New York Times*, p. A 1, col. 1.
3. *Id.*, July 4, 2006, SA, at 12, col. 2.
4. *Id.*, July 4, 2006, SA, at 12, col. 4.

Ellen G. Makofsky is a *cum laude* graduate of Brooklyn Law School. She is a partner in the law firm of Raskin & Makofsky with offices in Garden City, New York. The firm's practice concentrates in elder law, estate planning and estate administration.

Ms. Makofsky serves as Chair of the Elder Law Section of the New York State Bar Association ("NYSBA"). She has been certified as an Elder Law Attorney by the National Elder Law Foundation and is a member of the National Academy of Elder Law Attorneys, Inc. ("NAELA"). Ms. Makofsky serves on the Executive Board of the Estate Planning Council of Nassau County, Inc., is the immediate past co-chair of Senior Umbrella Network of Queens, has served as co-chair of the Long Island Alzheimer's Foundation ("LIAF") Legal Advisory Board and is a past president of the Gerontology Professionals of Long Island, Nassau Chapter. She is the former co-chair of the Senior Umbrella Network of Nassau and serves on the Board of Directors of Landmark on Main Street.

Ms. Makofsky has spoken on the radio and television and is a frequent guest lecturer and workshop leader for professional and community groups.

New York State Bar Association
Elder Law Section
2007 Call for Nominations

The Nominating Committee of the Elder Law Section is soliciting nominations for candidates for Section officers, District Delegates of the 1st, 3rd, 7th and 10th Judicial Departments and 3 Member-At-Large positions.

The Committee seeks nominees who have shown an interest in and commitment to Section activities. Nominations may be made either by the nominee or by a third party. Nominations should include an overview of the nominee's education, practice, Section activities, local Bar Association activities, speaking engagements, honors received, if any, and activities with organizations serving the elderly and persons with disabilities.

The Nominating Committee will announce the slate of nominees on the Section's website by December 1, 2006. By January 10, 2006, other qualified nominees may be added to the ballot by petition of at least 15 Elder Law Section members. Such nominations shall be sent to Daniel Fish, Chair, Nominating Committee, c/o Lisa Bataille via email at lbataille@nysba.org or by mail to One Elk Street, Albany, NY 12207, or fax to (518) 487-5579.

New officers will be elected at the Annual Meeting of the Elder Law Section on January 23, 2007, and will begin serving their terms on June 1, 2007.

Please transmit nominations to NYSBA Section Staff Liaison, Lisa Bataille via email at lbataille@nysba.org or by mail to One Elk Street, Albany, NY 12207, or fax to (518) 487-5579. All nominations will be forwarded to Daniel Fish, Chair of the Nominating Committee.

Guardianship News

By Robert Kruger

Medicaid Liens Redux

Seven years ago, the New York State Court of Appeals ruled in *In re Calvanese*, 93 N.Y.2d 111, 672 N.Y.2d 410 (1999), that Medicaid law required that a preexisting Medicaid lien be paid in full prior to funding a supplemental needs trust. The Court had previously ruled, in *In re Cricchio v. Pennisi*, 90 N.Y.2d 296, 660 N.Y.S.2d 679 (1997), that the preexisting Medicaid lien had to be satisfied prior to funding the supplemental needs trust. *Calvanese* ruled that "satisfied" meant "payment in full."

Now, to the satisfaction of Charley and Joan Robert and the author (I argued *Calvanese* and Charley Robert argued the companion case, *Callaghan*), not to mention the trial lawyers, who now have another arrow in their quiver, the Supreme Court of the United States speaketh. And for a change, the decision goes our way.

The case is *Arkansas Dept. of Health and Human Services v. Ahlborn* decided May 1, 2006. In *Ahlborn*, the Supreme Court ruled that only that portion of a recovery, by verdict or settlement, that represented compensation for past medical expenses, is available to pay the Medicaid lien.

Ahlborn's case was settled for $550,000 and the Medicaid lien was $215,645.30. The Agency did not participate, nor ask to participate, in the settlement negotiations, but the Agency did assert its lien.

Surprisingly, Ahlborn and the Agency stipulated that the settlement represented 1/6 of the reasonable value of Ahlborn's claim and, if Ahlborn prevailed, the Agency would be entitled to 1/6 of $215,645.30, or $35,581.47.

In rejecting the Agency's claim for reimbursement in full, the Court noted that 42 U.S.C. § 1396k(c)(1)(A) requires Medicaid recipients to assign to the Agency any rights "to payment for Medical care," not their rights to payment for, e.g., lost wages.

The Court ruled that 42 U.S.C. § 1396a(a)(25)(B), which requires the states to seek reimbursement for medical assistance to the extent of the legal liability of third parties, refers to medical assistance only, not other elements of damages in a personal injury claim. Again, interpreting 42 U.S.C. § 1396a(a)(25)(H), which requires states to enact laws giving them the right to recover from legally responsible third parties, the Court limited the States recovery to medical expenses alone, not other elements of damage in a personal injury claim.

The Court found the Agency's position to be squarely in conflict with the anti-lien provision of federal Medicaid law (42 U.S.C. § 1396p(a)(1)), which prohibits states from imposing liens on the property of Medicaid recipients prior to death on account of medical assistance paid to the recipient.

The Court rejected the Agency's argument that Ahlborn lost her rights to this property the instant she applied for Medicaid because that argument is inconsistent with Medicaid's statutory lien. Medicaid would not need a lien on its own property.

The Court noted that the risk to the Agency that the parties to a personal injury action can allocate away the Agency's interest can be avoided either by obtaining the Agency's advance agreement to an allocation or by submitting the matter to the Court for an allocation decision.

Once again, I invite letters and comments from the bar and the judiciary. I can be reached at 225 Broadway, Suite 4200, New York, NY 10007, phone number: (212) 732-5556, Fax: (212) 608-3785 and E-mail address: *RobertKruger@aol.com.*

Robert Kruger is the Chair of the Committee on Power of Attorney Legislation, Elder Law Section of the New York State Bar Association. Mr. Kruger is an author of the chapter on guardianship judgments in Guardianship Practice in New York State (NYSBA 1997) and Vice President (four years) and a member of the Board of Directors (ten years) for the New York City Alzheimer's Association. He was the Coordinator of the Article 81 (Guardianship) training course from 1993 through 1997 at the Kings County Bar Association and has experience as a guardian, court evaluator and court-appointed attorney in guardianship proceedings. Robert Kruger is a member of the New York State Bar (1964) and the New Jersey Bar (1966). He graduated from the University of Pennsylvania Law School in 1963 and the University of Pennsylvania (Wharton School of Finance (B.S. 1960)).

