MISCELLANEOUS DRAFTING ISSUES: PROMISSORY NOTES, ANNUITIES, CARE GIVER CONTRACTS

by

DAVID GOLDFARB, ESQ.

Goldfarb Abrandt Salzman & Kutzin LLP
New York City

and

JOSEPH A. ROSENBERG, ESQ.

ADVANCED DOCUMENT DRAFTING FOR ELDER LAW PRACTITIONERS

Miscellaneous Drafting Issues:

Promissory Notes, Annuities, Care Giver Contracts

New York Elder Law by David Goldfarb and Joseph A. Rosenberg, (Lexis/Matthew Bender 2013)

Excerpts from: CHAPTER 8 Medicaid: Transfer of Assets, Liens and Estate Recovery

§ 8.02 Medicaid Eligibility and Outright Transfers of Assets

[1] Federal and New York Law Governing Transfer of Assets

[a] Imposition of a Penalty Period

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No penalty period is imposed on transfers made for full and adequate consideration (e.g., sale of an asset for fair market value).[19]

Under DRA '05, the purchase of an annuity is treated as a transfer for less than fair market value, unless the annuity meets the following criteria: (1) it names the State as the first remainder beneficiary for at least the total amount of medical assistance paid on behalf of the institutionalized individual or the second remainder beneficiary after a community spouse or minor or disabled child;[20] (2) it is irrevocable and nonassignable; (3) is actuarially sound; (4) it provides for equal payments during the term with no deferral or balloon payment.[21] For a sample annuity see Form 8.206, *below*. The provisions (2) through (4) do not apply to annuitizing certain qualified retirement plans, an IRA or a Roth IRA.[22]

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[19] SSL § 366(5)(d)(3).

[20] 42 USC § 1396p(c)(1)(F); SSL § 366(5)(e)(3)(i). The state statute does not reflect the technical correction in the federal law and still references only "medical assistance paid on behalf of the annuitant" rather than "medical assistance paid on behalf of the institutionalized individual."

[21] 42 USC § 1396p(c)(1)(G). Actuarially sound will be determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration. SSL § 366(5)(e)(3)(i). Tables are attached to GIS 12 MA/025 (10/01/2012).

[22] 42 USC § 1396p(c)(1)(G)(i)(I) and (c)(1)(G)(i)(II); SSL § 366(5)(e)(3)(i).

Caution:

If annuitizing a retirement plan, make sure that it falls under the Internal Revenue Code sections listed in the statute. Even so, the restrictions in (1) above—naming the state as a remainder beneficiary—may apply, if under the plan there are remainder beneficiaries after the annuitant or his spouse.[23]

New York implementing legislation provides that for nursing facility services an application or recertification shall disclose any interest the individual or community spouse has in an annuity or similar financial instrument and include a statement that the state becomes a remainder beneficiary.[24]

The transfer of assets under DRA '05 includes funds used to purchase a promissory note, loan or mortgage unless the note, loan or mortgage: (1) has a repayment term that is actuarially sound; (2) has equal repayments during the term of the loan, with no deferral or balloon payments; (3) prohibits cancellation upon death of the lender.[25] For a sample promissory note see Form 8.208, *below*. However, a promissory note may not be considered to be for fair market value where there is no reasonable expectation that it will be paid back.[26]

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[2] Exempt Transfers

[d] Personal Service Contracts

Funds paid to a care provider, including a friend or relative, may be considered "a transfer for fair market value or other valuable consideration" if the compensation is reasonable and in accord with the fair market value of the services. The parties should take into consideration in arriving at this compensation the cost in the community of the services to be provided including the average compensation for court-appointed guardians, geriatric care managers, and for providers of personal needs services. The parties should considered the average number of hours for each type of service to be provided. Consider which services will be provided and which services the care provider will merely arrange to provide (such as home attendant services) with the recipient's funds. Retain the basis for the compensation calculation in case the Medicaid agency challenges the contract as an uncompensated transfer of assets.

The local Medicaid agency is more likely to treat the funds as a compensated transfer if the payments were done for services provided on a weekly or monthly basis. However, a lump sum payment for an actuarially sound lifetime contract based on the life expectancy of the person receiving the care, may also be considered "for fair market value or other valuable consideration." The parties should take into consideration in arriving at this lump sum compensation the age and life expectancy of the care

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[23] *But see* Matter of Entz, Index No. 2009-10454 (Sup. Ct Monroe County March 9, 2010) (court found that there is no requirement that an IRA owned annuity must name the state as a beneficiary).

[24] SSL § 366-a(10), *added by* 2006 N.Y. Laws 57 § 50-b.

