BASICS OF MEDICAID ELIGIBILITY

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I. OVERVIEW OF MEDICAID

In 1965 the Federal Medicaid Assistance Program commonly known as "Medicaid" was created as part of the same legislation that created the Medicare program. Medicaid was created as a health insurance program for the poor. It is a "means tested" entitlement program wherein individuals are entitled to benefits if they are financially and categorically eligible. It is a jointly financed federal-state program.[1]

In 1966, New York State Statutorily adopted the Medicaid program.[2] New York's program encompasses virtually every medical program available. New York elected to give

1 42 U.S.C. §1396 et seq.1 42 C.F.R. §430 35 et seq

the responsibility for administering Medicaid to the Counties.

For every dollar spent on Medicaid in New York, approximately fifty (.50) cents comes from the Federal Medicaid Program, twenty-five (.25) cents from New York State and twenty-five (.25) cents from the Counties.[3]

The Medicare Catastrophic Coverage Act of 1988, effective October 1, 1989, made significant changes to the structure of the Medicaid program in three main areas: (1) the transfer of assets rules, (2) the rules regarding the treatment of assets owned by the spouse of an institutionalized patient, and how the assets of that spouse would effect the eligibility for Medicaid of the institutionalized patient, and (3) the rules regarding the amount of income and resources the spouse living in the community would be allowed to keep.

Further changes to the Medicaid program were later enacted as part of the Revenue Reconciliation Act of 1993 (often referred to as "OBRA 93" which became effective on August 10, 1993). These changes were adopted by the New York Legislature and signed into law on June 9, 1994. OBRA 93 applied to transfers of assets made after August 10,

3 Soc. Serv. L. §62

1993, and with respect to applications for and recertifications of eligibility for medical assistance submitted on or after September 1, 1994.

The enactment of the Deficit Reduction Act of 2005 ("DRA") on February 8, 2006 imposed harsh restrictions upon Medicaid eligibility and the rules relevant to the transfers of assets for Medicaid eligibility. The New York State Department of Health on July 20, 2006, issued Administrative Transmittal #06 OMM/ADM-5, which interprets and implements the provisions of the DRA in New York effective August 1, 2006.[4] The federal agency responsible for Medicaid, the Center for Medicare and Medicaid Services ("CMS"), issued its guidance to the DRA on July 27, 2006 in publication SMDL #06-108 and SMDL #06-019.

II. Categories of Medicaid Coverage

A. Community Medicaid - Physicians, dentists, pharmaceutical, nursery services and other professional services provided to individuals on a clinical or outpatient basis for individuals who are eligible; and

4 Public Law 109-171(2006)

B. Home Care Services - Home health services, such as personal care services, nursing, physical therapy, occupational therapy and home health aid services; and

C. Institutional Services - Hospitals, other medical facilities, nursing homes.

III. Eligibility for Medicaid

A. Medicaid may be authorized for individuals whom are:

a. Medically needy

b. Categorically needy

B. To be eligible for New York Medicaid, the applicant must be:

a. A legal U.S. resident, citizenship is not a requirement. There is no durational residency requirement.

On October 26, 2004, ADM 04-OMM/ADM-07 was issued to clarify the Department of Health's policies relevant to Medicaid for non-citizens and aliens. The ADM provides a detailed historical overview of prior legislation relevant to Medicaid eligibility for non-citizens and aliens, and creates the guidelines as to how the Medicaid program will continue to be available to immigrants. The ADM can be

found at www.health.state.ny.us/nysdoh/medicaid/ publications/docs/adm/04adm-7.pdf.

b. The applicant must be a resident of the state and county where the application for Medicaid is made. Residency requires a physical presence within the state and the "intent to remain." Any person age twenty-one (21) and over is a resident of New York State[5] if he or she is living in the State and:

(i) intends to remain permanently or indefinitely; or

(ii) is unable to state intent unless he or she is in an institution, and another state made the placement.[6]

c. Under the age of twenty-one (21) or over the age of sixty-five (65).[7]

If you are between the ages of twenty-one (21) and sixty-five (65) you can be eligible for Medicaid, only if you are:

1. Disabled - a physical or mental incapacity which prevents you from any gainful employment, which is expected to endure for at least one (1) year;[8]

5 Soc. Serv. L. §§117,18; 18 NYCRR §§349.4, 360.2
6 18 NYCRR § 360-3.2(g)(5)
7 Soc. Serv. L. §366(1),(2),(3)
8 Soc. Serv. L. §366 (1)(a)(2), 18 NYCRR §360-3.3 (a)(3)

2. Blind - certified blind by NYS Commission for Blind and Visually handicapped.[9]

3. Eligible for Public Assistance – either receiving or be eligible to receive safety net assistance or family assistance, thus, must be below the public assistance income and resource levels;[10] or

4. Recipient of Supplemental Security Income ("SSI") - If receiving SSI from the Social Security Administration, you will be automatically eligible for Medicaid. No application for Medicaid is necessary.[11]

C. Medicaid is a "means tested" entitlement program:

There are both resource and income eligibility requirements. Applicant must have income and assets below specified amounts.[12]

Factors considered in determining financial eligibility:

1. Size of the household of the applicant, i.e., is applicant single or married;

2. Income - available to the applicant during period for which Medicaid is requested.

9 18 NYCRR §368.13
10 Soc. Serv. L. §366 (1)(a)(4),(7)
11 Soc. Serv. L. §366 (1)(a)(2)
12 18NYCRR §360-4.1

- Medicaid counts most income with certain specified exceptions, irrespective of whether the income is earned or unearned.[13] Certain income is exempt (not counted as available) for Medicaid eligibility purposes.[14] For example, the first twenty ($20) dollars per month of income whether earned or unearned is exempt. German and Austrian reparation payments, Nazi Persecution Funds, State Crime Victims Assistance Funds as well as other income sources are totally exempt, so long as they are kept segregated from other funds.[15]

- Income can be "deemed" or attributed to another irrespective of whether it is actually paid. "Deeming" is only applied to legally responsible relatives, i.e., husband and wife, parents and a child under age twenty-one (21). However, deeming not applicable in "Spousal Refusal" cases.[16]

3. Resources available to the applicant during period for which Medicaid is requested.

A. Available Resources

- Resources are defined to include property of all differing kinds, e.g., personal property, (cash, IRA's, stocks,

13 18 NYCRR §360-4.3 (b)(2) and 18 NYCRR §360-4.3(b)(3)
14 18 NYCRR §360-4.6 (a)
15 18 NYCRR §360-4.6 (b)(2)(iv), 18 NYCRR §360-4.6(a)(1) (xxii)
16 18 NYCRR §360-1.4(e)

bonds) real property, tangible, intangible, liquid or illiquid (real property).

- NYS DSS Administrative Directive: 96 ADM - 8, “assets” for purposes of Medicaid are defined as all income and resources of the individual applicant and the applicant’s spouse.

- Income and/or resources which the applicant or the applicant’s spouse is entitled to, but does not obtain because of action or inactions takes by (a) the applicant or his or her spouse, or (b) a person, Court, administrative body with legal authority to act on behalf of applicant or applicant’s spouse; or (c) a person, Court or administrative body acting at the direction or request of the applicant or applicant’s spouse.

