

PATH

Department of Prevention, Assistance, Transition, and Health Access

FROM Patricia House, Commissioner
for the Secretary

BULLETIN NO. 02-11

DATE July 16, 2003

SUBJECTS SSI-Related Medicaid Regulations Concerning
Income, Resources, and Transfer of Assets

CHANGES ADOPTED EFFECTIVE 08/01/2003

INSTRUCTIONS:

X Maintain Manual - See instructions below.
_____ proposed Regulation - Retain bulletin
and attachments until you receive
Manual Maintenance Bulletin: 02-11F
_____ Information or Instructions - Retain until

CURRENT MANUAL REFERENCES

M200 TOC M360 M400 TOC
M200-M299 M400-M499

Introduction

This bulletin substantially amends the rules used to determine long-term care eligibility, including SSI-related Medicaid rules related to resources and income, as well as 1rules concerning spenddowns, patient share determinations, and transfer of assets.

These changes make the department's rules consistent with federal law, internally consistent, incorporate more than 50 interpretive memoranda (PP&Ds), and revise a number of declaratory rulings that no longer reflect the department's policies.

The department seeks greater consistency and improved clarity to its SSI-related Medicaid eligibility rules through amendments that define basic concepts, including financial responsibility group and Medicaid group. This will assist PATH staff in determining eligibility, members of the private bar helping Vermonters with estate planning, and others trying to understand the eligibility rules for long-term care.

Significant amendments related to income eligibility include adding a financial eligibility income determination process for LTC, including waiver and hospice coverage.

New Rule Sections

These rules incorporate all regulatory content in current rules and policy memoranda (PP&Ds) as appropriate. To the extent any other existing PP&Ds, declaratory rulings, or procedures are inconsistent with the new rules, the new rules are intended to supercede them and be the controlling authority. An index cross-referencing the new rules with old rules and policy memoranda follows after this narrative description of the changes.

M200 SSI-Related Medicaid Eligibility - reorganizes, clarifies, simplifies and updates existing regulations

M200.1 Definitions – adds new content by defining terms used throughout M200-M299 such as: community spouse, couple, coverage group, individual, institutionalized individual, institutionalized spouse, long-term care, Medicaid group, financial responsibility group, waiver services. Incorporates policy content from interpretive memos on guardians, qualified individuals. Eliminates content duplicated by M133.

M200.2-M200.4 Coverage groups - describes three general categories of SSI-related Medicaid coverage groups: categorically needy, medically needy and Medicare cost-sharing.

M210-M214.3 Nonfinancial Eligibility Tests for SSI-Related Medicaid - **revised title of M210 to clarify connection between its content and that of other sections in the M200s.**

M220 Financial Eligibility for SSI-Related Medicaid – Clarifies existing regulations by defining concepts essential to resource and income eligibility determinations, such as financial responsibility group, Medicaid group and deeming.

M230 Overview of Resource Requirements - reorganizes, clarifies, simplifies, and updates existing regulations that give an overview of SSI-related resource requirements. It incorporates the grandfather provision formerly located at M201 and is broadened to encompass new provisions in M230-M239.

M231-M231.3 Types of Resources - More expansive description of the kinds of nonliquid and liquid resources whose availability the department may consider in determining Medicaid eligibility. Trust description includes and clarifies content from former M237. Incorporates policy content from interpretive memos and clarifies life estates, burial spaces, retirement funds, and home equity conversion plans. Adds description for accounts in financial institutions, stocks, bonds, mutual funds and money market accounts, annuities, mortgages and promissory notes.

M232 Excluded Resources – adds new content on resource exclusions merged with existing policy at M234 reorganized under the following subsections.

M232.1 - M232.18 Real Property - contains the home exclusion, formerly located at M201.21

M232.12 - expands subparagraph 4 of the provisions formerly located at M234.1. It expands regulations concerning proceeds from the sale of an excluded home to be consistent with federal regulations.

M232.13-M232.18 – contains information formerly located at M201.22 – M201.25 and incorporates policy content from interpretive memos.

M232.2 Life Insurance - clarifies the life insurance exclusion, contains information formerly located at M234(11).

M232.3 Burial Funds – incorporates provision from M201.26.

M232.4 Annuities - incorporates provision from M201.27.

M232.5 Resources Managed by a Third Party - excludes trusts and contains provisions formerly located at M234(10), M237-M237.2, and in interpretive memos.

M232.6 Early Withdrawal Penalties and Surrender Fees - adds a provision specifying when early withdrawal penalty fees are excluded.

M232.7 Jointly Held Accounts – Clarifies the provision formerly located at M232.

M232.8 Resources Excluded for Limited Periods - describes resources excluded for limited periods, provisions formerly located at M234.1.

M232.9 Other Excluded Resources - describes other excluded resources, provisions formerly located at M234(3)-(4), (6), (8)-(9), (14)-(18).

M233 – M233.2 Value of Resources Counted Toward the Medicaid Resource Limit – contains content formerly at M232, M233, M237, M238 and M270.2 under one heading broadly applicable to valuation of resources in general. Incorporates the provisions formerly located at M201.31 – M201.32. Clarifies the department's treatment of jointly held liquid and nonliquid resources. Incorporates the provision formerly located at M201.33 specifying how the department treats jointly held real property.

M234- M234.4 Determination of Countable Resources - content from former M235 moved here and described by type of applicant and coverage group.

M240 Overview of Income Requirements - reorganizes, clarifies, simplifies, and updates existing regulations that give an overview of SSI-related income requirements

M241-M241.2 Types of Income – content from former M241 and M242 included and reorganized here.

M242-M242.2 Income Exclusions – content from former M241.1, M242.2 and M260 moved here.

M243 General Rules for Determining Countable Income – some content from former sections M243 and M250-M250.2 included here.

M245-M245.2 Income Deductions – content from former M241.2, M242.2, and M243 moved here.

M360 - Individuals with a Community Spouse Requesting Long-Term Care - replaces repetitive content with crossreferences to the applicable rules.

M400 – Spenddown, Patient Share, and Transfer of Resources - explains that the provisions in M400-M499 apply to both SSI-related Medicaid and ANFC-related Medicaid.

M401-M402.2 – Types of Living Arrangements and Accounting Periods - content from former sections M410-M412, M420-M421, and M440 moved and updated here. Describes living arrangements and accounting periods needed to determine spenddowns and patient share obligations.

M410-M413 – Treatment of Excess Income and Resources to Meet Financial Eligibility Standards - content from former M400-M402.2 moved and updated here. Clarifies how the department treats excess income and resources when determining Medicaid eligibility. Adds content to address how excess income and resources affect eligibility for waiver living arrangements.

M420-M423 - Medical Expense Spenddowns - content from former M423-M434 updated and included here.

M430-M433 - Patient Share Payment Provisions - content from former M413-M415.6 moved and updated here.

M440-M440.44 - Transfer of Income or Resources by Individuals Requesting Long-Term Care Coverage – content from former M417- M417.22 moved and updated here. Clarifies when the department allows long-term care applicants and recipients to transfer income and resources and when it penalizes them. Expands definition of fair market value and clarifies how the department determines the penalty period for disallowed transfers and undue hardship.

Summary of Public Hearing and Written Comments

A public hearing was held on January 27, 2003 at 1:00 p.m., in the Planning and Evaluation Division's Blue Room, Department of PATH, State Office Complex, Waterbury, Vermont. Two Vermont attorneys with private Elder Law practices attended and testified. Written comments were received from four private attorneys with Elder Law practices as well as from the Community of Vermont Elders. Five attorneys representing four special projects of Vermont Legal Aid also commented: the Disability Law Project, the Office of Health Care Ombudsman, Senior Citizens Law Project, Vermont Ombudsman Project. The Centers for Medicare and Medicaid Services also provided clarification.

The comments are summarized and responded to below.

General comments

Necessity of the comprehensive revisions

Comment: Several commenters expressed that this proposed rule is a great improvement over existing rules because it cleans up many things that were in more than one place before and organizes the rules in a form that can be more easily used by practitioners. Two attorneys from Vermont Legal Aid said the changes present no significant improvement and make the rules more difficult for users.

Response: These revisions seek to clarify the department's policies concerning the types of resources that people must use toward meeting their needs before becoming eligible for publicly funded health benefits. The department's SSI-related Medicaid program covers community Medicaid for the aged, blind and disabled as well as long-term care services, including six Medicaid waiver programs and hospice. By defining more clearly what income and resources count toward the eligibility determination for SSI-related Medicaid, the department hopes to offer access to health services to all Vermonters whose income and resources cannot be stretched to include health insurance. The legislature directed that specific corrections be made through expedited rules effective July 1, 2002. Additional revisions are proposed here for the SSI-related Medicaid program that has evolved without comprehensive clean-up for over 20 years. The department made changes to improve organization and render its rules consistent with federal law.

Interpretive memoranda

Comment: One commenter opposed incorporation of any interpretive memoranda in the Medicaid Procedures Manual. Others asked that the proposed rule retain all regulatory content and interpretive memoranda be removed only after the issuance of procedural content in the Medicaid Procedures Manual.

Response: The department shall retain interpretive memoranda until the regulatory content are incorporated into approved rules or the procedural content is issued through the Medicaid Procedures Manual and is available to the public.

Citation form

Comment: References would be more useful if the citations to the Social Security Act were replaced with citations to the United States Code.

Response: Since both citation forms are commonly used in this area of law, the department has added parallel references to the United States Code, following each Social Security Act citation.

Application of these rules to civil unions

Comment: Several commenters asked how the proposed rules will be applied to parties to a civil union. The department was asked to: define the term spouse to include a civil union partner; signal that tenancy by the entirety applies to real property of partners in civil unions as well as married couples; and include civil union partners included in the department's use of the term "married".

Response: Although federal law prohibits Vermont from using federal funds to cover parties to a civil union as spouses, the state will proceed with a separate state program for parties to a civil union to ensure that parties to a civil union receive the same treatment for public health care eligibility and benefits as married couples. With respect to all health care eligibility determinations for SSI-related Medicaid, including long-term care, parties to a civil union will be treated as spouses. The department has amended its proposed rules to remove all references to the term "married" and replaced it with the inclusive term "spouse." (See 15 V.S.A. §1204(b)). The department will add "civil union" as a status along with "married, single," etc., to its application forms. It will use the same eligibility rules for both groups. It will pay for these benefits through an accounting mechanism that routes claims for payment from solely state funds, as required.

Specific Comments and Responses by Proposed Regulation Sections

Where appropriate to the comment, the department's response includes parenthetical citations to relevant authority of the Social Security Act (SSA), Code of Federal Regulations (CFR), State Medicaid Manual (SMM) published by the Centers for Medicare and Medicaid Services (CMS) and PATH interpretive memoranda (PP&D).

M200 SSI-Related Medicaid Eligibility

Comment: The former heading "Medicaid Eligibility for the Aged, Blind and Disabled" should be retained because it includes SSI-related and Medically Needy coverage groups.

Response: SSI-related Medicaid includes the categorically needy (rule M200.2) and the medically needy (rule M200.3).

Comment: Please incorporate into the introduction the former reference to the availability of Medicaid funding to cover some Medicare costs.

Response: This clarification has been made to the final proposed rule.

Comment: Please maintain the detailed explanation of an adult developmental home and therapeutic foster care home found in the interpretive memoranda (PP&D opposite M200 dated 6/13/95)

Response: The index on the coversheet has been changed to reflect that this procedural content will be moved to the Medicaid Procedures Manual. The department anticipates issuance of the updated procedures on the date these rule changes become effective.

Comment: Have the provisions for federal essential spouses been excluded because individuals can no longer qualify for this group?

Response: Yes. In the late 1980's only eleven people remained in this group. No individuals are currently in this group.

M200.1 Definitions

Comment: How do the terms spouse and community spouse work when both receive waiver services?

Response: Proposed rule M200.1(b) describes the department's approach. Both spouses may be considered a "community spouse" if both are receiving waiver services. (SSA §1924(h); 42 U.S.C. §1396r-5(h)).

Comment: The department is using the terms Medicaid group, coverage group and financially responsible group interchangeably throughout the definitions and rules. If there are substantive differences between them, the department must make this clear.

Response: All three terms are new to the department's SSI-related Medicaid rules. They have been added and used specifically throughout the proposed rule as the concepts are fundamental to understanding eligibility. All three terms are defined in rule M200.1(c)(d) and (h). In addition, the terms Medicaid group and financial responsibility group are explained and applied in more detail in rules M222 and M221 respectively.

Comment: Please add each department's role in making eligibility determinations for waiver services, defined in subsection (k).

Response: The final proposed rule describes the roles of other departments in determining the non-financial aspects of eligibility.

M200.21 SSI-Recipient Coverage Group

Comment: Please revise the regulation to include that presumptive disability constitutes Medicaid eligibility if the applicant meets the other Medicaid requirements.

Response: This clarification has been made to the final proposed rule.

Comment: Individuals granted SSI/AABD who do not receive a payment because of recoupment belong in the description of this group.

Response: The final proposed rule makes this correction.

M200.22 SSI-Eligible Coverage Group

Comment: Are individuals in the coverage group described in subsection (a) required to have income and resources at or below SSI/AABD maximums and meet the nonfinancial criteria for SSI-related Medicaid?

Response: Yes. This clarification has been made to the final proposed rule.

Comment: The proposed rule in subsection (b) should include the requirement that PATH must make a “separate determination of whether or not the individual continues to be eligible for Medicaid under any other coverage group.”

Response: This nonfinancial requirement is generally applicable to all eligibility decisions made for SSI-related Medicaid and already incorporated by the crossreference in rule M200. The final proposed rule adds another, more specific, citation to this principle in rule M200.2 providing: “When an individual becomes ineligible for one coverage group, the department tests for other categorical and then medically needy eligibility. Medicaid remains open until an individual no longer passes any of the eligibility tests, per rule M133.”

Comment: The proposed rule in subsection (b) provides only that the department consider publicly funded attendant care services. This narrows the criteria without a rationale because SSI/AABD and Medicaid funded personal care services are excluded.

Response: The term publicly funded is sufficiently broad to include all publicly funded personal care programs, including but not limited to those paid for by SSI/AABD and Medicaid.

M200.23 Long-Term Care Medicaid Coverage Groups

Comment: Please include the formal name of this program in the heading for subsection (d).

Response: This clarification has been made to the final proposed rule.

Comment: Why did the department remove from subsection (d) the language specifying that children need not be eligible for waiver services?

Response: The structure of the revision states only what must be established for eligibility, rather than what is not required.

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

Comment: Why was the interpretive memo (PP&D opposite rule M200(C)(17), 7/1/01) explaining the term “uninsured” removed?

Response: As noted in the detailed cross-reference index of the bulletin coversheet (PP&D opposite M200 P.5), this interpretive memo will be retained.

Comment: It would clarify subsection (b) if the department would revise it in a style that is parallel with the others in this section.

Response: The final proposed rule makes this revision.

M200.25 Coverage Groups Open to Former Recipients of SSI, SSI/AABD, or Medicaid

Comment: Please provide more structure for commenters to evaluate whether this section retains the content of the existing rule.

Response: Here are crossreferences to proposed subsections (a) through (e) to the existing rules.

- (a) Interpretive memo, opposite M200, 2/16/98
- (b) M200 (C)(6); M200 (C)(13), respectively
- (c) M200(C)(11)
- (d) M200(C)(5)
- (e) M200(C)(2), (M200(C)(3), (M200(C)(1), respectively
- (f) M200(C)(4), para. 2, (M200(C)(4), para. 1, respectively

Also, the final proposed rule revises subsections (b) through (d) because a technical assistance paper published recently by CMS provides a clearer explanation of these groups.

Comment: Please include the formal name of this program in the heading for subsection (d).

Response: This clarification has been made to the final proposed rule as follows, “Individuals determined eligible under the Pickle Amendment to Title XIX of the Social Security Act (SSA §1935(a)(5)(E); 42 U.S.C. §1396v(a)(5)(E))”.

M200.4 SSI-Related Medicare Cost-Sharing Coverage Groups

Comment: Please maintain the language from the existing rule that explains that individuals may be dually eligible for one of the cost-sharing groups, as well as one of the categorical or medically needy groups.

Response: For the final proposed rules this clarification has been added, “Individuals eligible for one of the following Medicare costsharing coverage groups may also be eligible for the full range of Medicaid covered services if they also meet the requirements for one of the categorical (M200.2) or medically needy coverage groups (M200.3).”

Comment: Please specify the resource requirement in each subsection for ease of reference.

Response: The final proposed rule removes the resource requirement from the main section and adds it to each subsection.

M213 State Residence

Comment: The Centers for Medicare and Medicaid Services recently provided the state with guidance that an institutionalized individual cannot be considered a Vermont resident if the individual owns a home in another state which the individual intends to return to.

Response: This guidance has been incorporated to clarify M213(6).

M220.1(c)-(e) Definitions

Comment: When using the phrase “is not eligible” does that department mean that the individuals do not meet the nonfinancial eligibility criteria?

Response: Yes. This clarification has been made to the final proposed rule.

M222.21(a) Exceptions to the Rules for Forming SSI-Related Medicaid Groups for Adults with Spouses

Comment: The rule should clearly state that it is the concurrence of receipt of long-term care services with a Medicaid application that triggers treating a spouse as a Medicaid group of one, when both spouses still live together.

Response: This clarification has been made to the final proposed rule.

M222.21(d) Exceptions to the Rules for Forming SSI-Related Medicaid Groups for Adults with Spouses

Comment: What is the purpose of the six-month requirement?

Response: The six-month requirement ties to reviews of long-term care eligibility at these intervals (rule M132).

M222.3 SSI-related Medicaid Groups for Children

Comment: Please add that Medicaid groups for a parent and child requesting SSI-related Medicaid may include living with a spouse.

Response: The final proposed rule makes this distinction.

M223.1 Temporary Absences and Deeming Rules

Comment: What do you mean by “ineligible”?

Response: “Ineligible” is defined in the proposed rule M220.1 (20 C.F.R. §416.120(c)).

M230 Overview of Resource Requirements

Comment: Please include the provisions of SSI regulation 20 C.F.R. §416.1201(a)(1) in the first paragraph of the proposed rule.

Response: The final proposed rule makes this more explicit.

M230.1 Changes to Resource Rules Effective May 1, 2003

Comment: Since the proposed rule incorporates existing interpretive memoranda it should accurately reflect the policy they contain and this disclaimer should be eliminated.

Response: The final proposed rule omits the reference to interpretive memoranda, stating: “To the extent any existing declaratory rulings are inconsistent with the new regulations, the new regulations are intended to supercede them and be the controlling authority.”

M231.2 Liquid Resources

Comment: Please restore the phrase in existing rule M231(1) providing that mortgages and promissory notes are counted as resources only if they are “payable to the applicant and negotiable.”

Response: The final proposed rule adds the term “ordinarily” to the definition to match more precisely the department’s description of liquid resources with federal law. (20 C.F.R. 416.1201(b)).

M231.21 Accounts in Financial Institutions

Comment: Please include a reference to a new type of bank account, the “joint fiduciary account” established by legislation last year.

Response: The department has added this reference in final proposed rule M231.21, M231.35 and M231.71.

M231.32 Power of Attorney

Comment: Please include the significance of this term in determining resources of an individual requesting Medicaid.

Response: The department has provided this clarification in the final proposed rule.

M231.33 Guardians and Conservators

Comment: Please delete references to conservators since Vermont law does not use the term and remove the prescriptive guidance on how funds in a guardianship fund shall be evaluated.

Response: The department has removed the term conservator and the prescriptive language from the final proposed rule.

M231.34 Representative Payee

Comment: Please include the significance of this term in determining resources of an individual requesting Medicaid.

Response: The department has provided this clarification in the final proposed rule.

M232 Excluded Resources

Comment: Two commenters asked that the second sentence of this introductory section should be limited to the primary residence in order to be consistent with federal law.

Response: This sentence has been moved to subsection 232.11 since federal law permits the transfer of excluded assets, other than the home, without penalty. (SSA §1917(e); 42 U.S.C. §1396p(e); SMM §3259.6(F)).

M232.11 A Home and Contiguous Land

Comment: Why does the department consider a home conveyed to a revocable trust a countable resource?

Response: Homes placed in revocable trusts are countable resources pursuant to federal law. (SSA §§1917(d)(3), 1917(e); 42 U.S.C. §§1396p(d)(3), 1396p(e) SMM § 3259.6(F)).

Comment: Please revise this rule to incorporate the content of the interpretive memoranda dated 12/20/88 defining dependent relatives.

Response: The department has included this content in the final proposed rule.

Comment: The term “nonresidential” in paragraph one adds unnecessary complexity.

Response: The final proposed rule eliminates this term.

M232.12 Proceeds From the Sale of an Excluded Home

Comment: What is the three-month exclusion period derived from?

