DRAFTING PERSONAL SERVICES CONTRACTS AND REIMBURSEMENT AGREEMENTS

by

FRANCES M. PANTALEO, ESQ.

Walsh, Amicucci & Pantaleo LLP
Purchase

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PERSONAL SERVICES CONTRACTS

I. INTRODUCTION:

Since the enactment of the Deficit Reduction Act in 2006, Personal Services Contracts (PSC), have been increasingly utilized by elder law practitioners as an alternate Medicaid planning tool. Personal Services Contracts enable family members to be compensated for providing essential long term care. Today, more than 65 million Americans are involved in some form of family care giving. Informal 'family style' care provides approximately 75% of all the long term care given in this country. This care is often provided at great financial sacrifice when family members leave the work force to care for their relatives with long term or chronic illnesses.

Family care giving has decreased due to the following societal conditions:

1. The family caregivers are now in the work force themselves and are unavailable to provide substantial elder care.
2. Women are having children later in life and are still fully engaged in their own children's needs and cannot take on elder care. In some cases, the elder had later life children, and these are not fully matured themselves to take on the care.
3. The birth rate has decreased. Thus, with fewer children, there are fewer potential caregivers.
4. Elderly people are living longer and the level of care needed at home is more intense and requires special training and skills. Family caregivers may be ill equipped to meet the requirements and burden of care.
5. The pool of available professional caregivers is shrinking as individuals seek more highly compensated and less physically demanding work.

In light of this new reality, informal or family caregivers who are willing to take on their relative's care burden increasingly need to be paid. This payment can offset the loss of their previous income and make up for the loss of their own Social Security (SSA) credits towards their future retirement. Paying for informal care giving should be a legitimate public policy objective in that it acknowledges the valuable service family caregivers perform and encourages this work to continue. With the lengthening of the life cycle, with its greater likelihood of chronic illnesses, the need for long term personal care is ever increasing. Our country will need to find a new economic model to replace this shrinking unpaid family labor force. The shortage of professional caregivers and the complexity and cost of care has made compensating the informal and family caregiver a necessity.

The PSC is not a new elder law planning technique. Outside of NY, the PSC had been used successfully for many years as a Medicaid planning tool and was found to be a "compensated transfer" i.e. payments made pursuant to the PSC were not subject to Medicaid transfer penalties. However, New York elder law

practitioners had not widely used the PSC because of the easier availability of gifting strategies and the liability of the paid caregiver to pay income taxes on sums received for family care. Informal caregivers often took their compensation in the form of direct gifts from the elder, with no resulting income tax liability for the caregiver.

The enactment of the Deficit Reduction Act (DRA) changed the manner in which the Medicaid program calculates penalties for transfers of assets. The change lengthened the "look back" period for uncompensated transfer of assets from three to five years. Moreover, for all transfers which take place on or after February 8, 2006, the penalty for an uncompensated transfer now begins on "the first day of a month during or after which assets have been transferred for less than fair market value, **or the date on which the individual is eligible for medical assistance under the State Plan and would otherwise be receiving institutional level care…based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection."** (Emphasis added.) As a result of this change, individuals who transfer assets must be prepared for a transfer penalty which can be imposed for a full five years after the gift has been made. This change forced caregivers and elder law attorneys to re-examine the wisdom of outright gifts to family caregivers and to consider the use of Personal Care Contracts as an alternate way of compensating family members for legitimate provision of care services. As a compensated transfer for value, it was believed that payments made to family care givers would not interfere with Medicaid eligibility.

II. PERSONAL SERVICE CONTRACTS:

A. Definition:

In 2007, the Department of Health issued GIS 07/MA 019 "Evaluating Personal Services Contracts for Medicaid Eligibility". The GIS defines a personal service contract, also known as a caregiver agreement, as "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." The GIS imposes many limitations on the use of these contracts, but confirms that payment for services under a properly drafted personal services contract, when combined with good record keeping by the caregivers, is not a transfer of assets for less than fair market value and should not result in a period of Medicaid disqualification. *See Exhibit A for GIS 07 MA 019.*

B. Rebutting the Presumption of Care Provided for Free:

In order to establish the validity of a contractual relationship for service between the elder and the care giver, it is critical to have a formal written document which specifically sets out the services which will be provided and the rate of compensation for each service.

The Medicaid program has historically applied a presumption that services provided by family caregivers are intended to be uncompensated and are provided for love and affection alone. See the following language from 96 ADM-8 page 12:

> …while relatives and families members legitimately can be paid for care they provide to the individual, there is a ***presumption*** that services provided for free at the time were intended to be provided without compensation. Thus, a transfer to a relative for care provided for free in the past was normally not considered a transfer of assets in which the recipient of the service received FMV. ***However, an individual can rebut this presumption*** that the value was received with tangible evidence that services were performed and that the services were received or agreed to receive in the future. An example of acceptable evidence would be a ***promissory note or written care contract*** executed at the time services were provided. (See also HCFA Transmittal 64, section 3258.1(A). (emphasis supplied.)

Practice Tip: A properly drafted personal services contract can rebut the presumption that care provided by family caregivers is provided without expectation of remuneration, but is performed as a fee for service. However, in a recent fair hearing, *In the Matter of Basil E.* discussed later, a PSC was found not to be a compensated transfer in part because the caregiver daughters had provided their father with services for free prior to the institution of the contract and prior to the application for Medicaid benefits. DOH took the position that because services were provided for free before the start of the contract, the payment for services pursuant to the contract is not a compensated transfer but a technique solely for Medicaid planning.