Examples of actions taken which would cause resources or income not to be received, but still considered as an available resource or income pursuant to NYS DSS 96 ADM - 8 are:

a. Renunciation of an inheritance or waiver of spousal right of election;

b. Waiving pension income irrevocably; and

c. Waiving or not accessing personal injury or tort settlements.[17]

C. IRA’s KEOGH’s and 401K’s

17 26 U.S.C.A §408

- Are considered available as illiquid resources for Medicaid eligibility purposes.[18]

- Medicaid will not consider the IRA or retirement account as an available resource if the applicant places the account into “payout status” (begins taking the minimum required distribution or “MRD”). However, Medicaid will count the income received as available income.[19]

- If an IRA is cashed out, even before age 59 1/2, the net proceeds (after payment of any taxes or penalties) are considered an available resource for eligibility purposes.[20]

D. Annuities

- Annuities must meet the requirements of the DRA and 06 0MM/ADM-5 which are discussed in greater detail herein.

- Annuities are a type of investment wherein one (“annuitant”) in consideration for his or her investment will receive the right to receive fixed periodic payments either for a term of years or for life.

- If the projected return (“payout”) from the annuity is reasonably proportionate (“actuarially sound”) to the investment made (based on life expectancy and rate of return) for Medicaid purposes the purchase of the annuity will be considered a compensated transfer, thus, not creating a period of

18 18 NYCRR §§360-4.4; 4.6 (b)(2)(iii)
19 GIS 98 MA/024
20 ID at 18

ineligibility for Medicaid. However, if the projected return is proportionately less than the investment made, Medicaid will consider the purchase of the annuity as a trust related transfer in an amount less than fair market value, which creates a period of ineligibility for Medicaid nursing home.[21]

- Health Care Financing Administration, State Medicaid Manual Transmitted No. 64 (November 1994) and HCFA Pub. 45-3 (HCFA Transmittal No. 64) delineates how annuities are treated under the trust/ transfer provisions.

- If the annuity is "actuarially sound" and the annuity has been reduced to an income stream (a "fixed annuity"), no period of ineligibility for Medicaid would be created under the trust/transfer provisions. However, the monthly payout will be considered and counted as available income.[22]

The following have been determined to be "exempt resources", therefore, they are not considered or counted for purposes of Medicaid eligibility:

(1) "Homestead" - "primary residence" (not a second or vacation home) which is occupied by the applicant, applicant's spouse, minor, blind or disabled child.[23] A one, two or three family home, condo, co-op, mobile home is considered to be a homestead. The homestead can be income producing property, or

21 NYSDSS 96ADM-8,(a)8
22 Id at 21
23 Soc. Serv. L. §366 (2)(a); 18 NYCRR §§360-1.4 (f), 4.7 (a)(1)

even attached or contiguous to income producing property. Although the primary residence will be considered as an exempt homestead, however, any income will be counted and treated as available.[24]

The DRA has placed a cap on the equity of the homestead of an applicant who does not have a spouse, child under 21 or a blind or disabled child residing in the home may have and still qualify for certain Medicaid benefits. The DRA provides that an individual applying for "nursing facility or other long term care services" is not eligible for such services if his or her equity in the home exceeds $500,000. However, each state was given the option to increase this amount to $750,000. New York has increased the equity cap to $828,000 for the year 2015.[25] Pursuant to New York State Department of Health Administrative Transmittal 06 OMM/ADM-5, there is a hardship exception to the home equity cap, if a legal impediment prevents the applicant from accessing his or her equity in the homestead and the denial of Medicaid would deprive the applicant of medical care to the extent the applicant's health or life would be endangered or deprive the applicant of food, clothing, shelter or other necessities of life.

24 18 NYCRR §360-1.4 (f); 18 NYCRR §360-4.3 (d)
25 Soc. Serv. L. §366 (2)(a)(1)(ii)

- If the applicant is institutionalized and expresses the intent to return home, the homestead will not lose its exempt status but Medicaid may place a lien on the home. However, the homestead can lose its exempt status if the applicant is declared to be in "permanent absent status."[26]

A declaration of permanent absent status can be made upon the applicant entering the nursing home, or if applicant remains in a hospital for more than six (6) months. By declaring the individual to be in permanent absent status, Medicaid can count the house as a resource and find the applicant ineligible for Medicaid if there is no "intent to return home". Medicaid can place a lien on the homestead, if an "intent to return home" has been filed.[27]

(2) Burial Allowance - $1,500 cash or face value of life insurance. Must be in a separate account designated as "burial allowance."[28]

(3) Burial Space and Irrevocable Burial Trust - Applicant may own in addition to the $1,500 burial allowance, a burial space, grave, crypt, mausoleum, headstone, casket, without effecting Medicaid eligibility.[29]

- A Medicaid applicant/recipient may pre-pay his

26 18 NYCRR §360-4.10
27 18 NYCRR §360-7.11 (a)(3)
28 18 NYCRR §360-4.6 (b)(1)
29 18 NYCRR §360-4.7

or her funeral and burial expenses with a funeral home director by using an Irrevocable Trust Fund. There is no dollar limit on the amount that can be placed in the Irrevocable Trust. However, it is not recommended that the trust be over funded, because any monies not utilized for the funeral and burial must be turned over to Medicaid.[30]

(4) Personal Property - The applicant's personal belongings and furnishings are exempt. No valuation is made for Medicaid eligibility purposes.[31] One automobile, irrespective of its value, is also exempt.

(5) $14,850 of Exempt Resources a/k/c "Luxury Fund" for the year 2015.

4. Comparison of Applicant's Net Available Income and Resources to the Eligibility Standards for His or Her Medicaid Household Size.

If the applicant's net available resources exceed the eligibility standards for his or her household size, then he or she will be ineligible for Medicaid until he or she has incurred medical expenses equal to or greater than the amount of his or her excess resources. Similarly, if the applicant's net available income is above the income standard for his or her Medicaid household size, he or she

30 Soc. Serv. L. §209 (6)(b), General Business Law §453 (1)(b)
31 18 NYCRR §360-4.7 (a)

will be ineligible for Medicaid until medical expenses are incurred equal to or greater than the excess income.

IV. Income and Resource Eligibility Requirements for 2015

A. Income Levels for a Single Individual

(i) For Community/Homecare Medicaid - $825.00 per month plus $20 per month disregard.[32]

(ii) For Nursing Home - all of the recipients monthly Income (except exempt income) in excess of $50 per month ("personal needs allowance"), [33] must be paid to nursing home as an offset to the services provided by Medicaid.

Pursuant to the Section 6013 of the DRA, all states are required to attribute or allocate the maximum available income of the institutionalized spouse to the community spouse before granting an increase of the community spouse resource allowance ("CSRA") under Section 1924 (e)(2)(C).

B. Income Levels for a Couple

(i) For a Couple receiving Community/Home Care Medicaid - $1,209 per month, plus a $20 per month disregard.[34]

C. Resource Levels for a Single Individual

32 GIS 06 MA/029 Exhibit A

34 Id at 32

- $14,850 Total[35] - Known as “Luxury Fund”

D. Resource Levels for a Couple for Community/ Medicaid

- $21,750[36]

E. Income and Resource levels for the Community Spouse of an Institutionalized (Nursing Home) Medicaid Recipient

- Minimum Monthly Maintenance Needs Allowance (MMMNA)

- $2,980.50 per month[37]

- Community Spouse Resource Allowance (“CSRA”)

On a sliding scale from a minimum of $74,820 to a maximum of $119,220 total.[38]

V. Spousal Impoverishment Provisions

As part of the Medicare Catastrophic Coverage Act (“MCCA”) of 1988, changes were made to prevent the impoverishment of the Community Spouse. Congress granted the states the authority to establish income and resource levels for the community spouse of an institutionalized Medicaid recipient. However, the law established a maximum level that could be utilized by the states.[39] New York has adopted and consistently selected the Federal maximums.[40]

