Preservation of Assets / Medicaid Planning Q&A

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How to use this guide

Senior Law Day Collaborative Q&As are intended to guide older adults and caregivers as they address issues related to aging and planning for the future. We suggest you review this information in the full before seeking out an elder law attorney or other professional, so that you are familiar with the terms and can be ready to ask questions specific to your needs.

At our website – **seniorlawday.info** – you will find:

- additional Q&As for review and download
- a library of recorded webinars on topics relevant to elders and caregivers
- an opportunity to get your specific questions answered via email or during our quarterly consultation events
- notice up upcoming educational programs

All services of the Collaborative are offered at no charge. Our goal is to help you get the answers you need so you can plan and move forward with confidence.

This Q&A was written by members of the Senior Law Day Collaborative, including Deepankar Mukerji. This publication is based on the original Elder Law Q&A: An Introduction to Aging Issues and Planning for the Future by Steven A. Schurkman. (July 2023)

Preservation Of Assets / Medicaid Planning

What is Medicaid?

Medicaid is a "needs based" government program established during President Johnson's administration to pay for the medical costs of the indigent population. As health care costs (particularly those for long term custodial care[1]) have outpaced the rate of inflation, the middle class and upper middle class have also looked to the Medicaid program to pay for skyrocketing long term care expenses.

On February 8, 2006, President Bush signed into law legislation entitled the Deficit Reduction Act of 2005 (the "DRA"), which made significant modifications to the then existing Medicaid laws. In addition, in April 2006, New York State passed legislation adopting the DRA and making other modifications to the laws implementing Medicaid in New York for applications filed beginning in August 2006. The Medical Assistance Program, which is the New York State plan for provision of Medicaid programs, has also been significantly modified since 2011 by legislative enactment of the recommendations of Governor Cuomo's Medicaid Redesign Team and the adoption of expanded Medicaid under the Affordable Care Act. In 2020, Governor Cuomo empaneled a group known as the Medicaid Redesign Team II to make recommendations for additional savings in the Medical Assistance Program. A number of the team's recommendations were adopted by the New York legislature and signed by Governor Cuomo as part of the 2020- 2021 New York State budget (Chapter 56 of the Laws of 2020) and has significantly affected long term care coverage.

1 Custodial care is care required to assist an individual with his or her activities of daily living (e.g., care during recovery from a stroke or while suffering from Alzheimer's disease or other dementia). Activities of daily living include eating, bathing, dressing, transferring or mobility (e.g., moving from a bed to a chair) and toileting.

Where relevant, these changes to the Medicaid laws, as well as the possible effect of such changes on strategies for Medicaid qualification, are discussed in this section.

Asset protection and Medicaid planning are very complicated areas of law, particularly as a result of the DRA and legislation in New York State. It is highly recommended that you see an elder law attorney and/or other qualified professional as part of developing an appropriate estate plan.

Can you retain assets and income and still qualify for Medicaid?

Yes, subject to very stringent statutory limitations. The asset and income criteria for qualification for nursing home and home care Medicaid differ, as do the Medicaid qualification requirements for a married couple as compared to a single person. Such qualification criteria are adjusted for inflation annually and are set forth below (please note, these figures are for the year 2023 only).

In 2022, Governor Hochul proposed raising the asset and income limits for Medicaid effective January 1, 2023, which was approved with some modifications as part of the 2022-2023 New York State budget. The new income limit has been established at 138% of the Federal Poverty Level ("FPL"), with a corresponding increase in asset limits, which has expanded Medicaid eligibility.

Medicaid in a Nursing Home

If married, the institutionalized spouse will qualify for Medicaid provided he or she has no more than $30,182 in resources and $50 per month of income, and provided that the Community Spouse (well or non-applying spouse) does not have resources or income in excess of the following items, which are exempt:

1. The family residence (no matter what the value) and provided the Community Spouse, or a minor or disabled child, resides there
2. Between $74,820 and $148,620 of non-homestead assets
3. $3,715.50 of monthly income which may consist of the Community Spouse's income and income from institutionalized spouse if the Community Spouse's income is insufficient

4. Automobile of any value
5. Life insurance not exceeding $1,500 in cash value, if designated as a burial fund
6. Retirement assets (such as IRAs, 403(b), 401(k), or other retirement plans) except for those that are in required minimum distribution (RMD) status.
7. A reasonable amount for burial expenses pursuant to a prepaid irrevocable funeral contract, plus an additional $1,500 to be deposited in a burial fund account (except if there is already $1,500 in life insurance designated as a burial fund as noted above)

