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SUMMARY OF CHANGES TO MEDICAID IN THE DEFICIT REDUCTION ACT OF 2005

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Original training materials available at http://onlineresources.wnylc.net/healthcare/docs/OutlineDRA.pdf

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I. Asset Transfer Penalty for Institutional Medicaid

A. Extended Look-Back Period

1. Under the old rule, whenever someone applies for **Institutional Medicaid**, they must submit documentation of their assets (i.e., bank statements) going back three years into the past. If the applicant has any trusts, they must submit five years of statements. The purpose of the look-back period is for Medicaid staff to identify transfers of assets. If they find transfers which are not exempt, they then calculate a "penalty."

> **Institutional Medicaid** – For purposes of the look-back period and transfer penalty, this includes:
>
> - Nursing Home
> - Hospital "Alternative Level of Care" (ALOC)
>
> **NEW – UNDER A NEW DOH DIRECTIVE dated 9/24/07, the look back and penalty do NOT apply to Waiver Services** (including Lombardi, TBI Waiver, OMRDD HCBS, AIDS Home Care Program, etc.)[1] GIS 07 MA/018 posted at http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/07ma018.pdf

2. The DRA changed the look-back period for non-trust assets from three years to five years. However, the longer look-back period will be phased in gradually, as illustrated by the chart below.

Phased-In Five-Year Look-Back Period

	Look-Back Period	
Date of Application	**Assets other than trusts**	**Trusts**
1993 until Jan. 31, 2009	36 months	60 months
February 1, 2009	36 + 1 = 37 months	60 months
March 1, 2009 through Jan. 31, 2011	Look-back grows by one additional month, for example:	60 months
February 1, 2010	36 + 13 = 49 months	60 months
February 1, 2011	60 months for all transfers	

[1] Waiver programs provide some "waivered" and some "non-waivered" services. Only the "waivered" services are subject to the transfer penalty and look-back. However, it is unclear whether waiver participants will be able to wait out the penalty period while receiving only "non-waivered" services.

3. Remember that the look-back period does NOT APPLY to **Community-Based Long Term Care Services**, nor to any non-LTC Medicaid services.

> **Community-Based Long Term Care Services** – For purposes of the look-back period and transfer penalty, this includes:
>
> - Medical model adult day care
> - Medicaid Assisted Living Program (ALP)
> - Personal Care Services ("Home Attendant" in NYC)
> - Certified Home Health Agency (CHHA)
> - Private Duty Nursing
> - Consumer Directed Personal Assistance Program (CDPAP)
> - Managed Long-Term Care in the community (VNS Choice, Guildnet, Independence Care Systems, etc.)
> - Hospice (in the community AND hospice residence program)
> - Personal Emergency Response System (PERS)
> - Residential treatment facility (drug or alcoholism treatment)
> - Nursing Home for Short-Term Rehabilitation[2]
> - **WAIVER** SERVICES – Lookback no longer applies, as of 9/24/07 to Lombardi and other waiver services

B. New Transfer Penalty Rule

1. If an applicant for Institutional Medicaid transferred any assets for less than Fair Market Value during the look-back period, then Medicaid will impose a transfer penalty. In other words, Medicaid is looking for gifts. If an applicant spent $10,000 on new furniture, it will not trigger a penalty.

2. The length of the transfer penalty – the DRA did not change how to calculate the number of months during which the applicant will be ineligible for Medicaid to pay for institutional care. The number of months is calculated as follows:

   (Total amount transferred) ÷ (Monthly regional nursing home rate) = (Number of months ineligible for Medicaid coverage of institutional care)

   The 2007 monthly regional nursing home rate for New York City is $9,375.

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[2] This benefit, created by state law in 2002, allows up to 29 days of Medicaid nursing home care within the community Medicaid benefit – without having to file the 36-60 month application that would trigger the transfer penalty. However, this was not included in the Administrative Directive issued by the State to implement the DRA. NYS DOH Administrative Directive, 06 OMM/ADM-5 (July 20, 2006), available at http://www.health.state.ny.us/health_care/medicaid/publications/pub2006adm.htm

EXAMPLE: Judy transferred $30,000 before she applied for Medicaid nursing home care. The penalty is just over 3 months: $30,000 ÷ $9375 = 3.2 months. If she transferred $300,000 instead, the penalty would be 32 months.

