New York Medicaid Law

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Attorney Advertising
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**Introduction**

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

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

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

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

The Deficit Reduction Act of 2005 (“DRA”), signed by President Bush on February 8, 2006, has further amended Section 1917 of the Social Security Act making it even more difficult to obtain Medicaid benefits. The DRA has made many changes to

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¹ N.Y. Soc.Serv.L. §366(1)(a)
² 18 NYCRR §350.4
³ 18 NYCRR §360-2.4(c).
⁴ 96 ADM 8
Medicaid eligibility rules including a change to the asset transfer rules and the look-back period. The DRA mandates the disclosure of annuities; requires that the State be named as beneficiary of annuities; counts as an available resource certain entrance fees for continuing care retirement communities; makes the transfer of additional assets, such as funds used to purchase a promissory note, loan, mortgage or life estate, subject to the imposition of a penalty unless the purchase meets certain criteria; and amends Section 1919 of the Social Security Act to impose a home equity limitation for nursing facility services and community-based long-term care services.5

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

**Medicaid Eligibility**

**Resources** - In order to qualify for Medicaid, an individual may have non-exempt resources totaling no more than $14,250 (as of January 1, 2012). A married couple applying for Medicaid may have combined non-exempt resources of no more than $20,850. The community spouse of a nursing home recipient may retain resources of up to $113,640.

Medical bills may be used to offset excess resources. Individuals may also spend excess resources on an irrevocable pre-need funeral agreement.

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

Effective January 1, 2011, pre-need funeral agreements established with the assets of a Medicaid applicant/recipient or a legal responsible relative for the funeral and/or burial expenses of a family member must also be irrevocable. Family members are defined as spouse, minor and adult children (including adoptive children and step-children), brothers, sisters, parents, adoptive parents and the spouses of those individuals

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5 For purposes of accuracy, most of the description of post-DRA law herein is substantially derived/quoted from 06 OMM/ADM 5
6 N.Y.Soc.Serv.L. §209(6)(b) and 18 NYCRR §360-4.6(b)(1)
7 N.Y.Soc.Serv.L. §141(6)
as long as the marriage is in effect.\textsuperscript{8}

For community based Medicaid applicants, the applicant/recipient's home is considered an exempt resource, and will not affect Medicaid eligibility.\textsuperscript{9} Under the DRA, equity in the home in New York State may not exceed $786,000 (increased in 2012). Medicaid can \textit{recover} against the home at the time of the recipient’s death if the home is part of the recipient’s estate, as defined by current regulation. For institutionalized applicants, an applicant who holds title to a homestead with equity not exceeding $786,000 will be eligible if there is a possibility that the individual can return home from the nursing home, or if the recipient has stated his or her intention to return home.\textsuperscript{10} However, Medicaid has the right to place a lien on the home, which will be removed if the applicant returns home.\textsuperscript{11} In Anna W. v. Bane, the Court held that a client’s \textit{subjective} intent to return home was sufficient to determine that a homestead shall not be counted as an available resource. The Court concluded that a State’s presumption that a Medicaid applicant had no expectation of returning home was a violation of federal law.

A lien will not be placed on the home, and the home will not be countable, even if the applicant does not intend to return home, if the home is occupied by a spouse, minor or certified blind or certified disabled child. In the case of a home that is occupied by a sibling with an equity interest in the home and who has lived in the home for at least one year prior to the applicant/recipient’s (“A/R”) admission to a medical facility, a lien will not be placed, but the home will be a countable resource if there is no intent to return. However, the home will not be counted if the sibling’s name is on the deed and the sibling refuses to liquidate or purchase the applicant’s share of the property or if the sibling is a dependent relative of the applicant. If the nursing home Medicaid recipient has no intention of returning home from the institution and none of the exemptions apply, the home will be treated as any other non-exempt resource, creating ineligibility.\textsuperscript{12}

IRAs or qualified retirement accounts of the applicant are exempt if the applicant is receiving periodic payments. The periodic payments, however, are deemed to be income and will be budgeted by Medicaid accordingly. New York City Medicaid’s policy on IRA’s changed in early 2002 and Nassau County followed suit shortly thereafter. Upstate New York maintained its policy that IRAs of the applicant were available for Medicaid purposes, until the \textit{Matter of Arnold S.}, a fair hearing that was decided on May 28, 2002. The decision in \textit{Arnold S.} made it clear that IRAs and any qualified retirement accounts of the applicant will not be counted as resources. IRAs and qualified retirement accounts of a non-applying spouse that are in periodic payment status are also exempt.

