

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

DCF

Department for Children and Families

BULLETIN NO.: 06-46F

FROM: Joseph Patrissi, Deputy Commissioner
Economic Services Division

DATE: January 17, 2007

SUBJECT: Deficit Reduction Act of 2005 - New federal requirements applicable to determining financial eligibility for Medicaid payment of long-term care.

CHANGES ADOPTED EFFECTIVE: February 1, 2007

INSTRUCTIONS:

Maintain Manual - See instructions below.
 Proposed Regulation - Retain bulletin and attachments until you receive Manual Maintenance Bulletin: 06-46F
 Information or Instructions - Retain until _____

MANUAL REFERENCE(S):

M159.24	M232.4	M432.2	M440.34
M200	M232.85	M433	M440.36
M200.1	M233.12	M440.21	M440.41
M221.2 –M221.3	M233.26	M440.3	M440.44
M231.24	M234.3	M440.32	
M232.11	M243.4		
M232.2-M232.22			

This bulletin proposes the implementation of new federal requirements. The new federal law is known as the “Deficit Reduction Act of 2005” (DRA). Most provisions went into immediate effect on February 8, 2006. Many are mandatory and impact Medicaid eligibility. Specifically, the DRA makes fundamental alterations to financial eligibility for long-term care Medicaid. These changes are described more fully below.

I.

New Long-term Care Financial Eligibility Requirements

A. Background

The vast majority of these long-term care rule changes are mandatory under federal law. Although many of the provisions were effective upon passage (February 8, 2006), the Vermont Agency of Human Services (agency) anticipated Vermont would be given a reasonable amount of time to implement these changes. Given the significance of the mandates, the agency decided to pursue formal rulemaking in advance of implementation.

The Department for Children and Families (department) prepared and shared its first draft of these rules with interested parties in May 2006. The draft garnered feedback on the proposals and resulted in modifications reflected in this filing. These provisions are a product of conversations with members of the private bar, advocacy organizations, and partners within the agency including the Office of Vermont Health Access, the Department for Disabilities, Aging and Independent Living, and the Assistant Attorneys General. The agency also received formal guidance from the Centers for Medicare and Medicaid Services (CMS) on July 27, 2006, which has been incorporated.

Although long-term care resource standards and methodologies remain unchanged and existing hardship waiver provisions remain, the DRA has changed significant aspects of the transfer of assets provision in the Social Security Act (42 U.S.C. §1396p). While most of the DRA changes are mandated, States have been given flexibility in implementing the provisions related to home equity, undue hardship, and a state long-term care insurance partnership program. Both mandatory and optional changes are described in detail below.

B. Summary of Proposed Rule Changes

The following long-term care rule changes are proposed:

- Prohibiting Medicaid coverage for long-term care services when an individual has *home equity* in excess of \$500,000;
- Imposing a transfer penalty for the purchase of a *life estate* when the individual lives in the residence for less than 12 months after purchase;
- Penalizing transactions involving *annuities and promissory notes* unless specific criteria are met;
- For transfers made on or after February 8, 2006 - commencing the *start date for transfer penalties* on the later of the date of the Medicaid application, or the date of discovery;
- Extending the *look-back period* for transfers subject to penalty from 36 months to 60 months;
- Providing for Medicaid payment of long-term care in cases where imposition of the asset transfer or home equity provisions would result in *undue hardship*; and
- Permitting retention of assets or resources equal to amounts paid under a state qualified *long-term care insurance partnership* policy.

C. Changes to the Transfer of Asset Penalty Treatment for Specific Kinds of Property

Home Equity - M233.26 (implementing DRA Section 6014; 42 USC 1396p(f))

Individuals with an equity interest in their home of greater than \$500,000 (or up to \$750,000 at State option) are ineligible for Medicaid funding of nursing facility and other long-term care services and must pay for these services privately. This provision applies to individuals who are determined eligible for long-term care based on applications filed on or after January 1, 2006. The department is proposing adoption of the \$500,000 equity cap. Its review of the state-wide average and median values of residential and farm property transfers in 2005 and in the first half of 2006 reflect fair market values well below the proposed equity cap.

Life Estates – M440.32 (implementing DRA Section 6016(d); 42 USC 1396p(c)(1)(J))

This provision redefines “assets” to include the purchase of a life estate interest in another individual’s home unless the purchaser resides in the home for at least one year after the date of purchase. It applies to payments made for services given on or after April 1, 2006.

Annuities – M440.21, M440.34 (implementing DRA Section 6012; 42 USC 1396(c)(1)(F)(G))

This section specifies that annuities are considered a transfer subject to penalty unless the State is named as the remainder beneficiary in the first position for at least the total amount of Medicaid expenditures paid or is named as such a beneficiary in the second position after the community spouse and/or minor or disabled child. It applies to transactions (including the purchase of an annuity) made on or after February 8, 2006. In addition, annuities purchased by the institutionalized spouse shall be treated as a disposal of assets for less than fair market value unless they meet specific criteria. Vermont also will require the issuer of the annuity to notify the State when there is a change in the amount of income paid or principal withdrawn from the annuity.

Promissory Notes – M440.36 (implementing DRA Section 6016(c); 42 USC 1396p(c)(1)(I))

This section requires that the definition of “assets” include funds used to purchase a promissory note, loan or mortgage, unless the repayment terms are actuarially sound, provide for payments to be made in equal amounts during the term of the loan and with no deferral or balloon payments, and prohibits the cancellation of the balance upon the death of the lender. In the case of those instruments that do not satisfy these conditions, the value of the instrument will be the outstanding balance due as of the date of the individual’s application for long-term care Medicaid.

Long-term Care Insurance Partnership – M159.24, M232.22 (implementing DRA Section 6021; 42 USC 1396p(b))

This section permits a long-term care Medicaid applicant to have exempted from estate recovery resources or assets equal in value to the benefits paid out to or on the applicant’s behalf under a State qualified long-term care insurance partnership policy, contingent upon passage of changes to 33 V.S.A. 1908a as specified in the rule. The department will also seek CMS approval to allow an applicant to retain resources or assets equal in value to benefits paid out under a State qualified long-term care insurance partnership policy at the time of application for Medicaid payment of long-term care services.

D. Changes to the Transfer of Asset Penalty Process

Penalty Period Start Date – M440.41 (implementing DRA Section 6011(b); 42 USC 1396p(c)(1)(D))

This provision changes the start date of the penalty period for all transfers made on or after February 8, 2006 to the *later* of either:

- the first day of the month during or after which assets have been transferred for less than fair market value, or
- the date on which the individual is otherwise eligible for long-term care Medicaid.

Five Year Look-Back – M440.3 (implementing DRA Section 6011(a); 42 USC 1396p(c)(1)(B))

This change lengthens the look back period for the transfer or disposal of all assets to 60 months (5 years). Most transfers subject to penalty are made within 12 months of the date of application for Medicaid coverage of long-term care. Under prior law, States considered transfers made up to 36 months before a Medicaid application was filed. Under current law, States must consider transfers made on or after February 8, 2006 up to five years. As a practical matter, this lengthening of the look-back period from 36 to 60 months will first impact penalty period calculations for applications filed on or after February 9, 2009. The phase-in will be as follows: in March, 2009 there will be a 36 month lookback and in April, 2009 there will be a 37 month lookback. By March, 2010, there will be a 48 month lookback. By March, 2011 the lookback will be fully phased in at 60 months.

Hardship Waivers – M440.44 (implementing DRA Section 6011(d); 42 USC 1396p(c)(2)(D))

This section requires the department to pay for long-term care Medicaid when imposition of a transfer penalty or home equity provisions would result in undue hardship. States have flexibility in establishing an undue hardship process. At a minimum, the waiver process must provide for notice that an undue hardship exception exists; a timely process for determining whether an undue hardship waiver will be granted; and a process under which an adverse determination can be appealed. The process also must permit a long-term care provider to file hardship requests on behalf of an individual it serves.

Under the DRA, undue hardship exists when application of a transfer of assets or home equity penalty would deprive the individual: of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life. While these criteria and procedural requirements are listed in the statute for the first time, they are the same criteria and procedures CMS provided in state guidance several years ago.

Vermont Medicaid has elected to follow the undue hardship process used by the Social Security Administration in its Supplemental Security Income program (SSI), since SSI financial methodologies are already used in determining financial eligibility for long-term care paid by Medicaid. The proposed undue hardship process also derives from comments the department received on its draft version, guidance CMS sent to states, as well as the department's survey of approaches taken by other states in establishing a hardship process.

E. Other DRA Long-term Care Provisions

The DRA contains other mandates that Vermont (and many other states) previously implemented as state options. For example, Vermont already follows the income-first rule (Vermont rule M432.31; DRA Section 6013; 42 USC 1396r—5(d)). It also aggregates penalty periods and imposes them on the first day of the month following the date of the transfer (Vermont rule M440.42; DRA Section 6016(b); 42 USC 1396p(c)(1)(H)). It has also required the disclosure of annuities (Vermont rules M128, M233.21; DRA Section 6012(a); 42 USC 1396p(e)(1)).

In addition, the DRA gives states the option to make bed-hold payments to facilities on behalf of individuals for whom an undue hardship waiver is pending, but not for more than 30 days. (DRA Section 6011(e)(2); 42 USC 1396p(c)(2)(D)). Vermont is not pursuing this option at this time.

Last, the DRA mandates the treatment of entrance fees for continuing care retirement communities (CCRC). (DRA Section 6015; 42 USC 1396p(g)). Since Vermont has only one CCRC and it is not a Medicaid provider, implementation of this provision is deferred at this time.

II.
Additional Rule Changes

This bulletin also contains other rule changes that make existing rules more explicit and conform our rules to state and federal requirements as described specifically in the table below. In brief, the following changes are proposed:

- Revises the definition of long-term care to reflect terms used under the Choices for Care waiver.
- Clarifies an ambiguity in the definition of a dependent child limiting it to the age of 21; simplifies the definition of an ineligible child.
- Clarifies that financial responsibility of parents ends when a child reaches age 18.
- Deletes inaccurate examples because annuities that have been annuitized or are irrevocable are sometimes able to be sold.
- Makes a technical correction to the grandfathering date of annuities from September 15, 2005 to October 7, 2005.
- Implements a state law change in joint tenancy law as prescribed by 27 VSA §2.
- Clarifies that the home upkeep deduction may be applied at any point during institutionalization.
- Replaces antiquated language with terms used under the Choices for Care waiver.
- Inserts cross-reference to new citizenship rules.