3. **WHEN THE PENALTY PERIOD COMMENCES** -- The DRA made a very significant change in WHEN the penalty period commences or "starts running."
   a. **PRE-DRA -- The penalty period began to run the month *after* the date of the transfer.**
      i. **THIS RULE STILL APPLIES TO TRANSFERS MADE *BEFORE* FEBRUARY 8, 2006**.
      ii. **EXAMPLE**: Betty transferred $ 27,000 on February 1, 2006 to her daughter, who does not live with her. Her remaining assets are within the asset limits -- $4150 for a single person, a $1500 burial fund and an irrevocable burial agreement that cost $5000. She applied for Medicaid Home Care in March 2006. She was fully eligible for Medicaid Home Care because there is and was no "transfer penalty" for Medicaid in the community. She received home care until November 2006, when she had a stroke. No longer able to climb the stairs to her apartment, on Nov. 9, 2006, she went into a nursing home and applied for Medicaid.

      Medicaid "looked back" three years to see what assets she transferred. The $27,000 she transferred in February 2006 was revealed in that "lookback." Since the transfer was BEFORE the new law was enacted, the penalty period began in March 2006, the month after she made the $27,000 transfer. The penalty was just under three months (the penalty rate in 2007 in NYC is $9,375) and expired as of June 1, 2006.

      When she was admitted to the nursing home in November 2006, the transfer penalty had long ago expired, and she is fully eligible for Medicaid to pay for her nursing home care.
   b. **POST-DRA -- DELAYED PENALTY PERIOD**
      i. **THE NEW RULE**: The penalty begins "running" on <u>the later of:</u>

      (a) the date the assets are transferred *or*

      (b) the "date on which the individual is eligible for [Medicaid] …and would otherwise be receiving institutional level care …based on an *approved application* for such care but for the application of the penalty period…."[3]

[3] 42 U.S.C. 1396p(1)(D)(ii), as added by Sec. 6011 of the Deficit Reduction Act.

ii. The (b) alternative is what will apply in most situations.[4] This means that the penalty won't start running until the individual has already been admitted to a nursing home AND has applied for Medicaid AND is financially eligible for Medicaid, except for the transferred assets.

iii. EXAMPLE -- Betty's case above UNDER THE NEW LAW -- If Betty's transfer was on February 9, 2006 -- *after* the DRA went into effect:

Home care -- Betty would still be eligible for Medicaid home care after the transfer, the same as before. The new federal law does not change the current rules for community-based care.

When Betty enters a nursing home and applies for Medicaid in November 2006:

LOOKBACK -- Is still 3 years, because it is before Feb. 2009. This transfer made in Feb. 2005 will be revealed in the lookback.

The three-month penalty period that was caused by this transfer will first begin to "run" in November 2006 -- This is the first month in which she is:

☒ in a nursing home,

☒ has applied for Medicaid, and

☒ is eligible to receive Medicaid, except for the transfer.

Betty's application will be denied because of the transfers. But it is still worth her applying because only if she applies will the penalty period start to run out. It will run for 3 months from November 2006 - January 2007. In those 3 months, Medicaid will not pay for her nursing home care. Her daughter or someone else must pay for it out of the transferred assets or other funds. In February 2007 she must re-apply for Medicaid and will be eligible.

iv. **The new rule applies to all transfers made on or after February 8, 2006.** Transfers made *before* February 8, 2006 will be assessed under the old rules. The penalty on these transfers started running the month after the transfer. Thus two different rules will be applied when Medicaid evaluates different transfers made in a Medicaid application.

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[4] The only time that (a) would apply is when the client is already in a nursing home and on Medicaid, and inherits money or settles a lawsuit, and transfers that money. In that case, the penalty would start running on the date the assets were transferred.

EXAMPLE: Mary applies for Medicaid for nursing home care in December 2007. She made 2 transfers in the 3-year "lookback period," which began December 1, 2004. One transfer in January 2006 will be evaluated under the OLD rules -- the penalty will start "running" in the month after the transfer was made. The other transfer in March 2006 will be evaluated under the NEW rules -- the penalty will start "running" as explained above, once she applies for nursing home or Lombardi care.

