

DAIL is implementing major reforms of the Vermont long-term care system under a waiver “Choices for Care: Long-Term Care Medicaid Waiver” (Social Security Act Section 1115 Demonstration Project Number 11-W-00191/1) (hereafter referred to as “Choices for Care”). The waiver restructures the long-term care system for aged and disabled individuals receiving nursing facility services, in part by giving individuals the choice to receive care at home or in a nursing facility. In contrast to the current system, under Choices for Care an unlimited number of eligible individuals can be served at home.

While DAIL will administer the waiver, including the clinical eligibility and provider requirements, the Department for Children and Families (DCF) will continue to determine financial eligibility for all who seek long-term care Medicaid, including Choices for Care participants. These rule changes update SSI-related Medicaid regulations to conform to changes brought about by Choices for Care.

These rule changes also expand the income and resource disregards to enable more individuals who are disabled and working to qualify for Medicaid coverage, pursuant to H. 543, § 4.

Lastly, technical rule changes also are proposed to clarify existing rules, incorporate interpretive memoranda, and include another option for individuals with annuities who seek SSI-related Medicaid coverage.

Specific Changes

Section	Description of change
M200.1 Definitions	<p>Clarifies subsection (b) defining community spouse to mean the spouse of an individual who is not living in a medical institution or nursing facility to conform to federal requirements.</p> <p>Clarifies subsection (i) defining Medicaid services to include services defined in the DAIL “Choices for Care: Long-term Care Medicaid Waiver” regulations.</p> <p>Clarifies subsection (k) defining waiver services to reflect changes in the Vermont Agency of Human Services organization and commencement of “Choices for Care” waiver.</p>
M200.24 SSI-Related Medicaid Coverage Groups	<p>Adds new financial eligibility criteria for individuals with disabilities who are working and seeking Medicaid coverage.</p>
M213 State Residence	<p>Corrects typographical error.</p>

**M220
Financial
Eligibility for SSI-
related Medicaid**

Clarifies roles and responsibilities for financial eligibility determinations for SSI-related Medicaid by the departments within the Vermont Agency of Human Services.

**M222.2
SSI-related
Medicaid Groups**

Corrects typographical error.

**M230
Overview of SSI-
related Medicaid
Resource
Requirements**

Eliminates table.

**M230.1
Changes Effective
August 1, 2003**

Deletes obsolete section.

**M232.4
Annuities,
Promissory Notes,
and Similar
Resources that
Produce Income**

This provision was clarified significantly following public comment and incorporates amendments approved by the Joint Legislative Committee on Administrative Rules on August 25, 2005 (DCF Bulletin 05-19F).

Clarifies existing rules to make treatment of annuities in their accumulation phase consistent with federal law. Since annuities in their accumulation phase can be liquidated or sold, the department considers them a countable resource.

Since the updated annuities regulation is more restrictive than the existing annuities rule, the department added a grandfathering provision in subsection (a)(iii) for annuities established in reliance under old rule.

Broadens the exclusion to exclude annuities owned by individuals or their spouses when Vermont Medicaid is designated as the primary beneficiary of their annuity up to the amount owed until fully paid and a contingent beneficiary thereafter.

**M232.52
Excluded Trusts**

Inserts a reference in subsection (d) to “third-party trusts and supplemental needs trusts.” Removes supplemental needs trust from provisions of subsection (f).

**M232.98
Stocks, Bonds,
Mutual Funds and
Money Market
Accounts**

Clarifies subsection (b) relating to savings bonds. Specifies that using funds from savings bonds to purchase other excluded assets is impermissible.

**232.99
Resource
Disregard for
Certain
Individuals
Receiving Home-
Based Long-term
Care**

This provision was clarified following public comment. An additional resource disregard of \$3,000 is allowed for elderly and disabled individuals without a spouse who own their principal place of residence and choose home-based long-term care services.

M233.11 Tenancy in Common	Clarifies subsection (b) describing the treatment of liquid resources.
M233.21 Annuities	Specifies how the department will assign a value to annuities.
M242.2 Unearned Income Exclusions	Changes the unearned income exclusion for working disabled in subsection (gg). Clarifies treatment of unearned income exclusions related to business expenses in subsection (c), reverse mortgages in subsection (hh), and supplemental needs trusts in subsection (jj).
M431 Determining Residence Period for Long-Term Care	Clarifies that individuals needing long-term care for fewer than 30 consecutive days are covered under community Medicaid or VHAP Managed Care.
M431.2 Determining the Maximum Patient Share	Clarifies how the department determines the maximum patient share.
M432.2 Home Upkeep Deduction	Clarifies the deduction for individuals in a nursing home or receiving enhanced residential care (ERC) services through Choices for Care.
M432.31 Allocation to Community Spouse	Clarifies the existing rule to conform to federal requirements.
M440.31 Allowable Transfers Involving Trusts for Less than Fair Market Value	Eliminates subsection (a) as obsolete. Clarifies subsection (b) through (e) to conform to federal requirements. <u>Subsections (b) through (d) were clarified significantly following public comment.</u>
M440.33 Other Allowable Transfers to Family Members for Less than Fair Market Value	Clarifies subsection (c) to conform to federal requirements.

**M440.34
Transfers
Involving
Annuities**

Makes subsection (a) consistent with changes to M232.4 made in response to public comment.

Clarifies subsection (b) to specify more explicitly when transfer penalties apply to annuities and makes the department's valuation of annuities consistent with the transfer of other income-producing resources. This provision was clarified significantly following public comment referring to guidance in section 3258.9 of the state Medicaid manual.

**M900
Long-term Care
Institutions**

Clarifies the relationship between DCF regulations and DAIL regulations concerning long-term care covered services.