The aggregate of all German and Austrian reparation payments made to the A/R as a result of Nazi persecution are considered as exempt resources. However, income generated from the resources (interest or dividends) will be countable. A/Rs receiving

\textsuperscript{8} 11 OHIP/ADM-4  
\textsuperscript{9} 18 NYCRR §360-4.7(a)(1)  
\textsuperscript{10} See Anna W. v. Bane, 863 F.Supp.125 (W.D.N.Y. 1993)  
\textsuperscript{11} 18 NYCRR §360-7.11(a)(3).  
\textsuperscript{12} 18 NYCRR §360-4.7(a)(1)(ii)
such payments should obtain a letter from Germany or Austria to prove the amount of reparations received to date.

**Additional Exempt Resources** – Exempt items include personal property such as clothing, furniture, personal effects and a car. Life insurance policies with no cash surrender value (typically term or group policies) are also exempt.\(^{13}\)

**Income** – Effective January 1, 2012, a community-based Medicaid recipient is permitted to retain income of $792 monthly and an additional $20 per household if the Medicaid recipient is aged, blind or disabled. A couple may retain $1,159 monthly. A nursing home Medicaid recipient may retain $50 of income each month for personal needs. Income exceeding the allowance must be contributed toward the individual’s health care unless there is a community spouse with income under $2,841 per month.\(^{14}\) Under such circumstances, the applicant/recipient’s income may be budgeted to the community spouse, to bring her income to the $2,841 level.

**Institutional Medicaid Eligibility Pre-DRA**

**Transfers Of Assets For Less Than Fair Market Value** – Prior to enactment of the DRA, the agency to which the institutional application was submitted “looked back” at an individual’s financial records for a period of 36 months prior to the requested “pick-up date” (the date on which the applicant needs Medicaid to begin providing benefits).\(^{15}\) Under OBRA-93, the look-back period in the case of payments to or from certain trusts was increased to 60 months. Analyzing the applicant’s financial transactions within the look-back period was, and still is, used to determine whether the applicant (or spouse) transferred, i.e. gifted, income and/or resources for less than fair market value.

When an applicant makes a gift within the look-back period, the Medicaid agency will impose a period of ineligibility, or “penalty period”, during which the applicant will be required to pay privately for care. New York State calculates the penalty period as commencing on the first day of the month following the month in which the transfer was made.\(^{16}\)

The penalty period is calculated by dividing the total cumulative, uncompensated value of assets transferred for less than fair market value by the current average monthly cost to a private-pay patient in a nursing facility within the region. New York State has exercised the federally granted option to apply community-based private-pay averages, which differentiate between the various counties in the State. The resulting number is the number of months the applicant will be ineligible for institutional Medicaid benefits. According to the New York State Department of Health, the average cost of nursing home care for 2012 is $10,957 in New York City (all 5 counties), $11,849 in Nassau and Suffolk Counties, $10,335 in the Northern Metropolitan Region; $8,015 in the Central

\(^{13}\) 18 NYCRR §360-4.6(b)
\(^{14}\) N.Y.Soc.Serv.L. §366-c(2)(h).
\(^{15}\) 18 NYCRR §360-4.4(c)(2)(i)(c)
\(^{16}\) 96 ADM 8, p.5
Region, $8,540 in the Northeastern Region, $9,363 in the Rochester Region and $8,337 in the Western Region.

Transfers made by a community spouse to any individual or entity other than the Medicaid recipient, after acceptance has been determined, will not affect the institutional spouse’s Medicaid eligibility.

It is important to note that OBRA-93 has eliminated the "cap" on penalty periods, which may be a trap for the unwary. For example, suppose that a Nassau County resident transferred $802,230 to his son on February 1, 2010. If he applies for institutional Medicaid benefits after the post-DRA 60 month look-back period (i.e. March 1, 2015 or thereafter), he would be eligible for institutional Medicaid benefits. However, if that same individual is admitted to a nursing home 36 months after the transfer (February 1, 2013) and applies for Medicaid, the Department of Social Services (“DSS”) would impose a penalty period for 73.22 months ($802,230 divided by $10,957 = 73.22) commencing on February 1, 2013 (the date that the individual is a resident of a nursing home and applies for Medicaid). By failing to wait the additional 24 months to apply for Medicaid, this individual would have to pay privately for nursing home care for 78 months unless other planning measures are taken.