- Response: This rule derives from the supplemental security income rules upon which SSI-related Medicaid is based. (20 C.F.R. §416.1210(d)(1)).
- Comment: Please include an explanation of the treatment of installment sales contracts and promissory notes.
- Response: The department has provided this clarification in the final proposed rule. (20 C.F.R. §416.1212(d)(2) and (3)).
- Comment: This section does not accurately capture the content of the interpretive memo opposite M234.1 dated 11/08/94.
- Response: The final proposed rule tracks federal regulations in its requirement to count both the value and payments of a promissory note or installment sales contract if they result from the sale of a home and are not reinvested within 3 months. (20 C.F.R. §416.1212(d)(2)).

M232.13 Real Property for Sale

- Comment: What is the derivation of the requirement that any offer at least two-thirds of the most recent estimate of the property's fair market value is considered reasonable?
- Response: This rule was prescribed by the legislature last year in Act 142 §148(m)(4) and derives from the supplemental security income rules upon which SSI-related Medicaid is based. (20 C.F.R. §416.1245(b)(3)(iii)).

M232.15 & M233.23 Jointly Owned Real Property

- Comment: These two sections appear contradictory with respect to the 36-month requirement.
- Response: Section M233.23 has been revised to be consistent with M232.15 and with Act 142 §148(m)(3).
- Comment: This section is more restrictive than the SSI rules because it does not contain an undue hardship exception.
- Response: The final proposed rule adds an undue hardship provision, consistent with SSI regulations. (20 C.F.R. § 416.1245(a)).

M232.16 Life Estates

- Comment: Two commenters asked for clarification on the difference between the treatment of life estates established before and after July 1, 2002.

Response: The confusion is based on a drafting error. The final proposed rule revises subsection (b) and (c) to remedy the confusion.

M232.17 Real Property Producing Significant Income

Comment: Six percent of fair market value seems too restrictive for real property.

Response: This rule was prescribed by the legislature last year in Act 142 §148(m)(5) and derives from the supplemental security income rules upon which SSI-related Medicaid is based. (20 C.F.R. §416.1222).

M232.18 Real Property Producing Goods For Home Consumption

Comment: Please add a crossreference to indicate that the portion of property used for income production should be evaluated based on the criteria in rule M232.17.

Response: The department has provided this clarification in the final proposed rule.

M232.3 Burial Funds

Comment: How will the department value burial spaces included as burial funds?

Response: Burial spaces paid for in full are excluded; those subject to an installment sales contract are treated as burial funds. (20 C.F.R. §416.1231). The final proposed rule modifies the third paragraph of subsection (a) to make this clearer.

Comment: Will interest on burial funds be an excluded resource?

Response: Yes. M232.3(b) provides that interest earned on burial funds left to accumulate is excluded.

M232.4 Annuities

Comment: What is the federal statutory authority for making the payout period match the life expectancy of the applicant or spouse, rather than permitting the payout period to be for a shorter period than the annuitant's life expectancy?

Response: Section 1917(d)(6) of the Social Security Act provides that the term "trust" includes an annuity to the extent and in such manner as the Secretary of Health and Human Services specifies. The Secretary has specified in the State Medicaid Manual that "if the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the beneficiary, the annuity can be deemed actuarially sound" and not an abusive shelter for assets. (SMM § 3258.9(B)).

- Comment: Proposed rule (b)(iv) is problematic. The return on some types of annuities (e.g., annuities for one life) depends on how long a person actually lives. How will the department treat annuities when the individual dies sooner than their life expectancy?
- Response: This criteria relates to the criterion in (b)(iii). The department will consider the terms of the exclusion met if, when established, the annuity satisfies all five criteria.
- Comment: Proposed rule (b)(v) should be stricken. As long as an annuity is paying the applicant or spouse during their lives, there is no reason the state should prohibit the contractual right of a Medicaid recipient to pay a contingent remainderman at their death or that of their spouse.
- Response: This criteria derives from statute. Last year the legislature prescribed these criteria in Act 142 §148(m)(8). Its purpose is to require the maximum available resources to be used for medically necessary health care expenses, rather than permit transfer of wealth to the next generation.

M232.51 Definition of Trust

- Comment: The third full paragraph use of the term “grantee” is confusing.
- Response: The word has been replaced with “grantor”.

M232.52 Excluded Trusts

- Comment: Three commenters expressed concern that this section omits mention of “third party” trusts.
- Response: The department has restored the exclusion providing that “trust property in a trust established by persons other than the individual or spouse are excluded unless the terms of the trust permit the individual to revoke the trust or to have access to it without trustee intervention” in the final proposed rule at subsection (d).
- Comment: Do criteria (c) and (d) of rule M232.52 apply to supplemental needs trusts?
- Response: No. The conjunction following subsection (d) has been changed from “and” to “or” to clarify that trusts meeting the criteria in any one of the subsections (a) through (e) are excluded.

Comment: Proposed rule M232.52(c) improperly assumes a trustee's full exercise of discretion for irrevocable trusts. This rule was changed in OBRA 1994.

Response: The Social Security Act and CMS guidance still mandate this approach. Changes to federal law in 1994 concerning the treatment of trusts made the rules more restrictive. To the extent that existing PATH rules are inconsistent with federal law, they are being revised.

Counting all possible resources remains the underlying objective of treatment of irrevocable trusts in SSA §1917(d); 42 U.S.C. §1396p(d). Even if a trust is irrevocable, the corpus is still treated as an available asset to the extent that there is discretion to pay it out to the applicant. "[I]f there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income" to or for the individual are treated as income to the individual, and for any other purpose will be treated as a transfer of assets subject to fair market value determination. SSA §1917(d)(3)(B); 42 U.S.C. §1396p(d)(3)(B). In other words, if the applicant is the beneficiary of an irrevocable trust, the corpus of the trust is a countable resource in the maximum amount that could be received by the applicant. H.R. Rep. No. 103-111(II), 103rd Cong., 1st Sess. at 207-208 (1993), reprinted in 1993 U.S.C.C.A.N. 378, 534-35. If, on the other hand, the applicant can in no way benefit from the trust, no part of the corpus will be treated as a countable resource to the institutionalized spouse. Any other payments from the trust, i.e., to other people, are considered a transfer of assets and subject to the fair market value requirement for transfers of assets. SSA §1917(d)(3)(B); 42 U.S.C. §1396p(d)(3)(B).

Comment: Two commenters noted that the department's proposed rules should include testamentary trusts in the list of excluded trusts.

Response: This omission has been corrected. The first paragraph of rule M232.52 has been amended to add: "Trust property is also excluded as a resource when the grantor is a member of the financial responsibility group and established a testamentary trust, also known as establishing a trust by will." (SSA §1917(d)(2)(A); 42 U.S.C. §1396p(d)(2)(A))

Comment: Proposed rule M232.52(e)(i) contains a clause "unless the grantor is the beneficiary's parent" which contradicts the provision in (e)(iii)(B).

Response: This clause has been redacted. The final proposed rule provides for an exclusion of a trusts when the grantor is the beneficiary's parent and the other criteria of the subsection are met.

M232.53 Trusts Excluded Due to Undue Hardship

Comment: The list of public assistance programs omits food stamps and veteran's benefits based on need. The more general term should be restored.

Response: The department clarifies existing rules by specifying what it means by public assistance programs. Consistent with this objective and to accommodate the commenters' concern, the final proposed rule adds "Food Stamps, or another public assistance program requiring a comparable showing of financial need."

Comment: This section omits the guidance that department staff should refer individuals requesting hardship exemptions to Vermont Legal Aid.

Response: The department will include this guidance as well as other procedural content from the interpretive memoranda dated 7/19/94 in the Medicaid Procedures Manual. (SSA §1917(c)(2)(D); 42 U.S.C. §1396p(c)(2)(D))

M232.6 Early Withdrawal Penalties and Surrender Fees

Comment: Please revise the proposed rule to permit the exclusion of taxes and tax penalties if they are actually paid when the resource is liquidated.

Response: The department counts the value of the proceeds of the liquidated assets after deducting early withdrawal penalties and surrender fees assessed by the financial institution. The rules for the supplemental security income (SSI) program also exclude certain tax-related income, such as tax refunds (rule M232.86; 20 C.F.R. §416.1103(d)) and earned income tax credits (rule M232.93; 20 C.F.R. §416.1111(c)(1)). Income tax withholding and income tax penalties are not deductible because the SSI program does not permit these exclusions.

M232.7 Jointly Held Accounts

Comment: What authority supports the requirements in this subsection?

Response: The documentation requirements derive from 20 C.F.R. §416.1208(c)(4) and this section has been revised to clarify it's consistency with federal rules.

M232.82 Vehicles

Comment: Does the parenthetical example mean that another automobile is unusable, or just that it cannot be used to transport the aged, blind or disabled person?

Response: The final proposed rule clarifies this example.

M232.85(b) Retirement Funds

Comment: Two commenters stated that this exclusion imposes requirements upon the community spouse that appear inconsistent with the requirements of 20 C.F.R. §416.1202.

Response: This section has been revised to reflect the difference in treatment between community Medicaid and long-term care. Federal law normally requires SSI financial methodologies to govern SSI-related Medicaid but a special provision supercedes all other provisions of Title XIX and requires all resources of a couple to be considered for the purposes of resource assessment and allocation. (SSA §§1902(a)(10)(C)(i); 1924(a); 1924(c); 42 U.S.C. §1396a(a)(10)(C)(i); 42 U.S.C. §§1396r-5(a), 1396r-5(c); 42 C.F.R. §435.601(b)).

M232.98(b) Stocks, Bonds, Mutual Funds, and Money Market Funds

Comment: The Department of the Treasury has changed the minimum retention period for bonds purchased after February 1, 2003.

Response: The rule has been changed to exclude bonds during the minimum retention period, without reference to a specific length of time.

M233.22 Nonexcluded Life Estates

Comment: In what circumstances will M233.22 apply?

Response: For life estate interests created on or after July 1, 2002, the proposed rule applies whenever a person owns a life estate interest in real property that is not their home. For life estate interests created before July 1, 2002, the proposed rule applies whenever a person owns a life estate interest in real property that is not their home and retains the right to sell.

M240 Overview of Income Requirements

Comment: Please clarify the heading to show that these rules apply only to SSI-related Medicaid. In paragraph three, replace the term “apply” with “are eligible for”, add a cross reference to the medically needy section, and explain the term spenddown.

Response: The title to this section has been revised to reflect its relationship to SSI-related Medicaid. Paragraph 3 has been revised for clarity. Explanations of the terms medically needy and spenddown have been made by adding cross-references.

M241 Types of Income

Comment: Please remove the qualifying phrase in the first sentence.

Response: The change has been made to the final proposed rule.

M241.1 Earned Income

Comment: Please explain why “net” income was removed from the existing regulation and replaced with “gross” income in the proposed rule.

Response: The final proposed rule refers to self-employment income more generally here. The final proposed rule adds the specific information from existing rule M241 to M241.11. It also revises the heading to M245.11 for clarity.

Comment: Is there any significance to the removal of the phrase income is “counted as earned in the month received”?

Response: No. A correction has been made and the phrase has been added to final proposed rule M243.

Comment: Please define WIA.

Response: The final proposed rule specifies that WIA means the Workforce Investment Act of 1998 (29 U.S.C. §794d). It has also been added to rule M242.1.

M241.11 Self-Employment Income

Comment: What is the department’s rationale for treating the income of a new business differently than a business that has been established for years?

Response: The rule provides flexibility for applicants to provide alternate documentation if they believe their income tax returns are not reflective of their situation. The department’s general approach of verifying countable income for SSI-related Medicaid reflects how it operates for other programs it operates. This has proven to be a uniform, reliable and available method of verification.

M241.2 Unearned Income

Comment: Does unearned income include social security benefits for survivors and widows?

Response: Yes. The final proposed rule has been revised to make this explicit.

Comment: What is the purpose of the new requirement in last sentence in the first paragraph mandating that individuals choose periodic payments over lump sums to be eligible?

Response: This sentence has been removed from the final proposed rule.

Comment: What is the basis for subsection (k)?

Response: This provision derives from federal law. (20 CFR § 416.1123(d)).

Comment: Why was the subsection of existing rule M242(6) removed, providing for the exclusion cash received as the beneficiary of a life insurance policy, minus up to \$1500 in burial or illness expenses?

Response: The final proposed rule restores this provision at subparagraph (r).

M242.1 Earned Income Exclusions

Comment: Should foster care payments be listed as an earned income exclusion as well as deduction?

Response: No. Foster care payments should be considered deductible from earned income as provided in rule M241.11(e). Rule M242.1(c) has been deleted.

M242.2 Unearned Income Exclusions

Comment: Expenses should not have to be a prerequisite to be excluded, just incurred in establishing the right to the income.

Response: The final proposed rule revises subparagraph (a) for clarity.

Comment: Are the exclusions in subsection (b) new?

Response: As noted in the detailed cross-reference index of the bulletin coversheet, this material incorporates an existing interpretive memo.

Comment: Please clarify the last sentence of subsection (e).

Response: This subsection has been moved and inserted as the new second paragraph of rule M241.2 in the final proposed rule.

Comment: Two commenters asked what subsection (g) meant.

Response: This subsection along with subsections (c) and (f) have been revised and moved to final proposed rule M242.1(n) (o) (p) and (q).

Comment: Should subsection (i) be two separate exclusions?

Response: The final proposed rule makes this correction.

Comment: Did the department intend to narrow the exclusion in proposed rule 242.2 (dd) by adding a temporal requirement?

Response: No. The final proposed rule has been revised to make this correction.

Comment: Did the department intend to eliminate the two existing exclusions at M242.2(13) and (25)?

Response: No. The content of existing rule M242.2(13) is in proposed rule M232.3(b), paragraph 2. The content of M242.2(25) has been added second from the end of the list at final proposed rule M242.2.

Comment: Should the list of unearned income exclusions include payments from supplemental needs trusts?

Response: Yes. The final proposed rule has been revised to include that payments made from a supplemental needs trust made to or for the benefit of an individual are excluded pursuant to federal law. (SSA §1917(d); 42 U.S.C. §1396p(d)).

M243 Determination of Countable Income for SSI-related Medicaid

Comment: Please remove the phrase “general approach” since this is the overview of how the department calculates income.

Response: The final proposed rule replaces the phrase with alternative language.

Comment: Please explain the phrase “applicable payment maximum” in subsection (b).

Response: The final proposed rule has replaced the phrase “applicable payment maximum” with applicable income maximum.

Comment: Why has the department changed the headings of subsections to proposed rule M243 and what specific changes have been made?

Response: The proposed rule retains the provisions of existing rules M243.1-M243.3 as explained below.

It limits the provisions of existing rule M243.1 to individuals without spouses, including Katie Beckett Applicants, in proposed rule M243.1 and retains the provisions of existing rule M243.1 related to couples, in proposed rule M243.2. This approach aligns with concept of financial responsibility groups introduced to the department’s SSI-related Medicaid regulations through these proposed rules.

It clarifies that the existing rule M243.2 applies to children, other than those seeking Katie Beckett coverage, in proposed rule M243.4.

It retains existing rule M243.3 in proposed rule M243.3, with a clearer section heading.

The proposed rule also brings the content in existing rule M270 related to countable income for long term care applicants into this section.

M243.2 Financial Responsibility Groups For Two Married Individuals Seeking Community Medicaid

Comment: Please clarify why the department has used the term “two married individuals” in the heading rather than the word “couple”.

Response: The final proposed rule has been revised to make this clearer: Financial Responsibility Groups When One or Both Spouses Seek Community Medicaid.

Comment: Please explain what you mean by “ineligible” in subsection (a).

Response: Proposed rule M220.1 defines the term “ineligible”. (20 C.F.R. §416.120(c)).

M243.3 Financial Responsibility Groups For a Parent and Child Living Together Seeking Community Medicaid

Comment: Please clarify when the payment standard for two referenced in subsection (a) applies.

Response: The final proposed rule clarifies that this applies when the adult is married.

Comment: Subsection (b) refers to a section with eleven subsections, not fourteen.

Response: The proposed rule referenced has fourteen subsections that continue from one page onto the next.

M243.4 Financial Responsibility Groups For Children Seeking Community Medicaid or Katie Beckett Coverage

Comment: Please clarify this section heading.

Response: To make the heading consistent with the body of the rule, the final proposed rule provides: “Financial Responsibility Groups For Children Seeking Community Medicaid Other Than Katie Beckett Coverage.”

M245.11 Work Expenses from Self-employment

Comment: Has the department deliberately limited deductible expenses for children in SRS foster care to room and board, rather than including the possibility that other expenses may be deducted?

Response: No. The rate of payment by SRS for foster care is established to cover expenses only, with no allowance for profit or difficulty of care. Therefore, the final proposed rule has been revised, consistent with the department’s Reach Up program rule 2253.2, as follows: “payments made by the Department of Social and Rehabilitation Services (SRS) to licensed foster homes, including room and board of children in custody of and placed by SRS when the Medicaid group includes a foster parent.”

Comment: How does the department treat capital expenses referenced in subsection (f)?

Response: The department treats capital expenses as specified in subsection (a).

M245.12-13 Work Expenses from Income of Blind Individuals Under the Age of 65

Work Expenses from Income of Disabled Individuals

Comment: Please clarify that these deductions are allowable in addition to other allowable deductions.

Response: The final proposed rule has been revised to make this more explicit.

M245.2 Unearned Income Deductions

Comment: Please retain the word “all” from the existing rule M243.1(2) to require all unearned income of proposed subsection (a) be based on need.

Response: The final proposed rule has been revised to make this correction.

M420.1 Eligibility Date

Comment: Please add the word “income” to the first sentence.

Response: The final proposed rule removes the first sentence because it is confusing and repeats the content more clearly expressed in the second sentence.

M420.3 Time Frames for Deductible Expenses

Comment: Please clarify that the same expenses may not be used to meet more than one spenddown.

Response: The final proposed rule makes this clarification.

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

Comment: Reference to long-term care residents as patients is inappropriate because many reside in their own homes or residential care homes. It is also inappropriate for nursing home residents because a nursing home is more than a medical facility, it is the resident’s home.

Response: The department has tracked the “patient” income language used by the federal Medicaid regulations. Since no alternate term is proposed by the commenter for the department’s consideration, the term has been retained in the final proposed rule. (42 C.F.R. Part 435, Subpart H).

Comment: Please incorporate the guidance from existing rule M415 describing how and why a patient share payment might fluctuate.

Response: The department has included this information in final proposed rule M430.

Comment: Please include the language from M415 specifying that the department has the discretion to adjust a patient share payment.

Response: Federal law does not permit the department to adjust patient share payments using its discretion. (42 C.F.R. §§435.725, 435.726; SMM §§3700-3713).

Comment: Please incorporate the language from existing rules M411 and M415 specifying the beginning and ending of the period of long-term care coverage.

Response: The department has included this information in final proposed rule M431.

Comment: Please explain the legal basis for the proposed rules imposing a requirement that individuals pay their patient share payment by the last day of the month in which they receive the income.

Response: The final proposed rule has been revised to provide: “individuals owe their patient share payment by the last day of the month in which they receive the income.”

M431.2 Determining the Maximum Patient Share

Comment: The section omits the income deductions in existing rule M413.

Response: The income deductions in existing rule M413 are specified in proposed rule M432.

Comment: The section omits the content from the interpretive memoranda explaining that state and federal taxes as well as VA Aid and Attendance income was excluded from gross income.

Response: The department has not incorporated these provisions because they are inconsistent with federal law. (42. C.F.R. §435.725 (a), (c); 42. C.F.R. §435.726 (a), (c)).

Comment: Why has the department eliminated the concept of applied income?

Response: The department has endeavored to simplify the rules by eliminating unnecessary terms of art. In existing rules, this term was defined. It meant the amount of money left after computing the maximum patient share less allowable deductions (see existing rule M400.1(2)). The department retains the concept in its proposed rules, but has chosen to express it in plain English, as in proposed rule M430, “An individual’s patient share is determined by computing maximum patient share and deducting allowable expenses.” Although labels are sometimes helpful, the department felt that “applied income” added an unnecessary layer of complexity here.

M432.2 Home Upkeep Deduction

Comment: The section appears to limit the deduction to individuals receiving SSI, and differs from existing rule M413.1

Response: The final proposed rule clarifies that the deduction broadly applies to any individual receiving long-term care and living in a nursing facility, provided the criteria are met. The deduction applies to individuals who may receive an SSI payment but it includes others as well.

M432.3 Allocation to Family Members

Comment: The section appears to allow allocations to any family member, not just those listed in the following subsections.

Response: The final proposed rule has been revised to make this clearer. It states: “The department allows individuals to allocate their income to certain family members as described in the following subsections.”

