

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

DCF

Department for Children and Families

FROM: Betsy Forrest, Deputy Commissioner
Economic Services Division

BULLETIN NO.: 05-19F

DATE: August 30, 2005

SUBJECT: Changes to SSI-related Medicaid Required by
the Fiscal Year 2006 Budget Act (Act 71)

CHANGES ADOPTED EFFECTIVE 9/1/05

INSTRUCTIONS

Maintain Manual - See instructions below.
 **Proposed Regulation - Retain bulletin
and attachments until you receive
Manual Maintenance Bulletin: _____
Information or Instructions - Retain
until _____**

SECTION REFERENCE(S):

M200 TOC	M232.16	M233.22	M400 TOC	M440
M200.23	M232.4	M233.25	M420	M440.21
M231.24	M232.83	M243.5	M430	M440.36
	M232.85	M243.51	M432	M440.41
		M243.52		

This bulletin proposes changes enacted by the Legislature in the fiscal year 2006 budget act, Act 71 §303(a) (June 2005) (An Act Making Appropriations for the Support of Government). The proposed changes affect the rules used to determine eligibility for all SSI-related Medicaid applicants. SSI-related Medicaid includes applicants seeking long-term care coverage, including waiver and hospice services. The bulletin is filed using the expedited rule-making process authorized by §302(b) of the budget act.

Background

Over the past several years, the department has identified a small number of applicants who are not financially needy but have qualified for long-term care by using Medicaid long-term care financial eligibility rules to convert their available assets into excludable assets (“Medicaid crisis planning”).

In recent years, the legislature has authorized rule changes to prevent Medicaid crisis planning. For example, in 2002 it required a rule change related to annuities, real estate and burial funds; in 2003 and 2004 it authorized rule changes related to treatment of savings bonds.

Since the last of these rule changes became final in June 2004, new Medicaid crisis planning techniques have emerged. These emerging techniques were reported by officials from the agency of human services in 2005 to the Legislature. The Legislature concluded that rule changes could help address the immediate long-term care Medicaid budget problem. The rule changes are a less restrictive measure than elimination of optional coverage groups for those with higher incomes, such as the medically needy coverage group.

Summary of Rule Changes

The following rule changes help sustain Vermont Medicaid coverage for the aged, blind and disabled (SSI-related Medicaid) by:

- clarifying which long-term care Medicaid beneficiaries are subject to rules concerning transfer of assets and patient share;
- requiring individuals with incomes above the institutional income standard to spend down to the protected income level;
- prohibiting long-term care expenses incurred during periods of ineligibility for Medicaid from reducing the share of income applied to the cost of long-term care Medicaid;
- imposing requirements on private contracts for care to limit their use as an excluded resource;
- counting as a resource a life estate held by the applicant or recipient with a reserved power to mortgage, unless the life estate is held in the principal place of residence;
- treating promissory notes and other similar resources that produce income in the same fashion as annuities by making them excludable resources only when certain conditions are met;
- adding tools used to determine life expectancy so that the department ensures that applicants and beneficiaries are likely to have their resources returned to them in full during their lifetime; and
- penalizing transfers beginning on the first day of the month following the date of the asset transfer.

These changes endeavor to ensure that individuals who really need Medicaid assistance receive it.

Rules concerning transfer of assets and patient share

(M200.23 (b), M430, M440)

The current rules are ambiguous as to who is subject to patient share and transfer of asset requirements, known as “post-eligibility rules.” The proposed rules clarify that these requirements only apply to those who qualify for home-based care as part of the special income group (42 USC §1396a (a) (10) (A) (ii) (VI)), or as medically needy (42 USC §1396a (a) ((10) (C)), or if they are in a medical institution. The final proposed rule adds further clarification to the definition of the special income group in section M200.23(b) to make it consistent with Rule M243.52(c)(i).

Spenddown requirement

(M243.5 - .52, M420)

The current rules are not consistent in specifying that individuals with incomes above the institutional income standard (currently \$1737 per month) must spend down to the protected income level (currently \$866 per month in Chittenden County and \$800 per month in all other counties) to be eligible for long-term care. The proposed rules make this explicit. With the approval of the Joint Legislative Committee on Administrative Rules, the new rule has been further clarified to make the spenddown standard applicable to the medically needy coverage group more explicit.

Expenses allowed to reduce patient share obligation

(M432)

Currently some individuals whose assets exceed Medicaid limits are not using those assets to pay for long-term care privately but instead make gifts or other purchases. After expending their assets on items other than long-term care expenses, they meet the financial threshold for Medicaid. Thereafter, they claim their unpaid nursing facility or home health bills are a debt that should reduce their patient share obligation. This prevents long-term care providers from receiving timely payment of incurred private pay charges. This also increases the claims paid by Medicaid because the patient share covers less or none of them. Consequently, Medicaid pays more for the cost of care for these individuals. The new rule prohibits long-term care expenses incurred during periods of ineligibility for Medicaid from reducing the share of income applied to the cost of long-term care Medicaid. With the approval of the Joint Legislative Committee on Administrative Rules, the new rule has been limited to prohibit long-term care expenses incurred during *penalty* periods for Medicaid from reducing the share of income applied to the cost of long-term care Medicaid.

Allowable contracts for personal services

(M232.83)

Currently contracts for personal services are sometimes written after services are rendered. Also, the unused balance of the contract may not be available to pay privately for care. Last, private resources may be used for services that would have been covered by Medicare and private insurance, thereby depleting private resources unnecessarily. The proposed rule imposes requirements on private contracts for care by: (a) limiting their use as an excluded resource to circumstances that assist individuals under age 65 to avoid nursing home placement, (b) specifying conditions that must be met, and (c) prescribing the use of any remaining funds when the individual no longer needs the care covered in the contract. The final proposed rule changed significantly based on public comments received by the department.

With the approval of the Joint Legislative Committee on Administrative Rules, the final rule changed significantly based on discussions with the commenters. The department proposed an alternate approach that would be consistent with the legislation, and address the concerns raised by commenters related to the payback provision. The rule addresses the objectives of the department and Legislature and assures the provision will have not harm a broader group of Medicaid applicants than intended. It encourages the use of private funds to cover as much home-based care as possible, as well as assures that any balance is applied to the cost of care, rather than used for another purpose, protecting the Medicaid budget. In addition, the Commissioner of the Department of Disabilities, Aging and

Independent Living agreed to review the monthly payment amount (\$500) and overall cap (\$30,000) once it has experience running the Choices for Care waiver and observes how these contracts are used and needed to determine whether these amounts should be increased or decreased.

Limitations on Life Estate Exclusions

(M232.16)

Currently the department considers life estates an excluded resource if an individual retains the power to fully mortgage the property, even though the individual owns only a life estate without the power to sell the property. The power to mortgage effectively makes the full value of the asset available to the individual. The proposed rule provides that the department will count an applicant's life estate as a resource if the applicant retains the power to sell or mortgage, unless the life estate is held in the applicant's principal place of residence. This eliminates an unnecessary disregard of a private resource available to pay for care.

Treatment of Promissory Notes and Other Resources that produce income

(M232.4, M233.25, M440.36)

Currently some individuals with countable assets, shortly before filing a Medicaid application, loan them in exchange for a promissory note that requires low monthly payments and a balloon payment in a few years, within their life expectancy as measured by the tables referenced by the Centers for Medicare and Medicaid Services. In this way, individuals convert available resources to excluded resources. The proposed rule clarifies that the department will count promissory notes as an available resource unless they meet the criteria specified in the rule. It treats promissory notes and other similar resources that produce income in the same fashion as annuities by making them excludable resources only when certain conditions are met. The department will exempt promissory notes and other resources that produce income if they were created *more* than 36 months before application. If they are created *less* than 36 months before application, the department will exclude them only if they meet specific criteria. With the approval of the Joint Legislative Committee on Administrative Rules, the department modified the date referenced in M233.25(b) from July 18 to September 1, 2005, the new effective date of this rule. It also clarified M440.36 to cover transfers for full fair market value.

Measuring Life Expectancy

(M440.21)

Currently transfers of assets are exempt from penalty if individuals receive the full fair market value within their lifetime. The department uses actuarial tables based on healthy individuals to measure life expectancy. Since healthy people have a longer life expectancy, the current life expectancy tables allow a longer period for the long-term care Medicaid applicant or spouse to receive the full fair market value. The proposed rule acknowledges the department may in the future promulgate a rule using a table based on individuals who are ill and in need of long-term care to evaluate transfers made by individuals requesting long-term care. By imposing a shorter life expectancy in some cases, the department aims to ensure assets are more likely returned to individuals and spouses during their actual lifetime. With the approval of the Joint Legislative Committee on Administrative Rules, the department has removed language concerning specific changes it anticipates making to the life expectancy tables and replaced it with a more general reference to the fact highlighting that alternate tables are being developed.

Penalties for Transfers of Income or Resources
(M440.41)

Currently the department imposes a transfer penalty beginning the first day of the month during the month of the transfer. The proposed rule allows the department to commence the penalty period on the first day of the month following the date of the transfer. This prevents Medicaid from paying for long-term care any sooner than necessary. The final proposed rule adds an express provision related to the effective date of the rule based on public comments received by the department.