If single, a Medicaid applicant may only retain:

1. A limited homestead exemption (potentially subject to a lien) if the institutionalized individual has subjective intent to remain home and provided the equity value of the residence does not exceed $1,033,000.
2. $30,182 of resources
3. $50 monthly income
4. No automobile
5. Life insurance not exceeding $1,500 in cash value, if designated as a burial fund
6. Retirement assets except for required minimum distribution (RMD), which must be paid out in monthly installments
7. A reasonable amount for burial expenses pursuant to prepaid irrevocable funeral contract, a deed to a grave or family plot, plus additional $1,500 to be deposited in a burial fund account (except if there is already $1,500 in life insurance designated as a burial fund as noted above)

Medicaid at Home

If married, the spouse applying will qualify provided the married couple has no more than $40,821 of joint resources and $2,268 of monthly income, although the Medicaid applicant spouse may have more income and still qualify for Medicaid subject to certain limitations (see below) and provided that the Community Spouse (well or non-applying spouse) does not have resources or income in addition to the following:

1. Family residence of any value
2. $40,821 of joint resources
3. $2,268 per month of income, with an additional $20 per month of unearned income
4. Automobile
5. Life insurance not exceeding $1,500 cash value, if designated as a burial fund

6. Retirement assets except for RMD, which must be paid out in monthly installments
7. A reasonable amount for burial expenses pursuant to prepaid irrevocable funeral contract, plus an additional $1,500 to be deposited in a burial fund account (except if there is already $1,500 in life insurance designated as a burial fund as noted above)

If a married person is applying for Managed Long Term Care Services, which is now required for most individuals in need of home care (see below), the Medicaid applicant spouse may retain $543 in monthly income and the Community Spouse (well or non- applying spouse) can retain $3,715.50 in monthly income. This may consist of the Community Spouse's income and income from spouse receiving Medicaid services, if the Community Spouse's income is insufficient. In addition, the couple can retain the following resources:

1. The family residence (no matter what the value) and provided the Community Spouse, or a minor or disabled child resides there
2. $30,182 in resources for the applying spouse and between $74,820 and $148,620 of non-homestead assets for the community spouse
3. Automobile of any value
4. Life insurance not exceeding $1,500 in cash value, if designated as a burial fund
5. Retirement assets except for required minimum distribution ("RMD") which must be paid out in monthly installments and counted as income
6. A reasonable amount for burial expenses pursuant to a prepaid irrevocable funeral contract, a deed to a grave or family plot, plus an additional $1,500 to be deposited in a burial fund account (except if there is already $1,500 in life insurance designated as a burial fund as noted above)

If single, a Medicaid applicant may retain:

1. Family residence of any value provided equity value of residence does not exceed $1,033,000
2. $30,182 of resources
3. $1,677 per month of income, with an additional $20 per month of unearned income
4. Automobile
5. Life insurance not exceeding $1,500 cash value
6. Retirement assets except for RMD, which must be paid out in monthly installments
7. A reasonable amount for burial expenses pursuant to a prepaid irrevocable funeral contract, plus an additional $1,500 to be deposited in a burial fund account (except if there is already $1,500 in life insurance designated as a burial fund as noted above)

The New York State expansion of Medicaid, in response to the Affordable Care Act, includes coverage under Modified Adjusted Gross Income (MAGI) rules for persons under age 65 and not in receipt of Medicare. Coverage may be obtained for individuals with monthly income from 100% of FPL (or $1,215 in 2023); up to 223% of FPL, (or $2,710 in 2023) with no resource test. However, MAGI individuals cannot have surplus income.

Can an individual qualify for Medicaid even if his or her income exceeds Medicaid limits?

Yes, although non-MAGI individuals applying for community Medicaid (Home Care Services) must pay their income in excess of the Medicaid allowance towards their cost of care. As an alternative they can join a community pooled trust and then place their surplus income into their own trust sub-account. Since the trust assets are an exempt resource, the funds are then sheltered from a Medicaid spend down. Community pooled trusts are, by law, established and operated by a not-for-profit organization and can only be used by disabled individuals; however, once the account is established, the funds can be used to pay for household bills in the name of the Medicaid applicant who is the trust beneficiary. In this way, Medicaid applicants may continue to use their income for their own benefit and still qualify for community Medicaid without a monthly spend down. Most trusts require both a small monthly administrative fee and that the funds be used for supplemental needs. This includes almost anything other than medical care, which is assumed to be covered by Medicaid. These trusts cannot be utilized by someone receiving nursing home Medicaid, and any funds remaining in a trust account after the beneficiary's death are retained by the not- for-profit organization. In addition, any amounts not spent for the sole benefit of the individual may be considered a transfer of assets and subject the individual to penalties.

