

# New York Medicaid Eligibility and Limits for Income, Assets and Spousal Impoverishment, 2017 Changes

---

By: **Shane M. McCrohan**

## *What is Medicaid?*

Medicaid is a needs based system, whereby only persons who are in financial need will qualify for Medicaid. Medicaid is not to be confused with Medicare, which is not a needs based system.

## *What does Medicare pay for?*

Medicare is government subsidized health insurance which is generally only available for persons 65 and older. There are now four (4) parts to Medicare: Part A (hospital insurance with limited nursing home coverage), Part B (medical insurance - physician and outpatient coverage), Part C (private all-inclusive plan) and Part D (prescription drugs). In order for Medicare Part A to cover the costs of a nursing home, the patient must have been in the hospital for three consecutive days (including the day of admission) and must enter the nursing home within 30 days of leaving the hospital. Medicare generally limits patients to 100 days of coverage per illness. The first 20 days of nursing home care are covered in full. For days 21 through 100, there is daily coinsurance (currently \$164.50 per day) required to be paid by the patient. In addition, Medicare will typically only cover patients for therapy and physical rehabilitation, and will not cover extended custodial care (like bathing and dressing).

As of January 1, 1999, the Medicare Advantage (formerly known as Medicare+Choice and also referred to as Part C) program permits an array of private Medicare options, including Health Maintenance Organizations (HMOs) [available since 1982], Provider-Sponsored Organizations (PSOs), Medical Savings Accounts (MSAs), Preferred Provider Organizations (PPOs) and Private Fee-For-Service Plans (PFFS). These health plans must cover items and services offered by traditional Medicare under Parts A and B. 42 U.S.C. Section 1395w-21, et. seq.; 42 C.F.R. Section 422. Beginning January, 2003, PPO demonstration plans became available in 23 states, including New York.

Beginning January 1, 2006, Medicare began offering the new prescription drug coverage program called "Medicare Prescription Drug Coverage" (also referred to as Part D). Medicare Prescription Drug Coverage will help individuals with their prescription drug costs, no matter how they currently pay for them. Everyone with Medicare has the option to join a drug plan to obtain this coverage, but everyone is required to make a decision about their drug coverage. Individuals could join as early as November 15, 2005. If an individual does not elect to join when first eligible, they may pay a penalty if they later elect to join.

Individuals with little or no income and resources may be eligible to receive the Medicare Prescription Drug Coverage program with little or no cost. There are different plans that can be chosen and each plan's cost varies depending on what it covers. For example, the individual can choose a plan that covers only prescription drugs and then keep the rest of their Medicare coverage the same or can join a Medicare Advantage or other Medicare Health Plan to cover physician and hospital care in addition to prescription coverage. Individuals who receive prescription drug coverage through their employer or union should contact their benefits administrator to discuss their options.

***If Medicaid is needs based, who qualifies for Medicaid?***

After the passage of the Affordable Care Act, Medicaid eligibility was expanded to include individuals who are under 65 years of age and have annual modified adjusted gross income (MAGI) below a certain threshold amount (expressed as a percentage of the federal poverty line), regardless of the amount of assets owned by those individuals. The specific rules for Medicaid qualification for these individuals are not addressed in this outline, but note that the asset transfer penalty rules (discussed below) still apply for any individuals applying for nursing home Medicaid coverage.

The Medicaid qualification rules discussed in this outline below apply to those individuals who are either: (a) 65 years of age or older; or (b) under 65 years of age and disabled. There are several different standards for which Medicaid will judge a person's availability:

**Individuals:**

For an individual seeking home care aid - a person cannot have more than \$14,850 in resources and \$825 a month in income (plus an unearned income credit of \$20 per month).

For an individual seeking nursing home aid - a person cannot have more than \$14,850 in resources and \$50 of income.

If the individual seeking home care or nursing home aid has income above the required level, he or she must have medical expenses that exceed the income overage. For example, if an individual applying for home care aid has \$1,245 of monthly income, he or she must have monthly medical expenses over \$400 (or \$1,245-\$845) to meet the income test.

**Married Couples:**

For a married couple seeking home care aid, they cannot have more than \$21,750 in resources and \$1,209 a month in income (plus an unearned income credit of \$20 per month).

