TRANSMITTAL LETTER FOR MANUAL RELEASES

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF ELIGIBILTY SERVICES ADMINISTRATION
DIVISION OF ELIGIBILITY POLICY
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MANUAL: **Medical Assistance** **EFFECTIVE DATE: March 1, 2013**

RELEASE NO: **MR-159** **ISSUED: April 30, 2013**

APPLICABILITY: MA-LTC, clarifications regarding transfers made exclusively for purposes other than qualifying for Medical Assistance.

Note: Because OES is now updating the on-line Manual rather than pages of the paper version, no instructions for insertion or deletion are listed. Following a summary of the primary changes to sections 800.17 through 800.25, the sections appear in their entirety with new text highlighted in the chapter revisions.

Chapter 8: New Policies and Procedures for Identifying Allowable Transfers Within the Look-back Period

The purpose of this manual release is to introduce new provisions to the on-line Medicaid Eligibility Manual that:

- help identify valid alternative purposes for transfers for less than fair market value, and
- clarify the kinds of evidence that will suffice as "convincing."

The rules for transfer penalties require us to examine carefully transfers a MA-LTC applicant may have made during the look-back period for less than fair market value. However, "[a]n individual may **not** be determined ineligible for Medical Assistance by reason of the transfer of any asset, excluded or nonexcluded, if . . .[t]he individual furnishes convincing evidence that the asset was transferred **exclusively for a purpose other than to qualify for Medical Assistance**[.]" COMAR 10.09.24.08-1B(8) (emphasis added). Experience has shown that it is generally easier for workers to spot reasons for penalizing a transfer than it is to determine that a gift or disposal was made for reasons unrelated to establishing financial eligibility for Medicaid.

The purpose of this manual release is to introduce new provisions to the on-line Medicaid Eligibility Manual that

- help identify valid alternative purposes for transfers for less than fair market value, and
- clarify the kinds of evidence that will suffice as "convincing."

We are releasing Sections 800.17 through 800.25, to show the policy changes in context. Highlighted areas indicate new and revised text.

Summary of Significant Policy Changes

At Section **800.17(b)**, at page 160 in the on-line Manual, **"What are Disposals Subject to Penalty,"** we have clarified some of the examples describing disposals that may be subject to penalty. In the same section, we have clarified the language about resources that may have lost value over time, such as a home that is now worth much less than the purchase price and that would require further expenses to prepare for sale to a third party.

At Section **800.20(d)**, **"Reasons Not to Penalize a Disposal,"** we have removed language about the CM's subjective "satisfaction" with evidence of a non-Medicaid purpose. We have also specified that acceptable written evidence may include bills, affidavits, written agreements, or restatements or ratifications of oral agreements put in written form at a later date.

At Section **800.23**, **"Presumption of Reason for Disposal,"** we have added further examples of expenditures an A/R/S may have made for non-Medicaid purposes. These include, but are not limited to, a natural disaster affecting the A/R/S or a family member, serious financial hardship of a family member (with specific examples of supporting documentation), and modification of (or addition to) a house for the purpose of enabling the A/R/S to live there (provided A/R/S actually resides there for any period of time). We have clarified that an A/R/S may make payments to contribute to household expenses while residing with another person, and that oral agreements between A/R/S and the recipient of a transferred resource may be supported by signed statements put in writing after the fact, *i.e.*, at or near the time of Medicaid application. The examples provided are intended to be illustrative and do not limit the types of transactions that may be done for a purpose other than to establish Medicaid eligibility. Also in this section, we have listed relationships that are included when a non-Medicaid purpose is described specifically as gifts to (or expenses for) "a family member."

At Section **800.24**, **"When Gifted Assets are Returned,"** we have clarified some language applicable to the reduction of the penalty period when a gift is returned. While payments from the A/R/S's income for the cost of private-pay nursing facility services during a penalty period is part of the purpose of the penalty, if funds are returned to the A/R/S by or on behalf of the person who received the transferred funds, the return reduces or exhausts the penalty and the A/R/S must be permitted to use the funds that are returned to pay for care during the remainder of the adjusted penalty period. The penalty period is also reduced or exhausted if payments on behalf of the A/R/S are made directly by or on behalf of the person who received the transferred funds.

The updated manual sections in this release, sections 800.17 through 800.25, correspond to current pages 860 through 893 in the on-line Manual. This Manual Release will be available for reference before the complete revisions to Chapter 8 of the online Manual chapter are released and posted on-line.

We will display Manual Release 159 on the DHMH website page where the online Manual and Eligibility Updates are located:
https://mmcp.dhmh.maryland.gov/SitePages/Medical%20Assistance%20Eligibility%20Updates.aspx

Direct questions about this policy issuance to the DHMH Division of Eligibility Policy at 410-767-1463 or 1-800-492-5231, option 2, extension 1463.

800.17 Disposal of Assets for Less than Fair Market Value

This section presents policies and procedures related to the disposal of assets (countable or excludable) for less than fair market value (FMV) by an institutionalized individual or the individual's spouse. A penalty period may be imposed to exclude Medicaid coverage of nursing facility and home and community based 1915(c) waiver services. The federal Deficit Reduction Act of 2005 (DRA), enacted on February 8, 2006, changed certain policies related to penalties for disposals, including methods for establishing penalty periods, as specified in this section.

NOTE: The terms "disposal" and "transfer" are used interchangeably. When "disposal of assets" is referenced, it also includes a transaction establishing or changing a trust that is subject to a penalty. When "nursing facility" is referenced, it also includes a medical institution with a level of care equivalent to a nursing facility (e.g., beds in a hospital that are licensed for nursing facility level of care).

The look-back for disposals and a penalty period are only imposed if an A/R/S is institutionalized and determined otherwise eligible for:

- Long-term care (LTC) coverage in a nursing facility (NF) or a medical institution with a level of care equivalent to a nursing facility; or
- Enrollment in a Home and Community-Based Services (HCBS) waiver under § 1915(c) of the Social Security Act.

Therefore, these requirements do not apply for:

- A community resident who is not applying for coverage under a 1915(c) waiver; or
- An institutionalized individual in a long term care facility other than a nursing facility (e.g., chronic care or psychiatric hospital).

A penalty for disposals does not affect Medicaid eligibility. During an imposition of a penalty period, Medicaid will not pay for long-term care services received in a nursing facility or services provided under a HCBS 1915(c) waiver.

When an CM learns that an institutionalized individual (NF or waiver A/R) and/or the individual's spouse disposed of an asset for less than FMV at any time on or after the A/R's applicable look-back date, this information must be considered part of an eligibility determination or scheduled redetermination for Medicaid (MA) coverage of NF or 1915(c) waiver services, or should trigger an unscheduled redetermination of a recipient. Penalties are also imposed for the establishment or change of a trust under certain conditions on or after an institutionalized individual's look-back date. It does not matter whether the disposed asset is considered countable or excludable for determining Medicaid financial eligibility.

For each disposal, the CM must determine if there is any uncompensated value. If so, the disposal may be subject to a penalty. Disposals for which fair market value is received are not penalized. If the A/R's spouse died, or the A/R/S was divorced, prior to the period under consideration, this is not considered a "spousal impoverishment" case. Therefore, assets that belonged to the deceased spouse or ex-spouse, and in which the A/R/S had no ownership interest, do not affect the A/R's current eligibility and do not need to be verified in order to determine the A/R's current eligibility. Also, **these assets are not reviewed for disposal of assets for less than FMV, even if the spouse died or the divorce occurred within the A/R's look-back period.**

(a) Definitions

The following definitions are relevant to this section:

- "Assets" are defined as all income and resources owned by an individual or the individual's spouse, including any income or resources to which the individual or spouse is entitled but does not receive because of an action or inaction on the part of the individual, spouse, or person acting on their behalf.
  - Resources: Accumulated, available personal wealth for which the A/R/S has an ownership interest or is entitled to receive, and has the legal right, authority, or power to sell, transfer, or liquidate and convert into currency for the individual's or household's support and maintenance. Examples include cash, savings or checking accounts, stocks, bonds, real property, and personal property.
  - Income: Earned or unearned monetary payment or benefits (lump sum or regular) that an A/R/S receives or is entitled to receive, which can be applied directly to meet the individual's or household's needs for support and maintenance.
- "Available" means that there is no legal impediment, regardless of penalty, to the use of income or the sale, transfer, or liquidation of a resource.
- "Community spouse" means an individual who:
  - is married to an institutionalized individual;
  - lives in the community, not in a long-term care facility; and
  - is not enrolled in a HCBS 1915(c) waiver.
- "Disposal" means a transfer or divestiture of ownership interest in assets owned by an applicant, recipient, or the individual's spouse.
- "Encumbrance" means a debt, mortgage, lien, or anything else that hinders or limits an owner's absolute and unqualified title to an asset.
- "Equity interest" means the equity value of an individual's ownership interest in a resource.
- "Equity value" means the fair market value of a resource:
  - Including any tax withholding or other deductions; and