C. Relationship of Medicaid and SSI program:

Federal law provides that the rules governing the Medicaid program may not be more restrictive than the rules which govern the Supplemental Security Income (SSI) program.[1] The rules governing the SSI program can be found at 42 U.S.C.§1381 et seq, 20 CFR §416 and the Social Security

[1] 42 USC 1396a (a)(10)(c); 42 CFR. 435.4 and 435.840(b)(2).

Administration's manual entitled Program Operation Manual Systems, otherwise known as the POMS.[2]

The POMS contains guidance regarding the factors to be considered in determining whether an exchange of money for services will be considered a transfer for fair market value.

D. Fair Market Value (FMV):

The Medicaid program imposes periods of disqualification for nursing home services upon individuals who transfer assets for less than fair market value ("FMV"). However, a person will not be ineligible for Medicaid as a result of a transfer of assets if a satisfactory showing is made that the individual intended to dispose of the asset at fair market value, or for other valuable consideration or that the asset was transferred exclusively for a purpose other than to qualify for Medicaid. See, 42 U.S.C. §1396p(c) (2(C) (i); New York Social Services Law §366.5, 18 N.Y.C.R.R. 360-4.4(c) (ii) (d).

The SSI POMS contains several pages of guidance entitled "Determining Fair Market Value" at SI 01150.005. Fair Market Value is defined as "the current market value (CMV) of a resource at the time the resource is transferred. The CMV of a resource is the going price for which it can be reasonably expected to sell on the open market in the geographic area involved."[3] The POMS goes on to state that compensation for a resource may include "in-kind support and maintenance or services to be provided to the individual because of the transfer."[4] "The transferor may actually receive the compensation before, at, or after the actual time of transfer.[5]

New York State's GIS 07 MA 019 is similar to the POMS and states that the rate of compensation must be "commensurate with a reasonable wage scale, based on fair market value for the actual job performed and the qualifications of the caregiver." The GIS directs Medicaid eligibility workers to the U.S. Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook for assistance in evaluating job duties and pay rates and indicates that if the pay rate in the contract is higher than the amount spelled out in the contract, the lesser rate should be used to calculate the rate of fair market compensation.

The POMS specifically discusses agreements to provide personal services for compensation and provides several examples of how such contracts

[2] The POMS and the regulations can be accessed through the Social Security Administration's user friendly website: http://www.ssa.gov
[3] POMS SI 01150.005 at B.1
[4] Id. at B. 2
[5] Id. at C. 2

should be evaluated, thus evidencing the appropriateness of their use in family or informal caregiving situations. *POMS annexed as Exhibit B.*

Services for Life and Lump Sum Payments for Future Services

The POMS also addresses **lump sum** payments for services. These will be considered to be for fair market value as long as the compensation is reasonable when compared to the going market rate for such services and the term during which the services are rendered does not exceed the individual's life expectancy.

Example: Advance payment for room and board over 5 year period: The POMS provides an example of an individual who pays his sister $30,000 pursuant to a written agreement that she will give him room and board in her home at a cost of $500 per month. The transfer is considered to be a transaction for fair market value.

Commentary: The POMS appears to assume that a lump sum pre-payment for personal services will be considered a transfer for FMV as long as the term of the pre-payment is not for a period longer than the individual's life expectancy.[6] Another example given under the POMS is a pre-payment of five years of yard maintenance services. From the examples provided in the POMS, it would seem that a lump sum pre-payment for future services is acceptable, even if the care recipient dies sooner than his or her life expectancy.

The POMS indicates that contracts to provide services over the lifetime of the individual will be considered to be Fair Market Value transactions if such agreements are calculated using the **life expectancy tables** promulgated by the Social Security Administration.[7] The Social Security Administration's life expectancy tables are periodically revised. *The currently applicable table is attached to these materials as Exhibit C.* [8]

GIS 07 MA/019 does not provide specific guidance about the mechanism for calculating a lump sum payment for services for life. However, the GIS does refer to payments over the "calculated life expectancy" of the care recipient. The GIS is more restrictive than the POMS by adding the following additional requirement:

[6] See also POMS SI 00835.480 which discusses prepayment of in-kind maintenance and support.
[7] Id. at D.3.c. and D.4.c.
[8] The New York State administrative directive regarding the implementation of the DRA, 06 ADM-5, directs local social services districts to use the life expectancy tables promulgated by the Social Security Administration. 12 MA/025 directs local offices to use the updated table annexed as Exhibit C to these materials.

"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 an 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."

Commentary: Some elder law attorneys have argued that the GIS requirement that a lump sum payment must be refundable in the event that the care recipient dies is in conflict with the POMS provisions which permit lump sum payments which are actuarially reasonable. Participants in a panel discussion of DSS and DOH attorneys sponsored by the Elder Law Section a few years ago stated that DOH is not bound by the POMS in programmatic issues such as personal service contracts. This issue has been addressed in fair hearing discussions and appeals discussed below and may be the subject of future appeals and decisions.

Services Provided on an "As Needed" Basis: GIS 07 MA/019 provides "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".

Practice Tip: Individuals who apply for community Medicaid services do not have to disclose the existence of a Personal Services Contract, as there is no transfer of assets penalty for community Medicaid. However, if the individual applies for nursing facility coverage, the contract must be disclosed and evaluated. "When doing such an assessment, if the district determines that the funding of personal services 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. Thus, if the contact provided for compensation on an "as need basis", the district would still need to give credit for the actual services provided. See fair hearing and court decisions discussed below.