Please see Appendix G for a more detailed illustration of the use of community pooled trusts.

What is Managed Long Term Care?

On Sept. 4, 2012, the federal Center for Medicare and Medicaid Services (CMS) approved a "1115 waiver" that allows New York State to require all dually eligible (for Medicare and Medicaid) adults now applying for or receiving long term care in the community to enroll in a Managed

Long Term Care (MLTC) plan. MLTC providers are health care companies that either provide services directly or by contracting with licensed agencies.

The MLTC provider now controls access to, approves, and pays for all Medicaid home care services and other long term care services in the MLTC service package. This is the only way to obtain these services for adults who are dually eligible, unless they are exempt or excluded from MLTC.

Those already receiving Medicaid home care services will not have their level of care affected for 60 days after enrollment. After that, services may change based on needs.

Who must enroll in Managed Long Term Care?

People must enroll if applying for the following services:

- Adult Day Care
- Certified Home Health Aides
- Consumer Directed Personal Assistance
- Personal Care/Home Attendant
- Private Duty Nursing

How do I enroll in a plan to receive home care services?

Once an applicant receives approval for Medicaid, he or she must first contac the New York Independent Assessor (NYIA) at their helpline at 1-855-222-8350. Recently implemented as part of the laws of 2020, through a contract with MAXIMUS Health Services, Inc. (MAXIMUS), the NYIA conducts independent assessments, provides independent practitioner orders, and performs independent reviews of high needs cases for personal care/home attendant and consumer-directed services. Once the NYIA confirms the individual has active Medicaid, they will schedule both a Community Health Assessment and a clinical appointment for the individual. The individual will be advised to have relevant medical records available, including a list of current prescriptions. The NYIA will offer individuals the option of a telehealth or in-person assessment and clinical appointment.

The assessment and clinical appointment will be scheduled to be completed within 14 calendar days of contact with the NYIA. The individual will receive reminder calls from the NYIA and the

Nurse Assessor in advance of the appointments.

The Community Health Assessment will assess the individual's need for services, as well as eligibility for MLTC plan enrollment. Upon completion of both the assessment and the clinical appointment, the individual will receive a Notice providing direction on next steps, including how to enroll in a MLTC plan and how to contact the local Medicaid office to complete the care planning and service authorization process.

Based upon the Community Health Assessment and clinical appointment, the NYIA will transmit their findings to the local Medicaid office, which will develop a plan of care that will determine the quantity and type of services that the individual will receive from the MLTC.

The New York State laws, effective October 1, 2020, provide that in order to qualify for MLTC services, an individual must need assistance with more than two Activities of Daily Living (ADLs) or more than one if the individual has also been diagnosed with dementia. Proposed regulations implementing this change have been published by the NYS Department of Health; however, due to the Public Health Emergency due to Covid 19, these provisions have not been implemented to date. Activities of Daily Living as defined in the regulations include eating, bathing, dressing, transferring or mobility (e.g., moving from a bed to a chair) and toileting. In response to the Consolidated Appropriations Act of 2023 ending the Continuous Coverage requirements due the Covid 19 Public Health Emergency ("PHE") declaration effective March 31, 2023, the New York State Department of Health has said that all easements and suspensions of eligibility standards in effect during the PHE will be lifted effective July 1, 2023. Presumably the ADL requirements for Medicaid Home Care will go into effect at that time.

Will Medicaid pay for Assisted Living?

Assisted Living combines residential and home care services. Most facilities are designed as an alternative to nursing home placement for people who do not require daily supervision by skilled nurses. Assisted living residences provide services that may include housing, meals, housekeeping, supervision, personal care, case management and home health services. There are many different varieties of Assisted Living which range from places offering basic room and board to residences that are designed for people with special needs.

Certain residences are licensed by New York State as Assisted Living Program (ALP) residences. ALP's accept Medicaid as full payment for residency. Your Social Security and other income must be remitted to the ALP on a monthly basis up to the level set by New York State, and

residents are entitled to keep a personal needs allowance. In addition, a community pooled trust may be used for surplus income in excess of the New York State level. A directory of Medicaid Assisted Living Program residences can be found at **health.data.ny.gov**. Note that some ALP's are also licensed to provide enhanced care, which bridges the gap between assisted living and a skilled nursing facility. Additional information can be found at **health.ny.gov/publications/1505.pdf**.

