# Planning and Skills for Chronic Care Medicaid: Part I

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**Medicaid Overview**

To determine whether or not your client needs Medicaid, you first need to understand what Medicaid is, its various benefits, and why it may be an appropriate program for an individual or family. At its core, Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. The Medicaid system is a joint program of the federal government and the states. It is administered by the states according to federal requirements. The program itself is funded jointly by states and the federal government.

States establish and administer their own Medicaid programs and determine the type, amount duration, and scope of services within broad federal guidelines. States are required to cover certain "mandatory benefits," and can choose to provide other "optional benefits" through the Medicaid program.

States have the option to charge premiums and establish out-of-pocket (cost sharing) requirements for Medicaid enrollees. Out-of-pocket costs may include copayments, coinsurance, deductibles, and other similar charges. Maximum out-of-pocket costs are limited, but states can impose higher charges for targeted groups of somewhat higher income people. Certain vulnerable groups, such as children and pregnant women, are exempt from most out-of-pocket costs, and copayments and coinsurance cannot be charged for certain services.

The Medicaid program allows for the coverage of long-term care services through several vehicles and over a continuum of settings. This includes institutional care and home and community-based long-term services and supports. Medicaid covers certain inpatient, comprehensive services as institutional benefits. In Medicaid coverage,

institutional services refer to specific benefits authorized in the Social Security Act. These services include:

- Hospital services;
- Intermediate care facilities for people with intellectual disabilities;
- Nursing facility;
- Preadmission screening and resident review;
- Inpatient psychiatric services for individuals under age 21; and
- Services for individuals age 65 or older in an institution for mental diseases.

Institutional benefits share the following characteristics:

- Institutions are residential facilities, and assume total care of the individuals who are admitted.
- The comprehensive care includes room and board. Other Medicaid services are specifically prohibited from including room and board.
- The comprehensive service is billed and reimbursed as a single bundled payment. (States vary in what is included in the institutional rate, versus what is billed as a separately covered service; for example, physical therapy may be reimbursed as part of the bundle or as a separate service).
- Institutions must be licensed and certified by the state, according to federal standards.
- Institutions are subject to survey at regular intervals to maintain their certification and license to operate.

- Eligibility for Medicaid may be figured differently for residents of an institution, and therefore access to Medicaid services for some individuals may be tied to need for institutional level of care.

**Basic Medicaid Eligibility Criteria**

Medicaid is a multi-faceted program which provides the primary source for long-term care services in New York State. Medicaid can provide benefits for care in the community and in skilled nursing facilities. Eligibility rules for these programs have significant differences. For community-based Medicaid, eligibility factors include medical need, income standards, and resource standards. For skilled nursing facility benefits (i.e., chronic care Medicaid), those three factors are considered, but importantly, a complete financial review of the prior sixty (60) months of transactional activity is also required. This may cause problems for some people who became eligible for community-based benefits, and later need to transition to a skilled nursing facility. It also raises an issue, such that having minimal financial resources does not absolutely qualify someone for coverage. The impact of any transfers and potential period of ineligibility should be evaluated by an elder law attorney as early as possible.

Managed Long-Term Care (MLTC) is a system that streamlines the delivery of long-term care services to people who are chronically ill or disabled and who wish to stay in their homes and communities. These services, such as home care or adult day care, are provided through managed long-term care plans that are approved by the New York State Department of Health. The entire array of services to which an enrolled member is entitled can be received through the MLTC plan the member has chosen. Enrollment in a

MLTC is mandatory for those who are dual eligible (i.e., eligible for both Medicare and Medicaid) and over 21 years of age and need community-based long-term care services for more than 120 days.

