TAX LAW AND ESTATE PLANNING SERIES
Tax Law and Practice
Course Handbook Series
Number D-489

29th Annual Elder Law Institute

Co-Chairs
Jeffrey G. Abrandt
Douglas J. Chu

To order this book, call (800) 260-4PLI or fax us at (800) 321-0093. Ask our Customer Service Department for PLI Order Number 185776, Dept. BAV5.

Practising Law Institute
1177 Avenue of the Americas
New York, New York 10036

1

Douglas J. Chu, Ch.6: Medicaid for the Elderly, Blind, or Disabled, Practising Law Institute, New York Elder Law (September 2015)

Douglas J. Chu

Hynes & Chu LLP

Reprinted from the PLI Legal Treatise, New York Elder Law (Order #587)

If you find this article helpful, you can learn more about the subject by going to www.pli.edu to view the on demand program or segment for which it was written.

Chapter 6

Medicaid for the Elderly, Blind, or Disabled

by
Douglas J. Chu, J.D.

Douglas J. Chu has been involved in the area of Elder Law since 1990. Before becoming a partner at the firm of Hynes and Chu, LLP, he was the Senior Staff Attorney for the Brookdale Center on Aging of Hunter College from 1990 to 1999, where he specialized in Medicaid eligibility and government entitlements. Mr. Chu was also the Attorney in Charge of the Evelyn Frank Legal Services Program at Selfhelp Community Services, Inc. from 1995 to 1999. In addition to maintaining a legal practice specializing in Elder Law, Mr. Chu is a regular lecturer for the Alzheimer's Association of New York City, the New York State Bar Association, the Practising Law Institute, and the National Constitution Center. He is the current Co-Chair of the Practising Law Institute's Annual Elder Law Institute (1999 to present). Mr. Chu is also the current Co-Chair of the New York City Citywide Medicaid Advisory Council (1997 to present). A graduate of Rutgers Law School (Camden), Mr. Chu is admitted to the Bars of New York, New Jersey, and Washington, D.C. Before entering the field of Elder Law, Mr. Chu was involved in the area of white collar criminal defense work in Washington, D.C.

§ 6:1 Introduction

This chapter has been designed to provide useful information and guidance to attorneys and advocates who are involved with establishing and maintaining eligibility in the New York State Medicaid program for the elderly, blind, or disabled. This chapter does *not* cover the recent expansion of Medicaid to many people under the age of sixty-five under the Affordable Care Act (also known as the MAGI ("Modified Adjusted Gross Income") population).[1] The information contained in this chapter is current as of the date this chapter is published. Attorneys and advocates are cautioned to stay current with program changes which may take place after the publication of this chapter.

The Medicaid Program is very complicated, and the application process is often compared to completing an income tax return. To make the subject matter manageable this chapter progresses from the basic components of Medicaid eligibility (services covered, income and resources rules, citizenship, etc.) to the more complicated technical issues (transfers, spousal impoverishment, liens, etc.). The procedures and regulations necessary to applying for Medicaid "home-care" services are found in chapter 7. No single chapter can cover every aspect of Medicaid eligibility, for this reason only the most common and useful subjects and topics have been selected for discussion.

§ 6:2 Background and Description of the Medicaid Program

Medicaid is a joint federal-state program administered by local governments; it was established by the federal government in 1965.[2] Its purpose is to provide payment for a comprehensive range of medical

---

1. On January 1, 2014, New York State expanded its Medicaid program to many individuals under the age of sixty-five under the Affordable Care Act. The newly eligible individuals are known as the MAGI population, because their eligibility for Medicaid is determined by their "Modified Adjusted Gross Income."
2. 42 U.S.C. §§ 1396 *et seq*. The Medicaid program must be distinguished from the Medicare program. Medicare is the non-needs-based federal health insurance program for the aged and disabled established under Title XVIII of the Social Security Act. 42 U.S.C. §§ 1395 *et seq*. Medicare is structured as a health insurance system with eligibility linked to Social Security eligibility.

services for persons with low income and resources. It is a "means-tested" program; that is, applicants for Medicaid must show financial need by meeting certain income and resource guidelines.

The federal government reimburses states for a portion of their Medicaid expenditures.[3] In New York, the federal share is about 50%. The remaining costs are shared by the state and local governments.

While the federal government sets the guidelines for Medicaid, each state designs its own particular program within the limits of federal law and regulations. Therefore, Medicaid programs vary greatly from state to state. This chapter covers only the New York State Medicaid program for the elderly, blind, and disabled. The Medicaid rules and regulations discussed and cited in this chapter should not be applied to Medicaid applicants or recipients in other states.

The Medicaid program recently went through a major change in how it pays for and delivers services. On September 4, 2012, the federal government approved a federal waiver that allows NYS to require all community-based long-term care to be provided through a network of Managed Long-Term Care (MLTC) plans.[4] The result is that NYS Medicaid has changed from "fee-for-service"[5] program to a "capitated rate"[6] program, where an MLTC plan will be paid a flat monthly fee to provide home health care services to each member of the plan. All Medicaid applicants who wish to receive personal care, home attendant, long-term Certified Home Health Agency services, or coverage for permanent nursing home placement will be required to enroll in an MLTC plan. The MLTC plan will determine how much care is provided and how it is delivered. These MLTC plans have taken over the job previously undertaken by the local CASA (local Medicaid

---

3. 42 U.S.C. § 1396(a)(1); 42 U.S.C. § 1369d(b).
4. N.Y. Soc. Servs. L. § 364-j (Amended L. 2011, ch. 59); 18 N.Y. Comp. Codes R. & Regs. §360; DOHHS Letter approving Medicaid section 1115 demonstration waiver, dated August 31, 2012.
5. Prior to this change, the Medicaid program was a third-party payment program, which enabled a Medicaid recipient to receive medical services and have the bill sent to the state Medicaid program for payment.
6. A "capitated rate" means that the Managed Long-Term Care plan that will provide home care for the Medicaid recipient will receive a single monthly payment (a capped amount) each month to provide all the care necessary for that individual Medicaid recipient. The concern is that under this change an MLTC can actually make more money if they provide less services.

offices). Medicaid recipients must receive their long-term home health care services through the network of providers that contract with the MLTC plan they have chosen. For a complete discussion of how the new Home Care MLTC program works, see chapter 7 of this handbook.

Once approved for Medicaid, each recipient will receive a plastic identification card that will reflect to which MLTC plan the recipient has been enrolled, and if home care services are being provided. Medicaid will continue to pay doctors, hospitals, and nursing homes directly, even if the Medicaid recipient has enrolled in an MLTC plan.

Medicaid will not pay for services of a provider who has not registered in the Medicaid program. Providers who participate in the Medicaid program must accept all Medicaid recipients as patients. Before obtaining treatment, recipients should be sure to find out whether the provider they intend to use accepts Medicaid. If the provider does not accept Medicaid, the recipient of services will be personally liable to pay for the cost of services provided.

At the federal level, the Department of Health and Human Services (DHHS), through the Health Care Financing Administration (HCFA), issues regulations and guidelines and monitors state compliance with federal laws and rules.[7] DHHS publishes the *State Medical Assistance Manual* for use by the states in administering the program.[8] There have been two major revisions of the Federal Medicaid Law since it was established in 1965. The first revision was the Omnibus Budget Reconciliation Act of 1993 (OBRA '93),[9] which was passed by Congress and signed into law on August 10, 1993 (these changes were enacted in the 1994 New York State Budget Bill[10] and became effective for all Medicaid applicants on or after September 1, 1994).[11] The second revision was by the Deficit Reduction Act of

---

7. 42 U.S.C. §§ 1396 *et seq.*; 42 C.F.R. §§ 430 *et seq.*
8. State Medicaid Manual, Part 3—Eligibility, effective Dec. 13, 1994. Transmittal No. 64, Date: November 1994 (HCFA-Pub. 45-3).
9. Omnibus Budget Reconciliation Act of 1993 (H.R. 2264), Pub. L. No. 103-66.
10. Chapter 170 of the Laws of 1994 (Senate 8599-A11854). The Medicaid provisions are contained in §§ 449–55 (see § 57 for effective dates).
11. Different effective dates apply to transfer of assets and to trusts under the New York State Budget of 1994. In its continuing effort to clarify implementation of OBRA '93 in New York, the Department of Social

2005 (DRA '05) and the Tax Relief and Health Care Act of 2006[12] (these changes were adopted as part of the 2006 New York State Budget[13]).

At the state level, the New York State Department of Health (DOH) is the agency responsible for issuing regulations and guidelines for Medicaid eligibility and coverage through their Office of Medicaid Management.[14] The DOH also supplements and clarifies its regulations and guidelines by issuing New York State Administrative Directives (OMM/ADM) and Informational Letters (OMM/INF).[15] Administrative Directives and Informational Letters (known as ADMs and INFs) are instructional manuals which explain how Medicaid regulations and policies are to be implemented at the local level. ADMs and INFs are two of the primary sources of information on how the Medicaid program works at the local level.

Local agencies are responsible for the day-to-day administration of the Medicaid program. In New York City, the local agency is known as the Medical Assistance Program (MAP), an agency within the Human Resources Administration (HRA). Elsewhere within New York State, the county Departments of Social Services (DSS) continue to administer Medicaid. The New York City MAP publishes its own Procedures and Info Letters to clarify the city's interpretation and implementation of Medicaid rules and regulations.

Identifying the sources of authority is important because there is a hierarchy of authority. Federal laws (statutes) have greater weight than state statutes. State statutes have more authority than state regulations, which, in turn, have more weight than local administrative directives or informational letters.

Services has issued an administrative directive (ADM) entitled "OBRA '93 Provisions on Transfers and Trusts" (96 ADM-8), issued on Mar. 29, 1996. The relevant portions of this ADM are cited where appropriate in this chapter.

12. Deficit Reduction Act (DRA) of 2005, Pub. L. No. 109-171.
13. 2006 N.Y. Laws 57 and 2006 N.Y. Laws 109. The N.Y.S. Department of Health issued their interpretation of the DRA in 06 OMM/ADM-5.
14. N.Y. SOC. SERV. LAW §§ 363 *et seq*. (as amended by chapter 165 of the Laws of 1991, chapter 938 of the Laws of 1990, and chapter 41 of the Laws of 1992); N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-1 *et seq*.
15. Both Administrative Directives (ADMs) and Informationals (INFs) contain specific information about the procedures to be followed by the local Medicaid agency in particular cases.

The advocate should also be aware of the Medicaid Reference Guide (MRG).[16] This is the desk reference guide used by all Medicaid intake personnel when processing applications. The MRG explains how the intake worker should deal with a large variety of issues covered by Medicaid regulations, for example, the income and resources of the Medicaid applicant. The MRG covers the most commonly encountered questions regarding income and resources, and it provides citations to the *New York Code of Rules and Regulations* as well as the state's ADMs (Administrative Directives).

§ 6:2.1 Internet Resources

The following is a list of website resources for Medicaid-related information:

1. New York State Medicaid Plan
   www.hcfa.gov/medicaid/stateplan/toc.asp?state=NY
2. N.Y. State Medicaid Reference Guide (MRG)
   www.health.state.ny.us/nysdoh/medicaid/mrg/index.htm
3. N.Y. State Admin. Directives, GIS, Local Commr's Memos
   www.wnylc.net/web/welfare-law/otda-materials.htm
4. Fed. Medicaid Regulations—42 C.F.R.
   www.access.gpo.gov/nara/cfr/cfr-table-search.html or
   www.wnylc.net/web/welfare-law/statutes-regulations/federal-misc.htm
5. State regulations—titles 10 (Dep't of Health) and 18 (Medicaid Regulations)
   www.health.state.ny.us/us/nysdoh/phform/phforum.htm
6. N.Y. State Bar Association Website—Elder Law Section
   www.nysba.org
7. New York Health Access—A website for not-for-profit advocates for the aging www.wnylc.com

---

16. Medicaid Reference Guide, *available at* www.health.ny.gov/health_care/medicaid/reference/mrg/.

§ 6:3 Eligibility Categories

Medicaid is generally thought of as an assistance program for the poor, but it does not cover all poor people. Applicants for Medicaid must first fit into one of the categories of eligibility described below. The financial eligibility requirements may vary for the different categories.

§ 6:3.1 Supplemental Security Income (SSI) Recipients[17]

Some applicants are "automatically" or "categorically" eligible for Medicaid benefits because they receive cash benefits under Supplemental Security Income (SSI), which is the federal assistance program for the aged, blind, or disabled.[18] There are, however, certain situations where individuals may become ineligible for SSI and still remain eligible for the Medicaid program. Individuals who become ineligible for SSI as a result of Social Security cost of living increases may still be eligible for Medicaid even though they are no longer receiving SSI or state supplemental payments.[19]

§ 6:3.2 Disability Claimants

Individuals who meet the standards used to determine eligibility for disability payments under the SSI and Social Security disability programs are also eligible for the Medicaid program.[20] Generally, if the Social Security Administration has determined that an individual is disabled, Medicaid accepts that determination and the individual is

---

17. N.Y. SOC. SERV. LAW § 360-3.3(a)(3).
18. 42 U.S.C. § 1396A(a)(10)(A)(i), § 1396c; N.Y. SOC. SERV. LAW § 366.1(a)(2); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-3.3(a)(3).
19. Four groups of individuals remain eligible for Medicaid even though no longer receiving SSI or state supplemental payments: those who have received the 20% increase in Social Security benefits (OASDI) in 1972, 42 U.S.C. § 1396; those who lost SSI or state supplementary payments due to OASDI benefits after April 1977 only because the increase was not deducted from income ("Pickle people"), 42 U.S.C. § 1396(a); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-3.3(c)(10); widows and widowers who lost Medicaid due to 1984 increases, 42 U.S.C. § 1396a(a)(10)(A)(1)(II), § 1383c(b); 87 ADM-29; and widows and widowers ages sixty to sixty-four as of Apr. 1, 1998, whose widows' benefits made them lose SSI ("Kennelly widows"), 42 U.S.C. § 1383c(d), § 1396a(a)(10(A)(i)(II).
20. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-5.1–360-5.9; 87 ADM-41. For a detailed description of the disability program, see *supra* chapter 3.

categorically eligible for Medicaid coverage as a disabled individual, regardless of their age. However, where there has been no previous determination of disability by Social Security Disability, Medicaid will have to make a determination about the applicant's disability before eligibility can be established.[21]

§ 6:3.3 Medically Needy Claimants

The "medically needy"[22] are those who do not receive cash grants under the SSI program. These individuals would be otherwise eligible for the SSI program, except that their income and/or resources are above the established income and resource limits established for the SSI program. Medically needy individuals who are age sixty-five or older are known as "SSI-related" by virtue of their age. Persons who are certified blind or certified disabled are also SSI-related. These medically needy individuals can qualify for Medicaid if they meet the financial income and resource limits set by New York State for the medically needy. The current income and resource levels for SSI-related individuals can be found in Appendix 6A.

Individuals with income above the allowable limits may still be eligible for medical assistance under the "income spenddown program," which allows the individual to contribute the surplus income toward the cost of medical care. (The income spenddown program is discussed later in this chapter.)

§ 6:3.4 Medicaid Buy-In Program for the Working Disabled

The "Medicaid Buy-In Program"[23] is designed to help those disabled working persons who are not eligible for traditional Medicaid because their income or resources exceed the allowable Medicaid (SSI Levels), yet they meet the medical criteria of having a disability. This program allows working disabled individuals to obtain Medicaid by

---

21. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-2.4(a)(2).
22. 42 U.S.C. § 1396(a)(10)(C); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-3.3(b).
23. Sections 62–69 of Part A of Chapter 1 of the New York State Health Workforce Recruitment and Retention Act of 2002 (signed into law 1/16/02); 03 OMM/ADM-4. For more information about the Medicaid Buy-In program, see Medicaid Buy-In program for Working People with Disabilities Toolkit, *available at* www.health.ny.gov/health_care/medicaid/program/buy_in/docs/working_people_with_disabilities_030413.pdf.

paying an out-of-pocket premium. All the Medicaid rules, regulations and services discussed in this chapter apply to participants eligible for this program, as long as they meet the following additional requirements:

- the Applicant must be certified disabled by the Social Security Administration;[24]
- he or she must be at least sixteen years of age, but under age sixty-five;
- he or she must be engaged in either part-time or full-time paid work;
- he or she must have a gross annual income at or below 250% of the federal poverty level (FPL);
- he or she may have non-exempt resources up to $20,000 for individuals and $30,000 for couples (homestead and car are exempt).

Once eligibility has been established, an out-of-pocket premium will be based upon the individual's "countable" income.

However, at this time no premiums are being collected from eligible applicants pending the implementation of an automated premium collection system.

The application process is handled through the local Department of Social Services (DSS) by completing the general public assistance application (form 2921). In addition the local DSS must conduct a face-to-face interview to ensure that the applicant meets the basic requirements of age, disability, and work, as well as income and resource limits. To learn more, visit the New York State Department of Health website and search, "Medicaid Buy-In Program" (www.health.ny.gov).

§ 6:4 Elderly, Blind, or Disabled

The first eligibility requirements for Medicaid eligibility is for the applicant to be either elderly, blind, or disabled.

---

24. Certified disabled under the SSI rules. If the individual receiving "Buy-In" is no longer considered disabled under the SSI rules, but continues to have a "severe" medically determined impairment, then coverage will continue under the "Medical Improvement Group" category (the individual must be employed at least forty hours a week and earn at least federal minimum wage).

§ 6:4.1 Elderly

An individual is considered elderly if they are sixty-five years of age or older.[25]

§ 6:4.2 Blind

To be considered blind an individual must be determined "legally blind" by the New York State Commission for the Blind.[26]

§ 6:4.3 Disabled

The standard used to establish disability for Medicaid eligibility purposes is the same as that used in determining disability for Supplemental Security Income (SSI) or Social Security Disability (SSD).[27] Therefore, a disability is defined as a physical or mental incapacity to perform any gainful employment, which is expected to last at least one year.

§ 6:5 What Medicaid Covers

This section describes the types of services covered by Medicaid, including the "sub-programs" which exist within the Medicaid Program. Once a Medicaid applicant is accepted into the program he or she will find that there are many separate sub-programs which have their own rules, regulations, and eligibility requirements.

§ 6:5.1 Provider Services

New York State Medicaid covers the costs of a wide range of provider services for qualified beneficiaries. These services can be grouped into three separate categories: community medical services, home care services, and institutional care services.

Community services[28] include the following:

- services of physicians "furnished in other than a hospital room or hospital based clinic, except for ambulatory surgery

---

25. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-3.3(b)(1).
26. *Id.* § 360-5.12.
27. *Id.* § 360-5.2(b); § 360-3.3(a)(3).
28. *See* N.Y. SOC. SERV. LAW § 365-a; N.Y. COMP. CODES R. & REGS. tit. 18, pts. 505–510.

services,"[29] dentists, nurses, optometrists, podiatrists,[30] and other related professional personnel;

- out-patient or clinic services;
- sickroom supplies, eyeglasses, and prosthetic appliances;
- rehabilitation services, including physical therapy, speech therapy, and occupational therapy;
- laboratory and x-ray services;
- transportation when essential to obtain medical care;[31] and
- prescription drugs, durable medical equipment, and sickroom supplies.

Home care services[32] include:

- nursing;
- home health aide services;
- physical, speech, and occupational therapy;
- personal care services; and
- care provided through the long-term home health care program (LTHHCP), popularly known as the "Lombardi" or "nursing home without walls" program.

Institutional care services[33] include care in hospitals, nursing homes, and other medical facilities.

---

29. 1995 N.Y.S. Budget § 75 (amending N.Y. SOC. SERV. LAW § 365-a.2.(a)(1), effective July 1, 1995).
30. Private podiatry services will be covered by Medicaid for those individuals who are enrolled in the Medicare program. For persons without Medicare coverage, some clinics may offer podiatry service. Letter dated May 1, 1992, to Medicaid recipients explaining changes in Medicaid from DSS. The statutory and regulatory language is confusing, as it appears to limit podiatry services to Medicare beneficiaries enrolled in the Medicare Buy-In program. N.Y. SOC. SERV. LAW § 365-a.2.(*l*); N.Y. COMP. CODES R. & REGS. tit. 18, § 505.12.
31. N.Y. SOC. SERV. LAW § 365-h, added in 1995 N.Y.S. Budget § 78, requires local Social Service commissioners to maximize cost savings for transportation by using free or public transportation where available and giving prior authorization for use of all Medicaid-reimbursed transportation services. N.Y. COMP. CODES R. & REGS. tit. 18, § 505.10, 92 ADM-21.
32. For a full description of Medicaid home care services and 1995 N.Y.S. Budget restrictions, see *infra* chapter 7.
33. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 505.9, 505.4.

Some of these services and supplies (for example, adult diapers or transportation) require prior agency approval for coverage and other services and supplies are covered only under certain conditions or limitations.[34]

§ 6:5.2 Medical Assistance Utilization Threshold Program (MUTS)[35]

Effective September 15, 1991, Medicaid implemented a program known as Medical Assistance Utilization Threshold (MUTS). "Utilization thresholds" are limitations on the number of physician/clinic, pharmacy, and laboratory services a Medicaid recipient may receive each year. Each time Medicaid recipients use one of the above-listed services their MUTS account is reduced by one point. If the Medicaid recipient runs out of points, they cannot receive the medical goods or services unless it is an emergency situation. This program applies only to outpatient services.

The purpose of utilization thresholds is to deter and prevent the unnecessary utilization of selected outpatient services, while insuring that most recipients of Medical Assistance still receive all the available medical services they need. This program may be a precursor to Medicaid Managed Care.

[A] Annual Limits

The following annual utilization thresholds ("points") apply to each elderly, blind, or disabled Medicaid recipients at the start of each year (anniversary of establishing eligibility):

- Ten physician and clinic visits, excluding the following services: anesthesiology, psychiatry, alcoholism/substance abuse treatment, and mental retardation or developmental disability treatment.
- Forty pharmacy items for those age sixty-five or older, certified disabled or blind. Each prescription, refilled prescription, prescription for a nonprescription drug, and medical or surgical

---

34. *See, e.g.*, N.Y. COMP. CODES R. & REGS. tit. 10, § 85.27 (limitations on drug reimbursements); N.Y. COMP. CODES R. & REGS. tit. 18, § 505.10(c) (prior authorization for transportation).

35. N.Y. SOC. SERV. LAW § 365-g; N.Y. COMP. CODES R. & REGS. tit. 18, § 511; MAP Informational 32/91; 91 ADM-22 (addressing the early version of MUTS, which applied only to the home relief population).

supply counts as a single item, and home care supplies such as adult diapers are included in the pharmacy limitations.

- Eighteen laboratory tests.
- Three dental clinic services.
- Forty mental health clinic services.

Each time the Medicaid uses goods or services from one of these categories, one point is deducted from their MUTS account.

[B] Programs and Services Exempt from MUTS

Within the MUTS program, certain programs and services are exempt from the threshold levels. Elderly, blind, or disabled individuals utilizing any of the following programs or services are not subject to having services or medical supplies counted under the MUTS program:[36]

- Managed care programs, that is, programs in which the medical care provided is coordinated by a single individual or facility such as health maintenance organizations (HMOs), preferred provider plans, and physician case management programs (call the HRA Info Line at 718-291-1900 for more information);
- Prior approved or authorized services, such as home care, long-term home health care (Lombardi) services, and nursing home care; and
- Hemodialysis services (except for related pharmacy items and laboratory tests).

Note that individual patients enrolled in these programs will continue to have MUTS limitations applied to any services which are provided outside the scope of the above listed programs and services.

[C] Need for Emergency Services

Regardless of a Medicaid recipient's threshold (points) status, a Medicaid provider can always provide "emergency" medical services or services for an "urgent medical need." This means that a doctor or pharmacist who is providing such emergency services should receive

36. N.Y. SOC. SERV. LAW § 365-g(5); N.Y. COMP. CODES R. & REGS. tit. 18, § 511.3.

compensation for such services even though the patient has run out of MUTS units or is awaiting a determination on an application for more annual units (see discussion below).

Emergency services are defined in the regulations as medical care, services, or supplies provided for a sudden medical condition which, if left untreated, could result in impairment or dysfunction of bodily parts or organs or otherwise place a recipient's health in serious jeopardy.[37] An urgent medical need exists when an active medical problem, if left untreated, could increase the severity of the symptoms, increase the recovery time, or result in an emergency.[38]

Doctors and pharmacies obtain reimbursement for these emergency services by indicating on their reimbursement forms that the service was furnished for a medical emergency or urgent medical need. Each emergency service is counted towards the Medicaid recipient's threshold limit as long as the recipient continues to have service units available. Once the recipient has reached his or her utilization threshold, services will continue to be provided for emergencies and urgent medical needs without being counted against the recipient's threshold limits.

[D] Requesting Additional Service Units or Exemption

When a Medicaid beneficiary is nearing his or her threshold limit and is running out of MUTS units, Medicaid alerts the beneficiary by letter. A second Medicaid letter is sent when the beneficiary has indeed reached the annual limit. Beneficiaries should be advised to take these letters to their doctors, who will submit them with an "override application." Medicaid providers should have the necessary forms for such applications. Doctors must complete an override application to request increases for physician/clinic visits, pharmacy items, or laboratory tests.[39]

Additionally, if the Medicaid beneficiary has a chronic medical condition that requires ongoing and frequent medical care, services, or supplies, the Medicaid provider should consider applying for either an override or a total "exemption" from the utilization program. An exemption means that Medicaid places no limits on the number of

---

37. N.Y. COMP. CODES R. & REGS. tit. 18, § 511.1(c)(4).
38. *Id.* § 511.1(c)(3).
39. The regulations also allow a physician's assistant, nurse practitioner, or nurse midwife to complete the override application. *Id.* § 511.6(a)(1)(ii).

services. The override application form can also be used to request exemptions. When completing the application for an increase in threshold limits, the doctor must specifically request an increase or exemption for one or more of the MUTS categories (physician/clinical, pharmacy, and/or laboratory test). A general request for extra services or an exemption will be inadequate. Sufficient factual data and medical evidence must be submitted to Medicaid to enable an objective determination regarding the increase or exemption. Applications for overrides or exemptions must be renewed each year.

