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Significant Items in
06 OMM/ADM-5 *Deficit Reduction Act of 2005 – Long Term Care Medicaid Eligibility Changes*
and CMS Guidance dated July 27, 2006

This memo does not explain the changes made by the DRA, since this has been done previously. See, e.g. http://onlineresources.wnylc.net/healthcare/docs/OutlineDRA.pdf . This memo identifies policies or procedures in the ADM issued July 20, 2006 [referred to as "the ADM" or the "new ADM"] that fill gaps in the DRA or which raise questions. The memo also cites the new CMS "Transfer of Assets" Guidance issued on July 27, 2006, posted at http://www.cms.hhs.gov/smdl/smd/list.asp (scroll to Transfer of Assets Guidance dated 7/2706)

CAUTION: The analysis in this document are opinions of the author based on an initial review of the state and federal directives discussed herein. Many policies, including those discussed here, still have to be clarified by the federal and state government.

Thanks to David Goldfarb and Ira Salzman for contributing Points 9 – 12 and to them, Michael Cathers, and Andrew Koski (Home Care Association) for comments on the draft.

1. What services are subject to new transfer penalty?

We already knew the transfer penalty will apply to an "institutionalized individual" who receives "nursing facility services," which include nursing home care, "alternate level of care" in hospitals, and a person "who is receiving care, services or supplies pursuant to a waiver granted pursuant to subsection (c) of section 1915 of the federal social security act." SSL § 366.5(e)(1)(vii), ADM at 10. These waivers are the Lombardi program, TBI and OMRDD waivers, and other home and community based waiver programs.

The new clarification in the ADM is the definition of "Community-based Long Term Care Services," which are services that are *not* subject to the transfer penalty. ADM p. 10.

A. As expected, "Community-based Long Term Care Services" include:

a. Medical model adult day care

b. Medicaid home care --

(1) Personal Care services - ("home attendant" in NYC)

(2) Certified home health agency services ("CHHA")

(3) Private Duty Nursing services.

(4) Consumer Directed Personal Assistance Program (CDPAP)

(5) Managed long-term care in the community

c. hospice in the community AND hospice residence program;

d. Personal emergency response system (PERS);

e. Residential treatment facility (Note: this is presumably for alcoholism and drug treatment)

f. Medicaid Assisted Living Programs (ALP) -- NYS Medicaid Reference Guide p. 354 says that during a transfer penalty period an applicant will not be eligible for "nursing facility services including home and community-based services [waiver]," and refers to page 303.9 for a list of "nursing facility services." This list at 303.9 lists ALPs under Community-Based Long Term Care programs, and not as Nursing Facility services. In the community-based category, there is no lookback period. MRG 303.4-303.9.

For a list of ALPS in NYS see http://www.health.state.ny.us/nysdoh/acf/map.htm. Other information on ALPs - admission requirements, etc. is posted at http://www.health.state.ny.us/facilities/assisted_living/.

g. **NON-waivered services provided within a home and community-based waiver program**.

(1) The ADM does not specify which services are "non-waivered," but they are services normally covered by Medicaid, so are not extra non-medical services provided solely as part of the waiver:[1]

(a) Personal care

(b) Skilled nursing visits

(c) Physical and speech therapy

(d) Social work counseling

(e) Medical transportation

(f) Medication and supplies.

As services now defined as community-based services, the above services should not be subject to the transfer penalty even when provided

[1] NYS Dept. of Health Long Term Home Health Care Program Reference Manual (June 2006) Ch. 3 <http://www.health.state.ny.us/health_care/medicaid/reference/lthhcp/lthhcpmanual.pdf

by a Lombardi or other waiver program. (Though they are subject to the homestead equity limit). Therefore someone denied waiver services because of a transfer penalty should be able to receive the above non-waiver services from the same Lombardi or other waiver provider… and thereby trigger running of the transfer penalty(!)

