

Twenty Questions about Planning for Medicaid and Nursing Home Care

By Peter A. Karl III

IN BRIEF

For elderly individuals entering into nursing care, financial assistance through Medicaid can defray the often significant costs. But Medicaid has stringent needs based requirements and transfer of asset rules that taxpayers and their advisors need to take into account in their planning. The author answers 20 common questions about the qualification requirements for Medicaid's nursing home care provisions and provides financial planning strategies for taxpayers contemplating entering themselves or a loved one into nursing care.

This article will address the various tax and legal issues facing elderly persons in New York who have the possibility of entering a nursing home or needing home care in the future while being concerned about family asset protection. Medicaid requirements and eligibility in particular are a focus of the 20 common questions answered below.

1. What Is the Difference between Medicare and Medicaid in Providing for Nursing Home Care?

Medicare is a federal insurance program for individuals over age 65 who pay for hospital costs through deductibles and premiums for nonhospital expenses. Provided that an individual has been hospitalized for at least three days, Medicare Part A will pay the first 20 days in a Skilled Nursing Facility (SNF) for acute medical or

rehabilitation care. The succeeding 80 days in an SNF will be covered after a copayment, provided the following requirements are met:

- The individual must enter the SNF within 30 days after the hospital stay.
- The care must be skilled (i.e., not merely custodial) and based on the same condition that caused the hospitalization.
- The care must be under a physician's orders.

It should be noted that the maximum coverage of 100 days by Medicare depends upon demonstrating that the medical rehabilitation will improve the individual's condition.

In contrast, Medicaid eligibility for coverage in a nursing home is based on an individual's financial ability in terms of both income and assets as of the date of application.

2. What Assets Are Considered in Determining Medicaid Eligibility?

For New York State in 2018, a Medicaid needs assessment involves reviewing the applicant's assets with respect to two parameters. First, if the applicant is a single individual, the amount of assets that can be retained (resource allowance) is \$15,150, along with any exempt assets. Second, under the Medicaid spousal impoverishment provisions, a certain amount of the couple's combined resources is protected if the recipient (the institutionalized spouse) has a spouse living at home (community spouse). The minimum allowance is \$74,820, and the maximum is \$123,600, which represents one-half of the couple's combined assets (referred to as the spousal share; this assumes the couple has assets of at least



\$247,200). The combination of the single and maximum community spousal allowances is referred to as the Joint Spousal Allowance (JSA), totaling \$138,750 (\$123,600 + \$15,150), which is not countable for Medicaid, along with any exempt assets. Exempt assets include the following:

- Irrevocable burial accounts for the applicant, children, and siblings, along with any spouses
- Burial life insurance with a face value of no more than \$1,500, such as a term policy
- An automobile and personal property
- Irrespective of how the home is titled, the personal residence (with maximum equity of \$858,000) in which the community spouse or a disabled child resides
- Retirement accounts [i.e., IRAs, 401(k) plans, 403(b) plans] that are in a periodic pay status (i.e., annuity payments over the individual's life expectancy). Though the account will be exempt from consideration as a countable asset, the income will be considered in the calculation of months of ineligibility, described below. The retirement account of a community spouse will also be exempt if in a payout status when the income will be subject to the

Medicaid income limitations. Most New York counties use the IRS tables for the required monthly distribution (RMD) calculation, while a few others (e.g., Nassau, Suffolk, Rockland, Orange, and Dutchess counties) utilize a Social Services Life Expectancy Table. The latter significantly increases the amount required for the periodic distribution.

- An applicant's business property and all liquid reserves needed for the operation of the family enterprise. This includes vehicles, machinery, equipment, inventory, tools, and livestock.

3. What Else Determines Medicaid Eligibility under the Needs Assessment?

In the Medicaid needs assessment, all of an applicant's income must be provided to the nursing home, less a \$50 allowance able to be retained by the individual in New York State. In the case of the community spouse, this allowance (from any earned or unearned source) is up to \$3,090 of combined monthly income. To the extent the community spouse has monthly income above that allowance, 25% of the excess must be used to pay for the nursing home care. If the income is less

than this allowance, application can be made to Medicaid to make up the differential by retaining a portion of the family assets.