M432.31 Allocation to Community Spouse

Comment: The section implies that a spousal deduction is automatic.

Response: The final proposed rule has been revised to make this clearer.

Comment: The section should clarify that individuals receiving hospice services are eligible for the spousal deduction.

Response: The first sentence of this section in the final proposed rule contains this provision.

M432.32 Allocation to Other Family Members

Comment: This section implies that the definition of dependent applies to all children, even those under 18.

Response: In the final proposed rule, the conjunction “or” has been replaced with “and” to track the existing rule M413.22.

Comment: Did the department intend to change the formula for the family allocation established in federal law?

Response: No. In the final proposed rule, the divisor has been revised to three. (SSA § 1924(d)(1)(C); 42 U.S.C. §1396r-5(d)(1)(C))

M433 Determining Which Provider Receives Patient Share Payment

Comment: Please include the general information about patient share payments from existing rule M415.2

Response: The final proposed rule adds this content to this section.

M433.3 Payment of Patient Share When Long-Term Care Recipient Is Discharged from a Nursing Facility and to Waiver Services

Comment: Please make explicit the implied requirement that the community maintenance allowance be used to redetermine patient share.

Response: The final proposed rule clarifies the second sentence to specify that the community maintenance allowance is used to redetermine the patient share obligation of individuals receiving waiver services.

M433.5 Payment of Patient Share for the Month Long-Term Care Recipient Is No Longer Eligible for Medicaid Coverage of Long-Term Care

Comment: Please include the due process language from existing rule M415.5 paragraph 2.

Response: Due process provisions apply to terminations or reductions of Medicaid eligibility of any type and are contained in existing rule M141, applicable to all Medicaid recipients, including long-term care. Inclusion of this language here is redundant.

M433.6 Payment of Patient Share in the Month of Death

Comment: Please include the examples from existing rule M415.6.

Response: The examples from the existing rule M415.6 have been incorporated into this section of the final proposed rule.

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

Comment: The department omits that federal requirement present in existing rule M416.1 specifying that assts transferred by the community spouse after the initial month of long-term care eligibility are not considered.

Response: The department has revised the final proposed rule to address this requirement. (SSA 1924(c)(4); 42 U.S.C. §1396r-5(c)(4)).

M400 Spenddown, Patient Share and Transfer of Resources Provisions

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

Comment: The department's use of the terms "income or resources" rather than "assets" adds a new, unauthorized requirement in contravention of controlling state and federal law.

Response: The department has used the phrase consistently with federal law. (SSA 1917(e); 42 U.S.C. §1396p)

M440.1 Definition of Transfer

Comment: Does the department intend the transfer to take place when the funds are withdrawn from the account (current rule), or when an individual's name is added or removed from the account (proposed rule)?

Response: The second sentence of this section has been removed because it refers to jointly held assets and creates confusion. The final proposed rule adds a new section at M440.35, related to treatment of transfers of jointly held assets. The interpretive memo opposite M416 P.2, 8/18/94 has no basis in federal law. The final proposed rule M440.35 tracks federal guidance. (SMM §3258.7)

M440.1 Definition of Transfer

M440.2 Allowable Transfers for Fair Market Value

Comment: The department's proposal to apply actions by "members of the financial responsibility group" or "any other person" adds a new, unauthorized requirement in contravention of controlling state and federal law.

Response: In the final proposed rule, the department has added a cross-reference to the defined term "financial responsibility group" (rules M200.1(d); and M221) and uses the phrase consistently with federal law. (SSA §1917(c); 42 U.S.C. §1396p(c)) The phrase "any other person" has been qualified by adding "with lawful access to the income or resources (see rule M440.35)". As noted above, the final proposed rule adds a new subsection for treatment of transfers involving jointly held assets.

M440.3 Allowable Transfers for Less than Fair Market Value

Comment: Three commenters noted that the rules lack a provision specifying no penalty for transfer of an excluded asset for less than fair market value, per guidance issued by CMS through Transmittal 64.

Response: The rule has been amended to add subsection (g) permitting the transfer of excluded resources, other than the home, without consideration of whether fair market value was received. (SSA §1917(e); 42 U.S.C. §1396p(e); SMM §3259.6(F)). This section also includes a new subsection (f) to comply with federal law. (SSA § 1917(c)(2)(C)(i); 42 U.S.C. §1396p(c)(2)(C)(i)).

Response: The rule has been amended to add subsection (g) permitting the transfer of excluded resources, other than the home, without consideration of whether fair market value was received. (SSA §1917(e); 42 U.S.C. §1396p(e); SMM §3259.6(F)). This section also includes a new subsection (f) to comply with federal law. (SSA § 1917(c)(2)(C)(i); 42 U.S.C. §1396p(c)(2)(C)(i)).

Comment: Subsection (d) of the proposed rule imposes a new unauthorized legal threshold of “convincing evidence” different from existing rule M416.1 “satisfactory showing” in contravention of controlling state and federal law.

Response: Subsection (d) of the final proposed rule derives from federal guidance. (SMM § 3258.10(c)(2)).

Comment: The rules should restore a provision from existing rule M416.1 that the unexpected loss of other resource after a transfer are exempt from penalty.

Response: Subsection (d) of the final proposed rule includes examples but does not limit convincing evidence to these illustrations.

Comment: Please incorporate the content of the PP&D dated 1/12/94 opposite section 416.

Response: Application of the department’s proposed rule M440.1 covers this situation. Individuals who transfer their homes and retain the power to sell them, do not “reduce or eliminates . . . ownership or control” of the resource and are not subject to penalty.

Comment: Are the rules for joint accounts established before 1994 still as set forth in the interpretive memorandum opposite Rule M416 P.2 dated 1/1/94?

Response: The final proposed rule adds a new rule, M440.35, specifying how joint accounts will be treated for long-term care eligibility determinations. The content of the 1994 interpretive memo has been retained.

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

Comment: The department’s rules should permit transfers to a trust for the benefit of a disabled child per SSA §1917(c)(2)(B)(iii) and (iv) ; 42 U.S.C. §1396p(c)(2)(B)(iii) and (iv)).

Response: The final proposed rules M440.31(c) and M440.33(c) permit this.

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

Comment: Two commenters asked whether residual beneficiaries are included when the rule mentions trust beneficiaries.

Response: This section has been redesignated as subsection (e) in the final proposed rule and revised to align more clearly with federal law (SSA §1917(d)(3); 42 U.S.C. §1396p(d)(3)).

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

Comment: Two commenters noted that the department has created a disqualification for spouse to spouse transfers, contrary to federal law.

Response: Subsection (b) has been revised to permit the transfer if it meets this criteria: “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.”

Comment: The department has imposed to strict a definition of trusts to qualify for the exclusion under subsection (c).

Response: Subsections (c) and (d) have been revised to reflect one, broader exclusion.

M440.35 Transfers Involving Jointly Held Income or Resources

Comment: Please add a clear statement incorporating the content of the interpretive memorandum opposite M416 dated 1/12/94. Although proper application of the proposed rules will lead to this result, private attorneys find this area confusing and would like explicit guidance.

Response: An example has been added to the final proposed rule M440.35(a) to reflect the content of this interpretive memorandum.

M440.42 Penalty Period

Comment: The department has omitted the principle that the penalty period includes no fraction of a month in contravention of controlling state and federal law.

Response: The final proposed rule includes this provision for transfers that occurred before July 1, 2002. A new rule permitting the penalty period to be determined by days rather than by months was prescribed by the legislature last year in Act 142 §148(m)(6), and promulgated by existing rule M417.22.

M440.44 Undue Hardship

Comment: The list of public assistance programs omits food stamps and veteran’s benefits based on need. The more general term should be restored.

Response: The department clarifies existing rules by specifying what it means by public assistance programs. Consistent with this objective and to accommodate the commenters concern, the final proposed rule adds “food stamps, or another public assistance program requiring a comparable showing of financial need.”

Additional comments were received that were not directly relevant to the proposed policy. The department has responded to those questions separately.

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PP&D facing M242 (P.3)	6/7/91	M242.2(b)
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PP&D facing M242 (Page 1 of 3)	8/2/94	M242.2(b)
PP&D facing M242	4/13/95	M241.2
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Vertical lines in the left margin indicate significant changes. Dotted lines at the left margin indicate changes to clarify, rearrange, correct references, etc., without changing regulation content significantly.

Manual Maintenance

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For more information about the Administrative Procedures Act and the rules applicable to state rulemaking, please call Louise Corliss at 828-2863 or go to the website of the Office of the Vermont Secretary of State at: <http://vermont-archives.org/apa/rules.html>

For information on upcoming hearings before the Legislative Committee on Administrative Rules, please call 828-5760 or go to the website of the Vermont Legislature at: <http://www.leg.state.vt.us/schedule/schedule2.cfm>

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M200 SSI-Related Medicaid Eligibility

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

M200.1 Definitions

This section defines terms used throughout M200-M299.

- (a) Community Medicaid means Medicaid services other than long-term care.
- (b) Community spouse (CS) means the spouse of an institutionalized individual. 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 home-and-community-based waiver or in a long-term care facility licensed by the Department of Aging and Disabilities.
- (f) Institutionalized spouse (IS) means an institutionalized individual whose spouse qualifies as a community spouse.
- (g) Long-term care means level I and level II care, as determined by the licensing division of the Department of Aging and Disabilities, received by people living in nursing facilities, rehabilitation centers, intermediate care facilities for the mentally retarded (ICF-MR), and other medical facilities for more than 30 consecutive days. It also includes waiver and hospice services.

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M200.1 P.2

M200-M299 SSI-Related Medicaid Eligibility

M200.1 Definitions (Continued)

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

It includes certain services administered by the Department of Aging and Disabilities (DA&D):

- enhanced residential care,
- home-and-community-based services for the aged and disabled, and
- traumatic brain injury services.

It also includes certain services administered by the Department of Developmental and Mental Health Services (DDMHS):

- home-and-community-based waiver services for the developmentally disabled, and
- children's mental health waiver services.

PATH determines financial and nonfinancial eligibility, other than disability, for these services. PATH, through the disability determination services unit determines whether individuals are blind or disabled according to the criteria in rule M211.2-M211.4, with these exceptions:

- (i) when DA&D administers the waiver services, it determines whether applicants need the level of care in a nursing facility or out-of-state rehabilitation facility qualified to serve persons with a traumatic brain injury.
- (ii) when DDMHS administers the waiver services, it determines whether applicants meet the disability criteria and need the level of care provided in an intermediate care facility for the mentally retarded; or an inpatient psychiatric facility for children under age 22, if waiver services were not available.

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M200.2

M200-M299 SSI-Related Medicaid Eligibility

M200.2 SSI-Related Categorically Needy Coverage Groups

To be eligible for SSI-related Medicaid as categorically needy, individuals must meet the criteria in one or more of the following coverage groups, in addition to other nonfinancial and financial requirements. When an individual becomes ineligible for one coverage group, the department tests for other categorical and then medically needy eligibility. Medicaid remains open until an individual no longer passes any of the eligibility tests, per rule M133.

M200.21 SSI Recipient Coverage Groups

Individuals granted SSI/AABD by the Social Security Administration are eligible for SSI-related Medicaid. In addition to SSI/AABD recipients, this group includes individuals determined presumptively disabled and those who do not receive an SSI/AABD payment because of recoupment.

M200.22 SSI-Eligible Coverage Groups

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

- (a) Individuals who would be eligible for SSI/AABD except that they:
- have not applied for SSI/AABD, or
 - do not meet SSI/AABD requirements not applicable to Medicaid, such as participation in vocational rehabilitation or a substance abuse treatment program.

Individuals in this categorically needy coverage group must have income and resources at or below SSI/AABD maximums and meet the nonfinancial criteria for SSI-related Medicaid.

- (b) Individuals who the Social Security Administration determines eligible under the Social Security Act §1619(b) because they meet all SSI/AABD eligibility requirements except for the amount of their earnings and who:
- do not have sufficient earnings to provide the reasonable equivalent of publicly funded attendant care services that would be available if they did not have such earnings; and
 - are seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment.

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M200.23

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

M200.23 Long-Term Care Medicaid Coverage Groups

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

- (a) Medical institution - Individuals who live in a medical institution and have gross income under the institutional income standard.
- (b) Waiver services - Individuals who:
 - would be eligible for Medicaid if they were living in a medical institution or are disabled and have countable income as specified in M200.24(b);
 - can receive appropriate medical care in the community, the cost of which is no greater than the estimated cost of medical care in an appropriate institution; and
 - qualify for waiver services.
- (c) Hospice care - Individuals who:
 - would be eligible for Medicaid if they were living in a medical institution;
 - can receive appropriate medical care in the community, the cost of which is no greater than the estimated cost of medical care in an appropriate institution; and
 - receive hospice care as described in section M401.2 and defined in section 1905(o) of the Social Security Act.
- (d) Disabled Child in Home Care (DCHC, Katie Beckett) - Individuals who:
 - require the level of care provided in a medical institution;
 - would be eligible for Medicaid if they were living in a medical institution;
 - can receive appropriate medical care in the community, the cost of which is no greater than the estimated cost of medical care in an appropriate institution;
 - are age 18 or younger;
 - have income, excluding their parents' income, no greater than the institutional income standard; and
 - have resources, excluding their parents' resources, no greater than the resource limit for a Medicaid group of one.

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M200.24

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

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

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

- (a) Breast or cervical cancer - Women found to have breast or cervical cancer, including precancerous conditions, screened through the National Breast and Cervical Cancer Early Detection Program and who:
- are under age 65;
 - uninsured; and
 - otherwise not eligible for SSI-related or ANFC-related Medicaid.

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

- (b) Working people with disabilities - Individuals with disabilities who are working and otherwise eligible for SSI-related Medicaid except that their net income:
- (i) is below 250 percent of the federal poverty level associated with the applicable family size; and
- (ii) does not exceed either the Medicaid protected income level for one or the SSI/AABD payment level for two, whichever is higher, after disregarding the earnings and up to \$500 of social security disability insurance benefits (SSDI) of the individual working with disabilities.

Earnings and SSDI shall not be disregarded for applicants with spenddown requirements.

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M200.25

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

M200.25 Coverage Groups Open to Former Recipients of SSI, SSI/AABD, or Medicaid

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

- (a) Children who lost their SSI or SSI/AABD eligibility because of the more restrictive definition of disability enacted in 1996 but who continue to meet all other SSI-related Medicaid criteria until their 18th birthday (Personal Responsibility and Work Opportunity Reconciliation Act §4913).
- (b) Surviving spouses or spouses who have obtained a legal dissolution and remain single (and was the spouse of the insured for at least 10 years) with a disability who meet one of the following groups of criteria under the Social Security Act (SSA §§1634(b)(1); 1634(d); 42 U.S.C. §§1383c(b)(1); 1383c(d)).
 - (i) Individuals who:
 - applied for SSI-related Medicaid no later than July 1, 1988;
 - were receiving SSI/AABD in December, 1983 and lost SSI/AABD in January 1984 due to a statutory elimination of an additional benefit reduction factor for surviving spouses before attainment of age 60 who have been continuously entitled to surviving spouse insurance based on disability since January 1984; and
 - would continue to be eligible for SSI/AABD if they had not received the increase in social security disability or retirement benefits.
 - (ii) Individuals who:
 - lost SSI/AABD benefits due to a mandatory application for and receipt of social security disability, retirement or survivor benefits;
 - are not yet eligible for Medicare Part A;
 - are at least age 50, but have not yet attained age 65; and
 - would continue to be eligible for SSI/AABD if they were not receiving social security disability or retirement benefits.
- (c) Individuals with a disability under the Social Security Act (SSA §1634(c); 42 U.S.C. §1383c(c)) who:
 - are over age 18;
 - have blindness or a disability that began before age 22;
 - are entitled to social security benefits on their parent's record due to retirement, death or disability benefits and lost SSI/AABD due to receipt of this benefit or an increase in this benefit; and
 - would remain eligible for SSI/AABD in the absence of the social security retirement, death or disability benefit or increases in that benefit.

8/1/03

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M200.25 P.2

M200.2 SSI-Related Categorically Needy Coverage Groups

M200.25 Coverage Groups Open to Former Recipients of SSI, SSI/AABD, or Medicaid
(Continued)

- (d) Individuals determined eligible under the Pickle Amendment to Title XIX of the Social Security Act (SSA §1935(a)(5)(E); 42 U.S.C. §1396v(a)(5)(E)) who:
- are receiving social security retirement or disability benefits;
 - became eligible for and received SSI or SSI/AABD for at least one month after April 1977; and
 - lost SSI/AABD benefits but would be eligible for them if all increases in their Medicaid group's social security benefits due to annual cost-of-living adjustments (COLAs) were deducted as income.
- (e) Individuals who were eligible for Medicaid in December 1973 and meet at least one of the following criteria:
- an institutionalized individual who has been eligible for Medicaid each consecutive month after December 1973;
 - a blind or disabled individual who meets all current requirements for Medicaid eligibility except blindness or disability and has been eligible for Medicaid each consecutive month after December 1973; or
 - an essential spouse whose needs have been included in computing the SSI or SSI/AABD payment to an aged, blind, or disabled individual living with the essential spouse since December 1973 and both have continuously received AABD.
- (f) Individuals who:
- were entitled to social security retirement or disability and eligible for AABD in August 1972 or would have been eligible if they had applied or were not in a medical institution or intermediate care facility; and
 - would be eligible for SSI or SSI/AABD now, except that the 20 percent cost-of-living increase in social security benefits effective September 1972 raised their income over the AABD limit.

8/1/03

Bulletin No. 02-11

M200.3

M200.3 SSI-Related Medically Needy Coverage Group

Individuals who would be members of a categorically needy coverage group may qualify for Medicaid as medically needy even if their income or resources exceed coverage group limits. These individuals may become eligible if they incur enough noncovered medical expenses to reduce their income to the applicable standard. For community Medicaid, individuals must reduce their income to the protected income level (PIL). For long-term care, including waiver and hospice services, individuals also must spend down their income to the PIL. In addition, all individuals must have resources below the categorically needy program resource limit. The rules in M411-M423 specify how individuals may use noncovered medical expenses to “spend down” their income or resources to the applicable limits.

M200.4 SSI-Related Medicare Cost-Sharing Coverage Groups

Limited Medicaid benefits are available to pay for out-of-pocket Medicare cost-sharing expenses for certain Medicare beneficiaries. Such beneficiaries are eligible for Medicaid payment of certain Medicare costs if they meet the additional criteria specified for one of the groups in M200.41-M200.44.

Individuals eligible for one of the following Medicare costsharing coverage groups may also be eligible for the full range of Medicaid covered services if they also meet the requirements for one of the categorical (M200.2) or medically needy coverage groups (M200.3).

Applicants may not spend down income or resources to meet the financial eligibility tests for these coverage groups. The department disregards annual cost-of-living (COLA) increases in social security benefits in determining eligibility for these groups until the month after the annual publication of the official poverty line revisions.

M200.41 Qualified Medicare Beneficiaries (QMB)

Individuals are eligible for Medicaid payment of their Medicare Part A and Part B premiums, deductibles, and coinsurance if:

- their Medicaid group has countable income at or below 100 percent of the federal poverty level;
and
- they are members of a Medicaid group with resources at or below twice the SSI-related Medicaid limit applicable to the group’s size.

Benefits under this provision become effective on the first day of the calendar month immediately following the month in which the individual is determined to be eligible.

8/1/03

Bulletin No. 02-11

M200.42

M200.4 SSI-Related Medicare Cost-Sharing Coverage Groups (Continued)

M200.42 Qualified Disabled and Working Individuals (QDWI)

Individuals who have lost their Medicare benefits based on disability because they returned to work, are eligible for Medicaid payment of their Medicare Part A premiums if they:

- are disabled;
- belong to a Medicaid group with countable income at or below 200 percent of the federal poverty level applicable to the Medicaid group's size;
- are members of a Medicaid group with resources at or below twice the SSI-related Medicaid limit applicable to the group's size; and
- are not otherwise eligible for Medicaid.

Benefits under this provision become effective on either the date of application or the date on which all eligibility criteria are met, whichever is later. The department may grant benefits for a retroactive period of up to three months prior to that effective date, provided that the individual meets all eligibility criteria.

M200.43 Specified Low-Income Medicare Beneficiaries (SLMB)

Individuals are eligible for Medicaid payment of their Medicare Part B premiums if:

- they receive Medicare Part A;
- their Medicaid group has countable income greater than 100 percent but no greater than 120 percent of the federal poverty level; and
- they are members of a Medicaid group with resources at or below twice the SSI-related Medicaid limit applicable to the group's size.

Benefits under this provision become effective on either the date of application or the date on which all eligibility criteria are met, whichever is later. The department may grant benefits for a retroactive period of up to three months prior to that effective date, provided that the individual meets all eligibility criteria.