Summary of Transfer Penalty Rules[1]

Application Date	Look-Back Period[2]	Transfer Date	Rule
Before 2/8/06	3 years	Before 2/8/06	*Old rule* - Penalty runs from date of transfer
2/8/06 – 8/1/06	3 years	Before 2/8/06	*Old rule* - Penalty runs from date of transfer
		After 2/8/06	*Old rule* - Penalty runs from date of transfer (special grace period for these transfers, since technically they should be under *New rule* - hopefully, Medicaid will not come back and re-assess these transfers at a later date)[3]
8/1/06 – 2/8/09	3 years	Before 2/8/06	*Old rule* - Penalty runs from date of transfer
		After 2/8/06	*New rule* - Penalty runs from date that applicant is receiving institutional care, has applied for Medicaid, and is otherwise eligible but for the transfer
2/8/09 – 2/8/11	Phase in period to 5 years	Before 2/8/06	*Old rule* -Penalty runs from date of transfer
		After 2/7/06	*New rule* -Penalty runs from date that applicant is receiving institutional care, has applied for Medicaid, and is otherwise eligible but for the transfer
After 2/8/11	5 years	After 2/7/06	*New rule* - Penalty runs from date that applicant is receiving institutional care, has applied for Medicaid, and is otherwise eligible but for the transfer

(1) Note that for any particular application submitted between August 1, 2006 and February 8, 2011, some transfers will be evaluated under the old rule and some under the new rule, depending upon the date of the transfer. Thus, a pre-2/8/06 transfer penalty may be over by the time of application, but a post-2/8/06 penalty may only begin running at the time of application.

(2) Except for transfers to trusts, for which look-back period is always 5 years.

(3) See 06 OMM/ADM-5 at 5,10, 29 (July 20, 2006), in footnote 2, above.

C. Practical Implication

1. Because the penalty period does not begin to run until the applicant has applied for Medicaid and is receiving institutional care, it is no longer feasible to simply wait out the penalty period at home. Instead, applicants will have to do the "**DRA Two-Step."**

2. **Step One** – Applicant submits Medicaid application when admitted to nursing home to determine if she is "otherwise eligible" but for the transfer of assets. In other words, Medicaid will first determine whether applicant's income and resources are within the limits NOW, before doing the look-back for asset transfers. If applicant is found to be currently financially "otherwise eligible" for Medicaid, but there is a transfer penalty, the application is *denied* but the penalty period starts running. If applicant was not "otherwise eligible," the application would be denied but the penalty period would NOT start running.
   a. Once the penalty period starts running, applicant can either stay in the nursing home and pay privately for the institutional care, or return to the community -- home or assisted living, where s/he may receive Medicaid home care, which is unaffected by the transfer penalty.

3. **Step Two** – Once the applicant has waited out the penalty period, she can successfully re-apply for Institutional Medicaid. As a practical matter, if the penalty period is six months or less, there might not actually be two applications. Since the first application takes so long to process, the penalty period might be over by the time the first application is processed.

NOTE ABOUT WAIVER PROGRAMS – As of 9/24/07, an individual will not be disqualified from receiving Lombardi services because of a transfer. Also, the penalty period will not start running when an individual receives Lombardi services. An individual must be in a nursing home for the penalty period to start running.

D. THE PENALTY PERIOD CONTINUES TO RUN IF CLIENT LEAVES THE NURSING HOME AFTER MEDICAID APPLICATION IS DENIED BECAUSE OF A PENALTY -- Some good news:

   a. "Once a penalty period has been established for an otherwise eligible individual, the penalty period continues to run regardless of whether the individual continues to receive nursing facility services or remains eligible for Medicaid." ADM at 17. This means that one may enter a nursing home, apply for Medicaid, and have application rejected because of the transfer penalty. Once the application is rejected, you may then LEAVE the nursing home program, and the penalty period will run. While the penalty is running, there is no requirement that the client pay for or even receive any services, or that she be on Medicaid.

b. Thus the penalty period will run even if the client leaves the nursing home and receives Medicaid home care - personal care, CHHA, Consumer-Directed -- or goes into a Medicaid assisted living program, or privately pays for home care, while running out the penalty period.

c. After the penalty expires, if she needs and applies for nursing home care again, then she is eligible with no penalty (unless she's made subsequent transfers). If the penalty has not yet expired when she later enters a nursing home, then she is not eligible for those services until the remainder of the penalty has expired.

E. Exceptions to the Transfer Penalty

These are the existing exceptions, which the DRA has not changed.

1. Transfers to the **spouse**
   a. The community spouse may keep the higher of $74,820 in assets or half the couple's assets up to $99,540. If the spouse's assets exceed these limits, s/he may do a *spousal refusal*, with the risk of being sued depending on the amount.

2. Transfers to the individual's **child who is certified blind or disabled,** or to a supplemental needs trust established for the benefit of the individual's blind or disabled child.