Snowbird News

Spousal Refusal in Florida

By Howard S. Krooks and Scott Solkoff

Howard S. Krooks

Although the right of a spouse to refuse the availability of his or her assets to the other spouse has been recognized by federal law since 1988, Florida only began to observe the rule in 1999. New York, on the other hand, has been utilizing the "Spousal Refusal" option for 18 years. When Florida adopted the rule in its State Medicaid Manual, Florida attorneys looked to the New York experience for guidance. In this article, we will share with you the status of spousal refusal in Florida so that you may advise your snowbird clients accordingly.

Before detailing the nuances, you should know that the spousal refusal option is working well in Florida, although change may be coming. Many Florida spouses today are able to protect themselves from impoverishment by exercising their right of spousal refusal. Prior to 1999, Florida attorneys were still able to assist their clients in protecting a spouse's assets; however, the "Just Say No" option allows for greater flexibility and ascertainable risks. Now for some details:

The Florida spousal refusal rule follows the language of the Medicare Catastrophic Coverage Act of 1988 (42 U.S.C. § 1396r-5)(g)) by providing as follows:

The institutionalized spouse may not be determined ineligible based on a community spouse's resources if all of the following conditions are found to exist:

1. The institutionalized individual is not eligible for Medicaid institutional services because of the community spouse's resources and the community spouse refuses to use the resources for the institutionalized spouse; and
2. The institutionalized spouse assigns to the State any rights to support from the community spouse by submitting the Assignment of Support Rights form referenced in Rule 65A-1.400, F.A.C., signed by the institutionalized spouse or their representative; and
3. The institutionalized spouse would be eligible if only those resources to which they have access were counted; and
4. The institutionalized spouse has no other means to pay for the nursing home care.

   Fla. Admin. Code R. 65A-1.712(4)(g).

Scott M. Solkoff

Just as in New York, the Florida rule allows an otherwise qualified Medicaid applicant to be eligible for benefits if the community spouse refuses to make available his or her assets and the Medicaid applicant assigns his or her support rights. The State of Florida has promulgated a form for the assignment of support rights. Most Florida practitioners submit that form with the application. Although not required by the rule, it is also advisable and common practice to include a "Statement of Refusal" from the community spouse.

With a properly completed spousal refusal form, the government is prohibited from counting the community spouse's assets. The reality is that in most Florida districts, the case workers require verification of the spouse's assets and are sometimes swayed by the amount of assets disclosed. In some Florida districts, the case workers and their counsel are philosophically opposed to the rule and have not been educated in its application. Because of this lack of understanding on behalf of the case workers and the relative newness of the rule, the elder law bar in Florida has been confronted with difficulties in some districts within the State. In one recent case, a case worker in Palm Beach County refused to accept the spousal refusal and assignment of right of support forms claiming that they lacked the Florida Department of Children and Families' logo in the upper left hand corner. One of the co-authors of this article is handling this case and it remains to be seen whether this will cause a denial or delayed Medicaid eligibility date.

If all steps in the Florida rule (recited above) are met, the government must approve the applicant's eligibility. As in New York, the law allows the government to take an assignment of the institutionalized spouse's support right and to therefore stand in the shoes of the Medicaid recipient and sue the community spouse.

In Florida, to the authors' knowledge, no person has been sued by the State under this rule. If the State

does try to sue a community spouse, the community spouse will have at least one defense not available in New York, that being Florida's abrogation of the common-law doctrine of necessaries.

The common-law "doctrine of necessaries" has been completely abrogated in Florida. The Florida Supreme Court abolished the ancient doctrine because it made husbands responsible for their wives' "necessaries" but did not make wives bear a reciprocal responsibility. *Connor v. Southwest Fla. Reg'l Med. Ctr., Inc.*, 668 So. 2d 175, 175 (Fla. 1995). The Court could have held that husbands and wives are now equally responsible but opted instead to abrogate the doctrine altogether.

It should be noted that Florida case workers are admonished not to let people know about "spousal refusal" rights. The case workers are administratively barred from bringing up the solution and can only address it if the applicant raises the issue. The Florida Medicaid Manual states: "This . . . is not an option that a [worker] suggests to an ineligible couple, but rather a solution to an existing situation which is brought to the [worker's] attention."

In New York, there are several cases which have held in the State's favor when it came to recovery against the community spouse. *See, e.g., Spellman*, 243 A.D.2d 45, 672 N.Y.S.2d 298 (N.Y.A.D. 1st Dep't 1998). In *Spellman*, the Department of Social Services' claim that Social Services Law § 366-(3)(a) expressly creates an implied contract between the Department and the community spouse for the recovery of benefits paid was upheld. This right of recovery, however, is limited by the community spouse being of sufficient ability to pay at the time expenses are incurred. Therefore, one possible defense to a recovery action in New York is that the community spouse lacked either or both sufficient income or sufficient resources at the time Medicaid paid for services provided to the institutionalized spouse. *See In re Craig*, 82 N.Y.2d 388, 604 N.Y.S.2d 908 (1993).

There is no such case law in Florida. While "Spousal Refusal" remains a viable option in New York (notwithstanding recent attempts by the current governor's administration to remove it), it is perhaps an even more attractive option for the Florida client. To the best of the authors' knowledge, there has been no recovery on a spousal refusal case in Florida. There is probably good reason for this. The *Spellman* case relied greatly upon specific New York statutory authority. Moreover, the doctrine of necessaries remains intact in New York, unlike in Florida.

In one recent Florida case, Florida's 1st District Court of Appeals questioned the ability of an ill spouse to transfer all assets to the community spouse and for the community spouse to then exercise the right of spousal refusal. In *Feldman v. Department of Children and Families* (Case No. 1D04-4914), the Court determined that Medicaid eligibility was properly denied where the community spouse refused to make assets available for the institutionalized spouse's care and then, after this refusal, the community spouse became the recipient of additional assets of the institutionalized spouse. This case is very likely limited to its facts (think bad facts = bad law): On February 4, 2004, Mrs. Feldman signed an assignment of support rights and her husband signed a spousal refusal. On March 11, 2004, Mrs. Feldman transferred $227,000 (most likely after discovered assets) to her husband and applied for Medicaid on that date seeking retroactive benefits. On March 19, 2004, Mrs. Feldman signed a second assignment of support rights and Mr. Feldman signed another spousal refusal form. These new forms were submitted to the Department of Children and Families with a notice that the new forms were being submitted and the old forms were being withdrawn. On these facts, the 1st District Court of Appeals upheld the determination at Fair Hearing of the Department of Children and Families that retroactive benefits could not be obtained due to excess resources of the institutionalized spouse. Unfortunately, the Department of Children and Families in some counties, based upon dicta in the case, and demonstrating a lack of understanding as to why the rule exists in the first place, began rejecting numerous applications where pre-refusal transfers were also deemed improper.