(2) During the penalty period, they could not receive waivered services such as the following:

(a) Medical Social Services

(b) Nutrition counseling/ Educational services

(c) Respiratory therapy

(d) Home-delivered and congregate meals,

(e) Home maintenance tasks and Housing improvements,

(f) Moving assistance,

(g) Personal Emergency Response System (PERS),

(h) Respite care,

(i) Social adult day care and day care transportation .

(3) Note that the definition of "institutionalized individual," however, includes those "those receiving care, services and supplies pursuant to a …" 1915(c) or (d) waiver, without limiting that definition to "waivered" services. These definitions are inconsistent in this regard. This definition implies that no services may be provided to a waiver recipient who has a transfer penalty.

h. The list omits one service which should be included as exempt from the transfer penalty: "**Short-term rehabilitation**" in a rehabilitation facility -- This benefit is one short-term nursing home admission, up to a maximum of 29 *consecutive* days in a twelve-month period. This benefit is very limited, and is discussed in more detail below. It appears this omission is an inadvertent error, as the ADM at page 18 references this benefit in a way that implies it is not subject to the transfer penalty.

i. All other Medicaid services are not "community-based long term care services," so not subject to transfer penalty AND not subject to homestead equity limit: Acute inpatient hospital care, all outpatient services, all physician's services, lab tests and x-rays, outpatient rehabilitation, all other treatment and care in the community.

2. Which services are subject to the homestead equity limit of $750,000?

A. The list of community-based long term care services in the ADM set forth above purports to specify services subject to the equity limit. However, after the ADM was issued, the CMS guidance dated July 27, 2006 was issued. This guidance defines "other long term care services" subject to the homestead equity limit as including:

i. "A level of care in an institution equivalent to nursing facility services," COMMENT: This essentially means inpatient hospital "alternate level of care"

ii. Home and community based services under a waiver under section 1915(c) or (d) (Lombardi and other waivers), and

iii. Services for a non-institutionalized individual that are described in section 1905(a) of the Act [42 U.S.C. § 1396d] paragraphs:

¶ (7) home health care services (CHHA),

¶ (22) home and community care (to the extent allowed and as defined in section 1929 [42 USCS § 1396t]) for functionally disabled elderly individuals; NOTE: NYS does not have this type of waiver,

and

¶ (24) personal care services (home attendant in NYC)

iv. Other long term care services for which Medicaid is otherwise available, but only if a state has elected to apply the transfer of asset penalties to these services under section 1917(c) [42 USC 1396p*]. Since New York does not penalize transfers for other services, this section does not apply*.

B. Because of this more limited definition in the CMS guidance, the following services that the ADM lists as "long term care services" should NOT be subject to the home equity limit:

i. Medical model adult day care

ii. Private duty nursing

iii. Consumer-directed personal assistance program (CDPAP)

iv. Hospice

v. Personal Emergency Response System (PERS)

vi. Managed long term care program,

vii. Assisted Living Program (ALP). NOTE: While theoretically it is true that this service should not be subject to the home equity limit for the above reason, in practice, the homestead of an ALP resident will be a countable asset, not exempt, because she does not live in the home. If the ALP resident has a spouse, minor or disabled child living in the couple's home, the home is exempt from the equity limit anyway.

3. NO MORE APPLICATIONS FOR "FULL" MEDICAID COVERAGE -- INCLUDING NURSING HOME AND WAIVERED SERVICES -- FOR PEOPLE NOT CURRENTLY IN NEED OF THOSE SERVICES -- After Aug. 1, 2006, applications for a determination of eligibility for nursing home/ waiver services, with the 36-month (or 60 month) lookback will no longer be accepted unless the applicant is actually in need of those services. ADM p. 11. Before, someone applying in the community, whether at a CASA or regular Medicaid office in NYC, had the option of doing the full 36-month lookback even though they currently sought only community-based care, such as home care. They might have done it just to get it over with, knowing they may be going into a nursing home soon. This will no longer be permitted, but people who did that before get an extra bonus --

A. If someone who applied in the community was already determined eligible for "full" Medicaid, including nursing home/waivered services, they will NOT have to go through the new process once they do enter a nursing home or waiver program. These are called "Undercare" cases. ADM p. 11. The ADM does not give a date, but presumably they must have been determined eligible for full Medicaid as of Aug. 1, 2006. This benefit will only help those who made transfers after Feb. 8, 2006 and have already been determined eligible, since transfers made before that date are evaluated under the old rules anyway.