8/1/03

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M200.44

M200.4 SSI-Related Medicare Cost-Sharing Coverage Groups (Continued)

M200.44 Qualified Individuals (QI-1)

Individuals who receive Medicare Part A and do not receive other federally funded medical assistance are eligible for Medicaid payment of their Medicare Part B premium.

The QI-1 coverage group includes individuals in a Medicaid group with:

- income that is at least 120 percent but less than 135 percent of the federal poverty level are eligible for Medicaid payment of their Medicare Part B premium; and
- resources at or below twice the SSI-related Medicaid limit applicable to the group's size.

Benefits under this provision become effective on the first day of the calendar month immediately following the month in which the individual is determined to be eligible. The department may grant benefits for a retroactive period of up to three months from the date of application, provided that all eligibility criteria are met. The benefit period ends in December of each calendar year. People requesting this coverage must reapply each calendar year.

8/1/03

Bulletin No. 02-11

M201

M201 – M209 [Reserved]

M210 Nonfinancial Eligibility Tests for SSI-Related Medicaid

The following sections specify the nonfinancial eligibility tests that individuals not receiving SSI/AABD benefits must pass in order to receive SSI-related Medicaid.

M211 Relationship to SSI Based on Age, Blindness, or Disability

Applicants for SSI-related Medicaid must establish their categorical relationship to SSI by qualifying as one or more of the following:

- (a) aged, by being 65 years of age or over;
- (b) blind, by being determined blind by the state's disability determination services (DDS) unit or in receipt of social security disability benefits based on blindness; or
- (c) disabled, by being determined disabled by the state's disability determination services unit or in receipt of social security disability benefits based on disability.

M211.1 Definition of Age

Individuals qualifying on the basis of age must be at least 65 years of age in or before the month in which eligibility begins.

Blind or disabled children are individuals who are single or not the head of a household and are:

- under age 18
- under the age of 22 and a student regularly attending school, college or university, or a course of vocational or technical training to prepare him or her for gainful employment.

8/1/03

Bulletin No. 02-11

M211.2

M211 Relationship to SSI Based on Age, Blindness, or Disability (Continued)

M211.2 Definition of Disability

Individuals age 18 or older are considered disabled if they are unable to engage in any substantial gainful activity because of any medically determinable physical or mental impairment, or combination of impairments, that can be expected to result in death, or has lasted or can be expected to last for a continuous period of not fewer than 12 months. To meet this definition, individuals must have a severe impairment, which makes them unable to do their previous work or any other substantial gainful activity which exists in the national economy. To determine whether individuals are able to do any other work, the disability determination unit considers their residual functional capacity, age, education, and work experience.

Children under age 18 are considered disabled if they have a medically determinable physical or mental impairment, or combination of impairments, resulting in marked and severe functional limitations, that can be expected to result in death or that have lasted or can be expected to last for at least 12 consecutive months. Children engaging in substantial gainful activity may not be considered disabled.

M211.21 Substantial Gainful Activity

Substantial gainful activity is work activity that is both substantial and gainful.

Substantial work activity involves doing significant physical or mental activities. Work may be substantial even if it is done on a part-time basis or if individuals do less, get paid less or have less responsibility than when they worked before.

Gainful work activity is the kind of work done for pay or profit whether or not a profit is realized.

Individuals who are working with disabilities shall be exempt from the substantial gainful activity (SGA) step of the sequential evaluation of the disability determination if they otherwise meet the requirements set forth in M200.24 (b) for the categorically needy working disabled.

M211.3 Definition of Blindness

Blindness means having central visual acuity of 20/200 or less, even with glasses, or a limited visual field of 20 degrees or less in the better eye with the use of a correcting lens.

8/1/03

Bulletin No. 02-11

M211.4

M211 Relationship to SSI Based on Age, Blindness, or Disability (Continued)

M211.4 Determination of Disability or Blindness

Disability and blindness determinations are made by the disability determination services unit in accordance with the applicable requirements of the social security administration (SSA) based on information supplied by the applicant and by reports obtained from the physicians and other health care professionals who have treated the applicant.

The department explains the disability determination process to applicants, helps them complete the required forms and forwards this information to the disability determination unit.

The disability determination unit may determine individuals are disabled in any of the circumstances described below.

- (a) Individuals who have not applied for SSI/AABD.
- (b) Individuals who have applied for SSI/AABD and were found ineligible for a reason other than disability.
- (c) Individuals who have applied for SSI/AABD and SSA has not made a disability determination within 90 days from the date of their application for Medicaid.
- (d) Individuals who have been found "not disabled" by SSA, have filed a timely appeal with SSA, and a final determination has not been made by SSA.
- (e) Individuals who claim that:
 - their condition has changed or deteriorated since the most recent SSA determination of "not disabled,"
 - a new period of disability meets the durational requirements of the Act,
 - the SSA determination was more than 12 months ago, and
 - they have not applied to SSA for a determination with respect to these allegations.
- (f) Individuals who claim that:
 - their condition has changed or deteriorated since the most recent SSA determination of "not disabled",
 - the SSA determination was fewer than 12 months ago,
 - a new period of disability meets the durational requirements of the Act, and
 - they have applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations, or they no longer meet the nondisability requirements for SSI but may meet the state's nondisability requirements for Medicaid.

8/1/03

Bulletin No. 02-11

M211.4 P.2

M211 Relationship to SSI Based on Age, Blindness, or Disability

M211.4 Determination of Disability or Blindness (Continued)

The department has primary responsibility, through its disability determination services unit, for assuring that adequate information is obtained upon which to base the determination. If additional information is needed to determine whether individuals are disabled or blind according to the Social Security Act, consulting examinations may be required. The reasonable charge for any medical examinations required to render a decision on disability or blindness shall be paid by the department.

M212 Citizenship

The following definitions shall apply to determination of eligibility with respect to the citizenship requirement.

"U.S. citizen" means any native-born or naturalized citizen of the United States, defined in the Immigration and Nationality Act (INA) to include the 50 states, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands. A national from American Samoa or Swain's Island is also a U.S. citizen.

Qualified alien means:

- a legal permanent resident, defined as an alien lawfully admitted for permanent residence under the INA, including an American Indian born in Canada if he/she is at least one-half American Indian;
- a refugee, defined as an alien who has been admitted as a refugee under section 207 of the INA;
- an asylee, defined as an alien who has been granted asylum under section 208 of the INA;
- a parolee, defined as an alien who has been paroled in the U.S. for at least a year under section 212(d)(5) of the INA;
- a deportee, defined as an alien whose deportation is being withheld under section 243(h) of the INA; or
- a conditional entrant, defined as an alien who was granted conditional entry under section 203(a)(7) of the INA before April 1, 1980.

An individual meets the citizenship requirement as long as he or she is one of the following:

- (1) a U.S. citizen;
- (2) a qualified alien who is a refugee, asylee, or deportee;
- (3) a qualified alien who is a legal permanent resident, parolee, or conditional entrant and:
 - entered the U.S. before August 22, 1996, or
 - has been in the U.S. at least five years; or
- (4) a qualified alien who is a legal resident and either a veteran with an honorable discharge or a member of the U.S. armed forces on active duty, or the spouse or single dependent child of such an alien.

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Bulletin No. 02-11

M212.1

Deleted: 5/1/03

M212.1 Emergency Medical Services

An individual who does not meet the citizenship requirement is eligible for emergency services, provided such care and services are not related to either an organ transplant procedure or routine prenatal or post-partum care, if both of the following conditions are met:

- A. The noncitizen has, after sudden onset, a medical condition, including emergency labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
 - serious jeopardy to the patient's health,
 - serious impairment of bodily functions, or
 - serious dysfunction of any bodily organ or part.
- B. The noncitizen meets all other eligibility requirements for Medicaid except verification of alien status and, for illegal noncitizens, verification of a social security number.

M213 State Residence

An individual must be a resident of Vermont to meet the residence requirement. The state of residence of an individual is determined according to the following:

1. For individuals receiving a state supplemental payment, the state of residence is the state paying the supplement.

Exception: Individuals involved in work of a transient nature or who have moved to Vermont to seek employment, may claim Vermont as their state of residence and be granted Medicaid in Vermont if they meet all other eligibility criteria. These individuals may be granted Vermont Medicaid even though they continue to receive a state supplemental payment from another state.

2. For any blind or disabled individual under the age of 21 who is not residing in an institution, the state of residence is the state in which the individual is living.
3. For any institutionalized individual under the age of 21, or who is 21 or older and became incapable of indicating intent prior to the age of 21, state of residence is that of
 - (a) the parents or legal guardian, if one has been appointed, or
 - (b) the parent applying for Medicaid on behalf of the individual if the parents live in different states, or
 - (c) the individual or party who has filed the application on behalf of the applicant if the applicant has been abandoned by his or her parents and does not have a legal guardian.
4. For any non-institutionalized individual age 21 or older, residence is in the state in which the individual is living
 - (a) with intent to remain permanently or for an indefinite period of time, or
 - (b) while incapable of stating intent, or
 - (c) after entering with a job commitment or in pursuit of employment whether or not currently employed.

M213 State Residence (Continued)

5. For any institutionalized individual age 21 or older and who became incapable of stating intent at or after age 21, residence is in the state in which the individual is physically present, unless another state arranged for the individual's placement in a Vermont institution. (See M213.2).
6. For any other institutionalized individual age 21 or older, residence is in the state where the individual is living with the intention to remain there permanently or for an indefinite period, unless another state has made a placement (see rule M213.2). An institutionalized individual cannot be considered a Vermont resident if the individual owns a home (see rule M201.21) in another state which the individual intends to return to even if the likelihood of return is apparently nil.
7. For a blind or disabled child of a parent in the Armed Forces whose SSI eligibility continues even though he/she moves overseas, Vermont Medicaid does not continue and, in addition, the child is no longer eligible for the State Supplement (AABD) to SSI.

M213.1 Temporary Absences from the State

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

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

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

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

M213.3 Incapable of Stating Intent

Individuals are incapable of stating intent regarding residence if:

- (1) their IQ is 49 or lower, or they have a mental age of 7 or lower, based on tests acceptable to the Developmental Disabilities Division of the Vermont Department of Developmental and Mental Health Services, or
- (2) they are judged legally incompetent, or
- (3) medical documentation, or other documentation acceptable for disability determination purposes, supports a finding that they are incapable of stating intent.

M213.4 Residence as a Requirement for Payment

An individual must be a resident of Vermont at the time a medical service is rendered in order for Vermont Medicaid to pay for that service. The service does not, however, have to be rendered in Vermont.

M213.5 Specific Prohibitions

Medicaid eligibility may not be denied to an applicant for any of the following reasons:

- (1) failure to reside in the state for a specified period; or
- (2) failure of an institutionalized person to establish residence in the state before entering the institution, if the individual satisfies the residency rules set forth in this section; or
- (3) temporary absence from the state if the individual intends to return when the purpose of the absence has been accomplished, unless another state has determined that the person is a resident there for purposes of Medicaid; or
- (4) failure to have a permanent or fixed address. Homeless individuals may designate a mailing address with the exception that individuals who are also receiving Food Stamps may not designate the U.S. Post Office, c/o General Delivery.

M214 Living Arrangements

Individuals or couples living in their own home, in the household of another or living in certain institutions listed in M214.1-M214.2 meet the living arrangement requirement. An institution is an establishment that furnishes food, shelter and some treatment or services to four or more persons unrelated to the proprietor. The financial responsibility of relatives varies depending upon the type of living arrangement. Homeless individuals are considered to be living in their own home. See the Section Income and Resources: Introduction for definitions and treatment of relative responsibility.

M214.1 Living in a Public Institution

A public institution is defined as any institution meeting all of the following conditions:

- (1) The institution is owned, maintained or operated in whole or in part by public funds; and
- (2) control is exercised, in whole or in part, by any public agency or an official or employee of that agency; and
- (3) the institution furnishes shelter and care and can be termed a public institution by reason of its origin, charter, ownership, maintenance or supervision.

Only the following individuals meet the living arrangement requirements if they are living in a public institution:

- (1) Patients under the age of 21 in the Vermont State Hospital (VSH). If a Medicaid recipient is a patient of VSH upon reaching his/her 21st birthday, eligibility may be continued to the date of discharge or his/her 22nd birthday, whichever comes first, upon a finding by the VSH Disability Determination Team that the individual is blind or disabled according to SSI/AABD standards.
- (2) Patients age 65 or older in the Vermont State Hospital.
- (3) Residents in an Intermediate Care Facility for the Mentally Retarded.
- (4) Patients of any age in a facility supported in whole or in part by public funds whose primary purpose is to provide medical care other than the treatment of mental disease, including nursing and convalescent care, inpatient care in a hospital, drug and alcohol treatment, etc.

Residence in an institution is determined by the dates of admission and discharge. A person at home in the community on a visiting pass is still a resident of the institution.

M214.2 Living in a Private Facility

A private facility is defined as any home privately owned and operated, or any home or institution supported by private or charitable funds, over which neither the State nor any of its subdivisions has supervision or control even though individuals may be boarded or cared for therein at public expense. Vermont private institutions include boarding homes, fraternal homes, religious homes, community care homes, residential care facilities, medical facilities (i.e. general hospitals) and nursing facilities licensed by the State of Vermont.

An individual living in a private facility meets the living arrangement requirement if:

- (1) the primary purpose of the facility is to provide medical care other than the treatment of mental diseases, including nursing and convalescent care, inpatient care in a hospital, drug and alcohol treatment, etc.; and
- (2) the facility meets the following criteria:
 - (a) there is no agreement or contract obliging the institution to provide total support to the individual;
 - (b) there has been no transfer of property to the institution by the individual or on his/her behalf, unless maintenance by the institution has been of sufficient duration to fully exhaust the individual's equity in the property transferred at a rate equal to the monthly charges to other residents in the institution; and
 - (c) there is no restriction on the individual's freedom to leave the institution.

Individuals under the age of 21 or age 65 or older meet the living arrangement requirement if they live at the Brattleboro Retreat. In addition, individuals who are patients at the facility upon reaching their 21st birthday, have eligibility continued to the date of discharge (or end of ten day notice period, if later) or their 22nd birthday, whichever comes first, as long as continue to meet all other eligibility requirements.

M214.3 Living in a Correctional Facility

Individuals living in a correctional facility, including a juvenile facility are not eligible for Medicaid. Residence in a correctional facility begins on the date of admission and ends when the individual moves out of the correctional facility. An individual transferred from a correctional facility to a medical facility is considered to be still living in the correctional facility.

Individuals who are Medicaid recipients immediately prior to confinement have their Medicaid enrollment terminated as soon as administratively possible, including the provision for advance notice of termination.

8/1/03

Bulletin No. 02-11

M215

M215 – M219 [Reserved]

M220 Financial Eligibility for SSI-Related Medicaid

Individuals requesting SSI-related Medicaid must meet the nonfinancial requirements of citizenship, residence, living arrangement, and relationship to SSI/AABD specified in sections M210-M219. The department then determines whether the person requesting Medicaid meets the financial requirements specified in sections M220-M440. This includes financial eligibility determinations for Medicaid waiver programs operated by the Department of Developmental and Mental Health Services (DDMHS) and the Department of Aging and Disabilities (DA&D), except that DDMHS determines patient share costs for individuals eligible under its waiver programs.

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

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

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 student age 18 through 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 is under age 21, lives in the same household with the applicant, and does not meet the nonfinancial eligibility criteria for SSI-related Medicaid.
- (d) Ineligible parent means a natural or adoptive parent, or the spouse of a natural or adoptive parent, who lives with the applicant who is a child and is not eligible for SSI-related Medicaid. The income of parents who do not meet the nonfinancial eligibility criteria only affects the eligibility of the applicant if they are 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.

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.

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 on Qualifying Quarters of Coverage).

M221 Formation of the SSI-Related Financial Responsibility Group (Continued)

M221.31 Qualifying Quarters of Coverage

- (a) An alien shall be credited with the following qualifying quarters of coverage, as defined under title II of the Social Security Act:
 - (i) those worked by the alien;
 - (ii) those worked by a parent of such alien while the alien was under age 18 unless the parent received any federal means-tested public benefit during the period for which the qualifying quarter of coverage is credited after December 31, 1996, and
 - (iii) those worked by a spouse of the alien while they were spouses, as long as the alien remains the spouse or the spouse is deceased and the spouse did not receive any federal means-tested public benefit during the period for which the qualifying quarter of coverage is credited after December 31, 1996.
- (b) For this purpose federal means-tested benefits do not include:
 - (i) emergency medical assistance;
 - (ii) short-term, non-cash, in-kind emergency disaster relief;
 - (iii) assistance under the National School Lunch Act or the Child Nutrition Act of 1966;
 - (iv) public health assistance for immunizations or testing and treatment of symptoms of communicable diseases not paid by Medicaid;
 - (v) payments for foster care and adoption assistance under parts B and E of Title IV of the Social Security Act, under certain conditions;
 - (vi) programs, services, or assistance specified by the Attorney General;
 - (vii) programs of student assistance under titles IV, V, IX, and X of the Higher Education Act of 1965, and titles III, VII and VIII of the Public Health Service Act;
 - (viii) means-tested programs under the Elementary and Secondary Education Act of 1965;
 - (ix) benefits under the Head Start Act; or
 - (x) benefits under the WIA.

M222 Formation of the SSI-Related Medicaid Group

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

M222.1 SSI-Related Medicaid Groups for Single Adults

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

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

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

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

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

M222 Formation of the SSI-Related Medicaid Group (Continued)

M222.21 Exceptions to the Rules for Forming SSI-Related Medicaid Groups for Adults with Spouses

Adult applicants with spouses are treated as a Medicaid group of one in the following circumstances.

- (a) When one spouse in a couple is receiving long-term care services, including waiver and hospice services, and applying for Medicaid, the individual is treated as a Medicaid group of one for the determination of initial and ongoing income eligibility and resource reviews of eligibility. The department considers the couple no longer living together as of the first day of the calendar month the institutionalized spouse began receiving long-term care services. This remains true even if the other spouse begins receiving long-term care services in a subsequent month.
- (b) When the department determines the Medicaid eligibility of a community spouse whose spouse already receives waiver or hospice services at home, the department considers each spouse a Medicaid group of one.
- (c) When both members of the couple are admitted to the same residential care home, the department considers each spouse a Medicaid group of one, if the home is designed for four or more residents.
- (d) When both members of the couple are admitted to the same long-term care facility in the same month and have lived there at least six months beginning with the first month following the month of their admission, the department uses two separate Medicaid groups of one for the determination of initial and ongoing income eligibility and resource reviews of eligibility. They may be treated as one Medicaid group of two, however, if that is to their advantage.

This rule also applies if the couple lives in their home or a residential care home in the community, both were granted waiver services during the same month, and both have received waiver services for at least six months.

- (e) Applicants receiving custodial care in their home, as defined in the department's Aid to the Aged, Blind, or Disabled rules at 2731.4.

M222.3 SSI-Related Medicaid Groups for Children

The department treats a blind or disabled child requesting SSI-related Medicaid as a Medicaid group of one.

When a parent and dependent child living together are both requesting SSI-related Medicaid, the department treats them as two Medicaid groups of one, if the parent is not living with a spouse. If the parent is living with a spouse, the department treats the parents as a Medicaid group of two and the child as a Medicaid group of one.

M223 Deeming

SSI-related Medicaid financial eligibility is based on the financial eligibility rules for the Social Security Administration's Supplemental Security Income program (SSI). Like SSI, the department uses the term deeming to identify countable resources and income from other people belonging to applicants. When the deeming rules apply, it does not matter whether the resources or income of the other person are actually available to applicants.

Resources and income from two categories of individuals may be counted for SSI-related Medicaid applicants. These people are members of the financial responsibility group. The department considers:

- spousal resources and income to decide whether it must deem some of it to the Medicaid group; and
- parental resources and income for dependent children to decide whether it must deem some of it to the Medicaid group.

Section M234 specifies the resources counted by the department when determining SSI-related Medicaid financial eligibility.

Section M243 specifies the income counted by the department when determining SSI-related Medicaid financial eligibility.

M223.1 Temporary Absences and Deeming Rules

During a temporary absence, the department considers the absent person a member of the household.

A temporary absence occurs when applicants or their ineligible spouses, parents, or ineligible children leave the household but intend to and do return in the same month or the next month.

The department considers applicants who are eligible children temporarily absent from their parents' household if they are away at school but come home on some weekends or lengthy holidays and are subject to the control of their parents.

If the applicant's ineligible spouse or parent is absent from the household due solely to a duty assignment as a member of the armed forces on active duty, the department considers that person to be living in the same household as the applicant, unless evidence indicates that the applicant's spouse or parent should no longer be considered to be living in the same household. When such evidence exists, the department stops deeming their resources and income beginning with the month after the spouse or parent no longer lived in the same household.

