

**ADDENDUM TO THE NAELA ANALYSIS OF CHANGES TO FEDERAL
MEDICAID LAWS UNDER THE DEFICIT REDUCTION ACT OF 2005**

BASED ON ANALYSIS OF CMS GUIDELINES TO STATES DATED JULY 27, 2006

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This writing supplements the White Paper on Analysis of Changes to Federal Medicaid Laws under the Deficit Reduction Act of 2005.¹ On July 27, 2006, the Centers for Medicare and Medicaid Services (CMS) issued a series of letters designed to provide states with information regarding the implementation of new rules related to certain DRA provisions. Areas covered by the pronouncements include, among others, the extension of the lookback period to 60 months, the start date of the penalty period, home equity and undue hardship rules changes, and the expansion of the long-term care partnership program. The following analyses of CMS' guidelines to states attempt to explain CMS' regulatory directions to states as well as highlight areas of ambiguity in CMS' language. In many cases, CMS leaves unanswered questions regarding the precise implementation of the DRA.

Look-Back Period Extended to Five Years, §6011(A)

Although it had the opportunity to do so, CMS failed to confirm the interpretation set forth in the NAELA White Paper that the 60-month lookback period would be phased in beginning in February 2009 (37 months) with another month being added to the lookback period each month thereafter. Under this interpretation, a phase-in of the lookback period would be completed in February 2011. In fact, the only thing CMS says in this section of the Enclosure is that "...for any transfer of assets made on or after the date of enactment of the DRA (February 8, 2006), the look-back period is 60 months." Several states have formally indicated that the 60-month lookback period will be phased in over a two-year period beginning in February 2009.²

Commencement Date of Penalty Period, §6011(B)

Equally devoid of guidance is the CMS section on the start date of the penalty period. While CMS provides guidance in one distinct area, it leaves unanswered many of the critical questions raised in the NAELA White Paper. It is now clear that once a penalty period is imposed, it will not be suspended even if the individual subsequently stops receiving institutional level care. Therefore, with respect to an individual who receives institutional level care for a short period of time and who otherwise satisfies the criteria for the running of a penalty period, the penalty period will continue to run even if the individual no longer is receiving institutional level care. Or, simply put, the individual must only be receiving institutional level care at the start but not for the duration of the penalty period.

¹ NAELA Journal, "White Paper on Analysis of Changes to Federal Medicaid Laws under the Deficit Reduction Act of 2005," Volume 2, 2006, Special Edition.

² New York State Department of Health Administrative Directive 06 ADM-5, page 11. Arizona, Rhode Island and Oregon all have indicated that the lookback period will be phased in. Early drafts of the new policy in North Carolina indicate that North Carolina will phase in the lookback period.

Furthermore, it would seem that an individual may file a Medicaid application to trigger a penalty at any time after the penalty start date provided that s/he can prove that s/he was otherwise eligible as of the commencement date being sought. For example, if an individual transfers \$50,000 in July 2006 in a state where the divisor is \$5,000, and s/he is otherwise eligible to receive institutional level care in July 2006 and meets the state resource allowance, then an application in January 2007 should be sufficient to begin the 10 month penalty period effective in July 2006. The individual would need to provide medical evidence to establish the need for institutional level care in July 2006 and the ultimate determination of need would have to be approved by the Medicaid agency.

The question of what it means to be "otherwise eligible to receive institutional level of care" remains unclear. CMS has misinterpreted the DRA language "otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period." The DRA language and legislative history indicate that the individual does not actually have to be receiving the long term care services described in subparagraph (C) to begin the penalty period, only that the individual would otherwise be receiving such institutional level care but for the penalty.

However, CMS has rephrased this language in its Directive to read:

"The date on which the individual is eligible for medical assistance under the State plan and *is receiving* institutional level of care services (based on an approved application for such services) that, were it not for the imposition of the penalty period, *would be covered by Medicaid.*" (Emphasis added.)

CMS's version, if adopted by the states, would mistakenly require that the individual actually be receiving Medicaid covered institutional level of care services in order to start the penalty period. This is the language that was *excised* from the final version of the DRA that came out of Reconciliation. Therefore, further advocacy at the state level is required in order to correct this CMS interpretational error.

To illustrate the importance of this language, consider the following example:

On August 1, 2006, mother gives \$15,000 to caretaker daughter who uses the money to pay off her credit card debt. Mother now has less than \$2,000 of countable assets. A medical screening indicates that on August 1, 2006, mother requires an institutional level of care as defined in 42 USC 1396p(c)(1)(C). On November 1, daughter inquires at local nursing home about mother's potential placement and is told that her mother will not be eligible for Medicaid payment of her mother's nursing home bill for the first two months of her mother's placement because of the gift to the daughter. Neither mother nor her daughter has funds to pay the nursing home, so daughter provides full-

time care to her mother at her home. Two months later, on January 1, her mother is admitted to the nursing home and files a Medicaid application.

Under the DRA, as of August 1, the mother "is eligible for medical assistance... and would otherwise be receiving institutional level of care....but for the application of the penalty period."

Under the CMS Directive, as of August 1, the mother is not "otherwise eligible for Medicaid payment of long term care services" because she has not been placed in a nursing facility or found eligible for home or community based waived services.

This is exactly the situation Congress was trying to prevent when in the last stage of the legislative process (Reconciliation), it deleted the words, "and is receiving services described in subparagraph (C)" and inserted the alternative phrase "and would otherwise be receiving institutional level care described in subparagraph (C)... but for the application of the penalty period." This legislative change was designed to (1) eliminate the incentive to place an individual in a nursing home to begin the penalty period; and (2) avoid gaps in payment to nursing homes due to the individual being disqualified for medical assistance and being without assets to pay for care.

One question CMS seems to address, albeit very poorly, is the question of whether a Medicaid application must be filed in order to begin the running of a penalty period. CMS states "[s]tates should be aware that imposition of a penalty period for new applicants for Medicaid requires a denial notice." This could mean that in order to commence a penalty period, a Medicaid application must be filed followed by a denial notice which states 1) the length of the applicable penalty period, and 2) the date on which Medicaid will begin paying for services. Under this scenario, it would not be necessary to file a second Medicaid application as the denial notice itself also serves as the acceptance for benefits to begin at a later date. Further proof will be necessary at the time services are to begin that assets are below the resource allowance and showing how the money was spent during the penalty period. If a portion of the penalty period is "cured" through a partial return of funds, then a re-determination would become necessary in order to seek Medicaid services at an earlier date than that specified in the denial notice.