4. PENALTY PERIOD CONTINUES TO RUN IF LEAVE NURSING HOME, OR IF DENIED WAIVER SERVICES BECAUSE OF PENALTY -- Some good news: "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 nursing home program, apply and have application rejected because of the transfer penalty, then LEAVE the nursing home program, and the penalty period will run. While the penalty is running, there is no requirement that client pay for or even receive any services. Thus the penalty period will run even if client leaves nursing home and receives Medicaid home care - personal care, CHHA, Consumer-Directed -- or goes into a Medicaid assisted living program, or privately pays for care, while running out the penalty period.

A. APPLICATION OF THIS POICY TO LOMBARDI OR OTHER WAIVER SERVICES – This policy applies to waiver services, since they are part of "nursing facility services." If client is denied "waivered" services because of a transfer but she should be able to receive:

1. Medicaid home care services since they have no penalty, and while receiving them, the penalty should run.

2. Non-waiver services from the Lombardi or other waiver provider while she is running out the penalty period. This is because "non-waiver" services have been defined as community-based long term care services, not subject to a penalty. See discussion at Point 1.A.g. above of the definition at ADM p. 10. We do not yet know whether or how these programs will authorize a service plan with only non-waiver services.

3. Private pay services from any provider – need not be a CHHA or Lombardi /waiver provider

B. Under the ADM policy, the penalty may run and expire while the person denied nursing home or waiver services is receiving these "community-based" services. After the penalty expires, if she needs and applies for nursing home or waiver 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 or waiver program, then she is not eligible for those services until the remainder of the penalty has expired.

5. PARTIAL RETURN OF TRANSFERRED ASSETS -- The ADM at page 18 confirms that the policy stated in 96 ADM-8[2] regarding return of *part* of the transferred assets will continue. *Return of part of the assets will reduce the penalty period proportionally to the amount returned.* However, the ADM gives an example to point out that this policy does not allow a "rule of halves" transfer. In the example, half of the transferred assets are returned to the applicant at the time he applies for Medicaid in the nursing home. While the partial return of the assets does reduce the transfer penalty by half, the application will be denied because she is not "otherwise eligible" when she is in possession of the returned assets. The penalty on the assets that were *not* returned will *not* start running. When the returned assets are spent down, she must reapply. At that time she will now be "otherwise eligible" and the penalty on the half of the assets that were not returned will start running. If the transferred assets are not still available to pay the nursing home, she either has to resist the nursing home's attempts to discharge her for failure to pay through the penalty period OR return to the community and access Medicaid for home care, assisted living, and/or other community-based services to ride out the penalty period.

6. Definition of "Undue Hardship" for Transfer of Asset Penalty -- DRA 6011(d) requires each state to provide a process for granting a waiver if denying Medicaid would constitute an "undue hardship."

A. Definition of "Undue Hardship" in DRA -- Denying Medicaid because of the transfer penalty would deprive the individual of:

1. Medical care such that her health or life would be endangered if nursing home care is denied;

2. Food, clothing, shelter or other necessities of life

B. In the federal CMS guidance issued July 27, 2006, CMS does not further define the criteria in the DRA, but says that states have "considerable flexibility in deciding the circumstances…" that would constitute undue hardship.

C. State definition -- Existing state regulations, 96-ADM-8[3], and the new ADM state that undue hardship cannot be claimed:

1. IF BEST EFFORTS HAVE NOT BEEN MADE TO HAVE ASSETS RETURNED -- The individual must show she has made best efforts to have the

[2] ADM # 96 OMM/ADM-8 *OBRA '93 Transfer and Trust Provisions*

[3] ADM # 96 OMM/ADM-8 *OBRA '93 Transfer and Trust Provisions*

assets returned or sold for fair market value.[4] The applicant must cooperate to the best of her ability, as determined by the local district, in having the assets returned. Cooperation is defined as providing all legal records and other information about the transfer. 18 NYCRR §§ 360- 4.4(d)(2)(iii); New ADM p. 20; 96-ADM-8 at 23.