VI. Community Spouse Income Allowance

35 Id at 32
36 Id at 32
37 Id at 32
38 Id at 32

40 Soc. Serv. L. §366-c.2(h)

The Community Spouse is permitted a Minimum Monthly Maintenance Needs Allowance ("MMNA"), the maximum MMNA for 2015 is $2,980.50 per month. If the Community Spouse's income falls below the MMNA, the Community Spouse is permitted to receive total income up to the amount of the MMNA by deducting income of the Institutionalized Spouse. However, the income can be made available to the Community Spouse only if it is actually made available to or for his or her benefit.[41]

The DRA has made the "income first" approach mandatory for all states

VII. Enhanced Income Allowance

If the Community Spouse wishes to seek an increase of the permitted MMNA ($2,980.50 for 2015) he or she must either at a fair hearing or in a family court proceeding establish that there exist "exceptional circumstances which result in significant financial distress". If the above is established Medicaid must permit an amount adequate to provide additional necessary income to the Community Spouse from the income of the Institutionalized Spouse.[42]

In Gomprecht v. Sabol, 86 N.Y.2d 47, 629 N.Y.S. 2d 190 (1995), the NY Court of Appeals severely limited the

41 42 U.S.C. §1396r-5(d)(1)(b); Soc. Serv. L. §366-c.4 (b)
4218 NYCRR §360-4.10 (b)(6)

ability of Community Spouses to increase the MMNA in a state Court proceeding. The Court determined that the fair hearing "exceptional circumstances" test was to be utilized by the Court in support proceedings. The Court opined that "exceptional circumstances" must be the result of "true financial hardship that is trust upon the Community Spouse by circumstances over which he or she has no control." See Schachner v. Perales, 85 N.Y. 2d 316, 624 N.Y. 3d 558 (1995).

In an Article 78 proceeding, the Court in Matter of Balzarini v. Suffolk County Dept. of Social Services (2008 NY Slip of 06704), held that reasonable, ordinary expenses can be exceptional and thus, satisfy the standard established in Gomprecht. The expenses of the Petitioner in Balzarini were for housing, utilities, food, Medicare and her automobile. The Court held that these ordinary expenses met the statutory requirement and held that her MMNA should be increased to include such expenses.

In February 2011, the New York State Court of Appeals reversed the lower court's decision and held that "exceptional circumstances" causing "significant financial distree" do not encompass everyday living expenses.

VIII. Community Spouse Resource Allowance

The spouse of an Institutionalized Spouse, who is residing in the community (a/k/a "community spouse"), is granted by Federal Law a Community Spouse Resource Allowance ("CSRA") which is set by the State. The CSRA can be adjusted annually pursuant to the Consumer Price Index ("CPI").[43] The minimum spousal share for 2015 is $74,820. In cases where the spousal share exceeds $74,820, the community spouse is allowed to retain resources in an amount equal to the spousal share but not to exceed $119,220 for 2015. In order for the spousal share to be more than $74,820, the total countable resources of the couple would have to be more than $149,640. (See 06 OMM/ADM-3).

The spousal share is an amount equal to one-half of the total value of the countable resources of the community spouse and institutionalized spouse as of the beginning of the most recent continuous period of the institutionalization of the institutionalized spouse. Continuous period of institutionalization means at least thirty (30) consecutive days of institutional care in a medical institution and/or nursing facility, or receipt of home and community based waivered services, or a

combination of institutional and home and community based waivered services.

IX. Computation of Maximum CSRA

For budgeting periods beginning January 1, 2015 and after, Social Service Districts must use the minimum CSRA of $74,820 and the maximum CSRA of $119,220 to determine the amount of resources that a community spouse is allowed to retain. In applying these (2) figures to the community resource allowance formula, the applicable allowance is to be determined by taking the greatest of the following amounts:

1. $74,820; or
2. the amount of the spousal share not to exceed $119,220 effective January 2015; or
3. the amount established for support of the community spouse pursuant to a fair hearing decision or court order.

In order to determine whether a couple’s spousal share is applicable in determining the community spouse’s resource allowance, social service districts must first determine if the total countable resources of the couple were more than $149,640 as of the beginning of the most

recent continuous period of institutionalization of the institutionalizes spouse. If they fail to provide verification of resources for the beginning of the most recent period of institutionalization, the social services district shall use the minimum spousal resource standard of $74,820.[44]

X. Increasing the CSRA

As the DRA makes use of the "income first" approach mandatory for all states. Thus, all states are required to attribute or allocate the maximum available income of the institutionalized spouse to the community spouse before granting an increase in the CSRA under §1924(e)(2)(C) of the Act. This applies to determination of the CSRA made on or after February 8, 2006 and only when the institutionalized spouse became institutionalized on or after the effective date.

In cases where a community spouse is seeking an increased CSRA on the basis that additional resources are needed to generate the monthly maintenance needs allowance, (MMMNA) States may now follow the following steps:

44 06 OMM/ADM-3 NYSDOH, 42 U.S.C. §1896-5(c)(i)

1. Determine the MMMNA for the community spouse in pursuant to Sections 1924(d)(3),(4) and (5) of the Act;
2. Determine the community spouse's total gross monthly income, including income from income-producing assets (interest and dividends) retained by the community spouse;
3. Subtract the community spouse's total monthly gross income from the MMMNA. If there is a deficit, this is the amount of the income "shortfall" for the community spouse;
4. Determine the institutionalized spouse's total gross monthly income. Deduct the personal needs allowance. Allocate sufficient income from the remainder of the institutionalized spouse's income to meet the "shortfall" amount for the community spouse.
5. If after step 4 above, there is some "shortfall" remaining for the community spouse, determine the amount of increased resources needed to generate that amount of income for the community spouse.

> In making this calculation, States may use any reasonable method for determining the amount of resources necessary to generate adequate income including adjusting the CSRA to the amount a person would have to invest in a single premium annuity to generate the needed income, attributing a rate of return based on a presumed available rate of interest, or other methods.

The above steps are offered for illustrative purposes, and do not preclude States from applying the income first method in a different manner or sequence.

XI. Enhanced Resource Allowance

Pursuant to the Federal Statute if it can be established that the CSRA is an amount which is insufficient to raise the community spouse's income to the MMNA level, then Medicaid must permit as the CSRA an amount sufficient to do so.[45] Again, as set forth in 18 NYCRR §360-4.10 [a] [10].

For example, if a Community Spouse only has $1,000 of monthly income, he or she could argue that he or she should be entitled to retain resources in excess of the $119,220

45 Soc. Serv. L. §366-c.8(c)

CSRA permitted in 2015, so as to generate sufficient income to allow her to achieve the $2,980.50 MMMNA for the year 2015.

XII. Deficit Reduction Act ("DRA")

On December 18, 2005, the U.S. Senate in a vote of 51-50 with Vice-President Cheney casting the deciding vote passed the Deficit Reduction Act of 2005 ("DRA") On February 8, 2006, President Bush signed the legislation into law. The States, pursuant to the DRA, were granted a specified period of time within which to adopt said changes or enact enabling legislation if determined to be necessary. New York State Department of Health on July 20, 2006, issued Administrative Transmittal #060MM/ADM-5 which implemented the provisions of the DRA in New York effective August 1, 2006. See also CMS publication SMDL #06-108 and SMDL #06-109 for the Center of Medicare and Medicaid Services guidance relevant to the DRA.

The DRA affects Medicaid eligibility and the transfer of asset rules in three (3) significant ways:

1. Creation of a sixty (60) month look back period for all transfers of assets, irrespective of whether they are outright transfers or transfers to certain trusts.