Another question is whether an individual must continue to remain "otherwise eligible" for the duration of the penalty period? Since an individual need not be in receipt of institutional level care for the duration of the penalty period per the CMS guidance, although not specifically stated therein, it should not be necessary for the individual to meet the resource allowance for the entire duration but rather only at the start of a penalty period.

In any event, this is the full extent of CMS guidance provided to what can be described, at best, as highly ambiguous rules. It would seem that CMS is deferring to the states on many of these issues. Thus, although we have a new federal statute

regarding Medicaid eligibility rules, a strong advocacy effort is needed at the state level in order to prevent the lack of guidance from CMS resulting in a variety of inconsistent rules being applied throughout the country.

The Deficit Reduction Act Legislative History, 42 USC 1396p(c)(1)(D)(ii)

The crossed-out language was in the House version of the bill that became the DRA. Compare it to the language Congress adopted in Reconciliation, which became Section 6011 of the final DRA (in bold underlined):

(ii) In the case of a transfer of asset made on or after the date of the enactment of the Deficit Reduction Act of 2005, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.

Author's Comment: The change focuses on eliminating the requirement that an individual would have to actually be receiving nursing facility care and instead focused on when the individual would be considered in need of such care. Perhaps this change was meant to appease concern from the nursing home industry that the transfer penalty wouldn't begin until someone was placed and therefore they would end up with many patients who had made transfers, left themselves without funds and disqualified from Medicaid. With the change made at Reconciliation, the penalty can begin when the person is deemed in need of Medicaid covered institutional level of care services, not when they are actually receiving such institutional level of care services. Notice the language refers to "an application for such care," which would be a Medical Screening, and not an "application for medical assistance."

Undue Hardship, §6011(D) & (E)

While most of what CMS provides on undue hardship in the guidance letter is simply a reiteration of the language of the statute, a few things do stand out: 1) an ambiguous reference to the states' "considerable flexibility"; 2) the discussion of a facility's role in an undue hardship application filed on behalf of a resident; and 3) the eligibility standard for bed-hold payments.

CMS does repeat in the guidance the same point made in the NAELA White Paper on the DRA—that the new statutory provision is an adoption of what the CMS State Medicaid Manual already required. The agency says, "While [the new] criteria and procedural requirements are listed in the statute for the first time, they are the same criteria and procedures that CMS has provided to States in the State Medicaid Manual at Section 3258.10(C)(5). Thus, States should already be applying these criteria to the

determination of undue hardship." CMS warns states in the guidance that states "*must include information about their implementation of the DRA undue hardship waiver requirements in their State Medicaid plans.*" Emphasis added.

Putting this aside, the following is a discussion of the significant points raised by the CMS guidance.

"Considerable flexibility"

CMS says that "as long as [states] adhere to the DRA criteria, States still have considerable flexibility in deciding the circumstances under which they will not impose penalties under the transfer of assets provisions because of undue hardship." This sentence is taken almost in whole from the discussion of undue hardship in Section 3258.10(C)(5) of the CMS State Medicaid Manual. However, while the criteria for undue hardship contained in Section 3258.10(C)(5) was adopted by the DRA's authors, the "considerable flexibility" language was *not*. And given that the statute mandates, without exception, that states provide undue hardship waivers to individuals who establish that they will be deprived of either medical care, food, clothing, or shelter by application of a penalty period, the states' post-DRA flexibility must be more narrow than it was before.

CMS does not define "considerable flexibility" in the guidance letter, but the agency did define it in Section 3258.10(C)(5) of the State Medicaid Manual. There it is described as the state authority to "specify the criteria to be used in determining whether the individual's life or health would be endangered, and whether application of the penalty would deprive the individual of food, clothing, or shelter...[and]...*to specify the extent to which an individual must make an effort to recover assets transferred for less than fair market value.*" Emphasis added.

Did CMS have this definition in mind when writing the guidance letter? This question is more relevant to the states' latter discretion (the recovery effort requirement) than the former (the deprivation showing). Theoretically, states will continue to have the discretion to "specify the criteria" for a deprivation showing, but not because CMS says that they will have the "considerable flexibility" to do so. As a general rule, states have the discretion to fill any voids left in the Medicaid statute or regulations. See *Rosie D. v. Romney*, 410 F.Supp.2d 18, 24-25 (D.Mass. 2006). The statute does not specify the criteria for a showing of a deprivation of a life necessity, and CMS has not spoken to the issue in regulation or policy. In such a situation, states have authority to develop standards themselves. Of course, state discretion is not unlimited. For example, the criteria would at least have to be *reasonable* in accordance with the "reasonable eligibility standards" mandate by 42 U.S.C. §1396a(a)(17). See *Lankford v. Sherman*, 451 F.3d 496 (8th Cir. 2006). Nonetheless, because criteria is not specified in the statute or regulation, state flexibility exists, making CMS' note on flexibility, at least with respect to this issue, a statement of fact instead of an affirmative grant of authority.

But it is still critical to ascertain whether CMS had the Manual definition of “considerable flexibility” in mind when writing it into the guidance letter, because the Manual definition expressly provided states the authority to require undue hardship applicants to attempt to get the transferred property back. Again, the agency omitted from the guidance letter what it provided in the Manual on this subject, so it is very difficult to tell. Of some possible note, the agency declares in its press release that the statutory changes on undue hardship represent a “strengthening [of] the hardship waiver process,” and that the “[i]nability of a person to pay for needed nursing home care would be the key factor states would have to take into account in this process.” If the process has been “strengthened,” then it must have *changed* somehow. And given that CMS states in the guidance letter that the undue hardship *standard* has not changed, then the agency is presumably referring to some other aspect of the process that has become more favorable to beneficiaries. Maybe the agency is saying the end has come to state authority to require recovery efforts on the part of undue hardship applicants, which would give real meaning to the agency’s statement that the inability of an applicant to pay is now the “key factor” in determining undue hardship.

But this is all guesswork for now. How the agency is defining “considerable flexibility” will become clear soon enough, as states begin submitting their state plan amendments containing undue hardship standards that have recovery effort requirements attached to them. If CMS approves such plans, thereby signaling that it is currently defining “considerable flexibility” the same way it previously defined it in the Manual, it may be inviting litigation. The fact is that the previous CMS policy on undue hardship has been supplanted by a federal statute, and this statute does not contain a recovery effort requirement in its undue hardship standard.

“File” means “Represent”

The DRA permits a facility to *file* an undue hardship waiver application on behalf of a resident, provided the facility receives authorization from the resident or his/her personal representative. But does this language mean that a facility may actually *represent* a resident in the procedure? To the extent there was any question, CMS resolves the issue in favor of a more expansive reading of a facility’s authority by saying that a facility is allowed to “present information” on behalf of the resident to the state. The facility may also, with the additional consent of the individual, “represent” the individual in the appeals process.