Spousal refusal is still a viable option in Florida and one that is being watched closely by the elder law bar.

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Scott Solkoff, Esq. is a former Chair of the Florida Bar's Elder Law Section and a principal with Solkoff Associates, P.A., a law firm exclusively representing the interests of the elderly and disabled throughout Florida.

The Golden State News

Implementation of the DRA in California

By Steven M. Ratner

The previous edition of this column reviewed the generous Medi-Cal planning options in California. California has yet to implement many of the OBRA 1993 reforms. For example, the current look-back period is 30 months and an applicant may transfer a homestead to anyone without incurring a transfer penalty.

This issue of the Golden State News addresses implementation of several DRA provisions in California:[1]

Income-First Rule: California was a resource-first state prior to the passage of the DRA. On April 14, 2006, the Department of Social Services, State Hearings Division, issued an all-county welfare letter[2] (similar to an ADM in New York), instructing Administrative Law Judges to apply the income-first rule in fair hearings. The resource-first rule apparently still applies in civil court actions to increase the Community Spouse Resource Allowance.

Look-Back Period & Transfer Penalty Provisions: The State Department of Health has advised that it does not intend to implement the 60-month look-back period until 2008. DHS has advised that it may phase in the look-back starting in January 2008. The current look-back is 30 months. In addition, DHS has advised that the new rules will not be applied retroactively to February 2006.

Home Equity Provisions. The home equity provisions of the DRA allow states to increase the equity limit from $500,000 to $750,000. According to DHS, the home equity provisions will not be implemented until late 2007.

Homestead Transfer: California does not impose a transfer penalty on the transfer of an exempt asset, including the homestead (this is pre-OBRA law). According to the state, there is no plan to change this rule.

Endnotes

1. The information in this article is excerpted from a June 22, 2006 report issued by the California Advocates for Nursing Home Reform (http://www.canhr.org/).
2. ACWDL 06-12.

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Guardianships and Divorce Proceedings

The Family Law Committee of the Elder Law Section is researching matters concerning guardianship of incompetent persons and divorce proceedings instituted by or against them. We would like to hear from any Section members who have represented either party. Please contact Andrea Lowenthal at andrea@lowenthallaw.

Medicaid Nuts and Bolts

By Evan M. Gilder

Medicaid is a program for people who can't afford medical care. It is financed jointly by the federal government and the states, to provide health insurance for low-income people, including many in nursing homes. Medicaid provides health insurance for people who are 65 and older or disabled.

Supplemental Security Income (SSI) is a cash assistance program for people with very low incomes who are elderly, blind or disabled. People receiving Supplemental Security Income in New York State may also be entitled to Medicaid.

In order to qualify for Medicaid, an individual or head of household must meet certain federally mandated income and resource limits as defined in the chart below.

2006 Income & Resource Levels*

Number in Family	Monthly Net Income	Resources
1	$692	$4,150
2	$900	$5,400
3	$1,017	$6,100
4	$1,025	$6,150
5	$1,034	$6,200
6	$1,134	$6,800
7	$1,275	$7,650
8	$1,417	$8,500
For each additional person, add:	$142	$850

Table Source: U.S. Department of Health & Human Services —Centers for Medicare and Medicaid Services —Rates subject to change on a yearly basis.

Income includes such things as a paycheck, Social Security payment, child support and income from investments, such as stocks or bonds. Resources, on the other hand, are different from income. They include cash, bank accounts, certificates of deposit, stocks, bonds, IRAs and property. Any cash value component of a life insurance policy, annuity or pooled bond portfolio is considered a resource for Medicaid purposes.

Medicaid does not consider the following to be a resource:

- A burial fund or burial space
- A home (see limitations discussed below)
- Household furniture and appliances
- Tools and equipment necessary for employment
- Automobile (is *not* considered a resource only if it is needed for a person's medical care, work, or for operating a business)

Furthermore, under certain circumstances, an individual or head of household may still be eligible. Pregnant women and children can have higher income levels with no resource limits. In order to qualify for this, you must fall into one of the following three groups:

- Infants to age one and pregnant women—200% of the federal poverty level
- Children age 1 through 5 years—133% of the federal poverty level
- Children age 6 through 18 years—100% of the federal poverty level

Monthly Income Effective January 1, 2006*

Number in Family	100% FPL**	133% FPL**	200% FPL**
1	$817	$1,087	$1,634
2	$1,100	$1,463	$2,200
3	$1,384	$1,840	$2,767
4	$1,667	$2,217	$3,334
5	$1,950	$2,594	$3,900
6	$2,234	$2,971	$4,467
7	$2,517	$3,348	$5,034
8	$2,800	$3,724	$5,600
For each additional person, add:	+$284	+$377	+$567

* - Income Levels are subject to yearly adjustments.

** - FPL = Federal Poverty Level

Table Source: U.S. Department of Health & Human Services—Centers for Medicare and Medicaid Services —Rates subject to change on a yearly basis.

The Medicaid Act identifies numerous categories of medical services for which federal reimbursement is allowed. However, these broad categories of services do not describe specific medical treatments or procedures. Given the breadth of these categories, a specific medical treatment or health care service may fall within more than one category of service. These categories of service are classified as either mandatory or optional services.

States are required to cover approximately fourteen categories of services. Each of these required services is defined in federal regulations. The following is a list of required or mandatory services.

- Inpatient hospital care
- Outpatient hospital care
- Physicians' services
- Nurse midwife services
- Pediatric and family nurse practitioner services
- Federally qualified health center
- Laboratories and x-ray services
- Rural health clinic services
- Prenatal care
- Family planning services
- Nursing facility services for persons over age 21
- Home health care services for persons over 21 who are eligible for nursing facility services (includes medical supplies and equipment)
- Early and periodic screening, diagnosis, and treatment (for persons under age 21)
- Vaccines (for children)
- Transportation

In addition to the required services, New York State covers thirty-four optional services, as defined by federal regulation, under certain circumstances.