4. What Transfer of Asset Rules Are Applicable?

There is a lookback period of 60 months, which results in the review of any gift (known as an uncompensated transfer) made during that period other than to a spouse. In most New York counties, any disbursement of more than \$1,000 over this period will be scrutinized, but sales for full consideration will not. It should be noted that after Medicaid qualification, the spouse's assets can appreciate to any amount, while the institutionalized spouse's assets may not exceed the single allowance of \$15,150. This means that once the financial snapshot has been taken, assets or transfers by the community spouse are not considered; resource eligibility occurs only at the time of application. This would permit, for example, a sale of the principal residence by the community spouse who as the sole owner prior to Medicaid qualification would be able to exempt the proceeds

from the post-Medicaid qualification sale. Medicaid can even review an ex-spouse's assets unless the divorce occurred more than 60 months prior to the application. When uncompensated transfers are found, the amount of such transfers is divided by the average monthly regional rate (MRR) of a nursing home in the applicant's location to arrive at the number of months the applicant will be ineligible for Medicaid. For example, if the MRR for nursing homes is \$10,000 and a \$200,000 gift occurs during the lookback period, the Medicaid ineligibility period would be 20 months.

It should be noted that while the federal gift tax exclusion applies to transfers of less than \$15,000, this does not mean that such an amount is allowed as an uncompensated transfer under Medicaid.

5. When Does the Period of Ineligibility Begin?

The following three conditions must exist before the clock begins on the period of ineligibility for uncompensated transfer made during the lookback period:

- The applicant is admitted to a nursing home.
- The Medicaid application is filed (noting that the Department of Social Services will look back 90 days from the first day of the filing month). Eligibility will then be established in the month in which the applicant first meets the income and resource requirements.
- The applicant passes the needs assessment detailed above.

For example, assume an uncompensated transfer of \$100,000 is made 20 months prior to entering the nursing home, and the MRR is \$10,000 per month. This results in a 10-month ineligibility period based on the calculation described in Question 4. The commencement of the individual's ineligibility period is delayed until the three aforementioned conditions are met. Accordingly, assets cannot be retained as under the former "rule of halves," which allowed for the possibility of retaining up to half of available assets, gifting the rest and consequently substantially reducing the ineligibility

period. The individual in this case fails the need assessment requirement. This planning device has been replaced by the one outlined in Question 14 below, known as the "reverse rule of halves" strategy.

6. How Do the Medicaid Rules Differ for Home Care?

Currently, the lookback rules do not apply to community-based Medicaid (i.e., home care). This care can provide up to 28 hours per week (and, in certain situations, more) based on the Managed Long Term Care Plan (MLTC) assessment. This means that an individual could transfer all assets

Once the financial snapshot has been taken, assets or transfers by the community spouse are not considered; resource eligibility occurs only at the time of application.

above the single allowance of \$15,150 or the JSA of \$138,750 to the community spouse, provided they have an MLTC plan.

The income rules for Medicaid home care have lower limitations; excess monthly income for a single individual is anything above \$842 for an individual and \$1,233 for a married couple. Both of these figures are increased by a \$20 set-aside resulting in \$862 and \$1,253, respectively. Accordingly, if an individual who is deemed disabled wishes to apply for home care, any excess income must be paid to Medicaid.

A pooled income trust (PIT) is a type of supplemental needs trust (SNT) that is normally used for people of any age with a disability. It allows an individual to send, on a monthly basis, the excess income to a trust (the PIT) that has been established by various nonprofit agencies throughout the state. This income may then be applied

for needs not otherwise covered by Medicaid such as housing expenses (e.g. real property taxes, rent, utilities), supplemental private home care, travel and entertainment expenses, attorney fees, and living expenses. Unlike traditional SNTs, upon the individual's death any excess income will be retained by the trust. It should be noted that the definition of disability for a PIT qualification encompasses both mental and physical ailments, which may even include arthritis. In addition, veterans should check with the Department of Veterans Affairs regarding the availability of aid and attendance for home care, which can include the spouse if the veteran is deceased.

7. What Is a Caregiver Agreement?

A caregiver agreement involves a written contract in which one party is compensated for providing care to another in the individual's residence instead of in a nursing home. While the caregiver must pay income taxes on the money received (and the payor must pay the applicable payroll taxes), the amounts paid under this agreement will not be considered an uncompensated transfer. When the paid caregiver is a family member, an independent estimate from an area home care service provider should be obtained in order to determine that the remuneration paid to the caregiver is reasonable.