    - Excluding any penalty for early withdrawal and the cost of any legal debt or other encumbrances on the resource.
- "Fair market value" means:
    - Documented value of income or a liquid resource (e.g., bank account, stock, bond); or
    - Assessed value (i.e., current property tax assessment or recent professional appraisal); or
    - Price for which a property or other resource can reasonably be expected to sell on the open market in the relevant geographic area at a specific time.
- "Home" means any shelter where the A/R/S lives as the principal place of residence, including the parcel of land on which the shelter is situated and any related outbuildings necessary to its use as home property, rather than a business.
- "Institutionalized individual" or "institutionalized spouse" means an individual who is determined by the Department to have a level of care for long-term care services and is either:
    - Admitted to a long a long-term care facility for a continuous period of institutionalization of at least 30 days (or for at least a full calendar month if a child younger than age 21); or
    - Receiving long-term care services through enrollment in a HCBS 1915(c) waiver.
- "Look-back date" means the beginning date of a look-back period, before the individual's earliest effective date of eligibility as an institutionalized individual in a nursing facility or HCBS 1915(c) waiver.
- "Look-back period" means the period of time, beginning with the look-back date, for which the CM may evaluate the institutionalized individual's and the community spouse's assets, to determine if a disposal of assets for less than fair market value occurred.
- "Ownership interest" means the portion of a resource that an individual owns.
- "Penalty period" means the period of time during which an individual is not covered by Medicaid for nursing facility or HCBS 1915(c) waiver services, due to a disposal of the individual's or spouse's assets for less than fair market value during the individual's look-back period.
- "Unavailable" means "not accessible to the A/R/S or spouse ("A/R/S)."
- "Uncompensated value" means the difference between the fair market value of an individual's equity interest in an asset when it is disposed and the amount of compensation received by the individual for the asset.

b) What are Disposals Subject to Penalty?

A penalty may be imposed if, during the institutionalized individual's applicable look-back period:

- A resource was disposed for less than FMV; or
- Income was disposed for less than FMV in the same month that it was received (i.e., prior to being considered as a resource if the money is still retained in the month after receipt); or
- A stream of income (i.e., income received on a regular basis) or the right to a stream of income (e.g., pension) was transferred for less than FMV. Then, a determination must be made of the total amount of income that would have been received from this source during the individual's lifetime, based on an actuarial projection of the individual's life expectancy (see Schedule MA-9A, Period Life Table). The penalty is calculated based on the total projected income not received; or
- The A/R/S is entitled to income or a resource but did not receive it because of an inaction or action that prevented the asset from being received. This includes any inaction or action of the:
  - A/R/S; or
  - A court, any administrative body, or any person with legal authority to act in place of or on behalf of the A/R/S; or
  - Any person, court, or administrative body that acted at the direction or request of the A/R/S or their legal representative.

A disposal does not include use of the A/R/S's assets to pay bills incurred by the A/R/S for items or services used by the A/R/S (e.g., payment of bills, ordinary living expenses or medical expenses, purchase of personal items, purchase of a burial plan or life insurance for the A/R/S, repairs of the home property). Disposal of assets for less than FMV includes transactions by a person acting on behalf of an A/R/S. These persons include legal representatives such as guardians, attorneys, persons with power-of-attorney, or the parent of a minor child. However, there are circumstances where written evidence shows certain disposals for less than FMV to be for a purpose other than qualifying for Medicaid, as set forth below under "Reasons not to Penalize Disposals" and "Presumption of Reasons for Disposal." The lists in this Manual are intended to be illustrative and do not limit the types of transactions that may be done for a purpose other than to establish Medicaid eligibility.

Disposal includes any action that results in an asset being made unavailable or which reduces or eliminates the A/R/S's ownership interest without adequate compensation for this FMV. These actions include, but are not limited to:

- Making a gift or donation of resources that reduces the A/R's countable resources to the maximum resource limit;

- Paying bills (e.g., credit card bills) for another person other than a family member as defined in Section 800.23 below;
- Purchasing something for someone else's use (e.g., television, season tickets to sporting events, or other luxury items) that reduces the A/R's countable resources to the applicable resource limit;
- Selling or transferring assets for less than fair market value;
- Altering the A/R/S's ownership interest in an asset by adding new owners or removing an owner (e.g., adding a family member's name other than the spouse, by adding to the home property deed the name of a family member other than the spouse, a son or daughter who lived in the home and provided care that allowed the A/R/S to reside at home rather than in a nursing facility, or a sibling with an equity interest in the home who has resided there for at least 12 consecutive months, or by removing the A/R/S's name from the deed unless it falls under an exception to penalty, see Section 800.20(d) "Reasons not to Penalize Disposals");
- Transferring the home property and retaining only a life estate interest without powers for the A/R/S. See Section 800.18 Life Estate as Disposal;
- Rendering an asset unavailable by establishing a trust, annuity, or other legal or financial instrument. See Section 800.13 "Annuities," Section 800.14 "Trusts," and Section 800.19 "Promissory Notes, Loans or Mortgages as Disposal."

Disposals may also include any actions or inactions that result in the A/R/S's failing to receive assets to which they may be entitled. These actions and inactions include, but are not limited to:

- waiving the right to a source of income (e.g., pension income);
- postponing receipt of an asset;
- failing to take legal action to obtain a court-ordered payment that is not being paid (e.g., child support, alimony);
- failing to apply for all income benefits to which the A/R/S may be entitled and for which the eligibility worker explains the application process;
- not pursuing, accepting, or accessing injury settlements;
- diverting settlements or claims to another person;
- establishing a tort settlement which diverts funds from the defendant into an irrevocable trust or a similar unavailable resource to be held for the benefit of the plaintiff; or
- waiving the right to receive an inheritance.

Consider the circumstances to determine whether a failure to act constitutes a disposal for less than FMV, subject to penalty. For example, the cost of obtaining the asset may have been greater than the asset's value, making the asset's FMV essentially zero. Or, the individual might be unable to afford to take the necessary action (e.g., hire a lawyer) to obtain the assets to which the individual is entitled. In such a case, the inaction would not result in a penalty.

c) Who Made the Disposal?

Any action taken by, on behalf of, at the direction of, or upon the request of the A/R/S, or their representative may result in a penalty for the A/R. Therefore, a disposal may be subject to penalty even if the action was taken by an entity other than the A/R/S or their legal guardian or representative, such as by:

- administrative agencies;
- courts;
- insurers;
- trustees;
- joint owners.

d) Disposal by a Spouse

In most instances, a disposal by the A/R's spouse is penalized for the A/R/S in the same way as a disposal by the A/R. There is no special methodology to calculate a penalty for spousal disposals. For example, the spousal share is not "backed out" prior to calculation of the penalty. Transfers by the A/R's spouse include transfers by the:

- spouse's attorney-in-fact
- spouse's representative
- spouse's guardian
- any other person acting in place of or on behalf of the spouse.

The look-back period for disposals by a spouse is the same as for disposals by the A/R. Assets of the community spouse are not considered available to the recipient following the post-eligibility 90-day "protected period." The CM must determine whether any assets transferred to the community spouse from the institutionalized spouse were disposed for less than FMV during the look-back period and before the end of the post- eligibility "protected period." The CM must determine whether a transfer between spouses was part of the required post-eligibility transfer. Because inter-spousal transfers before or during the 90-day "protected period" are "protected," a penalty is not imposed for transfers during that period. However, transfers between spouses after the "protected period" may be subject to a penalty, unless the recipient or representative demonstrates to the CM's satisfaction that there was "good cause" for the delay in making the inter-spousal transfer (e.g., the CM neglected to send the notice to the recipient's representative).

Since a transfer by a community spouse has exactly the same effect as a transfer by the institutionalized spouse, disposals by a community spouse should not be evaluated

separately from disposals by the institutionalized spouse. If transfers were made by both the institutionalized spouse and the community spouse, a single penalty period is calculated for the institutionalized spouse, based on the total uncompensated value of all the disposals being penalized.

If a transfer is made by a community spouse who later is institutionalized and applies for Medicaid, the number of months remaining in the first institutionalized spouse's penalty period as of the other spouse's effective date for NF or waiver eligibility must be apportioned equally between the husband and wife. The penalty period is shortened for the first institutionalized spouse, and an equal number of months are penalized for the other spouse. The second institutionalized spouse's penalty cannot begin until the effective month of eligibility as an institutionalized person in a NF or HCBS 1915(c) waiver, since an individual (e.g., non-waiver community resident) may not otherwise be penalized.

Example:
If 6 months are remaining in the penalty period when the second spouse is institutionalized, each spouse is penalized 3 months.

If the first spouse to be institutionalized is no longer subject to a penalty (e.g., is deinstitutionalized, dies) when the other spouse is institutionalized, the remaining penalty period (which continues to run) reverts to the other spouse who is now institutionalized. For example, if there are 6 months remaining in the penalty period for a deceased spouse when the other spouse is institutionalized, the institutionalized spouse is penalized for 6 months.

e) Date of Disposal

When determining eligibility, the CM must pay special attention to disposals and trusts. First, the date of the disposal for less than FMV is identified. If more than one of the dates below is applicable, the date of disposal is considered to be the later of the dates.