It is not clear whether “present information” and “represent” mean anything different in this context. Is it possible that CMS is saying that a facility’s authority is limited to testifying (i.e., “presenting information”) at the initial hearing, and may only expand to full-fledged representation at the appellate level? Probably not. As pointed out in the White Paper, facilities were already representing Medicaid applicants in undue hardship proceedings even before passage of the DRA. So, the different language used to describe a facility’s authority during the stages of an undue hardship process seems to be a distinction without a difference. The ultimate point to derive from the guidance

on this issue, if CMS intended to make one, is that a facility's authority in this process extends beyond the mere act of filing an undue hardship application on behalf of a resident.

Eligibility for bed-hold payment

The DRA provides in the undue hardship section that a state may pay a nursing home for services provided to a Medicaid applicant with an undue hardship request pending in order to hold the bed for the applicant. Payment is at state discretion, and cannot exceed thirty days. The DRA states that individuals will be eligible for these "bed hold" payments if they meet "such criteria as the Secretary specifies." This criterion is identified in the guidance letter, and the criterion is at best less than clear, and at worst counterintuitive.

Under the DRA, an individual is only eligible for the bed hold payments while his or her application for an undue hardship waiver is *pending*. So, by necessity, eligibility for bed hold payments will only exist where the state agency has *not yet made the decision* on whether the individual's circumstances meet the undue hardship standard of the statute. For purposes of eligibility for bed hold payments then, the standard would at least have to be different, if not less strict, than the standard for undue hardship. Theoretically, the bed hold standard would require the individual to make some initial, immediate showing to establish eligibility. For example, maybe eligibility for bed hold payments would exist where the applicant has already been served with a discharge notice, or if the individual has been institutionalized for a minimum amount of time when the undue hardship waiver is filed. Regardless, one thing that is certain is that at the point in time in which an individual will seek bed hold payments, the determination of undue hardship *will not have been rendered*.

It appears, however, that the bed-hold eligibility standard CMS adopts in its guidance letter is the *undue hardship* standard ("States may, but are not required to, make bed hold payments to facilities on behalf of individuals for whom an undue hardship waiver application is pending...The application for an undue hardship waiver must meet the criteria specified in Section 1917(c)(2)(D) of the Act [i.e., the undue hardship standard]"). This sentence appears to say that in order to be eligible for bed hold payments while the application for undue hardship is *pending*, the individual must meet the undue hardship test. This is irrational. The person cannot possibly establish what the state agency is still in the process of determining.

An alternative reading may be this: that in saying that "the *application* for an undue hardship waiver must meet" the undue hardship criteria for purposes of bed hold payment eligibility, CMS means that that the four corners of the undue hardship application must contain allegations of a potential deprivation of medical care, or food, clothing or shelter (i.e., the undue hardship standard) in order for an individual to get the bed hold payments while the application is pending. Obviously, this would be a different standard, but it would mean that eligibility for the bed hold would turn more

on an individual's knowledge of the undue hardship standard than on the individual's actual circumstances.

The bottom line is that it seems CMS treated the bed hold eligibility standard as an afterthought in developing the guidance on the new transfer rules. While the guidance on the whole is hardly a model of clarity, the bed hold eligibility standard received particularly short shrift within the document. The only thing CMS makes clear in the discussion on the bed hold policy is that the statute gives states the discretion to choose whether or not to provide such payments, and limits the payments to 30 days. The overall theme seems to be that CMS is not very enthusiastic about the authority the statute provides to states to make bed hold payments.

Disclosure and Treatment of Annuities, §6012

The CMS guidance letter on the DRA annuity rules addresses the following practice issues:

a. When does the DRA apply to annuities purchased before February 8, 2006?

In addition to purchases, CMS states that certain transactions which occur on or after February 8, 2006, make an annuity, including one purchased before that date, subject to the provisions of the DRA. Such transactions include any action taken by the individual that changes the course of payments to be made by the annuity or the treatment of the income or principal of the annuity. These actions include additions of principal, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract, and similar actions taken by the individual on or after February 8, 2006.

For annuities purchased prior to February 8, 2006, routine changes and automatic events that do not require any action or decision after the effective date of enactment are not considered transactions that would subject the annuity to the provisions of the DRA. Changes that occur based on the terms of an annuity which existed prior to February 8, 2006, and which do not require a decision, election, or action to take effect are likewise not subject to the DRA.

b. What disclosure requirements does the DRA impose on annuities?

All states must alter their applications for medical assistance for long-term care services, including applications for recertification, to include a disclosure and description of any interest the applicant or the community spouse may have in an annuity. This disclosure is a condition for Medicaid coverage of long-term care services, including nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home and community-based services furnished under a waiver. This disclosure requirement applies regardless of whether or not an annuity is irrevocable or is treated as an asset.

CMS further requires that states include in the application for long-term care services, including the application for recertification, a statement that names the State as a remainder beneficiary on any annuity purchased on or after February 8, 2006. The State may require the issuer to notify it regarding any changes in disbursement of income or principal from the annuity.

However, §1396p(e)(1) requires only that the Medicaid “application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.” Paragraph (2) refers only to an “annuity under §(c)(1)(F).” It makes no reference to an annuity under §(c)(1)(G). This makes sense, because an annuity under §(c)(1)(F) must name the State as a preferred remainder beneficiary in order for the purchase of the annuity not to be treated as the disposal of an asset for less than fair market value. No such requirement applies to an annuity under §(c)(1)(G). Hence, the statement required by paragraph (2) of §1396p(e) should be limited to only those annuities under §(c)(1)(F).

c. What are the consequences for not meeting the annuity disclosure requirements?

If the individual, spouse, or representative refuses to disclose sufficient information related to any annuity, the State must either deny or terminate coverage of long-term care services only or deny or terminate eligibility for Medicaid entirely based on the applicant’s failure to cooperate. If the State cannot collect enough information about an annuity to allow the State to establish Medicaid eligibility, the State may deny eligibility entirely based on the applicant’s failure to cooperate.

In cases where an unreported annuity is discovered after eligibility has been established and after payment for long-term care services has been made, the State may terminate payment for long-term care services. CMS states that the State may also consider whether other steps should be taken including, if appropriate, possible civil and criminal charges, and potential recovery of benefits incorrectly paid. Civil and criminal charges for failure to disclose any interest the applicant or the community spouse has in an annuity are clearly inappropriate absent very clear notice of the requirement and the intentional failure to disclose.

d. What remainderman requirements does the DRA impose on annuities?