Rulemaking Process

1. A draft version of these rules was shared with representatives of Vermont Legal Aid, the Council of Vermont Elders, the Disability Law Project, the Long-term Care Ombudsman, the Senior Citizen's Law Project, Area Agencies on Aging, Home Health Care Providers, and Adult Day Services on June 10, 2005 and June 17, 2005.
2. The proposed rule was filed with the Medicaid Advisory Board on June 17, 2005 and presented at its meeting on June 23, 2005.
3. The proposed rule was filed with the Interagency Committee on Administrative Rules (ICAR) on June 23, 2005 and presented at its meeting on July 6, 2005.
4. The proposed rule was filed with the Senate Health and Welfare Committee and House Human Services Committee, as well as the Secretary of State's Office on July 8, 2005. The Office published notice of rulemaking on July 21, 2005 and July 28, 2005.
5. The department posted the proposed rule on its website and notified advocates and members of the private bar involved with Medicaid estate planning of the proposed rule.
6. A public hearing was conducted on Monday August 8, 2005 at 10 a.m., in the Agency of Human Services' Blue Room, DCF, State Office Complex, Waterbury, Vermont. No one attended.
7. Written comments were submitted by August 15, 2005.
8. On August 30, 2005 copies of the final proposed rule were filed with the Secretary of State and the Legislative Committee on Administrative Rules (LCAR).
9. The Health Access Oversight Committee reviewed the rule on September 12, 2005, and voted in support of approval of the rule.
10. On September 21, 2005 LCAR unanimously supported the rule.
11. The department filed the final rule on September 22, 2005.

Responses to Public Comments

The department received comments from one private attorney and three Vermont Legal Aid offices: the Office of Health Care Ombudsman, the Vermont Coalition for Disability Rights, and the Senior Citizens Law Project on behalf of itself and the Community of Vermont Elders.

Working People With Disabilities - M200.24(b)

Comment: Rule M200.24(b) should track the statute and add a disregard for assets attributable to earnings made after enrollment in working people with disabilities coverage group.

Response: This resource disregard has been in place since the coverage group was first enacted in 1999. Rule M200.24(b) describes the requirement for enrollment in the optional categorical eligibility group. Rule M232.88 remains unchanged and reflects the resource disregard for this group.

Annuities - M232.4, M233.21

Comment: To be consistent with the characterization of annuities in the POMS, the department should refer to annuities as resources that do not count rather than as “excluded”.

Response: The department has made this change. Since financial eligibility for SSI-related Medicaid cannot be more restrictive than rules for the supplemental security income (SSI) program, the department agrees that the SSI Program Operations Manual System (POMS) offers helpful guidance when construing SSI regulations.

Comment: Rather than require annuities to equal the life expectancy of the annuitant, Rule M233.21 should provide that annuities may not exceed the annuitant’s life expectancy.

Response: The department has made this change as it is consistent with guidance in the state Medicaid manual section 3258.9.

Comment: The department’s annuities rule which requires that no one may benefit from an annuity except the applicant or spouse is consistent with federal policy governing the Medicaid program. In a case that went to fair hearing, the department has taken a position that is more restrictive than this.

Response: The department appreciates the acknowledgment that this aspect of its annuities regulation is consistent with federal policy. The department is not at liberty to comment about a case under the fair hearing process. The fair hearing process is one of the remedies available to beneficiaries who wish to contest the department’s interpretations of rules as inconsistent with state or federal law.

Comment: Since the updated annuities regulation is more restrictive than the existing annuities rule, the department should add a grandfathering provision for annuities established in reliance under old rule.

Response: The department has added a grandfathering provision to the final proposed rule M232.4(b).

Resource Disregard for Certain Individuals Served by Choices for Care - M232.99

Comment: The rule should permit individuals to retain this higher resource disregard if they require nursing home care on a temporary basis.

Response: The final proposed rule has been clarified significantly. It specifies that the resource disregard applies following admission to a nursing facility until the next review of financial eligibility.

Comment: The higher resource disregard of \$3,000 for single individuals who own their own homes and choose home-based services allowed in M232.99 should be applied to all individuals in nursing homes and receiving enhanced residential care services who meet the home upkeep requirements of Rule M432.2.

Response: The federally approved waiver restricts the resource disregard to single individuals who own their own homes. The waiver request was not extended to individuals in nursing homes or receiving enhanced residential care services because they already have the benefit of the home-upkeep deduction (M432.2). In addition, individuals with spouses have the benefit of the \$95,100 spousal resource allocation (as well as the home-upkeep deduction) when in a nursing facility or receiving enhanced residential care services.

Comment: Since the department is not raising the allowed resource disregard to the full \$10,000 approved in the waiver, we ask the department to exclude \$3,000 plus an amount set aside for specific home improvements and modifications identified by the applicant.

Response: The department has permitted individuals to set aside up to \$7500 in resources for home modifications, pursuant to the requirements in Rule M232.83 (as approved by LCAR on August 25, 2005). DAIL also understands that it would be helpful to extend the resource disregard to \$10,000. In commencing the first program in the nation to offer individuals the choice of home-based services, however, DAIL is balancing the needs of individuals with the responsibility to the budget neutrality requirements of the program as a whole. DAIL requested and obtained flexibility from the federal government to start the resource disregard at \$3,000 and observe the impacts before it determines if the budget can sustain a higher disregard.

Comment: Phasing in the resource disregard increase will be unfair to people who come onto the program early because they will be forced to spenddown to a lower resource level than those who enter later.

Response: Individuals who apply now are entitled to the resource disregard specified at this time. If the resource disregard increases in the future, the increase will apply to all who meet the requirements specified at that time. Until individuals receive benefits from a program, their rights to receipt under specified rules do not vest.

Allowable Transfers Involving Trusts – M440.31

Comment: The last line of section (a) should be deleted because it is more restrictive than federal law.

Response: The department has deleted the phrase “and meets all other requirements for Medicaid eligibility” to render the provision consonant with Title XIX, section 1917 of the Social Security Act.

Transfers involving Annuities – M440.34

Comment: The rules governing treatment of annuities cannot be more burdensome than the rules governing annuities for the SSI program.