8/1/03

Bulletin No. 02-11

M224

M224 – M229 [Reserved]

M230 Overview of SSI-Related Medicaid Resource Requirements

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

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

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

Resource limits vary depending on the type of category and services and size of the Medicaid group. Resource eligibility for each coverage group is determined by comparing the resources of the financial responsibility group to the resource limit based on the size of the Medicaid group.

Type of Category	Medicaid Services	Resource Limit
SSI-Related Categorically Needy	Community Medicaid	P-2420(C)
	Long-term care	P-2420(C) and transfer test at M440
	Waiver	
SSI-Related Medically Needy	Waiver	P-2420(C) and transfer test at M440
	Long-term care	
	Community Medicaid	
SSI-Related Medicare Cost-Sharing	Payment of certain Medicare costs	P-2420(C)

M230.1 Changes to Resource Rules Effective August 1, 2003

The rules in sections M230-M239 apply to all eligibility determinations made on or after August 1, 2003. To the extent any existing declaratory rulings are inconsistent with the new regulations, the new regulations are intended to supercede them and be the controlling authority.

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M231

M231 Types of Resources

This section describes some of the kinds of resources whose availability the department considers in determining Medicaid eligibility. It cross-references sections in M232 which define additional resources whose availability is considered by the department in determining Medicaid eligibility. Section M232 also specifies when these resources are excluded from the department's Medicaid eligibility determination.

M231.1 Nonliquid Resources

A nonliquid resource means property that is not cash, including real and personal property that cannot be converted to cash within 20 working days. Real property, life estates, burial funds, and life insurance, described below, are some of the more common kinds of nonliquid resources.

Certain noncash resources, though they may occasionally be liquid, are nearly always nonliquid. These include, but are not limited to, household goods and personal effects, vehicles, livestock, and machinery.

M231.11 Real Property

Real property means land and generally whatever is erected, growing on, or affixed to land.

M231.12 Life Estate (see section M232.16)

M231.13 Burial Funds (see section M232.3)

M231.14 Life Insurance (see section M232.2)

M231.2 Liquid Resources

Liquid resources mean cash or other personal property that can be converted to cash within 20 days. Liquid resources ordinarily include, but are not limited to, accounts in financial institutions; retirement funds; stocks, bonds, mutual funds, and money market funds; annuities; mortgages and promissory notes; and home equity conversion plans.

M231.21 Accounts in Financial Institutions

Accounts in depository financial institutions such as banks and credit unions include, but are not limited to, savings accounts, checking accounts, joint fiduciary accounts, and certificates of deposit. Depository institutions may also manage mutual fund and money market fund accounts for depositors.

Nondepository financial institutions such as brokerage firms, investment firms, and finance companies also offer certificates of deposits as well as accounts and services related to the purchase and sale of stocks, bonds, mutual funds, money market funds, and other investments.

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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 (see section M232.98)

M231.24 Annuities (see section M232.4)

M231.25 Mortgages and Promissory Notes

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

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

M231.3 Resources Managed by a Third Party

Resources managed by third parties include, but are not limited to, trusts, guardianship accounts, and retirement funds. Resources of a member of the financial responsibility group managed by a third party (e.g., trustee, guardian, conservator, or power of attorney) are considered available to the member as long as the member can direct the third party to dispose of the resource or the third party has the legal authority to dispose of the resource on the member's behalf without the member's direction.

M231.31 Trusts (see section M232.5 – M232.53)

M231.32 Power of Attorney

Power of attorney means a written document signed by a person giving another person authority to make decisions on behalf of the person signing it, according to the terms of the document. Vermont law requires a power of attorney to be executed according to certain formalities, such as being signed, witnessed, and acknowledged. Funds managed by agents under a power of attorney are not property of the agent and cannot be counted as resources of the agent.

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M231.33

M231 Types of Resources (Continued)

M231.33 Guardian

Guardian means a person or institution appointed by a court in any state to act as a legal representative for another individual, such as a minor or a person with disabilities. Guardianship accounts are presumed to be available for the support and maintenance of the protected individual. Individuals may rebut the presumption of the availability of guardianship funds by presenting evidence to the contrary, including, but not limited to, restrictive language in the court order establishing the account or in a subsequent court order regarding withdrawal of funds.

M231.34 Representative Payee

Representative payee means an individual, agency, or institution selected by a court or the Social Security Administration to receive and manage benefits on behalf of another person. A representative payee has responsibilities to use these payments only for the use and benefit of the beneficiary, notify the payor of any event that will affect the amount of benefits the beneficiary receives or circumstances that would affect the performance of the payee responsibilities, and account periodically for the benefits received. Funds managed by a representative payee are not property of the representative payee and cannot be counted as resources of the representative payee.

M231.35 Fiduciary for a Joint Fiduciary Account (see section M232.71)

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. The department may consider it as a resource, however, when determining whether a long-term care 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.

M232 Excluded Resources (Continued)

M232.12 Proceeds From the Sale of an Excluded Home

The department excludes proceeds from the sale of a home to the extent that the owner intends to use them and, in fact, uses or obligates them to purchase or construct another home within three months of the date the proceeds are received. Use of proceeds from the sale of a home to pay costs of another home will be excluded only if the other costs are paid within three months of the sale of the home. Such costs are limited to the down payment, settlement costs, loan processing fees and points, moving expenses, necessary repairs to or replacements of the new home's structure or fixtures (e.g., roof, furnace, plumbing, built-in appliances) identified and documented prior to occupancy, and mortgage payments for the new home.

The value of a promissory note or similar installment sales contract constitutes a "proceed." Other proceeds consist of the down payment and the portion of any installment amount constituting payment against the principal. These are also excluded if used within 3 months to make payment on the replacement home.

When all of the proceeds are not timely reinvested as specified above, the portion of the proceeds retained by the individual are combined with the value of the note or installment sales contract and counted as a resource beginning with the month following the month the note is executed. If the entire proceeds are fully reinvested in a replacement home at a later date, the value of the note and reinvested proceeds are excluded beginning with the month after the month in which they are reinvested, but any proceeds not reinvested as specified above remain a countable resource until fully reinvested.

M232 Excluded Resources (Continued)

M232.13 Real Property for Sale

The department excludes real property from countable resources as long as owners verify that they are making reasonable efforts to sell it. Reasonable efforts to sell property means taking all necessary steps to sell it for fair market value in the geographic area covered by the media serving the area in which property is located, unless owners are prevented by circumstances beyond their control from taking these steps.

The steps considered necessary to sell the property depend on the method of sale. Owners may choose to list the real property with a real estate agent or undertake to sell it themselves. If owners choose to list it with a real estate agency, they must take the necessary step of listing it and cooperating with the real estate agent's efforts to sell it. If owners choose to sell it without an agent, they must take all of the following necessary steps:

- advertise it in at least one of the appropriate local media continuously;
- place a "For Sale" sign on the property continuously, unless prohibited by zoning regulations;
- conduct open houses or otherwise show the property to prospective buyers; and
- attempt any other appropriate methods of sale.

If any prospective buyer makes a reasonable offer for the property, owners must accept it or demonstrate why it was not a reasonable offer. Any offer at least two-thirds of the most recent estimate of the property's fair market value is considered a reasonable offer.

Fair market value means a certified appraisal or an amount equal to the price of the property on the open market in the locality at the time of the transfer or contract for sale, if earlier.

M232.14 Home Equity Conversion Plans

(a) Definition

Home equity conversion plans are financial instruments used to secure loans with real property as collateral. Home equity conversion plans include reverse mortgages, reverse annuity mortgages, sale-leaseback arrangements, time-sale agreements, and deferred payment loans.

(b) Exclusion

The department excludes as a resource, in the month of receipt, funds from any home equity conversion arrangements on real estate.

M232 Excluded Resources (Continued)

M232.15 Jointly Owned Real Property

(a) General exclusion

The department will exclude jointly owned real property from countable resources as long as the joint owner refuses to sell, if the joint ownership was created:

- (i) before July 1, 2002; or
- (ii) more than 36 months before the date of application.

The department considers that the addition of new joint owners creates a new joint interest and will be evaluated as a countable resource under M233.23.

(b) Exclusion due to undue hardship

Jointly owned real property will be excluded from resources if sale of the property by an individual would cause the other owner undue hardship due to loss of housing. Undue hardship would result when:

- (i) the property serves as the principal place of residence for one (or more) of the other owners;
- (ii) sale of the property would result in loss of that residence, and
- (iii) no other housing would be readily available for the displaced other owner.

M232.16 Life Estates

(a) Definition

Life estate means a legal arrangement entitling the owners to possess, rent, and otherwise profit from real or personal property during their lifetime. The owner of a life estate sometimes may have the right to sell the life estate but does not normally have future rights to the property.

Ownership of a life estate may be conditioned upon other circumstances, such as a new spouse. The document granting the life estate includes the conditions for the life estate and the right of the owner to sell or bequeath it, if these property rights were retained.

M232 Excluded Resources

M232.16 Life Estates (Continued)

(b) Exclusion for life estate interests created on or after July 1, 2002

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

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

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

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

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

M232.17 Real Property Producing Significant Income

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

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

M232.18 Real Property Producing Goods For Home Consumption

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

M232 Excluded Resources (Continued)

M232.2 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.

M232 Excluded Resources (Continued)

M232.3 Burial Funds

(a) Definition

A burial fund is any separately identifiable fund clearly designated as for burial expenses through the title to the fund or by a sworn statement provided to the department. Burial funds include contracts, trusts, or other agreements, accounts, or instruments with a cash value. Some burial funds include accumulated interest, and the value of some burial funds may change through time (e.g., when the fund consists of bonds). Burial expenses include burial spaces, items related to burial spaces, and services related to burial spaces.

The cash value of life insurance policies may also be treated as burial funds for the purposes of determining Medicaid eligibility if owned by an individual whose income and resources are considered in determining Medicaid eligibility and designated as specified above.

For the purposes of determining Medicaid eligibility, burial spaces, if not fully paid, are considered burial funds and include burial plots, gravesites, crypts, mausoleums, caskets, urns, and other repositories customarily and traditionally used for the deceased bodily remains. Items related to burial spaces include, but are not limited to, vaults, headstones, markers, plaques, and burial containers for caskets. Services related to burial include, but are not limited to, embalming, opening and closing of the gravesite, and care and maintenance of the gravesite, sometimes called an endowment or perpetual care.

(b) Exclusion

For any individual whose income and resources are considered in determining SSI-related Medicaid eligibility, the department excludes up to \$10,000 of burial funds, as long as the member shows that the funds are designated for burial expenses through the title to the fund or by a sworn statement provided to the department. They must be separately identifiable and not commingled with other funds.

A burial fund may be excluded as of the first day of the month in which the individual whose income and resources are considered in determining Medicaid eligibility established it. Interest and appreciation accrued on burial funds is excluded if the funds have been left to accumulate.

The value of certain burial spaces may also be excluded under the allowable limit of \$10,000 for each individual whose income and resources are considered in determining Medicaid eligibility. Such spaces must be held for the burial of a member of the applicant's immediate family. For this purpose, the immediate family includes the member's spouse, children, brothers, sisters, and parents.

Irrevocable burial trusts established prior to July 1, 2002 and funded in excess of \$10,000 shall be excluded up to the value of the trust as of June 30, 2002.

M232 Excluded Resources (Continued)

M232.4 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.

(i) Parties to an annuity

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

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

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

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

(ii) Types of annuities

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

Annuities that name revocable beneficiaries are available because they can be surrendered, cashed in, assigned, transferred, or allow the beneficiary to be changed. The department presumes revocability when an annuity contract is silent regarding revocability.

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

M232 Excluded Resources

M232.4 Annuities (Continued)

(iii) Standard annuity contract provisions

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.

Annuity contracts provide for payments over a certain period. For the purposes of Medicaid eligibility, the payout period of an annuity must equal the life expectancy of the person on whose life the annuity is based or else it will be counted as a resource or considered a transfer of assets at less than fair market value. The department determines life expectancy based on the tables in §3258.9 of the State Medicaid Manual published by the federal Centers for Medicare and Medicaid Services, and referenced in the department's Medicaid procedures manual.

(b) Exclusion

The department excludes annuities if they were purchased more than 36 months ago, or if they:

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

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

M232 Excluded Resources (Continued)

M232.5 Resources Managed by a Third Party

M232.51 Definition of Trust

A trust is a legal document setting forth the terms of any arrangement in which a person (the grantor) transfers liquid or nonliquid property (the trust principal) to another person or entity (the trustee) with the intention that it be held, managed, or administered by the trustee for the benefit of one or more individuals (the grantees). In some cases, the grantor is named as a grantee. The grantor may also be called the settlor or the trustor. The grantee may also be called the beneficiary.

Trust income refers to monies earned by the trust property. It may take various forms, such as interest, dividends, or rent payments. Trust income may also be called trust earnings. The trust principal plus the trust income make up the trust property.

A person shall be considered the grantor of a trust if both of these two conditions are met:

- (a) the assets of the person were used to form all or part of the principal of the trust; and
- (b) one of the following established the trust:
 - the person;
 - another person, court, or administrative body, with legal authority to act in place of or on behalf of the person; or
 - another person, court, or administrative body, acting at the direction of or upon the request of the person.

The trustee may be an individual or an entity, such as a bank or insurance company. In most cases, trustees do not have the legal right to use the trust property for their own benefit. Some, but not all, trusts grant discretion to the trustee to use judgment as to when or how to handle trust principal or trust income. A trust may provide reasonable compensation to the trustee for managing the trust as well as reimbursement for reasonable costs associated with managing the trust property.

A trust may name a person or entity, called the residual beneficiary, as the recipient of the trust property upon the death of the grantee.

M232 Excluded Resources (Continued)

M232.52 Excluded Trusts

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

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

- (a) trust property in a trust established prior to April 7, 1986, for the sole benefit of a mentally retarded person residing in an ICF-MR;
- (b) trust property in a trust for which the grantee is a disabled child under Sullivan v. Zebley, 49 U.S. 521 (1990);
- (c) trust property or any portion of the trust property that cannot be made available to the member of the financial responsibility group, either through full exercise of the trustee's discretion under the terms of the trust or through revocation of the trust by a member of the financial responsibility group;
- (d) trust property in a trust established by persons other than the individual or spouse are excluded unless the terms of the trust permit the individual to revoke the trust or to have access to it without trustee intervention;
- (e) irrevocable trusts, including homes placed in irrevocable trusts by institutionalized individuals who intend to return to them, from which no payment under any circumstances could be made to the individual; or
- (f) special or supplemental needs trusts or pooled trusts that meet the following requirements:
 - (i) The special or supplemental needs trust names a beneficiary under the age of 65 and meets all the criteria below in section M232.52(f)(iii).
 - (ii) The pooled trust was established and managed by a nonprofit association, a separate account is maintained for each beneficiary of the trust, and it meets all the criteria below in section M232.52(f)(iii).

M232 Excluded Resources

M232.52 Excluded Trusts (Continued)

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

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

M232 Excluded Resources (Continued)

M232.53 Trusts Excluded Due to Undue Hardship

The department may exclude trust property that has not been distributed if counting it as a resource would cause undue hardship to a grantor or grantee who is a member of the financial responsibility group.

Undue hardship includes situations in which a member of the financial responsibility group or someone in the member's immediate family would be forced to go without life-sustaining services because the trust property could not be made available to pay for the services. For this purpose, the immediate family includes the member's spouse, children, brothers, sisters, and parents.

The following situations also would cause undue hardship:

- (a) funds can be made available for medical care only if trust property is sold, and this property is the sole source of income for the member or someone in the member's immediate family; and
- (b) funds can be made available for medical care only if income-producing trust property is sold and, as a result of this sale, the member or someone in the member's immediate family would qualify 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.

Undue hardship does not exist when application of the trust regulations does not cause individuals risk of serious deprivation.

Individuals claiming undue hardship must submit a written request and any supporting documentation. Claims of undue hardship are forwarded to the commissioner's designee for evaluation. Required documentation from the individual can include but is not limited to the following:

- a statement from the attorney, if one was involved;
- verification of medical insurance coverage and statements from medical providers relative to usage not covered by the insurance; or
- a statement from the trustee.

When application of trust provisions are waived because they would cause the individual undue hardship, only amounts actually distributed from the trust and held for more than a month are counted as a resource. Request for consideration of undue hardship does not limit an individual's right to appeal denial of eligibility for any reason, including the determination of undue hardship.

M232 Excluded Resources (Continued)

M232.6 Early Withdrawal Penalties and Surrender Fees

The department excludes early withdrawal penalties and surrender fees assessed by the financial institution to the extent that they reduce the value of the liquidated proceeds. Examples of these resources are retirement funds, annuities, bonds, and certificates of deposit.

Income tax withholding and tax penalties for early withdrawal are not excluded.

M232.7 Jointly Held Accounts

The department will exclude a jointly held account only if the owner rebuts the presumption of availability by:

- (a) submitting a statement, along with corroborating statements from other account holders, regarding who owns the funds in the joint account, why there is a joint account, who has made deposits to and withdrawals from the account, and how withdrawals have been spent;
- (b) submitting account records showing deposits, withdrawals, and interest, if any, in the months for which ownership of funds is at issue; and
- (c) taking one of the following two actions:
 - correcting the account title to show that the member of the financial responsibility group is no longer a co-owner, if the member owns none of the funds; or
 - if the member owns only a portion of the funds, separating the funds owned by other account holders from the member's funds and correcting the account title on the member's funds to show they are solely owned by the member.

M232.71 Fiduciary for a Joint Fiduciary Account

(a) Definition

A joint fiduciary account is a deposit in a financial institution in the name of an owner naming one or more fiduciaries. The owner makes a clear statement about how the money can be used, and the fiduciary is required to follow those instructions and keep track of how the money is spent.

(b) Exclusion

When an individual owns such an account, it is counted as a resource. When an individual is designated a fiduciary, the joint fiduciary account is an excluded resource for the fiduciary.

M232 Excluded Resources (Continued)

M232.8 Other Excluded Resources

The department also excludes the following resources.

M232.81 Household Goods and Personal Effects

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

M232.82 Vehicles

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

M232.83 Cash Considered Income in the Month of Receipt

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.

M232.84 Cash Necessary to Operate a Business

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 Excluded Resources (Continued)

M232.85 Retirement Funds

(a) Definition

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

(b) Exclusion for community Medicaid

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

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

(c) Exclusion for long-term care

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

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

M232.86 Tax Refunds

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

M232 Excluded Resources (Continued)

M232.87 Student Benefits

The department excludes any portion of any grant, scholarship, or fellowship used to pay fees, tuition, or other expenses necessary to securing an education. Portions used to defray costs of food, clothing, or shelter must be counted.

M232.88 Savings from Excluded Income

The department excludes savings from excluded income and resources. This includes but is not limited to the following:

- (a) liquid resources, including interest earned by the resources accumulated from earnings by a person working with disabilities (see M200.24(b) on or after January 1, 2000, and kept in a separate bank account from other liquid resources, unless no bank within a reasonable distance from residence or place of work permits the person working with disabilities to establish a separate account without charging fees; and
- (b) nonliquid resources purchased by a person working with disabilities on or after January 1, 2000, with savings from earnings or with a combination of savings from earnings and other excluded income or resources.

M232.89 Resources Excluded by Federal Law

The following are excluded by federal law from both income and resources:

- (a) The value of meals and food commodities distributed under the National School Lunch Act and the Child Nutrition Act.
- (b) The value of Food Stamps or Food Stamp cash-out checks.
- (c) The value of food or vouchers received through the WIC Program.
- (d) The value of food or meals received under the Older Americans Act.
- (e) Compensation or remuneration received for volunteer work in ACTION programs including foster grandparents, RSVP, SCORE, ACV, ACE, VISTA, Senior Companion Program and UYA.
- (f) The value of assistance received under the U.S. Housing Act, U.S. Housing Authorization Act and the Housing and Urban Development Act.
- (g) The value of relocation assistance to displaced persons under the Uniform Relocation and Real Property Acquisition Policies Act.
- (h) Per Capital distributions to certain Indian Tribes and receipts from lands held in trust for certain Indian Tribes.
- (i) Payments received under the Alaskan Native Claims Settlement Act.