2. "if, 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." 96-ADM-8 p. 23, new ADM p. 20.

    a. This language does not specify whether, for a couple, the community income or resource limits are used or the spousal impoverishment levels.

3. "if the only undue hardship that would result is the individual's or the individual's spouse's inability to maintain a pre-existing life style." 96-ADM-8 p. 23, new ADM p. 20.

    a. COMMENT: The harsh limitations in (2) and (3) are only in the ADM's, not in state regulation. Though they have been state policy since at least 1996, the onerousness of these limitations may only be apparent now - with the delayed transfer penalties. The limitation in (2), especially, may violate the new criteria for hardship in the DRA.

    b. A "hardship waiver" has always been very difficult to obtain, and cannot be counted on.

4. PROCEDURE -- The DRA requires the state to establish a procedure for requesting a waiver, with the right to a hearing if it is denied. Strangely, the new state law designates the Office of Temporary & Disability Assistance, rather than the Dept of Health, to give notice of the procedure for requesting a waiver to new applicants. SSL 366, subd. 5(e)(4)(iv).

    a. A "nursing facility," may request a waiver on the resident's behalf. This right should extend to waiver programs.

        Bed hold payments -- New York State has exercised the option in the DRA for a nursing facility to qualify for payment for 30 days of care to hold the bed while a waiver request is pending. SSL 366, subd. 5(e)(4)(iv). The DRA directs CMS to develop criteria for bedholds, which the state law references. Unfortunately, the CMS guidance issued July 27, 2006 has no such criteria.

    b. State procedure - The new ADM at pp. 20-21 says that the individual, spouse, representative or nursing facility may apply for a waiver at the time of application, with consent. The determination must be made in the same time that the application is processed, and notice of denial may be appealed at a hearing.

[4] 18 NYCRR §§ 360- 4.10(a)(11), -4.4(c)(2)(ii). See also 96-ADM-8, pp. 23-24 http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/96adm8.pdf , new ADM p. 20.

Recipients of "limited coverage" -- apparently meaning Medicaid for home care but not for nursing home care -- may request consideration of hardship to obtain nursing facility services at any time during the penalty period. The hardship determination may be retroactive back to 3 months prior to the month in which the request for review of hardship is made. ADM p. 21

7. STEPS OF DETERMINING ELIGIBILITY AND ASSET PENALTY FOR APPLICANTS IN NURSING HOMES or WAIVER PROGRAMS:

A. The new ADM at pp 12-16 details the steps in determining financial eligibility and assessing the penalty.

B. APPLICATION ONE - STEP ONE -- Application for Medicaid filed for coverage of nursing home or waiver services. Note that this may only be filed when person has already been admitted to nursing home, or is in need of waiver services. This step determines whether the individual is "otherwise eligible" for Medicaid for nursing home or waiver care.

1. Resource eligibility -- Does the institutionalized individual have resources that exceed the individual resource limit ($4150 - 2006), after disregards have been applied, after the community spouse resource allowance has been deducted for married couples, and after given an opportunity to establish an irrevocable pre-need funeral agreement? If she still has excess resources, if s/he has medical bills that offset the excess amount, she is resource-eligible, and you go on to evaluate income eligibility. If unpaid medical bills are less than the amount of her excess resources, stop here.

   a. NOTE: Since client is not on Medicaid yet, the unpaid nursing home bill is at the higher private rate, not the Medicaid rate. This higher unpaid medical bill may help her get past this threshold.

2. Income eligibility -- For this initial eligibility determination, community and not "chronic care" budgeting is used. This is consistent with current practice for initial budgeting before the person is in "permanent absence" status. See Medicaid Reference Guide p. 230. This means that the community-budgeting SSI-related income disregards are used, and the excess income is the amount over the community income level for one ($692 - 2006). The community spouse's income is not counted in this budget, and no community spouse income allowance is allotted at this stage. New ADM p. 13. The spousal income allowance is calculated only at "step three" below.

   a. If the unpaid medical bills (those not used to offset the excess resources and are not paid by Medicare or another third party) exceed the excess income, the individual is income-eligible. If the excess income is enough to pay the unpaid bills, including the nursing home bill, then the individual is not "otherwise eligible" for Medicaid.