With married couples in which one spouse is seeking nursing home aid, it is important to distinguish between the Institutionalized Spouse (the spouse in the nursing home) and the Community Spouse (non-institutionalized spouse). Medicaid will deem that it is the responsibility of the Community Spouse to support the institutionalized spouse. Therefore,

Medicaid will consider all of the Community Spouse's non-exempt assets available for care except the Community Spouse may retain up to \$120,900 but a minimum of \$74,820 in non-exempt assets/resources and \$3,022.50 per month (\$36,270 per year) of income. If a couple's total non-exempt asset level is between \$149,640 and \$241,800, the Community Spouse is entitled to retain one-half (1/2) of the combined non-exempt asset level. If the combined non-exempt asset level exceeds \$241,800, the Community Spouse is entitled to retain only the \$120,900 amount. For simplicity purposes, the \$74,820 resource level will be referred to for the remainder of this outline. The amount of assets/resources that the Community Spouse is allowed to keep is known as the "Community Spouse Resource Allowance" or "CSRA". The amount of monthly income that the Community Spouse is allowed to keep is known as the "Minimum Monthly Maintenance Needs Allowance" or "MMMNA".

Prior to **September 24, 2013**, the protections of the CSRA and the MMMNA were only available to married couples where one spouse is in a nursing home or in the now-defunct Long Term Home Health Care program (or "Lombardi" program). Beginning on **September 24, 2013**, these protections are available to married participants in all Managed Long Term Care (MLTC) programs, including the Program for All-Inclusive Care for the Elderly ("PACE") and Medicaid Advantage Plus plans.

***What if the Community Spouse's resources are more than \$74,820?***

Those assets will need to be liquidated to pay for the cost of a nursing home before the Institutionalized spouse will be eligible for Medicaid.

***What if the Community Spouse's income is in excess of \$3,022.50 per month?***

The income which is in excess of \$3,022.50 per month will need to be contributed to defer the cost of the nursing home; however, only 25% of such excess income will be available, not 100%.

***Are there any exceptions to the available resource rule?***

Yes, in addition to the \$74,820 of resources a Community Spouse may have, the Community Spouse may also retain:

1. The Primary Residence up to a maximum home equity limit of currently \$840,000, so long as the Community Spouse still resides in the home or the individual has the subjective intention to return to the Primary Residence after the individual's stay in the nursing home; New York elected to increase the amount of equity an individual is permitted to have from \$500,000 (which was the minimum amount required under the **Deficit Reduction Act of 2005**) to \$840,000.
2. One automobile;
3. Essential personal property (i.e. clothes, furniture, phone, television, etc.);

4. \$1,500 of cash value of life insurance;
5. \$1,500 burial account;
6. Unlimited pre-paid irrevocable funeral contract, provided any funds not used for funeral expenses must be paid to Medicaid to the extent of Medicaid benefits paid; and
7. Other various smaller items (i.e., burial plot, etc.).

### **Transfer of Assets:**

In order to prevent individuals from inappropriately establishing financial eligibility for Medicaid by giving assets to family members, the transfer of assets rule was established.

**The following paragraphs describe Medicaid after to the passing of the Deficit Reduction Act of 2005 ("DRA 2005") by the Federal government on February 8, 2006. Please feel free to contact me if you would like to discuss how transfers made prior to February 8, 2006 are going to be treated by Medicaid.**

### **Look Back Period**

When an individual is applying for Medicaid Assistance, the individual will be required to provide up to sixty (60) months of all financial reports (i.e. bank accounts, tax returns, sales transactions, annuity information, brokerage statements, etc...). This is referred to the "Look Back Period".

### **Penalty Period**

If a Medicaid Applicant or the Applicant's spouse transfers assets for less than fair-market value on or after February 8, 2006, then the Applicant will be ineligible for Medicaid Assistance for a period of time known as the "Penalty Period". As the Look Back Period is sixty (60) months, any transfers made during this Look Back Period will create this Penalty Period.

The Penalty Period, however, cannot begin to start until the **later** of (1) the Medicaid Application date or (2) the date on which the Medicaid Applicant (and his/her spouse) is otherwise eligible for Medicaid Assistance under New York law and is receiving institutional level care (i.e. nursing home care) based on an approved application for such care but for the application of the Penalty Period.