Under the DRA, for transfers made on or after February 8, 2006, the look back period is 60 months.

2. The penalty period (period of disqualification for Medicaid) created by a non-exempt transfer of assets will commence on the later of (a) the first day of the month after assets have been transferred, or (b) the date on which an individual is both receiving institutional level of care (i.e., is in a nursing home) and whose application for Medicaid would be approved, but for the imposition of a penalty period at that time. 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 an applicant, an exception may be made to the application of the penalty. However, there are no substantive changes to the high standards of "undue hardship" as described in 96 ADM-8; however, the procedural requirements as required by the DRA have changed. Undue Hardship requests in the past have been rarely granted utilizing the standards of 96 AMD-8 ("exceptional

circumstances resulting in significant financial distress").

Thus, the penalty period for a non-exempt transfer of assets made within the sixty (60) month look back period will commence when the applicant has $14,850 or less, is receiving institutional care in a nursing home, has applied to Medicaid for assistance, and the application would be approved, but for the penalty period imposed. This is the most onerous measure contained in the new legislation.

It should be noted that, pursuant to the provisions of the DRA and as under the prior law, no penalty period is imposed for transfers made by an applicant requesting community Medicaid (homecare Medicaid).

3. An applicant's Homestead (house, condo, co-op) with net equity above $828,000, in 2015, in New York will render an applicant ineligible for Medicaid. This provision does not apply if a spouse, child under age of 21, or a blind or disabled child resides in the house. Additionally, homeowners will have the ability to reduce their equity through a reverse mortgage or home equity loan.

Some of the other significant changes contained in the DRA with respect to Medicaid are that: (a) annuities will be required to name the state as a remainder beneficiary, and annuities that have a balloon payment will be considered a countable asset; (b) multiple transfers in more than one month must be aggregated; (c) the "income first" rule will be mandatory in all states (already required in New York); (d) penalty periods will be imposed for partial months (rounding down will no longer be permitted); (e) Partnership long term care insurance policies will be permitted in additional states other than the four presently permitted, including New York.

Thus, in a Post DRA crisis situation the elder law attorneys options other than a "Medicaid crisis plan" (which is discussed later herein) is to consider transfers and transactions that are not uncompensated transfers (gifts), but, transactions which involve the applicant receiving consideration for the transfer of assets made. Some of the transactions which can be utilized are as follows:

(a) Purchase of a Life Estate

The DRA provides that if one purchases a life estate interest in the home of another and does not reside

in it for at least one year after the date of purchase, the purchase would be treated as a transfer of assets, even if it was for full consideration. Thus, the DRA explicitly creates the possibility of purchasing a life estate in the home of another and having the transfer not be considered a transfer of assets (uncompensated transfer/gift) so long as purchaser resides in the home for at least one year. Need to be aware of capital gains tax consequences.

(b) Personal Service Contract

An agreement between two or more parties in which one or more parties agree to provide managerial or personal services to the other party in exchange for compensation for services provided. Generally, the services can be for such services as cooking, cleaning, assisting with activities of daily living, care giving. If the agreement is with family members, it is advisable to consult with a geriatric care manager whom services the particular geographic area in question, to ascertain what the going fair market value rate for the services to be provided is.

The personal service contract can have both a managerial component and a personal care services component.

The payment options can be either in lump sum or multiple payments. Compensation received by the care giver is income taxable to the care giver. If in a lump sum, could be negative income tax consequences, may want to spread out over 1 or 2 years. Could also possibly have payment made to an escrow account, with annual payments being made therefrom.

-Contract should not have compensation payable to care giver which is higher than market rate compensation.

-Real Estate can be used as a consideration for services, so long as it is commensurate with value of services provided.

-May wish to use escrow agent for payment

See Matter of the Appeal of Jerome Carolla, Fair Hearing # 3565848H.

(c) Annuities

Both annuities and Promissory Notes will need to meet the stringent requirements provided in the DRA and 06 OMM/ADM-5.

With respect to an annuity, the applicant will generally either pay to a family member or an entity (bank or insurance company) a lump sum of money in return for which he or she will receive regular payments of income for

the balance of his life or fixed payment of time. Presently, there are few commercial annuities on the market for the short period of time needed to do the crisis planning, thus, most elder law attorneys will need to create private annuities or promissory notes. One other option is where the applicant makes a gift of a certain amount of assets, which creates a period of ineligibility and an additional transaction is entered into which will create the annuity.

The DRA and the ADM treat the annuity as an uncompensated transfer of assets (gift) unless it is part of a retirement plan or if it meets the following requirements:

(a) It must be irrevocable;

(b) Non-Assignable;

(c) Actuarially sound;

(d) No deferral of payments is permitted;

(e) Balloon payments are not permitted;

(f) Payments must be made in equal amounts during the annuities term;

(g) Effective 8/1/06 if an applicant or the applicant’s spouse purchased an annuity on or after 2/8/06, and the applicant is seeking

Medicaid coverage for nursing facility services, the State must be named as remainder beneficiaries in the first position or the purchase of the annuity will be considered an uncompensated transfer of assets.

If there is a community spouse, blind or disabled child, the State must be named in the second position, and in first position if said spouse or representative of such child disposes of the remainder for less than fair market value.

If applicant or applicant’s spouse refuses to name state as a remainder beneficiary, the purchase of the annuity will be considered an uncompensated transfer of assets.

**It appears from a close reading of the ADM that letters (b) through (f) above may not apply to an annuity created by the spouse of the applicant.

(d) Promissory Note

The DRA and ADM provide that the funds used to purchase a promissory note, loan or mortgage on or after February 8, 2006 will be treated as an uncompensated transfer (gift) of assets unless it satisfies the following criteria:

(a) the repayment term is actuarially sound;

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

(c) prohibits cancellation of the balance upon the death of the applicant/recipient.

** Promissory Note does not require that the state be named as a remainder beneficiary in the first position or second position. However, it is possible that the note could be treated as an accounts receivable upon the death of the applicant, thus, as asset against which Medicaid will have a claim, if the individual was receiving Medicaid benefits.

At this time there still exists significant uncertainty as to how Medicaid will decide upon an application where the above stated crisis planning vehicles have been utilized. The risks attendant thereto will need to be explained to the client in great detail.

XIV. Utilizing A Medicaid Crisis Plan When Advance Planning Is Not An Option

The following is an example of a typical crisis plan:

After keeping $14,850 (the “luxury fund”) in separate bank account and paying for a pre-need irrevocable burial agreement, if the Medicaid applicant so chooses, the Medicaid

applicant would gift 40-45% of his or her assets to a family member/friend. Simultaneously, the applicant will lend to a family member/friend, his or her remaining excess resources, to be returned monthly pursuant to the terms of a DRA compliant promissory note.

The gift of assets made by the Medicaid applicant will trigger a period of ineligibility for Medicaid covered nursing home care. The monthly promissory note payments will pay for the cost of nursing home care during the period of ineligibility. The monthly payments are made to the Medicaid applicant as the “payee” under the promissory note from the “maker”, the person to whom the Medicaid applicant loaned the money, pursuant to the DRA complaint promissory note. In turn the payee will pay the nursing home.

Once the Medicaid applicant’s resources are below $14,850 and he or she is residing in a nursing home, he or she should then be eligible for Medicaid in all respects, but for the ineligibility period created, by the uncompensated gift made. Thus, for example if the dollar value of the gift is $100,000, the period of ineligibility for a Westchester County resident would be 8.73 months of ineligibility (100,000 divided by 11,455). A Medicaid application would then be filed with the local Department of Social Services

(DSS). The application should be denied on the sole basis of the gift. The denial will serve as formal notification of the Medicaid penalty period of ineligibility created by the uncompensated transfer for Medicaid-covered nursing home care.