8. How Do the Different Types of Trusts Affect Medicaid Eligibility?

Two types of inter vivos, or living, trusts can be created by one or more grantors/creators (e.g., a husband and wife). In a revocable trust, the income and assets are considered as a resource entirely available in the Medicaid needs assessment because the trust creators are able to access the principal at any time. Thus, a creditor (including Medicaid) takes on the role of a beneficiary and is able to obtain whatever benefits this individual has access to receive under the document.

An irrevocable living trust (ILT) provides limited benefits to the creators, such as income only. This revenue is then available to Medicaid, but not the underlying principal

(provided the 60-month lookback period has expired). In addition, such a trust can distribute income, and even principal, to other family members for their health, education, maintenance, and support (referred to as a sprinkling trust), with such distributions at the discretion of the trustee. Also, if the creator is on Medicaid at home or in a nursing home, the distribution of income can be stopped as long as 60 months have passed since the ILT was executed and funded.

In contrast to living trusts, a testamentary trust is created at the time of the first spouse's death, either within the language of the individual's will or in the wording of one of the two living trusts discussed above. Medicaid will consider only those benefits under this type of trust that are required to be paid to the surviving spouse, but not those that are discretionary. The 60-month lookback is not applicable, as these trusts are funded at death.

9. What Planning Options Exist Regarding Personal Residences?

If both spouses were to enter a nursing home, there are two strategies to protect real property used as a personal residence from Medicaid (subject to the 60-month lookback period). The first is a life estate arrangement, in which an individual executes and records a deed that reserves and retains the life use of the property while designating, for example, any children as remaindermen who will become titleholders after both parents are deceased. The second is an irrevocable living Medicaid asset protection trust (MAPT), in which the residence is retitled to the trust, providing life use of the realty for trust creators who are not the trustees. Similar to a life estate, title passes to designated family members upon the death of the trust creators. The MAPT should be structured as a grantor trust under IRC section 671 in order to obtain the tax benefits outlined in Question 10 below.

10. What Are the Benefits of a Life Estate or MAPT?

First, either strategy avoids probate on the retitled assets. Second, under Internal Revenue Code (IRC) section 2036, the future recipients

of the realty receive a step-up in basis, which would not have been the case if the home had been gifted outright during life to the children. Third, the transferor will be able to retain any real property tax exemptions, such as those available to a veteran or the elderly. Fourth, the transferor may retain a limited power of appointment (LPOA) in his estate documentation to change the ultimate property recipients among family members. Because of the LPOA, the transfer of the residence is deemed to be an incomplete gift, resulting in no need to file a transfer tax return.

Though a community spouse is obligated to financially support the institutionalized spouse, an application can be made to avoid this financial responsibility; this is called a "spousal refusal."

Finally, if the property is sold before it is ultimately vested with the remainder beneficiaries, the gain exclusion for a personal residence under IRC section 121 would be available because of the use of an LPOA. In the case of a life estate with no LPOA, the IRS actuarial tables must be utilized for the calculation of the gain exclusion. For an MAPT, the full exemption will be available if the document is structured as a grantor trust under IRC section 671.

11. What Are the Advantages of an MAPT over a Life Estate?

First, if any of the children who are beneficiaries upon the death of the life tenants (i.e., the remaindermen) were to incur a lien (e.g., through a judgment), this could be filed against the property that is subject to the life estate. This would have an adverse effect on the title when the property is subsequently sold or refinanced during the judgment collection period. The children may be facing

other issues such as divorce or bankruptcy. In any event, the parents as life tenants could never be divested of their right to occupancy while alive. None of these events affect the realty held by the MAPT.

Second, if the property subject to a life estate is sold prior to the life tenant's death (even after the expiration of the 60-month lookback period), Medicaid will look to receive the net proceeds after those due to the remaindermen based on the IRS actuarial tables of the value of the life tenant's interest.

Third, while the life tenant is institutionalized, if the property is rented (to a third party or at Medicaid's request because of a non-spouse family member residing there), rental income (net of operating expenses) from the property must be paid to the nursing home to preserve continued Medicaid eligibility.

Finally, the assets titled in the name of the MAPT are not limited to a personal residence; for example, investment assets can be part of the trust, with income (but not principal) distributions payable to the trust creators. Gifting the assets to a MAPT has the added benefit of the assets receiving a step-up income tax basis at death, as opposed to an outright transfer to the children during life, when the carryover basis rules would apply.