III.
Specific changes

Section	Description of change
M159.24	Implements the long-term care insurance partnership provision permitted by the DRA.
M200	Fixes typographical error; inserts cross-reference to new citizenship rules.
M200.1	Revises the definition of long-term care to reflect terms used under the Choices for Care waiver.
M220.1	Clarifies an ambiguity in the definition of a dependent child limiting it to the age of 21; modifies the formatting of definitions of ineligible child and adults; simplifies the definition of an ineligible child.
M221.2	Clarifies that financial responsibility of parents ends when a child reaches age 18.
M221.3	Adds a cross-reference to rule on Qualifying Quarters of Coverage.
M231.24	The definition of annuities has been added to reflect that private annuities are subject to the annuity rules prescribed by the department.
M232.11	Adds a cross-reference to new DRA home equity provision.
M232.2- M232.22	Seeks to implement the long-term care insurance partnership provision provided by the DRA to an applicant's resources at the time of application for long-term care Medicaid. Renumbers the insurance section to accommodate this proposed additional language.
M232.4	Deletes inaccurate examples. Annuities that have been annuitized or are irrevocable are sometimes able to be sold. Makes a technical correction to the grandfathering date of annuities from September 15, 2005 to October 7, 2005. Clarifies that when an individual names Vermont Medicaid as a beneficiary of an annuity, it must specify that Vermont Medicaid is the beneficiary up to the amount of payments made on behalf of the applicant or spouse.
M232.85	Conforms retirement fund resource exclusion rule to federal law and supplemental security income treatment of retirement funds.
M233.12	Implements state law change in joint tenancy law as prescribed by 27 VSA §2.
M233.26	Implements the new home equity provision mandated by the DRA.
M234.3	Clarifies that financial responsibility of parents ends when a child reaches age 18.
M243.4	Clarifies that financial responsibility of parents ends when a child reaches age 18.
M432.2	Clarifies that the home upkeep deduction may be applied at any point during the institutionalization.

Section	Description of change
M433	Clarifies that patient share payments are owed when they are receiving long-term care Medicaid services.
M433.1	Eliminates antiquated language to reflect terms used under the Choices for Care waiver.
M440.21	Deletes language related to annuities and promissory notes rendered obsolete by the DRA; references new life expectancy tables as prescribed by the DRA.
M440.3	Specifies new look-back period requirement for transfers made on or after February 8, 2006 in subsection (a); amends subsection (d) to eliminate nonessential language; clarifies federally required SSI methodology for treatment of asset transfers in subsection (g).
M440.32	Adds new life estate transfer penalty requirement mandated by the DRA.
M440.34	Harmonizes transfer of asset regulation concerning annuities to DRA mandates.
M440.36	Changes transfer of asset regulation concerning promissory notes and similar resources to the requirements of the DRA.
M440.41	Makes imposition of the penalty date consistent with new DRA requirements.
M440.44	Substantially revises undue hardship regulation to meet the new DRA requirements and to be in accord with SSI methodology.

IV. **Rulemaking Process**

A. Informal Public Input Process

1. On March 9, 2006, the department met and provided the DAIL Advisory Board with an overview of the new long-term care federal mandates.
2. On March 23, 2006, the department met and provided the Medicaid Advisory Board with an overview of the new long-term care federal mandates.
3. On May 16, 2006, the department sent a draft version of its proposed rules implementing the long-term care changes to the following groups and announced two upcoming public discussions and invited review and comments:
 - Adult Day Care providers
 - AHS Field Directors
 - American Association of Retired Persons (AARP)
 - Area Agencies on Aging
 - Assisted Living Providers
 - Community of Vermont Elders (COVE)
 - DAIL Advisory Board
 - Designated Agencies

- Home Health Agencies
 - Legislators (Joint Fiscal Committee, House Appropriations, Senate Appropriations, House Human Services, Senate Health and Welfare, Health Access Oversight, Administrative Rules)
 - Long-term Care Clinical Care Coordinators
 - Long-term Care Eligibility Specialists
 - Medicaid Advisory Board
 - Medicaid planning attorneys in private practice
 - Nursing Home Administrators
 - Probate Court Judges
 - Residential Care Home Providers
 - Vermont Bar Association Elder Law Committee
 - Vermont Coalition for Disability Rights (VCDR)
 - Vermont Council on Independent Living (VCIL)
 - Vermont Legal Aid – Health Care Ombudsman
 - Vermont Legal Aid – Long-term Care Ombudsman
 - Vermont Legal Aid Disability Law Project
4. On May 30, 2006, the department held a public meeting in Springfield, Vermont from 1-4 pm.
 5. On June 1, 2006 the department held a public meeting in Waterbury, Vermont from 1-4 pm.
 6. On June 22, 2006, the department met and provided the Medicaid Advisory Board with a detailed description of the long-term care financial eligibility changes.
 7. The proposed rule was filed with the Medicaid Advisory Board on August 22, 2006 and presented at its meeting on August 31, 2006.
 8. The proposed rule was filed with the Interagency Committee on Administrative Rules (ICAR) on September 8 and presented at its meeting on September 18, 2006.
 9. The proposed rule was filed with the Senate Health and Welfare Committee and House Human Services Committee, Health Access Oversight Committee as well as the Secretary of State's Office on September 22, 2006. The Office published notice of rulemaking on October 5 and October 12, 2006.
 10. In late September, 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.

B. *Formal Notice and Comment Period*

1. A public hearing took place on October 23, 2006 at 1:00 p.m., in the Agency of Human Services' Blue Room, DCF, State Office Complex, Waterbury, Vermont. No one attended.
2. Written comments were submitted by October 30, 2006. The department has responded to the comments as set forth in the next subsection.

3. On November 17, 2006 copies of the final proposed rule were filed with the Secretary of State and the Legislative Committee on Administrative Rules (LCAR).
4. The department presented the rule to the Health Access Oversight Committee on December 12, 2006 and to LCAR on December 13, 2006. It requested an extension of time to confer with advocates in an effort to resolve remaining concerns about the discretionary sections of the rule concerning home equity and undue hardship, as well as to assure that the annuities section complied with amendments made to the DRA on December 9, 2006 by Congress in the Tax Relief and Health Care Act of 2006.
5. The department presented the rule to the Health Access Oversight Committee on January 5, 2007. The committee unanimously endorsed the rule with the following changes, to which the department agreed:
 - a. Add the following text at the end of proposed rule M232.22(b) as follows: “This section is further contingent on the passage of changes to 33 V.S.A. 1908a necessary to bring the Vermont statute on Long-Term Care Partnership Insurance into conformance with the requirements of section 6021 of the federal Deficit Reduction Act of 2005.”
 - b. Delete the provision in the proposed rule related to the use of home equity funds in proposed rule M233.26(d), since members of the committee wanted greater opportunity to consider the policy implications of this recommendation; and
 - c. Combine undue hardship reasons in proposed rule M440.44(c)(6) and (7), since members of the committee thought all transferees should be treated the same, rather than treat relatives differently from other persons (including corporations)
6. The presented the rule to LCAR on January 10, 2007.
7. The department expects to file the final rule no later than January 17, 2007.
8. The rule is expected to be effective on February 1, 2007.

C. Responses to Public Comments

The department received written comments from Vermont Legal Aid’s Senior Citizen’s Law Project, the Community of Vermont Elders (COVE), American Association of Retired Persons (AARP), and the Vermont Chapter of the National Academy of Elder Law Attorneys (VT-NAELA).

Each of the commenters expressed appreciation for the changes made by the department in response to its meetings with them during the informal process leading up to these rules.

As set forth below, the department has considered the additional revisions requested by the commenters and responds as follows.

Explanatory Coversheet

Comment: The explanation of changes needs to make clear that the DRA section 6012 applies only to an annuity purchased by a Medicaid applicant, not the community spouse.

Response: We agree. Most of the DRA annuity provisions apply to the Medicaid applicant and community spouse equally, since they are both part of the same financial responsibility group. There is one exception, however. DRA Section 6012(c)(1)(G) applies solely to the Medicaid applicant. The coversheet explanation has been clarified to reflect this.

Comment: The explanation of changes should reflect that the DRA Section 6012 now allows for the purchase of annuities from private family members.

Response: The DRA prescribes when the purchase of annuities should be treated as a transfer of assets for less than fair market value. Private annuities are among those subject to the new DRA transfer provisions. The department has amended its definition of annuities at Rule M231.24(a) and has made it explicit that its regulations pertaining to annuities encompass private annuities.

Comment: The explanation of changes must distinguish between qualified money annuities and non-qualified money annuities.

Response: The department agrees that its regulations must distinguish between qualified money and non-qualified money annuities but it has not elected to provide this level of detail in its explanation of changes. Instead, the department's comments are meant to offer a general orientation to the changes made. By stating that "an annuity purchased *by the institutional spouse* shall be treated as a disposal of assets for less than fair market value unless it meets specific criteria," the department has clarified that there are new criteria applicable to institutionalized spouses that trigger when an annuity is subject to penalty.

Comment: The explanation of changes makes no reference to the DRA language. The penalty language was amended by 32 U.S.C.S. 1396p(c)(1)(b)(I) amended by DRA section 6011(section (b)(2)(c). The appropriate language is "but for the application of the penalty."

Response: The department has clarified the proposed rule to plainly articulate the DRA's requirement. For transfers made on or after February 8, 2006, the penalty date starts on the first day an individual "*would otherwise have been eligible for long-term care Medicaid*".

Comment: The last line of the explanation of changes concerning penalty period phase-in needs to be explicit.

Response: We agree and have incorporated this suggestion into the coversheet. The phase-in will be as follows: in March, 2009 there will be a 36-month lookback and in April, 2009 there will be a 37-month lookback. By March, 2010, there will be a 48-month lookback. By March, 2011 the lookback will be fully phased in at 60 months.