- For income disposed in the month that it is received, the month of disposal is the month of receipt.
- For income that is diverted or refused, the month of disposal is the month in which the income should have been received.
- For resources that are transferred, the month of disposal is the month in which the transfer occurred.
- For jointly owned assets, the month of disposal is the month in which an action was taken that reduces or eliminates the A/R's ownership, access, or control of the asset. This includes withdrawals or liquidations by joint owners other than the A/R, as well as changes in ownership.

- For a revocable trust, the date of disposal is the date that payment to someone other than the grantor was made.
- For an irrevocable trust, the date of disposal is the date that the trust was established or, if later, the date on which payment to the grantor was prohibited.
- For assets made unavailable by placement in an irrevocable trust, which cannot be accessed by the A/R/S under any circumstances, the date of disposal is the date that the assets were placed in the trust.
- When a trust contains conditions that prohibit payment to the A/R, the date of disposal is the effective date of that clause—the date that the trust was established or later.
- When a trust is amended to make the trust's corpus unavailable to the A/R, the date of disposal is the amendment's effective date.
- When a trust is amended to make the income from the trust unavailable to the A/R, the date of disposal is the date that income first accrues to the trust after the amendment's effective date.
- When assets are added to an established trust that is considered unavailable to the A/R, the date of disposal is the date that the assets are placed in the trust.

f) Look-Back Date and Look- Back Period

The look-back date is 60 months. An individual's look-back date and period are established based on the effective date of an institutionalized individual's initial (first) approval for Medicaid eligibility in a nursing facility or HCBS 1915(c) waiver. Penalties may not be imposed for transfers that took place prior to the individual's look-back date. An individual's look-back period begins on the individual's look-back date and does not have an end-date. Therefore, all transfers of assets on or after the institutionalized individual's look-back date (i.e., during the individual's look-back period) are reviewed for whether a penalty should be imposed.

The look-back date is 60 months before an institutionalized individual's earliest effective date of MA eligibility in a nursing facility or HCBS 1915(c) waiver. The individual's look-back date does not change once established, regardless of any subsequent institutionalization, eligibility period, or application. If an individual has multiple periods of institutionalization in a NF and/or HCBS 1915(c) waiver, multiple periods of MA eligibility, multiple applications, or multiple transfers between facilities, the look-back date is based on the earliest effective date of the individual's MA eligibility as an institutionalized individual in a nursing facility or HCBS 19l5(c) waiver.

800.18 Life Estate as a Disposal

A life estate is an ownership interest in real property. A life estate is established when the owner of real property (the "grantor') deeds, grants, or otherwise transfers ownership of the property to

another entity (the "remainderman"). The grantor conveys the property on the condition that the grantor or other specified "life tenant" retains certain ownership rights to that property (a "life estate interest") for the rest of the individual's lifetime. Upon the life tenant's death, the property's ownership passes directly to the remainderman without going through probate procedures.

(a) Life Estate Without Powers

If an A/R/S establishes a life estate without powers, the life tenant does not have the power to sell or transfer the property included in the life estate (e.g., home property), unless specifically noted in the deed. A life tenant does, however, have the right to live in the property and otherwise use it in any way that might be beneficial, unless a restriction is stated in the deed.

A life estate is countable as the life tenant's resource according to the property's availability. Life estates with non-home property or with income-producing home property are countable as a resource for the life tenant according to the current FMV of the life estate interest (not the full value of the assets included in the life estate). The countable amount is calculated by multiplying the property's current equity value (FMV minus any encumbrances) by the life estate interest factor for the life tenant's age in Schedule MA-7. Since most life estates without powers or with limited powers that include residential, non-income producing, non-rental property are not marketable in Maryland, such a life estate interest is considered a countable resource, but with a FMV of $0.

Because the grantor/life tenant may not sell the assets included in a life estate without powers, the grantor is considered to have made a disposal for less than FMV by placing property in a life estate. Therefore, a penalty is imposed for the remainderman's share of the property's FMV, if an institutionalized A/R/S or the A/R's spouse established a life estate on or after the A/R's applicable look-back date. The remainder interest is determined and a penalty period is calculated for the A/R/S as follows:

1. Multiply the asset's equity value (FMV minus any encumbrances) as of the transfer date by the applicable remainder interest factor from Schedule MA-7. This gives the dollar value of the remainder interest that was transferred to the remainderman.
2. Divide the remainder interest's value by the monthly amount in Schedule MA-6. This gives the number of penalty months.
3. Divide the remaining amount by the daily amount in Schedule MA-6. This gives the number of penalized days during the final partial month.

Example:

Ms. Corddry placed her home property in a life estate without powers in April 2012. She was admitted to a nursing facility in July 2012. The property's FMV was appraised as $150,000 and Ms. Corddry was 82 years old when the life estate was created. Because the home property was transferred to a life estate without powers that is unavailable to
Ms.Corddry, the home property is countable as a resource with a FMV of $0. Ms. Corddry is determined to be MA eligible for coverage group L98 effective July 1, 2012.
However, since the life estate was created after the look-back date, a penalty period is imposed during which Ms. Corddry is eligible for MA but is not covered for her nursing facility services. Based on Schedule MA-7, the remainder interest in the life estate (the value of the property considered to have been transferred for less than FMV) is calculated as:

STEP 1: $150,000 x .59705 =$89,557.
STEP 2: $89,557 ÷ $6,800 = 13 months of penalty.
STEP 3: $6,800 x 13 = $88,400
STEP 4: $89,557 - $88,400 =$1,157
STEP 5: $1,157 ÷ $223 = 5 days of penalty in the last partial month.

A penalty period of 13 months and 5 days begins on July 1, 2012. Ms. Corddry is excluded from MA coverage of her nursing facility services until July 6, 2013.

MMIS recipient screen 1 reflects Ms. Corddry's eligibility in coverage group L98 beginning July 1, 2012. A span may not be loaded to MMIS recipient screen 4 for coverage of nursing facility services until July 6, 2013. The eligibility CM must indicate, through a DESILTC 813 faxed to DHMH, if necessary, that a span must not be opened on MMIS recipient screen 4 for coverage of nursing facility services or on screen 8 for HCB waiver services.

(b) Life Estate with Full or Partial Powers

If the owner of a life estate retains full or partial powers to sell or transfer the assets included in the life estate ("life estate with powers"), the assets are considered available to the life tenant. The remainderman might be left with nothing upon the life tenant's death. Therefore, the deed establishing a life estate with full or partial powers is not considered a transfer of ownership. Because of that, the full current equity value of the resources included in a life estate with full or partial powers (not just the life estate interest) is countable as a resource in a MA financial eligibility determination for the life tenant, including any home property that is part of the life estate. (If the home property was not in a life estate and the institutionalized individual intended to return home, the home would not be countable as a resource.)

The establishment of a life estate with full or partial powers is penalized, even though the resources are countable for financial eligibility. This is because a lien may not be imposed on property included in a life estate, unless the owner voluntarily sells the property before the individual dies. Therefore, if a life estate was established by an institutionalized A/R or the A/R's spouse on or after the applicable look-back date, a penalty period is imposed for the A/R, based on the FMV of the remainder interest (calculated using Schedule MA-7). (See the prior example under the section for "Life Estate without Powers.")

(c) Deficit Reduction Act of 2005 (DRA) - Purchase of Life Estate in Another Individual's Home

For a MA application submitted or redetermination conducted for nursing facility or HCBS waiver services, the eligibility CM evaluates disposals that occurred on or after the A/R's applicable look-back date. If the A/R purchased a life estate interest for the right to live in property that belongs to another individual (e.g., son's or daughter's home), this transaction may be penalized as a disposal for less than FMV.

The transaction is not penalized if:

- The amount paid for the life estate interest did not exceed its FMV at the time of the purchase; and
- The A/R lived in the property as the A/R's home for at least 12 consecutive months, beginning with the date of the life estate's purchase (verified by such means as the A/R's residential address on official documents such as a driver's license or income tax reports). The individual is considered to reside in the property if the individual is away for a brief acute or rehabilitative hospital inpatient stay, on vacation, etc., but not if the individual is institutionalized in a long-term care facility.

Otherwise, if both of these conditions are not met, a penalty period is imposed for the institutionalized A/R.

- If the A/R did not live in the property for the full 12 months as required, a penalty is imposed based on the full amount of the life estate's purchase price, rather than just the remainder interest. The amount penalized should not be reduced or prorated based on how long the individual lived in the property. The penalty is imposed even if the individual intended to live in the home for at least 12 months, but could not meet this commitment, such as because the individual died or was institutionalized after an acute hospital stay.

Even if the A/R lived in the property for the required 12 months, a penalty is imposed if the individual paid more for the life estate interest than its fair market

- value (i.e., the FMV of the life estate interest for the portion of the property in which the individual lives, such as one-fourth of the property). A penalty is imposed based on the difference between what the individual paid and the FMV of the life estate interest. The FMV is calculated using the life estate interest factor in Schedule MA-7 for the individual's age at the time of the transaction.

800.19 Promissory Notes, Loans, or Mortgage as a Disposal

FAC

All loans are excluded for FAC when the A/R is the lender in a promissory note, loan, or mortgage.