Medicaid eligibility for community-based Medicaid programs is similar to chronic care (nursing home) Medicaid eligibility in some ways, and yet different in others. While a single individual receiving chronic care Medicaid benefits may retain $50 of income per month, a single individual receiving Medicaid residing in the community may retain $842/month* of income for 2018 (*plus $20 disregard). For married couples, chronic care income budgeting permits the Medicaid recipient to retain $50/month of income, with the Community Spouse permitted to retain $3,090/month. Should the Community Spouse have personal income in excess of that figure, he or she may typically be requested to contribute approximately 25% of the excess towards the cost of his or her spouse's care expenses. For traditional community-based Medicaid, a married couple may retain $1,233/month* of income (*plus $20 disregard). Any income over that amount must be spent on medical care before Medicaid will begin paying for care at home. For many community-based Medicaid applicants/recipients, the use of a pooled trust is a tremendous tool in satisfying the required "spend-down" for his or her excess income. It is important to note that the income allowances discussed above apply for traditional community-based Medicaid recipients. The election of spousal impoverishment budgeting may in some cases provide a married couple with more favorable income treatment, which will be discussed later.

The asset level for community-based Medicaid is also different from that of chronic care Medicaid applicants in some instances. While a single individual may retain

$15,150 in countable assets whether he or she is applying for community-based Medicaid or chronic care Medicaid, a married couple has different asset thresholds in community based Medicaid cases. Unless Managed Long Term Care or the NHTD program is being applied for (again, electing for spousal impoverishment treatment), a married couple seeking community-based Medicaid coverage for one spouse may retain no more than $22,200 of assets. This is vastly different than the $74,820-$123,600* (*the $123,600 is the spousal share, meaning that a Community Spouse may retain up to one-half of the couple's resources up to $123,600) Community Spouse Resource Allowance that the Community Spouse of a chronic care Medicaid applicant is permitted to retain.

**The Deficit Reduction Act and Look-Back Period**

The federal provisions governing Medicaid benefits and eligibility are codified in the Social Security Act under Chapter 7, Subchapter XIX of Title 42 of the United States Code. The Social Security Act was amended by the Deficit Reduction Act (the "DRA") of 2005, which was signed into law on February 8, 2006. The State of New York has codified the law pertaining to Medicaid benefits and eligibility under Title 11 of the Social Services Law. New York adopted the provisions of the DRA and applied the provisions to all Medicaid applications made on or after August 1, 2006. In 06 OMM/ADM-5, the New York State Department of Health advised local departments of social services of the long-term care Medicaid eligibility provisions of the DRA, which, among other things, changed asset transfer rules.

Following the DRA, the look-back period was increased to sixty (60) months for individuals applying for Medicaid coverage of nursing facility services. Previously, only trust-related transfers were subject to a sixty month look-back evaluation.

Importantly, for transfers 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.

**Calculating the Ineligibility Period**

Once a local department of social services (LDSS) determines that a Medicaid applicant for skilled nursing home care meets the eligibility standards for medical need, income eligibility, and resource eligibility, it will conduct the financial review of the past 60 months. If the LDSS then determines that transfers were made for less than fair market value, a penalty period will be imposed. The penalty period is the period of time in which a Medicaid applicant is ineligible for Medicaid benefits. It is calculated by dividing the value of the transfer(s) (i.e., gift(s)) by the regional rate of care.

Currently, refer to GIS 17 MA/019: "Medicaid Regional Rates for Calculating Transfer Penalty Periods for 2018," to obtain the relevant regional rate. In 2018, the average regional nursing home rates in New York State are as follows:

- Northeastern - $10,719;
- Western - $10,239;
- Rochester - $11,692;
- Central - $9,722;
- NYC - $12,319;
- Long Island - $13,053; and
- Northern Metropolitan - $12,428.

The LDSS must use the regional rate in effect on the date the institutionalized individual applies or requests an increase in coverage. For example, an application in February 2018 for coverage retroactive to November 2017, would utilize the 2018 rates as set forth in GIS 17 MA/019. It is also important to note that the rate must be utilized in the region where the facility is located, not necessarily where the application is made (based on residency).