3. POSSIBLE ELIGIBILITY OUTCOMES OF STEP ONE:

   a. If Financially Ineligible – Application for nursing home/ waiver services is denied with notice. NO review is done of transfers in the lookback period.

Even if there were no disqualifying transfers, the person is simply not eligible anyway. If there *were* disqualifying transfers, the penalty could not begin running because the person is not currently "otherwise eligible."

b. If Financially Eligible (p. 14) - District does lookback (Step Two).

C. APPLICATION ONE - STEP TWO - LOOKBACK REVIEW of ASSETS & DETERMINATION OF TRANSFER PENALTY (ADM p. 14)

1. As predicted, the lookback will continue to be 36 months (and 60 months for transfers into trusts) until February 1, 2009, when it will begin to increase to 60 months in one-month increments. ADM p. 14.

2. The ADM gives examples of calculation of the penalty period. The only one that illustrates a point not obvious in the DRA is Example 3 on pp. 16-17, which shows that in some cases ADVANCE 10-DAY NOTICE must be provided before a penalty is imposed. This example is of a transfer made *after* the date of institutionalization and application for Medicaid. The way this occurs in the example is that the institutionalized individual, already on Medicaid while in a nursing home, made a transfer by declining his right of election of his spouse's estate.[5] This situation could also occur if the nursing home resident settles a lawsuit or receives an inheritance.

   The penalty should begin the month following the month of the transfer, since this is later than 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…."[6]

   The ADM makes the point that ADVANCE 10-DAY NOTICE is required of the determination of the penalty period and of the date that the penalty period would begin. Since this notice may not be retroactive, the penalty period may have to begin running later than it otherwise would. In the example, if the transfer was in July 2006, the penalty should theoretically begin running in August 2006. However, if the district first learns about this transfer in September 2006, it must give notice 10 days before Oct. 1, 2006 in order to begin the penalty period on that date.

3. If non-exempt transfers are identified in the lookback period, the application for nursing home care will be denied. The notice is called "Notice of Limited Coverage," and approves coverage for community Medicaid, while denying nursing home coverage and giving notice of the transfer penalty. See Attachments III and IV of new ADM.

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[5] This example shows another change in state policy regarding determination of the date of transfer for a failure to exercise a right of election. See Point below.

[6] 42 U.S.C. 1396p(1)(D)(ii), as added by Sec. 6011 of the Deficit Reduction Act.

a. Attachment III is for people who did not receive any form of Medicaid before, and approves "limited coverage," indicating the amount of the spend-down, if any.

b. Attachment IV is for someone who had community Medicaid and is now given "limited coverage" in that the request for nursing home/waiver Medicaid is denied. This notice is confusing.

c. These notices specify the amount of the transfer and the number of months in the penalty. Though the notices do not specify the date on which the penalty begins, they do have a space for the end date of the penalty. It is not clear whether this blank must be filled in, or is optional.

d. Attachment V is the notice of decision on request for Undue Hardship.

4. Once the notices have been issued determining the transfer penalty, the penalty begins to run. As stated in Point 4 above, the penalty will continue to run even if the individual leaves the nursing home. For waiver applicants denied because of a transfer, they may wait out the penalty period by receiving "non-waiver" services from the waiver provider, or by receiving other community-based Medicaid home care services, or if they receive no Medicaid services at all. See above, Point 1.A.g.

D. APPLICATION ONE - STEP THREE -- If there is no penalty because no transfers were made in the lookback period, or because the transfers were exempt, or if undue hardship was found, the next step is to determine the budget. The ADM does not describe Step Three, since this step has not changed from before the DRA. In this step, chronic care budgeting would be used. ADM p.15 (top of page). For married couples, the spousal impoverishment income and resource allowances would be determined.

