PIERRO, CONNOR & STRAUSS, LLC

Trusted Counsel

2023 NEW YORK MEDICAID PLANNING GUIDE

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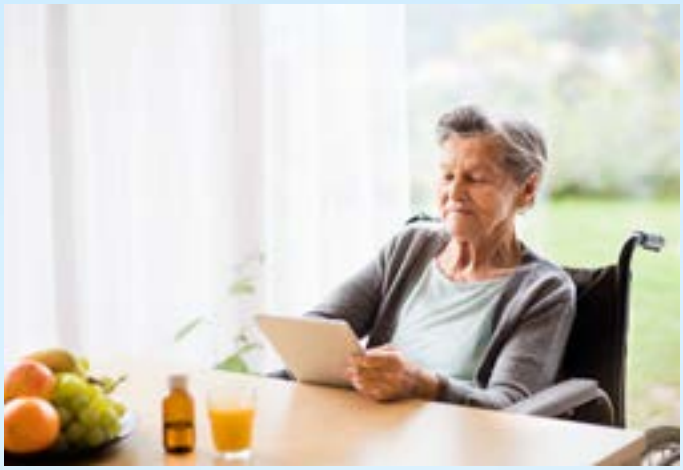
I. INTRODUCTION

Your Home…or the Nursing Home? Where do you prefer to live as you age?



The majority of Americans answers yes to the first option: home, according to an AARP study. A slim minority would choose a nursing home setting. It is one of those situations where we feel "It could never happen to me". Studies show that approximately two out of every five people reaching age 65 will need some type of long-term care. Without proper long-term care planning, the lack of available services and the staggering price-tag may leave you and your family with few alternatives.

What is Long-Term Care? Long-term care involves a variety of services which help meet both the medical and non-medical needs of people with chronic illness, disability or advanced age who cannot care for themselves. Long-term care can be assistance with normal daily tasks like dressing, bathing, meal preparation and using the bathroom, or medical care that requires the expertise of skilled practitioners to address the multiple chronic conditions associated with older populations. Long- term care can be provided at home, in the community, in assisted living or in nursing homes. People of any age may need long-term care, although it is a common need for senior citizens.

In New York State, the annual cost of nursing home care ranges from approximately $175,000.00 to over $225,000.00, and it is climbing each year! That is an average of over $500 per day. If you choose to stay at home, where most of us would prefer to be, and hire home health aides, the cost of your care could be even more. Home health care costs vary widely, but agencies charge anywhere from $22 to $30 per hour for companions and personal care aides. In some cases, people pay over $250,000.00 per year for 24 hour-a-day home care.

The Medicare Myth. What many people fail to realize is that their health insurance and Medicare will not cover the cost of long- term care, whether at home, in assisted living or in a nurs-

ing facility. ***Paying for long-term care is a personal responsibility which has become a burden for all age groups across New York and the nation.***

II. MEDICAID

If an individual has insufficient income to private pay for care, and does not have or cannot get a long-term care insurance policy, the only option available is Medicaid. Unlike Medicare, Medicaid is a government program which pays both medical costs and long-term care costs. However, Medicaid is designed as a payor of last resort and to qualify you must meet strict financial and other eligibility requirements. The rules governing Medicaid are complex, and frequently change, requiring great care in the planning and application for benefits. That does not have to happen, however, and we have helped hundreds of clients navigate the "minefield" of the Medicaid planning and filing process.

For decades, New York residents seeking long-term care in their homes have reaped the benefits of one of the most generous Medicaid Home Care programs in the nation. Over the past few years, however, lawmakers and the Department of Health have implemented new rules that restrict eligibility. In this Guide, you'll learn about the rollout of those changes currently in place and future restrictions to come.
If you or a loved one is in need of Medicaid, please contact our office to schedule a consultation. As described below there are excellent planning options available for long-term care, but under the new Medicaid eligibility rules, waiting to plan is NOT one of those options.

a. Medicaid Income & Resource Limits

In 2023, New York raised the required maximum levels of income and resources to become eligible dramatically. This allows applicants to keep more of the money they take in from social security, pension, retirement distributions and in some cases, business income. An individual may retain $1,583 of <u>income</u> per month, but if that individual is in a nursing home, he / she is entitled to keep only a $50/month allowance. An individual applying for Medicaid can have $28,133 in total <u>assets</u>, plus an irrevocable burial fund of any reasonable amount and certain exempt assets (a car, IRA, clothing, etc). If the individual owns a home that is occupied by a spouse, his or her child who is under the age of 21, or certified blind or disabled, the home is not included in the total asset calculation and is not subject to

a Medicaid lien. If the individual owns a home that is not occupied by one of those protected people, the home may be subject to a Medicaid lien. It may also be subject to an estate recovery action by the State if it is included in the Medicaid recipient's probate estate at the time of death.