E. DOCUMENTING THE REASONABLENESS OF THE RATE OF COMPENSATION

Case law and the administrative directives governing the Medicaid program support the need for caregivers and their attorneys to establish fair market rates by researching rates charged in the market place. The

POMS instructs the social services agency to contact at least one local knowledgeable source in addition to the provider to verify the current market value of the services if the services were not purchased on the open market. Similarly, GIS 07/MA 019 refers Social Services district officials who are evaluating the hourly rates for services contained in Personal Care Contracts to the U.S. Department of Labor, Bureau of Labor and Statistics, Occupational Outlook Handbook which can be found at the Department of Labor website: http://www.bls.gov/oco. Districts which determine that a reasonable pay rate for a particular service is less than the amount spelled out in the contract are advised to use the lesser amount in calculating the amount of compensation received for the transfer.

The Occupational Handbook cited in the GIS is frequently updated by the Department of Labor and contains both regional and national averages for various occupations. The 2012-2013 Handbook lists the national average hourly rate of pay for home health aides as $10.49 with a mean hourly rate in NY state of $10.21. The Handbook documents the tremendous variations in rates of compensation in various regions of the country and throughout each state.

Another reputable resource for establishing fair market rates for caregiving is **The Genworth Financial Cost of Care Survey[9],** which is updated annually. For 2013, the survey reports that the national average hourly rate for home health aides was $19, and that the national average hourly rate for homemakers/companions was $18. In New York State, the survey reports the hourly rate for licensed homemaker services to range from a low of $15 to a high of $33. Licensed home health aide services range from a low of $15 to a high of $36 per hour. However, these are average rates for care provided by licensed agencies, not the rates received by the caregiver aide.

On March 11, 2010, Maria L. Colavito, Associate Attorney for the New York State Department of Labor, issued an Opinion Letter which interprets New York's minimum wage regulation to require that "live-in companions" "must be paid not less than for thirteen hours per twenty-four hour period provided that they are afforded at least eight hours of sleep and actually receive five hours of uninterrupted sleep, and that they are afforded three hours for meals. If an aide does not receive five hours of uninterrupted sleep, the eight-hour sleep exclusion is not applicable and the employee must be paid for all eight hours. Similarly, if the aide is not actually afforded three work-free hours for meals, the three-hour meal period exclusion is not applicable." The letter also makes it clear that individuals who work in excess of forty hours per week must be paid not less than one and one half times the minimum wage rate for all hours

[9] . The Genworth 2013 Cost of Care Survey can be found at https://www.genworth.com/corporate/about-genworth/industry-expertise/cost-of-care.html.

worked in excess of forty hours per week. This opinion letter can be utilized to justify the rate and number of hours of compensation for family caregivers who provide services on a live-in basis. *Opinion letter is annexed to these materials as Exhibit D.*

In addition to providing personal care and home health services, family caregiver services often include bookkeeping, bill paying, coordination of medical services, housekeeping and other services. In the opinion of the author of these materials, the following rates for professional services in the NY metropolitan region are reasonable and commonplace:

Geriatric care management: $75 to $150 per hour
Bookkeeping: $30 to $50 per hour

Note, however, that local Departments of Social Services may be reluctant to approve compensation at these higher rates of services if the care provider does not possess a professional degree in the area in which the service will be provided.

Attorneys who draft Personal Services Contracts should independently document the reasonableness of the hourly rates of pay for various services in their region by obtaining letters or invoices from professionals in the particular field and researching the rates for these services listed in the U.S. Department of Labor, Bureau of Labor and Statistics, Occupational Outlook Handbook.

Practice Tip: The GIS acknowledges that the services detailed by the contract may be personal or managerial. The pay scale for services under the contract may provide different rates of compensation for varying types of duties performed. The personal service contract should specify the current market value of the services which will be provided. The contract should set forth the range of costs for each service in the local area. The practitioner must be able to document the open market price for each service identified in the contract if asked. Records of billing rates of local geriatric care managers, home care agencies, bookkeepers, personal assistants, housekeepers, etc. should be available to justify contract rates. It may be helpful to secure a social assessment of need by a professional such as a Geriatric Care Manager or Social Worker to establish the medical necessity of the care and services detailed in the contract.

In Matter of J.C., , FH decision 3565848H, the hearing officer required the appellant, on remand, to document the need for services which were paid at a rate of 24 hours per day pursuant to the agreement. *(Decision annexed as Exhibit E.)*

F. SCOPE OF SERVICES: Services provided to Nursing Home Residents

GIS O7 MA/019 contains a boldface note on page 2: **"No credit is allowed for services that are provided as part of the Medicaid nursing home rate."**

The Department of Health has consistently taken the position that a person who is in a nursing facility does not need supplemental assistance from family caregivers and that the services in the contract duplicate services already provided by the facility and paid for by the Medicaid program. (*See, **Matter of M.G.** fair hearing decision discussed below and annexed as Exhibit F.)*

Practice Tip: In light of fair hearing and court decisions which have imposed transfer of asset penalties for services provided to residents of nursing facilities, the use of the PSC for nursing home residents has been severely curtailed.

G. Cases and Fair Hearing Decisions:

Personal care contracts have been upheld as legitimate fair market value transactions which do not constitute transfers of assets which result in the imposition of a Medicaid transfer penalty. Recent NY fair hearing decisions dealing with personal service contracts do not negate their use, but narrow the types of cases in which they will be accepted as a transfer for fair market value.