In essence, this means the Penalty Period does not begin until the Medicaid Applicant moves to the nursing home, applies for Medicaid Assistance and is otherwise eligible for Medicaid (meaning once the Medicaid Applicant has spent his/her resources down to \$14,850 in New York or \$74,820 for the Community Spouse). In other words, the Penalty Period does not begin until the nursing home resident is out of funds and cannot afford to pay the nursing home.

The penalty period is calculated by dividing the value of the uncompensated transfer (or amount of gift) by the average monthly cost of nursing home care for the Applicant's region, as published by the Centers for Medicare & Medicaid Services ("CMS"). The resulting figure is the number of months during which the Applicant is disqualified from receiving Medicaid coverage (the "Penalty Period").

Example 1: Using the year 2017 average cost of nursing home care of \$9,511 for the Central New York region, if an Applicant gave away assets worth \$95,110, the Applicant would be disqualified from receiving Medicaid coverage for ten (10) months ( $95,110/9,511$ ). A penalty period of ten (10) months will apply regardless of whether the recipient of the gift was a natural person or a trust, since ten (10) months is shorter than sixty (60) month maximum.

**CAVEAT** The Medicaid Applicant now must apply for Medicaid Assistance in order to get this ten (10) month Penalty Period to begin to run. If the Medicaid Applicant waits ten (10) months to apply, then the Penalty Period will begin to run when the Medicaid Applicant applies ten (10) months later. Therefore, in essence, the Penalty Period become twenty (20) months because the Penalty Period would not start now until the Medicaid Applicant actually filed the Medicaid Application.

Example 2: Same figures as in Example 1, except that the Applicant gave away \$570,000 to her daughter. After calculating the number of months of ineligibility ( $570,000/9,511$ ), the Applicant would be disqualified from Medicaid for just under sixty (60) months. Therefore, if the Applicant waited until the sixty-first (61st) month to apply for Medicaid, the Applicant would not have to disclose the \$570,000 transfer because it was beyond the sixty (60) month Look Back Period and the Applicant would be eligible for Medicaid (assuming the Applicant was "otherwise eligible" - i.e. had resources under \$14,850 for 2017).

### **Regional Rates**

The cost of care for a private patient is derived at by utilizing the following formula. The average Medicaid rate for the private care facilities within a particular region where the patient is institutionalized is multiplied by 120%. The 2017 Regional Rates are as follows:

#### **2017 Regional Rates**

Central	\$9,511
Long Island (Nassau and Suffolk)	\$12,811
New York City (5 Boroughs)	\$12,157
Northeastern	\$10,242
Northern Metropolitan (includes Westchester)	\$12,198
Rochester	\$11,237
Western	\$10,078

Consideration should be given to setting aside a reserve amount that can be used for unexpected expenses that may arise during the private pay period that could result in a depletion of all available funds prior to the originally expected Medicaid application date. If that occurs, there may be a need to go back to recipients to collect funds for the support for the Applicant. Some of the unexpected expenses that may not be covered by insurance during the private pay period include:

1. Daily rate of maintaining a bed while the Applicant has gone to a hospital for more care;
2. Hearing aids and other medical aides that may not be provided or protected by insurance;
3. Extraordinary medical expenses not covered by basic or medigap insurance plans (i.e. visits to a doctor/dentist along with the transportation costs to and from the doctor's/dentist's appointments); and
4. Other miscellaneous costs.

#### **Exceptions to the Asset Transfer Rule:**

First, the asset transfer rule does not apply to transfers of assets between spouses. Second, the rule does not apply to Applicants who are not in a nursing home (e.g. ones applying for home care aid) or, under certain conditions, who are receiving comparable care in their community or home (such as the Program for All-Inclusive Care for the Elderly or "PACE" and Medicaid Advantage Plus). Third, transfers by a Non-Applicant/Community Spouse made after the Institutionalized Spouse has been approved for Medicaid coverage are not taken into account by Medicaid and will not subject the Institutionalized Spouse to a penalty period (such transfers will only affect the Non-Applicant/Community Spouse's future eligibility for Medicaid). Fourth, transfers of certain exempt assets such as an automobile, household furniture, appliances and household equipment are not subject to the asset transfer rule. In addition, there are certain exceptions to the asset transfer rule for the transfer of the Medicaid Applicant's home (see below under Exempt Transfers of Home).