Specific Changes

Section	Description of change
M200.23 Long-term care Medicaid coverage groups	Clarifies that the special income group is a distinct optionally categorically needy coverage group from the working people with disabilities group. Both groups qualify for home-based waiver services if additional criteria are met.
M231.24 Definition of Annuities	Moves content from former M232.4 (a) to this section.
M232.16 Life estates	Makes a life estate held by the applicant or recipient with a reserved power to mortgage count as a resource, unless the life estate is held in the principal place of residence.
M232.4 Annuities, Promissory Notes, and Similar Resources That Produce Income	Moves definition in subsection (a) to M231.24. Clarifies that the 36-month period relates to the date of the individual's Medicaid application. Makes resource exclusion criteria for annuities also apply to promissory notes and similar resources that produce income. Specifies that transfer penalties will be assessed if the beneficiary is changed to anyone other than the long-term care applicants or his or her spouse once eligibility has been determined. Eliminates the current rule that precludes recipients from allocating income to the community spouse in the amount of the previously available payment.
M232.83 Contracts for Personal Services	Imposes requirements on private contracts for care to limit their use as an excluded resource.

M232.84 Cash, Including Cash Necessary to Operate a Business	Moves content from the current M232.83 and adds it to M232.84.
M232.85 Retirement Funds	Makes the manner in which the department determines life expectancy for retirement funds consistent with the method used for annuities, promissory notes and other similar resources producing income.
M233.22 Nonexcluded Life Estates	Makes the manner in which the department determines life expectancy for nonexcluded life estates consistent with the method used for annuities, promissory notes and other similar resources producing income.
M233.25 Promissory Notes	Describes how the department values promissory notes.
M243.5 – M243.52 Determination of Countable Income for Long-term Care Applicants	Clarifies that individuals with incomes above the institutional income standard must spend down to the protected income level in order to be eligible for long-term care Medicaid coverage.
M420 Spending Down	Clarifies that individuals with incomes above the institutional income standard must spend down to the protected income level in order to be eligible for long-term care Medicaid coverage.
M430 Patient Share Payment for Long-term Care, Including Waiver and Hospice Services	Clarifies which long-term care Medicaid beneficiaries are subject to patient share rules.
M432 Deductions from Patient Share	Prohibits long-term care expenses incurred during periods of ineligibility for Medicaid from reducing the share of income applied to the cost of long-term care Medicaid.
M440 Transfers	Clarifies which long-term care Medicaid beneficiaries are subject to transfer of asset rules.
M440.21 Scheduled Receipt of Fair Market Value After Date of Transfer	Clarifies the tools used by the department to determine life expectancy. Makes fair market value criteria for annuities also apply to promissory notes and similar resources that produce income.

M440.36 Transfers Involving Promissory Notes or Similar Resources that Produce Income	Describes when transfer penalties apply to promissory notes or similar resources that produce income.
	Specifies how the department will assign a value to the promissory note or similar resource when assigning a transfer penalty.
M440.41 Penalty Date	Penalizes transfers beginning on the first day of the month following the date of transfer, rather than the first day of the month in which the transfer was made.

Expedited Rulemaking Process

The Vermont Legislature authorized the department to adopt these rules through an expeditious rulemaking process (Act 71 §302(c)).

1. On June 23, 2005 notice of rulemaking was published in *The Burlington Free Press*, *The Rutland Herald*, and *The Barre-Montpelier Times Argus*.
2. On June 23, 2005, the department posted the proposed rule on its website and notified advocates and members of the private bar involved with Medicaid estate planning.
3. On June 23, 2005, copies of the proposed rule were filed with the Secretary of State and the Legislative Committee on Administrative Rules.
4. On June 23, 2005, copies of the proposed rule were sent to the House committees on appropriations and human services as well as the Senate committees on appropriations and health and human services.
5. On June 30, 2005 at 4:30 p.m. the seven-day public comment period closed. Written comments were due no later than 4:30 p.m., on June 16, 2005. Responses to the public comments follow in the next below.
6. The department filed the final proposed rule with the legislative committee on administrative rules on July 14, 2005.
7. The department will file the final rule on or before September 1, 2005.

Responses to Public Comments

The department received comments from two private attorneys, the American Association of Retired Persons, Vermont Legal Aid, the Community of Vermont Elders, the Senior Citizens Law Project, the Health Care Ombudsman, and the Long-term Care Ombudsman. The department's responses to the comments are set forth below. First, the department addresses comments concerning compliance with federal law, legislative intent, and the effects of the rules in general. Second, the department responds to comments related to the specific rule changes authorized by Act 71. Last, the department answers questions concerning aspects of the rules that are not subject to change under Act 71.

I. Responses to General Comments

Compliance with federal law

Comment: Many of the proposed changes violate federal law and impermissibly tighten long term care Medicaid.

Response: The department believes the proposed rules are consistent with the goals articulated in the legislative process and specified in Act 71, section 303. In addition, all of the proposed changes are either mandated or permitted by federal law.

Compliance with legislative intent

Comment: These rules go far beyond the goals articulated by the department during the legislative process.

Response: The department has endeavored to promulgate proposed rules that follow the enabling legislation in section 303 of Act 71. During the legislative session the department maintained that these expedited rules were needed to prevent individuals from manipulating long-term care Medicaid regulations to qualify for assistance. In addition, the department maintained that critical rule clarifications needed to be in place from the beginning of the Choices for Care: Long-term Care Medicaid Waiver.

Comment: The proposed rules are contrary to the state's intention to save funds by implementing the home and community based 1115 waiver.

Response: The proposed rules aim to be fully consistent with the state's intention to give individuals who qualify for long-term care Medicaid equal access to long-term care options (nursing facility and home-based services) and promote early intervention for at-risk populations.

Since July 2003, the Department for Children and Families along with the Office of Vermont Health Access have partnered with the Choices for Care: Long-Term Care Medicaid team with a special focus on ways to assure that clinical and financial eligibility criteria result in cost avoidance, savings, and an affordable level of services.

The commissioner for the Department of Disabilities, Aging and Independent Living (DAIL), testified in strong support of these changes in several legislative committees by explaining how these rule amendments support the prioritization strategy. This strategy ensures that those with the highest needs are served first and to the full extent of their needs.

Comment: The seven day comment period did not take into account the intervening weekend. Five business days is insufficient to review and analyze complex proposed rule changes and for a full, open public discussion.

Response: The comment period was not the only opportunity for consideration of the content of the proposed rule. The House Appropriations and Human Services committees took testimony during April and May of 2105. These hearings informed the content of section 303, the basis for the rules. Notably, this commenter was formally represented by three separate witnesses before the committees, including their preference for regular rulemaking, rather than an expedited process. Following debate, the legislature concluded that the changes contained in Act 71 section 303 should be promulgated as expedited rules following an abbreviated public comment period. The committees considered and specifically rejected an emergency rule process which would have eliminated public comment altogether and promulgation of rules using the regular APA process. In the view of the department, the committees balanced the need to avoid incurring unnecessary Medicaid costs with the need for public comment.

Effects of the proposed rules

Comment: While savings may be achieved through denying Medicaid coverage and critical health care services to low-income and disabled Vermonters, there will be unintended costs shifts as people are forced into other more costly care options.

Response: The cost shifts requiring those with private resources to pay for care are intentional. The proposed rules affect only those individuals with income or resources available to pay toward the cost of long-term care services, as required by state and federal law. Low-income aged and disabled Vermonters remain unaffected by these rules.

Comment: The proposed regulations will result in the denial of Medicaid coverage for those who unquestionably need long-term care and supportive services and no longer have the resources to pay for that care simply because they do not have the skills to evaluate or comply with these complicated Medicaid regulations.

Response: The department agrees that regulations for LTC Medicaid are complex. These complexities are not introduced by these rule amendments. The vast majority of the complexities stem from federal requirements that were imposed more than a decade ago. Vermont's regulatory provisions are driven from this enabling legislation. The department strives to write the rules in plain language, make them consistent with federal law and internally consistent.

All of the proposed rule changes amend current rules, with one exception: contracts for personal care, Rule M232.83. The amendments clarify a few ambiguous provisions that were not identified in 2003, when Vermont undertook a major overhaul of these regulations. The 2003 changes advanced consistency and improved clarity to the department's SSI-related Medicaid eligibility rules through amendments that defined basic concepts, including financial responsibility group and Medicaid group. These changes have assisted staff in determining eligibility, members of the private bar helping Vermonters with estate planning, and others trying to understand the eligibility rules for long-term care.

Comment: Individuals may be denied Medicaid because they paid their property taxes instead of their home health bill or because they transferred their home to their children in return for years of care and assistance.

Response: The rules provide for the circumstances described by the commenter. For example, payment of a property tax bill would be considered a fair market value transaction and would not result in imposition of a transfer penalty. Rule M440.2(e). Provisions for care and assistance in exchange for remuneration are permissible under the circumstances specified in Rules M440.2(e) and in M440.32-M440.33. In all other circumstances, Vermont is required by federal law (section 1917(e)(5) of the Social Security Act) to impose a transfer penalty when individuals transfer their home or a remainder interest in their home.