In re Appeal of J.C. Fair hearing #3565848H, February 20, 2002. An 81 year old father began living with his son in October 1999. In December 1999 the father entered into a personal services contract with his son and his daughter. Under the terms of the contract, the father agreed to pay his children as caregivers the lump sum of $150,000 pending the sale of the father's home, or in the alternative, if the house was not sold within 120 days of the signing of the contract, to transfer his ownership of the home to the children. The father lived with both the daughter and his son until he entered a nursing home in November 2000. In May 2000, the home was sold for $140,057 and the proceeds provided to the son. The hearing officer reversed the initial determination that the transfer of the proceeds from the sale of the house to the son was a transfer of assets for less than fair market value. The contract enumerated the specific services to be provided by the children as including room and board, housekeeping, laundry, personal assistance, financial management and securing health care services at a rate of $131,400 per year which was based upon a rate of $15 per hour for 24 hours per day for a year of personal care and financial management at a cost of $21,900 per year based upon three hours per

week at $20 per hour. Room and board was charged at $800 per month or $9,600 for the year. The Commissioner upheld the contract as an agreement to provide services at a fair market value. Given the clear intent of the parties and the detailed terms of the contract, the Commissioner found that the Appellant overcame the presumption that personal services were provided out of love and affection and not for compensation. However, as the contract required the caregivers to keep detailed records and it was not clear whether they had done so, the matter was remanded for further proceedings. The Commissioner also directed the parties to provide medical documentation that that the Appellant required 24 hour care, especially as the record indicated that the Appellant had been attending a day care program during the period he was living with his children. The children were directed to show documentation that they actually earned the compensation which they claimed under the contract. (*Decision annexed as Exhibit E.)*

Carpenter v. State of Louisiana, Department of Health and Hospitals, 94 So.2d 604 (Louisiana , 1st Cir. 2006) 92 year old woman left her daughter's home to reside in a nursing home in February 2004. The Medicaid application submitted in March 2004 was denied due to a finding that the mother had made an uncompensated transfer of assets in the amount of $29,339.68 shortly prior to her admission to the skilled nursing facility. The daughter presented evidence that in March 1989, her mother had entered into a personal care contract with the daughter in which she agreed to pay daughter the sum of $1,000 per month on demand by the daughter. The agreement was signed by the mother, the daughter and two witnesses. No payments were made pursuant to the agreement until the mother was about to enter the nursing home. At that time, the mother transferred the balance of an investment account to the daughter, pursuant to the terms of the note and in compensation for the services the daughter provided to the mother over the intervening fifteen years since the agreement was signed. The Department of Social Services officials argued that the signature on the document was questionable and that the agreement was not notarized. However the witnesses testified as to the signature and that the mother was competent when she signed it, immediately prior to moving in with the daughter. The hearing officer's decision upholding the Medicaid denial indicated suspicion of the testimony of the witnesses and the genuineness of the signature but no contrary evidence had been submitted. The court reviewed the provisions of the Louisiana Medicaid manual which permit relatives to be paid for services pursuant to a written agreement and determined that the agreement appeared to be valid on its face. The court rejected the argument that the agreement should have been notarized or dated, as no such requirements were contained in the state Medicaid manual. There was nothing in the Medicaid Manual which required that payments had to

be made at the time the contract was signed or prohibited an "on demand" payment.

Thomas v. Florida Dept of Children and Family Services, 707 So. 2d 954 (Fla. App.4 Dist. 1998) The Fourth District Appellate court reversed a finding that a payment of $67,725 to a daughter pursuant to a personal services contract by which the daughter agreed to care for the mother over the course of the mother's lifetime was a transfer for less than fair market value. The evidence presented at the hearing proved that the Medicaid applicant had in fact paid a fair market value for the services provided under the contract. No contrary evidence was presented at the hearing.

Reed v. Missouri Department of Social Services , 193 S.W.3d 839 **(**Missouri Court of Appeals Eastern District 2006) Appellate court upheld a trial court finding that a payment of $11,000 by a nursing home resident to her daughter was an uncompensated transfer of assets. The court found that it was reasonable for the daughter to be compensated for services such as feeding her mother in the nursing home, purchasing clothing, interacting with the staff in order to safeguard the mother's care, relocating lost items, monitoring usage of prescription drugs, accompanying the mother to social events in the facility as the mother would otherwise lie in bed and refuse to participate, taking the mother to restaurants and on trips outside the facility. The court noted that the daughter regularly drove sixty miles round trip three or four times per week to perform these services and found that "these services, among others, support (the mother's) independence, autonomy, well-being and care in ways that the facility's services do not. They enhance (the mother's) life in ways that the facility does not, and are above and beyond the care provided by the facility. "

Brewton v. State of Louisiana Department of Health and Hospitals
(Louisiana, 5th Cir. 3/13/07) Appellate court upheld a decision of the district court reversing the Medicaid agency's denial of Medicaid eligibility. Mr. and Mrs. Brewton both entered a skilled nursing facility in 2003. In August 2003, the Brewtons entered into a personal care service agreement with three relatives: a niece, her husband and a nephew. The agreement set forth services which would be provided by the relatives on behalf of Mr. and Mrs. Brewston and set forth compensation in a lump sum of $150,000 upon the sale of the home. Upon the sale of the home, a total of $118,805.22 was provided to the relatives pursuant to the terms of the agreement. The Medicaid agency argued that the agreement "was not actuarially sound" because the recipients were residing in a nursing home. The ALJ upheld the agency determination as it found that the services provided in the agreement were already provided by Medicaid and could thus have no value. The Appellate Court upheld the reversal by the District Court finding that the Brewtons did receive valuable services. The

evidence revealed that the relatives spent many hours rendering services such as managing personal and financial affairs, dealing with the sale of the home, cleaning, repairing, inspecting and arranging for professional inspection prior to the sale of the home. The services rendered by the family members were not duplicative of nursing home services. They included replacing lost laundry, providing phone and phone service, replacing lost hearing aides, regular visits to the home, visiting the residents upon hospitalization, attending periodic conferences at the home and making funeral arrangements, purchasing a radio and record player, providing music, ordering cable television, bringing furniture to the home, replacing personal items, accompanying the Brewtons to medical appointments, providing holiday gifts, decorating the room, bringing a pet to visit and dealing with Medicaid personnel. All of these services were found to be valuable consideration for the transfer of funds.