3. Transfers to a **supplemental needs trust** established for the benefit of either:
   a. Applicant, but only if s/he is under age 65,
   b. Applicant's disabled adult child, OR
   c. *Any* individual under 65 years of age who is disabled (does not have to be related to the person setting up the trust).

4. The client can show that she didn't intend the assets to be a "gift" but to sell them at **fair market value**, or for other valuable consideration.

5. The assets were transferred exclusively for a **purpose other than to qualify** for medical assistance for nursing facility services.

6. Transfers of **Holocaust Reparations**

7. Transfer of the **home** to:
   a. a spouse,
   b. a child under 21, or who is an adult and blind or disabled,
   c. a son or daughter if s/he lived in the home for 2 years immediately before the date the individual becomes an institutionalized individual and cared for client, or
   d. a sibling with equity interest who lived in home for 1 year immediately before the date the individual was institutionalized.

8. **Undue Hardship**

   Transfer penalty will be waived if it would deprive the individual of:
   a. Medical care such that her health or life would be endangered; OR
   b. Food, clothing, shelter or other necessities of life

   In addition, the State has said that it will only grant a hardship waiver where:

   c. Best efforts have been made to have the assets returned, and
   d. "…After payment of medical expenses, the individual's or couple's INCOME AND/OR RESOURCES ARE AT OR ABOVE THE ALLOWABLE MEDICAID EXEMPTION STANDARD for a household of the same size." In other words, a couple must have income below $900 and resources below $5,400.

F. Strategies for Working Around Transfer Penalty

1. Use the exceptions to the transfer penalties

2. Minimize the transfer by pre-paying rent and other expenses

   Because these payments are for fair market value, they are not subject to the transfer penalty.

3. Purchase pre-paid burial arrangements

4. Pay off mortgage or debt

5. Enter into caregiver agreement

6. Purchase Long-Term Care Insurance

7. Use annuity or loan with promissory note, in combination with the transfer (more explained below)

8. Purchase a **life estate** in someone else's home

   If an applicant purchases a life estate in his daughter's home, the money paid to the daughter for this purchase will not be counted as a transfer, but the **applicant**

must reside in the home for a continuous period of at least one year after the date of purchase.

> **Life Estate** – The right to live in a home for the rest of one's life. When the holder of the life estate dies, the home passes to the holder of the "remainder" interest.

II. Equity Value of Primary Residence

A. New Rule

1. Individuals with more than $750,000 in home equity are not eligible for Medicaid coverage of "nursing facility services or other long-term care services."
2. A home may be worth more than $750,000, but have less than $750,000 in *equity*, if there is an outstanding mortgage, for example.

B. Services Covered by New Rule[5]

1. Nursing home
2. Waiver programs (Lombardi, etc.)
3. Home Health Care (CHHA)
4. Personal Care Services (Home Attendant), and
5. Alternate Level of Care (ALOC) services in a hospital.

C. Exceptions

1. This cap on home equity would not apply to homes in which the individual's **spouse** or **minor or disabled child** are living.

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[5] The NY State implementation of the DRA, however, lists more services as subject to the home equity limit than those above. Since the state issued this ADM before the CMS Guidance was issued, we hope that the State will revise its list. Meantime, clients denied the following "Community-based Long Term Care Services" because of the home equity limit may be able to challenge the denial:

- Medical model adult day care
- Private duty nursing
- Consumer-directed personal assistance program (CDPAP)
- Hospice (in-patient or home hospice)
- Personal Emergency Response System (PERS)
- Managed long term care program,
- Assisted Living Program (ALP)

III. Annuities and Loans

A. Purchasing an annuity is not a transfer of assets subject to the transfer penalty, as long as the annuity is:

a. **Irrevocable**
Annuity must be structured so that the purchaser cannot cancel the annuity and get their money back.

b. **Actuarially Sound**
Annuity must be expected to pay out the entire face value over the purchaser's remaining life expectancy.

c. **Immediate Payments**
Payments must begin immediately, and not be deferred until later (i.e., not "balloon annuities").

> **Annuity** – An annuity is a contract by which one receives fixed payments on an investment for a lifetime, or for a specified number of years.

d. **State must be named the death beneficiary**, unless the beneficiary is the applicant's **spouse** or **minor or disabled child**. Before the DRA, anyone could be named as the death beneficiary. Thus, before, the applicant could receive the annuity payments during life, and upon her death transfer the remainder to a family member, for example. Now, the remainder must go the State, which would be paid back what Medicaid paid.