- Podiatrists' services
- Optometrists' services and eyeglasses
- Chiropractic services
- Private duty nurses
- Clinic services
- Dental services
- Physical therapy
- Occupational therapy
- Speech, hearing and language therapy
- Prescribed drugs
- Dentures
- Prosthetic devices
- Diagnostic services
- Screening services
- Preventive services
- Rehabilitative services

- Services for persons age 65 or older in mental institutions
- Intermediate care facility services
- Inpatient psychiatric services for persons under age 22
- Christian Science schools
- Nursing facility services for persons under age 21
- Emergency hospital services
- Personal care services
- Hospice care
- Case management services
- Respiratory care services
- Home and community-based services for individuals with disabilities and chronic medical conditions

Recent Changes in Federal Laws

A brief word on the citizenship requirement stated above. Buried in the Deficit Reduction Act of 2005 is a provision that requires all individuals who apply for Medicaid to prove they are citizens by showing passports or birth certificates, and in certain circumstances, a limited number of other documents.

Until now, federal health officials gave states broad discretion in validating citizenship. Most applicants simply filled out an affidavit attesting to citizenship since this was the easiest way to satisfy the requirement. Self-attestation of citizenship and identity is no longer an acceptable practice. Furthermore, when individuals go through their annual Medicaid recertification process, they will be required to produce this documentation. Within the State of New York, this will affect all four million residents.

Also included in the Deficit Reduction Act is a change to the review and attestation of financial resources associated with a Medicaid application. The new law mandates that the look-back period be FIVE years on all transfers, not just transfers into a trust. This change is only effective for nursing home Medicaid and Lombardi home care, and not for community-based care, including most home care.

It is important to understand that the three-year look-back period will still be in effect until February 8, 2009. This represents three years from the date the law was enacted. Transfers made before February 8, 2006 are evaluated under the old rules, for which the look-back period was three years. So looking back more than three years before February 8, 2009 would be unnecessary. For the next three years, applicants for nursing home care should still be required to furnish only three years of financial records.

Beginning February 2009, the look-back period will be phased in by one extra month until February 2011, by which point the look-back period will reach the five-year requirement.

The Medicaid Application Process

If there was any one word to associate with the Medicaid application process, it would be documentation (and lots of it). Medicaid applications are processed by each county's Department of Social Services. An exception to this rule is New York City, which processes applications on behalf of the five counties within the City of New York.

Here is a listing of common documentation that must be provided as part of every Medicaid application:

- Proof of identity
- Proof of marital status
- Proof of citizenship or alien status
- Recent paycheck stubs (if you are working)
- Proof of all income sources (i.e., Social Security, Supplemental Security Income, life insurance)
- Any bank books and insurance policies that you may have
- Proof of where you live, like a rent receipt or landlord statement
- Insurance benefit card or the policy (if you have any other health insurance)
- Medicare Benefit Card (if applicable)

When filing a home care Medicaid application, it is best to choose a provider that is already a Medicaid agency so that the transition when filing the application will be easier. However, an agency will be chosen by Medicaid when an application is filed.

Long-term home care includes the same type of care as nursing home care, but in the confines of the home. This differs from personal home care in that it does not include physical to IV (intravenous) therapy. Personal home care requires only a maximum of eight hours per day for as many days per week as is determined by the Medicaid agency.

Long-term care requires a look-back period of 36 months with explanations of transactions of $3,000 or more. There is further discretion on the look-back period on a county-by-county basis. For example, in Nassau County, long-term home care requires a look-

back period of 36 months with explanations of transactions as follows:

- For Calendar Year 2002, all amounts of $5,000 or more
- For Calendar Year 2003, all amounts of $5,000 or more
- For Calendar Year 2004, all amounts of $5,000 or more
- For Calendar Year 2005, all amounts of $3,000 or more
- For Calendar Year 2006, all amounts of $3,000 or more

In New York City (and five counties), the look-back period for all savings accounts is 36 months and six months for all checking accounts, with explanations for all transactions $1,500 or more. In Westchester County, long-term care requires a look-back period of 36 months for both checking and savings accounts, with explanations for all transactions of $3,000 or more. Putnam County requires explanations of all transactions of $5,000 or more for all accounts.

As a general rule, a Medicaid application takes about 45 days to process. If the applicant has a disability, the process can take up to 90 days. Many assumptions go into these numbers and any delay in supplying required documentation will have a cursory delay in the application process, so the important part of any application is to do as much legwork as possible up front to expedite it.

Evan Gilder is a principal of Redlig Financial Services. Evan received his MBA from Fordham University and spent almost 20 years working on financial technology initiatives throughout his career. Redlig Financial Services concentrates on the fields of Daily Money Management, Household Payroll Services, Tax Return Preparation, Medical Billing Dispute and Resolution, and acting as Trustee. In short, these services alleviate the burdens placed on a family to keep their loved ones out of financial harm. In 2003, Evan also became a Registered Financial Gerontologist through the American Institute of Financial Gerontology. Evan also lectures at various symposiums on money management issues and works with the American Association of Daily Money Managers. His current endeavor includes enhancing the electronic accountability model so that family members can get a snapshot at any point in time as to the financial standing of a loved one. Redlig Financial Services also provides an extensive listing of checklists for professionals working with mature adults and their families.

Available on the Web

Elder Law Attorney

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Some Basics—Special Needs Trusts to Benefit the Mentally Ill Client or Family Member

By Marcia J. Boyd and J. David Seay

Introduction

This article is not intended as a complete guide to the Special Needs Trust (SNT), but focuses on unique areas of interest when the intended beneficiary has a mental illness. A Special or Supplemental Needs Trust is an estate planning and living trust tool for persons with disabilities, who receive or may in the future receive either Medicaid or Supplemental Security Income (SSI), or both. The SNT, authorized by both state and federal law,[1] provides funds for goods and services not covered by Medicaid and/or SSI benefits. The SNT is an important planning tool because it provides family or friends with a method to provide financial support to loved ones with disabilities, while also protecting the trust beneficiaries from losing their eligibility for Medicaid[2] and/or SSI.[3]

Using the Special Needs Trust for the mentally ill client or family member raises some questions unique to those with "severe and persistent mental illness." The SNT provides some crucial planning choices for this client. This article attempts to highlight some unique challenges in providing complete legal advice to such clients, and, furthermore, when meeting ANY client for the first time, in identifying such clients during the initial interview.

Practitioners should also be aware of other resources in the community, such as the nearest affiliate of the National Alliance on Mental Illness (NAMI) as well as NAMI New York State, that can help clients with mental illness or clients with family members with mental illness better understand the causes, diagnosis and treatments of the various brain disorders that are collectively called mental illness. To find contact information for such affiliates and to obtain additional information in New York, clients and practitioners can visit the web site of NAMI New York State (NAMI-NYS) at www.naminys.org and click on the "affiliates" section or call the statewide toll-free help line at 800-950 FACT (3228) during normal business hours. A wealth of information on mental illness is also available on the national NAMI organization's web site, at www.nami.org.