But see, the following cases in which payments pursuant to a personal services contract were found to be transfers of assets for less than fair market value:

Andrews v. Division of Medical Assistance , 861 N.E.2d 483 (Mass. Ct. App. 2007) Mass. App. Ct. refused to reverse a finding by the Medicaid agency that payments made to the Medicaid applicant's daughter and her husband were a transfer of assets. After the Medicaid applicant moved into a nursing home, her daughter and son in law quit their jobs to renovate her ramshackle Victorian home for sale. The renovations took almost two years and increased the value of the house by approximately $230,000 and the house was sold. The Tekulas paid themselves $100,000 for the work they did in the renovations. However, there was no written agreement which permitted the Tekulas to be paid for their services. Accordingly, they failed to rebut the presumption that services provided by family members was intended to be provided for free.

In the Matter of M.G., Fair hearing decision #473952M (May 3, 2007) (*Copy annexed as Exhibit F*.) In November 2006, an application for Medicaid nursing home eligibility was filed on behalf of a 94 year old woman. The local Medicaid agency denied the application on the grounds that the applicant had made an uncompensated transfer of assets valued at $101,053.44 resulting in a 16.22 month period of Medicaid disqualification. The decision states that the applicant entered a skilled nursing facility in June 2006. On August 5, 2006, the applicant entered into a "Personal Service Support and Maintenance Contract" with her two daughters. The daughters were to be paid $15 per hour pursuant to the terms of the contract for services to be rendered to the mother over the course of her lifetime. (The decision does not specify the number of hours of care to be provided by the daughters pursuant to the terms of the agreement.) The applicant submitted logs prepared by the daughters which

set forth the services they performed pursuant to the agreement, the date each task was performed and the amount of time spent on each task. The daughters testified that the services they performed included checking the mother's oxygen tank at the facility which was found to be empty on at least one occasion. Other tasks included monitoring the mother for changes related to her medication, assisting with her personal hygiene and grooming of hair and nails, obtaining items such as blankets and clothing and monitoring her finances. The daughters argued that some of these tasks were medically necessary and that others were above and beyond the care provided by the nursing home staff and supported the mother's well-being and care in ways the nursing home staff does not. The daughters argued that the services they provided for their mother were similar in nature to the services provided by the Long Term Care Ombudsprogram. On cross-examination, a daughter admitted they did not file complaints with the Department of Health about deficits in the mother's treatment by the nursing home and that she had performed many of these services without compensation prior to entering into the personal services contract with her mother. The hearing officer upheld the determination that an uncompensated transfer of assets had occurred. Since the mother was residing in a skilled nursing facility, any medically necessary services were already provided by the nursing home and "have already been purchased." The hearing officer also found that a significant number of the entries in the logs consisted of mere "visits" with mom and that "It is difficult to separate a visit to an aged and infirm parent by an adult child as a paid services (sic) and valuable consideration from one motivated by love and affection." The services consisting of shopping for clothes, calling mother by telephone, shoveling snow from the driveway and roof, mopping the cellar and mowing the lawn were found not to constitute personal care "within the context of the regulations." Lastly, the logbook showed that the services provided by the daughters sometimes overlapped. Since the daughters testified that they had performed many of these services prior to the execution of the contract, they "cannot now claim payment for services they provided to their mother, out of their love and affection for her." The hearing officer also found that the services provided by the daughters in the nature of financial management were duties that the daughters had elected to undertake under the terms of a power of attorney which made no specific provision for payment to them as agents. Lastly, the hearing officer distinguished the decision in the J.C. fair hearing (discussed above) as the Medicaid applicant in J.C. entered into the personal services contract prior to his admission to a skilled nursing facility.

In the Matter of Basil E; Fair hearing decision #4832282L (November 12, 2007). (*Decision annexed as Exhibit G.)* Basil E., aged 90, entered into a PSC with his two daughters for his care while a resident of a skilled nursing facility in Scotia, NY. The lifetime contract was valued at

$106,860.00. The daughters were to perform services such as visitation, providing amenities (entertainment, recreational and social activities) monitoring health care, shopping, securing health care, and providing financial management. The Agency determined that the $106,860 paid on the PSC was an uncompensated transfer and imposed a 14 month penalty period for this transaction.