#### **Spousal Refusal Statement**

Although spouses are generally obligated to provide for each other's medical care, the Medicaid rules in New York state provide that Medicaid cannot be denied to an Applicant merely because his/her spouse refuses to meet that spouse's support obligation. This can be done by filing a "Spousal Refusal Statement" with the Medicaid Application.

By filing a Spousal Refusal Statement, neither the Community Spouse's income nor the Community Spouse's assets are counted in determining the Institutionalized Spouse's Medicaid eligibility. With the Spousal Refusal, the Community Spouse is only required pay over twenty-five percent (25 %) of his/her excess income (the amount in excess of \$3,022.50 for 2017) to the

nursing home for the Institutionalized Spouse's care. This, therefore, allows the Community Spouse to keep seventy-five cents (\$0.75) of every dollar (\$1.00) of excess income. This can be quite substantial. After the Community Spouse has filed the Spousal Refusal Statement and the Institutionalized Spouse's Medicaid eligibility has been determined, the Community Spouse can transfer his/her own assets without triggering a Penalty Period for the Institutionalized Spouse.

If the Community Spouse refuses to provide the level of support mandated under Medicaid by executing a Spousal Refusal Statement, the only remedy DSS can pursue is a court order requiring the Community Spouse to support the Institutionalized Spouse. Further, Medicaid is only allowed to pursue this remedy during the life of the Community Spouse. Upon the Community Spouse's death, Medicaid may not interpose a claim against the Community Spouse's estate for the first time.

As a practical matter, Medicaid has generally not sought such court orders in Central New York, although there have been some rare instances where Medicaid has pursued a claim. Even if Medicaid did pursue a refusing spouse in court, the court is likely to be a much friendlier forum for the claims of the Community Spouse than Medicaid. In addition, with all the added costs and delays associated with litigation, Medicaid is often willing to compromise with the Community Spouse rather than take the Community Spouse to court.

It is important to note, however, that it is expected, and it is likely that, Medicaid will change its stance in the future and pursue the Community Spouse for support. This trend has been prevalent in the New York City area and is moving Upstate. At this time, Medicaid still does not regularly pursue Community Spouses who sign a spousal refusal statement, but Medicaid personnel in Onondaga County and surrounding counties have at least threatened to start pursuing the Community Spouse. One should be aware that this is a very aggressive planning technique, and there is always the possibility of litigation.

### **Purchase an Annuity:**

An individual can purchase an annuity to receive a stream of income for life or for a term of years with the remaining principal balance at his/her death (or the death of the survivor if a joint and survivor annuity) paid to their children and/or grandchildren. Again, before one becomes Medicaid eligible, he/she can use the income stream to pay life insurance or long-term care insurance premiums.

There are a few caveats to mention with the purchase of annuity. One, **the annuity must be actuarially sound, irrevocable, non-assignable and have no cash value** in order to be a Medicaid Qualified Annuity. In New York, the individual's life expectancy is determined solely on age, not the individual's health characteristics. Two, the individual is only entitled to a certain amount of income after becoming Medicaid eligible. All the income in excess of these amounts (\$50 for the Institutionalized Spouse and \$3,022.50 for the Community Spouse in 2017) must be paid over to Medicaid. The Community Spouse, of course, could file a Spousal Refusal Statement. Three, depending on the length/term of the annuity, especially if the term of the annuity is required to be 5 years or less to be "actuarially sound", it may be very difficult to find

an insurance company who is licensed in New York State that can issue a Medicaid Qualified Annuity.

One, however, must be aware of IRC § 72(u) regarding transfers of annuities to prevent the adverse tax consequences of a "deemed" liquidation of the annuity.