Threshold Problem—How to Identify the Client

Due to the widespread perception of the stigma of mental illness, the client often does not tell the lawyer that a family member is disabled due to one of the severe mental illness conditions, including bipolar disorder, schizophrenia, psychosis, major or clinical depression, and other diagnoses. Best practice is to ask every client if they have a family member with any disability and then to wait for a response. The response may not be that their child has a mental illness, but instead, after a long pause, that one or another family member has "some problems." The response may also be very hesitant and vague. Follow up questions can include some of the following: Does the person work? Receive any sort of disability benefits? Receive any type of treatment? Ever been hospitalized? What sort of condition? How long has the condition been a problem? Where does the person live? Such follow up questions can help the lawyer determine if use of the Special Needs Trust may be a useful planning option.

The client of course should be reminded of the nearly absolute confidentiality afforded by the attorney-client privilege and that the practitioner can better assist the client when all the relevant information and facts are disclosed and known, including the fact that the proposed SNT beneficiary has been diagnosed with a mental illness. Because the advisor may not meet directly with the disabled person, it is important to determine if "the client," for representation purposes, is the family member in the lawyer's office or the disabled person. In this article the term "client" is used in a more general sense without addressing that specific issue.

If the family or disabled person is referred by a mental health agency or related referral source the threshold question of recognizing the client as one who may benefit from such planning does not occur. Then it can be very helpful for the lawyer to indicate an understanding of mental illness, ask about the diagnosis and treatment plan, and inquire as to health services or agencies providing support services.

The concept of the Special Needs Trust or the existence of a disabled family member may never be mentioned if these questions are not part of the practitioner=s *routine* initial interview. These conversations often occur in the context of estate planning or Medicaid planning. It is vital to ask such questions because otherwise the person with a disability could be adversely affected by the plan or may not benefit from some options available to them.

For example: Mother (M) is going into nursing home. For many years adult son (A) with mental illness

has lived with mother in the mother's house. Another child of M comes to the attorney for advice concerning Medicaid planning, preparation of a Power of Attorney, estate planning, or some other question unrelated to A's needs. Unless the practitioner finds out A exists and that A is disabled, the following planning opportunities cannot be explored:

1. Under current Medicaid rules the house can be transferred to A (or to A's SNT) with no adverse impact on M's Medicaid eligibility.
2. M can transfer some of her assets, savings or resources to a Special Needs Trust for the benefit of A, without any transfer penalty being imposed on M, and thus no effect on M's Medicaid eligibility.
3. Such a transfer, if properly made to an SNT, will not adversely affect A's continued receipt of Medicaid and/or SSI.
4. It may be important for A to be connected to more support services, intensive case management, or other help, so A's daily life continues without unnecessary adverse impact, after M's move to assisted living or a nursing home or, or M's death.

Some Examples—When to Use the Special Needs Trust

For many people with severe and persistent mental illness, full-time employment is not a viable option. As a result, many of these individuals rely on two separate programs, Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). In New York a person receiving SSI will "automatically" receive Medicaid. For the mentally ill, keeping Medicaid has to be a primary goal, because without Medicaid the person could not afford their medications or treatment.

In New York State, if the disabled person received SSDI less than $692 per month due to their limited work history, he or she will also receive SSI in an amount to bring their total income up to the $692 threshold. With the SSI, the person also becomes automatically eligible for, and will start to receive, Medicaid. After the Medicare eligibility waiting period, the person will also receive Medicare. Thus one person may receive benefits from *four* programs: SSDI and Medicare, and SSI and Medicaid.

Both SSI and Medicaid are "needs-based" programs. To qualify, individuals must establish that their income and resources do not exceed program limits. For example, a person with savings of more than $2,000 is not eligible for SSI or the related Medicaid benefits. A person with monthly income of more than $692 (2006 amount) is subject to a Medicaid "spend-down"—whereby income in excess of $692 must be spent each month on medical expenses (as defined for this purpose by Medicaid) before Medicaid will cover remaining monthly expenses. The person who becomes disabled after working for a few years, having thus accumulated a Social Security earnings history, would receive monthly SSDI benefits based on their earnings history, similar to calculations for retirement benefits. This person would also become eligible for Medicare benefits after the waiting period. These Medicare benefits are the same as those available to retired persons. However, if the mentally ill person has high medication and treatment costs, most of which are not covered by Medicare, they will have to "spend-down" their disability income in excess of $692/month on "medical needs" (as defined by Medicaid), before Medicaid will pick up any of these costs.

Effective January 1, 2006, persons who were eligible for both Medicare and Medicaid ("dual eligibles") had their primary prescription drug coverage shift from Medicaid to the new Medicare Part D drug program. Such individuals were automatically enrolled in a randomly selected plan from among the various plans offered in New York State. They may change plans at any time. However, there are co-payments required under Medicare that were not required under Medicaid. Therefore, these dually eligible beneficiaries will actually see their own out-of-pocket costs increase under the new plan, thus perhaps increasing or exacerbating their need for a SNT. A complete discussion of the ongoing impact of Medicare Part D medication coverage is not within the scope of this article.

The complexity of understanding and successfully accessing multiple benefit programs is of particular concern for persons with serious mental illness and their families. Because of this complexity and difficulty in navigating these programs and benefits, family members of persons with mental illness and their advocates need to be aware of the eligibility and application rules and procedures of these programs. If the disabled person receives services from an agency with experienced staff, they may be a valuable source of guidance to the intricacies of these programs, including the myriad employment rules. Practitioners are often in a unique position to facilitate this educational process or referral to appropriate support services and lay advocates. Such education and understanding can help to maximize a mentally ill family member's benefits (or the mentally ill person may be the direct client) while at the same time helping the client structure an estate plan or SNT with the same objectives.

The following examples of actual cases may assist the lawyer in identifying issues affecting this group of clients and their families:

EXAMPLE 1: B is 45 years old. About 10 years ago she was diagnosed with anxiety disorder, bipolar and post traumatic stress disorder. Before these conditions disabled her, B worked for several years as a teacher. During her employment she saved about $50,000 in retirement funds which were rolled over into an IRA when she became disabled. During the past few years she has accumulated about $40,000 in medical bills because the medical insurance provided by her former employer covers only one-half of costs when she is hospitalized in the psychiatric center, which occurs about once a year. She has been able to pay for her medications because she found drug company subsidy programs to provide her medications at reduced cost and she pays the balance from her SSDI income.