CMS interprets §(c)(1)(F) to require that an annuity name the State as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the annuitant, unless there is a community spouse and/or a minor or disabled child. If the State has been named after a community spouse and/or a minor or disabled child, and any of those individuals or their representatives dispose of any of the remainder of the annuity for less than fair market value, the State must then be named in the first position.

The correct interpretation is that §(c)(1)(F)'s requirement that the State be named as beneficiary in the first or second position applies only to annuities that do not meet the requirements of §(c)(1)(G). With respect to a transfer of assets, §(c)(1)(G) explicitly excludes from the term "assets" the retirement annuities described in §(c)(1)(G)(i) and the irrevocable and non-assignable actuarially sound annuities that meet the requirements of §(c)(1)(G)(ii)(III). Section (c)(1)(G) says that such annuities are not "assets" with respect to a transfer of assets. Therefore, they cannot be assets that can be disposed of for less than fair market value. Hence, §(c)(1)(F)'s requirement that the State be named as the remainder beneficiary in the first or second position should apply only to annuities that are not excluded as "assets" pursuant to §§(c)(1)(G)(i) or (G)(ii).

e. What are the consequences for not meeting the annuity remainderman requirements?

If the State is not named as a remainder beneficiary in the correct position, the purchase of the annuity will be considered a transfer for less than fair market value. CMS interprets this position to mean that the full purchase value of the annuity will be considered the amount transferred.

However, neither the provision being interpreted nor any other provision of the DRA addresses the value of the amount transferred. A better interpretation more consistent with past treatment of annuity purchases is that only the uncompensated value of the transferred asset is subject to a transfer penalty.

f. The purchase of an annuity is treated as a transfer of assets for less than fair market value unless the annuity satisfies what criteria?

An annuity purchased by or on behalf of an annuitant who has applied for Medicaid will not be treated as a transfer of assets if the annuity is an individual retirement annuity,³ a deemed Individual Retirement Account (IRA) under a qualified employer plan,⁴ purchased with proceeds from a traditional IRA,⁵ a certain account or trust which is treated as a traditional IRA,⁶ a simplified retirement account,⁷ a simplified employee pension,⁸ a Roth IRA,⁹ or is irrevocable and non-assignable, actuarially sound, and provides payments in approximately equal amounts with no deferred or balloon payments.

³ I.R.C. §408(b)

⁴ I.R.C. §408(q)

⁵ I.R.C. §408(a)

⁶ I.R.C. §408(c)

⁷ I.R.C. §408(P)

⁸ I.R.C. §408(K)

⁹ I.R.C. §408(A)

To determine that an annuity is established under any of the above provisions, the Medicaid agency will rely on verification from the financial institution, employer, or employer association that issued the annuity. Absent such documentation, the purchase of the annuity will be considered a transfer for less than fair market value which is subject to a penalty. CMS states that this means that the full purchase value of the annuity will be considered the amount transferred. As noted in section e. above, a better interpretation is that only the uncompensated value of the transferred asset is subject to a transfer penalty.

g. If an annuity satisfies criteria such that its purchase is not treated as a transfer of assets for less than fair market value, must the annuity still satisfy the remainderman requirements of the DRA?

CMS has chosen to treat subsections (F) and (G) of §1396p(c)(1) conjunctively such that the requirements of both subsections must be met before an annuity is not treated as a disposal of assets for less than fair market value. Hence, CMS concludes that the criteria for the purchase of an annuity to not be treated as a transfer of assets for less than fair market value are in addition to the requirements pertaining to the State's position as a remainder beneficiary.

However, paragraph (2) of §1396p(e) requires that the statement that "the State becomes a remainder beneficiary under such an annuity" be included on applications or recertifications where there is an annuity under (c)(1)(F) but not under (c)(1)(G). This is consistent with the necessity of the State being a remainder beneficiary unless the annuity satisfies the requirements of (c)(1)(G). An annuity that meets the requirements of (c)(1)(G) is not included within the term "assets." Since such an annuity is not an "asset," its purchase cannot be treated as the disposal of an asset for less than fair market value. Only an annuity that is an "asset" can be treated as the disposal of an asset for less than fair market value under (c)(1)(F). However, (c)(1)(G) explicitly excludes from the term "assets" the qualified retirement annuities described in (G)(i) and non-qualified retirement annuities that are irrevocable and non-assignable, actuarially sound, and provide for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.

h. Do the DRA requirements apply to annuities purchased by the community spouse?

CMS says that the purchase of an annuity shall be treated as a disposal of an asset for less than fair market value unless the State is named remainder beneficiary. CMS applies this to annuities purchased by an applicant or by a spouse, and to transactions made by the applicant or spouse.

However, as discussed in sections d. and g. above, (c)(1)(F)'s requirement that the State be named as beneficiary in the first or second position applies only to annuities that do not meet the requirements of (c)(1)(G). Therefore, annuities purchased by the

community spouse also should need only name the State as beneficiary if the requirements of (c)(1)(G) are not met.

Even if the community spouse were required to name the State as remainder beneficiary, §(c)(1)(F) only requires that the State be named as remainder beneficiary “for at least the total amount of medical assistance paid on behalf of the **annuitant**” [emphasis added]. Unless the applicant is the annuitant, the assistance paid on behalf of the applicant is irrelevant. If the community spouse is the applicant and receives no assistance, the State is entitled to nothing as remainder beneficiary regardless of the assistance paid on behalf of the applicant.

i. Are annuities that are not penalized as a transfer for less than fair market value still considered in determining eligibility?

CMS says that even though an annuity is not penalized as a transfer for less than fair market value, it still must be considered in determining eligibility, including spousal income and resources, and in the post-eligibility calculation, as appropriate. In other words, CMS interprets the DRA such that even if an annuity is not subject to penalty under the provisions of the DRA, it still may be treated as income or a resource.

However, the DRA says nothing to change pre-DRA law concerning the treatment of an annuity as income or a resource. Rather, the DRA only says at §1396p(e)(4) that the State may deny eligibility “based on the income or resources **derived** [emphasis added] from an annuity.” If the actuarially sound annuitization of an annuity resulted in the annuity being treated under §3258.9 of the State Medicaid Manual as income rather than a resource, then the same result should occur despite the other changes to the treatment of annuities by the DRA.

j. If an annuity meets the transfer requirements, is the transfer of the annuity subject to penalty?

Even if an annuity meets the transfer requirements and the purchase is not treated as a transfer, the transfer of the annuity or the income stream from the annuity, except to a spouse or disabled child or to another individual for the sole benefit of the spouse or disabled child or to a trust for the sole benefit of the spouse or disabled child, may be subject to penalty. For example, the annuity or its income stream may be transferred without penalty from the annuitant to the spouse or the disabled child.