ABD

When a promissory note, loan or mortgage for which the A/R/S is a lender is considered for the A/R/S's financial eligibility, the CM must determine whether payments of the principal received by the A/R/S are available and therefore are countable as a resource for determining financial eligibility. Payments of interest received by the A/R/S for the loan are countable as the A/R/S's income upon receipt. If the A/R/S has not received FMV for the loaned money (e.g., the borrower has made no payments and there is no written agreement for repayment), the loan transaction may be penalized as a disposal for less than FMV. An oral agreement may be restated or ratified at a later date in written form.

Federal Deficit Reduction Act of 2005 (DRA)

For a Medicaid application submitted or redetermination conducted for nursing facility or HCBS waiver services, the CM evaluates disposals that occurred on or after the A/R's applicable look-back date. If the A/R/S was the lender for a promissory note, loan or mortgage established on or after April 1, 2006, these funds are considered a disposal for less than FMV and a penalty is imposed. However, the transaction is not penalized if the repayment terms in the written agreement signed and dated by both the lender (A/R/S) and the borrower meet **all** of the following requirements, and payments are made according to the written terms (an oral agreement, or a written agreement that was not signed by both the lender and the borrower may be restated or ratified at a later date in written form):

- Are actuarially sound, in accordance with the A/R's life expectancy determined using Schedule MA 9-A "Period of Life Table;"
- Are legally binding;
- Prohibit cancellation of the remaining debt upon the lender's death; and
- Provide for payments to be made to the lender (A/R):
    - In equal amounts during the loan's term;

- With no deferral of payments; and
- With no balloon-payments (i.e., minimal payments during most of the loan's term, with the remaining amount paid in a lump sum at the end of the term).

If the A/R/S makes a loan that does not have all of these repayment terms, the loan is considered a disposal for less than FMV unless the loan is restated or ratified in a written agreement signed by both the A/R/S (or legal representative of A/R/S) and the borrower with all the repayment terms referenced above. A penalty period must be calculated based on the outstanding balance due on the loan as of the institutionalized individual's month of MA application for nursing facility or HCBS 1915(c) waiver coverage.

(a) Jointly Owned Assets

An asset is considered as a disposal for less than FMV by the individual when any action is taken, by the individual or any other person, which reduces or eliminates the individual's ownership interest, access, or control of the asset. This includes assets held by an individual in common with another individual(s) in a joint tenancy, tenancy in common, joint ownership, or a similar arrangement.

Merely placing another person's name as a joint owner on an account or other asset may not constitute a transfer of assets. If the individual's ownership rights and access to and control of the account or asset are not changed and, thus, the individual still has the right to withdraw all of the funds in the account or access all of the asset's worth at any time, the asset is still considered to belong to the individual.

Example:
The other person's name may be put on the account as the individual's legal guardian, in order to be able to access the funds on the individual's behalf if the individual becomes incapacitated. If, on the other hand, another person may now remove the funds or property from the individual's control, such as by withdrawing funds from the account, this situation would be considered a transfer of assets to be penalized. Also, if placing another person's name on the account or asset actually limits the individual's right to sell or otherwise dispose of the assets (e.g., the other person must now agree to the sale or disposal of the asset), the addition of an owner constitutes a transfer of assets.

If, during an A/R's applicable look-back period, a co-owner withdraws or sells funds from an account or other resource jointly owned with the A/R, this disposal must be evaluated for a penalty. If the A/R cannot demonstrate the co-owner's ownership interest in the amount disposed (e.g., that the money is actually the co-owner's money rather than the A/R's), the withdrawal/sale is considered a disposal subject to penalty for the A/R. Also, a withdrawal/sale by a co-owner in excess of that person's verified ownership

interest IS considered a disposal subject to penalty for the A/R, based on the excess amount.

The CM must review all withdrawals or other disposals of resources for which there is joint ownership with the A/R. If the timing and amount of the disposal is such that a penalty may be necessary, the CM must determine what portion of the jointly held asset is presumed to belong to the A/R and verify the details of the transaction, such as: who made the disposal, for how much, on what date, for what purpose, and how the funds were actually used. The co-owners must be provided with the opportunity to rebut the presumption of ownership. If it is demonstrated that the funds in question were the sole property of the co-owner, the withdrawal or other change in the assets should not result in a penalty for the A/R.

(b) Transfer of Income

Income, in addition to resources, is considered to be an asset when transfers and trusts are evaluated for penalty. Thus, if an individual's income is given away or assigned in some manner to another person, is diverted or refused, or if the individual fails to take the necessary action to obtain income to which the individual is entitled, this may be considered a disposal of assets for less than FMV.

The CM must determine whether regularly received income or a lump sum payment, which the A/R/S would otherwise have received, was disposed for less than FMV. Normally, such a disposal takes the form of a transfer of the right to receive income (e.g., a private pension may be diverted to a trust, and no longer paid to the A/R/S). If income or the right to receive income is transferred, a penalty must be imposed for that disposal. The following methods are used to determine the length of the penalty period:

- If a lump sum payment is transferred (e.g., the money is given to another person in the same month that the income is received), the penalty period is prorated based on the amount of the lump sum payment.
- If regularly received income is transferred, the CM calculates the total amount that would have been received during the individual's lifetime, based on an actuarial projection of the individual's life expectancy using Schedule MA 9-A "Period Life Table." The penalty is calculated based on the projected total income transferred.

(c) Trust as a Disposal

When a countable asset is placed in a trust, this transaction is usually considered a disposal, because the grantor generally gives up ownership of the asset to the trust.

- If the individual does not receive FMV for the disposal, a penalty may be imposed.
- If the trust is revocable or if payment can be made to the grantor under any circumstances, from all or a portion of the trust, the available portion of the trust is countable as a resource for the MA financial eligibility determination, and is not penalized as a disposal.

The following transactions involving a trust or portion of a trust are considered a disposal of assets for less than FMV:

- If any payments are made from the trust's corpus or trust's income to, or for the benefit of, someone other than the A/R/S (grantor) who established the trust (see COMAR l0.09.24.08-2B(4)(c) and (5)(a)(ii)).
  - The date of disposal is the date of the payments.
  - The value of the disposal is the amount of the payments.
- If a trust is established or the trust's terms are changed so that funds cannot be disbursed from all or a portion of the trust's corpus or trust's income, under any circumstances, to, or for the benefit of, the A/R/S (grantor) who established the trust (see COMAR 10.09.24.08-2B(5)(b)).
  - The date of disposal is the date that the trust was established or, if later, the date on which payment to the grantor was prohibited.
  - The value of the disposal is based on the trust's value as of the date of the trust's establishment or the date that payments are prohibited, including the amount of any payments made, for whatever purpose, from that portion of the trust on or after that date.
  - If the trustee or grantor adds funds to the trust's unavailable portion after these dates, this transaction is considered a new disposal; the date of disposal is considered the date that the funds were added.

When determining whether payments can be made to the grantor from a trust, the CM must take into account any restrictions on payments that are included in the trust document's written terms, such as a clause placing use restrictions, permitting specified actions, or placing limits on the trustee's discretion.

Example:

- If a trust provides that the trustee can disburse only $1,000 to, or on behalf of, the individual out of a $20,000 trust, only that amount is treated as available. Therefore, the available $1,000 portion of the trust is considered a countable resource, and the unavailable $19,000 portion is penalized as a disposal.
- If payments may be made from the trust under certain specified conditions (e.g., for certain non-medical expenses, at a specified date in the distant future), the entire trust is considered to be available and countable as a resource, and is not subject to penalty.

If an excluded asset (either income or a resource) is transferred into a trust, this transfer is not penalized. The excluded nature of the asset does not change, unless the asset becomes available and countable when it is placed in the trust. An exception to this is an institutionalized individual's home. Placing the home in a trust is a penalized transaction because the Department cannot place a lien on property held in a trust.

(d) Exclusion of Long-Term Care Coverage During a Penalty Period

If an institutionalized individual applies and is determined eligible for MA coverage of long-term care services in a nursing facility or HCBS 1915(c) waiver, the CM must perform a look-back for disposals. If an asset was disposed for less than FMV on or after the recipient's applicable look-back date, the CM must determine whether to impose a penalty period. If a penalty period is established that has already expired, MA will not pay for service dates during the penalty period for:

- services in a nursing facility or a medical institution with a level of care equivalent to a nursing facility; or
- HCBS 1915(c) waiver services.

The individual is still determined MA eligible in the appropriate coverage group, and is covered for all Medicaid State Plan services except for nursing facility or equivalent institutional services and for HCBS 1915(c) waiver services. Therefore, the recipient must have an open span on MMIS recipient screen 1 for MA eligibility in the appropriate coverage group, but may not have an open span on either MMIS recipient screen 4 for coverage of nursing facility services or screen 8 for coverage of HCBS 1915 (c) waiver services. The CM must review MMIS recipient screen 1 and either screen 4 or 8, to assure that the information is correct on MMIS. If MMIS is incorrect, the CM must send a DES/LTC 813 form with the necessary changes to the DHMH Division of Recipient Eligibility Programs (DREP).

For long-term care or waiver applications, there is no deduction from a recipient's available income for the cost of care for non-covered services received during a penalty period.