If the Medicaid applicant is married, and enters a nursing home while the other spouse remains in the community, the "community spouse" may keep $74,820 in assets, in addition to the home, while the institutionalized spouse still keeps $28.133. The spouse in the nursing home is entitled to keep only a $50.00 per month allowance while the "community spouse" is allowed a minimum income of $3,715.50 per month, with adjustments for certain items. Without proper planning, all assets and income above these levels must be spent on care or on exempt items before Medicaid will become available.

b. Changing Home Care Rules

Even though home care applicants can today keep more of their income and assets when applying for Medicaid, they will deal with new restrictions in obtaining the needed hours of care or 'immediate needs' for care. Here is a summary:

In Effect as of May 16th, 2022 For Managed Long Term Care Enrollment And All New Requests For The Personal Care Services Program And CDPAP (Consumer Directed Personal Assistance Program) (Standard Timeframe)

New Independent Assessor

In-home care services must be prescribed by an independent physician approved by the New York State Department of Health, rather than the applicant's current medical provider. This created new challenges as applicants are forced to arrange an assessment with an unknown medical provider who is unfamiliar with their long-term health, past history and family situation. As a result there have been delays in processing applications.

New Independent Practitioner Panel and New Independent Review Panel if > 12 hours are Needed

A new assessment tool was implemented to help Medicaid providers and local departments of social services determine the number of hours needed for in- home care.

The new tool is supposed to identify how the needs of Medicaid recipients can be met through telehealth, family and social support. However, if Medicaid will be leaning on new telehealth options, this presents a new unknown piece as to how Medicaid will be administered in the future.

In Effect as of December 1, 2022 for "Immediate Needs" Requests, Expedited Personal Care And CDPAP

Immediate Need applicants who apply to their local Department of Social Services (HRA in NYC) for a Fast-Track Application for Medicaid and Home Care must use the Independent Assessor (outlined above) to qualify. Includes Personal Care and CDPAP. Adults in mainstream managed care plans (for people without Medicare) newly requesting approval Personal Care or CDPAP services from these plans, where request is made on an expedited timeframe (72 hours-17 days) also have to follow the above procedures.

Medical Information Needed to Qualify for Community Medicaid (Home Care):

An individual must meet medical criteria as well as financial criteria to be eligible for Community Medicaid. An applicant is required to need assistance with at least two "Activities of Daily Living" (ADLs) to be eligible for Medicaid benefits at home. The applicant must require supervision with more than one ADL if the individual has an Alzheimer's or dementia diagnosis. The ADLs commonly include:

1. **Bathing**
2. **Personal Hygiene**
3. **Dressing (Upper Body / Lower Body)**
4. **Walking / Locomotion**
5. **Transfer to Toilet**
6. **Toilet Use / Incontinence Care**
7. **Bed Mobility – Turn & Position**
8. **Eating**
9. **Walking / Locomotion**

There are also "Level II" personal care tasks that may be factored into eligibility stan-

dards. Examples of Level II tasks include:

1. **Administration of Medications**
2. **Preparation of meals with modified diets**
3. **Providing routine skin care**
4. **Changing of simple dressings**

In addition, in-home care services must be prescribed by an independent physician approved by the New York State Department of Health, rather than the applicant's current medical provider. This will create new challenges as applicants will be forced to arrange an assessment with an unknown medical provider who is unfamiliar with their long-term health, past history and family situation.

Spousal Refusal Still an Option

A bright spot here is that the planning opportunity known as Spousal Refusal is still available. This means that a Medicaid applicant's eligibility for Medicaid (in home or nursing home) does not take into consideration the assets or income of his or her "community" spouse, who often still lives in the home.