Income First, §6013

Section 6013 of the DRA provision mandates “income first” as the only permissible methodology for determining whether a spouse of a nursing home resident is entitled to an increased community spouse resource allowance. The CMS Enclosure makes it clear that in states using the resource-first approach, the requirement to

switch to income first applies only to *determinations of the CSRA made on or after* the effective date of February 8, 2006, and only when the institutionalized spouse *became institutionalized on or after such effective date*.

Thus, if a couple applied for Medicaid before February 8, 2006, and requested an increased community spouse resource allowance and the hearing was not held until after the effective date, CMS states that the income first methodology must be used as long as institutionalization occurred on or after February 8, 2006. In the unlikely event that an individual in a resource-first state applied for Medicaid coverage of long term care services prior to February 8, but was institutionalized on or after February 8, CMS is saying that income first would apply, assuming the determination of the CSRA at the hearing took place on or after February 8. The CMS position contradicts the general legal principle that the Medicaid rules in effect on *the date of application* for benefits should apply. See *Martin v. Ohio Dept of Human Services*, 130 Ohio App.3d 512; 720 N.E.2d 576; 1998 Ohio App. LEXIS 5475, citing *Miller v. Ohio Dept. of Human Serv.* (1995), 105 Ohio App. 3d 539, 543, 664 N.E. 2d 619. However, this contradiction is not critical given that a pre-February 8 application involving a post-February 7 institutionalization is unlikely to have occurred, and in any case, such an application is unlikely to be pending at this point.

Couples who have had increased CSRA's calculated under a resource-first methodology prior to February 8, 2006 will not be affected by the change to income first. In addition, if the institutionalized spouse became institutionalized before February 8, 2006, a resource-first state may continue to use the resource-first methodology to determine the community spouse resource allowance regardless of the date of application or the date the determination of the CSRA is made. Thus, in resource-first states, there may be individuals applying for Medicaid two years from now who will still be able to require a resource-first methodology, if institutionalization occurred prior to February 8, 2006. In those states, couples may need to be advised of the possible loss of the use of this methodology, if the institutionalized spouse were to return home for a few months and were then institutionalized again.

CMS describes the steps states may take to determine the amount of the increased community spouse resource allowance under income first. These steps are "for illustrative purposes only" and do not preclude States from applying the income first methodology differently than what is described in the CMS Enclosure. There are two potential problems with the steps outlined.

First, CMS mistakenly instructs states to determine the "gross monthly income" of the institutionalized spouse and, after deducting the personal needs allowance, allocate the remainder to supplement the community spouse's gross income in order to meet the MMMNA. This step omits the deduction of the Medicare (and supplemental health insurance) premium from the institutionalized spouse's gross income, which would normally be allowed. Surely, neither CMS, nor the states have any intention of requiring institutionalized spouses to give up their Medicare in order to divert additional

“gross” social security income to the community spouse pursuant to income first. Hopefully, states will continue to deduct Medicare (and other supplemental health insurance) premiums from the institutionalized spouse’s income before deeming it to the community spouse.

Second, CMS gives states latitude in using “any reasonable method for determining the amount of resources necessary to generate adequate income, *including adjusting the CSRA to the amount a person would have to invest in a single premium annuity to generate the needed income*, attributing a rate of return based on a presumed available rate of interest, or other methods.” Thus, states could determine the cost of a Single Premium Lifetime Monthly Payment Annuity (SLIMPA) that would produce monthly payments in an amount sufficient to make up the shortfall in the community spouse’s income and then only allow the community spouse’s resource allowance to be increased to that cost.

This annuity methodology allows the protection of far fewer assets for the community spouse since annuity payments consist of both income and a return of principal, rather than income alone. This method was used in the early 1990’s in several states. In 1993, it was challenged in Iowa and upheld as a reasonable interpretation of the Medicare Catastrophic Coverage Act (MCCA) in *Ford v. Iowa Dep’t of Human Servs.*, 500 N.W.2d 26, 1993; 1993 Iowa Sup. LEXIS 117. However, two New York state courts recently held that a state Medicaid agency lacks the authority to limit the amount of an increased CSRA to the amount required to purchase a SLIMPA that would generate a monthly payment sufficient to raise the community spouse’s income to the MMMNA. *Berg v. Novello et al* (No. 1681/0)(Supreme Ct. Sullivan Co., Sackett, J. March 1, 2006); see also *Parks vs. Moon* (No.122885) (Supreme Ct. Sullivan Co., Feb. 14, 2006). States are not required to use this annuity method and hopefully will continue to use other methods to calculate the amount of additional resources a community spouse may keep when facing a shortage of income, as long as “income first” is applied.

Home Equity Cap Under the DRA, §6014

The CMS discussion of Section 6014 offers some elucidation, while sidestepping some of the more difficult issues.

In discussing a state’s option to increase the presumptive \$500,000 cap to an individual’s equity interest in the residence to over \$500,000, it states that a particular state “need not use the higher amount on a statewide basis.” This acknowledges the fact that homes can vary substantially in value within a state. This is particularly important in states where real property values vary enormously within their boundaries. Note that two states, New York and Massachusetts, which have widely varying property values, have adopted the \$750,000 cap statewide.

The guidance letter adds a three-part definition of "other long-term care services," which is the alternative coverage area (in addition to "nursing facility services") in Section 6014. The definition is important, as it bears on the commencement date of a period of ineligibility under Section 6011 ("when an individual is receiving institutional levels of care"; see related comments on the commencement date in the discussion that specifically addresses this topic). The three component definition includes "a level of care in any institution equivalent to nursing facility services," "home or community-based services under a waiver," and "services provided to a non-institutionalized individual with specified needs if a state has so elected."

A bold-faced "Note," suggesting emphasis, states that a home "of any value" remains exempt for purposes of "determining eligibility for Medicaid." It explicates that the change in law applies to "payment" (emphasis original) for identified services. In limited circumstances, and regardless of Medicaid payments, the determination of eligibility may result in the provision of other services or allow access to other programs.

To determine the equity value of a residence, it directs that "states should follow their existing policies to determine current market value."

If home ownership is shared, "only the fractional interest of the applicant" is to be considered. If an applicant/resident owns her home in joint tenancy, for example, only half of the value is to be counted. Fortunately, this creates only a presumption – an individual may be able to prove that her ownership interest (apparently based on invested value) is less than the share reflected by the form of ownership.

Given the lack of reliable CMS guidelines regarding undue hardship waivers, co-ownership can present a dilemma. An applicant may own an interest with value in excess of \$500,000, but be unable to obtain a loan or reverse mortgage because the other owner refuses to cooperate. Undue hardship is suggested in such circumstances. The \$500,000 cap does not apply when a disabled child is in the residence. CMS guidelines indicate that permanent and total disability is required in Guam, Puerto Rico, and the Virgin Islands.