A simple example illustrates the calculation of the penalty period. If it is deemed that an applicant has transferred $105,000 during the relevant 60 month look-back period, and the regional rate for Western New York is used, the penalty period is determined as follows:

$105,000/$10,239 = 10.25 months.

Again, the penalty period begins to run on the later of: (1) the date when (a) the Medicaid applicant: (i) is resource eligible; (ii) is income eligible; (iii) requires nursing home level care; and (iv) has filed a Medicaid application and (b) no other period of Medicaid eligibility is outstanding; or (2) the first day of the month after which assets have been transferred.

Now that the penalty period has been imposed, the applicant will be ineligible for Medicaid benefits for the relevant determined period of months, meaning that the applicant will be required to continue privately paying during that time period.

**Exempt vs. Countable Assets**

The New York State Medicaid Reference Guide defines resources as property of all kinds, including real, personal, tangible, and intangible. All resources of an SSI-related applicant/recipient ("A/R") are reviewed to determine their availability and value as of the first day of the month for which the A/R is applying for or receiving Medicaid. This review will be important for both an individual, and for a married couple.

Assets may include both available assets, as well as assets which the applicant, or applicant's spouse, is entitled to, but does not obtain because of action or inaction (i.e., renunciation of inheritance, waiver of right of election, etc.). Certain assets may be considered resources, unless certain elections are made, such as in the case of individual retirement accounts which are not in "pay-out status."

Certain resources may be considered as "exempt" in a Medicaid determination. For a single individual, exempt resources made include irrevocable pre-paid funeral and burial arrangements, tangible personal property, and certain limited life insurance (i.e., life insurance with a face value not exceeding $1,500 designated for a burial allowance). For a married couple, the Medicaid applicant/recipient may again retain the same exempt resources, as previously mentioned for a single A/R. The Community Spouse may also retain those exempt items. Additionally, the Community Spouse may retain his or her residence (with equity up to $858,000) and an automobile.

**Methods of Calculation and Allocation of Income and Resources**

For chronic care Medicaid for a single person, use countable Medicaid income, deduct $50, and arrive at the "spend-down" (income contribution required to be paid toward cost of care). For chronic care Medicaid for a married couple, the Community Spouse is permitted to retain $3,090 of income per month, which is the Minimum Monthly Maintenance Needs Allowance (MMMNA). In each case, health insurance costs are permitted disregards. If the Community Spouse ("CS") has income of his or her own exceeding $3,090, he or she will be asked to contribute 25% of excess towards the cost of the medically needy spouse's care. An example illustrates the way income is budgeted, and also the importance of which spouse is requiring care. We can look at a married couple with two scenarios, and in each case the Husband has $3,775/month of countable income and the Wife has $1,500/month of countable income. In the first scenario, the Wife is the A/R and the Husband is the CS.

| | | | |
|---|---|---|---|
| $1,500 | Wife's Income | $3,775 | Husband's Income |
| ($50) | Income Allowance | ($3,090) | MMMNA |
| $1,450 | Wife's Contribution to Care | $685 | Husband's Excess Income |

In this example, the Husband will be typically required to contribute 25% of his excess income to the Wife's care, or $171.25/month. The total family monthly income contribution to care is $1,621.25.

In scenario two, Husband is the A/R and Wife is the CS. Wife/CS does not have sufficient income to bring her up to the MMMNA level of $3,090. Wife/CS will be deemed income from Husband/A/R up to the MMMNA level.

| | | | |
|---|---|---|---|
| $3,775 | Husband's Income | $1,500 | Wife's Income |
| ($50) | Income Allowance | $1,590 | Income from H |
| ($1,590) | H's Inc. deemed to Wife | _________ | |
| $2,135 | H's Contribution to Care | $0 | Wife's Excess Income |

In this example, the total family monthly income contribution to care is $2,135. While the Community Spouse/Wife will be deemed income from her Husband, the impact to the family is different than in the first scenario.