When an override application is filed, an initial review is performed. Applications will be granted automatically if three conditions are satisfied:

(1) The amount of the additionally requested services does not exceed double the annual limits of the original utilization threshold established for that particular service;

(2) The override application is complete and the medical necessity for the override is properly certified by a participating physician, physician's assistant, nurse practitioner, or nurse midwife; and

(3) The Medicaid recipient has not previously been restricted by Medicaid.[40]

All override applications not approved under the initial review process are subject to a second level of review by a medical review team[41] which will have access to medical specialists for consultation on more complicated issues. The medical review team has full authority to investigate and review the override application in order to make a determination on the medical necessity of the requested increase or exemption, and it will also consider whether the Medicaid recipient should be referred to a managed care program.

At present, requests for total exemptions from the MUTS program *must* be approved when merely increasing the threshold amount is insufficient to meet the medical needs of a Medicaid recipient who has certain verifiable chronic conditions requiring ongoing medical attention.[42] For example, if an override application shows an HIV-related diagnosis or a need for hemodialysis, an exemption should be

40. *Id.* § 511.6(a)(1).
41. *Id.* § 511.6(a)(3).
42. *Id.* § 511.6(b)(3).

automatically granted for all services. For other chronic conditions, the requirement for more services must be documented by a physician.

[E] Override Application Process and Due Process

As with any Medicaid decision that could result in change or termination of benefits, certain due process rights attach to the review process when a Medicaid recipient submits an override application. (Due process rights are fully discussed in the last section of this chapter.)

Pending a determination on a submitted override application but prior to a fair hearing on the matter, a Medicaid recipient is automatically eligible for a package of additional service units consisting of two physician/clinic visits, six pharmacy items, and four laboratory tests if (1) the provider indicated on the application that the recipient has reached the utilization threshold; and (2) either the application was rejected during the initial review process (for reasons other than the inability to verify Medicaid eligibility status), or the application has been referred to the medical review team.[43]

Medicaid recipients are also eligible for a second package of additional service units (two physician/clinic visits, six pharmacy items, and four laboratory tests) when their override application has been denied, they have reached the utilization threshold, and they have requested a fair hearing within ten days of the mailing of the denial determination. Authorization for these additional services should appear in the computer system within ten working days after receipt of the request for a fair hearing.[44] While recipients can receive the second package of services by requesting a fair hearing, they do *not* have a right to "aid continuing"[45] pending the hearing decision. This means that no additional service units will be added until a fair hearing decision is made.

Medicaid must issue a written determination approving or partially approving an override application within twenty-five days of receipt of the application.[46] A copy of the written determination will be sent to the recipient and the provider. However, when Medicaid

---

43. *Id.* § 511.7(a).
44. *Id.* § 511.7(b).
45. *Id.* § 511.9(b)(3).
46. *Id.* § 511.8(c).

requests further information, the approval time is extended by the number of days from the date of the request to the date the information is supplied.[47] Override applications are deemed automatically approved if a determination is not reached within the twenty-five-day period.

To verify that an override application was received or to check on the status of the application, call the Computer Sciences Corporation (800-421-3893/3891).

§ 6:5.3 Copayment System

The copayment system is a nominal cost-sharing program instituted by Medicaid, and is similar to an insurance deductible. Under this system, most eligible Medicaid recipients are asked to make an out-of-pocket contribution toward the cost of the goods and services they receive under the Medicaid program.[48] Whenever a Medicaid recipient uses medical goods or services, Medicaid automatically reduces the payment made to the provider by the copayment amount. For a list of the copayment amounts and those goods and services that are exempt from copayments, see Appendix 6B.

[A] Inability to Pay Copayment

Collection of the copayment is the responsibility of the Medicaid provider. However, no provider may deny goods or services to an eligible individual who is unable to pay the copayment amount. Those Medicaid recipients who cannot afford to pay the copayment should inform the provider of medical goods or services that they are unable to pay. All Medicaid providers (clinics, pharmacies, laboratories, hospitals, etc.) are required by law to provide the needed drugs, tests, supplies, or medical services, even when an individual cannot afford to pay the copayment. Providers are not allowed to question the reason for the failure to pay and may not request any proof about whether an individual can afford a copayment.[49] Although providers cannot refuse goods or services to an individual who cannot afford the copayment, they are allowed to bill the individual directly for the amount of the copayment.

---

47. *Id.*
48. *Id.* § 360-7.12.
49. *Id.* § 360-7.12(f).

[B] Copayment Annual Cap

Currently there is an annual cap of $200.00 per Medicaid recipient for all copayments incurred. "Incurred" means that every copayment billed to the Medicaid recipient will count towards the annual cap, even if it remains unpaid. Once the annual cap is reached, Medicaid providers will no longer have their payments reduced by the copayment amount, nor will they be required to begin collecting copayments until the start of the next benefit year. The Medicaid computer system will inform providers when the cap has been reached. However, individuals should not rely on the Medicaid system to keep track of their copayments and should save all receipts from both paid and unpaid copayments. In addition, individuals who are on the "spend down" or "surplus income" program should save all copayment receipts because these payments count towards their spenddown in the next month. Even if the copayment is not paid, Medicaid recipients should ask for a bill showing that they have incurred the copayment, since an incurred medical expense counts towards a spenddown.

[C] Copayment Exemptions

Not all Medicaid recipients will be asked to pay copayments. Many Medicaid recipients are exempt from copayments and should never be charged a copayment. For an explanation of who is exempt from copayments, see Appendix 6C.

[D] Grievance Procedures

If a provider denies services to a Medicaid recipient who cannot pay the copayment, pressures the recipient to pay, or charges too much, the recipient should call the New York State Department of Social Services Hotline at 800-541-2831 and contact the local legal services or legal aid office. Fair hearings are not a remedy for a denial of services; fair hearings are only permitted to challenge Medicaid's determination of a date of birth or whether an individual is a member of an exempt group.

§ 6:5.4 Health Insurance Premiums

When a Medicaid recipient has third-party health insurance, such as a Medigap insurance policy, the Medicaid program may decide to pay part or all of the premium, deductibles, coinsurance, or other

cost-sharing obligation if it is deemed cost effective and economical to the Medicaid program.[50] Medicaid is the payor of last resort. This means that a Medicaid recipient must seek and receive all other medical coverage they are eligible to receive, before they can present any medical bills to Medicaid for payment.

[A] Employee Health Insurance

Medicaid recipients who are employed must be enrolled in their employer's group health plan, as long as no employee contribution is required.[51] If an employee contribution is required, Medicaid makes an evaluation as to whether it should pay to keep that coverage in place based on cost effectiveness.

For individuals who have lost their jobs and are eligible for COBRA health insurance continuation[52] from their former employer, Medicaid may pay for their COBRA premiums if they meet the required standards of income and resources for Medicaid eligibility.[53]

[B] Coverage for Medicare Premiums, Copayments, and Deductibles

Medicaid also provides varying amounts of financial assistance to Medicare beneficiaries. Generally known as the Medicare Savings Programs, these sub-programs within the Medicaid Program help qualified individuals pay some or all of the premiums, copayments, and deductibles associated with the Medicare Program. Individuals may apply for these programs without applying for full Medicaid coverage. A description of these programs follows.

---

50. N.Y. SOC. SERV. LAW § 367-a(1)(c); N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-3.2(d), 360-7.5(g). *See also* exempt income for health insurance premiums.
51. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-3.2(d).
52. The Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272 § 1000 (COBRA '85), provided that employers with twenty or more employees who maintain a group health plan must offer employees and their dependents the option to elect continuation of coverage under that plan, after certain qualifying events have occurred. Coverage may continue up to eighteen months. *See* 91 ADM-53.
53. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.5(h). *See also* 91 ADM-53 (COBRA); 91 ADM-54 (AIDS: Health Ins. Continuation).

[B][1] Qualified Medicare Beneficiary (QMB) Program[54]

Under this program, state Medicaid programs are required to "buy-in" or pay for the Medicare Part B premiums, Medicare Part A premiums (for individuals who would otherwise be required to pay part A premiums out of pocket), and certain Medicare deductibles and copayments for beneficiaries.[55] To be eligible for this program, clients must meet the following requirements:

- be entitled to Medicare Part A; and
- have incomes below 100% of the federal poverty line.

Since April 1, 2008, there is no resource limit in New York State. The current income and resource levels for QMB "buy-in" eligibility can be found in Appendix 6A at the end of this chapter.

[B][2] Specified Low Income Medicare Beneficiary (SLIMBs) Program[56]

Under this program, state Medicaid programs are required to "buy-in" or pay only the Medicare Part B premiums of individuals who:

- are entitled to Medicare Part B; and
- have income greater than 100% and less than 110% of the poverty level.

Since April 1, 2008, there is no resource limit in New York State. The current income and resource levels for QMB "buy-in" eligibility can be found in Appendix 6A at the end of this chapter.

[B][3] Qualified Individuals 1 (QI-1's)[57]

As a result of the Federal Balanced Budget Act of 1997, a new mandatory group of low income Medicare beneficiaries was created.

---

54. 42 U.S.C. § 139a(10)(E) and § 1396(d)(p)(l)(B); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.7 and -7.8; 90 ADM-6; 89 ADM-7 at 7; 89 INF-26.
55. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.8; *but see* N.Y. City Health & Hosp. Corp. v. Perales, 954 F.2d 854 (2d Cir. 1992) (federal court determined that for individuals who are both eligible for Medicaid and Medicare, Medicaid must pay the copayments and deductibles required under the Medicare program).
56. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.7(i); 93 ADM-30.
57. New York Chapter 33 of the Laws of 1999, implementing section 4732 of the Federal Balanced Budget Act of 1997.

The income eligibility level for this program is higher than those required for the SLIMB program described above. It is known as the "QI-1." Eligible individuals will have their full Medicare Part B premium paid.

This program is "capped," meaning there is fixed annual funding for the program. When those funds are used up for the year the program ends. Therefore, this program exists on a first-come first-served basis.

§ 6:6 Medicaid Application

The Medicaid applicant's first experience with the Department of Social Services is the application process. The following section explains the steps for which both the applicant and the advocate must be prepared as they embark upon that process. The application procedures for Medicaid home care services are briefly discussed in this chapter at section 6:10, and a more complete discussion can be found in chapter 7.

Individuals completing the Medicaid application have an obligation to be truthful and honest as they provide answers and documentation. This requirement applies to both the applicant and anyone who is assisting the applicant. To provide untrue information could be considered perjury and/or obtaining Medicaid by fraud, which could result in criminal prosecution and repayment to Medicaid for all Medicaid services received. However, it is equally important to remember to answer only the specific questions asked. There is no obligation to volunteer unnecessary information. In other words, do not tell Medicaid any more than they need to know to establish Medicaid eligibility. Many times you will find that too much information can unnecessarily delay an application for the simple reason that Medicaid will feel obligated to investigate all the information that was provided to them, even though it was never requested and would not effect Medicaid eligibility.

§ 6:6.1 Completing and Submitting an Application

Assuming that the applicant falls into one of the basic eligibility categories (over sixty-five,[58] blind,[59] or disabled[60]), any person,

---

58. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-3.3(b)(1).
59. *Id.* §§ 360-5.2(a), 5.12.
60. *See infra* notes 74 and 75; N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-5 *et seq.*; 87 ADM-41.

relative, or other representative acting on behalf of the individual or household may apply for Medicaid on a state-prescribed Medicaid application form, which is available from the local Department of Social Services Medicaid offices.[61] This means that once a Medicaid application is completed and signed by the applicant or signed on their behalf, it may be sent or hand-delivered to a Medicaid office. Please note that the application form must be an original, not a photocopy. As always, it is best to keep a photocopy of all papers submitted to the Medicaid office and, where possible, to obtain a receipt to prove the date of submission. Under the new Managed Long-Term Care (MLTC) Medicaid Program, applications may be submitted through an MLTC provider.

A common problem encountered when completing and submitting a Medicaid application is gathering the supporting documentation. While it is not the best practice to submit incomplete applications, incomplete applications are routinely accepted by Medicaid. Medicaid will then send a letter to the applicant requesting the missing documentation. The applicant will then have only two weeks to supply the requested documentation. While this has been the current practice, Medicaid continues to have the option to immediately deny an incomplete application once it is submitted for eligibility review.

§ 6:6.2 Presumptive Eligibility

Medicaid will authorize a period of presumptive eligibility[62] for persons in hospitals who are not currently receiving Medicaid, and who could receive necessary home health care, hospice, or nursing facility care and services if Medicaid were available to help offset the cost of such care. If the applicant meets the conditions for presumptive eligibility, presumptive eligibility begins on the date of the discharge from the hospital and continues for up to sixty days or until the standard eligibility determination is completed, whichever is earlier. The hospital must assist the client in the completing of the application (DSS-2921).

The ability to apply for and receive presumptive eligibility is often prevented or delayed because of a fear, on the part of the home care

---

61. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-2.2(d); 91 INF-19; *see also supra* note 1, regarding other individuals who may be eligible for Medicaid.
62. 97 ADM-10, N.Y. SOC. SERV. LAW § 364-i, and N.Y. COMP. CODES R. & REGS. tit. 18 § 360-3.7.

provider, that the applicant may be found ineligible "after" home care services are put in place. If the applicant is found to be ineligible in this situation, then the home care provider may have to continue services without receiving Medicaid reimbursement for their services.

The eligibility conditions for presumptive eligibility are:

(1) Applicant is receiving care in an acute care hospital at the time of application;

(2) A physician certifies there is no longer a need for acute hospital care, but requires medical care from a Certified Home Health Agency, Long-Term Home Health Care Program, nursing facility, or hospice;

(3) Applicant states that there is insufficient insurance coverage for the type of care needed and the applicant is unable to pay for the care on his or her own;

(4) It reasonably appears that the cost of care requested is less than 65% of the cost of continued hospital care computed at the Medicaid rates;[63] and

(5) The applicant reasonably appears to meet all the criteria, financial and nonfinancial, for Medicaid.

During the period of presumptive Medicaid eligibility, all Medicaid covered services will be covered except:

(1) Hospital-based clinic services;

(2) Hospital emergency room services;

(3) Acute hospital inpatient services (unless part of hospice); and

(4) Bed-hold for coverage of nursing facility services.

The decision on presumptive Medicaid eligibility must be mailed to the applicant within five working days of Medicaid's receipt of the application package, or by the discharge date if that date is later. This is to be followed by a routine Medicaid eligibility determination.

---

63. Sixty-five percent of the 1996 per diem rate for each region of New York: Northeastern ($80.29), Western ($74.28), Rochester ($83.05), Northern Metropolitan ($97.19), Long Island ($108.95), New York City ($123.50), and Central ($77.17). Alternate Level of Care rate: New York City/Metro Region ($192.54) and Upstate ($126.00).

Applicants who are denied presumptive eligibility are not entitled to a fair hearing. If, after being accepted with presumptive eligibility, the applicant is determined to be ineligible, he or she will be entitled to fair hearing rights but no aid continuing pending the fair hearing determination.

Any benefits paid on behalf of a presumptively eligible applicant who is later found to be ineligible will be subject to recoupment by Medicaid from the applicant.

§ 6:6.3 Face-to-Face Interview Eliminated

Effective April 1, 2013, Medicaid has eliminated the requirement of a face-to-face interview as part of the application process.[64] However, an applicant will continue to be required to submit proper proof of identity and citizenship.

§ 6:6.4 Required Documentation

Medicaid, like all means-tested programs, requires extensive documentation to establish eligibility. Proof is required to verify identity, age, residence, citizenship, disability (if the applicant is under sixty-five and is claiming to be disabled), marital status, income and resources, and assorted other personal facts.[65] A detailed list of required documents may be found in Appendix 6J. It is important to remember that both the advocate and applicant are obligated to provide accurate and complete information on income, resources, and other factors affecting the applicant's eligibility for medical assistance under the Medicaid program.[66] This obligation continues with respect to any new and relevant issues that may arise after the initial application is submitted to Medicaid. Minimal instructions are provided with the Medicaid application. The applicant must read the questions and decide what documents are being requested.

[A] Missing Documentation

If documents requested by the Medicaid agency are not obtainable, the applicant should present any available substitute documents or

---

64. *See* 10 OHIP/ADM-4, Elimination of the Personal Interview Requirement for Medicaid and Family Health Plus Applicants. *See also* Dep't Regs. § 360-2.2(f)(1).
65. 93 ADM-29.
66. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-2.3(a).

information which might serve as valid secondary information that would provide the information requested. It is always better to submit some piece of paper, even a letter or note of explanation, rather than giving Medicaid nothing in response to a document request. Additionally, an applicant should always keep copies of any documents submitted because documents are often lost or misplaced during the application process. The Medicaid agency is jointly responsible with the applicant for exploring all factors concerning eligibility and should assist the applicant where possible.[67]

[B] Resource Attestation (Verification of Countable Resources)

As of September 20, 2004,[68] Medicaid applicants/recipients who are subject to a resource test and who are *not* seeking coverage of long-term care services (nursing home coverage) are allowed to "attest" to the amount of their resources in order to qualify for short-term rehabilitation services.[69] Medicaid no longer processes applications under the "simplified resource review" process. Under these new rules, in certain situations, Medicaid will take the applicant's word for what resources they have and will not require them to supply resource documentation in support of their application for Medicaid services. The new attestation policy is similar to the old simplified applications for Medicaid and will have no real effect on the way individuals apply for home care services, as long as the applicant is not applying for long-term care services.

All individuals applying for Medicaid services will now fall into one of the three following categories:

1. Community Coverage Without Long-Term Care—requires a self-attestation to the amount of current resources;
2. Community Coverage With Community Based Long-Term Care—requires proof of current resources (or up to three months retroactive);[70] or

---

67. *Id.* § 360-2.3(a)(2).
68. DOH State of New York Dep't of Health, 05 OMM/INF-2 [Questions and Answers: Resource Attestation].
69. DOH State of New York Dep't of Health, 04 OMM/ADM-6 [Resource Documentation Requirements for Medicaid A/R's (Attestation of Resources)].
70. *See infra* section 6:6.6.

3. Medicaid coverage of all covered care and services (including nursing facility services)—requires a resource review for the past thirty-six months (sixty months for trusts).[71]

The application of attestation rules focuses on the definition of "Long-Term Care." For the purposes of attestation of resources rules, long-term care services include the following:

1. Nursing Facility Services: alternate level of care provided in a hospital, hospice in a nursing home, nursing home care (except for short-term rehabilitation),[72] intermediate care facility, home and community-based waiver services, or managed long-term care in a nursing home; or

2. Community-Based Long-Term Care Services: adult day health care (medical model), limited licensed home care, certified home health agency services (except for short-term rehabilitation),[73] hospice in the community, hospice residence program, personal care services, personal emergency response services, private duty nursing, consumer directed personal assistance program, assisted living program, managed long-term care in the community, residential treatment facility, home and community-based services waiver programs.[74]

When attesting to resources, Medicaid will still require disclosure of any trust agreement in which the applicant is named as the creator or beneficiary. Additionally, if an applicant has an irrevocable pre-need funeral agreement, a copy of the agreement must be provided to Medicaid for verification.

---

71. DOH State of New York Dep't of Health, 04 OMM/ADM-6 at 4.
72. Individuals who seek MA coverage for short-term rehabilitation services may attest to the amount of their resources. Short-term rehabilitation services include one commencement/admission in a twelve-month period, up to a maximum of twenty-nine consecutive days of each of the following: certified home health care and nursing home care. Beyond twenty-nine consecutive days would require submission of proof of his or her resources.
73. *Id*.
74. That is, long-term home health care program, traumatic brain injury waiver program, care at home waiver program, and Office of Mental Retardation and Developmental Disabilities home and community-based waiver program.

§ 6:6.5 Time for Determining Eligibility

The Medicaid agency is required to make an eligibility determination within forty-five days of the date of application.[75] A written notice of any decision, acceptance, or denial must then be sent to the applicant. The time is extended to ninety days if the basis of the application is disability.[76] In reality, however, a determination of eligibility often takes three months or more. The delays usually arise when Medicaid requests further information or documentation from the applicant. Such a request effectively stops the forty-five-day clock from running until the requested information or documentation is submitted. Again, problems arising from Medicaid's loss of submitted documentation can be overcome by keeping copies of everything submitted.

§ 6:6.6 Date of Coverage and Retroactive Reimbursement

All notices of acceptance sent from Medicaid should indicate the effective date of coverage, usually the first day of the month in which the application is approved.[77] Once accepted, the Medicaid claimant is entitled to Medicaid coverage retroactive to the third month prior to the month of application,[78] if the applicant was or would have been eligible[79] when he or she received medical care and incurred such medical expenses in the three-month retroactive period.[80]

[A] Medicaid Reimbursement

Reimbursable out-of-pocket medical expenses may be refunded to relatives, agencies, or other third parties who expend funds on behalf of the Medicaid recipient/applicant. If the Medicaid recipient

---

75. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-2.4(a).
76. *Id.* §§ 360-2.4(a)(2), 360-5.7; 92 ADM-52.
77. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-2.4(c); 89 ADM-51.
78. 42 U.S.C. § 1396a(a)(34); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-2.4(c).
79. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.8(b). As discussed later in the chapter, it is possible for individuals to be eligible for Medicaid even when they have excess resources, if their incurred medical expenses equal or exceed the excess resources.
80. 42 U.S.C. § 1396a(a)(34); N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-2.4(c), 360-7.5(a)(5); 89 ADM-51.

is on the "surplus income" program (see income section), the reimbursement unit may only allow a credit against the recipient's monthly surplus, rather than actually refunding cash. Remember, Medicaid will reimburse only for "paid" medical bills once an individual is receiving Medicaid; if they are unpaid, the vendor seeking to collect payment should submit the bill directly to Medicaid for payment.

[A][1] Three-Month Retroactive Coverage

A newly accepted Medicaid recipient can be reimbursed for all paid medical bills from the three months before they applied for Medicaid, as discussed above. Unpaid medical bills should be submitted directly by the vendor to Medicaid. These medical bills need not be from an authorized Medicaid provider; however, any payment made by Medicaid will be at the Medicaid reimbursement rate that was in effect at the time the services were provided, not the private pay rate.[81]

[A][2] Pending Application Approval

A Medicaid applicant can seek reimbursement for out-of-pocket medical expenses that are paid for the period of time between the date of application and the date when eligibility is approved. This means that applicants with pending applications (forty-five-day processing period) are entitled to receive reimbursement for medical bills that they have paid while they were waiting for their eligibility to be approved.[82] However, this reimbursement is limited only to medical expenses paid to "enrolled" Medicaid providers, unless it can be proven that Medicaid failed to inform the applicant that he or she had to use Medicaid providers while the application was pending.[83] It is also important to note that reimbursement for this category of

---

81. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.5(a)(5); 88 ADM-31, Medicaid Reimbursement for Certain Paid Medical Bills (Krieger v. Perales). *See also* Seittelman v. Sabol, 91 N.Y.2d 618 (Apr. 2, 1998) (reimbursement permitted for money paid or bills incurred to a provider not enrolled in Medicaid, but only at the Medicaid rate (not private pay rate)). However, medical bills incurred from non-Medicaid providers at a private rate can be counted towards the spenddown amount for those recipients in the "surplus income" program.
82. 88 ADM-31 at 3.
83. Seittelman v. Sabol, 91 N.Y.2d 618 (Apr. 2, 1998).

medical expenses will be made at the Medicaid reimbursement rate, not the private pay rate.[84]

[A][3] Pending Activation

Expenses incurred after being accepted by the Medicaid program, but before an active Medicaid card and number have been issued, may be reimbursed to a Medicaid recipient.[85] Medical expenses incurred while the Medicaid eligibility process is being conducted are reimbursable at the Medicaid reimbursement rate if incurred from a Medicaid vendor, or at the reasonable private pay rate if incurred from a non-Medicaid vendor.[86] However, there is some debate on whether there must have been some Medicaid error or fault involved before reimbursement at the reasonable private pay rate will be permitted.[87] Once the Medicaid recipient has been issued a usable Medicaid number, he or she must use a Medicaid vendor to obtain medical care if he or she wants Medicaid to pay for the goods or services.

[A][4] Agency Error or Delay

Finally, there are those medical expenses that are incurred as a result of administrative error or delay. If Medicaid is found to be at fault, through a fair hearing, and to have made an error that prevented the applicant from receiving coverage to which he or she was entitled, reimbursement will be made for all out-of-pocket expenses for medical services Medicaid should have paid at the private pay reimbursement rate, and with no restrictions upon whom provided the services.[88]

[B] Applying for Reimbursement

When submitting a request for reimbursement, be sure to include your Medicaid Client Identification Number (CIN) or Social Security Number, and an explanation of why Medicaid was not used. Claims should be sent to your local Department of Social Services.

---

84. *Id.*
85. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.5(a)(5).
86. Medicaid is following the second modified judgment issued in Greenstein v. Perales, 833 F. Supp. 1054 (S.D.N.Y. 1993), signed on February 24, 1995 (89 Civ. 1038-RWJ).
87. Second modified judgment issued in Greenstein v. Perales, 833 F. Supp. 1054 (S.D.N.Y. 1993), signed on February 24, 1995 (89 Civ. 1038-RWJ).
88. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.5(a)(1); 88 ADM-31, 87 ADM-48. *See* Greenstein v. Perales, 833 F. Supp. 1054 (S.D.N.Y. 1993).

[C] Vendor's Request for Medicaid Payment

As a general rule, medical bills must be submitted by the vendor within ninety days of the date the medical care, services, or supplies were furnished to a Medicaid eligible person, unless the delay is beyond the vendor's control.[89]

§ 6:6.7 Annual Renewal

Medicaid is usually authorized for a twelve-month period.[90] At the end of the authorized eligibility period, the recipient must complete the necessary forms to be recertified for continued eligibility.[91] The recertification is usually completed by mail. If the requested recertification documentation is not returned, the client will lose coverage. As part of the recertification process, the Medicaid recipient usually must submit banking records for the previous twelve months.

A recurring problem is Medicaid's failure to process recertification forms in a timely manner. The delays have caused Medicaid recipients to be terminated from Medicaid for failure to renew, even though they have submitted their recertification documents on time. To address this problem, the Department of Social Services (DSS) has been given permission to streamline the renewal process.[92] If and when local districts begin implementing some of these streamlining options, advocates should see extended periods of Medicaid authorization and fewer document requirements at the time of recertification. There are also legal efforts pending against DSS that should help improve the renewal process.