12. What Is Spousal Refusal?

Though a community spouse is obligated to financially support the institutionalized spouse, an application can be made to avoid this financial responsibility; this is called a "spousal refusal." After a refusal is filed, an applicant who otherwise qualifies is now immediately eligible for Medicaid. New York counties are, however, authorized to pursue collection for Medicaid benefits that have been paid. The results of these efforts have varied in practice. Even if the collection is successful, the community spouse need only reimburse the county at the Medicaid rate, which is less than if the funds were paid directly to the nursing home.

13. What Appeal Rights Are Available?

If Medicaid eligibility has been denied, an individual can file a "Reconsideration

Application.” If this is unsuccessful, a fair hearing can be pursued because of “undue hardship.” Such a hearing could address the need for excess assets to be retained in order for the community spouse to have enough for the amount allowed as an income allowance or the issue of separated assets in a second marriage.

14. What Strategies Are Available for Individuals about to Enter a Nursing Home?

While planning should occur years before entering a nursing home, individuals do have a last-minute option with respect to excess assets (i.e., those exceeding the resource allowance and exemptions). An individual in such a situation could use a qualifying promissory note (QPN) meeting the following four parameters:

- The repayment term is actuarially sound based on the age of the individual who is about to enter a nursing home.
- Equal payments are made during the term of the loan, with no deferral provisions or balloon payments.
- The interest rate charged is reasonable.
- The note states that it cannot be cancelled upon the death of the lender and that payments will continue to be paid to the estate of the decedent.

All assets in excess of the applicable allowances would be transferred to family members by the Medicaid applicant. Approximately one-half of the amount transferred would be incorporated in a QPN executed by the family members, payable to the applicant, with the repayment period ending when the ineligibility period expires. The loan’s monthly payment (along with any other income of the applicant) will be used to pay a nursing home each month on a private pay basis. As a result, both the funds used to pay the nursing home and the ineligibility period run out at the same time (i.e., when the applicant’s assets/resources need to be below the Medicaid allowance level of \$15,150 for single filers or \$138,750 for JSA filers).

15. What Options Exist for Long-term Care Insurance (LTCI)?

The options for LTCI include the following:

- Traditional LTCI
- Hybrid life insurance/annuity policies with LTCI
- NYS Partnership Policies.

Many states, including New York, offer an LTCI partnership option, which involves three parties: the insured, the state, and the insurance company. The insured is required to purchase a contract with a minimum benefit period. Upon entering a nursing home, the insurance company covers expenses pur-

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suant to the contract’s limitations. If the insured is still in the nursing home after the coverage period, the state does not require the forfeiture of any family assets, although 25% of income in excess of the monthly community spouse allowance would be expected as a contribution. If the individual is single, only \$50 per month of income can be retained. The *Exhibit* illustrates various NYS Partnership policies.

A regular, nonpartnership LTCI policy provides the stated benefit for the period purchased. Nursing home expenditures incurred when there is a shortfall in the policy’s benefit or when the coverage period expires will have a required contribution of asset and income under the Medicaid rules. Consequently, a 60-month coverage period

is recommended for these types of policies, with any uncompensated transfers needing to occur prior to the policy’s issuance.

LTCI provides several tax advantages. First, annual premiums are deductible as medical expenses (subject to AGI limitations), with individual dollar limitations. For example, an individual aged 60–69 is able to deduct \$4,160 in 2018, while anyone over age 70 may deduct up to \$5,200. Note that nursing home and home care costs are eligible for deduction to the extent they are medically related (as opposed to custodial care). Revenue Procedure 2016-55 addresses the issue of the taxation of per diem reimbursements paid to the insured when these are in excess of the related costs.

In addition, self-employed individuals can deduct LTCI premiums with the same dollar limits depending on age. If the LTCI premium is paid by an employer for an employee or spouse, it represents a tax-free fringe benefit and is not subject to FICA. Also, tax-free distributions (up to the individual limits) can be made from a health savings account (HSA), but not a flexible savings account (FSA). Furthermore, when a life insurance policy (including one within an LTCI policy) provides a living accelerated benefit for the terminally ill, these proceeds may be tax free if death is expected within 24 months pursuant to IRC section 101. Finally, in New York, there is a 20% tax credit for premiums paid for qualified LTCI policies.