Navigating these Changes

Navigating the maze of community care requires an in-depth knowledge of the services available in the home, and in adult homes and assisted living facilities. We work closely with our clients to coordinate care in the proper setting, and to manage income and resources to maximize their value, while utilizing Medicaid services wherever available to supplement the care provided by the individual's family.

Community-based Medicaid services are available through several programs, including the Personal Care Aide ("PCA") program, the Consumer Directed Personal Assistance Program ("CDPAP"), the Nursing Home Transition and Diversion Waiver ("NHTD"), and traditional home care. Generally, however, Medicaid does not pay for adult home or assisted living care (with limited exceptions), which under existing rules must be paid for privately.

Medicaid recipients are required to enroll in a Managed Long-Term Care Program (MLTC). An MLTC company is a private insurance company that receives a fee from Medicaid to approve and provide home care services. The MLTC takes over the role of the local Medicaid/ DSS office in completion of the home care assessment and the determination of many hours of care you need. The MLTC then arranges with home care providers it has contracted with to provide the care to you in your home. The new MLTC rules are complex, and you should work with an experienced Elder Law Attorney

to help navigate the system.

In order to access community-based care, an individual is allowed to keep the same $28,133 in total assets, but he/she may also retain the home in which they live along with the other exempt assets listed above. Recipients of Medicaid home care are allotted an income allowance of $1,697 per month, $2,126 for a couple living at home. Income over the allowance is technically available to Medicaid, but rather than spending it down, an alternative is to contribute the excess income to a "Pooled Trust." The Pooled Trust can then be used to pay other expenses necessary to live in the community. The Pooled Trust is an excellent planning tool, allowing all income to be used to support the Medicaid recipient at home. Detailed information on the various home care programs, and the planning available to access community-based Medicaid, is available upon request.

c. Transfer of Asset Rules: Changes Coming

What if an individual gives asset away in order to qualify for Medicaid?
As you might expect, there are rules governing such transfers. When one gives money or property away, that individual and their spouse will be ineligible for Medicaid for a certain number of months, known as the "penalty period." For nursing home applicants, the lookback remains at five years. For Home Care, there is currently no lookback, but that is changing:

Expanded "Lookback" for Community-Based Long-Term Care Services

Prior to October 1, 2020, there was no lookback for Community Medicaid (Medicaid Home Care). This meant that elder law attorneys could help families complete planning immediately, and long-term care services could typically begin in the home within a few months.

However as early as April 2024, the new rules will impose a 30-month lookback period for transfer of assets of the Medicaid applicant in order to be eligible for Community Medicaid. For example, if an applicant applies for Medicaid home care in May of 2024, the lookback period may be imposed on all transfer of assets made after November 1, 2021. But if a Medicaid application is filed prior to enactment of this rule, there will be no lookback period applied for transfers made before that date.

While we are still getting clarification from New York State on some of the details involved with the new 30-month lookback, this change will be dire for seniors. Instead of

getting needed care in the comfort of home, seniors who have failed to plan will be ineligible to receive help at home immediately and will be forced to spend down life savings and / or privately pay during a penalty period before Medicaid is available.

Are there Exceptions?
Exceptions are made for transfers to a spouse or a disabled child and for certain transfers of the home to siblings or caretaker children. How far back does Medicaid look to find asset transfers, or what is the "lookback" period? When applying for "nursing home" Medicaid, the Department of Social Services will ask for financial records, bank statements, tax returns, etc. for the past 60 months (5 Years), and will examine all transactions within that time frame. Starting in approximately April 2024, there will be a phased-in lookback period which will reach 30 months. All transactions for homecare applications will be scrutinized, just like nursing home applications.

Where Does This Leave You or a Loved One?

There is still a short period of time to take advantage of current favorable rules to qualify for Medicaid before the new, harsher rules take effect sometime in 2024, most likely in April.

If you have completed your long-term care or Medicaid planning before October 1, 2020, or move quickly before these laws take effect, Pierro, Connor & Strauss can help you or your loved one do the planning necessary to qualify for Medicaid benefits without a period of ineligibility. A thorough analysis of all transactions within either lookback period must be undertaken prior to filing for Medicaid, and a "paper trail" provided to DSS.