§ 6:6.8 Assignment of Third-Party Recovery

As a condition of eligibility, Medicaid applicants are required to assign to Medicaid their rights to third-party payments for medical support and care.[93] This assignment is found in the small print at the end of the standard Medicaid application. The assignment authorizes Medicaid to legally pursue financial medical support from persons

---

89. N.Y. COMP. CODES R. & REGS tit. 18, § 540.6.
90. *Id.* 18, § 360-2.2(e) and § 360-6.2(a); 86 ADM-47.
91. 92 INF-49 (How to complete recertification forms).
92. *See* Local Commissioners Memorandum, Transmittal No. 94 LCM-84, dated July 20, 1994.
93. 42 U.S.C. § 1396(a)(45) (added by Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2367(a)(3), 98 Stat. 494, 1108 (1988)); 42 U.S.C. § 1396(a) (1986); 42 C.F.R. §§ 433.145 to 433.148, 435.604, 436.604; HCFA, State

having legal responsibility for supporting the applicant (usually the healthy spouse), or from other third-party sources. Based upon this assignment, Medicaid may bring a lawsuit against a spouse who is refusing to pay for the medical support of their ill spouse,[94] ask for reimbursement out of a personal injury recovery,[95] or pursue any third-party insurance coverage. Further discussion of this and related topics can be found in this chapter under the headings Spousal Refusal and Liens and Rights of Recovery.

§ 6:6.9 U.S. Citizenship Requirements

Establishing Medicaid eligibility requires the applicant to pass through a screening process to determine the Medicaid applicant's legal status in the United States. Only U.S. citizens and specifically defined legal residents are eligible to receive Medicaid benefits.[96] A list of the documents which are considered proof of U.S. Citizenship is found in Appendix 6D. All aliens, regardless of their legal classification, are eligible to receive coverage for "emergency medical conditions."[97]

Defining who is legally residing in the United States has recently been revised by a series of class action lawsuits[98] that have been aimed at rolling back the changes implemented by the Personal

---

Medicaid Manual § 390 (Feb. 1990) (Transmittal No. 40). *See also* HCFA Transmittal Notice Region IV, MCD-14-87(PO) (Aug. 4, 1987) (discusses denial of Medicaid eligibility for refusing to assign rights to medical support or refusing to cooperate in obtaining such support).

94. N.Y. SOC. SERV. LAW § 101(1); *see also* Comm'r of Dep't of Soc. Servs. v. Spellman, N.Y.L.J., Feb. 10, 1997, at 1, 4; and discussion of spousal refusal later in this chapter.

95. N.Y. SOC. SERV. LAW § 104-b; *see* Cricchio v. Pennisi, 90 N.Y.2d 296 (1997) (Medicaid can collect on N.Y. SOC. SERV. LAW § 104-b lien before placing proceeds in Supp. Needs Trust). Calvanese v. Calvanese, 92 N.Y.S.2d 410 (2d Dep't May 1998) (entire settlement amount, not just portion for past medical expenses, is available to satisfy Medicaid lien), *leave to appeal granted*, 92 N.Y.2d 810, 680 N.Y.S.2d (Sept. 15, 1998) (Table No. 756).

96. Social Security Act §§ 1901 *et seq.*, 42 U.S.C. § 1396; N.Y. SOC. SERV. LAW §§ 122, 131k; 97 ADM-23, 00 OMM/ADM-9.

97. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-3.2(f)(2); *see also* Greenery Rehab. v. Hammon, 150 F.3d 226 (2d Cir. 1998) (limiting coverage to acute short-term care).

98. Aliessa v. Novello, N.Y. Court of Appeals, 1 No. 73 (June 5, 2001); Aliessa v. Whalen, 181 Misc. 2d 334, 694 N.Y.S.2d 108 (Sup. Ct. N.Y. Cnty., 1999); Alvarino v. Wing, 690 N.Y.S.2d 262 (1st Dep't 1999).

Responsibility and Work Opportunity Reconciliation Act of 1996,[99] hereafter referred to as the 1996 welfare reform legislation or PRWORA. The substantive changes made by the 1996 legislation was to create a specific list of "qualified aliens" who would be considered eligible for governments benefits, subject to their entering into the United States either before or after the signing of the law on August 22, 1996. If certain aliens entered after the signing of the law, then they would face a five-year ban on their eligibility to all government benefits, including Medicaid.

A recent class action lawsuit has been successful in restoring Medicaid benefits to an entire class of legal immigrants and almost entirely eliminating the five-year ban on eligibility for all aliens[100] in New York State. The newly restored class of legal immigrants are known as "Permanent Residents Under Color of Law," referred to as PRUCOL. Therefore, current Medicaid policy is to grant Medicaid eligibility to U.S. Citizens, Qualified Aliens, and PRUCOL Aliens. The definitions of "PRUCOL" eligibility and "Qualified Alien" can be found in the following sections.

[A] Aliens Permanently Residing in the United States Under Color of Law (PRUCOL)

Aliens without an officially legal status, but who are permitted by the U.S. Immigration and Naturalization Service (INS) to stay in the United States for an indefinite period of time, are eligible to receive Medicaid benefits.[101] Medicaid will consider an alien as being in PRUCOL status if:

(1) based upon all the facts and circumstances in that particular case, it appears that INS is otherwise permitting the alien to reside in the United States indefinitely; or

(2) it is the policy or practice of the INS not to enforce the departure of aliens in a particular category.[102]

---

99. Pub. L. No. 104-193, 110 Stat. 2105 (signed into law on Aug. 22, 1996); 8 U.S.C. §§ 1601 *et seq.*; N.Y. SOC. SERV. LAW § 122, as amended by the New York State Welfare Reform Act of 1997, ch. 436, § 7 (Aug. 20, 1997).
100. Aliessa v. Novello, N.Y. Court of Appeals, 1 No. 73 (June 5, 2001). *See* GIS 01 MA/015 and GIS 01 MA/026 (copies of these GIS may be obtained from The Greater Upstate Law Project 716-454-6500 or at www.gulpny.org).
101. *See* General Information Statements (GIS) 01 MA/026; N.Y. COMP. CODE R. & REGS. tit. 18, § 360-3.2(f)(1)(ii); 88 ADM-4.
102. GIS 01 MA/026.

The Welfare Reform Act of 1996 remains in effect at the federal level of funding for Medicaid benefits; however, due to a recent class action lawsuit,[103] non-qualified aliens who are PRUCOL can be eligible for full Medicaid benefits with state and local funds only. Non-qualified aliens who are *not* U.S. PRUCOL continue to be limited only to Medicaid coverage for emergency medical conditions.

The restoration of benefits to PRUCOL aliens is a very sudden development, and so the procedures for implementing coverage are still being developed. A list of PRUCOL aliens is provided in the revised Medicaid form DSS-3622(A), found in Appendix 6E, along with a chart explaining the current alien eligibility rules.

[B] Qualified Aliens

Qualified Aliens, as defined by the Welfare Reform Act of August 22, 1996, are eligible for Medicaid coverage. A list of Qualified Aliens can be found in Appendix 6E, along with a chart explaining the current eligibility rules.

[C] Non-Eligible Aliens in Nursing Facilities

The State of New York has passed legislation to continue Medicaid coverage for non-eligible alien nursing home residents even though federal Medicaid funding is no longer available for them.[104] The New York Social Services Law states that any person who, as of August 4, 1997, "was residing in a residential health care facility licensed by the department of health or in a residential facility licensed, operated or funded by the office of mental health or the office of mental retardation and developmental disabilities, and was in receipt of"[105] Medicaid will continue to receive Medicaid coverage, assuming they meet the other eligibility requirements. Individuals in the same situation, who were not residing in a nursing facility as of August 4, 1997, will be held to the same rules which apply to all other non-qualified aliens.

§ 6:6.10 New York State Residency Requirements

In addition to proving citizenship or acceptable alien status, a Medicaid applicant must document that he or she is a resident of the State of New York. Two things are required to establish residency

---

103. Aliessa v. Novello, N.Y. Court of Appeals, 1 No. 73 (June 5, 2001).
104. N.Y. SOC. SERV. LAW § 122(c), *amended by* the New York State Welfare Reform Act of 1997, ch. 436, § 7 (Aug. 20, 1997).
105. *Id.*

in New York: (1) physical presence in New York State, and (2) the present intention to make New York State one's home.[106]

There is no minimum time period for establishing residency.[107] Technically, a person can become a resident as soon as he or she has the legitimate intention to become a resident. Since the intention to remain in a place is a state of mind, as a practical matter Medicaid requires some objective proof of an applicant's intention. Examples of objective factors that will assist the applicant in demonstrating residency are owning a home or leasing an apartment in New York State; or other connections with the state, such as prior residence, family presence, employment, voter registration, driver's license, tax return filings, and location of bank accounts.[108] Residents in institutions, such as nursing homes, are considered to be permanent residents of the state.[109]

[A] Lack of Mental Capacity

A person over twenty-one who lacks the mental capacity to indicate an intention to remain in the state is considered to be a resident of the state in which he or she is physically present, unless another state has made the placement and is paying for the care.[110] In any case, a Medicaid applicant should never be denied benefits by both states on the basis of a lack of residence.

[B] Temporary Visits to or Absences from New York

Persons who are temporarily in the state and who require immediate emergency medical care can receive Medicaid, provided that they did not enter the state for the purpose of obtaining such care.[111] They should be prepared to present documentation to corroborate that they entered the state for a purpose unrelated to receiving medical care. Additionally, Medicaid makes special provisions for Medicaid recipients who must leave the state on a temporary basis.[112] Reasons for temporary absences from the state or the primary residence may include employment, hospitalization, military service, vacation,

---

106. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-3.2(g).
107. *Id.* §§ 349.4, 360-3.2(7).
108. *Id.* § 351.2(g).
109. *Id.* § 360-3.2(g)(5)(iv).
110. N.Y. SOC. SERV. LAW § 360-3.2(5)(iii).
111. N.Y. SOC. SERV. LAW § 366(1)(b); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-3.6.
112. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 349.4, 360-3.2(g)(7)(iv), 360-1.4(p).

education, or visits. As a general rule, a temporary absence should last no longer than thirty days.

[C] Moving from One Medicaid District to Another

When a Medicaid applicant or recipient moves between counties, it can be a problem establishing which public welfare district (county) must furnish Medicaid to the applicant. For example, if Mrs. Smith, who lives in Westchester County, enters a hospital near her daughter in Suffolk County, and then decides to enter a nursing home in Suffolk County, to remain near her daughter, which county would provide Medicaid coverage? The answer is that Westchester would remain responsible, because Mrs. Smith never established residency in Suffolk County before she entered the nursing facility.[113] If Mrs. Smith had taken up residence at a private house in Suffolk County before she entered the nursing home, then Suffolk County would have been responsible for her Medicaid coverage.

Often there are disputes between counties as to which one should provide Medicaid to an otherwise eligible individual. In such circumstances, the district in which the applicant is physically present is responsible for providing Medicaid, unless that Medicaid applicant is placed in the district by another district. In the case of one district placing a Medicaid applicant or recipient into another district, the "from" district retains the responsibility for Medicaid coverage.[114] When a Medicaid recipient moves, of their own free will, from one district to another and continues to be Medicaid-eligible, the "from" district continues to be responsible for providing Medicaid during the month of the move and may continue assistance for a month after the move. Thereafter, the "where found" district assumes the responsibility for Medicaid coverage.[115] If it chooses, the district where the recipient is found may request a fair hearing to determine the proper responsibility based on the applicant's permanent residence in a different county.[116]

---

113. N.Y. SOC. SERV. LAW §§ 62-1, 5.(d) (residence of the applicant immediately preceding hospital admission is controlling); 97 ADM-1 (District of Fiscal Responsibility).
114. OMM/ADM 97-1 (District of Fiscal Responsibility); 08 OHIP/ADM-5 ("District of Fiscal Responsibility Change for SSI Cases and Changes to Auto-SDX Processing for Moves Into and Out of NYC").
115. *Id*. at 4.
116. *Id*. N.Y. COMP. CODES R. & REGS. tit. 18, § 311.2–.4; 86 ADM-40, 80 ADM-4.

§ 6:7 Financial Requirements

After establishing that an individual meets the preliminary requirements for Medicaid eligibility (elderly, blind, or disabled), the applicant must meet income and resource limits to be eligible for Medicaid benefits.

§ 6:7.1 Rules Regarding Income

The Medicaid program places a maximum allowable income limitation on all applicants. When evaluating an applicant's income, only "actually available income"[117] is to be considered when determining Medicaid eligibility. For this reason, it is important to inventory the applicant's income from all sources to make a determination of its actual availability and to determine if it will be counted towards the Medicaid income limit, or if it falls under any of the income exemptions. The current income levels for non-institutional Medicaid recipients and additional allowances that may be permitted for larger households can be found in Appendix 6A.[118] For individuals receiving institutional Medicaid services, the income limit is $50 per month.[119] Additional allowances may be permitted for larger households. Current income levels may be found in Appendix 6A.

[A] Definition of Income

"Income" is any recurring payment made to the Medicaid applicant. These payments are counted in the month in which they are received. Income includes both earned and unearned income.[120] Examples of income payments include payments of Social Security, Veterans Administration benefits, pensions, interest, dividends, and net rents on real property. Maximum monthly income limits for the medically needy are listed in Appendix 6A. A person applying for Medicaid must produce documentation for all of his or her earned

---

117. 42 U.S.C. § 1396a(a)(17)(B); N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-4.1(b)(2), 360-4.2(b); 87 INF-8. Although this language appears clear and self-evident, income not in fact actually available has been deemed to be available.
118. *See* N.Y. SOC. SERV. LAW § 366.1(a)(7).
119. *See id.* § 366(2)(10)(i)(A).
120. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.3.

and unearned income for at least the previous three months.[121] Please note that "gross" income (pre-tax) is countable for Medicaid purposes.

[B] Countable Income

[B][1] Previously Exempt Income That Is Now Counted

Prior to January 1, 1991, New York law exempted court-ordered support payments and mandatory income tax and Social Security payroll deductions in determining Medicaid eligibility.[122] The change in New York State legislation provided that the following income was no longer exempt:

- income taxes (federal, state and local);
- Social Security taxes and other payroll deductions; and
- court-ordered payments for support of dependents, in Medicaid community or home care cases only (court-ordered support payments continue to be exempt for an institutionalized spouse paying support).

[B][2] Employment Income and Income-Producing Property

For the elderly, blind, or disabled (SSI-related) Medicaid claimants, the first $65 of employment income per month is exempt and only one-half the balance counts as income.[123] Real property (for example, land, buildings, and cooperative or condominium apartments) or property used to produce goods or services is a countable resource for the amount of its equity value which exceeds $12,000.[124]

---

121. Examples of documents requested are an award letter from a benefits program, a copy of a check from a benefits program, pay stubs, and bank statements of interest. For earned income, current policy is to require only four weeks of pay stubs.
122. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360.2(a)(5) (repealed Feb. 28, 1989). *See* N.Y. SOC. SERV. LAW § 366.2(a)(7) (repealed Aug. 13, 1991); 91 ADM-27 at 13.
123. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-4.6(a)(2)(iv), 360-4.3(c), 360-4.4(d) (income-producing property); *see also* 91 ADM-30 (income-producing property).
124. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(d); *see also* 91 ADM-30 (Aug. 20, 1991).

[B][3] Duty to Apply for Available Funds and Income

Medicaid applicants and recipients are required to apply for and accept any funds which are due them. The two most common situations in which this obligation arises are inheritances and a spouse's right to take an elective share of their spouse's estate at death.[125] For example, a nursing home Medicaid recipient who is notified that he or she will inherit $10,000 cannot renounce the inheritance[126] in order to remain on the Medicaid program, because that would be considered a transfer of assets. Similarly, a spouse cannot refuse to seek the spouse's right to elect a share of the deceased spouse's estate, even if disinherited under the deceased spouse's will.[127]

[B][4] Personal Injury Recoveries

When a Medicaid recipient has a lawsuit for personal injuries, Medicaid imposes a lien upon the damage award. This lien allows Medicaid to recover directly from the damage award.[128] The lien or recovery is limited to damages awarded for medical expenses and may only be for the amount of Medicaid payments made for expenses related to the injury.[129]

The part of the award that is not subject to recovery by Medicaid (for example, any recovery for pain and suffering) is treated as income to the Medicaid claimant in the month it is received.[130] If retained

---

125. E.P.T.L. 5-1.1.
126. *See* 42 C.F.R. §§ 435.603, 436.603. *See* Molloy v. Bane, 631 N.Y.S.2d 910 (2d Dep't 1995). *See also* HCFA State Medicaid Manual, Part 3—Transmittal 64 at § 3257.B3. *See also* n.227 regarding transfers of income.
127. *See* Matter of the Estate of Jeannette Dionisio v. Westchester Cnty. Dep't of Soc. Servs., N.Y.L.J., Nov. 24, 1997, N.Y. App. Div. 96-08851 (2d Dep't); Tannler v. Wis. Dep't of Health & Soc. Servs., 564 N.W.2d 735 (Wis. 1997).
128. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11(a); *see also* MAP Procedure 92-1.
129. *See* Cricchio v. Pennisi, 90 N.Y.2d 296 (Mar. 25, 1997) (discussing limitation of Medicaid lien on personal injury recovery to medical recovery).
130. *See* Calvanese & Callahan cases, 93 N.Y.2d 111, 710 N.E.2d 1079, 688 N.Y.2d 479 (1999) (entire personal injury settlement available to satisfy Medicaid lien, prior to establishing a Supplemental Needs Trust, and not only from that portion allocated from medical expenses).

beyond the month after receipt, these monies are classified as resources, and depending upon the size of the recovery, the beneficiary may be made ineligible for Medicaid. Individuals in this situation who wish to remain eligible for Medicaid should spend such awards in the month received or consider transferring them, subject to the transfer provisions discussed later in the chapter.

[C] Non-Countable Income (Exemptions)

Certain income is not counted in Medicaid's calculation of income in determining an applicant's or recipient's eligibility.[131] For all SSI-related applicants or recipients, the following types of income are exempt and not counted as income under the Medicaid program.

[C][1] Health Insurance Premiums (Including Medicare Part B)

Income in an amount equal to any medical insurance premiums paid by the applicant or recipient is exempt. If Medicaid pays the premium, it is treated as non-countable in-kind income.[132]

[C][2] Interest on a Separate Exempt Burial Account

Interest accumulating on a separate exempt burial account is exempt.[133] A full discussion of the exempt Medicaid burial account can be found in the exempt resource section of this chapter.

[C][3] German Restitution Payments

Restitution payments made by the Federal Republic of Germany to Holocaust survivors[134] and payments under sections 500–506 of the Austrian General Social Insurance Act[135] are exempt income in the month received and are also considered an exempt resource when retained beyond the month of receipt. This applies not only to applicants and recipients in the community but also to those receiving institutional services.

---

131. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(a)(1). *See also* 91 ADM-8.
132. N.Y. SOC. SERV. LAW § 366.2(a)(6); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(a)(2)(vii).
133. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(a)(2)(xvii).
134. *Id.* § 360-4.6(a)(2)(ii); *see also* 91 ADM-23 (German reparations).
135. *See* 92 ADM-32 (Austrian payments); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(a)(2)(xxii).

To be exempt as a resource, accumulated reparation payments must be separately identifiable. This is best accomplished by depositing these payments in a separate bank account. Note, however, that interest on reparation accounts is not exempt and is considered unearned income.[136] For this reason, accumulating interest on such accounts must be considered as a factor when evaluating the Medicaid recipient's countable income.[137]

[C][4] $20 Household Income Disregarded

For Medicaid applicants who are elderly, blind, or disabled (SSI-related), the first $20 per month of unearned household income is disregarded.[138] This exemption is granted to the household and does not increase with the number of individuals in the household. A couple will receive only one $20 exemption.

[C][5] "In-Kind" Income or Support

Contributions of goods or services from individuals who are not "legally responsible relatives,"[139] in support of a Medicaid claimant, are not counted as income to the Medicaid recipient. These contributions are referred to as "in-kind support."[140] For elderly Medicaid recipients, the spouse is the only "legally responsible relative"; children are not legally responsible for their parents. This means that children or even friends may directly pay a Medicaid recipient's expenses (for example, rent and food bills) without having these payments or other in-kind support counted as income to the Medicaid beneficiary. However, actual cash payments or an allowance, including gifts made directly to the Medicaid recipient, are treated differently; they are counted as unearned income to the Medicaid claimant, even if the actual purpose of the money was to pay for rent or food.

---

136. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(a)(2)(ii).
137. Funds remaining in a Medicaid recipient's probate estate at death may be subject to a reimbursement claim by Medicaid. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11(b)(1), (2). However, if a reparations account is established as an "in trust for . . ." account, the funds pass directly to the designated beneficiary without going into the estate of the Medicaid recipient.
138. N.Y. SOC. SERV. LAW § 366.2(a)(5); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(a)(2)(iii).
139. 42 U.S.C. § 1396(a)(a); N.Y. SOC. SERV. LAW §§ 366.2(b), 366.3(b)(iii); N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-1.4(h), 360-4.2(b), 360-4.3(f).
140. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.3(e).

[C][6] Other Restitution Payments

Payment to Japanese-Americans and Aleuts who were evacuated, relocated, or interned during World War II, made under the Federal Civil Liberties Act of 1988 or the Aleutian and Pribilof Islands Restitution Act, are exempt.[141]

[C][7] Agent Orange Payments

Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the Agent Orange product liability litigation[142] are exempt.

[C][8] Reverse Mortgage Income

Income from a reverse mortgage or other home equity conversion plan are not counted as income for eligibility purposes.[143] This exemption includes the proceeds of any loan and repayment of principle. Medicaid will require proof that an actual loan agreement was established. Any income accumulated from this source (a loan) will be considered countable resources and be subject to the resource limitations of the Medicaid program if it is accumulated in a bank account beyond the month in which it is received.

[C][9] Income to Supplemental Needs Trust (SNT)

Monthly income of a Medicaid recipient, usually under the age of sixty-five, may be diverted into a properly established Supplemental Needs Trust (also known as a Medicaid Exception Trust).[144] Monthly income that is deposited directly into the Supplemental Needs Trust (SNT) will not be counted as available income for Medicaid purposes

---

141. *Id.* § 360-4.6(a)(1)(xxi).
142. *Id.* § 360-4.6(a)(1)(xxii).
143. *Id.* § 360-4.6(a)(1)(xxv).
144. A Supplemental Needs Trust (Exception Trust) is a trust that is used to provide for the beneficiaries "supplemental" needs, over and above what is already provided for by Medicaid or other government benefit programs. As established in 96 ADM-8, there are two exception trusts that are recognized by Medicaid for the purpose of holding the income or assets of a disabled individual: (1) an individual OBRA '93 "payback" trust for a disabled individual under the age of sixty-five; and (2) an OBRA '93 pooled trust established for a disabled person of any age. OBRA '93 refers to the Omnibus Budget Reconciliation Act of 1993. *See also* N.Y.E.P.T.L.7-1.12; N.Y. SOC. SERV. LAW § 366(2)(b)(2)(iii); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.5(b)(5).

and therefore will not be counted for "Surplus Income" purposes.[145] The funds held in the SNT can then be used for expenses not covered by Medicaid. All SNTs must receive approval from Medicaid's legal department.[146]

A full discussion of Supplemental Needs Trusts (SNTs) or Medicaid Exception Trusts is beyond the scope of this chapter; however, an advocate should know that under the correct circumstances a properly established SNT can be used to shield monthly income for Medicaid eligibility purposes.[147] Individuals who may benefit from an income SNT should be referred to an experienced elder law attorney.

[C][10] Pooled Trusts for Income

Disabled individuals (over or under the age of sixty-five) may direct "surplus income"[148] into a "pooled supplemental needs trust."[149] By placing the applicant's surplus income into this type of pooled trust, the surplus income becomes exempt and will not be counted as part of the Medicaid applicant's income budget for eligibility purposes.[150] The pooled trust may then spend the surplus income for anything the Medicaid applicant needs, as long as that need is not already covered by Medicaid. The most common expenses that a pooled trust might spend the income on would be rent, utilities, food, additional home care services, etc. However, for Medicaid applicants over the age of sixty-five who require institutional care services

---

145. 96 ADM-8 at 8, § 7(b). *See also* Joseph R.K. v. DeBuono, 97 CV-0948 (N.D.N.Y. Feb. 25, 1998); *In re* Ullman, 184 Misc. 2d 7, 707 N.Y.S.2d 603 (Sur. Ct. Onondaga Cnty. 2000); *In re* Lynch, File No. 90-1897 (Sur. Ct. Onondaga Cnty. 2000).
146. *See also infra* sections 6:7.3[E][11] and 6:8.5[G].
147. The most commonly used exception trust is the "Payback Trust." The payback SNT must be established for the sole benefit of the disabled person under the age of sixty-five by a parent, grandparent, guardian or court; the SNT must be funded with the assets or income of the disabled individual and the SNT must provide for the ultimate repayment of Medicaid from the SNT at the death of the disabled individual.
148. For a discussion of "surplus income," see *infra* section 6:7.2.
149. A pooled trust is a trust managed by a not-for-profit organization. Each beneficiary of the trust has their own individual account, although all the funds of the trust are pooled together. Upon the death of the trust beneficiary the remaining resources in the trust account are retained in the pool to assist other members of the pooled trust. There is no Medicaid pay-back at the death of the Medicaid recipient.
150. 42 U.S.C. § 1396p(d)(4)(C); N.Y. SOC. SERV. LAW § 366(2)(b)(2)(iii)(B). *See also* OBRA '93 exception trusts.

(nursing home), the pooled trust will not work. Medicaid considers this diversion of monthly income to be a "penalty transfer" against institutional coverage[151] if the individual is over the age of sixty-five.

A list of pooled trusts can be found in Appendix 6K. Many of these pooled trusts have requirements that may be restrictive for certain individuals of modest income or savings. One should call to verify the eligibility requirements of each pooled trust. The NYSARC Trust has no minimum funding requirements, making it a prime choice for holding monthly surplus income of small amounts.