Until the Secretary of Health and Human Services establishes a process for undue hardship waivers, states may use their existing procedures or new ones developed in light of the DRA.

Implications of the CCRC Provisions of the DRA, §6015

NAELA's interpretation of the (DRA) is consistent with that of CMS on the issue of Continuing Care Retirement Communities (CCRCs). The DRA not only decriminalizes, but for a specific class of MA certified Long Term Care facilities within MA-participating CCRCs, *legalizes* the ability to require prepayment of fees. Until the passage of the DRA,

prepayment of fees was a felony under 42 U.S.C. §1320a-7b(d), and remains so for all other MA participating Long Term Care providers. The DRA provisions regarding entrance fees and assets represent a giant leap backwards to the CCRCs of the 19th Century. In those, a resident exchanged all his or her assets for a guarantee of lifetime care. Under the DRA, CCRCs are allowed to require residents to use all their assets in the CCRC *without* a guarantee of lifetime care.

Other Operational Changes in the Imposition of Transfer Penalties: Partial Month Penalties, §6016(A)

The CMS interpretation of the “no rounding-down” provision of DRA 6016(a) appears to encompass a broader category of transfers than mandated by the provisions of the statute or as envisioned in the Committee Report. There are three fact situations where the direction to impose partial-month penalties could be applied.

The first, clearly delineated in the Committee Report and the initial NAELA analysis, was the situation where the application of the formula for determining a penalty period [(Amount Transferred) divided by (Average Cost of Nursing Home Care) = (# months of penalty)] resulted in other than a whole number quotient. The example used in the Committee Report provided a clear illustration of this. Where the transferred amount was \$53,000 and the Average Cost of Care \$4,100, the formula quotient was 12.92. In a 31 day month, the .92 month penalty equates to 28 days. Under the statute, as explained in the Committee Report, States are now required to impose a 28 day transfer penalty.

The second situation is where there is a transfer, within a month, of less than twice the average cost of care. For example, using the same facts as in the Committee Report, a transfer of \$8,000 (slightly less than 2x the \$4,100 average cost of care) results in a 1.95 month penalty. However, where the .95 is rounded down, no penalty is applied in the month following the initial transfer. The result is that \$24,000 transferred over three months in \$8,000 payments would be result in a three-month transfer penalty period rather than 5 or 5.85 (\$24,000/\$4100). While not specifically addressed in the Committee Report or the CMS transmittal, the effect of no rounding-down results in the elimination of this disparity.

The third situation, which was not addressed in the Committee Report, dealt with the consequence of *de minimis* transfers. Here, CMS directly addresses small, irregular or isolated transfers by identifying small transfers, i.e. \$500, previously disregarded by some states as the focus of the provision. The requirement that these small transfers incur a penalty period, which under the new format, is generally imposed at the time of application, confirms the concern of many that DRA not only might, but based on the CMS position, must, apply to punish individuals for small transfers.

One issue that is addressed in the CMS guidance is the provision that answers the question of whether the requirement that partial month penalties not be “disregarded” would authorize the imposition of a penalty for the entire month in which the fractional penalty occurred. CMS suggests that the statute requires that the number of days of penalty in the month in which the fraction occurs must be in proportion to the average cost of care used to calculate the penalty. In the Committee Report example cited above, that means that the .92 translates to 31 days x .92 = 28.5; or, calculated fully $\$4,100/31 = \132.26 per day: $\$4,100 \times .92 = \$3,772/132.26 = 28.5$.

Option to Combine Multiple Transfers, §6016(B)

In light of the ambiguity in Section 6016(b) of DRA, it was difficult in the initial analysis of this provision to identify the provision’s purpose and intent. The option to either treat multiple transfers during the look-back period as one transfer or multiple transfers had been consistent with the law prior to DRA.

The CMS transmittal’s interpretation of Section 6016(b) of DRA provides some basis for analysis. The example used is a transfer of \$1,000 per month for 60 months. Under the accumulation option, the total transfer is \$60,000. Using the example in partial month penalties, the state average cost of care is \$4,100: the penalty period is 14.63 months. Under the separate penalty option according to CMS (with the fractional month penalty), the result would be .24 months ($\$1,000/4100 = .24$) per transfer, which in an average 31-day month would be 7.6 days; $60 \times 7.6 = 456$ days of penalty, or again, 14.7 months.

It is not clear whether the State would determine a penalty period on each transfer separately, as set forth in the example above. In the alternative, the state may treat the separate penalty periods for separate transfers, as opposed to aggregating them, as running concurrently from the same penalty start date.

Under the CMS transmittal, the State must declare, in its State Medicaid Plan, which option it will use.

Treatment of Notes, Loans, and Mortgages as Asset Transfers, §6016(C)

The CMS guidelines provide how to determine if a loan, note, or mortgage is actuarially sound. The note, loan, or mortgage must adhere to the actuarial tables provided by the Office of the Chief Actuary of the Social Security Administration. Its Period Life Table should be consulted to determine if the note, loan, or mortgage is actuarially sound. One should consult the SSA’s Actuarial Publications Statistical Tables Web page under the heading, “Life Table” at <http://www.ssa.gov/OACT/STATS/table4c6.html>. If the note, loan, or mortgage is not

actuarially sound, the outstanding balance due as of the date of the individual's application for Medicaid coverage of services is treated as a transfer of assets.

Although the Guidelines provide some additional insight into the treatment of notes, loans, and mortgages, they fall short in addressing many of the issues already outlined in the white paper.

Purchase of Life Estates, §6016(D)

CMS, pursuant to §6016(d) of the DRA, has provided the following guidance:

1. CMS sets forth the purpose of §6016(d), which is to deter transforming countable resources (cash) into non-countable resources (the life estate).
2. This section provides that unless an individual purchasing a life estate in another individual's home actually resides there for a period of at least one year after the date of the purchase. The transaction should be treated as a transfer.
3. CMS states that the amount of the transfer should not be reduced or prorated to reflect an individual's residency for a period of less than one year.
4. CMS points out that existing law still applies as to the rules regarding resource eligibility and transfer of assets, even in cases where individuals reside for more than one year in another person's home.
5. CMS has clarified some of the mechanics in calculating whether a transfer has occurred and for what period of time.
 - A. If payment for a life estate exceeds the fair market value of the life estate as calculated in accordance with the POMS, the difference should be treated as a transfer of assets
 - B. If an individual makes a gift of the life estate interest, the value of the life estate should be treated as a transfer of assets.
 - C. Unless a State has a provision for excluding the value of life estates in its approved State Medicaid Plan, or the property in which the individual has purchased a life estate qualifies as the individual's exempt home, the value of the life estate should be counted as a resource in determining Medicaid eligibility.
 - D. The DRA provisions pertaining to life estates does not apply to

retention of life estate by individuals transferring real property.