Medicaid generally will not pay for assisted living other than at an ALP facility; however, a number of assisted living residences are also licensed to provide enhanced care. In those residences, Medicaid will not pay for room and board, but it can pay for home care and other community- based covered services. Since there are many different types of residences that could call themselves "Assisted Living," you should always check with the admissions staff at the residence prior to signing any admission agreements. Though Medicaid may not be available to pay for room and board, it may pay for home care and other community-based covered services in a non-Medicaid assisted living residence. Since there are many different types of residences that could call themselves "Assisted Living," you should always check with the admissions staff at the residence prior to signing any admission agreements.

How many months of financial records must be submitted to the Department of Social Services for review with a Medicaid application?

The DRA legislation stated that up to 60 months of financial records can be reviewed for nursing home Medicaid. This review period is referred to as a "look-back period." If during the look-back period, the Department of Social Services (DSS) discovers that an uncompensated transfer of assets (i.e., a gift) was made to a third party, DSS will apply a formula to determine how long an individual must wait before becoming eligible for nursing home Medicaid. Such waiting period is referred to as a penalty period.

For the first time in New York, there will be a 30 month look-back for home care. The law became effective October 1, 2020, and is expected to apply to all Medicaid applications after March 2024. This delayed implementation is in response the Public Health Emergency created by Covid-19. A penalty period of up to 30 months will be imposed for persons otherwise eligible for Medicaid long term care services.

May an individual transfer assets and still qualify for Medicaid and, if so, how is the "penalty period" calculated?

For Home Care Medicaid

Under the current law in New York State, gifts made during the look-back period for purposes of qualifying for home care Medicaid (also referred to as Community Based Long Term Care) are not subject to a penalty period. Rather, an individual may qualify for home care Medicaid on the first day of the month after the gift is made provided, at the time of the filing of the Medicaid application, the individual seeking home care Medicaid does not have more than $30,182 of resources ($40,821 if the Medicaid Applicant is married) nor more than $1,697 ($1,677 + $20 unearned income disregard) of monthly income in their single name. To the extent the individual has income exceeding the $1,697 monthly income limit, such excess must be: 1) used to pay the home health care agency providing services; 2) be paid to a pooled income charitable trust to pay the ongoing household and other expenses of the home care Medicaid applicant; or 3) to pay the premiums of a private health insurance plan.

Under the 2020 law, which will most likely not be implemented before March 2024, individuals now applying for Medicaid home care will have to submit financial documentation going back 30 months. Most transfers of assets will result in a penalty period (i.e., delay in qualification for Medicaid) equal to one month for every $13,906 transferred. Said amount of $13,906 is fixed by New York State as the average monthly nursing home cost in Westchester County during the year 2023 and is revised annually. (The 2023 rate amount in New York City is $4,142.) The maximum penalty period for home care Medicaid is expected to be 30 months.

For Nursing Home Medicaid

Yes. There is, however, a penalty period resulting from a gift made when the donor of the gift will be applying for nursing home Medicaid. If applying for nursing home Medicaid during the applicable look-back period, most transfers of assets will result in a penalty period (i.e., delay in qualification for Medicaid) equal to one month for every $13,906 transferred. Said amount of $13,906 is fixed by New York State as the average monthly nursing home cost in Westchester County during the year 2023 and is revised annually (the 2023 rate amount in New York City is $14,142).

For both home care cases (now that the new law has been implemented) and nursing home cases, a penalty period is computed by taking the amount transferred during the look-back

period and dividing such transferred sum by the regional rate New York State mandates as the average monthly nursing home cost in the area in which the donor of the gift resides (i.e., $13,906 in Westchester or $14,142 in New York City). The quotient of such formula is the penalty period in that it determines how many months an individual applying for Medicaid must wait until eligible.

By way of example, in Westchester County, New York State has fixed $13,906 as the average monthly nursing home cost in 2023. Thus, if the donor gifted the sum of $139,060 during the look-back period, such a transfer would result in a penalty period of ten months ($139,060 ÷ $13,906 = 10 months). The determination of the commencement date of the penalty period is further discussed below.

When does the penalty period begin?

The penalty period to receive nursing home or MLTC Medicaid commences on the date the individual is "otherwise eligible" for Medicaid and would be receiving care services based on an application, but for the application of the penalty period. The legislation indicates that in order to start the penalty period running, all of the following must occur:

1. The Medicaid applicant must have less than $30,182 in non-exempt resources
2. The Medicaid applicant must be in a nursing home or receiving home care services
3. The Medicaid applicant must have formally applied for Medicaid benefits

Applying the current law to our example would have the following result: If the Medicaid applicant transferred the sum of $139,060 in November 2020, and was admitted to a nursing home and also submitted a Medicaid application in November 2023, the look-back period (which extends back 60 months prior to the date of the application) would capture the transfer made 36 months before the date of the application and the resulting penalty period would cause the Medicaid applicant not to be eligible for Medicaid nursing home coverage until August 2024.