(e) Uncompensated Value of a Disposal

To compute the length of a penalty period, the CM must first determine the uncompensated value of the disposal, calculated based on the asset's FMV as of the transfer date. The uncompensated value is calculated as follows:

- Determine the A/R/S's equity interest in the asset. Subtract the amount of any encumbrances on the asset from the FMV of the A/R/S's ownership interest in the asset at the time of the transfer.

  (FMV of the A/R/S’s ownership interest - encumbrances = A/R/S’s equity interest)

- Then, calculate the uncompensated value. Subtract from the A/R/S’s equity interest the amount of any valuable consideration received by the A/R/S in

compensation for the transfer or disposal. Any difference greater than $0 is the uncompensated value, which is used to compute the A/R's penalty period.

(A/R/S's equity interest - value received = uncompensated value)

"Valuable consideration" means that an individual receives in exchange for his/her right or interest in an asset some act, object, service, or other benefit that has a tangible and/or intrinsic value to the individual that is roughly equivalent to or greater than the value of the transferred asset. A transfer made for "love and consideration," for example, is considered a transfer for less than FMV.

While relatives may legitimately be paid for care they provide a family member, an agreement for compensation cannot be made retroactively after the care has been provided. Oral agreements for compensation/payment for services may, however, be restated or ratified at a later date in written form. If services were provided for free when they were rendered, it is presumed that the intent was for the services to be provided without compensation. Thus, a transfer to a relative for care provided for free in the past is considered a transfer of assets for less than FMV. The only exception is if the A/R/S can document that a bona fide agreement for payment was entered into prior to receipt of the care, which was not satisfied until the transfer. If tangible evidence of such an agreement for payment is presented (e.g. affidavit(s), restatement or ratification of an oral agreement in written form or other documentary evidence, there must also be documentation of why the compensation was not paid at the time services were rendered, and was not paid until the transfer in question.

The A/R or representative must provide the CM with **all** of the following documentation of a disposal:

- date of disposal;
- who transferred the asset;
- to whom the asset was transferred;
- description of the resource or income transferred;
- asset's fair market value at the time of disposal;
- information about the A/R/S's ownership interest in the asset;
- information about any encumbrances on the asset;
- amount and nature of compensation received; and
- reason for the disposal.

The CM determines the asset's FMV at the time of disposal by documentation presented by the A/R or representative (e.g., bank statements, property tax assessments, professional appraisals) or by other reliable means. The value of compensation received is determined by documented receipts, bills of sale, written purchase agreements or statements, or other reliable means that establish, by a preponderance of the evidence, the amount of compensation, if any, that the A/R/S received for the asset. Compensation received by the A/R/S is considered to be the total amount paid for the asset.

When a penalty is imposed due to placing assets in a trust, the CM determines the value of the portion of the trust which cannot be paid to the individual (i.e., the amount considered disposed). Do not subtract from the value of the trust any payments made, for whatever purpose, after the later of: the date the trust was established or the date that payment to the individual is prohibited. However, if funds were added to that portion of the trust after these dates, those funds are considered a new transfer for less than FMV. Thus, when penalizing portions of a trust that cannot be paid to an individual, the value of the transfer amount is no less than its value on the date of the trust's establishment or the date that payment was prohibited, and may be greater if funds were added to the trust after that date.

When an excluded asset (income and resource) other than the home is placed in a trust, it remains excludable. However, placement of home property in a trust results in the home's becoming a countable resource, since it prevents a lien from being imposed.

800.20 Basic Principles of a Penalty Period

Penalties must adhere to all of the following basic principles:

- The penalty is only applied to MA coverage of certain services for an institutionalized individual who is determined eligible for long-term care or waiver-nursing facility services, institutional services with a level of care equivalent to nursing facility, and services under an HCBS 1915(c) waiver. Since the penalty does not impact MA eligibility, the individual is still determined eligible in the appropriate community or long term care coverage group, and is covered for all other MA State Plan services (e.g., hospital, physician, pharmacy).
- The total, uncompensated value of all of the asset(s) transferred for less than FMV, and not previously penalized, is used to determine the length of the penalty period.
- If multiple disposals are being penalized in the same penalty period, the penalty period must begin on the start date that would apply to the earliest disposal.
- Penalty periods may not overlap, and may not run concurrently in any way.
- Once a penalty period for an eligible recipient is instituted for non-coverage of nursing facility or HCBS 1915(c) waiver services, the period continues until its completion. The penalty period may not start and then stop and resume at a later time. The period is not interrupted, temporarily suspended, or adjusted (i.e., not shortened or lengthened) for reasons such as a subsequent termination of eligibility, discharge from the nursing facility, disenrollment from a waiver, or additional disposals subject to penalty.
- A new penalty period may not begin while a previous penalty period is in effect, but must be delayed to begin on the date immediately after the previous penalty period ends.
- Timely written notice of adverse action (issued at least 10 days before the adverse action takes effect) must be sent to the recipient and any representative (and to any nursing facility provider) before a penalty period may be imposed, if a penalty period begins after the effective date of MA eligibility. An applicant is informed of the penalty as part of the notice approving eligibility.

- The date that the CM discovers a disposal does not impact the beginning date of a penalty period. When the disposal is reported or discovered, the state may institute recoveries of MA expenditure, if MA has already paid for services that should have been subjected to penalty. The case should be reported for recovery of the incorrect payment of benefits, in accordance with Section 1500 of this manual.

(a) Length of Penalty Period

The CM will need the DES/LTC 811, Transfer/Disposal of Assets Worksheet, and Schedule MA-6 (which list the current average rates) in order to calculate a penalty correctly. The completed DES/LTC 811 must be maintained in the case record.

A full calendar month of penalty is imposed when the uncompensated value of disposals is greater than or equal to the average monthly amount payable for care in a nursing facility as listed on Schedule MA-6. The number of days in the actual calendar month is not considered (28 -31 days).

There is no rounding up or down when the length of a penalty period is calculated. The penalty period is calculated in whole months or days, not with decimals or fractions.

Example:
If a penalty of 3.24 days or 3.89 days is calculated, the penalty is 3 days.

There is no maximum length for a penalty period. The minimum unit for a penalty is a day. The average daily amount payable for care in a nursing facility is listed on Schedule MA-6. For an uncompensated disposal amount that is less than the average monthly amount, a penalty period is calculated in terms of days. Any remaining amount less than the average daily amount is not penalized.

Note: Please refer to Schedule MA-6 for the current average monthly and daily amount payable for care in a nursing facility.

To compute the length of a penalty period:

1. Add the uncompensated value of all assets disposed by, or on behalf of, the individual or the individual's spouse on or after the applicable look-back date that have not yet been penalized. If there are a series of transfers, the penalty period is calculated based on the total uncompensated value of all the assets transferred, even if each transfer is less than the average monthly amount payable for care in a nursing facility. (See Schedule MA-6).

2. Divide the total, cumulative uncompensated value by the amount in Schedule MA-6. The unrounded result equals the number of full calendar months in the penalty period.

3. Divide by the average daily amount any remainder from #2 that is less than the monthly figure in Schedule MA-6. The unrounded result equals the number of

days of non-coverage in the final partial month of the penalty period. Disregard any remainder less than the average daily amount..

Example:

An applicant has a series of transfers during the look-back period before the month of Medicaid application: $8,000, $200, and $4,200. The total uncompensated value is $12,400. The penalty period is calculated as follows:

STEP 1: $12,400 ÷$6,800 (the average monthly payable amount) =1 months.
STEP 2: $6,800 x 1= $6,800
STEP 3: $12,400 - $6,800 = $5,600
STEP 4: $5,600 ÷ $223 (average daily amount) =25 days

The penalty period is 1 months and 25 days.

Since the penalty is based on the average monthly or daily amounts found in Schedule MA-6, the penalty period is not changed if the individual's actual nursing facility or waiver costs during the penalty period are less than or greater than those amounts. Payments to a LTCF or for the A/R/S's other expenses during a penalty period reduce or exhaust the penalty period for a transferred asset, if the payments come from funds that were returned to the A/R/S by or on behalf of the person who received the transferred funds, or are made directly to the facility/company/provider by or on behalf the recipient of the transferred funds. See Section 800.24 "When Gifted Resources Are Returned."

When a penalty is imposed for a partial month, the recipient's available income must be applied to the cost of care for the portion of the month not under penalty that Medicaid covers.

If the institutionalized individual who is penalized has a spouse who is also institutionalized and determined eligible for nursing facility or HCBS 1915(c) waiver services during the penalty period, the CM apportions the penalty period between them.

When a penalty has been calculated and imposed the CM must forward the DES/LTC 813 to the Division of Recipient Eligibility Programs (DREP). DREP voids MMIS screen 4 (LTC) or screen 8 (waivers) to prevent payment to the LTCF, or for waiver services. The individual remains eligible for Medicaid services as indicated on MMIS screen 1.