The calculation of resources for the chronic care Medicaid applicant is fairly straightforward, following the rules provided in earlier sections. By way of review, as resources are evaluated, the single Medicaid A/R may have resources valuing $15,150 or less. For married couples, spousal impoverishment guidelines are utilized, such that the A/R spouse's resources must be $15,150 or less, while the CS' resources may not exceed $74,820-$123,600, depending on the method chosen. See GIS 17 MA/020: "2018 Medicaid Levels and Other Updates."

For a single person in a community-based Medicaid situation, you are typically looking at a straightforward calculation of income based on a threshold value of $862/month (includes disregard), and countable resources of $15,150.

For spousal budgeting in a community-based Medicaid situation, there are some variations to consider. For income purposes, under traditional community-based Medicaid, the couple is allotted $1,253 of income/month (includes disregard) and

resources not to exceed $22,200. However, if spousal impoverishment budgeting is chosen, utilizing either a waivered program or MLTC, then both income and resource thresholds change significantly. With spousal impoverishment budgeting, the CS may keep the Community Spouse Monthly Income Allowance (CSMIA) income purposes, or $3,090/month, while the A/R spouse may keep $391.00/month as the personal needs allowance. This results in total combined monthly income for the couple of $3,481/month.

Prior to 16 ADM-02, a married person applying for Medicaid to enroll in a MLTC had to initially apply using traditional community based Medicaid rules. However, based on an application for "Immediate Need" Medicaid in an MLTC case, spousal impoverishment budgeting may be utilized from the outset. In cases where "Immediate Need" cannot be met, then the application may be approved under traditional community-based income budgeting in the first month, with a request then being made immediately upon approval to proceed with spousal impoverishment budgeting in the second month. Finally, if spousal impoverishment budgeting is not helpful, as in cases where the CS has significant income, then the A/R may request to be evaluated as a single person for income purposes. Even if the A/R then has a high monthly spend-down, he or she may utilize a pooled trust for excess income, and the result may be the most favorable option.

In cases where spousal impoverishment budgeting is utilized for a married couple, resource thresholds also increase from the traditional community-based levels to the higher levels used in nursing home applications.

**Specifically Exempt Transfers**

The transfer of a homestead (i.e., the principal residence) will be exempt (meaning, no penalty period will be imposed) if transferred to:

1. The spouse;
2. The child of the A/R who us under 21;
3. A blind or disabled child, regardless of age;
4. Sibling of the A/R with an equity interest in the home, and who has resided at the home, and is using it as his or her primary residence for at least one year prior to the A/R's admission to a skilled nursing facility; or
5. The child of the A/R who has resided in the home as his or her residence for at least two years immediately prior to the A/R's admission to a skilled nursing facility and has provided care to the A/R.

The transfer of an asset other than a homestead will be considered exempt if transferred to:

1. The A/R's spouse or to another for the sole benefit of the A/R's spouse;
2. From the A/R's spouse to another for the sole benefit of the A/R's spouse;
3. Disabled child;
4. To a trust for the sole benefit of an individual under sixty-five (65) years of age who is disabled.

There are a few other scenarios when transfers will be considered exempt for Medicaid purposes;

1. Post-eligibility transfers by the Community Spouse will be considered exempt as to the A/R's continued eligibility, but will impact the CS' personal eligibility (if relevant in the future);
2. Transfers made for purposes other than qualifying for Medicaid; and
3. Undue Hardship.

**Treatment of Retirement Accounts and Annuities**

The most significant issue when evaluating qualified assets and retirement accounts in a Medicaid eligibility scenario is whether or not the account is in pay-out status. If it is not, then the account is considered a resource. If it is in pay-out status, then the distributions from the account are considered part of the monthly income of the A/R, or the CS. Pay-out status typically refers to taking the required minimum distribution ("RMD") from the particular account. In a Medicaid eligibility context, pay-out status is relevant whether or not the individual is required to take RMDs based on Internal Revenue Code rules. It is important for the practitioner to be aware of the local practice with respect to how a particular LDSS determines the required countable value for income purposes, as there are differences throughout New York State from county-to-county.