**Institutional Medicaid Eligibility Post-DRA**

The look-back period for transfers made on or after February 8, 2006, has increased from 36 to 60 months for nursing home Medicaid applications. For transfers made on or after February 8, 2006, the beginning date of the period of ineligibility is the first day of the month after which assets have been transferred for less than fair market value, or the date on which the otherwise eligible individual is receiving nursing facility services for which Medicaid coverage would be available but for the imposition of a transfer penalty, whichever is later, and which does not occur during any other penalty period. As a result, in most cases, the waiting period for nursing home Medicaid eligibility will not start until the A/R is in a nursing home, has assets of no more than $14,250 (plus other exempt assets) and has applied for benefits.

To apply these regulations post-DRA, again consider a New York City resident who gifted the sum of $100,000 to his daughter. However, in this example, the gift was made on January 1, 2008, (after the effective date of the DRA), and the applicant was admitted to a nursing home in January, 2012. The calculation of the penalty period for Medicaid nursing home benefits remains the same - $100,000 gift divided by $10,957, or 9.13 months. However, in this post-DRA example, the resulting penalty period of 9.13 months does not commence until February 1, 2012, assuming that in January, 2012 the individual had assets below the Medicaid resource level and applied for Medicaid benefits prior to May, 2012 (ninety days from when the penalty commences).

Most of the provisions of the DRA apply to Medicaid nursing home applications filed on or after August 1, 2006. Nevertheless, Social Services districts continued to require resource documentation for the prior 36 months (60 months in the case of a trust)
until February 1, 2009, when districts began requiring resource documentation for the prior 37 months. The look-back increased by one-month increments until February 2011, when the 60-month look-back was fully phased in.

In the event that the imposition of a transfer penalty would create an undue hardship for the A/R, an exception to the application of the penalty may be made. There are no substantive changes to the definition of undue hardship as described in 96 ADM 8, but the procedural requirements have changed pursuant to the DRA. Procedural changes are found in 06 OMM/ADM 5.

**Return of Transferred Assets**

According to 06 OMM/ADM-5, if all or part of the transferred assets are returned after the Medicaid eligibility determination, the assets must be counted in recalculating the individual’s eligibility as though the returned assets were never transferred, and the length of the penalty period must be adjusted accordingly. The recalculated penalty period, if any, will begin when the individual is receiving nursing facility services for which Medicaid coverage would be available but for the imposition of the transfer penalty. Therefore, the recalculated penalty period cannot begin before the assets retained by the individual at the time of transfer, combined with the assets transferred and subsequently returned to the individual, are spent down to the applicable Medicaid resource level.

If an application is denied or a case discontinued where a transfer penalty has been imposed, the individual must file a new application. If upon reapplication the transferred assets have been returned to the applicant, the original transfer penalty period is to be reduced by the amount of returned assets.

**Undue Hardship Waiver**

If an individual is unable to demonstrate that a transfer was made exclusively for a purpose other than to qualify for nursing home benefits, the individual may nevertheless receive coverage if he can establish undue hardship. For transfers made on or after February 8, 2006, undue hardship exists when:

- the individual applying for nursing facility services is otherwise eligible for Medicaid; and
- despite his/her best efforts, as determined by the social services district, the individual or individual’s spouse is unable to have the transferred assets returned or to receive fair market value for the asset or to void a trust; and
- either: the individual is unable to obtain appropriate medical care such that the individual’s health or life would be endangered without the provision of Medicaid for nursing facility services; or
- the transfer of assets penalty would deprive the individual of food, clothing, shelter, or other necessities of life (this provision was added by the DRA).
Annuities Pre-DRA

Prior to the enactment of the DRA, one way to protect assets of the community spouse was to purchase an \textit{irrevocable} annuity that complies with HCFA Transmittal No. 64, in that its term was no longer than the life expectancy of the spouse and is therefore actuarially sound. The annuity also had to be irrevocable, non-assignable, non-commutable, with no cash value. Medicaid did not consider such an annuity as an available resource nor did it consider the purchase of the annuity to be a transfer of assets because the annuitant was receiving an income stream in exchange for the assets.