Home Equity Cap (M232.11) (M233.26)

Comment: In order to minimize the impact of this change on Vermont's seniors, Vermont should opt for the higher amount permissible under the Deficit Reduction Act: \$750,000. The department should exercise the option to increase the equity cap to the \$750,000 amount allowed by the DRA. If the state retains the \$500,000 amount, this figure should increase based on the consumer price index beginning in 2011.

Response: Long-term care Medicaid is a program for low-income individuals. The department does not consider applicants with home equity in excess of \$500,000 as low-income. We agree that the rule should incorporate the CPI increases beginning in 2011 and have modified the rule to incorporate this provision.

Comment: The draft regulations do not indicate how equity value will be determined. Equity value should be determined by subtracting all current debt and liens on the property from the home value noted in the most recent property tax assessment.

Response: We agree and have incorporated this formula into the rule.

Comment: The rule should include the DRA-required waiver of the equity cap in cases where application of this provision would result in hardship.

Response: Although the proposed rule already included the hardship waiver provision, the final proposed rule has been revised to make this provision more obvious.

Comment: The regulations should be modified to prevent the denial of Medicaid for those who are not eligible for reverse mortgage loans (all those under age 62) or home equity loans.

Response: The proposed undue hardship regulations already provide the department with discretion to consider that these circumstances may merit granting a hardship waiver. For example, someone ineligible for a reverse mortgage or home equity loan could bring this circumstance to the department's attention as part of their allegation of hardship based on having "exhausted all reasonable efforts to meet their needs from all other available sources." (Proposed Rule M440.44(c)(6)).

Comment: The regulations should be modified to parallel current Medicaid law. They should exempt the following individuals from the home equity provision: individuals who have siblings with an equity interest in the home; individuals whose siblings reside in the home; or individuals with a son or daughter who resides in the home and provides care to the individual.

Response: Current Medicaid law only exempts the home from estate recovery for the groups described in this comment. The DRA does not permit States to qualify a Medicaid applicant for long-term care Medicaid funding when one of these groups resides with the applicant.

We have clarified the regulation to specify that when a person other than a spouse resides in the home with the Medicaid applicant and has a joint tenancy interest, the applicant's equity should be considered reduced by the amount of the other individual's equity interest in the property.

Qualified State Long Term Care Insurance Partnership (M232.22)

Comment: States should be cautious in creating Long-term Care (LTC) Partnership programs. Data from the existing four states that have Partnership programs does not support the conclusion that they live up to their promise to states as a cost-effective means of reducing Medicaid expenditures. So far, the data are inconclusive because the programs are still relatively new and few purchasers have begun to use benefits. States should only move forward after careful analysis of the state costs for promoting and administering a new program balanced against potential savings. Like other LTC insurance, Partnership policies will most likely not be available to those most likely to require Medicaid. Individuals with low incomes can not afford to buy them, particularly as they reach advanced age. Those with existing medical conditions are generally barred from purchasing them. Partnership policies, with their added asset protection provisions and potentially higher cost, will be sold primarily to healthy individuals with significant income and assets, *i.e.*, those least likely to need Medicaid coverage. While the sale of Partnership policies may mean that more people buy long-term care insurance, it may be costly for the state by making Medicaid coverage available to those who would otherwise be over-assets for Medicaid and because of the costs of creating, promoting, administering and regulating a new program.

Response: There will be challenges to ensure that qualified state long-term care insurance Partnership policies are affordable and available to consumers, as well as being cost-effective to the State. The department, in collaboration with the Department of Banking, Insurance, Securities and Health Care Administration, the Office of Vermont Health Access, and the Department of Disabilities, Aging and Independent Living, intends to collect, analyze and report out on data that will help track and inform policy on these important issues.

Comment: If the department for children and families and state legislature and the Insurance Department decides to allow Partnership policies, implementation should be delayed. CMS still has not issued policy guidance to the states on issues including state reciprocity and state reporting requirements. The National Association of Insurance Commissioners (NAIC) is in the process of modifying its LTC Insurance model legislation and regulations to accommodate new Deficit Reduction Act (DRA) standards that on Partnership policies. States will need to review and incorporate the final NAIC standards. The department should address Partnership insurance through regulations and a state Medicaid plan amendment when this process is completed.

Response: The department is collaborating closely with the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA). BISHCA is fully engaged with the NAIC policy development process concerning state reciprocity and state reporting requirements; however, those issues need not be fully resolved before the department can proceed with this rule. In fact, having this provision and the accompanying Medicaid state plan amendment in place is complementary to those efforts and will position Vermont to be able to start implementation more timely when the related NAIC issues are resolved. BISHCA is the Department responsible for certifying Partnership policies and for promulgating the rules that establish policy requirements based on the NAIC model.

- Comment:** Vermont should also modify its proposed regulation to reflect the inflation protection requirements for Partnership policies outlined in the DRA: compound annual inflation protection for purchasers below age 61, some level of inflation protection for purchasers ages 61 to 75, and for purchasers age 76 and over the policy may (but is not required to) provide some level of inflation protection.
- Response:** The department recognizes that inflation protection is optional when sold to an individual who has attained age 76 and has changed this provision by cross-referencing the BISHCA rule for further detailing on this issue.
- Comment:** Substantial time and resources will be needed to train insurance agents and to provide appropriate education for the public. Public education will be critical for the Partnership program, so that consumers understand how the program works, the eligibility criteria for Medicaid and that this criteria could change, and the scope and limitations on coverage and benefits. Partnership programs may not appropriate for some consumers, such as those who would not qualify for Medicaid because they have home equity in excess of the new home equity cap (see below) or income over the Medicaid income limits. Additional consumer protections should be adopted relating to Partnership policies, such as premium stability.
- Response:** The National Clearinghouse for Long-Term Care Information, established under Section 6021(d) of the DRA of 2005, will educate consumers with respect to the availability and limitations of coverage and will provide objective information to assist consumers with the decision making process for determining whether to purchase such policies. Comments concerning the possible need for additional consumer protections and the training of insurance agents will be addressed in the context of the rule that will be filed by the Department of Banking, Insurance, Securities and Health Care Administration.
- Comment:** We have no comment at this point other than to state that we assume that the proposed regulation will incorporate the language of DRA Sec. 6021.
- Response:** Yes, the rule filed by the Department of Banking, Insurance, Securities and Health Care Administration will incorporate the language of DRA Sec. 6021 as necessary.
- Annuities, Promissory Notes, and Similar Resources that Produce Income (M232.4)***
- Comment:** The regulation fails to categorize annuities in the manner mandated by DRA. Specifically, it fails to distinguish between annuities that are purchased by the Medicaid applicant or those purchased by the community spouse. It also fails to distinguish between annuities purchased with qualified monies and nonqualified monies. Further, it makes promissory notes subject to the same requirements as annuities, without DRA authority. Finally, it does not make reference to the appropriate life tables for annuities or promissory notes.
- Response:** The DRA only modified the aspects of Medicaid law governing transfer of assets (Social Security Act Section 1917). The issues raised in this comment relate to Medicaid resource standards and methodologies which remain unchanged (Social Security Act Section 1902).

Life Tables (M232.4, M440.21)

Comment: M232.4 should refer to tables.

Response: We agree and have made this change.

Comment: Annuities purchased with qualified monies should be based upon annuity tables under the Internal Revenue Service Code.

Response: This is not a requirement of the DRA. In two places, the DRA references tables prepared by the Office of the Chief Actuary of the Social Security Administration. The DRA does not reference annuity tables under the Internal Revenue Code.

Comment: Annuities purchased with non-qualified monies should be based upon a table as determined in accordance with the actuarial publications of the Office of the Chief Actuary of the Social Security Administration.

Response: We agree and have incorporated this reference into the rule.

Comment: M440.21 states that the department is developing alternate actuarial tables. However, the DRA preempts the state's authority in this regard.

Response: The department has the authority to develop alternate actuarial tables as long as they are consistent with federal law. When the department is ready to propose the alternate tables, it will work with the federal Centers for Medicare and Medicaid Services on a state plan amendment or waiver amendment or otherwise assure its proposal meets with federal approval.

Promissory Notes or Similar Resources that Produce Income (M232.4(b))

Comment: The requirement in M232.4(b) (i) that promissory notes meet the annuity requirements stated "in subsections (a)(1)(A) through (E) above," is without DRA authority. The regulation also fails to state the proper life table.

Response: The DRA only modified the aspects of Medicaid law governing transfer of assets. The issues raised in this comment relate to Medicaid resource standards and methodologies which remain unchanged. We agree that it would be helpful to include a reference to the life expectancy table used for promissory notes in the resource section and have added it.

Substantial Home Equity (M233.26)

Comment: The last paragraph of this section requires that those with equity in excess to the cap who take out a reverse mortgage or equity loan to expend the proceeds exclusively for items and services relating to the individual's care. This paragraph should be removed.

Response: When determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, Section 6014 of the DRA of 2005 requires that the individual not be eligible for such assistance if the individual's equity interest in the individual's home exceeds \$500,000. A State may elect a higher amount up to \$750,000; however, Vermont has elected the \$500,000 threshold. The intent of this requirement is to ensure that individual's with substantial equity resources are not able to get publicly funded medical assistance when they have assets of their own to pay for their care. This last paragraph simply seeks to ensure that the excess equity is indeed expended on the individual's care.

Comment: This requirement would prevent the use of these proceeds to cover the costs of the loan (upfront fees, monthly fees, and interest) and such critical items as payment of prior debt on the home, current and past due taxes, home repair, home insurance, and home improvements to reduce operating costs (insulation, a more efficient heating unit, etc.) or to pay for other necessities of life (food, heat, utilities, medical transportation costs, etc.). This narrow limitation would effectively preclude many, if not all, loans.

Response: A reverse mortgagee must always be in the first secured position; therefore, all existing encumbrances on the individual's home, including mortgages and current and past due taxes, as well as costs associated with securing the reverse mortgage, such as upfront fees, monthly fees and interest, are required to be paid as a matter of course either at closing or during the course of the loan by the reverse mortgagor. Therefore, with regards to reverse mortgages, the rule need not specify those expenses, nor does it prevent them from being paid. To the extent that a home equity loan can be in a lower secured position, the rule has been clarified to allow for those payments. Furthermore, it is rarely if ever advisable to convert unsecured debt to secured debt, particularly when given the effect of compounding interest due to negative amortization under reverse mortgages, and so the rule does not include prior unsecured debt as an allowable expenditure. By incorporating the definitions at M232.83(a) and allowing for additional expenses related to activities of daily living, the rule broadly encompasses reasonable expenses necessary to keep an individual at home and out of a skilled nursing facility.