The New York Department of Health has ruled this to be an acceptable practice at the fair hearing level.[152] On April 19, 2005, the state Medicaid program issued an information letter explaining the procedures for processing pooled trusts.[153]

Note that the processing time for Medicaid's approval of a pooled trust can be lengthy. Medicaid has taken the position that all applicants submitting a pooled trust must provide written proof of their medical disability in order to quality for the pooled trust income exemption. Proof of one's disability must be submitted regardless of the person's age or health. On average, the approval will take about six months.[154]

[C][11] American Recovery and Reinvestment Act of 2009

The one-time payment of $250 granted under the American Recovery and Reinvestment Act of 2009 ("The Stimulus Bill")[155] is

---

151. *See infra* section 6:8.

152. Matter of M.O., Medicaid Fair Hearing Decision No. 3945750N (New York City MAP, Feb. 25, 2004) (N.Y. Dep't of Health held that income may be diverted to the NYSARC Trust and will not be considered income for the purposes of computing available income for contribution to the cost of care). *See also* Matter of G.G., Medicaid Fair Hearing Decision No. 3660793L (Onondaga Cnty. Apr. 1, 2002) (if the Agency finds that the trust in question meets the legal definition, the Agency is directed to exempt monthly income which the Appellant places in (or diverts to) the trust).

153. Dep't of Health Informational Letter, 05 OMM/INF-1 ["Pooled Trusts and Disability Determinations for Individuals 65 Years of Age and Over"].

154. Medicaid is requiring submission of forms: DSS-1151 (Disability Interview); LDSS-486T (Medical Report for Determination of Disability); and LDSS-654 (Disability Determination Request). *See* Dep't of Health Informational Letter, O5 OMM/INF-1 ("Pooled Trusts and Disability Determinations for Individuals 65 Years of Age and Over").

155. American Recovery and Reinvestment Act of 2009, 111 Pub. L. No. 5, 123 Stat. 112 (Feb. 17, 2009).

not countable for Medicaid purposes for individuals who are receiving Supplemental Security Income (SSI) or Social Security. For the purpose of determining Medicaid eligibility, the one-time payment is not to be counted as income and is not to be considered a resource in the month it is received or for the following nine months.[156] Similarly, the additional $25 per week of unemployment insurance benefits under the 2009 Stimulus Bill is also disregarded.[157]

§ 6:7.2 Surplus Income Program (Spenddown)

Many Medicaid applicants have total monthly income which exceed the Medicaid allowable income limits (see Appendix 6A for income limits). The amount by which an individual's monthly countable income exceeds the Medicaid monthly income allowance is called "surplus" or "excess" income. The Medicaid program will provide medical coverage for these individuals if the amount of their incurred medical expenses exceed their excess income. This program is known as the "surplus income program" or the "spenddown program."[158] This program works like an insurance deductible. Once the Medicaid recipient has incurred bills equal to their monthly surplus they will be eligible to have Medicaid pay their Medical bills, minus the surplus amount. As will be discussed below, a Medicaid recipient may be able to pre-pay their surplus (deductible) to Medicaid before they use or need to use any Medicaid services.

Note that the Medicaid recipient need not actually have paid out the surplus income; it is enough to have incurred the medical expenses.[159] An individual incurs a medical expense when a medical service is provided for which the individual is expected to pay money from his or her own pocket. This does not mean that the individual has already paid, but only that a provider of medical services has a legitimate claim against that person for payment and continues to seek payment.

---

156. *Id.* § 2201(c)(1).
157. GIS 09 MA/012 (Apr. 21, 2009).
158. N.Y. SOC. SERV. LAW § 366.2(b)(3); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.8(c); *see also* 89 ADM-47; 89 ADM-4.
159. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-4.1(b)(i), 360-4.8(b); 90 ADM-28.

[A] Surplus Income for Community Care (Non-Home Care Services)

The practical operation of the surplus income program is complicated and varies depending on the type of medical services an individual requires from the Medicaid program.[160] The key points to remember when considering the spenddown program for non-home care services are:

- Both paid and unpaid bills[161] (including bills of a non-eligible spouse) may be used to meet the income surplus.[162]
- Paid bills may be credited prospectively up to six months, so that if an individual whose surplus is $30 per month presents bills for $180, he is eligible for Medicaid for six months.[163]
- Any expense which is part of a medical treatment plan can be used to meet the surplus, including bills for non-reimbursable items, such as nonprescription drugs, bills of doctors not participating in Medicaid, transportation, and chiropractic bills.

For participants in the surplus income program who require non-home care Medicaid services (for example, doctor or pharmacy), the process of meeting the monthly spenddown becomes more complicated and time-consuming (but see "Pay-In" program described below). Each month community Medicaid recipients must prove to their local Medicaid office that they have incurred or paid medical bills in amounts equal to their surplus income. This is accomplished by physically showing receipts and bills for medical services and goods that were paid for or incurred in the previous month. Documentation may be submitted in person or by registered mail. Community Medicaid recipients should be advised to

(1) incur expenses as early in the month as possible;

(2) take (or get someone to take) bills and receipts to the Medicaid office, since mail is often delayed; and

(3) retain photocopies if bills are in fact mailed.[164] Paid bills can be credited for up to six months prospectively.

---

160. *See* 91 ADM-17; 87 ADM-47.
161. An unpaid medical bill may be used for this purpose as long as it remains "viable." See *infra* note 226, for an explanation of this term.
162. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.8(c)(2).
163. *Id.*
164. See also the earlier discussion of disposing of excess resources.

[B] "Pay-In" Program

Federal and state laws regarding spenddown have been amended to allow the pre-payment of the spenddown amounts directly to local social service districts by Medicaid.[165] This program, known as the "Pay-In" program, was implemented in New York City as of January 1, 1997.

The optional prepayment program became part of the Social Service Law in 1995; however, deciding when to implement this program has been left up to local Medicaid districts. Therefore, this program may or may not exist in each county of New York. New York City began implementing this program, known as the "Pay-In" program, as of January 1, 1997.[166]

Under the "Pay-In" program, Medicaid-enrolled recipients who are not receiving home care services are permitted to "pre-pay" their monthly surplus income (as described in the previous section) directly to Medicaid. This means that a Medicaid recipient can avoid the old process of collecting monthly medical receipts for out-of-pocket medical expenses and physically submitting them to Medicaid to meet their monthly surplus spenddown.

This program requires the Medicaid recipient to enroll in the "Pay-In" program (form MAP 931A). It can be compared to opening a savings account at Medicaid, into which the Medicaid recipient will deposit money and from which Medicaid will make monthly withdrawals to meet the Medicaid recipient's monthly surplus liability. Example: If Mrs. Jones has a surplus income of $25/month and she wishes to pay for three months of advance coverage, she must pay-in $75. Prepayments can be made up to a maximum of six months of surplus.

All forms and applications are available from local Medicaid offices. Medicaid recipients should be warned that once money is paid into the program it cannot be easily withdrawn. If the Medicaid recipient does not use services in a month in which he or she has already paid and wishes to have a refund, he or she will have to wait until the end of the year. If deposited funds are not used, those funds will be credited against future months in which the Medicaid

---

165. N.Y. SOC. SERV. LAW § 366.2b(3)(a)(c), *amended by* 1995 N.Y.S. Budget § 127; N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.8(c)(4).

166. 96 ADM-15 [Excess Income Program Clarifications/Payment of Client Liability (Pay-In) Program].

recipient has a surplus that must be met. If no deposits are made for three consecutive months, the Medicaid case may be closed.

[C] Requirement to Pay Surplus Income for Home Care Services

If a Medicaid recipient is receiving home care services, and is only eligible for their home care services through the "Surplus Income Program," the home care agency (or the MLTC plan) will bill their Medicaid home care client each month for the amount of the surplus income.

A major change has occurred under the new MLTC plan for home care and the payment of surplus income. Prior to the coming of MLTC Medicaid, if an individual receiving home care services failed to pay some or all of their surplus income to the provider of care, that provider could not stop providing services. However, under the new MLTC contracts with the providers, now a provider is not required to continue providing home care services if the monthly surplus payments are not made to the provider of care. For this reason, establishing a "pooled-income trust"[167] to protect the surplus income is now a vital part of Medicaid planning. Using a pooled-income trust will eliminate the surplus income.[167.1]

[D] Surplus Income and Hospital Services

An individual who has been hospitalized and who is only eligible for Medicaid with surplus income can become eligible for Medicaid covered hospital services only after first incurring medical bills equal to six times their monthly surplus income.[168]

[E] Surplus Income and Nursing Homes

An individual who enters a skilled nursing facility must contribute their surplus income to the nursing facility. Surplus income in a Medicaid nursing home setting is known as the "Net Available Monthly Income" (NAMI). Medicaid calculates the NAMI by subtracting allowable deductions from the Medicaid recipient's monthly income; any remaining income belongs to the nursing facility to offset Medicaid's payment to the nursing home. Allowable deductions

---

167. *See supra* section 6:7.1[C][10].
167.1. For a discussion of pooled trusts, see *supra* section 6:7.1[C][10].
168. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.8(c)(2).

would be the Medicaid recipient's monthly income allowance,[169] allowable premium payments for supplemental health insurance, and income contributions to the "community spouse" under the spousal impoverishment budgeting rules as explained in sections 6:9.6[A] and [B] of this chapter.

§ 6:7.3 Rules Regarding Resources

Medicaid beneficiaries are limited in the amount of resources they are permitted to retain for Medicaid eligibility. As with the income limitations, there are certain resources that are exempt from being counted toward the resource limits set for determining Medicaid eligibility. Current resource levels may be found in Appendix 6A.

[A] Definition of Resources

Medicaid reviews all resources when determining an applicant's eligibility. Resources include, among other things: savings accounts, checking accounts, stocks, bonds, certificates of deposit, and real property. Only actually available resources can be considered in determining Medicaid eligibility.[170] The reason Medicaid reviews the applicant's resources is to see if any of them could be used for medical expenses. Basically, anything that is not an exempt resource and could be converted into cash is considered an available resource for Medicaid eligibility purposes. When applying for Medicaid, the applicant must produce documentation of his or her resources going back at least thirty-six months.[171]

[A][1] Date to Evaluate Resources

Medicaid will look to the first of the month in which the applicant submits his or her Medicaid application when evaluating the value of the assets held by the applicant. Example: an application submits an application on January 10 when the applicant's bank accounts total no more than the allowable resource level. However, on January 1 the

---

169. Note: the income allowance for a Medicaid nursing home resident is $50.00 per month, not the higher home care income allowance listed in Appendix 6A.
170. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-4.4, 360-2.3(c), 351.2 (e)(1).
171. Examples of required documentation are savings bank books, checking statements, stock and bond certificates, life insurance policies, burial fund records, burial plot agreements, funeral agreements, and deeds to real property.

same applicant had resources that exceeded the allowable resource level; this applicant is not eligible for the entire month of January for non-institutional services.[172]

However, when applying for institutional Medicaid services, Medicaid will make allowances for some excess resources in the month of application. If the applicant has resources that continue to exceed the allowable resource level on the first of the month in which they are applying for nursing home care, Medicaid will consider the applicant eligible if they agree to contribute the excess resources to the nursing home (making it part of the NAMI).[173] If these excess resources exceed the monthly average cost of nursing home care,[174] Medicaid will not allow the applicant to contribute the excess resources and will deem the applicant ineligible for Medicaid in that month.

[B] Jointly Owned Bank Accounts and Real Estate

Under New York State banking laws, joint bank accounts are presumed to be owned equally by each person whose name is on the account.[175] For example, if Mr. and Mrs. Smith have a joint bank account of $10,000, each is presumed to own $5,000. This presumption also applies to accounts owned by unrelated individuals holding joint accounts with a Medicaid applicant or recipient.

Medicaid, however, is not required to follow the New York law and instead makes the presumption that jointly held funds belong entirely to the Medicaid claimant. The burden then rests with the claimant to establish actual ownership of the funds in a joint bank account. A claimant must present evidence to establish how much of the bank account actually belongs to him or her. In determining ownership of a jointly owned bank account, Medicaid considers who established the account, who makes deposits and withdrawals, the use made of the withdrawals, and who pays the taxes on the earned interest.[176]

Under OBRA '93, the federal Medicaid law now moves closer to the existing New York Department of Social Services policy on the

---

172. Federal law permits the states the option to begin counting transfers (expenditures) from either the month during which the transfer occurred or the following month. New York begins counting from the month following the date of the transfer. *See* 42 U.S.C. § 1396p(c)(1)(D); N.Y. COMP. CODES R. & REGS. tit. 18 § 360-4.4(c)(2)(iv)(b); 96 ADM-8 at 15.
173. *See supra* section 6:7.2[E].
174. *See infra* Appendix 6F.
175. N.Y. BANKING LAW § 675.
176. *See* MAP Informational 20/90 and 96 ADM-8 at 18.

treatment of jointly held property, including bank accounts. Under the new law, Medicaid transfer rules (discussed below) are to be applied to all jointly held assets. In effect this means that any action taken by a Medicaid applicant, or any other person, that reduces or eliminates the applicant's ownership or control over assets held in joint name will be considered a transfer of assets incurring a period of ineligibility for institutional services (and possibly non-institutional services; see discussion of transfer rules below).[177] This law applies to all commonly held assets, whether held in joint tenancy, tenancy in common, or other similar arrangements.

Medicaid has clarified the effect of placing a person's name on the bank account or asset of a Medicaid applicant/recipient.[178] Merely placing another person's name on an account or asset as a joint owner does not necessarily constitute a transfer of assets. Only when the other (non-applicant) person actually withdraws or removes some of the assets will there be a transfer of assets. Also, if placing another person's name on the asset (real estate or brokerage account) actually limits the Medicaid applicant's right to sell or dispose of the asset, such placement would constitute a transfer of assets.[179]

Real estate (land or homes) held under a deed of ownership is not treated like a joint bank account. Ownership is determined by how the deed is written and by how the name(s) appear on the deed. The transfer of real estate or the addition of new names to an existing deed of property ownership held by the Medicaid applicant may be treated as a transfer of assets under the transfer rules. (See transfer section of chapter.)

[C] Spousal Resources

Husbands and wives have a legal duty of support for each other; therefore, spousal resources will be considered mutually available for Medicaid eligibility purposes. This legal duty may be altered for Medicaid eligibility purposes through the use of a "spousal refusal" letter.[180] Special income and resource budgeting rules may apply for

---

177. OBRA '93 § 13611(a)(2)(e); 42 U.S.C. § 1396p(c)(3). *See also* 96 ADM-8 at 18.
178. 96 ADM-8 at 19.
179. *Id.*
180. For a discussion of spousal refusal, see *infra* section 6:9.3[A].

spousal resources when the applicant spouse is institutionalized or receives "waivered" services through a Lombardi program.[181]

[D] Non-Liquid Resources

Effective October 9, 1996, Medicaid amended its regulations to say that Medicaid cannot be authorized for an individual who is ineligible due to excess non-liquid resources.[182] In effect, this change eliminates Medicaid's previous practice of allowing local districts the option to authorize Medicaid eligibility pending the liquidation of the excess resource.

This means that if a Medicaid applicant/recipient has resources, in excess of the allowable resource limits, and those resources are not considered exempt (for example, homestead, car), then that individual is not considered eligible until those resources are eliminated. There are no exceptions for situations where the excess resources cannot be sold or transferred. See also discussion of effect on vacant non-exempt homesteads.

[E] Resource Exemptions

The following resources are exempt[183] and will not be considered by Medicaid in determining eligibility.

[E][1] Homestead

A Medicaid applicant's homestead (house, condominium, co-op, or mobile home)[184] and the surrounding (attached) land on which the applicant resides is exempt and not counted as a resource.[185] However, the recently enacted Deficit Reduction Act of 2005[186] (DRA 2005) has now imposed a maximum home equity value. The current

---

181. "Waivered" services are discussed *infra*. *See* the discussion of Spousal Impoverishment budgeting in this chapter; *see also* Appendix 6G.
182. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(e) (repealed Sept. 16, 1996) (allowed social services districts the option to authorize Medicaid for an ineligible MA-only applicant/recipient with excess non-liquid resources pending liquidation of the resources). *See also* GIS Message 96-MA/036 and 30 MM/ADM-1 ("Elimination of Conditional Eligibility and Treatment of a Homestead").
183. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-1.4(f).
184. *Id*.
185. N.Y. SOC. SERV. LAW § 366.2(a)(1); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(b)(2)(i).
186. Deficit Reduction Act (DRA) of 2005, Pub. L. No. 109-171.

limit for 2015 is $828,000.[187] This home equity limit does not apply if one or more of the following persons are lawfully residing in the home:

- the spouse of the individual; or
- the individual's child who is under age 21 or certified blind or disabled; or
- if an "undue hardship" is claimed and the denial would endanger the individual's health.

Assuming the individual's homestead does not exceed the maximum $828,000, the home will continue to be exempt as long as one of the following individuals continues to reside in the homestead: the applicant; the applicant's spouse; a child under the age of twenty-one; a blind or disabled child of any age; or another dependent relative.[188]

If the exempt homestead is sold, the proceeds from the sale would be a countable resource for Medicaid eligibility purposes, unless those proceeds are used to purchase another homestead (in which the applicant resides) or some other exempt resource.

[E][1][a] Vacant Homesteads

A vacant or unoccupied homestead will allow Medicaid to count the value of the homestead as an available resource, which would cause the Medicaid applicant/recipient to be ineligible for Medicaid as long as he or she remained the owner of the home. Medicaid would also consider the homestead to be a non-exempt resource if the house is occupied only by a non-exempt individual (see previous section for a listing of exempt individuals).

Should the Medicaid recipient need to be temporarily absent from the homestead, the homestead will retain it exempt status. "Temporary absence"[189] means that the Medicaid recipient is expected to return home. Reasons for temporary absence may include employment, hospitalization, military service, vacation, education, or visits.[190] When a Medicaid applicant/recipient is away from the home

---

187. 06 OMM/ADM-5 at 7; GIS 12 MA/002.
188. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.7(a)(1). Special rules governing transferring of an exempt homestead are discussed. *See infra* section 6:8.5.
189. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-1.4(p).
190. *Id.*

for medical reasons (hospitalization or placement for rehabilitation therapy), Medicaid will presume it to be a temporary absence if there is medical proof that the placement is temporary and a "medical discharge plan" exists.[191]

[E][1][b] Vacant Non-Liquid Homesteads

Often the applicant/recipient is in the position of being unable to dispose of the empty homestead when entering a skilled nursing facility. This could be due to a lack of capacity to sign the necessary papers to transfer or sell the house, or simply because a buyer cannot be found. This situation poses a serious problem for the Medicaid applicant/recipient. Until 1996, Medicaid had a policy of providing conditional eligibility to applicants/recipients who were unable to liquidate their homesteads. This policy had allowed Medicaid to provide services to the applicant/recipient pending the ultimate sale of the homestead.[192] The repeal of this policy leaves only one option available to Medicaid applicants/recipients who are unable or unwilling to dispose of their non-exempt home. An individual in this position must supply Medicaid with a letter expressing the subjective intent that they will ultimately return home (discussed in the next section).

[E][1][c] Subjective Intent to Return Home

Based on a 1993 district court decision,[193] a Medicaid claimant's home will continue to be an exempt resource, even after the individual becomes permanently institutionalized, if the homeowner makes a statement of a subjective intent to return home. This means that once Medicaid is informed of the homeowner's intent to return home, with or without medical evidence to support this intention, Medicaid cannot consider the vacant home as a countable resource and cannot force the sale of the property. The intent to return home must be documented in the case record by a written statement from

---

191. 92 ADM-53 at 3 (discharge plan), 11 (at least twenty days provided to establish discharge plan).

192. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(e) (repealed 1997). This regulation was referred to as conditional Medicaid Eligibility.

193. Anna W. v. Bane, 863 F. Supp. 125 (W.D.N.Y. 1993) (enjoining Medicaid from including an unoccupied homestead as a resource if intention to return home is established). *See also* N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.7(a)(1) (amended 1996) and GIS Message 93-MA/024.

the individual or an authorized representative. Note, however, that Medicaid is still permitted to impose a lien on the vacant home of the institutionalized individual if none of the relatives specified in the previous paragraph continues to live in the home. (See the discussion later in this chapter of lien laws as they apply to a homestead.)

[E][1][d] Homesteads Subject to a Life Estate Deed

A homestead is often transferred to another individual, subject to a "life estate." In simple terms, this means that the ownership of the property has been changed to another person; the original owner, however, has retained a life-time lease to hold and use the property. The main reason for using a life estate, rather than a regular transfer of the property, is to reduce any taxes owed on the appreciated value of the home when the home is later sold.

For Medicaid purposes, the "life-time lease" held by a Medicaid recipient under a life estate deed has no value for eligibility purposes and no lien may be placed upon it.[194] However, it must be noted that the creation of a life estate deed will cause transfer penalties to be imposed by Medicaid for institutional services (see section 6:8 on transfer penalties). Any penalties imposed will be based upon the age of the property owner at the time the life estate was established, and on the value of the homestead. The Medicaid program provides tables that calculate value of the transfer based upon the age of the property owner.[195]

As part of the Deficit Reduction Act of 2005[196] (DRA 2005), as of February 8, 2006, when a Medicaid applicant or their spouse purchases a life estate interest in property owned by another individual, that purchase is to be treated as a transfer of assets for less than fair market value, unless the purchaser resides in the home for at least a continuous period of one year after the purchase.[197] This change does not apply to applicants or their spouses who transfer property and "retain" life use.

[E][1][e] Non-Liquid Resource Due to Legal Impediment

A resource may be considered to be unavailable, and therefore not counted for Medicaid purposes, if there exists a "legal impediment"

---

194. 03 OMM/ADM-1 at 5; 96 ADM-8; *see also infra* section 6:8.8.
195. 03 OMM/ADM-1 (attached tables).
196. Deficit Reduction Act (DRA) of 2005, Pub. L. No. 109-171.
197. 06 OMM/ADM-5 at 23–24. This provision applies to applications filed on or after August 1, 2006, for nursing facility services.

that prevents the sale or transfer of that resource.[198] For example, a jointly owned piece of property, where the joint owner refuses to cooperate with the sale or transfer of the property, or the applicants' lack of capacity pending appointment of a guardian.

[E][2] Personal Property

Essential personal property such as clothing, furniture, personal effects, and a car are exempt.[199] A car may be of any value, if it is for the personal use of the Medicaid applicant or their spouse. However, a value of approximately $4,500 is placed on a used car owned by the Medicaid recipient, should the car be transferred to another individual.

[E][3] Life Insurance

There are two basic types of life insurance, "whole life" insurance, which may or may not have a cash value (redemption value prior to death), and "term" or "group life" insurance, which never has a cash value. Life insurance with no cash value is entirely exempt for Medicaid purposes and is not counted as a resource.[200]

When an individual has life insurance policies with redeemable cash values attached to them, the first step is to total up their "face value," also referred to as the death benefit. If the total face value of the policies is $1,500 or less, the cash value of these policies will not count as resources in the determination of Medicaid eligibility. If the total face value of these countable life insurance policies exceeds $1,500, then the total cash value of these policies is counted as a resource and may be assigned as part of an exempt burial fund. See discussion of burial funds, below.

[E][4] Burial Funds and Burial Expenses

Medicaid recipients may set aside money in a separate burial fund which will not be counted as a resource.[201] Up to $1,500 for an individual or $1,500 each for a couple may be set aside for burial or

198. 03 OMM/ADM-1 (Jan. 29, 2003) at 10, § IV.D.4.
199. N.Y. SOC. SERV. LAW § 366.2(a)(2); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.7(a)(2).
200. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(b)(2)(ii).
201. N.Y. SOC. SERV. LAW § 366.2(a)(3); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(b)(1); *see also* 91 ADM-19; 91 ADM-17 (relative to excess resources at 6).

related expenses. An eligible individual may also set up a burial fund for a non-eligible spouse.[202] The burial fund must be a separate bank account.[203] All interest that accrues on an exempt burial fund is exempt for Medicaid income purposes.[204] This bank account is not to be touched until the Medicaid recipient's death.[205]

[E][5] Resources and Incurred Medical Bills

A household's excess resources (amount over the maximum resource level) is exempted to the extent of incurred medical bills.[206] This means that if a Medicaid applicant had $5,000 in excess resources and $5,000 of incurred medical bills, which are not going to be covered by Medicaid, then that $5,000 of excess resources will not be counted for eligibility purposes.

[E][6] Life Insurance and Burial Expenses

Life insurance policies may be designated as an exempt burial fund if specific rules and requirements are met. If the total face value of all countable life insurance policies is $1,500 or less, a burial fund can be established with the life insurance policies, plus any other resources from separate funds, to bring the total burial fund to the maximum limit of $1,500.

If the total face value of all countable life insurance policies is more than $1,500, ignore the face value but count the cash value as a resource. If the cash value is less than $1,500, other funds held in a separate account may also be designated as a burial fund to bring the total amount up to the $1,500 burial account limit. If the cash value is more than $1,500, only $1,500 of the cash value may be exempt as the burial fund,[207] and the remainder of the cash value is counted towards the individual's countable resources.

---

202. 91 ADM-19 at 2.
203. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(a)(2)(xvii); *see also* 91 ADM-19; MAP Informational 33/91.
204. *See* 91 ADM-19; MAP Informational 33/91.
205. *See also infra* section 6:7.3[E][7], "Irrevocable Burial Trusts."
206. 90 ADM-28, implementing Westmiller v. Sullivan, 729 F. Supp. 260 (W.D.N.Y. 1990); *see also* 91 ADM-17.
207. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(b)(1)(ii); *see also* 91 ADM-19.

[E][7] Irrevocable Burial Trusts

An additional burial-related resource exclusion is the exemption for burial spaces and irrevocable burial agreements.[208] The actual ownership of a burial space is considered an exempt resource. However, if Medicaid recipients wish to prepay for a complete funeral they must meet certain requirements under an amendment to New York State laws on funeral contracts.