Response: The department has made subsection (a) consistent with changes to M232.4 made in response to public comment. It has also clarified subsection (b) to specify more explicitly when transfer penalties apply to annuities and makes the department’s valuation of annuities consistent with the transfer of other income-producing resources.

Financial Eligibility Determinations for Moderate Needs Group Served by Choices for Care

Comment: It would be more efficient and less confusing for the Department for Children and Families to make all the financial eligibility determinations for Choices for Care, including the moderate needs group.

Response: The financial eligibility requirements for the Moderate Needs group are significantly less complex than long-term care financial eligibility determinations for the Highest and High Need coverage groups served by Choices for Care. Both DCF and DAIL have concluded it is simpler and more efficient for DAIL to continue to oversee clinical and financial eligibility for the Moderate Needs group.

* * * * *

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.

Manual Maintenance

<u>Remove</u>		<u>Insert</u>	
M200 TOC P.3	(05-19)	M200 TOC P.3	(05-25)
M200 TOC P.4	(05-19)	M200 TOC P.4	(05-25)
M200	(02-11)	M200	(05-25)
M200.1P.2	(02-11)	M200.1P.2	(05-25)
M200.24	(03-17)	M200.24	(05-25)
M213P.2	(02-11)	M213P.2	(05-25)
M220	(02-11)	M220	(05-25)
M222	(02-11)	M222	(05-25)
M230	(02-11)	M230	(05-25)
M232.4	(05-19)	M232.4	(05-25)
M232.52	(02-11)	M232.52	(05-25)
M232.52 P.2	(02-11)	M232.52 P.2	(05-25)
M232.98	(04-11)	M232.98	(05-25)
M233.11	(02-11)	M233.11	(05-25)
M233.2	(05-19)	M233.2	(05-25)
M242.2	(02-11)	M242.2	(05-25)
M242.2P.3	(02-11)	M242.2 P.3	(05-25)
M431	(02-11)	M431	(05-25)
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M432.2	(02-11)	M432.2	(05-25)
M432.3	(02-11)	M432.3	(05-25)
M440.31	(02-11)	M440.31	(05-25)
M440.32	(02-11)	M440.32	(05-25)
M440.34	(02-11)	M440.34	(05-25)
M900	(83-14)	M900	(05-25)

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M200

M200 SSI-Related Medicaid Eligibility

Individuals who are aged, blind, or disabled (M211) are eligible for Medicaid if they meet the financial and nonfinancial requirements for participation in the Medicaid program. Financial requirements (M220-M223) relate to the availability of resources (M230-M239) and income (M240-M249). Nonfinancial requirements include general requirements for Medicaid participation (M100-M199), the criteria for one of the coverage groups identified in M200.2-M200.4, citizenship (M212), Vermont residency (M213), and living arrangement (M214). The coverage groups include the categorically needy groups described beginning with rule M200.2, the medically needy group described at rule M200.3, and the Medicare cost-sharing groups described beginning with rule M200.4.

M200.1 Definitions

This section defines terms used throughout M200-M299.

- (a) Community Medicaid means Medicaid services other than long-term care.
- (b) Community spouse (CS) means the spouse of an institutionalized individual who is not living in a medical institution or a nursing facility. A person is considered a community spouse even when receiving waiver services if that person is the spouse of an individual who is receiving long-term care.
- (c) Coverage group refers to individuals who meet the specific financial and nonfinancial requirements of eligibility for Medicaid payment of particular medical services.
- (d) Financial responsibility group means the people whose income and resources are considered when determining eligibility for a Medicaid group.
- (e) Institutionalized individual means a person requesting Medicaid coverage for long-term care, whether the care is received at home in the community pursuant to a waiver or in a long-term care facility licensed by the Department of Disabilities, Aging and Independent Living.
- (f) Institutionalized spouse (IS) means an institutionalized individual whose spouse qualifies as a community spouse.
- (g) Long-term care means level I and level II care, as determined by the licensing division of the Department of Disabilities, Aging and Independent Living received by people living in nursing facilities, rehabilitation centers, intermediate care facilities for the mentally retarded (ICF-MR), and other medical facilities for more than 30 consecutive days. It also includes waiver and hospice services.

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M200-M299 SSI-Related Medicaid Eligibility**M200.1** Definitions (Continued)

- (h) Medicaid group means one of two kinds of groups in SSI-related Medicaid: or spouses where at least one spouse is aged, blind or disabled, or an aged, blind or disabled individual with no spouse. The countable income and resources of the financial responsibility group are compared against the income and resource standards applicable to the Medicaid group's size.
- (i) Medicaid services means medical services funded through Medicaid. They include Medicaid services (M500-M899), long-term care (M900-M999), and services defined in the Department for Disabilities, Aging and Independent Living Choices for Care regulations.
- (j) SSI-related Medicaid means health care coverage available to members of the Medicaid group who are aged, blind, or disabled and pass financial and nonfinancial eligibility criteria for Medicaid. SSI-related Medicaid is based on two financial assistance programs federally administered by the Social Security Administration: the supplemental security income program (SSI) and aid to the aged, blind and disabled program (AABD).
- (k) Waiver services means specialized medical services approved under an exception to standard Medicaid rules for a specific population.

It includes certain services administered by the Department of Disabilities, Aging and Independent Living (DAIL):

- home-based and enhanced residential care services for the aged and disabled (known as "Choices for Care"),
- traumatic brain injury services (TBI waiver), and
- home-and-community-based waiver services for the developmentally disabled (DS waiver).

It also includes services administered by the Vermont Department of Health's Division of Mental Health (VDH):

- children's mental health waiver services.

DCF determines financial and nonfinancial eligibility, other than disability, for these services. DCF, through the disability determination services unit determines whether individuals are blind or disabled according to the criteria in rule M211.2-M211.4, except as stated below.