II. Responses to Specific Comments Related to Proposed Changes

Rules concerning transfer of assets and patient share (M200.23(b), M430, M440)

Comment: We do not see the ambiguity identified by the Department that the patient share and transfer of assets rules are intended to correct. We agree that recipients who qualify for Medicaid as part of the special income group or as medically needed are subject to these post eligibility rules.

Response: The proposed regulations add a definition for the special income group by name. In addition, the proposed rules clarify that patient share and transfer of asset rules apply to only two groups of home-based recipients.

Comment: We ask the department to release the audit that apparently identified this problem and is the basis for this change. The department does not adequately explain how these cost savings will be realized, or what they are currently doing that has resulted in increased costs.

Response: These proposed changes bring Vermont into compliance with federal law mandates. An audit has not prompted the department's changes to patient share and transfer of asset rules. With respect to patient share, the department had learned that the lack of clarity in the rules resulted in the inconsistent application of post-eligibility provisions. Automation of patient share requirements for the home-based population will likely result in savings; measurement processes are currently being developed.

Expenses allowed to reduce patient share obligation (M432)

Comment: Under Federal law, a state may establish "reasonable limits" on the amounts of past medical expenses used to reduce the patient share. 42 C.F.R. §§435.725; §§435.733; CMS State Medicaid Manual §3703.8. A blanket exclusion of long term care costs when the person is ineligible for Medicaid is not permissible under these sections.

Response: The department is following an approach approved by CMS to the state Medicaid plan in Arizona, as specified at Supplement 3, to Attachment 2.6-A, page 1.

Comment: The meaning of “periods of ineligibility” should not include periods when an individual is otherwise eligible for Medicaid. For example, it should not include individuals which, through no fault of their own, a timely Medicaid application was not submitted on their behalf. We suggest that this provision be redrafted to read as follows: (d) reasonable medical expenses incurred, if applicable (M420-M422). For purposes of this subsection, “reasonable medical expenses” do not include institutional care received during a penalty period imposed under M440.4.

Response: Act 71 specifies that unpaid long-term care expenses should not be deductible from a patient share obligation. The proposed language is intended to be broad enough to include community based long-term care services as well as those provided in institutions. It is intended to prevent unpaid nursing facility, home health, and other bills for long-term care services incurred during periods of ineligibility for long-term care Medicaid from being used to reduce a subsequent patient share. Unpaid medical expenses other than those considered to by long-term care remain a permissible deduction.

The proposed rules do not alter the current approach in which Medicaid will cover long-term care expenses for a retroactive period of up to three months, when applicants meet the long-term care eligibility requirements during that retroactive period.

Comment: Individuals who might qualify for Medicaid by spending down or converting countable resources to excludable resources should not be included in the definition of “periods of ineligibility.”

For example, someone may have to choose between paying the property taxes on their home or paying for nursing home care, or may choose to set aside funds for burial purposes. In those situations, the person should not be precluded from applying unpaid nursing home bills to their patient share when they are not granted retroactive Medicaid eligibility.

Response: In these examples, the department would find the individual eligible for long-term care Medicaid as of the month the property taxes were paid or burial fund established, provided all other eligibility criteria were met.

Currently individuals who delay disposing of excess assets through permissible means (paying bills, setting up a burial fund) are ineligible for retroactive long-term care Medicaid because they had available resources to pay for their care. This will remain the same under the proposed rules.

Comment: The explanation prepared by the department in support of this rule is inaccurate. When past nursing home bills are used to reduce patient share, long term care providers continue to bill the individual for the full private care rate regardless of whether the individual’s income is applied to pay the bill or included in their patient share for their current bill. The difference for the nursing home is that under the proposed rule, the past due bill will never be paid.

Response: The department has revised its explanation of this change in the final proposed bulletin coversheet. The proposed rule will encourage timely payment of long-term care charges.

Comment: Will reducing the patient share for long term care expenses incurred during a period of ineligibility affect caregiver agreements providing for care in addition to the hours that the Medicaid waiver provides (for a person receiving waiver), reducing the patient share?

Response: According to M432(d) (incorporating M421.23 by reference), the department will reduce a patient share based on payments for reasonable expenses for personal services that meet the requirements of M421.23.

Limitation of life estate exclusion (M232.16)

Comment: The life estate with power of sale is considered ownership under the regulations. This makes sense because the person who can sell gets all of the value of the property and cuts off the remaindermen, if a sale occurs.

Response: The proposed rule recognizes that an individual with the ability to mortgage has the ability to get most if not all of the value of the property, even if the person does not retain the right to sell it. Accordingly, the person has access to the value of the property and it should be a countable asset, unless the life estate with power to sell or mortgage is held in the principal place of residence.

Comment: Can a life estate with a power to sell or mortgage be countable, if it's on a property that is already excluded for another reason, i.e. income producing property?

Response: No.

Allowable contracts for personal services (M232.83)

Comment: Other than in the context of a Medicaid Qualifying Trust, there is no authority for a requirement that a recipient reimburse the Medicaid program. If the resource is excluded in order to fund the contract for care, the individual does not have an obligation to pay for Medicaid received during the period of time. They were entitled to Medicaid, and have no liability to reimburse the Department for that care, other than through estate recovery. At the termination of the contract for care, the remaining balance should be treated as an available resource, and the individual should be allowed the opportunity to spend that resource on other excluded resources, or to pay for private care, as they so choose.

Response: The department agrees that federal law requires repayment of Medicaid expenses when individuals under age 65 establish special needs trusts, sometimes referred to as Medicaid Qualifying Trusts. Vermont was willing to permit individuals to use contracts for personal care as an alternate vehicle to special needs trusts, provided the contract contained a payback provision comparable to those required by special needs trusts.

Response (continued) Under the current Social Security Act 1915(c) authority, the Department of Disabilities, Aging and Independent Living (DAIL) is required to consider contracts for personal care as a basis for denying eligibility for home-based care. DAIL recognizes that contracts for personal care (Rule M232.83) can play a valuable role in supplementing the department's overall system of care for long-term care: by encouraging the use of private funds to cover as much home-based care as possible, Medicaid funds go further.

DAIL and the Department for Children and Families agree that existing federal provisions appear to limit the payback requirement to special needs trusts. While the department would like to encourage the use of private funds to cover as much home-based care as possible, this is only viable with assurance that any balance is applied to the cost of care, rather than used for another purpose. The departments will continue to explore whether there is a permissible mechanism to encourage long-term care Medicaid services to be provided concurrently with a contract for care. The department needs its federal partner to confirm that rules containing this requirement (and others) will meet federal approval.

Accordingly, they will be an excluded resource and a permissible additional support for those under age 65 with excess resources who seek to fund additional supports in their homes, provided the required criteria are met. In cases where services have been prepaid under a contract for care by individuals age 65 or older, however, federal law appears to not permit revocability and repayment approach because it is a trust-like instrument that could have the effect of circumventing federal and state law related to special needs trusts and irrevocable trusts.

Comment: In the event that a person is over-resourced and has needs that will exceed Medicaid's ability to provide services, we may prepay money for care as long as the proposed changes in M232.83 are met. Normally we set up an escrow account for care to spenddown assets. Please confirm that these types of prospective care contracts can be used to spenddown resources.

Response: Yes, but only for individuals under age 65.

Comment: This section appears to apply to care contracts written for future services and prepaid and to detail how these services will be paid.

Response: Yes. The final proposed rule permits contracts for care to be an excluded resource only for individuals under age 65 and otherwise meet the requirements of the requirements specified for special needs trusts in Rule M232.52(f)(i).

Comment: When care has been provided before the need for Medicaid long-term care, can assets be reduced by paying the caregiver retrospectively as long as verified?

Response: Yes, pursuant to Rule M440.2(e).

- Comment: The regulations will unfairly punish the innocent who provide care for friends or family members.
- Response: Regulations currently support those who provide care for friends and family members by considering verified payments as transfers for fair market value. The proposed regulations maintain this commitment to care given by friends and family members.
- Comment: It is reasonable for the contract to be in writing and signed by the parties. We do not agree that this needs to be done before services are provided. Services provided and paid for before the contract is signed should be evaluated to determine if fair market value was received under existing transfer of asset rules.
- Response: The contract must meet the requirements in M232.83(b) in order to be an excludable resource. In order for the contract to be considered an excluded resource set aside for future care, the department proposes to apply the special needs trust rules (M232.52(f)(i)).
In cases where the applicant pays for past care, the department will apply the transfer rules (M440 et seq.) and if verified, will not impose a penalty. Verification of past care given will be evaluated under the more flexible requirements of Rule M440.2(e). However, a written contract before services are provided offers a stronger indication of validity for verification than an oral one. To the extent a contract is set aside for future care, the department will consider this a transfer for less than fair market value.
- Comment: These proposed provisions will discourage family care givers, ignoring their incredible contribution in providing long-term care and their impact on reducing the need for Medicaid covered services. It is highly unlikely that the frail elderly will know, well before they apply for Medicaid, how to hire informal care givers in a manner that fully complies with all seven requirements.
- Response: The department currently supports and will continue to encourage family caregivers by reducing any transfer penalties for past personal services care by verified compensation for personal services, per Rule M440.2(e).
- Comment: Someone may transfer their house to one of their children in exchange for a promise that they provide care for the person for the rest of their life. There are specific regulations and procedures governing such a transfer in the SSI program. *See* POMS SI 01150.005.
- Response: The proposed rule only concerns situations when an asset is available as a resource to a Medicaid applicant. The proposed rule explains when an available resource is not counted and is excludable.
In contrast, transfers of homes as an exception to the requirement for fair market value transfer are governed by the provisions in Rule M440.32. This rule derives from Title 19 of the Social Security Act (SSA) §1917. Transfer provisions concerning Supplemental Security Income (SSI), whether expressed in Title 16 of the SSA or explained in the program operations manual, are not controlling for long-term care Medicaid.