Example 1:
Mrs. Swift is determined eligible for Medicaid coverage of nursing facility services effective December 12, 2011, and her eligibility in coverage group L98 is approved to begin December 1, 2011. As of December 1, 2011, however, her husband is institutionalized in a nursing facility with a penalty period scheduled to end in six months. Therefore, the unexpired penalty period is divided between them, so they each have a three-month penalty period scheduled to end March 1, 2012. Both Mr. and Mrs. Swift should be eligible in coverage group L98 on MMIS recipient screen 1 for all Medicaid State Plan services, except nursing facility. A long-term care span on

MMIS recipient screen 4 should not be opened for either of them until March 1, 2012, which is when the penalty is scheduled to end and Medicaid payment may begin for their nursing facility. The CM must send a DES/LTC 813 to ensure MMIS recipient screen 4 is closed and they do not have eligibility spans for the penalty period. The CM should check MMIS recipient screens 1 and 4 to assure that this information is correctly transmitted and, if not, take appropriate action

Example 2:
Mr. Fox is determined eligible for Medicaid Coverage of nursing facility services effective February 3, 2012, and his eligibility in coverage group L98 is approved to begin February 1, 2012. His wife died in a nursing facility in December 2011. She had an unexpired penalty period for disposal of assets that is scheduled to end June 1, 2012. Since her penalty period has not expired when Mr. Fox is determined eligible in a nursing facility, her penalty period is now applied to his coverage of nursing facility services.

Therefore, Mr. Fox should be eligible effective February 1, 2012 in coverage group L98 on MMIS recipient screen 1 for coverage of all Medicaid State Plan services, except nursing facility. The CM must send a DES/LTC 813 to ensure that MMIS recipient screen 4 is closed during the client's penalty period. A long-term care span on MMIS recipient screen 4 should not be opened for him until June 1, 2012, which is when the penalty is scheduled to end and Medicaid payment may begin for his nursing facility services. The CM should check MMIS recipient screens 1 and 4 to assure that this information is correctly transmitted and, if not, take appropriate action.

Penalty Period for Multiple Transfers

The penalty period is based on the total, cumulative, uncompensated value of the assets disposed on or after the applicable look-back date, that have not yet been penalized, beginning on the earliest date applicable to any of the disposals. If more than one disposal occurred, a single, continuous penalty period is calculated using the total uncompensated value of the multiple disposals.

Penalty periods may not overlap or run concurrently. Therefore, if assets are transferred or are evaluated by the eligibility CM at different times, use the following methods for calculating the penalty periods:

- Multiple transfers with penalty periods that would overlap - If assets are transferred in amounts and/or frequency that would make the calculated penalty periods overlap, add together the uncompensated value of all the assets transferred. Calculate a single penalty period, which begins on the earliest date that would apply to any of these disposals.

Example:
Miss White is approved for MA eligibility in a nursing facility. She has one penalty period that would begin on December 1, 2011 and last for four months. She has another penalty period that would overlap and begin on January 1, 2012, lasting for two months. Therefore, a combined penalty period is imposed that begins on December 1, 2011 and lasts for six months. MA will cover her nursing facility services beginning on June 1, 2012.

- Multiple transfers with penalty periods that would not overlap - If multiple transfers are made in such a way that the penalty periods for each would not overlap, treat each transfer as a separate event, with its own penalty period.

  Example:
  Mr. Long is approved for MA eligibility in a nursing facility. He has one penalty period that would begin on June 1, 2012 and last for 2 months. He has another penalty period that would not overlap because it would begin on September 1, 2012 and last for four months. Therefore, he will not be eligible for MA coverage of nursing facility services in June or July 2012; he will be eligible for NF coverage in August 2012; he will not be covered for September -December 2012; and his NF coverage will resume effective January 1, 2013. The eligibility CM must indicate, through a DES/LTC 813 faxed to DHMH that a span must not be opened on MMIS recipient screen 4 for coverage of nursing facility services.or on screen 8 for HCB waiver services.

- Multiple penalty periods imposed consecutively rather than concurrently - If a penalty period imposed at a previous eligibility determination or redetermination is still in effect when the CM calculates a penalty period for additional transfers, the penalty period for the additional transfers begins on the day immediately after the previous penalty period ends.

  Example:
  Mrs. Little has a penalty period that is scheduled to end March 1, 2012. When her eligibility is redetermined in November 2011, another disposal is discovered for which the penalty period would have begun effective November 1, 2011 and last for four months. Since the previous penalty period has not expired, the new penalty period will begin on March 1, 2012 and last for four months until July 1, 2012 when her coverage will begin for nursing facility services. The CM must indicate, through a DES/LTC 813 faxed to DHMH, that a span must not be opened on MMIS recipient screen 4 for coverage of nursing facility services.

(b) Penalty Begin Date

For assets disposed or trusts established and considered for a Medicaid nursing facility or HCBS waiver application submitted or redetermination conducted, the beginning

date for a penalty period is based on the first day of the month that the institutionalized individual's Medicaid eligibility begins in a nursing facility or a HCBS 1915(c) waiver (i.e., the effective date of Medicaid eligibility). A penalty period begins on the:

- 1st day of the month that Medicaid eligibility takes effect for nursing facility or HCBS waiver services, if the disposal occurred on or before the effective date of Medicaid eligibility; or
- Later of the following dates, if the disposal occurred after the effective date of Medicaid eligibility:
  - 1st day of the month that the disposal occurred; or
  - 1st day of the month after the penalty period would have begun, if more time is needed to provide the required timely notice of adverse action (at least 10 days before the action's effective date); or
- 1st day of the month that the earliest disposal would have begun, if more than one disposal is being penalized in the same penalty period; or
- The day immediately following the end of an earlier penalty period, so that the new penalty period will not begin during the earlier penalty period.

If an institutionalized individual is denied Medicaid eligibility (e.g., due to excess resources, lack of verifications), the look-back period is not established and a penalty period may not begin (assuming that the disposal is still within the look-back period) until the 1st day of the month that nursing facility or HCBS 1915(c) waiver eligibility takes effect, based on a subsequent reapplication or the reactivation of an earlier application.

Example 1:
A recipient made multiple disposals on or after the look-back date, before applying for Medicaid. The uncompensated values are totaled for all of the assets disposed. One penalty period is calculated based on the total amount of the disposals, beginning on the first day of the month of Medicaid eligibility for NF or HCBS 1915(c) waiver services.

Example 2:
A recipient has a penalty period for assets disposed on or after the look-back date. Then, the recipient makes another disposal of assets after the effective month of Medicaid eligibility. Since penalty periods may not overlap, the second penalty period will begin on the day immediately after the first penalty period ends.

(c) Withdrawal of Application

Withdrawal of an application and a subsequent reapplication do not affect the length of the penalty that was calculated based on an earlier application, except that the beginning date of the penalty period may change.

(d) Reasons Not to Penalize Disposals

Under various circumstances, a penalty period is not imposed for a disposal for less than FMV on or after an institutionalized individual's look-back date. A penalty period is not imposed if one of the following circumstances applies to the transfer:

For certain transfers of home property, as described in the section below about "Disposal of Home Property:"

1. If the assets were transferred:
   - to the individual's spouse, or to another entity for the sole benefit of the individual's spouse (see the "Sole Benefit" section that follows); or
   - from the individual's spouse to another entity for the sole benefit of the individual's spouse (see the "Sole Benefit" section that follows); or
   - to the A/R's son or daughter who is blind or disabled; or
   - under certain circumstances, to a trust established for the sole benefit of:
     - the A/R's blind or disabled son or daughter; or
     - a disabled individual who is younger than 65 years old (see the "Sole Benefit" section that follows).

2. If convincing evidence is provided to the CM, consisting of testimony or other corroborative evidence that the individual intended to dispose of the assets for fair market value or for other valuable consideration. The A/R must establish, to the satisfaction of the CM, that the individual intended to transfer the asset for FMV. Verbal statements alone are, generally, not sufficient. Instead, the individual should be required to provide written evidence of attempts to dispose of the asset for FMV, as well as evidence to support the value (if any) at which the asset was disposed.

3. If convincing evidence is provided to the CM, consisting of testimony or other corroborative evidence that the assets were transferred exclusively for a purpose other than to qualify for Medicaid. (See the section below about "Presumption of Reason for Disposal.") The A/R/S must establish that the asset was transferred for a purpose other than to qualify for Medicaid. Written evidence must be presented to substantiate the specific purpose for which the asset was transferred such as bills, written agreements, oral agreements restated or ratified in written form at a later date, or affidavits. Sometimes, an individual may argue that the asset was not transferred to obtain Medicaid because the individual was already eligible for Medicaid. While that may be true, the asset in question (e.g., a home) might have been counted as a resource or had a lien placed on it in the future. Also, the asset could have been sold to pay for the individual's cost of care. In such a situation, the argument that the individual was already Medicaid eligible is not accepted.

2. If the full value of the transferred assets is returned to the individual (see the section below about "Assets Returned").

3. If the individual receives FMV for the resource, the penalty period ends the month that the individual receives FMV for the resource that was transferred. This refers

only to outright payment for the resource. The compensation must then be evaluated as a resource effective the month that it is received, and the individual's resource eligibility must be redetermined on that basis. The A/R is ineligible for each month that the individual's total countable resources exceed the resource standard as of the first day of the month.

4. If an undue hardship waiver is approved by the DHMH Division of Eligibility Policy (see the section below about "Undue Hardship Waiver").