To pre-purchase a funeral for a Medicaid recipient, the funds must be placed in an "Irrevocable Pre-Need Trust," as provided by state law.[209] These are the basic rules under which a pre-need burial trust must be established:

- The trust must be irrevocable (nonrefundable);
- No limit is placed on the dollar amount placed in the trust;
- Applicant may have both a $1,500 burial account and an irrevocable burial trust (subject to the next rule);
- Any dollar amount not designated for a burial-space-related item (for example, flowers, religious services, transportation) will be used to reduce the separate $1,500 burial account (see example below);
- The trust can include both a burial space and burial funds;
- Any funds remaining after the funeral will revert to Medicaid; and
- The trust may be moved from funeral home to funeral home.

Example: An irrevocable burial trust is established that includes $5,000 for burial space items and $500 for non-burial-space-related items. In this situation, the Medicaid recipient can only put aside $1,000 in a separate burial account instead of the full $1,500.

---

208. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.7(a)(3); 91 ADM-19.

209. Senate Bill 6313-A, effective Jan. 1, 1997. Applies to all contracts or agreements entered into on or after Jan. 1, 1997. Medicaid requires every applicant/recipient to convert his or her prepaid burial agreements to "irrevocable" agreements after Jan. 1, 1997. Anyone not converting will have the burial-space-related portions of their agreements counted as an available resource. The only individuals exempted from this conversion requirement are those currently enrolled in SSI.

[E][8] German and Austrian Reparation Savings Accounts

War reparation payments made by the Federal Republic of Germany to Holocaust survivors and payments under sections 500 to 506 of the Austrian General Social Insurance Act are considered exempt resources when retained beyond the month of receipt.[210] This applies both to claimants in the community and to those receiving institutional services.

Accumulated reparation payments must be a separately identifiable resources. This is best accomplished by depositing these payments in a separate bank account.

[E][9] Robert Wood Johnson Insurance Policies

Resources accumulated and remaining after fulfilling the requirements of insurance policies offered by the New York State Partnership for Long-Term Care are considered exempt resources.[211]

[E][10] Non-Applicant Spouse Retirement Accounts

A non-applying "community spouse" who has work-related retirement accounts (for example, IRA, 401K, or Keogh accounts) in periodic payment status will not have the retirement accounts counted for the purposes of determining the amount of the "community spouse resource allowance" (see section 6:9.6[B]) or for the purpose of establishing the institutionalized spouse's Medicaid eligibility.[212] So, if the "community spouse" is receiving regular payments from his or her retirement accounts on a recurring basis, Medicaid will basically exempt those retirement accounts for all Medicaid purposes. This includes situations where the retirement accounts of the community spouse exceeds the allowable community spouse resource allowance.

---

210. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(b)(2)(iv); *see also* 92 ADM-32; 91 ADM-8.

211. Pub. L. No. 103-66, § 13612(a) (amending 42 U.S.C. § 1396p(b)); N.Y. SOC. SERV. LAW § 367-f; 92 ADM-53 at 7, 14. *See also* 96 ADM-8 at 21. For general information about these policies, call 518-486-4121.

212. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-4.4, 360-4.6(b)(2)(iii). *See also* 90 ADM-36 and 88 ADM-30; General Information System (GIS) 06 MA/004 and 98 MA/024.

If the community spouse is not receiving periodic payments from his or her retirement accounts, they must submit a "spousal refusal letter" (see section 6:9.3) before the applicant spouse can submit a Medicaid application. The amounts being dispersed from these retirement accounts would be considered monthly income to the non-applying spouse and would be considered in calculating the "spousal impoverishment income allowance" (see section 6:9.5).

[E][11] Supplemental Needs Trusts for the Disabled

A supplemental needs trust[213] may be established to hold a disabled individual's resources for Medicaid eligibility purposes. If the supplemental needs trust is established according to the following rules, the principal and income from that trust will not be considered as available income or resources for Medicaid eligibility purposes:

- The beneficiary of the trust must be disabled;
- The beneficiary must have been under the age of sixty-five when the trust was established;
- The trust is funded with the assets of the disabled beneficiary;
- The trust may only be established by a parent, a grandparent, a legal guardian, or a court; and
- The trust agreement provides that upon the death of the beneficiary the state must receive reimbursement out of the remainder of the trust for all Medicaid benefits paid on behalf of the disabled beneficiary.[214]

This type of trust for a disabled Medicaid recipient is usually used to protect court awards or settlements from personal injury cases awarded to individuals who will need chronic care the rest of their lives.[215]

---

213. A supplemental needs trust (also known as a special needs or luxury trust) is a trust written in such a way that the income generated from the trust will not prevent the recipient of that income from receiving public benefits such as Medicaid, SSI, or public assistance. The income from the trust cannot be used to pay for any of the recipient's needs that are being covered by the public benefits program in which they are enrolled. For example, if the beneficiary of the trust is on Medicaid, none of the trust income can be used to pay for medical-related goods or services.

214. N.Y. SOC. SERV. LAW § 366.5(d)(3)(ii)(D). *See also* 96 ADM-8 at 11.

215. *See also supra* section 6:7.1[C][9] and *infra* section 6:8.5[G].

[E][12] Availability of Resources (Windfalls and Inheritance)

Only actually available resources (or income) will be considered countable for the purposes of establishing Medicaid eligibility.[216] Availability is measured from the point when the resource is in the control of the applicant/recipient or anyone acting on their behalf.[217] Therefore, an inheritance is not considered an available resource for Medicaid purposes until it is received.[218]

[E][13] Retirement Funds

A retirement fund (IRA, pension, disability, Keogh, etc.) owned by an individual is a countable resource when an individual is not receiving payments, but is allowed to withdraw all of the principal. The value of the resource is the amount of money that the individual can currently withdraw, regardless of penalties. If the bank withholds any money for an early withdrawal, only the net amount is counted. Income taxes that may be due on the withdrawn amount are not deducted in determining the value.[219]

For the purposes of Medicaid eligibility, work-related retirement accounts or plans (IRA, Keogh, 401K, etc.) owned by the applicant/recipient will be considered an exempt asset if that retirement account is in pay-out status.[220] In other words, once an individual has applied for or is receiving periodic minimum distributions or payments from his or her retirement account, the entire value of the retirement account (principal) will not be a countable resource.[221] These monthly payments/withdrawals must be calculated based upon the applicant's life expectancy as is established by the Medicaid program.[222] Upon the death of the individual, the retirement account would pass to the designated beneficiary. See the discussion in the spousal resource section regarding treatment of retirement funds of a non-applicant spouse.

---

216. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-2.3(c)(1).
217. *Id.* § 360-4.4(b)(1).
218. Matter of Little, 684 N.Y.S.2d 124 (4th Dep't 1998).
219. *See* MAP Procedure 00-2, Treatment of Retirement Funds, Jan. 27, 2000. Note that this is a New York City Program (MAP) operation procedure and may not be the operating practice of other Medicaid districts.
220. *See* Matter of Arnold S. (Medicaid Fair Hearing ruling).
221. *See* GIS 98 MA/024; MAP Procedure 00-2, Treatment of Retirement Funds, Jan. 27, 2000.
222. *See* 06 OMM/ADM-5.

[E][14] Annuity Reporting and Beneficiary Requirement

Effective August 1, 2006, all applications for Medicaid coverage of nursing facility services must disclose a description of any interest the applicant (or the spouse) has in an annuity, regardless of whether the annuity is irrevocable or treated as an asset.[223]

For annuities purchased by the applicant or the applicant's spouse on or after February 8, 2006, the purchase of the annuity shall be treated as transfer of assets for less than fair market value unless:

- the state is named as the remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of the annuitant, or
- the state is named as such a beneficiary in the second position after the community spouse or minor or disabled child, or the first position if such spouse or representative of such disabled child disposes of any such remainder for less than fair market value.[224]

[F] Disposing of Excess Resources

Often, prior to the date of application, the Medicaid applicant's total non-exempt resources are greater than the allowed amount listed in Appendix 6A. There are three basic means of disposing of these excess resources.

First, the applicant may simply spend the resources down, for his or her own personal benefit, to the allowable levels. There are no limitations on how or where these resources may be spent, as long as fair market value goods or services are received in return.[225] For example, if the applicant needs a new television or wants to have the house painted, excess resources may be used as long as the applicant has a receipt to show where and how the money was spent.

Second, if the applicant has incurred necessary medical expenses in an amount equal to or greater than the amount of the excess, these expenses cancel out excess resources.[226]

Finally, in certain situations, excess resources may be transferred to another individual. (The transfer rules are discussed below.)

---

223. 06 OMM/ADM-5 at 22.
224. *Id*.
225. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(d)(1)(i).
226. *Id.* § 360-4.1(b)(v), 4.8(b). *See also supra* discussion of income spend-down; 90 ADM-28; 91 ADM-17.

When incurred medical bills are used to offset excess resources, the bills are applied in the following order to reduce the excess resources:

(1) paid bills (in month of application),

(2) bills for non-covered unpaid services,

(3) bills from nonparticipating unpaid providers,

(4) unpaid "viable bills"[227] in oldest service date order, and

(5) bills payable by Medicaid.[228]

§ 6:8 Medicaid Transfer Rules and Penalties After the Deficit Reduction Act of 2005

This section reviews the rules governing the transferring of excess assets (income and resources) by a Medicaid applicant. The transfer rules are designed to penalize Medicaid applicants for transferring away assets (income or resources) that could have been used to pay for medical expenses such as nursing home care and other long-term care services. If a Medicaid applicant has made a non-exempt transfer of assets, then a calculated penalty (or waiting period) is imposed. During this penalty waiting period the applicant cannot receive certain long-term care services; this is also known as the period of restricted coverage. The transfer penalty rule should really be considered to be a two-stage process. The first stage of the rule is the "look-back" period; Medicaid is looking back over the applicant's financial history to see if any non-exempt gifts were made. The second stage of the rule is calculating the length of the penalty; all discovered non-exempt transfers are totaled and that amount is put into a formula that results in the number of months during which the applicant cannot receive certain long-term care services. As discussed below, a new third stage of the transfer penalty rule has now been added; the new section deals with when the calculated penalty waiting period begins to expire.

---

227. A "viable" bill is a bill for which a creditor continues to seek payment. For example, if an applicant has excess resources of $500, but has unpaid doctor's bills of $400 and unpaid pharmacy bills for $150, the applicant will be eligible from the date of application until he or she is recertified, despite having actually been over-resourced at the time of application. *See* 91 ADM-17.

228. *See id.*

Throughout this section you will see references to the DRA of 2005 and OBRA '93. These references are referring to the Deficit Reduction Act of 2005[229] (DRA of 2005) and to the Omnibus Reconciliation Act of 1993[230] (OBRA '93). Both of these federal budgetary acts have made amendments and changes to the original federal Medicaid law. The DRA of 2005, signed into law on February 8, 2006, has made some dramatic changes to the Medicaid transfer rules, while at the same time leaving some parts of the law as they were. The following sections will explain the current state of the Medicaid program after the enactment of the DRA of 2005.

Anyone dealing with the transfer rules should take special note of the fact that Medicaid may bring legal action, under the Debtor and Creditor Law of New York,[231] to set aside any transfer that appears to have been made for the sole purpose of qualifying an individual for Medicaid services.[232]

§ 6:8.1 Transfer Penalties Only for Nursing Home Services, No Penalty for Home Care

Under current New York State Medicaid law, there continues to be *no* transfer penalties applied to applicants who are only applying for community-based home care services.[233] Penalty/waiting periods are only calculated and applied to those Medicaid applicants seeking long-term care services (defined below). While New York State Medicaid has always had the option to impose a penalty waiting period for community-based home care services, the New York legislature has again failed to pass such legislation in the current New York State budget. Please be alert to the fact that the current ability to transfer assets and obtain Medicaid home care services in the month following the transfer is subject to repeal by the New York legislature.

---

229. Deficit Reduction Act (DRA) of 2005, Pub. L. No. 109-171.
230. Omnibus Reconciliation Act of 1993 (OBRA '93); this Act amends the Social Security Act and provides the basis for New York State's legislation and regulations governing transfer of assets and Medicaid eligibility.
231. N.Y. DEBT. & CRED. LAW §§ 273–76.
232. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11(b)(6); *see also* 92 ADM-53 at 9.
233. Currently, New York State only imposes transfer penalty waiting periods on individuals applying for institutional Medicaid services. However, under OBRA '93, states have the option to also apply transfer penalty waiting periods to non-institutional home care services.

§ 6:8.2 Transfer Rule (Stage 1)—Look-Back Period of Five Years

The look-back period is a financial review period or Medicaid audit. Medicaid is looking to see if the applicant, or the applicant's spouse, has made any non-exempt transfers of assets that could have been used to pay for nursing home care services.[234] When a Medicaid application is submitted, the applicant must document their resources for the full look-back period. If non-exempt transfers are discovered during the look-back, then "stage 2" of the transfer rule must be applied. The look-back begins from the date an applicant is both institutionalized and requesting coverage to be established for nursing facility services.[235] A shorter look-back rule applies to applicants seeking non-institutional home care Medicaid (see below).

The current look-back period for nursing home applications is sixty months.

[A] Five-Year Look-Back for Existing Trusts

An extended look-back of sixty months will apply when "trust-related" transfers are made on or after August 11, 1993.[236] Disclosing on the Medicaid application that the applicant has been involved in a "trust-related transfer"[237] will trigger the sixty-month look-back. The trusts and other similar legal instruments targeted by this rule are certain self-settled trusts.[238] Trusts established under a will and trusts for certain disabled individuals are exempt from this rule.[239]

Trust planning is a complicated and specialized practice area of the legal profession which has an important part to play in certain Medicaid situations. However, a full discussion of the relationship

---

234. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(i); *see also* 96 ADM-8 at 12.
235. 06 OMM/ADM-5: "Deficit Reduction Act of 2005—Long Term Care Medicaid Eligibility Changes," issued July 20, 2006 at 9–11.
236. 96 ADM-8 at 12.
237. Trust-related transfers are defined in 96 ADM-8 as funding a new trust, transfers to an existing trust, distribution from a trust to someone other than the Medicaid recipient, or removing a trustee's ability to distribute trust assets to the Medicaid recipient due to a "trigger provision" in the trust agreement.
238. Trusts as defined by 42 U.S.C.§ 1396p(d); *see also* N.Y. SOC. SERV. LAW § 366(2)(b)(2).
239. N.Y. COMP. R. & REGS. tit. 18, § 360-4.5(b)(5); 96 ADM-8 at 9–10, 13–14.

between Medicaid eligibility and trusts is beyond the scope of this chapter.[240]

[B] Shorter Look-Back for Home Care Applications

For Medicaid home care applications there is no need to comply with the look-back. Under the "Resource Attestation"[241] process (see section 6:6.4[B] above), applicants seeking coverage for non-institutional community-based long-term care (such as personal care services) are only required to provide Medicaid with resource documentation for the month of application. If, however, the applicant seeks to obtain Medicaid coverage for a retroactive period, prior to the date the application is submitted (see section 6:6.6 above), then the applicant must submit resource documentation for the period of requested retroactive coverage. In practice, many Medicaid offices will require three months of resource documentation. Should the Medicaid home care recipient later need institutional Medicaid services, he or she will need to comply with the resource documentation of sixty months.

§ 6:8.3 *Transfer Rule (Stage 2)—Calculating the Penalty Period*

The penalty period can be defined as a period of months during which a Medicaid recipient is ineligible for Medicaid institutional services; that is, Medicaid will refuse to pay for institutional services.[242] The idea behind the penalty period is that had the Medicaid recipient not made a transfer of assets, the individual could have used those assets to privately pay for institutional services, if and when they became necessary. The imposition of the penalty period requires the individual to find some source of payment, other than Medicaid, to pay for any institutional services required during the calculated penalty period. Some people prefer to describe the penalty period as a restriction on Medicaid coverage. When there is a penalty

---

240. Individuals interested in this area of Medicaid planning should review 96 ADM-8 and consult with an experienced elder law attorney.

241. O4 OMM/ADM-6: "Resource Documentation Requirements for Medicaid Applicants/Recipients (Attestation of Resources)," issued July 20, 2004; 05 OMM/INF-2: "Questions and Answers: Resource Attestation," issued June 8, 2005. This replaces the program known as "simplified asset review."

242. "Institutional services" was defined earlier.

period, Medicaid will authorize payment for all services, except institutional services, during the running of the penalty period.

Whenever an applicant has transferred funds, there will be a period of ineligibility for institutional services even though the applicant may, at the same time, be simultaneously eligible for Medicaid home care or community services.

[A] The Formula

The period of ineligibility, or period of restricted coverage for Medicaid institutional services, is calculated by the following formula: Dollar value of transfer divided by average monthly cost for one month of nursing home care[243] equals the number of months of ineligibility for Medicaid institutional services. If, when calculating the penalty period, a "partial month" is calculated, a partial penalty period will be calculated for a percentage of a month.[244] There is no cap on the length of a penalty period;[245] the length is relative to the amount of assets transferred. Periods of ineligibility begin on the first day of the month following the month of transfer.[246]

§ 6:8.4 Transfer Rule (Stage 3)—Penalty Period Begin Date

Under the DRA of 2005 and the New York State Budget of 2006, the date when a calculated penalty period (Stage 2) will begin to expire has changed. The current rule states that any calculated penalty period will only begin to expire when the applicant is both residing in a skilled nursing facility and financially eligible for Medicaid coverage.

---

243. The average cost of nursing home care is a number provided by the Medicaid. It is to be used to calculate the penalty period. These numbers can be found in Appendix 6F of this chapter.

244. 96 ADM-8 at 16. *But see* Brown v. Wing, N.Y.L.J., June 30, 1998, p.31, col. 6, where the Supreme Court, Appellate Division, Second Department, held the date must begin during the month in which the assets were transferred; Brown v. Wing, 675 N.Y.S.2d 103 (2d Dep't June 22, 1998), *aff'd.* Medicaid is appealing this decision and continues, as of this date, to count penalty periods from the month after the transfer.

245. 96 ADM-8 at 15. For example, a $250,000 transfer will create approximately twenty-seven months of penalty for institutional services in the New York City Area ($250,000 ÷ $9,132 = 27.38).

246. 96 ADM-8 at 15. For example, if a transfer is made on July 10, the calculated penalty period would begin to run or expire beginning on August 1. *But see also Brown*, N.Y.L.J. at 31, *supra* note 244.

[A] Transfers on or After February 8, 2006[247]

For transfers made on or after February 8, 2006, the penalty waiting period begins to expire on the first day of the month after which assets have been transferred for less than fair market value, or the first day of the month the otherwise eligible institutionalized individual is receiving nursing facility services for which Medicaid would be available but for the transfer penalty, whichever is later, and which does not occur during any other period of ineligibility. To commence the expiration of a penalty waiting period, the following requirements must be met:

1. the individual must be residing in a nursing facility;
2. the individual must be financially and otherwise eligible to receive Medicaid nursing home coverage; and
3. the individual would otherwise be eligible except for the calculated penalty period.[248]

§ 6:8.5 *Transfers Exempt from Penalty*

When evaluating transfers of assets, certain assets may be transferred without causing a penalty period to be calculated. The transferring of these assets is known as making "exempt transfers."

[A] Transfers for Fair Market Value

If the Medicaid applicant makes a showing that he or she disposed of resources for fair market value, no penalty period will be imposed.[249] This means that the resources have been spent on goods or services for their personal consumption. The claimant can usually establish this fact by producing a bill of sale or receipt for the item purchased or the services received.

---

247. 06 OMM/ADM-5 at 15.
248. 96 ADM-8 at 15.
249. N.Y. SOC. SERV. LAW § 366(5)(c)(3)(iii)(A); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(ii)(c); *see also* 89 ADM-45 at 13.

[B] Transfers for Purpose Other Than Qualifying for Medicaid

If the claimant submits strong evidence that the transfer of resources was exclusively for a purpose other than qualifying for Medicaid, no penalty period will be imposed.[250] This is generally difficult to prove.

Factors considered in determining whether a transfer was made for a purpose other than to qualify for Medicaid include whether the applicant was ill at the time of the transfer, what percentage of the applicant's resources were transferred, and how many months prior to submitting the Medicaid application the transfer was made occurred.

[C] Transfers to a Blind or Disabled Child

If the applicant transfers assets to his or her child (of any age) who is blind or permanently and totally disabled, no penalty is imposed.[251] Transfers can also be made to a trust established for the sole benefit of any disabled individual under the age of sixty-five.[252]

[D] Transfers Between Spouses

If the applicant transfers assets to his or her spouse, no penalty period is imposed.[253] When one spouse is applying for institutional Medicaid services, any transfers from the applicant spouse to the non-applicant spouse must be completed within a ninety-day period after a determination of eligibility for the institutional Medicaid spouse has been made.[254] If the transfers or division of assets is not completed within the ninety days, the assets will be divided according to ownership; this in turn may cause the applicant spouse to lose his or her Medicaid eligibility. Additionally, a transfer made to another, for the "sole benefit" of a spouse, is also considered an exempt transfer.[255] As long as the terms and conditions of the transfer are specified in a written instrument of transfer (such as a trust document, deed, or other signed and

---

250. *Id*. and 96 ADM-8 at 23.
251. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(ii)(b)(2); *see also* 89 ADM-45 at 16.
252. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(1)(iv); 96 ADM-8 at 22.
253. N.Y. SOC. SERV. LAW § 366.5(c)(3)(ii); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(ii)(c)(2)(i); *see also* 91 ADM-37.
254. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(c)(6).
255. *See* N.Y. SOC. SERV. LAW § 366(5)(d)(3)(ii)(A) & (B); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(iii)(c)(1)(i), (ii).

acknowledged statement), the instrument, which must be executed at or about the time of the transfer, must clearly limit the use and enjoyment of the transferred property to the individual's spouse.[256]

[E] Undue Hardship

If the applicant demonstrates "undue hardship,"[257] no penalty period is imposed. New York has implemented a restrictive definition of "undue hardship" for this purpose. Undue hardship exists only if (1) the individual is otherwise eligible for Medicaid, (2) the individual is unable to obtain necessary medical care without Medicaid, and (3) the individual makes "best efforts" to obtain return of the transferred asset and agrees to cooperate as deemed appropriate by Medicaid in pursuing return of the resource or obtaining fair market value for the resource. Medicaid may require the individual to pursue the return of the asset by bringing a lawsuit.

[F] Returning Transferred Assets

If all or a portion of the transferred assets are returned to the applicant prior to the eligibility determination, no transfer penalty is imposed.[258] If a portion of the transferred assets is returned prior to the eligibility determination, the transfer penalty is reduced by the amount of the returned assets.[259] These same rules apply even if the assets are returned, in whole or part, to the Medicaid recipient after eligibility is determined.[260] Transferred assets are considered returned if the holder of the transferred assets uses them to pay for nursing facility services for the Medicaid applicant, or provides them with an equivalent amount of cash or other liquid assets.[261]

---

256. 96 ADM-8 at 7–8.
257. N.Y. SOC. SERV. LAW § 366.5(c)(3)(iv); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(ii)(d)(2). *See also* 91 ADM-37 at 3–4; 90 ADM-29; 89 ADM-45 at 15.
258. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(iii)(d)(1)(iii).
259. 96 ADM-8 at 23.
260. *Id.* The penalty period must be recalculated as if the assets were never transferred. *But see* Weiss v. Suffolk Cty. Dep't of Soc. Servs., No. 2013-09464 (N.Y. Sup. Ct., Oct. 1, 2014) (Transferred assets were not considered returned, if not spent on nursing home care for the Medicaid applicant. Assets were spent on assisted living for the applicant).
261. 96 ADM-8 at 23. Returning assets to a Medicaid recipient will, of course, make them ineligible for Medicaid services since they will now be over the maximum resource allowance.

[G] Transfers into a Supplemental Needs Trust (SNT)

Transferring the assets (income or resources) of a Medicaid applicant into an approved Supplemental Needs Trust (SNT)[262] will not cause a period of ineligibility to be imposed for institutional Medicaid services as long as:

- the SNT is for the sole benefit of the disabled individual;
- the SNT or Pooled Trust is an approved exception trust; and
- the transfers into the SNT are made before the disabled individual reaches the age of sixty-five.[263] Transfers after age sixty-five will be subject to the transfer penalty rules.

§ 6:8.6 Transfers of Homesteads on or After October 1, 1989

There are special rules regarding the transfer of "homesteads" (defined earlier in the chapter). Transfers of homesteads made on or after October 1, 1989, will result in a period of ineligibility for institutional Medicaid services, even if the home is an exempt resource at the time of the transfer, that is, even if the applicant is living in the house at the time of application. This means that the transfer of an exempt home would be penalized as any transfer of resource would be. However, the transfer of a homestead will not result in a period of ineligibility if the homestead is transferred to one of the following individuals:

- the spouse of the individual;[264]
- a child of the individual who is under twenty-one or certified blind or permanently and totally disabled;[265]

---

262. *See* discussion in *supra* sections 6:7.1[C][9] and 6:8.5[G].
263. N.Y. SOC. SERV. LAW § 366(5)(d)(3)(ii)(D); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(iii)(C)(iv).
264. N.Y. SOC. SERV. LAW § 3.66.5(c)(3)(i)(A); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(iii)(b)(1); *see also* 89 ADM-45.
265. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(iii)(b)(2); *see also* 89 ADM-45.

- a sibling of the individual who has an "equity interest"[266] in the home and was residing in the home for at least one year immediately before the date of institutionalization;[267]
- a non-disabled adult son or daughter, who was residing in the home for at least two years immediately before the date of institutionalization and who was "providing care"[268] to the individual which permitted him or her to reside at home.

§ 6:8.7 Transfers Made by the Non-Applicant Spouse

Special rules apply for transfers of resources by the non-applicant spouse. A Medicaid applicant may, in fact, incur a penalty period for institutional Medicaid services as a result of a transfer by the applicant's spouse. In order to avoid this penalty, it is important to consider the applicable rules, paying particular attention to the timing of the actual transfer. The following sections deal with transfers made by the non-applicant spouse.