Comment: As drafted, there are no limitations on the imposition of a life-long penalty period. For example, the person who started with \$505,000 in home equity and no knowledge about Medicaid in 1990, reduced this to \$495,000 by an interest-only home equity loan of \$10,000 to replace an inoperable furnace in 1991 and applies for Medicaid fifteen years later would be denied Medicaid forever.

Response: The department agrees and has added a sentence at the end of this paragraph to address this issue.

Comment: The proposed requirement exceeds the authority granted to the states by the DRA. The DRA's provision only authorizes the denial of Medicaid for those with equity above the cap. It does not authorize a cap-related denial of Medicaid for the person with equity below the cap under any circumstance.

Response: The DRA is silent on this issue; it does not specifically allow for it or disallow it. The rule indicates however that implementation of this requirement is subject to approval from the Centers for Medicare and Medicaid Services.

Comment: In this section, the Department indicates that it intends to seek a waiver amendment to allow it to require that the individual use the proceeds from a home equity loan or reverse mortgage to pay for medical care. I was unable to find this section in the Deficit Reduction Act. This requirement seems excessively narrow and ill advised. The Department should forgo this restriction on the use of funds from a home equity loan or reverse mortgage.

Response: The department may not need a waiver amendment to proceed, but it will require federal approval and so the rule language has been amended accordingly. The department holds that the requirement is neither excessively narrow, nor ill advised.

Comment: The last section of your regulation requires that reverse mortgages be used only for certain purposes. The DRA encourages the use of reverse mortgages in DRA Sec. 6014. There is no authority for the state to regulate how money is being spent. We note that you have not included taxes, maintenance, repair, replacement, caregivers, animal control or pet care in your list of expenses. The only issue that the state should be concerned with is whether the medical applicant has engaged in a transfer of resources with the monies received from the reverse mortgage.

Response: The DRA is silent on this issue; it does not specifically allow for it or disallow it. The rule indicates however that implementation of this requirement is subject to approval from the Centers for Medicare and Medicaid Services. The subject requirement is written in such a way as to allow for all reasonable expenses necessary to keep an individual at home and out of a skilled nursing facility.

Court-ordered Support (M432.31)

Comment: The department's must address DRA 6013, section 5, the community spousal monthly income allowance for the spouse shall not be less than the amount of monthly income so ordered.

Response: The department's regulations at M432.31 are congruent with this request. This approach was adopted in Vermont several years ago, before the enactment of the DRA.

Retroactive Application of the Rule Changes (M440.3, M440.41)

Comment: Medicaid applications and transfers related to Medicaid applications should be governed by the Medicaid rules in effect at the time of the application or transfer.

Response: The department has elected to not apply the new federal provisions to applications filed before the effective date of the new rules. Further, the DRA's transfer provisions will be phased in over time. However, once implementation begins, the department must apply the new rules to all applications filed on or after the effective date to be fully compliant with federal law.

Rebuttable Presumption M440.3(d)

Comment: The proposed rules appear to eliminate the rebuttable presumption that resources were transferred for the purpose of establishing eligibility for Medicaid.

Response: The last sentence of paragraph one explicitly retains this presumption.

Allowable Transfers (M440.3)

Comment: Two commenters asked for the addition of a threshold amount for transfers that may be made without penalty. The concern was that seniors need to know how gifts and charitable contributions will be considered by the department and that standards are essential to avoid arbitrary imposition of penalties on some gifts and donations, but not on others. One of the commenter indicated that several states currently allow cumulative transfers up to \$12,000 over the 3-year look-back period without penalty.

Response: The DRA does not give the department the discretion to exempt gifts and charitable contributions from transfer penalties. It does not appear that, since the enactment of the DRA, any state has included in regulations a threshold disregard for cumulative transfers.

Penalty Date (M440.41(b))

Comment: To comport with the DRA, the last phrase of this clause should be amended by deleting the words "except for the sole reason of the penalty" and replaced with the words "but for the application of the penalty period." This will permit the use of the federal cases interpreting as precedent in Vermont.

Response: The department has revised its regulation to make this concept more understandable and consistent with federal guidance. The language of the regulation is intended to be synonymous with the federal statute and the department also will rely on case law interpreting the federal provision as authority.

Undue Hardship (M440.44)

Comment: This section provides that: “[u]ndue hardship does not exist when the application of a transfer penalty merely causes an individual or individual’s family member(s) inconvenience or restricts their lifestyle.” There is no authority for this provision. Likewise, there is nothing that authorizes or permits the addition of the language “such that would be at risk of serious deprivation.” These clauses should be deleted.

Response: CMS has given States considerable flexibility to define the parameters of undue hardship. Vermont included these descriptions as general parameters framing what the state of Vermont will consider undue hardship. They signify that at one end of the spectrum, hardship must be more than inconvenience. At the other end, is something more than inconvenience and involves loss of basic needs that lead to a risk of serious deprivation.

Comment: The rule proposes that “[u]ndue hardship does not exist when the individual transferred the assets to the community spouse and the community spouse refuses to cooperate in making the resources available to the individual.” This should be changed to read: *undue hardship does not exist when the individual transferred the assets to the community spouse and the individual refuses to assign right of support to the department.*

Response: Spouses are financially responsible for one another. When making determinations of undue hardship, the department will consider the extent to which the community spouse may have transferred resources or remains in possession of excluded resources, especially those that exceed the community spouse resource allocation.

Comment: It is unclear from the rule whether the Department intends to impose the clear and convincing standard for the burden of proof on the applicant. There is no basis for such imposition. Federal law provides that the applicant may rebut the presumption by a “satisfactory showing” that the assets were transferred for a purpose other than to qualify for Medicaid. A “satisfactory showing” clearly does not require “convincing evidence.” The rule should be revised accordingly.

Response: We agree that the preponderance of the evidence standard is adequate to assure that all fact finders use the same norm.

Comment: The following provision should be added to the rule: *The department shall delay imposition of a penalty period until it determines that the applicant has the income and resources sufficient to pay for all necessary medical and support care and treatment, food, housing, utilities, and other necessities of life for the duration of the penalty period. The department shall provide advance written notice to the applicant identifying the income and resources available and the projected costs of medical and support care and treatment, food, housing, utilities, and other necessities of life during the penalty period. The applicant shall be afforded the opportunity to appeal this determination. Prior to the imposition of the penalty period, the department shall assist the applicant in developing a care plan and budget for medical and supportive services and necessities for the duration of the penalty period.*

Response: Under the rules of the Medicaid program, federal financial participation (FFP) is not available to states for provision of long-term care services until a person has been determined eligible for the highest need group in Choices for Care Long-term Care Medicaid. Thus, the department may not claim federal matching funds to develop care plans and budgets for medical and supportive services and necessities for the duration of the penalty period. The Legislature has not appropriated state funds to cover the additional staff needed to perform these tasks. Area Agencies on Aging Case Managers are available to support those waiting to qualify for Medicaid payment of long-term care services.

Comment: The rules should permit the establishment of undue hardship upon the basis of a signed statement by the individual that “demonstrate(s) hardship.”

Response: The proposed approach will not provide for sufficient verification of the existence of undue hardship. Accordingly, as with many other aspects of eligibility determinations, before granting an undue hardship exemption, the department will require corroborating information from applicants claiming undue hardship.

Comment: There is no harm to the department by allowing the individual to request the hardship exemption at any time. Many hardship requestors will be low income seniors or people with disabilities, without an attorney to represent them, and they will be limited in their ability to pursue these appeals in a timely manner.

Response: The department has given individuals 20 days to request a hardship waiver. It will grant extensions upon request for individuals who need more time. Moreover, the proposed rule has been clarified to specify the process for seeking an undue hardship exemption once a penalty period is imposed and eligibility is denied. Effectively, individuals will be able to appeal an initial denial of eligibility due to imposition of a transfer penalty within 90 days. The department also will consider undue hardship requests filed later if new circumstances leading to undue hardship arise during the duration of a transfer penalty period.

Comment: Commenters requested clarification regarding the process the department will employ to review claims of undue hardship.

Response: The department will establish a committee of representatives from the agency to meet twice each month to review and make decisions on undue hardship requests.

Undue Hardship Reasons (M440.44(c))

Comment: This list should be deleted from the rule, as the examples given are more restrictive than needed under federal law governing the exemption. The rule should be revised to make that clear: *undue hardship is established when one or more of the following circumstance, or any other comparable reason, exists.*

Response: The department’s examples conform to the approaches that are being taken nationwide. The department has made the revision suggested by the commenter.

Comment: Rule M440.44(c)(4) - should permit a sworn statement by applicants as they have no control over whether or not police or other investigatory agencies will actually take action.

Response: We agree and have made this change.

Comment: Rule M440.44(c)(5) should replace the word “extraordinary” with *similar*.

Response: We agree and have made this change.

Comment: Examples should be added to make it clear that onerous or futile attempts to seek the return of gifts and donations are not required.

Response: By replacing the word “extraordinary” with “similar” the department has accomplished this meaning.

Comment: Rule M440.44(c)(6) should exclude the individual’s home.

Response: We disagree. We have modeled our hardship rules on those of the Supplemental Security Income program (SSI). In cases of undue hardship, SSI exempts burial funds but it does not exempt the home.

Comment: Rule M440.44(c)(7) should not require applicants to exhaust all reasonable efforts, since they often lack the ability to make such efforts. Some will simply be unable or unwilling to seek recovery from their churches or charities on reasonable moral or religious grounds. It is also noteworthy that there is generally no enforceable legal basis to recover gifts. Instead, the department should consider modifying the regulations to require the applicant to assign the right to support, and the Department can pursue and appropriate collection whenever this would be reasonable and cost-effective.