How is the Penalty Period Calculated?

The penalty period for non-exempt transfers is calculated by dividing the total value of all assets transferred by the average monthly cost of nursing home care in your area, called the "Monthly Regional Rate". The State determines this "average" each year for different regions across New York State. See Appendix A for a list of 2023 NY Regional Rates.

Example 1: Nursing Home Medicaid
Mr. Smith, who is single and lives in New York City and who needs to be placed in a nursing home, transferred a bank account and savings bonds worth $494,970 to his two nephews in 2015 to help pay for their college tuition. Mr. Smith enters a nursing home, and once reaching the $30,182 asset limit applies for Medicaid in May 2023.

There is NO resulting penalty period.

Why? The transfer of his assets was completed 7+ years ago and is now outside the look

back period. Had Mr. Smith waited until 2019 to transfer his assets, the resulting penalty period would be 35 months.

$494,970 (value of transfer made within look-back period)
divided by $14,142 (2023 NYC Regional Rate) = 35-month penalty period.

The penalty period does not begin to run until the applicant meets 3 conditions:

i. He or she enters skilled nursing care;
ii. He or she has $28,133 or less of countable assets; and
iii. He or she actually applies for Medicaid

Example 2: Patricia, a widow who lives in the Capital District and is applying for Medicaid Home Care with these factors:

- Income $3,000/ Month
- Assets
  - IRA $75,000
  - Savings & Checking $80,182
  - Home $250,000
  - $100K in Stock

Patricia's retained Pierro, Connor & Strauss for legal planning to become eligible. Since her income is higher than the $1,697 allowed, the attorneys helped her create a Pooled Trust for excess income over that amount each month. Funds in the Trust, held by a charity, can be used to pay Patricia's expenses for multiple needs, including pre-paid burial, mortgage, utility and tax payments, home improvements, food, additional care if Medicaid isn't providing all that is needed, and monthly service costs for in-home technology that Patricia's children want in order to communicate with her and a care manager.

The attorneys also designed a Medicaid Asset Protection Trust for Patricia's assets over the $28,133 allowed. Patricia transferred her home, stock and $50,000 into the Trust. This planning then qualified Patricia for Medicaid by the 1st of the next month. At that time, Patricia's children and care manager worked the Medicaid assessment process to obtain the approved number of hours of home care that would be paid by Medicaid. The amount of services is determined by several assessments done by the New York State Independent Assessor (NYIA) and other medical providers. Services would be ex-

pected to start within three or so months of her approval.

d. Other Medicaid Rules

How Does Medicaid Treat Jointly Held Assets?

If assets are held in an account by a Medicaid applicant and another individual as "joint" owners, and funds are withdrawn by either individual, it may count in full as a transfer against the Medicaid applicant. For example, withdrawal of funds from a "joint" bank account by the child of a Medicaid applicant will be treated as though the Medicaid applicant parent had transferred all the funds to the child. In addition, funds held in a joint account in a bank or similar financial institution will be presumed by the Department of Social Services to be owned entirely by the applicant. If both signatures are required to withdraw funds (i.e., brokerage accounts require all named owners to sign), however, only ½ of the value will be counted as belonging to the applicant. Each asset must be evaluated to determine ownership and ownership rights prior to filing a Medicaid application.

How Does Medicaid Treat Trusts?

If assets are held in a revocable trust, they are considered fully available for Medicaid purposes. An individual who establishes an irrevocable trust (sometimes known as a "Medicaid Asset Protection Trust" or MAPT), will protect the assets held by the trust after the expiration of the applicable penalty period imposed as a result of the transfer of property into the trust. Income generated by assets held in an irrevocable trust will usually be available to the Grantor, and considered available to pay for the cost of long-term care. Decisions regarding the use of a trust as part of a Medicaid plan require careful review of an individual's circumstances, as discussed below.

Can Medicaid Recover from a Beneficiary's Estate?

Under Federal Law, states are required to seek recovery of benefits paid to a Medicaid recipient from his or her estate. It has been left to each individual state to determine what assets will be included in the "Medicaid estate," which could conceivably include assets which are exempt during life and other partial transfers, such as deeds with retained life estates.