[25] 42 USC § 1396p(c)(1)(I). Actuarially sound will be determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration. SSL § 366(5)(e)(3)(iii). Tables are attached to GIS 12 MA/025 (10/01/2012).

[26] Matter of G.F., FH # 5013919Q (Suffolk County, 10/28/2008) (penalty upheld where son gave promissory note that otherwise met the criteria under DRA '05 in return for joint interest in homestead, but no payments were ever made, there was no evidence of payment demand, no litigation was commenced, and applicant/recipient entered a nursing home and applied for Medicaid based on hardship due to his inability to receive income from the note).

recipient. However, a personal service contract that does not provide for the return of any lump sum payment if the care provider becomes unable to fulfill her duties under the contract, or if the applicant/recipient dies before her calculated life expectancy, will be treated as a transfer of assets for less than fair market value.[59] Also, no credit is allowed for services that are provided as part of the Medicaid nursing home rate.[60] The district will evaluate services based on credible documentation, such as a log book. Credit is given for services actually provided, based on the fair market value of the services performed.[61]

For a sample Personal Services Care Contract see Form 8.207, *below*.

In *Delaware County Department of Social Services v. Pontonero*,[62] a niece and attorney-in-fact for an applicant/recipient claimed the transfer of a mortgage to herself six months before applicant/recipient entered a nursing home was not a transfer of assets, but for in consideration of the past care and housing that she had provided to the applicant/recipient and her husband. In allowing the local agency to reopen the Medicaid acceptance the court found that there were questions of fact as to whether the mortgage transfer effectuated by the niece was fraudulent.

In *Matter of Barbato v. New York State Dep't of Health*,[63] the court found Personal Service Contracts to be transfers for less than fair market value because (1) where services were to be provided "as needed" there is no basis to determine the fair value of the services; (2) the absence of a refund provision if the applicant/recipient fails to meet her life expectancy renders the services not for fair market value; and (3) services provided by caregivers that are duplicative of services afforded by a nursing facility in which the applicant/recipient resides are non-compensable. However the court did allow calculation of the fair market value of the non-duplicative services which were performed. *Stern v. Daines*[64] followed *Barbato*, and remanded the case to the local agency solely for the purpose of re-evaluating the value of any services actually received from the date of the Personal Services until the Medicaid eligibility determination. Likewise in *Matter of Kerner v Monroe County Dept. of Human Servs.*,[65] the court remanded for an opportunity to identify with reasonable specificity the services rendered and the number of hours spent rendering those services, as well as the fair market value of those services.

Matter of Swartz v. New York State Dept. of Health[66] involved a dispute between an applicant's estate and the local agency regarding the value of services provided under a personal care contract before the applicant entered a nursing home. The Appellate Division held that the agency could disallowed credit for services rendered during nighttime where there was just a general plan of care and no detailed

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[59] GIS 07 MA/019 (9/24/07). Matter of Gitter v. State of New York Dept. of Health, 2009 N.Y. Misc. LEXIS 6345 (Sup. Ct. New York County 2009) (court found the interpretation in the GIS to be reasonable and SSI POMS are not dispositive since separate transfer-of-assets rules were enacted for the Medicaid program).

[60] GIS 07 MA/019 (9/24/07); Matter of M.G., F.H. # 473952M, (Oneida County, 5/3/2007); Matter of Basil E, F.H. # 4832282L (Albany County 11/12/2007).

[61] GIS 07 MA/019 (9/24/07).

[62] Delaware County Dept. of Social Servs. v. Pontonero, 31 A.D.3d 999, 820 N.Y.S.2d 151 (3d Dep't 2006).

[63] Matter of Barbato v. New York State Dep't of Health, 65 A.D.3d 821, 884 N.Y.S.2d 525 (4th Dep't 2009)

[64] Stern v. Daines, 2009 N.Y. Misc. LEXIS 3670 (Sup. Ct. Queens County 2009).

[65] Matter of Kerner v. Monroe County Dept. of Human Servs., 75 A.D.3d 1085, 1087, 904 N.Y.S.2d 616 (3d Dep't 2010)

[66] Matter of Swartz v. New York State Dept. of Health, 946 N.Y.S.2d 698 (3d Dep't 2012).

contemporaneously-prepared records documenting the services allegedly provided each night and that the agency could use the U.S. Department of Labor mean hourly wage rate for a personal home healthcare aide in this state rather than the rate provided in the contract.