- (i) When DAIL administers the waiver services, it determines whether applicants need the level of care provided in a nursing facility, an intermediate care facility for the mentally retarded, or out-of-state rehabilitation facility qualified to serve persons with a traumatic brain injury. For the TBI and DS waivers, DAIL also determines whether applicants meet the disability criteria.
- (ii) When VDH administers the waiver services, it determines whether, if waiver services were not available, children under age 22 need the level of care provided in an inpatient psychiatric facility for children.

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M200.24

M200.2 SSI-Related Categorically Needy Coverage Groups (Continued)

M200.24 SSI-Related Medicaid Coverage Groups Open to New Aged, Blind, or Disabled Applicants

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

- (a) Breast or cervical cancer - Women found to have breast or cervical cancer, including precancerous conditions, screened through the National Breast and Cervical Cancer Early Detection Program and who:

are under age 65;
uninsured; and
otherwise not eligible for SSI-related or ANFC-related Medicaid.

Coverage under this category begins following the screening and diagnosis and continues as long as a treating health professional verifies the woman is in need of cancer treatment services.

- (b) Working people with disabilities - Individuals with disabilities who are working and otherwise eligible for SSI-related Medicaid and whose:

resources at the time of enrollment in the group do not exceed \$5,000 for an individual and \$6,000.00 for a couple (see M232.88 for resource exclusion after enrollment);

income is below 250 percent of the federal poverty level (FPL) associated with the applicable family size;

income does not exceed either the Medicaid protected income level for one or the SSI/AABD payment level for two, whichever is higher, after disregarding the earnings, social security disability insurance benefits (SSDI), and any veteran's disability benefits of the individual working with disabilities; and

earnings are documented by evidence of Federal Insurance Contributions Act tax payments, Self-employment Contributions Act tax payments, or a written business plan approved and supported by a third-party investor or funding source;

Earnings, SSDI, and veteran's disability benefits are not disregarded for applicants with spenddown requirements who do not meet all of the above requirements and seek coverage under the medically needy coverage group (M200.3).

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M213 P.2

M213 State Residence (Continued)

5. For any institutionalized individual age 21 or older and who became incapable of stating intent at or after age 21, residence is in the state in which the individual is physically present, unless another state arranged for the individual's placement in a Vermont institution. (See M213.2).
6. For any other institutionalized individual age 21 or older, residence is in the state where the individual is living with the intention to remain there permanently or for an indefinite period, unless another state has made a placement (see rule M213.2). An institutionalized individual cannot be considered a Vermont resident if the individual owns a home (see rule M232.11) in another state which the individual intends to return to even if the likelihood of return is apparently nil.
7. For a blind or disabled child of a parent in the Armed Forces whose SSI eligibility continues even though he/she moves overseas, Vermont Medicaid does not continue and, in addition, the child is no longer eligible for the State Supplement (AABD) to SSI.

M213.1 Temporary Absences from the State

Temporary absences from Vermont for any of the following purposes do not interrupt or end Vermont residence:

- (1) visiting,
- (2) obtaining necessary medical care,
- (3) obtaining education or training under a program of Vocational Rehabilitation, Work Incentive or higher education program, or
- (4) residence in a long-term care facility in another state, if arranged by an agent of the State of Vermont, unless the individual or his/her parents or guardian, as applicable, state intent to abandon Vermont residence and to reside outside Vermont upon discharge from long-term care.

M213.2 Individuals Placed in Vermont Institutions by Out-of-State Agencies

When an agent of another state arranges for an individual's placement in a Vermont institution, the individual remains a resident of the state which made the placement, irrespective of the individual's intent.

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M220

M220 Financial Eligibility for SSI-Related Medicaid

Individuals requesting SSI-related Medicaid must meet the nonfinancial requirements of citizenship, residence, living arrangement, and relationship to SSI/AABD specified in sections M210-M219. The department then determines whether the person requesting Medicaid meets the financial requirements specified in sections M220-M299 and M400-M499. This includes financial eligibility determinations for Medicaid waiver programs operated by the Vermont Department of Health's Division of Mental Health (VDH) and the Department of Disabilities, Aging and Independent Living (DAIL), except that VDH determines patient share costs for children eligible under its waiver program and DAIL determines patient share costs for individuals enrolled in the home-and-community-based waiver for the developmentally disabled.

To determine an individual's eligibility for SSI-related Medicaid, the department compares countable income and resources of the individual's financial responsibility group to maximums based on the size of the individual's Medicaid group. The first step in determining financial eligibility is to identify which individuals are members of the financial responsibility group and which are members of the Medicaid group. Aged, blind, or disabled persons requesting SSI-related Medicaid are always members of both groups.

The rules for forming the SSI-related Medicaid group and financial responsibility group are specified in M221 and M222.

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M222

M222 Formation of the SSI-Related Medicaid Group

The SSI-related Medicaid group consists of individuals whose needs are included in the financial eligibility determination for SSI-related Medicaid. The following subsections set forth the rules for determining membership in the Medicaid group. The department compares countable income and resources of the financial responsibility group to maximums based on the size of the Medicaid group.

M222.1 SSI-Related Medicaid Groups for Single Adults

The department treats a single adult requesting SSI-related Medicaid, including long-term care, as a Medicaid group of one.

M222.2 SSI-Related Medicaid Groups for Adults with Spouses

When two spouses are living together, the department considers both the individual requesting Medicaid and the individual's spouse members of the individual's SSI-related Medicaid group, a Medicaid group of two, unless one of the exceptions specified in M222.21 applies. This is true whether or not the spouse is also requesting Medicaid.

A couple is also considered living together in any of the following circumstances:

- (a) until the first day of the month following the calendar month of death or separation, when one spouse dies or the couple separates;
- (b) when the number of days one spouse is expected to receive long-term care services, including waiver and hospice services, is fewer than 30 days; and
- (c) when the department assesses and allocates the resources of the couple as of the date of application for Medicaid coverage of long-term care services, including waiver and hospice services.