Annuities Post-DRA

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

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

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

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

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

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

Based upon the DRA rules regarding notes, it is possible to use the promissory note to
preserve some of an institutionalized individual’s assets. While the traditional “half-loaf” plan no longer renders one eligible for Medicaid because retaining assets in one’s name prevents the penalty period from beginning to run, it is possible to utilize the promissory note as part of asset protection planning. In order to be “otherwise eligible” for Medicaid, the applicant must transfer all assets out of his or her name, rather than transferring one-half and retaining one-half to pay privately during the resulting penalty period. Hence, using the promissory note plan, the individual gifts one-half of the assets and loans approximately one-half of the assets. The applicant uses the loan repayments to pay the nursing home privately during the penalty period. It is imperative that the loan repayments, along with any other income received by the applicant, do not exceed the cost of nursing home care. If income exceeds the cost of care, the applicant will not be otherwise eligible and the penalty period will not begin to run.

**Home Equity Value Post-DRA**

Section 366.2(a)(1) of the Social Services Law is amended to require that for applications for nursing facility services and community-based long-term care services made on or after January 1, 2006, an individual will not be eligible for such care and services if the individual’s equity interest in his or her home exceeds $786,000 (increased in 2012). The limitation does not apply if a spouse or minor, blind or disabled child is residing in the home.

The equity value is derived by subtracting any legal encumbrances (liens, mortgages, etc.) from the fair market value. If the home is owned jointly with one or more individuals, each owner is presumed to have an equal interest in the property, absent any evidence to the contrary. Individuals cannot spend down excess equity with the use of medical bills to obtain eligibility. Individuals whose equity interest in the home exceeds $786,000 will not be eligible for Community based Medicaid coverage.

Despite the foregoing, an otherwise eligible applicant will be provided Medicaid coverage of long-term care services if the applicant meets the criteria of undue hardship. The DRA provides for separate undue hardship criteria regarding the primary residence. Undue hardship exists when denial of Medicaid coverage would (a) deprive the applicant of medical care such that the individual’s health or life would be endangered or (b) deprive the applicant of food, clothing, shelter, or other necessities of life AND there is a legal impediment that prevents the applicant from being able to access his or her equity interest in the property.

**Continuing Care Retirement Community Contracts and Life Care Community Contracts**

Individuals with contracts for admission to a State licensed, registered, certified or equivalent continuing care retirement or life care community may be required to use their admission fees before applying for Medicaid. Under certain circumstances an individual’s paid entrance fee to a CCRC or life care community will be considered a resource when determining Medicaid eligibility.
Effective for Medicaid applications filed on or after August 1, 2006, an individual’s entrance fee in a continuing care retirement community or life care community shall be considered a resource to the extent that:

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

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

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

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

**DRA Long-Term Care Partnership Provisions**

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

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

The DRA requires state partnership programs to comply with model guidelines established by the National Association of Insurance Commissioners. DHSS must develop standards for “uniform reciprocal recognition” of partnership policies from state to state so that “benefits paid under such policies will be treated the same by all states.” DHSS must also establish a National Clearinghouse for Long Term Care Information. The DRA sets out the requirements for the clearinghouse.

**Life Estates**

96 ADM 8 states that “a life estate will not be considered an available resource”. Thus, the retention of a life estate by a Medicaid applicant will not preclude eligibility.

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17 §6021 of DRA codified at 42 USCS 1396p(b)(1)(c)(iii)
When a Medicaid applicant retains a life estate on a property, the penalty period resulting from the transfer of the property is reduced by the value of the life estate. However, note that there is amendment to New York State’s Social Services Law, as enumerated in the New York State Department of Health Directive, 11 OHIP ADM 8, which sets forth a new method to calculate the value of life estates based on IRS Table S and the federal midterm interest rate, i.e. the Section 7520 rate.

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

**Purchase of a Life Estate Post-DRA**

For nursing home Medicaid applications filed on or after August 1, 2006, the purchase of a life estate interest in another individual’s home on or after February 8, 2006 is treated as an uncompensated transfer of assets unless the purchaser resided in the home for a continuous period of at least one year after the date of purchase. If an applicant resided in his daughter’s home for at least one year after purchase of a life estate, the purchase would not be considered a gift and would not incur a penalty period.

**Options Regarding The Homestead**

**Transfer of Homestead and Retain a Life Estate**

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

If the grantor retains a life estate and the home is not sold during the grantor’s lifetime, the home will be part of the grantor’s taxable estate and his or her heirs will consequently receive the home with a “stepped up” basis. In other words, the tax basis of the home will be increased or “stepped up” to the market value on the date of the grantor’s death (or alternate valuation date), reducing capital gains taxes that may be due upon the beneficiary’s sale of the home. However, life estates are now subject to Medicaid recovery.