The monthly promissory note payments paid by the maker coupled with the applicant’s monthly Social Security and other income, such as a pension, will provide an income stream from which he or she will pay the nursing home during the Medicaid period of ineligibility. The total monthly income plus - the promissory note payment, Social Security income and pension, if you receive one and/or any other income received by the applicant for Medicaid- must total less than the private pay rate of the nursing home, amounting to a monthly short fall. This shortfall amount should not be paid to the nursing home until the Medicaid application has been approved by Medicaid.

When the penalty period expires, a second Medicaid application or recertification is filed with DSS, which should be approved.

XV. The DRA's Effect Upon The Planning Options Available To Preserve Real Property For The Family

Even before the enactment of the DRA the decision to transfer the primary residence raised a number of important issues and concerns for both the attorney and client, for example; gift taxes, potential capital gains tax consequences and, of course, the transfers impact on the Medicaid eligibility of the senior.

However, once the decision was made to transfer the primary residence to someone other than a spouse, for Medicaid planning purposes, there were generally three primary planning options available:

(a) Outright Transfer of the Residence Without the Reservation of a Life Estate. Perhaps the least desirable option available, as the transferee of the property will receive the transferor's original cost basis in the property (original purchase price/value upon receipt plus capital improvements), and the outright transfer is a completed gift subject to gift taxes. For Medicaid eligibility purposes and pursuant to the DRA, the outright transfer of the residence would be subject to a 60 month look back period, and if the transfer of the residence was made within the look back period, the ineligibility period created would not commence

until the individual was in the nursing home had applied for Medicaid and would otherwise be eligible for Medicaid, but for the transfer. For example, although the formula used to calculate the period of ineligibility created by a non-exempt transfer of assets would be to take the fair market value of the property transferred, and divide said amount by Medicaid Nursing Home Rate for County of Applicant's Residence ($500,000 ÷ $11,455 (Westchester County Rate) equals approximately 43.65 months of ineligibility), under the DRA if Medicaid was needed within the 60 month look back period, the period of ineligibility would not commence until the applicant was receiving institutional care (in a nursing home), had applied for Medicaid and would have been approved but for the transfer made.

Additionally, from a tax perspective the use of an outright transfer of the residence results in the transferor losing the Internal Revenue Code ("IRC") §121(a) principal residence exclusion for capital gains of $250,000 (single person) or $500,000 (married couple). However, if the transferee owns and resides in the premises for two out of the five years he or she will be able to use said principal residence exclusion. Any Veteran's, STAR and Senior Citizen's Exemptions are also lost. It is necessary to

obtain a fair market value appraisal of the premises gifted for purposes of calculating the federal gift tax credit ($5,430,000 per person) utilized by the transfer.

(b) Transfer of the Residence with the Reservation of a Life Estate. Under prior law and from purely a Medicaid planning perspective relevant to the length of the ineligibility period created by a non-exempt transfer, this option had some important advantages. Because the retained life estate was given a value by Medicaid, which is subtracted from the overall fair market value of the premises at the time of transfer, the period of ineligibility for Medicaid could, depending on the age of the transferor, be significantly reduced. It was possible to create a period of ineligibility for Medicaid that was often less than 36 months. This was a distinct advantage over the use of a deed without the reservation of a life estate, and a transfer to an Irrevocable Income Only Trust, wherein no reduction in the value of the fair market value of the assets transferred was permitted, for purposes of calculating the period of ineligibility. However, the DRA has significantly reduced the effectiveness of this option. Pursuant to the DRA, if the transfer was made within the look back period (60 months), the period of ineligibility would not commence until

the applicant was receiving institutional care in a nursing home, and was otherwise eligible for Medicaid, but for the transfer made (has no more than $14,850). Thus, under the DRA a transfer of real property by deed with a retained life estate will also require that the transferor not apply for Medicaid within the look back period to avoid an onerous period of ineligibility.

Pursuant to §2036(a) of the IRC, the transfer of a residence with a retained life estate permits the transferee of the residence to receive a full step up in his or her cost basis in the premises upon the death of the transferor, to its fair market value on the transferor's date of death. This occurs because the residence is includible in the gross taxable estate of the transferor upon his or her demise. This, of course, presumes the existence of an estate tax upon the death of the transferor. A "life estate", pursuant to §2036(a) of the IRC, is the possession or enjoyment of, or a right to the income from the property or the right either alone or in conjunction with another to designate the persons who shall posses or enjoy the property or income thereof.

The most significant problem in utilizing a deed with the reservation of a life estate results if the premises are sold during the lifetime of the transferor. A sale during

the transferor's lifetime will result in (a) a loss of the step up in cost basis, thus, subjecting the transferee to a capital gains tax on the sale with respect to the value of the remainder interest being sold (difference between transferor's original cost basis, including capital improvements, and the sale price), and (b) the life tenant pursuant to Medicaid rules is entitled to a portion of the proceeds of sale based on the value of his or her life estate. This portion of the proceeds could be significant and will be considered an available resource for Medicaid eligibility purposes, thus, impacting the transferor's eligibility for Medicaid or being an asset against which Medicaid may have a lien. The existence of the possibility that the premises may be sold prior to the death of the transferor(s) poses a significant detrimental risk that needs to be explored in great detail with the client.

If for tax planning purposes it is prudent to make the gift an "incomplete gift" for gift tax purposes, the reservation of a limited power of appointment to the Grantor should be considered.

It should be remembered that §2702 of the IRC values the transfer of the remainder interest to a family member at its full value without any discount for the life estate retained.

Retention of a life estate falls within one of the exceptions of §2702.

If the transfer does not fall within §2702 of the IRC, or if one of the available exceptions applies (e.g. treated as a transfer in trust to or for the benefit of), calculation of the life estate is performed pursuant to IRC §7520, and the tables for the month in issue need to be consulted to determine the correct tax value of the remainder interest.

Pursuant to IRC §2702 if the homestead is transferred to a non-family member, the use of a traditional life estate will result in a completed gift of the remainder interest. It should also be remembered that the gift of a future interest (remainder or reversionary interest) is not subject to the annual exclusion of $14,000 per donee for the year 2015.

(c) Transfer to an Irrevocable Income Only Trust a/k/a ("Medicaid Qualifying Trust"). As a result of the enactment of the DRA and from a purely Medicaid Planning perspective, the use of the Irrevocable Income Only Trust may be the most logical advance planning option. As previously explained, irrespective of the fair market value of the residence transferred to the Trust, the period of ineligibility will effectively be five years (60 months), in

order to avoid the harsh penalties contained in the DRA for transfers made within the look back period. However, the properly drafted Irrevocable Income Only Trust will allow the residence to be sold during the lifetime of the transferor with little or no capital gains tax consequences, as it is possible to utilize the transferor's personal residence exclusion of up to $500,000 if married, and $250,000 if single, by reserving in the trust instrument the power to the Grantor(s) in a non-fiduciary capacity and without the approval and consent of a fiduciary to reacquire all or any part of the trust corpus by substituting property in the trust with property of equivalent value. The Grantor(s) will be considered the owner for income tax purposes. See IRC §675(4). Additionally, the transfer to the Trust can be structured to allow the transferee to receive the premises with a stepped up cost basis upon the death of the transferor, through the reservation of a life income interest (life estate) to the Grantor. §2036(a) of the IRC.