Comment: Example 1: Applicant pays friend or family for unquestionably necessary home care that prevents nursing home placement for 2 years (\$100 week or \$10,400) with medical necessity and provision of care documented by doctor and Medicare home health care agency and payment documented by checks. Result: A penalty is imposed for the \$10,400 because there was no written “contract for care” signed before any services were provided.

Example 2: Same as above, but with a written contract, but payments are made at end of each month in which services are provided: Result: A penalty is imposed because “amounts due are paid after the services are rendered.”

Response: In each example, the commenter describes a result that differs from the one the department would reach. In both examples, the department could allow any transfer penalty to be reduced by verified compensation for personal services, per Rule M440.2(e).

Comment: The individual providing the service should not be required to report the receipt of money for tax purposes as a condition of excluding the resource. This simply is not within the control of the Medicaid recipient, and raises serious questions as to how such a requirement would be enforced by the Department.

Response: The department has removed this requirement from the final proposed rule.

Comment: Does the person have to be Medicaid LTC eligible at the time the contract is written?

Response: No. Contracts for personal services may be written before a person applies for long-term care Medicaid. At the time of a Medicaid application, the department will consider the contract an available resource unless it meets the criteria for exclusion in M232.83.

Comment: The individual should have the ability to privately contract for care, including for care that is more expensive than care received under the waiver program, and certainly more expensive than the minimum wage. We have assumed that a reasonable hourly fee for nonlicensed care giving in this area is \$15.00/hour. The range appears to be approximately \$12.00 to \$25.00 per hour. Please confirm that \$15 is reasonable. The language should be changed to say that the value of services will be based upon the average county-wide rate for agencies supplying similar services.

Response: This requirement is not part of the final proposed rule.

Comment: There is no policy basis to distinguish between licensed and unlicensed service providers for a contract for care. The following two sentences in the draft rule are unclear:

“Payments under a contract for personal services to a nonlicensed individual or provider shall be considered to be an available resource unless all of the following are met.”

“Payments under a contract for care to a licensed health professional or facility shall not be considered an excluded resource if paid in advance of receipt of services.”

Response: This requirement is not part of the final proposed rule.

Comment: The proposed regulations lack any hardship protections or exceptions.

Response: The proposed regulations are part of a larger body of regulations that already contain hardship protections and exceptions (e.g., hardship provisions related to trusts (M232.53) and transfer of resources (M440.44). Moreover, Vermont’s long-term care resource and income provisions incorporate the most generous disregards and allocations permitted by federal law.

Treatment of Promissory Notes (M232.4, M233.25, M440.36)

Comment: The proposed rules go beyond the legislative intent of treating promissory notes like annuities and are overly restrictive. For example, an otherwise valid promissory note involving repayments of a loan by adult children would trigger the denial of Medicaid coverage simply because the contract requires no payments or a smaller payment in December so that the family can buy Christmas presents. This would violate the proposed regulation’s inflexible requirement for repayment at “equal intervals and amounts.”

Response: The current annuity rule requires payment “at equal intervals and amounts.” The proposed rule will treat promissory notes in the same way. In response to the example, parties could structure repayment at quarterly intervals and assure the repayment schedule did not fall on December. Neither the current rule nor the proposed rule permits unequal intervals or amounts.

Comment: Federal law and the SSI methodology do not support the restriction on who is named the beneficiary of the annuity or the promissory note. If the Medicaid recipient names or adds another person as a beneficiary to the annuity, that should be evaluated under the transfer of asset rules, in order to determine if the transfer was for fair market value, and to determine the actual value of the interest that was transferred.

Response: The department received approval for its treatment of annuities in Act 142 (enacted June 21, 2002) and through its state Medicaid plan amendment 02-14 (effective July 1, 2002). The proposed rule extends that treatment to promissory notes and other similar income-producing resources, all of which are trust-like instruments because they hold a lump sum and pay it out over time under specified conditions.

Comment: The change to the final paragraph of M232.4(b) is beyond the scope of what is permissible in these expedited rules.

Response: The department agrees and corrected this provision to remain identical to the current rule. It is proposing a change to this provision in proposed rule 05-25, however. Proposed 05-25 addresses adding a beneficiary to an annuity, denying an allocation to the community spouse, and imposing a transfer penalty.

Comment: Individuals should have the right to designate a contingent beneficiary so long as the income is increasing the patient share of an applicant, or being paid to the community spouse.

Response: The department is not authorized by Act 71 section 303 to make changes to this section as requested. It will, however, try to be responsive to this comment through proposed rule 05-25.

Measuring Life Expectancy (M440.21)

Comment: If the Department wants to make changes to these rules at some future point, then the APA requires DCF to do so under a separate filing that gives the public an opportunity to review and comment at that time on that rule in its entirety.

Response: The department will promulgate any future changes to the life expectancy tables using the APA process. To acknowledge the receipt of state legislative authority to develop alternate tables, and assure the public of its intent to use the APA for this change, it included the following phrase in the proposed regulations “until the department adopts by rule an actuarial table based on the life expectancy for aged and disabled individuals” (emphasis added).

Comment: The summary of rule changes (on page 4 of 7 of Bulletin 05-19P) says that the Department is exempting assets from penalty if the individuals receive fair market value within their lifetime. Does this mean that a commercial annuity, for a term of years shorter than the life expectancy in the CMS table, would be exempt if made payable to only the Medicaid beneficiary or the spouse?

Response: Yes.

Comment: We do not support the Department's future intention to develop its own actuarial tables governing life expectancy. It will be costly, potentially discriminatory toward applicants and in violation of federal law which governs how the SSI program determines a person's life expectancy. If there is a healthy community spouse involved in an annuity or promissory note, then there is no "shortened life expectancy." Not all disabled people have a shortened life expectancy. The existing life expectancy tables already make allowance for those with a shorter likelihood of survival within the population. The proposal for another sort of table sounds like discrimination on the basis of disability, which creates problems under the Americans with Disabilities Act and constitutional [sic] equal protection issues. Federal law governing the SSI program has specific rules governing how to determine a person's life expectancy. *See e.g.* POMS SI 01150.005 Exhibit F (Life Expectancy Table). CMS has adopted this approach and includes the SSI tables in the State Medicaid Manual. The complexity of this project is not accurately set out in this proposed rule, including the economic impact statement.

Response: The department appreciates these comments and will take them into full consideration in developing the new life expectancy tables. The economic impact, federal law compliance and state law issues will be addressed when the rule is promulgated in the future.

Penalties for Transfers of Income or Resources (M440.41)

Comment: This needs to be clarified to state that it impacts gifts made after August 15, 2005. Gifts made before the date of the regulation taking effect should be treated under the existing rules.

Response: Those who make gifts before the regulation takes effect and apply after the effective date of the new rules will not be grandfathered. Until individuals receive benefits from a program, their rights to receipt under specified rules do not vest.

A vested interest arises when a person has a legitimate claim of entitlement to a governmental benefit, rather than a unilateral expectation. Those who apply after the effective date of the new rules will be assigned a transfer penalty beginning the date following the transfer, as specified in the new rule (transfer penalty begins on the first day of the month of the transfer). Until a person is granted benefits, individuals have a unilateral expectation of an interest.

The department recognizes the vested rights of persons who have already acquired specific benefits. Those who apply on or before the effective date of the new rules will be assigned a transfer penalty based on the existing rules (transfer penalty begins on the first day of the month of the transfer).

The department has added a provision to make clear that the new rule applies to individuals who apply after August 15, 2005 and that the old rule applies to individuals who have been granted eligibility on or before August 15, 2005.

III. Responses to Comments Not Subject to the Provisions of Act 71

Comment: It would be helpful if examples were included in the regulations. The IRS does that in their regulations and it makes the abstract wording of the regulations more understandable.

Response: We agree that examples are useful and have formed a long-term care workgroup to develop training materials and procedures that publish this content.

Comment: The Department has simultaneously promulgated other Medicaid rules which are inconsistent and overlapping with the ones at hand, which make it more difficult to determine which version of these three rules the Department actually intends to adopt.