The decision found in favor of the Agency and determined that the PSC was not a compensated transfer and the 14 month penalty period was upheld. The Personal Service Contract was found to be invalid for the following reasons:

- The written contract did not provide tangible evidence to overcome the presumption that the services provided by the children are intended to be without compensation since they had **previously** provided the same services for free.
- The main objection is that the contract was entered into 11 weeks after the Appellant entered the nursing facility and four weeks prior to the filing of the Medicaid application. These facts were used to distinguish this contract from the J.C. Fair hearing decision in which the family members provided their father with care while he was living in their homes.
- The services being performed under the contract were already being performed by the skilled nursing facility and therefore were built into the cost of care and represented a duplication of services.
- The contract tasks which were not deemed to part of the medical care provided by the skilled nursing facility such as visiting with father, transporting father home for meals, cleaning father's house, walking with father, grooming father and laundering father's clothes, are the types of tasks each daughter performed **prior** to the execution of the contract, out of their love and affection for their father and the decision held that these cannot now be claimed to be done because payments are being made.
- The contract allows for services to be performed on an "as needed basis" which was found to be vague and ambiguous.
- It was uncertain if the caretakers will meet their expected contractual obligation since contract was based on the father's life expectancy not on a date certain.
- The hourly rate charged for the services rendered was found to be too high and not commensurate with the daughter's skills and training.
- The provision of financial, managerial and administrative services was held to be a duplication of other paid services or was covered under the caretaker's durable power of attorney which does not provide for compensation.

Commentary: Ironically the decision honored the contractual obligation between the A/R and the home repair contractor, while in the same decision the hearing officer did not apply the same contractual obligation to the contract between the father and his caretaker daughters. The decision implies that these kinds of non--medical services might be acceptable if the parties could provide better documentation of specific services and appropriate pay scales.

Matter of Barbato; 65 A.D. 3rd 821, 884 N.Y.S. 2d 525 (4th Dept. 2009) The 4th Department upheld determinations by the Herkimer and Oneida County Departments of Social Services that found lump sum payments for services pursuant to personal services contracts to be uncompensated transfers of assets. The decision indicates there was no way to determine fair value for contracts which contained provisions that services be provided on an "as needed basis." Moreover, the court found that the absence of a refund provision raises the possibility that a caregiver will receive a windfall in the event that the Medicaid recipient dies before his or her expected life expectancy. However, the matters were remanded to the respective local social services districts to make determinations regarding the fair market value of services rendered between the date on which each agreement was executed and the date of the eligibility determination. The court concluded that "substantial evidence supports the determinations that services provided by caregivers that are duplicative of services afforded petitioners by the nursing facilities in which they reside are non-compensable… Inasmuch as service logs kept by the caregivers for each petitioner are included in the record, the …duplicative services may be identified, and the services provided distinguished from those yet to be provided. Moreover, the fair market value of the non-duplicative services performed may be determined and used in calculating each of the periods during which petitioners are ineligible for medical assistance benefits….The determination of the issue whether certain services are duplicative of those provided by the nursing facilities may be facilitated by reference to the standards for services in such facilities set forth in 10 NYCRR 415.1 through 415.27."

Stern v. Dairies, (Queens Co. 2009) 2009 NY Slip Opinion 32836 (unpublished) (*Decision annexed as Exhibit H.)* Appeal from a fair hearing decision which found that a lump sum payment pursuant to a PSC was an uncompensated transfer. The PSC was executed by an agent under power of attorney subsequent to the admission of the care recipient to a nursing home. The court rejected that appellant's argument that GIS 07 MA/019 was promulgated in violation of the rule making provisions of the State Administrative Procedure Act. The court found that the contract was

defective as it provided for services on an "as needed basis" and failed to contain a refund provision. The court also determined that the Medicaid program is not bound by the arguably narrower interpretation of fair market value in the SSI POMS as the Medicaid and SSI programs have different rules regarding transfers of assets. The respondent Social Services district conceded that in light of **Barbato**, the case should be remanded for a determination of the actual fair market value of the services provided from the time of the execution of the PSC and the date of the Medicaid eligibility determination. The court also noted that the caregiver under the PSC was also the agent under power of attorney for the care recipient, and that she had the authority to transfer the resident to another facility if she was dissatisfied with the care received at the nursing home. No credit should be given for services provided by the nursing home.

Kerner v. Monroe County Department of Human Services, 2010 NY Slip Op 5904, 2010 N.Y. App.Div. LEXIS 5776. The 4th Department reversed a determination of the Monroe County Department of Social Services which imposed a thirteen month transfer penalty for services rendered pursuant to a PSC by the Medicaid applicant's son. The son was paid $9,283 per month for room and board, care and supervision, food and food preparation and daily assistance with personal care needs, laundry, cleaning, transportation and medical office visits. The son alleged this rate of service was commensurate with nursing home costs. The Medicaid applicant lived with his son and his wife from September 2006 until July 2007 and was paid $105,041 for services pursuant to the PSC. Services pursuant to the contract were provided on an "as needed basis." The 4th Department concluded that although a daily log of hours worked and services rendered is not necessarily required, the local district erred in issuing a decision which refused to give credit for any services. The matter was remanded to allow the local district the opportunity to recalculate the transfer penalty. The caregiver was to be given the 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.

Swartz v. New York State Department of Health, 3rd Department, June 14, 2012 . (*Decision annexed as Exhibit I.)*The Medicaid applicant and his wife executed a PSC with his daughter in which they were to pay her at rates ranging from $15.50 to $17 per hour for various services. The contract required the daughter to maintain contemporaneous records of the dates and nature of the services that she provided. The daughter was not paid until the father entered a nursing home and his home was sold. The local district determined that $36,056.74 of the total compensation to the daughter of $51,940.50 was uncompensated as the daughter failed to maintain detailed contemporaneous time records. The court noted that the

Medicaid applicant bears the burden of proof to establish that the transfer of funds to the daughter was not an uncompensated transfer and that this burden was not met as the daughter failed to maintain detailed records. Moreover, the rate of compensation was higher than the mean rate for a home health care rate as established by the US Department of Labor.