(e) Disposal of Home Property

With certain exceptions and qualifications, the transfer of assets provision also applies to the transfer of home property in which the NR or spouse has an ownership interest and where the A/R lived before institutionalization. The "home property" of an institutionalized individual means property that met the definition of "home" at the time of its transfer. Transfer of the home property may be penalized; even if the transfer was not made for the purpose of establishing or continuing Medicaid eligibility, and regardless of whether the property is excludable as a countable resource. This is because transfer of the home property interferes with the Department's ability to implement the lien provision for property owned by a recipient residing in a nursing facility. Also, a lien may not be imposed for property owned by a community resident, such as a waiver enrollee.

Transfer of home property for less than FMV on or after the institutionalized individual's applicable look-back date will not be penalized if title to the home was transferred to the individual's:

- Spouse; or
- Brother or sister who:
  - has equity interest in the home, and
  - resided in the home for at least 12 consecutive months immediately before the date the individual became institutionalized or was enrolled in an HCBS waiver; or
- Natural or adoptive son or daughter younger than 21 years old; or
- Natural or adoptive son or daughter of any age who is determined by the Social Security Administration or the State to be blind or disabled; or
- Natural or adoptive son or daughter who:
  - resided in the home for at least 24 consecutive months immediately before the date the individual became institutionalized or was enrolled in an HCBS waiver; and
  - has verified, to the satisfaction of DHMH, that he/she provided or paid for the care which enabled the institutionalized parent to reside at home rather than in a nursing facility or community-based facility (e.g., assisted living facility) (see the section below about "Verification That Parental Care Was Provided").

800.21 Verification That Parental Care Was Provided

If an adult son or daughter claims that he/she provided care for at least 24 consecutive months immediately prior to the parent's institutionalization that enabled the parent to remain at home rather than in a nursing facility or community-based facility (e.g., assisted living facility), the son or daughter must provide the eligibility CM with documentation to support that claim. The LDSS or other entity determining eligibility must then forward the documentation to:

Department of Health and Mental Hygiene
Division of Eligibility Policy
201 West Preston Street, Rm. SS-I0
Baltimore, MD 21201

The Division of Eligibility Policy will determine whether the evidence submitted fully documents the son's or daughter's claim of providing the necessary care before the parent's institutionalization. The required verification includes the following:

- Utility bills, automobile registration, or other documents containing the son's or daughter's name and address (one document dated 24 months and another dated one month prior to the parent's institutionalization), to verify that the son or daughter resided in the home during that entire period; and
- Written verification from the parent's attending physician, stating that the parent's medical and physical condition was such that he/she needed long-term care (i.e., nursing facility or higher level of care) during the entire 24-month period; and
- A statement from the son or daughter that he/she:
    - Provided the needed care that delayed the parent's institutionalization (e.g., quit a job to care for the parent, and has a letter from the former employer to document the voluntary resignation); or
    - Paid for the parent's care while the son or daughter was at work by:
        - Hiring a nurse to care for the parent (must be verified by the nurse or by the agency through which the nurse was employed); or
        - Hiring a home health aide to care for the parent (must be verified by the agency through which the aide was employed); or
        - Placing the parent in a medical day care center (must be verified by the medical day care center).

800.22 Sole Benefit

A transfer or trust is considered to be for the sole benefit of the A/R's spouse, the A/R's blind or disabled son or daughter, or a disabled individual under age 65 if the transfer is arranged in such a way that no individual or entity except the spouse, child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future. A transfer or trust that provides for funds or property to pass to a beneficiary other than the spouse, blind or disabled child, or non-elderly disabled individual is not considered to be established for the sole benefit of one of these individuals.

If it is alleged that an asset was transferred to or for the sole benefit of an individual who is blind or disabled, it must be determined whether the individual meets the federal definition of blindness or disability used by the SSI program. If the individual is receiving SSI or SSDI benefits, or is eligible for Medicaid as a result of blindness or disability, that determination of blindness or disability is accepted as evidence. However, if the individual is not receiving SSI, SSDI, or ABD Medicaid based on blindness or disability, the eligibility CM must refer the individual, to whom the asset was transferred, to the State for a determination of blindness or disability.

When evaluating whether an asset was transferred for the sole benefit of the individual's spouse, blind or disabled child, or a disabled individual, the eligibility CM should ensure that the transfer was accomplished via a written instrument of transfer (e.g., a trust document) which legally binds the parties to a specified course of action, and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer. A transfer without such a document cannot be said to be made for the sole benefit of the spouse, child, or a disabled individual, since there is no way to establish that only the specified individual may benefit from the transfer.

In addition, a written transfer document or trust instrument must provide for the spending of the funds involved for the individual's benefit (i.e., the spouse, child, or disabled individual) on a basis that is actuarially sound based on the individual's life expectancy (see Schedule MA 9-A in this Manual's Appendix). Otherwise, any potential exemption from penalty or consideration for eligibility is void. A trust may be exempted from penalty if the trust instrument specifies that the State will receive the remainder of the trust upon the beneficiary's death, up to the amount of Medicaid payments on the individual's behalf. For this type of trust, it is acceptable to disburse any funds remaining after the State's claim is satisfied to other beneficiaries. Also, "pooled" trusts may provide that the trust can retain a certain percentage of the funds in the trust account when the beneficiary dies.

800.23 Presumption of Reason for Disposal

It is presumed that any disposal for less than FMV was made to establish or continue Medicaid eligibility or to avoid Medicaid's liens or recoveries provisions, unless the A/R/S successfully rebuts this presumption. The A/R/S or representative has the right to rebuttal by furnishing authentic documentary evidence to the CM that the disposal was exclusively for a purpose other than establishing or continuing Medicaid eligibility or avoiding Medicaid's provisions on liens or recoveries. The burden of proof rests with the A/R/S. If the A/R/S or representative wishes to rebut the presumption, the CM must evaluate the evidence presented and determine the intent of the disposal. The evidence must include the following information:

- The A/R's health status at the time of the disposal;
- The A/R's relationship, if any, to the entity receiving the asset;
- The A/R's purpose for disposing of the asset;
- The A/R's reasons for accepting less than FMV; and

- The A/R's means or plans for meeting his/her medical needs and necessities of life (food, clothing, shelter) after disposing of the asset.

The pertinent documentary evidence must be filed in the A/R's case record (e.g., bank records, promissory notes, loan agreements, correspondence, contracts, and income tax forms). The presumption of the reason for disposal is considered successfully rebutted only if the evidence submitted shows that the disposal was exclusively for some other purpose. Although other reasons may be acceptable, the presence of one or more of the following circumstances shall constitute evidence that the disposal was exclusively for a reason other than to qualify for Medicaid, and no penalty will be imposed if assets were transferred for less than fair market value under the following circumstances:

- The traumatic onset of a disability after the disposal (e.g., accident, stroke, heart attack);
- Expenses related to traumatic onset of disability including payments made for family members' travel expenses (whether paid directly by the A/R/S or reimbursed to the family member(s)) to visit the A/R/S, including, but not limited to airfare, train fare, bus fare, gas, mileage reimbursement for wear and tear on automobiles, accommodations and food;
- The unexpected loss of income or resources that would have provided payment for the A/R's medical expenses and needs (e.g., layoff of a nonelderly individual);
- The unexpected loss of health insurance coverage (e.g., employer stopped offering health insurance as a job benefit);
- A natural disaster affecting the A/R or a family member:
- Serious financial hardship of a family member (defined below this list) evidenced by an eviction notice, shut-off notice, foreclosure notice, repossession notice for business or farming equipment, or bankruptcy filing;
- Contribution to household expenses, including, but not limited to, rent, mortgage utilities, cable, home maintenance, transportation and food, evidenced by written agreement or an oral agreement restated or ratified in written form at a later date;
- Charitable contributions up to $200 per donation per organization, or any amount if there is a consistent pattern of giving over several years, to an educational institution, religious institution, or other organization with a benevolent purpose and 501(c)(3) tax exemption status;
- Previous oral agreements (generally among family members) for compensation/payment for services reduced to writing at the time of application;
- Traditional gifts of up to $200 per person per event, or any amount if there is a consistent pattern of giving over several years, to family for weddings, holidays, religious milestones, graduation, birthdays and new births, and other special occasions;
- Payments to help family members or close friends or relatives as defined below pay for documented expenses for education;

- Payments to help family members or close friends or relatives as defined below pay for documented medical expenses; or
- Payments to modify a house for accessibility to enable the A/R/S to live there (including building an addition to the house), provided the A/R/S lives there for any period of time.

This list is intended to be illustrative and does not limit the types of transactions that may be done for a purpose other than to establish Medicaid eligibility.

Family Members or Close Friends or Relatives

A family member includes a spouse, descendant (child or grandchild), stepchild, step grandchild/great grandchild, parent, stepparent, grandparent, step grandparent/great grandparent, brother, sister, niece, nephew, cousin, uncle, or aunt, whether of the whole or half blood or by adoption.

A family member for purposes of allowable transfers can also be a friend or other relative who is a competent individual and who presents an affidavit to the CM that states:

1. That the person is a relative or close friend of the A/R; and
2. Specific facts and circumstances demonstrating that the person has maintained regular contact with the A/R sufficient to be familiar with the A/R's activities, health, and personal beliefs.