She now receives SSDI of about $1,400 per month and has monthly medical costs (including medications) of about $600 per month, in addition to the back bills. This leaves her with only about $800 for all her living expenses, although, without her disproportionately high medical costs, her income would be enough to provide her with an acceptable standard of living in her western New York rural community.

The large teaching hospital where she was twice hospitalized referred her $7,000 bill to a collection agency, which is aggressively pursuing payment from her. This unpaid hospital bill raises several interesting issues not within the scope of this article and is included because it is a common problem for those with a serious mental illness.

EXAMPLE 2: C is now 32 years old. His only income is SSI of $692 per month. He also receives a housing subsidy and food stamps. Recently, C learned he will inherit $55,000 from an uncle in California. If he took the inheritance directly he would lose all his benefits. He calculates he would use up the entire inheritance within 1 or 2 years, primarily due to his medical expenses.

There is another even more critical reason C and his intensive case manager are very concerned he would lose his Medicaid benefits. Because his services are through Medicaid-funded programs, if he lost his Medicaid coverage, he might not be able to stay in the same treatment programs, and he would have to find new therapists. Such a change would probably lead to a recurrence of his more serious symptoms and be a serious setback to his gradual improvement.

He is also very concerned that if he receives the $55,000 inheritance he will lose his SSI benefits. It took more than 2 years from date of initial application for C to be determined eligible for SSI. He was successful only after employing an attorney experienced in obtaining disability benefits for mentally ill persons, who represented C through the hearing stage before C was finally found eligible. The thought of having to reapply for SSI has triggered his anxiety disorders and may lead to his rehospitalization.

EXAMPLE 3: D is 28 years old and part of an intensive case management program. He receives SSDI of $850 per month based on his deceased parent's Social Security account. To meet the Medicaid "spend-down" requirements he must spend $158 per month on medical costs before he can receive Medicaid, which pays for his intensive treatment program and his medications. He heard he could benefit from the $158 each month if it goes into an "income-only" Special Needs Trust. His case manager referred him to a lawyer familiar with Special Needs Trusts for more information.

EXAMPLE 4: H and W have three children. Two are married with children and financially secure. The third child, T, age 35, does not work and seems to have some "problems." Upon further inquiry the lawyer learns the "problems" in fact stem from a serious and persistent mental illness that prevents T from working, living independently or being able to manage her own finances. The other children do not associate with T because of her behavior issues and noncompliance with treatment and medication recommendations the family thinks have been offered to T. The parents, H and W, wish to provide for T in their wills but do not want to leave any inheritance directly to her because she cannot manage money, especially if she is in what has been described to them as her "manic" phases. None of the other children can agree to be the trustee of the SNT due to the adverse impact on their own families from contact with the ill family member, who does not respect their boundaries.

EXAMPLE 5: G is 55 years old, has a law degree, and was able to work for a year or two after law school graduation. G's problems with paranoia, bipolar disorder and other conditions then worsened and G returned home to live with her father (F) who subsidized her and provided support with daily living. When F died G was not receiving any services, and was not receiving any mental health treatment. The attorney handling F's substantial estate did not realize that G was disabled because she never told him she was and presented herself as a self-sufficient person, although she had been receiving SSDI of about $550 for a few years and was receiving Medicare. G received her inheritance outright and started to use it to augment her SSDI (her only income) and to pay for her medical needs, which increased greatly due to the loss of her father.

F's will did not include an SNT for G for several reasons: the will was over 15 years old; F did not and never would have told his attorney about G's special needs due to stigma related concerns; the lawyer did not ask the questions to find out about G's special needs; the family did not ask the estate lawyer about an SNT because none of them had ever heard of one; and they did not view G's situation as that of a disabled

person but rather of a person who was too dependent on F and had "to learn to stand on her own two feet" as had all of F's other children. In addition, the local lawyer in the rural county where F lived and who had worked with F and long advised the family had never heard of a Special Needs Trust.

After G met with three lawyers, the last one mentioned the option of the SNT. By this time G had used part of the inheritance and had only a portion left to fund the SNT. Without the SNT she would have had to use almost all her money before she could be eligible for either SSI to augment the SSDI or Medicaid to cover all her medical costs not covered by Medicare.

How the Special Needs Trust Benefits the Mentally Ill Beneficiary

The SNT is especially useful for the person with serious and persistent mental illness in five primary applications:

1. Income-only (self-settled)[4]
2. Self-settled with disabled person's own savings or IRA account or other resources[5]
3. Testamentary—in the Will of a parent, grandparent or other person[6]
4. Living or *inter vivos* trust set up by a "third party" (parent, grandparent, sibling, friend, other) for the benefit of the disabled person, using "third party's" funds[7]
5. Court established—based on construction proceeding of Will leaving funds to a disabled person, but not in the form of an SNT.

If any of these versions of the SNT is properly implemented, the beneficiary can receive the benefit of the SNT funds AND continue to receive SSI and/or Medicaid. The government benefit eligibility is not affected provided the trustee complies with certain restrictions applicable to use of SNT funds.[8] Payments may be made only to a third party, not to the beneficiary directly. And the SNT cannot be used to provide needs covered by the benefits received. This is defined as "food and shelter" if the beneficiary receives SSI, and as "medical expenses covered by Medicaid" if the beneficiary receives Medicaid. But special rules may apply if the beneficiary's rent is more than one-third of the SSI benefit[9] and in some circumstances the SSI grant may be reduced by one-third, not stopped completely.[10] Note that a beneficiary receiving Medicaid does not necessarily have to also receive SSI, even if also eligible for SSI.

If a person with disabilities does not and *will not in the future* need or receive Medicaid and/or SSI, the SNT should not be used. However, because the course of severe and persistent mental illness is often difficult to predict, and may be lifelong, it is often wise to set up the SNT as part of an estate plan in the event it will be applicable sometime in the future, when the parent or other settlor dies. For example, a beneficiary may not receive SSI and/or Medicaid while living with a parent, but will need one or both after death of the caretaker parent.

While somewhat different criteria apply to a third party SNT than to a self-settled SNT, as a general rule in New York State similar, although not identical, rules apply to both. In general, requirements to establish a valid SNT also must be consistent with Medicaid and SSI eligibility requirements. If the trust meets the statutory criteria, then the beneficiary, who is eligible for and/or receives SSI and/or Medicaid, can also benefit from payments from the SNT. It is essential that trust distributions are made only for certain purposes as discussed above and payments may be made only to a third party *on behalf of* or *for the benefit of* the beneficiary, *not directly* to the trust beneficiary.