On the other hand, if the grantee sells the home on which the A/R has retained a life estate while the A/R is alive, the A/R is entitled to the present value of the life estate pursuant to Medicaid’s charts, which would create ineligibility for Medicaid benefits upon the sale.
Transfer of Homestead Without Retaining a Life Estate

If the A/R transfers the home, whether to an individual or trust, without retaining a life estate, the calculation of the penalty period is based on the entire fair market value of the home. Furthermore, transfers to individuals (not to trusts) without retention of a life estate result in a carry-over basis for the grantee, making it more likely that the grantee will have gain, and resulting taxes, upon sale of the home (unless he or she occupies the home and is entitled to the $250,000 exemption).

Sale of Homestead

Another option is for the A/R to sell the home immediately, allowing the A/R to receive the $250,000 capital gains exemption. When the house is sold, the A/R can gift some or all of the proceeds, creating a penalty period pursuant to the provisions of the DRA as outlined above.

“Intent to Return Home”

If the A/R needs nursing home care immediately and does not have cash to pay privately during a penalty period, the A/R could sign a letter of “intent to return home”, apply for Medicaid and begin receiving benefits right away (assuming he/she is otherwise eligible and the equity in the home is $786,000 or less). The Medicaid agency will put a lien on the home if it determines that the A/R is not reasonably expected to return home. The A/R can sell the home subsequent to becoming Medicaid eligible. Upon the sale, the A/R will have to reimburse Medicaid at the Medicaid rate (often 30% less than the private rate). After reimbursing Medicaid, the A/R can still preserve a portion of the net proceeds of the sale. The A/R’s attorney may be able to negotiate an escrow agreement with DSS, allowing the A/R to stay on Medicaid and pay to Medicaid the sum that would be paid privately during the waiting period. If not, the A/R’s Medicaid will be discontinued, at which point he or she can transfer assets using the gift/promissory note plan discussed above.

Transfer of Homestead to an Irrevocable Trust

If the A/R does not wish to transfer the home to an individual, he or she may transfer the home into an irrevocable trust, whereby the A/R retains the right to use the home and to receive income generated from the trust for the A/R’s lifetime. The transfer into the trust may entitle the grantor A/R to retain the $250,000 capital gains exemption on sale provided the trust is drafted properly. Transfer into a properly drafted trust will also entitle the beneficiaries to a stepped-up basis. If the home is sold after the look-back period has expired, Medicaid benefits will not be discontinued, as the proceeds will be held by the trust.

Finally, one of the most commonly exercised options is to transfer the remainder interest into an irrevocable trust, retaining a life estate, thereby reducing the period of ineligibility while maintaining the capital gains exemption. Such transfer also avoids issues resulting from the death, incapacity or financial problems of a grantee. As mentioned earlier, retention of a life estate will entitle the Grantor to a portion of the proceeds if the house is sold during Grantor’s lifetime, affecting Medicaid benefits. However, as mentioned earlier, life estates are now subject to estate recovery so an attorney must engage in a cost/benefit analysis of retaining the life estate.
Exempt Transfers

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

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

Transfers involving spouses - Transfers between spouses are exempt from Medicaid ineligibility rules.\(^\text{18}\) The purpose is to protect against the impoverishment of a community or well spouse. The following transfers are also exempt:

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

The regulations permit transfers between spouses to be completed within 90 days after a determination of eligibility, if the community spouse’s assets do not exceed the Community Spouse Resource Allowance (see below for discussion of the CSRA).\(^\text{19}\) However, completing all transfers to a spouse prior to submission of the Medicaid application simplifies the application process.

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

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

\(^{18}\) N.Y. Soc.Serv.L. §366(5)(e)(4)(i)(A) and (ii)(A)
\(^{19}\) 18 NYCRR §360-4.10(c)(6).
1. the transfer of assets to a trust established solely for the benefit of the applicant/recipient’s blind or disabled child; and
2. the transfer of assets to a trust established solely for the benefit of an individual under 65 years of age who is disabled.

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

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

**Institutionalized Applicants With Spouses**

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

With regard to the income maximum, a community spouse’s income of up to $2,841 per month (for 2012), including interest, is considered unavailable to pay for the institutionalized spouse’s care. The amount includes income of both spouses, regardless of who earns or receives it. As such, if the income of the community spouse is less than $2,841 monthly, he or she will be entitled to keep the amount of the institutionalized spouse’s income necessary to bring her income up to $2,841. In the event a community spouse’s income is greater than $2,841, the Medicaid agency will request that the community spouse contribute 25% of the excess towards the care of the institutionalized spouse.