Practice Note

As an Alternative, Have Relatives Consider Paying for Medical or Nursing Home Care and Taking an Income Tax Deduction. A relative can include medical expenses he paid for his dependent. Deductions are limited to the extent the expenses exceed 7.5% of adjusted gross income of the taxpayer and for alternative minimum tax only to the extent they exceed 10% of adjusted gross income. The person must have been a dependent either at the time the medical services were provided or at the time the relative paid the expenses. A person generally qualifies as a dependent for purposes of the medical expense deduction if the person was a qualifying child or a qualifying relative including a father, mother, grandmother, grandfather, aunt, or uncle and for whom he provided over half of the support. See IRC Section 213 and Internal Revenue Service Publication 502.

To the extent these expenses are paid with funds recently received from the dependent relative, this might be considered a step transaction and disallowed.

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[5] Managing the Penalty Period: Rule of Halves

For transfers made prior to February 8, 2006, the formula used to calculate the penalty period and the effective date of the penalty period are structured in such a way that a person who follows the "rule of halves" may transfer approximately half of her assets, using the remainder to pay for the cost of nursing home care during the period of ineligibility that results from the transfer. In order to maximize the benefits of this strategy, both the penalty period and the length of time it will take to spend down the retained assets must be calculated.

Comment:

The relative amount of the assets to transfer and the amount to be retained to pay for the cost of care during the penalty period would vary, depending on the factors involved in each case (e.g., the actual cost of the nursing home, the amount of monthly income available to pay for care).

Caution:

This planning technique would no longer apply after the implementation of DRA '05 to transfers on or after the enactment date. Under DRA '05, the effective date of the penalty period will be the first day of the month after which assets have been transferred, **or** the date on which the individual is eligible for Medicaid and would otherwise be receiving institutional care based on an approved application but for the application of the penalty period, **whichever is later**.[122] See § 8.02[3][b], *above*. In other words, an individual can no longer transfer assets and use other funds to wait out a penalty period because he would not be "otherwise" eligible, by virtue of the retained funds.

Some practitioners anticipated that a "rule of halves" strategy could still be undertaken, by transferring assets then after part of the penalty period ran, making a partial return of assets and having

[122] 42 USC § 1396p(c)(1)(D)(ii).

the initial penalty period recalculated. However, although a partial return of assets is allowed, the recalculated penalty period will not begin to run on the original transfer date, because the returned assets will not render the individual as "otherwise eligible."[123]

A similar planning technique is available under DRA 2005, by combining a transfer with an actuarially sound annuity or loan. See discussion of annuities and loans at 8.02[1], *above*. At the time of the transfer the institutionalized person would have to make a loan or purchase an annuity, so that funds are not retained and she is otherwise eligible for Medicaid. The institutionalized person's monthly income, including the annuity or loan repayment, would have to render her Medicaid eligible, but she could not actually receive Medicaid during the penalty period from the transfer. The shortfall for the nursing home payment could be made by an in-kind voluntary contribution from a non-legally responsible relative; see income exemptions discussed at § 6.05[3], *above*; or alternatively the individual's income could be between the Medicaid rate and the private pay rate at the facility, rendering her a "certain medicaid-eligible individual" (individuals who are otherwise entitled to Medicaid in the facility but such benefits are not being paid because, their income exceeds the Medicaid level).[124] For a sample annuity see Form 8.206, *below*. For a sample promissory note see Form 8.208, *below*. For a sample Medicaid Application based on a gift and loan see Form 9.210A, *below*.

A number of fair hearings have upheld that an actuarially sound promissory note is not a transfer of assets.[125] In *Matter of DeGroat*,[126] the Department of Health found that the prepayment clause which allowed borrower to prepay but with a penalty, did not violate the DRA criteria. Another issue is that although under the DRA the purchase of an annuity, or making a loan or mortgage may not be considered a transfer; nevertheless the annuity or promissory note may be given a value as a resource even though they are drafted as "nonassignable." There is some question whether a note or annuity can be made nonassignable under New York law.[127] Thus the applicant would not be otherwise eligible and no penalty period would be triggered.[128] However, a number of fair hearings have concluded that the promissory notes were non-negotiable because they did not have quantifiable value on the open market. In those cases experts established that the notes were worthless due to the fact there is no secondary market.[129]

In *Matter of M.L.*,[130] the court approved medicaid planning by a guardian in the form of a gift and loan provided the promissory note met the criteria of DRA '05.

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[123] 06 OMM/ADM-5 at 19.

[124] 42 USC § 1396r(c)(7)(A); 42 CFR § 447.20. However, it is not clear if that person is "receiving nursing facility services for which Medicaid would otherwise be available but for the transfer penalty."