Response: The department believes that the individual, guardian or power of attorney responsible for the transfer is in the best position to request return of the assets or their value. The approach suggested by the commenter would encourage gift-giving as a strategy for the circumvention of the transfer of asset rules. It would leave the state in the position of exerting its limited resources to pursue return of the gift or collection of the value transferred.

Comment: The presumption in Rule M440.44(c)(8) should exclude minors and family members who are recipients of Social Security or SSI disability benefits.

Response: The department has clarified the proposed rule to require the long-term care applicant request the required facts and verification from the family member who is financially responsible for a minor child. The department also revised the rule to not require the long-term care applicant to request facts and verification from family members in receipt of SSI. The rule continues to apply to transfers to all other relatives, including those in receipt of social security retirement or disability benefits. Other transfer exemptions prescribe other permissible vehicles to enable family members to give support to disabled family members.

Comment: Rule M440.44 does not comply with the State and Federal Nursing Home Bill of Rights which requires the approval of the applicant, or his agent or guardian, before a discharge can occur.

Response: The commenter appears to refer to the rules concerning transfer and discharge of individuals from nursing facilities. Under those rules, discharge may occur only under limited circumstances after specific steps have been taken. The Medicaid rule does not in any way abridge the rights accorded to nursing home residents subject to transfer or discharge.

The state statute (33 V.S.A. §7301 (2)(D)) does not require the approval of the applicant before a discharge can occur. It requires notice in writing, with the reasons for the transfer or discharge at least 72 hours (transfer) or 30 days (discharge) before. The notice can be appealed. The nursing home (and other LTC facility) regulations spell out the process for appealing a notice of discharge, but also do not require the approval of the individual before the transfer or discharge can take place. Vermont's law tracks federal law, except that under federal law there is no right to a hearing regarding a notice of transfer.

* * * *

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

Manual Holders: Please maintain manuals assigned to you as follows.

Manual Maintenance

Medicaid Rules

<u>Remove</u>		<u>Insert</u>	
TOC P.3 (M100)	(06-48)	TOC P.3 (M100)	(06-46)
Nothing		M159.24	(06-46)
TOC P.3 (M200)	(05-25)	TOC P.3 (M200)	(06-46)
TOC P.4 (M200)	(05-25)	TOC P.4 (M200)	(06-46)
M200	(05-25)	M200	(06-46)
M220.1	(02-11)	M220.1	(06-46)
M221	(02-11)	M221	(06-46)
M231.22	(05-19)	M231.22	(06-46)
Nothing		M231.24	(06-46)
M232	(02-11)	M232	(06-46)
M232.2	(02-11)	M232.2	(06-46)
Nothing		M232.22	(06-46)
M232.4	(05-25)	M232.4	(06-46)
M232.4 P.2	(02-11)	M232.4 P.2	(06-46)
M232.84	(05-19)	M232.84	(06-46)
M233.12	(02-11)	M233.12	(06-46)
Nothing		M233.26	(06-46)
M234	(02-11)	M234	(06-46)
M234.4	(02-11)	M234.4	(06-46)
M432.2	(05-25)	M432.2	(06-46)
M433	(02-11)	M433	(06-46)
M440.21	(05-19)	M440.21	(06-46)
M440.3	(02-11)	M440.3	(06-46)
M440.32	(05-25)	M440.32	(06-46)
M440.34	(05-25)	M440.34	(06-46)
Nothing		M440.34 P.2	(06-46)
M440.35	(05-19)	M440.35	(06-46)
M440.4	(05-19)	M440.4	(06-46)
Nothing		M440.42	(06-46)
M440.44	(02-11)	M440.44	(06-46)
Nothing		M440.44 P.2	(06-46)
Nothing		M440.44 P.3	(06-46)

M158	Third-Party Liability
M158.1	Health Insurance Premiums
M159	Adjustment or Recovery
M159.1	Adjustments or Recoveries from Estates
M159.2	Exemptions from Estate Adjustment or Recovery
M159.21	Undue Hardship Exemptions Applicable to Homesteads
M159.22	Methodology for Adjusting a Claim Against a Homestead
M159.23	Methodology for Retroactive Homestead Exemption Claims
M159.24	Exemptions for Qualified Long-Term Care Insurance Partnership
M160	Health Care Improvement Trust Fund
M170	Citizenship or Alienage Status and Identity
M170.1	Requirement
M170.2	U.S. Citizen
M170.21	Notice of Obligation to Satisfy Documentation Requirement
M170.22	Acceptable Documentation of Citizenship and Identity
M170.3	Qualified Alien
M170.31	Battered Alien
M170.32	Acceptable Document of Qualified Alien Status
M170.4	Five-Year Bar for Qualified Aliens
M170.41	Acceptable Documentation to Determine the Five-Year Bar
M170.5	Non-Qualified Aliens
M170.51	Illegal Aliens
M170.52	Undocumented Aliens
M170.6	Ineligible Aliens/Non-Immigrants
M170.7	Confirmation of Immigration and Citizenship Status
M170.8	Emergency Medical Services

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M159.24

M159.24 Exemptions for Qualified State Long-Term Care Insurance Partnership

The department will exempt assets or resources pursuant to Rule M232.22 in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified State long-term care insurance partnership policy whether or not an heir requests an exemption.

M230 Overview of SSI-Related Medicaid Resource Requirements

M231 Types of Resources

- M231.1 Nonliquid Resources
 - M231.11 Real Property
 - M231.12 Life Estate
 - M231.13 Burial Funds
 - M231.14 Life Insurance
- M231.2 Liquid Resources
 - M231.21 Accounts in Financial Institutions
 - M231.22 Retirement Funds
 - M231.23 Stocks, Bonds, Mutual Funds, and Money Market Funds
 - M231.24 Annuities
 - M231.25 Mortgages and Promissory Notes
 - M231.26 Home Equity Conversion Plans
- M231.3 Resources Managed by a Third Party
 - M231.31 Trusts
 - M231.32 Power of Attorney
 - M231.33 Guardian
 - M231.34 Representative Payee
 - M231.35 Fiduciary for a Joint Fiduciary Account

M232 Excluded Resources

- M232.1 Real Property
 - M232.11 A Home and Contiguous Land
 - M232.12 Proceeds From the Sale of an Excluded Home
 - M232.13 Real Property for Sale
 - M232.14 Home Equity Conversion Plans
 - M232.15 Jointly Owned Real Property
 - M232.16 Life Estates
 - M232.17 Real Property Producing Significant Income
 - M232.18 Real Property Producing Goods For Home Consumption
- M232.2 Insurance
 - M232.21 Life Insurance
 - M232.22 Qualified State Long Term Care Insurance Partnership
- M232.3 Burial Funds
- M232.4 Annuities, Promissory Notes, and Similar Resources that Produce Income
- M232.5 Resources Managed by a Third Party
 - M232.51 Definition of Trust
 - M232.52 Excluded Trusts
 - M232.53 Trusts Excluded Due to Undue Hardship
- M232.6 Early Withdrawal Penalties and Surrender Fees
- M232.7 Jointly Held Accounts
 - M232.71 Fiduciary for a Joint Fiduciary Account

M232.8	Other Excluded Resources
M232.81	Household Goods and Personal Effects
M232.82	Vehicles
M232.83	Contracts for Medical Care, Assistive Technology Devices, and Home Modifications
M232.84	Cash, Including Cash Necessary to Operate a Business
M232.85	Retirement Funds
M232.86	Tax Refunds
M232.87	Student Benefits
M232.88	Savings from Excluded Income
M232.89	Resources Excluded by Federal Law
M232.9	Resources Excluded for Limited Periods
M232.91	Retroactive Social Security and SSI/AABD Payments
M232.92	Funds for Replacing a Lost, Stolen, or Damaged Excluded Resource
M232.93	Earned Income Tax Credit
M232.94	Cash Payments for Medical or Social Services
M232.95	Victim's Compensation Payments
M232.96	Relocation Payments
M232.97	Funds for Expenses Resulting from Last Illness and Burial
M232.98	Stocks, Bonds, Mutual Funds, and Money Market Funds
M232.99	Resource Disregard for Certain Individuals Receiving Home- Based Long-term Care
M233	Value of Resources Counted Toward the Medicaid Resource Limit
M233.1	Counting Jointly Owned Resources
M233.11	Tenancy in Common
M233.12	Joint Tenancy
M233.13	Tenancy by the Entirety
M233.2	Value of Certain Resources
M233.21	Annuities
M233.22	Nonexcluded Life Estates
M233.23	Jointly Owned Real Property
M233.24	United States Savings Bonds
M233.25	Promissory Notes and Similar Resources that Produce Income
M233.26	Substantial Home Equity
M234	Determination of Countable Resources for SSI-Related Medicaid
M234.1	Determining Countable Resources for Individuals Other than Children
M234.2	Determining Countable Resources for Individuals Requesting SSI-Related Medicaid, Other than Long-Term Care, When They Have a Spouse
M234.3	Determining Countable Resources for Blind or Disabled Children
M234.4	Determining Countable Resources for Individuals Requesting Long-Term Care, Including Waiver and Hospice Services, When They Have a Spouse
M234.41	Assessment of Resources for Individuals with a Community Spouse
M234.42	Allocation of Resources for Individuals with a Community Spouse
M235-M239	[Reserved]

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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 (M170, 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 highest need and high need 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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M220.1

M220 Financial Eligibility for SSI-Related Medicaid (Continued)**M220.1** Definitions

These definitions apply throughout the SSI-related Medicaid financial eligibility sections.

(a) Dependent child means an individual who has always been single, lives with the parent, and is:

- under age 18; or
- a disabled student age 18 up to age 21.

A child is not considered living with the parent when:

- the parent has relinquished control to a school or vocational facility;
- the child is confined to a public institution or in the custody of a public agency;
- the child is a member of the armed forces;
- the child lives in a private nonmedical facility; or
- the child has been admitted to long-term care.

A child away at school who returns to a parent's home for vacations, holidays, or some weekends is considered living with the parent.

A child who qualifies for the Katie Beckett coverage group is not considered a dependent child for the purposes of determining financial eligibility for SSI-related Medicaid.

Individuals are no longer considered dependent children on the first day of the month following the calendar month in which they no longer meet the definition of dependent child.

(b) Adult means an individual who is not a dependent child.