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M230

M230 Overview of SSI-Related Medicaid Resource Requirements

This section gives an overview of resource requirements. Resources are available cash or other property owned by individuals and available for their support and maintenance. Resources are treated in different ways depending on the rules of the coverage group involved (M200.2-M200.4) and the type and liquidity of the resource (M231). All resources of the members of the financial responsibility group must be counted except those specifically excluded (M232). Resources are counted only if group members have the right, authority, or power to liquidate a resource or their share of the resource.

Resources are counted based upon their availability and the ease with which an item can be converted into cash. Availability is often affected when more than one person has an ownership interest in the same resource.

The department considers equity value as well as availability when determining the amount of a resource that counts (M233). Equity value means the price an item can be reasonably expected to sell for on the local open market minus any encumbrances.

Resource limits vary depending on the type of category and services and size of the Medicaid group. Resource eligibility for each coverage group is determined by comparing the resources of the financial responsibility group to the resource limit based on the size of the Medicaid group. Resource maximums are specified at P-2420 in the Medicaid procedures manual.

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

(a) Annuities

The department does not count as a resource annuities that can not be cashed or sold (annuitized or irrevocable annuities) and meet the criteria in (i) (A) through (E) below. Annuities in their accumulation phase may be liquidated or sold and are a countable resource under M233.21. Annuities that do not meet the criteria below or are not countable under M233.21 are evaluated for whether they are subject to a transfer penalty, under M440.34.

- (i) Annuities that can not be cashed are not a countable resource if they:
 - (A) have no beneficiary other than an individual requesting Medicaid or his or her spouse; and
 - (B) provide for payments to applicants or their spouses in equal intervals and equal amounts; and
 - (C) do not exceed the life expectancy of the applicants or their spouses, as determined by the department; and
 - (D) 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
 - (E) do not pay anyone other than the applicant, the applicant's spouse, even if the applicant or spouse dies before the payment period ends.
- (ii) The department will also consider an annuity to meet the requirements of subsections (A) and (E) above, if the owner of the annuity elects to designate Vermont Medicaid as the primary beneficiary up to the amount of long-term care payments it made, and names a contingent beneficiary other than the applicant or spouse to receive any surplus after Vermont Medicaid is paid.
- (iii) For applications filed before September 15, 2005, the department does not count annuities regardless if revocable or in the accumulation phase if either:
 - (A) purchased more than 36 months before the date of application; or
 - (B) purchased less than 36 months before the date of application and meet criteria (i)(A) through (E) above.

(b) Promissory Notes and Other Income Producing Resources

The department does not count as a resource promissory notes and similar resources that produce income if:

- (i) they meet the requirements in subsection (a)(i)(A) through (E) above, or
- (ii) the individual owned a nonnegotiable or nonassignable promissory note executed before September 1, 2005 and 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, as determined by the department.

All other promissory notes and similar resources that produce income are evaluated for whether they are a countable resource as specified in M233.25 or subject to a transfer penalty as specified in M440.36. Notes and similar income-producing resources that do not meet the criteria at M232.4 and are determined to have fair market value shall be considered either as an available resource, or subject to a transfer penalty, in the discretion of the department.

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M232.52

M232 Excluded Resources (Continued)M232.52 Excluded Trusts

In general, the department excludes trusts as a resource to individuals who cannot revoke the trust or receive trust property, whether or not the trustee exercises his or her full discretion. Trust property is also excluded as a resource when the grantor is a member of the financial responsibility group and established a testamentary trust, also known as establishing a trust by will.

The following trust property is excluded as a resource when either the grantor or the grantee is a member of the financial responsibility group:

- (a) trust property in a trust established prior to April 7, 1986, for the sole benefit of a mentally retarded person residing in an ICF-MR;
- (b) trust property in a trust for which the grantee is a disabled child under Sullivan v. Zebley, 493 U.S. 521 (1990);
- (c) trust property or any portion of the trust property that cannot be made available to the member of the financial responsibility group, either through full exercise of the trustee's discretion under the terms of the trust or through revocation of the trust by a member of the financial responsibility group;
- (d) trust property in a trust (known as third-party or supplemental needs trusts) established by persons other than the individual or spouse are excluded unless the terms of the trust permit the individual to revoke the trust or to have access to it without trustee intervention;
- (e) irrevocable trusts, including homes placed in irrevocable trusts by institutionalized individuals who intend to return to them, from which no payment under any circumstances could be made to the individual; or
- (f) special needs trusts or pooled trusts that meet the following requirements:
 - (i) The special needs trust names a beneficiary under the age of 65 and meets all the criteria below in section M232.52(f)(iii).
 - (ii) The pooled trust was established and managed by a nonprofit association, a separate account is maintained for each beneficiary of the trust, and it meets all the criteria below in section M232.52(f)(iii).

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M232 Excluded ResourcesM232.52 Excluded Trusts (Continued)

(iii) The special needs or pooled trust:

- (A) contains the assets of a disabled individual;
- (B) was established by a parent, grandparent, or legal guardian of the individual or by a court;
- (C) was established for the sole benefit of the beneficiary, which means that no individual or entity except the disabled beneficiary can benefit from the trust in any way, until after the death of the beneficiary and then not before the department receives sums owed under the payback provision; and
- (D) includes a payback provision which requires that, upon the death of the beneficiary, any amounts remaining in the trust will first be paid to the department in an amount equal to the total Medicaid payments made on behalf of the individual.

In the case of a trust with more than one grantor, these exclusions apply only to that portion of the trust attributable to the income or resources of a member of the financial responsibility group. In the case of a trust with more than one grantee, the exclusions apply only to that portion of the trust available for the benefit of a member of the financial responsibility group.

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M232.98

M232 Excluded Resources (Continued)M232.98 Stocks, Bonds, Mutual Funds, and Money Market Accounts

(a) Definition

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.

(b) Exclusion

Savings bonds are excluded during their minimum retention period if individuals have requested a hardship waiver based on financial need due to medical expenses and received a denial from the United States Department of the Treasury, Bureau of Public Debt, Accrual Services Division in Parkersburg, P.O. Box 1328, Parkersburg, West Virginia 26106-1328.