The following applies to any annuity purchased on or after February 8, 2006:

- a. Full disclosure required;
- b. Any transaction exceeding \$100,000 in the past sixty (60) months must be disclosed regardless of whether it was for Fair Market Value and will be treated as a transfer for less than Fair Market Value unless proved to Medicaid it was for Fair Market Value (i.e. now a purchase of an annuity will be deemed a transfer for Medicaid purposes incurring a Penalty Period);
- c. Beneficiary designation must be include a "pay-back" provision to Medicaid unless there is a spouse or minor child or disabled child;
- d. In its enabling legislation, New York state imposes an additional requirement that the state to be named the primary beneficiary of all annuities upon death of an individual who was receiving Medicaid, up to the amount of money expended for such individual's medical care, unless there is a Community Spouse or disabled child.

#### **Exempt Transfers of Primary Residence:**

Under the Medicaid transfer rules, the transfer of the individual's Primary Residence is an exempt transfer if it is transferred to the individual's spouse; the individual's minor (under 21) child, or the individual's blind or disabled child; to the individual's brother or sister who has an equity interest in the Primary Residence and who resided in the Primary Residence for at least one (1) year prior to the individual's institutionalization; or to the individual's child, provided the individual's child has resided in the Primary Residence for at least two (2) years and has provided care so as to keep the individual from becoming institutionalized. If the Primary Residence is not transferred to one of the above listed individuals, the transfer of the individual's Primary Residence will subject the individual to the Medicaid asset transfer rules.

#### **Transfer of Primary Residence and Retain a Life Estate**

An individual can transfer his/her Primary Residence to his/her children and reserve a life estate because the Primary Residence is an exempt asset as long as one spouse continues to live in it or, at least, the individual intends to return to live at the house. Reserving a life estate entitles the individual to continue to receive all of the real estate tax exemptions (i.e. STAR, Homestead, Veteran's, etc...), the individual received when he/she/they owned the full Primary Residence. For many elderly clients, this is very important to know because they rely on those tax exemptions each year.

The problem with such a transfer is that Medicaid assigns a value to the life estate based on the IRS Table S (Single Life Factor). Therefore, if the Primary Residence is ever sold, the amount of the proceeds received by the individual (Medicaid recipient) retaining the life estate could be substantial. This could cause the individual to no longer be eligible for Medicaid and have to use these proceeds for his/her care in the nursing home.

Another problem with such a transfer is if there is any outstanding mortgage or debt on the property. Mortgage payments must still be paid on the property, otherwise the bank or creditor could foreclose on the property. Medicaid will not allow the Community Spouse to retain assets in excess of the \$74,820 amount, with some minor exceptions. Therefore, the remaindermen (the children and/or grandchildren) could end up having to pay the mortgage because the individual's assets will not be sufficient to pay all the mortgage payments, unless the mortgage balance is low.

### **Transfers of Primary Residence into Irrevocable Income Only Trust**

Another option for transferring the Primary Residence is to transfer the Primary Residence into an Irrevocable Income Only Trust ("IIOT"). By transferring the Primary Residence into an IIOT, the individual(s) retains the right to all of the income earned by the trust and is the taxpayer for the trust. Traditionally, this was treated as the equivalent of the individual retaining the right to live in the Primary Residence for the individual(s) remaining lifetime(s) thereby entitling the individual(s) to continue to receive all of the real estate tax exemptions (i.e. STAR, Homestead, Veteran's, etc...). This is similar to transferring the Primary Residence and reserving a life estate.

\*\*\*As of February 15, 2017, however, the City of Syracuse Assessor's office has denied the real estate tax exemptions when the Primary Residence was transferred into an IIOT unless the IIOT specifically provides language stating the individual(s) reserved the right to reside in the Primary Residence for the individual(s) lifetimes or retained all the right to use and occupy the Primary Residence for the individual(s) lifetimes. Therefore, for Primary Residences in the City of Syracuse, individual(s) may lose the real estate tax exemptions if the specific language is not included in the IIOT. The downside to including this specific language in the IIOT is that Medicaid may now equate that retention to the equivalent of a life estate and the benefit of the IIOT, described in the paragraph below, may be lost.