[125] Matter of Rose M. F.H. # 346495 (Albany County, 5/18/2007) (upholding the agency finding that there was a transfer because the promissory note did not state it was non-assignable and a modification did not cure the defect because there was no return of the funds); Matter of Mary K. F.H. # 4733465H (Albany County, 8/29/2007); Matter of A.G. F.H. # 4733471N (Albany County 8/29/2007); Matter of G.A. F.H. # 4733466Z (Albany County, 8/29/2007); Matter of A.A. F.H. # 4733476H (Albany County, 9/7/2007); Matter of Edward H., F.H. # 4819798M (Albany County, 11/21/2007); Matter of Else F.H. # 5313861K (Nassau County, 11/20/2009)(upholding note even when signed when individual resided in nursing home).

[126] Matter of DeGroat, 1 F.H. #5061459Y (Rockland County, 10/01/08).

[127] UCC §§ 9-406, 9-408; Ins. Law § 3212.

[128] *But see* James v. Richman, 547 F.3d 214 (3d Cir. 2008) which finds nonassignable annuity purchased by community spouse to have no value as a resource.

[129] Matter of Mary K. F.H. # 4733465H (Albany County 8/29/2007); Matter of A.G. F.H. # 4733471N (Albany County 8/29/2007); Matter of G.A. F.H. # 4733466Z (Albany County 8/29/2007); Matter of A.A. F.H. # 4733476H (Albany County 9/7/2007).

[130] Matter of M.L., 25 Misc. 3d 1217A, 901 N.Y.S.2d 907 (Sup. Ct. Bronx County 2009).

Caution:

Another suggestion for creating an annuity with no value as a resource is to use a Grantor Retained Annuity Trust (GRAT). However, the Medicaid rules for the treatment of a trust will also deem this an available resource since the periodic payments from the GRAT will be treated as a restriction as to when distributions may be made, which would be ignored in deeming the trust resource available.[131]

A planning technique may be available under DRA 2005, to a disabled person under age 65 in need of nursing home care by combining an outright transfer and a transfer to a self-settled Supplemental Needs Trust. See § 8.03[1][a], *below*. There would be a penalty based on the outright transfer and the funds in the trust would be used to pay for nursing home care during the penalty period.

[131] 42 USC § 1396p(d)(3)(B)(i) states, "if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, … payment to the individual could be made shall be considered resources available to the individual … ." And 42 USC § 1396p(d)(2)(C) states that "this subsection shall apply without regard to—… (iii) any restrictions on when or whether distributions may be made from the trust … ." The periodic payments from the annuity may be treated as a restriction as to when distributions may be made, which would be ignored in deeming the resource available. *See* Matter of Lillian M. F.H. # 4908178H (Erie County 3/21/2008) (finding the GRAT an available resource under the Medicaid trust rules) and Matter of Lillian R. F.H. # M248653 (Albany County 10/31/2007) (finding the Trustee's close relationship to the applicant made the GRAT an available resource). In Matter of Joan S. F.H. # 4813356Q (Onondaga County 12/19/2007) and Matter of V.D. F.H. # 4811493M (Onondaga County 19/21/2007) the Department of Health initially found that the GRATS were not available resources, however the Department of Health has reversed its approval in both these fair hearings and declared that a Medicaid GRAT would be treated as a Medicaid qualifying trust; thus, any portion of the income or principal of the trust that can be paid to or for the benefit of the Medicaid applicant must be deemed an available resource.

Form 8.206 Private Annuity Agreement

THIS AGREEMENT is made _____[*date*], by and between _____[*Obligor*], "Obligor" residing at _____[*address*], and _____[*Annuitant*], "Annuitant" residing at _____[*address*].

1. Annuitant agrees to transfer and convey _____[*describe property*], the "Property," absolutely to Obligor.

2. In consideration Obligor agrees to pay the Annuitant _____[*amount*] each month; such payments shall commence on _____[*commencement date*]; payments shall be made no later than the _____[*date*] day of each month. Such payments shall end on [*termination date*].

3. Obligor shall be personally and absolutely liable for the payments due hereunder, and such payments are not contingent upon Obligor's future earnings from or ownership of the Property.

4. Obligor's obligation hereunder shall not terminate upon the death of Annuitant, but payments shall continue to be paid to the [surviving spouse/minor child/disabled child] of the Annuitant. Any surplus remaining shall be paid to the state of New York in an amount not to exceed the total medical assistance paid on behalf of the Annuitant.

5. Annuitant has no security interest, mortgage, or lien with respect to the Property transferred hereunder.

6. Annuitant shall not sell, transfer or assign his rights under this agreement, nor shall Annuitant sell, transfer or assign his rights to the income stream payable to him. Any such sale, transfer or assignment shall render this annuity unenforceable.