6. Issue of Concern #1: CMS states that if an individual does not meet the one year residency requirement, then there is no pro ration of the penalty period based on the number of months the individual has resided in the residence. This approach is overly restrictive. An individual who has paid full value of a life estate interest and then lives in the other person's home for a period of less than one year should receive some benefit for such residency under the transfer rules.

For example, if an individual paid \$120,000 for a life estate interest in another's residence and then lived in the residence for ten months before entering the nursing home, it would be appropriate to pro rate the penalty period based on the number of months that the individual resided in the residence. In this case, the penalty should be based on \$20,000 (\$120,000 – purchase price of the life estate x 2 months – representing the number of months the individual did not spend in the residence in order to meet the one year test divided by 12 months – the one year residence requirement).

This is not a case of an uncompensated transfer and hence it may be appropriate to apply a more restrictive approach. There are a number of situations where an individual may not be able to meet the one year test, for example, an unexpected illness which causes hospitalization or nursing home care.

7. Issue of Concern #2: CMS was silent on the point that the one year residency test does not require a period of one continuous year. The Statute sets forth that "... unless the individual resides in the home for a period of 1 year after the date of the purchase." A plain reading of the statute provides for a one year test with no requirement that the number of days is consecutive or that the one year is immediately after the purchase of the life estate.

CMS should clarify that this one year residence test can be met by non-continuous periods of time with no requirement that the one year be immediately following the purchase of the life estate.

Expansion of State Long-Term Care Partnership Program, §6021

Home Equity Trap. Because the LTC Partnerships policy protects assets for purposes of eligibility, CMS has made clear that "the use of a qualified Partnership policy will not affect an individual's ineligibility for payment for nursing facility services, or other LTC services, when the individual's equity interest in home property exceeds

the limits set forth in ... the DRA.” The home equity limits are not eligibility limits; rather, they are restrictions on paying for long-term care services for a person who is otherwise eligible. This means that Partnership policies will be of no practical use to a person whose home’s value exceeds or is likely to exceed the home equity cap of \$500,000 to \$750,000 as established by the individual state. Since future increases in the fair market value are hard to predict and have historically had swings in which values increase far beyond normal inflation rates, a great many seniors are potentially at risk in wasting their money on Partnership policies if they have a home with a value anywhere near the limit.

Agent Training. The interaction of the home equity limit is just one example of how different components of the DRA can interact in unexpected ways. This reality underscores the need for thorough, high quality training of insurance agents who sell these policies. Section 6021 of the DRA mandates that each state Medicaid agency provide “information and technical assistance to the State insurance department on the insurance department’s role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.” A consumer representative to the National Association of Insurance Commissioners (NAIC) informed us that the Senior Issues committee of NAIC recommended that agents be required to take 8 hours of training initially on Partnership Policy/Medicaid LTC coverage issues, and then be required to take 8 more hours during each licensing period thereafter. However, another committee of NAIC has recommended simply 2 hours of training initially and none thereafter. It was also suggested that other senior advocacy groups such as NAELA could have an impact on NAIC by writing position letters directly to NAIC.

The LTC Expenses Definition Trap. What policy payments will states count toward the total of assets to be protected? Like the statute, the CMS letter “provides for the disregard of resources, when determining estate recovery obligations, in an amount equal to the LTC insurance benefits paid to, or on behalf of, an individual who has received medical assistance.” The letter goes on to say: “The insurance benefits upon which a disregard may be based include benefits paid as direct reimbursement of LTC expenses, as well as benefits paid on a per diem, or other periodic basis, for periods during which the individual received LTC services.” However, the letter leaves open the possibility that some states may take a very restrictive view of the meaning of “LTC expenses” paid under a policy, limiting it to those kinds of LTC expenses actually covered by Medicaid. We have heard that many states are reluctant to give credit for expenditures that Medicaid would not have covered in the first place. If states are permitted to take this restrictive approach it would mean that, if the Partnership policy covers LTC services not covered by Medicaid -- such as home modifications, respite care, personal care, adult day care, caregiver training, alternate plans of care – then the state may decide not to include those insurance payments in the total asset amount it disregards for eligibility purposes. This will affect people at the time they have

exhausted their insurance coverage and then discover that a substantial chunk of the assets they thought would be protected are not.

Portability Concerns. The DRA requires the Secretary to develop, not later than January 1, 2007, “standards for uniform reciprocal recognition of such policies among States with qualified State long-term care insurance partnerships under which benefits paid under such policies will be treated the same by all such States...”. These standards are to be developed in consultation with NAIC, insurance companies, the pre-DRA Partnerships states, other states, and “representatives of consumers of long-term care insurance policies.” However, if the states defined eligible LTC expenses differently, portability will be a virtually insurmountable obstacle. Uniform portability standards should be developed to carry out the intent of the DRA regarding Partnership policies.

Effective Dates for Provisions of the DRA

CMS provides little additional instruction or interpretation of the DRA in regard to effective dates. Most guidelines are merely restatements of the statutory provisions. Unfortunately, CMS fails to address issues such as whether Medicaid applications that have been processed under old law will later need to be re-examined under DRA provisions once a state’s State Plan has been amended to include these new provisions. Questions of whether the State may or must retroactively apply DRA provisions to applications filed after DRA effective dates, but before State implementation, are unanswered.

CMS Guidelines Provide Little Assistance to Resolve the Complexities of the “Effective Date” of Particular Provisions and Merely Restate DRA Provisions

a. State Long-Term Care Insurance Partnership.

The effective date defined in the DRA is self-explanatory.

With no ambiguity, the CMS guidelines merely restate the DRA effective date.

b. Income-First Rule.

The DRA defines the effective date as the date of enactment of the DRA, February 8, 2006, but only to determinations of the CSRA made on or after the effective date **and** only when the institutionalized spouse became institutionalized on or after the effective date.

CMS guideline restates the DRA.

CMS fails to address whether resource-first may still be used in situations where the "snapshot date" occurred before February 8, 2006.

c. Counting Home Equity above \$500,000 as a Resource.

The DRA defines the effective date as January 1, 2006 for individuals who are determined eligible for medical assistance with respect to nursing facility services or other long-term care services based on an application filed on or after January 1, 2006.

CMS guideline restates the DRA.