The benefit of transferring the Primary Residence into an IIOT is that if the Primary Residence is ever sold, the trust receives all of the proceeds of sale, not the individual. The individual is still only entitled to receive the income earned by the trust. Whereas, if the Primary Residence is sold when the individual has a life estate, the individual will receive cash in an amount equal to his/her life expectancy (as determined under the IRS Table S). This could cause the individual to have excess resources which would make the individual ineligible for Medicaid until he/she has spent down those assets to get him/her back down to the Medicaid resource eligibility levels.

The main caveat with transferring the Primary Residence into an IIOT, however, is that the individual is no longer the “owner” of the Primary Residence and the Trustees of the IIOT could sell the Primary Residence. If this happens, all the individual(s) will receive is the income earned from the sales proceeds of the Primary Residence (if a successor residence is not purchased). Thus, it is very important to discuss all these options with the individual(s) and their family.

### **Sale and Leaseback**

Another option that can be pursued is for the individual or spouse to sell the Primary Residence to his/her/their children or another individual(s) in return for a mortgage. The children will pay the parent the mortgage amount each month and the parent(s) will then pay the children a monthly mortgage amount for the right to live there. The mortgage must be commercially reasonable (i.e. in regards to the term and the interest rate) and the lease must also be commercially reasonable (i.e. in regards to term and must be for the fair market rental value for property of similar size and use) in order to for Medicaid not to enforce a "gift" because of the discounted value of the transaction (i.e. the mortgage, mortgage note, mortgage payment, rental amount or rental term).

### **Long-Term Care Insurance**

A long-term care insurance policy allows an individual to transfer a portion of the costs of long-term care to an insurance company in exchange for regular premium payments. If an individual is eligible for a long-term care insurance policy, the yearly premiums will always be less the yearly cost to privately pay for the nursing home. These policies can pay for skilled, intermediate or custodial nursing care and some policies may even pay for home health care, thereby protecting the family's resources from the potentially devastating cost of a long-term disability or chronic illness.

It has become increasingly more difficult to obtain long-term care insurance policies because of the escalating costs to the insurance companies to cover the benefits promised under those policies. Currently, there are only a few insurance companies remaining who issue new individual long-term care policies in New York state, which include Genworth Life Insurance Company of New York and Massachusetts Mutual Life Insurance Company. There are, however, some additional insurance companies such as Lincoln National Life Insurance Company (MoneyGuard®) and Transamerica Financial Life Insurance Company (TransLegacy<sup>SM</sup>) who have added a long-term care rider to their life insurance contracts. For an additional fee, the riders will provide a benefit, typically a percentage of the face value of the policy, to help cover the cost of long-term care.

### **Benefits of a Long-Term Care Insurance Policy**

If an individual has a long-term care insurance policy and has to enter a nursing home, the insurance policy pays the costs of the individual's care for the term of the policy. During the time the policy is paying the nursing home costs, the individual may begin spending down or

transferring his/her assets. When the insurance policy payments terminate, the individual will have spent down or transferred enough assets to become Medicaid eligible.

For clients with large amounts of assets and very little income, the New York Partnership Plan may offer those clients the best of all worlds. The New York Partnership Plan offers two main categories of plans: one category allows the individual to become Medicaid eligible at the termination of the policy, regardless of his/her resource levels and does not consider any transfers of assets (referred to as the "Total Asset Protection" plan); and the other category reduces the individual's resources to be counted for Medicaid eligibility purposes at the termination of the policy by the amount of the policy benefits paid (referred to as the "Dollar for Dollar Protection" plan). In the Dollar for Dollar Protection plan, if the policy pays out \$275,000 in long-term care benefits, then \$275,000 of the individual's assets when he or she applies for Medicaid are not counted. The caveat, however, is that the individual must remain a New York resident and enter a New York nursing home to be eligible for Medicaid following the term of insurance coverage. However, there are several states that have entered into reciprocity arrangements with New York state that will preserve the Medicaid protection benefits of the New York Partnership Policy if a New York resident later moves to that state and applies for Medicaid there.

**Beginning on June 1, 2012, there were three key changes made to the New York Partnership Plan.**

First, a new plan option referred to as "Total Asset 2-4-50" is now being offered, which is less expensive to purchase than the other "Total Asset Protection" plans (namely, the "Total Asset 3-6-50" and "Total Asset 4-4-100"). It provides for two (2) years of nursing home coverage and four (4) years of home care coverage. The nursing home minimum daily benefit amount is \$304 and the home care minimum daily benefit amount is \$152 (or 50% of the daily nursing home benefit amount).