If a community spouse’s monthly income is below $2,841, Medicaid will look first to the income of the institutionalized spouse to bring the community spouse’s income up the allowable level. In Golf v. New York State Dept. of Social Services, the Court held that the county Department of Social Services should use an “income first” method, allocating first the income of the institutionalized spouse rather than increasing the Community Spouse Resource Allowance (see below) in order to generate a higher

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20 N.Y.Soc.Serv.L. §366(5)(e)(4)(i) and (ii)
21 18 NYCRR §360-4.10(b)(5)
22 674 N.Y.S.2d 600 (N.Y., 1998)
monthly income. However, in *Robbins v. DeBuono*\(^2^3\), the Second Circuit held that the deeming of the institutionalized spouse’s Social Security benefits to his community spouse was considered an “alienation,” in violation of the Social Security Act. As such, after *Robbins*, the income first rule no longer applied to Social Security benefits and the State issued an informational release indicating same.\(^2^4\) As a result, elder law attorneys had the opportunity to advocate for an enhanced Community Spouse Resource Allowance rather than deeming the institutionalized spouse’s Social Security benefits as available to the community spouse. However, *Robbins* was subsequently undermined by the United States Supreme Court decision *Washington State Dep’t of Social & Health Services v. Guardianship Estate of Keffeler*,\(^2^5\) which questioned inalienability of Social Security benefits and *Ruck v. Novello*\(^2^6\) which the Court distinguished from *Robbins*. New York State consequently issued a memorandum rescinding GIS 00 MA/027 and the Department of Health no longer treats institutionalized spouses with Social Security income differently than other institutionalized spouses.\(^2^7\)

The New York Court of Appeals ultimately held in *Matter of the Estate of Tomeck* that New York's income-first policy, which took Social Security benefits into account when deeming or attributing income from institutionalized spouse to community spouse before allowing the community spouse resource allowance to increase, did not violate the anti-alienation provision of Social Security Act.\(^2^8\)

All resources held by either spouse are considered available to the institutionalized applicant. The community spouse is entitled to retain a Community Spouse Resource Allowance (“CRSA”), currently $74,820, or ½ of the couple’s total resources, up to a maximum of $113,640 (2012). The CSRA, as well as the homestead in which the spouse resides, are considered unavailable to pay for the institutionalized spouse’s care. The community spouse may retain more than the CSRA if her income (including interest from her assets) is below the Minimum Monthly Maintenance Needs Allowance (MMNA) of $2,841 (2012). The need for an increase must be determined by a fair hearing or court order.

Community spouses who require more monthly income than the MMNA must request spousal support, typically in Family Court. For a more in-depth discussion of spousal support, see *Gomprecht v. Gomprecht*,\(^2^9\) in which the Court of Appeals held that income payments to a community spouse may be increased above the minimum monthly maintenance needs allowance only upon a finding of “exceptional circumstances.” Also see *Jenkins v. Fields*,\(^3^0\) in which the court found that in adopting the exceptional circumstances standard the judges in *Gomprecht* were not in violation of the basic congressional intent of the applicable statute. As a result, the court found that the spouse

\(^{23}\) 218 F.3d 197  
\(^{24}\) GIS 00 MA/027  
\(^{25}\) 537 U.S. 371  
\(^{26}\) 295 F.Supp.2d 258  
\(^{27}\) GIS 05 MA/002  
\(^{28}\) 8 N.Y.3d 724  
\(^{29}\) 86 N.Y.S.2d 47 (1995)  
\(^{30}\) 1996 U.S. Dist. LEXIS 5852
had shown no probability of success on the merits and denied her motion for a preliminary injunction.

The elder law attorney must engage in extensive advocacy in cases where an argument can be made for an enhanced CSRA or increase in support. Ronald Fatoullah & Associates has successfully represented community spouses in fair hearings, resulting in increased CSRAAs, as well as in Family Court, receiving an increase in support, above the MMNA, from the institutionalized spouse.31

**Spousal Refusal** – As discussed above, if a community spouse has assets and/or income in excess of the CSRA and/or MMMNA, such assets and income will be considered available to pay for the institutionalized spouse’s care. However, under current New York law, Medicaid benefits will not be denied to the institutional spouse if the community spouse refuses to contribute any of his or her excess assets and or income by signing a “Spousal Refusal” letter.32 In addition, when a community spouse refuses to contribute to the institutional spouse’s care, the Medicaid applicant/recipient must execute an assignment of support rights against the community spouse and in favor of the Department of Social Services.33 A formal assignment of support will not be required if the applicant is unable to execute the assignment because of a mental or physical impairment, or if the denial of assistance would create an undue hardship.34 In such circumstances, the assignment of support rights from the institutionalized spouse to the Department of Social Services will be implied.