Response: The department has two pending rules. (The third one, a proposed emergency rule Bulletin 05-18E, was not filed following consideration of public comments).

The expedited rules in proposed 05-19P contain only provisions authorized and essential as expedited rules. In addition, the department is promulgating rules through the regular APA process in Bulletin 05-25. The department specified in 05-25 that it intends to incorporate therein the provisions approved through 05-19.

Comment: Rule M231.24 does not distinguish between an annuity fund, which is still liquid, and an annuity that has been annuitized for periodic payments. Once a contract has been annuitized, then the beneficiaries are irrevocable.

Response: The department is not authorized by Act 71 section 303 to make this change. It will, however, try to be responsive to this comment in proposed rule 05-25.

Comment: Rule M232.17 should define allowable expenses and limit them to principal and interest payments and real property taxes. This is not being applied the same way state-wide. Insurance is not relevant because owners choose the amount of insurance that they wish to have on the commercial building. Maintenance is irrelevant because it amounts to a capital improvement.

Response: The department is not authorized by Act 71 section 303 to make this change. It will, however, try to responsive to this comment through proposed rule 05-25.

Comment: In section M232.85(c), you talk about "member of the financial eligibility group". It sounds like you are including the Medicaid recipient since you do allow the recipient's funds to be excluded for community Medicaid in the preceding section, M232.85(b).

The term "retirement age" is confusing. It needs a definition, or examples. Are you talking about the age (70 1/2) at which a person must start taking distributions under the minimum distribution rules for IRAs and qualified plans? What happens to someone, like a community spouse, who has not reached that age and may be working part-time - does that person have to start taking distributions early to preserve the exemption? What about people who are disabled, and can draw from their IRAs early - are those assets protected, even if the person hasn't reached the traditional "retirement age" of 65?

Response: The department is not authorized by Act 71 section 303 to make changes to clarify this section as requested. It will, however, try to responsive to this comment through proposed rule 05-25.

Comment: The rules contain no public outreach or education provisions.

Response: Although not part of the formal regulatory process, the department agrees that public outreach and education is essential. Outreach and education has begun in the department's conversations with the DAIL Advisory Board, Medicaid Advisory Board, Legislators and advocates. In addition to the following planned education and outreach, the department welcomes additional suggestions on effective ways to communicate with individuals affected by these changes.

DCF is collaborating with DAIL to include this information in the Choices for Care Outreach that DAIL will engage in with its community partners and through various media. A detailed description of this effort is included in Section F of the Choices for Care Operational Protocol.

DCF plans to train financial eligibility staff in September.

DCF will collaborate with DAIL to include this information in its initial training of nursing facility and home health providers as well as Choices for Care staff in August. DCF will also work with DAIL to include this information in its subsequent six provider training sessions thereafter.

Both DCF and DAIL have an ongoing collaboration with advocates, including the Long-term Care Ombudsman, Senior Citizens Law Project, COVE, and members of the private bar and will be responsive as questions arise.

In addition, DCF is willing to speak at meetings of AARP, AAA and other similar groups, as invited.

* * * * *

Vertical lines in the left margin indicate significant changes. Dotted lines indicate at the left indicate changes to clarify, rearrange, or correct references, without changing the content of the rule.

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Manual Maintenance

<u>Remove</u>		<u>Insert</u>	
TOC P.3 (M200)	(02-11)	TOC P.3 (M200)	(05-19)
TOC P.4 (M200)	(03-17)	TOC P.4 (M200)	(05-19)
M200.23	(02-11)	M200.23	(05-19)
M231.22	(03-17)	M231.22	(05-19)
Nothing		M231.24 P.2	(05-19)
M232.16 P.2	(02-11)	M232.16 P.2	(05-19)
M232.4	(02-11)	M232.4	(05-19)
M232.8	(02-11)	M232.8	(05-19)
Nothing		M232.83. P.2	(05-19)
M232.85	(02-11)	M232.84	(05-19)
M233.2	(02-11)	M233.2	(05-19)
M233.24	(04-11)	M233.24	(05-19)
M243.5	(02-11)	M243.5	(05-19)
M243.51	(02-11)	M243.51	(05-19)
TOC P.3 (M400)	(02-11)	TOC P.3 (M400)	(05-19)
M420	(02-11)	M420	(05-19)
M430	(02-11)	M430	(05-19)
M432	(02-11)	M432	(05-19)
M440	(02-11)	M440	(05-19)
M440.21	(02-11)	M440.21	(05-19)
M440.35	(02-11)	M440.35	(05-19)
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M200.23

M200.2 SSI-Related Categorically Needy Coverage Groups (Continued)**M200.23 Long-Term Care Medicaid Coverage Groups**

The following individuals are eligible for SSI-related Medicaid as categorically needy.

- (a) Medical institution - Individuals who live in a medical institution and have gross income under the institutional income standard.
- (b) Special income group – Individuals who qualify for waiver services and who:
 - would be eligible for Medicaid if they were living in a medical institution;
 - have gross income between the protected income level and the institutional income standard; and
 - can receive appropriate long-term medical care in the community, as determined by the Department of Disabilities, Aging and Independent Living.
- (c) Working people with disabilities – Individuals who qualify for home-based care under the waiver serving the aged and disabled and meet the financial eligibility requirements specified in M200.24(b).
- (d) Hospice care - Individuals who:
 - would be eligible for Medicaid if they were living in a medical institution;
 - can receive appropriate medical care in the community, the cost of which is no greater than the estimated cost of medical care in an appropriate institution; and
 - receive hospice care as described in section M401.2 and defined in section 1905(o) of the Social Security Act.
- (e) Disabled Child in Home Care (DCHC, Katie Beckett) - Individuals who:
 - require the level of care provided in a medical institution;
 - would be eligible for Medicaid if they were living in a medical institution;
 - can receive appropriate medical care in the community, the cost of which is no greater than the estimated cost of medical care in an appropriate institution;
 - are age 18 or younger;
 - have income, excluding their parents' income, no greater than the institutional income standard; and
 - have resources, excluding their parents' resources, no greater than the resource limit for a Medicaid group of one.

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M231.22

M231 Types of Resources (Continued)

M231.22 Retirement Funds (see section M232.85)

M231.23 Stocks, Bonds, Mutual Funds, and Money Market Funds

(a) Definitions

Legal instruments authenticating an investment, such as stocks, bonds, mutual funds, and money market funds pay interest at specified intervals, sometimes pay dividends, and are convertible into cash either on demand or at maturity.

(i) United States Savings Bonds

- (A) Series E and EE bonds are sold at one half of their face value and increase in redemption value as interest accrues.
- (B) Series I bonds are sold at their full face value and increase in redemption value as interest accrues.
- (C) Series H and HH bonds are sold at their full face value and do not increase in value. Instead, they pay interest to the owner each six months.

M231.24 Annuities

(a) Definition

For Medicaid purposes, an annuity is a contract reflecting payment to an insurance company, bank, charitable organization, or other registered or licensed entity. There are two phases to an annuity: an accumulation phase and a payout phase. Annuities vary in how they accumulate and payout money. Annuities may accumulate money by payment of a single lump sum or by payments on a schedule, which accumulate interest over time. Once an annuity has matured, money is paid to the beneficiary according to the terms of the annuity contract.

(i) Parties to an annuity

There are always two parties to an annuity: the writer of the annuity, usually an insurance carrier or charitable organization, and the purchaser who owns the annuity.

In addition to the formal parties to an annuity, annuities also name a beneficiary: the person who will be paid a regular stream of income from the annuity in equal payments. Anyone can be a beneficiary, including but not limited to, the owner of the annuity, a spouse, dependent, trust, estate, commercial entity, proprietorship, or charitable organization.

Beneficiaries may be revocable or irrevocable. A revocable beneficiary can be changed by the owner of the annuity at any time. An irrevocable beneficiary can be changed only by the written permission of that beneficiary.

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M231.24 P.2

M231 Types of Resources

M231.24 Annuities (Continued)

In addition to the primary beneficiary, annuities can provide for a contingent beneficiary or residual beneficiary. A contingent or residual beneficiary will receive annuity payments upon the occurrence of a specified condition

(ii) Types of annuities

There are many types of annuities. For Medicaid purposes, the department considers whether annuities of any type are available as a liquid resource. Since annuities are trust-like instruments, the department uses terminology similar to trusts when it describes the availability of cash from annuities.

Annuities that name revocable beneficiaries are available because the owner can change the beneficiary, surrender, cash in, assign, or transfer the annuity. The department presumes revocability when an annuity contract is silent regarding revocability.

Annuities are unavailable when the owner of an annuity is not the individual requesting Medicaid or the individual's spouse or the individual or spouse has abandoned all rights of ownership.

(iii) Standard annuity contract provisions

Annuity contracts provide for payments over a certain period. For the purposes of Medicaid eligibility, the payout period of an annuity must be within the life expectancy of the person on whose life the annuity is based or else it will be counted as a resource or considered a transfer of assets at less than fair market value. The department determines life expectancy as specified in M440.21.