B. Loans, Mortgages, and Promissory Notes

1. Loans, mortgages and promissory notes can be used the same way as annuities. They must meet all of the requirements for annuities, with the following exceptions:
   a. The re-payment term can be individualized, rather than needing to be spread over the individual's life expectancy,
   b. Payments must be in equal amounts over the course of the loan, and
   c. The loan document must prohibit the cancellation of the balance upon the death of the lender.

C. How Annuities and Notes can be used – Elder lawyers are beginning to use Promissory Notes to do Medicaid planning and minimize the amount that must be paid to the nursing home out of excess assets. For example, Sam has $100,000 in assets and needs to enter a nursing home immediately. He has no spouse, disabled children or caretaker child. On September 15th, he is admitted to the nursing home and gifts $50,000 to his adult daughter Sarah. The transfer penalty on that amount is about 5.3 months. On the same day, he transfers another $50,000 to Sarah, who signs a promissory note in which she promises to repay her father $10,000/month for five months plus 5% interest, beginning October 1st.

Medicare paid for the care in September. He applies for Medicaid on October 1st, when Medicare stopped paying. His only remaining assets are $4250 in the bank and a pre-paid burial arrangement. He is otherwise eligible for Medicaid. He will pay the nursing home bill for October and the next 4 months using the $10,000 plus interest in payments on the note he receives from his daughter, plus his own income of $3000/month. The penalty period on the gifted $50,000 starts running in October and will expire after 5.3 months. After that time, he can reapply and will be eligible for Medicaid. The gifted $50,000 has been preserved.

Warning: Don't try this at home! An experienced elder lawyer needs to make these calculations, which involve determining the length of the payback period using actuarial tables, calculating interest, taking into account income, payments by Medicare and Medigap insurance, if any, setting up pre-paid burial arrangements, etc. The calculation could work out very differently depending on these variables. However, this example is given to you so that you know it is worth referring a client for legal help even after the DRA.

IV. Citizenship Documentation

A. New Rule

FOR CITIZENS AND NATIONALS ONLY, all Medicaid applications and redeterminations made after July 1, 2006 must establish citizenship/nationality in accordance with specific documentation requirements.

1. **Single document that proves both citizenship and identity**
   a. U.S. Passport (need not be current)
   b. Certificate of citizenship or naturalization

– OR –

2. **One document proving citizenship, PLUS one document proving identity:**
   a. **Citizenship**
      i. U.S. public birth certificate issued before age 5
      ii. Certification of Report of Birth or Report of Birth Abroad

iii. US Citizen ID card issued by INS until the 1980's, certain ID cards for Mariana islands, American Indians, final adoption decree showing US birth
iv. Evidence of US Civil Service employment before 6/1/76
v. US Military record showing US birth
vi. Hospital record extract on hospital letterhead established at the time of birth and created 5 years before the INITIAL application for Medicaid[6]
vii. Life, health, or other insurance record created at least 5 years before INITIAL Medicaid application date and indicating a US place of birth[6]
viii. A variety of other documents can be used if none of the above exist or can be obtained, and are to be used only in the rarest of circumstances.

b. **Identity**
i. Drivers license issued by state or territory with picture OR other identifying information - sex, race, height, eye color
ii. School ID with photo
iii. US Military card or draft record or military dependent's ID card, US coast guard merchant mariner card
iv. ID issued by US, state, or local gov't with same info included on drivers license
v. Native American Tribal documents
vi. NOT voter's registration or Canadian drivers license

3. All documents must be originals or copies certified by the issuing agency.
4. Once citizenship is documented, subsequent changes in eligibility or redeterminations should not require repeating.

B. Exemptions

1. These new documentation rules do NOT apply to:
a. Medicare beneficiaries, and
b. SSI recipients

C. For more information, see documents on http://onlineresources.wnylc.net/healthcare/health_care.asp -- Scroll down to heading under **MEDICAID. B. Citizenship Documentation Requirements – including:**

Proof Of Identity For Medicaid - New Requirements For People Who *Do Not Have* Medicare Or SSI
http://onlineresources.wnylc.net/healthcare/docs/PROOF_OF_IDENTITY.pdf

[6] But only if items (i) through (v) cannot be obtained.

NYS Dept. of Health Chart of Documentation Required to Prove Citizenship and Identity for Medicaid (For people not on Medicare or SSI)
http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/06ma021att.pdf

Summary of New Interim Regulation on Citizenship Documentation
http://onlineresources.wnylc.net/healthcare/docs/Summary%20of%20New%20Citizenship%20Regs.pdf