(c) Ineligible child means

- the applicant's natural child or adopted child, or
- the natural or adopted child of the applicant's spouse, or
- the natural or adopted child of the applicant's parent or of the applicant parent's spouse, who lives in the same household with the applicant, and is a dependent child.

(d) Ineligible parent means

- a natural or adoptive parent, or
- the spouse of a natural or adoptive parent, who is not eligible for SSI-related Medicaid and who lives with a child applying for SSI-related Medicaid. The income of parents who do not meet the nonfinancial eligibility criteria only affects the eligibility of an applicant who is a dependent child.

(e) Ineligible spouse means the spouse living with the applicant who does not meet the nonfinancial eligibility criteria for SSI-related Medicaid.

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M221

M221 Formation of the SSI-Related Financial Responsibility Group

The SSI-related financial responsibility group consists of the individuals whose income and resources are considered available to the Medicaid group in the eligibility determination. With some exceptions, spouses are considered financially responsible for each other, and parents are considered financially responsible for their dependent children. The following subsections set forth the rules for determining membership in the financial responsibility group and the portion of the group's income considered available to the Medicaid group.

M221.1 SSI-Related Financial Responsibility Groups for Adults

The financial responsibility group for an adult requesting SSI-related Medicaid, including long-term care, is the same as the adult's Medicaid group.

M221.2 SSI-Related Financial Responsibility Groups for Dependent Children

The financial responsibility group for a dependent child requesting SSI-related Medicaid includes the child and any parents living with the child, until the child reaches the age of 18.

M221.3 SSI-Related Financial Responsibility Groups for Noncitizens with a Sponsor

The financial responsibility group for a noncitizen admitted to the United States on or after August 22, 1996 based on a sponsorship under section 204 of the Immigration and Nationalization Act (INA) includes the income and resources of the sponsor and the sponsor's spouse, if living with the sponsor, when all four of the following conditions are met:

- (a) the sponsor has signed an affidavit of support on a form developed by the United States Attorney General as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 to conform to the requirements of Section 213A(b) of INA;
- (b) the noncitizen is lawfully admitted for permanent residence, and a five-year period of ineligibility for Medicaid following entry to the United States has ended;
- (c) the noncitizen is not battered; and
- (d) the noncitizen is not indigent, defined as unable to obtain food and shelter without assistance, because his or her sponsor is not providing adequate support.

The above financial responsibility of a sponsor continues until the noncitizen is naturalized or credited with 40 qualifying quarters of coverage by the Social Security Administration (see section M222.31 on Qualifying Quarters of Coverage).

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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) 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.

(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.
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M231.24

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. It may also be a private contract between two parties. 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 (sometimes referred to as the annuitant).

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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M232

M232 Excluded Resources

This section specifies the resources whose value the department excludes in determining SSI-related Medicaid eligibility.

M232.1 Real Property

The department excludes the following real property as resources when determining Medicaid eligibility.

M232.11 A Home and Contiguous Land

The department excludes a person's home as a resource, regardless of its value. For long-term care applicants, however, the department considers the home a resource when the applicant has equity greater than \$500,000 in it (M233.26). The department also may consider it as a resource when determining whether the applicant has transferred it and should be subject to a penalty period (M440).

Home means the property in which an individual resides and has an ownership interest and which serves as the individual's principal place of residence. This property includes the shelter in which an individual resides, the land on which the shelter is located, related outbuildings, and surrounding property not separated from the home by intervening property owned by others. Public rights of way, such as roads that run through the surrounding property and separate it from the home, will not affect the exemption of the property. The home includes contiguous land and any other buildings located on the land.

The home exclusion applies even if the owner is making an effort to sell the home.

The home exclusion also applies if the owner is absent from the home due to institutionalization, provided that the owner has not placed the home in a revocable trust and:

- intends to return to the home even if the likelihood of return is apparently nil;
- has a spouse or dependent residing in the home; or
- has a medical condition that prevented the owner from living there before institutionalization.

Dependent means: child, stepchild, or grandchild; parent, stepparent, or grandparent; aunt, uncle, niece, or nephew; brother or sister, stepbrother or stepsister, half brother or half sister; cousin; or in-law.

Unless one of the exceptions listed above applies, the home becomes a countable resource when the owner moves out of the home without the intent to return, because it is no longer the owner's principal place of residence.

Temporary absences, such as for hospitalization or convalescence with a relative, do not affect the determination of an individual's principal place of residence.

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M232.2

M232 Excluded Resources (Continued)M232.2 InsuranceM232.21 Life Insurance

(a) Definition

Life insurance is a contract that provides for its purchaser to pay premiums to the insurer, who agrees to pay a specific sum to a designated beneficiary upon the death of the insured. Life insurance is usually sold by an insurance company but may also be sold by other financial institutions, such as brokerage firms.

The face value of a life insurance policy is the amount it pays the beneficiary upon the death of the insured. Term life insurance is life insurance that does not accumulate any cash value through time as premiums are paid. Whole life insurance (sometimes called ordinary life, limited payment, or endowment insurance) accumulates value as premiums are paid. It may also pay periodic dividends on this value when all premiums have been paid. These dividends may be paid to the owner, or they may be added to the cash surrender value of the policy.

The cash surrender value (CSV) of a whole life policy represents the amount the owner would receive upon terminating the policy before the insured dies. It is a form of equity that accumulates over time as life insurance premiums are paid. The policy owner may borrow against the CSV according to the terms of the policy. A loan against a policy reduces its CSV.

A life insurance policy can be either a group or individual policy. Group policies are usually issued through a company or organization insuring the participating employees or members and perhaps their families. The group policy may be paid partially by the employer. Group insurance policies generally have no CSV.

(b) Exclusion

The value of a life insurance policy is excluded as a resource according to the following rules:

- (i) If the combined face value of the whole life insurance policies owned by any one member of the financial responsibility group does not exceed \$1500, their cash value may be excluded. If the total face value exceeds \$1500, their cash value, excluding any amounts up to \$1500, and all dividend additions are considered a countable resource.
- (ii) Regardless of its face value, term life insurance is not countable as a resource.

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M232.22

M232.22 Qualified State Long Term Care Insurance Partnership

(a) Definition

The term “Qualified State Long-Term Care Insurance Partnership” means a State plan amendment that provides for the disregard of any assets or resources in an amount equal to the insurance benefits payments that are made under a long-term care insurance policy (including a certificate issued under a group insurance contract), but only if—

- the policy covers an insured who, at the time coverage under the policy first becomes effective, is a resident of such State or of a State that maintains a Qualified Long-Term Care Insurance Partnership;
- the policy is a qualified long-term care insurance contract within the meaning of section 7702B(b) of the Internal Revenue Code of 1986;
- the policy provides some level of inflation protection as set forth in regulations promulgated by the Vermont Department of Banking, Insurance, Securities and Health Care Administration;
- the policy satisfies any requirements of State or other applicable law that apply to a long-term care insurance policy as certified by the Vermont Department of Banking, Insurance, Securities and Health Care Administration; and
- the issuer of the policy reports—
 - to the Secretary of the federal agency of Health and Human Services (HHS), such information or data as the Secretary may require; and
 - to the State, the information or data reported to the Secretary of HHS (if any), the information or data required under the minimum reporting requirements developed under section 2(c)(1) of the State Long-Term Care Partnership Act of 2005, and such additional information or data as the State may require.

(b) Exclusion

Subject to approval by the federal Center for Medicare and Medicaid Services, the department will exclude assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified State long-term care insurance partnership policy. This section is further contingent on the passage of changes to 33 V.S.A. 1908a necessary to bring the Vermont statute on Long-Term Care Partnership Insurance into conformance with the requirements of section 6021 of the federal Deficit Reduction Act of 2005.

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M232.4

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 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 are not a countable resource if they:

- (A) have no beneficiary or payee 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 using the annuity tables published by the Office of the Chief Actuary of the Social Security Administration (<http://socialsecurity.gov/OACT/STATS/table4c6.html>) and specified in the Medicaid procedures manual ; 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 and community Medicaid payments it made on behalf of the applicant or spouse, 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 October 7, 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.

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M232.4 P.2

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

(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 using the annuity tables published by the Office of the Chief Actuary of the Social Security Administration (<http://socialsecurity.gov/OACT/STATS/table4c6.html>) and specified in the Medicaid procedures manual.

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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M232.84

M232 Excluded ResourcesM232.8 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

The department excludes retirement funds owned by a member of the financial responsibility group requesting Medicaid when:

- (i) The individual must terminate employment in order to obtain any payment; or
- (ii) The individual does not have the option of withdrawing a lump sum from the fund; or
- (iii) The individual is not eligible for periodic payments; or
- (iv) The individual has reached retirement age and the individual is drawing on retirement funds at a rate consistent with the individual's life expectancy, as specified in M440.21

If the individual is eligible for lump sum or periodic benefits, the individual must choose the periodic benefits. If the individual receives a denial on a claim for periodic retirement benefits but can withdraw the funds in a lump sum, the department counts the lump sum value in the resources determination for the month following that in which the individual receives the denial notice.

When a member of the financial responsibility group who is seeking long-term care Medicaid services holds pension funds held in an individual retirement account (IRA) or in work-related pension plans (including Keogh plans) as defined by the Internal Revenue Code, no change in title of ownership to these funds is required in order for them to be treated as an excluded resource for the benefit of the community spouse.

M232.86 Tax Refunds

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

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M233.12

M233 Value of Resources Counted Toward the Medicaid Resource Limit (Continued)M233.12 Joint Tenancy

Joint tenancy means each of two or more persons has an equal undivided interest in the whole resource.

The department follows state law in requiring the presence of four unities in order to recognize that joint tenants hold a resource. The four unities are: interest, possession, title, and time. A joint tenancy requires an undivided share and interest (interest) by all owners to possess the whole resource (possession). The words “joint tenants” must appear on the account or deed (title). Lastly, the joint tenants must have acquired their interest in the property at the same time (time).

When a member of the financial responsibility group owns a resource as a joint tenant, the department counts the entire equity value of the resource as available to the member. When the instrument creates an unequal interest of the joint tenants, the department counts only the portion available to the member of the financial responsibility group.