While the lengthy Medicaid ineligibility period must be appropriately considered, however, the tax advantages and the continued flexibility of being able to sell the premises during the transferor's lifetime without income tax

consequences makes the Irrevocable Income Only Trust an option worthy of consideration, in most circumstances.

The transfer of the residence to the Irrevocable Income Only Trust is a taxable gift of a future interest, no annual exclusion available. Full value of premises reported on gift tax return.

If a limited power of appointment is retained, the gift to the trust is incomplete. Treasury Reg. 25.2511-2(b). No gift tax return is required.

On the death of the Grantor of the Trust, the date of death value of all assets in the trust will be included in the Grantor's taxable estate pursuant to §2036(a) of the IRC, as a result of the life income interest retained by the Grantor. Inclusion in Grantor's estate will result in a full step up in cost basis for all trust assets pursuant to §1014(e) of IRC, assuming an estate tax is still in existence at the time of the Grantor's demise.

The DRA more than anything else severely punishes those who procrastinate in planning for their long term care. Whether it be the transfer of assets to an Irrevocable Income Only Trust, use of a deed with a life estate or the purchase of long term care insurance, it is clear that with advance

planning one can limit the extent of his or her exposure to the costs of long term care.

XVI. Regional Nursing Home Rates for 2015

The regional rates pursuant to the Regulations are to be updated on January 1 of each year by Medicaid.[48] For 2015, the regional rates are as follows:

REGION	MONTHLY RATE
Central	$ 8,768
Long Island	$ 12,390
New York City and Five Boroughs	$ 11,843
Northeastern	$ 9,414
Northern Metropolitan (Westchester, Putnam, Orange, Rockland, Dutchess)	$ 11,455
Rochester	$ 10,660
Western	$ 9,442

The regional rate which is in effect at the time the Medicaid application is made, not the date of transfer, is used to calculate the ineligibility period.[49]

XVII. Some General Rules Relevant to Transfers of Assets and Income

The transfer of asset rules apply to the assets and income of the applicant or his or her spouse as well as any income or assets that they are entitled to receive, but do

48 18 NY CRR §360-4.4(c)(2)(iv)(a),GIS 07 MA/002

49 NYS Dept. Of Soc. Serv. Administrative Directive: 95 ADM-14

not receive because of any action or inaction on their part, court or administrative body, or person acting on their behalf, such as, waiving pension income, renunciations of inheritance, waiver of right of election.[50]

- In New York the transfer of asset penalty periods do not apply to Medicaid homecare. OBRA 93 permits the states to extend the penalty periods to the Medicaid home care program.

- In New York jointly owned assets are presumed to be owned entirely by the Medicaid applicant. However, this presumption can be overcome by evidence that the joint owner actually owns part or all of the property.[51] The joint owner would need to submit documentary proof, i.e., deposit slips. The presumption that the applicant owns the joint account entirely does not apply to non bank account such as brokerage accounts or other financial service account. The joint tenants are personal to own the account equally.

- If assets are held by the applicant as a tenant-in-common, an asset transfer will be deemed to have occurred when any action is taken which reduces or eliminates his or her ownership interest or control. The act of placing

50 18 NY CRR §360-4.4(c)(2)(i)(a), §360-4.4(c)(2)(i)(a)(1), Soc. Serv. L. §366.5(d)(1)(i)

51 Soc. Serv. L. §366(5)(d)(5)

another's name on an asset is not in and of itself a transfer of assets.[52]

- Penalty periods are imposed for a partial month.[53]

- Post DRA, multiple transfers made during the look back period, including the transfers that would otherwise result in a fractional penalty, are accumulated into one total amount to determine the penalty period.

- Life estates are not available/countable resources for purposes of Medicaid eligibility.[54]

- When real property or assets are transferred to a lifetime trust, the value of the life estate retained is not subtracted for purposes of determining the value of the uncompensated transfer for purposes of calculating the period of Medicaid ineligibility.[55]

XVIII. Exempt Assets and Transfers

There are transfers of assets which can be made by the Medicaid applicant which do not trigger a period of ineligibility for Medicaid:

1. If an asset other than the homestead is transferred to: (a) the applicant's spouse, or to another for

52 NYS Dept. Of Soc. Serv. 96 ADM-8
53 Id
54 18 NY CRR §360-4.4 (c)(1)
55 Id

the sole benefit of the individual'sspouse;[56] (b) from the applicant's spouse to another for the sole benefit of the individual's spouse;[57] (c) disabled child;[58] or (d) to a trust established solely for the benefit of an individual under 65 years of age who is disabled;[59] the transfer will be an exempt transfer which does not create any period of ineligibility for Medicaid.

2. If the homestead is transferred to: (a) the spouse of the applicant;[60] (b) a child of the applicant who is under age 21;[61] (c) a child of the applicant who is blind or disabled, regardless of age;[62] (d) the sibling of the applicant who has an equity interest in the home, and who has resided in the home, and is using it as his or her primary residence for at least one (1) year prior to applicant's admission

56 18 NY CRR §360-4.4(c)(2)(iii)(c)(1)(i); Soc. Serv. L. §366.5(d)(3)(ii)(A)

57 18 NY CRR §360-4.4(c)(2)(iii)(c)(1)(i); Soc. Serv. L. §366.5(d)(3)(ii)(A)

58 18 18 NY CRR §360-4.4(c)(2)(iii)(b)(1)(iii); Soc. Serv. L. §366.5(d)(3)(i)(C)

59 18 NY CRR §360-4.4(c)(2)(iii)(b)(1); Soc. Serv. L. §366.5 (d)(3)(i)(D)

60 18 NY CRR §360-4.4(c)(2)(iii)(b)(1); Soc. Serv. L. §366.5 (d)(3)(i)(A)

61 18 NY CRR §360-4.4(c)(2)(iii)(b)(2); Soc. Serv. L. §366.5 (d)(3)(i)(B)

62 18 NY CRR §360-4.4(c)(2)(iii)(b)(2); Soc. Serv. L. §366.5 (d)(3)(i)(B)

to a long term care facility;[63] or (e) a child of the applicant who has resided in the home as his or her residence for at least two (2) years immediately prior to applicant's admission to the long term care facility and has provided care to his or her parent,[64] ("caretaker exempt transfer") the transfer will be an exempt transfer that does not create a period of ineligibility for Medicaid.

3. Transfers Made by the Community Spouse

If after the institutionalized spouse has been residing in the nursing home for thirty (30) days and receiving Medicaid, any non-exempt transfer of assets made by the community spouse, will only effect his or her eligibility for Medicaid and not the eligibility of the institutionalized spouse.[65]

4. Transfers Made For Purposes Other Than Qualifying for Medicaid

If the applicant can factually establish that the asset transfer was made for purposes other than qualifying for Medicaid for nursing home care,

63 18 NY CRR §360-4.4(c)(2)(iii)(b)(3); Soc. Serv. L. §366.5 (d)(3)(i)(C)
64 18 NY CRR §360-4.4(c)(2)(iii)(b)(4); Soc. Serv. L. §366.5 (d)(3)(i)(D)
65 NYS Dept. Of Soc. Serv. Administrative Directive: 96 ADM-11

i.e., catastrophic illness occurred unexpectedly after transfer was made; the transfer will be an exempt transfer for Medicaid eligibility purposes.[66]

5. Imposition of Penalty Period Creates an Undue Hardship

If it can be established that the imposition of an eligibility period would cause an "undue hardship" upon the applicant, Medicaid is prohibited from denying nursing home benefits to the applicant.

In order to establish an "undue hardship" it must be shown that:

a. The applicant is otherwise eligible for Medicaid;

b. Applicant and/or applicant's spouse are unable to have transferred assets returned despite their efforts to do so;

c. The denial of care would endanger the applicant's health or life.[67]

The granting of Medicaid based upon "undue hardship" rarely occurs in New York.