[A] Transfers by Healthy (Non-Applicant) Spouse

There may be serious consequences to the Medicaid applicant spouse when their non-applicant spouse makes any transfers, before the applicant is eligible for institutional Medicaid services. Under current regulations any transfers made by either spouse would trigger the transfer penalty rules and cause a penalty period for nursing facility services.[269] This would mean that any non-exempt transfer made by a non-applicant spouse prior to an application for institutional Medicaid services would cause ineligibility for the applicant

---

266. "Equity interest" is an ownership interest in the property as evidenced by being named on the deed, having paid monthly mortgage payments, or having made "capital improvements." Capital improvements include structural renovations (such as widening of doorways or installation of ramps) as opposed to cosmetic painting, landscaping, kitchen or bath remodeling, and the like. 92 ADM-53 at 3.

267. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(iii)(b)(3); *see also* 89 ADM-45.

268. "Providing care" includes making arrangements for or actively participating in providing care, either directly or indirectly, full-time or part-time. 92 ADM-53 at 4 (Dec. 15, 1993). *See also* N.Y. COMP. CODES R. & REGS. tit. 18, § 360-404(c)(2)(iii)(b)(4).

269. N.Y. COMP. CODES R. REGS. tit. 18 § 360-4.4(c)(2)(ii), (i)(b); *see also* 96 ADM-8 at 5, 6, 16.

spouse. It makes no difference which spouse owned the transferred asset at the time of the transfer.[270]

However, the Medicaid rules make a distinction between "pre-eligibility" and "post-eligibility" transfers made by a non-applicant spouse. The rules state that any "post-eligibility" transfers of assets made by the spouse of an institutional Medicaid recipient, will not cause a penalty period to be assessed against the spouse receiving the institutional level of care.[271]

[A][1] Spousal Transfer Example

If an applicant spouse transferred $40,000 to his or her non-applicant spouse, the applicant would not incur a period of ineligibility, because a transfer between spouses is exempt. If the non-applicant spouse then re-transferred that amount to the applicant's son, before the applicant began to receive institutional Medicaid services, the applicant would be ineligible for institutional services for a period of time determined as if the applicant spouse had personally made the transfer. However, if the applicant's spouse had waited until after the applicant was receiving institutionalized Medicaid services, and then re-transferred the $40,000, no period of ineligibility would be applied to the spouse who was receiving institutional Medicaid services.

It is important to note that under this rule the non-applicant spouse is restricted from making transfers of resources only prior to the applicant spouse's acceptance for institutional Medicaid services. This means that transfers of resources by the non-applicant spouse "after" the month in which the institutionalized spouse's eligibility is established will not result in a penalty period for the institutionalized spouse.[272] While no penalty is assessed against the spouse receiving institutional care, there will be a penalty assessed against the spouse who made the transfer; and if so, the non-applicant spouse may later be ineligible for institutional Medicaid services. The formula used to determine the length of the penalty period is the same as the one applied if the applicant had made a transfer of his or her own resources.

---

270. *See* chapter 165 of the Laws of 1991; 91 ADM-37; 90 ADM-36 at 12; 89 ADM-47 at 13.
271. 91 ADM-37 at 3.
272. *Id.*

§ 6:8.8 Multiple Consecutive Transfers

When multiple consecutive transfers of assets have been made in the "look-back period," the current rules do not permit the penalty periods from multiple transfers to overlap.[273] Medicaid will add all the transfers together as if a single transfer were made with one single penalty period.[274] This rule applies to all Medicaid applications filed or pending on or after September 9, 1992.[275]

§ 6:8.9 Life Estates and Transfer Rules

The creation of a "life estate"[276] interest is considered a partial transfer of assets for Medicaid purposes. Upon the creation of the life estate, Medicaid considers a portion of the designated property (usually the house) to have been transferred, even though the applicant/recipient remains in possession of the property and continues to reside there.[277] Medicaid has ruled that the right of the Medicaid applicant/recipient to continue to reside on the property, based on the creation of the life

---

273. An example of the consecutive transfer rule is the following. Assume the average cost of nursing home care is $5,000 per month. The total resources owned are $200,000. All are available in January. Further assume this sequence of transfers:

January:	$100,000	=	20-month penalty
February:	$50,000	=	10-month penalty
March:	$40,000	=	8-month penalty
April:	$10,000	=	2-month penalty

Under the old rule, the total penalty for these transfers would be twenty months. Under the new rule, Medicaid calculates the penalty as if all the transfers ($200,000) had been made in January, resulting in a forty-month penalty.

274. N.Y. SOC. SERV. LAW § 366.5(d)(4); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(iii)(c) (effective Sept. 9, 1992). *See also* 96 ADM-8 at 15.

275. 92 ADM-44 at 3.

276. Simply explained, when a parent creates a life estate relative to their house, they have given the house to someone (usually a child) and have retained a life-long lease which permits them to live in that house until their death. Upon their death the lease ends and the title holder takes possession of the house.

277. Dep't of Health and Human Servs. State Medicaid Manual, part 3—Eligibility, section 3258: "Transfers of Assets for less than Fair-market Value," Transmittal No. 64, Nov. 1994.

estate, will not be considered a countable resource for Medicaid purposes.[278] However, a transfer penalty will be calculated for the portion (percentage) of the property transferred.[279] When a Medicaid applicant (or his or her spouse) has transferred assets to purchase a life estate in property owned by another individual on or after February 8, 2006, the purchase will be treated as a transfer of assets (see section 6:8.11, below) for less than fair market value, unless the purchaser resides in the home for at least one year after the date of purchase.[280]

§ 6:8.10 Documentation of Transfers

Medicaid requires full documentation of transfers, including proof that the applicant/recipient no longer owns the resource, the date and amount of the transfer, name and relationship to whom it was transferred, and current ownership of the transferred resource.

Whenever a transfer is made, Medicaid wants two kinds of documentation: documentation to prove that the applicant gave the resource away and documentation from the recipient that he or she has actually received the resource.

When gathering and preparing documentation, it is important to distinguish between outright transfers and fair market value purchases. Spending money on goods and services for oneself will not incur a penalty. The claimant should be prepared, however, to show receipts for all large expenditures. In particular, all withdrawals or expenditures of funds in excess of $2,000 will generally require some explanation and documentary evidence of how the money was spent or to whom the funds were transferred.

Even if an applicant is applying only for non-institutional Medicaid services (community or home care services), for which there would be no penalty for transferring resources, the applicant must still provide documentation concerning all transfers made during the "look-back" period. Medicaid requires this disclosure to enable calculation of any potential penalty period should the Medicaid recipient later require institutional services.

Once the applicant is notified in writing of Medicaid eligibility, the application may not be withdrawn, and any penalty period imposed

---

278. 96 ADM-8 at 21.
279. The value of the transferred portion is based upon life expectancy. Actuarial tables are provided in HCFA Trans. No. 64. *See id*.
280. 06 OMM/ADM-5 at 23–24.

will remain in effect, even if the applicant subsequently reapplies for Medicaid.[281]

§ 6:8.11 Spouse's Right of Election

When Medicaid applicants waive their legal right to elect a portion of their deceased spouse's estate, it constitutes a transfer of assets that creates a period of ineligibility for institutional Medicaid services; even if the waiver is mutual.[282] Any transfer penalty would begin to expire at the death of the spouse.

§ 6:8.12 Transfer Rule Definitions

[A] Assets

For the purposes of the transfer rules only, there is no distinction made between the transferring of income or resources. Under the transfer rules, both income and resources are defined as "assets."[283] Therefore, when an applicant/recipient transfers assets (income or resources), there will be a calculated penalty period for institutional services. When dealing with Medicaid eligibility rules (not transfer rules), the terms income and resources continue to have separate meanings.

[B] Long-Term Care or Nursing Home Services

As discussed above, the penalty period assessed against the Medicaid recipient is currently for institutional nursing home Medicaid services only.[284] It is important, therefore, to define which services are considered institutional. For the purposes of the transfer rules only, individuals are considered institutionalized if they are receiving any one of the following types of care:

- care in a nursing facility;
- services provided under the Office of Mental Retardation and Developmental Disabilities waiver (OMRDD);[285]

---

281. 96 ADM-8 at 17.
282. In the Matter of Estate of Dionisio v. Westchester Cnty. Dep't of Soc. Servs., 1997 WL 738872 (N.Y. App. Div. 2d Dep't).
283. 96 ADM-8 at 5.
284. N.Y. SOC. SERV. LAW § 366.5(c)(1)(i). An attempt during the 1996 New York State Budget process to apply the transfer rules to home care was defeated.
285. 96 ADM-8 at 7.

- services provided under the Traumatic Brain Injury waiver;[286]
- services provided under the Care At Home Program;[287] or
- a level of care in a medical institution usually provided in a nursing facility (alternate level of care (ALC) in a hospital).

Note that care in a long-term home health care program (LTHHCP), also known as "Lombardi" or "nursing home without walls" services, is no longer subject to "look-back" or transfer penalty rules. Therefore, effective September 24, 2007, "if an individual applies for Medicaid coverage of home and community-based waiver services, the applicant is only required to provide documentation of his/her current resources. The individual is not subject to a transfer of assets look-back period nor is the individual subject to any transfer penalty period."[288]

§ 6:9 Spousal Budgeting Rules

For married couples, Medicaid income and resource budgeting rules vary depending on who needs services and the type of Medicaid services they require. There are basically three possible combinations of budgeting situations for married couples:

(1) Both spouses need services;

(2) One spouse needs non-institutional services; or

(3) One spouse needs institutional services.

The budgeting rules for each of these combinations are discussed below. A chart summarizing the budgeting rules for couples is found in Appendix 6G.

§ 6:9.1 Budgeting for When Both Spouses Require the Same Services

In this situation, both spouses are in need of the same type of Medicaid services. They will be subject to the income and resources levels for a couple. See Appendix 6A for the income and resource levels for a couple.

---

286. *Id.*
287. *Id.*
288. *See* General Information System Memo, GIS 07 MA/018, *Transfer of Assets and Medicaid Waiver Applicants/Recipients* (Sept. 24, 2007).

§ 6:9.2 Budgeting When Both Spouses Require Different Services

In this situation, each spouse requires a different types of service. For example, one spouse may need home care Medicaid services and the other need skilled nursing home placement. In this case, each spouse will be budgeted separately, as if they are single individuals. Each spouse would be subject to the income and resource budgeting rules for their respective types of Medicaid services.

§ 6:9.3 Budgeting When One Spouse Needs Non-Institutional Services (Home Care/Community Services)

In New York, as in most states, spouses are legally responsible for each other.[289] When Medicaid is making an eligibility determination they will count all the available income and resources of any legally responsible relative.[290] Therefore, even if only one spouse needs Medicaid services, Medicaid will look at the income and resources of both spouses when determining eligibility.

If only one spouse needs Medicaid services in the community, it will be necessary to submit a written statement from the non-applicant spouse (spousal refusal letter) informing Medicaid that he or she is unable or unwilling to contribute financial medical support to their spouse. If Medicaid does not receive notice of the "spouse's refusal" (see following section) from the non-applicant spouse, Medicaid will budget the two spouses as a couple under the Medicaid budgeting guidelines.

Once the spousal refusal letter is submitted to Medicaid, along with the Medicaid application, the applicant spouse will be budgeted as a single individual on Medicaid.

[A] Spousal Refusal

As discussed in the section above, spouses have a legal duty to support each other. This legal duty is only severed when the income and resources of one spouse is made unavailable to the other spouse. The New York Social Services Law states:

---

289. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.3(f).
290. *Id.* § 360-1.4(h).

> Medical assistance shall be furnished to applicants in cases where, although such applicant has a responsible relative [spouse] with sufficient income and resources . . . , the income and resources of the responsible relative are not available to such applicant because of the absence of such relative or the refusal or failure of such relative to provide the necessary care and assistance.[291]

Therefore, when a "spouse"[292] refuses to provide financial medical support to their spouse, Medicaid cannot consider the income and resources of the refusing spouse when determining the eligibility of the applicant spouse. A non-applicant spouse may exercise this right to submit a "spousal refusal letter"[293] for medical support whether the applicant spouse is receiving non-institutional Medicaid services[294] or institutional Medicaid services.[295] Note that a non-applicant spouse's right of "spousal refusal" in the home care and community Medicaid settings is only established under New York State statutory law;[296] there is no parallel provision in federal law. This provision, therefore, is always subject to repeal by the state legislature, and a number of unsuccessful attempts to repeal it have in fact been made.

In cases where there is to be a spousal refusal, the applicant must submit a written statement, at the time of application, stating that his or her spouse refuses to contribute to the applicant's medical costs. New York City Medicaid now provides forms for the refusing spouse to sign in such cases, but a simple letter is acceptable. If the refusing non-applicant spouse does not cooperate in providing this signed form or letter, the applicant should provide Medicaid with a letter stating that their spouse is refusing to provide financial medical support.

Once informed of a spousal refusal, Medicaid must base its eligibility determination solely on the income and resources of the applicant, since the income and resources of the refusing spouse are

---

291. N.Y. SOC. SERV. LAW § 366(3)(a).
292. Only spouses and parents are considered "responsible relatives" for the purpose of the Medicaid law. Children are not responsible relatives to their parents.
293. *Id.*
294. *Id.* In the institutional setting, this right to refuse is also protected under federal law. 42 U.S.C. § 1396(a)(17)(c).
295. N.Y. SOC. SERV. LAW § 366(3)(a).
296. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.3(f)(1)(i). *See also* 89 ADM-47 at 27; MEP Procedure 89-10.

not "available" for the applicant's medical needs. Medicaid services cannot be denied to the applicant spouse based on the refusal of the non-applying spouse to provide information about his or her own income and resources.[297] Even though the non-applicant spouse is not required to supply personal financial information, it is recommended that this information be supplied in order to avoid raising any unnecessary red flags which might delay the application process. This rule is different for institutional Medicaid cases. For applications for institutional Medicaid services, the non-applicant spouse must supply personal financial information before eligibility for institutional Medicaid services is approved.

Medicaid maintains the right to sue the refusing spouse, based on that spouse's legal duty to support. Medicaid may pursue this right in Family Court or Civil Court.[298] Medicaid has been very active in seeking these recoveries. However, the risks of being sued by Medicaid vary greatly and are dependent on the amount the of non-applicant spouse's resources and in which county the applicant resides. Each Medicaid District vary in their collection policy.

[B] Marriage Equality Act—Same Sex Marriage

Following the passage of the Marriage Equality Act,[299] New York State now legally recognizes same-sex marriages performed in New York. Therefore, the New York State Medicaid program will now treat same-sex couples as they do heterosexual couples. All Medicaid rules relating to spouses will now apply to same-sex couples.

§ 6:9.4 Budgeting When One Spouse Is Residing in a Nursing Home

Income and resource budgeting becomes more complicated when the applicant spouse requires institutional (nursing home) Medicaid services. When one spouse must physically leave the home to enter a

297. 89 ADM-47 at 27; MEP Procedure 89-10 at 1, 4.
298. N.Y. SOC. SERV. LAW § 366.3(c); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.3(f)(1)(i).
299. On June 24, 2011, chapters 95 (Marriage Equality Act) and 96 (amending the religious exception language) of the Laws of 2011 were signed into law. *See also* GIS 11MA/023 (Same-Sex Marriage Update—Marriage Equality Act).

skilled nursing facility, the spouse at home is in fear of losing the income and resources of the spouse who must be placed in the nursing home. This was a real fear until Congress passed legislation in 1988 adding protection against "spousal impoverishment" to the federal Medicaid law.[300]

The spousal impoverishment income and resource provisions, explained below, apply when dealing with nursing home applications. The non-applicant spouse is referred to as a "community spouse when dealing with nursing home applications."[301] These rules provide the non-applying spouse with an income and resource allowance which is to come from the institutionalized spouse's excess available income and resources.

Before proceeding with a discussion of budgeting for an institutionalized spouse, it is necessary to define clearly who is an institutionalized spouse. For the purposes of the spousal impoverishment rules, an institutionalized spouse is a person (1) who is married to a person who is not in a medical institution or nursing facility and is not receiving "community-based waivered services" (nursing home without walls program);[302] and (2) who is either receiving care in a medical institution or nursing facility and is expected (based on medical diagnosis) to remain there for at least thirty consecutive days, or is receiving long-term home health care with waivered services.[303]

Once the Medicaid applicant meets this definition of an institutionalized individual or is in need of the institutional services listed above, the following budgeting rules are applied to the applicant and the non-applicant community spouse. A chart summarizing these rules may be found in Appendix 6G.

These provisions do not apply in cases where both spouses are institutionalized, since there is no longer a community spouse who needs protection from impoverishment. These allowances also do not apply to a non-applicant spouse whose spouse is only receiving Medicaid community or home care services without waivered services.

---

300. 42 U.S.C. § 1396r-5(h); N.Y. SOC. SERV. LAW § 366-c (implemented in New York on Oct. 1, 1989).

301. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(a)(2), (7); 89 ADM-47.

302. "Home and community-based waivered services" (nursing home without walls) are comprehensive health care services provided to individuals who would otherwise be institutionalized in a skilled nursing facility or intermediate care facility. *See* description in section 6:8.12[B].

303. 42 U.S.C. § 1396r-5(h); N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-1.4(c) and (k), 360-4.10(a)(7); 89 ADM-47 at 10.

[A] Snapshot of the Budget

Prior to applying for Medicaid, in situations where a spouse already has begun a period of institutionalization, either spouse may request an assessment of the community spouse income and resource allowances and the family allowance.[304] This assessment, also known as a "snap shot," allows spouses to plan financially for the period after institutionalization of one spouse. Spouses who are considering applying for Medicaid but who are concerned about the effect of Medicaid's income and resource budgeting rules may want to consider this option. Both spouses must supply documentation of their income and resources if they request an assessment. A spouse who disagrees with the assessment may request a fair hearing on the matter. Medicaid charges a $25 fee for providing the assessment, if the request is not filed with a Medicaid application, that is, if it is filed for planning purposes prior to application. Asset or income changes that occur during the period between the assessment and the application will be adjusted at the time of application.

§ 6:9.5 Budgeting When One Spouse Is Receiving MLTC Home Care Services

Recently, Medicaid expanded the spousal "impoverishment" budgeting rules to all Managed Long-Term Care (MLTC) Community Home Care cases.[305] Prior to this change, the impoverishment rules could only be applied to the spouse of a nursing home resident. Under the new policy, the spousal impoverishment income and resource rules have been expanded to cover the spouses of MLTC Medicaid home care recipients. Medicaid must offer this option to all spousal MLTC cases, if they feel that it would be more financially advantageous to the married couple.

Therefore, all existing spousal impoverishment rules for income and resources discussed in this chapter may now be applied to MLTC home care cases. There is only one major difference between a Medicaid applicant who is in a nursing home and a Medicaid applicant who is receiving MLTC home care services. The difference

---

304. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(c)(1); 89 ADM-47 at 12; 90 INF-19 at 2.

305. This expansion of the "spousal impoverishment rules" to MLTC community home care cases is pursuant to federal approval under New York State's 1115 waiver.

is the amount of their personal need allowance (PNA). For nursing home residents on Medicaid, the PNA is set at $50 per month. For an MLTC home care recipient, the PNA is set at $381 per month. Any income over the PNA is first budgeted to the well, non-applicant spouse, to bring them up to the maximum spousal impoverishment income allowance (see Appendix 6A).

Please note that due to this expansion of the nursing home spousal impoverishment rules to MLTC home care cases, the term "community spouse" is interchangeable with the term "non-applying spouse."

§ 6:9.6 Spousal Income Budgeting Rules

This section describes the Medicaid income budgeting rules for both the applicant and non-applicant spouse, when one spouse requires institutional Medicaid services or one spouse requires community Medicaid services (home care).

[A] Income Allowance When a Spouse Is Residing in a Nursing Home

The institutionalized spouse is entitled to an "income allowance," also known as a "personal needs allowance," which is lower than the amount they would be allowed to keep if they were receiving regular community Medicaid services. In the traditional institutional nursing home setting, the Medicaid recipient is permitted to keep a personal needs allowance of $50 a month.[306] The remainder of the Medicaid recipient's income goes to the non-applying community spouse; and/or towards the cost of his or her care in the nursing home (see discussion below). An applying spouse who is remaining at home and is receiving Home and Community Based Waivered Services (nursing home without walls program) is also limited to a personal needs allowance of $50 a month, as long as there is a legally responsible community spouse able to provide support.[307]

Income is generally counted as available to the spouse in whose name payment is made.[308] If payment of income is made to both

---

306. N.Y. SOC. SERV. LAW § 366.2(10)(i)(A); N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-4.9(a)(1), 360-4.10(b)(4)(i). *See* 95 ADM-19 and MAP Procedure 95-1.
307. 95 ADM-19.
308. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(b)(2)(ii); 89 ADM-47, at 16.

spouses (for example, interest on a joint bank account), one-half of the income is considered available to each of them.[309] When income is derived from property with no "instrument" (a document stating the interest of each spouse), one-half is considered available to each spouse.[310]

[B] Spousal Impoverishment Income Allowance for the Non-Applying Spouse

The non-applying spouse (community spouse) is entitled to an income allowance (CSIA), known as the Federal Spousal Impoverishment Income Allowance (see Appendix 6A for the current income allowance).[311] This allowance is made up of the community spouse's own income combined with enough of the institutionalized spouse's excess available income to produce a total amount equal to the community spouse income allowance (CSIA). The community spouse can only receive the income allowance if the institutionalized spouse has excess income above the $50 monthly personal needs allowance (as explained above). An example of how to calculate the allowance is found in Appendix 6H.

It is important to remember that the community spouse income allowance is made up solely from the incomes of the two spouses. No funds are provided from the Medicaid program to make up the difference if the total spousal incomes fall short of the CSIA allowance level.

In determining the community spouse's personal income, the following items may be deducted to determine the community spouse's available income: court-ordered support payments required to be paid by the community spouse, actual incapacitated adult or child care expenses, and health insurance premiums.[312]

A community spouse who needs non-institutional Medicaid services may not refuse to accept the community spouse income allowance, even if it raises his or her income over the Medicaid monthly income eligibility level. The community spouse may, however, contribute the community spouse income allowance toward

---

309. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(b)(2)(iii); 89 ADM-47.
310. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(b)(2)(vi); 89 ADM-47.
311. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-4.10(a)(8), 360-4.10(b)(4)(ii), 90 ADM-35; 89 ADM-47 at 10; 90 INF-19.
312. 91 ADM-27 at 11; 89 ADM-47 at 17.

the cost of the institutionalized spouse's medical bills and thereby achieve Medicaid eligibility for himself or herself.[313]

[B][1] Community Spouse Excess Income (Twenty-Five Percent Rule)

If the community spouse already has a personal income equal to or greater than the community spouse income allowance (CSIA), then no funds will be made available to the community spouse from the institutionalized spouse. In such cases, Medicaid may request from the community spouse a contribution of 25% of the amount in excess of the CSIA to be used to offset the cost of care for their institutionalized spouse.[314]

If the community spouse is self-employed or receives income from the rental of real property, the business expenses which are incurred in producing this income and which are allowable for income tax purposes may also be deducted.[315] Medicaid has the right to pursue the 25% in court, under their right to seek third-party recovery from a legally responsible relative.

Medicaid is now actively pursuing recovery of the 25% from spouses who are refusing to contribute. The 25% figure is used as a guideline for spousal contribution; if Medicaid decides to seek an income contribution from the refusing spouse in court, they can seek a contribution in excess of the 25% figure.[316]

[C] Family Allowance

In addition to amounts deducted from the institutionalized spouse's income for the community spouse's monthly income allowance, a "family allowance"[317] for each qualified "family member"[318] residing

---

313. 89 ADM-47 at 17; 90 INF-38 at 3.
314. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(b)(5); 89 ADM-47 at 20, 26.
315. 89 ADM-47.
316. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(b)(5).
317. *Id.* §§ 360-4.10(b)(4), 360-4.10(a)(6) (calculation of family allowance); 89 ADM-47 at 17.
318. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(a)(5), (6); *see also* 89 ADM-47 at 9. The term "family member" includes only minor or dependent children, dependent parents or dependent siblings, or the institutionalized or community spouse. "Dependent" is defined to mean that over 50% of the family member's maintenance needs are met by the community spouse and/or the institutionalized spouse.

with the community spouse is also deducted from the institutionalized spouse's income, if his or her income is large enough for this purpose.

§ 6:9.7 Spousal Resource Budgeting Rules

This section discusses the Medicaid resource budgeting rules for the applicant and non-applicant spouse, when one spouse requires either institutional Medicaid services or community home care services.

[A] Resource Limit of Institutionalized Spouse

The resource limit for an institutional spouse is the same as for all other Medicaid recipients (see Appendix 6A).

[B] Spousal Impoverishment Resource Allowance

In addition to the previously discussed income allowance, the non-applying spouse is allowed to retain a specified amount of exempt resources known as the community spouse resource allowance (CSRA), known as the "Federal Spousal Impoverishment Resource Allowance"[319] (see Appendix 6A for the current resource allowance). The purpose of this resource allowance is to protect the non-applicant spouse from becoming impoverished. Determining the amount of the community spouse resource allowance became more complicated after the 1995 New York State Budget.[320] Because of the changes made in the 1995 budget, we now have a range of community spouse resource levels.[321] The non-applying spouse resource allowance is established by applying one of the following rules:

- an amount less than or equal to the minimum allowance;[322]
- the amount of the spousal share,[323] which is equal to one-half of the married couple's resources, as of the date of the first

---

319. 42 U.S.C. § 1396r-5(g); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(a)(4); 90 ADM-35 at 4; 89 ADM-47 at 11–13; 92 ADM-18.
320. 1995 N.Y.S. Budget § 83. Although the amount of the allowance had increased annually in accordance with the consumer price index since 1989, the state legislature decided to freeze the level at $74,820 until 1997.
321. N.Y. SOC. SERV. LAW § 366-C(2). See Appendix 6I for examples.
322. In 1996, the New York State legislature attempted to lower this minimum amount, but was unsuccessful.
323. The "spousal share" could be any amount that falls between the minimum and the maximum. "Spousal share" is considered to be one-half of

"continuous period of institutionalization,"[324] up to the federal maximum;

- the amount established by a fair hearing; or
- the amount established by a court order.

An example of how the calculate the spousal share for the CSRA can be found in Appendix 6I.