M232 Excluded Resources

M232.89 Resources Excluded by Federal Law (Continued)

- (j) Grants or loans received for educational purposes under any U.S. Department of Education program.
- (k) Any assistance received under the Emergency Energy Conservation or Energy Crisis Program.
- (l) Any assistance received under the Low-Income Home Energy Assistance Act, either in cash or through vendor payments.
- (m) Compensation paid to Americans of Japanese or Aleut ancestry as restitution for their incarceration during World War II.
- (n) Agent Orange Settlement payments.
- (o) German reparations to concentration camp survivors, slave laborers, partisans, and other victims of the Holocaust. Settlement payments to victims of Nazi persecution or their legal heirs resulting from the confiscation of assets during World War II.
- (p) War reparations paid under the Austrian government's pension system.
- (q) Radiation Exposure Compensation Trust Fund payments.
- (r) Assistance received under the Disaster Relief and Emergency Assistance Act or other assistance provided under a Federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States. Comparable assistance received from a State or local government, or from a disaster assistance organization is excluded. Interest earned on the assistance is also excluded.
- (s) Netherlands' Act on Benefits for Victims of Persecution 1940-1945 payments.
- (t) Any account, including interest or other earnings on the account, established and maintained in accordance with section 1631(a)(2)(F) of the Social Security Act. These accounts are established with retroactive SSI payments made to a child under age 18 and used in ways specified in the Act. The exclusion continues after the child has reached age 18.
- (u) Earnings deposited in a special savings account under the Tangible Assets project managed by the Central Vermont Community Action Council and authorized by The Personal Responsibility and Work Opportunity Reconciliation Act of 1996.
- (v) Payments as the result of a settlement in the case of Susan Walker v. Bayer Corporation, et al. made to hemophiliacs who contracted the HIV virus from contaminated blood products.

M232.9 Resources Excluded for Limited Periods

The department excludes the following resources for specific periods, beginning with the date on which a member of the financial responsibility group received the resource.

M232.91 Retroactive Social Security and SSI/AABD Payments

The department excludes retroactive payments of federal SSI, the AABD supplement to SSI, or social security benefits for nine months beginning with the month after the month of receipt. These payments are also excluded as resources during the month of receipt.

M232 Excluded Resources (Continued)

M232.92 Funds for Replacing a Lost, Stolen, or Damaged Excluded Resource

The department excludes cash and interest earned on that cash received from any source, including casualty insurance, for the purpose of repairing or replacing an excluded resource that is lost, stolen, or damaged, if used to replace or repair that resource. The exclusion is allowed for nine months from the month of receipt. An extension of an additional nine months can be granted for good cause.

M232.93 Earned Income Tax Credit

The department excludes state and federal earned income tax credit refunds and advance payments from consideration as resources.

M232.94 Cash Payments for Medical or Social Services

The department excludes cash received for medical or social services for the calendar month following the month of receipt. The month following the month of receipt, the department counts it as a resource if it has been retained.

M232.95 Victim's Compensation Payments

The department excludes state-administered victims' compensation payments for nine months after the month of receipt.

M232.96 Relocation Payments

The department excludes state and local government relocation payments for nine months after the month of receipt.

M232.97 Funds for Expenses Resulting from Last Illness and Burial

The department excludes payments, gifts, and inheritances occasioned by the death of another person provided that they are spent on costs resulting from the last illness and burial of the deceased by the end of the calendar month following the month of receipt.

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M232 Excluded Resources (Continued)

M232.98 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.

(b) Exclusion

The department excludes U.S. savings bonds during their minimum retention period.

M233 Value of Resources Counted Toward the Medicaid Resource Limit

Unless an exception in one of the subsections below applies, the department values ownership interests of financial responsibility group members according to these general rules.

- (a) Resources not excluded under M232 are valued at their equity value.
- (b) The portion of jointly owned resources not excluded under M232 and countable toward the Medicaid resource limit is determined according to the rules in M233.2.
- (c) The value of any resource owned in its entirety by members of the financial responsibility group and not excluded under M232 is counted toward the Medicaid resource limit.

Equity value is the fair market value minus the total amount owed on it in mortgages, liens, or other encumbrances. The department will use the original estimate of the equity value of a resource unless the owner submits evidence from a disinterested, knowledgeable source that, in the department's judgment, establishes a reasonable lower value.

M233.1 Counting Jointly Owned Resources

This section defines each type of joint ownership and the amount of the resource counted.

When two or more parties share rights to sell, transfer, or dispose of part or all of personal or real property, the department counts the ownership share held by members of the financial responsibility group as prescribed by state law. Shared ownership or control occurs in different forms, including tenancy in common, joint tenancy, and tenancy by the entirety. The department determines the type of shared ownership involved and uses it to compute the countable value of the resource. If an individual submits evidence supporting another type of shared ownership, the department makes a decision about which type applies. When the department decides not to use the type suggested by the individual, it provides the individual with a written notice stating the basis for its decision.

Under Vermont law, a co-owner may demand partition, the dividing of lands held by more than one person. For this reason, the department counts the individual's proportionate share of the lands as an available resource, unless excluded as a home (M232.11) or property up for sale (M232.13).

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M233 Value of Resources Counted Toward the Medicaid Resource Limit (Continued)

M233.11 Tenancy in Common

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

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

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

(a) Nonliquid Resources

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

a. Liquid Resources

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

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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 identical interest (interest) by all owners to possess the whole resource (possession). A joint tenancy cannot be divided into percentages. 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.

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.

M233 Value of Resources Counted Toward the Medicaid Resource Limit (Continued)

M233.2 Value of Certain Resources

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

M233.21 Annuities

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

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

M233.22 Nonexcluded Life Estates

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

M233.23 Jointly Owned Real Property

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

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,
- 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.

M234 Determination of Countable Resources for SSI-Related Medicaid (Continued)

M234.4 Determining Countable Resources for Individuals Requesting Long-Term Care, Including Waiver and Hospice Services, When They Have a Spouse

For individuals requesting long-term care who have spouses, the department performs the resource evaluation process of assessment and allocation set forth M234.41 and M234.42 at the beginning of the first continuous period of long-term care. Individuals discharged from long-term care and readmitted later do not undergo these steps again; only the resources of and any new transfers by the readmitted spouse are counted.

An institutional spouse who receives additional resources after allocating less than the community spouse resource allocation (CSRA) maximum and being found eligible for Medicaid, may continue to transfer resources to their community spouse up to a combined total transfer of no more than the CSRA maximum until the annual review of eligibility. After the first regularly scheduled annual redetermination of eligibility, the rules regarding transfers apply (M440).

M234.41 Assessment of Resources for Individuals with a Community Spouse

At the time of admission to long-term care and application for Medicaid long-term care services, including waiver programs, the department completes an assessment of resources. An individual or their spouse may also request an assessment prior to admission to long-term care. The department provides a copy of the assessment to each spouse and retains a copy. The assessment must include at least:

- the total value of countable resources in which either spouse has an ownership interest;
- the basis for determining total value;
- the spousal share or one-half the total;
- conclusion as to whether the institutionalized spouse would be eligible for Medicaid based on resources;
- the highest amount of resources the institutionalized and community spouse may retain and still permit the institutionalized spouse to be eligible;
- information regarding the transfer of assets policy; and
- the right of the institutionalized spouse or the community spouse to a fair hearing at the time of application for Medicaid.

M234 Determination of Countable Resources for SSI-Related Medicaid (Continued)

M234.42 Allocation of Resources for Individuals with a Community Spouse

The department completes an allocation of resources at the time of application for Medicaid long-term care services, including waiver programs, as follows:

- (a) The department determines the total countable resources of the couple at the time of application for Medicaid, regardless of which spouse has an ownership interest in the resource;
- (b) The department deducts the greatest of the following:
 - community spouse resource allocation maximum,
 - amount set by a fair hearing, or
 - amount transferred from the institutional spouse (IS) to the community spouse (CS) under a court order.
- (c) The department compares the remaining resources allocated to the IS, to the resource maximum for one, to determine whether or not the IS passes the resource test for Medicaid. If the IS does not pass the resource test, see the spenddown provisions at M411-M421. The department considers the resources of the CS available to the IS until the month after the month in which the individual becomes eligible for long-term care coverage. If the CS fails to make the resources accessible to the IS, after the department has determined that they are available, the department may still grant long-term care coverage if:
 - the IS assigns any rights to support from the CS to the department; or
 - denial would work an undue hardship, as specified in M440.44.
- (d) The department provides the CS with the amount determined to be the share of the CS (or to someone else for the sole benefit of the community spouse). The transfer from the IS to the CS must be completed by the next review of eligibility. The department verifies the transfer at the next regularly scheduled redetermination of eligibility.

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M235

M235 – M239 [Reserved]

M240 Overview of SSI-Related Medicaid Income Requirements

Income means any form of cash payment from any source received by individuals or their financially responsible relatives. Income is considered available and counted in the month it is received or credited to the individual with the exception of a lump sum receipt of earnings such as sale of crops or livestock. These receipts are only counted if received during the six-month accounting period and are averaged over the six-month period.

The department counts all earned and unearned income of individuals who are aged, blind or disabled and their financially responsible relatives, except income that is specifically excluded (M242) or deducted (M245). The department verifies all countable income.

Countable income depends on the coverage group for which individuals are eligible. It is determined according to the rules at (M243) and compared to the highest applicable income standard. If total countable income for the Medicaid group exceeds the income standard for every coverage group in rules M200.2- M200.44, individuals are denied eligibility and given a spenddown (see rules M410, M420).

M241 Types of Income

This section describes the kinds of income the department considers when determining SSI-related Medicaid eligibility.

M241.1 Earned Income

Earned income includes all gross salary, wages, commissions, bonuses, severance pay received as a result of employment. It includes income from self-employment.

Earned income includes payments from Economic Opportunity Act of 1964 programs as recipients or employees, such as:

- Youth Employment Demonstration Act Programs
- Job Corps Program (Title I, Part A)
- Work Training Programs (Title I, Part B)
- Work Study Programs (Title I, Part C)
- Community Action Programs (Title II)
- Voluntary Assistance Program for Needy Children (Title II)

Earned income also includes income from:

- employment under Title I of the Elementary and Secondary Education Act (e.g., as a teacher's aide, lunch room worker, etc.)
- wages from participation in the Limited Work Experience Program under the Workforce Investment Act of 1998 (29 U.S.C. §794d)
- earnings from the Senior Community Service Employment (SCSE) program.

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M241 Types of Income (Continued)

M241.11 Self-Employment Income

The department counts net earnings from self-employment. Net earnings means gross income from any trade or business less the allowable deductions specified in M245.11.

The department uses tax forms to determine countable income from self-employment. Applicants who state that income on their tax forms is no longer reflective of their situation may submit alternate documentation.

When the applicant's business has been the same for several years, the department uses income reported on tax forms from the last year.

When the applicant's business was new in the previous or current year and the applicant has business records, the department uses income reported on tax forms and other available business records and divides the income by the number of months the individual has had the business.

When the applicant's business has no records, is seasonal or has unusual income peaks, the department includes income reported on the applicant's signed statement estimating annual income.

M241.2 Unearned Income

Unearned income means any payments other than earned income from any source received by individuals or their financially responsible relatives. It is the gross payment, less allowable deductions at M245.2. The department counts periodic benefits received by individuals as unearned income.

Unearned income includes income from capital investments in which the individual is not actively engaged in managerial effort. This includes rent received for the use of real or personal property, and interest earned on liquid resources. Ordinary and necessary expenses of rental property such as interest on debts, State and local taxes, the expenses of managing or maintaining the property, etc. are deducted in determining the countable unearned income from this source. The deduction is permitted as of the date the expense is paid. Depreciation or depletion of property is not a deductible expense.

Unearned income also includes, but is not limited to, the items listed below.

- (a) Social Security retirement, disability, supplemental security income, or survivor benefits for surviving spouses, children of the decedent, and dependent parents
- (b) Railroad Retirement
- (c) unemployment compensation
- (d) private pension plans
- (e) annuities
- (f) income from capital investments in which the individual is not actively engaged in managerial effort, such as rent for the use of real or personal property, and interest earned on liquid resources or life insurance dividends
- (g) regular and predictable voluntary cash contributions received from friends or relatives
- (h) cash prizes or awards
- (i) withheld overpayments of unearned income, unless the overpayment was counted as income in determining Medicaid eligibility in the month received
- (j) royalty payments to holders of patents or copyrights for which no past or present work was or is involved
- (k) retroactive Retirement, Survivors and Disability Insurance (RSDI) benefits for individuals with drug addiction or alcoholism and is treated as if it had all been received in a lump sum payment, even if paid in installments
- (l) Veteran's Administration pension, compensation and educational payments that are not part of a VA program of vocational rehabilitation and do not include any funds which the veteran contributed
- (m) Interest payments received in the month of receipt
- (n) proceeds of a loan in the month received when the individual is the borrower
- (o) interest payments received by the individual on promissory notes, property agreements, and loan agreements that cannot be sold, when the individual is the lender
- (p) alimony and support payments received
- (q) royalties which are payments to the holder of a patent or copyright, owner of a mine, etc., for which no past or present work was or is involved
- (r) cash received by the beneficiary of a life insurance policy minus any expenses incurred, up to a maximum of \$1,500, in paying for the cost of the insured individual's last illness and burial

M242 Income Exclusions

M242.1 Earned Income Exclusions

The following are excluded from earned income.

- (a) Support service payments made directly to the providers of services in the Limited Work Experience Program under the Workforce Investment Act of 1998 (29 U.S.C. §794d) or needs-based payments of \$10 per day made to participants in the program are excluded income.
- (b) The earned income of a child under the age of 22 who is a student regularly attending school. This applies to wages received from regular employment, self-employment, or payments from the Neighborhood Youth Corps, Work Study and similar programs.
- (c) Infrequent or irregular earned income received, not to exceed \$30 per calendar quarter.
- (d) Any in-kind assistance received from others.
- (e) Earned Income Tax Credit payments (both refunds and advance payments).
- (f) The earned income of a working disabled person when performing the second step of the categorically needy eligibility test redetermining net income, set forth in M200.24 (b).
- (g) The earned income of a child under the age of 18.

M242 Income Exclusions (Continued)

M242.2 Unearned Income Exclusions

Unearned income exclusions are limited to the following items.

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

M242 Income Exclusions

M242.2 Unearned Income Exclusions (Continued)

- (h) Any public agency's refund of taxes on food or real property.
- (i) Infrequent or irregular income payments that do not exceed \$20.00 in a month.
- (j) Bills paid directly to vendors by a third party.
- (k) Replacement of lost, stolen or destroyed income.
- (l) Weatherization assistance.
- (m) Receipts from the sale, exchange or replacement of a resource.
- (n) Any assistance based on need which is funded wholly by the state, such as General Assistance.
- (o) Public assistance benefits of individuals who are living with an applicant, as well as any income that was used to determine the amount of those benefits
- (p) Any portion of a grant, scholarship or fellowship used to pay tuition, fees or other necessary educational expenses.
- (q) Home produce used for personal consumption.
- (r) Assistance and interest earned on assistance for a catastrophe from the Disaster Relief and Emergency Assistance Act or other comparable assistance provided by the federal, state or local government.
- (s) Irregular and unpredictable voluntary cash contributions or gifts received from friends or relatives.
- (t) Payments for providing foster care for children or adults placed in the individual's home by a public or private non-profit placement agency.
- (u) One-third of child support payments received for a child in the household of the applicant or recipient. Note: the remaining two-thirds of the support payments are considered the unearned income of a child received from an absent parent.
- (v) Income paid for chore, attendant or homemaker services under a government program, such as Title XX personal services payments or the \$90.00 Department of Veterans Affairs (VA) Aid and Attendance payments to veterans in nursing homes.
- (w) Any "in-kind" assistance received from others.

M242 Income Exclusions

M242.2 Unearned Income Exclusions (Continued)

- (x) Assistance provided in cash or in kind (including food, clothing, or shelter) under a government program that provides medical care or services (including vocational rehabilitation).
- (y) That portion of a benefit intended to cover the financial need of other individuals, such as AABD-EP grants.
- (z) Retroactive payments of federal SSI, the AABD supplement to SSI or Old Age and Survivor and Disability Insurance (OASDI) benefits if the payments were included in determining financial eligibility for Medicaid in the month it was actually owed to the individual.
- (aa) Home energy assistance provided by a private nonprofit organization or a regulated supplier of home energy.
- (bb) State-administered victims' compensation payments.
- (cc) State or local government relocation payments.
- (dd) Payments occasioned by the death of another person to the extent that they are used to pay for the deceased person's last illness and burial, including gifts and inheritances.
- (ee) Payments occasioned by the death of another person to the extent that they are used to pay for the deceased person's last illness and burial, including gifts and inheritances.
- (ff) Earned Income Tax Credit payments (both refunds and advance payments).
- (gg) Cash received as the beneficiary of a life insurance policy minus any expenses incurred, up to a maximum of \$1,500 set aside to pay for the cost of the insured individual's last illness and burial.
- (hh) Up to \$500 per month of social security disability insurance benefits (SSDI) provided to working disabled persons when performing the second step of the categorically needy eligibility test redetermining net income, set forth in M200.24 (b).
- (ii) Dividends paid on life insurance policies, excluding interest.
- (jj) Payments made from a supplemental needs trust made to or for the benefit of an individual.
- (kk) Exclusions based on federal law as set forth in M232.89.

M243 Determination of Countable Income for SSI-Related Medicaid

The department counts the earned and unearned income of the members of the financial responsibility group. Income is considered available and counted in the month it is received or credited to the individual.

This section describes the general approach the department follows when it determines countable income for SSI-related Medicaid. These general rules apply to all applicants.

(a) Determine income of the financial responsibility group

The department combines the income of all members of the financial responsibility group, and applies the appropriate exclusions (M242) and standard deductions (M245).

(b) Compare countable income to the applicable income standard

Applicants pass the income test when their Medicaid group's income does not exceed the appropriate PIL, or the applicable income maximum, whichever is higher.

Applicants with income greater than the applicable income standard may establish financial eligibility by incurring eligible medical expenses that at least equal the difference between their countable income and the applicable PIL.

The subsections which follow specify how the department allocates and deems income based on the type of coverage sought and the size of the financial responsibility group.

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M243.1

M243 Determination of Countable Income for SSI-Related Medicaid (Continued)

M243.1 Financial Responsibility Groups for One Individual Seeking Community Medicaid

The department determines countable income for individuals seeking SSI-related community Medicaid with a financial responsibility group of one according to the following rules. Common financial responsibility groups of one include single adults, residential care home residents, and children seeking Katie Beckett coverage.

The following steps must be followed in determining the countable income of individuals who are aged, blind or disabled.

- (1) Determine and combine the total countable unearned income of the individual.
- (2) Subtract a \$20 disregard unless all the unearned income is from a source that gives assistance based on financial need.
- (3) Deduct an allocation for each child in the household for whom the individual is financially responsible. The amount of each allocation is equal to the maximum allocation amount minus any countable income of the child. If the unearned income is not at least equal to the applicable allocation amount, any remaining allocation may be deducted from earned income.
- (4) Deduct from unearned income amounts used to comply with the terms of court-ordered support or Title IV-D support payments. If unearned income is insufficient, any remaining amounts may be deducted from earned income.
- (5) Determine and combine the individual's countable earned income.
- (6) Deduct any remaining amount of the \$20 disregard, allocations for children and child support payments from the earned income.
- (7) Deduct \$65 from the remaining earned income.
- (8) Deduct allowable work expenses for the disabled (M245.13).
- (9) Deduct one-half of the remaining earned income.
- (10) Deduct any allowable work expenses for the blind (M245.12).
- (11) Combine the remaining earned income with any remaining unearned income.
- (12) Deduct amount of Plan to Achieve Self-support (PASS), if applicable.
- (13) The result is the individual's countable income for the month. Compare it to the countable income to the PIL or the SSI/AABD payment standard for one, whichever is higher.

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M243.2

M243 Determination of Countable Income for SSI-Related Medicaid (Continued)

M243.2 Financial Responsibility Groups for Individuals When One or Both Spouses Seek Community Medicaid

The department determines countable income for SSI-related Medicaid applicants with a financial responsibility group of two according to the rules at M243.1, as well as the following additional rules.

(a) Deem income at step M243.1(1):

The department deems earned and unearned income to the applicant at step M243.1(1) from their ineligible spouse or ineligible parent, except no income is deemed to adult applicants from their ineligible children.

(b) Allocate income at step M243.1(3):

The department allocates income from the financial responsibility group to each member of the financial responsibility group who is not applying for SSI-related Medicaid at step M243.1 (3) in the amounts listed below:

- (i) For a child, the department allocates the difference between the SSI federal payment rate for one and the SSI federal payment rate for a couple. The department reduces the allocation for ineligible children if they have income, unless the ineligible children are students with earned income. No allocation is made to dependant children receiving public assistance.
- (ii) For a parent in a one-parent financial responsibility group, the department allocates the SSI federal payment for one.
- (iii) For parents in two-parent financial responsibility groups, the department allocates the SSI federal payment for two.