Upon verification of a denial of a hardship waiver, as described above, the department considers United States savings bonds owned by one or more individuals an available resource following the expiration of the minimum retention period. Once the minimum retention period expires, the denial of a hardship waiver is not a basis for exclusion of new bond purchases or other excluded assets purchased with the proceeds.

Savings bonds purchased before June 15, 2004 that have their minimum retention period expire after that date, continue to be an excluded resource if they are not redeemed, exchanged, surrendered, reissued, used to purchase or fund other excluded assets, or otherwise become available.

M232.99 Resource Disregard for Certain Individuals Receiving Home-Based Long-term Care

Single individuals who qualify for SSI-related Medicaid are permitted to retain the standard \$2,000 resource allowance. An additional resource disregard of \$3,000 is allowed for aged and disabled individuals without a spouse who reside in and have an ownership interest in their principal place of residence and choose home-based long-term care services (M200.1(k), M232.11), provided all other eligibility criteria are met.

The resource disregard remains available until the recipient is admitted to a nursing facility or receives enhanced residential care services. Thereafter, those who meet the requirements of the home upkeep deduction (M432.2) are eligible to continue the resource disregard for up to 6 months.

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M233.11

M233 Value of Resources Counted Toward the Medicaid Resource Limit (Continued)M233.11 Tenancy in Common

Tenancy in common applies to all jointly owned resources when title to the resource does not specify joint tenancy or tenants by the entirety.

Tenancy in common means that each party has a portion of interest that may not be equal. In tenancy in common, two or more persons each have an interest, which may not be equal, in the whole property for the duration of the tenancy. Co-owners may sell, transfer, or otherwise dispose of their respective shares of the property without permission of other owners but cannot take these actions with respect to the entire property. When a tenant in common dies, a surviving tenant has no automatic survivorship rights to the deceased's ownership interest in the property. Upon a tenant's death, the deceased's interest passes to his or her estate or heirs.

When one or more members of the financial responsibility group (M221) own a resource as tenants in common with one or more persons who are not members of the financial responsibility group, the department counts the resource depending on its classification as either a nonliquid resource (M231.1) or a liquid resource (M231.2).

(a) Nonliquid Resources

The department divides the total value of the property among the total number of owners in direct proportion to the ownership interest held by each.

(b) Liquid Resources

Unless otherwise excluded (M232.7), the department counts the entire equity value of funds held in an account in a financial institution. The department considers that the entire equity value is available to the members of the financial responsibility group who own the account.

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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 under M232.4 or treated as a transfer under M440.34, the department counts the fair market value of annuities, as defined in section M231.24 as well as those that may be cashed or sold.

The fair market 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 to the beneficiary. 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. The life estate table is found in the Medicaid Procedures Manual. 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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M242.2

M242 Income Exclusions (Continued)M242.2 Unearned Income Exclusions

Unearned income exclusions are limited to the following items.

- (a) Expenses incurred as a condition of receiving the unearned income. For example, guardianship fees may be deducted if having a guardian is a requirement for receiving the income or attorney fees, and court costs may be deducted if they were incurred in order to establish a right to the income.
- (b) Certain Veteran's Administration payments:
 - (i) portion of pension or compensation payment for aid and attendance and housebound allowances, even when the provider is a spouse or a parent;
 - (ii) augmented portion of pensions, compensation or other benefits for a dependent of a veteran or veteran's spouse;
 - (iii) \$20 from educational benefits to the veteran funded by the government;
 - (iv) educational benefits paid as either part of a plan of vocational rehabilitation or by withdrawals from the veteran's own educational fund;
 - (v) clothing allowance; and
 - (vi) payment adjustments for unusual medical expenses
- (c) Ordinary and necessary expenses of rental property and other capital investments except depreciation or depletion of property. This includes but is not limited to interest on debts, state and local taxes. The expenses of managing or maintaining the property, as of the date the expense is paid, are deductible.
- (d) Infrequent or irregular payments of interest and dividends, up to \$20.00 per month.
- (e) Royalties that represent self-employment earnings from a royalty-related trade or business.

Medical care and services or social services provided in cash or in-kind, including vocational rehabilitation and payment of medical insurance premiums by a third party.

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M242.2 P.3

M242 Income ExclusionsM242.2 Unearned Income Exclusions (Continued)

- (w) Assistance provided in cash or in kind (including food, clothing, or shelter) under a government program that provides medical care or services (including vocational rehabilitation).
- (x) That portion of a benefit intended to cover the financial need of other individuals, such as AABD-EP grants.
- (y) Retroactive payments of federal SSI, the AABD supplement to SSI or Old Age and Survivor and Disability Insurance (OASDI) benefits if the payments were included in determining financial eligibility for Medicaid in the month it was actually owed to the individual.
- (z) Home energy assistance provided by a private nonprofit organization or a regulated supplier of home energy.
- (aa) State-administered victims' compensation payments.
- (bb) State or local government relocation payments.
- (cc) Payments occasioned by the death of another person to the extent that they are used to pay for the deceased person's last illness and burial, including gifts and inheritances.
- (dd) Payments occasioned by the death of another person to the extent that they are used to pay for the deceased person's last illness and burial, including gifts and inheritances.
- (ee) Earned Income Tax Credit payments (both refunds and advance payments).
- (ff) Cash received as the beneficiary of a life insurance policy minus any expenses incurred, up to a maximum of \$1,500 set aside to pay for the cost of the insured individual's last illness and burial.
- (gg) Social security disability insurance benefits (SSDI) and veteran's disability benefits provided to working disabled persons when determining categorically needy eligibility, specified in M200.24(b).
- (hh) Income from reverse mortgages is not counted as income to that individual.
- (ii) Dividends paid on life insurance policies, excluding interest.
- (jj) Payments made to a supplemental needs trust.
- (kk) Exclusions based on federal law as set forth in M232.89.