M231.25 Mortgages and Promissory Notes

A mortgage is the pledging of real estate or conveyance of an interest in land to a creditor as security for repayment of a debt. A promissory note is a written promise to pay a certain sum of money to a certain person, the bearer, upon demand or on a specified date.

M231.26 Home Equity Conversion Plans (see section M232.14)

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M232.16 P.2

M232 Excluded ResourcesM232.16 Life Estates (Continued)(b) Exclusion for life estate interests created on or after July 1, 2002

The department excludes life estates in real property when the owner does not retain the power to sell or mortgage the real property.

When owners retain the power to sell or mortgage the entire real property, including any remainder interest, the department excludes the value of the life estate in the real property only if the life estate is an interest in the individual's home (M232.11). For this purpose, the value of the life estate includes the value of the remainder interest.

(c) Exclusion for life estate interests created before July 1, 2002

When owners retain the power to sell the entire real property, including any remainder interest, the department excludes the value of the life estate in the real property only if the life estate is excludable on another basis, such as because it is real property producing significant income (M232.17).

The department excludes life estates in real property when the owner does not retain the power to sell the real property.

M232.17 Real Property Producing Significant Income

Real property producing significant income is exempt from consideration as a resource. Real property is considered to produce "significant income" if it generates at least 6 percent of its fair market value in net annual income after allowable expenses related to producing the income are deducted.

Until July 1, 2003, determinations and redeterminations of eligibility for individuals who have received SSI-related or ANFC-related Medicaid at any time between July 1, 2001 and June 30, 2002, and have property producing significant income, shall have property producing significant income evaluated based on the rules in effect on June 30, 2002.

M232.18 Real Property Producing Goods For Home Consumption

Real property used to produce goods for only home consumption (e.g., a garden plot used to raise vegetables to be eaten at home or a wood lot used to provide fuel to heat the home) is exempt from consideration as a resource. When real property is used to produce goods for both home consumption and income production, the department excludes only the part used to produce goods for home consumption. The part of the property used for income production is evaluated for exclusion under rule M232.17.

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M232.4

M232 Excluded Resources (Continued)M232.4 Annuities, Promissory Notes, and Similar Resources that Produce Income

The department excludes annuities, promissory notes, and similar resources (contracts) that produce income if the obligation to pay the income was established more than 36 months before the individual's application, or if they:

- (i) have no beneficiary other than an individual requesting long-term care Medicaid or his or her spouse; and
- (ii) provide for payments to applicants or their spouses in equal intervals and equal amounts; and
- (iii) are based on the life expectancy of the applicants or their spouses, as specified in M440.21; and
- (iv) return to the beneficiary at least the amount used to establish the contract and any additional payments plus any earnings, as specified in the contract; and
- (v) do not pay anyone other than the applicant or the applicant's spouse, even if the applicant or spouse dies before the payout period ends.

Once eligibility has been determined, if someone other than the long-term care recipient or spouse becomes a beneficiary of the contract, the recipient shall be precluded from allocating income to the community spouse up to the amount of the previously available contract payment.

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M232.8

M232 Excluded Resources (Continued)M232.8 Other Excluded Resources

The department also excludes the following resources.

M232.81 Household Goods and Personal Effects

The department excludes home furnishings, apparel, personal effects, and household goods. This includes tools, equipment, uniforms and other nonliquid property required by an individual's employer or essential to self-support.

M232.82 Vehicles

The department excludes all automobiles. It also excludes other vehicles, such as trucks, boats, and snowmobiles, only if they are used to provide necessary transportation (i.e., an automobile is unavailable or cannot be used to transport the aged, blind or disabled individual).

M232.83 Contracts for Medical Care, Assistive Technology Devices, and Home Modifications

(a) Definitions

Contracts for medical care, assistive technology devices, and home modifications means any written agreement, contract, or accord (including modifications) for reasonable and necessary medical care, assistive technology devices, or home modifications not covered by Medicare, private insurance, or Medicaid and determined by the Department of Disabilities, Aging, and Independent Living (DAIL) to be needed to keep an individual at home and out of a skilled nursing facility.

Medical care means care not covered by the Choices for Care waiver, including but not limited to, general supervision when required by the cognitive impairment of the individual and/or unstable medical condition that requires monitoring of the individual.

Assistive technology devices means any item, piece of equipment or product system whether acquired commercially off the shelf, modified, or customized, to increase, maintain, or improve the individual's functional capabilities.

Home modifications means physical adaptations to the individual's home that ensure the health and welfare of the individual, or that improve the individual's ability to perform activities of daily living or instrumental activities of daily living.

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M232.83 P.2

M232 Excluded ResourcesM232.83 Contracts for Medical Care, Assistive Technology Devices, and Home Modifications
(Continued)

(b) Exclusion

Resources set aside for a contract or contracts for medical care, assistive technology devices, or home modifications (contract) shall be considered to be an available resource unless all of the following criteria are met:

- (1) The contract is in writing and signed before any services are provided;
- (2) The funds, not to exceed a total of \$30,000, are held in a separate bank account from other resources in the sole name of the Medicaid applicant;
- (3) Any amounts due are paid after the services are rendered;
- (4) The payments for:
 - a. medical care or assistive technology services do not exceed \$500 per month; and
 - b. home modifications shall not exceed a one-time expenditure of \$7,500;
- (5) The payments to nonlicensed individuals or providers do not exceed the fair market value of such services being provided by similarly situated and trained nonlicensed individuals, not to exceed the amount paid under the DAIL Choices for Care waiver, currently \$10 per hour.
- (6) Periodic accountings, as requested by the Department for Children and Families, must be provided specifying the amount of each expenditure, who was paid, the service given, and the number of hours and dates of service covered;
- (7) The applicant/recipient has the power to modify, revoke or terminate the contract for care;
- (8) The contract ceases upon the death of the applicant/recipient. It also ceases upon admission to a nursing facility for more than 45 days if not eligible for the home upkeep deduction (M432.2) or 6 months if eligible for the deduction. In addition, revocation or termination of the contract ceases the agreement.
- (9) Upon cessation of the contract as specified in the previous paragraph, any remaining balance of funds set aside for the contract for care shall be treated either:
 - a. as an asset of the Medicaid beneficiary's estate, if the Medicaid beneficiary is deceased; or
 - b. as an available resource that may not be converted to an excluded resource and must be applied at the Medicaid pay rate toward nursing facility services if the Medicaid beneficiary is admitted to a nursing facility for more than 6 months. In cases where the Medicaid beneficiary dies before the resource is fully expended, the remainder shall become an asset of the Medicaid beneficiary's estate; or
 - c. as an excluded resource, if the individual revokes or terminates the contract and continues to receive services under the Choices for Care waiver.

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M232.84

M232.8 Other Excluded Resources (continued)

M232.84 Cash, Including Cash Necessary to Operate a Business

The department excludes income as a resource in the month of receipt, such as automatic deposit of a social security check into a checking account. The department excludes cash necessary to operate a business, using a month's average expenditures as determined by tax returns, or business receipts and expenses for the past 12 months. No more than three times the average monthly cash expenditures can be excluded.

M232.85 Retirement Funds

(a) Definition

Retirement funds include any resources set aside by a member of the financial responsibility group to be used for self-support upon the withdrawal from active life, service, or business. Retirement funds include but are not limited to IRAs, Keogh plans, 401K plans, pensions, mutual funds, stocks, bonds, securities, money market accounts, whole life insurance, and annuities.

(b) Exclusion for community Medicaid

The department excludes retirement funds owned by the individual requesting Medicaid when both criteria are met.

- (i) The individual must resign from a job to receive retirement benefits from the funds or has applied for periodic retirement benefits in lieu of a lump-sum payment.
- (ii) If the individual has reached retirement age, the individual is drawing on retirement funds at a rate consistent with the individual's life expectancy, as specified in M440.21.

(c) Exclusion for long-term care

The department excludes retirement funds owned by a member of the financial responsibility group when both criteria are met.

- (i) The owner is not applying for or receiving Medicaid and either:
 - must resign from a job to receive retirement benefits from the funds; or
 - has applied for periodic retirement benefits in lieu of a lump-sum payment.
- (ii) If the member of the financial responsibility group with retirement funds has reached retirement age, the member is drawing on retirement funds at a rate consistent with the individual's life expectancy, as specified in M440.21.

M232.86 Tax Refunds

The department excludes tax refunds on real property, income, and food.

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M233.2

M233 Value of Resources Counted Toward the Medicaid Resource Limit (Continued)**M233.2** Value of Certain Resources

The following sections describe exceptions to the general rules in M233. They describe how the department values certain resources of financial responsibility group members.

M233.21 Annuities

Unless otherwise excluded, the department counts the cash value of annuities that are considered available, as defined in section M231.24. In addition, the department counts the cash value of annuities that do not equal the life expectancy of the individuals on whose life the annuities are based.

The cash value is equal to the amount of money used to establish the annuity and any additional payments used to fund the annuity, plus any earnings and minus any early withdrawals and surrender fees, unless the individual can furnish evidence from a reliable source showing that the annuity is worth a lesser amount. Reliable sources include banks, other financial institutions, insurance companies, and brokers, as well as any other the department considers, in its discretion, to be reliable.