Benefits received from the SNT and assets transferred in the SNT are not considered "available resources" when determining eligibility for Medicaid or SSI. Likewise, income directed into an "income-only" SNT is not counted as "income" when determining eligibility for Medicaid or SSI. Possible impact from the recently enacted Deficit Reduction Act is not within the scope of this article, but the SNT does not seem to be directly affected.

If properly authorized by the local Medicaid attorney, the beneficiary who receives Medicaid and/or SSI can also benefit from payments from the SNT. The SNT pays for goods and services for the beneficiary that are not provided by the government benefits received by the beneficiary. For example, under federal law decrees that "food and shelter" are provided by SSI benefits, so, in general, the SNT may not be used to pay for food or shelter for the beneficiary. Some exceptions for shelter payments paid from the trust are not within the scope of this article.

Types of Special Needs Trusts

In general, the SNT is an irrevocable trust, established and funded by a "third party" on behalf of an individual under the age of 65; or funded by the disabled person him or herself as a "self-settled" trust. The third party trust can be in a will to be funded upon death of the donor, or be a stand-alone trust funded by the donor while still living, or some combination of these. The self-settled trust is either a stand-alone trust or can be part of a pooled trust. The third party can also fund an account in a pooled trust, either during the donor's lifetime or upon death by will. A limited exception to the "under 65" rule is discussed below.

There is also some use of income-only pooled trusts for those over 65, mostly in the New York City area. In certain situations, a will can include an SNT for a beneficiary over the age of 65. Also a court can establish a Special Needs Trust for a personal injury or malpractice award.

The New York State statute includes specific language to use in the third party SNT. It is prudent to use the statutory language as a beginning for all types of Special Needs Trusts, and also to include other specific language from other sources, and tailored to the type of SNT being drafted. Other general considerations include obtaining a tax ID number; filing annual fiduciary income tax returns; complying with any reporting requirements of Medicaid, the court or others; advising Trustees of their general fiduciary duties and the special rules for SNTs; fully informing all parties (including the trustee, settler, and self-settled donor) concerning trustee commissions; coordination of establishing the SNT and receipt of the funds to avoid overpayment issues with relevant government agencies; if the beneficiary receives or will apply for SSI, informing the Social Security Administration of the existence and funding of the SNT, and advocating with SSA if the client's worker is not familiar with the concept of the SNT; and coordination with the case manager if the client needs that assistance to successfully complete this very complicated and often frustrating process.

Self-Settled Trusts

Persons with severe and persistent mental illness under the age of 65 (including a person under 18 by their parent or guardian), who meet the criteria for "disabled," may use their own income or savings to fund their SNT. They may have accumulated savings, an inheritance, retirement accounts, or other assets. However, as in example "1" herein, medication and those hospital costs and therapy not covered by insurance could quickly exhaust these savings. By transferring their assets to a self-settled SNT, persons with mental illness who meet Medicaid's disability criteria, if not already determined disabled by the Social Security Administration, will probably then qualify for Medicaid (and possibly also SSI and/or SSDI once SSA makes a favorable determination) to pay for their medical care, while the trustee uses the SNT to pay for some of their other expenses not covered by basic SSI of $692 per month. Examples of expenses often paid by the SNT include cable TV, high speed Internet access, treatment not covered by Medicaid, tickets to social events, a computer, furniture, and car expenses. Thus the SNT preserves the disabled person's assets and uses their own assets for their own benefit, while basic needs are provided by government benefits.

The law requires a third party—parent, grandparent, guardian or court—to act as "settler" of the SNT.[11] If the beneficiary's parents or grandparents—or any one of them—is living and willing to sign the SNT, they may sign the trust as "settlor." They are not funding the trust and may not even be the trustee. But their signature is required to "set up" the trust. If a parent or grandparent is not available to sign the SNT, and if the person does not have a guardian and does not need a guardian because they do not lack capacity, a court can be petitioned to establish the trust. Procedurally, consent and approval of the SNT by the appropriate social services attorney is filed with the court with the petition. Such a trust is "self-settled" in the sense that it is funded with the disabled person's own funds—savings and/or income, and, in the case of a proposed beneficiary with mental capacity, usually with the consent of the beneficiary.

A self-settled trust *must include* a payback provision so any funds remaining in the SNT at the death of the beneficiary are first used to reimburse Medicaid for benefits paid. If the trust is funded by a third party—such as a parent or grandparent or friend—then the payback requirement is not included in the SNT.

Third Party SNTs

The most common implementation of the "third-party supplemental needs trust" is by parents or grandparents by including a SNT in as part of their Wills. This type of SNT is funded only upon the death of the parent or grandparent (or friend or other person). This testamentary SNT is an excellent estate-planning tool to benefit persons with severe mental illness. As in example "2" herein, if the person with a mental illness ("B") were to receive the bequest or inherited gift outright, B would most likely no longer qualify for SSI or Medicaid and be forced to spend all of the inheritance for daily expenses and medical costs before being able to reapply for the benefit programs. By using the SNT as part of the estate plan, usually as a provision within the Will, then B can benefit from inheritance over a long period of time.

As a third-party trust, the testamentary trust is not subject to the payback rules. Consequently the donor can state in their will the persons or charity to whom the remainder funds are distributed at the death of the beneficiary. Some family members use this as a method to provide for a later donation to a mental health service agency providing services to their loved one or to support education and advocacy organizations such as NAMI New York State.

Who Is the Trustee?

The trustee named in the SNT may be a family member, friend, social service not-for-profit agency, or

a financial institution. The SNT usually also names a successor trustee or co-trustees, and may provide for naming a successor trustee by the named trustee. This provides flexibility in planning in the event the named trustee cannot continue in that role. When the beneficiary is disabled due to mental illness, it may be difficult to locate a family member or friend willing and qualified to act as trustee. Some social services agencies will not agree to act as trustee without a "gatekeeper" or active case management services due to difficult behavior by a particular beneficiary. Financial institutions often require a high minimum amount to agree to serve as Trustee and again may require a case management agency or the like to act as intermediary with the beneficiary. This is a particular problem if the beneficiary exhibits difficult behavior patterns that could make the trustee's job very difficult.

The Pooled Trust

One solution to the problem of finding a suitable trustee is for local mental health social service agencies to establish pooled trusts.[12] The pooled trust is also ideal for trusts funded with smaller amounts which do not justify the cost of setting up an individual SNT.