Upon the death of one of only two joint tenants, the survivor becomes sole owner. Upon the death of one of three or more joint tenants, the survivors become joint tenants of the entire interest.

M233.13 Tenancy by the Entirety

Tenancy by the entirety means that each person owns all of the resource. It applies only to real property of spouses and must be so designated in the document establishing ownership. It means the property can be disposed of only with the consent of both parties. Upon the death of one tenant by the entirety, the survivor takes the whole. Upon legal dissolution, the former spouses become tenants in common (M233.21), and one can sell his or her share without the consent of the other.

When a member of the financial responsibility group owns a resource as a tenant by the entirety, the department counts the entire equity value of the resource as available to the member.

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M233.26

M233 Value of Resources Counted Toward the Medicaid Resource Limit (Continued)M233.26 Substantial Home Equity(a) Definition

Home equity means the value of a home based on the town assessment minus the total amount owed on it in mortgages, liens, or other encumbrances. For example, when a Medicaid applicant has a joint tenancy with someone other than their spouse, the equity should be considered reduced by the amount of the other individual's equity interest in the property when the joint tenant resides in the home.

(b) Substantial home equity precludes payment for long-term care services

Individuals with equity interest in their home (M232.11) in excess of \$500,000 are ineligible for long-term care services due to excess resources unless one of the following individuals lawfully reside in the individual's home.

- Individual's spouse;
- Individual's child who is under age 21; or
- Individual's child who is blind or permanently and totally disabled, regardless of age.

Individuals with excess equity in their home who are found ineligible for long-term care services may receive other Medicaid services besides those for long-term care, if they meet the eligibility criteria for a coverage group that covers services other than long-term care.

Beginning with the year 2011, the \$500,000 amount shall be increased from calendar year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest \$1,000.

(c) Hardship waivers

Individuals who are ineligible for long-term care services due to excess equity in their homes may request an undue hardship waiver based on the criteria specified at M440.44.

Individuals are permitted to use a reverse mortgage or home equity loan to reduce the individual's equity interest in the home. In such circumstances, the department values the funds as follows:

The department does not consider the existence of a line of credit to diminish the equity value except in amounts from the line of credit actually paid to the borrower.

During the month of receipt, lump sum payments are an excluded resource (M232.14(b)) and proceeds paid in a stream of income are excludable income (M242.22(hh)). Lump sum payments from loans that are retained for more than a month, continue to be an excluded resource. Lump sum payments and streams of income are subject to transfer penalties if given away in the month of receipt or thereafter.

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M234

M234 Determination of Countable Resources for SSI-Related Medicaid

The department determines countable resources by combining the resources of the members of the financial responsibility group (M222), and comparing them to the Medicaid group's resource standard. The department determines countable resources for different types of SSI-related Medicaid groups: adults without spouses, adults with spouses, children, and individuals requesting long-term care. If the resources of the Medicaid group fall below or are equal to the applicable resource standard, the resource test is passed. If an excess resource amount remains after all exclusions have been applied (M232), the individual has not passed the resource test. Individuals may become eligible for Medicaid by spending down or giving away excess resources as provided in M411 subject to transfer of resource rules (M440) for those seeking long-term care coverage.

M234.1 Determining Countable Resources for Individuals Other than Children

The department follows the general rule in M234 to determine whether total resources, after exclusions, of individuals other than children fall below the resource maximum for one.

M234.2 Determining Countable Resources for Individuals Requesting SSI-Related Medicaid, Other than Long-Term Care, When They Have a Spouse

The department follows the general rule in M234 to determine whether the total resources, after exclusions, of individuals living with their spouses and requesting SSI-related Medicaid, other than long-term care, fall below the resource maximum for two.

M234.3 Determining Countable Resources for Blind or Disabled Children

Unless otherwise specified in the coverage group rules at M200.22–M200.3, the department determines the countable resources of blind or disabled children by:

- combining the resources of the parents living with the child with the child's resources, until the child reaches the age of 18,
- subtracting the resource maximum for one, if one parent or two, if two parents, from the parent's countable resources; and
- deeming and adding the remainder to the blind or disabled child's own countable resources.

If the blind or disabled child's total countable resources fall below the resource maximum for one, the resource test is passed.

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M243.4

M243 Determination of Countable Income for SSI-Related Medicaid (Continued)**M243.4** Financial Responsibility Groups for Children Seeking Community Medicaid other than Katie Beckett Coverage

The department determines countable income for SSI-related Medicaid child applicants other than Katie Beckett (see M243.1), children whose parent also requests Medicaid (see M243.3), or long-term care (see M243.5) as a financial responsibility group of one according to the following rules. Since parents are responsible for their children, their income must be considered available to their disabled or blind children requesting SSI-related Medicaid coverage, until the child reaches the age of 18.

- (1) Determine the total countable income, both earned and unearned, of the parents living with the child requesting coverage.
- (2) Deduct an allocation specified in M243.2 (b) (ii) or (b) (iii) for the needs of the parents living in the household from the total countable income of the parents.
- (3) Deem the remaining amount to the blind or disabled child. If there is more than one blind or disabled child in the household, divide the remainder by the number of blind or disabled children and deem an equal portion to each. Do not deem more income to a child applicant than the amount which, when combined with the child's own income, would bring his or her countable income to the PIL. If the share of parental income that would be deemed to a child makes that child ineligible because that child has other countable income, deem parental income to other blind and disabled children under age 18 in the household and no portion to the child applicant.
- (4) Add the child's own unearned income. This is the total unearned income.
- (5) Deduct the \$20 disregard. This is the total countable unearned income.
- (6) Determine the earned income of the child.
- (7) Deduct the balance of the \$20 disregard.
- (8) Deduct the \$65 earned income exclusion from any earned income.
- (9) Deduct any allowable work expenses of a disabled child (M245.13).
- (10) Deduct one-half of the remaining earned income.
- (11) Deduct any allowable work expenses of a blind child. (M245.12)
- (12) Combine the remaining earned and unearned income.
- (13) Deduct the amount of a Plan to Achieve Self-Support (PASS), if applicable.
- (14) The result is the applicant/recipient child's countable income. Compare it to the protected income level (PIL) for one. Children with income below the PIL, pass the income test.

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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 individual receiving long-term care services in a nursing facility or receiving enhanced residential care (ERC) services to help maintain their owned or rented home in the community. This deduction is allowed 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 three months and to return home immediately after discharge.

If the situation changes during this 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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M433

M433 Determining which Provider Receives Patient Share Payment

Individuals receiving long-term care sometimes move from one facility to another, such as from one nursing home to another or from a nursing home to a hospital and back to the same or another nursing home. Patient share payments must be paid toward the cost of the individual's care from income received by the individual during each month of a continuous period of receiving long-term care Medicaid services.

As a general rule, the provider giving long-term care services to the individual on the last day of the preceding month sends the individual a bill for the patient's share of the cost for that month. Payment is made to the nursing facility if the individual was receiving long-term care in a nursing facility on the last day of the preceding month. Payment is made to the highest paid provider of waiver services if the individual is active on a waiver program on the last day of the preceding month. Exceptions to this rule are specified in the subsections below.

If payment of a patient share results in a credit to the provider then the provider sends the excess to the Office of Vermont Health Access.

M433.1 Payment of Patient Share when Long-Term Care Recipient Enters a Hospital

Long-term care Medicaid recipients who are hospitalized remain long-term care recipients and their patient share amount is not redetermined. The department allocates payment of the patient share to the providers as follows:

- (a) For acute care: the patient share is paid directly to the Office of Vermont Health Access when the recipient is hospitalized and receiving acute hospital care on the last day of the month preceding the month in which income is received. Failure to pay the patient share may result in closure of long-term care Medicaid eligibility.
- (b) For long-term care: the patient share is paid to the hospital when the recipient is hospitalized and receiving long-term care services in the hospital on the last day of the month preceding the month in which income is received.

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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.

- (a) Expected lifetime of the institutionalized individual will be measured at the time of the transfer as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration) (<http://socialsecurity.gov/OACT/STATS/table4c6.html>) and set forth in the Medicaid procedures manual.
- (b) Expected lifetime of the spouse will be measured at the time of the transfer as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration) (<http://socialsecurity.gov/OACT/STATS/table4c6.html>) and set forth in the Medicaid procedures manual.

Pursuant to the authority granted in Vermont Act 71 § 303(7)(2005), the department is developing alternate actuarial tables that will be consistent with federal law and adopted by rule.

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M440.3

M440 Transfer of Income or Resources by Individuals Requesting Long-Term Care Coverage (Continued)**M440.3 Allowable Transfers for Less than Fair Market Value**

The department does not impose a penalty period for transfers made by members of the financial responsibility group for less than fair market value that meet one or more of the following criteria.

- (a)
 - (i) The income or resource was transferred before February 8, 2006 and was not in a trust, and the date of the transfer was more than 36 calendar months prior to the first month in which the applicant or recipient both requests Medicaid coverage of long-term care expenses and meets all other requirements for Medicaid eligibility.
 - (ii) The income or resource was transferred on or after February 8, 2006 and the date of the transfer was more than 60 calendar months prior to the first month in which the applicant or recipient both requests Medicaid coverage of long-term care expenses and meets all other requirements for Medicaid eligibility.
- (b) The transferred income or resources have been returned to the individual or otherwise remain available to the individual or another member of the financial responsibility group.
- (c) The action that constituted the transfer was the removal of a member's name from a joint account in a financial institution, and the member has demonstrated, to the department's satisfaction, that the funds in the account accumulated from the income and resources of another owner who is not a member of the financial responsibility group.
- (d) The member has documented to the department's satisfaction convincing evidence that the resources were transferred exclusively for a purpose other than to become or remain eligible for long-term care. A signed statement by the individual is not, by itself, convincing evidence. Examples of convincing evidence are documents showing that:
 - the transfer was not within the individual's control (e.g., was ordered by a court);
 - the individual could not have anticipated long-term care eligibility on the date of transfer (e.g., the individual became disabled due to a traumatic accident after the date of transfer); or
 - a diagnosis of a previously undetected disabling condition leading to long-term care eligibility was made after the date of transfer.
- (e) The transfer meets the criteria specified in M440.31-440.32 for transfers involving trusts, transfers of homes, and transfers for the benefit of certain family members.
- (f) The individual intended to dispose of the income or resources either at fair market value, or for other valuable consideration.
- (g) The member transferred excluded income or resources. Penalties are imposed for the transfer of any asset considered by the social security administration's supplemental security income program to be countable or excluded income or resources. For example, transfer of the home or of the proceeds of a loan are both subject to penalty.