66 NYS Dept. Of Soc. Serv. Administrative Directive: 96 ADM-8
67 18 NY CRR §360-4.4(c)(2)(iii)(e); Soc. Serv. L. §366.5 (d)(3)(iv)

6. Assets Comprising the Non-Exempt Transfer are Returned to Applicant

If prior to a decision being made as to Medicaid eligibility, all of the assets comprising the non-exempt transfer are returned, a period of ineligibility will not be imposed.[68]

If only a portion of the assets comprising the non-exempt transfer are returned prior to a decision being made on Medicaid eligibility, the value of the uncompensated transfer is reduced by the value of the portion returned.[69]

XIX. Spousal Refusal In New York

A. Overview

As part of the Medicare Catastrophic Act of 1988, Congress passed the "spousal impoverishment" rules. This allowed the spouse who remained at home("community spouse") to retain resources and income above the levels permitted to unmarried individuals without impacting the eligibility of the spouse applying for Medicaid. The statute created a Minimum Monthly Maintenance Needs Allowance(MMMNA), which for the year 2015 in New York is $2,980.50 per month and a

68 18 NY CRR §360-4.4(c)(2)(iii)(d)(1)(iii); Soc. Serv. L. §366.5 (d)(3)(iii)(c)

69 NYS Dept. Of Soc. Serv. Administrative Directive: 96 ADM-8

maximum Community Spouse Resource Allowance(CSRA) which for 2015 is $119,220.

More importantly, Congress permitted the community spouse to refuse to contribute his or her assets above the CSRA without jeopardizing the eligibility for the nursing home spouse, provided that the State was assigned the nursing home spouse's ("institutionalized spouse") right of support.[70]

The State of New York codified these "spousal refusal" rules so that the community spouse may keep resources and income in excess of the CSRA once two documents are executed:[71]

a. A "spousal refusal" letter, signed by the community spouse, stating that he or she refuses to make available his or her resources to the institutionalized spouse; and

b. An "assignment of support" which is signed by the institutionalized spouse, or if the spouse is unable to sign, a statement explaining the medical reason is to be provided.

The signing of the "assignment of support" authorizes the Department of Social Services ("DSS") to commence an

70 42 U.S.C. §1396K(a)(1)(A)
71 Soc. Serv. L. §366(3)(a)

action for support against the refusing spouse. DSS will be able to assert its claim against the refusing spouse once the application has been approved and Medicaid services provided.

From a practical perspective, the decision of whether or not to file the “spousal refusal” is more often than not a purely financial decision. Obviously, if the surviving spouse has income and resources only slightly above the MMMNA and CSRA, the community spouse may consider alternatives other than utilizing the “spousal refusal”, e.g., funding an irrevocable burial trust, creating a “luxury fund” or making improvements to the homestead. However, when the resources and income are significantly in excess of the permitted amounts and the prospect of spending in excess of $175,000 per year for the nursing home looms in the background, “spousal refusal” may be the only viable alternative. Additionally, the election of “spousal refusal” will allow the nursing home spouse to be eligible for Medicaid immediately without necessitating a spend down of the community spouse’s resources. This is especially important when the community spouse is younger than the institutionalized spouse, and requires significant resources to be able to continue to reside in the community.

B. Executing a Spousal Refusal

1. In order to qualify the institutionalized spouse for Medicaid nursing home benefits, the institutionalized spouse will generally need to transfer his or her resources to the community spouse who will then often own non-exempt resources in excess of the current maximum CSRA level of $119,220 and/or have monthly income above the current MMMNA level of $2,980.50 Thus, an otherwise Medicaid eligible institutionalized spouse will be deemed ineligible for Medicaid. The community spouse will then need to execute a "spousal refusal".

A transfer of assets between spouses will not affect the applying spouse's right to secure Medicaid. Said transfer is commonly known as an "inter-spousal transfer".[72]

2. Under Federal law, the community spouse may exercise "spousal refusal", and may thereby retain resources and income in excess of the CSRA or the MMMNA without jeopardizing the institutionalized spouse's Medicaid eligibility, provided that:[73]

a. As to Resources - (i) the institutionalized spouse assigns to the state any right of support from

72 42 U.S.C. §1396 P(c)(2)(A)(i)
73 42 U.S.C. §1396K(a)(1)(A)

the community spouse; [74] or (ii) if the institutionalized spouse is unable to execute an assignment of support due to physical or mental impairments, in which case the state may commence a support proceeding against the community spouse without the assignment;[75] or (iii) the state finds that the denial of eligibility would "work an undue hardship".[76]

b. As to Income - The exercise of a "spousal refusal" necessitates that during any month in which an institutionalized spouse is in the institution, except as provided in certain specific circumstances, no income of the community spouse shall be deemed available to the institutionalized spouse.[77]

c. Statutorily Authorized in New York To Establish Medicaid Eligibility Through the Execution of a "Spousal Refusal"

1. "Medical assistance shall be furnished to applicants in cases where, although such applicant has a responsible relative with sufficient income and resources to provide medical assistance as determined by the regulations of the department,

75 42 U.S.C. §1396R-5(C)(3)(B)

76 42 U.S.C. §1396R-5(c)(3)(C); Soc. Serv. L. §366-C.5(b)

77 42 U.S.C. §1396R-5(b)(ii)

the income and resources of the responsible relative are not available to such applicant because of the absence of such relative or the refusal or failure of such relative to provide the necessary care and assistance. In such cases, however, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from such relative in accordance with title six of article three and other applicable provisions of law."[78]

d. "Spousal refusal" can be used in the context of not only Medicaid nursing home benefits, but also other types of community-based Medicaid. For example, the Lombardi Long Term Home Health Care Program and home care.

3. Impact of "Spousal Refusal"

a. Medicaid may only consider the income and resources of the applying spouse.

b. The community spouse, outside New York City must disclose information about his or her resources and income, as well as any personal information which must be included as part of the Medicaid application.

78 Soc. Serv. L. §366.3(A)

c. If a husband and wife were living “separate and apart” from one another at the time that the applying spouse was institutionalized, he or she may be unable to obtain information as to the income and resources of the non-applying spouse.

d. Refusing spouse does not have to sign the Medicaid application on behalf of the institutionalized spouse.

4. Spousal Recovery Suits

- If the non-applying spouse has resources and/or income above the allowable levels, and exercises his or her “spousal refusal” to render the ineligible applying spouse, eligible for Medicaid, the refusing spouse may be sued by Medicaid for the benefits paid on behalf of the spouse receiving Medicaid.[79]

- In New York, Medicaid also relies on Social Services Law §101 in asserting its right to seek reimbursement from the “responsible relative”.

- Social Services Law §101 provides the refusing spouse have “sufficient ability”, which infers that the refusing spouse must only have resources or income above the allowable Medicaid levels.

79 Soc. Serv. L. §366(3)(a)

- Spousal recovery cases are pursued both in State Supreme Court and Family Court, although there is no authority for Medicaid to bring such proceedings in Family Court under the Family Court Act.