CMS fails to address situations where an individual with excess home equity is approved under prior law, but before implementation. For example, if the applicant applied January 2, 2006 with \$550,000 in equity and was approved February 2, 2006 using old law, may the States retroactively terminate benefits? Or, will that same applicant be denied benefits on redetermination even though DRA and/or State Plan amendments were not in effect?

d. Treatment of Continuing Care Retirement Community Entrance Fees.

The DRA defines the effective date as the date of enactment of the DRA, February 8, 2006

CMS guideline restates the DRA.

e. Extension of the Look-Back Period to 60 Months and Penalty Period.

The DRA defines the effective date as the date of enactment, February 8, 2006.

CMS guideline restates the DRA.

CMS fails to address how to treat transfers made after the date of enactment, but before implementation of state rules. Must the state retroactively apply DRA provisions to applications filed before state rule enactment that report post-DRA transfers? May the state instead apply pre-DRA rules to such transfers? How about applications filed after the state rule that report transfers that occur after DRA, but before state rule enactment? If the state treats the two applicants differently for transfers made in the same time period, might this be a Constitutional violation? CMS gives no guidance on this issue. However, some states that have amended their state Plan to implement DRA have provided some guidance on this issue. For example, New York provides that if the transfer **and** application were made after the effective date of DRA, but before the effective date of the state rule, then those transfers are treated under pre-DRA rules.

f. Partial Months and Accumulation of Multiple Transfers into One Penalty Period, Purchase of Promissory Notes, Loans, or Mortgages and Purchase of Life Estates.

The effective date under the DRA is for payments made under Title XIX of the Act for calendar quarters beginning on April 1, 2006, and thereafter. These provisions do not apply to:

Medicaid provided for services furnished before February 8, 2006;
Disposal of assets made on or before February 8, 2006; or
Trusts established on or before February 8, 2006.

Date of implementation may be extended if the Secretary of Health and Human Services determines the State Medicaid plan requires State legislation in order for the plan to meet the additional requirements imposed by the amendments.

CMS restates the DRA. However, the guideline provides a process for State's to obtain the extension. States must submit a letter to CMS regional office including the date of implementation. Date must be first day of first calendar quarter beginning after close of first regular session.

Without CMS guidance it is unclear what the scope and start date of these transactions are. The non-statutory effective-date provision raises several issues. It recognizes that State plan amendments will be necessary but contemplates that states will have implemented it by April 1, 2006. It permits the Secretary to grant each state an extension, but only if state legislation is needed and even with such extension, permits insufficient time for state rule-making, policy drafting and training of eligibility workers. As a practical matter, the Secretary is unlikely to withhold federal Medicaid match to states that fail to meet an impossible deadline, but Congress's failure to realistically address the implementation time issue is further evidence that the implications of this legislation were inadequately considered.

Furthermore, the effective date language specifically exempts the Secretary from issuing regulations to interpret the legislation. This is no small problem, because the new law requires interpretation.

The non-statutory provision states:

"The amendments made by this section shall not apply--

(A) to medical assistance provided for services furnished before the date of enactment;

(B) with respect to assets disposed of on or before the date of enactment of this Act; or

(C) with respect to trusts established on or before the date of enactment of this Act."

Does this mean that the State can impose the new requirements retroactively on transactions that occurred on February 9, 2006, for instance, even though state law or policy permitted the transaction at that time? The federal law was explicit in most other sections of the DRA that it did apply to transactions made on or before the date of enactment, but here such retroactivity is suggested, but neither clearly mandated nor prohibited.

What about a loan made or a life estate purchased with trust funds, when the trust was established prior to February 8, 2006? Arguably, this law prohibits the state from penalizing a Medicaid applicant or recipient because his existing trustee entered a transaction that did not conform to the new criteria.

g. Annuity Rules.

The DRA defines the effective date as transactions occurring on or after the date of enactment, February 8, 2006.

CMS guideline restates the DRA. The guideline then adds that states should take reasonable steps to implement these provisions as soon as practicable. Further, states should consider if pending applications need to be supplemented to collect information regarding annuities, or if this information is already specifically collected to determine income and resources. States should also consider how to best notify applicants and recipients of the State's rights regarding annuities purchased after date of enactment.

The CMS guideline seems to contemplate immediate application of this provision regardless of when a respective state amends its State Plan to incorporate the new DRA provisions.

Specific implementation "watch" issues for advocacy with the Secretary and each State as these new provisions are implemented:

- In general, transactions made prior to February 8, 2006 should never be tested under DRA revisions.
- Annuities purchased prior to February 8, 2006, should be tested under the State's prior transfer of assets rules concerning annuities and never subjected to the more restrictive transfer of assets provisions of DRA and should never require naming the State as remainder beneficiary. DRA §6012(d).
- Notices to Medicaid applicants and recipients and State forms used in applications and recertification developed under 42 U.S.C. § 1396p(e)(1) should clearly state that annuities purchased prior to February 8, 2006 are exempt from the new provisions. However, the guidance provided by the Secretary under 42 U.S.C. § 1396p(e)(3) did not clarify these points.
- Life estates in another's home purchased prior to February 8, 2006 should not be subjected to transfer of assets provisions just because the person does not live in the home for one (1) year. DRA §6016(e).
- Multiple fractional transfers that occurred before February 8, 2006 should not be subjected to transfer of assets provisions if they would not have been subject to those provisions under prior state law. DRA §6016(e).
- Any form of transfer of assets made prior to February 8, 2006 should be considered under prior law and never subjected to penalty that begins on the date of application.

- Any trust established prior to February 8, 2006 should be considered under old rules and never subjected to penalty that begins on the date of application. DRA §6016(e), cf. 42 U.S.C. §1396p(c)(1)(D)(ii) and DRA §6011(c).
- According to DRA § 6016e, any transaction involving a trust established prior to February 8, 2006 should:
 - Use the State's prior rules on rounding down
 - Use the State's prior rules on multiple, fractional transfers
 - Use the State's prior rules for the treatment of notes, loans or mortgages, and
 - Use the State's prior rules on the purchase of a life estate in another's home
- Income-first must not be applied retroactively when the institutionalized spouse became institutionalized prior to February 8, 2006. DRA §6013(a).

Conclusion

The Deficit Reduction Act made extensive changes to Medicaid long-term care eligibility and other rules affecting seniors' access to health care coverage, and CMS has failed to fully clarify how these new provisions will be implemented. This document attempts to instruct Elder Law attorneys on possible issues that arise from this lack of definition in practice so that attorneys and clients can successfully navigate these complicated new rules. Medicaid remains a beneficial resource for seniors and should be made available to them. NAELA's true goal, however, is to achieve the repeal of the most harmful provisions through coordinated public policy efforts so that Medicaid rules allow seniors to get needed care.