Organizations such as the local NAMI or Mental Health Association affiliates, NAMI-NYS or the Mental Health Association in New York State (MHANYS) may be resources of information on whether such pooled trusts are made available by organizations in the client's or beneficiary's community. Except for the statewide NYSARC pooled trust, there are very few pooled trusts available outside the New York City area and perhaps none meeting the specialized case management needs of the mentally ill. Local organizations may be encouraged to set up such pooled trusts if aware of the benefits to their consumer population and if community members support and assist in establishing a pooled trust for their own area.

A pooled special needs trust can be managed by a not-for-profit organization that combines the contributions of many families into one "pooled" trust for multiple beneficiaries, thus providing common investment and management advantages. The pooled trust is an attractive option for families who have only a modest amount to put in the trust for their loved one. The not-for-profit organization also benefits by being able to pay for its services in administering the trust from the trust and can also be designated to receive the balance in the account after the beneficiary's death.

A pooled trust allows parents or others to provide for the future needs of the named beneficiary even when they do not have enough money to justify the expense of establishing a separate trust. They pool their donation with funds held in the pooled trust for others. Funds remaining at the death of the trust beneficiary may be given to the administering organization, but are subject to some limitations if from a self-funded account. If the funds are self-funded, part of the remainder may be subject to Medicaid payback rules before the rest can be paid to remainderpersons, including the administering not-for-profit. If any portion is paid to a third party, other than to the administering agency, then the funds are subject to payback rules. However, if all the remainder funds go to the organization, the pay-back rules do not apply.

Another advantage of the pooled trust is that it can be self-funded by a person with a disability of any age, including over the age of 65. However, if the self-funder is over age 65, he or she will be subject to the Medicaid five-year "look-back" period for transfers to a trust.

Pooled trusts are underutilized. They can be highly beneficial for people with mental illnesses and as a long-term funding plan for not-for-profit organizations providing services to this population. As mentioned previously, there are a number of mental health organizations that may have information on the availability of such pooled trusts in particular areas or may be interested in establishing a pooled trust.

Self–funded "Social Security" SNT

The SNT funded with a lump sum retroactive payment from Social Security may be funded by a person of any age, and is not restricted to those under the age of 65. This beneficiary can establish their own SNT and the requirement that the SNT be set up by a "parent, grandparent, guardian or court" does not apply. In general, the lump sum award and trust assets must first be used to repay benefits received while waiting for the disability determination. However, future SSD benefits are not subject to self-settled payback requirements upon death of the beneficiary. The law permits Social Security beneficiaries of any age, including those over 65, to establish and fund their own SNT with the lump sum award.[13]

The Insurance Problem

New York State is one of the few states in which the law does not require insurance companies to cover mental illness treatment the same as treatment for other conditions. For example, in New York State, a person presenting with personality changes and headaches who was referred for mental health treatment, under a typical policy with the most generous benefits would have coverage limited to 20 doctor visits a year, a co-pay of one-half (e.g., for a visit to a psychiatrist reimbursed at rate of $120, patient pays co-pay of $60 and insurer pays $60). If the same person is later rediagnosed with a brain tumor, then all doctor visits and other treatment are fully covered, with the nominal co-

pays applicable to most doctor visits and only medical criteria—not an arbitrary and fixed number—used to limit the number of hospital days and number/type of doctor visits.

If this person required hospitalization for what had been diagnosed as a brain tumor, the entire stay would be covered. If the diagnosis was one of the mental illnesses, virtually every policy in New York State would cover a maximum of 30 days in the hospital. Thus the person with a persistent and serious mental illness, who lives in New York state and has good health insurance, will still need Medicaid, unless that person can afford to pay out-of-pocket for one-half of all doctor visits (or the entire cost if more than the 20 or so limit per year), any and all hospitalization more than 30 days, the probably uncovered 50% co-pay for hospitalization, and for medication co-pays.

A proposed statute, commonly referred to as "Timothy's Law" has been pending for several years in the New York State legislature. Although it or similar versions are annually passed by the Assembly, the State Senate has yet to approve any version of a parity law for the state, although a majority of the State Senators signed as sponsors of such a law in 2005. In 2006 the Legislature may yet enact a compromise version of insurance parity although they did not as part of their regular session.

Conclusion

If assets or income are used to fund the SNT, it becomes an important estate planning and living trust tool to benefit persons with severe and persistent mental illness, especially those under age 65 who are eligible for Medicaid and/or SSI. With proper planning, the SNT can be incorporated into a will or used as a living trust to improve the quality of life for people with disabilities, without adversely affecting their government benefits. Practitioners should realize that SNT beneficiaries with serious mental illness may have more difficulty than the general population or client population in understanding their rights and benefits under the terms of these various SNT arrangements. Extra care should be taken in helping them (using a subjective standard), as well as their settlers, trustees, guardians, case managers and family members to fully understand and make maximum use of their SNT.

Endnotes

1. 42 U.S.C. § 1396p(d)(4)(A), (C); EPTL § 7-1.12; Soc. Serv. Law § 366(2)(b)(2); 18 N.Y.C.R.R. § 360-4.5(B)(4).
2. 42 U.S.C. § 1396p(c)(20(B); HCFA State Medicaid Manual, Transmittal No. 64 § 3258.1(6); Soc. Serv. Law § 366(5)(d)(3)(ii)(D).
3. 42 U.S.C. § 1396p(d).
4. *In re Lynch*, 703 N.Y.S.2d 653 (Sur. Ct. 2000).
5. *See* note 2, *supra*.
6. EPTL § 7-1.12; Soc Serv Law §104(3).
7. *Id*.
8. 20 C.F.R. § 416.1123; EPTL § 7-1.12(b)(3); 18 N.Y.C.R.R. § 360-4.5(b)(4).
9. *Ruppert v. Bowen*, 871 F.2d 1171 (2d Cir. 1989).
10. 20 C.F.R. § 416.1103(g).
11. 42 U.S.C. § 1396p(d)(4)(A).
12. 42 U.S.C. § 1396p(d)(4)(C)(i)-(iv); (C); Soc. Serv. Law § 366(2)(b)(2)(iii)(B).
13. EPTL 7-1.12(a)(5)(v).

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Message from the Chair
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the discussion groups that interest them. This program will enable each participant to both contribute and absorb valuable information and insight.

Conclusion

We have a very full agenda this year. With much already accomplished there is still much more we can do. I look to each of you to contribute your time and talents to helping seniors and the disabled, promoting legislation that helps our clients, sharing your ideas about how to deal with the new legislative landscape and participating in the Section's meetings.

"Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has." Margaret Mead

Ellen G. Makofsky

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