16. When Should One Buy a Nonpartnership LTCI Policy?

A determination must be made as to whether a person’s income is derived from the fruits of labor (FOL) or the fruits of capital (FOC). The former includes pension income; the latter is earned from investments. FOL income cannot be separated from the individual and is available to Medicaid if in excess of the applicable allowance. In contrast, the transfer of underlying capital (e.g., stocks or bank accounts) results in FOC income being shifted to the new payee under the “name on the check” rule. This calculation

will reduce the extent of income exposure to a nursing home and Medicaid claims. Consequently, if the calculations reflect that a substantial portion of an individual's FOL income from a large pension will be subject to contributing 25% of the excess income to Medicaid, consideration should be given to the purchase of a nonpartnership policy. Nonpartnership policies have evolved over the years, resulting in offerings with hybrid features wherein an individual, in return for the initial payment of a lump sum premium, will receive life insurance along with the LTCI; some include a premium refund following the policy issuance.

17. What Are the Relevant Considerations When Reviewing an LTCI Policy?

Besides the insurance company's rating, the cost of the policy must be weighed against the following typical features:

- Daily nursing home benefit and home care (compared to the local rate)
- Number of years over which benefits are payable, or the maximum total benefits
- Percentage of the daily benefit that may be used toward home healthcare
- Initial waiting or elimination period before eligibility for benefits
- Specific coverage for Alzheimer's and related diseases
- Inflation adjustments to the daily benefit (i.e., simple or compound interest)
- Discount for joint spousal policies
- Waiver of premium feature
- If the LTCI policy is a partnership one, the consequences of moving out of state.

Given the probability of eventual long-term illness among the elderly, LTCI should be considered by everyone except those on either extreme of the economic scale (after taking into consideration the potential asset and income exposure in the event of one or both spouses being institutionalized).

18. What Estate Planning Recommendations Should Be Reviewed?

Along with family members, professional advisors should review the last will and testament of an elderly couple and consider chang-

ing an "I love you" will (i.e., one where everything is distributed outright to the surviving spouse) to one containing a testamentary trust limiting distribution for the surviving spouse's "health, education, maintenance, and support."

Similarly, the beneficiary designations on nonprobate property such as life insurance and annuities should be checked to avoid having, for example, the death benefit proceeds of a life insurance policy be paid outright to the surviving spouse. Again, the use of a testamentary trust as described above may be appropriate.

If an "I love you" will is being probated, consideration for future asset protection should be given to filing a spousal dis-

While an elder individual is still competent, advisors should review the power of attorney to be certain that it permits gifts in excess of the federal gift tax exemption.

claimer or renunciation (which can be total or partial) within nine months of death.

While an elder individual is still competent, advisors should review the power of attorney to be certain that it permits gifts in excess of the federal gift tax exemption and names a successor agent after the primary one since this individual is usually the individual's spouse. This concept also applies to the separate healthcare proxy.

19. What Strategies Exist Regarding Asset Protection?

Prior to applying for Medicaid (the "snapshot date"), the following scenarios should be considered.

The purchase of a Medicaid annuity (i.e., an immediate annuity that is irrevocable and nonassignable), having no cash or surrender

value and permitting no withdrawals of principal, should be considered. The annuity contract must provide a monthly income for a period no longer than the actuarial life expectancy of the annuitant-owner; the income generated from the annuity must be used towards the nursing home costs. In the event the annuitant dies before the end of the annuity payout period, the policy's successor beneficiary would receive the remaining installments. This strategy can convert a nonexempt excess asset into a revenue stream that is subject to the more liberal community spouse income retention rules. When the annuity is purchased, New York must be named as a primary beneficiary for at least the amount of Medicaid that has been paid on behalf of the institutionalized individual unless there is a community spouse, a minor, or a disabled child. In that case, New York need only be named as a successor beneficiary. Consequently, the use of an annuity may provide benefits to a surviving spouse if the owner does not live long enough to receive all of the applicable lifetime benefits.

Nonexempt assets under Medicaid can be converted to exempt assets. The community spouse could buy a larger personal residence (up to \$858,000 in equity) or add capital improvements. This planning tool also applies to the purchase of a new automobile or personal property (such as furniture).

When using an MAPT, it should be drafted as a Grantor Trust under IRC section 671 to avoid taxation when an asset such as a nonqualified annuity is retitled to an MAPT or to retain the full IRC section 121 gain tax exclusion for a principal residence.