M233.22 Nonexcluded Life Estates

Unless the life estate is excluded, the department establishes the value of life estates by multiplying the fair market value of the property at the time of the transfer by the number in the life expectancy table that corresponds with the individual's age at the time of the transfer creating the life estate, as specified in M440.21. Individuals may submit evidence supporting another method of establishing the fair market value of such a life estate. The department shall make a decision about which method to use. If the department decides not to use the alternate method advocated by an individual, the department shall provide that individual with a written notice stating the basis for its decision.

M233.23 Jointly Owned Real Property

Regardless of any co-owner's refusal to sell, the department presumes that individuals who own real property jointly with others own the entire equity value of the real property if the joint ownership was created after July 1, 2002 and less than 36 months prior to the date of application. Individuals may rebut this presumption by showing through reliable sources that others have purchased shares of the property at fair market value. Reliable sources include cancelled checks or property transfer tax returns. When individuals establish that one or more co-owners purchased shares of the property, the department counts the proportional interest owned by the individual requesting long-term care.

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M233.24

M233 Value of Resources Counted Toward the Medicaid Resource Limit (Continued)**M233.24** United States Savings Bonds

Savings bonds are counted as a resource beginning on the date of purchase unless:

- (a) individuals have requested and been denied a hardship waiver pursuant to the provisions of Rule M232.98; or
- (b) individuals owned savings bonds that were in their minimum retention period on June 15, 2004 and the bonds have not been redeemed, exchanged, surrendered, reissued or otherwise become available.

To establish the value of the bonds, the department uses the Savings Bond Calculator or the Comprehensive Savings Bond Value Table on the U.S. Bureau of Public Debt's Internet web site at: www.publicdebt.treas.gov/sav/savcalc.htm. Alternatively, the department obtains the value by telephone from a local bank. The following general rules apply to valuation.

- (a) Series E and EE bonds are valued at their purchase price.
- (b) Series I bonds are valued at their face value.
- (c) Series HH bonds are valued at face value.

M233.25 Promissory Notes and Similar Resources that Produce Income

Promissory notes are counted as a resource unless:

- (a) they meet the criteria for exclusion pursuant to the provisions of M232.4; or
- (b) the individual owned a nonnegotiable promissory note executed before September 1, 2005.

Unless one of the above criteria for exclusion is met, or is subject to a transfer penalty under M440.36, the department counts the fair market value of promissory notes and similar income-producing resources (contracts). Regardless of negotiability, fair market value equals the amount of money used to establish the contract and any additional payments used to fund it, plus any earnings and minus any payments already received. If the individual furnishes evidence of a good faith effort to sell by obtaining three independent appraisals by reliable sources which reflect that the value of the note is less than the fair market value, the department will consider the note available only in the amount of this discounted value. Reliable sources include banks, other financial institutions, insurance companies, and brokers, as well as any other the department considers, in its discretion, to be reliable.

For individuals requesting long-term care, contracts valued at a discount either shall be treated as an available resource at the discounted amount or subject to a transfer penalty to the extent of the amount discounted from the fair market value, in the discretion of the department. Where the contract is determined to have no value on the open market, a transfer penalty for the full value used to establish the contract and any additional payments used to fund it, plus any earnings and minus any payments already received shall be applied.

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M243.5

M243 Determination of Countable Income for SSI-Related Medicaid (Continued)M243.5 Financial Responsibility Groups for Individuals Seeking Long-Term Care

The department determines countable income for SSI-related Medicaid long-term care applicants, including waiver and hospice services, according to the following rules.

The department compares the countable income of individuals requesting long-term care to the applicable income standard for their coverage group beginning with the date of admission to long-term care.

The institutional income standard (IIS) for individuals equals 300 percent of the maximum SSI federal payment to an individual living independently in the community. The IIS for couples equals twice the IIS for individuals.

When the department has an indication that individuals will need long-term care for fewer than 30 days, it uses the protected income level (PIL) for the month of admission, and applies the rules for SSI-related Medicaid, other than long-term care.

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M243.51

M243 Determination of Countable Income for SSI-Related Medicaid (Continued)**M243.51** Determination of Countable Income for Long-Term Care Applicants in Nursing Facilities

The department determines countable income for applicants for long-term care in nursing facilities according to the rules at M243.1, except the department:

- (a) allocates income to the community spouse, dependent children and for home upkeep, according to the rules in M432;
- (b) allocates a personal needs allowance to the applicant; and
- (c) compares the countable income of the Medicaid group to the institutional income standard (IIS) beginning with the date of admission to long term care.

For individuals whose gross income exceeds the IIS, the department determines whether they may spenddown their excess income to the protected income level (PIL) to establish their financial eligibility as medically needy, according to the rules at M412. The department determines whether the individual has incurred eligible medical expenses that equal the difference between their countable income and the PIL.

M243.52 Determination of Countable Income for Long-Term Care Applicants Seeking Waiver or Hospice Services

The department determines countable income for applicants for long-term care in nursing facilities according to the rules at M243.1, except the department:

- (a) allocates income to the community spouse, dependent children and for home upkeep, according to the rules in M432, and
- (b) allocates a community maintenance allowance to the applicant.
- (c) approves income eligibility if applicants:
 - (i) have gross income that does not exceed the IIS; or
 - (ii) seek coverage for home-based waiver services for the aged and disabled, administered by the Department of Aging and Independent Living, and pass the net income test for individuals working with disabilities (M200.24 (b)).

For individuals whose gross income exceeds the IIS, the department determines whether they may spenddown their excess income to the PIL to establish their income eligibility as medically needy using the rules in M412. The department determines whether the individual has incurred eligible medical expenses that equal the difference between their countable income and the PIL.

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M420

M420 Spending Down Excess Income on Medical Expenses

The amount of a Medicaid group's spenddown is the amount by which their countable income or resources exceed the applicable standard for the accounting period.

An individual with income greater than the protected income level (PIL) may spend the excess down to the PIL on medical expenses following the methodology specified below to receive community Medicaid as part of the medically needy coverage group. An individual with income greater than the institutional income standard (IIS) may spend the excess income down to the PIL on medical expenses following the methodology specified below to receive long-term care Medicaid as part of the medically needy coverage group.

The spenddown methodology is the same for all living arrangements, except that a one-month accounting period applies to long-term care living arrangements and a six-month accounting period applies to those in the community living arrangement.

M420.1 Eligibility Date

Medicaid groups with excess income meet the spenddown requirement on the first day within the accounting period that their deductible medical expenses meet or exceed the spenddown requirement. Sometimes this allows for retroactive coverage as specified in M113.

Eligibility becomes effective on the first day of the month when a spenddown requirement is met using health insurance and noncovered medical expenses.

Eligibility becomes effective later than the first day of the month when a spenddown requirement is met using covered medical expenses.

Special eligibility dates apply, as set forth in M421.24 for Medicaid groups who meet their spenddown requirement using noncovered assistive community care services (ACCS).

Medicaid groups remain responsible for medical expenses incurred before the date of eligibility.

When they receive services from more than one provider on the day that coverage begins, Medicaid groups must decide which services they will be responsible for paying and which ones Medicaid will cover. Medicaid pays for covered services on the first day that the group's expenses exceed the amount of the group's spenddown. Medicaid continues until the end of the accounting period, unless the Medicaid group's situation or protected income level changes.

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M430

M430 Patient Share Payment for Long-Term Care, Including Waiver and Hospice Services

Once the department determines individuals are eligible for long-term care, including waiver and hospice services, it computes how much of their income must be paid to the long-term care provider each month for the cost of care (patient share). A patient share is computed for an individual in a medical institution or who qualifies for home-based waiver services as part of the special income group (M200.23(b)) or as medically needy (M200.3). The department determines the patient share amount at initial eligibility, eligibility redeterminations, and when changes in circumstances occur.

An individual's patient share is determined by computing the maximum patient share and deducting allowable expenses. Sections M431-M431.2 describe how the department determines the maximum patient share. Sections M432-M432.32 describe allowable deductions from the patient share. The actual patient share equals the lesser of either the balance of a patient's income remaining after computing the patient share or the cost of care remaining after the third party payment.

In cases in which allowable deductions exceed the individual's income, the patient share payment is reduced by the deductions, sometimes resulting in no patient share obligation. When monthly income and medical expenses are stable, the patient share amount remains constant. When income or allowable deductions fluctuate, the patient share payment usually varies.

Individuals owe their patient share by the last day of the month in which they receive the income. Payment is made either to the facility in which they resided or the highest paid provider of long-term care waiver services. The department may adjust patient share payments to long-term care providers when a patient transitions from one living arrangement to another, as specified in M433-M433.3.

When monthly income and medical expenses are stable, the patient share payment remains constant. When deductions fluctuate, the patient share payment is likely to vary. When allowable deductions exceed the individual's income, the patient share payment is zero for as many months needed to exhaust the medical expenses against the patient's available income. The month when the remaining medical expense deductions no longer exceed the patient's income, the balance is the patient share payment for that month.