After an initial determination has been made on ownership of resources and eligibility is established for the institutionalized spouse, no resources acquired thereafter by the non-applying spouse will be considered available to the applicant spouse for eligibility purposes.[325]

[C] Separating Spousal Resources (Ninety-Day Rule)

After the applicant spouse is determined to be eligible for Medicaid institutional services, the Medicaid applicant spouse is permitted ninety days to make any transfers of assets necessary to provide for the community spouse resource allowance.[326] If these transfers are not made by the end of the ninety days, the resources remaining in the name of the applicant spouse will be considered available to the applicant spouse and may cause ineligibility due to excess resources. This ninety-day period requires prior approval from Medicaid.

This rule is usually applied in situations where an asset held by an applicant spouse is held jointly with the non-applicant spouse and some extra time is needed to allow the applicant spouse to remove his or her name from the jointly held asset.

---

the total combined resources of a married couple. This evaluation is made as of the beginning of the first continuous period of institutionalization of the Medicaid applicant. *See* 42 U.S.C. § 1396r-5(c)(1); N.Y. SOC. SERV. LAW § 366-c(2)(a). See examples for a clearer explanation.

324. A "continuous period of institutionalization" is defined as a period likely to last at least thirty consecutive days in length. *See* N.Y. SOC. SERV. LAW § 366-c(2)(a), N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(a)(7) and 89 ADM-47 at 10.

325. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(c)(5), (6); 90 ADM-36 at 12; 89 ADM-47 at 13.

326. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(c)(6).

[D] Exceeding the Community Spouse Resource Allowance

Any non-exempt resources held by the community spouse, which exceed the community spouse resource allowance (CSRA) are considered available resources of a legally responsible relative. These excess resources will be factored into the applicant spouse's eligibility determination, unless a "spousal refusal letter"[327] is submitted to Medicaid for the amount of the excess resources. Under the current regulations, a community spouse who refuses to contribute resources in excess of the community spouse resource allowance continues to be eligible to receive the community spouse monthly income allowance (CSIA).[328] However, Medicaid is entitled to sue the community spouse for any resources held in excess of the resource allowance, subject to the following exceptions.

[D][1] Exceptions to the Maximum Allowance

The maximum community spouse resource allowance (CSRA) may be exceeded in certain situations. Medicaid will permit the non-applicant spouse to exceed the CSRA (without the threat of lawsuit) where the community spouse requires additional resources, above the CSRA, to generate additional income to make up for a short fall in the community spouse monthly income allowance (CSIA).[329] When establishing the CSIA for this purpose, Medicaid follows the "income first rule." Under the "income first rule" Medicaid will first look to the income available from the institutionalized spouse to see if there is enough income available to provide the community spouse with the CSIA, before counting any income of the community spouse. Therefore, the community spouse must first use the institutionalized spouses income before asking to keep a greater CSRA to generate additional income to make up for any shortfall in the CSIA.[330]

The CSRA may also be exceeded if a court order provides that the community spouse shall receive an amount in excess of the

---

327. For an explanation of the spousal refusal letter, see *supra* section 6:9.3[A].
328. 91 ADM-33 at 2–3; 90 INF-19; 89 ADM-47 at 23.
329. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(c)(7); 91 ADM-33; 90 INF-19; 89 ADM-47 at 23.
330. Golf v. N.Y. State DSS, 91 N.Y.2d 656 (1998).

community spouse resource allowance from the institutionalized spouse.[331]

If the community spouse retains resources in excess of the community spouse resource allowance, the institutionalized spouse cannot be denied Medicaid, provided that: (1) the institutionalized spouse agrees to give the state the right to pursue the community spouse for support (this is part of the original Medicaid application); or (2) the institutionalized spouse is physically or mentally impaired and cannot assign the right to sue for support if, as in New York, the state has that right independent of the institutionalized spouse's consent.[332] For an explanation of how to calculate the range of community spouse resource levels, see Appendix 6I.

[E] Disclosure of Financial Information

In general, the community spouse does not have the right to refuse to disclose information about his or her income or resources. Such refusal will result in a denial of Medicaid for the spouse applying for institutionalized care, because the community spouse income and resource allowances cannot be determined without this information.[333] However, if a denial of eligibility would result in an "undue hardship" to the Medicaid applicant,[334] eligibility will not be denied as long as the applicant has cooperated with Medicaid in seeking the financial support from the non-cooperative spouse.[335]

For example, the undue hardship exception would apply in a situation where the institutionalized spouse, if discharged from a nursing home, would be in danger of harm, neglect, or hazardous conditions in the home because the community spouse has threatened to harm the institutionalized spouse or has threatened not to provide or arrange for necessary care. In this case, Medicaid cannot be denied for the institutionalized spouse because the community spouse has refused to furnish information about his or her resources.

---

331. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(a)(4); 90 ADM-35 at 4; 89 ADM-47 at 17.
332. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(c)(4); 89 ADM-47 at 14–15.
333. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(c)(3); 90 ADM-29 at 2–3; 89 ADM-47 at 13–14.
334. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-4.10(a)(11), 360-4.10(c)(4); 90 ADM-36 at 6; 90 ADM-29 at 3; 89 ADM-47 at 14–15.
335. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(c)(3). *See also* 90 ADM-29 at 2–3; 89 ADM-29 at 13–14.

§ 6:10 Liens and Rights of Recovery

§ 6:10.1 Imposition of a Lien

A lien is a claim instituted against an individual's property during that person's lifetime as security for the payment of an incurred debt. The imposition of a Medicaid lien means that the property cannot be sold unless the claim is satisfied out of the proceeds of the sale. Liens against the property of a living Medicaid recipient are permitted in only three situations: first, when a Medicaid recipient becomes institutionalized and is "not reasonably expected" to be discharged to return home;[336] second, pursuant to a court judgment determining that benefits were incorrectly paid;[337] and third, when a Medicaid recipient is expecting an award in a personal injury suit.[338]

§ 6:10.2 Liens on the Homestead

Special rules apply to the homestead of a Medicaid recipient. No lien may be placed on an institutionalized individual's home if the Medicaid recipient or one of the following persons is lawfully living in the home:

- the spouse of the individual;
- a child of the individual who is under twenty-one or certified blind or permanently and totally disabled; or
- a sibling of the individual who has an "equity interest" in the home and was residing in the home for at least one year immediately before the date of institutionalization.[339]

Medicaid may impose a lien on homestead, but cannot require the sale of that property as long as one of the following individuals resides there:

---

336. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11(a); 92 ADM-53 at 5, 12. If, however, the individual is discharged from the institution and returns home, the lien will be dissolved. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11(a)(3)(i).
337. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11(a)(3); 92 ADM-53.
338. 92 ADM-53 at 5.
339. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11(a)(3)(ii).

- a sibling who resided in the home for one year before the Medicaid recipient entered a nursing facility;
- a child who provided care and resided in the home for two years prior to the Medicaid recipient entering a nursing facility;[340] or
- a dependent relative.[341]

Furthermore, Medicaid may not require sale of property in cases where that property is income-producing and used in a trade or business.[342]

§ 6:10.3 Recovery Against Personal Injury Award

When a Medicaid recipient has a pending lawsuit for personal injuries, Medicaid has the authority to impose a lien upon the award or settlement to recover for any payments made by Medicaid related to the injury.[343] Refer to section 6:11.1 below for additional information.

§ 6:10.4 Estate Recovery Rules

[A] Recovery Against Estate of Medicaid Beneficiary

Medicaid funds which were correctly paid[344] cannot be recouped during the life of the Medicaid recipient. They may be recovered only from the recipient's estate after death and only when: (1) the recipient was fifty-five or older[345] when the assistance was given; and (2) after

---

340. *Id.* § 360-7.11(b)(3)(i), (ii).
341. 92 ADM-53 at 12. A dependent relative is one for whom the Medicaid claimant has provided over 50% of maintenance needs.
342. 92 ADM-53 at 12.
343. MAP Procedure 92-1; *see also* Cricchio v. Pennisi, 90 N.Y.2d 296 (1997) (Medicaid can collect on N.Y. SOC. SERV. LAW § 104-b lien before placing proceeds in Supp. Needs Trust); Calvanese v. Calvanese, 92 N.Y.S.2d 410 (2d Dep't 1998) (entire settlement amount, not just portion for past medical expenses, is available to satisfy Medicaid lien/leave to appeal granted); 92 N.Y.2d 810, 680 N.Y.S.2d 54 (1998) (Table, No. 756).
344. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11(a).
345. Under the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), the age for estate recovery will be lowered from sixty-five to fifty-five. OBRA '93 § 13612(a); 42 U.S.C. § 1369p(b)(1)(B). For services received prior to August 11, 1993, Medicaid could recover only for services provided to individuals over age sixty-five.

the death of the surviving spouse, if any, and when there is no surviving child who is under twenty-one, blind, or totally disabled.[346] In order to recover such amounts, the local Department of Social Services must file a claim in Surrogate's Court against the Medicaid recipient's estate (see estate recovery section below).

For purposes of recovery against an estate by Medicaid, an estate is generally considered to include only those resources that the Medicaid recipient owned directly in his or her own name at the date of death, or benefits directly payable to the individual's estate. These include a bank account solely in the individual's name, real property solely in the individual's name, and insurance or pension benefits payable directly to the individual's estate.

The following kinds of property are not included in the individual's estate for the purpose of Medicaid recovery, since they pass by law to the co-owner at the moment of the individual's death:

- a joint bank account;
- a bank account in trust for another;
- real property jointly owned with right of survivorship;
- property held under a life estate;[347]
- securities jointly held with right of survivorship; and
- life insurance or pension benefits payable to a named beneficiary.

[B] Recovery Against Estate of Surviving Spouse

Medicaid may also recover against the estates of surviving spouses who have refused to contribute their income towards the cost of caring for their Medicaid recipient spouses and who had the "sufficient ability" to provide such support when the recipient was on Medicaid.[348]

[C] N.Y. Partnership Long-Term Care Policy

No lien or estate recovery will be imposed for Medicaid correctly paid where an individual has used a long-term care insurance policy

---

346. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11(b)(1), (2); 92 ADM-53 at 5.
347. 92 ADM-53 at 13.
348. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11(b)(2). *See In re* Estate of Craig, 82 N.Y.2d 388, 624 N.E.2d 1003, 604 N.Y.S.2d 908 (1993).

certified under the N.Y. Partnership for Long-Term Care before receiving Medicaid services.[349]

[D] Statute of Limitation

Medicaid's ability to pursue a recovery from the estate of a Medicaid recipient is limited to the "six" years following the appointment of the fiduciary.[350]

§ 6:10.5 Debtor and Creditor Law

Social Services districts may now bring legal action under the Debtor and Creditor laws of New York to set aside any transaction which appears to have been made for the purposes of avoiding a lien or recovery for Medicaid paid on behalf of a Medicaid recipient.[351]

§ 6:11 Appeals

The right of an eligible applicant or recipient to appeal a Medicaid action or determination is based on the premise that the right to receive Medicaid is a property right.[352] Under the federal and New York State constitutions, an individual may not be deprived of property without due process of law;[353] that is, without the state following specific procedures that allow the claimant's side of the story to be heard. The most basic due process right for all Medicaid claimants is that decisions made by the Medicaid program may be appealed.[354] These decisions may relate to such matters as eligibility requirements, denial or reduction of benefits, and number of hours of home care services.

This section reviews the rights of claimants and procedures to be followed and makes suggestions for the advocate aiding a Medicaid claimant in pursuit of an appeal.

---

349. 92 ADM-53.
350. N.Y. SOC. SERV. LAW § 104; McKinney's CPLR 213; In the Matter of Bustamante, 682 N.Y.S.2d 102 (1998). *But see* Matter of Kappen v. D'Elia, 602 N.Y.S.2d 662 (within ten years of death on implied contract).
351. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11; 92 ADM-53 at 9.
352. Goldberg v. Kelly, 397 U.S. 254 (1970).
353. U.S. CONST. amends. V and XIV.
354. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 358-3.1(b)(3)(4), (7), 360-2.9.

§ 6:11.1 Due Process Rights

Once the Medicaid claimant has filed a written application, the following due process rights apply.

[A] Right to Written Notice

Every claimant has a right to a timely, specific, and written notice of the proposed Medicaid action, together with the reasons for it.[355] Whenever Medicaid makes a determination with which a claimant disagrees, the first step towards making an appeal is to insist upon a written and dated decision from Medicaid officials. This is vital to a client's case, as it is very difficult, if not impossible, to appeal oral decisions.

[B] Right to "Aid Continuing"

Medicaid claimants have a right to receive continuing Medicaid benefits (commonly known as "aid continuing") if a request for fair hearing and continuing benefits is made within ten days of a notice of reduction or denial of benefits.[356] Benefits will continue upon request only until a decision has been reached after the fair hearing is held. The right to aid continuing applies only to those already receiving Medicaid benefits, not to new applicants.

[C] Right of Access to Files

All claimants have a right of access to all the material that Medicaid officials will use at the fair hearing and a right to make copies. Reviewing a client's Medicaid files in advance of a hearing is important to avoid misunderstandings or surprises. Advocates should know that in home care cases, Medicaid holds two files on each recipient, one for eligibility and one for the medical assessment.[357]

[D] Right to Representation

Medicaid claimants have the right to be represented by an attorney, social worker, advocate, relative, or friend. The client should give written consent to the representative, who will then have access to the

---

355. *Id.* §§ 360-2.5, 360-2.6. *See also* 84 ADM-41.
356. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 358-3.6, 358-3.3(a)(1), 360-6.5.
357. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 358-3.4(b)(c), 358-3.7; *see also* Informational #15/92.

client's files. The representative has the right to appear on behalf of the claimant and to present documents and other evidence, including witnesses. Once the client is represented, the client's presence is not necessary during the appeals process, although often it may be very helpful.[358]

[E] Rights Related to Fair Hearing

Medicaid claimants have a right to a preliminary fair hearing by telephone if they are too ill or disabled to attend a fair hearing.[359] In addition, claimants have the right to ask questions of witnesses (cross-examination) and the right to require the presence of (subpoena) individuals with knowledge of the case. If subpoenas are needed, an attorney should be consulted.

[F] Right to Impartial Judgment

Medicaid claimants have the right to an impartial judgment. Medicaid fair hearings are conducted by a special division of the New York State Department of Social Services that has no connection with the county agencies that administer the Medicaid program.[360]

[G] Right to Written Decision

Every Medicaid claimant has a right to receive a written decision in matters which the claimant has appealed.[361]

[H] Disclosure Rules Under HIPAA

To meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA), the New York City Medical Assistance Programs must now receive a written authorization from the applicant or his or her legal representative before permitting the release of any information to third parties. The actual policy, procedures, and forms necessary to meet the HIPAA requirements are still being formulated. However, preliminary forms are being provided to all applicants for Medicaid. All advocates who wish to have Medicaid notices mailed to themselves must have this form completed and filed with Medicaid. These requirements do not alter or change existing

---

358. N.Y. COMP. CODES R. & REGS. tit. 18, § 358-3.4(e).
359. *Id.* § 358-3.4(j).
360. *Id.* § 358-5.6.
361. *Id.* § 358-6.1(a).

policies or procedures regarding Medicaid Fair Hearings and the representation of Medicaid recipients.

§ 6:11.2 Time Factors

Every step of the appeals process has time limits. Advocates should know what these time limits are and adhere to them strictly. Note particularly that the request for a fair hearing must be made within sixty days of the decision notice. Failure to appeal within the time limit may be excused for "good cause," but the burden of proof is on the client. If, through no fault of the client, an application for Medicaid is not acted on within thirty days (sixty days if related to disability), this delay is considered tantamount to a rejection and an appeal may be requested.

§ 6:11.3 Fair Hearing Procedures

A fair hearing is a legal procedure in which the Medicaid claimant challenges an action (or lack of action) by the Medicaid program. The fair hearing system is managed by the New York State Department of Social Services. The hearings are conducted by administrative law judges (ALJs), all of whom are attorneys.

Fair hearings may be requested by calling 800-342-3715 or 212-417-6550, or requests may be faxed to 518-473-6735. Be sure to have available important client information such as name, address, Social Security number, Medicaid number (if any), and date of birth, and be prepared to state the problem as succinctly as possible. Also, if applicable, request aid to continue (see discussion of aid continuing, above). Always take the name of the person with whom you speak and follow up with a confirming letter to Fair Hearing Section, New York State Department of Social Services, 40 North Pearl Street, Albany, New York 12243. To demonstrate the timeliness of your request, letters should be sent certified, return receipt requested.

The actual fair hearing procedure is quite simple and usually very informal. At least three people are usually present at a fair hearing: the ALJ, the individual who is appealing, and a representative of Medicaid. The client may also have a representative and one or more witnesses. Everybody sits around a table, and a tape recording is made of the proceedings. First, the ALJ sets forth the points at issue; then the Medicaid representative presents his or her case; and

then the client (or representative) presents the other side. Cross-examination is permitted and the ALJ participates freely. No decision is made at the fair hearing. A written decision is sent to all concerned in four to six weeks. If Medicaid fails to comply with any favorable decisions, contact the compliance unit of New York City Medicaid at 212-630-1000.

An interpreter, if needed, should be requested in advance. Also, the client and witnesses are entitled to be reimbursed for transportation to the fair hearing. Make the request for this reimbursement to the ALJ.

§ 6:11.4 Conference Meeting

A conference[362] is a review of a Medicaid decision conducted by the Medicaid Conference Unit (212-630-0996 in New York City) or the local DSS office. The request for a conference review must be made within thirty days of the decision notice date. Initiate the request by telephone and if possible follow up with a confirmation letter.

A request for conference review is not a fair hearing request and does not replace a fair hearing request; nor does it extend the time to request a fair hearing. A fair hearing and a conference should be requested simultaneously.

The conference has certain advantages. A conference officer has authority to reverse determinations; and corrective action can be taken immediately, without waiting for a formal fair hearing decision.

On the other hand, there are disadvantages. Conference offices do not function independently as they are part of Medicaid. Challenges to existing practices or policies are not likely to be successful at a conference.

§ 6:11.5 Judicial Review

The fair hearing decision may be appealed to a state court within 120 days of the receipt of the decision. Ordinarily, an attorney should be retained to bring such an appeal. The conduct of such an appeal is beyond the scope of this chapter.

---

362. *Id.* § 358-3.8.

Appendix 6A

Medicaid Income and Resource Levels for the Medically Needy

The following levels are effective as of January 29, 2015 (and remain the same for 2016), and apply when calculating eligibility under the medically needy and surplus income programs.

Family Size	Monthly Income	Disregard*	Resources**
1	$825	$20	$14,850
2	$1,209	$20	$21,750
3	$1,390		$25,013
4	$1,571		$28,275
5	$1,753		$31,538
6	$1,934		$34,800

* The first twenty dollars ($20.00) of monthly income is disregarded per household for SSI-related (aged, blind, or disabled) applicants/recipients.

** In addition to the resource levels listed, each SSI-related individual may have a separate burial fund of up to $1,500.

MEDICARE SAVINGS PROGRAM

The following levels are effective January 1, 2016, for participation in the qualified Medicare Buy-in Program (QMBs):

Family Size	Monthly Income	Resources**
1	$1,010	No Limit
2	$1,355	No Limit

The following levels are effective January 1, 2016, for participation in the Specified Low Income Medicare Beneficiaries Program (SLIMBs):

Family Size	Monthly Income	Resources**
1	$1,208	No Limit
2	$1,622	No Limit

**In addition to the resource levels listed, each SSI-related individual may have a separate burial fund of up to $1,500.

COMMUNITY SPOUSE ALLOWANCES

The community spouse allowances when one spouse is institutionalized, effective January 1, 2016, are $2,980.50 per month income and between $23,844 and $119,220 in resources.

Appendix 6B

Medicaid Copayments and Exempt Services

MEDICAID COPAYMENTS & EXEMPT SERVICES (New York State Department of Social Services)			
SERVICE OR ITEM	**AMOUNT**	**DETAILS ABOUT CO-PAY**	**NO CO-PAYS FOR THESE SERVICES**
Clinic visits	$3.00	Outpatient clinics in hospitals or freestanding clinics such as community health centers	Mental Health Clinics Family Planning/Parental Services Alcohol, Drug Abuse, Methadone Clinic Tuberculosis Directly Observed Therapy Developmental Disability/Mental Retardation Clinics Emergency Care
Brand Name Prescription	$3.00	One copayment charge for each new prescription or order and for each refill	NO CO-PAY FOR: • Drugs to treat mental illness (psychotropics) • Birth Control or Fertility drugs • Any drugs in an emergency • TB drugs
Generic and Over-the-counter	$1.00		
Lab Tests	$0.50	Several co-pays may be charged for one blood test because each test procedure has a co-pay	NO CO-PAY for pregnancy or fertility or prenatal tests
X-Rays	$1.00	X-Rays in hospital clinics, freestanding clinics, community health clinics	NO CO-PAY for x-rays in private doctor's office or x-rays for emergencies
Medical Supplies	$1.00	Syringes, bandages, gloves, sterile irrigation solutions, incontinent pads (diapers), ostomy bags, hearing aid batteries, nutritional supplements, etc.	NO CO-PAY for birth control supplies—condoms, diaphragms, contraceptive creams
Overnight Hospital Stays	$25.00 on last day	One $25 co-pay for hospitalization of any length involving at least one overnight stay	NO CO-PAY for hospital stays for childbirth, miscarriage, fertility procedures, reproductive health services, prenatal care or any emergency condition
Emergency Room	$3.00	Co-pay is only for non-urgent or non-emergency services	NO CO-PAY for urgent or emergency services received in an emergency room
Private Doctor's Office, Home Care, transaction	No Co-pay	No Co-pay	NO CO-PAY for services provided in a private doctor's office, emergency or urgent care received in the Emergency Room, Home Care or Transportation

NOTE: DO NOT PAY ANY CO-PAY IF YOU CANNOT AFFORD IT. YOU MUST BE GIVEN THE DRUG OR SERVICE IF YOU CANNOT PAY. IF YOU ARE PRESSURED TO PAY A COPAYMENT OR CANNOT GET A DRUG OR OTHER MEDICAL CARE, CALL THE "DSS HOTLINE" TOLL-FREE AT 800-541-2831.

Appendix 6C

Medicaid Copayment Exemptions

MEDICAID COPAYMENT EXEMPTIONS (New York State Department of Social Services)	
PEOPLE EXEMPT FROM COPAYMENTS	HOW TO SHOW PROVIDERS THAT YOU ARE EXEMPT
Children and teenagers under 21 years old	Medicaid card shows date of birth. If your card has the wrong birthdate, tell your care worker and request a hearing.
Pregnant women are exempt during the pregnancy and for two months after the month in which the pregnancy ends.	Carry a doctor's note **OR** you look pregnant **OR** pregnancy is obvious from type of service or prescription **OR** ask pharmacy or clinic to call your doctor.
Anyone entitled in a Health Management Organization (HMO) or other management program (CMCM).	A code on the Medicaid computer tells providers you are in an HMO or CMCM or other managed care program.
Nursing Home residents	Most services you receive are paid for by the nursing home and are not subject to co-pay. The nursing home must inform the provider for other services that you are receiving.
Residents of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD)	A code on the Medicaid computer tells providers that the person lives in an ICF.
Community Residence (CR) or OMR (Office of Mental Retardation) or OMH (Office of Mental Health) residents and people enrolled in OMH/OMRDD Home and Community-Based Services Waiver Programs (HCBS). This category does not include adult homes.	CR staff and case managers for community-based programs must give residents and participants proof of residence (a letter) to show pharmacist, clinic, and other providers.

Chart provided by the New York State Department of Social Services,
Division of Health & Long-Term Care.

Appendix 6D

Request for Documentation of Citizenship/Alien Status

Under the Personal Responsibility and Work Opportunity Reconciliation Act, the only **non-U.S. citizens** who can receive Medicaid, **if otherwise eligible**, are qualified aliens who were in the United States as of the date of enactment of the law **(August 22, 1996)** and certain aliens who arrived in the United States after that date.

In accordance with the new Federal law, the Medical Assistance Program must now review the citizenship/alien status for all Medicaid recipients.

If you and other members of your household in receipt of Medicaid are **U.S. citizens**, you **must** submit a clear photocopy of one of the following documents for **each** member of your household.

PROOF OF UNITED STATES CITIZENSHIP:

- Certified copy of a public record of birth in U.S. (Birth Certificate)
- Naturalization Certificate, INS Form N-550 or N-570
- United States Passport
- Religious document such as a baptismal record, when **place** (U.S.A.) and date of birth are listed
- U.S. Military Discharge papers, Form DD-214
- Report of Birth Abroad of a Citizen of the U.S., Form FS-240, U.S. Department of State
- Certification of Birth, Form FS-545, U.S. Department of State
- U.S. Citizen I.D. Card, INS Form I-197 or I-179
- Certificate of Citizenship, INS Form N-560 or N-561
- Proof of Filing for a New Naturalization Certificate
- Expired U.S. Passport
- Document issued by the **Bureau of Indian Affairs** that indicates membership in a **federally recognized tribe**
- Document from a spokesperson or authorized representative of a **federally recognized tribe**, indicating membership in that tribe

- INS Form G-641, Application for Verification of Information, from INS records where INS indicates on the form that the person is a **naturalized citizen** or has been **certified as a citizen**
- Court records that indicate U.S. **citizenship**

Appendix 6E

Alien Status Desk Guide
Notice of Eligibility for Coverage for the Treatment of an Emergency Medical Condition

CASE NAME CASE NUMBER DATE

The applicant(s) indicated on the attached DSS-3622 has been determined to be eligible for Medical Assistance for coverage for emergency medical care and services only, for the reason indicated below:

> The applicant is not a citizen, qualified alien or permanently residing in the United States under color of law (PRUCOL). Persons who are not citizens, qualified aliens or PRUCOL may receive Medical Assistance coverage only for the treatment of emergency medical conditions or for medical services provided to pregnant women, if they are otherwise eligible.

Qualified aliens include:

- Persons lawfully admitted for permanent residence;
- persons admitted as refugees;
- persons granted asylum;
- persons granted status as Cuban and Haitian Entrants;
- persons with deportation withheld;
- persons admitted as Amerasian immigrants;
- persons paroled into the United States for at least one year;
- persons granted conditional entry; or
- persons determined to be battered or subject to extreme cruelty in the United States by a family member.