New York State has traditionally defined "estate" as the "probate" estate only (meaning assets only in the individual name of the decedent where there is no beneficiary designation) -- those assets passing by will or by intestacy (where there is no will). Thus, only probate assets are subject to recovery. There have been proposals to expand the right of recovery to non- probate assets. Such proposals have not been adopted but changes may be adopted in the future because of budgetary problems.

Can Medicaid Recover from a Community Spouse's Estate?

If assets are held by a community spouse, the state may have rights to recover for Med-

icaid paid on behalf of the Medicaid recipient spouse from amounts that exceed the Community spouse's "Resource Allowance." These rules are evolving, and must be analyzed in each case.

Are There any Exceptions to the Medicaid Transfer of Asset Penalty Rules?
Yes. A person who needs Medicaid is permitted to transfer her or his assets without triggering the transfer of asset penalty rules to the following persons:

1. A spouse
2. A child with disabilities
3. A blind child
4. A trust for the sole benefit of one of the above
5. Where an undue hardship exists

What does Medicaid Consider an "Undue Hardship?"
New York State is required to establish procedures to determine whether the denial of Medicaid eligibility would pose an undue hardship on an applicant. If an individual makes transfers "innocently," which disqualify him or her from receiving Medicaid, the state may waive the eligibility requirements if:

i. The applicant meets the other eligibility requirements;
ii. The applicant or his or her spouse is unable to get the transferred assets back, despite his or her best efforts; and
iii. The applicant cannot get appropriate medical care that would endanger his or her health or life if Medicaid did not pay for nursing home care or the penalty period would deprive the applicant of food, clothes, shelter or other necessities of life.
As a practical matter, these hardship exceptions are difficult to prove and not often granted.

III. PLANNING FOR LONG-TERM CARE

a. Use of Trusts

If long-term care insurance is not an option, and personal income and resources are not sufficient to pay the future costs of Long-Term Care, the most popular planning technique is to transfer assets into a Medicaid Asset Protection Trust (MAPT), retaining the income for the "Grantor", and preserving the principal of the assets (the assets held by the "Trustee") for a spouse, children or other beneficiaries. When properly drafted, the trust will provide asset protection along with significant tax benefits, including avoidance of gift taxes, elimination of capital gains taxes, and maintenance of real property tax exemptions (NY STAR). In addition, using a trust can avoid the need for a family to go through probate which can be costly and time consuming.

The MAPT does allow the Trustee to access the principal of the trust during the Grantor's lifetime for the benefit of the Grantor's children or other beneficiaries, although the Trustee cannot give the principal directly to the Grantor. The remaining principal will go to the beneficiaries upon death of the Grantor. Most Grantors also choose to maintain the right (called a Special Power of Appointment) to change the ultimate beneficiaries of the trust, by "reappointing" the assets to different family members at a later date. This power retains control for the Grantor, and prevents transfers to the trust from being treated as taxable gifts.

A properly drafted MAPT is an "income-only" trust, which provides a valuable long-term care planning tool, to preserve assets, provide income, ensure favorable tax treatment and allow the Creator of the MAPT to maintain control of the Trustee and Beneficiaries. Therefore, a senior doing estate planning may keep the income from an irrevocable, "income only" trust for himself or herself, with the remainder distributable to specific beneficiaries, and qualify for Medicaid (once the applicable "penalty period" for has expired) without the assets in the trust being considered by the Department of Social Services as available to pay for the cost of long-term care.

b. How The MAPT Works

Trustee – manages trust assets for the Beneficiaries
Client – income for life and right to use real property
Heirs = Remaindermen -inherit when trust ends

What Goes into the Trust:
- Home
- Bank Accounts Stocks & Bonds
- Annuities
- Life Insurance
- Business
- Real Estate

Mandatory or discretionary income
Principal can NOT be given back to the client directly.