For guidance on the treatment of annuities, one should review the DRA guidelines as set forth in 06 OMM/ADM-5. These rules require the A/R to disclose the description of any interest the A/R or spouse has in an annuity, regardless of whether it is irrevocable or treated as an asset. If an A/R or spouse purchases an annuity after February 8, 2006, New York State must be named as a remainder beneficiary in the first position of the

purchase will be deemed a transfer of assets. If there is a Community Spouse or disabled child, New York State must be named in the second position.

If the 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 IRC; or
- The annuity is purchased with the proceeds from an account described in subsection (a), (c), (p) of Section 408 of the Code; a simplified employee pension (within the meaning of Section 408(k) of the Code); or a Roth IRA described in 408A of the 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 SSA); and
    - Provides for payments in equal amounts with no deferral and no balloon payments made.

The criteria applies to transactions on or after February 8, 2006, with transactions including: any action to change the course of payment or that changes the treatment of the income or principal; additions of principal; elective withdrawals; requests to change the distribution of the annuity; elections to annuitize the contract, etc.

**Crisis Planning With Promissory Notes**

A gift-note plan is a crisis planning technique allowing a client to engage in asset protection planning while financing long term care expenses. In comparison with other planning techniques, the gift-note plan is a short-term planning strategy. An individual must be in need of institutional level of care for this plan to be utilized. The context is critical, since implementation of a gift-note plan will require the penalty period to be triggered.

A promissory note is an "unconditional promise, signed by the maker, to pay absolutely and in any event a certain sum of money either to, or to the order of, the bearer or designated person." To implement a gift-note plan, the practitioner must draft a Deficit Reduction Act (DRA) compliant promissory note to evidence the loan made by the applicant/recipient, which will be repaid with interest over a specified period of time. The DRA modified the rules governing the purchase of promissory notes, loans and mortgages. The DRA amended Social Security Act Section 1917(c)(1) by adding new rules governing the purchase of these investments (see Section 6016(c) of the DRA). New York State adopted these rules (see 06 OMM/ADM-5). Under the DRA, funds used to purchase a promissory note, loan or mortgage are considered to be a transfer of assets unless all of the following criteria are met:

(1) the repayment term is actuarially sound;

(2) the payments are made in equal amounts during the term of the loan, with no deferral of payments and no balloon payments; and

(3) the promissory note, loan or mortgage prohibits the cancellation of the balance upon the death of the lender.

A promissory note complying with the DRA criteria will be considered a bona fide transaction, and the purchase of such an asset will not be classified as a transfer of assets. Given the clear language of the DRA, the drafting practitioner will want to ensure that these criteria are met on the face of the note. It is advisable to consider including language stating that the note is non-negotiable, non-assignable, and otherwise non-transferrable by the promisee. This defeats the argument that the note could be considered a negotiable instrument, and thus an available resource to the applicant/recipient, by means of potential resale of the investment to a third party. The practitioner, in this context, may also consider the exclusion of otherwise standard note terms, including: acceleration language in the event of default, increase in interest rate upon default, authorizing the collection of attorneys' fees in the event of default, and other terms that would make the note attractive to a third party. Proper attention will also need to be given to the appropriate interest rate, which makes the note a viable investment.

Prior to implementing a gift-note plan, a significant amount of critical information is needed, including: the Medicare cut-off date, a comprehensive understanding of the individual's assets and income, a historical review of prior transactions, the private cost of care, outstanding liabilities, the need for retained assets, the liquidity of assets, the regional penalty period divisor, and the cost basis/tax considerations for liquidated and transferred assets.