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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) the member's 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.

The department also does not impose a penalty period for the purchase of a life estate interest in another individual's home when it is the purchaser's residence and the purchaser resides in the home for a period of at least one year after the purchase.

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 member's son or daughter who is blind or permanently and totally disabled or to a trust for the sole benefit of a member's son or daughter who is blind or permanently and totally disabled, regardless of age.

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

M440.34 Transfers involving Annuities

Annuities purchased by the institutionalized individual or community spouse on or after February 8, 2006 must name Vermont Medicaid as the first remainder beneficiary up to the amount of long-term care and community service Medicaid payments made by the state on behalf of the institutionalized individual. In cases where a minor or disabled child, or a community spouse is named as a beneficiary ahead of the state, Vermont Medicaid must be named as the secondary beneficiary. If Vermont Medicaid is not named as a remainder beneficiary in the correct position, the purchase of the annuity will be considered a transfer for less than fair market value. When Vermont Medicaid is a beneficiary of an annuity, issuers of annuities are required to notify Vermont Medicaid of any changes in the disbursement of income or principal from the annuity as well as any changes to the State's position as remainder beneficiary.

(a) Allowable Transfers

The department does not impose a penalty for the purchase of an annuity when it meets one or more of the four alternatives described below. To determine that an annuity is established under any of the various provisions of the Internal Revenue Code that are referenced in items 3 and 4 below, the department relies on verification from the financial institution, employer or employer association that issued the annuity. The burden of proof is on the individual to produce this documentation. Absent such documentation, the department will consider the purchase of the annuity a transfer for less than fair market value which is subject to a penalty.

- (1) The annuity meets the provisions of M232.4 or M233.21.
- (2) The annuity is purchased by the institutionalized spouse and:
 - (A) is irrevocable and nonassignable;
 - (B) provides for payments to applicants or their spouses in equal intervals and equal amounts with no deferral and no balloon payments made; and
 - (C) is actuarially sound because it does not exceed the life expectancy of the applicants or their spouses, as determined by the department using the actuarial publications of the Office of the Chief Actuary of the Social Security Administration (<http://socialsecurity.gov/OACT/STATS/table4c6.html>) and set forth in the Medicaid procedures manual and returns to the beneficiary at least the amount used to establish the contract and any additional payments plus earnings, as specified in the contract.
- (3) The annuity is purchased by the institutionalized spouse and considered either:
 - (A) an individual retirement annuity (according to Sec. 408(b)) of the Internal Revenue Code of 1986 (IRC), or
 - (B) a deemed Individual Retirement Account (IRA) under a qualified employer plan (according to Sec. 408(q) of the IRC).

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M440.34 P.2

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

M440.34 Transfers involving Annuities

(4) The annuity is purchased by the institutionalized spouse with proceeds from one of the following:

- (A) a traditional IRA (IRC Sec. 408a); or
- (B) certain accounts or trusts which are treated as traditional IRAs (IRC Sec. 408 §(c)); or
- (C) a simplified retirement account (IRC Sec. 408 §(p)); or
- (D) a simplified employee pension (IRC Sec. 408 §(k)); or
- (E) a Roth IRA (IRC Sec. 408A).

(b) Impermissible Transfers

Annuities that do not meet the criteria in M440.34(a) 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.

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M440.35

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

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) shall be assessed a transfer penalty based on their fair market value unless they:

- (a) have a repayment term that is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration (<http://socialsecurity.gov/OACT/STATS/table4c6.html>) and specified in the Medicaid procedures manual;
- (b) provide for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and
- (c) prohibit the cancellation of the balance upon the death of the lender.

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 as of the date of the Medicaid long-term care application.

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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 before February 1, 2007, 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 after February 1, 2007 the period of restricted coverage is dependent upon the date of the transfer.

- (a) When the transfer occurred before February 8, 2006 and not in any other period of restricted coverage, the penalty date starts on the first day of the month following the date the asset was transferred.
- (b) When the transfer occurred on or after February 8, 2006 and not in any other period of restricted coverage, the penalty date starts on the first day in which the individual would have been otherwise eligible for long-term care Medicaid.

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.

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M440.42

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

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.

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M440.44

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

M440.44 Undue Hardship

The department does not establish a penalty period resulting from an improper transfer when it determines that restricted coverage will result in an undue hardship. Undue hardship is considered only in cases where the department has first determined that a transfer has been made for less than fair market value and that no transfer exception applies (M440.3-M440.34).

For the purposes of this section the term individual refers to the long-term care applicant or recipient as well as a long-term care service provider. Providers may file a request for undue hardship on behalf of the individual with the consent of the individual or the personal representative of the individual.

(a) Definition of undue hardship

Undue hardship means depriving the individual: of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life such that would be at risk of serious deprivation. Undue hardship does not exist when the application of a transfer penalty merely causes an individual or individual's family member(s) inconvenience or restricts their lifestyle. Undue hardship does not exist when the individual transferred the assets to the community spouse and the community spouse has countable or excluded resources in excess of the community spouse resource allocation standard.

(b) Process for reviewing undue hardship requests

The department shall inform the individual of the right to request an undue hardship exception through written notice of a penalty period of ineligibility for Medicaid payment of long-term care services because of an impermissible asset transfer. The notice shall specify the factual and legal basis for the imposition of the penalty, and shall explain how the individual may request a hardship exception. Individuals may receive an undue hardship exception to the transfer of assets penalty if they can show that the penalty will cause an undue hardship to them. Undue hardship shall be established when the individual demonstrates by a preponderance of the evidence that denial of Medicaid payment for long-term care services will cause actual and not merely possible undue hardship. The department's decision may waive all or a portion of the penalty period.

Individuals subject to a transfer penalty may request an undue hardship within 20 days of notification of the transfer penalty by providing documentation supporting the request to the department. Once the department determines that it has received complete documentation, the department shall inform the individual within 10 business days of the undue hardship decision and of the right to request a fair hearing. The department may extend these periods if the department determines that extenuating circumstances require additional time. If no request for undue hardship is received within 20 days after notification of the transfer penalty, or if the request is denied, the department shall issue an eligibility determination specifying the applicable penalty period. If the

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

M440.44 Undue Hardship (Continued)

individual is a recipient, the notice shall include the date of Medicaid long-term care termination and include the right to request a fair hearing and continuing benefits.

When undue hardship requests are made for the first time at the time of requesting a fair hearing, individuals challenging the penalty period must raise all claims and submit all evidence permitting consideration of undue hardship at least 10 business days in advance of the fair hearing. Undue hardship shall be referred to the department for consideration and the department shall inform the Human Services Board of its decision on undue hardship within 10 business days of receipt.

Undue hardship requests also may be filed at any time during the penalty period if new circumstances leading to undue hardship arise during the duration of a transfer penalty period. If granted, the undue hardship request shall be prospective from the date of the request.

The department shall have no obligation to pay for long-term care services during the penalty period unless it grants an undue hardship exception or the beneficiary prevails at the fair hearing.

(c) Undue Hardship Reasons

In determining the existence of “undue hardship”, the department shall consider all circumstances involving the transfer and the situation of the individual. Undue hardship is established when one or more of the following circumstances, or any other comparable reasons, exist.

- (1) Whether imposition of the transfer penalty would result in the immediate family qualifying for Supplemental Security Income; Reach Up; Aid for the Aged, Blind or Disabled; General Assistance; Food Stamps; or another public assistance program requiring a comparable showing of financial need.
- (2) Whether funds can be made available for long-term care only if assets such as a family farm or other family business are sold, and the assets are the primary source of income for the individual's spouse, parents, children or siblings.
- (3) Whether a power of attorney (POA) or guardian transferred the asset, and the POA or guardian was not acting in the best interest of the individual when the transfer was made as determined by the department or a court, or the transfer forms the basis for a report to the Department of Disabilities, Aging and Independent Living for investigation of abuse, neglect or exploitation.

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M440.44 Undue Hardship

(c) Undue Hardship Reasons (Continued)

- (4) Whether the individual was deprived of an asset by fraud or misrepresentation. Such claims must be documented by official police reports or civil or criminal action against the alleged perpetrator or substantiated by the Department of Disabilities, Aging and Independent Living or by a sworn statement to the department attesting to the fact that the claim was reported to the police or DAIL.
- (5) Whether the individual cannot recover the assets due to loss, destruction, theft, or other similar circumstances.
- (6) (a) When the transfer is to a person the department presumes the recipient of the transferred resource could make arrangements for the individual's care and the care of dependent family members up to the value of the transfer unless the evidence submitted indicates that there is no reasonable way that the person can make any of these arrangements. The facts and verification required to determine if the recipient of the transferred resource can make other arrangements to pay or provide the care of the individual, or to provide for the needs of financially dependent family members may include the following, if applicable:
- A copy of the tax return for the preceding calendar year;
 - All earnings pay stubs for the past 12 months;
 - All bank books, stocks, bonds, certificates, life insurance policies (e.g. bank books must include those before and after receipt of the transferred resource); and
 - All documents associated with the proceeds of the transferred resource which will show the value of any purchase of new resources from the sale proceeds of the transferred property.

When the transfer is made to a relative who is a minor, a family member with financial responsibility for the minor must be asked to provide the required facts and verification.

(b) If the individual rebuts the presumption and shows there is no reasonable way that the recipient of the transferred resource can make arrangements for the individual's care and the care of dependent family members up to the value of the transfer, the department will consider whether the individual has exhausted all reasonable efforts to meet his or her needs from other available sources. This includes whether the individual has exhausted all reasonable efforts to obtain return of the assets transferred, and demonstrated that efforts to obtain return of the asset or adequate compensation would probably not succeed. The department will take into consideration all excluded and countable assets above the protected resource standard and income above the monthly maintenance needs allowance. Burial funds and the individual's principal place of residence will continue to be excluded.