KEEP OUT
Cash, Bank Accounts, IRA, 401K

Security Features
- Choose initial Trustee, and change at any time.
- Choose initial beneficiaries, and change at any time

- With the consent of all beneficiaries, in some jurisdictions the trust can be “amended or revoked”

c. Crisis Planning for Nursing Home or Home Care

Even if someone needs long term care imminently, planning opportunities still exist to protect a substantial portion of the applicant’s assets (generally approximating half of non- exempt assets). Proper use of the Medicaid transfer rules allows individuals to provide security for themselves and a legacy to their families, while ensuring that they will receive quality long- term care. Pierro, Connor & Strauss can advise families on the use of creative planning, such as

Promissory Notes and Private Annuities, as vehicles which permit gifts and transfers when an unplanned situation is encountered by the family. Proactive planning is always a better solution, but we understand that families do not always realize the need to plan until a crisis presents itself.

d. Creative Planning for Home Care

Medicaid benefits for home care are a well-kept secret, and Pierro, Connor & Strauss prides itself on being proactive advocates for our clients who wish to stay in their own home.

Caution must be exercised, however, because while home health care may be appropriate initially, the individual’s condition may deteriorate to the point where he or she cannot be safely maintained at home and skilled nursing facility placement may be required. If this higher level of care is needed, a new application is required, and the harsher Medicaid transfer rules - the 5- year lookback - will be imposed. Thus, when planning for home care, the possible need for institutional services must be evaluated before transfers are made.

Moving in with a relative or family member may also be an option for a senior. There are several programs available through Medicaid to help pay for personal care aides and home health aides to replace and/or supplement care provided by family. In addition, a senior can put in place a Caregiver Agreement and/or Personal Service Contract to make a transfer to a family member as compensation for their agreement to provide home care services.

e. Life Care Management

In the past, families facing a senior crisis could count on help from a variety of sources, including hospital social workers, discharge planning nurses or home care assistants. These positions have been virtually eliminated, however, due to cost-cutting measures in the health care system. Comprehensive planning assistance for families and follow-through services for newly discharged older persons have all but disappeared from the hospital scene.

This is where a Life Care Coordinator ("LCC") becomes a vital cog in the planning wheel. The professional LCC conducts a comprehensive clinical assessment of the long-term care needs. This includes consideration of all financial and other resources available to sustain the individual at the highest possible level of independence. After a thorough assessment, a plan is developed and care management is then coordinated by the LCC, with the legal and financial plan coordinated by Pierro, Connor & Strauss.

We have found that our clients benefit from the LCC's varied contacts and vast knowledge of the local health care system, and we have integrated LCC services into Long-Term Care Planning so the LCC and attorney work as a team to develop and follow through on a long-term care plan to ensure success.

IV. WHAT THE FUTURE HOLDS

The crisis in health care and long-term care will shape public policy for years to come. It has become clear that individuals need to make their own plans for long-term care, such as nursing home and home health care. The Government faces continuing pressure to limit expenditures on existing programs, including Medicare and Medicaid.

Reforms of Medicare, Social Security and Medicaid have risen to the top of the government's agenda in Washington, DC, Albany and every county in the state. It is thus imperative that seniors, those approaching retirement age, and the families of those needing long-term care take advantage of the planning opportunities that exist today. Everyone's situation is unique, and although this outline provides valuable information, it is impossible to discuss all of the planning opportunities in this outline.

As with any planning, a good way to begin is to seek competent advice from a qualified professional. At, Pierro, Connor & Strauss we are dedicated to helping you find solutions to your long- term care concerns. Please call us at for a consultation or visit us on the web at www.pierrolaw.com.

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APPENDIX A: 2023 NYS MEDICAID REGIONAL RATES

REGION	COUNTIES	2023	2022	2021
New York City	Bronx, Kings (Brooklyn), NY (Manhattan), Queens, Richmond (Staten Island)	$14,142	$13,415	$13,037
Long Island	Nassau, Suffolk	$14,136	$14,012	$13,834
Northern Metropolitan	Duchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	$13,906	$13,389	$13,206
Western (Buffalo)	Alleghany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	$12,130	$11,884	$11,054
Northeastern (Albany)	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	$12,744	$12,560	$11,689
Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates	$13,421	$13,376	$13,020
Central (Syracuse/Utica)	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins	$11,726	$11,328	$10,857

Use the region in which the individual resides or in which the facility is located. For out of state facilities, use the region closest to the location of the facility.

LOCATIONS

CAPITAL REGION
43 British American Boulevard
Latham, NY 12110
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