The gift-note plan will first assess the need for any spend-down items, prior to implementation. Also, in preparing for the anticipated Medicaid application filing, it is important to determine if any resources were transferred for less than fair market value

during the relevant “look-back” period. If so, accommodations should be made in the plan to address the transfers. Then, resources will essentially be divided into three parts: the retained portion, the gift portion, and the loan portion (which is documented by the promissory note). Due care is needed to ensure that retained assets do not exceed the applicable resource threshold. The individual’s income, including the new monthly loan payment, must not exceed medical expenses.

Once the plan is implemented, the Medicaid application should be filed to establish an “otherwise eligible” determination. Note payments should be made during the term of the plan, and a structured plan should be followed with clear expectations as to the term and eventual Medicaid “pick-up” date. The individual will private pay for skilled nursing home care expenses during the ineligibility period, with a combination of note income, and the individual’s other standard income (i.e., Social Security, pension, etc.). There should also be an understanding of the ultimate goals of the plan, including the assets being protected and how those assets are to be held in the future.

**Joint Tenancy and Life Estates**

Typically, jointly owned assets are considered to be owned entirely by the Medicaid A/R. However, this presumption may be rebutted by evidence that the joint owner actually owns all or a portion of the property. This is most common in the case of financial institution accounts. However, brokerage accounts are evaluated differently, such that each owner is presumed to own an equal portion of the assets. If a Medicaid A/R added an individual as the joint owner of a brokerage account, for example, then it

will be presumed that the A/R transferred one-half of the value of the account to the other individual at that time, thereby also retaining one-half of the account.

If an individual transferred the remainder interest in real property (such as a personal residence, vacation property, etc.) to another person(s), thereby retaining a life estate interest, the first question in a Medicaid eligibility determination will be to consider the timing of the transfer. If the transfer occurred prior to the sixty (60) month look-back period, the life estate interest is exempt, so long as the property is not sold during the lifetime of the Medicaid A/R. If the transfer occurred during the look-back period, then the value of the remainder interest will be considered an uncompensated transfer, and thus subject to a penalty period. The value of the remainder interest will be established utilizing IRC Table S taking into account the 7520 rate as of the month of transfer. If the property is sold, the A/R should receive the proceeds of the sale equal to the life estate value, utilizing the same calculation procedures.

**Irrevocable Trusts**

Typically in the advance planning context, an individual or couple may consider transferring certain assets with the eventual goal of asset protection by utilizing an irrevocable income only trust. This type of trust is established by a grantor (or potentially grantors, in the context of a married couple) naming an independent trustee. This trust can hold many different types of assets, including real estate, brokerage accounts, bank accounts and other investment vehicles. The grantor will retain the right to the income generated by the trust during his or her lifetime. This allows the income generated by the trust assets to be taxed at the individual's income tax level. Another feature involves the

grantor retaining the right to use any real property owned by the trust during his or her lifetime. While the trust owns the property, the grantor is permitted to retain tax exemptions, which is often very advantageous. The grantor can also retain the right to pay all maintenance, tax, insurance and other carrying costs in the context of real property. Assets in the trust enjoy an income tax benefit known as a "step-up" in cost basis upon the death of the grantor. Thus, if the assets have appreciated in value over time, the cost basis for tax reporting purposes will change to the appreciated value on the date of death. This can provide a significant tax benefit to the trust's ultimate beneficiaries, especially in the context of real property and stock.

The grantor will only have access to trust income and will not be permitted to receive trust principal. While the trust can permit distributions of trust principal to a specified class of beneficiaries, the restriction of the grantor's access to principal is required for the purpose of asset protection. Certain provisions can be included in the trust giving the grantor some additional rights, including a limited power of appointment, the right to substitute property of an equivalent value, the right to change trustees (to someone other than the grantor), among others. If the assets held by an irrevocable income only trust are transferred 60 months prior to a Medicaid application, they will be considered exempt, but the income generated by the trust will be relevant for income budgeting purposes.