800.24 Resources Returned

For the purposes of this section, if a payment is made for the A/R's bills or other expenses directly to the facility/company/provider by or on behalf of the person to whom the A/R/S transferred funds, the total amount of those payments is to be treated as a return in determining the amount that is transferred subject to penalty.

If a gifted asset is returned, or its equivalent is returned, a penalty is not imposed, or a penalty already imposed is voided. When the resource or resources are returned, or the A/R receives the FMV of the resource or resources, the A/R's resource eligibility must be re-evaluated going back to the month of the transfer.
After the resources are re-evaluated, if the A/R is determined ineligible for MA for any month in which the A/R's resources exceeded the standard as of the 1st day of the month, deny those months. If A/R received MA during any ineligible month(s), the CM must refer the A/R to Recoveries. If the A/R is resource eligible for the period under consideration, void the penalty period in MMIS and have the providers re-bill for the eligible period.

Example:
In June 2012, Mrs. Poole removed her name from her savings account with $40,000 in deposits, and transferred ownership to her daughter. In August 2012, Mrs. Poole entered a nursing facility and in September was determined MA eligible in coverage group L98 with a certification period beginning August 1, since the resources were no longer in her name. MA paid claims totaling $650 for pharmacy and physician services that she received in August and September. A penalty period was imposed due to the $40,000 disposal, for when MA will not cover her nursing facility services. The penalty period was calculated as:

Note: See Schedule MA-6 for current monthly and daily amounts

STEP 1: $40,000 ÷ $6,800 = 5 months of penalty
STEP 2: $6,800 x5 = $34,000
STEP 3: $40,000 -$34,000 = $6,000
STEP 4: $6,000 ÷ $223 =26 days

The penalty period was 5 months and 26 days, lasting August 1, 2012 – January 27, 2013.

When Mrs. Poole was informed of the penalty, her daughter transferred ownership of the $40,000 savings account back to Mrs. Poole in October. Mrs. Poole's MA eligibility in coverage group L98 was redetermined beginning with the original application month of August 2012. She was determined ineligible because the $40,000 savings account made her resource overscale. The $650 in incorrectly paid claims was referred for recovery to the DHMH Recoveries Division. In response, Mrs. Poole established a burial fund with a funeral home for $10,000. She sent a check for $650 to DHMH Recoveries. She gave $27,350 to the nursing facility to pay her bills for August through October and to pre-pay for her future services. This left her with $2,000 in her savings account as of November 1. She reapplied for MA in November and was determined eligible in coverage group L98 and was covered for nursing facility services effective November 1.

If part of an asset, or its equivalent value, is returned, a penalty period will be modified but not voided. Subtract the returned portion from the amount of the original transfer and re-calculate the penalty, which will shorten the penalty period. Under this method, the reduction will be effective the month that the asset is returned and will shorten the penalty period by eliminating the penalty beginning with the final month of the original penalty period and working backwards.

Example of partial return:
Original transfer $20,000

20,000 ÷ 6800 = 2 months

2 x 6,800 = 13,600

20,000 - 13,600 = 6,400

6,400 ÷ 223 = 28 days

Original transfer penalty = 2 months and 28 days

Recalculated penalty when $10,000 is returned:

10,000 ÷ 6,800 = 1 month

1 x 6,800 = 6,800

10,000 – 6,800 = 3,200

3,200 ÷ 223 = 14 days

New penalty = 1 month 14 days

A penalty period may not be modified based on payment from the A/R's income of LTC or other expenses incurred by the A/R during a penalty period. Payments to a LTCF or for the A/R/S's other expenses during a penalty period reduce or exhaust the penalty period for a transferred asset if the payments come from funds that were returned to the A/R/S, or are made directly to the facility/company/provider, by or on behalf of the recipient of the transferred funds. See Section 800.20, "Basic Principles of a Penalty Period."

If a life estate is converted back to fee simple ownership, the Medicaid Program may impose a lien, including recovery of any MA expenditures on or after the eligibility effective date. Because a penalty period is imposed due to the creation of the life estate, once that impediment to future recoveries is removed, it is permissible to grant MA coverage back to the effective date of the penalty period, now voided.

800.25 Undue Hardship Waiver of Penalty Period or Trust Provisions

An institutionalized individual who is otherwise subject to a penalty period may have the penalty waived and may be covered by Medicaid for nursing facility or HCBS 1915(c) waiver services if:

- The individual, representative, or nursing facility (if authorized by the individual or representative to act on their behalf):
    - Requests an undue hardship waiver; and
    - Follows the required procedures and provides the necessary information for DHMH to evaluate the request; and
- The DHMH Division of Eligibility Policy approves the waiver request because the documentation demonstrates that the coverage exclusion would cause undue hardship for the institutionalized individual.

Undue hardship exists when imposition of a penalty or application of the trust provisions would result in an undue hardship for the institutionalized individual, because the A/R would be placed at risk of serious deprivation by being deprived of:

- Food, clothing, shelter, or other necessities of life; or
- Medical care such that his/her health or life would be endangered.

When a penalty is imposed for a disposal for less than FMV, the CM must issue an adverse action notice, which must include information about the right to apply for an undue hardship waiver and the process to be followed (see the section about "Adverse Action Notice").

If the A/R is residing in a nursing facility, the provider may file an undue hardship waiver request on the individual's behalf. Before filing the request, the facility must have the consent of the A/R or the A/R's representative, if the nursing facility is not the A/R's representative. In addition to filing a waiver request, the facility may present information on the individual's behalf and may, with the specific written consent of the A/R or the A/R's representative, represent the A/R throughout the appeals process.

The burden of proof for undue hardship lies with the institutionalized individual, representative, or nursing facility acting on the individual's behalf. When requesting a hardship waiver, the A/R, representative, or nursing facility must do more than assert that the institutionalized individual would experience undue hardship if the individual is excluded from Medicaid coverage of nursing facility or HCBS 1915(c) waiver services. They must demonstrate justification, such as the following:

- That now there are no funds available for the institutionalized individual or another source to pay for the institutionalized individual's needed care, and there is no other way to provide for the "endangered" institutionalized individual's medical care and other necessities of life (food, clothing, shelter, etc.);
- Why the person or entity that received the asset is now unable to pay or provide for the institutionalized individual's medical care and other necessities of life; or
- That the individual's health did not indicate a predictable need for long term care services at the time the asset was transferred.

The CM must evaluate whether another source of funding or care is available if the person is denied Medicaid coverage for the nursing facility or HCBS waiver services. Possible sources for the funding or services are the individual's spouse, sons, daughters, and other relatives. The person(s) who received the transferred asset, or who is the beneficiary or trustee of the trust, may be able to return the asset or pay for the needed services. The person(s) responsible for the transfer should attempt to negotiate access to the asset from whoever now possesses the asset in liquid or non-liquid form, or has access to the asset.

If a request with accompanying documentation is received for an undue hardship waiver, the CM should mail a complete recording and documentation of the facts to:

Department of Health and Mental Hygiene
Division of Eligibility Policy
201 West Preston Street, Rm. SS-l0
Baltimore, MD 21201

The CM must submit to the DHMH Division of Eligibility Policy the following facts and verification that are required to determine if the penalty period would cause undue hardship for the institutionalized individual and if the entity which received the transferred asset can arrange to pay or provide for the A/R's care:

- Documentation of the income and resources (excluding qualified retirement accounts) of the person(s) who received the asset(s):
  - A valid copy of the tax return for the preceding calendar year;
  - All earnings pay stubs for the past 12 months; and
  - Verifications of all resources - all bank statements, stocks, bonds, certificates, life insurance policies, etc. Financial records must include those before and after receipt of the transferred asset.
- All documents associated with the proceeds of the transferred asset, which will show the value of any purchase from the sale of the transferred property.
- If applicable, medical or other information about the institutionalized individual's service needs, relevant to the claim of undue hardship.

The DHMH Division of Eligibility Policy may grant an undue hardship waiver for an institutionalized individual who would otherwise be subject to a penalty period, if it is demonstrated that Medicaid's denial of coverage for nursing facility or HCBS 1915(c) waiver services would cause undue hardship for the institutionalized individual.

When evaluating a request for an undue hardship waiver, the Division of Eligibility Policy only considers the potential impact of a penalty period on the institutionalized individual, not if a penalty period would cause hardship for someone other than the A/R (e.g., the community spouse, provider). A hardship waiver is also denied if a penalty period would only cause inconvenience for the institutionalized individual, spouse, and/or family or might restrict their lifestyle or choices, but would not put the A/R at risk of serious deprivation.

Referrals to the DHMH Division of Eligibility Policy should be made only as indicated above. The DHMH Division of Eligibility Policy will evaluate the facts and render a decision as to whether the penalty provisions should apply. The Division will inform the CM of the decision, who will then take the necessary action and inform the A/R and other involved parties (e.g., the A/R's representative, the nursing facility which requested the hardship waiver on the A/R's behalf).

An A/R or representative may appeal through the Fair Hearings procedures the Department's decision to uphold a penalty period. Therefore, if the Department decides to uphold a penalty and deny a hardship waiver, the written adverse action notice from the CM to the A/R, representative, and/or nursing facility provider must also inform them of the policies and procedures for appealing through the Fair Hearings process.