In cases involving spousal refusal, Medicaid has the right to commence an action on behalf of the recipient against the community spouse, in order to compel support and for reimbursement of expenses incurred on behalf of the institutional spouse.35 Further, Medicaid has the right to recover from the community spouse for benefits paid on behalf of the institutionalized spouse. See supra for a discussion of recovery.

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

32 N.Y.Soc.Serv.L. §366(3)(a); 18 NYCRR §360-4.3(f)(1)(i)
34 18 NYCRR §360-4.10(a)(12)(iv)(b).
Community-Based Medicaid Eligibility

Medicaid rules regarding transfer of asset penalty periods currently apply only to persons seeking or receiving coverage for nursing home services. Therefore, if a person needs medical assistance to pay for a home health aide or for a hospital visit, there is no period of ineligibility resulting from the transfer of assets. For example, if a client is seeking community-based Medicaid to begin coverage in February, 2011, the client may transfer his or her assets above the allowable resource level in January, 2011. The same resource levels for the applicant/recipient apply for both community based and institutional Medicaid. It must be noted that there are no statutory protections of resources and income of well spouses of community-based Medicaid recipients. Thus, a spousal refusal is submitted for virtually all home care Medicaid applications in which the well spouse has assets. The homestead, as well as the surrounding land, is an exempt resource for applicants applying for community based Medicaid, but keep in mind the home equity restriction of $786,000 discussed earlier.

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

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

Trusts

Trusts Established by the Medicaid Applicant

OBRA 93 (which applies to all trusts created on or after August 11, 1993) changed the rules regarding trust funds, imposing restrictions on Medicaid eligibility. Irrevocable income-only trusts are often used as a tool to protect assets of a Medicaid applicant. These trusts typically provide that while income is distributed to the grantor, the trust principal cannot, under any circumstances, be distributed to the grantor. As such, HCFA’s interpretation of OBRA 93 is that in such cases, only the income (not the principal) will be deemed available to the applicant. If a self-settled trust provides that principal may be paid to the grantor, whether or not it is for a limited purpose or at the sole discretion of the trustee, the entire principal of the trust is deemed available to the grantor, creating Medicaid ineligibility.

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

Of course, assets held by a revocable trust for which the Medicaid applicant is the grantor will be considered available. As such, revocable trusts are often not used as Medicaid planning tools, but for other purposes, including avoiding probate and continuing management of assets if the grantor becomes incapacitated.

**Exempt Self-Settled Trusts**

Under OBRA-93, certain types of trusts are exempt from the Medicaid transfer rules and the 60-month look back period. In other words, neither the creation nor the funding of such trusts affects Medicaid eligibility of the settlor or the beneficiary. The following trusts are “self-settled”, i.e. funded with the A/R’s assets

**“Under 65” Special Needs “Payback” Trusts** - This type of trust is funded by individuals who are under 65 years of age and disabled. The Special Needs Trust must be created for the individual’s benefit by a parent, grandparent, legal guardian, or by a court.

The Trust will remain exempt if the individual lives beyond 65 years of age. However, assets that are added to the trust after the beneficiary reaches 65 will be subject to Medicaid transfer penalty rules.

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

**Pooled Trusts** – In a “Pooled Trust”, the assets of many disabled persons are held in a single trust with separate accounts for each person. A Pooled Trust must be established and managed by a non-profit organization. Similar to the Special Needs Trust, the Pooled Trust is limited to disabled individuals. However, unlike the Special Needs Trust, there is no requirement that the beneficiary be under the age of 65. Nevertheless, funding of the trust with assets is exempt from Medicaid penalty periods only if the individual is under age 65 at the time of the funding.

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36 EPTL § 7-1.12.
37 Id.
38 42 USCS §1396p(d)(4)(A)
39 42 USCS §1396p(d)(4)(C)
40 Id.
A separate account for each disabled person must be maintained. The trust must be funded by the disabled person, his parents, his grandparents, his legal guardian, or a court. The trust must contain language indicating that payments will not replace or reduce Medicaid benefits of the disabled individual.