5. Spousal Recovery Cases

a. Matter of Shah, 95 N.Y.S. 2d. 148, 711 N.Y.S. 2d 824(2000), the Court of Appeals recognized the doctrine of “spousal refusal” and upheld the refusing spouse’s right to transfer all of the institutionalized spouse’s assets to her, and to thereafter execute a “spousal refusal” to render the institutionalized spouse eligible for Medicaid nursing home benefits.

b. Department of Social Services v. Fishman, NYLJ July 23, 1998, p.21 (Supreme Ct. NY Co.), reversed, 713 N.Y.S. 2d. 152 (1st Dept. 2000). The trial court dismissed the complaint filed by Medicaid seeking reimbursement from the refusing spouse on that ground that they did not plead that income and resources of the refusing spouse were above the allowable levels at all times during the period that Medicaid had paid for the institutionalized spouse’s care. The complaint had instead only plead that there were excess resources at the time that eligibility was established.

c. The Appellate Division, First Department reversed, finding that: “Since “the furnishing of such assistance” to an applicant who has a “responsible relative with sufficient income and resources...as determined by the regulations of the department” who has failed or refused to provide assistance “creates an implied contract with such relative,” the implied contract is created at the time the responsible relative refuses to make his or her income available to provide care to the institutionalized spouse. A contrary interpretation would engraft on to the statute a requirement that DSS make continual reassessments of the responsible spouse’s ability to pay.” 713 N.Y.S. 2d. At 154.

d. Commissioner of the Department of Social Services v. Mandel, N.Y.L.J., September 14, 2001, p. 18, col. 1, Supreme Court, New York County): Medicaid was awarded summary judgment on its claim that the community spouse owed Medicaid $319,656.50 for benefits paid on behalf of the institutionalized spouse. The Court held that the community spouse (assets exceeding $1.5 million) had sufficient ability to pay for his wife’s care. The community spouse’s argument that his assets

included illiquid commercial real estate that should be considered exempt was rejected by the Court. The Court also ordered interest be paid.

e. Matter of Craig, 82 N.Y. 2d 388, 604 N.Y.S.2d 908 (1993), in which DSS sought recovery from the estate of the refusing spouse of a Medicaid recipient, the Court of Appeals held "recovery" against the refusing spouse's estate in the nature of an implied contract for support is possible against the estate of the refusing spouse who was possessed of "sufficient ability" to provide support to the institutionalized spouse at the time that Medicaid paid benefits out on behalf of the institutionalized spouse. "The plain import of the Social Services Law §366(3)(a),... allows the belated recovery [emphasis added] from the responsible relative only if that party had sufficient means during that period of medical assistance was rendered." 82 N.Y.2d at 393, 604 N.Y.S.2d at 911.

f. Matter of the Estate of Lois Link, 718 N.Y.S.2d 758 (App. Div. 4th Dep't 2000): Medicaid was allowed to recover monies from the estate of the community spouse that it had paid on behalf of an institutionalized spouse. The Court opined that the

community spouse had sufficient income and resources to pay for the institutionalized spouse's care. It also determined that Medicaid was also entitled to interest at the rate of 9 percent per year from the date of each separate payment of medical assistance made on the institutionalized spouse's behalf.

6. Recovery Against the Estate of a Refusing Spouse

- Claims against the estate of the institutionalized spouse are not permitted if he/she survived by the refusing spouse. However, at the time that the refusing spouse dies, a lien for the amount paid on behalf of the Medicaid spouse can be placed against the refusing spouse's estate.[80]

- New York only seeks to recover against assets which are part of the Medicaid spouse's estate and passing under a valid Last Will or in intestacy (does not include property passing by operation of law).[81] However, this regulation would not protect the refusing spouse's estate in the event that Medicaid seeks reimbursement for monies paid out on behalf of the Medicaid spouse.

- A 10 year statute of limitations prohibits Medicaid's recovery of benefits paid 10 years or more after the Medicaid

80 18 NY CRR §360-7.1(b)(2)

spouse's death also applies to the refusing spouse and his or her estate.[82]

- If the refusing spouse survives the Medicaid spouse by more than 10 years, and if Medicaid benefits were paid on behalf of the Medicaid spouse when he or she was 55 years or older, Medicaid has no claim against the refusing spouse or the refusing spouse's estate.[83]

- In the event that the refusing spouse predeceases the Medicaid spouse, then a lien may be placed against the refusing spouse's estate for benefits paid on behalf of the Medicaid spouse as long as Medicaid can show that the refusing spouse had "sufficient ability" to pay for the Medicaid spouse's care during the period in question. Matter of Craig, supra (i.e., that the refusing spouse had resources and/or income above the CSRA and MMMNA levels respectively).

XX. Spousal Right of Election

Pursuant to New York's Estates, Powers & Trusts Law (EPTL) §5-1.1-A, the surviving spouse has a "personal right of election" to take a pecuniary amount equal to the greater of $50,000, or one-third of the net estate.

A pecuniary amount is defined as a specific amount (not a fractional share) of the ultimate amount. 1/3 of the net

82 Soc. Serv. L. §104(b)
83 18 NY CRR §348.4, §352.31(d)(5)

estate means 1/3 of the pecuniary value of the decedent's estate at the time of death. The net estate does not increase or decrease during the estate administration.

The net estate is comprised of the following:

(a) All assets passing under the Will;

(b) All property passing under intestacy;

(c) All "Testamentary Substitutes". Within the definition of testamentary substitutes are included:

- US Savings Bonds
- General Powers of Appointment
- Totten Trusts
- Gifts Causa Mortis
- Retirement Plans
- Joint Bank Accounts, Joint/POD Accounts
- Transfers made within 1 year of death
- Revocable Trusts

Exercise of the Right of Election

- The surviving spouse can exercise the right of election. The election cannot be made by a fiduciary after the death of the surviving spouse.

- When authorized by the Court, the right of election can be exercised on behalf of the surviving spouse by:

- The guardian of the property of an infant/mentally retarded or developmentally disabled (SCPA Article 17-A guardian) spouse;

- The committee/conservator of an incompetent spouse, when so authorized by the court;

- The guardian ad litem for the surviving spouse;

- A guardian authorized under Mental Hygiene Law Article 81.

How to Exercise the Right of Election

- Must be made within 6 months from the date of issuance of letters testamentary or letters of administration, but not later than 2 years after the date of decedent’s death.

- The original must be filed with proof of service in the Surrogate’s Court where letters were issued.

- Written notice must be served upon any personal representative in the manner provided within the statute, or upon a person named in the Will on file in the Surrogate’s Court.

- Waiver of the right of election may be made by a spouse during the lifetime of the other spouse.

- The waiver of election must be in writing and subscribed by the maker thereof, and acknowledged or proved in the manner required by the laws for the recording of real property.

- An unacknowledged waiver is ineffective.

Right of Election and Medicaid Transfer of Asset Rules

- A waiver of the right of election constitutes a transfer for less than adequate and full consideration... and results in a penalty period for Medicaid eligibility purposes.

- "The critical question is the consequences of such inaction, irrespective of its legality... The test relative to Medicaid is the availability of this resource."

- Matter of Maffei, 169 Misc.2d 989 (Nassau County 1996) Date of Transfer for Failure to Exercise Right of Election

- Example 3 p.16 of 06 OMM/ADM-5 involves the transfer penalty imposed on the failure to exercise a right of election.

- The ADM states that the date of transfer is "the last date the institutionalized individual could have pursued his elective share..."

- The position stated in the ADM significantly differs from the position established in prior case law. Estate of Dionisio v. Westchester County DSS 244 A.D. 2d 483, 655 N.Y.S. 2d 204, the date of death was considered the date of transfer for failure to exercise a right of election.

- The DRA penalty will not begin to run until one has applied for Medicaid, is otherwise eligible for Medicaid in a nursing home or a waivered program and not from the transfer date, it is uncertain what impact this change will have. However, if death was before February 8, 2006 or, if later, more than 5 years before the Medicaid was filed, it could be significant.