NOTE: While not a change from current rules, the State's emphasis on the use of "chronic care/ post-eligibility budgeting" reflects a recent bad trend. The distinction between post-eligibility budgeting and the community budgeting used in "Step One" to determine "eligibility" in a nursing home has recently been used by the State to deny persons under age 65, who are in nursing homes or waiver programs, the right to place their excess income into a Supplemental Needs Trust to eliminate their contribution to the cost of care. *Matter of J.S.,* FH No. 4457519H, dated 7/21/06 (Aytan Bellin, counsel for Appellant). The rationale is that in post-eligibility budgeting, income excluded in step one "eligibility" budgeting – such as income placed into an SNT – is not excluded in post-eligibility budgeting.

E. APPLICATION TWO – If the first application was denied after Step Two because of a transfer penalty, once the transfer penalty runs out, the same person must file a second application for nursing home or waiver care if she still needs it. In the meantime, during the penalty period, she could have had someone pay for her care, left the nursing home and received Medicaid or private home care or assisted living services, or received "non-waiver" services in a waiver program.

8. "**Short Term Rehabilitation Benefit**" -- This benefit was created by statute in 2002, and allows limited days of Medicaid coverage of rehabilitation in a nursing home within the *community* Medicaid benefit -- without having to file the 36-60 month application that would trigger the transfer penalty. This benefit is one short-term nursing home admission, up to a maximum of 29 *consecutive* days in a twelve-month period.[7]

i. Though the new DRA ADM does not list this benefit as one of the "community based long term care services" that is not subject to the transfer penalty, it implicitly acknowledges that this benefit is not subject to the penalty. ADM at 18. If the initial days of a nursing home stay were covered under this benefit, the lookback period would be the period immediately preceding the month the short-term rehab service began. The transfer penalty for an "otherwise eligible" individual (which anyone receiving the short-term rehab benefit must be) would begin in the first month the short-term rehab service began. While the ADM does not say so, presumably the penalty does not bar coverage of the rehab benefit, but begins when it expires.

ii. NOTICE -- The ADM at 18 provides that if, when someone receiving the short-term rehab benefit then applies for "full" Medicaid nursing home coverage, and a transfer penalty is imposed, since this is a reduction in benefits, the district must give 10-day advance notice before imposing the penalty. However, if the 29-day rehab benefit has already ended, the 10-day notice requirement does not apply.

As a practical matter, it is doubtful that anyone would ever be entitled to the 10-day notice. The full nursing home application with the lookback and penalty determination will never be completed within the 29-day benefit.

More information about the 29-day benefit -- unaffected by the DRA - is below.

iii. **The 29 days must be *consecutive***. Client cannot spread it over two or more rehab stays in a year. EX: Client was in a nursing home rehab program, where she applied for and used part of the Medicaid rehab benefit. After only 15 days, she was sent back to the hospital for a week, and then went back to the nursing home for more rehab. The 14 remaining days from her 1st stay, of the 29-day maximum, are lost and cannot be carried over to her 2nd rehab stay. She would not qualify until the next year. She would have to do 36-month (60 month in 2009) resource documentation to receive more nursing home care after the hospital stay.

iv. **The 29-day short-term rehabilitation begins** on the first day the applicant/recipient is admitted to a nursing home on *other than a permanent basis*, regardless of whether the client has Medicare or other insurance to pay for the early part of the stay, *IF the client applies for Medicaid during that stay.*

Example: Susan is admitted to a nursing home for rehabilitation on November 8, 2004. Medicare covers November 8 through 27 (20 days) in full. Medicaid

[7] SSL § 366-a(2)(enacted 2002), 18 NYCRR 360-2.3(c)(3) (eff. 2/25/05), 04 OMM/ ADM-6, ADM # 04 OMM/ADM-6, GIS 05 MA 004 , 05 OMM-INF-2 June 8, 2005. (Q & A).

coverage for short-term rehabilitation is available starting November 28 through December 6 (the remaining 9 days of the short-term rehabilitation allowance).