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

**Pooled Income Trusts** - On April 19, 2005, the New York State Department of Health authorized use of the NYSARC pooled trust for the excess income of disabled individuals who are 65 or older.\(^{41}\)

Subsequent to the September 23, 1997 Addendum to 96 ADM 8, community Medicaid recipients are often advised to transfer their monthly surplus income into a pooled trust. As it is often impossible for an A/R in New York to meet living expenses with retained income of only $812 per month, the use of a pooled trust helps the disabled individual to remain in the community. The Department of Health has issued an informational letter instructing districts how to handle disability determinations.\(^{42}\)

**Estate Recovery**

Prior to OBRA 93, Medicaid was entitled to recover from the estates of individuals who received Medicaid benefits after age 65. OBRA-93 extended the right of recovery against the estates of individuals who received benefits after age 55.\(^{43}\) The law permits recovery for benefits paid within ten years of death.

OBRA-93 defines the term "estate" to include all real and personal property and other assets included within an individual's estate, as defined for purposes of the respective state’s probate law.\(^{44}\) This includes assets that may be administered if the individual had no will. OBRA-93 permits the optional expansion of the definition of "estate" to include jointly held assets, life estates and assets held in trust for recovery purposes.\(^{45}\) Until September 8, 2011, the definition of “estate” for recovery purposes included “all of the individual's real and personal property and other assets passing under the terms of a valid will or by intestacy.” In other words, New York State was legally entitled to recoup only from the probate estate of Medicaid recipients.

On April 1, 2011, New York State passed a budget bill expanding estate recovery under Section 369 of the Social Services Law to include life estates, joint accounts and assets with beneficiary designations. The New York 2012-2013 budget bill repealed the

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\(^{41}\) 05 OMM/INF-1
\(^{42}\) Id.
\(^{43}\) 42 USCS §1396p(b)(1)(B)
\(^{44}\) 42 USCS 1396p(b)(4)(A)
\(^{45}\) 42 USCS 1396p(b)(4)(B)
EER legislation that expanded the definition of “estate” beyond the probate estate. But fortunately, the 2012-2013 New York State budget bill repealed the expanded Medicaid estate recovery provisions and now, once again, non-probate assets may not be considered as part of the decedent’s estate for recovery purposes. Now, in New York State, there may be recovery only against the probate estate of a decedent who received Medicaid benefits during his or her lifetime.

**Recovery From Community Spouses**

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

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

Also note that the state may recover from the estate of the community spouse for benefits paid on behalf of the institutionalized spouse if he had sufficient means during the period the medical assistance was rendered to the institutionalized spouse.

**Conclusion**

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

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INCOME AND RESOURCE ALLOWANCES

The 2012 income and resource allowances are as follows:

<table>
<thead>
<tr>
<th>Allowance</th>
<th>Amount</th>
</tr>
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<tbody>
<tr>
<td>Individual Resource Allowance</td>
<td>$14,250*</td>
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<tr>
<td>Individual Monthly Income Allowance</td>
<td>$ 792**</td>
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<tr>
<td>Community Spouse Resource Allowance</td>
<td>$74,820***</td>
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<tr>
<td>Community Spouse Monthly Income Allowance</td>
<td>$ 2,841</td>
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* New York State increased the Individual Resource Allowance from $13,800 to $14,250 effective January 1, 2012.
** An additional $20 of monthly income per household will not be counted for Medicaid applicants who are aged, blind or disabled.
*** or one-half (1/2) of the married couple’s resources as of the first continuous period of institutionalization, up to a maximum of $113,640, whichever is greater.

MONTHLY REGIONAL NURSING HOME RATES

As of January 1, 2012

<table>
<thead>
<tr>
<th>Region</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York City (All boroughs)</td>
<td>$10,957</td>
</tr>
<tr>
<td>Long Island including all of Nassau &amp; Suffolk Counties</td>
<td>$11,849</td>
</tr>
<tr>
<td>Northern Metropolitan Area including Westchester, Putnam, Rockland, Orange, Dutchess, Sullivan, and Ulster Counties</td>
<td>$10,335</td>
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<tr>
<td>Central Region</td>
<td>$ 8,015</td>
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<td>Northeastern Region</td>
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<td>Rochester Region</td>
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<td>Western Region</td>
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