7. This agreement is binding on the heirs, successors, and assigns of Obligor.

8. This agreement shall be governed and construed in accordance with the laws of the state of New York.

IN WITNESS WHEREOF, this agreement is signed, and delivered on _____[*date*].

_____
Annuitant

_____
Obligor

Form 8.207 Personal Services Care Contract

THIS AGREEMENT is made _____[*date*], between _____[*Name of Care Provider*], "Care Provider" residing at _____[*address*], and _____[*Name of Care Recipient*], "Care Recipient" residing at _____[*address*].

1. Care Recipient agrees to pay _____[*amount*] to Care Provider. This compensation is based on the fair market value of the services to be provided. The parties have taken into consideration in arriving at this compensation, the age and life expectancy of the Care Recipient; the cost in the community of the services to be provided including the average compensation for court-appointed guardians, geriatric care managers, and for providers of personal needs services. The parties have considered the average number of hours for each type of service to be provided. This compensation is less than the fair market value of the services to be provided [optional: and has been discounted in that the Care Recipient does not have sufficient funds to pay the fair market value of the services to be provided].

2. The term of this agreement shall be the life of the Care Recipient. However, certain services shall be provided while the Care Recipient resides in the community and shall not be provided if the Care Recipient resides in a long term care health facility.

3. Care provider will provide the following personal care services to the Care Recipient during the life of the Care Recipient:
a. Handle finances including banking, check writing, bill paying; handling insurance matters including health care coverage;
b. Monitor physical and mental condition and nutritional needs on a regular basis in cooperation with health care providers;
c. Shop for clothing, toiletries, and other personal items;
d. Arrange transportation including but not limited to transportation for shopping, entertainment, and to health care providers;
e. Arrange for health care including but not limited to physical and mental assessment, services and treatment by appropriate health care providers, such as physicians, nurses, health aids, physical therapists, and mental health specialists;
f. Assist in carrying out health care instructions and directives including but not limited to medications and treatments; and
g. Arrange for social services by social service personnel.

4. Care provider will provide the following personal care services to the Care Recipient for as long as the Care Recipient resides in the community and not in a long term health care facility:
a. Arrange for assistance with household chores including laundry, house cleaning, and meal preparation;

b. Arrange for assistance with the activities of daily living including grooming, bathing, dressing, transferring out of bed or chair, ambulating inside and outside, and toileting; and
c. Shop for food.

5. Care Provider shall not be liable for the cost of Care Recipient's care including but not limited to health care, food, clothing, personal aids, and transportation. Care Recipient shall pay the cost of home attendants, home health aids, and household chore service providers. Care Provider shall solely be responsible for arranging for these services. Care Recipient agrees to reimburse Care Provider for any expenses incurred.

6. Care Provider shall return of any prepaid monies based on the remaining calculated life expectancy of the Care Recipient if the Care Provider becomes unable to fulfill his/her duties under this agreement, or if the Care Recipient dies before his/her calculated life expectancy.

7. Care Provider shall maintain and preserve the privacy of Care Recipient with respect to visitors, telephone conversations and mail. Family members and friends shall be permitted to visit Care Recipient.

8. This Agreement shall take effect on _____[*effective date*].

9. This Agreement contains the entire Agreement and understanding between the parties. This Agreement may be changed only by a written instrument executed by both parties.

10. This Agreement shall be governed by and construed in accordance with the laws of the State of New York.

_____
Care Recipient

_____
Care Provider

Form 8.208 Promissory Note

THIS AGREEMENT is made _____[*date*], between _____[*Name Borrower*], "Borrower" residing at _____[*address*], and _____[*Name of Payee*], "Payee" also called "Lender" residing at _____[*address*].

1. In consideration of _____[*principal Amount*] paid on this day to Borrower, the Borrower agrees to pay the Payee as follows:

2. Annual interest rate shall be 5.75%.

3. Borrower promises to pay Payee at _____[*place for payment*] and according to the terms for payment set forth below the principal amount plus interest at the rates stated above. Any unpaid amount shall be due by the final scheduled payment date.

4. This Note is due and payable as follows: _____[*Number of payments*] equal monthly payments of $_____[*Amount of Payments*], which includes principal and interest. The first payment is due and payable on _____[*date of first payment*], and a like payment shall be due and payable on the same day of each month thereafter until the total principal of $ [*principal amount*] is paid in full. If each payment is not paid on time, the remaining balance will be subject to the maximum amount of interest permitted by the Laws of the State of New York.

5. Borrower reserves the right to prepay this Note in whole or in part, prior to maturity, without penalty.

6. All past due payments of principal and/or interest and/or all other past-due incurred charges shall bear interest after maturity at the maximum amount of interest permitted by the Laws of the State of New York until paid.