August 2024 becomes the Medicaid eligibility or "pick- up" date because the commencement of the 10 month penalty period would start to run in December 2023, as that is the first month after the transfer in which the Medicaid applicant had: 1) no more than $30,182 in his or her name, 2) entered the nursing home and 3) submitted the Medicaid application.

During the period from the date of filing the Medicaid application, to entering the nursing home, being found "otherwise eligible" in November 2023 and until the expiration of the penalty period in August 2024, the Medicaid applicant would have to pay privately for their

stay at the nursing home, using funds previously gifted to others in November 2020.

For Medicaid applicants needing home care, any transfers after October 1, 2020 can result in a penalty being assessed when the law is implemented, which is expected in April 2024. For example, if the applicant transferred the sum of $139,060 in November 2022 and submits a Medicaid application seeking Managed Long Term Care home care services in November 2024, the look-back period goes back to June 1, 2022, a period of 30 months, and would capture the transfer made 24 months prior to the application and the transfer would cause the applicant to be ineligible for the requested Medicaid coverage for a period of 10 months, as calculated above. The applicant would not be able to receive home care services until August 31, 2024. As in the example above, the Medicaid applicant would have to pay privately for their care during this 10 month period, using funds that they had previously gifted.

Thus, in order to avoid the spend-down of previously transferred funds during the penalty period, it may be necessary for a Medicaid applicant to wait 2.5 or 5 years from the date of transfer until applying and becoming eligible for Medicaid.

Transfers of assets must be carefully calculated to assure that elderly individuals are not deprived of the funds they need to provide for their care during any resulting penalty period or Medicaid disqualification. No individual should transfer funds for Medicaid planning purposes without consulting with an experienced elder care attorney.

Can one spouse qualify for Medicaid even if the resources and/or income of the other spouse exceeds Medicaid limits?

Yes, by the practice of "Spousal Refusal." Current New York State law provides that Medicaid may not be denied to an ill spouse (the applicant spouse) even if the other spouse (the well or non-applying spouse) has excess resources and/or income if the well spouse refuses to contribute such excess resources to the cost of the care of the ill spouse. In such a case, the refusing spouse must disclose the amount of assets in their possession and the applicant spouse must assign their obligation of support from the refusing spouse to the State of New York. Spousal Refusal may result in the state of New York or local Department of Social Services suing the refusing spouse for the support the State has expended on behalf of the applicant spouse. (However, the state can only sue the refusing spouse for services provided at the Medicaid rate (often considerably less than the private pay rate), and which the refusing spouse would otherwise be paying.)

Are there assets that can be transferred which will not cause a transfer penalty period delaying Medicaid qualification?

Yes. The transfer of an asset is not subject to the Medicaid penalty period if:

1. The asset is transferred to the Community Spouse (however, a subsequent transfer by the Community Spouse may result in additional transfer penalties)
2. The asset is transferred to a blind or disabled child
3. The asset is transferred to a trust established solely for the benefit of any disabled individual
4. The asset is the Medicaid applicant's residence and the residence is transferred to a sibling of the Medicaid applicant with an equity interest in the house
5. The asset is the Medicaid applicant's residence and the residence is transferred to a child of the Medicaid applicant who is blind, disabled or less than 21 years of age
6. The asset is the Medicaid applicant's residence and the residence is transferred to a child of the Medicaid applicant who has resided with and cared for the Medicaid applicant for two years prior to institutionalization, which care allowed the Medicaid applicant to remain at home ("Caretaker Child" exception)

Will ownership of retirement assets by the Medicaid applicant disqualify such individual from Medicaid eligibility?

The answer is no, irrespective of the value of the retirement account, provided that the retirement account (e.g., IRA, 401(k), 403b or other retirement plan) is in periodic payment status. Thus, if the Medicaid applicant is taking his minimum distribution amount from his IRA or other retirement account on a monthly basis (as opposed to an annual basis), such retirement account will not be counted for Medicaid purposes and the Medicaid applicant can still qualify for Medicaid. However, although the principal portion of the retirement account is unavailable, the minimum distribution amount (which is deemed to be an income stream) must still be paid to the nursing home or home health care agency or pooled income charitable trust while the Medicaid applicant is receiving Medicaid benefits.