H. DRAFTING THE AGREEMENT

The written contract should clearly set forth the **type, frequency, and duration** of the services to be provided. *A sample contract is annexed as Exhibit J.*

When drafting the contract, be mindful that GIS 07/MA 019 states:

> if a personal services 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.

Practice Tip: Avoid the use of 'as needed' language in contracts which provide for services to be rendered to a nursing home resident. If the care recipient will be receiving care in the community, it may be acceptable for the contract to provide for services "as needed". However, the contract should lay out the expectation as to the average number of hours that such services will be provided on a typical week or month but that it is expected that during some periods the services will be rendered more frequently and in some, less. The contract should specify that there is a need for flexibility in delivering services and recognize that changing care needs may affect the frequency and scope of future services. ***The caregiver must be instructed to maintain meticulous, detailed logs regarding the dates, duration and types of services actually provided***.

Type of Services: The contract should specifically enumerate the types of services which will be provided by the caregivers. Some of these services may be equivalent to the services which may be provided by professionals such as geriatric care managers, nurses and accountants: for example, monitoring health care, accompanying the individual to doctor appointments, monitoring living arrangements, providing for social and entertainment activities, financial management, bill paying. In some instances, the services may include doing laundry, assisting the individual with bathing, toileting, feeding, hair care, manicures or other chores such as the services typically provided by personal care or home health aides.

Practice Tip: Individuals who enter nursing facilities often have apartments or homes which must be cleaned out and then returned to landlords or sold. Consider drafting a combined Personal Services Contract/Reimbursement Agreement which will provide for compensation and/or reimbursement to caregivers who clean out or maintain the residence, prepare the residence for sale or return to a landlord, arrange for sale or donation of personal property.

Frequency of Services: The contract should set forth a specific expectation as to the average number of hours in which services will be provided per week, or per month.

Compensation: The contract should set forth the understanding of the parties as to the average market rate for services being provided under the contract.

Practice Tip: The contract should separately enumerate a range of hourly rates in the locality for services which are equivalent to geriatric care management, accounting or financial management services and personal care or home health aide services. All assumptions used in the creation of the contract must be subject to verification, in writing, in the event the Medicaid application is denied and a fair hearing is required.

Do the Math! The contract should set forth the exact calculation of the fair market value for the services provided under the agreement. Provide the rate for each service and multiply by the number of hours the service will be provided over the duration of the contract. Consider using a rate for services which is considerably below the average rate charged by commercial service providers. **Remember: This contract will be closely scrutinized by Social Services officials.** Consider paying the caregiver less than the calculated fair market value for the services and stating that the services are being provided at a discounted rate.

Room and Board: If the individual receiving care will be living in the household of the caregivers, consider including an obligation to pay monthly room and board, in addition to the hands-on personal care services provided under the agreement. Be prepared to document the average cost for the room and board in the locality in which the clients live. The sample agreement annexed as Exhibit J provides for room and board at a rate commensurate with the monthly fees for charged by an independent living facility in the area.

Multiple Caregivers: There may be circumstances where multiple caregivers will be providing services under an agreement. The agreement

should specify whether each caregiver is to receive a pro rata part of the payment, or any other division, as appropriate and agreed upon by the parties. If the agreement provides for payment for only one of several children or would otherwise result in an unequal division of assets, the practitioner should be particularly cautious about ethical issues such as the competence of the elderly or disabled care recipient or undue influence by the provider and should proceed with caution.

Practice Tip: Consider calling a family meeting or preparing an agreement among the family members regarding the payments pursuant to the personal care contract. Similarly consider advising the recipient of the care and caregivers to retain separate counsel.

Execution of Documents. There is no requirement under New York law for a contract to be notarized or witnessed in order to be binding upon the parties. However each of the parties must sign the contract and the contract should be dated.

Execution by Agent under Power of Attorney: If the PSA is executed by an agent under power of attorney who is also the caregiver, the Power of Attorney document should contain specific authority in the Modifications section which specifically authorizes the agent to enter into such contracts. Sample language might be: "Enter into buy/sell agreements, and/or agreements for goods and/or services for my benefit, including but not limited to personal services agreements with any person, including my agent(s)."

The Power of Attorney document should also authorize the agent to be compensated for his or her services and the Modifications section should contain the parameters for reasonable compensation. Sample language could be: "Provide reasonable compensation to my agent for services provided pursuant to this document, provided that such compensation is authorized by section (j) below. Reasonable compensation shall be limited to hourly compensation for all services at a rate which shall not exceed $20.00 per hour."

I. Miscellaneous Issues and Considerations

Lump Sum vs. Periodic Payments: Most last minute or emergency Medicaid plans will utilize a lump sum payment for personal care services. However, there may be instances where it makes sense to enter into a care agreement for services which will be provided over time and paid for accordingly. The latter arrangement may be particularly appropriate as a way of providing market rate compensation for a caretaker child who has given up employment in order to care for an aging or disabled parent. The ongoing payments pursuant to the personal services contract can be

supplemented with additional post-DRA Medicaid planning techniques in the event that the parent requires a subsequent placement in a skilled nursing facility. This may be a particularly appropriate technique where the parent has highly appreciated assets which would result in a capital gains tax if transferred to the caregiver child or liquidated in order to make a lump sum payment. This arrangement may also offer advantages to the caretaker by offering social security earnings and the protection of worker's compensation coverage and unemployment insurance.

If a lump sum payment will be made under the contract, or services will be provided over the lifetime of the potential Medicaid applicant, consider adding language that the contract is irrevocable and may not be amended except upon consent of all of the parties. In light of recent fair hearing and judicial decisions, the contract should provide for a refund of payments which are not earned in the event that the caregiver becomes unable to provide services or the care recipient dies before receiving services paid for by the lump sum.