(c) Count income at step M243.1(13) for adult applicants applying for SSI-related Medicaid who have a spouse:

The department determines countable income for adults whose spouse is not applying for Medicaid, according to the rules at M243.1, except at step M243.1(13) the department compares the countable income of the Medicaid group to the PIL or the SSI/AABD payment standard for two, whichever is higher.

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M243.3

M243 Determination of Countable Income for SSI-Related Medicaid (Continued)

M243.3 Financial Responsibility Groups for a Parent and Child Living Together Seeking Community Medicaid

When a parent and child in the same household both request SSI-related Medicaid, the department determines countable income as a financial responsibility group of two according to the following rules. These groups include a parent who is aged, blind or disabled and a child who is blind or disabled.

- (a) First determine the net income available to the adult applicant following the steps in M243.1 if single, or M243.2 (a), (b), and (c) if the adult applicant has a spouse, except do not allocate any income to the applicant child. Compare the adult applicant's income to the protected income level (PIL) for one or, if married, the SSI/AABD payment standard for two.

If the adult applicant's countable income is below the highest applicable income standard, the adult has passed the income test for eligibility. If the adult applicant's income exceeds the highest applicable income standard, deem the amount of income in excess of the highest applicable income standard to the child applicant as unearned income.

- (b) Second, determine the child's countable income by deeming any income from M243.3(a) above and then following the steps in M243.4 (4)-(14). If the child's income is less than the PIL, both the parent and the child pass the income test for Medicaid eligibility.
- (c) When both a parent and child have a spenddown requirement, the parent and child will pass the income test once the child's spenddown requirement has been met because the parent's excess income was deemed to the child.

If the parent's spenddown requirement is less than the child's and the parent meets it, the parent will become eligible. The child, however, will remain ineligible until the remainder of the child's spenddown is met. The department deducts the parent's incurred eligible medical expenses from the spenddown requirements of both the parent and child because the parent's income was included in both income computations.

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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.

- (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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M243.5

M243 Determination of Countable Income for SSI-Related Medicaid (Continued)

M243.5 Financial Responsibility Groups for Individuals Seeking Long-Term Care

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

The department compares the countable income of individuals requesting long-term care to the applicable institutional income standard (IIS) or protected income level (PIL), whichever is most advantageous, beginning with the date of admission to long-term care.

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

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

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M243.51

M243 Determination of Countable Income for SSI-Related Medicaid (Continued)

M243.51 Determination of Countable Income for Long-Term Care Applicants in Nursing Facilities

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

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

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

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

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

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

For individuals whose income exceeds the applicable standard, the department determines whether they may spenddown their excess income to establish their financial eligibility as medically needy using the rules in M420-M429, if the total cost of their waiver services equals or exceeds their spenddown amount.

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M245

M245 Income Deductions

The department allows deductions from earned income (M245.1), self employment (M245.11), and unearned income (M245.2).

M245.1 Earned Income Deductions

A deduction of \$65.00 and one-half of the remainder applies to all determinations of earned income.

M245.11 Business Expenses from Self-employment

Deductions of business expenses from self-employment income are limited to the ones specified below.

- (a) Operating costs necessary to produce cash receipts, such as office or shop rental; taxes on farm or business property; hired help; interest on business loans; cost of materials, livestock and equipment required for the production of income; and any business depreciation.
- (b) The cost of any meals provided to children for whom individuals provide day care in their own homes, at the currently allowed rate per meal.
- (c) The actual operating expenses necessary to produce cash receipts for commercial boarding houses: an establishment licensed as a commercial enterprise that offers meals and lodging for compensation, or, in areas without licensing requirements, a commercial establishment that offers meals and lodging with the intention of making a profit.
- (d) Room and board, alone or as part of custodial care, provided that the amount shall not exceed the payment the household receives for room and board.
- (e) Foster care payments made by the Department of Social and Rehabilitation Services (SRS) to licensed foster homes, including room and board of children in the custody of and placed by SRS when the Medicaid group includes a foster parent.
- (f) Ordinary and necessary expenses for active management of capital investments, like rental property. These may include fire insurance, water and sewer charges, property taxes, minor repairs which do not increase the value of the property, lawn care, snow removal, advertising for tenants and the interest portion of a mortgage payment

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M245.12

M245 Income Deductions (Continued)

M245.12 Work Expenses from Income of Blind Individuals Under the Age of 65

In addition to other allowable deductions specified throughout section M245 and its subsections, work expenses from income of blind individuals includes the following items.

- cost of purchasing and caring for a dog guide;
- work-related fees such as licenses, professional association dues or union fees;
- transportation to and from work including vehicle modifications;
- training to use an impairment-related item such as braille or a work-related item such as a computer;
- federal, state and local income taxes;
- Social security taxes and mandatory pension contributions;
- meals consumed during work hours;
- attendant care services;
- structural modifications to the home; and
- medical devices such as wheelchairs.

M245.13 Work Expenses from Income of Disabled Individuals

In addition to other allowable deductions specified throughout section M245 and its subsections, work expenses from income of disabled individuals includes the following items.

- transportation to and from work, including vehicle modifications;
- impairment-related training;
- attendant care;
- structural modifications to the home; and
- medical devices such as wheelchairs.

M245.2 Unearned Income Deductions

- (a) The department deducts \$20.00 from unearned income unless the source of income gives all assistance based on financial need.
- (b) The department deducts from unearned income amounts used to comply with the terms of court-ordered support or Title IV-D support payments.

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M250

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M360 Individuals with a Community Spouse Requesting Long Term Care

The treatment of resources held by individuals requesting long-term care who have dependent children and a spouse are the same for ANFC-related Medicaid as for SSI-related Medicaid. The department assesses and allocates resources using the rules specified at M234.4–M234.42 for both coverage groups.

Individuals who meet the income rules for Reach Up financial eligibility (M330-M339) meet the income rules for long-term care eligibility, including home-and-community-based waiver services, specified at M243.52.

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M400

M400 Spenddown, Patient Share, and Transfer of Resources Provisions

The following spenddown, patient share and transfer of resources provisions apply to individuals requesting SSI-related and ANFC-related Medicaid depending on their living arrangement (M401-M401.2). They are calculated using an accounting period of either one or six months, depending on the type of Medicaid services requested (M402-M402.2).

When a Medicaid group's total countable income or resources exceed the applicable income or resource standard for eligibility after allocations are made, and exclusions and disregards are applied, a person requesting Medicaid may use spenddown provisions to attain financial eligibility (M410-M423).

The department requires individuals requesting long-term care to apply their available income to the cost of their care through payment of a patient share (M430-M433.3).

The department considers whether individuals otherwise eligible for long-term care, including waiver and hospice services, have transferred resources that should be subject to penalty period before eligibility begins. The rules at M440 apply to transfer of resources after July 1, 2002 and the rules at M450 apply to transfers before July 2, 2002.

M401 Types of Living Arrangements

The length of the accounting period used to compute spenddown requirements and patient share payments depends on the living arrangement of the person requesting Medicaid. For the purposes of Medicaid eligibility, a person may be in a community or long-term care living arrangement.

M401.1 Community Living Arrangement

Community living arrangements include any residence, such as a house, apartment, residential care facility, boarding house, rooming house. Persons requesting Medicaid coverage of long-term care services, including waiver and hospice services, are not considered to be in a community living arrangement.

In a community living arrangement, the person requesting Medicaid obtains and pays for basic maintenance items, such as food, shelter, clothing, personal needs, separately from medical care. The person requesting Medicaid may live alone, as a member of a family, or with non-relatives.

M401.2 Long-Term Care Living Arrangement

Persons requesting Medicaid coverage of long-term care, including waiver and hospice services, are considered to be in a long-term care living arrangement. Medicaid eligibility and patient share payments are determined according to long-term care rules for persons living in an institution or receiving waiver or hospice services.

Institutional living arrangements include nursing facilities, rehabilitation centers, and intermediate care facilities for the mentally retarded.

Individuals receiving waiver services are considered to be in a long-term care living arrangement. Individuals receiving Medicaid waiver services would be eligible for Medicaid if they lived in an institution and need enhanced residential care, home-and-community-based care, traumatic brain injury services, developmental disability services, or children's mental health services to live in the community.

Individuals receiving hospice services are considered to be in a long-term care living arrangement. Individuals receiving Medicaid hospice services are terminally ill and would be eligible for Medicaid if they live in an institution and need additional interdisciplinary medical care and support services to enable them and their families to maintain personal involvement and quality of life in their choice of care setting and site of death.

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M402

M402 Types of Accounting Periods

Accounting period means the one-month or six-month span of time the department uses to budget the income of a person requesting Medicaid.

M402.1 Six-Month Accounting Period

The department uses a six-month accounting period to determine spenddown requirements for persons in a community living arrangement.

The six-month period begins with the first month for which Medicaid coverage is requested, usually the month of application. If Medicaid coverage is requested for expenses incurred during any one or more of the three months preceding the month of application, the six-month period begins with the earliest of these three months in which expenses were incurred and the applicant met all other eligibility requirements.

To determine the amount of income a person must spend down, the department shall make reasonable estimates of future income, subject to review and adjustment if the applicant's circumstances change during the remainder of the six-month period.

M402.2 One-Month Accounting Period

The department uses a one-month accounting period to determine spenddown requirements and patient share payment amounts for persons in waiver, hospice, or institutional living arrangements.

A one-month accounting period begins with the first calendar month during which the person lives in long-term care for any part of the month, applies for Medicaid coverage for that month, and meets the general and categorical requirements for Medicaid eligibility.

A one-month accounting period ends with the last calendar month during which the person lives in long-term care for any part of the month and passes all other Medicaid eligibility tests.

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M403

M403 – M409 [Reserved]

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M410

M410 Spenddown of Excess Resources and Income to meet Financial Eligibility Standards

Individuals who pass all nonfinancial eligibility tests may qualify for Medicaid coverage by spending down the income or resources in excess of applicable maximums. The department specifies the income and resource maximums for each eligibility category in the benefit program descriptions found at M200.2 and M300.2, as well as in the Medicaid procedures manual.

Spending down is the process by which a Medicaid group incurs allowable expenses to be deducted from its income or spends resources to meet financial eligibility requirements, according to the rules in M410-M412.1 and M420-M423.

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M411

M411 Spending Down Excess Resources

A resource spenddown is the amount a Medicaid group must spend to reduce its excess resources to the resource standard applicable to the appropriate Medicaid coverage category. The department determines that a person requesting Medicaid with excess resources has passed the resource test upon proof that the excess resources are no longer held as a resource and have actually been spent or given away. A person with excess resources requesting long-term care services, including waiver and hospice services, is subject to the transfer of resource provisions specified in M440.

Medicaid may be granted for the month of application if the resource test is passed at any point in the month and all other eligibility criteria are met. A Medicaid group's resources may rise above the resource maximum, for example, due to interest added to bank accounts or failure to use the full monthly income amount protected for maintenance expenses during the month it is received. The recipient may maintain Medicaid eligibility for any month in which the Medicaid group's resources exceed the resource maximum by taking any action that reduces the excess amount, including giving the excess to the department to repay department expenditures on the individual's care. As long as resources are reduced to the resource maximum before the end of the month during which resources exceed the limit, Medicaid coverage continues without interruption.

In addition, when a third party who handles any resources of a member of the Medicaid group is unaware of a resource or its value, the department will provide uninterrupted Medicaid coverage as long as the excess amount is paid to the department as a recovery of Medicaid payments. Excess resources reimbursed to the department in these situations will not result in ineligibility.

Individuals seeking long-term care coverage may be subject to a transfer penalty if they spend or give away excess resources within the penalty period specified in M440.4 and its subsections.

M411.1 Allowable uses of Excess Resources to Qualify for Retroactive Coverage

One or more of the following actions may be taken to reduce excess resources in order to qualify for Medicaid up to three months prior to the month of application as long as all other eligibility test are passed:

- (a) Individuals may set up a burial fund that meets the requirements specified in M232.3 for an excluded resource.
- (b) If the Medicaid group's countable income is less than the applicable PIL, they may spend resources on maintenance expenses, such as housing, food, clothing and fuel, up to a maximum per month of the difference between their countable income and the applicable PIL.
- (c) Individuals may spend money on covered or noncovered medical expenses.

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M412

M412 Spending Down Excess Income

An income spenddown is the amount of qualifying medical expenses a Medicaid group must incur to reduce its income to the maximum applicable to their Medicaid coverage category. The department determines that a person requesting Medicaid with excess income has passed the income test upon proof that the Medicaid group has paid or incurred medical expenses (M420-M423) at least equal to the difference between its countable income and the applicable income maximum for the accounting period.

M412.1 Allowable uses of Excess Income

The medical expenses of the financial responsibility group, whether they are paid or incurred but not paid, may be used for individuals requesting Medicaid to meet the spenddown requirement (see (M243.5 and M330-M339).

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M413-M419

M413-M419 [Reserved]

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M420

M420 Spending Down Excess Income on Medical Expenses

An individual with income greater than the applicable maximum may spend down the excess on medical expenses following the methodology specified below to receive Medicaid as part of the medically needy coverage group. The amount of a Medicaid group's spenddown is the amount by which their countable income or resources exceed the applicable standard for the accounting period. The spenddown methodology is the same for all living arrangements, except that a one-month accounting period and the institutional income standard apply to long-term care living arrangements and a six-month accounting period and the protected income level apply to those in the community living arrangement.

M420.1 Eligibility Date

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

- Eligibility becomes effective on the first day of the month when a spenddown requirement is met using health insurance and noncovered medical expenses.
- Eligibility becomes effective later than the first day of the month when a spenddown requirement is met using covered medical expenses.
- Special eligibility dates apply, as set forth in M421.24 for Medicaid groups who meet their spenddown requirement using noncovered assistive community care services (ACCS).

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

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M420.2

M420 Spending Down Excess Income on Medical Expenses (Continued)

M420.2 Deduction Sequence

Eligible medical expenses are deducted from countable income in the following order:

- (a) Health insurance expenses (M421.1).
- (b) Noncovered medical expenses (M421.2-M421.24).
- (c) Covered medical expenses (M422 and M423) that exceed limitations on amount, duration, or scope of services covered (M500-M999).
- (d) Covered medical expenses (M422 and M423) that do not exceed limitations on amount, duration or scope of services covered and are incurred by the financial responsibility group. These must be deducted in chronological order of the date the service was received beginning with the oldest expense.

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M420.3

M420 Spending Down Excess Income on Medical Expenses (Continued)

M420.3 Time Frames for Deductible Expenses

Deductible expenses include medical expenses incurred by the financial responsibility group:

- during the current accounting period, whether paid or unpaid;
- before the current period and paid in the current period, or
- before the current period, remaining unpaid, and for which continuing liability can be established.

In addition, deductible expenses include medical expenses paid during the current accounting period by a state or local program other than those that receive Medicaid funding.

Medical expenses incurred before or during the accounting period and paid for by a bona fide loan may be deducted if the expense has not been previously used to meet a spenddown requirement and the financial responsibility group establishes continuing liability for the loan and documents that all or part of the principal amount of the loan remains outstanding at any time during the accounting period. A bona fide loan means an obligation, documented from its outset by a written contract and a specified repayment schedule. Only the amount of the principal outstanding during the accounting period, including payments made on the principal during the accounting period, may be deducted.

M420.31 Predictable Expenses

In general, an expense is incurred on the date liability for the expense begins. Only four types of predictable medical expenses may be deducted before they are incurred, if it can be reasonably assumed that the expense will continue during the accounting period:

- health insurance premiums (M421.1);
- medically necessary over-the-counter drugs and supplies (M421.21);
- ongoing, noncovered personal care services (M421.23); and
- assistive community care services provided to residents in a level III residential care home either not enrolled as a Medicaid provider or with admission agreements specifying the resident's financial status as private pay (M421.24).

M420.32 Prior Medical Expenses

Continuing liability for unpaid medical expenses or a loan used to pay medical expenses incurred before the current accounting period will be established when any of the following conditions is met. The liability was incurred:

- within six months of the date of application or the first day of the accounting period, whichever is later.
- more than six months before the date of application or the first day of the accounting period, whichever is later, and there is a bill for the liability dated within 90 days of that date.
- more than six months before the date of application or the first day of the accounting period, whichever is later, and the service provider or lender has confirmed that the unpaid liability has not been forgiven and is not expected to be forgiven at any time within the current accounting period.

M421 Allowable Medical Expense Deductions

The following deductions apply to spenddowns when excess income exceeds the applicable income maximum. Medical expenses that are the current liability of the Medicaid group and for which no third party is legally liable may be deducted from total excess income or resources for the accounting period. No medical expense may be used more than once to meet a spenddown requirement. A medical expense may be used to spend down either income or resources. If only a portion of a medical expense is used to meet the spenddown requirement for a given accounting period, that portion of the medical bill that was not used and remains a current liability may be applied toward a spenddown requirement in a future accounting period. Upon receiving coverage, the Medicaid group remains directly responsible to providers for expenses incurred before the spenddown was met.

M421.1 Health Insurance Expenses

Health insurance means insurance to meet costs of medical care and services, such as Medicare Part B, and similar group or individual policies. Premiums for the following types of insurance are not deductible:

- Income protection or similar insurance plans designed to replace or supplement income lost due to sickness or accident; or
- Automobile or other liability insurance, although these may include medical benefits for the insured or his family.

Health insurance expense also includes any enrollment fees, deductibles or coinsurance imposed by Medicare or other health insurance not subject to payment by a third party (such as another insurance policy).

This deduction is allowed for premium payments by a member of financial responsibility group if it can be reasonably assumed that coverage will continue during the accounting period. Coverage and premium or other expense amounts must be verified.

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M421.2

M421 Allowable Medical Expense Deductions (Continued)

M421.2 Medical Expenses not Covered by Medicaid

A deduction from excess income is allowed for necessary medical and remedial expenses recognized by state law but not covered by Medicaid in the absence of an exception for Medicaid coverage under M108. In determining whether a medical expense meets these criteria, the commissioner may require an individual Medicaid group to submit medical or other related information to verify that the service or item for which the expense was incurred was medically necessary and was a medical or remedial expense. The patient's physician shall verify medical necessity with a written statement or prescription specifying the need, quantity, and time period covered. These medical expenses, when not covered by Medicaid, include but are not limited to expenses for the services and items listed below:

- over-the-counter drugs and supplies (M421.21);
- transportation (M421.22);
- personal care services for recipients age 21 and older (M421.23);
- assistive community care services provided to residents in a level III residential care homes either not enrolled as a Medicaid provider or with admission agreements specifying the resident's financial status as private pay (M421.24);
- dental services in excess of the allowable annual maximum; and
- private duty nursing services for recipients age 21 and older.

Any medical bills, including those incurred during a period of Medicaid eligibility, that are the current liability of the Medicaid group and have not been used to meet a previous spenddown requirement may be deducted from excess income. Generally, the Medicaid group is required to present a bill or receipt to verify that medical expenses have been incurred or paid. Special requirements for certain medical expenses are specified in M421.21 – M421.24.

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M421.21

M421 Allowable Medical Expense Deductions (Continued)

M421.21 Over-the-Counter Drugs and Supplies

Either a standard deduction or actual costs, if greater, may be used to deduct noncovered over-the-counter drugs and supplies from excess income.

(a) Documentation

Documentation verifying medical necessity is not required when the department determines that an over-the-counter drug or supply is a common remedy for the medical condition of a member of the Medicaid group and the usage is within the maximum amount for common over-the-counter drugs and supplies. Documentation verifying medical necessity may be required whenever one or both of the following two situations apply: when the drug or supply is not a common remedy for the medical condition or when the reported usage exceeds the maximum amount.

(b) Amount Deductible

Instead of actual expenses, a reasonable estimate of ongoing expenses for over-the-counter drugs and supplies may be applied prospectively to the six-month accounting period. Reasonable estimates of unit sizes, costs and maximums for common over-the counter drugs and supplies used to meet the spenddown requirement are found in the Medicaid procedures manual. If the Medicaid group uses the expense to meet the spenddown requirement, they shall not be eligible to receive Medicaid coverage during that accounting period for the same expenses.

M421.22 Transportation

Noncovered commercial and private transportation costs may be deducted from excess income.

The actual cost of commercial transportation, verified by receipt, may be deducted.

Either a standard deduction or actual costs, if greater, may be used for deducting the cost of private transportation. These costs may be deducted from excess income without verification of medical necessity, provided that:

- the transportation was essential to secure the medical service; and
- the Medicaid group was responsible for the cost and was charged an agreed-upon fee or purchased fuel to use a family-owned vehicle or other non-commercial vehicle.

The process set forth in Medicaid procedures shall determine the deductible expense for private transportation.

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M421.23

M421 Allowable Medical Expense Deductions (Continued)

M421.23 Personal Care Services

The department will allow a deduction for noncovered personal care services provided in an individual's own home or in a level IV residential care home when they are medically necessary in relation to an individual's medical condition.