In addition, the retirement account of the community spouse, no matter its value, is also an unavailable resource because it forms part of the community spouse resource allowance. The community spouse's retirement account need not be in periodic payment status and is still a fully unavailable resource, even if the amount of the account exceeds the community spouse resource allowance.

Can a Medicaid applicant's home be protected upon entry into a nursing home?

However, if the Medicaid applicant enters a nursing home and becomes permanently absent from the premises, New York State (by its local County Department of Social Services) can place a lien on the premises, which could be satisfied out of the proceeds from the eventual sale of the residence. The payback of the lien is at the Medicaid rate rather than the private pay rate.

A Medicaid applicant's ownership of a residence with an equity interest in excess of $1,033,000 will make that residence an available resource that cannot be sheltered by the execution of a statement of intent to return home. However, any residence, no matter its value, could still be protected if occupied by: a spouse, minor or disabled child (or if transferred to such individuals), a caretaker child, a sibling with an equity interest as described above, or by encumbering the residence with a mortgage or other debt to reduce its equity interest below $1,033,000.

What are the methods for transfers of assets?

1. Outright gifts
2. Life Estate Deed
3. Transfers in Trust
4. Annuities, mortgages, promissory notes, personal service contracts

What are the consequences of making an outright gift for Medicaid qualification purposes?

You lose control of the asset by giving full control of the asset to another. In addition, depending upon the value of the asset, there may be gift tax considerations which must be evaluated. Finally, if you are transferring appreciated property (e.g., a residence or securities), the recipient of the property receives your original low cost tax basis, meaning that upon a subsequent sale of the property by the recipient, there may be a significant capital gains tax to pay.

What are the consequences of using a life estate deed for Medicaid qualification purposes?

A transfer of real property subject to the transferor's retention of a "life interest" in the property may be an effective way of sheltering an asset for Medicaid qualification. If properly drawn, it avoids the applicability of the federal gift tax law. In addition, use of a life estate deed allows the transferor to shorten the transfer penalty period, since the value of the asset transferred does not include the actuarial value of the transferor's life interest in the property.

For example, a 75 year old Westchester resident transferring a $300,000 property in June 2022 is only deemed to have transferred $207,954 for Medicaid transfer purposes and thus would qualify for Medicaid in 14.95 months ($207,954 ÷ $13,906= 14.95 months) rather than the 21.57 month period that would have applied if an outright transfer had been made ($300,000 ÷ $13,906 = 22.49 months).

In addition, if the property is not sold until after the death of the transferor, the remaindermen (i.e., the individuals referenced in the deed as receiving the property at the life tenant's death) will inherit the property at its fair market value as of the date of death. The appreciated property will have a higher cost basis (not the original purchase price cost basis) and should be able to be sold shortly after the transferor's death with negligible, if any, capital gains.

Selling the property during a transferor's lifetime, may create unintended tax consequences and may trigger undesirable additional Medicaid eligibility problems.

If the property is sold during the transferor's lifetime there will be a capital gains tax due on any portion of the gain that relates to the remainder interest in the property, as only the life interest is eligible for the $250,000 per person lifetime capital gains exemption. In addition, if the sale occurs during the transferor's life, it may cause significant asset exposure. The portion

of the sales proceeds allocable to the life estate interest must be returned to the life tenant and, again, becomes an exposed resource which would be subject to new look-back and penalty periods. It then would have to be retransferred to be further protected, which would only occur if such new look-back and penalty periods had expired before the need for Medicaid. Thus, if using a life estate deed, there should be a commitment that the property not be sold during the life estate owner's lifetime.

The advantages of using a life estate to shorten the transfer penalty period were greatly diminished after the passage of the DRA of 2006. The advantages were largely lost because the commencement of the Medicaid penalty period for all asset transfers which occur within the 30 or 60 month look-back period, including life estate transfers, commence when the Medicaid applicant applies for Medicaid and is otherwise eligible for benefits. Thus, a full five years has to elapse from the date of the transfer before a life estate transfer, like any other transfer, is not considered as a countable resource for Medicaid eligibility purposes.

However, it is still possible to do planning by having an individual purchase for value a life estate interest in the residence of another. If the purchaser of the life estate resides in such residence for at least a one year period following the date of purchase, then the funds used to purchase the life estate are an exempt resource and not countable when such individual applies for Medicaid. Thus, if a Medicaid Applicant is "over resourced" (i.e., has assets exceeding Medicaid eligibility limits) but uses such assets to purchase an interest in the residence of another and then resides there for at least one year thereafter, they will obtain Medicaid eligibility in just one year's time. This is far more quickly than if they had made a direct transfer of the excess assets to such individual, which would then be subject to the look back and penalty period computations previously mentioned.