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M431

M431 Determining Residence Period for Long-Term Care

The department assesses a patient share obligation in the month of admission to long-term care as long as the individual is expected to remain in long-term care for at least 30 consecutive days. If long-term care is expected to be needed for fewer than 30 consecutive days, the department does not assess any patient share. Instead, the department covers these services through community Medicaid or VHAP Managed Care, if the individual meets those eligibility rules.

(a) Beginning of long-term care residence period in a general hospital setting

The long-term care residence period in a general hospital setting begins with the first day that the utilization review committee finds acute hospital care is no longer medically necessary and skilled nursing care is medically necessary.

(b) Beginning of long-term care residence period in other long-term care settings

The long-term care residence period in long-term care settings, other than a general hospital, begins with the first day that the utilization review committee finds medical need for long-term care or the date of admission, whatever is later.

(c) Ending of long-term care residence period

A long-term care residence period ends with the earliest of the date of death; the date of discharge from a long-term care living arrangement (see rule M401.2); or the last day medical need for long-term care is established by utilization review committee.

A long-term care residence period is not ended by a leave of absence from the current setting (see rule M930.1). A long-term care residence period also continues despite transfer from either:

- one long-term care setting to another long-term care setting;
- a general hospital setting (where skilled nursing care has been continuously authorized while awaiting transfer) to another long-term care setting; or
- a long-term care setting to a general hospital setting followed by return to the long-term care setting without an intervening residence period in a community living arrangement (see rule 401.1).

M431.1 Determining the Percentage of the Month the Individual was in Long-Term Care

Determine the percentage of the month individuals were in long-term care using the appropriate table below.

All Months Except February

Day of the month admitted to long-term care	Percentage of month in long-term care	Day of the month admitted to long-term care	Percentage of month in long-term care	Day of the month admitted to long-term care	Percentage of month in long-term care
1	100%	11	67%	21	33%
2	97%	12	63%	22	30%
3	93%	13	60%	23	27%
4	90%	14	57%	24	23%
5	87%	15	53%	25	20%
6	83%	16	50%	26	17%
7	80%	17	47%	27	13%
8	77%	18	43%	28	10%
9	73%	19	40%	29	7%
10	70%	20	37%	30-31	3%

February

Day of the month admitted to long-term care	Percentage of month in long-term care	Day of the month admitted to long-term care	Percentage of month in long-term care	Day of the month admitted to long-term care	Percentage of month in long-term care
1	100%	11	64%	21	29%
2	96%	12	61%	22	25%
3	93%	13	57%	23	21%
4	89%	14	54%	24	18%
5	86%	15	50%	25	14%
6	82%	16	46%	26	11%
7	79%	17	43%	27	7%
8	75%	18	39%	28	4%
9	71%	19	36%	29	0%
10	68%	20	32%		

M431.2 Determining the Maximum Patient Share

To determine the maximum patient share, the department considers the individual's gross income less allowable deductions as specified in M432. This is the most that a long-term care recipient is obliged to pay toward the cost of long-term care. If an individual was in long-term care for less than a full month, multiply the maximum patient share by the applicable percentage in the table in M431.1.

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M432.2

M432 Deductions from Patient Share (Continued)

M432.2 Home Upkeep Deduction

The department deducts expenses from the monthly income of an individuals receiving long-term care and living in a nursing facility or receiving enhanced residential care (ERC) services to help maintain their owned or rented home in the community for three months, renewable for up to an additional three months. It is available for each separate admission to long-term care, as long as the criteria listed below are met. The home upkeep standard deduction equals three-fourths of the SSI/AABD payment level for a single individual living in the community.

The department grants the deduction when the Medicaid group has income equal to or greater than the standard home upkeep deduction and the Medicaid group has income greater than the personal needs allowance (PNA). Individuals who have less income than the standard home upkeep deduction may deduct an amount for home upkeep equal to the difference between the individual's income and the personal needs allowance.

This deduction may be applied at any point during the institutionalization as long as all criteria for the deduction are met:

- (a) no one resides in the long-term care beneficiary's home and receives an allocation as a community spouse or other eligible family member; and
- (b) the beneficiary submits a doctor's statement before each three-month deduction period, stating that the beneficiary is expected to be discharged from the institution within six months of the admission date and to return home immediately after discharge.

If the situation changes during this six-month period, the Medicaid group's eligibility for the home upkeep deduction must be redetermined. The department will deny or end the deduction when:

- the home is sold or rented,
- rented quarters are given up, or
- the individual's health requires the long-term care admission period to last longer than six months.

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M432.3

M432 Deductions from Patient Share (Continued)

M432.3 Allocation to Family Members

The department allows individuals to allocate their income to certain family members as described in the following subsections.

M432.31 Allocation to Community Spouse

The department may deduct a community spouse income allocation for the needs of spouses living in the community (community spouse) from the incomes of individuals receiving long-term care, including waiver and hospice services, (institutionalized spouse). The term community spouse applies to the spouse of an individual receiving long-term care services, even if the community spouse is also receiving waiver or hospice services. When one spouse in a nursing facility and the other is receiving waiver services, the waiver spouse may receive an allocation. When both spouses are receiving waiver services, either may allocate to the other.

Institutionalized spouses may allocate less than the full amount to their community spouse or may allocate nothing. The allocation is reduced by the gross income, if any, of the community spouse. Community spouses, as well as institutionalized spouses, have a right to request a fair hearing on the amount of the income allocation.

The standard community spouse income allocation equals 150 percent of the federal poverty level for two. The actual community spouse income allocation equals the standard community spouse allocation plus any amount by which actual shelter expenses exceed the standard allocation, up to the maximum. The maximum community spouse income allocation equals a maximum provided by the federal government each year by November 1.

The department applies the following presumptions to ownership of income when determining the community spouse allocation, unless an institutionalized spouse establishes by a preponderance of the evidence that the ownership interests in income are other than as follows:

- income paid in the name of the spouse is considered available only to the named spouse;
- income paid in the name of both spouses is considered available in equal shares to each;
- income paid in the name of either spouse and any other person is considered available to that spouse in proportion to his or her ownership interest;
- income paid in the name of both spouses and any other person is considered available to each spouse in an amount of one-half of the joint interest.