Real Estate as a form of Payment: The payment pursuant to the terms of the personal care contract may be in the form of a transfer of an interest in real property. However, the clients must be advised to obtain a current value real estate appraisal at the time of the transfer in order to document the value of the consideration received under the contract. Partial interests in real estate may be conveyed, as appropriate after consideration of the life expectancy of the potential Medicaid applicant and the nature, scope and duration of the services to be provided under the contract.

Assignments of a Future Interest to the Contract:
There may be situations where the individual entering into the contract for services does not currently have the funds to make a lump sum or periodic payment but will soon have such liquid funds i.e. anticipated proceeds from a lawsuit, inheritance or sale of an interest in real property. The individual can assign the future interest to the caregivers as consideration for the services to be provided under the contract. The assignment by an individual who is already receiving Medicaid services can avoid the loss of benefits which would be incurred if the lump sum payment was received and then transferred to the care providers under the agreement.

Query? Could the agreement impose interest charges if the provider of services has to wait for payment until such time as a residence is sold or an inheritance is received? Should the care provider perfect the claim for services by filing a lien against real property?

Employment Issues and Payment of Taxes: The payment to the caregiver pursuant to the terms of the agreement is taxable income. The practitioner is advised to provide written instructions to the caregivers that

the payment pursuant to the agreement must be reported on the annual income tax returns filed by the caregiver. If the provider of services meets the requirements to be considered an employee, as discussed below, the care recipient must provide the employee with a W-2 and report the wages paid to the employee.

Independent Contractor or Employee: IRS Publication 926 sets forth guidance regarding whether an individual who provides services in the household is a household employee. The publication states that a worker is an employee if 'the employer' can **control** not only what work is done, but how it is done:

> If only the worker can control how the work is done, the worker is not an employee but is self-employed. A self-employed worker **usually** provides his or her own tools and offers services to the general public in an independent business. (Emphasis supplied.) See also: The general rule is that an individual is an independent contractor if you, the person for whom the services are performed, have the right to control or direct only the result of the work and not the means and methods of accomplishing the result Employer's Supplemental Tax Guide, IRS, and Pub. 15A.

See IRS Training Manual: Independent Contractor or Employee? Training materials, Course 3320-102, p. 2-7 and IRS Rev. Rul. 87-41 for a list of factors that may be considered to determine independent contractor or employee status.

If the individual who is receiving services directs the provision of such services, the caregiver is an employee and not an independent contractor. The distinction is critical as an employer must pay and withhold social security and Medicare taxes, pay federal and state[10] unemployment taxes and worker's compensation [11] for the employee. An employer must also verify that the worker is eligible to work in the United States by verifying citizenship or alien worker status. An employer must also obtain an Employer Identification number by filing form SS-4 with the IRS. An employer is not required to withhold income taxes, but must report the income of all employees on a W-2 form. Federal and New York State taxing authorities have the ability to look beyond the filing of a W-2 or 1099 form to determine whether the individual is an employee or independent contractor.

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[10] For information about New York State unemployment taxes, see the Department of Labor website: http://www.labor.state.ny.us.

[11] An employer must make New York State worker's compensation payments for domestic employees who work 40 or more hours per week. See http://www.wcb.state.ny.us

Practice Tip: The practitioner should advise the clients to seek competent professional services from an accountant or payroll service regarding the obligations to pay and report payroll taxes, unemployment insurance and worker's compensation.

Record Keeping and Documentation of Services: The provider should be advised to keep detailed records of all services provided pursuant to the agreement as well as all expenditures made on behalf of the care recipient.

Practice Tip: Rather than evaluate each situation on a case-by-case basis, local districts of social services frequently issue decisions which find all payments pursuant to a PSC to be uncompensated transfers of assets. Medicaid applicants and family members must then request fair hearings to prove the adequacy of the contract and the legitimacy of the services provided. Attorneys who counsel clients about the option of entering into these contracts should warn the clients, at the outset, about the likelihood that a fair hearing will be required. This factor must be weighed in the determination whether to utilize this technique

III. REIMBURSEMENT AGREEMENTS

As stated in Section II above, the Medicaid program has historically applied a presumption that services provided by family caregivers are intended to be uncompensated and are provided for love and affection alone. See, 96 ADM-8 page 12. Accordingly, the Medicaid program will generally impose a transfer penalty period upon a payment to a child or other individual which is intended to be a reimbursement for out of pocket expenditures advanced by the child. For example, many times a child will pay real estate taxes, mortgage payments or other obligations of a parent who has meager resources. Later, upon the sale of the real estate, the parent will reimburse the child for these out of pocket expenses. However, in the absence of a written agreement that the funds advanced by the child were intended to be a loan, the Medicaid program will generally treat these later payments to the child as a gift, subject to a Medicaid transfer penalty. This result can be avoided by the use of a written reimbursement agreement between the parent and the child which clearly evidences a contractual agreement that the parent will pay the child back for the sums advanced, at a future date. *A sample reimbursement agreement is attached as Exhibit K.*

IV. CONCLUSION:

Family care giving is valid work which fulfills a real societal need.

If the work of the family caregiver was replaced by paid professional staff, the impact of the economy would be tremendous. A carefully drafted Personal Services Contract can provide valuable compensation to the family care giver and withstand scrutiny as a compensated transfer for value if the care recipient later requires placement in a skilled nursing facility and applies for Medicaid.