Note: If Susan was not in receipt of Medicaid upon admission and applied for Medicaid coverage to begin December 1 (not retroactive to November), November 8th would still count as Day One of the short-term rehabilitation.

Exception - If an individual does not apply for Medicaid coverage for a nursing home admission, that commencement/ admission is **not counted** toward the one commencement/admission limit per 12-month period. In the above example, if Susan had been in rehab in May of the same year, but did not apply for Medicaid during that stay, the full 29 days for that year would still be available for the current stay in November.

iv. **TIP --** Before client applies for Medicaid for nursing home care using the 29-day short-term Medicaid benefit, consider::

a. Whether Medicare and Medigap are expected to pay for most of the stay.

(1) If so, don't apply and waste the 29-day benefit.

(2) If Medicare won't pay for the full stay, and/or client doesn't have Medigap nursing home co-insurance, need to predict how long a stay might be to decide if it is worth applying for Medicaid for that stay

b. Likelihood that client will have a 2nd nursing home admission in the same year for which she'll need Medicaid – If so, then may not want to use up the benefit now, and wait to apply for it later. If it is very late in the year, so that it is less likely she will be admitted a 2nd time, it is more worth it to use this benefit. OR if for other reasons the risk of a 2nd nursing home stay in the same year is unlikely.

Example of Beating the Odds: Mrs. S applies for Medicaid coverage for a six-week nursing home stay which began on September 4, 2004. Six months ago she had a short-term nursing home stay but did not apply for Medicaid, expecting it to be less than 20 days and fully covered by Medicare. Medicaid coverage for short-term rehabilitation is available starting September 4, 2004, even if Medicare covers the first 20 days in full.

Example of Losing the Gamble: The same Mrs. S had the same short-term stay six months ago. She applied for Medicaid for that stay, just in case she'd stay more than 20 days. She has no Medigap insurance so was concerned about the $119/day co-insurance (2006). She left on Day 22, so Medicaid paid the coinsurance for 2 days using the short-term rehab benefit. For the 6-week nursing home stay beginning on Sept. 4, 2004, she has NO short-term Medicaid rehab coverage, even though she only used 2 days in the last stay. The days must be consecutive. She will have to do the full 36-to 60-month lookback to qualify for Medicaid to supplement the Medicare coverage. Next year she will have a new 29-day benefit.

c. Considerations under DRA -- Now that we know that the transfer penalty will start running even if client leaves the nursing home –

(1) If client has a transfer penalty, she may want to apply for Medicaid to have the penalty be determined and to have it start running, if she intends to return home after a short rehab stay. Once the transfer penalty is determined, and client goes home, penalty will continue to run while at home. The downside of this is that client is liable for the cost of care during the short term stay, to the extent that Medicare, Medigap, and the 29-day Medicaid rehab benefit were exhausted.

(a) Practical consideration -- Medicaid applications take months to process. If client leaves nursing home while Medicaid application is still pending, for Medicaid to cover the closed period of her admission, will the penalty still run in the same way while she is at home, once the notice of the penalty is issued retroactively?

(2) Conversely, if client does NOT want to trigger the transfer penalty, perhaps because she is near the end of the 3 – 5 year lookback period for a particular transfer, she will not want to apply for Medicaid during a short-term stay, and would want to rely on Medicare, Medigap, and private pay.

v. **Spend down cases** - One only needs to meet a one-month spend-down requirement for Medicaid payment for each month during a 29-day period of short-term rehab. If the period spans 2 calendar months, one must meet the spend down for each of the 2 months. Note that the 6-month spend-down requirement for hospital care does not apply. 04 OMM/ ADM-6 p. 10 and 05 OMM-INF-2 June 8, 2005.