PRUCOL aliens include:

- Persons paroled into the United States for less than one year;
- persons residing in the United States pursuant to an Order of Supervision;
- persons residing in the United States pursuant to an indefinite stay of deportation;
- persons residing in the United States pursuant to an indefinite voluntary departure;

- persons on whose behalf an immediate relative petition has been approved and their families covered by the petition;
- persons who have filed applications for adjustment of status that INS has accepted as "properly filed" or has granted;
- persons granted stays of deportation;
- persons granted voluntary departure;
- persons granted deferred action status;
- persons who entered and continuously resided in the United States before January 1, 1972;
- persons granted suspension of deportation; or
- other persons living in the United States with the knowledge and permission or acquiescence of the INS and whose departure the INS does not contemplate enforcing. (Examples include, but are not limited to: permanent nonimmigrants, pursuant to P.L. 99-239, applicants for deferred action or voluntary departure status, and aliens granted extended voluntary departure for a specified time due to conditions in their home countries.)

The care/services provided to (name(s))_____ on _____by_____ has been determined for the treatment of an emergency medical condition. Therefore, coverage will be provided for this treatment as follows:

Full coverage

Coverage with a SPENDDOWN requirement:

Gross monthly income	$_____
Total monthly deductions	$_____
Net monthly income	$_____
Allowable income standard	$_____
Monthly excess income (spenddown)	$_____

Based on these calculations, the liability toward the cost of care for the period of treatment is $_____. (See the enclosed "Explanation of the Excess Income Program" for information on how this liability may be met.)

The provider(s) of medical care/services has been notified of your eligibility for Medical Assistance coverage.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS. BE SURE TO READ THE ATTACHED NOTICE ON HOW TO APPEAL THIS DECISION.

Appendix 6E (continued)

Medicaid Eligibility for Immigrants After *Aliessa* (effective 6/01/01)

Immigrant Status	Relevant Date for Eligibility	Medicaid
Qualified Aliens		
Refugees	Entry	Yes
Asylees	Status Granted	Yes
Parolees	Entered before 8/22/96	Yes
	Entered after 8/22/96	After 5 years in the U.S.
Deportation or Removal Withheld	Status Granted	Yes
Conditional Entrants	Entered before 8/22/96	Yes
	Entered after 8/22/96	After 5 years in the U.S.
Legal Permanent Resident	Entered before 8/22/96	Yes
	Entered after 8/22/96	Yes (The *Aliessa* decision ends the 5-year waiting period.)
Non-Qualified Aliens		
PRUCOLs	None	Yes (The *Aliessa* decision restores eligibility.)

Immigrant Status	Relevant Date for Eligibility	Medicaid
Other Non-Qualified Aliens	None	Emergency Medicaid only
Non-immigrants (tourists, foreign students, employees of foreign corporations)	None	Emergency Medicaid only
Undocumented Aliens (persons who entered the U.S. illegally; persons who entered legally, but violated the terms of the visa)	None	Emergency Medicaid only

Appendix 6F

Regional Rates for Nursing Homes

(FOR CALCULATION OF PERIOD OF INELIGIBILITY AFTER TRANSFER OF RESOURCES)

These rates were issued on January 1, 2016 and apply to all transfers made in the year 2016.

REGION	2016 MONTHLY
• New York City (All Boroughs)	$12,029
• Long Island (Nassau and Suffolk Counties)	$12,633
• Northern Metropolitan (Orange, Westchester, Dutchess, Ulster, Putnam, Rockland and Sullivan Counties)	$11,768
• Western (Buffalo, Allegany, Genesee, Cattaraugus, Niagara, Chautauqua, Orleans, Erie and Wyoming Counties)	$9,630
• Northeastern (Albany, Franklin, Otsego, Warren, Clinton, Fulton, Rensselaer, Washington, Columbia, Greene, Saratoga, Delaware, Hamilton, Schenectady, Essex, Montgomery, and Schoharie Counties)	$9,806
• Rochester (Chemung, Seneca, Livingston, Steuben, Monroe, Wayne, Ontario, Yates and Schuyler Counties)	$11,145
• Central (Syracuse, Broom, Jefferson, Oswego, Cayuga, Lewis, St. Lawrence, Chenango, Madison, Tioga, Cortland, Oneida, Tompkins, Herkimer and Onondaga Counties)	$9,252

* Rates apply to applications for institutional services submitted in that year, regardless of the date of transfer.

Appendix 6G: Budgeting Guide for 2015

Care Required by Applicant	Applicant's Allowed Income for Personal Needs	Non-Applicant Spouse Income Allowance	Non-Applicant Spouse Exempt Resource Allowance	Spousal Refusal for Necessary Medical Support	Financial Documentation from Non-Applicant Spouse
Community Medicaid, Home Care	$825 for personal needs (plus $20 disregard) Excess income goes to cost of care (spenddown)	None Medicaid **may** sue community spouse for contribution of non-applicant spouse's income	None Medicaid **may** sue community spouse for contribution of non-applicant spouse's income	Spousal refusal form necessary for **all** income and resources of the non-applicant spouse	Documentation not necessary. Medicaid must accept applicant even if non-applicant spouse does not cooperate.
Institutional Care	$50 for personal needs allowance Excess income goes to cost of care (spend-down), after providing for community spouse income allowance	Non-applicant spouse's income raised to $2,980.50[1] (maximum) from applicant spouse's excess income over $50	May keep total exempt resources between $74,820[2] and $115,920	Spousal refusal form necessary only if community spouse's resources exceed the community spouse's allowances	Documentation necessary. Medicaid will not accept applicant spouse without documentation from non-applicant spouse.
Home Care for Married Couples	$381 for personal needs Excess income goes to cost of care (spend-down), after providing for well spouse's income allowance	Income raised to $2,980.50[1] (maximum) from applicant spouse's excess income over $381	May keep total exempt resources between $74,820[2] and $119,220	Spousal refusal form necessary only if community spouse's resources and combined income exceed the community spouse's allowances	Documentation necessary. Medicaid will not accept applicant spouse without documentation from non-applicant spouse.

1. Medicaid **may** request a contribution of 25% of the amount in excess of $2,980.50, if community spouse's personal income exceeds $2,980.50.
2. Medicaid **may** sue community spouse for income or resources in excess of the exempt community spouse's allowances.

Appendix 6H

Community Spouse's Income Allowance

The following example illustrates the calculating of the community spouse's income allowance:

Mr. and Mrs. A are a married couple. Mr. A is residing in a nursing home. Mrs. A is a well community spouse. Their income is as follows:

	Mr. A	**Mrs. A**	**Couple**
Social Security	$1,000	$350	$1,350
Employer Pension	2,000	0	700
Total	$3,000	$350	$2,050

The maximum monthly income allowance for the community spouse is $2,980.50 for 2015.

What is Mrs. A entitled to receive each month from her husband's income?

Step 1: Subtract Mr. A's personal needs allowance of $50 from his total monthly income:

$3,000
– 50
$2,950 = excess income goes to Mrs. A or Medicaid

Step 2: Subtract Mrs. A's income from $2,980.50:

$2,980.50
– 350
$2,980.50 = can go to Mrs. A from Mr. A.

Step 3: Compare the result in Step 2 to Mr. A's net income in Step 1. Since Mr. A's excess income is large enough, Mrs. A will get the full amount ($2,630.50) needed to bring her up to the $2,980.50 monthly maximum community spouse income allowance.

The remainder of Mr. A's net income ($2,950 – $2,630.50 = $319.50) must be paid to his nursing home for the cost of his care.

If Mr. A's income were not large enough to bring Mrs. A's income up to the monthly allowance amount of $2,980.50, Mrs. A would receive an allowance equal to the net amount of Mr. A's income computed in Step 1. Medicaid will not pay a supplement to couples whose joint monthly income is not adequate to bring the community spouse to the $2,980.50 level.

Ordinarily, the monthly income allowance for the community spouse cannot exceed $2,980.50 per month. However, the $2,980.50 level may be exceeded if a court has entered a support order for a larger amount. The hearing examiner or judge will determine how much additional support, if any, to award in such cases.[1] The $2,980.50 level may also be exceeded if a fair hearing decision sets a higher allowance based on "exceptional circumstances resulting in significant financial duress" to the community spouse.[2]

1. 89 ADM-47, at 16–17.
2. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(b)(6); 89 ADM-47, at 16–17. Significant financial duress means financial distress resulting from exceptional expenses which cannot be met from the community spouse monthly income allowance or resources of the community spouse. These may include recurring or extraordinary medical expenses, amounts to make major repairs to the home, or amounts necessary to preserve an income-producing asset.

Appendix 6I

Community Spouse Resource Allowance

The following three examples illustrate how to calculate the community spouse resource allowance:

Example #1: Spousal share is less than the minimum $74,820.

- Mr. and Mrs. A have jointly held resources of $78,000.
- Mr. A needs institutional Medicaid placement.
- Mrs. A's spousal share is $78,000 × ½ = $39,000.
- Since Mrs. A's spousal share is less than the minimum $74,820, she may keep up to the $74,820 minimum out of their jointly held resources and her husband can keep the remaining $3,180 (Mr. A is entitled to keep up to $14,250 personal resource allowance).

Example #2: Spousal share is greater than the minimum $74,820, but less than the maximum $119,220.

- Mr. and Mrs. A have jointly held resources of $150,000.
- Mr. A needs institutional Medicaid placement.
- Mrs. A's spousal share is $150,000 × ½ = $75,000.
- Since Mrs. A's spousal share is greater than the minimum but less than the maximum, her resource allowance is set at $75,000. Any amount Mrs. A retains in excess of $75,000, Medicaid would consider available for Mr. A's medical care. Medicaid may legally attempt to force Mrs. A to contribute these excess resources towards Mr. A's medical care.
- Mr. A will not be eligible until he meets the $14,850 personal resource allowance.

Example #3: Spousal share is greater than the maximum $119,220.

- Mr. and Mrs. A have jointly held resources of $300,000.
- Mr. A needs institutional Medicaid placement.
- Mrs. A's spousal share is $300,000 × ½ = $150,000.

- Since Mrs. A's spousal share is greater than the maximum of $119,220, she is limited to a resource allowance of $119,220. Any amount Mrs. A retains in excess of $119,220 would be considered available for Mr. A's medical care. Medicaid may legally attempt to force Mrs. A to contribute these excess resources towards Mr. A's medical care.
- Mr. A will not be eligible until he meets the $14,850 personal resource allowance.

In all three of the examples above, Mr. A can become resource-eligible for institutional Medicaid placement by transferring all of his resources to Mrs. A, since there is no transfer penalty for transfers between spouses (see discussion of transfer of assets earlier in this chapter).

Appendix 6J

Guide to Documentation for the Medicaid Application

In order to establish eligibility for Medicaid, the applicant must meet Federal and State financial and basic eligibility criteria. Medicaid determines eligibility based upon the documentation an applicant submits. Documents will be needed for initial application, reapplication or recertification for Medicaid. This guide describes the different types of documents that a Medicaid applicant may be required to submit. Because each person's situation is different, additional docurmentation may be requested.

FAMILY AND RELATIVE DATA. Applicant must verify who they are and where they live. In addition, applicant must prove age, citizenship or alien status and family relationship (wife, husband and children under 21).

IDENTIFICATION—

To verify identity, **one** of the documents below is usually sufficient:

- Birth Certificate
- Hospital Certificate of Birth
- Certificate of Birth from NYC Bureau of Vital Statistics
- Marriage Certificate with Date of Birth
- Immigration or Naturalization Papers
- Passport
- Current Driver's License
- Prior Public Assistance and Medicaid Care
- Medicare Card

If none of the above are available, **two** of the following documents can verify applicant's identity.

- Baptismal Certificate
- Marriage Certificate without Birthdate
- Naturalization Letter

- Voter Registration Card
- Military Discharge Papers
- Professional License
- High School/College Diploma
- School Records
- Permanent Residence Card
- Letters of Guardianship
- Methadone Program I.D.
- Final Judgment of Divorce or Separation
- Current Social Security Award Letters
- Auto Registration
- Life Insurance Policy
- Deeds, Mortgages or other records of Home Ownership
- Social Security Card/Railroad Retirement Card
- Hospital Clinic Card

RESIDENCE—

To verify applicant's residence, **one** of the following documents listed below should be sufficient.

- New York City Housing Authority rent book
- Rent receipt from landlord on his stationery
- Recent utility bill in applicant's name at listed address
- Hotel rent receipt
- New York City real estate tax bill
- Copy of current lease

CITIZENSHIP AND LEGAL ALIEN STATUS—

To verify citizenship for applicants **born** in **the United States**, *one of the following can be provided.*

- Birth Certificate
- Hospital Certificate of Birth
- Certificate of Birth from NYC Bureau of Vital Statistics—Citizenship Papers

- Baptismal Certificate—U.S. Passport
- Military Discharge Paper (Form DD-214)

To verify Naturalized and Legal Alien Status for applicants **NOT born** in **the United States**, *one of the following should be provided.*

- Certificate of Citizenship
- Certificate of Naturalization
- U.S. Passport
- Military Discharge Papers
- INS Form 1-179/1-197 (resident I.D.)
- Selective Service Registration Certificate
- Evidence of Lawful Admission for Permanent Residence (Alien Registration Receipt Card) (INS Form 1-151) or a re-entry permit
- Evidence of Permanent Residence: INS Form 1-94 to show that applicant has been permitted to remain in the U.S. for an indefinite period

SOCIAL SECURITY—A social security number and card is needed for all applicants. A current award letter stating their current monthly benefit.

DISABILITY—If applicant is disabled and is receiving Social Security Disability Benefits.

An award letter or a signed letter from the physician stating the type of illness or disability. If applicant is blind, a Certificate of Blindness from New York State Commission for the Visually Handicapped may be requested.

LIVING ARRANGEMENTS—To verify applicant's housing information, the following documents are required:

- Renters: Current rent receipt or cancelled rent check or letter from landlord or agent verifying name and address of landlord or copy of current lease.
- If applicant lives in someone else's home or apartment, written statement is needed which shows rental amount paid if any, number of persons in the household and bill addressed to primary tenant.

- Home Owners—yearly bills pertaining to the home (tax bills or receipts, insurance, heating and utility bills, mortgages, bank statements, deeds).

OTHER LIVING COSTS—Estimate applicant's average monthly expenses for food, clothing, telephone, medical expenses, etc. . . .

EMPLOYMENT—If applicant is not working, but is married, the spouse, if working, must verify their employment, even if signing a spousal refusal. The following documentation is required.

- Pay stubs for the past two months or statement from employer on business stationery, dated, signed with title showing beginning date of employment, gross pay, Federal, State and City taxes, FICA and health insurance deducted for the last two months.
- If applicant or spouse is self-employed, the last Federal Income Tax return with Schedule C will be required.
- If applicant's or spouse's employment is irregular, all W-2s and last Federal Income Tax Return are required.
- Work Related Expenses can be documented by providing statements or copies of bills such as Union dues, cost of tools, materials and special clothing, mandatory fees for licenses, or permits fixed by law, group insurance premiums, child care expenses.

CURRENT INCOME

1. If applicant receives any of the following, provide a copy of check or current statement from benefits program or award letter.

- Workmen's Compensation
- Veteran's Benefits
- Social Security Retirement Benefits
- Railroad Retirement Benefits
- Pension from Employment
- New York State Disability
- G.I. Allotment
- Union Benefits
- Supplemental Security Income

2. If applicant receives any of the following, corresponding document should be provided as indicated.

- Interest from Bank Accounts—current bank books or bank statement
- Dividends from stocks, bonds and life insurance—statement of dividends or copies of checks or statement from broker, life insurance policy
- Income from annuities—statement of annuity income or copy of checks
- Income from trust fund—copy of trust fund document
- Unemployment insurance benefits—unemployment insurance book or statement
- Scholarships—statement from school of all financial aid with breakdown of funds
- Income from training program—statement from program
- Court-ordered support payments—current check or copy of check and court order
- Support from friends or relatives—statement from relative(s) or friend(s) including full name(s), address(es), amounts and length of time
- Income from roomers, boarders, mortgages—statement from roomers, boarders, including amount paid, copy of mortgage agreement
- Food Stamps—food stamps ID Card
- Other—list on application and provide documentation of any other source of applicant's income

PAST MANAGEMENT

1. If the information provided for the applicant about income and expenses does not fully explain how they have managed to support themselves prior to the application, additional information or documents may be requested. The following are suggestions for documents which might apply:

- Tax statements for the past two years
- Letter from previous employer giving dates of employment, annual salary and reason for termination

- Letters from persons who have contributed to applicant's support
- Documentation of expired benefits or rejected claims for benefits
- Unemployment Insurance Benefits, Disability, Social Security, Workmen's Compensation, etc. . . .
- Cancelled bank books or statement of bank loans

2. If applicant is between the ages of 21-64 and not employed, provide proof of registration with New York State Employment Service
3. If applicant is unable to work, bring a medical statement to verify this and how long this is expected to last.

RESOURCES—If applicant has resources and/or property, the following documentation must be provided as indicated:

- Savings and Checking Accounts—savings books and/or statements and checking account statements indicating activity for the last three months (if requesting a Simplified Asset Review)
- Stocks and Bonds —certificates
- Credit Union—copy of record of deposits
- Real Property—deeds, mortgages, tax statements
- Trust Fund —copy of Trust Fund Document
- Life Insurance and Annuities —copy of policies
- Pending Lawsuit —any legal papers, name and address of lawyer
- Union Benefits (including life and/or health insurance policies)
- Health Insuranceand Medicare—Medicare ID Card, health insurance policies, premium payment receipts
- Other—list on application and bring in documentation of any other resources

NOTE: If applicant previously had resources or property, which was transferred or sold, they may be asked to verify their sale or transfer, even if a Simplified Asset Review Form is signed. Bring cancelled bank books, etc., or letters of termination from financial institutions.

This information was re-formatted from The City of New York, Human Resources Administration's W-296C, 1985 *Guide to Documentation for the Medicaid Application.*

Appendix 6K

Not-for-Profit Organizations That Have Pooled Trusts in New York State

AHRC New York City Foundation, Inc.
200 Park Avenue South
New York, NY 10003
212-780-2682

ACLD—Adults & Children with Learning and Developmental Disabilities, Inc.
(Third-party trusts only)
807 South Oyster Bay Road
Bethpage, NY 11714
516-241-3628

Center for Disability Rights, Inc.
497 State Street
Rochester, NY 14608
www.cdrnys.org

Community Living Corp.
105 South Bedford Road, Suite 300
Mt. Kisco, NY 10549

Disabled and Alone, Life Services for the Handicapped, Inc.
(Third-party trusts only)
352 Park Avenue South, 11th Floor
New York, NY 10010
212-532-6740

Family Services of Rochester, Inc.
30 North Clinton Avenue
Rochester, NY 14604
585-232-1840

Future Care Community Pooled Trust
(A partnership of Al Sigl Community of Agencies, Lifespan, and the Arc of Monroe)
1000 Elmwood Avenue

Rochester, NY 14620
www.futurecareplanning.org

LCG Community Trust
LCG Community Services, Inc.
14 Mount Hope Place
Bronx, NY 10453-6102
718-466-2200
info@lcgcs.org
www.lcgcs.org

NYSARC, Inc.
393 Delaware Avenue
Delmar, NY 12054
518-439-8311

United Community Services of Boro Park
1575 50th Street, 3rd Floor
Brooklyn, NY 11219
718-854-9300
trustdept@ucsbp.org

UJA Federation of New York
130 East 59th Street
New York, NY 10022
212-836-1339

Appendix 6L

Medical Request for Home Care (Form M-11q)

MEDICAL REQUEST FOR HOME CARE

NYC Human Resources Administration Department of Social Services

HCSP- M11Q 12/09/2014

GSS District Office _____ Attn: Case Load No._____

Return Completed Form to:

Address_____ Borough _____

Zip Code _____ Tel. No. _____

Date Returned to/Received byGSS

FOR GSS USE ONLY

1. CLIENT INFORMATION

Patient's Name	Birthdate	Social Security Number		Medicaid No.
Home address (No. & Street)		Borough	Zip Code	Telephone No.
Hospital/Clinic Chart No.	II. MEDICAL STATUS	Contact Person		Contact Tel. No.

PATIENT'S MEDICAL RELEASE: I hereby authorize all physicians and medical providers to release any information acquired in the course of my examination of treatment to the New York City HRA/ Dept. of Social Services in connection with my request for home care.

Date: _____ Signature(X) _____

How long have you treated the patient? _____ Date of this Examination: _____ Place of this Examination: _____ Date of next Examination: _____

A. CURRENT CONDITION

Date of Onset		Check(✓) prognosis of each: Anticipated Recovery 6 months (✓)	Chronic Condition (✓)	Deterioration of Present Function Level (✓)
	1. Primary Diagnosis/ ICD Code			
	2. Secondary Diagnosis/ ICD Code			
	3.			
	4.			
	5.			

B. HOSPITAL INFORMATION

☐ CURRENTLY IN: (Hospital Name)_____ Admission Date: _____

Reason for Hospitalization: _____ Expected Date of Discharge:

C. MEDICATION	Dosage	Oral or Parenteral	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Indicate patient's ability to take medication: (*)

1. ☐ Can self-administer
2. ☐ Needs reminding
3. ☐ Needs supervision
4. ☐ Needs help with preparation
5. ☐ Needs administration

(*) If patient CANNOT self-administer medication

(a) Can he/she be trained to self-administer medication? ☐ Yes ☐ No If no, indicate why not: _____

(b) What arrangements have been made for the administration of medications? _____

HCSP-M11-Q (12/09/2014) Page 1 of 3

D. MEDICAL TREATMENT Does the patient receive any of the following medical treatment? ☐ Yes ☐ No
Indicate medical treatment currently received: (✓)

1. Decubitus Care		7. Colostomy Care		15. Suctioning	
2. Dressings: Sterile		8. Ostomy Care		16. Speech/Hearing/ Therapy	
Simple		9. Oxygen Administration		17. Occupational Therapy	
3. Bed bound Care (turning, exercising, positioning)		10. Catheter Care		18. Rehabilitation Therapy	
4. Ambulation Exercise		11. Tube Irrigation		19. Indicate any special dietary needs	
5. ROM/Therapeutic Exercise		12. Monitor Vital Signs		20. Other	
6. Enema		13. Tube Feedings			
		14. Inhalation Therapy			

For each treatment checked, indicate frequency recommended, how the service is currently being provided and what plans have been made to provide the service in the future: (Attach additional documentation as necessary.)

Based on the medical condition, do you recommend the provision of service to assist with personal care and/or light housekeeping tasks?

☐ Yes ☐ No

Please indicate contributing factors (e.g. limited range of motion, muscular motor impairments, etc.) and any other information that may be pertinent to the patient's need for assistance with personal care services tasks.

Can patient direct a home care worker? ☐ Yes ☐ No If no, explain below:

E. EQUIPMENT/SUPPLIES

Please indicate which equipment/supplies the client has, needs or has been ordered.

	Has	Needs	Ordered		Has	Needs	Ordered		Has	Needs	Ordered
Cane				Bedpan/Urinal				Bath Bar			
Crutches				Commode				Bath Seat			
Walker				Diapers				Grab Bar			
Wheelchair				Hoyer Lift				Shower Handle			
Hospital Bed				Dressings				Other (Specify)			
Side Rails				Respiratory Aids							

If any needed equipment was not ordered, what other plans have been made to meet this need?

SSN: _____

F. REFERRALS

Has a referral been made to any of these agencies: Certified Home Health Agency, Hospital-Based Home Care Agency, Hospice, a Health Related Facility (HRF), a Skilled Nursing Facility (SNF) or the Lombardi Program? Yes ☐ No ☐

*IDENTITY AGENCY	SERVICE	STATUS OF SERVICE	REFERRAL DATE

G. ADDITIONAL COMMENTS

Describe any other aspects of the patient's medical, social, family or home situation which affects the patient's ability to function, or may affect need for home care. If necessary, please attach an additional sheet(s) explaining the patient's condition in greater detail.

Signature of Person Completing Additional Comments Section	Title	Date
	Agency	

Physician's Certification

I, the undersigned physician, certify that this patient can be cared for at home, and that I have accurately described his or her medical condition, needs and regimens, including any medication regimens, at the time I examined him or her. I understand that I am not to recommend the number of hours of personal care services this patient may require. I also understand that this physician's order is subject to the New York State Department of Health regulations at part 515, 516, 517, and 518 of title 18 NYCRR, which permit the department to impose monetary penalties on, or sanction and recover overpayments from, providers or prescribers of medical care, services or supplies when medical care, services or supplies that are unnecessary, improper or exceed the patient's documented medical condition are provided or ordered.

*(PRINT) Physician's Name _____ Specialty _____ *Physician's Signature _____ Intern ____ Resident ____

*Business Address _____ *City _____ *State _____ *Zip Code _____

Signature date must be within thirty days after medical exam of patient.

*Date Form Completed _____ *Registry Number _____ *NPI Number _____ *Physician's Telephone _____ Physician's E-mail _____

Indicate where form was completed:

Hospital/Clinic/Institution Name _____ Address _____ Telephone No. / E-mail _____

If Nurse /Social Worker/other person assisted in completing this form:

Name _____ Title _____ Address _____ Telephone No. / E-mail _____

*Mandatory

HCSP-M11-Q (12/09/2014) Page 3 of 3

EIGHT HELPFUL HINTS FOR ACCURATE COMPLETION OF THE MEDICAL REQUEST FOR HOME CARE (M11Q)

NYC Human Resources Administration Department of Social Services

HCSP-712b 12/09/2014

* Please provide this sheet to the physician filling out the Medical Request for Home Care (M-11Q).

Eight Helpful Hints for Accurate Completion of the Medical Request for Home Care (M-11Q)

1. The client's name, address and Social Security number must be provided.
2. The medical professional must complete the M-11Q by accurately describing the patient's medical condition.
3. The medical professional must not recommend or request the number of hours of personal care services.
4. The M-11Q must be signed by a NY State licensed physician.
5. The date of the examination must be provided.
6. The physician must sign and date the M-11Q within 30 days after the exam date.
7. The registry number, NPI (national provider ID), and the complete business address of the physician must be indicated.
8. The completed signed copy of the M-11Q must be forwarded within 30 calendar days after the medical examination.

NOTES

NOTES