7. Payee's forbearance in enforcing a right or remedy as set forth herein shall not be deemed a waiver of said right or remedy for a subsequent cause, breach or default of the Borrowers' obligations herein.

8. Interest on this debt shall not under any circumstances exceed the maximum amount of interest that may be contracted for and charged or received under law; any interest in excess of the maximum shall be credited on the principal of the debt and refunded.

9. Any check, draft, Money Order, or other instrument given in payment of all or any portion hereof may be accepted by the Payee and handled in collection in the customary manner, but the same shall not constitute payment hereunder or diminish any rights of the Payee except to the extent that actual cash proceeds of such instruments are unconditionally received by the payee and applied to this indebtedness in the manner herein provided.

10. If this Note is given to an attorney for collection or enforcement, or if suit is brought for collection or enforcement, or if it is collected or enforced through

probate, bankruptcy, or other judicial proceeding, then Borrower shall pay Payee all costs of collection and enforcement, including reasonable attorney's fees and court costs in addition to other amounts due.

11. If any provision of this Note or the application thereof shall, for any reason and to any extent, be invalid or unenforceable, neither the remainder of this Note nor the application of the provision to other persons, entities or circumstances shall be affected thereby, but instead shall be enforced to the maximum extent permitted by law.

12. This Note is intended to and shall be construed to comply with the requirements of the Deficit Reduction Act of 2005 [42 USC 1396p(c)(1)(I)], so that it is not a transfer of assets under Medicaid law and therefore will not create a transfer of asset penalty for Payee. In addition, this Note provides for equal payments and does not allow deferrals and/or balloon payments.

13. The cancellation of this debt, or any balance due of this debt, upon the payee's death is prohibited. This agreement shall be binding on and inure to the benefit of the heirs, legal representatives, and assigns of the parties hereto.

14. This Note is irrevocable and unassignable. Payee shall not sell, transfer or assign Payee's rights under this agreement, nor shall Payee sell, transfer or assign his rights to the income stream payable to him. Any such sale, transfer or assignment shall render this promissory note unenforceable.

15. This Note shall be governed, construed and interpreted by, through and under the Laws of the State of New York.

16. Borrower is responsible for all obligations represented by this Note.

DATE: [Date].

_____
Signature of Borrower

_____
Witness

_____
Print Name

_____
Sign Name

_____

_____
Address

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 06 OMM/ADM-5

TO: Commissioners of Social Services

DIVISION: Office of Medicaid Management

DATE: July 20, 2006

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

SUGGESTED DISTRIBUTION:
Medicaid Staff
Fair Hearing Staff
Legal Staff
Audit Staff
Staff Development Coordinators

CONTACT PERSON:
Local District Liaison
Upstate: (518) 474-8887
New York City: (212) 417-4500

ATTACHMENTS: See Appendix I for Listing of Attachments

FILING REFERENCES

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

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I. PURPOSE

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

II. BACKGROUND

A. ASSET TRANSFER CHANGES AND ANNUITIES

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

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

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

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

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

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

B. HOME EQUITY AND CONTINUING CARE RETIREMENT COMMUNITY CONTRACTS

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

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

III. PROGRAM IMPLICATIONS

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

A. TRANSFER OF ASSETS PROVISIONS

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

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

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

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

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

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

2. Annuities

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

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

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

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

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

the annuity is:

- irrevocable and non-assignable;

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

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

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

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

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

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

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

B. HOME EQUITY VALUE

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

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

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

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

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

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

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

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

IV. REQUIRED ACTION

A. DEFINITIONS

1. Assets

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

2. Blind

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

3. Disabled

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

4. Fair Market Value

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

5. Income

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

6. Resources

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

7. Look-Back Period

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

8. Institutionalized Individual

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

9. Intermediate Care Facility for the Mentally Retarded

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

10. Nursing Facility

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

11. Nursing Facility Services

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

12. Uncompensated Value

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

13. Non-Assignable

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

14. Community-Based Long-Term Care Services

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

B. TRANSFER OF ASSETS

1. Asset Transfer Changes

a. New Cases

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

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

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

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

b. Undercare Cases

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

2. Financial Eligibility

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

a. Resource Eligibility

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

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

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

b. Income Eligibility

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

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

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

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

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

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

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

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

c. Eligibility Outcome

(1) Financially Ineligible

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

(2) Financially Eligible

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

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

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

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

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

3. Penalty Period Begin Date for Otherwise Eligible Individuals

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

a. Transfers Prior to February 8, 2006

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

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

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

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

b. Transfers on or After February 8, 2006

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

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

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

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

The following examples demonstrate the new transfer provisions:

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

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

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

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

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

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

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

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

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

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

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

(i) Short-Term Rehabilitation

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

(ii) Treatment of Multiple Transfers

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

(iii) Exceptions for Transfers

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

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

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

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

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

(iv) Provision for Undue Hardship Waiver

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

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

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

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

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

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

Undue hardship cannot be claimed:

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

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

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

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

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

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

(v) <u>Explanation of the Effect of Transfer of Assets on Medical Assistance Eligibility</u>

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

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

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

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

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

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

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

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

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

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

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

- the annuity is:

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

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

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

- the annuity is:

    - o irrevocable and non-assignable;

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

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

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

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

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

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

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

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

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

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

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

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

C. TREATMENT OF SUBSTANTIAL HOME EQUITY

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

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

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

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

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

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

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

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

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

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

D. TREATMENT OF CONTINUING CARE RETIREMENT COMMUNITY CONTRACTS

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

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

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

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

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

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

V. NOTICE REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

VI. SYSTEMS IMPLICATIONS

A. UPSTATE WMS IMPLICATIONS

There are no systems implications.

B. CNS UPSTATE

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

1. New Notices

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

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

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

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

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

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

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

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

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

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

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

2. Revised Notices

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

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

C. NYC WMS IMPLICATIONS

NYC WMS instruction will be provided under separate cover.

VII. EFFECTIVE DATE

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

Brian J. Wing, Deputy Commissioner
Office of Medicaid Management

TO: Local District Commissioners, Medicaid Directors

FROM: Judith Arnold, Director
Division of Health Reform and Health Insurance Exchange Integration

SUBJECT: 2012 Update to the Actuarial Life Expectancy Table

EFFECTIVE DATE: Immediately

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

The purpose of this General Information System (GIS) message is to provide local departments of social services with the updated life expectancy table issued by the Office of the Chief Actuary of the Social Security Administration (SSA).

As advised in Administrative Directive 06 OMM/ADM-5, "Deficit Reduction Act of 2005 – Long-Term Care Medicaid Eligibility," the life expectancy table issued by SSA is required to be used in evaluating whether an annuity purchased by or on behalf of an applicant/recipient on or after February 8, 2006 is actuarially sound. The table is also used in determining whether the repayment term for a promissory note, loan or mortgage is actuarially sound.

The life expectancy table that was attached to 06 OMM/ADM-5 as Attachment VIII, is being updated to reflect the current information obtained from the Office of the Chief Actuary of the Social Security Administration. The revised life expectancy table is provided as an attachment to this GIS. Effective with the release of this GIS, districts must use the revised table.

Please direct any questions to your local district support liaison.

Life Expectancy Table

Age	Male Life Expectancy	Female Life Expectancy	Age	Male Life Expectancy	Female Life Expectancy
0	75.38	80.43	30	47.13	51.50
1	74.94	79.92	31	46.20	50.53
2	73.98	78.95	32	45.27	49.56
3	73.00	77.97	33	44.33	48.60
4	72.02	76.99	34	43.40	47.64
5	71.03	76.00	35	42.47	46.68
6	70.04	75.01	36	41.54	45.72
7	69.05	74.02	37	40.61	44.76
8	68.06	73.03	38	39.68	43.81
9	67.07	72.04	39	38.76	42.86
10	66.08	71.04	40	37.84	41.91
11	65.09	70.05	41	36.93	40.97
12	64.09	69.06	42	36.02	40.03
13	63.10	68.07	43	35.12	39.10
14	62.12	67.08	44	34.22	38.17
15	61.14	66.09	45	33.33	37.24
16	60.18	65.11	46	32.45	36.32
17	59.22	64.13	47	31.57	35.41
18	58.27	63.15	48	30.71	34.50
19	57.33	62.18	49	29.84	33.59
20	56.40	61.20	50	28.99	32.69
21	55.47	60.23	51	28.15	31.80
22	54.54	59.26	52	27.32	30.91
23	53.63	58.29	53	26.49	30.02
24	52.71	57.32	54	25.68	29.14
25	51.78	56.35	55	24.87	28.27
26	50.86	55.38	56	24.06	27.40
27	49.93	54.40	57	23.26	26.53
28	49.00	53.44	58	22.48	25.67
29	48.07	52.47	59	21.69	24.82