What are the consequences of transferring assets to an Irrevocable Trust for purposes of Medicaid qualification?

A properly drafted irrevocable trust will minimize gift and capital gains tax problems, whether the property is sold while the grantor is alive, or after the grantor's death, and allows the proceeds from the sale of property to remain in the trust and be protected. Generally, the income tax treatment of an irrevocable trust is the same as if the grantor of the trust had continued to own the asset in his or her individual name. An irrevocable trust also has the

advantage of allowing the grantor to place a variety of assets, in addition to the real estate, into the ownership of the trust.

The irrevocable trust further allows the grantor to retain certain control of the assets contributed because the grantor can continue to receive the income generated by the trust assets and still protect the principal asset (i.e., corpus of the trust) and still qualify for Medicaid. (Of course, the principal assets contributed to the irrevocable trust cannot be directly returned to the grantor). In addition, by having the trust document retain for the grantor a "power of appointment," the grantor will be able to change the identity of the beneficiaries of the trust.

Will the S.T.A.R., Veteran's and/or Senior's Exemption still apply to real property transferred to an Irrevocable Trust?

Yes, to the extent the grantor still retains a lifetime use and occupancy of the real property.

Can assets still be protected even after an individual has been admitted to a nursing home?

Yes, under current law, it is possible to protect assets even after an individual has been admitted to a nursing home. The percentage of the assets that may be protected, however, will not be as significant as if advance planning had been done. Gifts made by the Medicaid applicant in exchange for an annuity, loans extended in return for a promissory note, or the establishment of a personal services contract (where the Medicaid applicant enters into a formal contract with others, including family members, to have personal or financial care services performed) are possible asset savings strategies which can be utilized even after entry to the nursing home. These strategies are further discussed below.

Can the purchase of an annuity by the Medicaid applicant result in Medicaid qualification?

Sums used to purchase an irrevocable and actuarially sound annuity may, in certain limited circumstances, serve to shelter assets for Medicaid qualification. However, under the DRA legislation, the State of New York must be named as a beneficiary of the annuity to reimburse

the state for care it funded through Medicaid. Moreover, the income paid out by the annuity must be paid toward the cost of care or sheltered in a charitable pooled income trust. New York State does not need to be named a primary beneficiary if the Medicaid applicant has a spouse or minor or disabled child.

Can the making of a loan by a Medicaid applicant result in Medicaid eligibility?

Loans, mortgages and promissory notes may be used in a similar manner to the use of an annuity and New York State does not have to be named as a beneficiary of the remainder. However, the loan, mortgage or note must be actuarially sound, nonnegotiable and non- assignable, made in equal monthly installments over the term of the loan and cannot be canceled because of the death of the lender – meaning that the Medicaid applicant's estate may be responsible to pay back the State of New York for health services rendered to the Medicaid applicant

An example of the use of an annuity or promissory note loan to protect assets for Medicaid eligibility is as follows:

An 80 year old parent owns $667,488 in assets. The parent gifts one-half of that amount (i.e., $333,744) to the child, causing a penalty period delaying eligibility for the parent to receive Medicaid for 24 months (i.e., $333,744 ÷ $13,906 regional rate = 24 months). The penalty period does not begin to run until the parent makes a Medicaid application and is otherwise eligible for Medicaid but for the gift which was made.

The parent uses the other $333,744 to purchase an annuity or makes a loan for a term which cannot exceed her life expectancy (an 80 year old woman has life expectancy of 9.1 years or approximately 109 months). Based on a loan or annuity term of two (2) years (i.e., equal to the 24 month penalty period) and an interest rate of 3.0%, payments of $14,344.72 would have to be made on the annuity or loan to the parent which, in turn, would have to be paid for her care during said 24 month penalty period.

If her health care costs $15,500 per month privately, parent has Social Security and pension of $1,100 per month and the annuity or promissory note is producing $14,344.72 per month, then the parent has monthly income of $15,444.72 to pay toward the $15,500 per month health care cost leaving a short-fall of $55.28 per month. This could be paid from the

$333,744 gifted to the child, which over the 24 month penalty period would reduce said gift of $333,744 by $1,326.68 ($55.28 x 24 months).

Once the 24 month penalty period has expired, the parent is on Medicaid and no further payments from the child of the gifted funds are required. Thus, parent has safely transferred to child $321,888 (i.e., $667,488 - $344,273.32 promissory note payments including interest -

$1,326.68 = $321,888.) in order to qualify for Medicaid.