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M432

M432 Deductions from Patient Share

When determining the patient share amount, the department deducts the following from gross income:

SSI/AABD, AABD only and ANFC benefit payments still being received when the person first enters long-term care;
SSI/AABD payments intended to be used to maintain the community residence of persons temporarily (not to exceed 3 months) in institutions;
Austrian Reparation Payments;
German Reparation Payments;
Japanese and Aleutian Restitution Payments;
Payments from the Agent Orange Settlement Funds; and
Radiation Exposure Compensation.
VA payments for aid and attendance paid to a veteran residing in a nursing home or to the veteran's surviving spouse residing in a nursing home.

Then the department deducts the following items from the individual's patient share specified in the subsections below in the following order:

- (a) a personal needs allowance or community maintenance allowance (M432.1);
- (b) home upkeep expenses, if applicable (M432.2);
- (c) allocations to community spouse or maintenance needs of family members living in the community, if applicable (M432.3); and
- (d) reasonable medical expenses incurred, if applicable (M420-M422). For the purposes of this subsection, "reasonable medical expenses" do not include long-term care services received during penalty periods for long-term care Medicaid.

Unpaid patient share obligations may not be used to reduce a current patient share obligation.

M432.1 Personal Needs Allowance and Community Maintenance Allowance

The department deducts a reasonable amount for clothing and other personal needs of the individual from monthly income. For institutionalized individuals, the department applies a standard personal needs deduction. For individuals receiving waiver or hospice services, the department applies a standard community maintenance deduction. Unlike the institutionalized individual, whose room and board are covered by Medicaid, persons in the waiver and hospice living arrangements have higher allowances to provide a reasonable amount for food, shelter, and clothing to meet their personal needs.

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M440

M440 Transfer of Income or Resources by Individuals Requesting Long-Term Care Coverage

The department shall determine whether transfers of income or resources made by applicants and recipients requesting Medicaid coverage of long-term care expenses, or by any member of their financial responsibility group, are allowable transfers under the rules set forth in this section. This section applies to applicants and recipients in a medical institution or who qualify for home-based waiver services as part of the special income group (M200.23(b)) or as medically needy (M200.3). This section also applies to the spouses of applicants and recipients in a medical institution or who qualify for home-based waiver services as part of the special income group (M200.23(b)) or as medically needy (M200.3). If the department determines that such transfers are not allowable, the person requesting long-term care coverage shall not be eligible for such coverage until a penalty period has expired. The beginning and duration of the penalty period shall be based upon the date and value of the disallowed transfers.

The department shall make this determination concerning transfers occurring before the individual requests coverage of long-term care services, including waiver and hospice services, as part of its determination of initial eligibility for such coverage. Once the department has determined that a transfer is disallowed and has established a penalty period, that transfer is not reconsidered unless the department obtains new information about the transfer. If the department discovers that the individual has made additional transfers after the initial determination, the department shall also determine whether these are allowable, whether the dates of transfer are before or after the initial determination, and establish penalty periods as required. After the month in which an individual is determined eligible for long-term care Medicaid, no resources of the community spouse shall be determined available to the institutionalized spouse.

Section M440.1 sets forth a definition of transfers.

Sections M440.2 and M440.3 specify the criteria for allowable transfers, to which no penalty period applies, effective for all initial long-term care Medicaid eligibility determinations and redeterminations. No other transfers are allowable.

M440.1 Definition of Transfer

A transfer of income or resources, for the purposes of this section, means any action taken by a member of the financial responsibility group (see rules M200.1(d); and M221) or by any other person with lawful access to the income or resources (see rule M440.35) that disposes of the member's income or resources. The date of the transfer is the date this action was taken. It also applies to certain income and resources to which the member is entitled but does not have access because of an action taken by:

- a member of the financial responsibility group entitled to the income or resources;
- a person, including a court or administrative body, with legal authority to act in place of or on behalf of the member or the member's spouse, entitled to the income or resources; or
- a person, including a court or administrative body, acting at the direction or upon the request of the member or the member's spouse, entitled to the income or resources.

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M440.21

M440 Transfer of Income or Resources by Individuals Requesting Long-Term Care Coverage
(Continued)

M440.21 Scheduled Receipt of Fair Market Value after the Date of Transfer

If the value of a transferred resource is scheduled for receipt after the date of transfer, the department considers it a transfer for fair market value only if the individual or spouse can expect to receive the full fair market value of the resource within the expected lifetime of the individual or spouse.

Expected lifetime is determined by the department as specified in subsections (a) and (b) below.

When the transferred resource is an annuity, promissory note or other similar income-producing resource scheduled for receipt after the date of transfer, the department considers it a transfer for fair market value only if it:

- is actuarially sound;
- provides for payments at equal intervals and in equal amounts;
- returns at least the transferred amount to the individual or spouse within the individual's expected lifetime as determined by the department; and
- has been established for the sole benefit of the institutionalized individual or spouse.

- (a) Expected lifetime of the institutionalized individual will be measured at the time of the transfer using the tables from §3258.9 of the State Medicaid Manual published by the federal Centers for Medicare and Medicaid Services and set forth in the Medicaid procedures manual.
- (b) Expected lifetime of the spouse will be measured at the time of the transfer using the tables from §3258.9 of the State Medicaid Manual published by the federal Centers for Medicare and Medicaid Services and set forth in the Medicaid procedures manual.

Pursuant to the authority granted in Act 71 § 303(7), the department is developing alternate actuarial tables that will be consistent with federal law and adopted by rule.

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M440.35

M440 Transfer of Income or Resources by Individuals Requesting Long-Term Care Coverage**M440.35** Transfers involving Jointly Held Income or Resources**(a)** Transfers after January 1, 1994

For joint ownerships established after January 1, 1994, the portion of jointly held assets subject to penalty is evaluated by the department based on the specific circumstances of the situation. The department presumes individuals own the value of the resource using rules in M233 and its subsections. Individuals may rebut the presumption of ownership by establishing to the department's satisfaction that the amount withdrawn was, in fact, the sole property of and contributed to the account by the other person, and thus did not belong to the individual. In the case of accounts in financial institutions (M231.21), for example, the portion subject to transfer penalty is the amount withdrawn by a joint owner. In the case of life estates, for example, individuals may transfer their home and retain a life estate without being subject to penalty if they have retained the right to sell the property. In this situation their ownership interest has not been reduced or eliminated.

(b) Transfers before January 1, 1994

For joint ownerships established before January 1, 1994, the date of the transfer is the date the other person became a joint owner. The value of the transfer equals the amount that the resource available to the individual or the individual's spouse was reduced in value.

M440.36 Transfers involving Promissory Notes or Similar Resources that Produce Income

Promissory notes or similar income-producing resources (contracts) that do not meet the requirements of M232.4 and are determined by the department to have no value on the open market shall be assessed a transfer penalty based on their fair market value. Fair market value equals the amount of money used to establish the contract and any additional payments used to fund it, plus any earnings and minus any payments already received.

Contracts determined to have full fair market value or a discounted value as specified in M233.25 shall be considered either as an available resource, in the discretion of the department.

The department always considers contracts with a cancellation clause or with no value as a transfer in the amount of the full fair market value.

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M440.4

M440 Transfer of Income or Resources by Individuals Requesting Long-Term Care Coverage
(Continued)

M440.4 Determination of the Penalty Period for Disallowed Transfers

If a transfer is disallowed, the department imposes a penalty period of restricted Medicaid coverage to an otherwise eligible individual. During this period, no Medicaid payments are made for long-term care services, including waiver and hospice services. Medicaid payments are made for all other covered services provided to the recipient during the period of restricted coverage.

M440.41 Penalty Date

The penalty date is the beginning date of each penalty period imposed for a disallowed transfer.

For applications filed after August 15, 2005, the period of restricted coverage begins the first day of the month following the date the asset was transferred if that does not occur in any other period of restricted coverage.

For applications filed before August 15, 2005, the period of restricted coverage begins the first day of the month the asset was transferred if that does not occur in any other period of restricted coverage.

Penalty periods for transfers occurring in different months run consecutively rather than concurrently, in the order in which the transfers occurred. If, after establishing a penalty period for disallowed transfers, the department determines that additional disallowed transfers were made in a subsequent month but before the end of the first penalty period, the department shall designate the first day following the end of the first penalty period as the penalty date for the subsequent penalty period.

M440.42 Penalty Period

For transfers that occurred before July 1, 2002, the number of months in a penalty period shall be equal to the total value of all disallowed transfers made during a given calendar month divided by the average monthly cost to a private patient of nursing facility services as of the date of application. When a fraction of a month results, the months are rounded down to the nearest whole number.

For transfers that occurred on or after July 1, 2002, the number of days in a penalty period shall be equal to the total value of all disallowed transfers made during a given calendar month divided by the average daily cost to a private patient of nursing facility services in the state as of the date of application or the date of discovery, if the department discovered additional disallowed transfers after the initial determination of eligibility for long-term care coverage.

Penalty periods for transfers in different calendar months shall be consecutive and established in the order in which the disallowed transfers occurred.

A penalty period runs continuously from the first date of the penalty period, even if the individual stops receiving long-term care services, including waiver and hospice services.