(a) Deductible Personal Care Services

Deductible personal care services include those personal care services described in M740.3 and assistance with managing money. They also include general supervision of physical and mental well-being where a physician states such care is required due to a specific diagnosis, such as Alzheimer's disease or dementia or like debilitating diseases or injuries. Room and board is not a personal care service.

(b) Qualified Service Providers

Services may be deducted when performed by a home health agency or other provider identified by the physician as qualified to provide the service with the following exceptions. When the service provider is living in the home, deductions may not be based on payments for personal care services provided to an individual:

- under age 21 by the individual's parent, stepparent, or legal guardian, unless the individual is 18, 19, or 20 years old and payment for personal care services is made from and does not exceed the individual's own income or assets;
- by the individual's spouse;
- by the individual's sibling, child, or grandchild when the person providing the services is under age 18; or
- by a parent of the individual's minor child.

(c) Documentation

To document the need for personal care services, the physician must submit:

- a plan of care (PATH 288B);
- a list of the personal care services required;
- a statement that the services are necessary in relation to a particular medical condition; and
- a statement that the level of care provided by the particular level IV residential care home is appropriate or, if the individual is not living in a level IV residential care home and the services are not provided by a home health agency, that the provider is qualified to provide the service.

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M421.23 P.2

M421 Allowable Medical Expense Deductions

M421.23 Personal Care Services

(c) Documentation (Continued)

Upon the initial submission of a plan of care (PATH 288B), it is assumed that the individual will continue to need the personal care services for the entire six-month period, unless the plan of care has specified a date by which the individual's need for services is expected to change.

A new plan shall be submitted:

- whenever the service provider changes, unless the service is performed by a home health agency; and
- whenever the need for services in relation to the individual's condition is expected to change, according to the current plan of care.

In addition, a new plan shall be submitted:

- once every six months, when the physician has not specified an ongoing need for personal care services in the current plan; or
- once every two years, when the physician has specified an ongoing need for personal care services in the current plan.

(d) Amount Deductible

Either a standard deduction or actual costs, if greater, may be used for deducting personal care services from excess income. Expenses that have not been incurred yet may be deducted if they are predictable and meet the requirements in M420.31. Expenses also may be deducted if they have actually been incurred by the Medicaid group and are not subject to payment by Medicaid or any other third party.

The standard monthly deduction for personal care services shall be deducted for each full or partial calendar month in the accounting period during which the plan of care documents the need for services. The actual documented costs of personal care services may be deducted if they exceed the monthly standard deduction. Deductions may be made for anticipated need through the end of the accounting period.

All changes to these standards that result in lower standard deductions will be made via the Administrative Procedures Act.

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M421.24

M421 Allowable Medical Expense Deductions (Continued)

M421.24 Assistive Community Care Services

(a) Deductible Assistive Community Care Services

The department will allow a deduction for noncovered assistive community care services provided to individuals residing in a licensed level III residential care home. In addition, these individuals may deduct medically necessary personal care services included under the list at M740.3 but not part of the list at M781.2.

(b) Qualified Service Providers

Qualified service providers include all level III residential care homes licensed by the Vermont Department of Aging and Disabilities.

When a resident becomes eligible for Medicaid by projecting the cost of ACCS across part of the six-month accounting period, the residential care home may agree to function as a Medicaid provider for ACCS with respect to that resident for the remainder of the accounting period. In these cases, the provider may bill for ACCS services no sooner than the ACCS coverage date given to the resident and the provider in a notice from the department.

When a privately paying resident becomes eligible for Medicaid after having met a spenddown requirement by projecting the cost of ACCS across the entire six-month spenddown period, the home shall not function as a Medicaid provider of ACCS with respect to that resident during that the period when the resident is meeting the spenddown requirement.

(c) Documentation

Documentation verifying medical necessity is not required for assistive community care services. If an individual claims a deduction for medically necessary personal care services included under the list at M740.3 but not part of the list at M781.2, the physician must submit:

- a plan of care (PATH 288B);
- a list of the personal care services required;
- a statement that the services are necessary in relation to a particular medical condition; and
- a statement that the level of care provided by the particular level III residential care home is appropriate and that the provider is qualified to provide the service.

Upon the initial submission of a plan of care (PATH 288B), it is assumed that the individual will continue to need the personal care services for the entire six-month period, unless the plan of care has specified a date by which the individual's need for services is expected to change.

Beneficiaries with approved personal care services deductions must submit new plans at the frequencies specified in M421.23.

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M421.24 P.2

M421 Allowable Medical Expense Deductions

M421.24 Assistive Community Care Services (Continued)

(d) Amount Deductible

The deduction for assistive community care services (ACCS) may be used for the entire accounting period or part of it. Whether the standard daily or monthly deduction is used depends on the size of the spenddown requirement. The actual documented costs of ACCS may be deducted if they exceed the monthly standard deduction. Deductions may be made for anticipated need through the end of the accounting period. All changes to these standards that result in lower standard deductions will be made via the Administrative Procedures Act.

If the Medicaid group's excess income and resources after deduction of all expenses for which Medicaid coverage is not available equal or exceed the deduction for ACCS for the entire accounting period, for the purposes of meeting a spenddown requirement, ACCS are projected and deducted as if they were not Medicaid-covered services for the entire accounting period. Medicaid eligibility for services other than ACCS becomes effective on the day the spenddown requirement is met. Expenses for which Medicaid coverage is not available are:

- medical expenses excluded from coverage listed at M421.1 through M421.24;
- covered medical expenses incurred prior to the accounting period, not used to meet a previous spenddown requirement, and remaining unpaid; and
- covered medical expenses incurred and paid during the current accounting period.

If the Medicaid group's excess income and resources after deduction of all expenses for which Medicaid coverage is not available are less than the deduction for ACCS for the entire accounting period, ACCS expenses are not projected. Instead, they are deducted as covered expenses on a daily basis. In this case, Medicaid eligibility for all covered services other than ACCS becomes effective the first day of the accounting period. Medicaid coverage for ACCS begins later. It starts the day cumulative daily ACCS deductions exceed the group's remaining excess income and resources. The Medicaid group is not responsible for payment of a portion of the ACCS expense on the first day of ACCS eligibility.

In addition, the amount of the deduction for any services included under the list at M740.3 but not part of the list at M781.2 documented as medically necessary by the plan of care shall be determined based on the number of hours times minimum wage, or actual costs, if greater.

8/1/03

Bulletin No. 02-11

M422

M422 Covered Medical Services

Covered medical expense means any medical service that Medicaid would pay for if the person were an eligible Medicaid recipient (see Sections M500-M999).

Deductions are not limited to the Medicaid reimbursement for the service. The Medicaid group member's actual cost paid or incurred must be allowed. A standard deduction may be taken for assistive community care services, M781.2, as specified in Medicaid procedures.

M423 Expenses Subject to Third-Party Coverage

No deduction is allowed if the medical expense is subject to payment by a third party such as health insurance, worker's compensation, liability award, or other benefit program unless the third party is a state or local program other than Medicaid.

When a third party is liable for all or some medical expenses, only the portion owed by those requesting Medicaid may be deducted from their applied income. The department is required to take reasonable measures to determine the legal liability of third parties to pay for incurred expenses. Estimates of payment by the third party may be used if actual third party liability cannot be ascertained within the period for determining Medicaid eligibility. The department cannot delay an eligibility determination simply because actual third party liability cannot be ascertained or payment by the third party has not been received.

If an applicant or recipient is pursuing a liability award but liability has not yet been established, a deduction should be allowed. Eligibility must be based on the department's estimate of the amount the applicant owes for the bill. The Third Party Liability (TPL) Unit in the Office of Vermont Health Access should be notified of the pending potential liability award when the applicant is found eligible for Medicaid.

8/1/03

Bulletin No. 02-11

M424

M424 – M429 [Reserved]

8/1/03

Bulletin No. 02-11

M430

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

Once the department determines individuals are eligible for long-term care including waiver and hospice services, it computes how much of their income must be paid to the long-term care provider each month for the cost of care (patient share). The department determines the patient share amount at initial eligibility, eligibility redeterminations, and when changes in circumstances occur.

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

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

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

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

M431 Determining Residence Period for Long-Term Care

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

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

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

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

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

(c) Ending of long-term care residence period

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

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

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

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

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

All Months Except February

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

February

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

M431.2 Determining the Maximum Patient Share

Multiply the individual's gross income by the applicable percentage of the month that the individual resided in the institution or received waiver or hospice services from the tables at M431.1. This is the individual's maximum patient share in the month of admission.

M432 Deductions from Patient Share

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

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

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

- (a) a personal needs allowance or community maintenance allowance (M432.1);
- (b) home upkeep expenses, if applicable (M432.2);
- (c) allocations to community spouse or maintenance needs of family members living in the community, if applicable (M432.3); and
- (d) medical expenses incurred, if applicable (M420-M422).

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

M432.1 Personal Needs Allowance and Community Maintenance Allowance

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

M432 Deductions from Patient Share (Continued)

M432.2 Home Upkeep Deduction

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

- (a) 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).
- (b) An individual receiving less income than the standard home upkeep deduction may deduct an amount for home upkeep equal to the difference between the income and the standard home upkeep deduction. This deduction may be applied at any point during the institutionalization as long as all criteria for the deduction are met:
 - (i) 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
 - (ii) the beneficiary submits a doctor's statement before each three-month deduction period, stating that the beneficiary is expected to be discharged from the institution within six months and to return home immediately after discharge.

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

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

M432 Deductions from Patient Share (Continued)

M432.3 Allocation to Family Members

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

M432.31 Allocation to Community Spouse

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

Institutionalized spouses may allocate less than the full amount to their community spouse or may allocate nothing. The allocation is reduced by the gross income, if any, of the community spouse and is available only when the countable resources of the community spouse do not exceed the community spouse resource allocation maximum or a higher amount set by a fair hearing or court order. Community spouses, as well as institutionalized spouses, have a right to request a fair hearing.

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

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

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

M432 Deductions from Patient Share

M432.3 Allocation to Family Members (Continued)

M432.32 Allocation to Other Family Members

The department allows a deduction for the following family members, unless the member's countable resources exceed \$12,000:

- any child under age 18; and
- any dependent children, parents, or siblings of either spouse, as specified below.

For the purposes of this subsection, the department considers individuals dependents if they meet each of the following three criteria:

- they have been or will be a member of the household of the beneficiary for at least one year;
- more than one half of their total support is provided by the beneficiary; and
- they have gross annual income below \$2500 or are a child of the beneficiary under age 19 or under age 24 and a full-time student during any five months of the tax year.

When family members live with the community spouse of a person living in a nursing facility, the deduction equals the maintenance income standard reduced by the gross income of each family member and dividing by three. The resulting amount is the maximum allocation that may be made to each family member.

When family members do not live with the community spouse of the person living in a nursing facility, the deduction equals the applicable protected income level for the number of family members living in the same household as the family member, reduced by the gross income, if any, of the family members in the household.

The department may require the family members described above to apply for SSI, AABD or Reach Up, as long as this would not disadvantage them financially.

8/1/03

Bulletin No. 02-11

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 living in long-term care.

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 of the Department of Prevention, Assistance, Transition, and Health Access.

M433.1 Payment of Patient Share when Long-Term Care Recipient Enters 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 of the Department of Prevention, Assistance, Transition, and 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 patient share may result in closure of Medicaid eligibility.
- (b) For level I or II nursing care: the patient share is paid to the hospital when the recipient is hospitalized and receiving level I or level II nursing facility care in the hospital on the last day of the month preceding the month in which income is received.

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M433.2 Payment of Patient Share when Long-Term Care Recipient of Waiver Services Enters a Nursing Facility

- (a) For respite services: the department does not adjust patient share payment when a long-term care recipient of waiver services enters a nursing facility for respite services. The patient share is paid to the highest paid provider of waiver services, even if the individual is in a nursing home on the last day of the month and receiving respite services.
- (b) For other services: The department adjusts the patient share amount when a long-term care recipient of waiver services enters a nursing facility for services other than respite and has been in the nursing facility for a full calendar month. The patient share is paid to the nursing facility since the individual was receiving long-term care in a nursing facility on the last day of the month.

M433.3 Payment of Patient Share when Long-Term Care Recipient is Discharged from a Nursing Facility and to Waiver Services

The department adjusts the patient share amount when individuals are in a nursing facility for more than one full calendar month and discharged to waiver services. After the patient share payment is redetermined using the community maintenance allowance, the first month's patient share is paid to the nursing facility because the individual resided in the facility on the last day of the previous month. Thereafter it is paid to the highest paid provider of waiver services.

M433.4 Payment of Patient Share for the Month when Long-Term Care Recipient is Discharged from Long-Term Care

The department excludes all income long-term care recipients receive during the month of discharge from long-term care and any month after discharge when long-term care Medicaid recipients leave a long-term care living arrangement (M401.2). Long-term care providers must refund patient share payments made by long-term care Medicaid recipients when they pay their patient share from income received in the month of their discharge.

M433.5 Payment of Patient Share for the Month when Long-Term Care Recipient is No Longer Eligible for Medicaid Coverage of Long-Term Care

Long-term care Medicaid recipients become fully responsible for the total cost of any care they receive after the effective date of the decision when they remain institutionalized after a medical review team decision that they no longer need skilled nursing or intermediate care, or they become ineligible for other reasons. Recipients usually must pay in advance for such care as a private patient. They incur no patient share obligation for the calendar month that the review decision takes effect.

The long-term care providers must credit payment toward the cost of private care furnished after the effective date of the decision to end Medicaid long-term care coverage when long-term care Medicaid recipients have already paid their patient share to the institution during the calendar month the review decision takes effect.

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M433.6 Payment of Patient Share in the Month of Death

The department counts income received during the calendar month of the death of a long-term care Medicaid recipient and applies it to the cost of their care received during the prior month. For example, if a long-term care Medicaid recipient dies on June 26, the patient share payment from income received during June is due for care provided in May. If a long-term care Medicaid recipient dies on July 1, the patient share payment from any income received during July is due for care provided in June.

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M434

M434 – M439 [Reserved]

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

The department shall determine whether transfers of income or resources made by applicants and recipients requesting Medicaid coverage of long-term care expenses, or by any member of their financial responsibility group, are allowable transfers under the rules set forth in this section. If the department determines that such transfers are not allowable, the person requesting long-term care coverage shall not be eligible for such coverage until a penalty period has expired. The beginning and duration of the penalty period shall be based upon the date and value of the disallowed transfers.

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

Section M440.1 sets forth a definition of transfers.

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

M440.1 Definition of Transfer

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

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

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

M440.2 Allowable Transfers for Fair Market Value

No penalty period is applied to income or resources transferred for fair market value.

Fair market value means an amount equal to the price of an item on the open market in the individual's locality at the time of a transfer, or contract for sale, if earlier. The department determines whether an individual received fair market value for a transfer of income or resources by determining the difference, if any, between the fair market value of any asset reduced by any applicable deductions at the time of the transfer and the amount received for the asset.

Any of the following deductions may be used to reduce fair market value:

- (a) the amount of any legally enforceable liens or debts against the transferred income or resource at the time of transfer that reduced the transferor's equity in the income or resource;
- (b) the reasonable and necessary costs of making the sale or transfer;
- (c) the value of income or resources received in exchange for the transferred income or resources;
- (d) the value of income or resources returned to the individual; and
- (e) the following verified payments or in-kind support given to or on behalf of the individual as compensation for receipt of the income or resources by the person who received the income or resources:
 - personal services;
 - payments for medical care;
 - funeral expenses of the individual's deceased spouse;
 - taxes, mortgage payments, property insurance, or normal repairs on the transferred property;
 - or
 - support and maintenance (e.g., food, clothing, incidentals, fuel and utilities) provided in the individual's own home or in the home of the person who received the income or resource.

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M440.21

Deleted: 5/1/03

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 other than an annuity is scheduled for receipt after the date of transfer, the department considers it a transfer for fair market value if the individual can expect to receive the full fair market value of the resource within his or her expected lifetime, as determined by the department.

The department considers the purchase of an annuity a transfer for fair market value if the annuity:

- is actuarially sound;
- provides for payments at equal intervals and in equal amounts;
- returns at least the transferred amount to the individual within his or her expected lifetime, as determined by the department; and
- has been established for the sole benefit of a member of the Medicaid group.

The department uses an actuarial table set forth in the Medicaid procedures manual to determine life expectancy.

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) The income or resource transferred 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.
- (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 that the transfer was made exclusively for a purpose other than qualifying for Medicaid.

There is a rebuttable presumption that the resources were transferred for the purpose of establishing or maintaining eligibility for long-term care. The presumption is rebutted only if the individual provides 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, other than the home.

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M440.31

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

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

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

- (a) The income or resources were transferred to a trust, 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 income or resources were transferred to an irrevocable trust that does not under any circumstances allow disbursements to or for the benefit of the individual, and the date of the transfer was more than 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.
- (c) The action that constituted the transfer was the establishment of a trust solely for the benefit of a person under age 65 who is blind or permanently and totally disabled.
- (d) The action that constituted the transfer was the establishment of a special or supplemental needs trust or pooled trust, specified at M232.52(e).
- (e) The action that constituted the transfer was the establishment of a revocable trust. Payments to anyone other than the individual must be considered a transfer for less than fair market value, however.

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

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

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

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

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

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

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

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

M440.34 Transfers involving Annuities

(a) Allowable Transfers

The department does not impose a penalty when income or resources were used to purchase an annuity more than 36 months ago or meet the criteria for an excluded resource in M232.4.

(b) Impermissible Transfers

When the beneficiary has a spouse, an annuity will not be considered a permissible transfer if some one other than individual requesting long-term care Medicaid or his or her spouse, is a named beneficiary, even when both spouses die before the payout period ends.

Action by applicants or their spouses to abandon or transfer ownership of an annuity shall be treated as a transfer of resources.

When annuities are considered an impermissible transfer, the total value of the transfer is the cash value. The cash 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, unless the individual can furnish evidence from a reliable source showing that the annuity is worth a lesser amount. Reliable sources include banks, other financial institutions, insurance companies, and brokers, as well as any other the department considers, in its discretion, to be reliable.

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

M440.35 Transfers involving Jointly Held Income or Resources

(a) Transfers after January 1, 1994

For joint ownerships established after January 1, 1994, the portion of jointly held assets subject to penalty is evaluated by the department based on the specific circumstances of the situation. The department presumes individuals own the value of the resource using rules in M233 and its subsections. Individuals may rebut the presumption of ownership by establishing to the department's satisfaction that the amount withdrawn was, in fact, the sole property of and contributed to the account by the other person, and thus did not belong to the individual. In the case of accounts in financial institutions (rule 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 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. The period of restricted coverage begins the first day of the month the asset was transferred if that does not occur in any other period of restricted coverage.

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

M440.42 Penalty Period

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

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

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

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

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

M440.43 Assignment of Penalty Periods when both Spouses Request Long-Term Care Coverage

The department applies the following rules to the assignment of penalty periods when both members of a couple are requesting or receiving Medicaid coverage of long-term care services, including waiver and hospice services.

- (a) For spouses determined otherwise eligible for Medicaid payment of long-term care services at the same time, the department divides the value of the disallowed transfer by two to determine the number of days of restricted coverage for each member of the couple.
- (b) If the penalty period established for one member of the couple has not yet expired when the other member of the couple requests and is determined otherwise eligible for Medicaid payment of long-term care services, the number of days remaining in the penalty period shall be divided by two to determine the number of days of restricted coverage for each member of the couple.
- (c) When the member of the couple for whom a penalty period has been established dies, the days remaining in that member's penalty period shall not be reassigned to the member's spouse, if the spouse requests and is determined otherwise eligible for Medicaid payment of long-term care services.
- (d) When the department establishes a penalty period for a disallowed transfer by the second member of the couple to request and be determined otherwise eligible for Medicaid payment of long-term care services, the department assigns that penalty period to the spouse who made the transfer, provided that it was made after the determination of disallowed transfers for the first spouse.

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M440.44

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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 when it determines that restricted coverage would work an undue hardship. Undue hardship exists if one or more of the following conditions are met:

- (a) Funds can be made available for medical care only if assets such as a family farm or other family business are sold, and the assets are the sole source of income for the individual's spouse, parents, children or siblings.
- (b) Sale of the of the income producing assets 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.
- (c) A power of attorney (POA) or guardian transferred the asset, and the court has ruled the POA or guardian was not acting in the best interest of the individual when the transfer was made, or the transfer forms the basis for a referral to the Department of Aging and Disabilities, Division of Adult Protective Services, for investigation of abuse or neglect.
- (d) An individual presents other circumstances with similar impact, in the department's judgment, to those enumerated above.

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