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M440.31

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

M440.31 Allowable Transfers Involving Trusts for Less than Fair Market Value

The department does not impose a penalty period for transfers involving trusts that meet one or more of the following criteria.

- (a) The income or resources were transferred to an irrevocable trust that does not under any circumstances allow disbursements to or for the benefit of the individual, and the date of the transfer was more than 60 calendar months prior to the first month in which the applicant or recipient requests Medicaid coverage of long-term care expenses.
- (b) The action that constituted the transfer was the establishment of a trust solely for the benefit of a person under age 65 who is blind or permanently and totally disabled, specified at M232.52(f).
- (c) The action that constituted the transfer was the establishment of a pooled trust, specified at M232.52(f).
- (d) The action that constituted the transfer was the establishment of a revocable trust. Payments from the trust to anyone other than the individual are considered a transfer for less than fair market value and are subject to penalty unless the payments are for the benefit of the individual.

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M440.32

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

M440.32 Allowable Transfers of Homes to Family Members for Less than Fair Market Value

The department does not impose a penalty period for transfer of a home that meets the definition at M232.11, provided that title was transferred by a member of the financial responsibility group to one or more of the following persons:

- (a) the member's spouse;
- (b) the member's child who was under age 21 on the date of the transfer;
- (c) a son or daughter who is blind or permanently and totally disabled, regardless of age;
- (d) the brother or sister of the member requesting coverage of long-term care expenses, when the brother or sister had an equity interest in the home on the date of the transfer and was residing in the home continuously for at least one year immediately prior to the date the person began to receive long-term care services, including waiver and hospice services; or
- (e) the son or daughter of the member requesting coverage of long-term care expenses, provided that the son or daughter was residing in the home continuously for at least two years immediately prior to the date the parent began to receive long-term care services, including waiver and hospice services and provided care to the parent during part or all of this period that allowed the parent to postpone receipt of long-term care services, including waiver and hospice services.

M440.33 Other Allowable Transfers to Family Members for Less than Fair Market Value

The department does not impose a penalty period for transfers that meet any of the following criteria.

- (a) The transfer was for the sole benefit of the individual requesting coverage for long-term care services, including waiver and hospice services.
- (b) The income or resource was transferred by an institutionalized spouse to the community spouse before the initial determination of the institutionalized spouse's eligibility for long-term care coverage. This also applies to a transfer made to a third party for the sole benefit of the community spouse.
- (c) The income or resource was transferred to a son or daughter who is blind or permanently and totally disabled or to a trust for the sole benefit of a son or daughter who is blind or permanently and totally disabled, regardless of age.

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M440.34

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

M440.34 Transfers involving Annuities

(a) Allowable Transfers

The department does not impose a penalty for the purchase of an annuity when the provisions of M232.4 or M233.21 apply.

(b) Impermissible Transfers

Annuities that do not meet the criteria in M232.4 and are determined to have no value on the open market shall be assessed a transfer penalty based on their fair market value. The fair market value equals the amount of money used to establish the annuity and any additional amounts used to fund the annuity, plus any earnings and minus any early withdrawals and surrender fees.

Annuities that do not meet the criteria in M232.4 and are determined to have full fair market value or a discounted value shall be considered either as an available resource or subject to a transfer penalty, in the discretion of the department.

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M900

M900 Long-Term Care Institutions

These regulations apply to long-term care. Regulations promulgated by the Department of Disabilities, Aging and Independent Living (DAIL) serving aged and disabled individuals through the “Choices for Care: Long-Term Care Medicaid Waiver” (Social Security Act Section 1115 Demonstration Project Number 11-W-00191/1) shall control to the extent they are inconsistent with the provisions in the M900s chapter, including: M902, M940.2, M940.5, M940.6, M940.7, M950.1, M950.2, and M960.1.

M901 Definitions

The Medicaid Program (Title XIX) includes vendor payments for long-term care of eligible recipients in:

Skilled Nursing Facilities (SNF's)

An out-of-state SNF participating in that State's Medicaid Program or a facility (or distinct part of a facility) licensed by the Vermont Department of Health, and which pursuant to Section 1910(2) of the Social Security Act, has been certified for participation in Medicare, or if not participating in Medicare, has been continuously certified since July 1, 1980 for participation as an SNF as evidenced by a valid certification agreement on file with the Department of Social Welfare. An SNF provides, directly or by contract, room, board, skilled nursing and rehabilitation services on a 24-hour a day basis to assist patients to reach their optimal level of functioning.

Intermediate Care Facilities (ICF's)

A facility (or distinct part of a facility) which is licensed by the Vermont Department of Health and certified for participation in the Vermont Medicaid Program (or an out-of-state facility participating in that state's Medicaid Program) for the provision of Intermediate Care Facility (ICF) services as evidenced (for in-state facilities) by a valid certification agreement on file with the Department of Social Welfare executed under Section 1902(a)(27) of the Social Security Act and 42 CFR 442, Subparts A, B, C, E and F. An ICF provides directly or by contract, health related care and services to individuals who do not require the degree of care and treatment that an SNF is designed to provide but who do require care above the level of room and board that can be made available only in institutional facilities.

Intermediate Care Facilities for the Mentally Retarded (ICF-MR's)

A public institution (or distinct part thereof) which is licensed by the Vermont Department of Health and certified for participation in the Vermont Medicaid Program for the provision of Intermediate Care Facility services for the Mentally Retarded (ICF-MR) as evidenced by a valid certification agreement on file with the Department of Social Welfare executed under 1902(a)(27) of the Social Security Act and 42 CFR 442, Subparts A, B, C, E and G. An ICF-MR provides directly or by contract, health related care and services to mentally retarded individuals who do not require the degree of care and treatment that an SNF is designed to provide but who do require care above the level of room and board that can be made available only in institutional facilities.