Second, New York state has entered into a reciprocity arrangement which allows for a New York partnership policy holder to relocate to one of the other forty-three (43) participating U.S. states and keep the Medicaid asset protection advantage of the policy on a dollar-for-dollar level based on the amount of policy benefits paid. If an out-of-state resident purchases a partnership policy from another participating state and moves to New York, that policyholder will receive a similar level of Medicaid asset protection advantage from the policy.

Third, all Partnership plan policies now give participants the option to choose between a 3.5% inflation protection coverage and a 5% inflation protection coverage. Historically, these policies required a 5% inflation protection coverage.

Therefore, long-term care insurance is always the first option to pursue when considering long-term care planning. If long-term care insurance is not an option because the individual has a health condition excluding him/her from eligibility or is too old to purchase a policy, then the individual or couple should consider one or more of the above techniques for the transferring of assets in order to become Medicaid eligible and save some or most of the family's assets from the astronomical costs of long-term care.

### **Medicaid Estate Recovery**

When a Medicaid recipient dies, Medicaid has the right to recover from the Medicaid recipient's estate any benefits paid while the recipient is age 55 or older and within the last ten (10) years of the recipient's life. Historically, the right to estate recovery has been limited to the recipient's probate estate (e.g. property passing under the recipient's Will) and intestate estate (e.g. property passing under the laws of intestacy if there is no Will and the property does not pass under a contractual arrangement such as a beneficiary designation). However, for claims filed by Medicaid for recovery against the estates of Medicaid recipients between September 8, 2011 and December 5, 2011, Medicaid's right of estate recovery expanded to include not only the probate estate and the intestate estate but also certain non-probate property such as life estates, jointly-held property, revocable trusts and irrevocable trusts in which the recipient had, immediately prior to death, an interest in the trust principal. This "expanded" estate recovery no longer applies to claims for recovery filed against the estates of Medicaid recipients on or after December 6, 2011.

One important consideration to keep in mind is that Medicaid is prohibited from recovery against the estate of a Medicaid recipient if he or she is survived by a spouse or a disabled child. Therefore, if the spouse or disabled child of a Medicaid recipient outlives the recipient by more than 10 years, Medicaid cannot recover against the recipient's spouse's estate or the recipient's disabled child's estate on the account of the Medicaid recipient's own benefits.

### **Personal Care Contracts**

Personal care contracts (or caregiver agreements) are contracts which provide for a lump sum of money to be paid to an individual (usually a family member) to provide personal care services for another for that person's lifetime. These contracts are allowed in New York provided they are in writing. The hourly rate is based on the local community rate and the services provided are not by the facility. In addition, the contract must provide for a return of any prepaid monies if the caregiver does not fulfill the contractual obligations or if the person being cared for dies before his or her calculated life expectancy.

### **Applying for Medicaid**

As of April 1, 2010, CMS has issued the following new rules regarding the Medicaid Application process:

1. Personal/face-to-face interviews are no longer required for submitting Medicaid Applications on or after April 1, 2010. Instead, individuals applying for Medicaid may mail in their completed Medicaid Application and related documentation and information. If the individual prefers, a personal/face-to-face interview may still be requested;
2. Medicaid now requires the new Medicaid Application form to be utilized when submitting a Medicaid Application (these forms became available on April 8, 2010); and

3. Medicaid now is only requiring information and documentation on financial transactions consisting of \$2,000 or more, but reserves the right to inquire about any other financial transactions it desires.

Applying for Medicaid is a complicated process and the appropriate legal and accounting advice should be consulted. As such, this outline should not be *relied* upon as legal advice without first discussing your personal needs with respect to Medicaid issues with an attorney who practices in the area of Elder Law. Please feel free to contact me, Shane M. McCrohan, of Scolaro, Fetter, Grizanti, McGough & King, P.C. or visit my firm's website at [www.scolaro.com](http://www.scolaro.com) if you have any questions.

This memorandum was updated on February 15, 2017. Most of the above figures change every year.