9. Home Equity Limit – Prohibition of Transfer of Proceeds of Reverse Mortgage

The ADM at p. 25 states that if an individual takes out a reverse mortgage or home equity loan to reduce the equity in their home, the payments are not counted in the month of receipt for eligibity purposes. This is consistent with.. However, the ADM states, "...if the funds are transferred during the month of receipt, the transfer is to be considered a transfer for less than fair market value." The State Medicaid Reference Guide [MRG] has long stated that the loan is exempt as income in the month received but counts as a resource if retained into the next month. MRG p. 105. The new policy appears to be based on this interpretation, since if the loan counts as a resource if retained in the following month, then transfer of a countable resource incurs a penalty. However, the new ADM would penalize a transfer of the loan *during* the month of receipt, when it is exempt income. Moreover, both the MRG and the new ADM policy may be inconsistent with Real Property Law 131-x, which provides, "the proceeds of a reverse mortgage loan made in conformity with the requirements of Real Property Law 280 or 280a or exempted therefrom ... shall not be considered as income or resources of the mortgagor for any purpose under any law relating to . . . medical assistance...."

10. DATE OF TRANSFER for FAILURE TO EXERCISE RIGHT OF ELECTION –

Example 3 on p. 16 of the ADM involves a transfer penalty imposed on the failure to exercise a right of election. The ADM states that the date of transfer is "[t]he last date the institutionalized individual could have pursued his elective share...." This differs from policy in

previous case law, which uses the date of death as the date of transfer. *Estate of Dionisio v. Westchester County Department of Social Services* , 244 A.D.2d 483, 665 N.Y.S.2d 904 (2d Dep't 1997)(The date of transfer was considered to be the decedent's date of death). Since under the DRA, a penalty now runs from the date one applies for and eligible for Medicaid in a nursing home or waiver program, not from the date of transfer, the impact of this policy change is unclear. If the death was before Feb. 8, 2006 or, if later, more than 5 years before the Medicaid application was filed, it could be significant.

11. Purchase of Life Estate in Another's Home –

The DRA provides that a "...purchase of a life estate interest in another individual's home" is not a transfer of assets if the purchaser resides in the home for at lest one year after the date of purchase. 42 USC 1396p(C)(1)(J). The implementing state law tracks this language. SSL, subd. 5 (e)(3)(ii). The ADM at pp.23-24 speaks more broadly, arguably permitting purchase a life estate interest in any "property" owned by another individual, rather than limited to a "home" of another individual. Since such broad language would be inconsistent with both the federal and state law, it is presumably an error in drafting.

12. CMS Guidance on Spousal Impoverishment "Income First" Rule--

The CMS guidance concerning section 6013 of the DRA, called "Application of the Spousal Impoverishment 'Income First' Rule," implements the DRA requirement that makes the "income first" method mandatory for al States. States must allocate the maximum available income from the institutionalized spouse to the community spouse before granting an increase in the CSRA. The Guidance provides steps States "*may"* use where an increase in the CSRA is requested on the basis that additional resources are needed to generate the monthly maintenance needs allowance. If, after counting income generated by the community spouse's own assets and income from the institutionalized spouse, there is still a shortfall in the community spouse's income, the State is to determine the amount of increased resources needed to generate income t meet the shortfall.

> ". . . In making this calculation, States may use any reasonable method for determining the amount of resources necessary to generate adequate income, including adjusting the CSRA to the amount a person would have to invest in a single premium annuity to generate the needed income..."

CMS Guidance, Page 4, No. 5 <http://www.cms.hhs.gov/smdl/smd/list.asp> (scroll to Transfer of Assets Guidance dated July 27, 2006

The problem with this procedure is that an annuity returns principal as well as income. Unless they are planning to split out the income portion of the annuity payment in some way, by using this method they are essentially counting resources as both resources and income. In fact, a state court recently held that the state and local Medicaid programs lack authority to limit the amount of an enhanced CSRA to the amount required to purchase a single premium life annuity which generates a monthly payment sufficient to raise the community spouse's income to the MMMNA. *Berg v Novello et al* (No. 1681/0)(Supreme Ct. Sullivan Co., Sackett, J. March 1, 2006); see also *Parks vs. Moon* (No.122885) (Supreme Ct. Sullivan Co., Feb. 14, 2006) While the Guidance states that methods like the annuity calculation are offered for "illustrative purposes" only, and "do not preclude States from applying the income-first methodology in a different manner or sequence," the CMS stamp of approval on this method may be harmful.

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