In addition, if the parent dies prior to the expiration of an annuity, the balance of the annuity first must be used to pay back Medicaid expended by New York State as primary beneficiary, at the Medicaid rate – but the balance, if any, could be paid to the child as secondary beneficiary. Similarly, if the parent dies prior to expiration of promissory note, the estate of the parent, as owner of the note, must first pay back Medicaid before distributing further to the surviving family. However, generally with a promissory note, no Medicaid will have been paid because of the penalty period.

An asset preservation instrument called the Grantor Retained Annuity Trust (GRAT) has been used in New York with mixed results. A GRAT is similar to a private annuity and provides for the Trustee to make periodic payments back to the Grantor, similar to the promissory note and annuities described above. It has been used with some success in several parts of the state; however, there was a 2007 case where the entire trust was determined to be available to pay for nursing home care. In 2008, the State Department of Health determined that, since a GRAT was a trust, it could be invaded to the extent that any or all of it could be used for health care costs. Use of a GRAT in connection with Medicaid planning should only be undertaken under the supervision of an elder law attorney thoroughly familiar with the current treatment of GRATs in the Medicaid applicant's county.

Can a personal services contract be used to obtain Medicaid benefits?

Existing law has held that payment for personal or financial services pursuant to a written personal services contract is not a transfer of assets. To be recognized, such care agreements must be in writing, must be prospective in nature and the compensation must be reasonable. Such contracts can pay a lump sum to the service provider for anticipated services to be provided over the actuarial life of the Medicaid applicant. Family members can certainly be the providers of such services. Good record-keeping, with payments being made "on the books" as income taxable to the recipient with appropriate deductions for worker's compensation, etc. should be kept.

An example of the use of a personal services contract for Medicaid eligibility is as follows:

Daughter/Caregiver works full time and assists her 80 year old mother who has an actuarial life expectancy of 9.1 years. Daughter provides to her mother five (5) hours per week of financial and health care management at the rate of $30 per hour, and ten (10) hours per week of personal care at the rate of $25. In this example, the caregiver earns $150 per week or $7,800 annually for financial and health care management services and $250 per week or $13,000 per year for personal care services. For the 9.1 years of the estimated life of the contract, $70,980 represents the value of the contract's managerial component and

$118,300 represents the value of the contract's personal service component. The entire contract is valued at $189,280.

NYSDOH has indicated that a personal services contract will be considered a transfer of assets unless it provides for a return of prepaid funds if the caregiver is unable to continue services, or if the Medicaid recipient dies before his or her calculated life expectancy.

Also, the same directive issued in 2007, states that no credit will be given for services that are provided as part of the Nursing Home rate. This makes it very difficult to use a personal services contract for a nursing home resident.

However, a personal services contract can properly be used while a person is residing at home and can provide for compensation to family members who are acting as caregivers. Caregivers should also be aware that amounts received from a personal services contract are subject to income tax.

Can Medicaid take my assets after I die?

If you received Medicaid during your lifetime, a claim may be made against your estate for the amount of benefits you received after age 55. If your estate is greater than the total of benefits received, Medicaid's total recovery is limited to the amount of benefits provided; on the other hand, if your estate is less than the total of benefits received, the claim is limited to the funds in your estate. Funeral expenses, taxes, administrative expenses of the estate, including legal fees, and commissions earned by the estate fiduciary could all be paid first, and will reduce the amount available to pay this claim.

In addition, recovery is deferred, but not exempted, if there is a surviving spouse, a blind or disabled child of any age, or child under age twenty-one. If the sole asset of the estate is a homestead, Medicaid recovery is also deferred if the home is occupied by a "caretaker" child who resided in the home for two years prior to the institutionalization of the decedent, or a sibling of the decedent who resided in the home for at least one year prior to the institutionalization of the decedent.

Estate claims are limited to probate assets, and do not include jointly-held bank and investment accounts, retained life estates created in property, and/or jointly-held real estate.

In the case of a spouse who has refused to provide support (as discussed on page 84), a claim may be made against that spouse's estate to the extent that the refusing spouse had assets over the Medicaid allowance when benefits were being provided.

Information and documentation concerning the Medicaid applicant and his or her spouse must be gathered together and accompany the submission of a Medicaid Application. A checklist detailing the information required to complete the Medicaid application and a sample Medicaid application is set forth as Appendix H and Appendix I, respectively, in this booklet. The "Access New York" Medicaid application can be found here: health.ny.gov/forms/doh-4220.pdf