Age	Male	Female	Age	Male	Female
	Life Expectancy	Life Expectancy		Life Expectancy	Life Expectancy
60.	20.92	23.97	90	3.92	4.69
61	20.16	23.14	91	3.64	4.36
62	19.40	22.31	92	3.38	4.04
63	18.66	21.49	93	3.15	3.76
64	17.92	20.69	94	2.93	3.50
65	17.19	19.89	95	2.75	3.26
66	16.48	19.10	96	2.58	3.05
67	15.77	18.32	97	2.44	2.87
68	15.08	17.55	98	2.30	2.70
69	14.40	16.79	99	2.19	2.54
70	13.73	16.05	100	2.07	2.39
71	13.08	15.32	101	1.96	2.25
72	12.44	14.61	102	1.85	2.11
73	11.82	13.91	103	1.75	1.98
74	11.21	13.22	104	1.66	1.86
75	10.62	12.55	105	1.56	1.74
76	10.04	11.90	106	1.47	1.62
77	9.48	11.26	107	1.39	1.52
78	8.94	10.63	108	1.30	1.41
79	8.41	10.03	109	1.22	1.31
80	7.90	9.43	110	1.15	1.22
81	7.41	8.86	111	1.07	1.13
82	6.94	8.31	112	1.00	1.05
83	6.49	7.77	113	0.94	0.97
84	6.06	7.26	114	0.87	0.89
85	5.65	6.77	115	0.81	0.82
86	5.26	6.31	116	0.75	0.75
87	4.89	5.87	117	0.70	0.70
88	4.55	5.45	118	0.64	0.64
89	4.22	5.06	119	0.59	0.59

TO: Local District Commissioners, Medicaid Directors

FROM: Judith Arnold, Director
Division of Coverage and Enrollment

SUBJECT: Evaluating Personal Service Contracts for Medicaid Eligibility

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Liaison:
Upstate (518)474-8887 New York City (212)417-4500

The purpose of this message is to provide guidance for social service districts in evaluating personal service contracts.

A personal service contract, also known as a caregiver agreement, is a formal written agreement between two or more parties in which one or more of those parties agree to provide personal and/or managerial services in exchange for compensation paid by the party receiving the services. Since the enactment of the Deficit Reduction Act of 2005, which lengthened the look-back period for asset transfers and changed the penalty start date, districts have seen an increase in the number of Medicaid applications involving personal service contracts. Under the personal service contracts reviewed to date, the elderly applicant's resources are transferred in a lump sum to a family member in exchange for services to be provided by the family member for the lifetime of the applicant. This planning tool is being used to reduce the applicant's resources in order to qualify for Medicaid while compensating family members for services provided, even though the services may have been provided free of charge in the past.

For Medicaid eligibility purposes, a determination must be made as to whether the applicant received or will receive fair market value (FMV) for the resources transferred to the caregiver. If a determination cannot be made that the applicant will receive FMV for the resources transferred, the resources are subject to a transfer penalty.

Uncompensated Transfer – A personal service contract that does not provide for the return of any prepaid monies if the caregiver becomes unable to fulfill his/her duties under the contract, or if the A/R dies before his/her calculated life expectancy, must be treated as a transfer of assets for less than fair market value. If there are no such legally enforceable provisions, there is no guarantee that FMV will be received for the prepaid monies.

If a personal service contract stipulates that services will be delivered on an "as needed" basis, a determination cannot be made that FMV will be received in the form of services provided through the contract. A transfer of assets penalty must be calculated for an otherwise eligible individual.

Calculating the Transfer Penalty Amount - Districts do not need to evaluate personal service contracts until the individual applies for and is otherwise eligible for nursing facility services. When doing such an assessment, if the district determines that the funding of a personal service contract is an uncompensated transfer, the district must give the applicant credit (i.e., by reducing the transfer amount) for the value of any services actually received from the time the personal service contract was signed and funded through the date of the Medicaid eligibility determination.

Note: No credit is allowed for services that are provided as part of the Medicaid nursing home rate.

In order to assess the value of these furnished services, the district must be provided with credible documentation (e.g., a log with the dates and hours of services already provided). Any amount subtracted (i.e., the credit for caregiver services actually provided) must be commensurate with a reasonable wage scale, based on fair market value for the actual job performed and the qualifications of the caregiver. If credible documentation is not provided, no credit is deducted when calculating the uncompensated transfer amount.

For assistance in evaluating job duties and pay rates, districts may refer to the U.S. Departm*ent* of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook. The latest 2006-07 Edition is available at: http://www.bls.gov/oco/. The handbook includes information on training and other qualifications needed for particular jobs. If a district determines that a reasonable pay rate for a particular job/service is less than the amount spelled out in the contract, the district should use the lesser amount in calculating the amount of compensation received for the transfer.

Districts should contact their local district liaison if they have any questions concerning the treatment of a particular personal service contract.