All individual and joint assets in the name of the institutionalized spouse in excess of the single resource allowance of \$15,150 should be transferred to the community spouse or an MAPT based on the planning concepts discussed herein. If a transfer of the sole or joint interest in the personal residence to the community spouse is made prior to the Medicaid application, it can be sold subsequent to Medicaid approval, with the sale proceeds

Exhibit New York State Partnership for Long-term Care Available Plans

	Total Asset 50 2/4/50*	Total Asset 50 3/6/50*	Total Asset 100 4/4/100	Dollar for Dollar 50 1.5/3/50*	Dollar for Dollar 100 2/2/100
Nursing home coverage	2 years at a minimum daily benefit amount of \$315 (2018)	3 years at a minimum daily benefit amount of \$315 (2018)	4 years at a minimum daily benefit amount of \$315 (2018)	1.5 years at a minimum daily benefit amount of \$315 (2018)	2 years at a minimum daily benefit amount of \$315 (2018)
Home care coverage	4 years at a minimum daily benefit amount of \$157 (2018)	6 years at a minimum daily benefit amount of \$157 (2018)	4 years at a minimum daily benefit amount of \$315 (2018)	3 years at a minimum daily benefit amount of \$157 (2018)	2 years at a minimum daily benefit amount of \$315 (2018)
Residential care facility coverage	4 years at a minimum daily benefit amount of \$157 (2018)	6 years at minimum daily benefit amount of \$157 (2018) (at a minimum, includes home care services received in an assisted living residence)	4 years at a minimum daily benefit amount of \$315 (2018)	3 years at minimum daily benefit amount of \$157 (2018) (at a minimum, includes home care services received in an assisted living residence)	2 years at a minimum daily benefit amount of \$315 (2018)
Other basic coverage (shared by all plans)	3.5% or 5% annual compounded inflation protection required at purchase ages 79 and younger Care management services	14 days of respite care per year Nursing home bed reservation, 20 days per year	60-day grace period to ensure the premium is paid if you have designated someone to be notified when you fail to pay your premium on time Hospice care	Coverage of alternate level of care status in a hospital while awaiting nursing home placement or at-home services Review of denied benefit authorization requests	Guaranteed renewable
Optional coverage	Optional coverage is available depending on the type of plan.				
Asset protection if the minimum duration requirement of policy & apply for Medicaid is met	Total	Total	Total	Partial depending on the amount of benefit paid	Partial depending on the benefit paid

*In the event both nursing home coverage and home care or residential care facility coverage are used, 2 home care/residential care facility days equal 1 nursing home day for the purpose of meeting Partnership utilization requirements.

Source: <https://nyspltc.health.ny.gov/>

remaining as an exempt asset. If there are other joint assets that have been held with a nonspouse for at least five years, the co-owner can sign a statement refusing to sell the property.

Liquid resources can be used to pay off consumer debts, such as the personal res-

idence's mortgage, and to prepay the applicant's and family members' burial plots and funeral expenses (including a crypt).

The applicant and community spouse can contribute to a new or existing retirement plan since it is not a countable asset if in a periodic pay status; however, any

distributions must be applied to the cost of care. For those over age 70½, the retirement account will be exempt if RMDs are being made (or as referenced in Question 2 above, a higher amount in certain New York counties based on the Social Services Life Expectancy Table). For anyone younger than age 70½, periodic payments must also be based on this table.

The ownership of any term life insurance having the applicant as the insured should be changed to name a life insurance trust (i.e., not the MAPT) as the new owner and beneficiary. The proceeds would then be subsequently distributed to the surviving spouse pursuant to the ascertainable standards found in IRC section 2041 or, if not alive, to the children. This strategy would also apply to any whole life policy after taking into consideration its cash surrender value.

Mentally or physically disabled individuals seeking home care who have excess income should consider contributing the amount that would otherwise disqualify coverage to a PIT (see Question 6). A similar but more limited device for a disabled individual is an Achieving a Better Life Expectancy (ABLE) account.

20. What Are Some Sources for Additional Information?

The following resources provide additional information:

- NYS Medicaid Reference Manual (<https://on.ny.gov/2NL3yaa>)
- Center for Medicaid (<http://www.medicare.gov>)
- Medicaid in NY (http://www.health.ny.gov/health_care/medicaid/)
- PITs in New York (<http://wnylc.com/health/entry/4/>). □

Peter A. Karl III, JD, CPA, is a partner with the law firm of Paravati, Karl, Green & DeBella, LLP in Utica, N.Y., and a professor of law and taxation at the SUNY Polytechnic Institute (Utica-Rome). He is the author of <http://www.1031exchange-tax.com>, and a member of The CPA Journal Editorial Advisory Board.